NYS Health Innovation Council
# Agenda

<table>
<thead>
<tr>
<th>#</th>
<th>Topic</th>
<th>Time</th>
<th>Leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Welcome and Introductions</td>
<td>10:30 – 10:45</td>
<td>Paul Francis</td>
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<td>Dr. Howard Zucker</td>
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<tr>
<td>2</td>
<td>Evaluating SIM Progress to Achieve Goals: Key Questions</td>
<td>10:45 – 11:10</td>
<td>Kerry Griffin</td>
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<td>New York Academy of Medicine</td>
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<td>3</td>
<td>SIM Implementation Progress: Successes and Challenges</td>
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<td></td>
<td>• Provider Transformation</td>
<td>11:10 – 12:00</td>
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<td></td>
<td>- PT TA Expansion</td>
<td></td>
<td>Dr. Marcus Friedrich</td>
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<td>- Regional Rollout</td>
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<td>Edward McNamara</td>
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<td></td>
<td>- PCMH Alignment</td>
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<td>Jim Kirkwood</td>
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<td></td>
<td>• Payer Engagement</td>
<td>12:00 – 12:40</td>
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<tr>
<td></td>
<td>- Medicaid Primary Care Support</td>
<td></td>
<td>Carlos Cuevas</td>
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<td></td>
<td>- Health Plan alignment with APC</td>
<td></td>
<td>Dr. Marcus Friedrich</td>
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<td></td>
<td>- MACRA and APC Alignment</td>
<td></td>
<td>John Powell</td>
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<tr>
<td>4</td>
<td>Next Steps</td>
<td>1:15 - 1:30</td>
<td>Paul Francis</td>
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<td>Dr. Howard Zucker</td>
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SIM Evaluation
Questions

New York Academy of Medicine
New York State Innovation Model (SIM) Evaluation

NYS Health Innovation Council Meeting
May 31, 2017
The New York Academy of Medicine
SIM Evaluation: Context and Scope

- **Goal:** Support effective implementation of NY SIM
  - Note: objectives different than those of federal evaluation

- Mixed Methods: quantitative and qualitative

- Partnership between The New York Academy of Medicine and FAIR Health, Inc.
Guiding Questions

- What is the value-added of SIM?
- To what extent is NYS meeting its SIM targets?
- How is implementation proceeding, and what are the facilitators and barriers?
- What is the level of engagement from different stakeholders and what factors affect engagement?
- What are the most notable successes to date, and the drivers?
- What have been the key challenges?
- Have there been unintended consequences?
- How effectively is SIM addressing population health?
- Are there sufficient and appropriate resources to facilitate health innovation and improvement?
Analytical Approach

- An assessment of changes in program participation, and related costs, quality, and population health metrics statewide, regionally, and at the practice level

- Multi-pronged: complementary quantitative and qualitative research methods, including primary and secondary data, to evaluate the SIM and its component parts

- Timeframe: pre-SIM period (lookback of three years) through implementation (Nov 2018)

- Flexible and iterative, responding to program changes as they occur
Assessing APC Model Performance & Implementation: Quantitative

Comparing different levels and stages of APC implementation
- APC vs. APC-like (e.g., PCMH) vs. control
- Account for regional roll-out strategy

Measures of performance
- Measures calculated from multi-payer data using FAIR Health claims warehouse
  - HCI3 Episode of Care Measures for Chronic Conditions (cost and quality)
  - Total cost of care, hospitalizations, emergency department use
- APC scorecard measures
Assessing APC Model Performance & Implementation: Quantitative (Cont’d)
Proposed Metrics

Custom measures for primary care providers calculated from the FAIR Health database, supplemented with Medicare and Medicaid (pending) claims data, including:

- Total cost of care
- Hospital admissions
- ED utilization
- Primary care utilization
HCI3 Episodes of Care sensitive to changes in primary care. Each episode measure encompasses cost and quality:

<table>
<thead>
<tr>
<th>Episode of Care Measure</th>
<th>Variable Name</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>ASTHMA</td>
<td>EC0401</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>COPD</td>
<td>EC0402</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>CAD</td>
<td>EC0508</td>
</tr>
<tr>
<td>Depression &amp; Anxiety</td>
<td>DEPANX</td>
<td>EC1909</td>
</tr>
<tr>
<td>Diabetes</td>
<td>DIAB</td>
<td>EC1001</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>HF</td>
<td>EC0521</td>
</tr>
<tr>
<td>Hypertension</td>
<td>HTN</td>
<td>EC0511</td>
</tr>
<tr>
<td>Low Back Pain</td>
<td>LBP</td>
<td>EC0801</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>PREVNT</td>
<td>EX9901</td>
</tr>
</tbody>
</table>
Assessing APC Model Performance & Implementation: Qualitative

Wave 1
State Leadership and Key Staff

Wave 2
Practice Transformation Agents
SIM Committee and Workgroup Chairs and Members (e.g., ROMCs)
Professional Organizations (e.g., HANYS, NEBGH)
Payers

Wave 3
Practices
Consumers (focus groups)

Future waves: repeat interviews with stakeholders
Stakeholder Interviews: Sample Questions & Themes

State Leadership and Key Staff (Wave 1)
- Status of SIM implementation and how it fits into broader reform efforts
- What’s going well, what are key challenges thus far and in future? Have your plans changed?
- What information would be helpful to you as we speak with others? Who should we be sure to speak with?

SIM Committee and Workgroup Chairs and Members
- Status of relevant components (e.g., workforce)
- Expectations of progress; on track?
- Challenges or concerns now or in future?
Sample Questions & Themes (cont’d)

Practice Transformation Agents
- Availability of tools and resources to facilitate practice transformation
- Early challenges/ concerns recruiting practices

Practices
- Choosing APC vs. other vs. none; factors underlying choices
- Supports and resources necessary for transformation
- Early challenges/concerns
Sample Questions & Themes (cont’d)

Payers
- Incentives for supporting APC
- Role and engagement with ROMCs
- Early challenges/concerns

Professional Organizations (e.g., HANYS, NEBGH)
- Perceived value of SIM vs other reform efforts
- Level of engagement of members and factors affecting engagement
- For NEBGH: level of engagement of payers, purchasers? Challenges and opportunities for engagement moving forward?
Key Questions for Stakeholders (cont’d)

Consumers (focus groups)

- Experience of care at APC practices (vs. desired experience; vs. experience at “non-transformed” primary care practices)
- Knowledge of and preferences for advanced primary care models
Closing Thoughts

- Focus is on generating information that will be useful as SIM is being implemented (vs. seeing if “CMMI SIM program works overall”)

- Will be flexible in evaluation strategy as implementation strategy changes over time – being responsive to questions as they arise

- Will support sustainability planning for NY SIM
Project Key Contacts

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Linda Weiss, PhD, Co-Principal Investigator – Qualitative Analysis
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Anthony Shih, MD, Executive Sponsor
ashih@nyam.org
Questions/Comments
Provider Transformation
NY State Transformation Activities- 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
NY State of Transformation – SIM/APC Facts

- Launched Round 2 Practice Transformation (PT TA) vendors- 16 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
- PT TA “Train-the-Trainer” Webinars, Monthly Round Table, 1:1 Monthly PT TA “Pulse” conference calls with APC team
- As of May 24th, 101 practices enrolled, 58 in discussions
- 65% of the practices are small provider size (1-4 provider), the rest medium (5-10) and large (>10)
## NY State Transformation – TA Vendors

<table>
<thead>
<tr>
<th>#</th>
<th>Name of Awardee</th>
<th>Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adirondack Health Institute</td>
<td>AHI Capital District and Adirondacks</td>
</tr>
<tr>
<td>2</td>
<td>CDPHP</td>
<td>CDPHP Capital District, Mid-Hudson Valley and North Country</td>
</tr>
<tr>
<td>3</td>
<td>HANYS</td>
<td>HANYS Capital District and Long Island</td>
</tr>
<tr>
<td>4</td>
<td>Chautauqua County Health</td>
<td>CCHN Western (Buffalo)</td>
</tr>
<tr>
<td>5</td>
<td>Solutions 4 Community Health</td>
<td>S4CH Mid-Hudson Valley and Long Island</td>
</tr>
<tr>
<td>6</td>
<td>Institute for Family Health</td>
<td>IFH NYC</td>
</tr>
<tr>
<td>7</td>
<td>IPRO</td>
<td>IPRO NYC, Central NY (Syracuse) and Long Island</td>
</tr>
<tr>
<td>8</td>
<td>PCDC</td>
<td>PCDC NYC</td>
</tr>
<tr>
<td>9</td>
<td>Fund for Public Health in New York</td>
<td>FPHNY NYC</td>
</tr>
<tr>
<td>10</td>
<td>Finger Lakes (Common Ground Health)</td>
<td>CGH Finger Lakes (Rochester) and Central NY (Syracuse)</td>
</tr>
<tr>
<td>11</td>
<td>Niagara Falls Memorial Medical Center</td>
<td>NFMMC Western New York Region</td>
</tr>
<tr>
<td>12</td>
<td>New York eHealth Collaborative</td>
<td>NYeC Western New York Region, NYC, and Long Island</td>
</tr>
<tr>
<td>14</td>
<td>Chinese American IPA, Inc. d/b/a Coalition of Asian-American IPA</td>
<td>CAIPA New York City Region</td>
</tr>
<tr>
<td>15</td>
<td>EmblemHealth Services Company, LLC</td>
<td>Emblem New York City Region and Long Island</td>
</tr>
<tr>
<td>16</td>
<td>Maimonides Medical Center</td>
<td>Maimonides New York City Region</td>
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**Round 1 Entities**

**Round 2 Entities**
NY State Transformation – TA Vendors and enrolled practices

Capacity Projections - All Regions*

<table>
<thead>
<tr>
<th>Region</th>
<th>Practices</th>
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<tbody>
<tr>
<td>Region 1</td>
<td>130</td>
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<tr>
<td>Region 2</td>
<td>216</td>
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<tr>
<td>Region 3</td>
<td>125</td>
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<tr>
<td>Region 4</td>
<td>1081</td>
</tr>
<tr>
<td>Region 5</td>
<td>70</td>
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<tr>
<td>Region 6</td>
<td>70</td>
</tr>
<tr>
<td>Region 7</td>
<td>115</td>
</tr>
<tr>
<td>Region 8</td>
<td>379</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>2335</strong></td>
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Practice Transformation Tracking System (PTTS)

May 31, 2017

Practice Recruitment

Practice Sites Enrolled

Practice Sites Engaged

Enrolled Practice Sites by Practice Size

Enrolled Practice Sites by Region & Size

Enrolled Practice Sites by Region & TA

Enrolled Practice Sites by Region & TA

Enrolled Practice Sites by Region & TA

Practice Sites Enrolled

Enrolled Practice Sites by Practice Size

Enrolled Practice Sites by Practice Size

Enrolled Practice Sites by Practice Size

Enrolled Practice Sites by Practice Size

Enrolled Practice Sites by Practice Size

Enrolled Practice Sites by Practice Size

Enrolled Practice Sites by Practice Size

Enrolled Practice Sites by Practice Size

Enrolled Practice Sites by Practice Size
Current enrolled practices by size and region

Enrolled Practice Sites by Region & Size

Record Count

Region 1 Region 2 Region 3 Region 4 Region 5 Region 6 Region 7 Region 8
DFS Region

Practice Size
- Large Medium Small

Small = 1-4 primary care physician and mid-level providers; medium = 5-10; large = 11+
NY State of Transformation - Facts

PTTS Transformation Progress as of May 24th, 2017

Practice target based on Round 1 TA Agent estimates for 2017.
Success to achieve NY State SHIP goals depends on:

- 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
- Building and achieving sustainability of APC beyond SIM
Summary

- SIM/APC is operational and has capacity
  - How can we accelerate success towards NY State SHIP goals?
  - How do we objectively measure success?
  - How can we achieve sustainability?
Regional Rollout
Integrated Care Workgroup transition: Regional Rollout

**Movement from:**
- Development
- Gathering Input
- Statewide Only

**To:**
- Implementation
- Solving Problems
- State Steering and Regional Committees
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
Regional Rollout

Finger Lakes ROMC
- 15-20 participants
- Facilitator: Tom Mahoney, MD
- Convener: Common Ground Health

ADK Medical Home
- 25-30 participants
- Facilitator: Dennis Weaver, MD
- Convener: AHI

Public Payers
- Medicare FSS & Medicaid

Employers
- Kodak, Paychex, RIT

Providers
- ACOs, FQHC, Private Practice, Medical Society

Plans
- Aetna, Excellus BCBS, MVP

TA Vendors
- AHI

Commercial Plans
- BSNENY, CDPHP, Empire BCBS, Empire UHC, Excellus, Fidelis, MVP

Consumers

Regional Rollout

Employers

Providers

Plans

TA Vendors

Public Payers

ADK Medical Home

Finger Lakes ROMC
Regional Rollout

Capital/Hudson Valley ROMC
(15-20 participants)
Facilitator: Susan Stuard
Convener: NEBGH

Health plans
(CDPHP, Empire BCBS, MVP and UHC-Empire Plan)

Employers
(GE and Albany Medical Center)

Consumer Groups
(AARP)

TA Vendors
(CDPHP, HANYS, Solutions for Community Health)

NYC ROMC
(40-60 participants)
Facilitator: Dennis Weaver
Convener: NEBGH

Health plans
(Aetna, Affinity, Emblem, Empire BCBS, HealthFirst, UHC and UHC-Empire Plan)

Employers
(1199, 32BJ, National Grid, and NYC OLR)

Providers
(large health systems, IPAs, ACOs and small practices)

NYS DOH staff
PCMH Alignment
## NY State Practice Transformation Programs: Alignment with SHIP

<table>
<thead>
<tr>
<th>Program</th>
<th>Primary care model</th>
<th>VBP</th>
<th>VBP Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSRIP</td>
<td>PCMH or APC</td>
<td></td>
<td>Medicaid VBP roadmap</td>
</tr>
<tr>
<td>SIM/APC</td>
<td>SIM/APC primary care model</td>
<td>Commercial payers provide prospective, risk-adjusted PMPM payments</td>
<td>No VBP component</td>
</tr>
<tr>
<td>TCPI</td>
<td>TCPI transformation program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MACRA</td>
<td>Medical home generally</td>
<td>CMS, payers provide prospective, risk-adjusted PMPM payments</td>
<td>Advanced APM as part of CMS Medicare programs</td>
</tr>
<tr>
<td>CPC +</td>
<td>CMMI transformation program</td>
<td></td>
<td>CMS, payers provide prospective, risk-adjusted PMPM payments</td>
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### Goals of Alignment

Reduce confusion for providers and payers by:
- leveraging natural alignment
- achieving incremental changes where possible
While we are making progress, there is significant room for alignment and acceleration of implementation

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<thead>
<tr>
<th>From ...</th>
<th>... to (ILLUSTRATIVE)</th>
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<tbody>
<tr>
<td><strong>Provider adoption</strong></td>
<td>80+ practices signed up in 4 regions</td>
</tr>
<tr>
<td><strong>Payer support</strong></td>
<td>Compatible support from Medicaid and selected private payers</td>
</tr>
<tr>
<td><strong>Regional coverage</strong></td>
<td>ROMCs in 4 regions</td>
</tr>
<tr>
<td><strong>Impact</strong></td>
<td>Early communication and awareness</td>
</tr>
<tr>
<td><strong>Alignment</strong></td>
<td>Multiple program options with limited coordination</td>
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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:

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

Key points:
- Gradual submission
- Core and elective criteria updated
- Yearly check-ins

# APC Structural Milestones

**What a practice achieves on its own, before any TA or multi-payer financial support**

### Commitment

1. APC participation agreement
2. Early change plan based APC questionnaire
3. Designated change agent / practice leaders
4. Participation in APC Entity APC orientation
5. Commitment to achieve gate 2 milestones in 1 year

### Patient-centered care

1. Process for Advanced Directive discussions with all patients

### Population health

1. Commitment to developing care plans in concert with patient preferences and goals
2. Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year

### Care Management/Coord.

1. Identify and empanel highest-risk patients for CM/CC
2. Process in place for Care Plan development
3. Plan to deliver CM / CC to highest-risk patients within one year
4. Behavioral health: Evidence-based process for screening, treatment where appropriate, and referral

### Access to care

1. 24/7 access to a provider
2. Same-day appointments
3. Culturally and linguistically appropriate services

### HIT

1. Plan for achieving Gate 2 milestones within one year
2. Tools for quality measurement encompassing all core measures
3. Certified technology for information exchange available in practice
4. Attestation to connect to HIE in 1 year

### Payment model

1. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year
2. Minimum FFS with P4P contracts with APC-participating payers representing 60% of panel

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# Readiness for Care Coordination

**What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet**

### Prior milestones, plus...

1. Participation in TA Entity activities and learning (if electing support)

### Commitment

1. Advanced Directives shared across medical neighborhood, where feasible
2. Implementation of patient engagement integrated into workflows including QI plan (grounded in evidence base developed in Gate 2, where applicable)

### Patient-centered care

1. Participate in local and county health collaborative Prevention Agenda activities
2. Annual identification and reach-out to patients due for preventative or chronic care management
3. Process to refer to structured health education programs

### Population health

1. Commitment to developing care plans in concert with patient preferences and goals
2. Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year

### Care Management/Coord.

1. Integrate high-risk patient data from other sources (including payers)
2. Care plans developed in concert with patient preferences and goals
3. CM delivered to highest-risk patients
4. Referral tracking system in place
5. Care compacts or collaborative agreements for timely consultations with medical specialists and institutions
6. Post-discharge follow-up process
7. Behavioral health: Coordinated care management for behavioral health

### Access to care

1. At least 1 session weekly during non-traditional hours

### HIT

1. 24/7 remote access to Health IT
2. Secure electronic provider-patient messaging
3. Enhanced Quality Improvement including CDS
4. Certified Health IT for quality improvement, information exchange
5. Connection to local HIE QE
6. Clinical Decision Support

### Payment model

1. Minimum FFS + gainsharing contracts with APC-participating payers representing 60% of panel

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# Demonstrated APC Capabilities

**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...

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**May 31, 2017**

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[Department of Health Logo]
NCQA and APC are largely aligned

<table>
<thead>
<tr>
<th>APC specifications addressed by NCQA</th>
<th>Details of areas of difference</th>
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<tbody>
<tr>
<td>% of total (# of milestones)</td>
<td>▪ Behavioral health care management is ‘elective’ in NCQA</td>
</tr>
<tr>
<td></td>
<td>▪ Many APC CC/CM activities are ‘elective’ in NCQA (e.g., 24/7 phone support, Culturally informed population health management, Systematic referral tracking), or not directly addressed (e.g., Establish systems to recruit and train care managers)</td>
</tr>
<tr>
<td></td>
<td>▪ Advanced Directive integration with health IT and HIE is not directly addressed in the NCQA framework</td>
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<table>
<thead>
<tr>
<th>Not addressed</th>
<th>NCQA Elective</th>
<th>NCQA Core</th>
</tr>
</thead>
<tbody>
<tr>
<td>APC Gate 1 or 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(%) (x)</td>
<td>16% (5)</td>
<td>78% (25)</td>
</tr>
<tr>
<td>(%) (x)</td>
<td>6% (2)</td>
<td>7% (2)</td>
</tr>
<tr>
<td>(%) (x)</td>
<td>36% (10)</td>
<td>57% (16)</td>
</tr>
</tbody>
</table>
In this setting we have the opportunity to evaluate three options

<table>
<thead>
<tr>
<th>Proposal options</th>
<th>What you have to believe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue with independent NYS APC</td>
<td>▪ Remaining consistent with agreed-upon plan is important to maintaining APC momentum&lt;br&gt;▪ APC allows independence and self-determination for what is most important to the state&lt;br&gt;▪ Current TA resources with an independent verification body will be the most efficient way of moving forward while reducing fees to practices</td>
</tr>
<tr>
<td>Adapt custom NCQA PCMH program to meet NYS needs</td>
<td>▪ 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&lt;br&gt;▪ NCQA verification can be financed through practice fees, and is a familiar framework for many practices in NY</td>
</tr>
<tr>
<td>Use 2017 NCQA PCMH as-is for APC program</td>
<td>▪ The new NCQA guidelines now fulfill the reasons for which APC was designed, including gaining payor support, and adaptation would introduce unnecessary complexity&lt;br&gt;▪ NCQA is sufficient to merit financial support from Medicare, and nationwide alignment will make Medicare participation with APC more likely&lt;br&gt;▪ TA will prepare providers for current 2017 model&lt;br&gt;▪ NCQA verification can be financed through practice fees, and is a familiar framework for many practices in NY</td>
</tr>
</tbody>
</table>
NYS APC/PCMH: Proposed timeline

- **Frame and assess**
  - Criteria for successful APC
  - Assessing APC vs. NCQA 2017
  - Developing and assessing options

- **Build alignment**
  - Revise and refine priority options
  - Engage with stakeholders (payers, providers, others) and incorporate feedbacks
  - Subcommittee

- **Implement choices**
  - Discuss and refine preferred option e.g., partner w/NCQA
  - Document and help craft communications for plan
  - Begin implementation
  - Subcommittee

- Statewide Steerco
  - Statewide Steerco?
Summary

- Could alignment with NCQA PCMH 2017 accelerate success towards NY State SHIP goals?
- Are there other options for approaching NCQA PCMH 2017 that better drive meaningful participation by payers and providers?
- How can we achieve sustainability beyond the grant?
APC Scorecard
Alignment with other programs
May 31, 2017

Alignment of APC Measure set with Select National and State Reporting Programs, as of May 1, 2017

<table>
<thead>
<tr>
<th>APC Scorecard Measures (NQF #/Measure Steward)</th>
<th>eCQM</th>
<th>MIPS</th>
<th>CPC+</th>
<th>TCPI</th>
<th>QARR</th>
<th>DSRIP</th>
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<tbody>
<tr>
<td>Cervical Cancer Screening (#32/HEDIS)</td>
<td>124v5</td>
<td>✓</td>
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<td>Diabetes: Eye Exam (#55/HEDIS)</td>
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<td>Diabetes: Foot Exam (#56/HEDIS)</td>
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<td>Advance Care Plan (#326/HEDIS)</td>
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<td>CAHPS Access to Care, Getting Care Quickly (#5/AHRQ)</td>
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<td>Use of Imaging Studies for Low Back Pain (#52/HEDIS)</td>
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<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (#58/HEDIS)</td>
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<tr>
<td>Inpatient Hospital Utilization (HEDIS)</td>
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<tr>
<td>Plan All-Cause Readmissions (#1768/HEDIS)</td>
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<td>Emergency Department Utilization (HEDIS)</td>
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<tr>
<td>Total Cost Per Member Per Month</td>
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</tbody>
</table>
APD Update

Public & Private Benefit Package Data
- Qualified Health Plans (QHP) & Essential Plans (EP)
- Medicaid Managed Care Plans
- Medicaid FFS
- Child Health Plus
- Medicare
- Commercial Plans

Public & Private Member Enrollment Data
- QHP & EP Members Enrolled
- Medicaid Managed Care Members Enrolled
- Medicaid FFS Members Enrolled
- Child Health Plus Members Enrolled
- Medicare Members Enrolled
- Commercial Plan Members Enrolled

Public & Private Encounter/Claims Data
- QHP & EP Encounters
- Medicaid Managed Care Plan Encounters
- Medicaid FFS Claims
- Child Health Plus Encounters
- Commercial Plan Encounters

Provider Data
- National Plan and Provider Enumeration System (NPPES)
- New York State Provider Network Data System (PNDS)
- NYS DOH Health Facilities Information System (HFIS)
- Primary Care Physician Panel Data

Public Health Registries
- Vital Statistics Mortality Data
- Vital Statistics Birth Data
- Vital Statistics Marriage & Dissolutions Data
- Discussions w/other NYS DOH Registries

Other Non-Claims Data
- Electronic Health Records (SHIN-NY)
- Functional Assessment Data
- Survey Data
- Social Determinants of Health Data

Timeframes
- December 2017
- Beyond January 2018
Conducted pilot in 4Q 2016

- Leveraged 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 defined by Tax Identification Number (TIN) which was able to be provided by all payers

<table>
<thead>
<tr>
<th>Domains</th>
<th>NQF #/Developer</th>
<th>Measures</th>
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<tbody>
<tr>
<td>Prevention</td>
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<tr>
<td></td>
<td>32/HEDIS</td>
<td>Cervical Cancer Screening</td>
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<td>2372/HEDIS</td>
<td>Breast Cancer Screening</td>
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<td>33/HEDIS</td>
<td>Chlamydia Screening</td>
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<td>38/HEDIS</td>
<td>Childhood Immunization Status: Combination 3</td>
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<td>57/HEDIS</td>
<td>Comprehensive Diabetes Care: HbA1C Testing</td>
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<td>55/HEDIS</td>
<td>Comprehensive Diabetes Care: Eye Exam</td>
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<tr>
<td></td>
<td>62/HEDIS</td>
<td>Comprehensive Diabetes Care: Medical Attention for Nephropathy</td>
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<td>Persistent Beta Blocker Treatment after Heart Attack</td>
</tr>
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<td></td>
<td>1799/HEDIS</td>
<td>Medication Management for People With Asthma</td>
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<td>Behavioral Health/</td>
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<td>Substance Use</td>
<td>4/HEDIS</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
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<td></td>
<td>105/HEDIS</td>
<td>Antidepressant Medication Management</td>
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<tr>
<td>Appropriate Use</td>
<td>52/HEDIS</td>
<td>Use of Imaging Studies for Low Back Pain</td>
</tr>
<tr>
<td></td>
<td>58/HEDIS</td>
<td>Avoidance of Antibiotic Treatment in adults with acute bronchitis</td>
</tr>
</tbody>
</table>
Process for initial report production and release

- Requesting patient level detail (PLD) files from insurers with practice attribution – 1st files due August 2017
- Multiplayer aggregated results calculated for scorecard reports at Tax Id Number (TIN) level*
- Practice reports will be distributed to those involved in APC Transformation
  - Shared with Practices (TIN), Practice Transformation Technical Assistance Agents and Insurers contributing data

During 2-3 Q 2017, explore ability to use other data sources to calculate practice site level results
- Insurer PLD Files, Practice Transformation Tracking System, PCMH file, Provider Network Data (PNDS)
Reporting Frequency and Time line

- Semi-annual with move to quarterly if feasible

<table>
<thead>
<tr>
<th>Period Covered</th>
<th>Specifications</th>
<th>Deadline</th>
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<tr>
<td>Calendar Year 2016 (Jan. 1st – Dec. 31st)</td>
<td>HEDIS 2017</td>
<td>August 15th, 2017</td>
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<td>Rolling Year 2016/2017 (July 1st – June 30th)</td>
<td>HEDIS 2017</td>
<td>February 15th, 2018</td>
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<td>Calendar Year 2017 (Jan. 1st – Dec. 31st)</td>
<td>HEDIS 2018</td>
<td>August 15th, 2018</td>
</tr>
</tbody>
</table>

- Utilization Measures – added June 2018 cycle
- All other measures – late 2018 - early 2019
APC Scorecard Timeline - Updated

- **Version 1.0 Scorecard implementation and roll out**
- **2016**
  - 2Q: Payer assessment and preparation for reporting
  - 3Q: APC Scorecard content and format development
  - 4Q: Pilot reporting by payers
- **2017**
  - 2Q: Practice definition and attribution exploration work
  - 3Q: Data request to all providers statewide
  - 4Q: Payers deliver first metrics data files
- **2018**
  - 1Q: State produces baseline reports for distribution
  - 2Q: Payers deliver metrics data files – off cycle
HIT Enabled Quality Measurement
Quality Measurement Continuum

We are here

Claims-based Quality Measurement
Claims data quality measurement and/or HEDIS data collected from surveys, chart reviews, and claims data

Self-reported
Data captured, eCQM calculated in EHR and only numerator/denominator reported

Live automated data
Automated data acquisition from EHRs to central aggregator tool for calculation, comparison, reporting, and population level measures

Integrated data
Claims and clinical data integrated to analyze quality and address population health needs

Provider/Practice/Encounter Level Data

Patient-Centric Reporting
Provider-Centric Reporting
Practice-Centric Reporting
System-centric Reporting
Population-level Reporting

From ONC Conference: IT-enabled Quality Measurement (Aug 31 – Sep 1, 2016)
Intermediate Scorecard

Scorecard Contractor (IPRO)

Data Sources
- Payers
- Registries

Data Sourcing
- Claims X12
- Immunizations HL7
- Immunizations QE
- Immunizations CCDA
- Immunizations ADT
- Immunizations Care plan
- Immunizations EHRs

EHRs

Clinical Quality Measurement
- DSR
- Pay for Value

Priority Uses
- Clinical action and population health measurement
- Pt Cohort Decision support & management
- Program requirements and evaluation
- Cost and quality transparency public reporting

From ONC Conference:
IT-enabled Quality Measurement (Aug 31 – Sep 1, 2016)
CQM Data Sources & Intermediaries

Data Sources
- Payers/ APD
- Registries

Data Intermediary
(possibly state, payer, third party)

Reporting Formats
- QRDA III/I
- Num Denom

Priority Uses
- Clinical Quality Measurement
- Pay for Value
- Clinical action and population health measurement
- Pt Cohort Decision support & management
- Program requirements and evaluation
- Cost and quality transparency public reporting

Data Sourcing
- EHRs
- Immunizations HL7
- Claims X12

From ONC Conference:
IT-enabled Quality Measurement (Aug 31 – Sep 1, 2016)
Major Challenges to Implementing HIT-enabled Quality Measurement

- Increasing quality and completeness of data available through EHRs
  - EHR expectation vs. reality
  - How an EHR is used and implemented
  - Standardization
- Provider-Practice Site Problem
- Ensuring infrastructure is available and avoiding redundancy
Implementing Standards

SHIN-NY is focused on aligning with standards for Certified Health Information Technology

- SHIN-NY regulation
- Incentive programs for providers to connect to the SHIN-NY
- Supports providers and hospitals that need to meet MACRA and Medicaid Meaningful Use Requirements
- Aligns with national activities electronic quality measurement initiatives
Aligning with National Activities

Quality Data Model- Describes the relationship between the patient and clinical concepts to support standardized quality measurement

- Building blocks of electronic clinical quality measures
- Relies on multiple, recognized standards implemented in the community
Developing a Provider Directory to Support Measurement

- Numerous provider directory/provider index activities ongoing
  - PPSs, Plans, NYSDOH
- Importance to quality measurement:
  - Need standardized way of representing patient-provider-facility site-legal entity relationship
- Coordinating activity on Provider Index
- Data sources:
  - Practice Transformation Database, Provider Network Data System, Qualified Entity Information, EHR based data
Next Steps

Identify infrastructure currently in use that supports quality measurement
   - Public, private and shared infrastructure
   - Aligning with current measurement activities
   - Avoid unnecessary duplication

Continue efforts to increase data quality
   - Engaging APC providers on data necessary to support quality measure
   - Identify more opportunities for standardization
Questions/Comments
Questions for Provider Topics:

How well is SIM coordinated with other health reform and relevant initiatives in New York State?

What considerations factor in practice decisions with respect to APC? How are these considerations addressed in the program?

What do practices perceive as the benefits and challenges of the APC model?
Payer Engagement
Medicaid
New York State Health Initiatives

PREVENTION AGENDA

Priority Areas:
- Prevent chronic diseases
- Promote a healthy and safe environment
- Promote healthy women, infants, and children
- Promote mental health and prevent substance abuse
- Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases, and healthcare-associated infections

STATE HEALTH INNOVATION PLAN (SHIP)

Pillars and Enablers:
- Improve access to care for all New Yorkers
- Integrate care to address patient needs seamlessly
- Make the cost and quality of care transparent
- Pay for healthcare value, not volume
- Promote population health
- Develop workforce strategy
- Maximize health information technology
- Performance measurement & evaluation

ALIGNMENT:
Improve Population Health
Transform Health Care Delivery
Eliminate Health Disparities

MEDICAID DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

Key Themes:
- Integrate delivery – create Performing Provider Systems
- Performance-based payments
- Statewide performance matters
- Regulatory relief and capital funding
- Long-term transformation & health system sustainability

POPULATION HEALTH IMPROVEMENT PROGRAM (PHIP)

PHIP Regional Contractors:
- Identify, share, disseminate, and help implement best practices and strategies to promote population health
- Support and advance the Prevention Agenda
- Support and advance the SHIP
- Serve as resources to DSRIP Performing Provider Systems
DSRIP, VBP and CMS

- 1115 Waiver, which includes DSRIP, renewed by CMS for 5 years in December 2016.

- 2016 VBP Roadmap annual update approved by CMS in March 2017.
DSRIP Implementation Timeline and Key Benchmarks

We are here

Focus on Infrastructure Development/System Design

Q1|Q2|Q3|Q4

Submission/Approval of Project Plan

• PPS Project Plan Valuation
• PPS first DSRIP Payment
• PPS Submission of Implementation Plan and First Quarterly Report

Focus on Continued System/Clinical Improvement

Q1|Q2|Q3|Q4

Domain 3: Clinical Improvement P4P Performance Measures begin & MY 3 begins. Domain 2: Data collection for P4P measures begins

Focus on Project Outcomes/Sustainability

Q1|Q2|Q3|Q4

Domain 2: System Transformation P4P Performance Measures begin

Q1|Q2|Q3|Q4

Domains 2 & 3 are completely P4P

Domain 4: PPS working in collaboration with community and diverse set of service providers to address statewide public health priorities; system improvements and increased quality of care will positively impact health outcomes of total population.
How DSRIP and VBP Work Together

Old world:
- FFS
- Individual provider was anchor for financing and quality measurement
- Volume over Value

New world:
- VBP arrangements
- Integrated care services for patients are anchor for financing and quality measurement
- Value over Volume

DSRIP:
Restructuring effort to prepare for future success in changing environment
The New World: Paying for Outcomes not Inputs

By DSRIP Year 5 (2020), all MCOs must employ VBP systems that reward value over volume for at least 80 – 90% of their provider payments.

Volume of Care (FFS) → Value of Care (VBP)

Value Based Payment (VBP)

An approach to Medicaid reimbursement that rewards value over volume
An approach to incentivize providers through shared savings and financial risk
A method to directly tie payment to providers with quality of care and health outcomes
A component of DSRIP that is key to the sustainability of the program

VBP Arrangements

- **Arrangement Types***
  - Total Care for the General Population (TCGP)
  - Integrated Primary Care (IPC)
  - Maternity Care
  - Health and Recovery Plans (HARP)
  - HIV/AIDS Care
  - Managed Long Term Care (MLTC)
    - *Arrangements do not yet include Dually Eligible members

- Two VBP implementation subcommittees were created to focus on:
  - Social Determinants of Health and CBOs
  - Advocacy and Engagement
  - The full recommendations that came from these Subcommittees are available in the DOH VBP Resource Library:
Aligning Initiatives

- All Primary Care practices in a PPS are encouraged to become 2014 PCMH Level 3 certified or APC recognized by March 31, 2018 (end of DY3)
  - Gate 2 APC will satisfy the DSRIP requirement for meeting APC milestones

- Medicaid Primary Care Incentive Program
  - It is Medicaid’s intent to pay APC Gates 2 and 3 providers the same incentive as 2014 PCMH Level 3 (pending CMS approval)
  - Next steps include beginning to connect PCMH/APC incentives to value based efforts

- VBP measures selected for Total Care of the General Population and Integrated Primary Care arrangements were built upon the APC core measure set.
Health Plan Alignment with APC
Health Plans are a key stakeholder in implementation of APC:

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

Progress:
- Several payers were members of the Integrated Care Workgroup helping to design the APC model
- Almost all key payers are “at the table” with the ROMCs, actively engaged in discussions.
Health Plan challenges

All payers have their own primary care initiatives, different degrees of implementation

- Good news: payers recognize the value of transforming primary care, have seen results and have goals for more VBP uptake in primary care
- Bad news (but not so bad):
  - Payers’ primary care programs don’t exactly align with APC
  - Focus is on larger, higher performing practices
What are payers’ incentives to engage?

Case studies

Plan 1 (regional plan)
- Developed their own primary care program, made substantial investments into their program, has a high market share in regional market, targeting larger practices
- Realizes that there is still room to grow as half of network not meaningful engaged, participate in APC ROMC discussion, looking for alignment to expand

Plan 2 (regional plan)
- Developed their own ACO program, made substantial investments into their program, has a high market share in regional market, targeting large ACO’s with limited focus on primary care
- Primary care providers in ACO’s are benefitting differently but success is linked to ACO’s performance overall; less of an incentive to participate in meaningful APC ROMC discussions, looking for expansion within ACO contracts with limited need for expanding beyond existing contracts
At the ROMC: aligned goals between payers and NY State

As ROMC meetings progress, DOH and payers have shared goals:

- Building a high performing primary care system
- Controlling costs (e.g. by reducing preventable hospitalizations)
- Transform provider payments to value based
- Invest in HIT and make data available to make better informed decisions
- Align with prevention agenda and promote an evolved workforce

While sharing common goals, realization that payers have build their own programs:

- Recognition of existing payer primary care VBP programs that are successful and should be left untouched by APC

Suggested approach:

- Working together to identify practices that are not currently in payers’ primary care initiatives and to engage them in APC.
Looking Ahead

- Planning second round of one-on-one meetings with payers to discuss implementations goals, hurdles, etc.
- Planning survey of payers on percentage of members and primary care payments going towards APC and other value-based contracts.
- Continuing to explore regulatory “levers” to facilitate participation and implementation of APC
Alignment of Agency Review of Risk Sharing Arrangements

- Risk sharing arrangements between payers and providers triggers oversight of DFS and DOH, depending on degree of risk sharing.
- With advent of value-based contract, DFS and DOH are updating and better coordinating the oversight process.
- Three tier review structure (see next page for details):
  - Tier 1: File and Use (DOH will oversee)
  - Tier 2: DOH Review
  - Tier 3: Multi-Agency Review (DOH and DFS)
Provider Contract Review Process

1. Individual Contract Comes in for Review
2. Does the contract include prepaid capitation that triggers Regulation 164? (No)
3. More than $1,000,000 of annual payments to provider at risk (shared losses, withhold)? (No)
4. More than 25% of annual payments to provider at risk? (No)
5. More than 15% provider’s Medicaid Revenue? (No)
6. Off Menu VBP Arrangement? (No)

All contracts may be subject to Programmatic Review in addition to Financial Review.

Tier 1: File and Use
Tier 2: DOH Review
Tier 3: Multi-Agency Review
## VBP & Tier Crosswalk (detailed)

### VBP Arrangement Levels

<table>
<thead>
<tr>
<th>Tier 3: Multi-Agency (DOH + DFS) Review</th>
<th>Level 0 VBP**</th>
<th>Level 1 VBP**</th>
<th>Level 2 VBP**</th>
<th>Level 3 VBP**</th>
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<td><strong>An arrangement that does NOT trigger Regulation 164, has NO quality component, and contains:</strong></td>
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<tr>
<td>1. $1,000,000 of potential provider payments at risk; AND</td>
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<tr>
<td>2. At least one of the following:</td>
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<tr>
<td>a. $5,000,000 of potential provider payments at risk; OR</td>
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<tr>
<td>b. &gt;15% of a provider’s total Medicaid revenue; OR</td>
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<td>c. An Off-Menu arrangement.</td>
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<tr>
<td><strong>An arrangement that does NOT trigger Regulation 164, has NO quality component, and contains:</strong></td>
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<td>1. $1,000,000 of potential provider payments at risk; AND</td>
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<tr>
<td>2. At least one of the following:</td>
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<tr>
<td>a. &gt;20% of annual Medicaid MC or MLTC payments at risk; OR</td>
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<td></td>
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</tr>
<tr>
<td>b. &gt;15% of a provider’s total Medicaid revenue; OR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. An Off-Menu arrangement.</td>
<td></td>
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</tbody>
</table>

### Tier 2: DOH Review

<table>
<thead>
<tr>
<th>Tier 2: Multi-Agency (DOH + DFS) Review</th>
<th>Level 0 VBP**</th>
<th>Level 1 VBP**</th>
<th>Level 2 VBP**</th>
<th>Level 3 VBP**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>An arrangement that triggers Regulation 164 but has NO quality component</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>An arrangement that does NOT trigger Regulation 164 and contains:</strong></td>
<td></td>
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</tr>
<tr>
<td>1. $1,000,000 of potential provider payments at risk; AND</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. At least one of the following:</td>
<td></td>
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</tr>
<tr>
<td>a. &gt;20% of annual Medicaid MC or MLTC payments at risk; OR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. &gt;15% of a provider’s total Medicaid revenue; OR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. An Off-Menu arrangement.</td>
<td></td>
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</tbody>
</table>

### Tier 1: File and Use

<table>
<thead>
<tr>
<th>Tier 1: Multi-Agency (DOH + DFS) Review</th>
<th>Level 0 VBP**</th>
<th>Level 1 VBP**</th>
<th>Level 2 VBP**</th>
<th>Level 3 VBP**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>An arrangement that triggers Regulation 164 and contains:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. $5,000,000 of potential provider payments at risk; OR</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. At least one of the following:</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>a. &gt;20% of annual Medicaid MC or MLTC payments at risk; OR</td>
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<td>b. &gt;15% of a provider’s total Medicaid revenue; OR</td>
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<tr>
<td>c. An Off-Menu arrangement.</td>
<td></td>
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</tbody>
</table>

** = Level VBP arrangements include a cost savings component or a quality component, but not both.

** = Level 1, 2, and 3 VBP arrangements must include a quality component in addition to a cost savings component.

*** = There are a few exceptions such as NFP where a VBP arrangement with a quality bonus, but no cost savings component.

* = This type of VBP arrangement will not be subject to this particular Tier of contract review.

---

Tier 2 – DOH review, contract may be implemented 90 days after submission, could be prior to DOH approval.
Medicare –
MACRA/ MIPS
### Merit-based Incentive Payment System (MIPS)

#### Composite Performance Score (& payment adjustments)

<table>
<thead>
<tr>
<th>Component</th>
<th>Points</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource Use</td>
<td>10</td>
<td>Medicare to calculate</td>
</tr>
<tr>
<td>Clinical Practice Improvement</td>
<td>15</td>
<td>APC is a medical home model</td>
</tr>
<tr>
<td>Advancing Care Information (formerly MU)</td>
<td>25</td>
<td>Aligned with APC milestones</td>
</tr>
<tr>
<td>Quality (PQRS/VBM)</td>
<td>50</td>
<td>Aligned with APC scorecard</td>
</tr>
</tbody>
</table>

75% = ACI + PQRS/VBM

Graphic from Tom S. Lee, SA Ignite, HFMA presentation, May 2016
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*

Measure Categories:
- Preventive
- Chronic Disease
- Behavioral Health
- Patient Reported
- Appropriate Use

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

Improve the Activities (IA) account for 15% of MIPS Final Score with maximum of 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 subcategories

44-60** points

**Points vary by practice size

**Medium (weighted) points = 10

High (weighted) points = 20
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
Questions/Comments
Questions on Payer Topics:

• Beyond our efforts, how can we ensure success for NY State Primary Care practices in MACRA?

• Are there other ideas to address factors that facilitate or hinder enhanced payments for APC?
SHIP/DSRIP
Workforce
Workgroup Update
Supporting Transformation through the Workforce Workgroup

- Workforce is one of the underlying enablers for the State Health Innovation Plan (SHIP), supporting the five pillars and helping achieve the SHIP objective of moving towards the Advanced Primary Care model.

- The Workforce Workgroup also serves the goals of the Delivery System Reform Incentive Payment (DSRIP) Program and the work of Performing Provider Systems (PPS), supporting efforts to reduce avoidable hospital use and achieve the sustainable transformation of the delivery system.

- The charge of the Workforce Workgroup is to promote a health workforce that supports comprehensive, coordinated and timely access to care that will improve the health and well-being of New Yorkers, consistent with these transformational initiatives.
Identifying Barriers to Performance of Care Coordination Functions

- Workgroup Subcommittee #1 is reviewing the scope of care coordination functions carried out by licensed and non-licensed workers as well as non-licensed family and friends.

- While the scope of practice for licensed professionals generally does not preclude them from carrying out tasks related to care coordination, some barriers remain.

- The subcommittee is in the process of identifying and prioritizing these barriers with potential recommendations for statutory, regulatory or administrative action to address them.
Recommending Care Coordination Concepts for Licensed Practitioners

- Subcommittee # 2 is working to identify core concepts in care coordination that can be recommended for inclusion in the educational curricula for licensed professionals.

- The subcommittee has reviewed existing curricula for training health care professions to see the extent to which care coordination concepts currently exist.

- The subcommittee is in the process of developing a list of core competencies and learning objectives for each set of competencies.
Developing Core Curriculum Guidelines for Care Coordination

- The Workgroup recognized the need to identify consistent training guidelines for workers who carry out care coordination functions.
- Subcommittee # 3 developed core curriculum guidelines for training workers who provide care coordination.
- These guidelines are available at: https://www.health.ny.gov/technology/innovation_plan_initiative/docs/core_curriculum_train_ccw.pdf
- The guidelines, which have been widely distributed, will be updated as needed.
Addressing Gaps in Health Care Workforce Data

- The Workgroup found that more robust information is needed about the health care workforce, particularly with respect to the distribution of practitioners.

- As proposed by Subcommittee # 4, the Workgroup recommended statutory changes to support the collection of additional data from health care practitioners.

- Legislation has been introduced to incorporate additional information into the Physician Profile and obtain data from other health care practitioners upon registration and re-registration with the State Education Department.

- The information will be used for health care workforce research and planning with de-identified, aggregate information made available on the Department of Health website.
Promoting Behavioral Health Integration and Building its Workforce

- Efforts to integrate physical and behavioral health care require an appropriately skilled workforce, which includes care coordination concepts but must also incorporate evidence-based interventions (e.g., motivational Interviewing and problem solving therapy) that require more specialized training.

- Subcommittee # 5 is identifying barriers to effective integration, specifying key functions of behavioral health care managers, developing curricula, and recommending training guidelines to support behavioral health management for staff in primary care settings.

- Recommendations will be incorporated into the work of other subcommittees as appropriate.
Implementing the Rural Residency Program

- Six organizations are developing new primary care residency programs in rural communities
- SIM will provide two years of funding for the initial establishment of the programs and the organizations will provide support to cover ongoing costs (personnel, recruitment, curriculum development, accreditation, etc.)
- Each program will include a general hospital for inpatient rotations and community-based ambulatory care training sites (such as clinics, diagnostic and treatment centers, local health departments)
- Resident recruitment efforts will focus on rural communities and, when fully implemented, the programs will train approximately 50 residents each year
Implementing the Rural Residency Program (continued)

The six organizations that are developing new primary care residency programs are:

- Arnot Ogden Medical Center
- Cayuga Medical Center
- Champlain Valley Physicians Hospital
- Mary Imogene Bassett Hospital
- Samaritan Medical Center
- Sisters of Charity Hospital
Questions:

- Have workforce needs been identified?
- Are there licensure or other regulatory requirements that need changes?
Questions/Comments
Linking Interventions For Total Population Health
Linking Interventions For Total Population Health (LIFT Population Health)

- The funding for this initiative is from the 2015 State Innovation Model award provided by the Center for Medicare and Medicaid Innovation, which has central goals of promoting an integrated care system, providing patient centered, advanced primary care coordinated with community based and other health care providers.

- Total of six awards covering 18 counties

- Activities to be aligned locally with work being conducted by other initiatives in NYS (e.g., SIM, DSRIP, Prevention Agenda, PHIP, and other state and CDC-funded initiatives)
Three Buckets of Prevention

1. Traditional Clinical Prevention
   Increase the use of evidence-based services

2. Innovative Clinical Prevention
   Provide services outside the clinical setting

3. Total Population or Community-Wide Prevention
   Implement interventions that reach whole populations

Health Care
Public Health

Focus of LIFT

Communities will focus on one of five issues related to the Prevent Chronic Disease priority area of the New York State Prevention Agenda 2013-18

- Five projects chose Prevent and Control Obesity and Diabetes
- One project chose Prevent Cardiovascular Disease and Control High Blood Pressure

Awardees will develop portfolio of interventions across three categories or “buckets”

1. Traditional Clinical Prevention (10% of effort)
2. Innovative Clinical Prevention (30% of effort)
3. Total Population or Community-Wide Prevention (60% of effort)
## Selected LIFT Awardees

<table>
<thead>
<tr>
<th>Organization</th>
<th>Counties served</th>
<th>Focus Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>P2 Collaborative of Western NY</td>
<td>Erie, Niagara, Orleans and Genesee</td>
<td>Prevent and Control Obesity and Diabetes</td>
</tr>
<tr>
<td>University of Rochester</td>
<td>Monroe</td>
<td>Prevent and Control Obesity and Diabetes</td>
</tr>
<tr>
<td>S2AY Rural Health Network</td>
<td>Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne &amp; Yates</td>
<td>Prevent and Control Obesity and Diabetes</td>
</tr>
<tr>
<td>Healthlink NY</td>
<td>Orange</td>
<td>Prevent and Control Obesity and Diabetes</td>
</tr>
<tr>
<td>Fort Drum Regional Planning Organization</td>
<td>Jefferson, Lewis &amp; St. Lawrence</td>
<td>Prevent and Control Obesity and Diabetes</td>
</tr>
<tr>
<td>Fund for Public Health in New York, Inc.</td>
<td>Kings</td>
<td>Prevent Cardiovascular Disease and Control High Blood Pressure</td>
</tr>
</tbody>
</table>
Bucket One LIFT Activities

- Build upon existing Public Health Detailing (PHD) campaign to target additional primary care providers, dentists, pharmacists and patients.
- Recruit health care providers to participate in alert system development
- Provide general professional education for community physicians
- Implement evidenced-based clinical guidelines to identify patients with prediabetes and diabetes
- Develop care coordination teams to ensure referral of patients to appropriate clinical and community-based programs
Bucket Two LIFT Activities

- Conduct visits to pharmacies within the defined catchment area to disseminate key messaging and educational materials
- Implement a bi-directional clinical/community referral system at primary care practice sites
- Embed Diabetes Prevention Program trained health advocates in physician practices
- Work with insurers to cover the cost of chronic disease self-management programs
- Increase capacity by sending at least four credentialed staff to attend a CDC National Diabetes Prevention Program Lifestyle Change training
- Provide technical assistance and support for three community based organization Diabetes Prevention Programs to connect to a secure, electronic health information exchange.
- Print educational materials in various languages prevalent among the target population, including English, Spanish, Russian, Chinese, and Arabic
Bucket Three LIFT Activities

- Lead efforts to enact Complete Streets ordinances in all communities without one; develop or revise a Complete Streets toolkit around health
- Inventory and promote summer feeding programs and farmer’s markets through the Regional Farm to Cafeteria Committee
- Promote breastfeeding as a social norm and work with businesses, community based organizations, and public spaces to adopt breastfeeding friendly policies
- Run a multi-faceted prediabetes risk factor campaign that will include posters, radio PSAs, and transit ads
- Develop a workplace campaign to encourage staff to walk to increase physical activity
- Increase number of high-risk schools with comprehensive and strong Local School Wellness Policies
Questions/Comments
Next Steps
Next Steps

- Detailed Sessions for Topic areas (HIT, Workforce, Population Health)