NEW YORK STATE OF OPPORTUNITY. Department of Health

INTEGRATED CARE WORKGROUP

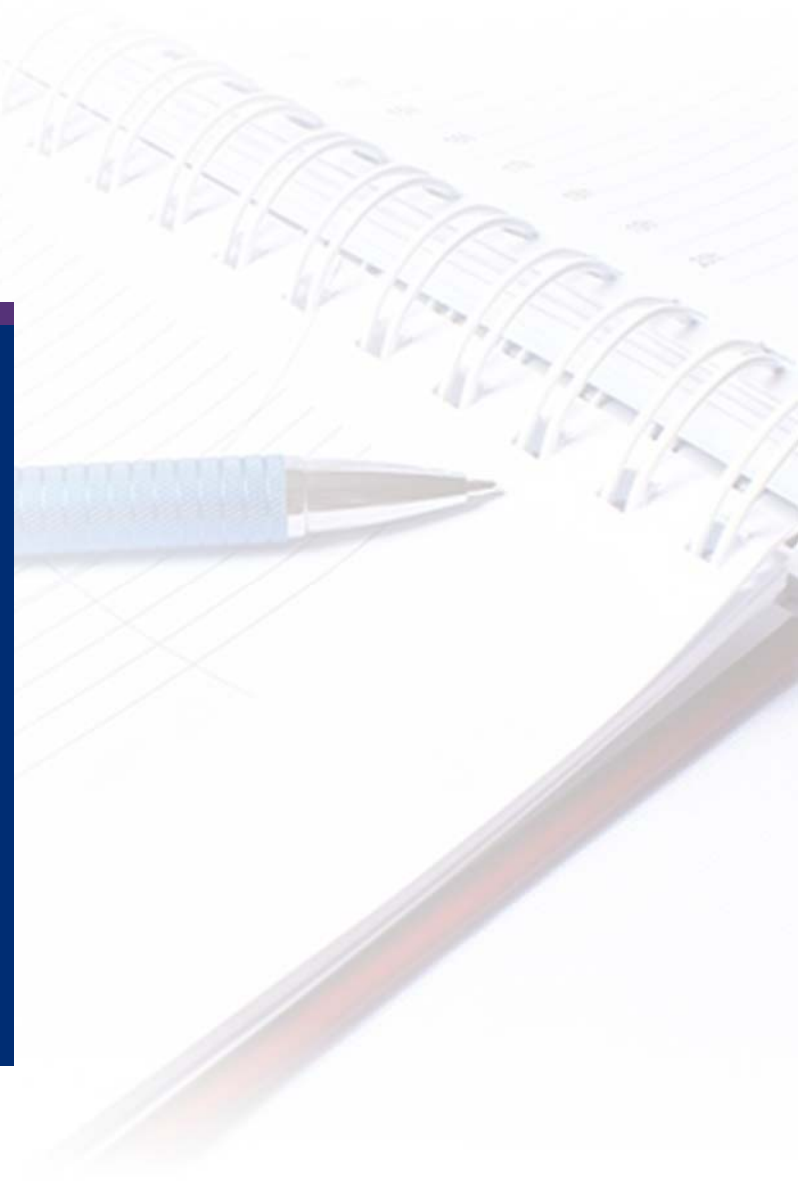
Meeting #9

October 16, 2015

Agenda – October 16, 2015

Timing	Topic	Lead
10:00-10:15am	Welcome and introductions	Foster Gesten/Susan Stuard
10:15a-11:30p	Updates to the APC Model: Capabilities and Milestones	Foster Gesten
11:30-12:30pm	Integration of allied programs into APC: NCQA, TCPI, CPCI, MAPCP, DSRIP	Foster Gesten, David Nuzum
12:30-1:00pm	Working lunch	
1:00-1:20pm	Updates on stakeholder engagement (payer focus)	John Powell, NEBGH
1:20-1:45pm	Updates on Core Measures and PT RFP	Anne-Marie Audet, Hope Plavin
1:45-2:00pm	Closing and next steps	Foster Gesten/Susan Stuard

10:15-11:30am: Updates to the APC Model: Capabilities and Milestones



Input from the group and other stakeholders has spurred several important refinements to the APC model

What we've heard

- **APC tiered standards are overly complex,** burdening both providers and payers with limited incremental benefit
  - Having both tiered standards and tiered milestones is unnecessary
  - Having both detailed standards and detailed milestones is unnecessary
- **Designing of APC is more critical now, relatively, than developing Premium APC**
- Stakeholders need to understand **how the several primary care transformation programs in the state align with APC- both conceptually and operationally**

Updates for discussion today

- **Streamlined APC Capabilities and Milestones clearly describing APC, and replacing tiered APC standards**
  - Make Capabilities high-level, keep Milestones granular
  - For discussion, create a version of the APC model without Premium APC Milestones
- **Proposed mechanism for alignment of NCQA, DSRIP, CPCI, and TCPI into APC**
  - Detailed proposal to follow

2 significant changes have been made to the APC Model

Interim APC updates	Beliefs guiding decision
I Make Capabilities high-level, keep Milestones granular	**Capabilities and Milestones can address two separate needs:** ▪ A high level description of APC Capabilities for clear messaging and to enable alternative approaches to APC ▪ A detailed description of APC Milestones to guide reimbursement, incorporating work from multi-tiered standards
II For discussion, create a version of the APC model without Premium APC	▪ Select Premium Milestones have been brought into the APC tier (Gate 3), limiting differentiation ▪ Premium APC can be revisited in the future, allowing APC to move forward with consideration for particular modules including Collaborative Care and advanced engagement in population health

A Premium APC tier will need further thought, during and after launch of the APC model

Challenges for Premium APC	Description
Limited differentiation from APC	▪ We have raised the bar for the APC tier so that differences with Premium APC have become less prominent ▪ There is not yet a clear plan for differentiating financial support for Premium APC
Various possible approaches to Premium	▪ Advanced practices may naturally improve to capture existing payment incentives under APC ▪ Varying payer approaches to value-added achievements beyond APC may work just as well

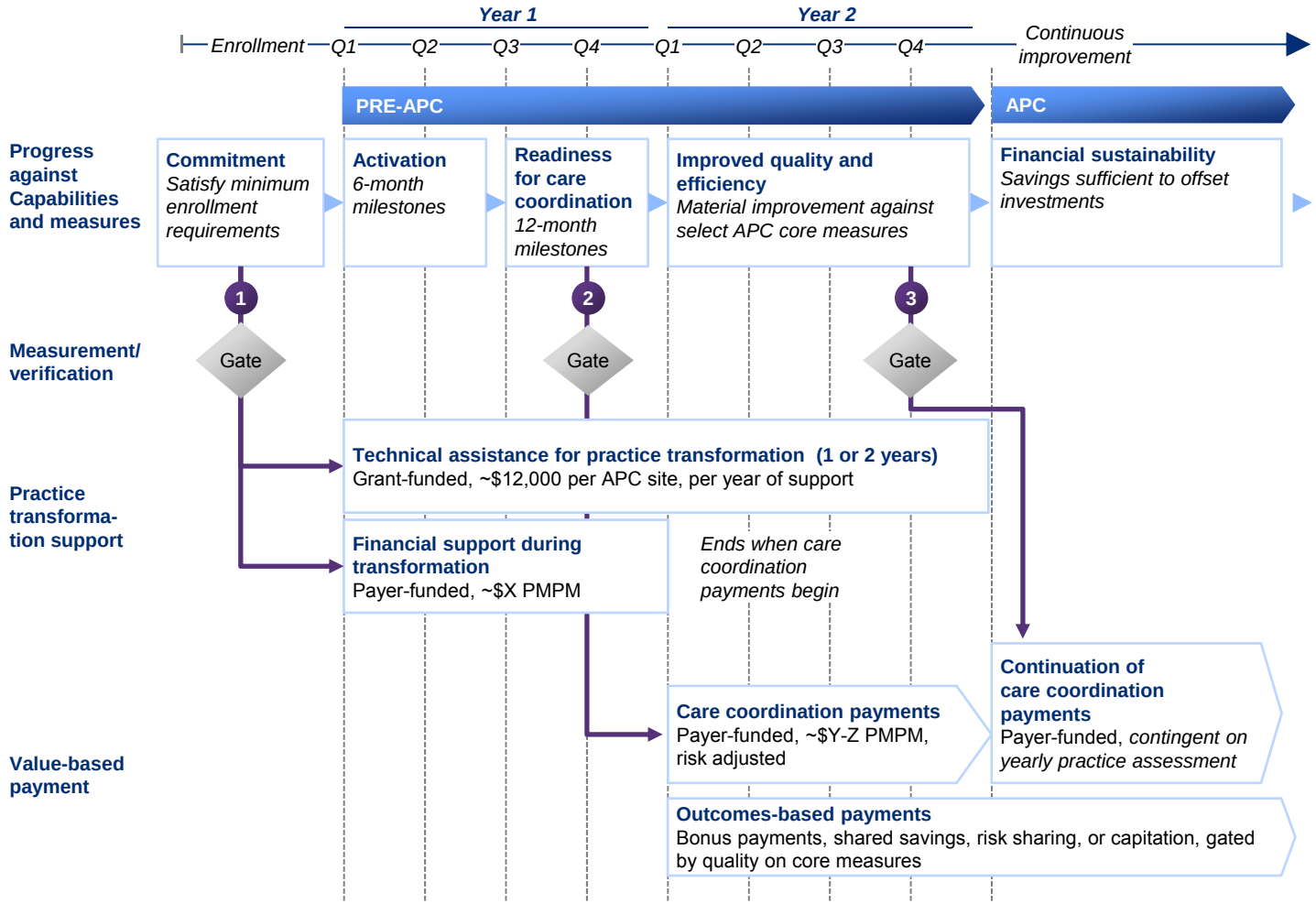
In revisiting Premium APC in the future, we will address several questions

- What components or modules (e.g., Collaborative Care, advanced engagement with population health) will be included?
- What will the model for financial support for payers look like for each component? What degree of variation is acceptable?
- Will Premium be defined as the completion of all components, or as a series of independent modules?

For discussion – APC Capabilities

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 for practices starting out



Gates

1. Gate to receive TA, eligibility for programmatic and financial support for transformation
2. Gate to receive care coordination payments, early outcomes-based payments
3. Gate to sustain care coordination payments and reach APC tier

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For discussion – Updated practice-wide structural Milestones

	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 vendor APC orientation ▪ Commitment to achieve gate 2 milestones in 1 year	▪ Participation in vendor activities and learning	▪ ---
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, 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, and CM delivered to highest-risk patients ▪ Referral tracking system ▪ Care compacts or collaborative agreements with medical specialists and institutions including BH ▪ Post-discharge follow-up process ▪ Behavioral health: evidence-based process for screening, treatment where appropriate, and referral; capabilities for BH care management
Access to care	▪ 24/7 access to a provider	▪ 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 RHIO 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

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Proposed measurement and performance Milestones

	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

For reference – Summary of current changes from tiers to milestones

Category	Content changes compared to tiers
Patient-centered care	▪ Added flexibility on method of engagement with patients and reduced minimum frequency to yearly ▪ Removed specification of care plans in concert with patient preferences and goals ▪ Premium APC: removed inclusion of family member into governance structure (Premium)
Population Health	▪ Moved specification of disparities to quality and performance ▪ Removed structured health education programs
Care management/ coordination	▪ Combined care management and care coordination ▪ Removed numeric requirement for % of high-risk patients ▪ Replaced reference to elements of Collaborative Care in APC with specific behavioral health requirements at an APC level
Access to care	▪ None
HIT	▪ Pre-APC: Removed specific requirement for EHR vendor ▪ Pre-APC: Removed up-front requirements for population health management tools
Payment model	▪ Added category and % of panel coverage
Quality and performance	▪ Updated quality measurement / QI to refer to core measures rather than CQM data ▪ Added specific performance requirements

Updated payment parameters by APC Gate

Flexibility subject to minimum participation constraints

Fully flexible across payers

- **Minimum design requirements ensure that providers progressing toward APC have access to a sufficiently-aligned "floor" of outcome-based payment models across all participating payers, and facilitate transformation at scale rather than a multiplicity of sub-scale models**
- **Providers and payers may collectively choose to "go beyond" the minimum requirements at any point, with more aspirational risk-based payment models**

Proposed payment design requirements

	1 Commitment	2 Readiness for C.C.	3 APC
Practice eligibility	▪ Any practice that has passed Gate 1	▪ Any practice that has passed Gate 2	▪ Any practice that has passed Gate 3
Incentive structure	▪ Standardized PT financial support	▪ CM payments ▪ OBP Min: P4P / bonus	▪ CM payments ▪ OBP Min: Upside risk-sharing
Incentive intensity	▪ Commitment to offer OBP that could increase reimbursement by at least X% within 1 year	▪ Potential for OBP to increase reimbursement by at least X%	▪ Potential for OBP to increase reimbursement by at least Y%
Attribution	▪ N/A	▪ TBD	▪ TBD
Risk adjustment	▪ N/A	▪ CM payments risk-adjusted	▪ CM payments risk-adjusted
Measurement	▪ N/A	▪ Measurement, reporting, and payment based on measures contained within the core measure set	▪ Measurement, reporting, and payment based on measures contained within the core measure set
Other	▪ N/A	▪ To be agreed between payers and providers; can include: – Benchmark trend – Min. savings to qualify? – Other?	▪ To be agreed between payers and providers; can include: – Benchmark trend – Min. savings to qualify? – Other?

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Practice transformation milestones in all practices participating in APC will have to be verified to trigger appropriate payments

Practice transformation milestone verification needs

Milestone determination

- Determine when practices have met milestones
- Report to data aggregator

Aggregation/auditing

- Aggregate and quality control data
- Audit vendors and practices to ensure accuracy

Use

- Use milestone data to determine payments to practices

A proposed model for verification of APC milestones is consistent with other initiatives in the state

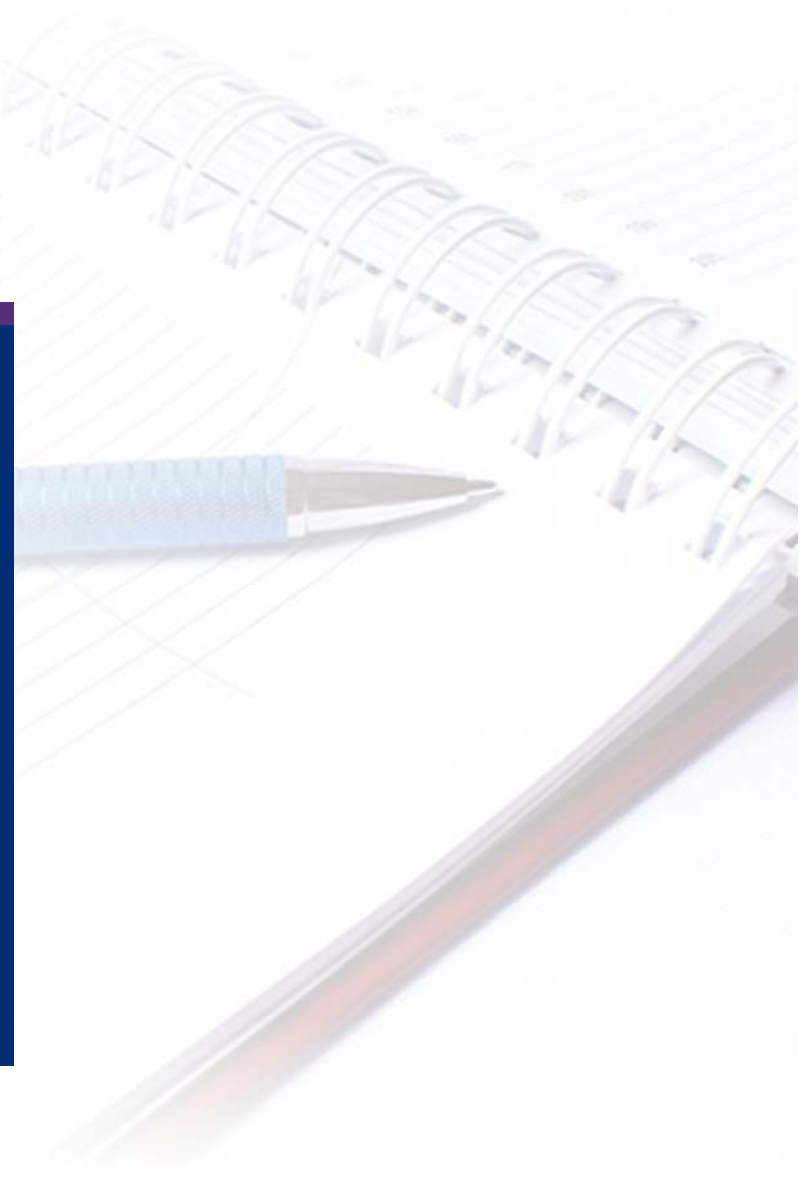
	Milestone determination	Aggregation/auditing	Use
CPCI approach	▪ Submission by web ▪ Content reviewed and corrected by Regional Learning Faculty	▪ TransforMed aggregates milestones nationally[1] ▪ Bland Associates audits finance and milestones	▪ Multi-payer group, CMMI
TCPI approach	▪ Vendors certify phases	▪ IPRO to aggregate and audit progress	▪ CMMI
Proposed APC approach	▪ Entities delivering PT TA certify milestones	▪ Statewide third–party vendor	▪ CMMI, State, providers and payers
Rationale	▪ In-practice verification or milestones is resource intensive for thousands of practices throughout NYS ▪ It would be duplicative for each payer to do this	▪ An aggregator ensures consistent high-quality data is available ▪ A third party can audit vendors to minimize the effect of inherent conflicts of interest ▪ Scale statewide is unwieldy	▪ Accurate data based on in-person visits will ensure true practice change triggers continued financial support

1 Mathematica aggregates performance data

Questions for discussion

- Does the current APC model ensure sufficient consistency across payers and providers while allowing for flexibility to adjust to individual situations?
- Are there details from APC tiers that are lost in a model that uses new Capabilities and milestones only?
- Are there other elements that need to be included in the Statewide mandatory APC model?
- If specification of Premium APC details are postponed to focus on APC roll-out, are there essential programmatic elements missing?
- Other comments?

11:30-12:30am: Integration of allied programs into APC: NCQA, TCPI, CPCI, MAPCP, DSRIP



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

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Practices that have participated in allied programs will have tailored technical and financial support

STRAWPERSON FOR DISCUSSION

- SIM-funded
- DSRIP-funded
- TCPI-funded
- Multi-payer

Practices entering at Gate 1 will receive standardized TA and financial support

	Entry into APC	TA *(by year)* 1	TA *(by year)* 2	Payer investment and payment: PT investment[1]	Payer investment and payment: Care coord.[2]	Payer investment and payment: Outcome-based[2]
APC	▪ Pre-assessment determines starting Gate (1, 2, or 3)	●	●	●	●	●

Practices participating in other programs will have tailored support and expectations as part of APC

Program	Entry into APC	TA *(by year)* 1	TA *(by year)* 2	Payer investment and payment: PT investment	Payer investment and payment: Care coord.	Payer investment and payment: Outcome-based
NCQA PCMH (without DSRIP)	▪ Gate 2 if NCQA 2014 Level III	○	?	○	●	●
NCQA PCMH (w/ DSRIP funds)	▪ Gate 2 if NCQA 2014 Level III	◐	◐	○	●	●
TCPI	▪ Gate 1 at Phase X (1?) ▪ Gate 2 at Phase Y (2?) ▪ Gate 3 at Phase Z (4?)	●	●	●	●	●
CPCi	▪ Gate 3 for practices meeting milestones	○	○	○	●	●
MAPCP	▪ Gate 3 for participating practices	○	○	○	●	●
ACO	▪ Pre-assessment determines starting Gate (1, 2, or 3)	○	○	○	○	●

1 After achieving Gate 1 milestones, for up to one year 2 After achieving Gate 2 milestones

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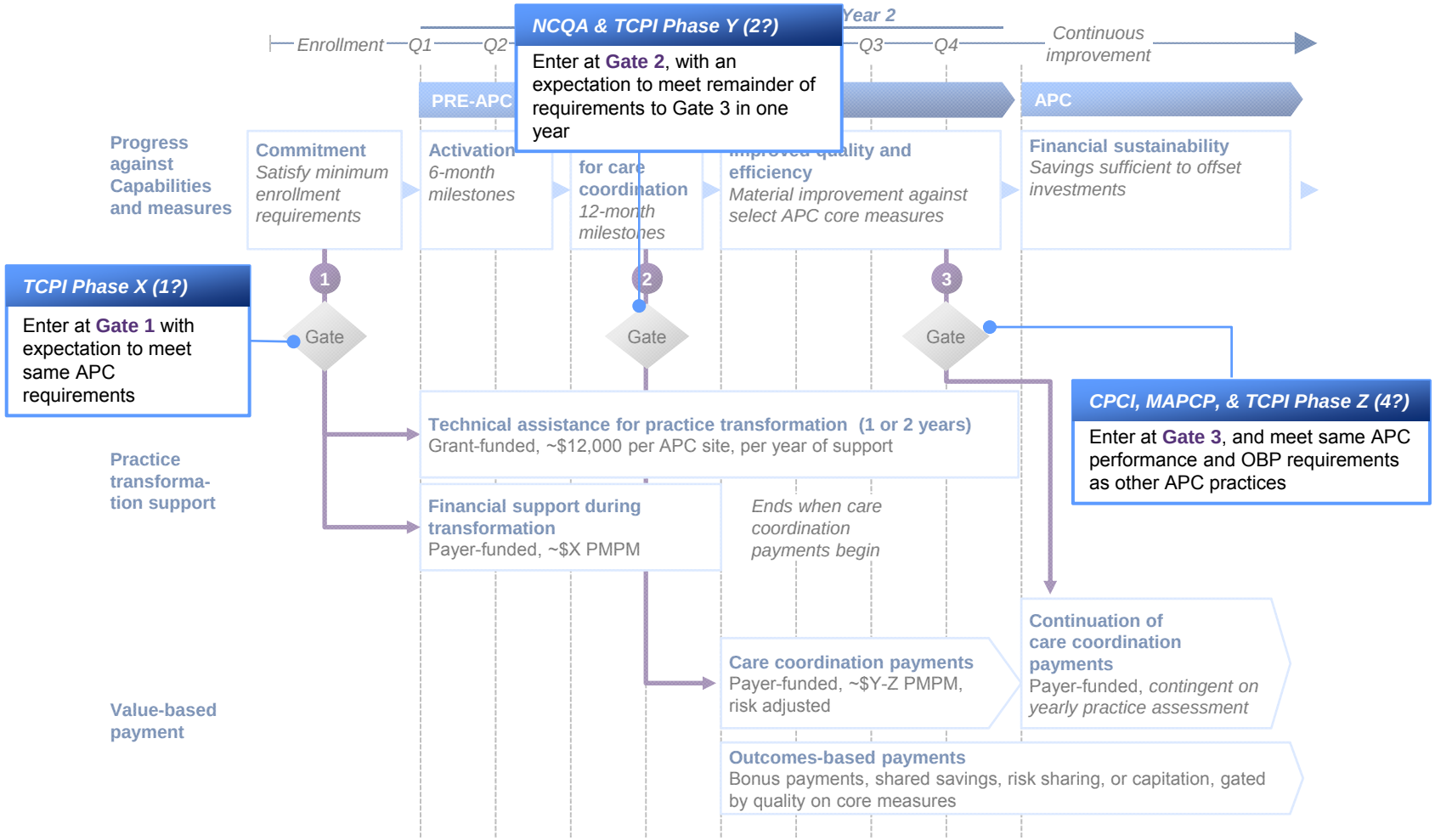
For discussion – Proposed entry points to APC for advanced practices



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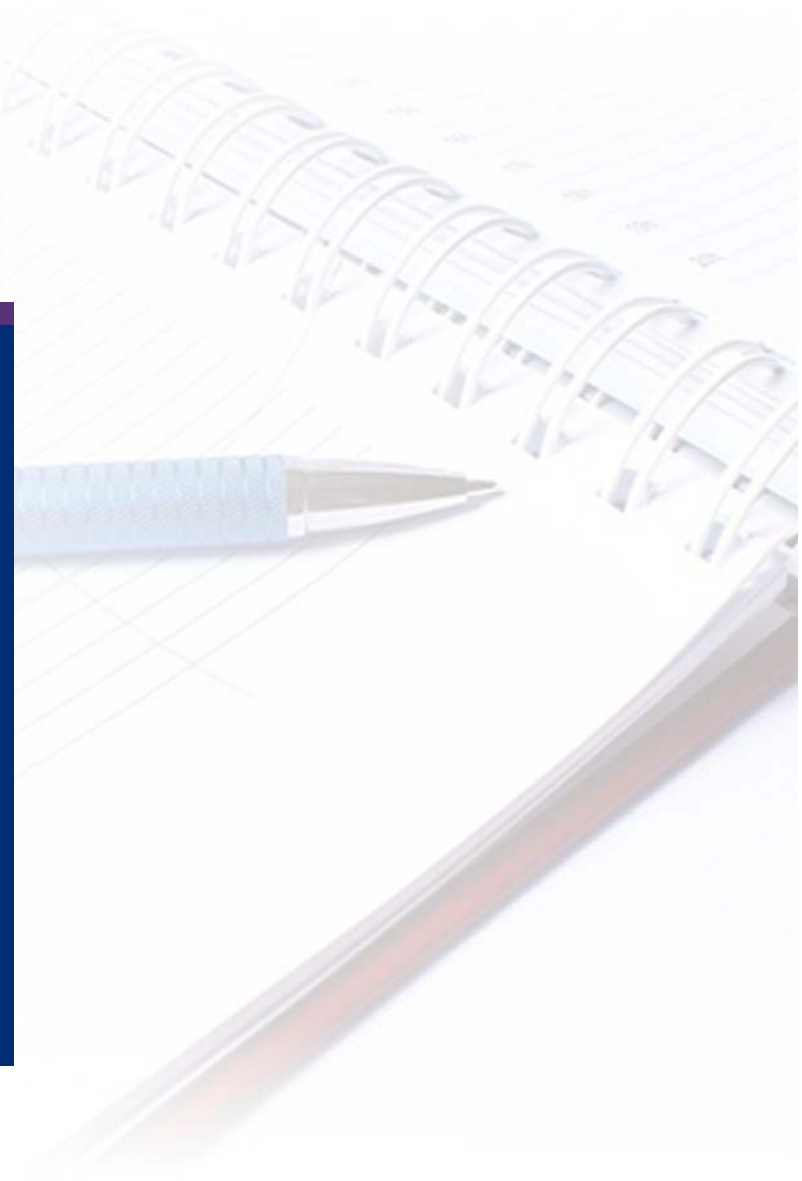
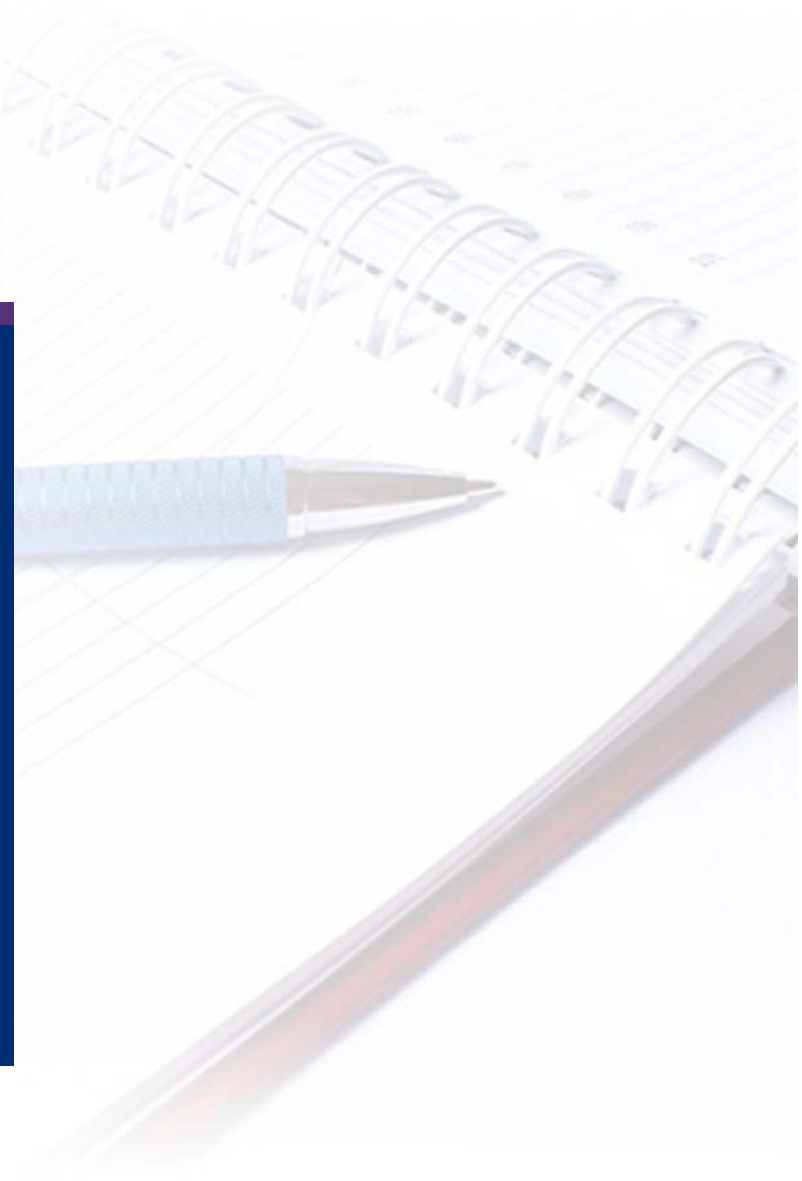
Questions for discussion

- What components of interaction with allied programs are missed in the previous diagrams?
- Do each of the programs (TCPI, CPCI, MAPCP, NCQA) provide sufficient evidence of progress to justify entry at each gate?
- Are there better ways to leverage the efforts of practices undergoing those programs?
- Others?

12:30-1:00pm: Working lunch



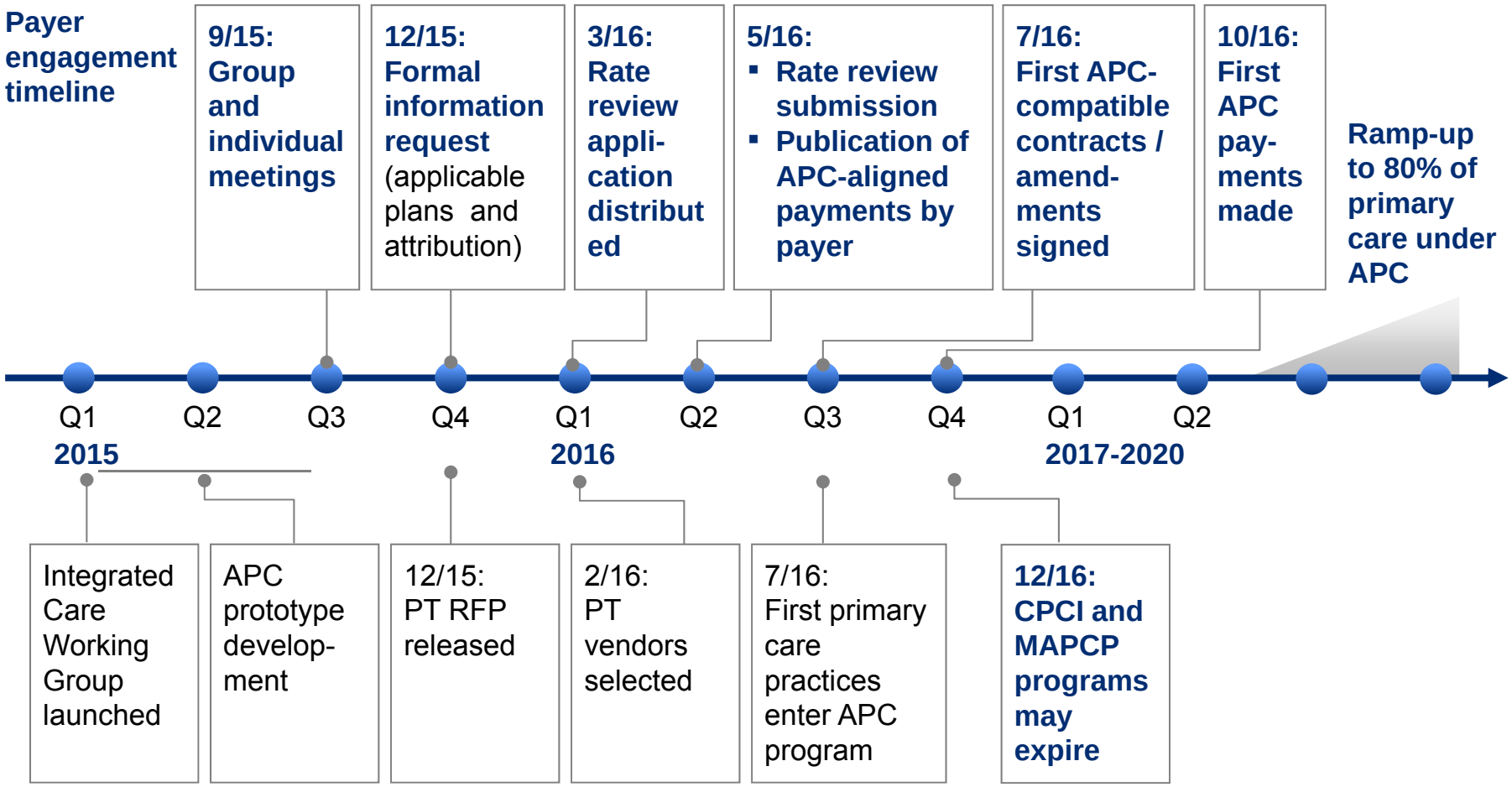
1:00-1:20pm: Updates on stakeholder engagement (payer focus)



Proposed timeline – Payer engagement focus

FOR DISCUSSION

New York State Advanced Primary Care Timeline



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A written information request will provide timely and necessary information for the APC program

Why

- For providers to agree to participate in APC in July 2016, information on payer participation and relevant attribution will be necessary 4-5 months in advance
- DFS and DOH will collect detailed information during one-on-one meetings with plans and a follow up written request
- Data can be supplemented with information gathered from rate applications in May 2016
- More detailed information will better support the APC model from the start

What to expect

December 2015 request:

- Non-binding information on how each plan would implement APC principles
- Highlight important technical changes necessary to implement APC plans at each payer
- Input for optimal format for multi-payer alignment

State will use information from responses and from payer meetings to finalize the multi-payer APC alignment model

NEBGH Update
Stakeholder engagement

- Regional listening sessions
  - Round 2 in process
- Health plan meetings
  - Monthly group meetings through 2015
    - **Areas of focus**: measures, payment, integration of behavioral health (and related payment), process for gaining alignment
  - One-on-one meetings with select health plans led by DFS
- Benefit consultant engagement
  - Meeting held on September 17th
- Purchaser Advisory Council
  - 15 members and growing

NEBGH Update

Round 2 Regional Listening Session Schedule

Region	Date & Time	Location
Rochester *(Delivered)*	10/1/2015 8:00-10:00 AM	Finger Lakes Health Systems Agency 1150 University Ave. Rochester, NY 14607
Adirondacks Click here to register	10/22/2015 9:00-11:30 AM	Glens Falls Hospital Community Learning Center Side A 100-102 Park Street Glens Falls, NY 12801
Albany Click here to register	10/22/2015 2:30-5:00 PM	CDPHP 500 Patroon Creek Blvd Adirondack Board Room Albany, NY 12206
Buffalo Click here to register	11/2/2015 8:30-11:00 AM	People Inc. 3131 Sheridan Drive Amherst, NY 14226
Syracuse Click here to register	11/2/2015 2:30-5:00 PM	Excellus BlueCross BlueShield 333 Butternut Drive Syracuse, NY 13214
Long Island Click here to register	11/9/2015 9:00-11:30 AM	Nassau-Suffolk Hospital Council (NSHC) 1383 Veterans Memorial Hwy, Suite 26 Hauppauge, NY 11788
Hudson Valley Click here to register	11/9/2015 2:30-5:00 PM	Crystal Run Healthcare 95 Crystal Run Road 3rd Floor Conference Room Middletown, NY 10990

Health Plan Group Meeting Schedule

Region	Date & Time	Location
NYC *(Delivered)*	9/28/2015 3:00-5:00 PM	UnitedHealthcare 1 Penn Plaza NY, NY 10119
NYC	10/15/2015 1:30-4:00 PM	UnitedHealthcare 1 Penn Plaza NY, NY 10119
Albany	11/16/2015 2:30-4:30 PM	Empire State Plaza S Mall Arterial Albany, NY 12242
NYC	12/17/2015 1:00-3:00 PM	TBA

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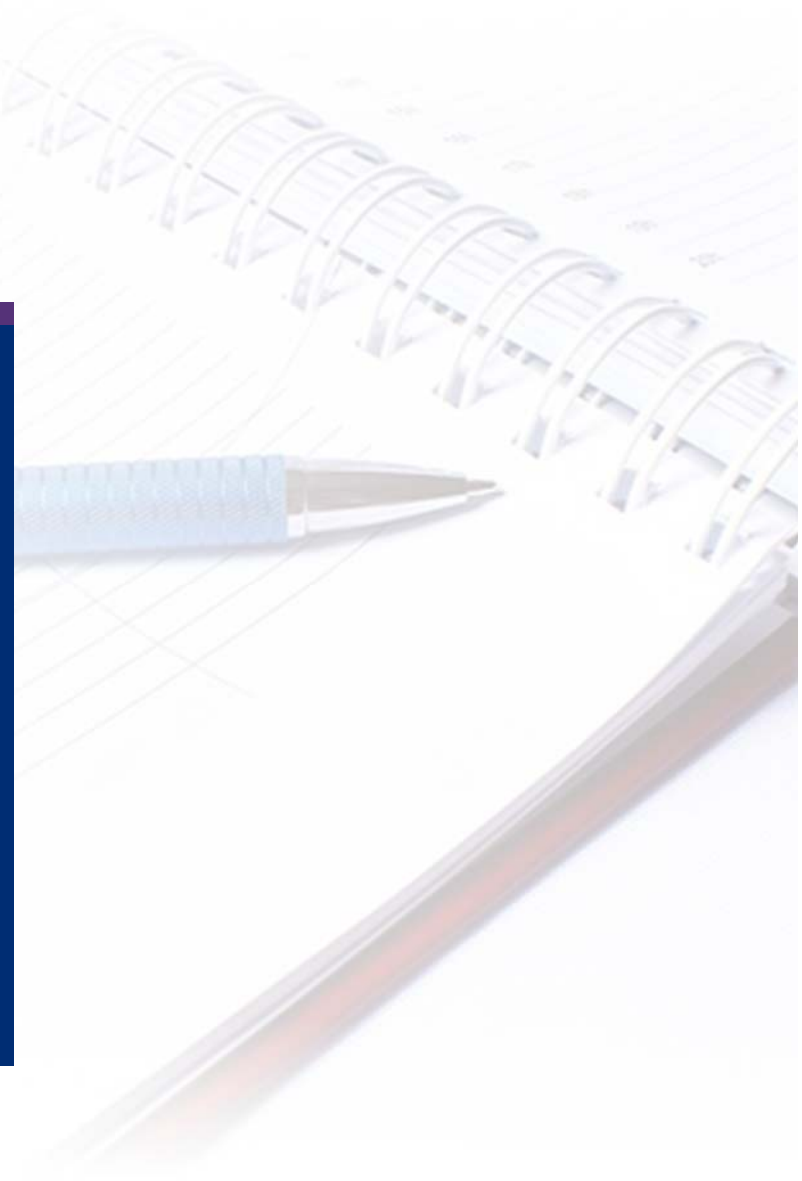
NEBGH Update
Purchaser Advisory Council Members

1:20-1:45pm: Updates PT RFP and Core Measures



PT RFP updates

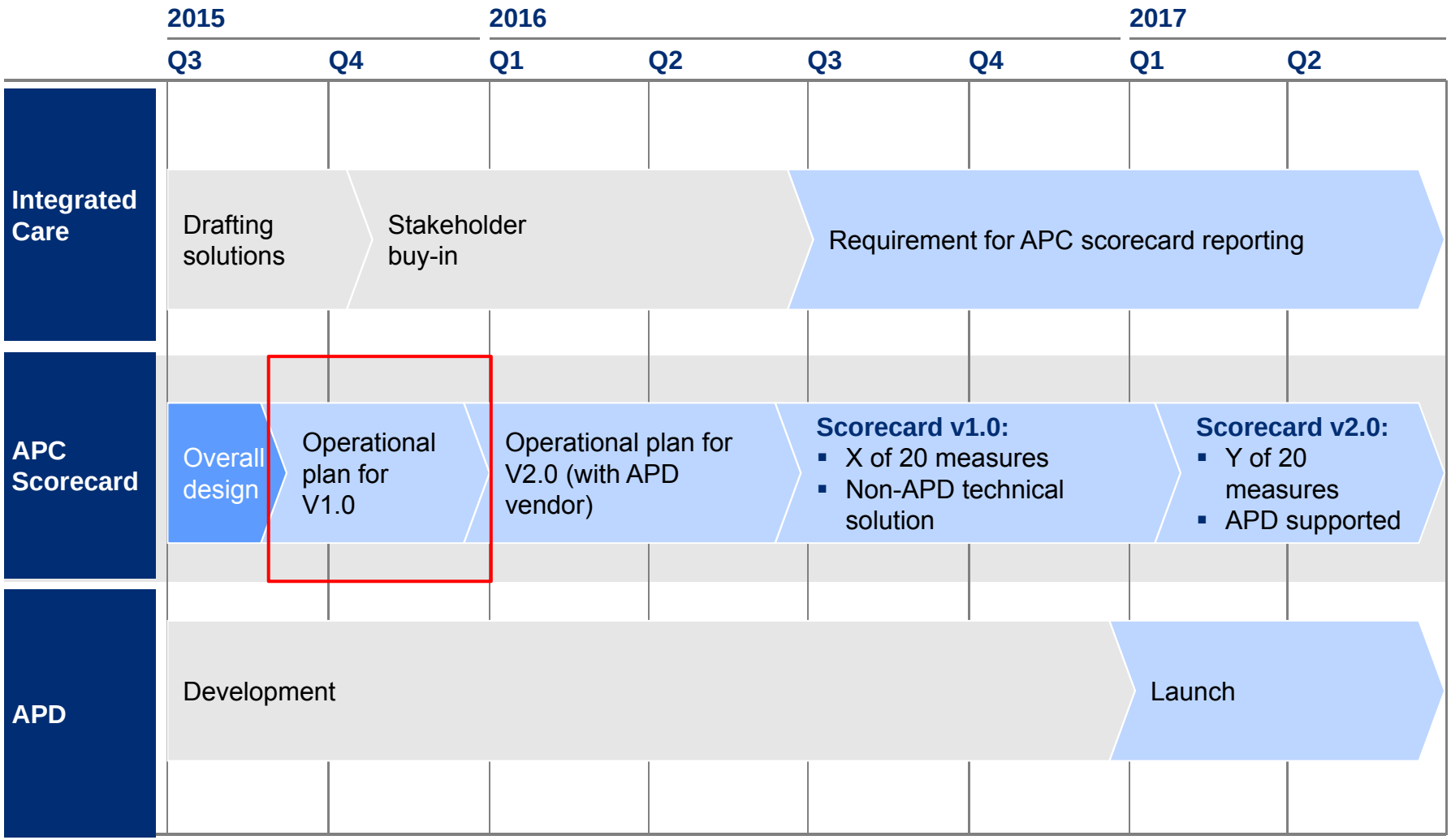
- PT RFP will be released in December 2015
- Responses expected February 2016
- Contracts to be awarded March 2016
- First PT technical assistance provided July 2016

We have made some tentative PT RFP decisions, though several issues remain

Areas of focus today

Domain	Agreed-upon approach	Issues being resolved
Definition of APC	▪ APC model description	▪ Ongoing refinement
Program architecture	▪ **PT structured regionally** ▪ Each region served by 1-4 vendors ▪ Vendors able to serve more than one region ▪ **All entities eligible to be PT vendors, with stringent expectations to ensure capability and performance and address potential conflicts of interest**	▪ Targeting of $67M for PT TA support by type of practice to maximize impact ▪ Coordination with other PT initiatives
Scope of services	Scope to include ▪ Provider engagement, assessment ▪ Pre-transformational assessment ▪ In-person and remote interactions ▪ Multi-practice collaborative ▪ Curriculum tailored to APC ▪ **Aid in gathering and reporting of milestone data**	▪ Performance requirements by service (e.g., minimum vs. distinctive) ▪ Pre-transformation assessment form detail ▪ Degree of standardization of curriculum ▪ Length of PT consultant contract / renewals ▪ Responsibility for provider recruitment ▪ Approach to population health goals
Payment model and contracting terms	▪ Funds flow from state directly to vendors ▪ Components include fixed startup amount, variable component per practice, and incentives	▪ Payment structure to maximize effectiveness and efficiency ▪ Variables for incentive payments ▪ Oversight of payments and contract renewals
Appendices	▪ Capabilities ▪ Milestones ▪ Measures	

High-level APC scorecard, Integrated Care, and APD timelines



APC Common Measure Set Implementation Plan – Producing and Using the "APC Quality Profile"

Goal – a valid performance profile at APC-level used for provider quality improvement and payment determinations.

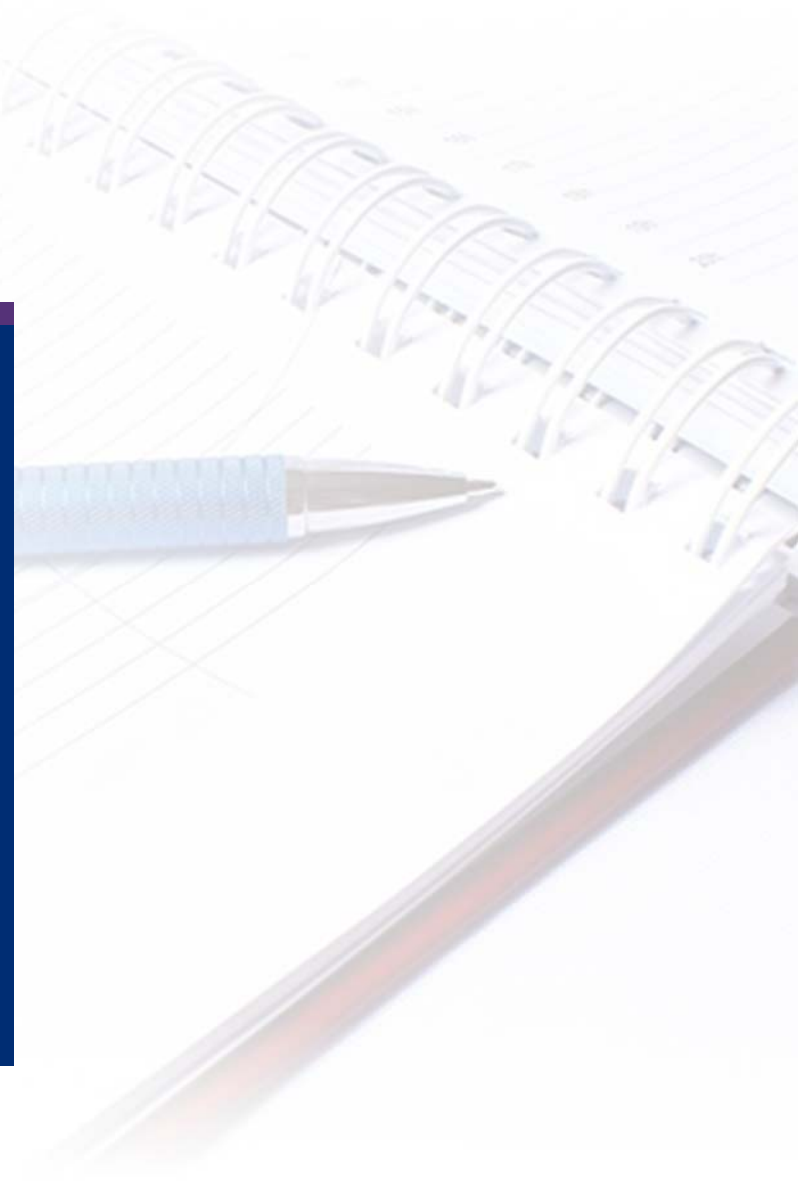
A number of areas under consideration to operationalize the APC Core Measure Set

- Finalizing the measure set
- Implementation path – 2016->
- Milestones for APC Performance

APC Common Measure Set Implementation – Putting the Pieces in Place

- **Sources of data (who collects and reports)**
  - Health Plans: e.g. claims
  - Providers: e.g. medical records
  - Other sources: laboratories, pharmacies, etc
  - Patient surveys: practice level CAHPS - who administers/ pays (CAHPS fielded by several parties in NYS)
- **Data repository**, data aggregation and analytics. Process for generating practice level reports
- **Unit at which quality is measured:** state, health plan, APC practice, individual provider
- **Eligibility and Attribution:** e.g. continuously enrolled, visit in past 6 months, plurality of visits, PCPs/NPs, other
- **Benchmarks:** e.g. national, state, regional, payer specific
- **Case Mix Adjustment: payer specific or all payer**
- **Timeframe and frequency** of data and report (just in time, weekly, monthly, quarterly, annually)
- **Quality Assurance**

1:45-2:00pm: Closing and next steps



Next steps

- Potential topics for ICWG 10, November 16:
  - 2-3 commercial payers describe their potential approach to APC
  - DSRIP describes their approach to APC
  - Measurement, reporting, and performance
  - Final input into PT RFP prior to release in December
- Ongoing discussions in groups and one-on-one with payers and providers

Appendix

Case example – CPCI follows a detailed 3-year timeline (1/2)

Milestone	Year 1	Year 2	Year 3
1 Budget	▪ Annual budget or forecast with anticipated CPCI expenses and flows	▪ Annotated annual budget forecast with projected new CPC Initiative practice	▪ Record actual CPC expenditures from Prev. year 2 and Complete an annotated annual budget
2 Care Manage-ment for High Risk Patients	▪ Provide information about care management of high risk patients	▪ Maintain at least 95% empanelment to provider and care teams ▪ Continue to risk stratify all patients; ▪ Provide care management to at least 80% of highest risk patients	▪ Continue to risk stratify all patients; Provide care management resources
3 Access and Continuity	▪ 24 hour, 7 days a week patient access to nurse or practitioner who has real-time access to practice's medical record	▪ Enhance access by implementing at least one asynchronous form of communication	
4 Patient Experience	▪ Assess and improve patient experience	▪ Conduct surveys and/or meetings with a Patient and Family Advisory Council (PFAC)	
5 Quality Improvement	▪ Generate and review practice- or provider-based reports with a minimum of one quality measure and one utilization measure	▪ Report the EHR clinical quality measures	▪ Continue to perform continuous quality improvement using EHR CQM data

Source: CMS.gov

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Case example – CPCI follows a detailed 3-year timeline (2/2)

Milestone	Year 1	Year 2	Year 3
6 Care Coordination across the Medical Neighborhood	▪ Demonstrate active engagement and care coordination by selecting and reporting on care coordination measures	▪ Describe activities undertaken to improve the results.	▪ Contact at least 75% of patients ▪ Maintain or enact care compacts/collaborative agreements
7 Shared Decision making	▪ Identify a priority condition, decision, or test that would benefit from shared decision making and the use of a decision aid	▪ Implement shared decision making tools or aids; Generate a metric for the proportion of patients who received the decision aid	▪ Use at least three decision aids to support shared decision making in preference sensitive care. ▪ Track use of the aids
8 Participate in learning Collaborative	▪ Participate in the market-based learning collaborative and share knowledge, tools, and expertise through attendance at three face-to-face meetings annually and in web-based meetings at least monthly	▪ Participate in all three all-day CPC learning sessions in your region. ▪ Participate in one learning webinar per month.	▪ Fully engage and cooperate with the Regional Learning Faculty
9 Health Information Technology	▪ Stage I meaningful use		▪ Stage II meaningful use

Source: CMS.gov

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Case example – TCPI uses five phases to track practice transformation

	Phase 1: Setting aims and developing basic capabilities	Phase 2: Reporting & using data to Generate improvements	Phase 3: Achieving aims of lower costs, better care, and better health	Phase 4: Getting to benchmark status	Phase 5: Practice has demonstrated capability to generate better care, better health at lower cost.
Operations	▪ Submit a Detailed Plan ▪ Perform self-Assessment and create baseline ▪ Start Training for at least 50% of staff		▪ Optimizing reports to drive clinical practice improvement on a monthly basis ▪ Sets clear expectations to optimize efficiency, outcomes, and accountability		▪ Practice has developed business acumen for the various types of alternative payment models
QI / Pop Health	▪ Establish measures, plans and mechanisms for addressing the needs of their patients/families	▪ Practice provides care management to at least 50% of highest risk patients	▪ Reduced unnecessary tests and hospitalizations by at least 25%	▪ Practices submit utilization reports to PTN on a monthly basis ▪ Continuously makes clinical improvement changes	▪ Practice sustains prior improvements in key metrics for at least one year
Care coordination		▪ Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, and billing data to drive clinical practice improvement	▪ Tracks, supports and follows up with patients ▪ Has a formal written vision related to care coordination	▪ Practice tracks patients, on a monthly basis ▪ Process in place to link the patient to a care provider and care team	

Source: CMS.gov

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