PPS Meeting: APC/SIM
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State Health Improvement Plan/State Innovation Model/Advanced Primary Care

- Goal is multipayer approach to aligned care/payment reform focused on primary care that:
  - Achieves (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

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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

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APC builds on existing primary care transformation projects in New York State

APC describes a statewide multi-payer approach to achieving the Triple aim through primary care transformation

	Approach	Expectations	Support
APC	▪ TA support ▪ Multi-payer alignment on payment	▪ Meet APC milestones and APC core measures, across 3 progressive gates	▪ State-funded TA ▪ Payer financial PT support, 1 yr ▪ Payer care coordination support, ongoing ▪ Payer outcome-based payment ▪ Payer tools and other in-kind support?

Multiple other programs within the state have similar aims with varying geographic and payer scope

Program	Approach	Expectations	Support
NCQA PCMH (without DSRIP)	▪ No prescribed approach	▪ Meet NCQA 2014 Level III requirements	▪ No upfront support ▪ Medicaid PMPM payment once NCQA 2014 requirements are met
NCQA PCMH (with DSRIP)	▪ DSRIP projects	▪ Meet NCQA 2014 Level III requirements ▪ Report and improve upon APC core measures	▪ DSRIP investments for TA to achieve NCQA ▪ Medicaid PMPM payment once NCQA 2014 requirements are met ▪ DSRIP primary care VBP
TCPI[1]	▪ TA support	▪ Undergo five phases of transformation	▪ CMMI-funded TA
CPCI[2]	▪ Multi-payer alignment	▪ Achieve CPCI milestones over three years	▪ Multi-payer care coordination support ▪ Multi-payer outcome-based payment
MAPCP[2]	▪ Multi-payer alignment	▪ NCQA 2011 Level II requirements	▪ Multi-payer care coordination support ▪ Multi-payer outcome-based payment
ACO	▪ System-based transformation	▪ Performance on quality and cost	▪ Risk and quality-based contracts with multiple payers, not standardized across payers

1 In early development in NYS- details being finalized

2 Currently slated to expire in 2016

Source: CMS, NCQA

Progress: Thanks to our Integrated Care Workgroup and Stakeholder Inputs

- Broad consensus on practice capabilities (and approach to measure/determine)
- Agreement to work towards set of shared 'core' measures (currently ~20)
  - Non-FFS payments depend on measures/performance
- Approach to aligned payment support
  - technical support to practices
  - care management support from payers
  - value/outcome based payments

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Alignment: The Opportunity and the Challenge

- PCMH and APC
- APC and DSRIP
- TCPI and APC
- APC and ACO(s)
- Public and Private Payers

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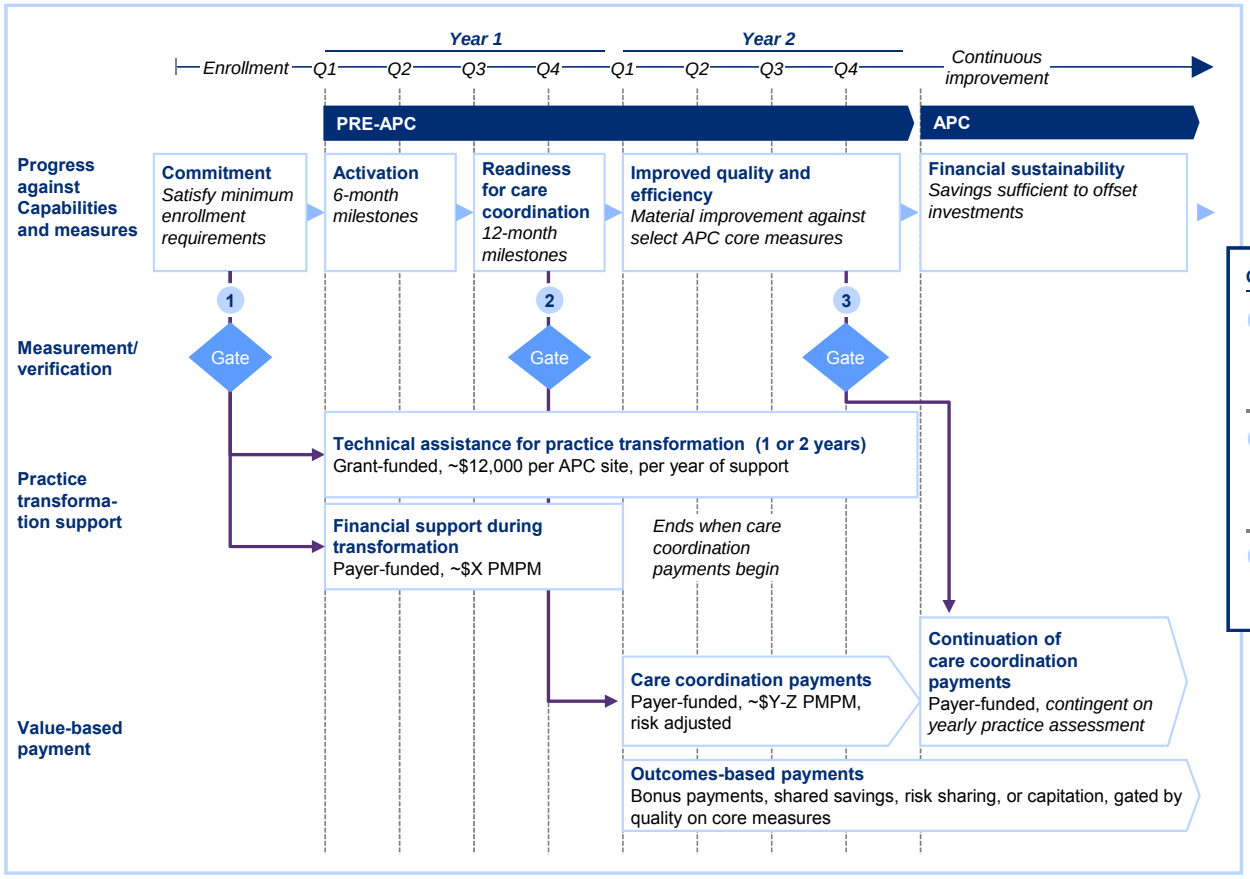
APC Capabilities: Nothing 'New'

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

Review: Path to APC over time for practices starting out



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Updated: Practice-wide structural Milestones

Updates since WG

	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*	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 …	**Prior milestones, plus …**
Participation	▪ Early change plan based on self-assessment tool ▪ Designated change agent / champion ▪ Participation in TA Entity APC orientation ▪ Commitment to achieve gate 2 milestones in 1 year	▪ Participation in TA Entity activities and learning **(if electing support)**	
Patient-centered care	▪ Process for Advanced Directive discussions with all patients	▪ Plan for patient engagement and integration into workflows within one year	▪ Engagement: survey, focus group, **advisory council** or equivalent, plus QI plan based on results (yearly)
Population health			▪ Participate in bimonthly Prevention Agenda calls ▪ Annual identification and reach-out to patients due for preventative or chronic care mgmt ▪ Process to refer to self-management programs
Care Management/ Coord.		▪ Tracking system to identify highest risk patients for CM/ CC ▪ Ramp-up plan to deliver CM / CC to highest-risk patients within one year ▪ Behavioral health: evidence-based process for screening, treatment where appropriate[1], and referral	▪ Care plans developed **in concert with patient preferences and goals** ▪ CM delivered to highest-risk patients ▪ Referral tracking system ▪ Care compacts or collaborative agreements for timely consultations with medical specialists and institutions ▪ Post-discharge follow-up process
Access to care	▪ 24/7 access to a provider **(synchronous and asynchronous communication with explicit response time goals)**	▪ Same-day appointments ▪ Culturally and linguistically appropriate services	▪ At least 1 session weekly during non-traditional hours
HIT	▪ Plan for achieving Gate 2 milestones within one year ▪ E-prescribing	▪ Tools for quality measurement encompassing all core measures ▪ Tools for community care coordination including care planning, secure messaging ▪ Attestation to connect to HIE in 1 year	▪ 24/7 remote EHR access ▪ Secure electronic provider-patient messaging ▪ Meet current Meaningful Use standards ▪ Connected to local HIE qualified entity and using data for patient care
Payment model	▪ Commitment to APC-compatible contracts representing 60% of panel within 1 year	▪ APC-compatible contracts with payers representing 60% of panel	▪ APC-compatible contracts with payers representing 60% of panel ▪ Minimum upside risk-sharing

Measurement and performance milestones to follow

1 Uncomplicated, non-psychotic depression

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APC Structural Milestones largely match up with NCQA 2014, with a few elements specific to APC

● NCQA 2014 "Must-pass" ○ Not mentioned in NCQA 2014
● NCQA 2014 other

	Commitment Gate 1	Readiness for care coordination Gate 2 Prior milestones, plus …	Demonstrated APC Capabilities Gate 3 Prior milestones, plus …
Participation	○ Early change plan based on self-assessment tool ○ Designated change agent / champion ○ Participation in TA Entity APC orientation ○ Commitment to achieve gate 2 milestones in 1 year	○ Participation in TA Entity activities and learning (if electing support)	
Patient-centered care	▪ Process for Advanced Directive discussions with all patients	○ Plan for patient engagement and integration into workflows within one year	○ Engagement: survey, focus group, patient advisory council, or equivalent, plus QI plan based on results (yearly)
Population health			● Annual identification and reach-out to patients due for preventative or chronic care mgmt. ▪ Process to refer to self-management programs ○ Participate in bimonthly Prevention Agenda calls
Care Management/ Coord.		▪ Tracking system to identify highest risk patients for CM/ CC ▪ Ramp-up plan to deliver CM / CC to highest-risk patients within one year ● Behavioral health: evidence-based process for screening, treatment where appropriate, and referral	● Care plans developed in concert with patient preferences and goals ▪ CM delivered to highest-risk patients ● Referral tracking system ● Care compacts or collaborative agreements with medical specialists and institutions ▪ Post-discharge follow-up process
Access to care	● 24/7 access to a provider (synchronous and asynchronous communication with explicit response time goals)	● Same-day appointments ▪ Culturally and linguistically appropriate services	● At least 1 session weekly during non-traditional hours
HIT	○ Plan for achieving Gate 2 milestones within one year ▪ E-prescribing	● Tools for quality measurement encompassing all core measures ▪ Tools for community care coordination including care planning, secure messaging ▪ Attestation to connect to HIE in 1 year	○ 24/7 remote EHR access ○ Secure electronic provider-patient messaging ▪ Meet current Meaningful Use standards ▪ Connected to local HIE qualified entity and using data for patient care
Payment model	○ Commitment to OBP payers representing 60% of panel within 1 year	○ OBP contracts with payers representing 60% of panel	○ OBP contracts with payers representing 60% of panel ○ Minimum upside risk-sharing

Must-pass elements make up only 27.5 points (out of 85 points needed for level 3)

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DATA: Proposed measurement and performance milestones

	Gate 1	Gate 2	Gate 3	
	Commitment *What a practice achieves on its own, before any TA or multi-payer financial support*	**Readiness for care coordination** *What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet*	**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*	**Yearly performance against core measures within APC**
Objective	Ensure practices can measure, report and engage with core measures in preparation for performance improvement			Ensure practices are using APC capabilities to drive improved performance
Proposed milestones	▪ **Data collection plan:** Plan for collecting and reporting non-claims-based data relevant for core measures	▪ **Report and use data** on all core measures, including data necessary to assess health disparities ▪ **QI plan:** On at least one claims-based measure	▪ **QI plan:** on 3 prioritized core measures, including utilization and addressing health access and outcome disparities ▪ **Positive trajectory** on utilization/cost core measures while meeting quality expectations	▪ **Closure of gap** to agreed-upon benchmark on 3 core measures (including at least one utilization measure), while meeting yearly core measure quality expectations ▪ **Net positive ROI on care management fees** through cost and utilization savings beginning in year three of transformation

APC performance milestones are similar, with greater expectations for yearly performance

● NCQA 2014 "Must-pass"
● NCQA 2014 other
▨ NCQA "Must-pass", with slightly different measures
○ Not mentioned in NCQA 2014

	Gate 1 Commitment	Gate 2 Readiness for care coordination	Gate 3 Demonstrated APC capabilities	Yearly performance against core measures within APC
Objective	Ensure practices can measure, report and engage with core measures in preparation for performance improvement			Ensure practices are using APC capabilities to drive improved performance
Proposed milestones	▨ **Data collection plan:** Plan for collecting and reporting non-claims-based data relevant for core measures	▨ **Report and use data** on all core measures, including data necessary to assess health disparities ● **QI plan:** On at least one claims-based measure	● **QI plan:** on 3 prioritized core measures, includ-ing utilization and addressing health access and outcome disparities ● **Positive trajectory** on utilization/cost core measures while meeting quality expectations	◉ **Closure of gap** to agreed-upon benchmark on 3 core measures (including at least one utilization measure), while meeting yearly core measure quality expectations ◉ **Net positive ROI on care management fees** through cost and utilization savings beginning in year three of transformation

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Of the 20 core measures proposed for the APC scorecard, 9-12 of the measures are targeted for V1.0

✓ Claims-only is possible

Candidate V1.0 measures

Categories	Measures	Claims	EHR	Survey
Prevention	1 Colorectal Cancer Screening	✓	✓	
	2 Chlamydia Screening	✓	✓	
	3 Influenza Immunization - all ages	✓	✓	✓
	4 Childhood Immunization (status)	✓	✓	
	5 Fluoride Varnish Application	✓		
Chronic disease	6 Tobacco Use Screening and Intervention	✓	✓	
	7 Controlling High Blood Pressure	✓	✓	
	8 Diabetes A1C Poor Control	✓	✓	
	9 Medication Management for People with Asthma	✓	✓	
	10 Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults	✓	✓	
BH/Sub-stance abuse	11 Depression screening and management	✓	✓	
	12 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	✓		
Patient reported	13 Record Advance Directives for 65 and older	✓	✓	✓
	14 CAHPS Access to Care, Getting Care Quickly			✓
Appropriate use	15 Use of Imaging Studies for Low Back Pain	✓		
	16 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	✓		
	17 Hospitalization	✓		
	18 Readmission	✓		
	19 Emergency Dept. Utilization	✓		
Cost	20 Total Cost Per Member Per Month	✓		

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For the scorecard to help drive practice performance, it must be tied to payment across multiple payers

FOR DISCUSSION

Value-based programs	Draft rule for payment weighting	Questions
Medicaid	▪ **≥80%** on Core APC quality measures (other measures limited to those associated with bundles, and CMS core measures)	▪ What Medicaid MCO measures will need to be added? ▪ How does this change for primary care practices in PPSs?
Commercial	▪ **≥80%** on Core APC quality measures	▪ What additional allowances must be made for ACOs?
Medicare advantage (MA Stars)	▪ **≥60%** on Core APC quality measures (MA Stars only other measures)	▪ What is the right limit on quality measures to recognize the need for MA stars measures?

- **Targets and benchmarks will not be standardized statewide in this iteration**
- **Continued progress and standardization will depend on ongoing collaboration with payers and providers**

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Questions/Discussion