Update on SIM/Advanced Primary Care
Report to the Committees on Public Health and Health Planning
July 21, 2016

Marcus Friedrich, MD, MBA, FACP
Medical Director
NYSDOH - Office of Quality and Patient Safety

New York State Health Innovation Plan (SHIP)

Goal	**Delivering the Triple Aim –** *Healthier people, better care and individual experience, smarter spending*				
Pillars	**Improve access to care for all New Yorkers, without disparity** Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way	**Integrate care to address patient needs seamlessly** Integration of primary care, behavioral health, acute and post-acute care; and supportive care for those that require it	**Make the cost and quality of care transparent to empower decision making** Information to enable individuals and providers to make better decisions at enrollment and at the point of care	**Pay for health care value, not volume** Rewards for providers who achieve high standards for quality and individual experience while controlling costs	**Promote population health** Improved screening and prevention through closer linkages between primary care, public health, and community- based supports
Enablers	**Workforce strategy**	**A**	Matching the capacity and skills of our health care workforce to the evolving needs of our communities		
	Health information technology	**B**	Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation		
	Performance measurement & evaluation	**C**	Standard approach to measuring the Plan's impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation		

NEW YORK STATE Department of Health | Innovation Center

NY SHIP - Overarching Goals

- 80% of the state's population will receive primary care within an APC setting, with a systematic focus on population health and integrated behavioral healthcare
- 80% of care paid for under a value-based financial arrangement

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
- Uncertain ‘return’ of outcome based payments to date
- Overwhelming number of performance measures
- Non-aggregated measurement that does not represent entire practice
- Heterogeneity of practice size, resources, capabilities
- Business case for both practices and payers
- Patient engagement in self-management
- Care management teams across practices
- Practical/effective integration of behavioral health and population health

Integrated Care Workgroup and Stakeholder Inputs

- Broad consensus on practice capabilities
- Agreement to work towards set of shared ‘core’ measures (currently ~28)
  - 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
- Focus on the patient

APC Practice 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

NEW YORK STATE Department of Health | Innovation Center

APC structural milestones

	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 Prevention Agenda activities ii. Annual identification and outreach to patients due for preventive or chronic care management iii. Process to refer to self-management and community-based resources
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

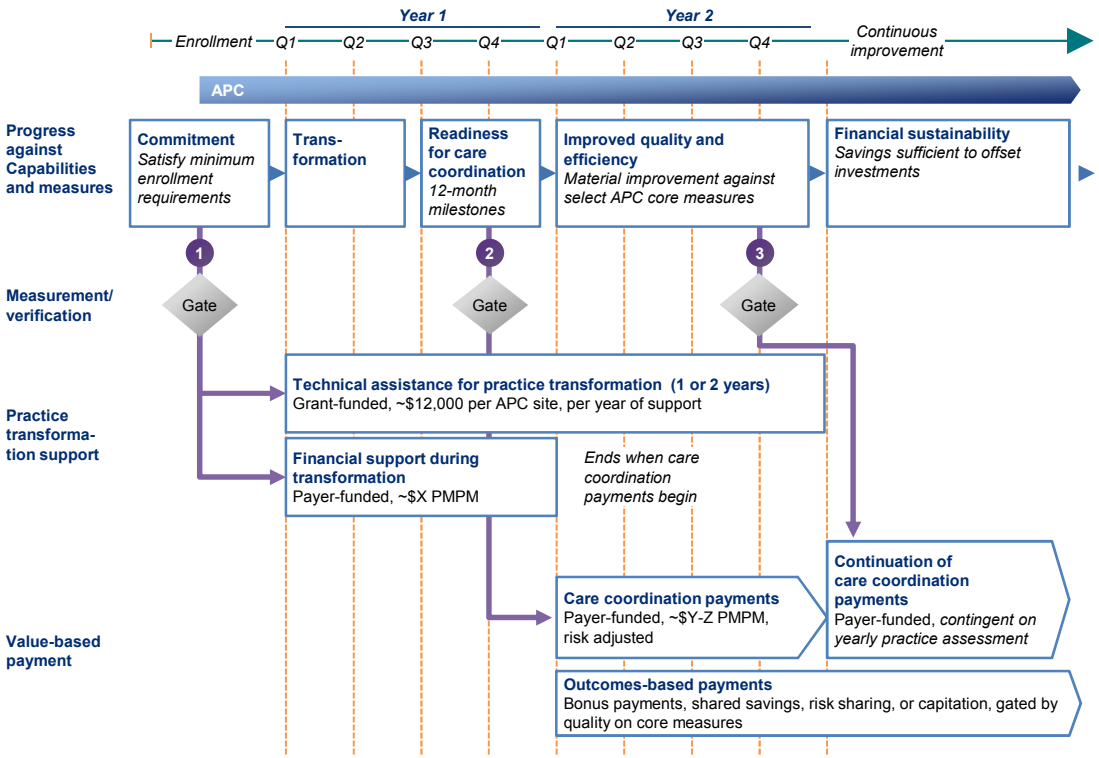
Shared 'core' measure set – 28 total, 18 measures in Version 1.0

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.	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. Claims-only possible.	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	✓

Innovation Center

CMS measures in yellow

Path to APC over time for practices starting out



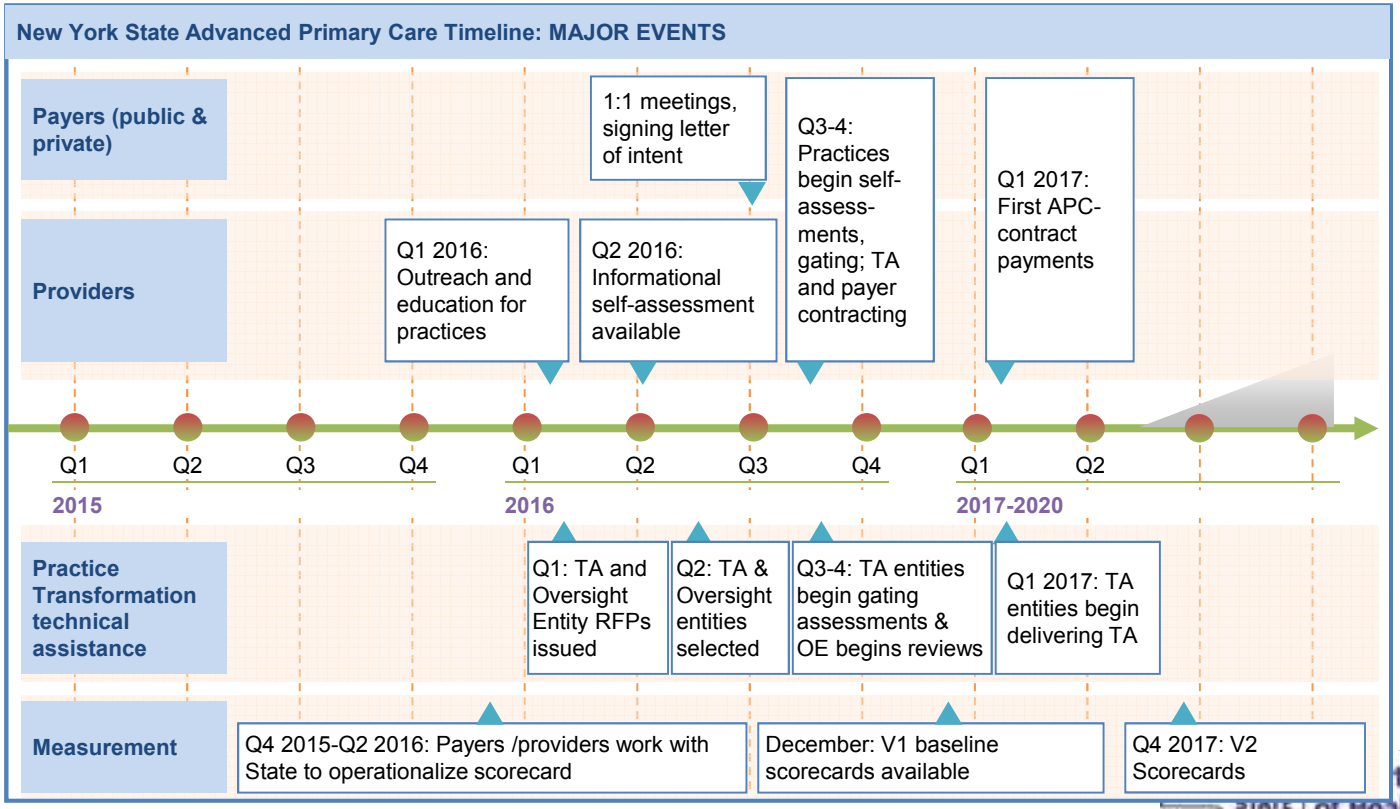
NEW YORK STATE Department of Health Innovation Center

APC design deliverables: Where are we?

- RFP for transformation agents (TA): applications received, being scored
- RFP for independent validation agent (IVA): to be released shortly
- RFP for communities to implement population health interventions: to be released shortly; opportunity to build on local Prevention Agenda collaborations focused on chronic disease prevention
- RFI for payers: released and being analyzed, 1:1 meetings conducted
- Set of criteria for structural milestones: finalized
- Core measure-set: finalized (1.0)
- State wide practice transformation database: finalized

NEW YORK STATE | Department of Health | Innovation Center

Overview of 2016 major events leading to full Jan 2017 implementation



Program Alignment

NY State Practice Transformation Programs for Providers: DSRIP, SIM, TCPI, CPC +, MACRA Highlights:

DSRIP	SIM/APC	TCPI	CPC +	MACRA
Focus: Primary care practices participating in PPS provider networks	**Focus:** Primary care practices: Implementation 2017	**Focus:** Clinician practices, both primary care and specialty	**Focus:** Primary care practices: Implementation 2017	**Focus:** All Medicare practices Implementation 2019
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	**Who provides funding/support to the provider:** CMS, commercial payers provide prospective, risk adjusted PMPM payments	**Who provides funding/support to the provider:** CMS, TA vendors
Resources/Payment: Practices are supported by PPSs to reach PCMH or APC designation	**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.	**Resources/Payment:** No additional payments, national CMS learning networks provide support	**Resources/Payment:** Budget neutral, penalties and bonus payments

NEW YORK STATE Department of Health | Innovation Center

Questions