NEW YORK STATE OF OPPORTUNITY. | Department of Health

NYS Health Innovation Council

May 11, 2016

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Agenda

#	Topic	Time	Leader
1	Welcome, Framing the Day	10:00 - 10:10	Paul Francis/Howard Zucker
2	Delivery System Reform Incentive Program	10:10 - 10:40	Peggy Chan
3	SIM Updates and Discussion		

	• Integrated Care
	  • Advanced Primary Care (APC) Model
	  • Integration and Alignment: Medicare/Medicaid/ SIM/DSRIP/ TCPI/CPC+
		10:40 - 11:10	Foster Gesten

	• APC Investments and Value Based Payments	11:10 - 11:30	John Powell
	• Population Health	11:30 - 11:45	Sylvia Pirani
	• Transparency, Evaluation, & Health Information Technology	11:45 - 12:15	Patrick Roohan
	• Workforce	12:15 - 12:30	Jean Moore
	• Access to Care	12:30 - 12:50	Joan Cleary-Miron
4	Final Comments and Closing	12:50 - 1:00	Paul Francis/Howard Zucker

Welcome

NEW YORK STATE | Department of Health | Medicaid Redesign Team

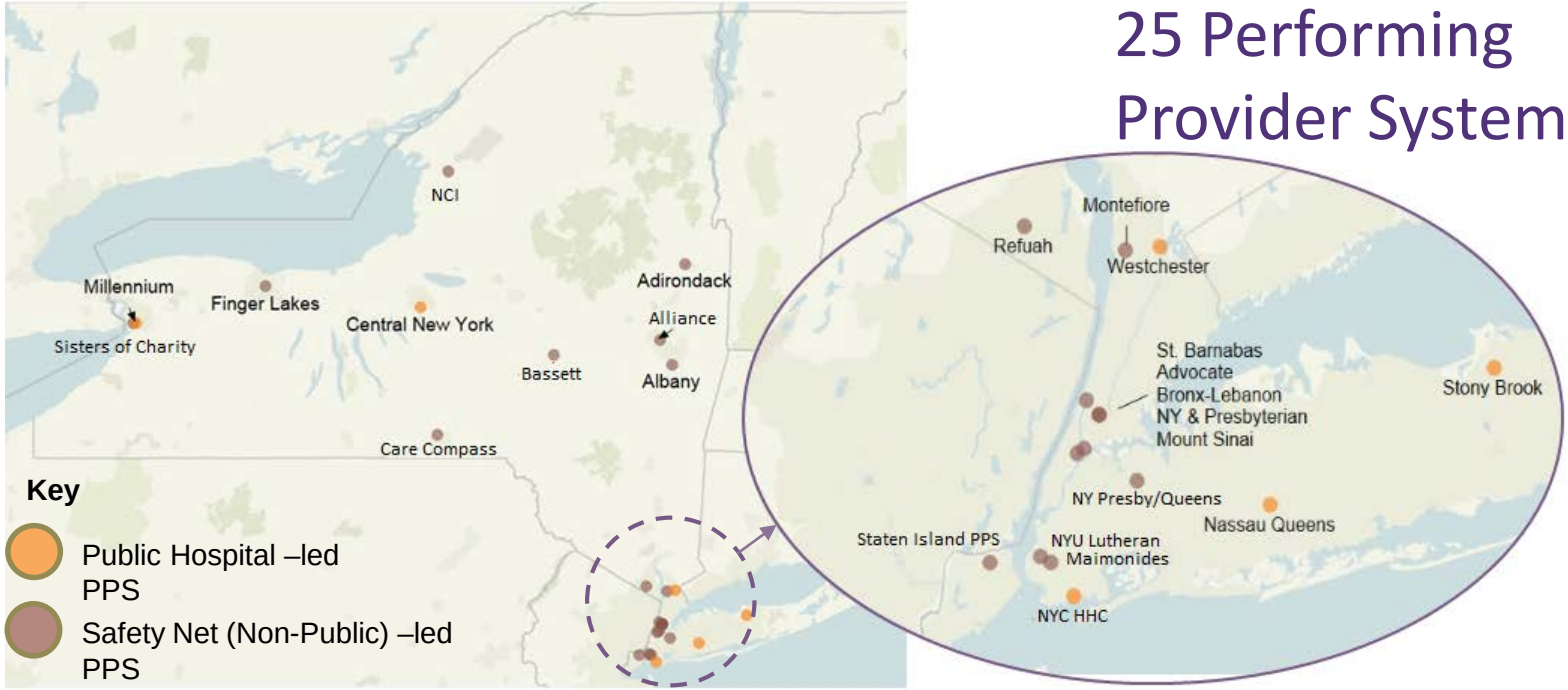
DSRIP Update

NYS Health Innovation Council

Peggy Chan, MPH
Delivery System Reform Incentive Payment (DSRIP) Program Director
Office of Health Insurance Programs
New York State Department of Health

May 11, 2016

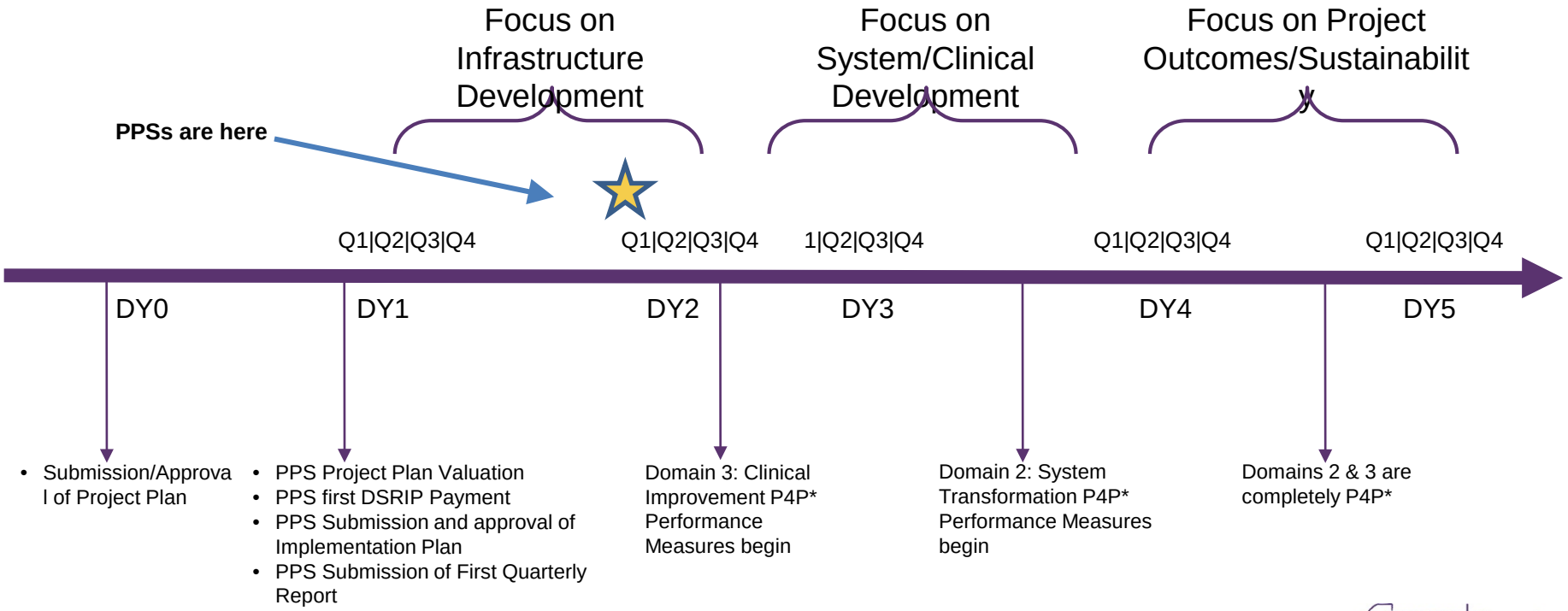
Performing Provider Systems (PPS)



25 Performing Provider Systems

Where We are Now

PPSs have transitioned from planning to implementing projects



Source: Independent Assessor Project Approval and Oversight Panel Presentation. Nov 9 – 10, 2015. NYS DSRIP Website.

** P4P = pay for performance*

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DSRIP Achievements to Date

- **119,226** providers have become affiliated with DSRIP across the 25 PPSs
- **5,283,175** Medicaid members have been attributed to the 25 PPSs
- First payments totaling **$866,738,947** were made to PPSs for successful application submission on **April 23, 2015**
- **98.6%** ($165,992,310) of available payments $168,387,230 were earned by the 25 PPS for activities targeted to building PPS organizational foundation performed in April – September 2015
- **$1.2 Billion** in CRFP awards to support DSRIP goals announced March 4th, 2016!

** Statistics as of December 2015*

Implementation – Building What Wasn't There

- ***Project Implementation Start-up***
- ***New Partnerships and Business Relationships***
  - Prelude to the "value" in value-based payment paradigm.
  - Community-based providers and smaller CBOs feel challenged for VBP.
- ***Current Capacity vs. Capacity-building***
- ***Funds Flow***
- ***New Friends and Mutual Interests***
- ***Reaching into Workforce***
- ***Fact-based Optimism***

Value Based Payments – Current Efforts

Various efforts are currently underway for value based payment, including the release of an updated VBP Roadmap for public commentary and the launch of the VBP pilot program

VBP Roadmap

- VBP Roadmap was released for a **public commentary period** from March 18th to April 18th
- Submission of the **VBP Roadmap to CMS for final review and approval** is scheduled for May (deadline for approval is 7/22)

VBP Workgroup

- VBP Workgroup held its third meeting on April 28th, to **review the comments received during the public comment period**
- VBP Roadmap has been updated to **reflect the recommendations** developed by the **VBP subcommittees**

VBP Pilot Program

- Support the **immediate adoption of VBP arrangements** and the State's transition to a VBP model
- Implement the VBP arrangement for two years, **moving to Level 2 by Year 2** (pilots may start at Level 1 in 2016)
- Receive technical and administrative assistance (e.g. target budget assistance, data analysis)
- Approximately **10-15 pilots will kick off in Summer 2016**, with a time frame of about two years
- Pilot VBP arrangements include Maternity, Total Cost of Care, IPC/Chronic, HIV/AIDS, and Health and Recovery Plans (HARPs)

VBP Bootcamp

- DOH will be hosting a **regional VBP learning** series called VBP Bootcamps that will help provider communities plan and gain more knowledge on VBP to ensure smooth transition to implementation
- The Bootcamps will **commence in June 2016**

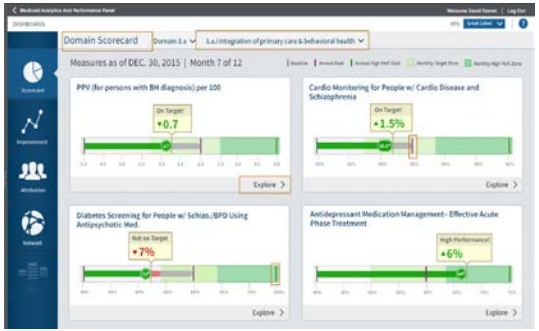
Medicaid Analytics and Performance Portal (MAPP)

A performance management system that provides tools and program performance management technologies to PPSs in their effort to develop and implement transformative projects in DSRIP

Performance Dashboards, which are accessed by PPSs through MAPP, have been designed to provide insight and actionable information to help visualize and manage performance.

Monitor Project Requirements

Track Gap to Goal for Performance Measures



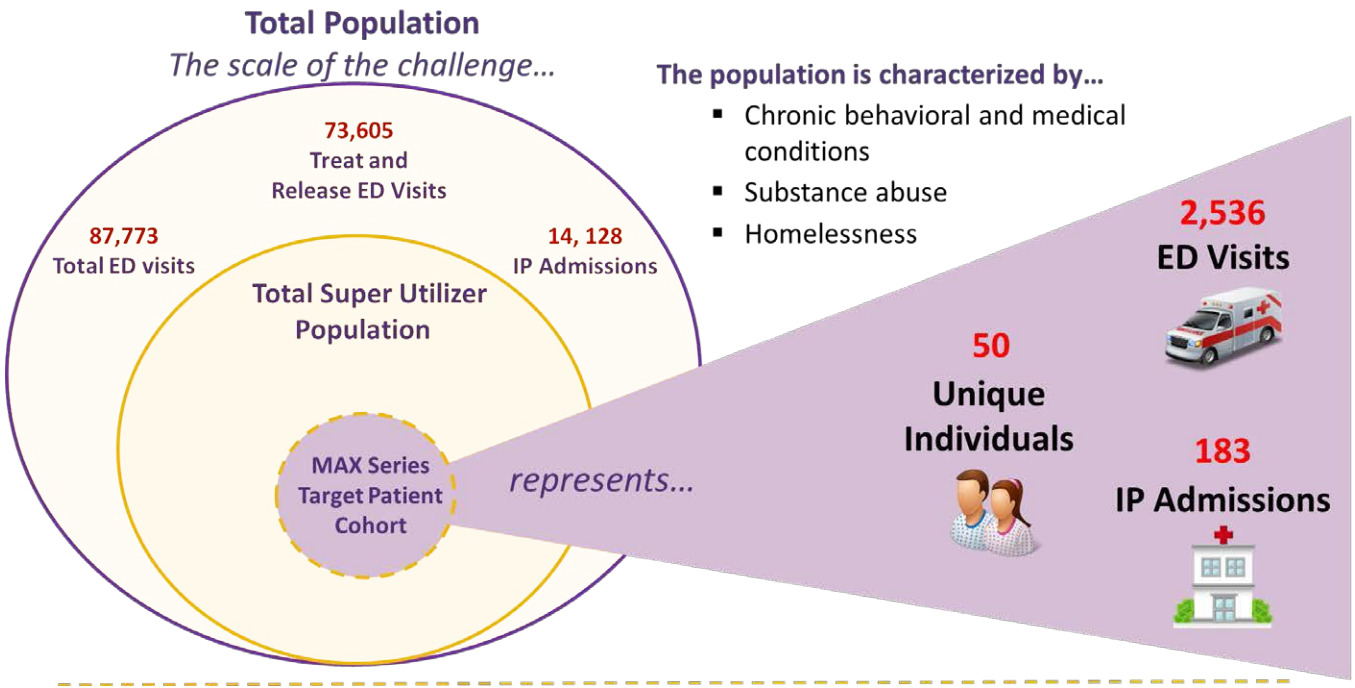
Gain Population Insight

DSRIP Teams in Action

- Integrated Delivery Systems
- Coordination of Care
- Population Health

Identifying Super Utilizers

Hospital data was used to identify each Action Team's cohort



Avg. ED Visits: **1.63**

Avg. ED Visits SU: **4.42**

Avg. ED Visits MAX: **>50**

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MAX Series Super Utilizer Case Study

MAX Action Teams are changing the trajectory of Medicaid members' lives

Quality improved – John had **82 ED visits and 2 inpatient admissions** over an 11 month period. Because he was identified as a Super Utilizer in the MAX Series, the Action Team has been able to connect him with a settlement house based in the Bronx. **He has not been back to the ED as of January 20, 2016**.

Time saved – **Three provider shifts are projected to be saved** over the course of the year. The ~**90 ED visits** diverted is equivalent to 36 provider hours

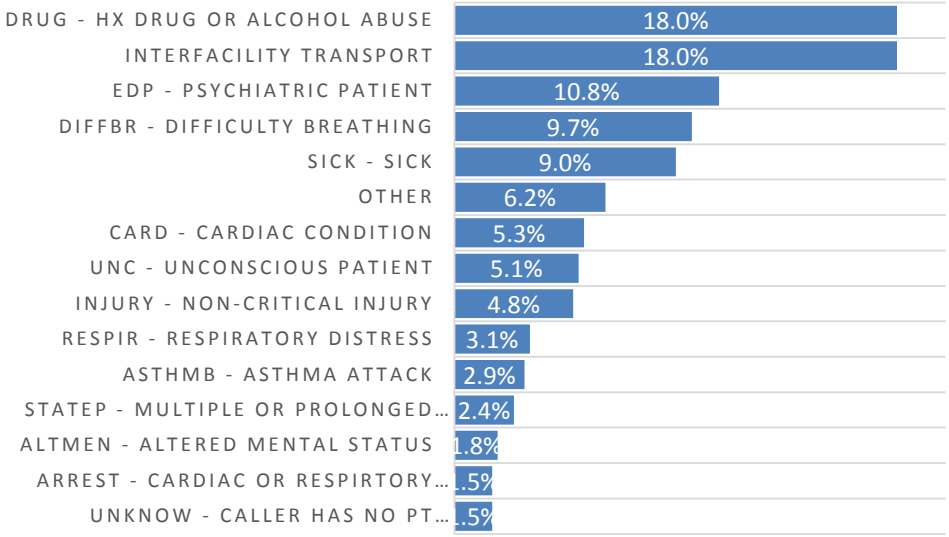
Dollars saved – The total charges were > **$68,000**

Staten Island PPS
EMS User Analysis: Volume by Dispatch Code, Chief Complaints

Volume by Dispatch Code

Dispatch Codes with volume less than 5 were grouped into the "Other" category, including:

Major Injury ; Sick Pediatric, <S Year Old ; Unknown Condition ; Seizures ; Minor Illness ; Minor Injury; Asthma Attack - Fever&Cough; Reaction To Medication ; Abdominal Pain ; Diff Breathing-Rash & Fever ; Miscarriage ; Seizures - Fever & Cough ; Internal Bleeding



Top 10 Chief Complaints

Chief Complaints	Counts	Percent
No Medical Problem	85	19%
Alcohol Intox	61	13%
Intox	26	6%
Psychiatric Emerg.	21	5%
Asthma Symptoms	19	4%
Dyspnea-SOB	15	3%
Alcohol Intox Severe	13	3%
Headache (no trauma)	10	2%
Behavioral Disorder	10	2%
Weakness	10	2%

DSRIP Demonstration Year 2 (DY2)

- ***Pay for Performance*** - PPS deliverables will begin to begin shift to P4P at the end of DY2.

- ***Mid-Point Assessment -*** mandated under the Standard Terms and Conditions (STCs) governing DSRIP.
  - The DSRIP Independent Assessor will begin the process in the Fall 2016.
  - A review of PPS progress towards the implementation of the approved DSRIP Project Plans and to determine any modifications necessary to ensure PPS success through the remaining years of the program.
  - Recommendations for changes will be provided for public comment, to the DSRIP Project Approval and Oversight Panel and then to the Commissioner of Health.
  - Commissioner of Health submits final recommendations to CMS for approval.

Questions?

DSRIP e-mail:

dsrip@health.ny.gov

State Innovation Model (SIM) Updates

NY's Advanced Primary Care (APC) Model

APC Background

- New York's APC model is:
  - An evidence informed set of capabilities/functions required of primary care practices coupled with payment to support those functions
  - A multi-payer approach to provide 'critical mass' of common signal and resources to practices to increase probability of success in value based payment
  - An initiative to align payers/practices to move along a continuum from sole FFS payments to (a larger portion) of value/outcome based payments associated with a common set of practice performance measures to evaluate success and 'transformation'

- New York's APC model is:
  - Based on existing multi-payer advanced primary care demonstrations (Adirondacks and CPC in Hudson Valley/Capital Region) which are successful/promising and expiring (as of December 2016)

APC - Where Are We Now? / Next Steps

The Integrated Care Work Group has:

- Developed consensus set of practice requirements to be reached over time (called ‘milestones’)
- Created a process to evaluate whether those requirements have been met (called ‘gates’)
- Agreed on a set of metrics to further evaluate practice progress and use for value based payments (called ‘common measures’)

- An RFA to fund practice transformation has been released – Responses due back May 13th

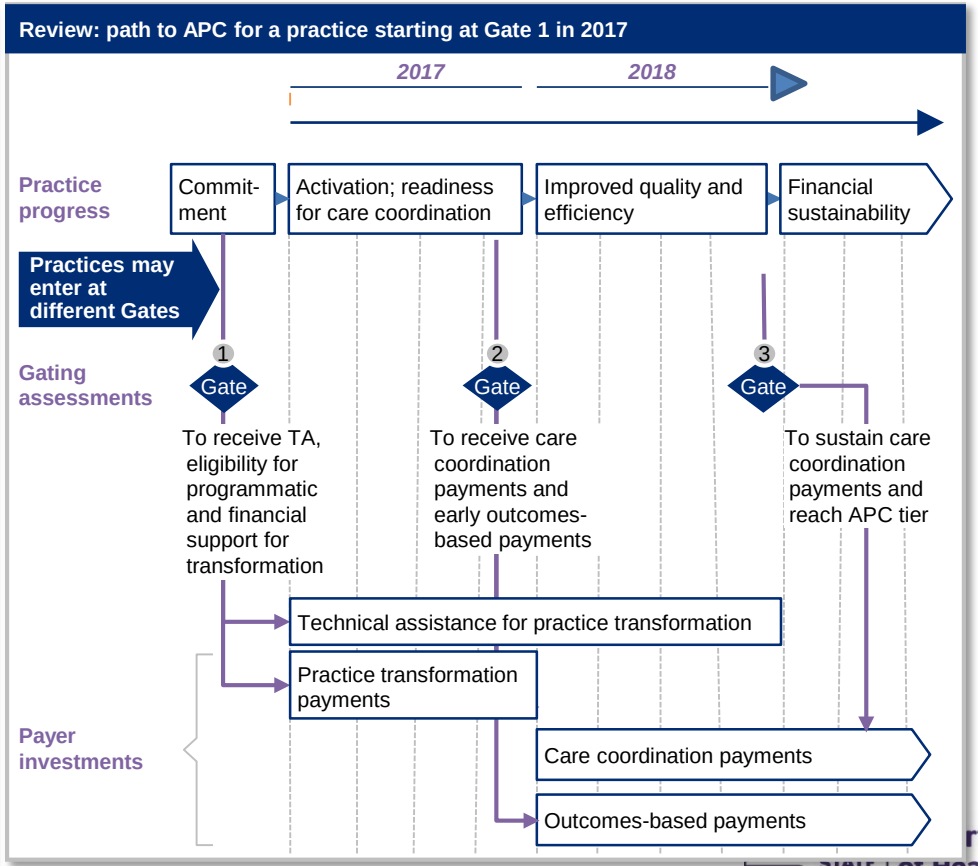
Next Steps: **Implementation**

- Payer and provider commitment
- Define regional ‘critical mass’

The APC model

The **common APC framework,** in which individual payers develop and implement APC-qualified contracts, include:

- Defined Practice **Capabilities**
- **Milestones** that define a practice's capabilities over time
  - **Structural milestones** – describing practice-wide process changes
  - **Performance milestones –** describing performance on Core Measures
- **Core Measures** that ensure consistent reporting and incentives
- **Progression to Outcome-based payments** to promote and pay for quality and outcomes
- A common on-site assessment to certifies practices' progress through **Gates** which mark progress through performance Milestones that trigger practice transformation, care management and outcome-based payments



APC structural milestones

	Commitment Gate 1 *What a practice achieves on its own, before any TA or multi-payer financial support*	Readiness for care coordination Gate 2 *What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet* **Prior milestones, plus …**	Demonstrated APC Capabilities Gate 3 *What a practice achieves after 2 years of TA, 1 year of multi-payer financial support, and 1 year of multi-payer-funded care coordination* **Prior milestones, plus …**
Milestone 1 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)	
Milestone 2 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 honed in Gate 2, where applicable)
Milestone 3 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
Milestone 4 Care Manage-ment/ Coord	i. Commitment to developing care plans in concert with patient preferences and goals ii. Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year	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
Milestone 5 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
Milestone 6 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
Milestone 7 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

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

APC Issues

- Alignment (standardization) vs Flexibility
  - More flexibility for payment approach vs practice requirements or measures?
  - Standardize across state to facilitate health plan participation vs need for local/regional variation?

- Prospective vs Retrospective Payments
  - Payers: 'When you transform and deliver value, we will make non-visit based payments'
  - Providers: 'I need different payment now in order to transform and create valuable services that are not currently reimbursed by FFS'
  - Need for mutual 'business case' for payers and practices

- 'Unit' of contracting, measurement, payment: providers, practices, IPAs, ACOs
  - Does it matter and should it drive differences in model?
  - Do alternative payments to larger entities change primary care provider practice and patient experience (if continued to be paid FFS or salary)?

DSRIP, SIM, TCPI, CPC+ Highlights:

DSRIP	SIM	TCPI	CPC +
Focus: Primary care practices participating in PPS provider networks	**Focus:** Primary care practices: Implementation 2017	**Focus:** Clinician practices, both primary care and specialty	**Focus:** Primary care practices: Implementation 2017
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 – • Care Transitions Network for People with Serious Mental Illness • Greater New York City Practice Transformation Network • New York State Practice Transformation Network	**Who provides funding/support to the provider:** Medicare, commercial and Medicaid payers provide prospective, risk adjusted PMPM payments
Resources/Payment: Practices are supported by PPSs to reach PCMH or APC designation	**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.	**Resources/Payment:** No additional payments, national CMS learning networks provide support

Comprehensive Primary Care Plus (CPC+)

- National advanced primary care medical home model led by CMMI/CMS that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation
  - Competitive procurement/20 regions/5000 practices/20,000 doctors/25 million patients
  - 5 year demonstration begins January 2017
  - Significantly aligned with APC
- 2 tracks
  - Advanced primary care (monthly care management fee + FFS)
  - Advanced primary care plus care management for complex patients (monthly care management fee + hybrid of comprehensive payments and reduced FFS)
- Multi-payer payment redesign is required
- DOH/DFS encouraging plans to apply

https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus/

Financial Support of APC

Request for Information (RFI)

NYS DFS issued a Request for Information to:

- Better understand current and evolving primary care delivery and payment models
- Assess the degree or extent of change that might be required to ensure alignment needed to create systemic efficiencies
- Define “what counts” for purposes of rate relief
- Evaluate specific regions of the state most appropriate for practice transformation investments to ensure long-term sustainability

Responses Received and Limitations

- RFI was sent to **18 Plans**
  - Plans were asked to provide information on both commercial and Medicare Advantage lines of business.

- **12 plans** responded
  - Responses were voluntary.
  - Some plans declined to respond due to smaller commercial LOBs or have a majority of Medicaid business and were responding to Medicaid VBP survey.
  - 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	

Finding #1: All payers have some type of high value primary care program.

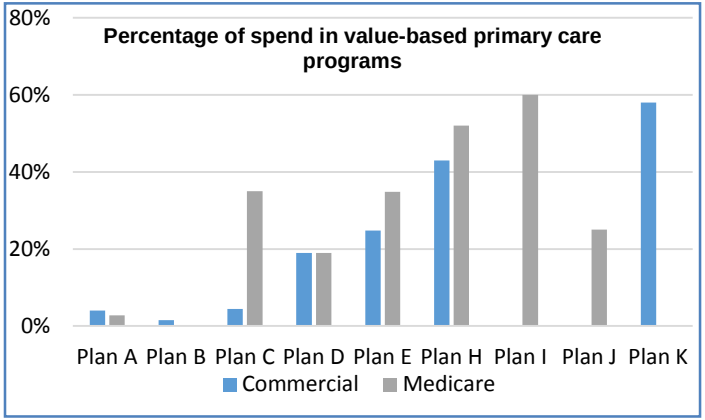
- Extensive work is ongoing to incent and realize delivery of high value care.

- **100%** of plans reported having contracts inclusive of primary care models that support team based care. Penetration and investment in these models varied widely.
- **92%** of the plans responding to the RFI indicated that they provide Practice Transformation (PT) support (which may include a stipend or PMPM)
  - In-kind support and investments vary and include the following examples
    - PMPM fees paid to groups and to develop systems and infrastructure need to coordinate care
    - 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

Finding #2: Extent of programs varies widely.

Percentage of Spend

- Investment in value-based programs as a proportion of total spend varies widely.
- Takeaway: While some plans have well developed programs, there are opportunities to incentivize and expand investments in high value primary care.



	Average (non weighted)	Range
Commercial	21%	4% to 48%
Medicare Adv.	32%	3% to 60%

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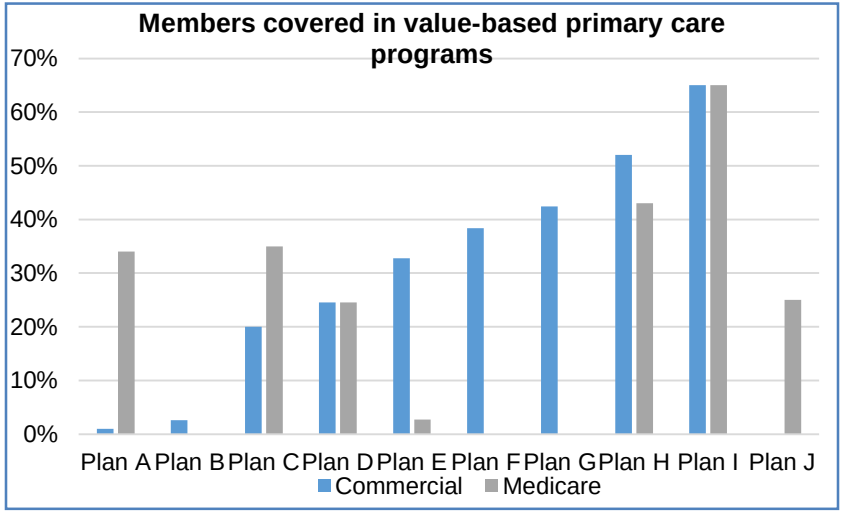
Percentage of Membership

- The percentage of members impacted varies widely.
- Takeaway: There are opportunities to bring high value primary care to more members to improve population health.



	Average (non weighted)	Range
Commercial	31%	1% to 65%
Medicare Adv.	32%	3% to 65%

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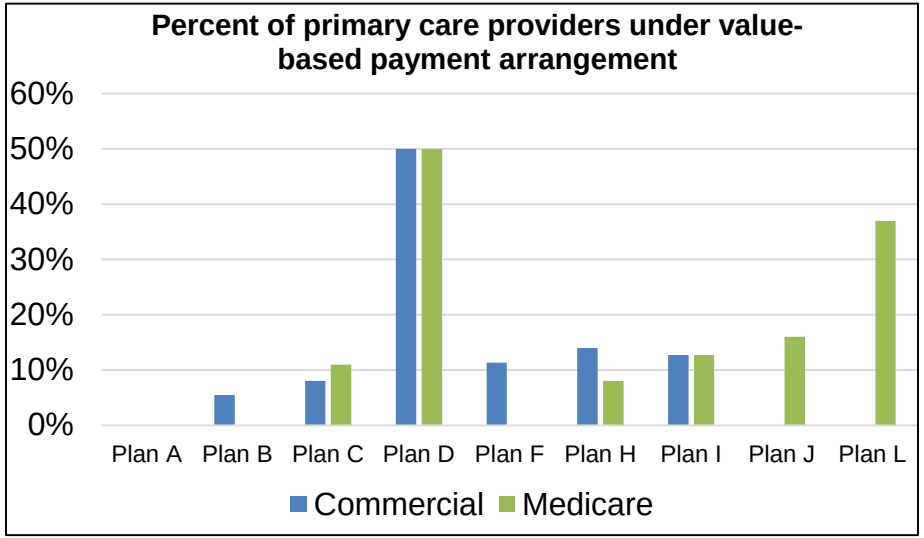
Percentage of Providers

- The percentage of providers contracted under high value primary care programs varies widely.
- Takeaway: There are opportunities to expand the APC model to more practices, and we can work to identify practices that are currently not contracted.



	Average (non weighted)	Range
Commercial	31%	1% to 65%
Medicare Adv.	32%	3% to 65%

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Finding #3: APC Alignment

- 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.

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 comment	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.

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

Memorandum of Understanding (MOU)

Purpose:

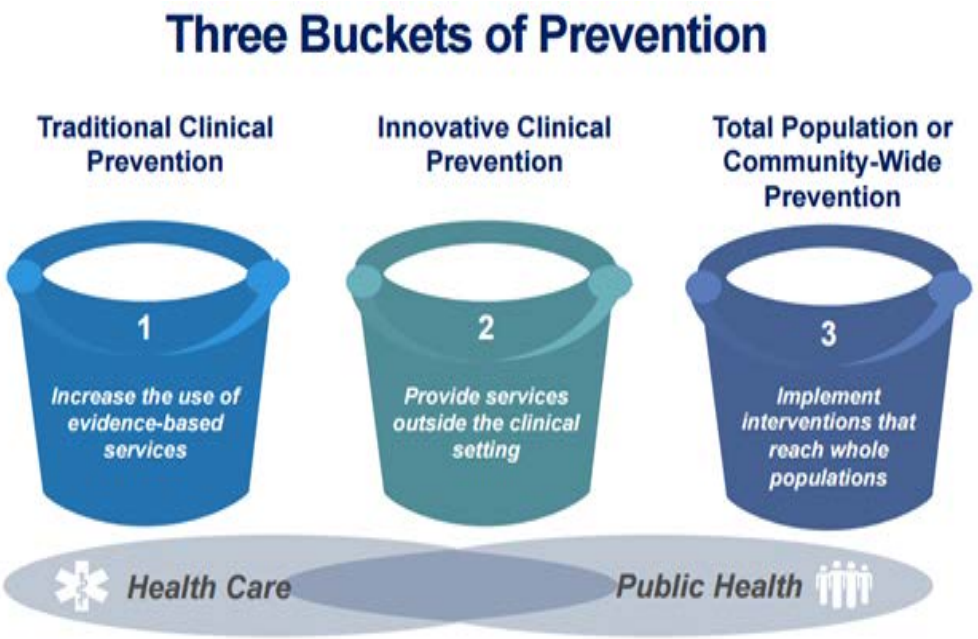
- To recognize those regions of New York State in which commercial plans are willing to work collaboratively to support practices that have, are and will transform to meet the guidelines and milestones of New York's Advanced Primary Care delivery model;
- To identify payers indicating a willingness to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

Challenge:

- Too Specific: No one will sign
- Too Vague: Meaningless

Population Health

Population Health and SIM: CDC's Framework



Auerbach J., The 3 Buckets of Prevention. Journal of Public Health Management and Practice 2016.
http://journals.lww.com/jphmp/Citation/publishahead/The_3_Buckets_of_Prevention_.99695.aspx

CDC

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Example of the Three Buckets of Prevention

Ms. Jones

- 55 years old, married
- Smokes, overweight, little exercise
- Asthmatic, high blood pressure, depression
- Other factors contributing to her health:
  - Lives in a neighborhood with crime, few parks; no supermarket
  - Under stress; child with substance abuse problem
  - Sub-par housing with mold and ventilation problem

Bucket 1: Ms. Jones receives **clinical preventive services:**

- Guideline-concordant care for asthma, tobacco dependency, HTN, obesity
- Recommended cancer screenings
- Screening and brief intervention for depression

Bucket 2: Ms. Jones receives **innovative patient-centered medical care** and is connected to **community services**:

- Home assessment by the local health department of asthma triggers
- Home blood pressure monitoring with follow up by a CHW
- Referral to a National Diabetes Prevention Program

Bucket 3: Ms. Jones lives in a **community that supports healthy lifestyles**:

- Smoke-free multi-unit housing
- Transportation systems that encourage mass transit, biking and walking
- Access to grocery stores with fresh vegetables and fruits

Population Health and New York's Innovation Initiatives

Buckets 1 and 2: Focus of DSRIP and APC

- Support preventive and chronic care management as needed/appropriate
- Refer patients to evidence-based self-management programs and community-based resources
- Participate in at least two Prevention Agenda activities annually in conjunction with local health departments
- Value Based Payment Supports Buckets 1 and 2
- Measurement: Integration of Prevention Agenda Measures:
  - APC Measure set
  - DSRIP Domain 4

Bucket 3: Traditional Public Health

- Least attention to date
- Public Good – Not tied to the individual
- Challenge: Integration of all three buckets and support of bucket 3.

Supporting Population Health and Prevention: Proposal

Support communities to bring together key sectors from public health, health care delivery system and community partners to collectively address a common health improvement goal.

Awards for communities to develop and implement a portfolio of interventions across all three CDC "buckets" of prevention.

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Transparency , Evaluation & HIT Workgroup

Health Information Technology Workgroup Charge

The HIT workgroup is charged with:

- Focusing on the State's Health Information Technology infrastructure;
- Development of recommendations for the NYS as the state moves to comprehensive health claims and clinical data bases;
- Submission of a report to the governor and legislature.
    - **Final Report Submitted December 1, 2015***

Future focus:

- Transparency
- Evaluation

*Final report available online: https://www.health.ny.gov/technology/innovation_plan_initiative/docs/hit_workgroup_final_report.pdf

Final Report: Findings and Recommendations

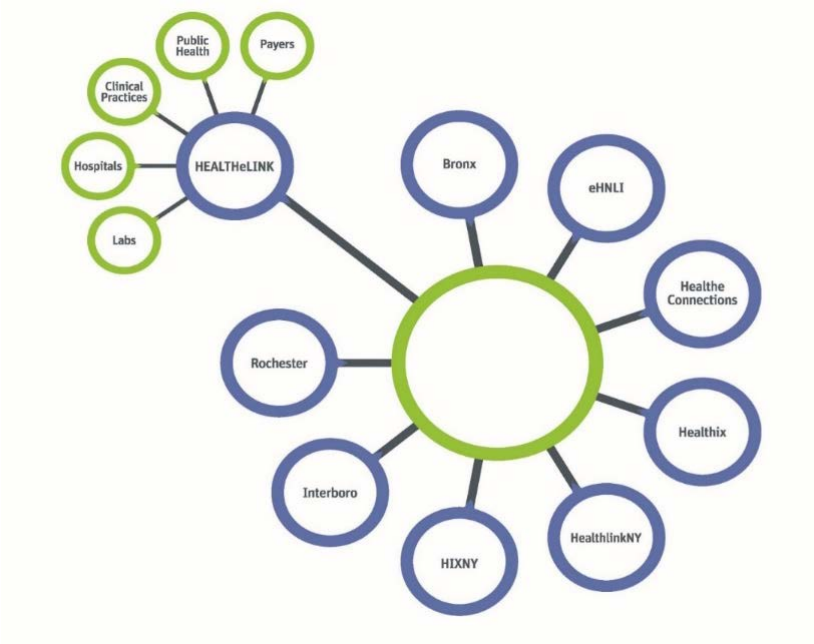
1. Efforts to implement the SHIN-NY must continue
2. The APD must be continued to be supported through full implementation inclusive of all payers
3. All health data collected must be discrete, meaningful and reliable
4. Development of a common set of measures to support the Advanced Primary Care Model is essential
5. Provider liability with respect to evolving electronic HIT must continue to be monitored and evaluated
6. Mechanisms for the collection of non-clinical data should continue to be explored

SHIN-NY: Issues and Challenges

1. Duplication
   - “Wire Once” policy
2. Consent
   - Opted In; Opted Out; CRF 42 restrictions; adolescent consent
3. Increase Adoption, improve completeness and data quality
4. Sustainability
   - New CMS 90-10 opportunity
   - State HCRA and Medicaid funds

SHIN-NY: Structure Today

- RHIOs are connected to each other via a central bus (the green ring in the middle)
- Data from a participant of any RHIO is available to any other RHIO's participant statewide
- This system is called Statewide Patient Record Lookup (sPRL)



SHIN-NY Timeline

Statewide patient lookup (connecting RHIOs to each other)

- All 8 RHIOS are connected and sharing data
- NYeC provides a Master Patient Index to support exchange across RHIOs

Concentrated efforts on adoption

- Individual providers
- Provider systems

DSRIP

- SHIN-NY is the primary vehicle for HIE for DSRIP

Regulation development

- Regulations went into effect on March 9, 2016
- SHIN-NY Policies and Procedures established

SHIN-NY Evaluation

Audacious Inquiry (AI)

- NYS engaged AI to develop an objective, fact-based assessment of the current status of both state-level and regional health information exchange efforts and make recommendations for moving forward.

- Report will assist DOH on the future SHIN-NY focusing on:
  - Governance
  - Technology
  - Sustainability

All Payer Database (APD)

Milestone Updates:

- Regulation Adoption and Guidance Documents
- Pre-Implementation Stakeholder Forum
- IT Solution – Vendor Award and Contract Approval
- Encounter Intake System Update
- Supreme Court Ruling: Gobielle vs. Liberty Mutual

APD Regulations: Status

- Regulatory Adoption Package initiated late December, final signoff imminent
  - Includes Definition of APD *Reporting Sources & Required Data Elements*, *Frequency & Scope of Reporting and Quality Requirements, Data Governance & Release Elements*

- Final adoption (public comment and review by Public Health and Health Planning Council) estimated August 2016

- Draft regulations and guidance documents will be shared with the HIT committee prior to our next meeting on May 20, 2016

APD Data Warehouse & Analytics

- Vendor Award – Optum Government Solutions Chosen 12/15 as winner of competitive procurement
  - Projected Contract Start – May 2016

- Interim Data Analytics (Jan 2017)
  - 200 State Agency Users
  - Consumer Facing Website

- Permanent Data Analytics & Warehouse (Sept 2017)
  - User Stories Reflecting 7 Stakeholder Groups:
  - APD Management, Consumers, Insurance Carriers, Healthcare Researchers, County & Other NYS Agencies, NYSDOH Information and Policy Managers, Providers
  - Data Aggregation, Linking, and De-identification
  - Data Validation – Across All Payers - Expected to be complete by summer 2018

APD Encounters Intake System Status and Timelines

Build Strategy:

- Collect data from NYSOH Qualified Health Plans (Began January 2015)
  - 23 QHP Issuers
- Transitioned in Medicaid Managed Care Plans (Began September 2015)
  - 55 Medicaid Issuers
- Collect data from Commercial Payers (Early 2017)
- Future Release(s):
  - Incorporate Medicaid Fee for Service encounters (December 2017)

Current Status:

- Approximately 83.3 million encounters in the Data Intake System (76.7 million Medicaid encounters (acceptance rate: 80%); 6.6 million QHP encounters (acceptance rate: 50%)

March Supreme Court Decision – disallowed APD reporting mandate on Self-Insured Plans (ERISA pre-emption)

The ruling presents structural blind spot to statewide health system analysis

New York Covered Lives Distribution *Estimate, N= 18.1 million

- QHP (NYS Health Exchange) = 1,000,000
- Medicaid and CHIP = 6,500,000
- Medicare = 3,100,000
- Large Group Commercial = 4,500,000
- ***Self-Insured Commercial*** estimated at over 3,000,000 and growing = in number to at least 40% of Commercial market, at least 16% overall

*Figures NOT point estimates, broadly stated values only due overlapping groups

Transparency

Issues to Address:

- Access to Data – combining claims data and clinical data from the SHIN-NY for a complete picture of a persons healthcare
- Use of data for rate review – use of efficiency measures for commercial rate review, including measures required for DSRIP
- Price Transparency – use of data to evaluate new models of health innovation including bundles, sub-capitation
- Consumer Transparency – tools to evaluate health care plans and providers for both cost and quality

Current Efforts Related to Transparency

Who?

- States
- Health Plans
- Third Parties

Metrics

- Cost/Charge
- Quality
- Volume
- Patient Perspective
- Combinations

Sample state tools for consumer transparency

ILLUSTRATIVE

	Goals	Approach	Results / Impact	Lessons for NY
Massachusetts	Empower patients to comparison-shop for care as part of legislation passed in August 2012	▪ Providers must disclose amount charged for admission or a service within 2 working days ▪ Providers must give patients or insurers information needed to calculate out-of-pocket costs for the patient	▪ According to a Pioneer Institute study, the "transparency law is still not a reality" – 9 of 23 sampled practices knew about the law – 13 of 25 sampled practices provided the cost of all fees within 2 days ▪ Some health systems have tools to give providers access to charges and patient costs	▪ Legislation alone cannot ensure compliance from providers and payers ▪ Consumers have difficulty understanding health care data without access to easy-to-use tools
Washington	Ensure that consumers can access cost / quality data through payer websites and mobile applications	▪ Payers required to provide the following data on website and a mobile application: – Cost data for common treatments and individual out-of-pocket costs – Quality metrics by provider (where available) – Options for patients to provide ratings or feedback	▪ Too early for data on consumer utilization and impact on medical trend (requirement begins January 1, 2016)	▪ Innovation should build off existing capabilities ▪ Alignment across major health care stakeholders can help enable reform

Source: Pioneer Institute: Mass. Healthcare Price Transparency Law Still Not a Reality; Massachusetts Medical Society: Massachusetts Medical Price Transparency Law Rolls out; Washington State website; Catalyst for Payment Reform

Sample payer tools for consumer transparency

ILLUSTRATIVE

	Tool features	Scope of services
Cigna	▪ **Personalized information** on physician and health facility quality and pricing ▪ Access to **real-time** status of health plan deductibles and co-insurance, as well as available health spending account funds	▪ Estimates cover more than 200 common procedures that represent 80 percent of Cigna's medical claims.
UnitedHealth Group	▪ Review **market average prices** for various medical services ▪ Locate nearby health care providers, and convenience care, urgent care and emergency care facilities	▪ 520 medical services across 290 episodes of care
Independent Health	▪ Directs patients towards FairHealth, **a third party online tool** that offers **non-personalized estimate of costs** for health services	▪ Thousands of medical and dental services ▪ Medical supplies ▪ Anesthesia services ▪ Ambulance rides

NEW YORK STATE | Department of Health | Innovation Center

Source: Company websites, Company interviews

Sample third party tools for consumer transparency

ILLUSTRATIVE

	Tool features	Scope of services
FAIR HEALTH Know Your Source	▪ **Free online tool** that gives both insured and uninsured users access to cost data ▪ For the insured, **non-personalized estimation of cost** for out of network vs in network provider	▪ Thousands of medical and dental services ▪ Medical supplies ▪ Anesthesia services ▪ Ambulance rides
guroo	▪ Offers a **free transparency tool** with national, state and local **non-personalized** cost and quality information for common health conditions and services ▪ Uses claims from Aetna, Assurant Health, Humana, and UnitedHealthcare	▪ Search by condition or care bundle for over 70 services ▪ Review step-by-step breakdown of the steps and costs of a care bundle (not out of pocket)
castlight HEALTH	▪ Employers **purchase Castlight subscription**, and employees gain access to provider listings, **out-of-pocket costs, and quality metrics**	▪ Thousands of medical services

NEW YORK STATE | Department of Health | Innovation Center

Source: FAIR Health website, NH Health Cost website, Company interviews

Next Steps

- Continue review of what is available today across the country
- Propose a framework for New York to promote price and quality transparency
- Develop tools for consumers, providers and payers that meet the needs of the future

Workforce Update

What Problems Need Solving?

- Primary care and specialist physician shortages
- NY-educated physicians who leave the state after training
- Lack of reliable and timely data on the state's health workforce
- Lack of reliable data/information on the types and numbers of workers that will be needed to support the APC practice model under SHIP and integrated delivery models under DSRIP and ability of the existing educational system to supply them
- Lack of student exposure to rural and non-hospital settings by helping rural providers to identify opportunities and create residency and other training programs
- Planned transition of the health care workforce from in-patient to out-patient as part of system transformation under DSRIP
- ***Confusion regarding the multiple types and tiers of care management and care coordination titles and possible redundancies.***

Where Are We Going?

- Strengthen the state's health workforce monitoring system
- Develop more reliable information regarding the numbers and types of workers that may be needed to support the APC practice model under SHIP and integrated delivery models under DSRIP and ability of the existing educational system to supply them
- Increase attractiveness of primary care careers throughout the State, including in underserved areas
- Increase care coordination capacity
- Clarify functional job classes related to care coordination and associated competencies for envisioned delivery system and assure available training and certification as deemed necessary.
- Provide technical assistance to providers for transformation effort
- Develop support for existing workforce in building team-based health, behavioral health, prevention effort, performance management and HIT skills

Workforce

PPSs are currently engaged in training workforce, with many new roles emerging as a result of DSRIP

1. PPSs **committed $450 million** in workforce transformation spending over the DSRIP time period

2. Key to this transformation is analyzing the **impact of service delivery changes** and projecting the necessary workforce and training

3. Many **new roles are emerging** resulting from DSRIP projects, including: Patient navigator, Care manager, Community health worker, Care transition coach

4. Many PPSs are **partnering with local educational institutions** to help develop training curricula and future pipelines for these roles

5. Care Coordination Core Curricula **Guidelines are being developed** by the DSRIP/SHIP Workforce Workgroup

PPS Spotlight: Staten Island PPS has developed a new community health worker training at College of Staten Island, awarding CUNY credits

Source: December 2014 PPS project application (aggregated workforce commitments)

Workgroup survey found consensus on need to “develop core competencies and/or training standards for workers in care coordination titles”

Three subcommittees convened to focus on different aspects of effective care coordination

- **Subcommittee 1**: Identification of core competencies and functions and regulatory barriers that could impede effective care coordination
- **Subcommittee 2:** Identification of curricular content for educating the health workforce on core concepts in care coordination (embedded in health professions education curricula and to use for continuing education)
- **Subcommittee 3:** Identification of recommended core curriculum for training workers in care coordination titles

Subcommittee 1: Progress to Date

- Built a common set of functions to be used by all 3 subcommittees
- Reached consensus on a set of functions and licensed titles for review
- Engaged the relevant NYSED Board Secretaries to support a shared vision and common work
- Completed review of statutory/regulatory barriers for selected licensed titled workers
- Launched review of statutory/regulatory barriers for non-licensed individuals

Subcommittee 1: Early Lessons Learned

- The set of functions selected is somewhat arbitrary – we had to start with something.
- The difference between a function and a task is just as debatable; as a result, we stopped debating it.
- We are well served by “eating the elephant one bite at a time.” We will start with the Licensed health workers but will identify barriers the impede effective care coordination by Certified and Lay workers.
- This is not an easy task for the subcommittee and we expect our need for full Workgroup engagement will be around “the very not easy tasks.”

Subcommittee 1: Next Steps

- Report Statutory/Regulatory Barriers for Licensed Titled workers to Subcommittee
- Determine Scope of Certified and Lay Titled workers for Analysis
- Report Statutory/Regulatory Barriers Certified and Lay Titled workers to Subcommittee
- Deliver Subcommittee report on Statutory/Regulatory Barriers for all “in-scope workers” to full Workgroup for review and refinement
- Receive and, as needed, incorporate recommendations from other subcommittees with regard to workforce preparation and/or on-going development

Subcommittee 2: Identification of Curricular Content for Educating the Health Workforce on Core Concepts in Care Coordination (to include in health professions education curricula and continuing education)

Subcommittee Charge:

- Describe the recommended curriculum for educating health professions students;
- Design a Curriculum to provide a basic understanding of what care coordination is and the health worker roles
- Initial focus on RNs, MD/DOs, PAs, NPs. Subsequent focus on MSWs, PharmDs & other licensed professionals
- First Meeting in late May/early June 2016

Subcommittee 3: Identification of Recommended Core Curriculum for Training Workers in Care Coordination Titles

Charge:

- Review curricula used by groups across the state for training workers in care coordination titles
- Examine overlap in core content of these training programs
- Identify key curricular components to include in all basic training programs for workers in care coordination titles

Subcommittee 3: Progress to Date

Primary focus of curricula review:

- New York Alliance for Careers in Healthcare Training
- North Country Care Coordination Certificate Program
- 1199SEIU Care Coordination Fundamentals
- CUNY Credited Course Sequence in Care Coordination and Health Coaching
- National literature searches on care coordination training were conducted as these curricula were being developed
- Reviewers found a great deal of consistency in content across the different training curricula

Core Curriculum Guidelines Developed

Consists of 9 modules that include:

- topics,
- learning objectives and
- resources

Estimated time to complete all modules between 36-45 hours

Designed to be adapted to fit local circumstances

- Could be embedded in medical assistant or home health aide training
- Could serve as a base for care coordination training worth college credit

Summary of Modules

- Introduction to New Models of Care and Health Care Trends
- Interdisciplinary Teams
- Person-Centeredness and Communication
- Chronic Disease and Social Determinants of Health
- Cultural Competence
- Ethics and Professional Behavior
- Quality Improvement
- Community Orientation
- Technology, Documentation and Confidentiality

Reference Materials

List of and links to (where available) all training programs reviewed

Resources

- Textbooks
- Supplemental readings
- Documentaries/programs
- On-line resources

Soliciting Feedback on Guidelines from Stakeholders

- Are guidelines needed?
- Was anything missing from content?
- Are there additional stakeholders who should review guidelines and provide feedback?
- What strategies could be used to encourage use of the guidelines?
- How can the guidelines be kept current?

Access to Care

Access Initiatives Addressed Today

Telehealth:

- Project ECHO
- Tele-Mental Health

Telehealth in New York State

- Many successful telehealth initiatives are currently in place and interest and momentum are building
- Telemedicine Credentialing and Privileging Law, effective 2012
- Telehealth Parity Law, effective January 1, 2016
- Despite progress, implementation barriers still exist

Project ECHO (Extension for Community Healthcare Outcomes)

"The mission of **Project ECHO**® is to expand the capacity to provide best practice care for common and complex diseases in rural and underserved areas and to monitor outcomes." http://echo.unm.edu

Benefits:

- Expands capacity of existing primary care workforce
- Addresses workforce shortages and maldistribution
- Deploy innovations and best practices
- Increase rural provider job satisfaction
- Improves quality of care provided to patient
- Reduces unnecessary referrals to specialty care
- Addresses increasing costs of health care

Tele-Mental Health: Benefits for Providers

Rural and Other Clinicians

- Improved access to mental health specialists for consultation.
- Improved quality of mental health care for patients.
- Reduced professional isolation. Improved access to continuing medical education programs.
- Improved continuity of care and follow-up.
- Psychiatric consultation in ED.

Mental Health Specialists

- Greater ability to serve rural and underserved communities even when living in large, urban areas without incurring the burden of frequent travel.
- Increased flexibility in work schedules.
- Ability to practice in states where licensed but not physically located.

Recommendations to Promote Access Through Tele-Health

- Support statewide expansion of the Project ECHO model.
- Publicize and promote expanded telehealth reimbursement policies to increase awareness among health care providers
- Streamline credentialing of providers delivering services through telemedicine by amending Public Health Law.
- Explore payment for select physician to physician consultations. Examples include post-transplantation or for pediatric mental health.
- Establish a statewide telehealth provider directory

Closing Remarks