NEW YORK STATE OF OPPORTUNITY. Department of Health

INTEGRATED CARE WORKGROUP

Meeting #8

September 11, 2015

Agenda- September 11, 2015

Timing	Topic	Lead
10:00-10:20am	Welcome and introductions	Foster Gesten / Susan Stuard
10:20-11:00am	Our progress in context: APC work since July 31st, including listening sessions and measures updates	Foster Gesten, NEBGH, Anne-Marie Audet
Bringing it all together		
11:00-12:30pm	A primary care practice's path through APC Milestones	Foster Gesten, David Nuzum
12:30-1:00pm	Working lunch	
How to move forward		
1:00-1:45pm	Approaches to payer and provider alignment to facilitate a successful and timely APC roll-out	Susan Stuard
1:45-2:00pm	Closing and next steps	Foster Gesten / Susan Stuard

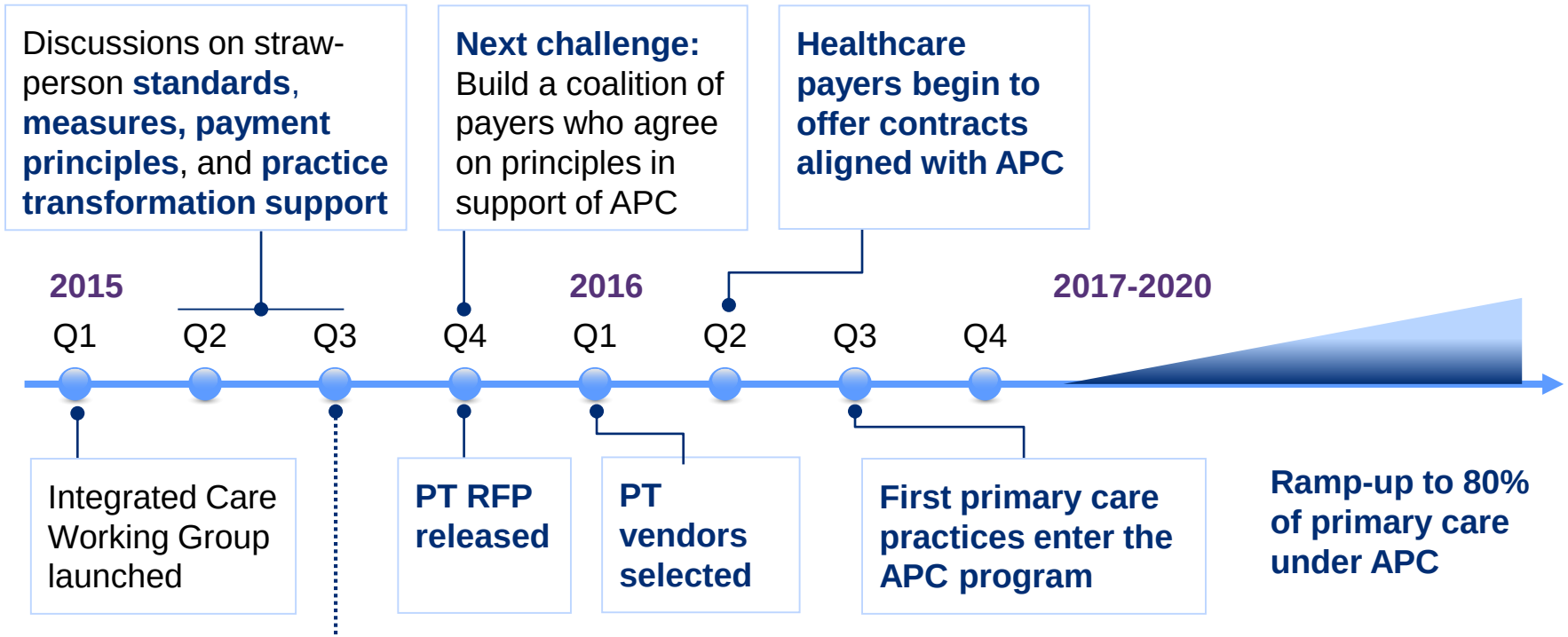
10:20-11:00am: IC / APC progress in context

Designing the NYS APC model to avoid common challenges

Dimensions	Most common problems	NYS APC design goals
Panel coverage	▪ Sponsoring payer accounts for only a minority of provider's revenue, limiting impact of incentives	▪ Sponsoring payers comprise majority of provider's revenue (and patient panel) ▪ Costs of transformation spread across multiple payers
Expectations	▪ Physicians recruited with limited expectations for behavior and capability change	▪ Practices must demonstrate progress prior to receiving alternative payments ▪ Progressive milestones communicated up front designed to ensure progress on both processes and efficiency
Improvement strategy	▪ Unbalanced focus on screening and prevention, without attention to avoidable costs and near term return on investment ▪ Over-reliance on structural measures of quality, rather than process or outcomes	▪ Clear focus on managing high-risk patients to reduce potentially preventable events ▪ Data and performance transparency ▪ Expectation that savings will cover costs of care management
Improvement mindset	▪ Practice transformation is seen as an 'end state' achieved through filling out forms and check-boxes	▪ Practice transformation conceived as a process of improvement based on data ▪ Physicians and office staff "own their own change" as program creators and office champions

Timeline of progress and next steps

New York State Advanced Primary Care Proposed Timeline



Today

- Discussion: A practice's path toward APC in the context of milestones
- Discussion: What will it take to begin APC implementation mid-2016? What steps should we take today?

To incorporate key APC program decisions, the Practice Transformation RFP will be released in Q4 2015

Key APC decisions to be integrated into the Practice Transformation RFP

Key decisions	Description
Fully-defined APC model	APC standards, milestones, and measures should be clear so that vendors expectations clearly described
Payer support for APC	Vendor enthusiasm will partly depend on ensuring that investments of time, money, and effort on transformation will be supported
Understanding roll-out over time	There should be a clear implementation plan (supported by multiple stakeholders) on how support will targeted by practice, geography and time and will be coordinated with other resources.

We will begin to address these today

Listening Sessions – We're hearing useful feedback from payers and providers

APC Model

How does it…

Differ from NCQA PCMH?

Align with DSRIP, ACO's and other Models?

Support small & economically-challenged practices?

Core Measures, Milestones & Standards

How will they…

Fit with Medicaid & all payer metrics?

Integrate palliative care & health literacy?

Meet a menu approach & regional concerns?

Rollout a meaningful & timely database by payers?

We Heard

Primary Care Current State

How are we…

Addressing provider "pace of change" and "burnout"?

Helping with clinical workforce shortages?

Assisting practices to find experienced staff for care coordination?

Helping small practices meet challenges of Milestones?

Payment & Sustainability

How will we…

Sustain APC through levels & payment mix?

Assist practices in transformation if revenue is not up front?

Account for attribution, small panels & risk adjustment?

Listening Sessions Responses – Items to be Addressed Today

APC model: How does it differ and how does it align?

APC standards, milestones, and measures should be clear to all – the topic of today's discussion

Payment and Sustainability

Detailed discussion of how practice reform is tied to payment reform and future outcome-based payment model(s)

Core Measures

Items to be discussed:

- Flexibility vs. standardization
- Availability of data resources beyond claims
- Ensuring comprehensive and timely data

We will begin to address these today

Core measures have been progressing along three activity streams since the last meeting

Activity stream	Areas of agreement	Remaining challenges
Vetting of principles	▪ Existing core measure set is directionally correct and appropriately parsimonious. ▪ Alignment across payers is critical ▪ There may be some substitutions at the margin – to address retiring measures, methodological updates (e.g., avoidable vs. all-cause admissions)	▪ Flexibility vs. standardization ▪ Understanding available resources for data collection beyond claims ▪ Overcoming small "n" for small practices ▪ Ensuring comprehensive and timely data ▪ Fair risk adjustment for payment
Aligning with standards / milestones	▪ See following page	▪ Standards and milestones should continue to facilitate performance on measures
Soliciting input on operational plan	▪ Where possible, measures should avoid the need for manual data entry ▪ It will be important to learn from payers and providers currently working with value-based measurement and payment systems	▪ Streamlining data collection from various sources: claims, health records, other ▪ Data reliability (e.g. coding consistency, missing data, low response rates) ▪ Measures reported at APC vs plan level ▪ Standardized attribution methodology ▪ Standardized vs. plan-specific risk-adjustment

Source: Internal analysis, input from listening sessions with payers and providers

Mapping APC Standards (core competencies) to APC Core Measure Set

APC Standard	Competencies Linked to Measure Set	Core Measure Set
Patient Centered Care: **2 Major Competencies**	i. Access to care in a timely way	14. CG-CAHPS – Getting Care Quickly
	ii. Advanced directives	13. Record Advanced Directives
Population Health: **5 Major Competencies**	i. Proactive management of panel of patients who need preventive care	1. Colorectal Screening 2. Chlamydia Screening 3. Influenza Immunization 4. Childhood Immunization 5. Fluoride Varnish
	ii. Proactive management of panel of patients who need chronic care management	6. Tobacco Use Screening and Intervention 7. Controlling High Blood Pressure 8. Diabetes A1C Poor Control 9. Appropriate Medication Mngt for People with Asthma 10. Weight Assessment and Counseling for Nutrition and Physical Activity for Child, Adolescent and Adult
	iii. Providing patients with self-management resources (in-house, community) iv. Providing patients with appropriate community-based services	No direct measures, these competencies are part of management of patients with chronic conditions and others as appropriate.
	v. Reducing disparities	All measures apply here, since performance on the full core set can be assessed by various groups by age, ethnicity, income, other.
Care Management: **2 Major Competencies**	i. Proactive management of high risk patients (5% who consume 50% of services)	17. Avoidable Hospitalizations 18. Avoidable Readmissions 19. Emergency Dept. Utilization 20. TCOC
	ii. Management of patients with BH and substance abuse	11. Depression Screening and Management 12. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Care Coordination: **2 Major Competencies**	i. Proactive management of patients during care transitions	18. Avoidable Readmissions 19. Emergency Dept. Utilization
	ii. Proactive management of specialty referrals	No direct measures of quality; this competency will be reflected in outcomes of care, in TCOC, and could be tracked with CG-CAHPS: getting referral care quickly
Access to Care	i. 24/7 access to provider – in-person, phone, tele-video, asynchronous	14. CG-CAHPS

11:00am-12:30pm: A primary care practice's path through APC Milestones

Questions for discussion in upcoming pages: A primary care practice's path through APC Milestones

- What should the path to APC look like from a practice perspective?
- What progress should be expected over time?
- How should practice transformation support align with the path toward APC?
- How should payment support align with the path toward APC?
- What kind of performance against core measures should be expected from practices at each of the milestones?
- How should we verify and report milestones at a practice level?
- What does the path toward APC look like for providers who are participating in other programs such as CPCi, TCPI, NCQA PCMH?
- Which parts of this model can be flexible or variable across health plans and/or providers?

Transformation starts with structural change and feeds into performance on quality, experience, and cost

The APC practice journey

Meeting milestones → **Performance against measures** → **Return on investment**

Workflows at a practice level that lead to improved performance on measures

- Participation
- Patient-centered care
- Population health
- Care management / coordination
- Access to Care
- Quality improvement
- HIT
- Payment model

Meaningful improvement on core measures moving toward the Triple Aim

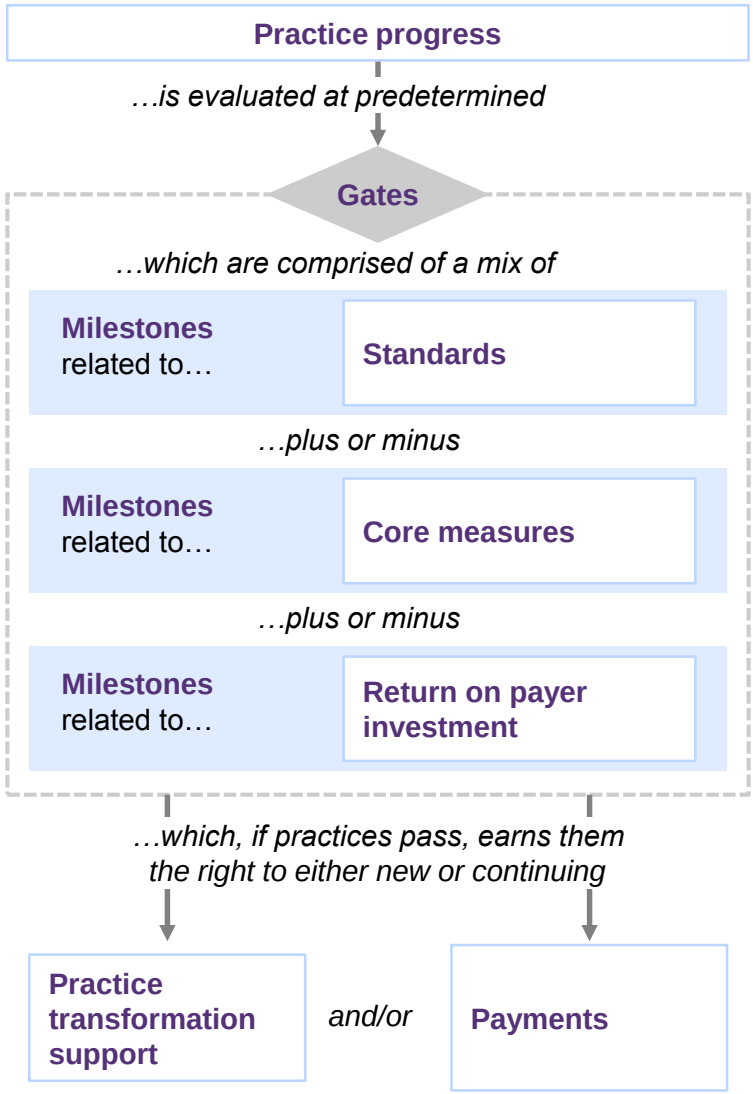
- Better care experience
- Better population health
- Lower cost

- Improvements in quality and experience that **health plan members value**
- Reductions in avoidable and unnecessary health expenditures that **offset investments in practices**

Goals and Proposed Strategy: Milestones

Goals	Proposed strategy
▪ Enrollment should allow broad participation but ensure practices are monitored closely for progress over the first 6-12 months	▪ Create a clear “gating” process to track progress during the pre-APC phase
▪ Need for parsimony	▪ Make choices to ensure only essential elements are included
▪ Need to recognize the readiness of the environment in which practices operate	▪ Set clear assessment process and goals for ‘sufficient’ payer support
▪ Need to communicate clearly and simply	▪ Describe milestones as simply as possible
▪ Move from meeting ‘structure and process’ requirements to achieving excellence and value	▪ Draft separate milestones related to: – structure/conduct (‘standards’) – performance (both ‘core measures’ and ‘financial sustainability’)

High level view on how practice reform is tied to payment reform



Gates - evaluation checkpoints that reward practice reform with payment reform – validation of a gate's milestones earns the practice either State and/or payer support

Milestones represent progress on structure and processes ('standards') or performance ('core measures' or 'financial sustainability')

Standards are criteria related to a practice's structure or processes / workflows (not performance on outcomes or financial sustainability)

Core measures are related to a practice's achievement of evidence-based patient / population outcomes related to the Triple Aim (health, patient experience and cost)

Return on payer investments are the savings / efficiencies generated by the practice as a proportion of payer investments, with 'budget neutral' being the state where former offset the latter

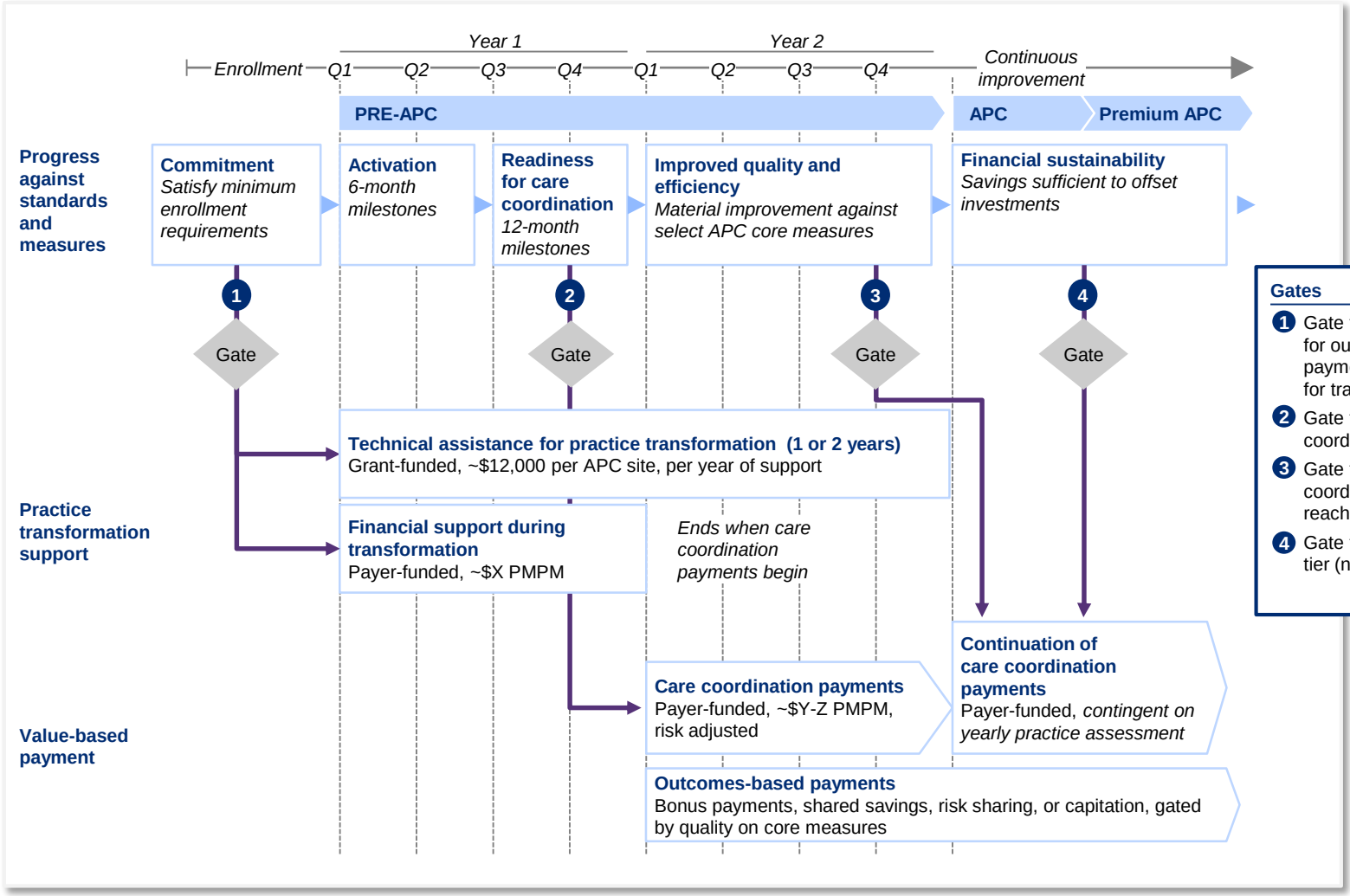
Transformation support is provided to practices in the pre-APC phase and can take two forms:

- *Technical assistance* is support to transform provided by a vendor and funded by the State
- *Financial support* is support to offset practice time and resource investments during transformation and funded by payers

Payments are financial investments provided by payers:

- *Care Coordination* payments are contributions towards a practice's costs of coordinating care
- *Outcome-based payments* reward a practice for performance against core measures

Straw person: how the pieces fit together for a generic practice starting out



The mix of milestones, TA, and payment progresses as practices progress

✓ Relevant to the gate

✘ Not relevant to the gate

Practice progress

Gates

		Commit-ment (Gate 1)	Readiness for care coord. (Gate 2)	APC (Gate 3)	Premium APC (Gate 4)
Milestones related to…	**Standards**	✓	✓	✓	✓
Milestones related to…	**Core measures**	✘	✘	✓	✓
Milestones related to…	**Return on payer investment**	✘	✘	✓	✓
Practice transformation support	*Grant-funded*	✓	✓	✘	✘
	Payer-funded	✓	✓	✘	✘
Payments	*Care coordination*	✘	✓	✓	✓
	Outcome-based payments (OBP)	✘	✓	✓	✓

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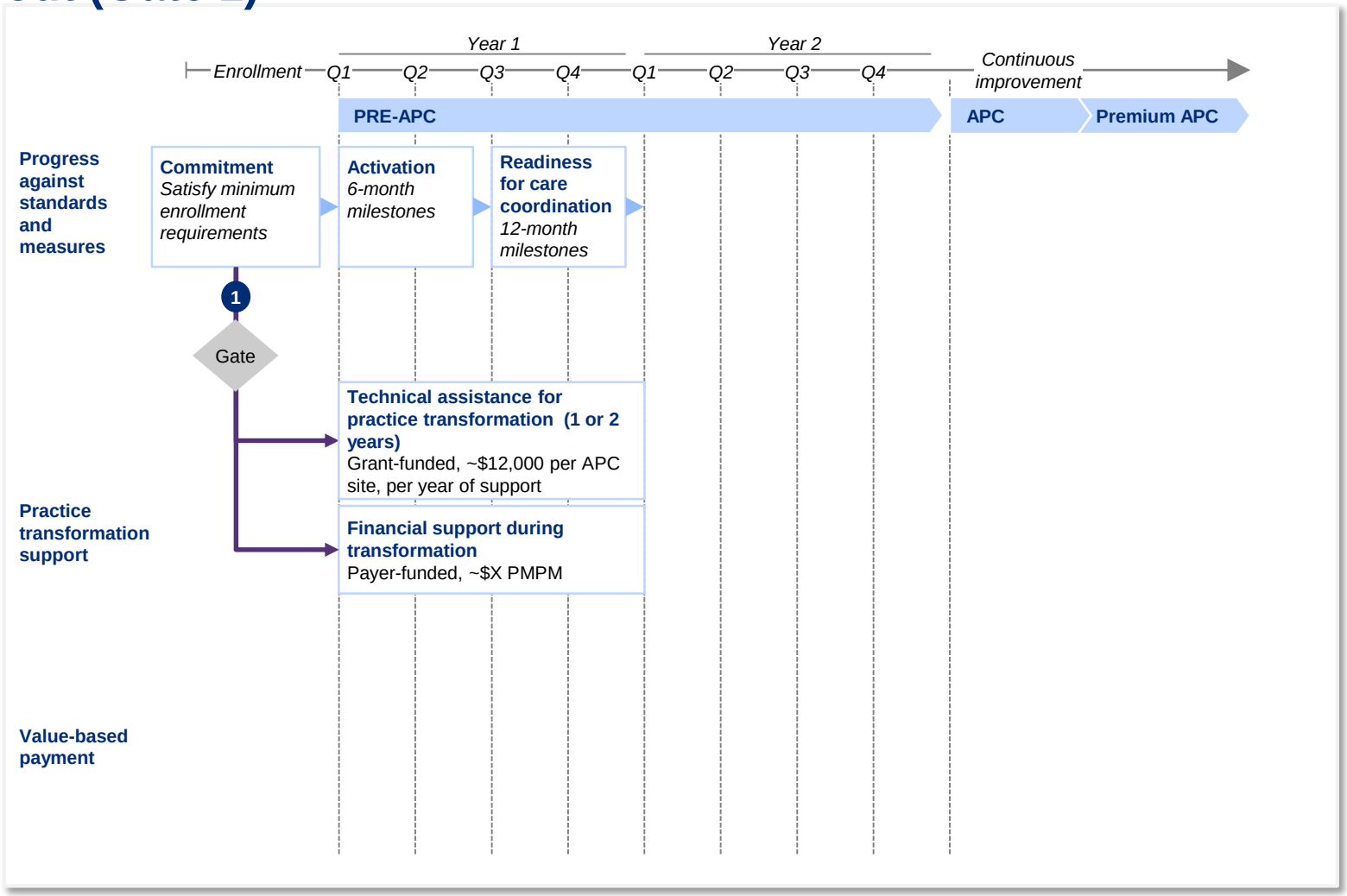
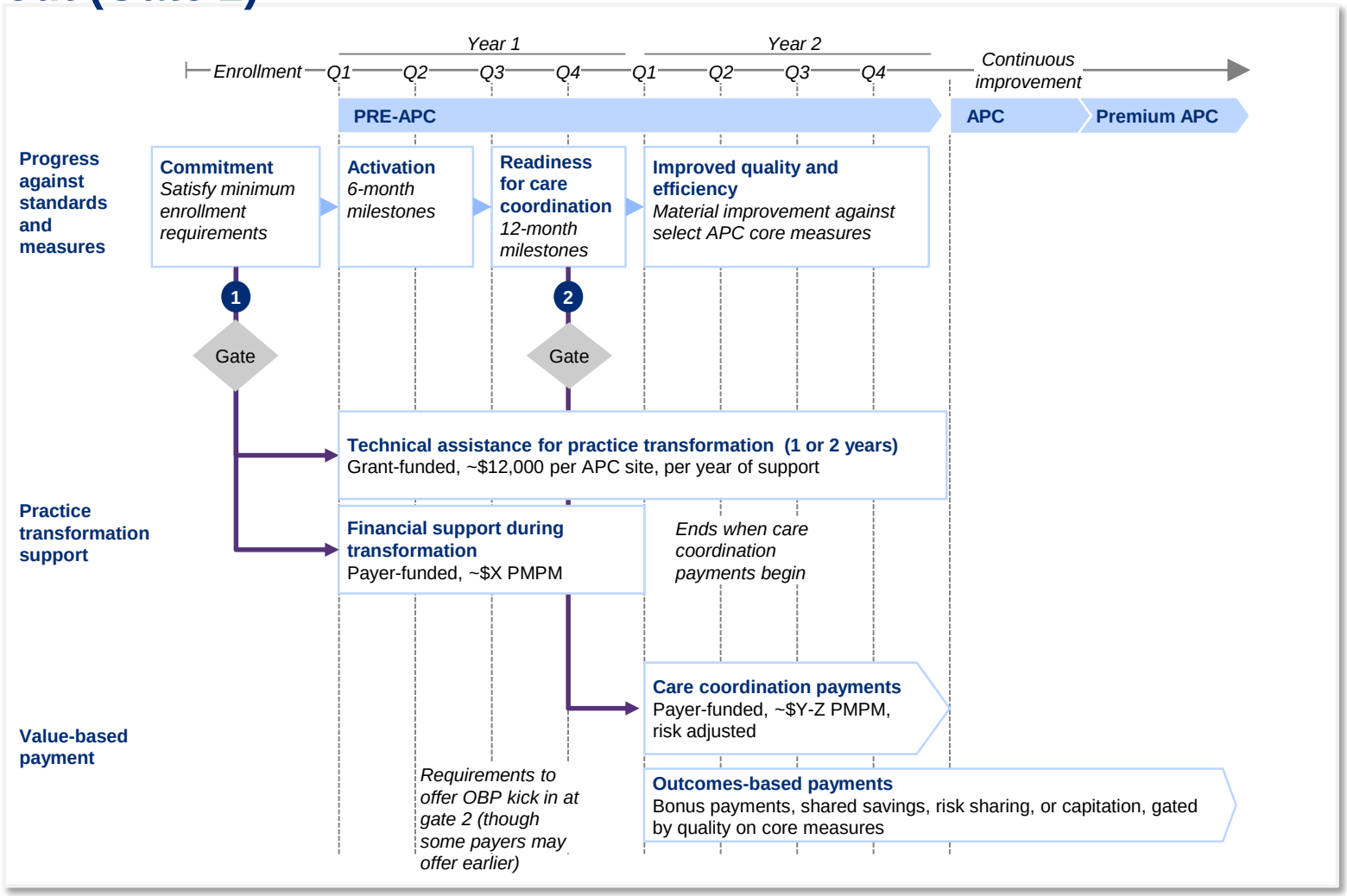
Straw person: how the pieces fit together for a generic practice starting out (Gate 1)



Straw person: how the pieces fit together for a generic practice starting out (Gate 2)



Proposed milestones related to standards (1/3)

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QI / Performance milestones to follow

	Commitment Gate 1	Readiness for care coordination Gate 2
		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 ▪ Affiliation into "pods" for practices with <5 providers	▪ Participation in vendor activities and learning
Patient-centered care	▪ ---	▪ Engagement: survey, focus group, or equivalent, plus QI plan based on results (yearly)
Population health	▪ ---	▪ ---
Care Management / Coord.	▪ ---	▪ High-risk patients: identification of 5% highest priority, tracking system ▪ Ramp-up plan to deliver CM / CC to 75% of high risk within one year ▪ Behavioral health: process for screening, treatment, and referral
Access to care	▪ 24/7 access to a provider	▪ Same-day appointments ▪ Culturally and linguistically appropriate services
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
Payment model	▪ Commitment to OBP[1] by payers representing **X%** of panel within 1 year	▪ OBP contracts with payers representing **X%** of panel

- **Are any key milestones missing? Does the suggested timing feel right?**
- **How should APC approach the need for functionalities currently provided by EHRs?**
- **Should there be a check-in or read out on performance at 6 months between gates 1 and 2?**

1 Outcomes-based payment

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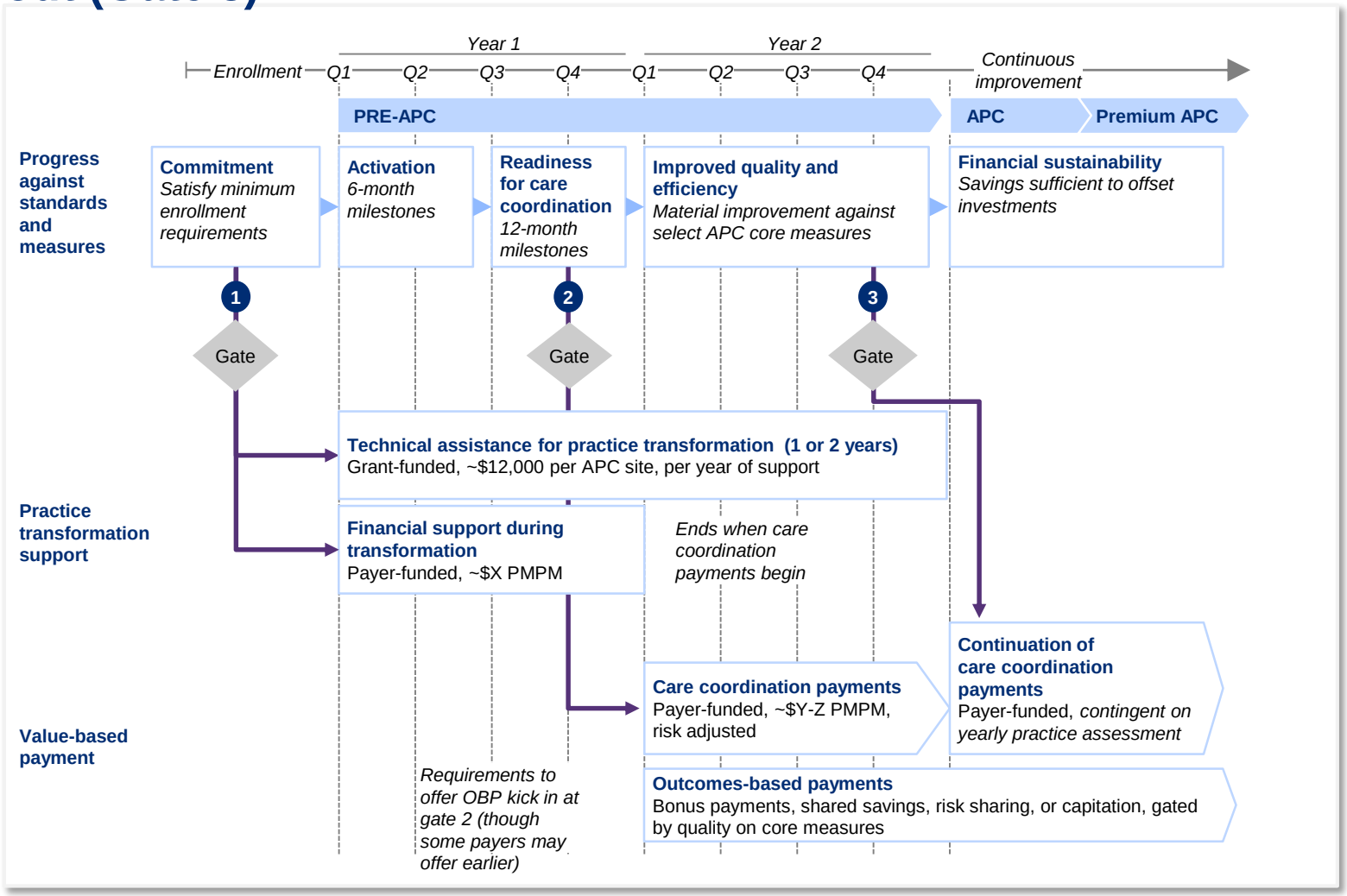
Straw person: how the pieces fit together for a generic practice starting out (Gate 3)



Milestones related to standards (2/3)

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QI / Performance milestones to follow

Achievement of APC

Gate 3

Prior milestones, plus…

Participation	▪ ---
Patient-centered care	▪ Process for Advanced Directive discussions with all patients
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.	▪ Care plans developed, and CM to 75% of high risk patients ▪ Electronic medication reconciliation for transitions ▪ Referral tracking system ▪ Care compacts or collaborative agreements with medical specialists and institutions including BH ▪ Post-discharge follow-up process ▪ Behavioral health: process for screening, treatment, and referral with elements of Collaborative Care Model
Access to care	▪ 1 session weekly during non-traditional hours
HIT	▪ 24/7 remote EHR access ▪ Secure electronic provider-patient messaging ▪ MU Stage 1 ▪ Connected to local HIE qualified entity
Payment model	▪ OBP contracts with payers representing **Y%** of panel ▪ Upside risk-sharing

- **Are any key milestones missing? Does the suggested timing feel right?**
- **Are there ways to simplify milestones / making these more parsimonious?**

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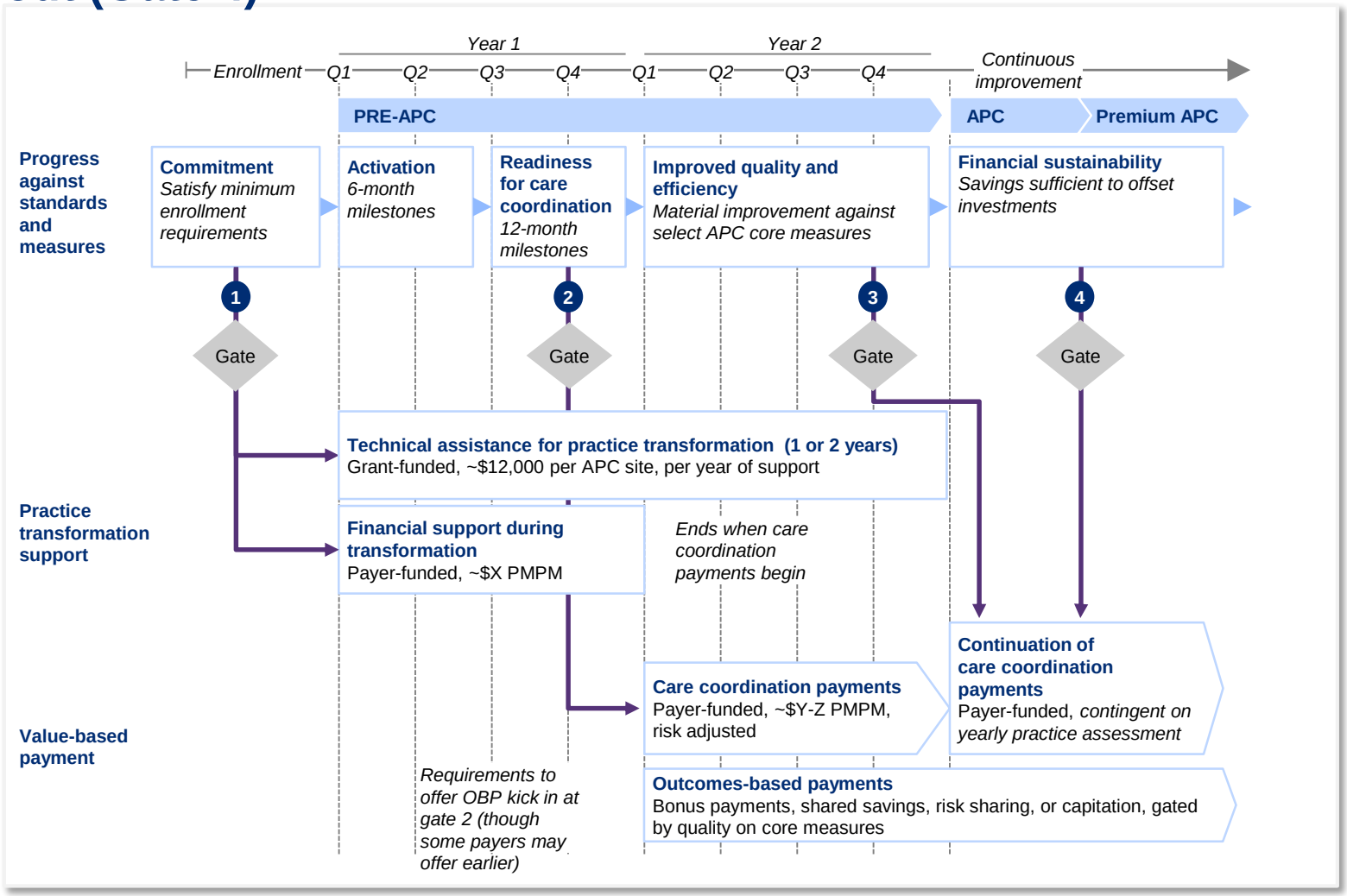
Straw person: how the pieces fit together for a generic practice starting out (Gate 4)



Milestones related to standards (3/3)

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QI / Performance milestones to follow

Achievement of Premium APC

Gate 4

Prior milestones, plus…

Participation	▪ ---
Patient-centered care	▪ ---
Population health	▪ More frequent than annual identification and reach-out to patients for preventative or chronic care management. ▪ List of community-based services relevant to high-risk patients and referral/feedback mechanisms to link to with these services
Care Management / Coord.	▪ Care plans developed, and CM to 100% of high risk patients ▪ Measure effectiveness of care transition processes (with QI as needed) ▪ Evidence-based screening, intervention and referral for substance dependence and abuse ▪ Integrate practice care management with Medicaid health home and health plan care managers (as appropriate)
Access to care	▪ Secure electronic provider-patient messaging with commitment to explicit response time goal
HIT	▪ MU Stages 2 and 3 met ▪ Connected to RHIO and using data for patient care
Payment model	▪ OBP contracts with payers representing **Z%** of panel ▪ Upside and down-side risk sharing

Key design principles for premium APC

- Best practice whole-person, integrated care for all high-risk patients
- Best-practice QI
- Best practice deployment of technology
- Sufficient financial accountability to change behavior while maintaining highest-quality care

- **Are any key milestones missing? Does the suggested timing feel right?**
- **Are there ways to simplify milestones / making these more parsimonious?**

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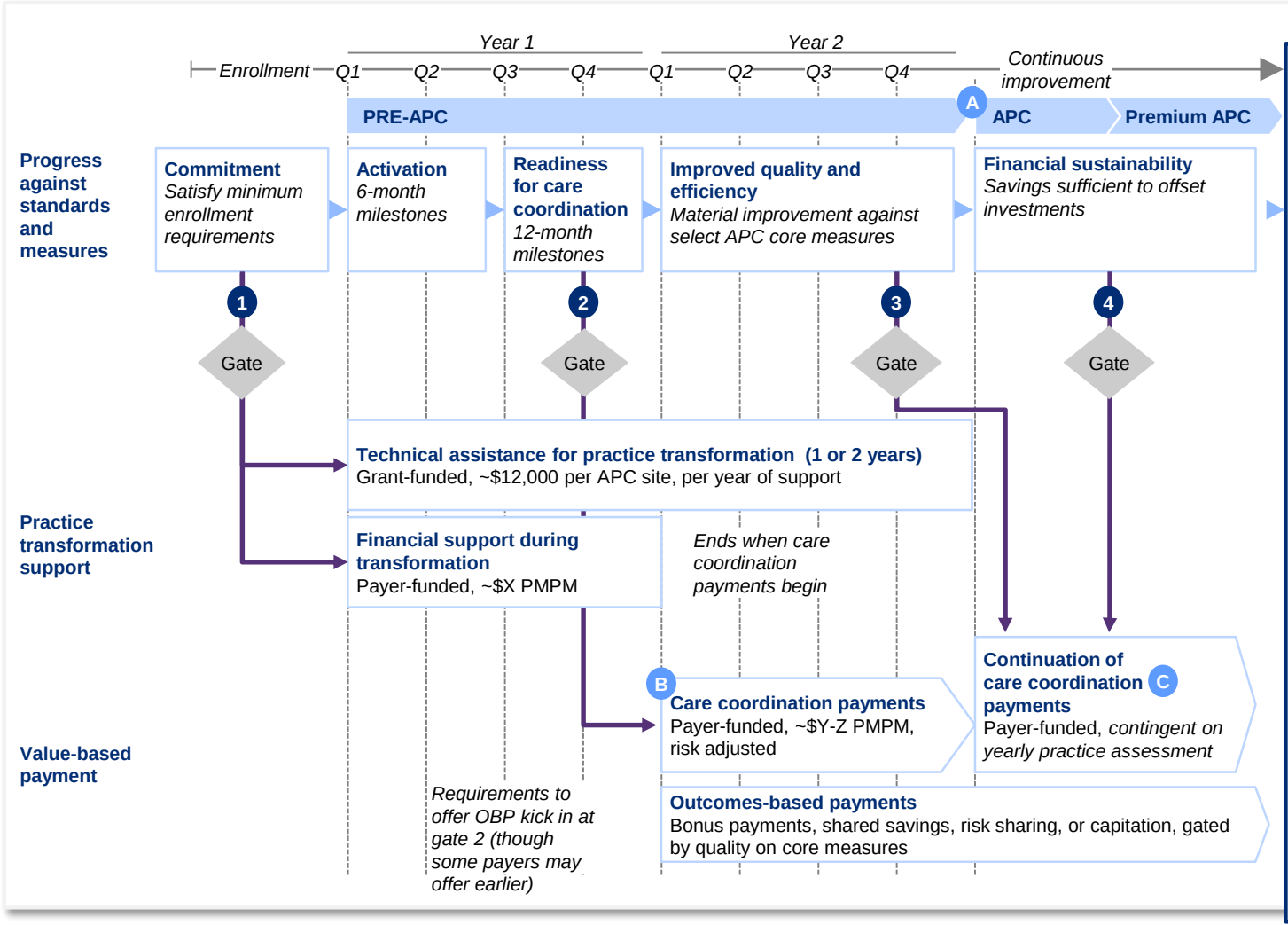
Milestones related to measures progress from a focus on collection and reporting to a focus on performance

	Commitment (Gate 1)	Readiness for care coordination (Gate 2)	Achievement of APC (Gate 3)	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 demonstrating material performance improvement and are on track for APC
Proposed milestones	▪ Develop a **plan for collecting and reporting** non-claims-based data relevant for core measures	▪ **Begin measurement** and reporting of all core measures ▪ **QI plan:** On at least one claims-based measure	▪ **QI plan:** on 3 prioritized core measures, incl. utilization ▪ **QI plan:** address health access and outcome disparities ▪ **Performance expectation?**	▪ Material improvement in at least 3 core measures, including at least one utilization measure (definition of "material improvement" made in contract between payer and provider) or ▪ Closure of gap to agreed-upon benchmark by at least 10% per year on 3 core measures (including at least one utilization measure) or ▪ Improvement on utilization metrics by at least 5% per year, contingent on meeting agreed-upon minimum quality standards

Questions for consideration:

- **At what point in the APC path will it be reasonable to expect improvements on core measures?**
- What is the **required strength of performance improvement** against this (sub)set of core measures? Is this best decided at a payer level?

Straw person: how the pieces fit together for a generic practice starting out



Gates

1. Gate to receive TA, eligibility for outcomes-based payments, financial support for transformation
2. Gate to receive care coordination payments
3. Gate to sustain care coordination payments and reach APC tier
4. Gate to reach premium APC tier (not time-bound)

Degrees of freedom

- **A** Some practices may require more than 2 years to meet all APC standards, but should still be "self-funding" in Yr 3
- **B** Large providers may favor higher shared savings in lieu of care coordination fees
- **C** Some payers may favor transition from care coordination fees to purely outcomes-based payments, over time

There will likely be tailoring of this approach to account for non-standard cases, e.g., NCQA-recognized practices, practices already doing VBP, practices receiving other grant-funding (DSRIP, TCPI)

Outcome-based payments: minimum design requirements for payers by APC Gate

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Flexibility subject to minimum participation constraints | Fully flexible across payers

	1 Commitment	2 Readiness for C.C.	3 APC	4 Premium APC
Practice eligibility	▪ N/A	▪ Any practice that has passed gate 2	▪ Any practice that has passed gate 3	▪ Any practice that has passed gate 4
Incentive structure	▪ Standard PMPM for PT support ($1)	▪ **Standardized** risk-adjusted CM payments ▪ OBP Min: P4P / bonus	▪ **Standardized** risk-adjusted CM payments ▪ Min: Upside risk-sharing	▪ **Standardized** risk-adjusted CM payments ▪ Min: Upside and down-side 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%	▪ Potential for OBP to increase or decrease reimbursement by at least Z%
Attribution	▪ N/A	▪ TBD	▪ TBD	▪ TBD
Risk adjustment	▪ N/A	▪ Payments risk-adjusted	▪ Payments risk-adjusted	▪ Payments risk-adjusted
Measurement	▪ N/A	▪ Mandatory subset of core measures, incl. – 1 cost measure – X quality measures ▪ Optional: Any other core measures	▪ Mandatory subset of core measures, incl. – 1 cost measure – Z quality measures ▪ Optional: Any other core measures	▪ Subset of core measures, incl. – 1 cost measure – Z quality measures – 1 experience measures? ▪ Optional: Any other core measures
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?	▪ To be agreed between payers and providers; can include: – Benchmark trend – Min. savings to qualify? – Other?

- **Does this straw person payment journey imply sufficient incentive for transformation at each stage? How should payments be calibrated to make the incentives effective?**
- **For each element, what degree of alignment across payers is necessary?**
- **What should be the approach to attribution? Common methodology or individual payer methodologies?**

Verification of practice milestones will be necessary to trigger practice transformation and care management payments

Proposed model straw-person

	Milestone determination	Aggregation and auditing	Use
Who	▪ PT vendors	▪ Statewide vendor	▪ State and payers
What	▪ Determine when practices have met milestones ▪ Report to data aggregator	▪ Aggregate and quality control data ▪ Audit vendors and practices to ensure accuracy	▪ Use milestone data to determine payments to practices
Why	▪ In-practice verification or milestones is resource intensive for thousands of practices ▪ 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	▪ Accurate data based on in-person visits will ensure true practice change triggers continued financial support

Once a practice enters the APC program, progress through milestones to reach APC is required to remain in the program

Implications of not passing a gate – straw person for discussion

- Case-by-case review:
  - **If progress is close to satisfactory,** the practice **may be allowed to continue** in current phase – with possible extension of TA and financial support
  - **If progress has been limited** and practice deemed unlikely to succeed, **participation will be terminated**

What should be the implications of not passing a gate on:

- Eligibility to continue the program
- Grace period for re-testing
- Impact to payments already in flight
- Duration of payments if grace period is granted

The APC program will allow for advanced / accelerated entrance for practices participating in allied programs

Key variants of practice

- A NCQA III
- B Advanced practices receiving value-based payments already
- C Practices receiving grant-funding already (e.g. TCPI, DSRIP)

Hypotheses for discussion

- **Meeting similar criteria for other programs will be sufficient proof of meeting matching APC milestones**, though proof of any APC-specific milestones will still be necessary to pass gates
- **Advanced practices may be eligible for an accelerated program** with earlier access to CC / CM payments and stronger outcomes-based payments
- **TA support will be prioritized for practices that have not already proven advanced-practice** through other methods

12:30-1:00pm: Working lunch

1:00-1:45pm: Approaches to payer and provider alignment

Moving toward an implementable APC model with aligned partners

Focus for today's discussion

- **The APC model for NYS is still a work in progress, but pieces are coming into place**
- **Our next challenge is to refine each component in an iterative fashion with stakeholders leaders interested in implementing APC**
- Important groups of stakeholders include:
  - **Payers**
  - **Providers**
  - Patients
  - Other allied groups

How can we best engage these stakeholders in a way that prepares APC for implementation?

Moving toward an implementable APC model with aligned partners

Focus for today's discussion

- Need input from Workgroup today on a proposed approach to garner indications of willingness to participate in the APC program
- We need to break the "chicken and egg cycle" of providers won't participate if payers don't and payers won't commit if there is not sufficient provider interest

What is your feedback on how to orchestrate a call and response on willingness to participate?

Case example: multi-payer alignment for an innovative payment program has been achieved before in NY and in other states

Comprehensive Primary Care Initiative (CPCI) engagement process

Phases of engagement	Description	Dates
"Prototype" release	CMS issues CPC program summary and invites health plans to reply within 30 days with non-binding letters of interest for participation	Oct 2011
Additional refinement	CMS provides additional model information via FAQs. Health plan application is due with detailed payment information	Jan 2012
MOU negotiated	CMS names seven CPC regions and negotiates a memorandum of understanding (MOU)	May-July 2012
CPC started	CPC launched in 7 regions	Oct-Nov 2012

Similar processes drove consensus with MAPCP and several statewide initiatives

In order for APC to succeed, a critical mass of payers will need to actively participate in program creation and execution

Proposed strategy for NYS APC: Payer engagement

Phases of engagement	Description	Proposed starting dates
Input	▪ Engage payers early to help co-create the APC program	March 2015 ->
Refinement	▪ Refine APC standards, measures and payment models with IC Workgroup ▪ Disseminate APC model to payers not in IC Workgroup ▪ Payer-specific one-on-one and small-group sessions for feedback on model and implementation possibilities and challenges	August 2015 ->
Commitment	▪ Discuss payer commitment to APC model and incentives for commitment ▪ Discuss possible form(s) of commitment (e.g., MOU, compact, etc) ▪ Identify early adopters to “champion” the APC model ▪ More broadly establish multi-payer alignment and commitment	October 2015 ->
Ongoing execution	▪ Ongoing efforts to refine model and ensure execution against commitments	May 2016 ->

Discussion: What will it take for payers to support APC in practice?

- **Who will be the payer champions** to help refine the APC program and prepare for implementation?
  - E.g., to sufficiently refine APC to pass the payer "litmus test" of constituting an opportunity for payer return on investment
  - E.g., to craft the first APC provider payment contracts in line with the APC program
- **What is the minimum group of payers** that could constitute a "critical mass" supporting APC – from the perspective of both payers and providers?
- **What is the right process to engage** with that "critical mass" of payers?
- **What are the sticking points** for payers in the current APC "prototype"

Providers will need to continue to be actively involved as APC takes shape

✓ Completed efforts

Phases of engagement	FOR DISCUSSION: Description / potential elements	Proposed starting dates
Input	**Engage providers early to help co-create an APC program that will work for all involved:** ✓ Working group meetings ✓ Listening sessions with groups of providers by region	March 2015 ->
Education and advocacy	**Educate providers on reasons to engage, fit with complementary programs, and business case** ▪ Memorandum detailing program and business case for practices ▪ Practice forums by region ▪ Individual vendor engagement with practices	November 2015 ->
Commitment	**Recruit and process practice applications for pre-APC, APC, and premium APC support** ▪ Practice application form and certifying organization ▪ Ongoing practice recruitment	May 2016 ->
Ongoing execution	**Ongoing efforts to refine model and ensure execution against commitments:** ▪ Statewide APC working group meetings ▪ Regional governance councils ▪ Certification of meeting milestones	June 2016 ->

Discussion: What level of input is needed from providers?

- What are the goals of provider engagement outside of the working group prior to finalizing the APC program?
- How will providers be educated and recruited into APC once the details of the programs are better understood? Who will participate in this process?

Appendix

Current measure set draft

	Proposed core measure
Prevention	1. Colorectal Cancer Screening 2. Chlamydia Screening 3. Influenza Immunization - all ages 4. Childhood Immunization (status) 5. Fluoride Varnish Application
Chronic Disease (Prevention and Management)	6. Tobacco Use Screening and Intervention 7. Controlling High Blood Pressure 8. Diabetes A1C Poor Control 9. Appropriate Medication Management for People with Asthma 10. Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults
BH / Substance 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+ 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. Avoidable Hospitalization 18. Avoidable readmission 19. Emergency Dept. Utilization
Cost of Care	20. Total Cost of Care

Latest work on standards – to be reviewed and finalized once milestones agreed

APC Tiers – Revised Aug 20, 2015 (1/4)

	PRE APC (Commits to meeting APC Standards within 1-2 years)	APC	PREMIUM APC
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.
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 for preventive or chronic care management services, communicate reminders and **ensure 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 feedback mechanisms for linking patients with these services.

APC Tiers – Revised Aug 20, 2015 (2/4)

Latest work on standards – to be reviewed and finalized once milestones agreed

	PRE APC (Commits to meeting APC Standards within 1-2 years)	APC	PREMIUM APC
3. Care manage-ment	a. Identify high risk patients who would benefit from care management (CM) b. 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. Evidence-based screening, intervention, and referral to treatment, to prevent, identify, and address substance use disorders
4. Access to care	a. 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
5. Quality improve-ment	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.

APC Tiers – Revised Aug 20, 2015 (3/4)

Latest work on standards – to be reviewed and finalized once milestones agreed

	PRE APC (Commits to meeting APC Standards within 1-2 years)	APC	PREMIUM APC
6. Care coordin-ation	a. 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 transitions processes in contacting and following up with patients and implement QI efforts as needed.
7. Health Inform-ation Tech-nology	Practice 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 a. Meets all MU Stage 2 and Stage 3 requirements. b. Connected to local RHIOs and uses data for patient care activities.

APC Tiers – Revised Aug 20, 2015 (3/4)

Latest work on standards – to be reviewed and finalized once milestones agreed

	PRE APC (Commits to meeting APC Standards within 1-2 years)	APC	PREMIUM APC
8. Particip-ation agreement	a. Completion of a standardized self-assessment tool and on-site audit to evaluate readiness for/interest in change. b. Up-to-date board certification.	All previous	All previous
9. Payment model	a. Agreement to transition to alternative payment model(s) with payers	a. Negotiates alternative payment model (s) with payers.	a. Negotiates alternative payment model(s) with 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.