NEW YORK STATE OF OPPORTUNITY. Department of Health

APC Webinar
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Frequently asked questions

- Is APC easier than PCMH?
- What kind of practices can apply? Can specialists be primary care providers?
- What is the relationship between PCMH and APC? Why should I be interested in APC?

APC basics

State Health Improvement Plan/State Innovation Model/Advanced Primary Care

- CMMI: SHIP (broad plan) vs SIM (grant application- $100 million over several years) vs APC (core component of grant…but not only component)

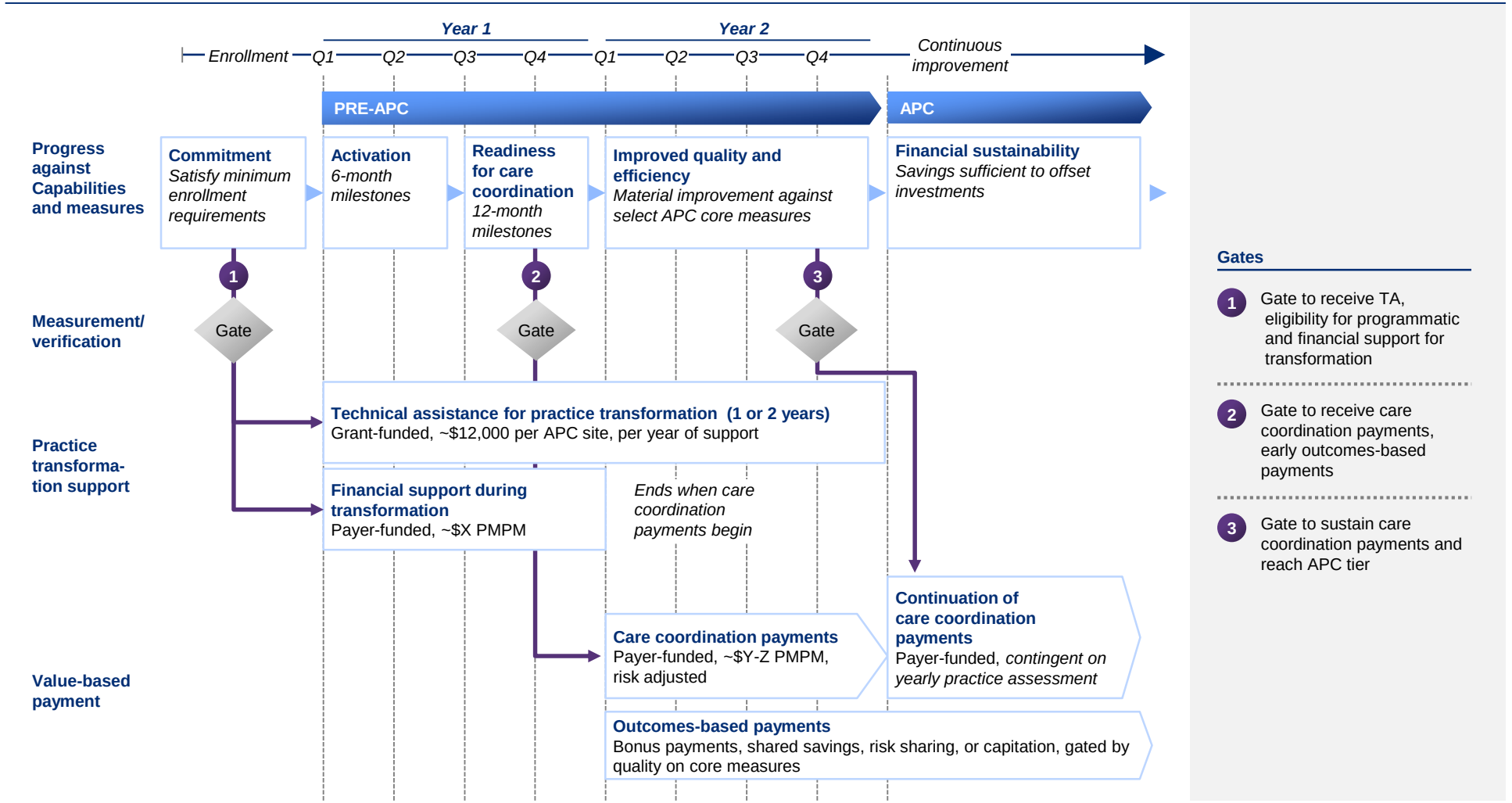
- Goal is multi-payer approach to aligned <u>care AND payment reform</u> focused on primary care that:

  - Works to achieve triple aim goals
  - Engages practices, patients, and payers
  - Builds on evidence, experience, existing demonstrations, PCMH
  - Is sustainable
    - Not ‘just’ a grant program
  - Is supported by HIT/HIE, workforce, access
  - Is statewide

APC Capabilities: Nothing completely new or unfamiliar

Category	Description
Patient-centered care	▪ Engage patients as active, informed participants in their own care, and organize structures and workflows to meet the needs of the patient population
Population Health	▪ Actively promote the health of both patient panels and communities through screening, prevention, chronic disease management, and promotion of a healthy and safe environment
Care management/ coordination	▪ Manage and coordinate care across multiple providers and settings by actively tracking the sickest patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and tracking and optimizing transitions of care
Access to care	▪ Promote access as defined by affordability, availability, accessibility, and acceptability of care across all patient populations
HIT	▪ Use health information technology to deliver better care that is evidence-based, coordinated, and efficient
Payment model	▪ Participate in outcomes-based payment models, based on quality and cost performance, for over 60% of the practice's patient panel
Quality and performance	▪ Measure and actively improve quality, experience, and cost outcomes as described by the APC core measures in the primary care panel

Updated path to APC over time



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Why not just use PCMH?

- Evidence supporting PCMH ‘alone’ as sufficient to improve quality, access, and costs/utilization is not compelling
  - Integration of BH and population health insufficient

- Studies suggest need for multi-payer reform coupled with care reform to achieve cost/efficiency goals (critical for payer interest and investment)

- Lack of adoption by payers and clinicians
  - For Medicaid PCPs, only ~ 1/3 are recognized (after several years of incentives)
  - Few payers make supplemental payments on PCMH recognition alone

Our goal is to improve……

- Non-aligned initiatives among payers
- Insufficient capital/support for practice changes, non-visit based care
- Non-critical mass of payers supporting something other than FFS payments
- Overwhelming number of performance measures
- Non-aggregated measurement that does not represent entire practice
- Patient engagement in self-management
- Care management teams across practices
- Practical/effective integration of behavioral health and population health

- Recognizing…
  - Heterogeneity of practice size, resources, capabilities
  - Need to make a compelling business case for practices and payers

Highlights of 3 Programs for Practice Support

DSRIP	SIM	TCPI
Focus: Primary care practices participating in PPS provider networks - required to achieve Level 3 PCMH (2014) or APC, by March 2018.	**Focus:** Primary care practices: Implementation 2017	**Focus:** Clinician practices, both primary care and specialty
Who provides funding/support to the provider: The PPS in relevant DSRIP projects.	**Who provides funding/support to the provider:** APC Technical assistance (TA) vendors.	**Who provides funding/support to the provider:** 3 TCPI funded grantees – • Care Transitions Network for People with Serious Mental Illness • Greater New York City Practice Transformation Network • New York State Practice Transformation Network
Resources/Payment: Practices are supported by PPSs to reach PCMH or APC designation through TA contracts or centralized resources.	**Resources/Payment:** TA vendor paid on a per-practice basis. Focus on smaller practices.	**Payment:** TA vendors paid on a per-provider basis – Focus on larger practices.

Alignment: The Opportunity and the Challenge

- Common Themes (SIM/TCPI/DSRIP):
  - transformational change in health system to improve quality and reduce avoidable costs
  - Provide technical assistance funding
  - Shift payment towards less FFS and more ‘value based’ payment

- PCMH and APC

- APC (multipayer) and DSRIP (Medicaid only)

- TCPI (primary and specialty practices) and APC

- APC and ACO(s)

- Public and Private Payers

APC Update

APC design deliverables: Where are we?

- RFP for transformation agents (TA): released
- RFP for independent validation agent (IVA): to be released shortly
- RFI for payers: released and being analyzed
- Set of criteria for structural milestones: finalized
- Core measure-set: finalized (1.0)

Aligning APC to CMS Measure Set Summary: Measures in green (found in CMS set only) would be added and the measures in red (found in APC only) would be removed.

Domains	NQF #/HEDIS	Measures
Prevention	32	Cervical Cancer Screening
	--/HEDIS	Non-recommended Cervical Cancer Screening in Adolescent Females
	2372/HEDIS	Breast Cancer Screening
	34/HEDIS	Colorectal Cancer Screening
	33/HEDIS	Chlamydia Screening
	41/AMA	Influenza Immunization - all ages
	38/HEDIS	Childhood Immunization (status)
	2528/ADA	Fluoride Varnish Application
Chronic Disease	28/AMA	Tobacco Use Screening and Intervention
	18/HEDIS	Controlling High Blood Pressure
	59/HEDIS	Comprehensive Diabetes Care: HbA1C Poor Control
	57/HEDIS	Comprehensive Diabetes Care: HbA1C Testing (currently proposed for version 1 of APC only)
	55/HEDIS	Comprehensive Diabetes Care: Eye Exam
	56/HEDIS	Comprehensive Diabetes Care: Foot Exam (currently proposed for version 1 of APC only)
	62/HEDIS	Comprehensive Diabetes Care: Medical Attention for Nephropathy (currently proposed for version 1 of APC only)
	71/HEDIS	Persistent Beta Blocker Treatment after Heart Attack
	1799/HEDIS	Medication Management for People With Asthma
	24/HEDIS	[Combined obesity measure] Weight Assessment and Counseling for nutrition and physical activity for children and adolescents
	421/CMS	[Combined obesity measure] Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
Behavioral Health/ Substance Use	418/CMS	Screening for Clinical Depression and Follow-up Plan
	4/HEDIS	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
	105/HEDIS	Antidepressant Medication Management (currently proposed for version 1 of APC only)
	710/MCM	Depression Remission at 12 months
	1885/MCM	Depression Response at 12 months – Progress towards Remission
Patient-Reported	326/HEDIS	Advance Care Plan
	5/AHRQ	CAHPS Access to Care, Getting Care Quickly
Appropriate Use	52/HEDIS	Use of Imaging Studies for Low Back Pain
	58/HEDIS	Avoidance of Antibiotic Treatment in adults with acute bronchitis
	--/HEDIS	Inpatient Hospital Utilization (HEDIS)
	1768/HEDIS	All-Cause Readmissions
	--/HEDIS	Emergency Department Utilization
Cost	--	Total Cost Per Member Per Month

New proposed APC Set - with CMS Alignment

28 measures total - 19 measures in Version 1 (claims-only measures)

Domains	NQF #/Developer	Version 1/Data Source	Measures	Version 1
Prevention	32/HEDIS	Claims/EHR. Claims-only possible.	**Cervical Cancer Screening**	✓
	2372/HEDIS	Claims/EHR. Claims-only possible.	**Breast Cancer Screening**	✓
	34/HEDIS	Claims/EHR	**Colorectal Cancer Screening**	
	33/HEDIS	Claims/EHR. Claims-only possible	**Chlamydia Screening**	✓
	41/AMA	Claims/EHR/Survey. Claims-only possible.	**Influenza Immunization - all ages**	
	38/HEDIS	Claims/EHR/Survey. Claims-only possible.	**Childhood Immunization (status)**	✓
	2528/ADA	Claims	**Fluoride Varnish Application**	✓
Chronic Disease	28/AMA	Claims/EHR	**Tobacco Use Screening and Intervention**	
	18/HEDIS	Claims/EHR	**Controlling High Blood Pressure**	
	59/HEDIS	Claims/EHR	**Comprehensive Diabetes Care: HbA1C Poor Control**	
	57/HEDIS	Claims	**Comprehensive Diabetes Care: HbA1C Testing**	✓
	55/HEDIS	Claims	**Comprehensive Diabetes Care: Eye Exam**	✓
	56/HEDIS	Claims	**Comprehensive Diabetes Care: Foot Exam**	✓
	62/HEDIS	Claims	**Comprehensive Diabetes Care: Medical Attention for Nephropathy**	✓
	71/HEDIS	Claims/EHR	**Persistent Beta Blocker Treatment after Heart Attack**	✓
	1799/HEDIS	Claims/EHR. Claims-only possible.	**Medication Management for People With Asthma**	✓
	24/HEDIS	Claims/EHR	**[Combined obesity measure] Weight Assessment and Counseling for nutrition and physical activity for children and adolescents**	
	421/CMS	Claims/EHR	**[Combined obesity measure] Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up**	
Behavioral Health/ Substance Use	418/CMS	Claims/EHR	**Screening for Clinical Depression and Follow-up Plan**	
	4/HEDIS	Claims	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**	✓
	105/HEDIS	Claims/EHR	**Antidepressant Medication Management**	✓
Patient-Reported	326/HEDIS	Claims/EHR	**Advance Care Plan**	
	5/AHRQ	Survey	**CAHPS Access to Care, Getting Care Quickly**	
Appropriate Use	52/HEDIS	Claims	**Use of Imaging Studies for Low Back Pain**	✓
	58/HEDIS	Claims	**Avoidance of Antibiotic Treatment in adults with acute bronchitis**	✓
	--/HEDIS	Claims	**Inpatient Hospital Utilization (HEDIS)**	✓
	1768/HEDIS	Claims	**All-Cause Readmissions**	✓
	--/HEDIS	Claims	**Emergency Department Utilization**	✓
Cost	--	Claims	**Total Cost Per Member Per Month**	✓

Milestones need to satisfy all three requirements:

- 1) Does it improve patient care and promote outcomes that matter to patients and families?
- 2) Is it meaningful for the practice and providers?
- 3) Are payers willing to support it?

APC structural milestones

DRAFT

	Commitment Gate 1 *What a practice achieves on its own, before any TA or multi-payer financial support*	Readiness for care coordination Gate 2 *What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet* **Prior milestones, plus …**	Demonstrated APC Capabilities Gate 3 *What a practice achieves after 2 years of TA, 1 year of multi-payer financial support, and 1 year of multi-payer-funded care coordination* **Prior milestones, plus …**
Participation	i. APC participation agreement ii. Early change plan based APC questionnaire iii. Designated change agent / practice leaders iv. Participation in TA Entity APC orientation v. Commitment to achieve gate 2 milestones in 1 year	i. Participation in TA Entity activities and learning (if electing support)	
Patient-centered care	i. Process for Advanced Directive discussions with all patients	i. Advanced Directive discussions with all patients >65 ii. Plan for patient engagement and integration into workflows within one year	i. Advanced Directives shared across medical neighborhood, where feasible ii. Implementation of patient engagement integrated into workflows including QI plan (grounded in evidence base developed in Gate 2, where applicable)
Population health			i. Participate in local and county health collaborative Prevention Agenda activities ii. Annual identification and reach-out to patients due for preventative or chronic care management iii. Process to refer to structured health education programs
Care Manage-ment/ Coord.	i. Commitment to developing care plans in concert with patient preferences and goals ii. Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year	i. Identify and empanel highest-risk patients for CM/CC ii. Process in place for Care Plan development iii. Plan to deliver CM / CC to highest-risk patients within one year iv. Behavioral health: Evidence-based process for screening, treatment where appropriate[1], and referral	i. Integrate high-risk patient data from other sources (including payers) ii. Care plans developed in concert with patient preferences and goals iii. CM delivered to highest-risk patients iv. Referral tracking system in place v. Care compacts or collaborative agreements for timely consultations with medical specialists and institutions vi. Post-discharge follow-up process vii. Behavioral health: Coordinated care management for behavioral health
Access to care	i. 24/7 access to a provider	i. Same-day appointments ii. Culturally and linguistically appropriate services	i. At least 1 session weekly during non-traditional hours
HIT	i. Plan for achieving Gate 2 milestones within one year	i. Tools for quality measurement encompassing all core measures ii. Certified technology for information exchange available in practice for iii. Attestation to connect to HIE in 1 year	i. 24/7 remote access to Health IT ii. Secure electronic provider-patient messaging iii. Enhanced Quality Improvement including CDS iv. Certified Health IT for quality improvement, information exchange v. Connection to local HIE QE vi. Clinical Decision Support
Payment model	i. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year	i. Minimum FFS with P4P[2] contracts with APC-participating payers representing 60% of panel	i. Minimum FFS + gainsharing3 contracts with APC-participating payers representing 60% of panel

1 Uncomplicated, non-psychotic depression
2 Equivalent to Category 2 in the October 2015 HCP LAN Alternative Payment Model (APM) Framework
3 Equivalent to Category 3 in the APM framework

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Example of auto-credit for other programs

Allowance Tables for Milestone 2
Gate 2: Patient-Centered Care

Sub-Milestone	Gating Criteria	Task Requirement	Guidance	MU 1,2	Auto-credit PCMH 2014	Auto-Credit TCPI*
Commitment to Patient Engagement activities, Integrated into Workflows within one year (by Gate 2)	● Plan for either a patient satisfaction survey ● Focus group ● Patient/Family Advisory Council representing practice population (and diversity)	●Provide a copy of designed Patient Survey OR ●Materials to begin Focus Group OR ●PFAC	1 2 2		6C,F1-4 4 points	PAT Phase 1.6 Score: 2 or 3

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Independent Validation Agent:Trust But Verify

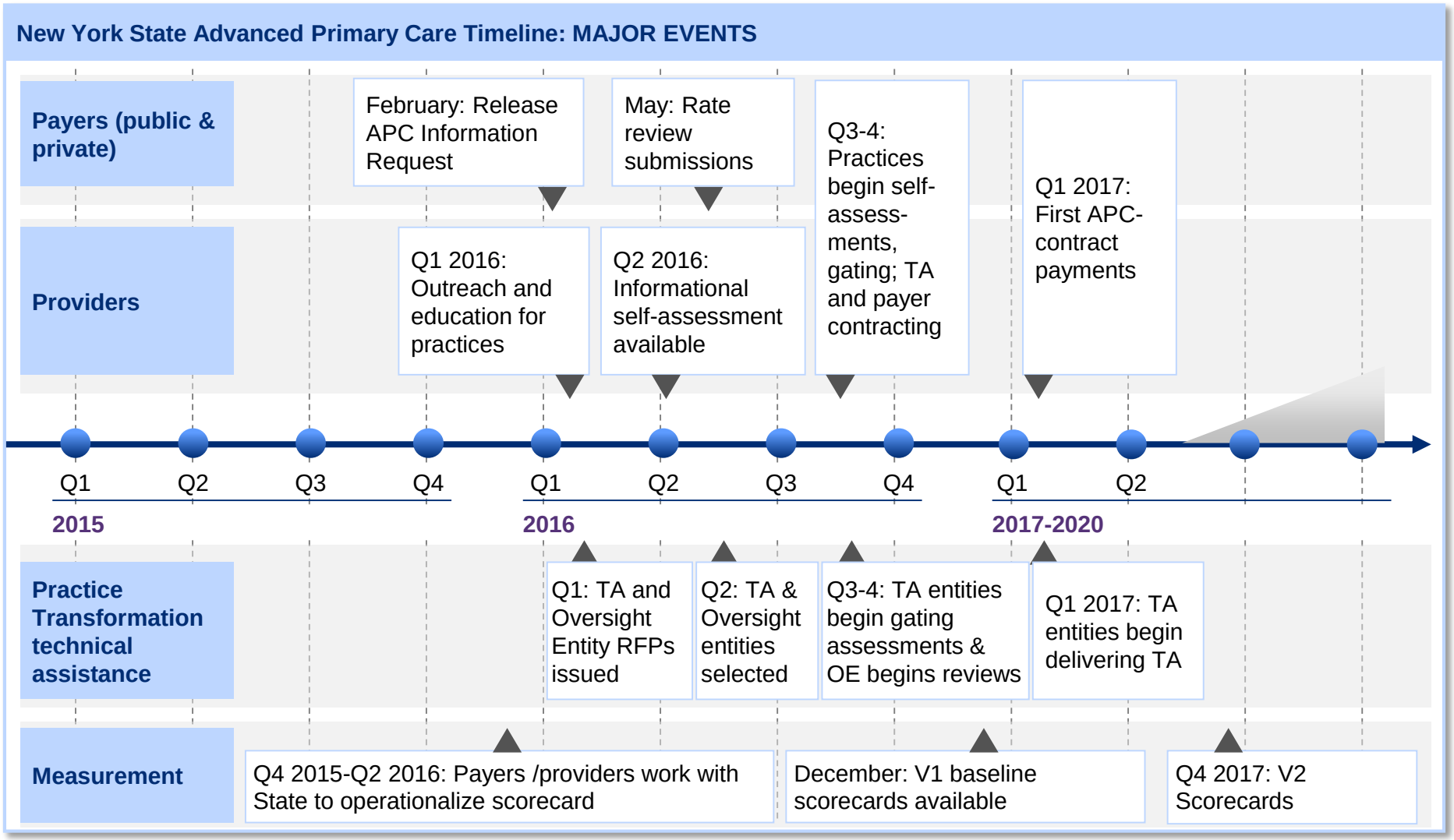
NYS APC program creates a new environment where “trust but verify” is possible:

Reliable Information: The IVA will audit *both* practices and TA entities participating in NYS’s APC program to ensure consistency across regions and application of a single state-wide standard for achievement of gates and milestones.

- The audit function creates a trusted, independent, third-party review of practice achievements in the APC program and TA performance in support of these practice achievements.

Alignment of Payment Models: The IVA’s verification and audit provides unbiased information about practice capabilities and eligibility for value-based payments for both commercial and government payers

Overview of 2016 major events leading to full Jan 2017 implementation



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Questions/Discussion