PPS Webinar: Update on NYS PCMH

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March 19, 2018

Agenda

- Primary Care Transformation in NY State
- NYS PCMH Model Details
- Medicaid PCMH incentive changes
- Next Steps

Primary Care Transformation in NY State

New York State Health Innovation Plan (SHIP)

Goal	**Delivering the Triple Aim –** *Healthier people, better care and individual experience, smarter spending*				
Pillars	**1 Improve access to care for all New Yorkers, without disparity** Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way	**2 Integrate care to address patient needs seamlessly** Integration of primary care, behavioral health, acute and post-acute care; and supportive care for those that require it	**3 Make the cost and quality of care transparent to empower decision making** Information to enable individuals and providers to make better decisions at enrollment and at the point of care	**4 Pay for health care value, not volume** Rewards for providers who achieve high standards for quality and individual experience while controlling costs	**5 Promote population health** Improved screening and prevention through closer linkages between primary care, public health, and community- based supports

Enablers	**Workforce strategy**	**A**	Matching the capacity and skills of our health care workforce to the evolving needs of our communities
	Health information technology	**B**	Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation
	Performance measurement & evaluation	**C**	Standard approach to measuring the Plan's impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation

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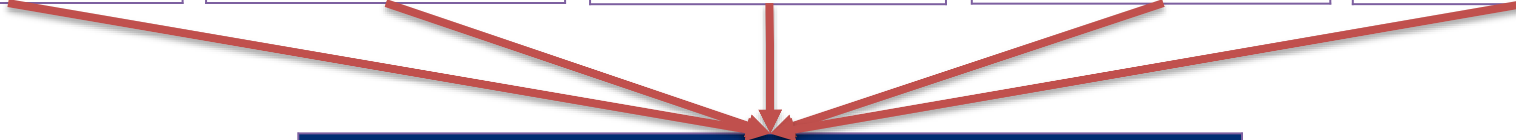
Main CMS Demonstration Programs in NY State:

DSRIP	SIM/APC
Health system transformation, including primary care transformation	Primary care transformation
Medicaid, Managed Medicaid plans	Commercial Multi-payer approach, including other lines of business
Overall goal: 25% reduction in avoidable hospital use	Overall goal: improve primary care outcomes for New Yorkers
Funding: $7.3 billion	$100 Million
Main driver for transformation: PPSs’	Transformation agent vendors
Primary Care Model: NCQA PCMH/recognition of APC Gate 2	Advanced primary care (APC)

Other NY State Practice Transformation Programs:

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



NYS DOH Goals:

- Reduce confusion between providers
- Alignment where possible
- Supporting practices in their transformation efforts

Medicaid/SIM Alignment Examples:

	DSRIP	SIM/APC
VBP approach:	Using Medicaid VBP Roadmap	Using developed commercial/ Medicare advantage programs
Primary Care focus:	Improve care + access to care	Improve care + access to care
Population Health approach:	NYS Prevention Agenda	NYS Prevention Agenda
Quality measurement:	Standardized measure set	Standardized measure set

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Health IT Alignment:

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
- APC requires connection to SHIN-NY

Quality Measure Alignment:

- Using the aligned measure sets across primary care providers for Medicaid VBP arrangements and APC
- Using the same measure methodology and approach

Current Program Participation:

	PCMH	SIM/APC*
Number of practices:	2,201	750
Number of physicians:	8,533	~3000
Level of recognition:	98.5% PCMH 2014	95% APC Gate1

About 15% of APC providers are already PCMH certified

*As of February 2018

What was missing?

State alignment around one common primary care transformation program

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

2017 improvements

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

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

Crosswalk between NCQA PCMH 2017 and APC (example):

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

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Why create a distinct “NYS PCMH”?

- A NYS PCMH program considers several state-specific components including investments in Health IT, Behavior Health integration, rigorous Care Coordination, Population Health, and the potential for multi-payer support
- Accelerating the transition toward value-based payment is a priority for NY

Why align with PCMH (NCQA PCMH 2017)?

- Accelerating the transition toward delivering value and succeeding in new payment models for all practices in NY State
- Opportunity to simplify a complicated landscape and reduce confusion
- Align Medicaid and SIM/APC around one common practice transformation program

NYS PCMH Program Details

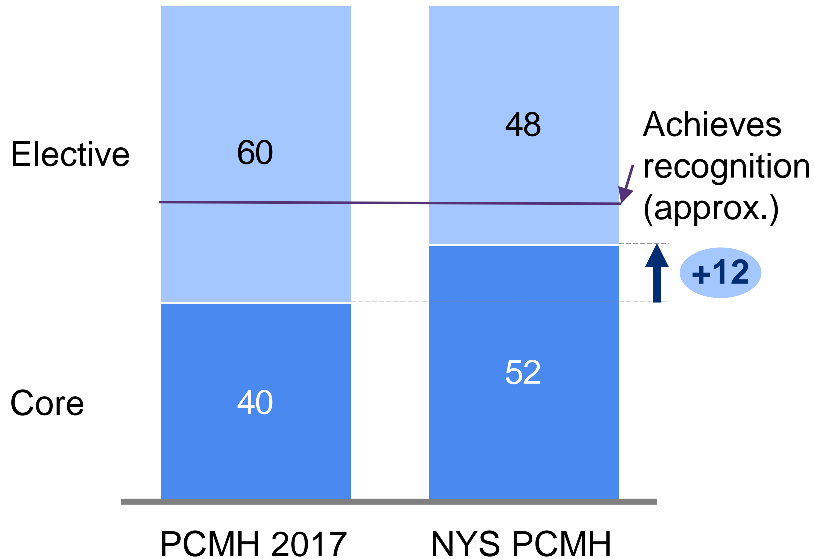
NYS PCMH aligns largely with the NCQA program, with several targeted revisions

Key differences

	From: NCQA PCMH 2017	To: NYS PCMH
Phases of transformation	1. Commit 2. Transform 3. Succeed	▪ Same- in the spirit of simplification, the current NCQA PCMH phases and assessment model would fully replace APC Gates
Requirements	1. Commit, self-assess, plan 2. Develop and document PCMH capabilities 3. Re-certify on an annual basis	1. Same, **plus commitment to adopt VBP** 2. **Additionally require 12 NCQA-elective Behavioral Health, Care management, Population Health, and Health IT capabilities as "Core"[1]** 3. Same
Recognition	▪ Recognition by NCQA as a PCMH 2017 practice	▪ Recognition by NYS and NCQA as an **NYS PCMH 2017** practice
State-funded Technical Assistance (TA)	▪ None	▪ **State-funded TA** to achieve NYS PCMH recognition (with minimal to no need for changes in curriculum), contingent on continued participation for up to 2 years
Medicaid support	▪ Incentive payment upon achieving PMCH 2017 recognition	▪ PMPM payment upon reaching NYS PCMH recognition

1 The 12 additional core criteria for NYS PCMH represent up to 18 elective credits in NCQA PCMH- so NYS PCMH practices would need to complete only an additional 7 credits of electives to achieve recognition

NYS PCMH builds on APC/PCMH 2017 by converting 12 Electives into Core without asking the practices to do more



Changes compared to NCQA PCMH 2017

- **12 Additional Core criteria** represent fundamental building blocks in the areas of:
  - Behavioral Health integration
  - More rigorous Care Coordination
  - Health IT capabilities
  - VBP arrangements
  - Population Health
- Providers would then complete **4-7 elective criteria to earn 7 additional credits**
- **Continuation of TA vendor activities**

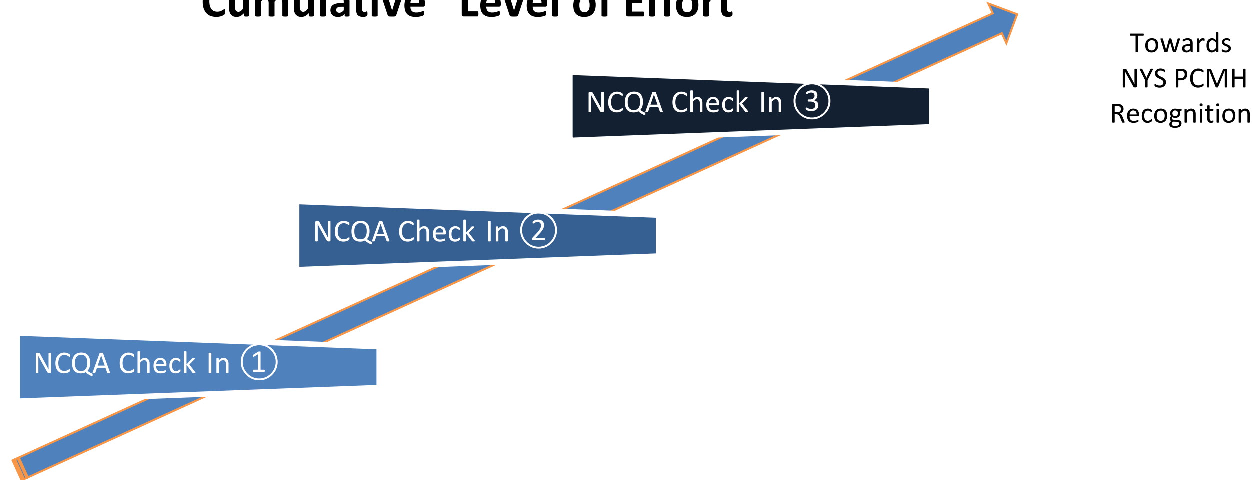
Detail: NYS PCMH 12 new “core” criteria

	Code	Criteria
Behavioral health	CC9	Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care
	KM4	Conducts BH screenings and/or assessments using a standardized tool. (implement two or more) A. Anxiety B. Alcohol Use Disorder C. Substance Use Disorder D. Pediatric Behavioral Health Screening E. PTSD F. ADHD G. Postpartum Depression
Care manage-ment and coordina-tion	CM3	Applies a comprehensive risk - stratification process to entire patient panel in order to identify and direct resources appropriately
	CC8	Works with non-behavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care
	CM9	Care plan is integrated and accessible across settings of care
	CC19	Implements process to consistently obtain patient discharge summaries from the hospital and other facilities
	KM11	Identifies and addresses population-level needs based on the diversity of the practice and the community (Demonstrate at least 2) A. Target pop. health mgmt. on disparities in care B. Address health literacy of the practice C. Educate staff in cultural competence
Health IT	AC8	Has a secure electronic system for two-way communication to provide timely clinical advice
	AC12	Provides continuity of medical record information for care and advice when the office is closed
	CC21	Demonstrates electronic exchange of information with external entities, agencies and registries (may select 1 or more): RHIO, Immunization Registry, Summary of care record to other providers or care facilities for care transitions
	TC5	The practice uses an EHR system (or modules) that has been certified and issued an ONC Certification ID, conducts a security risk analysis, and implements security updates as necessary correcting identified security deficiencies
VBP	QI19	The practice is engaged in Value-Based Contract Agreement[1].

1 A value-based program where the clinician/practice receives an incentive for meeting performance expectations but do not share losses if costs exceed targets.

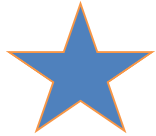
Transformation Agents Assist in Transformation towards NYS PCMH

- NCQA will conduct up to 3 Virtual Check-Ins with each Practice*
- Transformation agents will partner through the entire Check-In and recognition process
- Transformation agents will be required to ensure benchmarked progress for submitting documentation to NCQA



*Practices with NCQA PCMH 2014 Level 3 status subject to renewal or an accelerated path may not require 3 Check-Ins; others subject to Annual Reporting will be required to meet NYS PCMH Core requirements in addition to NCQA's specifications.

NYS PCMH Annual Reporting



NYS PCMH Recognition

Year 2

Year 3…

- Submit documentation for annual check-in to sustain recognition
- Sustained recognition based on practice performance across six categories
- NCQA randomly select practices for audit

Different Pathways to NYS PCMH:

	2018	2019	2020
New Practices	Enroll in NYS PCMH	Achieve NYS PCMH Recognition	NYS PCMH Annual Reporting
NCQA PCMH 2014 Level 1+2	Enroll in NYS PCMH Accelerated renewal	Achieve NYS PCMH Recognition/ NYS PCMH Annual Reporting	NYS PCMH Annual Reporting
NCQA PCMH 2014 – Level 3	**Practices expiring 2018:** Enroll in “First NYS PCMH Annual Report*” **Practices expiring 2019/ 2020:** “First NYS PCMH Annual Report*” optional.	**Practices expired in 2018:** NYS PCMH Annual Reporting. **Practices expiring 2019:** Enroll in “First NYS PCMH Annual Report*” **Practices expiring 2020:** “First NYS PCMH Annual Report*” optional	**Practices expired in 2018/2019:** NYS PCMH Annual Reporting. **Practices expiring 2020:** Enroll in “First NYS PCMH Annual Report*”
APC Practices	Enroll in NYS PCMH	Achieve NYS PCMH Recognition	NYS PCMH Annual Reporting

* For practices that are currently NCQA PCMH 2014 Level 3 recognized, the "First NYS PCMH annual report" will include evaluation of NCQA annual reporting requirements for the year and the 12 elective criteria required by New York State.

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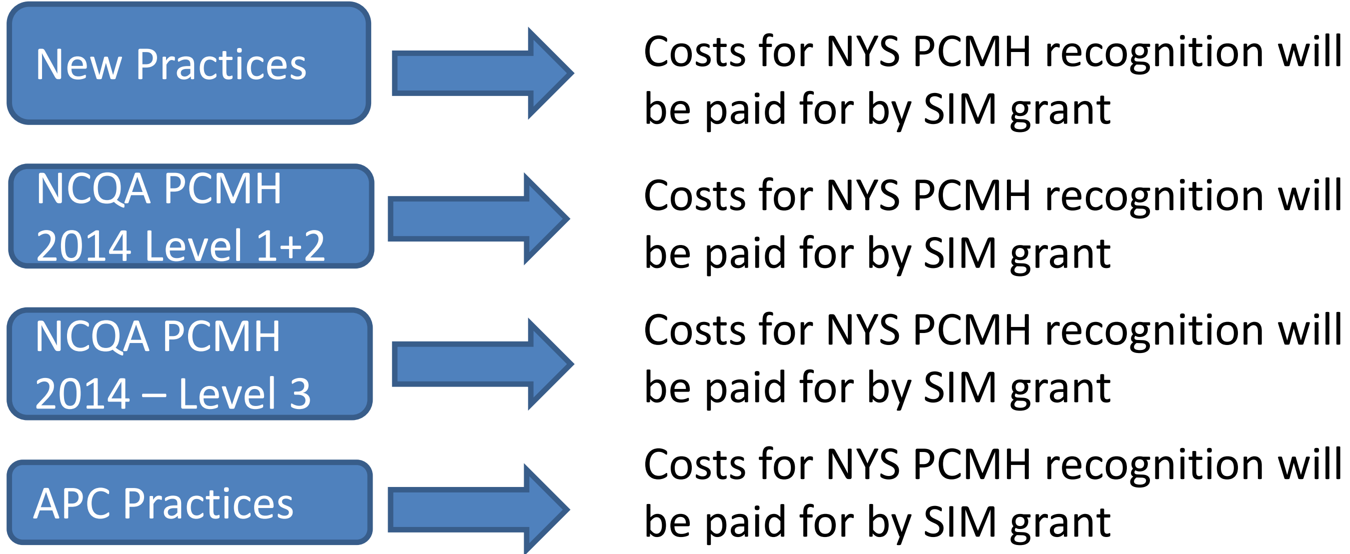
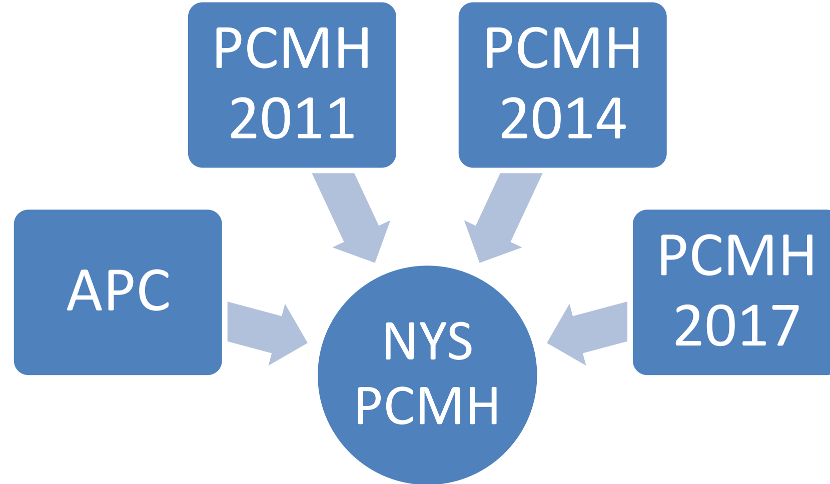
Costs of Transformation to NYS PCMH:



SIM grant funding will end February 2020

Important Date for NYS Transformation:

April 1st, 2018:



Why transform to NYS PCMH?

- Prepare practices for value-based payment environment for NY State Medicaid and commercial VBP arrangements.
- Participate successfully in Medicare, especially under MACRA/MIPS
- Take advantage of transformation fees paid by SIM grant.

Perspective

NYS DOH Perspective

- NYS continues to support primary care transformation
- NYS will continue path towards VBP
- NYS will continue to work with CMS on advancing care models

Medicaid PCMH Incentive Changes

Background

- In response to the fiscal constraints of the Medicaid Global Spending Cap and State efforts to increase participation in the PCMH program, the proposed 2018-2019 State budget caps funding for the PCMH incentive program for State Fiscal Years (SFYs) 2018-19 and 2019-20.

- Rates of the PCMH incentive payment will need to be adjusted.

- There is a payment lag from the Department to the Plans for this incentive, so to effect change in SFY 2018-19, the Department must make changes prior to July 2018.

PCMH Incentive from May – June 2018

The first change will be effective May 1, 2018 (see the January 2018 Medicaid Update):

PCMH incentive (PCMH Standard Year and Level)	Through April 30, 2018	May - June 2018
MMC PMPM (2014 Level 2)	$3.00	-
MMC PMPM (2014 Level 3, APC* or 2017)	$7.50	$2.00
FFS claim add-on Professional (2014 Level 2)	$20.50	-
FFS claim add-on Institutional (2014 Level 2)	$23.25	-
FFS claim add-on Professional (2014 Level 3, APC or 2017**)	$29.00	$29.00
FFS claim add-on Institutional (2014 Level 3, APC or 2017**)	$25.25	$25.25

**NYS Medicaid is planning to add APC providers, who are Gates 2 and 3 certified, into the PCMH incentive program once federal approval is obtained.*
***Starting April 1, 2018, the NCQA "NYS PCMH" model will take the place of PCMH 2017 in New York.*

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PCMH Incentive from July 2018 onward

- Effective on or after July 1, 2018, the Department proposes to tie the Medicaid Managed Care (MMC) and Fee-for-Service (FFS) PCMH incentive to value-based payment (VBP) contracting. Proposals assume:
  - Providers have PCMH certification at NCQA 2014 Level 3 or higher
  - Providers have a Medicaid VBP contract at Level 1 or higher
  - Providers need one Medicaid VBP contract with at least one MMC Plan
  - The FFS incentive will be tied to VBP contracting for those providers who participate in both FFS and MMC.

- Additional guidance and educational materials will be published once the policy is finalized.

Questions