



**Department
of Health**

Integrated Care Workgroup Meeting #16

July 12, 2016



**Department
of Health**

**Innovation
Center**

Integrated Care Workgroup Agenda

Timing	Topic	Lead
10:00 – 10:10	Introductions/Review Agenda	
10:10 – 10:40	Governance Proposal	Foster Gesten/ Susan Stuard/ Stefanie Pawluk
10:40 – 11:25	Update on payer engagement; Summary of recent payer-purchaser meeting	John Powell/ Amy Tippet-Stangler, NEBGH
11:25 – 11:50	APC and Other Updates	Lori Kicinski/ Marcus Friedrich
11:50 – 12:05	Scorecard Update	Anne Schettine/ Paul Henfield, IPRO
12:05 – 12:20	Working lunch	
12:20 – 1:45	Facilitated Discussion	Susan Stuard
1:45 – 2:00	Wrap-up	Foster Gesten/ Susan Stuard

Governance Proposal

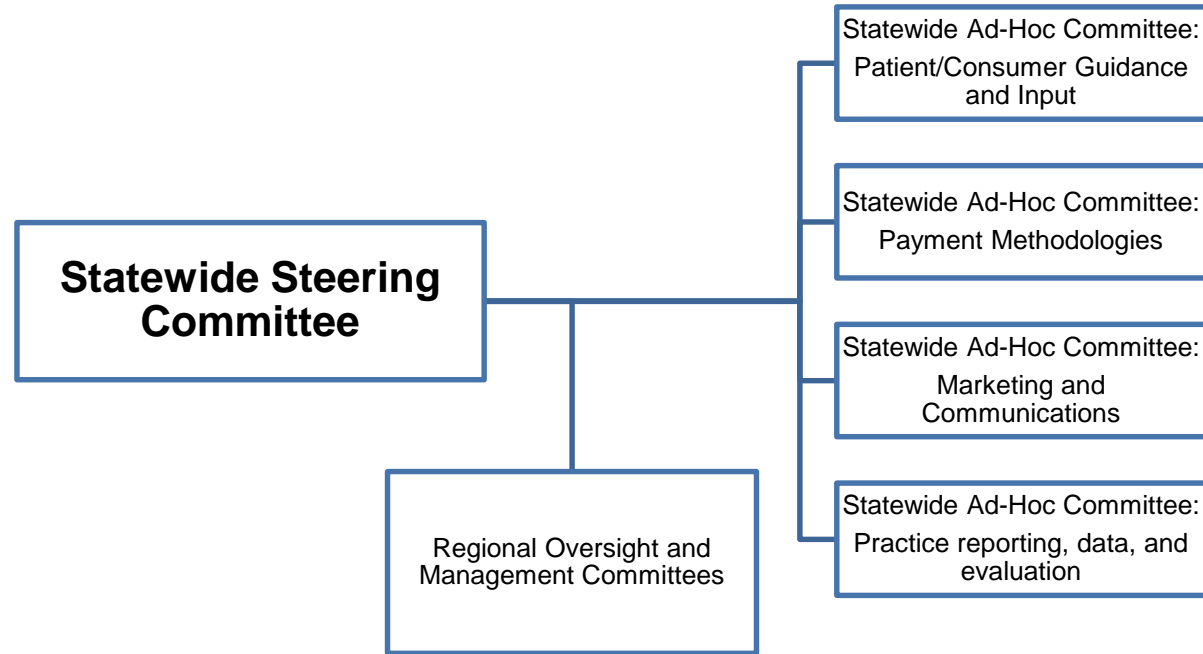
Governance

- Proposed APC Governance Model
 - Statewide Steering Committee
 - Ad Hoc Working Groups
 - Regional Oversight and Management Committees
- Consumer and patient engagement efforts
- Timeline/Next Steps

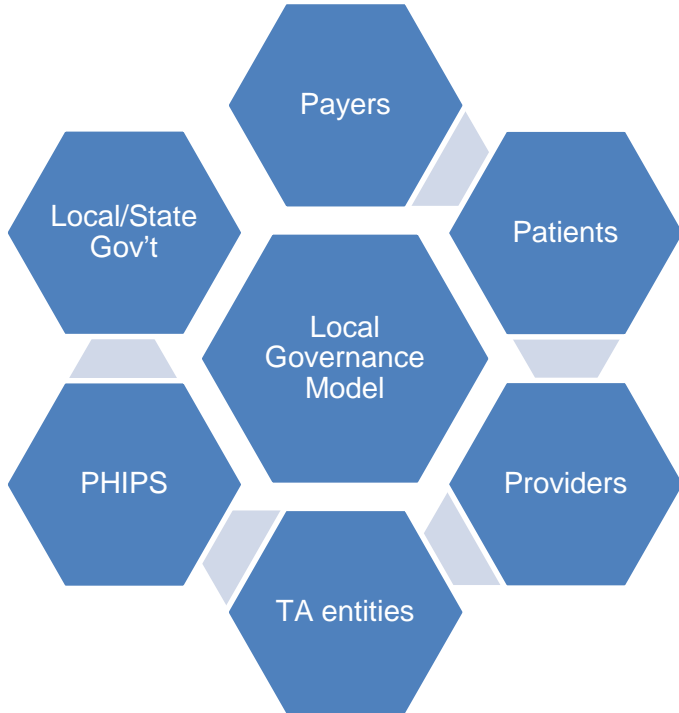


Statewide Governance

- Provides strategic direction and guidance to NYS to ensure overarching goals of APC are met.
- Evolve the APC model as needed including recommending changes to the model to reflect learnings during the implementation process
- Provide guidance regarding alignment across regions as well as alignment of numerous federal and state initiatives to ensure efficiency and coordination to achieve common goals.
- Report to the Health Innovation Council twice yearly to offer legislative and regulatory recommendations as needed and appropriate.
- Guide/provide recommendations regarding “activation” of regions in terms of practice transformation support.



Regional Governance



Regional Oversight and Management Committees will convene to:

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

Topics could include:

- Issues between TA entities and practices;
- Issues between payers and providers;
- Patient/consumer feedback;
- Best practices, lessons learned, and challenges;
- Regional linkages between clinical and community resources.



Consumer and Patient Engagement

- Goals:
 - Meaningful inclusion of consumer and patient voice in transformation
 - Patient perspective at statewide, regional, and practice levels
- Considerations
 - Regional governance
 - Coordination with other initiatives
- Next steps



Payer Engagement Update

One-on-One Payer Engagement Meetings

- To date:
 - Completed five one-on-one meetings with commercial plans, more scheduled
- Approach:
 - Targeting regions (Capital District, Adirondacks, Hudson Valley, Finger Lakes, NYC) but will include follow-up to all plans
- Framing:
 - Follow up to RFI, clarify APC and answer questions
 - Better understand existing programs, determine alignment with APC
 - Identify opportunities for multi-payer efforts



Next Steps

- Continue targeting regions
- Develop agreement to implement multi-payer initiative
- Identification of “possible universe of practices” to engage in a multi-payer, APC arrangement with practice transformation support



High-Level NEBGH Activity



Snapshot of organizations represented:

1199, CBS, Cold Spring Harbor Laboratory, Corning, CVPH, Deutsche Bank, Ernst & Young, Kodak, Finger Lakes Health Systems Agency, Goldman Sachs, Greater Rochester Health Foundation, H2M, KKR, LiDestri Foods, Mercer, Molloy College, Nassau-Suffolk Hospital Council, National Grid, News Corp, NYC Office of Labor Relations, Paychex, Premier Consulting Associates, Rochester Business Alliance, Rochester Institute of Technology, Rochester Regional Health, Southampton Hospital, Suffolk County Medical Society, University of Rochester, Time Warner Inc., Wegmans Food Markets, Xerox



Joint Payer/Purchaser Meeting Highlights

- Employees/patients need the right data and to be educated in order to choose providers based on quality and evidence rather than solely on convenience and cost
- Programs like PCMH and APC need to be marketed better to reflect why their primary care providers are ranked higher than others
- Purchasers are willing to make upfront payments for value based initiatives without the immediate promise of an ROI if they believe in the model
- Health plans are doing a multitude of things with value based care that purchasers don't understand; purchasers need to push for reporting on these initiatives from their health plans so they can understand the mechanics and use this to sell value based care to the C-suite
- Purchasers and their consultants are moving away from making purchasing decisions based on discounts to making purchasing decisions based on total cost of care and the value of care
- Plans don't want to increase ASO fees for VB initiatives without demonstrated success; they have re-directed dollars from failed programs to invest in new VB initiatives
- The shift to customization is creating a lot of volatility. "Are purchasers okay with that?"



APC and Other Updates

Updates

PT RFA Update:

- Received 19 applications from 13 bidders, for 8 DFS Regions
- Applications are currently evaluated
- Target 9/1/16 start date for contracts pending approvals

APC Milestone and Implementation Guide – V1

- 140+ pages, the Guide offers clear, practical and concise tools, forms and resources that can be used at practice level
- Input was provided by content experts, including 150+ links for easy access to resources
- Provides greater continuity of APC curriculum alignment for Statewide transformation agents and primary care practices to achieve successful outcomes
- Will be released in September

Example of APC Milestone and Implementation Guide – V1

Milestone2 Sub-Milestone	Gating Criteria	Task Requirement	Guidance	Auto-credit Tech	Auto-credit PCMH 2014	Auto-Credit TCPI
Commitment to Advanced Directives Discussion with all patients >65 at Gate 2	<ul style="list-style-type: none"> Practices uses protocols/processes with goal of reporting Advanced Directives (AD) on all patients >65 years 	<ul style="list-style-type: none"> Provide a narrative description of protocols/processes to engage/record AD for eligible patients Provide a 3-month spreadsheet or EHR-generated report: N=patients having ADs in chart, D=all eligible patients seen in one year; reports should include all declines responses in both N and D to flag reminders in paper chart or EHR 	1		3A, 12 3 points	

Reporting Advanced Directives: Most EHR templates offer discrete fields for AD and patients >65 can be triggered for a report. A checklist spreadsheet can also be used at time of visit. There is no threshold expected for the 3-month report, however, it is expected that the practice shows sustainable improvement over time. Determine who on the staff has responsibility for recording data. Data fields should include the following: Health Care Proxy, Living Will, DNR order. AAFP is also a source for printable forms <http://www.aafp.org/afp/2012/0301/p461.html>



Cont. Updates

DSRIP NCQA/PCMH Designation:

- March 2018 deadline for PCP's in DSRIP to be either PCMH 2014 or APC
- Special option for NCQA PCMH 2014 practice recognition submission deadlines for DSRIP (9/30/2017 – 1/31/2018 reduced fee and two year duration recognition)
- Agreement made that practices would be eligible to fulfill deadline by reaching APC gate 2



DSRIP NCQA/PCMH 2014 alignment with APC gates and milestones

PCMH fulfills all APC Gate 1 criteria	PCMH + .?. = APC Gate 2		PCMH + .?. = APC Gate 3
No additional requirements	Auto-credit for PCMH practices at Gate 2:	Additional requirements for PCMH practices at Gate 2:	Additional requirements for PCMH practices at Gate 3:
Participation Agreement Change Plan, Designate Change Agents/Practice Leaders	Patient Engagement activities Integrated into Workflows within one year (PCMH 6C, F1-4 4pt)	Assessing practice demands and offering same Day Appointments	Implementation of patient engagement integrated into workflows including Quality Improvement (QI) Plan (grounded in evidence-based criteria)
Commitment to creating a process for Advanced Directive Discussion with Patients	Commitment to Advanced Directives Discussion with all Patients >65 years (PCMH 3A, 12 points)	Signed APC Payer Contracts : readiness for VBP Models and business development by Year 3	Sharing Advanced Directives across Medical Neighborhood, where feasible
Commitment at Gate 1 to using Self-Assessments for BH integration	Implementing process to Identify Highest Risk Patients for Care Management (PCMH 2A, 1,2 up to 3 points)		Participating in Prevention Agenda Activities Identification and outreach to patients due for Preventive and Chronic Care Management
Commitment to providing 24/7 Access to a Provider at Gate 1 and improve communications with patients and health entities capabilities	Preparing and planning for Care Management and/or Care Coordination (CM/CC) delivery within one year (PCMH 2D, 5-7 MUST PASS, up to 4 points)		Creating a process to refer to Structured Health Education Programs and Community Based Resources Delivering Care Management to Highest Risk Patients Integrate High Risk Patient data from other sources (including payers)
	Commitment to integrating an Evidenced- Based behavioral health screening process; engage in BH integration training; form a Collaborative Care Agreement (PCMH 3C, 9 must receive score for depression screening tools; separate tool required for substance/alcohol abuse)		Delivering Coordinated Care Management for Behavioral Health Care Plan development in concert with Patient Preferences and Goals
	Creating a Referral Tracking System (PCMH 5B, 1-10 MUST PASS 6 points, 5B, 8)		Establishing Care Compacts or Collaborative Agreements for Timely Consultation with Medical Specialists and Institutions
	Providing 24/7 Access to a Provider and to improve communication capabilities (PCMH 1B 1-3, 3.5 points)		Creating a Post Discharge Follow-up Process for timely transitions in care
	Commitment to providing Culturally and Linguistically Appropriate Services (PCMH 2C 1-3 All 2.5 points)		Providing at least one Session Weekly during non-traditional Hours
	Utilizing Tools for Quality Measurement encompassing all Core Measures (PCMH 3B, 1-11, All 4 points)		Utilizing Tools for Quality Measurement encompassing all Core Measures
	Commitment to Attest to Connect to HIE in Year 1 and develop basic information exchange (PCMH 6G, 8 proof of Attestation required)		Securing Electronic Provider-Patient Secure Messaging

Cont. Updates

CPC+:

DOH Letter to Health Plans:

- CPC+/ APC/ Medicaid VBP roadmap broadly align
 - VBP payments to primary care practices allowing them for increase in funding and upfront investment in necessary capabilities
 - Focused on cost and quality
 - Defined but limited set of quality metrics
 - Practice transformation resources
- CPC+ consistent with SIM/APC goals
- CPC+ is Medicare's contribution to APC
- Goal was to have plans apply to CPC+ to engage Medicare to have CPC+ awarded in NY State
- Payer solicitation ended June 8th, CMS will publish CPC+ regions before practice applications start July 15th



Cont. Updates

NCQA PCMH 2017:

Redesign of PCMH recognition process:

- NCQA interacts with practices
 - Submission of documents at flexible intervals until recognized
 - Annual review and ongoing data submission to sustain recognition
 - “Phased engagement”
 - Core- and Additional requirements
 - No more “levels”
 - Continued expansion of HIT, use of measures, BH integration, community resource integration
-
- Public Comment period open till July 15th
- <http://www.ncqa.org/homepage/ncqa-public-comments/pcmh-2017-public-comment>
- Release date March 2017
 - Possibility to have a state-specific NCQA PCMH 2017 solution



PCMH 2017 vs. APC Milestones

PCMH 2017 Requirements (proposed categories)	APC Milestones
<p>Team-Based Care and Practice Organization The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers and organizes and trains staff to work to the top of their license and ability to provide effective team-based care.</p>	<p>PARTICIPATION Practice demonstrate readiness through either initial gating assessment or through certification</p>
<p>Knowing and Managing Your Patients The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.</p>	<p>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</p>
<p>Patient-Centered Access and Continuity Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.</p>	<p>ACCESS TO CARE Promote access as defined by affordability, availability, navigability, accessibility, of care across all patient populations 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</p>
<p>Care Management and Support The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.</p>	<p>CARE MANAGEMENT /CARE COORDINATION Manage and coordinate care across multiple providers and settings by actively tracking the highest need patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and track and optimize transitions of care. Care Management is defined as: focus on the comprehensive support of the highest risk subset of practice's patient population. Care Coordination defined as: the practice contributes to seamless care of all patient transitions across all environments</p>
<p>Care Coordination and Care Transitions The practice tracks tests, referrals and care transitions to ensure comprehensive care coordination and communication with specialists and other providers in the medical neighborhood.</p>	
<p>Performance Measurement and Quality Improvement The practice collects, reports and uses performance data to identify opportunities for quality improvement, sets goals and acts to improve clinical quality, efficiency, patient experience and engages the staff and patients/families/caregivers in the quality improvement activities.</p>	<p>HIT Use health information technology to deliver better care that is evidence-based, coordinated, and efficient</p>
	<p>PAYMENT MODEL Participate in outcomes-based payment models, based on quality and cost, for over 60% of the practice's patient panel</p>



APC/CPC+/NCQA PCMH 2017 Crosswalk

APC	CPC+	Proposed NCQA PCMH 2017
Participation	Limited enrollment/Participation requirements	Team-based Care and Practice Organization
Patient-Centered Care	Patient and Family Caregiver Engagement	Knowing and Managing Your Patients
Access to Care	Access and Continuity	Patient-centered Access and Continuity <i>and</i>
Population Health	Planned Care for Population Health	Care Management Support of a Population
Care Management/Care Coordination	Comprehensiveness and Coordination	Care Coordination and Care Transitions
Health Information Technology and Quality Improvement	Optimal use of HIT and Data Driven Quality Improvement (eCQM)	Performance Measurement and Quality Improvement
Advanced Payment Models	Use of Enhanced, Accountable Payment Models	None



APC Score Card Update

Preparations for Data Collection of Version 1 - Overview

Preparing for Data Collection and Aggregation

- Payer Readiness Survey – six organizations surveyed (June 2016)
- Individual Interviews being scheduled with the organizations

Pilot Data Collection in August with volunteer organizations

- Payers to submit subset of version 1 measures with member level results attached to provider/practices
- Practice level results aggregated across payers

Data Validation Pilot

- Member – Practice exploration
- Provider – Practice exploration

Guidance and Best Practices for all Payers for January 2017 initial submission



Payer Readiness Survey – Summary of Findings*

Current Reporting Capabilities

- All payers report HEDIS measures required for APC
 - all use vendors to calculate
- All payers report measures on a calendar year basis and can report year to date for trending
- All payers report measures by product
 - to report on entire book of business may require software/platform modification

* One organization doesn't currently report any measures and is not included in any of the summary results



Payer Readiness Survey – Summary of Findings*

Provider/Practice Reporting and Attribution

- All payers produce provider-level reports (e.g., Gaps in Care reports)
 - Different methods may be used to link providers to practices
 - Reporting is monthly
- All payers use internally-developed attribution logic to link patients to PCPs
 - Only one links patients to specialists

* One organization doesn't currently report any measures and is not included in any of the summary results



Payer Readiness Survey – Summary of Findings*

APC Reporting

- None report the non-HEDIS measures through a Cost of Care measure is calculated by some
- All payers have the capability to report on a 12 month rolling basis
 - Requires system modification and additional resources, both staffing and cost
- All payers can adapt their attribution logic for APC reporting
- All payers indicated timing and system issues in reporting measures on a quarterly basis

* One organization doesn't currently report any measures and is not included in any of the summary results



Payer Readiness Survey – Next Steps

Follow-Up Interviews (July – early August)

- Follow-up on potential barriers to APC reporting:
 - Any claims data limitation issues
 - How to capture entire book of business
 - How to introduce non-HEDIS measures
 - Resources/Staff needed for potential system modifications
 - Timing for quarterly reporting
- More detail about the attribution logic
- Preparation for Pilot Test
 - System modifications that may be required
 - Submission file/Data elements
 - Reporting period/submission date determination
 - Measures to be reported



Pilot Test

- August/September time period
- Approximately 12 measures – all HEDIS; 5 volunteer payers to participate
- Measurement period to be determined
- Results will be aggregated and practice reports generated
- Assess the accuracy of the attribution process - both provider to practice and patient to practice
- Findings used to identify any reporting issues
 - Data elements
 - Misattribution
 - Submission tool
 - Timing to report
 - Vendor support
- Identify and recommend best practices



Facilitated Discussion

Looking Back and Looking Forward

The ICWG has developed over 18 months:

- a consensus set of advanced primary care practice requirements
 - 'core' quality and cost measures
 - a payment approach to support practice transformation and value based payments for a statewide, multi-payer initiative
- What are the strengths and challenges of each component? Is there anything missing?
 - What do you think are the top 3 considerations for achieving success as we move from development of APC to implementation?



Breakout into Small Groups

- Break out into small groups for discussion
- Discuss within your group and agree upon two following items:
 - Identify 2-3 major accomplishments made by the Integrated Care Workgroup (ICWG) in the last 18 months
 - Identify the top 2-3 considerations/recommendations as the NYS advanced primary care model moves into its implementation phase
- Your break out group has to come to agreement on top 2-3 items for both A and B
- Be prepared to report out at end of session and share your top items with entire ICWG
- Please keep your notes of these top items as we'd like to collect and record them



Closing Remarks