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New York State Department of Health Statewide Steering Committee

May 1, 2017

Agenda

#	Topic	Time	Leader
1	Welcome and Introductions	10:30 - 10:45	Marcus Friedrich Susan Stuard James Kirkwood
2	SIM/APC in the Current Landscape	10:45 - 11:05	Marcus Friedrich Lori Kicinski
3	Scope and Purpose	11:05 -11:30	Susan Stuard
4	Advanced Primary Care (APC) Updates ▪ APC Scorecard ▪ Practice Transformation ▪ ROMC	11:30 - 12:45	Paul Henfield/Anne Schettine Ed McNamara Jill Byron Tom Mahoney Laurel Pickering
	Working Lunch	12:45 -1:00	
5	PCMH 2017 Alignment NYS – NCQA PCMH Program Alignment Strategy	1:00 - 2:15	Marcus Friedrich Susan Stuard
6	Next Steps	2:15 - 2:30	Marcus Friedrich Susan Stuard Jim Kirkwood

Rules of the Road

- Come to the meeting with a positive attitude.
- Treat members with respect.
- Be prompt arriving to the meeting and returning from breaks.
- Turn cell phones off or to vibrate.
- If you must take urgent calls, take your conversation outside.
- Talk one at a time, waiting to be recognized by the Chairpersons.
- Limit side conversations.
- Stay on the topic being discussed.
- Address any concerns about the discussion or the meeting with the Chairpersons.

Goals for Today

1. Review the landscape and tangible process to date
2. Set forth committee's scope and purpose
3. Begin discussion of APC strategic issues

SIM / APC

In the Current Landscape

New York State Health Innovation Plan (SHIP)

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New York State Health Innovation Plan (SHIP)

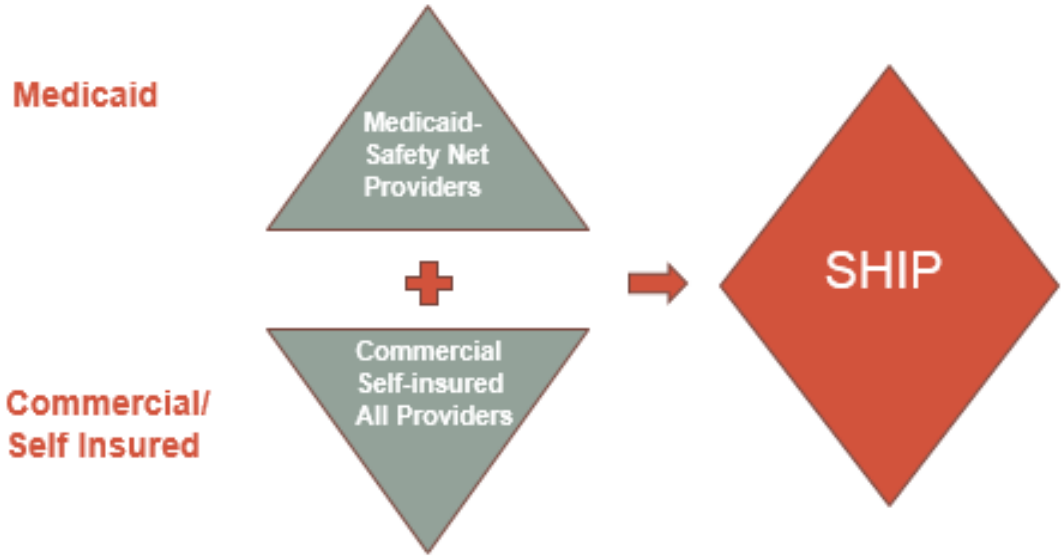
Three Core Objectives :

- 80% of the state's population will receive primary care within an APC setting, with a systematic focus on population health and integrated behavioral health care;

- 80% of the care will be paid for under a value-based financial arrangement; and,

- Consumers will be more engaged in, and able to make more informed choices about their own care, supported by increased cost and quality transparency

New York State Health Innovation Plan (SHIP)



Common Goals:

- Reduce preventable hospitalizations
- Transform provider payments to value based
- Invest in HIT
- Align with prevention agenda
- Promote an evolved workforce

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Our Assumptions

- Improved access to high performing primary care is key to improving value in health care and achieving Triple Aim goals.
- Practices and payers need a compelling clinical and payment model to invest in these changes.
- A practice meeting any ‘standards’ is helpful but not a sufficient guarantee of meaningful practice improvement.
- Transformational changes in practice will remain limited if care is reimbursed on a FFS basis rewarding volume over value/quality.
- Maximize transformation investments by agreeing upon a model/set of milestones for Advanced Primary Care aligned with SHIP goals.

NY State Transformation - Guiding Principles:

- Multi-payer scale and alignment are critical to transformation
- Fundamental change requires consistent focus and support over time, not just a proliferation of innovation
- Transformation requires actionable insights driven by data that are comprehensive, transparent, and relevant
- The public sector at both the State and Federal levels should continue to take an active leadership role, and commit to a step-change improvement in alignment and collaboration

SIM/APC

Where we wanted to go…
Develop an APC model
Integrate Behavioral Health, Population Health
Create a multi-payer approach to reimbursement
Support an evolving primary care workforce that meets future needs of an aging population
Using HIT, data to manage chronic disease and Population health
Decide on Core measures that are meaningful, obtainable, and aligned

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 sickest 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

APC structural milestones

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*
		Prior milestones, plus …	**Prior milestones, plus …**
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	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 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 local and county health collaborative Prevention Agenda activities ii. Annual identification and reach-out to patients due for preventative or chronic care management iii. Process to refer to structured health education programs
Care Management/ 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	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. Certified technology for information exchange available in practice for iii. 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 contracts with APC-participating payers representing 60% of panel	i. Minimum FFS + gainsharing contracts with APC-participating payers representing 60% of panel

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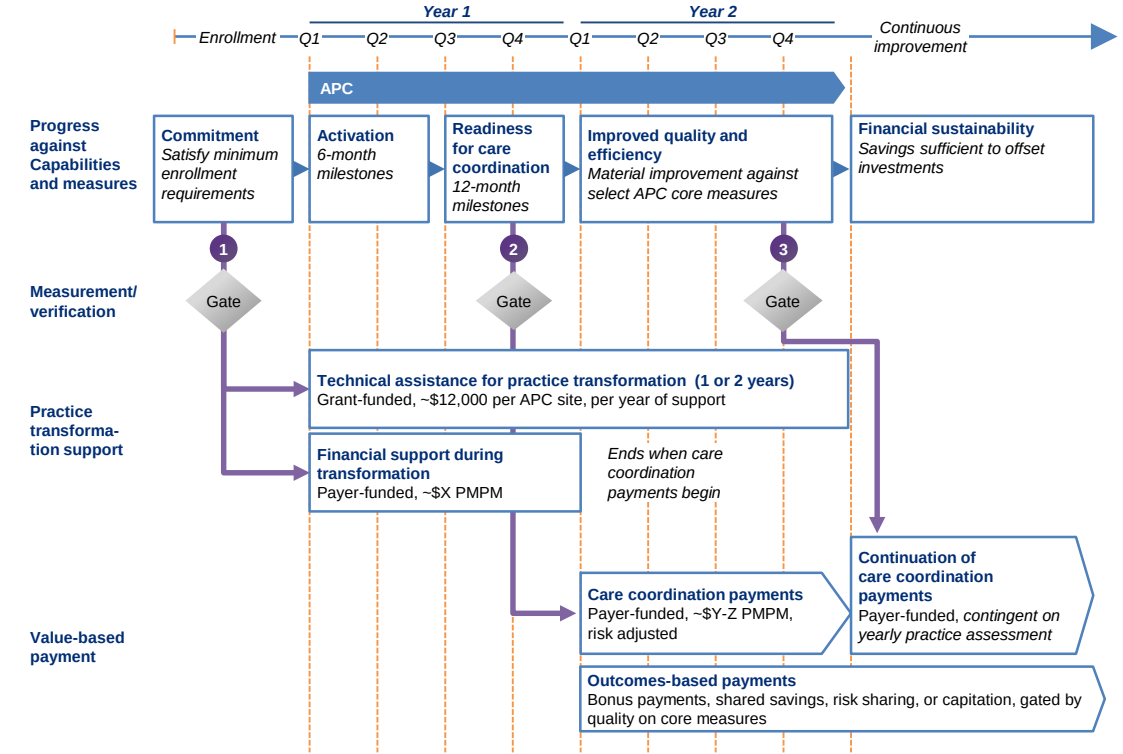
APC VBP Payment Model



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APC measure set– 28 measures, 18 measures in Version 1

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 & Counseling for nutrition/physical activity for kids	
	421/CMS	Claims/EHR	[Combined obesity measure] 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	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	

*Utilization measures to be added in future cycle once modified specifications are developed.

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NY State Practice Transformation Programs: Alignment with SHIP

DSRIP	SIM/APC	TCPI	MACRA	CPC +
Primary care model: PCMH or APC	**Primary care model:** SIM/APC primary care model	**Primary care model:** TCPI transformation program	**Primary care model:** medical home generally	**Primary care model:** CMMI transformation program
VBP: Medicaid VBP roadmap	**VBP:** Commercial payers provide prospective, risk-adjusted PMPM payments	**VBP:** No VBP component	**VBP:** Advanced APM as part of CMS Medicare programs	**VBP:** CMS, payers provide prospective, risk-adjusted PMPM payments

Goals of Alignment

Reduce confusion for providers and payers by:

- leveraging natural alignment
- achieving incremental changes where possible

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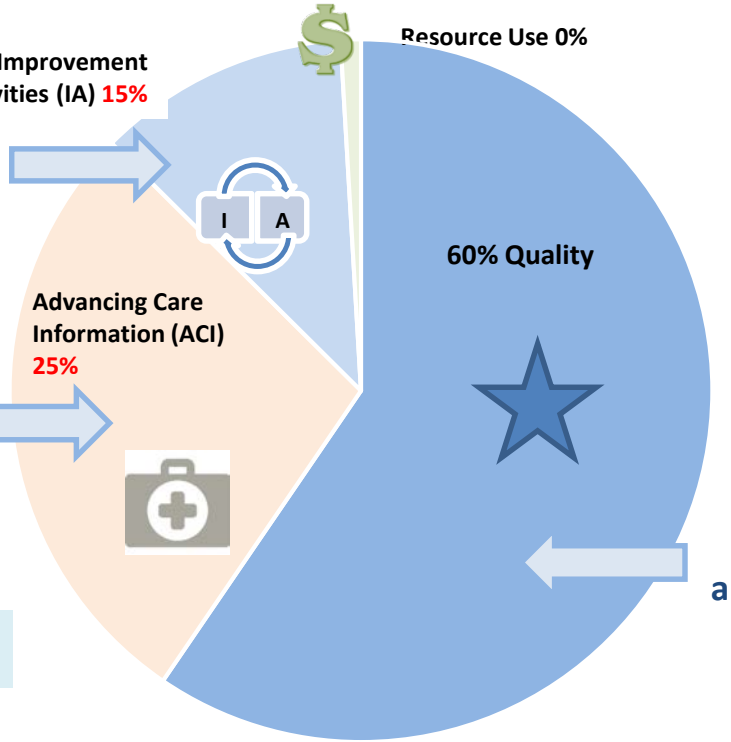
SIM/APC – MACRA Alignment Opportunities

Medicare Access and CHIP Reauthorization Act (MACRA) identifies new ways of paying physicians for caring for Medicare beneficiaries.

- SIM/APC as an option for practices to achieve MIPS goals

Performance Category Weights for MIPS



APC Technical Specifications align with 7 of 9 MIPS sub-categories

APC Milestone-related activities aligns with 12+ ACI reporting

2017 Transitional Year

Practices that participate in APC and receive transformation assistance can expect greater scoring impact in MIPS Performance categories

APC Scorecard aligns with 22 MIPS measures

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APC-Aligned MIPS Quality Payment Program (QPP) Categories

APC-participating practices will qualify for MIPS QPP points:

Quality accounts for **50%** of MIPS score with **80-90** points*

Improvement Activities (IA) account for **15%** of MIPS Final Score with maximum of **60** points**

Measure Categories:

- Preventive
- Chronic Disease
- Behavioral Health
- Patient Reported
- Appropriate Use

22 APC aligned measures

40-60+* points

7 of 9 IA Categories:

- Care Coordination
- Population Health
- Patient Safety & Practice Assessment
- BH and Mental Health
- Beneficiary Engagement
- Achieving Health Equality
- Expanded Practice Access

63 APC criteria align with IA sub-categories

44-60 points**

*Points vary by practice size
**Medium (weighted) points = 10
High (weighted) points = 20

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Roles of Practice Transformation in Aligning MIPS and APC

DOH is engaged in collaborative discussions to create a process to streamline alignment of MIPS during APC practice transformation.

- These tools will:
  - Reflect “timeline” criteria to best prepare practices to achieve maximum goals in both programs
  - Develop appropriate tools and messaging for APC practice transformation agents (PT TA) to assist practices in selecting aligned measures
    and performance activities that will satisfy both programs
  - Provide a continuous lens on MIPS QPP as a gateway to value-based payment opportunities reflective of both public and commercial payer

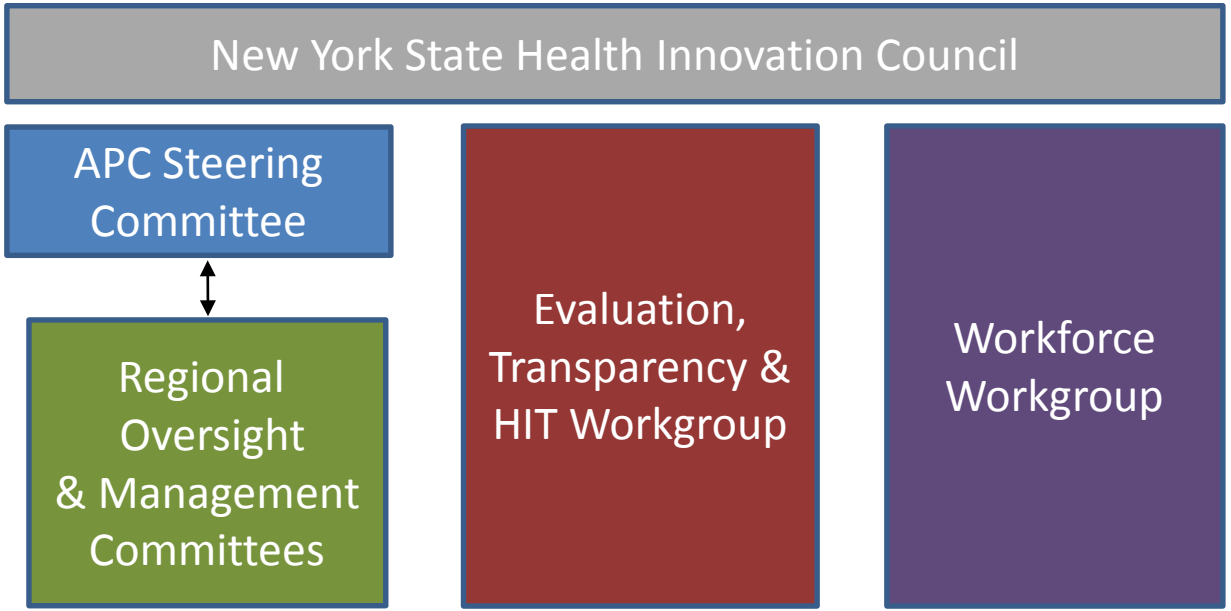
- Next Steps:
  - Engage stakeholders for discussion on best approach to ensure acknowledgement of the APC Model at CMS
  - APC Team will review activities prescribed at Gates 2, 3 to determine that practice capabilities reflect success for MIPS requirements
  - Provide timely awareness, education, and tools to APC PT TA’s

Scope and Purpose

Integrated Care Workgroup transition: Governance Structure

Movement from:		To:
Development	→	Implementation
Gathering Input	→	Solving Problems
Statewide Only	→	State Steering and Regional Committees

Governance Structure



Statewide APC Steering Committee: Scope and Purpose

1. **Support APC Goals**
   Support the core goals of the APC model and evolve it as necessary to ensure long-term success.
2. **Strategic Guidance**
   Provide strategic guidance to NYS to ensure overarching goals of APC are met.
3. **Encourage Participation**
   Promote participation in APC by payers and providers.
4. **Align Across Models**
   Provide input regarding alignment across regions, as well as alignment with federal and state initiatives.
5. **Communicate with ROMCs and NYS HIC**
   Report to NYS HIC offering legislative and regulatory recommendations as needed; support ROMC efforts to address barriers.

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Statewide APC Steering Committee: Assumptions

- Presumption that committee members are supportive of the APC model and its successful implementation, within reasonable constraints
- NYS will retain final decision-making authority for APC-related matters and will use this committee as key sounding board for APC issues
- Committee members should be able to represent the views of their organization in discussion and may also share individual views when appropriate
- Committee members should brief key stakeholders within their own organization about the APC model and committee discussions

Questions/Comments

Advanced Primary Care (APC) Update

APC Updates

- Scorecard and measurement
- Practice transformation has started
- Regional roll out of APC, ROMC activation
- Independent Validation Agent (IVA) RFP to be procured
- Medicaid update

APC Scorecard

The scorecard is a cornerstone of the APC program

What the Scorecard is:

- 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

What the Scorecard isn't:

- A replacement for scorecards and measures required for ACOs, MA Stars, etc.
- A collection of brand new measures

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APC Scorecard Measures

Determined by the Integrated Care Workgroup in April 2016

- Relevant to primary care
- Endorsed and/or used in national programs
- Recommended sets for primary care (such as CMS-AHIP)
- Used in provider payment programs
- Parsimonious measure set

Annual Review Process

- Measure set - measure changes, new measures
- Use by practices
- Use in VBP arrangements
- Capability to include non-claims based measures

Need for interim solution

The **eventual APC Scorecard** leverages both administrative claims data from the APD and clinical data from EHRs.

The **timelines for APC launch and APD roll out do not align**. The APC program launches in 2016, while the APD launch is not anticipated until 2018.

We need **an interim non-APD solution** that:

- Uses easily accessible data
- Minimizes burden on providers and payers
- Is high quality and consistent across all types of patients and payers
- Leverages already existing processes
- Employs processes that can be used in future versions of the scorecard

All Payer Database anticipates commercial data intake to begin in 2018

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Payer Survey: Key design questions

Feasible reporting	Reporting window	▪ What are your reporting period capabilities?
	Unit of reporting	▪ Would it be possible to report at individual provider per site level?
	Attribution	▪ What attribution methodology do you use? Are you able to do attribution across the entire membership or just a subset?
	Quality control and adjustments	▪ How are current reports quality and accuracy tested (e.g., taking sample of claims/members and cross-checking quality)
	Other	▪ Would it be feasible to submit numerators, denominators and provider information for each measure ?
Existing reporting	Benchmarks and goals	▪ What benchmarks / goals are currently used? What is the rationale?
	Payer to provider reports	▪ Which measures and other ancillary information are included?
	Provider measure submission to state	▪ Do you currently require providers to submit any e-measures or other measures of quality? What is the penetration of e-measure submissions among the providers? Do providers submit service information via EHRs?
	Other	▪ Can you report on metrics for your entire membership (vs. just on selected products)? Do you report on your entire book of business or just for certain products? Do you outsource reporting software or develop internally?

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Pilot – Data Collection

APC Scorecard Version 1 - Phase 1 Measures

Domains	NQF #/Developer	Measures
Prevention	32/HEDIS	Cervical Cancer Screening
	2372/HEDIS	Breast Cancer Screening
	33/HEDIS	Chlamydia Screening
	38/HEDIS	Childhood Immunization Status: Combination 3
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	105/HEDIS	Antidepressant Medication Management
Appropriate Use	52/HEDIS	Use of Imaging Studies for Low Back Pain
	58/HEDIS	Avoidance of Antibiotic Treatment in adults with acute bronchitis

- Conducted in 4Q 2016
- Leveraging HEDIS 2016 (submitted in June 2016) with practice information attached to member level file
- 4 payers participated (2 Upstate and 2 NYC); Commercial, Medicaid and Medicare members
- Goal was to determine data issues with practice aggregation across payers
- Practice site able to be reported by Tax Identification Number by all payers

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Defining Practice Site

Practice/Practice Group
TIN

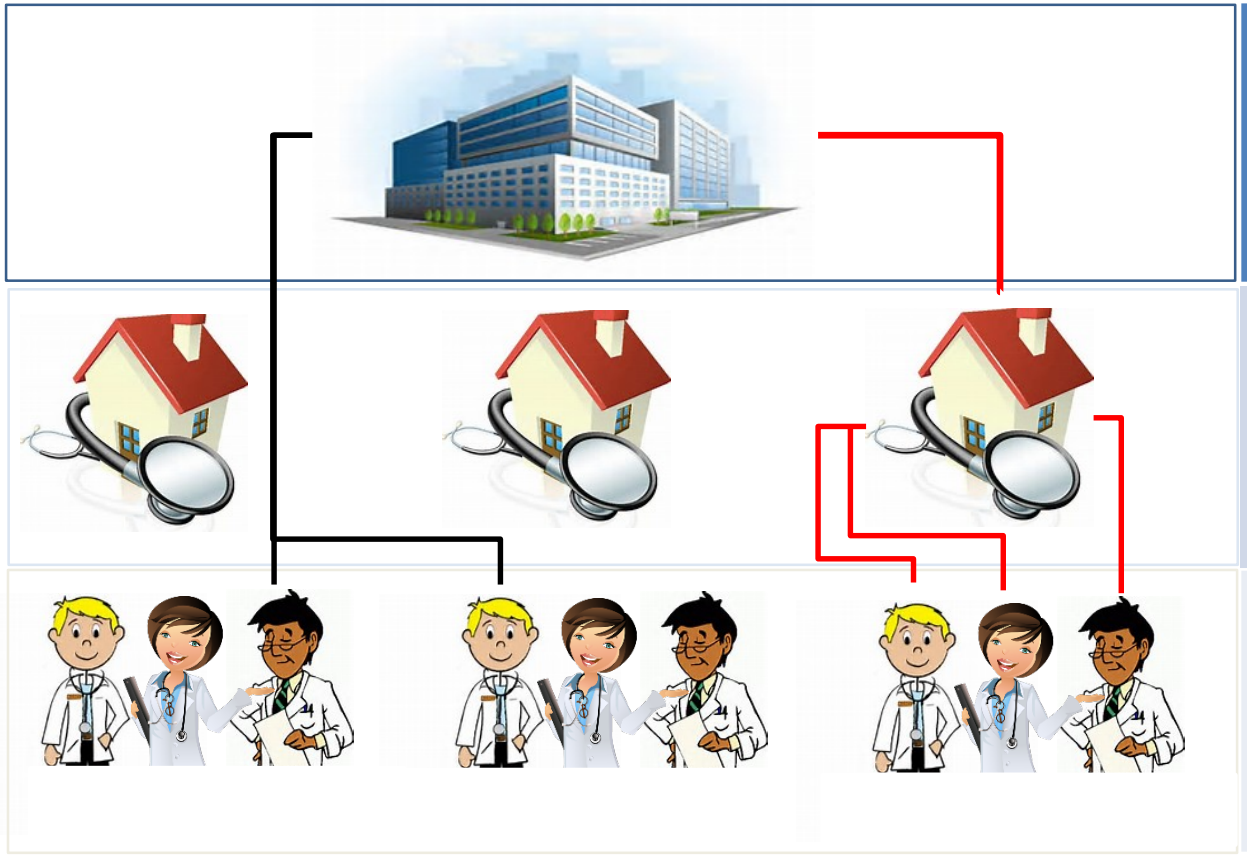


Practice Site/Medical Home
Servicing Location



Servicing Providers
Physicians & Mid-levels
Care Managers
Integrated Providers

Practices and Providers easier to define than Practice Site



Practice/Practice Group
TIN

Practice Site/Medical Home
Servicing Location

Servicing Providers
Physicians & Mid-levels
Care Managers
Integrated Providers

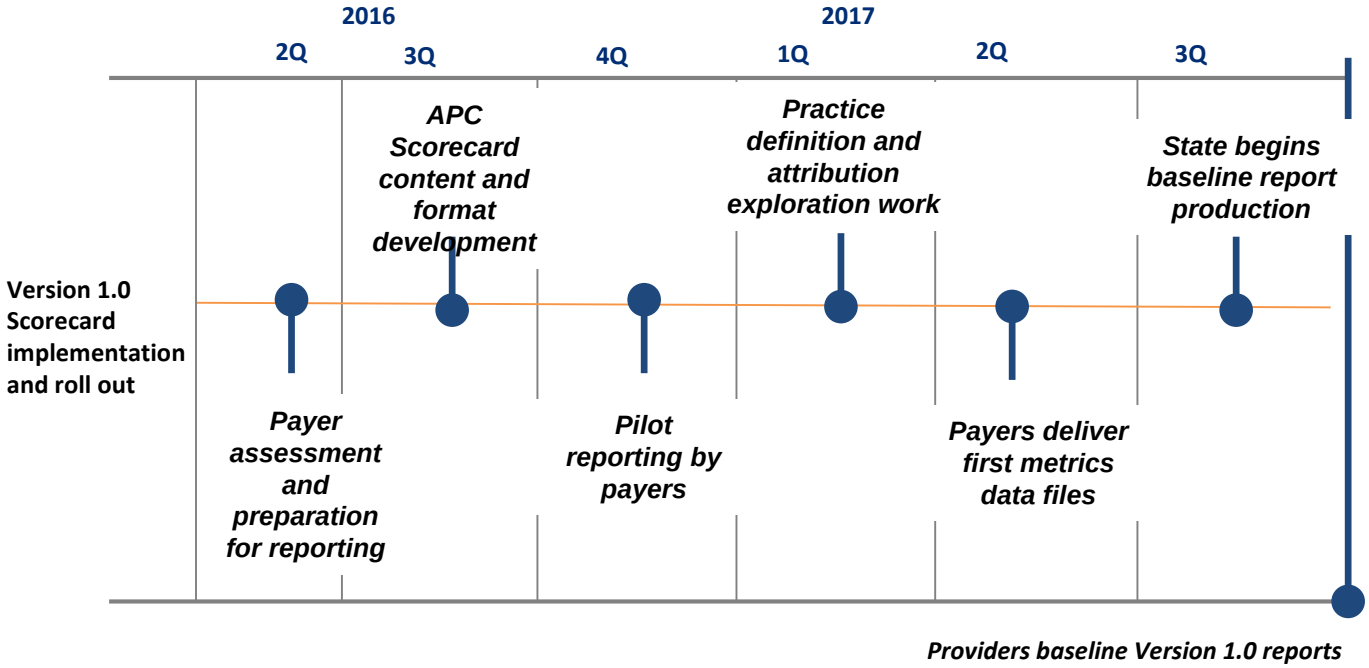
Process for Initial report production and release

- Multiplayer aggregated results in scorecard reports at Tax ID level*
- Reports distributed to practices involved in APC Technical Assistance
  - Reports shared with Practices, Practice Transformation Technical Assistance Agents and Payers
- *During 2-3 Q 2017, explore ability to use other data sources to calculate practice site level results
  - Practice Transformation Tracking System, PCMH file, Provider Network Data

Reporting Frequency

- Semi-annual with move to quarterly if feasible
- Discuss with payers their ability and willingness to calculate off-cycle HEDIS results for 1Q 2018
  - Ability to adjust HEDIS software dates for non-calendar year (July 2016-June 2017)
  - If able, will discuss with payers about calculating off-cycle results more frequently
- Utilization Measures – added June 2018 cycle
- All other measures – late 2018 – early 2019

APC Scorecard Timeline - Updated



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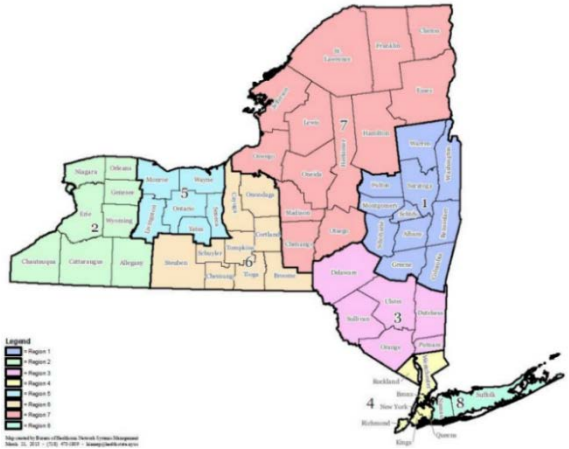
Practice Transformation

Making Progress

- Launched 10 Round 1 Practice Transformation (PT TA) contracts in 8 DFS Regions
- Held the first APC PT TA In-Person Summit:
  - attended by 38 Agents from 10 entities,12 Content Experts from 5 agencies, RHIOs, NYAM, and DOH APC staff
  - Breakout learning sessions for Behavioral Health, Population Health, Core Measures, HIT, Access, and Workforce issues
- Hosting bi-weekly PT TA “Train-the-Trainer” Webinars that focus on APC Milestones criteria and performance strategies
- Conducting Monthly Round Table discussions to encourage PT TA collaborative learning and sharing opportunities
- 1:1 Monthly PT TA “Pulse” conference calls with APC team
- Round 2 P TA applications are in review process and will deepen statewide penetration of APC recruited practices.



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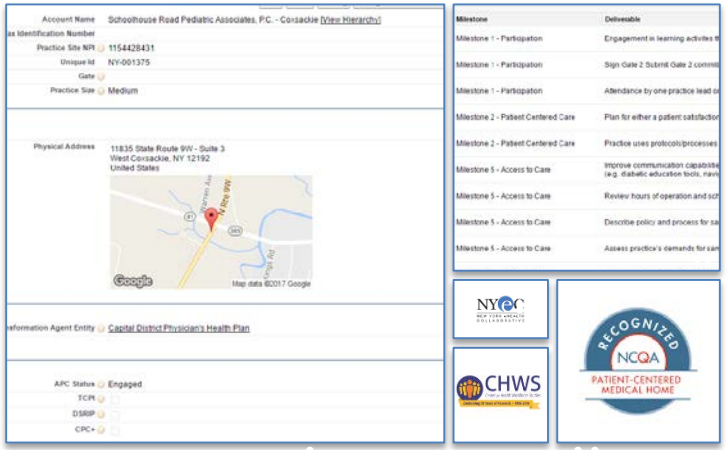
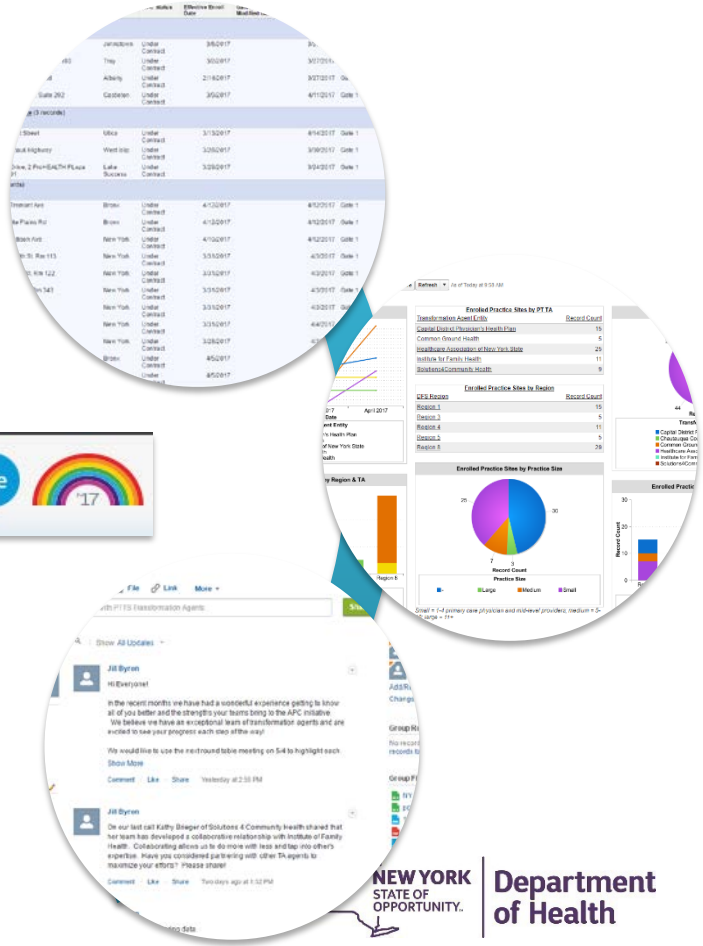
SIM/APC TA vendors

Name of Awardee	Region
Adirondack Health Institute	Capital District and Adirondacks
CDPHP	Capital District
HANYS	Capital District and Long Island
Chautauqua County Health	Western (Buffalo)
Solutions 4 Community Health	Mid-Hudson Valley and Long Island
Institute for Family Health	NYC
IPRO	NYC, Central NY (Syracuse) and Long Island
PCDC	NYC
Fund for Public Health in New York	NYC
Finger Lakes	Finger Lakes (Rochester) and Central NY (Syracuse)

Practice Transformation Tracking System

- Collect and organize practice site level data
- Identify practice sites participating in other federally funded transformation programs
- Assist in recruitment communication/strategies
- Monitor and report on program progress





Practice Recruitment Dashboard

Practice Recruitment

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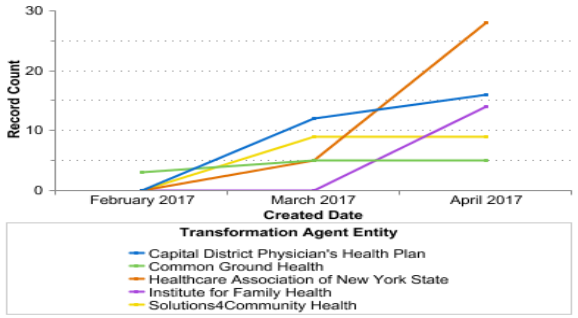
Practice Sites Enrolled



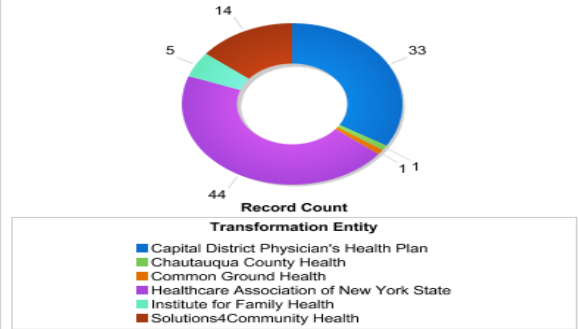
Enrolled Practice Sites by PT TA

Transformation Agent Entity	Record Count
Capital District Physician's Health Plan	16
Common Ground Health	5
Healthcare Association of New York State	28
Institute for Family Health	14
Solutions4Community Health	9

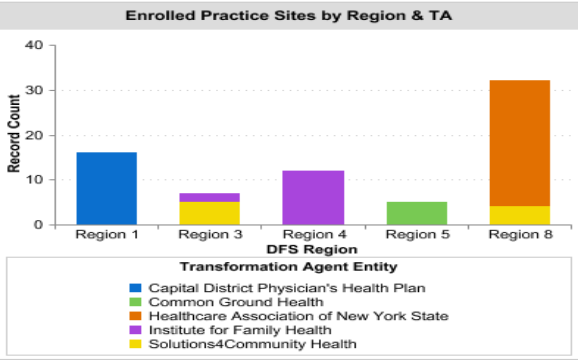
Enrolled Practice Sites by Region

DFS Region	Record Count
Region 1	16
Region 3	7
Region 4	12
Region 5	5
Region 8	32

Practice Sites Engaged



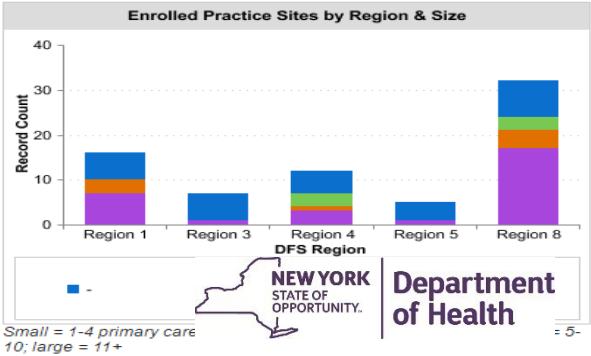
Enrolled Practice Sites by Region & TA



Enrolled Practice Sites by Practice Size

Small = 1-4 primary care physician and mid-level providers; medium = 5-10; large = 11+

Enrolled Practice Sites by Region & Size



Small = 1-4 primary care ... 5-10; large = 11+

Payer alignment
Medicaid/DSRIP Update: APC is one way to reach DSRIP requirement

- Primary Care practices in a PPS are expected to be 2014 PCMH Level 3 certified or APC (Gate 2) recognized by March 31, 2018 (end of DY3)
- Gate 2 APC will satisfy the DSRIP requirement for meeting APC milestones
- Medicaid will reimburse APC gate 2 and above practices same as PCMH 2014 Level 3

APC Independent Validation Agent (IVA)

- Independent Validation Agent (IVA) is an entity to verify the transformation work from TA vendors and practices.
    - (IVA) to be procured

ROMC

Regional Governance

Key objectives:

Using data to evaluate, monitor, and adjust APC locally to achieve:

- Increase in primary care practices with VBP contracts
- More primary care practices meeting APC milestones
- Progress in health, improvement in health quality, and reduction in preventable costs

Regional Oversight and Management Committees (ROMC) will convene to:

- Resolve questions or concerns that arise in the region
- Communicate with the Statewide Steering Committee on region-specific issues
- Ensure smooth implementation of the APC model within regional

ROMC Goals

Establish a collaborative in each region that will:

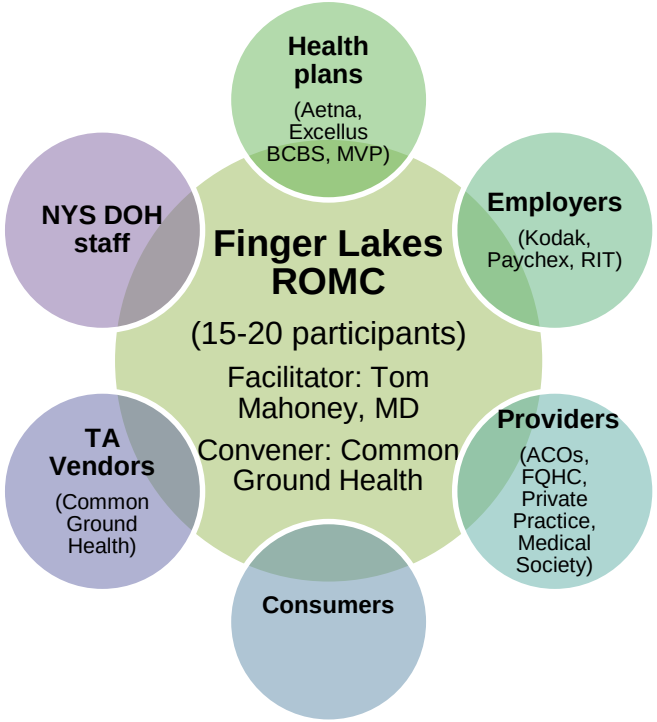
- **Guide the implementation** and operationalization of APC and provide input into the APC model as required
- **Convene providers and payers** to consider how best to advance payment reform according to the APC model
- **Facilitate engagement** of clinicians, payers, purchasers and patients in APC
- **Address regional population health priorities** as recommended by the NYSDOH and statewide steering committee
- **Support shift to value based reimbursement** by working toward alignment on measures and expectations of primary care practices

The ROMC

Purpose: Why have a ROMC?

- **ROMC intended to connect the state APC model with regional needs**
  - Health care is local, so market characteristics and region needs should guide APC implementation
  - What works in one region may not work in others
- **Convene regional stakeholders to support primary care transformation**
  - Establish regional priorities within APC model
  - Address questions or concerns that arise in the region with practices, payers, TA vendors and other key stakeholders
  - Communicate with the Statewide APC Steering Committee and NYS DOH on region-specific issues
- **Come to consensus on models, measures and payment**

Finger Lakes ROMC
Composition and Current Activity



Finger Lakes ROMC Activity to date

- 2 meetings completed (1/23, 3/27)
- Initial charter discussion
- Consumer Focus Group has met twice
- 1:1 meetings with health plans, providers and employers underway

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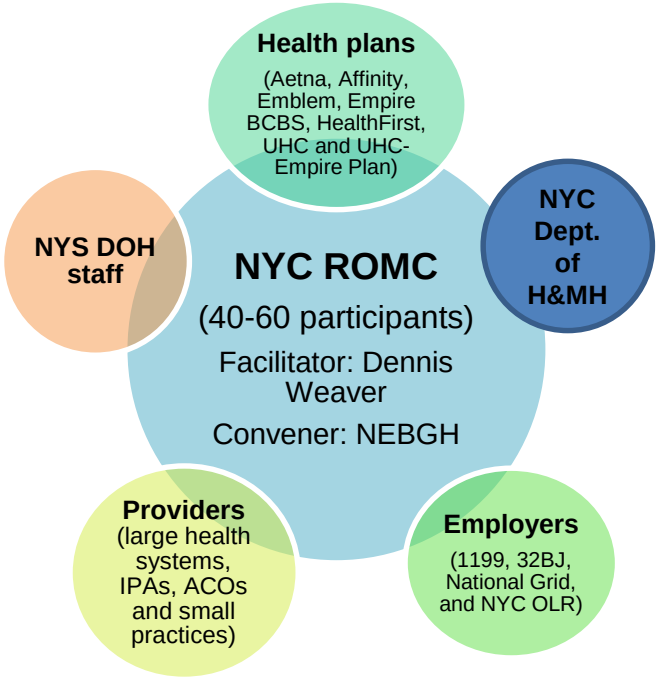
NYC ROMC
Composition and Current Activity



NYC ROMC Activity to date

- 2 meetings completed (2/28, 4/26)
- Meetings scheduled through December 2017
- Initial charter discussion
- Regional expansion to Long Island discussion
- 1:1 meetings with health plans, providers and employers underway

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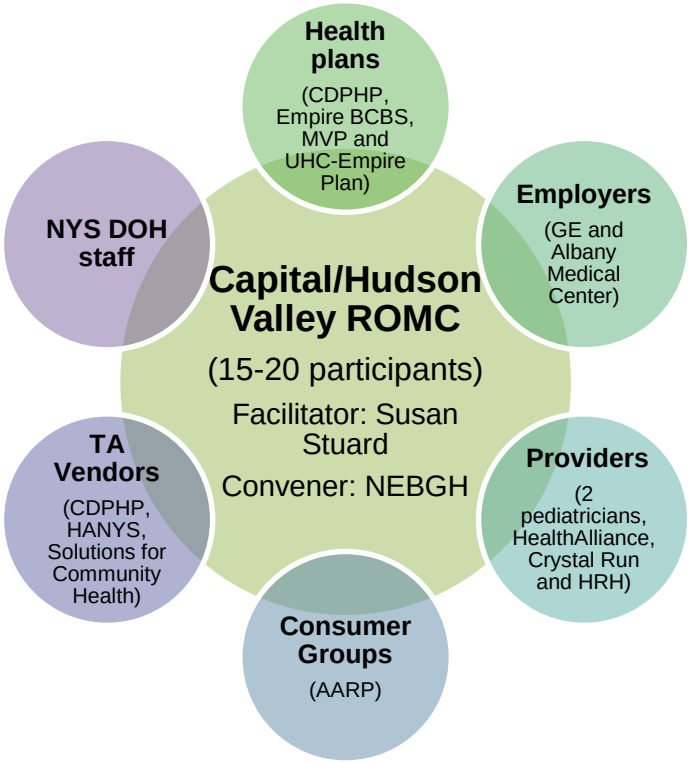
Capital/Hudson Valley Composition and Current Activity



Capital/Hudson Valley ROMC Activity to date

- 3 meetings completed (1/11, 3/8, and 4/5)
- Meetings scheduled through December 2017
- Charter complete
- Payer payment model comparison grid created and under review
- Initial review of payer core measure comparison grid

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So How's it Going?

- Finger Lakes ROMC
  - **Progress**
    - Enrolling Providers
    - Convened Consumer Focus Group
  - **Challenges**
    - Role of APC in a community with existing ACO agreements
- Capital/HV ROMC
  - **Progress**
    - Strong level of engagement
    - Eager to tackle payer payment alignment
    - Agreement on ROMC charter
  - **Challenges**
    - Family practice and internal medicine provider engagement
- NYC ROMC
  - **Progress**
    - Strong level of participation
  - **Challenges**
    - Complex region with a unique market and multiple stakeholders

Questions/Comments

NYS – NCQA PCMH Program Alignment Strategy

NCQA PCMH program alignment - overview

State and ICWG designed APC criteria with intention that this would be best solution for NYS needs

- Verifiable progress over time
- Transition to performance
- Consistency of financial and technical support

…But complexity in the setting of multiple primary care transformation programs has been an ongoing challenge

Critical question to address by our next Statewide Steering Committee

What approach toward reconciliation of APC and NCQA 2017 standards would increase provider participation and adoption, and facilitate greater payer support?

Goals for today

- Understand problem and timeline to address it
- Get early input on shaping options to evaluate
- Identify critical areas for further investigation
- Agree on subcommittee to drive the work

What is at stake?

The likelihood of success of:

- Providers embracing and succeeding in APC and other concurrent value-based programs
- Payers meaningfully evolving primary care transformation programs in a way that is aligned with and reinforcing of APC
- Medicaid DSRIP providers succeeding on VBP roadmap related components driven by primary care
- Achieving return on investment of $100 million in grant funds spent on practice transformation and development
- Achieving sustainability of APC beyond SIM

NYS APC was designed to meet the needs of our statewide transformation program

APC built upon CPC and PCMH with several additional goals	Design choices that followed
Ensure real transformation over time	▪ Gates that define tangible progress that include time expectations
Define a transition toward performance on outcomes that matter	▪ Define a set of “Core” measures that provide a consistent vision of success ▪ Build from expectation to measure to expectation to perform during transformation and “Gating” process
Facilitate a payment system that would support a new way of practicing primary care	▪ Time-limited technical and financial support in early phases to offset investments and financial risk of transformation ▪ Consistency in financial support across multiple payers

Despite similar intent, confusion regarding multiple new transformation programs in the state has been a challenge

APC	DSRIP/NCQA PCMH 2014	CPC+	Undecided practice
Patient-centered care	Team-Based Care and Practice Organization	Access and Continuity	
Population Health	Know and Manage Patients	Care Management	
Care management/ coordination	Patient-Centered Access and Continuity	Comprehensiveness and Coordination	
Access to care	Care Management and Support	Patient and Caregiver Engagement	
HIT	Care Coordination and Care Transitions	Planned Care and Population Health	
Payment model	Performance Measurement and Quality	Payment model	
Quality and performance			

The new NCQA PCMH 2017 release presents an opportunity to reconcile programs within the State

2017 improvements

- **Supports continuous practice transformation**:
  - Begins with three checkpoints to submit pieces of practice transformation
  - Certification assessment following
  - Yearly check-ups to verify continuous improvement
- **Improves flexibility** (e.g., electives)
- **Updates documentation methods**
  - Assigned a coordinator
- **Emphasizes comprehensive, integrated care**
- **Adheres to MACRA/MIPS standards**

NCQA has offered to create a program that adjusts their guidelines to NYS needs

Crosswalk between NCQA 2017 and APC:

NCQA PCMH 2017			APC					
Standard	Criteria	Criteria Level	Deliverable	Gate - Milestone	Aligned	Essential/ Questionable/ Non-Essential	Pre-CORE/ CORE/ ADVANCED	ALL/ MCAID/ MCARE/ PEDS
Team Based Care and Practice Organization (TC)	2.1 Has regular patient care team meetings or a structured communication process focused on individual patient care.	Core	> Conducts structured huddles/meetings to discuss cases with the care team.	3 - Care Management/ Care Coordination	Y	Essential	CORE	ALL
Team Based Care and Practice Organization (TC)	2.2 Involves care team staff in the practice's performance evaluation and quality improvement activities.	Core			N	Essential	CORE	ALL
Team Based Care and Practice Organization (TC)	E2.1 Has at least one care manager qualified to identify and coordinate behavioral health needs. (2 Credits)	Elective BH Distinct	> Has completed self-assessment for behavioral health integration and committed to meeting Gate 2 care management/care coordination milestones.	1 - Care Management/ Care Coordination	Y	Essential	CORE	ALL
Team Based Care and Practice Organization (TC)	E2.1 Has at least one care manager qualified to identify and coordinate behavioral health needs. (2 Credits)	Elective BH Distinct	> Completes training for behavioral health integration that broadens team-basd care and clinical treatment of depression.	2 - Care Management/ Care Coordination		Essential	CORE	ALL
Team Based Care and Practice Organization (TC)	3.1. Has a process for informing patients/ families/caregivers about the role of the medical home and provides patients/ families/caregivers materials that contain the information.	Core			N	Non-essential	CORE	ALL
Knowing and Managing Your Patients (KM)	1.1 Documents patient up-to-date problem list with current and active diagnoses	Core			N	Essential	Pre-CORE	ALL

NCQA PCMH 2017 – APC alignment

		Standards of Care	Core Requirement	Advanced/Elective
Essential	Essential	22	58	29
	Questionable	2	9	10
	Non-essential	0	0	1
Population	All	22	56	29
	Pediatrics	0	5	0
	MCAID/MCARE	0	0	0

Making a timely decision is critical to progress in the State

- **APC transformation is under way** with TA providers, and gate assessment underway
- **Independent assessor RFP** planned to be released shortly
- **NCQA to begin enrolling practices** in 2017 PCMH this year
- **Medicaid to make decisions on funding** for its practices
- **Providers need to plan their approach** to providing integrated care for their patient populations

In this setting we have the opportunity to evaluate three options

Proposal options	What you have to believe
A Continue with independent NYS APC	▪ Remaining consistent with agreed-upon plan is important to maintaining APC momentum ▪ APC allows independence and self-determination for what is most important to the state ▪ Current TA resources with an independent verification body will be the most efficient way of moving forward while reducing fees to practices
B Adapt custom NCQA PCMH program to meet NYS needs	▪ Alignment with new NCQA guidelines will better allow for multi-payer support (e.g., Medicaid, Medicare, and private payers), provided that certain APC changes are made ▪ NCQA verification can be financed through practice fees, and is a familiar framework for many practices in NY
C Use 2017 NCQA PCMH as-is for APC program	▪ The new NCQA guidelines now fulfill the reasons for which APC was designed, including gaining payor support, and adaptation would introduce unnecessary complexity ▪ NCQA is sufficient to merit financial support from Medicare, and nationwide alignment will make Medicare participation with APC more likely ▪ TA will prepare providers for current 2017 model ▪ NCQA verification can be financed through practice fees, and is a familiar framework for many practices in NY

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Discussion

- What are the highest priorities to solve for in making a decision on the approach to NCQA PCMH?
- Who needs to be involved in the process to make the decision?
- Are there other options for approaching NCQA PCMH 2017 that better drive meaningful participation by payers and providers?

We would like to create a subcommittee to quickly evaluate our options and propose a way forward

Proposed subcommittee charter

Basic question

- What approach toward reconciliation of APC and NCQA 2017 standards would increase provider participation and adoption, and facilitate greater payer support?

Definition of impact:

- Increased provider participation
- Increased payer participation
- Better quality primary care for patients
- Sustainability of APC beyond SIM
- Return on investment for SIM / TA investments

Types of participants

- Statewide thought leaders willing to devote time and effort to work representing payers, providers, consumers

Expectations for partners

- Be active participants in shaping and evaluating options, and ultimately making a recommendation for NYS
- Work to gather information to better inform policy options, including interviewing peer stakeholders and accessing data where relevant
- Meet at least twice in the month of May for subcommittee working sessions, with ad-hoc meetings in between
- Engage with State and McKinsey Support

Scope

- Decision on approach to NCQA with desired elements
- Analysis of implications
- Plan for implementation

Constraints of solution space

- Use combination of existing APC and NCQA elements and design choices only rather than re-invent either
- Ensure that choices balance stakeholder viewpoints

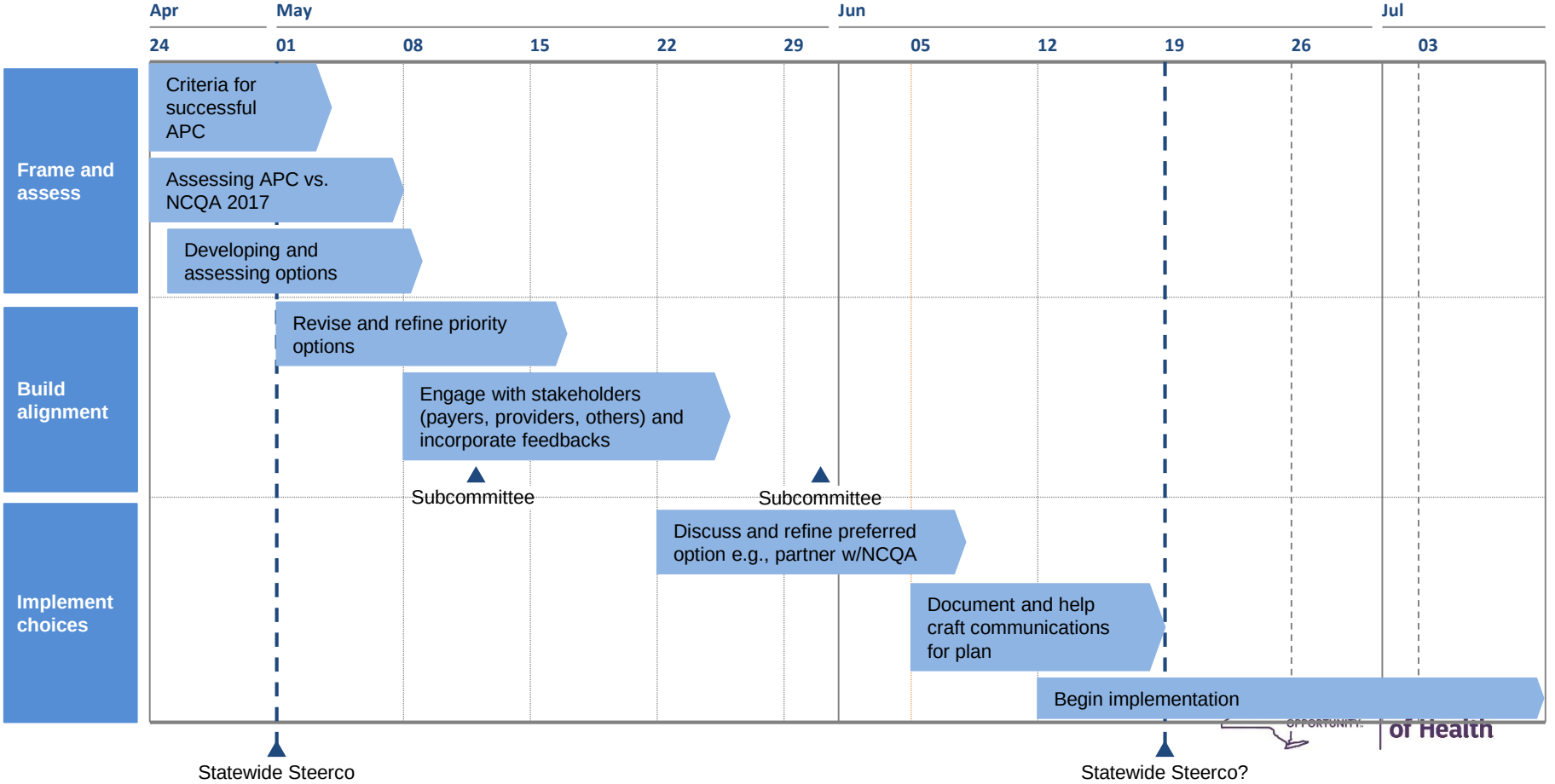
Key sources of insight

- Interviews
- Data review
- Financial impact

Criteria for success

- Develop recommendations for SSC by June 19 that are implementable and can achieve buy-in from payers providers and consumers

NYS APC/PCMH: Proposed workplan



Discussion

- What additional information do we need to have in order to make the best possible decision?
- What would be the effects of shifting to NCQA PCMH 2017 on payers?
- What would be the effects of shifting NCQA PCMH 2017 on providers? On consumers / patients?

Questions/Comments

Next Steps