Department of Health | Medicaid Redesign Team

Performing Provider Systems (PPS) Primary Care Plan

Updated from December 11th All-PPS Meeting

June 2016

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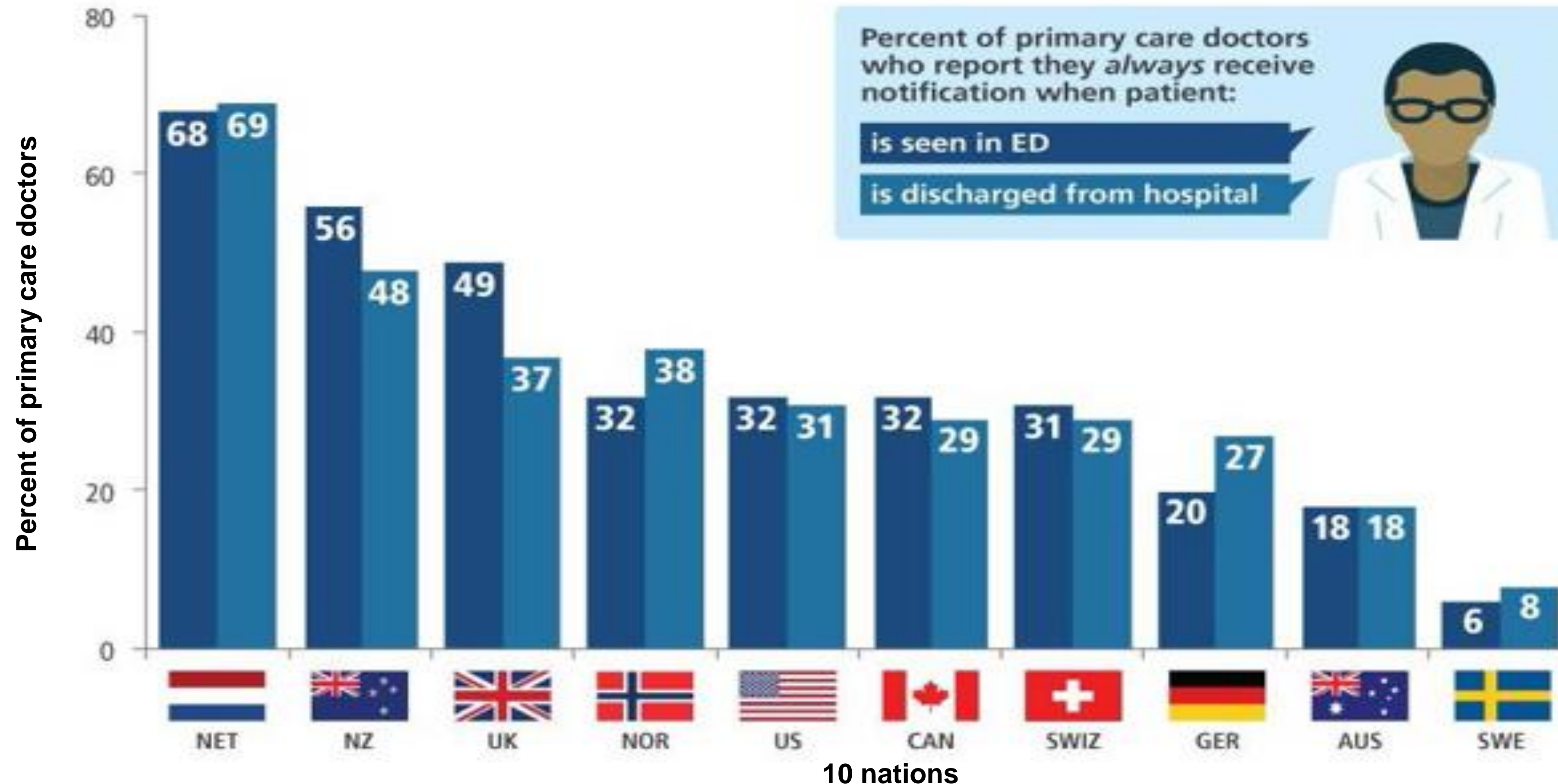
Primary Care in DSRIP

Global Challenges to Care Coordination for PCPs

In a 10-nation survey, doctors from every country reported that their primary care practices struggled to coordinate care and communicate with other health providers, which is the key to managing patients with complex care needs.

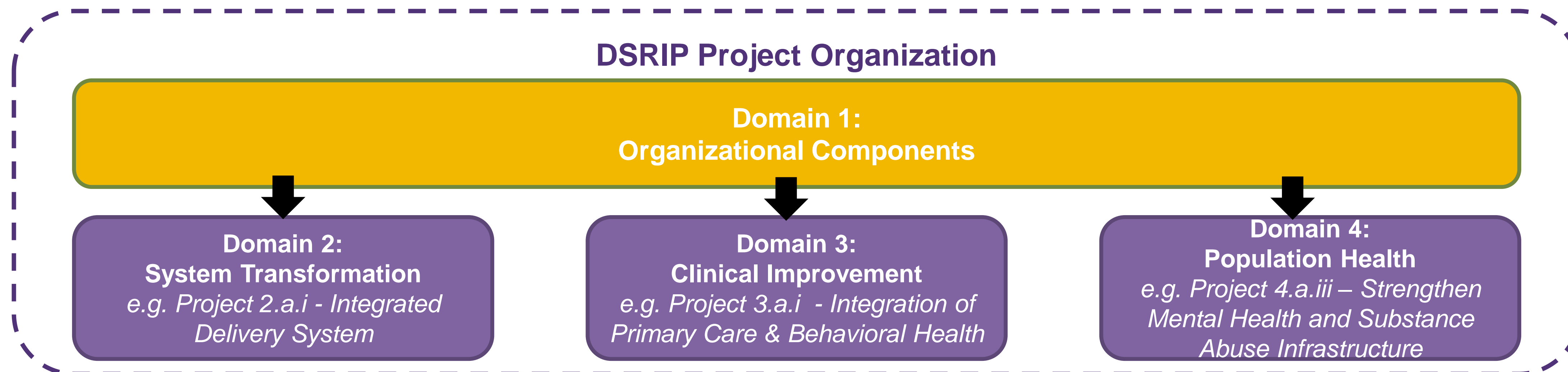


Source: 2015 Commonwealth Fund International Health Policy Survey of Primary Care Physicians

Primary Care in DSRIP

Primary Care Providers (PCPs) play a critical role in the success of the Delivery System Reform Incentive Payment (DSRIP) program and initiatives.

Performing Provider Systems (PPSs) committed to healthcare reform by choosing a set of projects best matched to the needs of their unique communities



- There are over **11,500 PCPs committed** to the DSRIP program
- Over **$400 million** in Domain 2 and 3 funding are directly **tied to primary care performance**
- PPSs are collaborating with PCPs to **expand both access and capacity**

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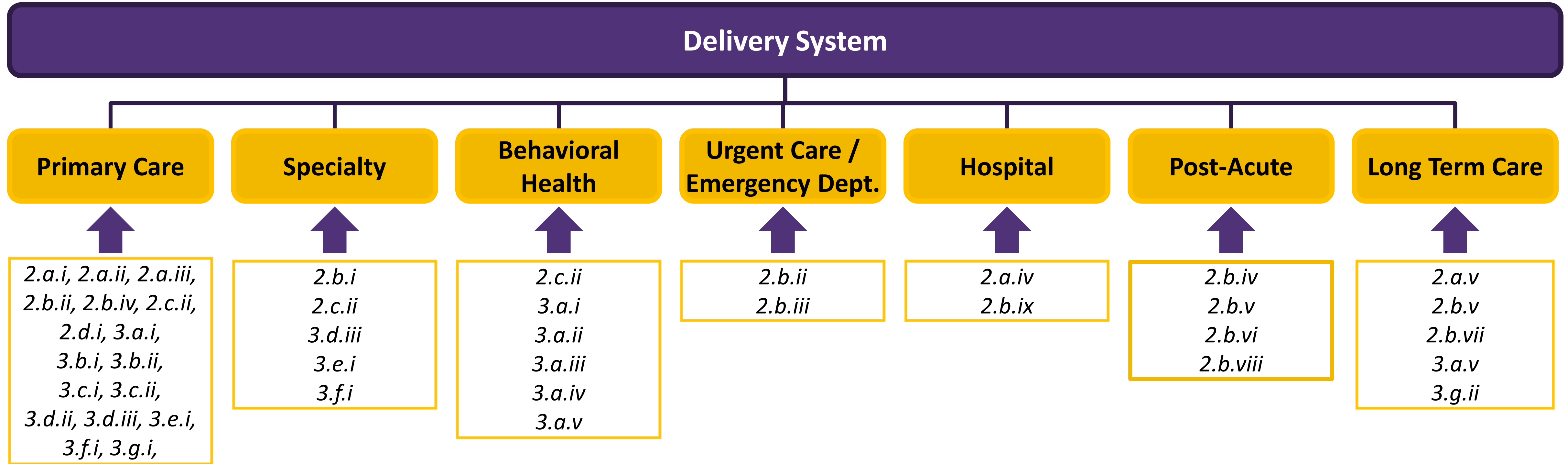
Primary Care in DSRIP (cont.)

DSRIP impacts across the health system, and many projects require enhanced primary care.



Domain 4 Projects cross multiple systems and impact all populations.

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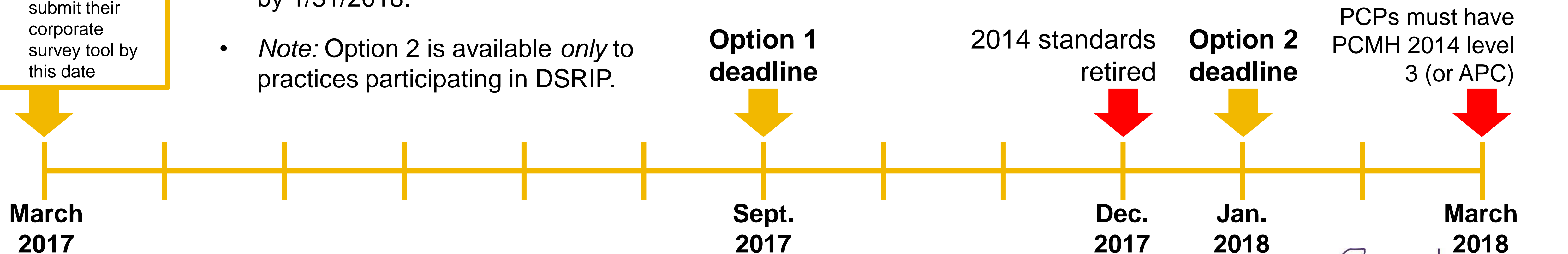
PCMH Project Requirement Updates

NCQA / PCMH Designation Updates

In March/April 2017, National Committee of Quality Assurance (NCQA) will release the new Patient Center Medical Home (PCMH) 2017 standards and recognition process. This may impact PPS planning and/or timing for supporting primary care practices to achieve PCMH 2014 level 3 (or Advanced Primary Care (APC)) recognition by the end of March 2018.

- **All** practices looking to renew under PCMH 2014 must purchase survey tools by March 31, 2017
- All **multi-site organizations** looking to renew under PCMH 2014 must also submit their corporate survey tool by this date

- **Option 1 – Standard Process**: NCQA has established a deadline of 9/30/2017 for practices to submit for PCMH 2014 recognition. Corporate survey tools must be submitted by 3/31/2017 to assure all multi-site site surveys are ready for submission by 9/30/2017. This will assure recognition decisions prior to 12/31/2017.
- **Option 2 – For DSRIP Only:** NCQA will create a discount code allowing NYS practices participating in the DSRIP program to submit PCMH 2014 surveys between 9/30/2017 and 1/31/2018 with a reduced fee and a two year duration of recognition. This will assure recognition decisions prior to 3/31/2018. Corporate survey tools must be submitted by 9/30/2017 to assure all multi-site site surveys are ready for submission by 1/31/2018.
- *Note:* Option 2 is available *only* to practices participating in DSRIP.



NCQA / PCMH Designation Updates (cont.)

NCQA PCMH 2014 Submission Extension Guidelines for NYS DSRIP PPS Primary Care Practices:

Who is eligible?	Primary Care Practices identified as participants in the NYS Performing Provider Systems Must meet NCQA PCMH eligibility
What is the NCQA deadline for PCMH 2014 survey submission for full three year recognition?	Purchase: 3/31/2017 Corporate Surveys: 3/31/2017 Add-on Surveys: 6/30/2017 **Site Surveys: 9/30/2017** Regular fees apply
What are the extended submission deadlines available to eligible practices?	Purchase: 3/31/2017 Corporate Surveys: 11/30/2017 Add-on Surveys: 1/31/2018 **Site Surveys: 1/31/2018** Recognition will be for two years Fees will be pro-rated for two years
How does the practice access the application and pay the prorated fee after the regular deadline?	Applications with a NYS address and the special discount code will be accepted through the regular application portal

NCQA cannot assure a recognition decision by 3/31/2018 for submissions on/after 2/1/2018

New York Medicaid EHR Incentive Program Updates

2016 is the last year that eligible professionals may begin participating in the New York Medicaid Electronic Health Record (EHR) Incentive Program, which provides financial incentives to eligible professionals and hospitals to promote the adoption and meaningful use of EHR technology.

NY Medicaid must receive a provider's registration for the program no later than **December 31, 2016**. Registration for the program is done through the CMS system at: **https://ehrincentives.cms.gov/hitech/login.action**

The provider must **attest for payment year 2016 by March 31, 2017**
(Note: the payment year officially ends December 31. Due to a 90-day grace period thereafter, the deadline is March 31, 2017.)

Please contact hit@health.ny.gov for program clarifications and details.

DSRIP Project 3.a.i, Model 2 Updates

For Model 2 of Project 3.a.i, PPSs are not eligible to achieve NCQA 2014 Level 3 PCMH or the Advanced Primary Care Model certification, as was stated in Project Requirement 1.

1	Co-locate primary care services at behavioral health sites.	PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.	List of participating NCQA-certified and/or APC-approved physicians/practitioners (APC Model requirements as determined by NY SHIP); Certification documentation	Provider (PCP)
		Primary care services are co-located within behavioral Health practices and are available.	List of practitioners and licensure performing services at behavioral health site; behavioral health practice schedules.	Provider (PCP, BH)

Primary Care Practices/Providers in a Behavioral Health setting are <u>not required</u> to:

- be in a PCMH/APC or from a PCMH/APC site to start the integration process
- be PCMH/APC certified by DSRIP year 3

- Individual providers working in a behavioral health setting should work toward the goals and principles of a Patient-Centered Medical Home (PCMH) or Advanced Primary Care (APC) Model
- Medical and behavioral health providers **<u>must collaborate on evidence-based standards of care</u>**, including medication management and care engagement processes

Planned Parenthood Updates

PPSs have been asking questions regarding Primary Care services provided by Planned Parenthood and eligibility of those providers for PCMH certification.

Planned Parenthood practices with providers who are providing comprehensive primary care, and not just medical screening, **are eligible** to become NCQA-certified Patient Centered Medical Homes

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PPS Primary Care Plan

PPS Primary Care Plan: Background

During the February 2015 DSRIP Project Approval and Oversight Panel (PAOP) meeting, the Panel voted to require each PPS to submit a Primary Care Plan (PC Plan).

The PC Plan will address:

- Current status of their primary care capacity
- Plans for reaching primary care-specific project milestones
- Progress toward primary care goals addressing areas of access, capacity, and quality

Stakeholders were able to review and provide feedback on the initial structure of these plans in Fall 2015, the results of which where presented to PPSs during the December 11, 2015 All-PPS meeting in Albany.

Stakeholder groups included:

- 2 PPSs
- Healthcare Association of New York State (HANYS)
- Community Health Care Association of New York State (CHCANYS)
- Greater New York Health Association (GNYHA)
- United Hospital Fund
- Primary Care Development Corporation (PCDC)
- Office of Mental Health
- Office of Quality and Patient Safety
- PAOP Primary Care Workgroup

Evolution of PPS Primary Care Profiles

The PC Profile was conceived as a PPS resource document, consolidating previous application materials and quarterly reporting information that described how each PPS was working with PCPs in their provider networks.

The intent of the Primary Care Profile was a PPS-specific resource to address the *six fundamentals*:

1. Assessment of current PC capacity, performance and needs, and a plan for remediating need
2. PC expansion and practice and workforce transformation to support training and technical assistance
3. PPS strategy for how PC will play a central role in an integrated delivery system
4. PPS strategy to enable PC to participate effectively in VBP
5. PPS funds flow support PC strategies
6. PPS progression towards integrating PC and behavioral health

Draft PC Profiles were created and shared with three PPS. The outcome of those discussions and subsequent internal review revealed that the value of the Profiles was limited and did not directly address the six fundamentals. In order to reduce redundant activities, increase usefulness to PPS and align with future reporting opportunities, PC Profiles will no longer be produced.

Evolution of Primary Care Provider Network Analysis

The PCP Network Analysis was performed with the goal of providing PPSs insights into the nature of their Primary Care Networks.

The set of metrics provided to each PPS is intended to help PPSs gain insight into how they might profile and get a better understanding of the PCPs in their network and to help inform DSRIP project planning and implementation

PCPs play an important role in any PPS network, and these metrics are provided as examples of how PPSs might understand who is in their network, the other PPSs those providers might be working with, and the level of Medicaid member access with those providers as reported by the Medicaid Managed Care Organizations (MCOs) through Provider Network Data System (PNDS) referenced below.

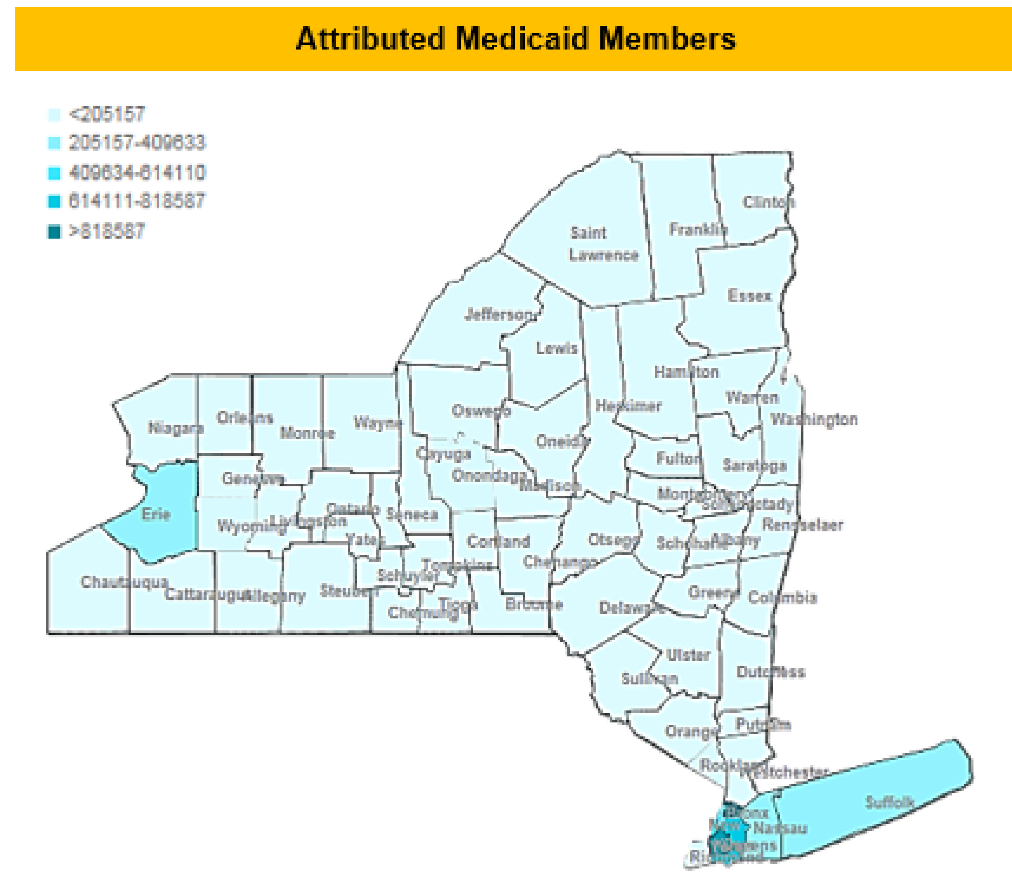
A Regional Analysis, comparing these metrics for PPSs both by size (based on attribution) and region (upstate vs. downstate), provides an opportunity for deeper understanding of the networks across the State.

These metrics are derived from an analysis of information in the PNDS, the DSRIP Performance Dashboards (MAPP), the Salient Interactive Miner Tool (SIM), and the PPS Provider Network Lists.

Primary Care Provider Network Analysis – Sample

A set of metrics was derived for each PPS to gain a better understand of their PCP networks.

Metric	Value	Source(s)
Total # of Primary Care Providers (PCPs) in PPS	500	Provider Network
Total # of PPS's network PCPs in the PNDS	495 (99%)	PNDS
Total # of PCPs participating in multiple PPS	100 (25%)	Provider Network
# of PPSs that a PCP Participates in: 1 2 3 4 5 or more	 25 (5%) 25 (5%) 15 (3%) 20 (4%) 15 (3%)	Provider Network
% of PCPs/Extenders Offering After-Hours Care*	25%	PNDS, Provider Network
Average Total Care Hours (per PCP per week)	36 hrs.	PNDS, Provider Network
% of PCPs Accepting New Medicaid Members	96%	PNDS, Provider Network
Total PCPs at Sites w/ PCMH 2011 Level 2 (Achieved)**	5 (1%)	SIM Tool
Total PCPs at Sites w/ PCMH 2011 Level 3 (Achieved)**	25 (5%)	SIM Tool
Total PCPs at Sites w/ PCMH 2014 Level 2 (Achieved)**	15 (3%)	Dashboards
Total PCPs at Sites w/ PCMH 2014 Level 3 (Achieved)**	10 (2%)	Dashboards
PPS Maps (Attributed Medicaid Members and Network PCPs)	(see right)	Dashboards



Data is not representative of a specific PPS. Numbers provided for illustrative purposes only.

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Primary Care Provider Regional Network Analysis

PPSs were categorized by attribution size* and divided into three categories (small, medium, large) then split between upstate and downstate.

Small: < 90,000 members

Small – Downstate

PPS	Attribution
The NewYork and Presbyterian Hospital PPS (NYP)	80,902
Staten Island PPS (SI)	68,693
The NewYork-Presbyterian/Queens PPS (NYPQ)	25,406

Small – Upstate

PPS	Attribution
Community Partners of Western New York (CPWNY)	80,618
Adirondack Health Institute (AHI)	74,941
Albany Medical Center Hospital PPS (AMC)	64,636
Samaritan Medical Center PPS (SMC)	39,049
Refuah Community Health Collaborative PPS (RCHC)	39,443
Bassett Medical Center PPS (BMC)	38,406

Medium: 90,000 – 200,000 members

Medium – Downstate

PPS	Attribution
Stony Brook University Hospital (SBUH)	148,118
Bronx-Lebanon Hospital Center PPS (BLHC)	133,117
NYU Lutheran Medical Center PPS (NYUL)	104,415

Medium – Upstate

PPS	Attribution
Central New York Care Collaborative (CNYCC)	167,136
Westchester Medical Center PPS (WMC)	120,232
Alliance for Better Health Care PPS (ABHC)	116,624
Care Compass Network PPS (CCN)	95,489

Large: > 200,000 members

Large – Downstate

PPS	Attribution
Advocate Community Providers LLC (ACP)	769,089
New York City Health and Hospital's Corporation, as fiduciary for the HHC-led PPS (HHC)	634,789
Maimonides Medical Center PPS (MAIM)	477,612
Nassau Queens PPS (NQPPS)	354,665
St. Barnabas Hospital dba SBH Health System (SBH)	344,665
Mount Sinai LLC PPS (MSMC)	279,751

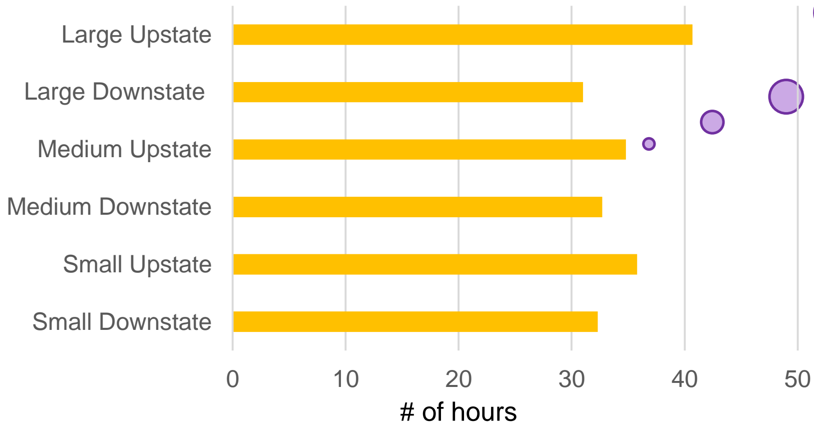
Large – Upstate

PPS	Attribution
Finger Lakes PPS (FLPPS)	279,678
Millennium Collaborative Care (MCC)	230,975
Montefiore Medical Center PPS (MONT)	213,505

*Based on attribution for performance numbers in January 2016

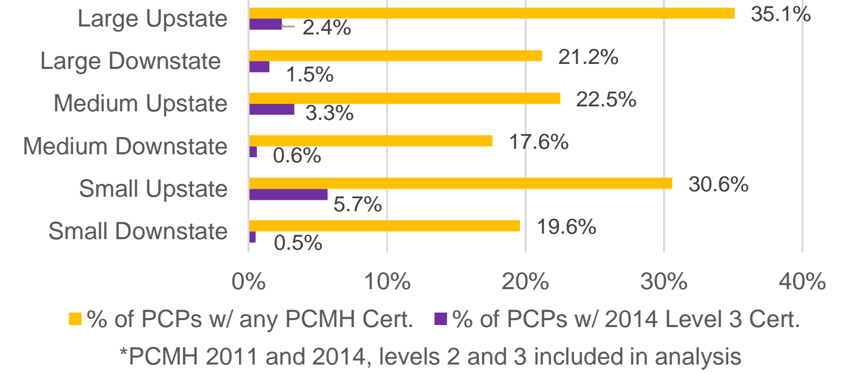
Primary Care Provider Regional Network Analysis

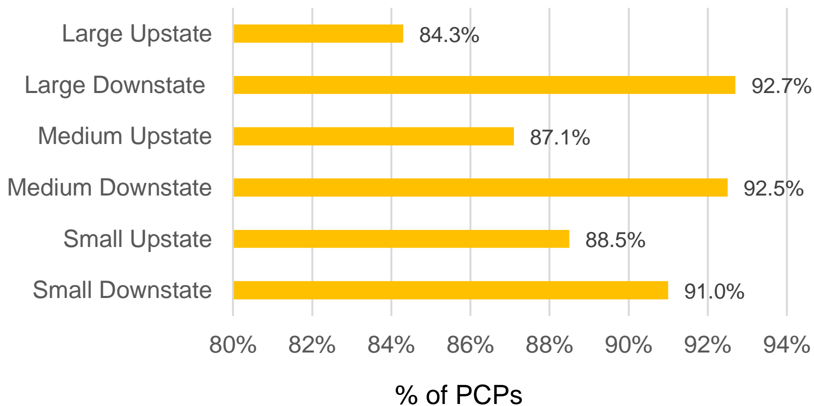
Key takeaways and trends.



Upstate PPSs have PCPs that work longer hours on average

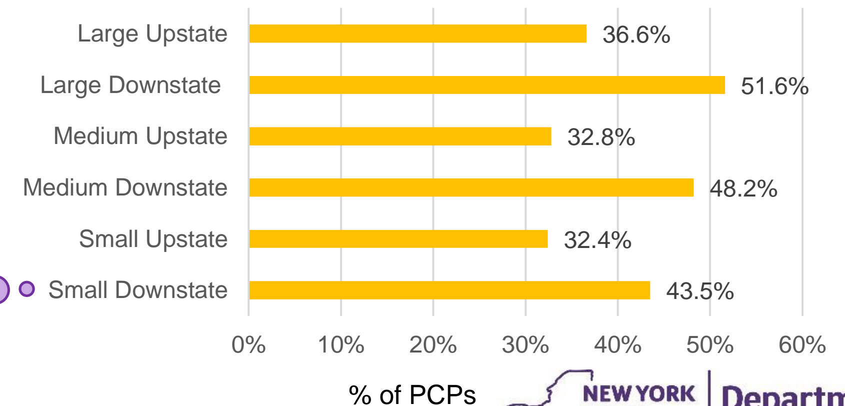
Upstate PPSs are leading the way in PCPs with PCMH 2014 Level 3 and PCPs with any PCMH certification





Downstate PPSs have a higher percentage of PCPs that accept new Medicaid members

Downstate PPSs tend to have more PCPs that participate in more than one PPS



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Current Vision

Primary Care Plans allow PPS the opportunity to convey their current status of primary care transformation activities and provide insight to the Department of Health (DOH) on their overall strategy for developing primary care access, capacity, and quality.

Insight

Provide insights into how the PPS will work with PCPs to achieve DSRIP goals and help understand the nature of their PCP Network

Opportunity

Opportunity to review and update, in a single place, disparate documentation that PPSs have provided to DOH regarding their approach to working with PCPs in their provider network

Accountability

Leverage the Midpoint Assessment process to provide accountability and visibility to PPS strategies for working with primary care

Primary Care Plans will be an annual submission to DOH. PPS will submit the first iteration of Primary Care Plans, consistent with project narrative formatting, by **August 31**, 2016 for review within the Midpoint Assessment,

Current Vision (cont.)

The PPS Primary Care Plan will address each of the following six “fundamentals” and will be submitted by the PPSs as a narrative component of the Demonstration Year Quarter 1 (DY2 Q1) reporting by each PPS with the delivery of project narratives for Midpoint Assessment within DY2 Q1 reporting.

Key stakeholders involved in the development of Primary Care Plans have created talking points under each fundamental. PPS should consider these questions when responding to each fundamental in their Primary Care Plan project narrative.

1. **Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs**
   - PPS’s over-arching approach for expanding Primary Care capacity and ensuring the provision of required services (including, as appropriate, addressing gaps in Primary Care capacity)
   - How is the PPS working with community-based PCPs, as well as institution-based PCPs?

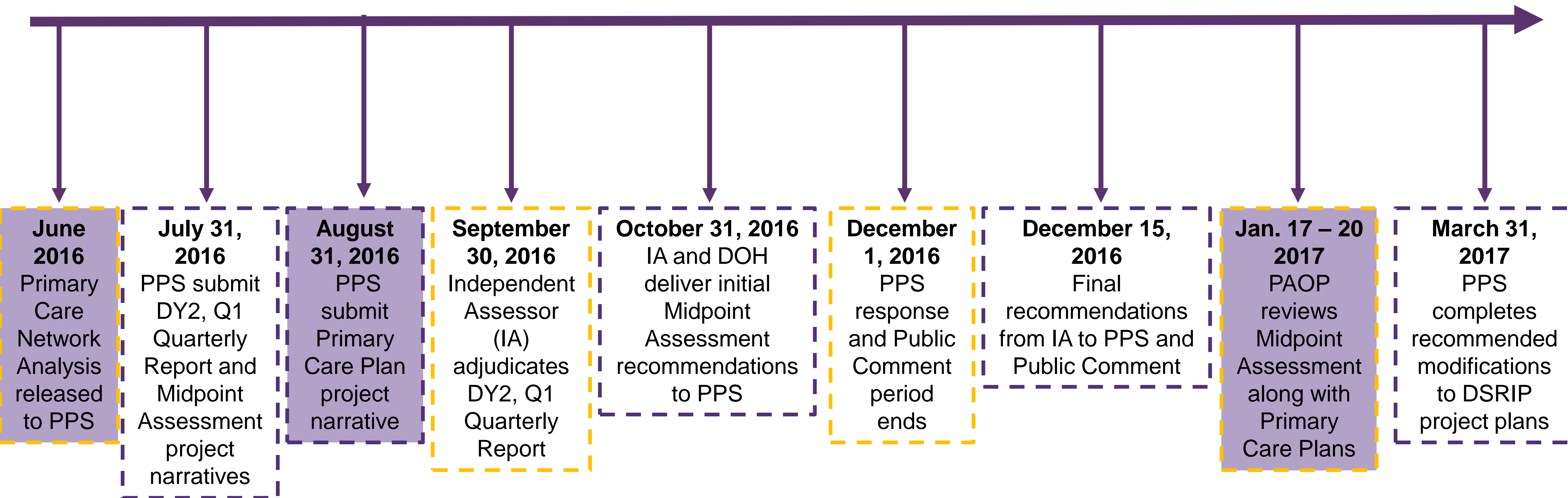
2. **How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?**
   - What are your PPS’s plans for working with Primary Care at the practice level, and how are you supporting them to successfully achieve PCMH/APC?
     - Resources could include collaboration, accreditation, incentives, training/staffing support, practice transformation support, central resources, vendors to support key activities, additional staffing resources, etc.
   - How is your PPS working to ensure that existing statewide resources for technical assistance are being leveraged appropriately?

Current Vision (cont.)

3. **What is the PPS's strategy for how primary care will play a central role in an integrated delivery system?**
   - How will the PPS strengthen the continuum of Primary Care and ensure meaningful linkages to necessary secondary and tertiary services?
   - How is Primary Care represented in your PPS's governance committees and structure and clinical quality committees?
4. **What is the PPS's strategy to enable primary care to participate effectively in value-based payments?**
   - How will key issues for shifting to VBP be managed? (e.g., technical assistance on contracting and data analysis, ensuring primary care providers receive necessary data from hospitals/emergency departments (EDs), creating transition plans, addressing workforce needs and behavioral health integration)
5. **How does your PPS's funds flow support your Primary Care strategies?**
   - What resources are being expended by your PPS to support PCPs in DSRIP?
6. **How is the PPS progressing toward integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i)?**
   - This would include both collaborative care and the development of needed community-based providers.

DSRIP Implementation Timeline and Key Benchmarks

Below are key dates for PPSs regarding their Primary Care Plan and the Midpoint Assessment



FAQs

1. **Is there any consideration to lift the restriction for PPS to utilize more than one funding source (DSRIP, TCPI, etc) to support practices in PCMH achievement?**
   - DOH cannot lift the restrictions, as CMS has specifically asked for assurances regarding non-duplication of resources. We suggest that if there is documented specificity and timeframes regarding the services being rendered, and to the degree that these services do not overlap by the different parties, that these measures may assist in addressing any questions that may arise down the road.
2. **Please clarify the timing of initial submission of Primary Care Plans within Midpoint Assessment.**
   - Midpoint Assessment timelines remain intact, meaning project narratives are still due with submission of the DY2, Q1 Quarterly Reports on July 31, 2016.
   - Primary Care Plans, formatted as project narratives, are due by August 31, 2016. The evaluation and recommendations on Primary Care Plans by the IA and DOH will be incorporated into the Midpoint Assessment schedule from there.
3. **Does the Primary Care Plan drive achievement values (AVs)?**
   - Primary Care Plans do not directly impact Domain 1 AVs.
4. **Will updated Primary Care Network Analysis be provided?**
   - Yes, aligning with annual submission cycles of the Primary Care Plan, annual updates to the Network Analysis will be provided to each PPS.

FAQs (cont.)

5. **How should PPS address Fundamental 3 if they have not selected Project 2.a.i?**
   - PPS should explicate overall transformation plans for PCPs to play a central role in their integrated, community-based delivery system, irrespective of participation in Project 2.a.i.
6. **Is there a specified length for Primary Care Plans?**
   - DOH expects 1-2 pages (500 words each) per fundamental, but PPS should feel free to provide as much information as needed to fully describe their annual plans. There is no page limit.
7. **Will review criteria be provided ahead of time, and will PPS have the opportunity to remediate based on recommendations?**
   - Criteria are available in the form of talking points under each fundamental – refer to slides 21 and 22. PPS will have the opportunity to respond to IA recommendations – refer to previously-released Midpoint Assessment guidelines, as well as slide 23 for timeline.
8. **When is the next period for providers to be included in DSRIP and a PPS network?**
   - The next network maintenance window, to add providers manually or via upload, is currently scheduled for the month of August 2016. PCPs added would be subject to the same timeline of March 31, 2018 for NCQA 2014 PCMH Level 3/APC recognition.
9. **Will the fee for option 2, with PCMH 2-year certification, be prorated?**
   - Yes, NCQA has informed DOH they will prorate the fee commensurate with a 2-year certification.

Questions?

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