NEW YORK STATE OF OPPORTUNITY. Department of Health

INTEGRATED CARE WORKGROUP

Meeting #6

June 30, 2015

Welcome and Introductions

The APC Straw-Person – Revised

APC Tiers – Revised June 3, 2015

PRE APC (Commits to meeting APC Standards within 1-2 years)	APC	PREMIUM APC
PATIENT-CENTERED CARE	**1. PATIENT-CENTERED CARE**	**1. PATIENT-CENTERED CARE**
At least **annual** patient survey, or patient advisory council or patient focus group and incorporation of results/recommendations as part of QI plan.	All previous plus: a. At least **semi-annual** patient survey, or patient advisory council or patient focus group and show evidence of incorporation of results as part of QI plan. b. Conduct comprehensive health assessment for each patient inclusive of discussion of advanced directives. c. Develop care plans in concert with patient preferences and goals d. Provide culturally and linguistically appropriate care and services to promote access and quality.	All previous plus: a. At least **quarterly** patient surveys or patient advisory council or focus group and show evidence of incorporation as part of QI plan. b. Report survey results to patients, payers or both. c. Include patient or family member as part of practice advisory council or governance structure. d. Report results of at least one standardized measure to patients.
POPULATION HEALTH	**2. POPULATION HEALTH**	**2. POPULATION HEALTH**
	a. Identify **at least annually** patients due for preventive or chronic care management services and communicate reminders. b. Evaluate health disparities in access/outcome as part of QI plan. c. Offer or refer patients to structured health education programs such as group classes, peer support, and self-management programs. d. Measure and report one prevention agenda (PA) goal consistent with local PA goals.	All previous plus: a. Evaluate health disparities as part of QI plan **and develop plan to address** b. Identify, **more than annually**, patients due f preventive or chronic care management services, communicate reminders and **ensur provision of appropriate follow-up care** c. Maintain a list of community-based services that are relevant to the practice's high-risk population and establish referral and feedba mechanisms for linking patients with these services.

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APC Tiers – Revised June 3, 2015

CARE MANAGEMENT	3. CARE MANAGEMENT	3. CARE MANAGEMENT
Identify high risk patients who would benefit from care management (CM) Screening, treatment and referral where indicated for behavioral health issues.	All previous plus: a. Provide/offer (CM) to **at least 75% of** high risk patients. b. Electronic medication reconciliation for patients transitioning from institutional care. c. Provide core elements of Collaborative Care model for depression screening and management, including assessment, data collection and tracking metrics over time.	All previous plus: a. CM services offered to **all** high-risk patients. b. Integrate practice care management with Medicaid health home and health plan care managers as appropriate. c. Evidenced based screening, intervention anc referral to treatment (such as SBIRT) to identify, reduce, and prevent problematic us abuse, and dependence on alcohol and illicit drugs.
ACCESS TO CARE	**4. ACCESS TO CARE**	**4. ACCESS TO CARE**
24/7 same day patient access to nurse or other clinician via telephone and/or secure electronic messaging	All previous plus: a. Access to EHR by the on-call clinician after hours. b. Patient access to care during non-traditional hours including at least one session/week of evening/weekend office hours. c. Synchronous and asynchronous communication such as secure electronic messaging between patient and provider with commitment to an explicit response time goal.	All previous
QUALITY IMPROVEMENT	**5. QUALITY IMPROVEMENT**	**5. QUALITY IMPROVEMENT**
a. Evaluate practice performance using a set of at least 3 standardized quality (HEDIS, QARR, MU CQMs, etc.).	All previous plus: a. Measure and report at least six standardized measures (including behavioral health and patient experience) b. Incorporate results as part of a formal QI process. c. At least half of measures should be from EHR.	All previous plus: a. At least half of measures make use of CQM data.

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APC Tiers – Revised June 3, 2015

CARE COORDINATION	6. CARE COORDINATION	6. CARE COORDINATION
System in place to track high risk referrals	a. Track referrals and reports of referral visit to PCP and have processes to address uncompleted referrals or reports. b. Have care compacts or collaborative agreements with specialists (including behavioral health) to improve transitions in care. c. Have systems in place to identify and contact patients seen in an ED or hospital discharges.	All previous plus: a. Measure the effectiveness of care transition processes in contacting and following up wit patients and implement QI efforts as needec
HEALTH INFORMATION TECHNOLOGY	**7. HEALTH INFORMATION TECHNOLOGY**	**7. HEALTH INFORMATION TECHNOLOGY**
ractice able to meet one of the following: a. Attest to Meaningful Use Stage 1 within one year b. Signed contract with an EHR vendor c. IT and data utilization capabilities including: • Tool to enable population health tracking and quality reporting over time • Access to and use of reports (clinical or claim-based) that identify high risk patients • Ability to electronically document and share a care plan, with all members of the practice.	All previous plus: a. Meaningful Use Stage 1 b. Connected to local RHIO or has plans to connect with six months.	All previous plus: a. Meets all MU Stage 2 and Stage 3 requirements. b. Connected to local RHIOs and uses data for patient care activities.

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APC Tiers – Revised June 3, 2015

PARTICIPATION AGREEMENT	8. PARTICIPATION AGREEMENT	8. PARTICIPATION AGREEMENT
Completion of a standardized self-assessment tool and on-site audit to evaluate readiness for/interest in change. Up-to-date board certification.	All previous	All previous
PAYMENT MODEL	**9. PAYMENT MODEL**	**9. PAYMENT MODEL**
Agreement to transition to alternative payment model(s) with payers	a. Negotiates alternative payment model (s) with payers.	a. Negotiates alternative payment model(s) wit payers including shared savings/risk

NOTE: Section on SHARED DECISION MAKING has been collapsed into other sections; Section on LOCAL/DISTANCE LEARNING COLLABORATIVES has been removed as standard. POPULATION HEALTH has been added as its own section.

Integrating Integrated Care

Complexity Can Limit Progress

William Streck, MD
HANYS

APC Facts and Aspirations

- *Required* APC results must include reduced costs through better resource management while maintaining quality.
- *Desired* consequences of the APC include improved quality, a better patient experience and provider satisfaction.
- A logical consequence of APC design is to begin with those elements that have been demonstrated to lower costs.
- This is not a research project.

ICW Ideas

- Quality measures
- Cost reductions
- Health education
- HIE
- Patient satisfaction
- 24/7 access
- Care management
- Team coaching
- Data reporting
- Provider satisfaction
- Admissions and ED decline
- Shared savings
- Patient surveys
- Payment models
- Referral tracking

Acronyms That Need To Sync

- Quality measures
- Cost reductions
- Health education
- HIE
- Patient satisfaction
- 24/7 access
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Already In The Game

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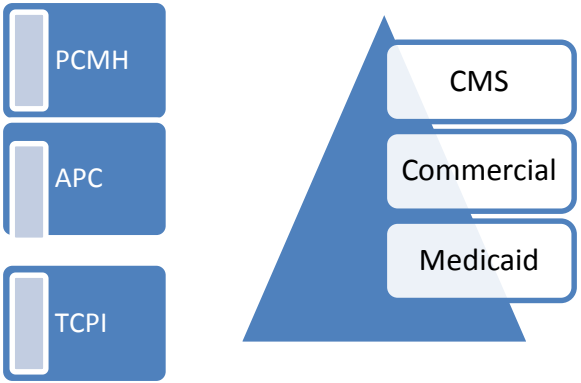

Organizing The Thinking

DESIGN

- Quality measures
- Cost reductions
- Health education
- HIE
- Patient satisfaction
- 24/7 access
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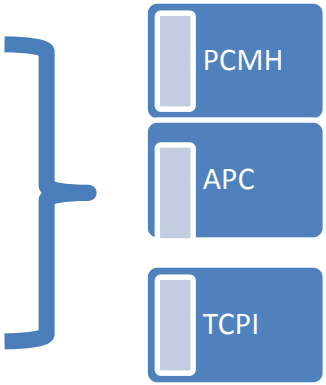
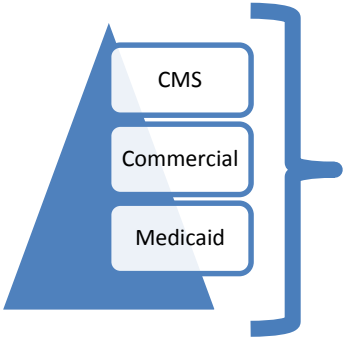
ESSENTIAL SHARED FEATURES



OUTCOMES



Using The Evidence

DESIGN

- Quality measures
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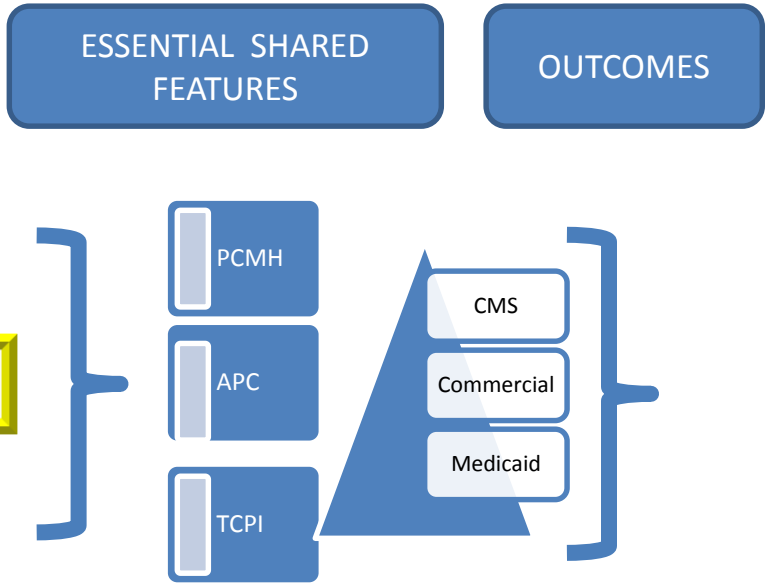

Tiers As Required

DESIGN

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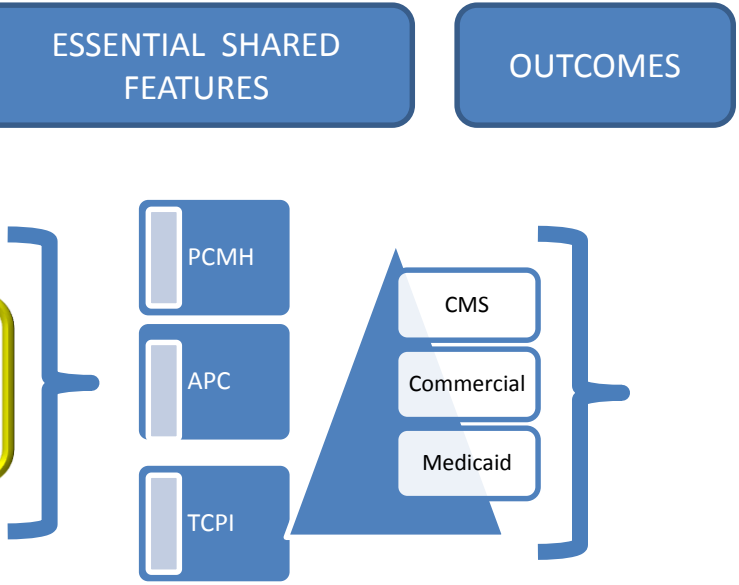

Advantage Of Commonality

DESIGN

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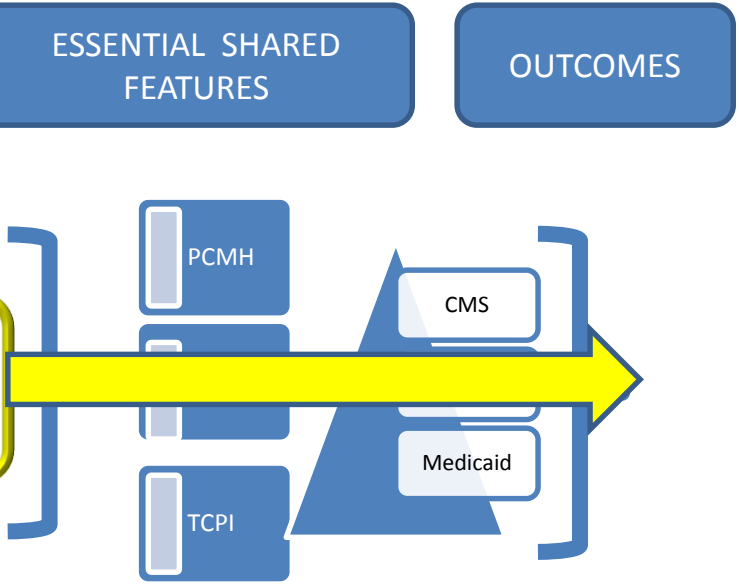

CMMI Recommended Metrics At The Start

DESIGN

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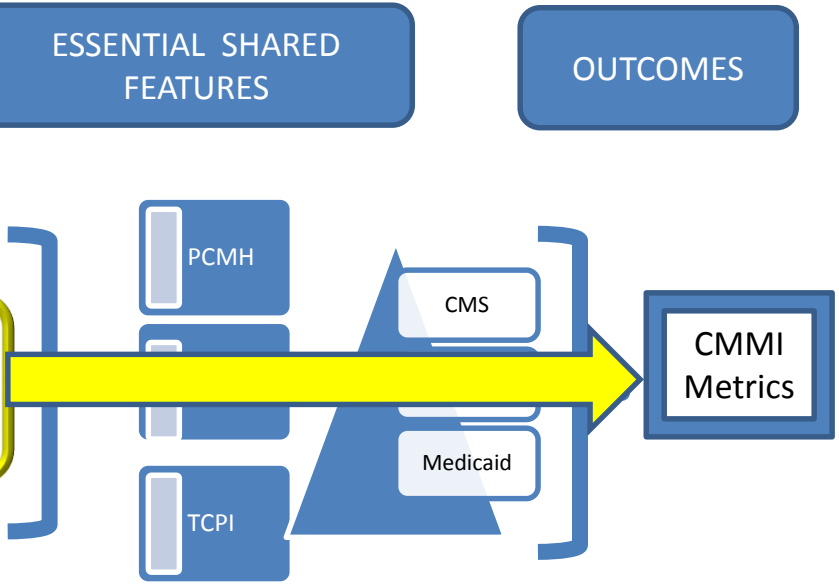
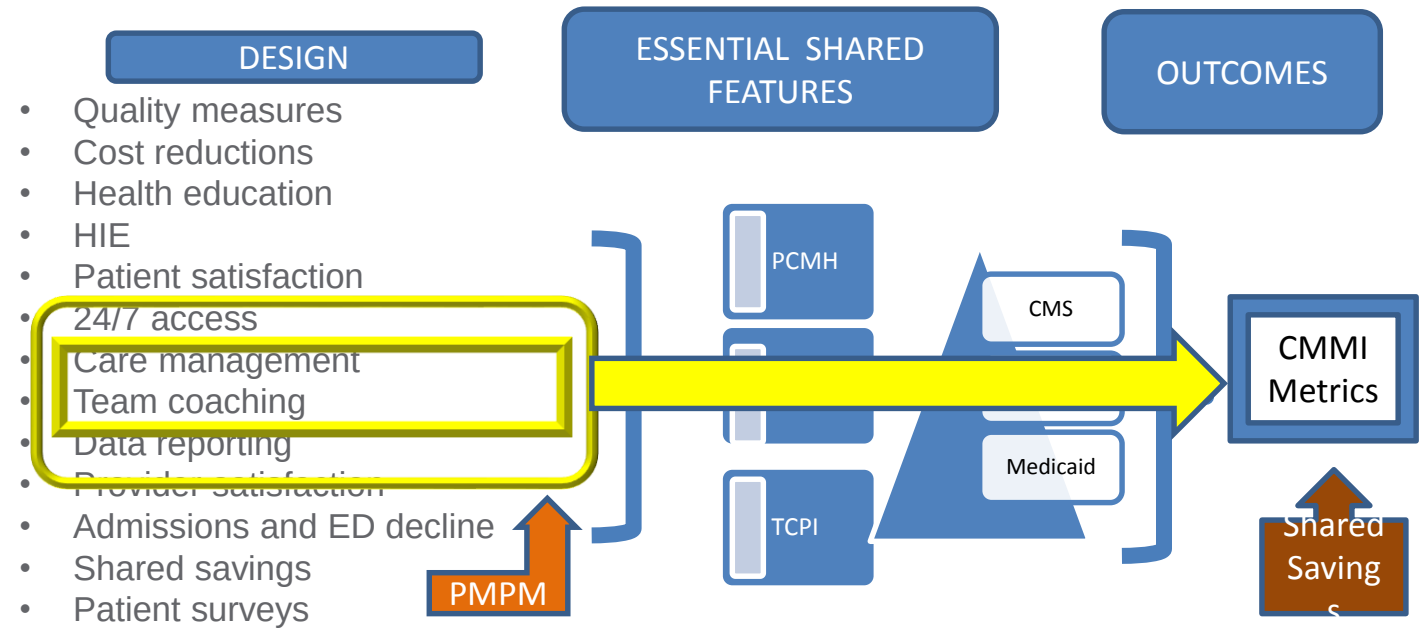


Where Dollars Are Effective



Summary

- APC that reduces costs
- APC that is inclusive of the key elements of other models
- APC that is understandable
- APC with a basic core upon which can be added more sophistication
- APC that may appeal to practitioners: $ to add care coordination with expectation of results
- APC that addresses CMMI goals

Design Matters

Common Measure Set for APC

Measure Set for APC

- Measures should fit purpose(s)
- Purpose(s) include:
  - Evaluate whether APC standards are in place and working effectively
  - Evaluate patient experience, clinical quality, and avoidable costs
  - Use for ‘value based’ payments

Measurement Goals

- Should strive towards alignment and parsimony
  - Alignment = same measures across payers
  - Alignment = measures that serve multiple purposes within APC, and without
- Avoid completely new measures
- Mix of process and outcome
  - Process measures should be closely associated with improved outcomes

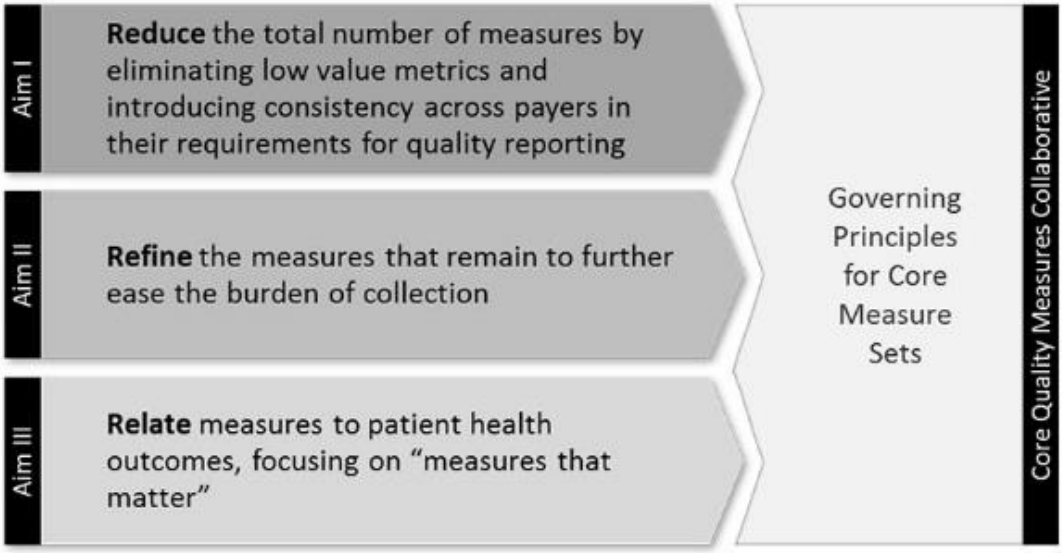
Measure Choice Considerations

- Alignment
- Fits Purpose(s)
- Opportunity
  - To improve
  - To meaningfully improve health
  - Influenced by health care providers/system
- Practical (lowest burden)
  - Data exists
  - Relatively easy to ‘mine’
  - Sufficient denominators
- Overuse and underuse

Measure Choice Considerations

- Reliable/Valid/Tested
  - NQF/NCQA/AMA-PCPI
- Relevant across population(s)
- Clinical quality measures includes:
  - Acute
  - Prevention
  - Chronic
- Mix: administrative, clinical/EHR, survey
- Meaningful to:
  - Patients
  - Payers
  - Providers

Core Quality Measures Collaborative 3Rs — Reduce, Refine, and Relate



Source: http://healthaffairs.org/blog/2015/06/23/the-core-quality-measures-collaborative-a-rationale-and-framework-for-public-private-quality-measure-alignment/

Governing Principles for Core Measures

1	Measure sets must be aimed at achieving the three part aim of the National Quality Strategy: better care, healthier people and communities, and more affordable care.
2	NQF-endorsed measures are preferred.* In the absence of NQF endorsement, measures must be tested for validity and reliability in a manner consistent with the NQF process where applicable.
3	Data collection and reporting burden must be minimal.
4	Overuse and underuse measures should both be included.
5	Measure sets for clinicians should be limited to fewer than 15 measures when possible.
6	Measures that are currently in use by physicians, measure patient outcomes, and have the ability to drive improvement are preferred.
7	Measures that are cross-cutting across multiple conditions to reflect a domain of quality (e.g., patient experience with care, patient safety, functional status, managing transitions of care, medication reconciliation) are preferred.
8	Measures should be meaningful to and usable by consumers, and also applicable to different patient populations.
9	Patient outcome measures should allow careful and prudent physicians to attain success.
10	As with all measures, those which reform payment or delivery systems should measure clinical quality, patient experience, and costs.

Source: http://healthaffairs.org/blog/2015/06/23/the-core-quality-measures-collaborative-a-rationale-and-framework-for-public-private-quality-measure-alignment/

Primary Care Measure Sets

NYS MAPCP – Adult Measures

Blood pressure management	Number of patients whose most recent BP is adequately controlled based on the following: - Members 18-59 years as of December 31 of the measurement year whose BP was <140/90mm Hg - Members 60-85 years as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm HG - Members 60-85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm HG
Colon cancer screening	Any of the following meet the criteria: - Fecal occult blood test during the measurement year. For administrative data, assume the required number of samples were returned regardless of FOBT type. - Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. - Colonoscopy during the measurement year or the nine years prior to the measurement year.
Pap smear	The number of patients who have had a pap smear within the last 3 years or patients who have had a pap and HPV with service dates 4 or less days apart during the measurement year or the four years prior
Breast cancer screening	The number of patients who received one or more mammograms any time on or between October 1st two years prior to the measurement year and December 31st of the measurement year
Depression Screening (12 & Older)	Patients screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented. (PHQ-2 / PHQ-9)
Pneumonia vaccine	The number of patients who received a pneumococcal vaccine
Diabetes Hgb A1C - Poor control	Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or for whom an HbA1c test was not done during the measurement year.
Retinal Eye Exam	Patients who received an eye screening for diabetic retinal disease. This includes people with diabetes who had the following: -a retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year OR –a negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. For exams performed in the year prior to the measurement year, a result must be available.

NYS MAPCP – Pediatric Measures

Immunizations	
HPV Vaccines	Received at least three doses of the human papillomavirus (HPV) vaccine with different dates of service on or between their 9th and 13th birthdays.
Childhood Immunization Status	Children who have evidence showing they received recommended vaccines by their second birthday including four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B(HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines
Adolescent Immunization Status	Adolescents who have evidence showing they received recommended vaccines by their 13th birthday including one meningicoccal and one Tdap or Td
Weight Assessment	
BMI Assessment	Body mass index (BMI) percentile documentation
Nutrition counseling	Documentation of nutrition counseling
Physical Activity Counseling	Documentation of counseling for physical activity
Access to Care/Preventive Care	
Chlamydia Screening	At least one chlamydia test during the measurement year.
ADHD Follow Up Visits - Initial Phase	An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD (index prescription start date)
ADHD Follow Up Visits - Continuation & Maintenance Phase	Patient who meet the following: numerator compliant for initial phase and then at least two follow-up visits from 31-300 days (9 months) after the IPSD with any practitioner
Annual Depression Screening	Patients screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented. (PHQ-2 / PHQ-9)

NYS CPCi (1 of 2)

NQF ID	Clinical Quality Measure Title	Required in 2013	Required in 2014 & 2015	Domain
0018	Controlling High Blood Pressure	Yes	Yes	Clinical Process/ Effectiveness
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Yes: CO, OK, OR No: AR, NJ, NY, OH	Yes: CO, OK, OR No: AR, NJ, NY, OH	Population/ Public Health
0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Yes	Yes	Population/ Public Health
0031[2]	Breast Cancer Screening	Yes	Yes	Clinical Process/ Effectiveness
0034	Colorectal Cancer Screening	Yes	Yes	Clinical Process/ Effectiveness
0036	Use of Appropriate Medications for Asthma	Yes: CO, NJ, NY, OH, OK, OR No: AR	Yes: CO, NJ, NY, OH, OK, OR No: AR	Clinical Process/ Effectiveness
0041	Preventive Care and Screening: Influenza Immunization	Yes	Yes	Population/ Public Health
0059	Diabetes: Hemoglobin A1c Poor Control	Yes	Yes	Clinical Process/ Effectiveness
0061	Diabetes: Blood Pressure Management	Optional[3]	No	Clinical Process/ Effectiveness
0064	Diabetes: Low Density Lipoprotein (LDL) Management	Yes	Yes	Clinical Process/ Effectiveness
0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Yes	Yes	Clinical Process/ Effectiveness

[2] NQF 0031 is no longer NQF endorsed.
[3] NQF 0061 should be reported if the CPC practice site was able to obtain the MU Stage 1 measure in their ONC Certified EHR. NQF 0061 was not included in Stage 2 MU, therefore it is considered optional.

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NYS CPCi (2 of 2)

NQF ID	Clinical Quality Measure Title	Required in 2013	Required in 2014 & 2015	Domain
0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Yes	Yes	Clinical Process/ Effectiveness
0101	Falls: Screening for Future Fall Risk	No	Yes	Patient Safety
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	No	Yes	Population/ Public Health

DSRIP Quality Measures (1 of 3)

Domain 2: System Transformation Projects
Potentially Avoidable Emergency Room Visits ±
Potentially Avoidable Readmissions ±
PQI 90 – Composite of all measures ±
PDI 90– Composite of all measures ±
Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement
Percent of eligible providers with participating agreements with RHIOs, meeting Meaningful Use criteria and able to participate in bidirectional exchange
Percent of PCP meeting PCMH (NCQA) or Advance Primary Care (SHIP) standards
CAHPS - Primary Care - Usual Source of Care - Q2
CAHPS - Primary Care – Length of Relationship – Q3
Adult Access to Preventive or Ambulatory Care – 20 to 44 years
Adult Access to Preventive or Ambulatory Care – 45 to 64 years
Adult Access to Preventive or Ambulatory Care – 65 and older
Children's Access to Primary Care – 12 to 24 months
Children's Access to Primary Care – 25 months to 6 years
Children's Access to Primary Care – 7 to 11 years
Children's Access to Primary Care – 12 to 19 years
CAHPS - Getting Timely Appointments, Care and information (Q6, 8, 10, and 12)
CAHPS - Helpful, Courteous, and Respectful Office Staff (Q24 and 25)
Medicaid Spending on ER and Inpatient Services ±
Medicaid spending on Primary Care and community based behavioral health care
H-CAHPS – Care Transition Metrics (Q23, 24, and 25)
CAHPS Measures – Care Coordination with provider up-to-date about care received from other providers

DSRIP Quality Measures (2 of 3)

Domain 3: Clinical Improvement Projects
Potentially Preventable Emergency Department Visits (for persons with BH diagnosis) ±
Antidepressant Medication Management – Effective Acute Phase Treatment
Antidepressant Medication Management – Effective Continuation Phase Treatment
Diabetes Monitoring for People with Diabetes and Schizophrenia
Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
Follow-up care for Children Prescribed ADHD Medications – Initiation Phase
Follow-up care for Children Prescribed ADHD Medications – Continuation Phase
Follow-up after hospitalization for Mental Illness – within 7 days
Follow-up after hospitalization for Mental Illness – within 30 days
Screening for Clinical Depression and follow-up
Adherence to Antipsychotic Medications for People with Schizophrenia
Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)
Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)
Prevention Quality Indicator # 7 (HTN) ±
Prevention Quality Indicator # 13 (Angina without procedure) ±
Cholesterol Management for Patients with CV Conditions – LDL-C Testing
Cholesterol Management for Patients with CV Conditions – LDL-C > 100 mg/dL
Controlling High Blood Pressure
Aspirin Use
Discussion of Risks and Benefits of Aspirin Use
Medical Assistance with Smoking and Tobacco Use Cessation – Advised to Quit
Medical Assistance with Smoking and Tobacco Use Cessation – Discussed Cessation Medication
Medical Assistance with Smoking and Tobacco Use Cessation – Discussed Cessation Strategies
Flu Shots for Adults Ages 18 – 64
Health Literacy (QHL13, 14, and 16)

DSRIP Quality Measures (3 of 3)

Domain 3: Clinical Improvement Projects (continued)
Prevention Quality Indicator # 1 (DM Short term complication) ±
Comprehensive Diabetes screening – All Four Tests (HbA1c, lipid profile, dilated eye exam, nephropathy monitor)
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ±
Comprehensive diabetes care - LDL-c control (<100mg/dL)
Prevention Quality Indicator # 15 Younger Adult Asthma ±
Pediatric Quality Indicator # 14 Pediatric Asthma ±
Asthma Medication Ratio (5 – 64 Years)
Medication Management for People with Asthma (5 – 64 Years) – 50% of Treatment Days Covered
Medication Management for People with Asthma (5 – 64 Years) – 75% of Treatment Days Covered
HIV/AIDS Comprehensive Care : Engaged in Care
HIV/AIDS Comprehensive Care : Viral Load Monitoring
HIV/AIDS Comprehensive Care : Syphilis Screening
Cervical Cancer Screening
Chlamydia Screening (16 – 24 Years)
Viral Load Suppression
Prevention Quality Indicator # 9 Low Birth Weight ±
Prenatal and Postpartum Care—Timeliness of Prenatal Care
Prenatal and Postpartum Care—Postpartum Visits
Frequency of Ongoing Prenatal Care (81% or more)
Well Care Visits in the first 15 months (5 or more Visits)
Childhood Immunization Status (Combination 3 – 4313314)
Lead Screening in Children
PC-01 Early Elective Deliveries ±
Risk-Adjusted percentage of members who remained stable or demonstrated improvement in pain
Risk-Adjusted percentage of members who had severe or more intense daily pain ±
Risk-adjusted percentage of members whose pain was not controlled ±
Advanced Directives – Talked about Appointing for Health Decisions
Depressive feelings - percentage of members who experienced some depression feeling ±
Annual Monitoring for Patients on Persistent Medications – ACE/ARB

CMMI's Recommended Metrics – SIM

- Cost of care: Total cost of care population-based per member per month (PMPM) index Beneficiaries impacted by SIM
- Ambulatory Care: Emergency Department Visits (HEDIS)Providers participating in SIM
- Plan All-Cause Readmissions
- Hospital Consumer Assessment of Health Care Providers and Systems Survey
- Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- Controlling High Blood Pressure
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

Categories of 19 most frequently used measures (Bailit Consulting)

7 Diabetes Care

- Comprehensive Diabetes Care (CDC): LDL-C Control <100 mg/dL
- CDC: Hemoglobin A1c (HbA1c) Control (<8.0%)
- CDC: Medical Attention for Nephropathy
- CDC: HbA1c Testing
- CDC: HbA1c Poor Control (>9.0%)
- CDC: LDL-C Screening
- CDC: Eye Exam

6 Preventative Care

- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status
- Colorectal Cancer Screening
- Weight Assessment and Counseling for Children and Adolescents
- Tobacco Use: Screening & Cessation Intervention

4 Other Chronic Conditions

- Controlling High Blood Pressure
- Use of Appropriate Medications for People with Asthma
- Cardiovascular Disease: Blood Pressure Management <140/90 mmHg
- Cholesterol Management for Patients with Cardiovascular Conditions

1 Mental Health/Sub-stance Abuse

- Follow-up after Hospitalization for Mental Illness

1 Patient Experience

- CAHPS Surveys (various versions)

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APC Core Measures

1. Colorectal Cancer Screening
2. Chlamydia Screening
3. Tobacco Use Screening and Intervention
4. Influenza Immunization - all ages
5. Childhood Immunization (status)
6. Controlling High Blood Pressure
7. Diabetes A1C Poor Control
8. Appropriate Medication Management for People with Asthma
9. Fluoride Varnish Application
10. Weight Assessment and Counseling for nutrition and physical activity for children and adolescents
11. Collaborative Care Suite of Measures for depression screening and management
12. Record Advance Directives for 65 and older
13. Use of Imaging Studies for Low Back Pain
14. Avoidable Hospitalization
15. Avoidable readmission
16. CAHPS Access to Care, Getting Care Quickly
17. Emergency Dept. Utilization
18. Total Cost Per Member Per Month

Payment Models Discussion

Delivery System Reform and Payment Reform – Both Necessary; Alone Insufficient

1. The goal of setting **APC standards** is to develop consensus about core elements of high quality primary care desired by patients and valued by providers and payers.

2. The goal of **payment reform** in the context of setting APC standards: Develop a payment model that supports and promotes proven interventions leading to high quality cost effective care

Goals and Principles

- **Multi-payer alignment.** Health care cost containment (and therefore affordability) cannot be achieved without delivery and payment system transformation across multiple aligned payers.
- **Flexibility.** Payment models should be flexible enough accommodate practice's and payer's individual needs and capabilities.
- **Rewarding quality**. The payment models should measure and reward the delivery of high quality primary care delivery.
- **Sharing Savings.** Savings that results from high quality primary care delivery should be shared by patients, providers and payers.
- **Transition away from FFS model.** Moving away from fee-for-service may be a transitional process and not happen all at once.
- **Identifying what "counts."** The SHIP's goal of 80% value-based coverage will require identification of what types of payment models count towards that benchmark.

APC Payment Assumptions

Providers need resources for:

1) Transformation Support.
   - For instance:
     - assist practices with preparation for APC certification,
     - support planning for behavioral and population health integration activities,
     - salary support for provider/teams participating in the proposed project,
     - Many other uses (see RFP slides)
   - Likely not ‘one and done’ but should diminish over time
   - Possible source of payment: SIM grant (Commercial payer ‘enthusiasm’ for this investment is limited)
   - MU, HEAL, DSRIP, SIM, TCPI, CMMI Grants, provide much of this

Payment Assumptions (cont.)

2) Infrastructure, new activities, not reimbursed by FFS payments

- For instance: care management, consultations with medical neighborhood, ‘virtual’ visits, etc.
- Possible sources of payment:
  - SIM grant
  - Other grants?
  - Payers (e.g., non-FFS PMPM upfront payment, in-kind provision of personnel or information, etc.)

Payment Assumptions (cont.)

3) Value based payments. Improved quality, patient experience, and cost avoidance

- For instance:
  - P4P / FFS w/ quality measures
  - Shared Savings
  - Shared savings/shared risk
  - Global budgets
- Possible source of payment: payers

Medicare VBP Model

	Payment Taxonomy Framework			
	Category 1: *Fee for Service—No Link to Quality*	**Category 2:** *Fee for Service—Link to Quality*	**Category 3:** *Alternative Payment Models Built on Fee-for-Service Architecture*	**Category 4:** *Population-Based Payment*
Description	*Payments are based on volume of services and not linked to quality or efficiency*	*At least a portion of payments vary based on the quality or efficiency of health care delivery*	*Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk*	*Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)*
Medicare FFS	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	• Eligible Pioneer accountable care organizations in years 3-5

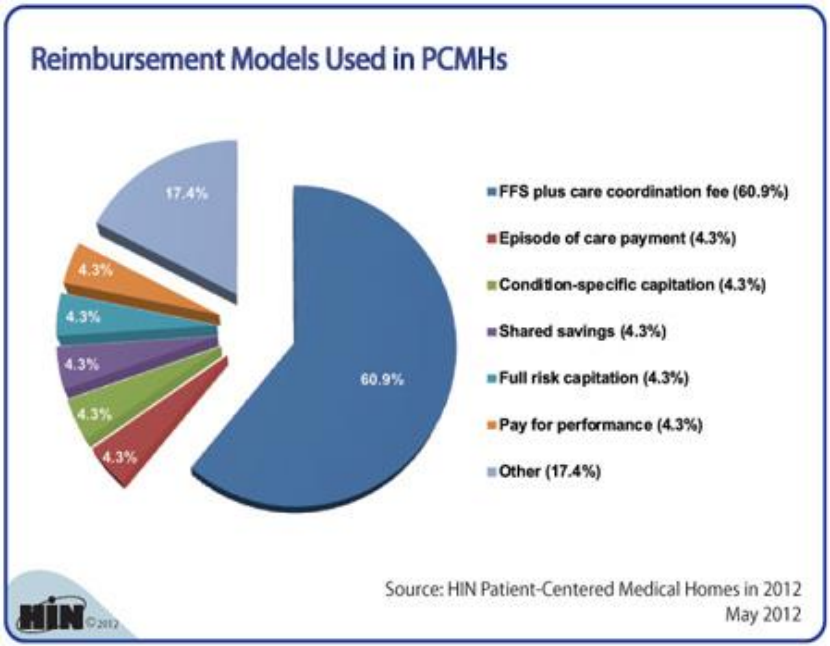
Coordination with DSRIP

- DSRIP/SHIP VBP Workgroup:
  - Step 1: Medicaid payment reform
  - Step 2: Alignment with Medicare
  - Step 3: Start discussion on VBP in commercial market (This is a separate policy discussion. The DSRIP Roadmap does not pertain to commercial market.)
- SHIP Integrated Care Workgroup:
  - Step 1: Discussion on Transformation Support and Infrastructure Payments
  - Step 2: Discussion of VBP payments in APC setting.
  - Step 3: Start discussion VBP in commercial market as a whole (in the VBP Workgroup)

DSRIP VBP Model

Options	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level; requires mature PPS)
All care for total population	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Global capitation (with outcome-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM subsidy) with upside-only shared savings based on total cost of care (savings available when outcome scores are sufficient)	FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for Primary Care Services (with outcome-based component)
Acute and Chronic Bundles	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when outcome scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Prospective Bundled Payment (with outcome-based component)
Total care for subpopulation	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on subpopulation capitation (savings available when outcome scores are sufficient)	FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for total care for subpopulation (with outcome-based component)

Reimbursement Models Used in PCMHs



Discussion Questions

- Coordinating transformation, infrastructure and VBP payments
- How much ‘alignment’ needed?
- How much flexibility?
- Should type of VBP payment model be connected to APC level?
- Relationship of APC payment model and other payment models
  - Medicare?
  - DSRIP?
- What counts towards SHIP benchmarks?

Practice Transformation RFP

Practice Transformation RFP

Overview of Initiative

Funding:

- $67M available for practice transformation through SIM grant

Awards:

- Number TBD

Timeline:

- RFP Released Fall 2015 (?)
- Contracts executed for February 2016 start date

Practice Transformation RFP

Key Considerations

1. Alignment:
   - APC goals and standards
   - DSRIP
   - TCPI
   - Other existing care delivery and payment models
2. Evaluation of practice need/readiness: most efficient use of scarce resources
3. Measurement and Evaluation – How do we know what works, where?

Practice Transformation RFP- Possible Uses of Funding (1/3)

- Assist practices with preparation for APC certification, such as gap analysis, assessment of patient and family centered care, quality improvement (QI) infrastructure, workflow assessment, or certification procedures.
- Support implementation activities and planning for behavioral and population health integration activities including SIM-funded public health consultants.
- Salary support for provider/teams participating in the proposed project.
- Quality improvement strategies to improve referrals to and transitions management between primary care and specialists, community partners and/or hospitals and long term care.
- Dissemination of quality improvement (QI) and change methodologies, tools, published literature, best practices, and lessons learned on practice transformation.
- Creation of community based peer groups to share QI resources and expertise to improve specific aspects of their practices and coordinate care in a common medical neighborhood.

Practice Transformation RFP- Possible Uses of Funding (2/3)

- Consultant contracts including those related to health information technology (HIT), workflow/process redesign, and implementation of quality improvement infrastructure (Q1).
- Project staff time to support workflow and process redesign or process flow mapping within the practice to increase efficiency of workflow and workforce utilization.
- Staffing to support care coordination of high risk patients with chronic diseases such as diabetes or patients with hypertension, depression, or other chronic illnesses.
- Implementation of strategies to enhance team-based and leadership skills.

Practice Transformation RFP- Possible Uses of Funding (3/3)

- Resources to improve cultural competency in staff and efficient use of interpreters.
- Data analytics support to assist practices in managing cost and improving quality.
- Internal assessment to identify and expand programs and policies that address health disparities and advance health equity.
- Support of consumers and their families through consumer advisory committees, surveys, or focus groups.
- Coaching, facilitation and technical assistance to practices including support in the systematic inclusion of patient and family engagement.