NEW YORK STATE OF OPPORTUNITY. Department of Health

New York State Department of Health Statewide Steering Committee

September 14, 2017

Agenda

	Topic	Time	Leader
1	Welcome and Introductions ▪ Center for Medicare & Medicaid Innovation Introductions and Opening Comment	10:30 - 10:45	Marcus Friedrich Susan Stuard Stephen Cha
2	SIM, APC, NYC PCMH Model Progress ▪ APC/NYS PCMH Model ▪ Practice Transformation Progress ▪ APC Scorecard Updates	10:45 - 12:00	Marcus Friedrich Lori Kicinski Jim Kirkwood Paul Henfield
3	MACRA Alignment ▪ Working lunch ▪ NYS Vision	12:00 – 1:00	Gene Heslin Marcus Friedrich
4	Statewide Evaluation and Regional Oversight ▪ NYS Innovation Model Evaluation ▪ ROMC Progress	1:00 – 2:10	Kerry Griffin Thomas Mahoney Amy Tippett-Stangler Susan Stuard
5	Closing Remarks & Next Meeting ▪ Questions for CMMI and Closing Discussion	2:10 - 2:30	Marcus Friedrich Susan Stuard

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APC/NYS PCMH Model

NCQA PCMH / APC program alignment - overview

APC criteria was designed with intention that this would be best solution for NYS needs

- Verifiable progress over time
- Transition to performance
- Building capacity for VBP payments
- Transforming with technical support

…But complexity in the setting of multiple primary care transformation programs has been an ongoing challenge

NY State DOH made decision to align transformation programs under NYS PMCH program

Goals for today

- Update on timeline, discussions
- Receive input on alignment progress
- Identify critical areas for further investigation

Why align with PCMH (NCQA PCMH 2017)?

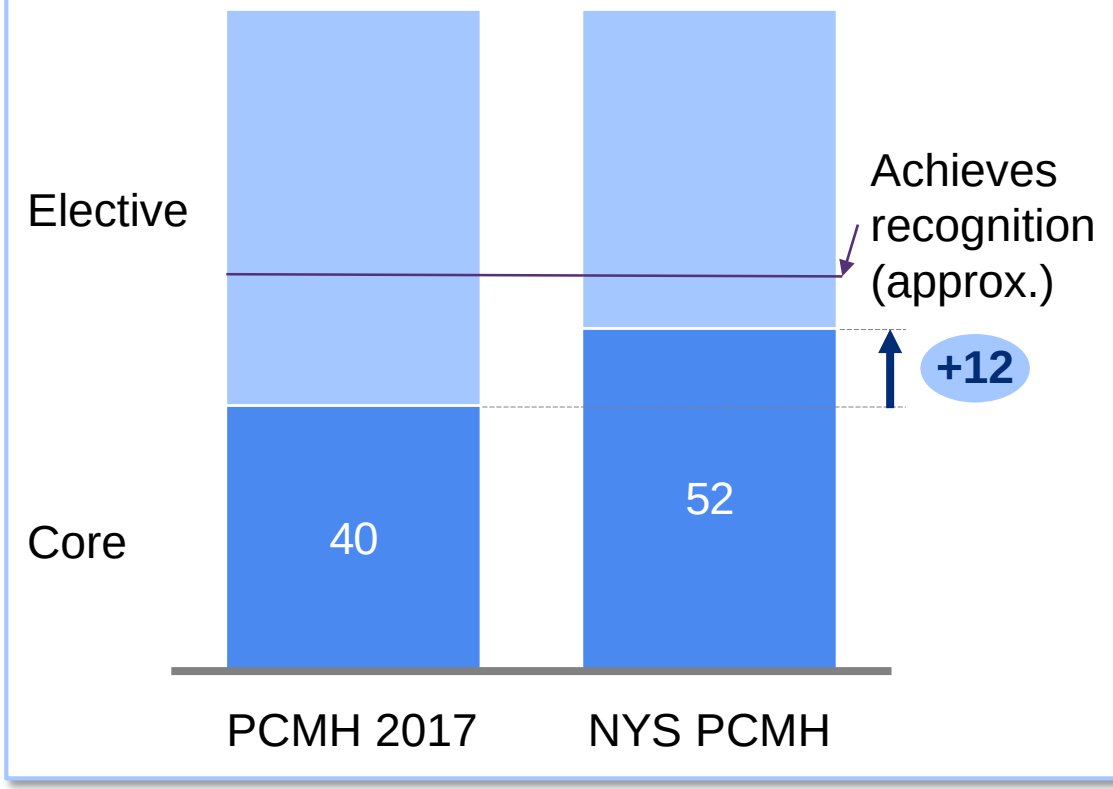
- Accelerating the transition toward delivering value and succeeding in new payment models for all practices in NY State
- Opportunity to simplify a complicated landscape and reduce confusion

Why create a distinct “NYS PCMH”?

- A NYS PCMH program considers several state-specific components including investments in Health IT, Behavior Health integration, rigorous Care Coordination, Population Health, and the potential for multi-payer support
- Accelerating the transition toward value-based payment is a priority for NY

NYS PCMH builds on APC/PCMH 2017 by converting 12 Electives into Core without asking the practices to do more

NYS PCMH criteria compared to PCMH 2017



Changes compared to NCQA PCMH

- **12 Additional Core criteria** represent fundamental building blocks in the areas of:
  - Behavioral Health integration
  - More rigorous Care Coordination
  - Health IT capabilities
  - VBP arrangements
  - Population Health
- Providers would then complete **4-7 elective criteria to earn 7 additional credits**[1]
- **Continuation of TA vendor activities**

1 From an NCQA point of view, the practice will have then completed NCQA's 40 Core criteria and earned 25 Elective credits (18-19 credits – depending on if VBP is upside only or full risk – earned from completing the 12 Elective criteria that were converted to Core for NYS PCMH, plus 6 additional credits).

Source: NCQA PCMH 2017

Detail: Proposed 12 new “core” criteria

	Code	Criteria
Behavioral health	CC9	Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care
	KM4	Conducts BH screenings and/or assessments using a standardized tool. (implement two or more) A. Anxiety B. Alcohol Use Disorder C. Substance Use Disorder D. Pediatric Behavioral Health Screening E. PTSD F. ADHD G. Postpartum Depression
Care manage-ment and coordina-tion	CM3	Applies a comprehensive risk - stratification process to entire patient panel in order to identify and direct resources appropriately
	CC8	Works with non-behavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care
	CM9	Care plan is integrated and accessible across settings of care
	CC19	Implements process to consistently obtain patient discharge summaries from the hospital and other facilities
	KM11	Identifies and addresses population-level needs based on the diversity of the practice and the community (Demonstrate at least 2) A. Target pop. health mgmt. on disparities in care B. Address health literacy of the practice C. Educate staff in cultural competence
Health IT	AC8	Has a secure electronic system for two-way communication to provide timely clinical advice
	AC12	Provides continuity of medical record information for care and advice when the office is closed
	CC21	Demonstrates electronic exchange of information with external entities, agencies and registries (may select 1 or more): RHIO, Immunization Registry, Summary of care record to other providers or care facilities for care transitions
	TC5	The practice uses an EHR system (or modules) that has been certified and issued an ONC Certification ID, conducts a security risk analysis, and implements security updates as necessary correcting identified security deficiencies
VBP	QI19	The practice is engaged in Value-Based Contract Agreement. (Maximum 2 credits) A. Practice engages in up-side risk contract[1]

1 A value-based program where the clinician/practice receives an incentive for meeting performance expectations but do not share losses if costs exceed targets.

Source: 2017 NCQA PCMH

Transition Date Options

- Start of TA vendor contract year on 2/1/2018
- DSRIP requirement that Primary Care practices in a PPS are expected to be 2014 PCMH Level 3 certified or APC (Gate 2) recognized by March 31, 2018 (end of DY3)

NCQA Negotiations:

- Exclusivity of NYS PCMH
- Transformation path for APC practices
- NCQA education for all transformation agent vendors
- Yearly practice check-in design

CMS Discussions

- Recognize NYS PCMH as a transformation program
- NYS proposal to use SIM grant funds to cover NCQA Initial recognition fee for practices
- 1 year contract Extension

SIM/APC Timeline

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Population Health Integration in APC

	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 and county health collaborative Prevention Agenda activities ii. Annual identification and reach-out to patients due for preventative or chronic care management iii. Process to refer to structured health education programs
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 contracts with APC-participating payers representing 60% of panel	i. Minimum FFS + gainsharing contracts with APC-participating payers representing 60% of panel

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Population Health Integration in NYS PCMH

PCMH Core Standards	PCMH Description Overview
CM 01*, 02*	The Practice monitors the percentage of the total patient population and identifies subsets for care management services, identifying risk, cost, and utilization
CM 03*	The Practice integrates a comprehensive risk-stratification process for entire patient panel and identifies high or at risk populations in need of care management, education, and/or external resources
CC 19*	A process is consistently in place for obtaining discharge summaries from hospitals and care facilities which includes active outreach, database activity or interoperability
KM 02*	A comprehensive health assessment includes capturing social, behavioral, cultural and communication needs of a patient using evidence-based guidelines that will provide foundation for population health management
KM 03*, 04*	The Practice plays a role in early identification of mental health and substance abuse disorders by conducting health screens/assessments using standardized tools
KM 09*	In understanding a population's unique characteristics, a Practice is required to identify specialized needs or systemic barriers in health outcomes in the communities they serve
KM 11*, 12*	The Practice identifies, addresses and monitors population-level needs based on diversity, health disparities, health literacy, and cultural competencies by providing patient-centered care
KM 20*	Clinical decision support (CDS) that follows evidence-based guidelines for care is implemented across conditions in the practice setting
KM 21*	The Practice identifies needed resources by assessing collected population information to direct patients to community-based organizations such as food banks or support groups
QI 01*, 08*	The Practice establishes a data-driven culture to monitor at least 5 quality measures, analyze barriers, sets goal's and acts to improve upon at least 3 measures

*NYS PCMH Core competency

Population Health Integration in NYS PCMH: Mandatory One-Year Check-in Elements

NYS PCMH Mandatory One-year Elements
KM 25 (PCMH Elective) **Engages with schools or intervention agencies in the community.**
KM 07 (PCMH Elective) **Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data.** **(Linked with KM02)**
KM 22 (PCMH Elective) **Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.**

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Practice Transformation: Planning for NYS PCMH Migration

APC Practice Transformation Organizations

Assessing Capacities	64% of PT TA field agents are Certified Content Experts in PCMH 2014
	57% plan to require staff to complete PCMH 2017 Courses
	42% will require staff to complete the NCQA 2017 Certified Content Expert Exam (CCE)
Addressing Operational Concerns	71% cited concerns on timely changes to curriculum re-design and material evidence requirements
	57% commented on concerns for APC Enrolled practices achieving Gate 2, 3 Milestones
Communications, Practice Preparedness, PT TA Training	Developing Communication Plans with NYSAFP, NYACP, and AAP for consistent messaging to primary care providers
	Conducting 1:1 and Round Table discussions to determine NYS PCMH training needs

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NCQA Discussion about Practice Transformation Agents:

Practice Transformation Impact

- To what extent will NCQA require PT TA training for PT TA's under APC contract?
- How will role shifts from 'validating' Milestones to 'verifying' acceptable material evidence for NYS PCMH 2017 affect TA operations?
- How will APC practices be "recognized" in the NYS PCMH process?
- What fees will practices have to pay for NYS PCMH applications?

Practice Transformation Updates

NY State of Transformation – SIM/APC Facts

- Launched Round 2 Practice Transformation (PT) Contracts in July (Currently there is 16 contracts in 8 Department of Financial Services (DFS) Regions

- PT Transformation Assistance (PT TA) "Train-the-Trainer" Webinars, Monthly Round Table, 1:1 Monthly PT conference calls with APC team

- Practice Summary (As of 09/11/17)
  - Current 8,000 Primary Care Sites are loaded in the Practice Transformation Tracking System (PTTS)
    - 229 Enrolled in APC (42 NCQA PCMH 2014)
    - 904 Engaged (in discussions) in APC (169 NCQA PCMH 2014)
    - 1,032 Sites not in APC, but are NCQA PCMH 2014

- 66% of the practices are small provider size (1-4 provider), the rest medium (5-10) and large (>10)
    - Small = 175
    - Medium = 38
    - Large = 16

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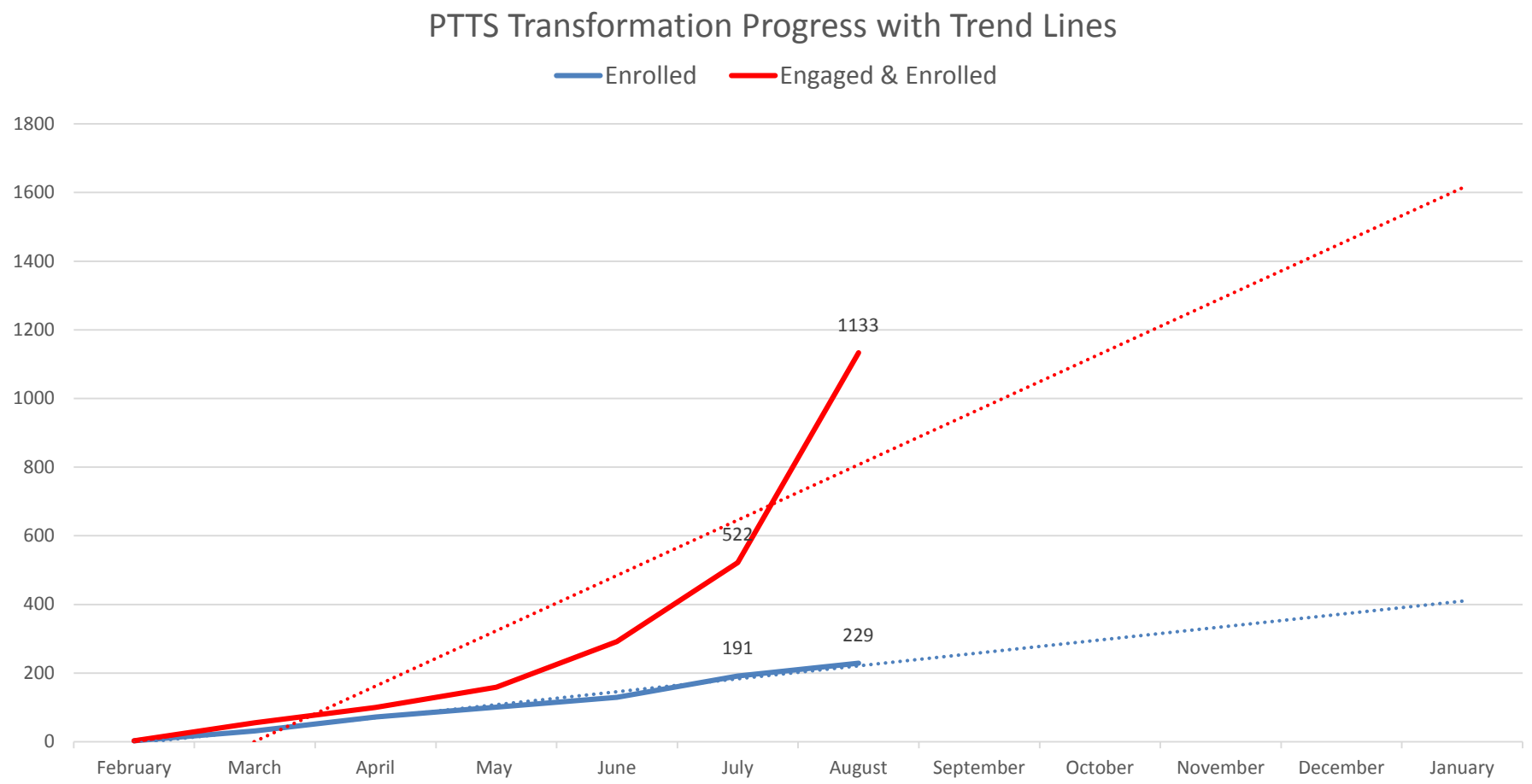
NY State of Transformation – SIM/APC Progression



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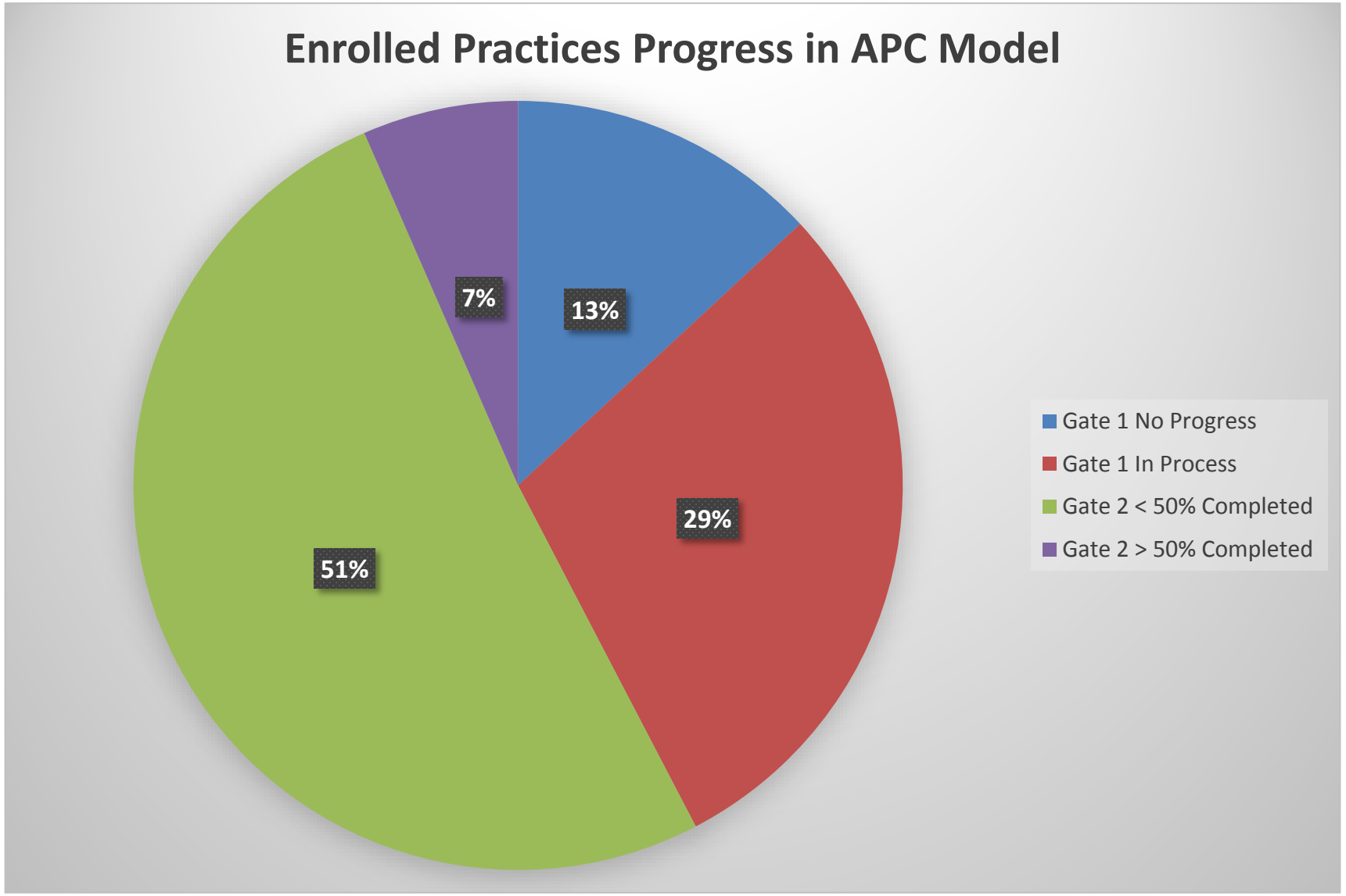
NY State of Transformation – SIM/APC Progression

- From June 2017 – September 2017 Enrolled Practices have increased at a rate of 43.7%
- 132 of 229 (57.6%) enrolled practices have completed APC gate 1
- 15 of the 132 (11.4%) practices are at 50% or greater in completing gate 2
- 30 Practices are newly enrolled and are just starting gate 1 activities



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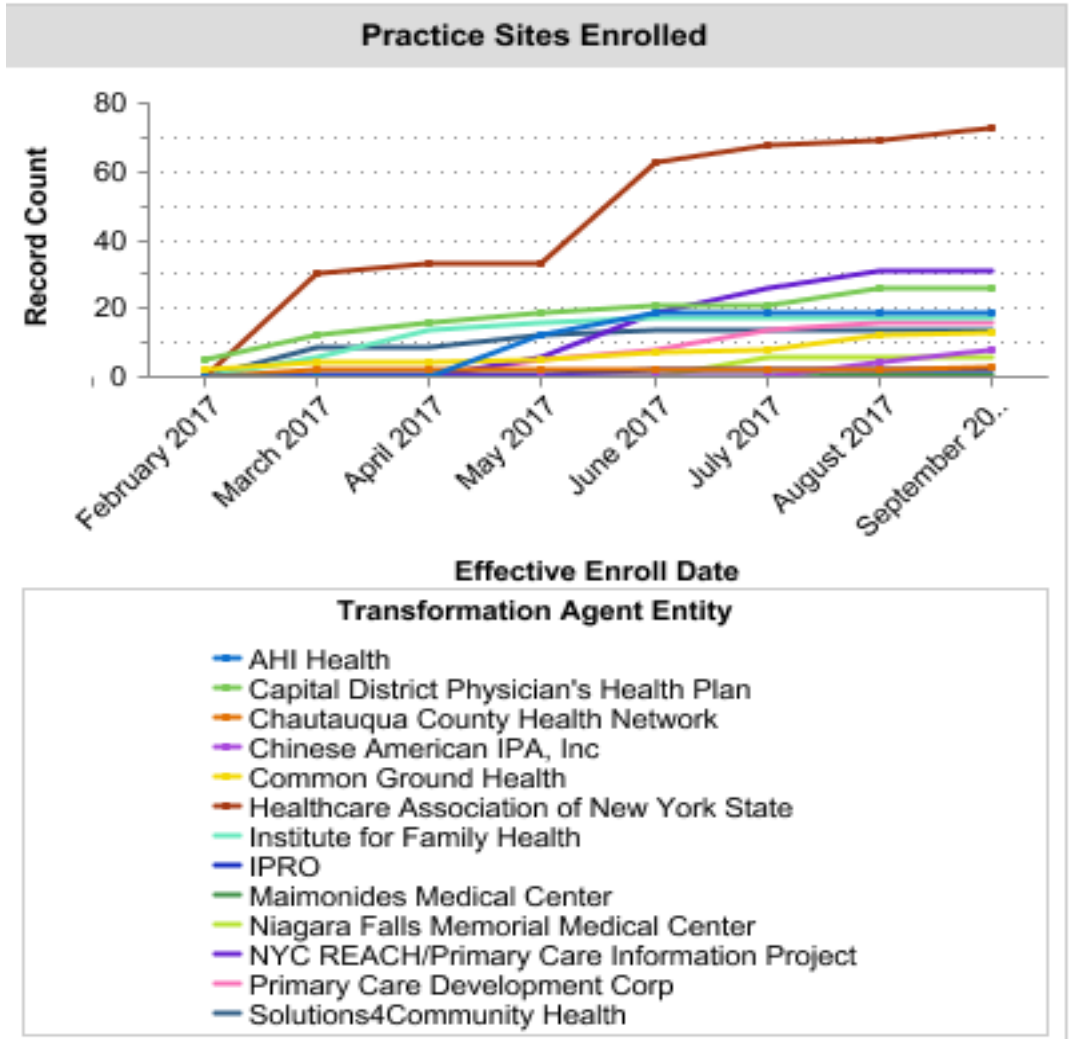
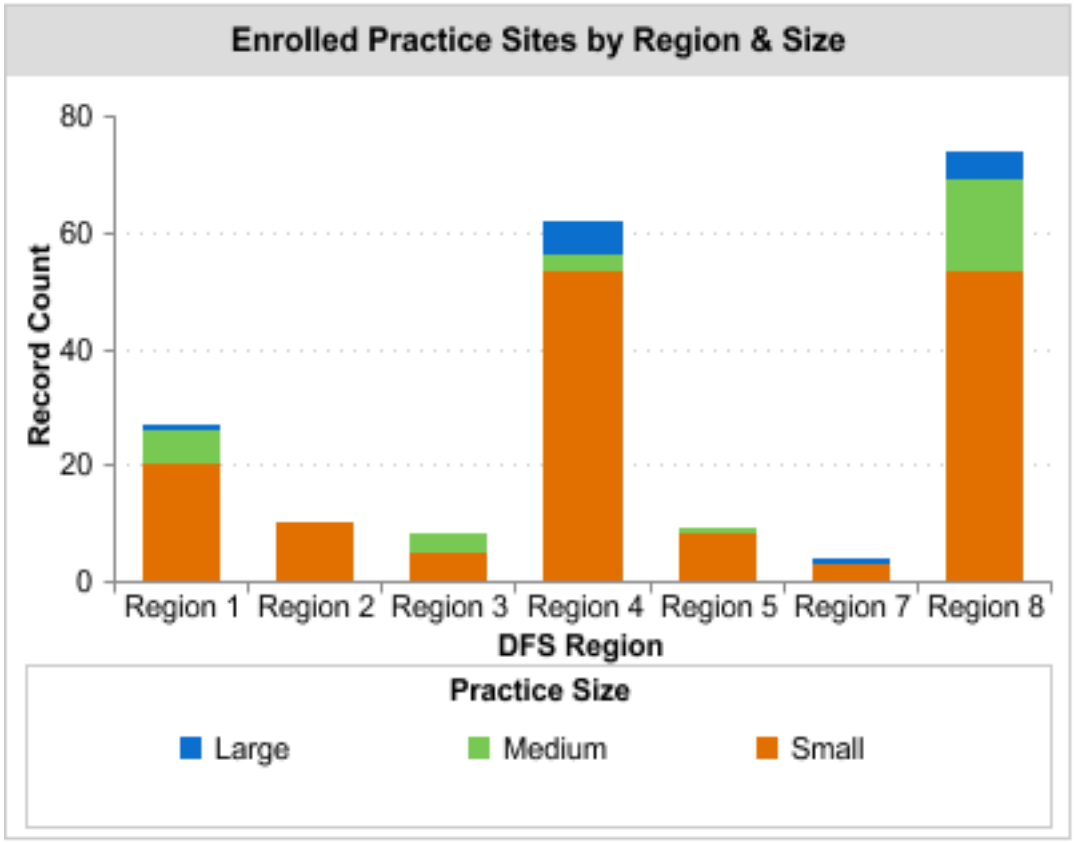
Practice Transformation Tracking System (PTTS)





Small = 1-4 primary care physician and mid-level providers; medium = 5-10; large = 11+

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SHIN-NY Connections Program

- The SHIN-NY Connections Program (SCP) for Enrolled APC Practices will provide a maximum potential funding amount of $13,000 per Practice. While the actual cost of connecting a practice's Certified EHR to the SHIN-NY varies by EHR vendor, size of practice, etc. an estimate of $10,000 - $15,0000 is the market average.

- Through the $13,000 in available funding per practice, the SCP will help offset the cost of connecting to the SHIN-NY for Primary Care practices

- Issued payments to APC practices:
  - Gate 2: $2,000
  - Gate 3: $11,000

SHIN-NY Connections Program

- NYeC will work with the state to achieve the following:
  - Track APC practices enrolled in SCP
  - Verify eligibility and cross-reference eligibility for Data Exchange Incentive Program (DEIP), if eligible for DEIP, direct practice to enroll in DEIP
  - Verify that Practice site has not enrolled in DEIP and received payment already
  - Track attainment of Gate 2 (QE Participation Agreements) and Gate 3 (contribution of clinical data to the SHIN-NY)

APC Scorecard Updates

APC Scorecard Report Overview

- Practice results are aggregated at a TIN (tax id) level.
- Table with measure results grouped by domain (Prevention, Chronic Disease, Behavioral Health/Substance Abuse, Appropriate) with benchmarks by product line (Commercial, Medicaid, Medicare).
  - Patient count information: total count, stratified by product line and by payer.

- Bar graph with practice measure results compared to the statewide benchmark.
- Written sections with technical notes, data definitions, available resources (UHF, IPRO, PT agents) and appendix to guide use of the report.

Measures Included in the Scorecard

- Childhood Immunization Combo 3
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Medication Management for People with Asthma
- Persistent Beta Blocker Treatment After Heart Attack
- Comprehensive Diabetes Care: HbA1c Testing, Eye Exam, Nephropathy
- Antidepressant Medication Management
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Use of Imaging Studies for Low Back Pain
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Payers that contributed data

23 payers in total:

- **Affinity**
- **Amida Care**
- **CDPHP**
- **Empire**
- **Empire BCBS**
- **Excellus**
- **Fidelis**
- **GHI**
- **HIP (EmblemHealth**
- **HealthNow NY**
- **HealthFirst**
- **Independent Health**
- **MetroPlus**
- **MVP**
- **Oscar**
- **Oxford**
- **Total Care**
- **United HealthCare**
- **United Community**
- **Univera**
- **VNS**
- **WellCare**
- **YourCare**

Members by LOB and Tax IDs

Total	Attributed to Tax ID	Commercial	Medicare	Medicaid
2,824,704		1,495,540	348,577	980,587
	1,855,190	645,801	273,062	936,327

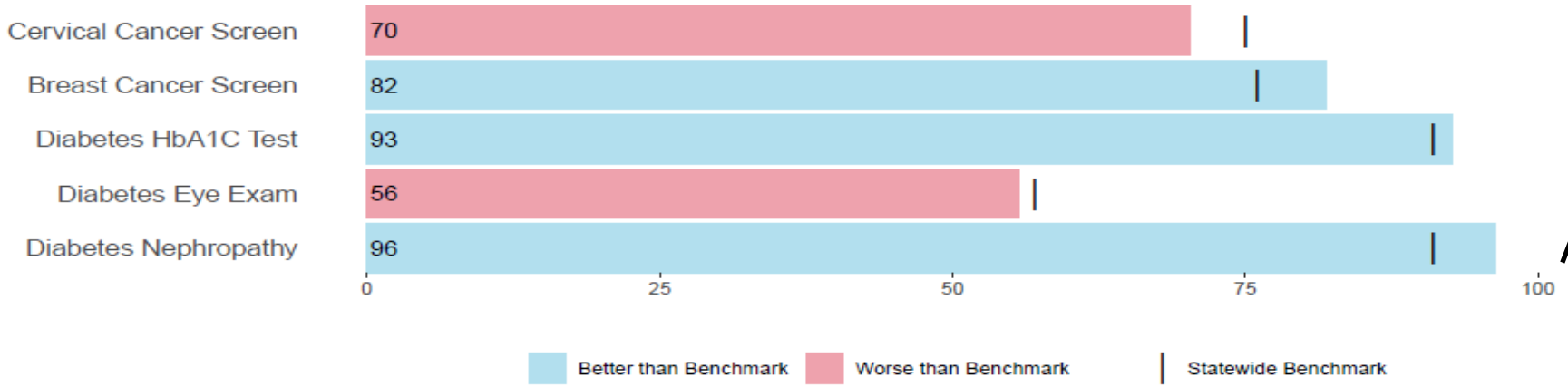
- Number of Unique Tax IDs (practices) = **25,284**

Note: Data from three payers not yet included

APC Scorecard Report Overview: Example

Domain	Measure	*Numerator*	*Denominator*	*Result*	*Commercial*	*Medicaid*	*Medicare*
	Cervical Cancer Screening	45	64	70	78	65	57
	Breast Cancer Screening	59	72	82	74	73	79
	Chlamydia Screening						
Prevention	Patients of age 16 - 20 years	SS	SS	SS	64	75	NA
	Patients of age 21 - 24 years	SS	SS	SS	70	76	50
	Total	SS	SS	SS	67	76	40
	Childhood Immunization Status - Combo 3	SS	SS	SS	76	76	NA

Table displays measure results and benchmarks by product



Graphic displays practice results compared to the statewide benchmark, with color indicating performance (better vs. worse than benchmark)

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Scorecard Distribution Channels

1

Health Plans

(Excel Format - DOH will send directly to Plans)

2

Transformation Agents (TA)

(PDF Format – Uploaded into the Practice Transformation Tracking System (PTTS) for each Enrolled Site)

APC Enrolled Practices

(PDF Format – Sent from the Transformation Agents)

Notes:

- NYSDOH will host a training webinar for the TA's to discuss the template.
- TA's will use data from the Scorecard to work with the APC enrolled practices to integrate and improve site performance for the Milestones

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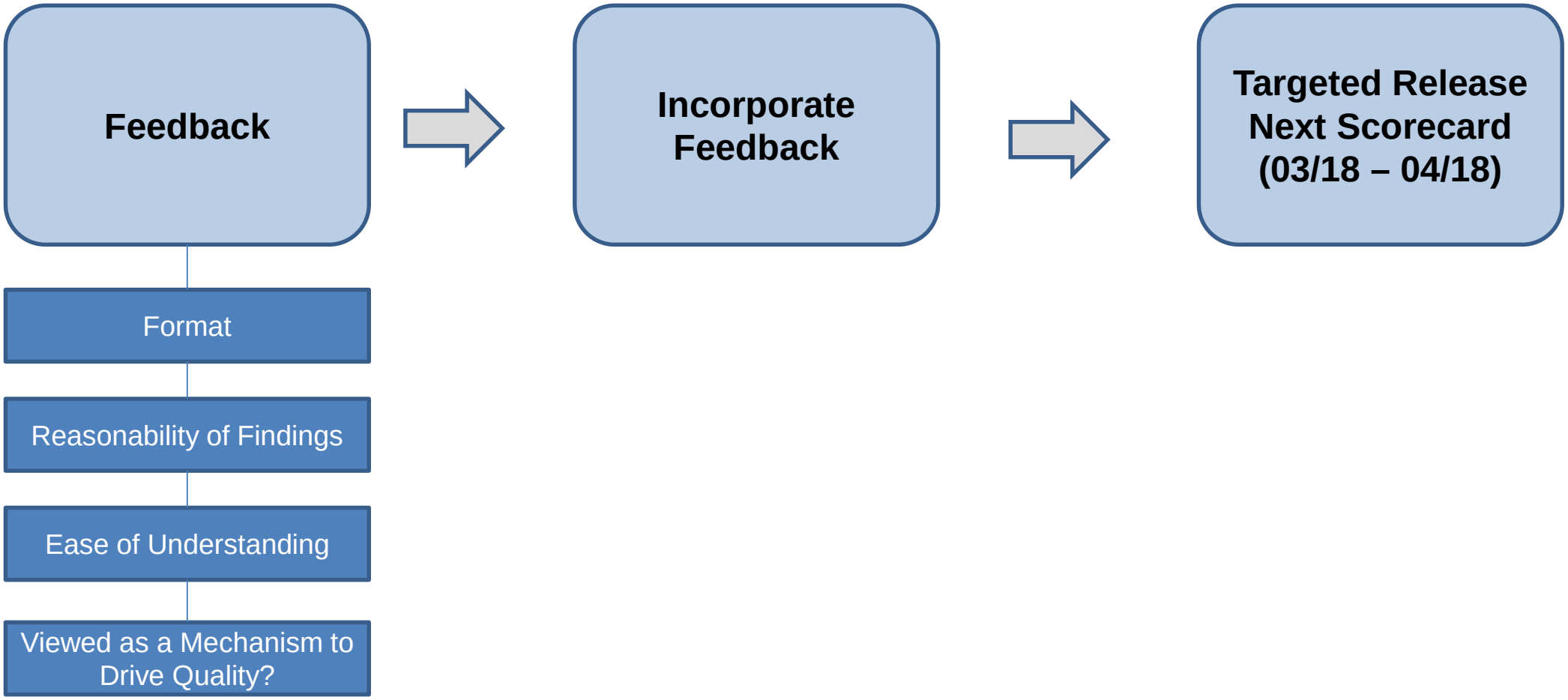
Post Scorecard Release



Projected Timeline

Activity	Projected Date
Data Submission ends	September 19, 2017
Data Aggregation	October 13, 2017
Scorecards Released	October 27, 2017
Feedback from Practices/TAs	November 30, 2017
Data Request for Next Cycle	Late December, 2017
Next cycle of Scorecards Issued	April, 2018

MACRA Alignment

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

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NY State Transformation - Guiding Principles

- **Build health system capacity**
- **Develop health systems that are adaptive and responsive**
- **Encourage and support systems change, alignment and scale-up on multiple levels, and across multiple sectors**
  - Physicians
  - Medicaid & Medicare
  - Commercial payers
- **Don’t let perfect get in the way of progress**

Increasing the Capacity of NYS Health System

- **Physicians across NYS have been told:**
  - Put the patient at the center of your practice
  - Build medical neighborhoods
  - Cooperate with other physicians instead of competing
- **Public and private payers are doing the same**
  - Rewarding value over volume
- **Need to be sure we're all rowing together**

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Streamlining NYS Transformation Efforts to Reduce Burdens on Physicians and Accelerate Change

NYS initiatives

DSRIP

SIM

NYS payer initiatives

CMS initiatives

CPC+ Comprehensive Primary Care Plus

TCPi Transforming Clinical Practices Initiative

Federal law

Practices & Providers

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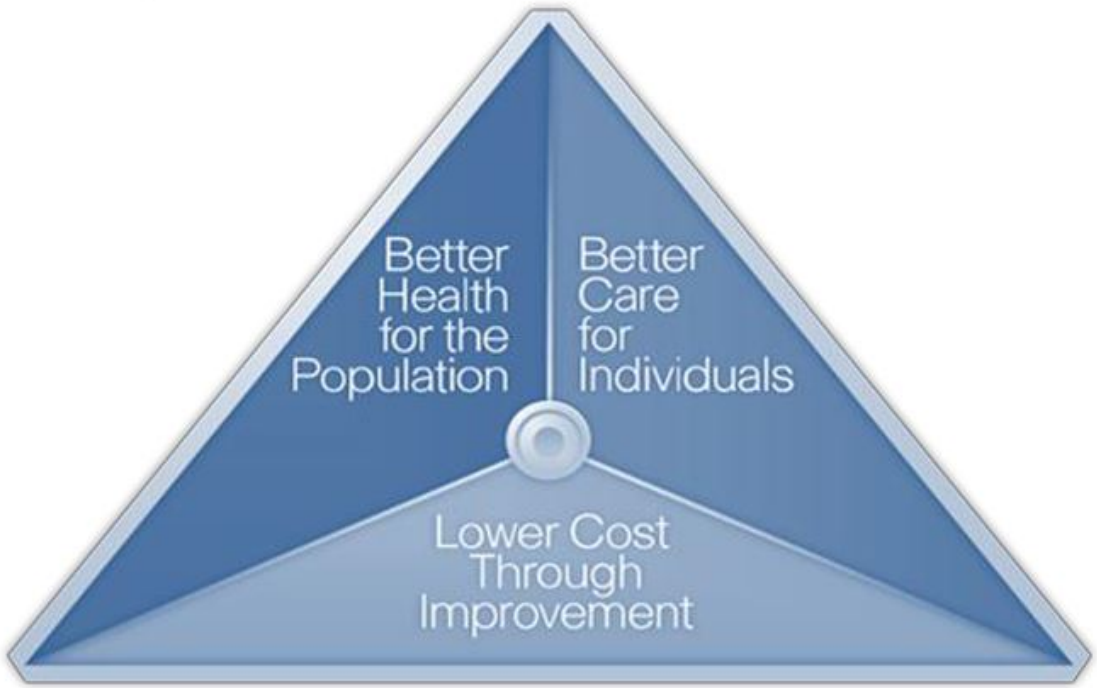
Aligning Multi-Sector Efforts to Achieve the Triple Aim



Medicare Access and CHIP Reauthorization Act (MACRA)

- **Medicare Access and CHIP Reauthorization Act (MACRA)**
  - Legislation implemented through CMS
  - Establishes value based incentives for physicians caring for Medicare beneficiaries
- **MACRA's Quality Payment Program (QPP)**
  - Mandatory for practices serving Medicare beneficiaries
  - Sets quality (and other!) measures practices must adhere to
  - Practices reaching milestones receive positive payment
  - Low performing practices may receive negative payment
- **MACRA's QPP mandates practice transformation**
  - Can accelerate efforts by NYS, payers, and physicians

New Rules for the MACRA Quality Payment Program

Proposed rule change for year 2 of Quality Payment Program (QPP) issued in June 2017

- Changes meant to decrease regulatory burden on providers
- Allow them to “pick their pace” for practice transformation

Rule change affects which practices are required to participate in program

- Could make it harder to engage small practices
- Could decrease overall participation in NYS practice transformation

Could change quality measures and risk that practices must assume

- Scoring could make it harder for high-performing practices to be recognized for improvement
- Set financial risk standards that may be too high for NYS practices to bear

Advocating for Changes that Accelerate NYS Practice Transformation

The Department took a strong stand on proposed changes

- Identified proposed changes likely to have the largest effects on NYS transformation efforts
- Encouraged collaboration between Medicaid and Medicare value-based initiatives to develop public comment
- Full public comment is available here: https://www.regulations.gov/document?D=CMS-2017-0082-1284
- Final rule change will be made public later in the year by CMS

Seeks Recognition of Medicaid & Medicare Value-Based Payment arrangements as Advanced APMs

Practices required to participate in QPP must choose one of two paths

- Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs)
- Advanced APMs allow practices to take on more risk, and to potentially receive a higher incentive payment as compared to MIPS

Advanced APM recognition provides an important incentive to practices that must participate in QPP to adopt State value-based models

- Advanced APM recognition provides more opportunity to encourage practice transformation
- Reduces burden on practices trying to satisfy multiple reporting criteria
- Value add for practices

Benefits of Advanced APMs for NYS Transformation Efforts

- **Advanced APM status:**
  - Supports DSRIP goal to have 80-90% of MMCO payments to be in value-based arrangements by 2020
  - NYS APC would aligns NYS APC with both QPP paths that Medicare practices must choose
  - Makes the NYS value-based payment models more attractive to practices
  - Helps to navigate provider confusion about participating in QPP
- **Aligns NYS Medicaid and Medicare programs with prevailing national standards**
- **Provides technical assistance and additional guidance for practices (especially important for small practices)**

CMS Advanced APM Criteria

CMS Advanced APM Criteria	NYS APC Model	NYS Medicaid Value Based Payment Arrangements
(1) Use Certified Electronic Health Record Technology (CEHRT)	Requires participants to use CEHRT	CEHRT requirements set through MCO and VBP Contractor agreements
(2) Provide payment for covered professional services based on quality measures comparable to those in MIPS	Prescribes payments from engaged payers based on a set of 28 measures aligned with QPP MIPS Quality Improvement categories	Provides payments through Medicaid based on measures aligned with QPP MIPS Quality Improvement categories
(3) Be a Medical Home Model expanded under CMMI **or** require advanced APM entities to bear more than a nominal amount of risk	Is a Medical Home Model expanded under CMMI SIM grant funding	Requires APM entities to bear more than a nominal amount of risk

Proposed rule change would increase the low-volume threshold

- **Excludes practices with less than $90,000 in Part B charges or fewer than 200 Part B beneficiaries from MIPS**
  - Effectively excludes 67% of practices from MIPS
  - Could discourage practices from engaging in practice transformation
  - May affect smaller practices already engaged in practice transformation
- **The Department asked that practices under the threshold be allowed to "opt-in"**
  - Important for transformation progress in smaller practices across NY
  - Small practices already engaged won't be discouraged from continuing to transition to value-based payment arrangements

Proposed Rule Change: Set Risk Standards for Advanced APMS

- **Generally Applicable Nominal Standard Amount:**
  - 8% of the average estimated total Medicare Parts A and B revenues of participating APM Entities, or
  - 3% of the expected expenditures for which an APM Entity is responsible under the APM.
- **All-Payer Combination Option/Other Payer Advanced APM**
  - Marginal risk of at least 30%,
  - Minimum loss rate of no more than 4%,
  - Total potential risk of at least 3% of expected expenditures.
- **Medical home model financial risk standard**
  - Exempts CPC+ participants that the standard only applies to APM entities with fewer than 50 clinicians in their parent organization.

Requests Lower Financial Risk Standards to Support Practice Transformation

- **The Department recognizes that these risk standards too high for many NYS practices and requests:**
  - Generally Applicable Nominal Standard Amount **reduced** by at least half
  - All-Payer Combination Option/Other Payer Advanced APM risk **reduced** by at least half
  - NYS Medicaid & Medicare VBPs **exempted** from requirement that medical home standards only apply Medical home model financial risk standard to APM entities with fewer than 50 clinicians in their parent organization

Proposed Rule Change: Linear Scoring on Quality Measures

- **The Department emphasized the importance of having scoring that recognizes improvement for both high and low performing practices**
  - High-performing practices might be discouraged from continuing to invest in their practices to achieve smaller, incremental, yet vital improvements in quality
  - May be punitive to early adopters of value-based initiatives in NYS
  - May discourage higher investments required to achieve advanced transformation
  - May discourage continuous improvement
  - ***The Department recommend the adoption of logarithmic rather than linear scoring***

Moving Forward

- **The Department will continue to work with CMS, payers, physicians, and other stakeholders to advocate for value-based transformation policies that make NYS a leader in health-care delivery**
  - Support the State Health Innovation Plan (SHIP)
  - Achieve the Triple Aim
  - Bend the cost curve

Caring for our patients is more than pills, potions, and mechanical things that we can do;

We as primary care must stand in front of them, behind them, and beside them.

-EPH, 2014

NY State Innovation Model Evaluation

Kerry Griffin – The New York Academy of Medicine

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New York State Innovation Model (SIM) Evaluation

Presentation to the APC Statewide Steering Committee

September 14, 2017

The New York Academy of Medicine

BACKGROUND

Context and Scope

- Goal: Support effective implementation of NY SIM*
- Mixed Methods: Quantitative and qualitative
- Partnerships: The New York Academy of Medicine and FAIR Health, Inc.

**Objectives are different than those of the federal evaluation*

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Guiding Questions

- What is the value-added of SIM?
- To what extent is NYS meeting its SIM targets?
- How is implementation proceeding?
  - What are the facilitators and barriers?
- What is the level of engagement from different stakeholders?
  - What factors affect engagement?
- What are the most notable successes to date, and the drivers?
- What have been the key challenges?
- Have there been unintended consequences?
- How effectively is SIM addressing population health?
- Are there sufficient and appropriate resources to facilitate health innovation and improvement?

Analytical Approach

Assessing changes in program participation, and related costs, quality, and population health metrics (statewide, regionally, and at practice level)

- Multi-pronged: Evaluating the SIM and its component parts through complementary quantitative and qualitative research methods (including primary and secondary data)
  - Flexible and iterative: responding to program changes as they occur

- Timeframe: pre-SIM period (lookback of three years) through implementation (Nov. 2018)

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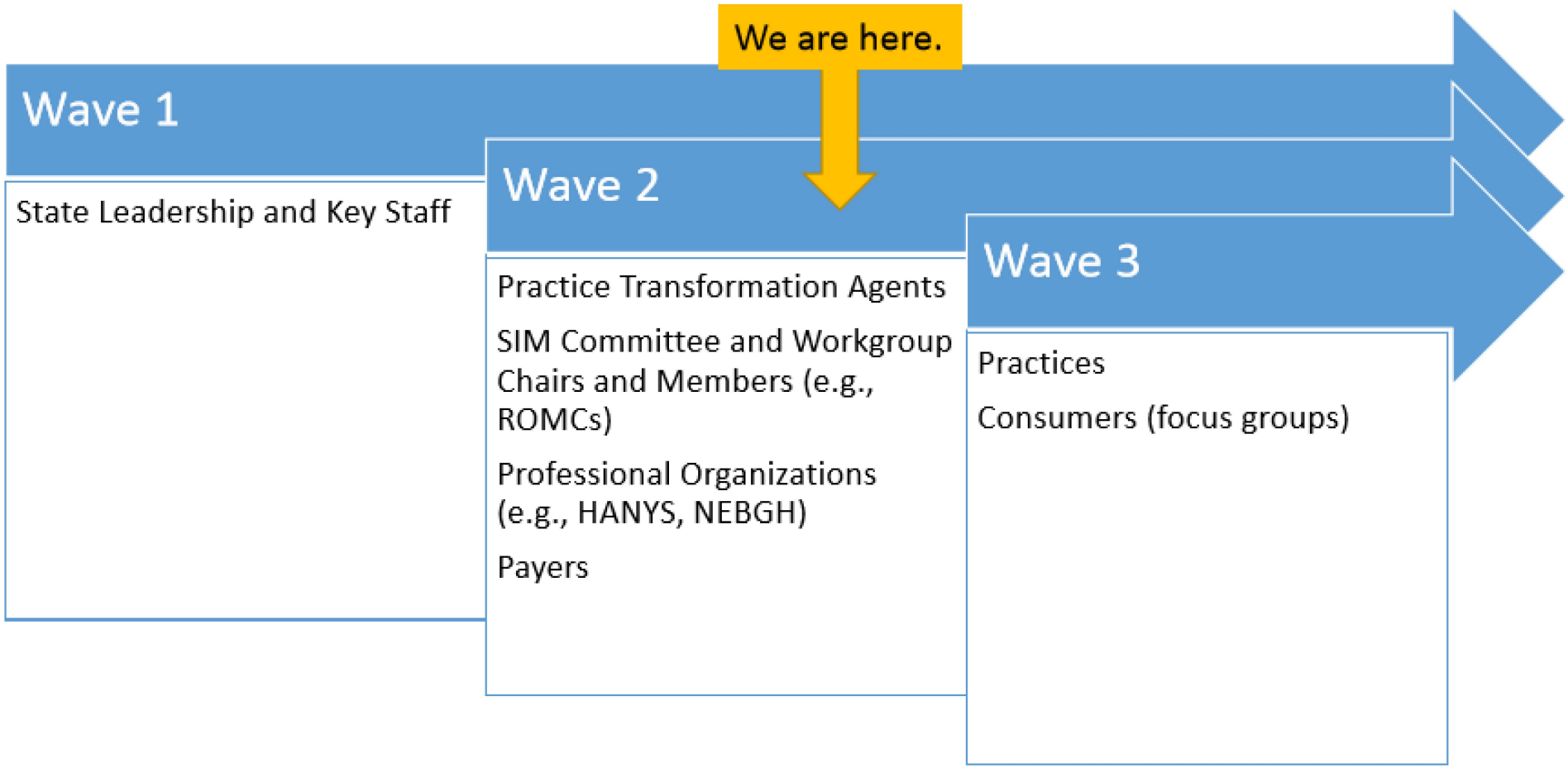
Qualitative Approach and Preliminary Findings

Assessing APC Model Performance & Implementation: Interviews and Focus Groups



Future waves: repeat interviews with stakeholders

Perceptions of SIM Strengths

The majority of interviewees had a positive view of the SIM

- Convened stakeholder groups in a way—and at a level—that had not occurred previously
- APC model is “all payer”
  - Shifts focus to outcomes and value-based payment, in ways PCMH had not
- Regional approach
- Significant progress with respect to workforce initiatives
  - Movement toward an electronic system to survey professionals during licensing renewal
  - Improved understanding of the health care workforce, including gaps by location and profession

Perceptions of SIM Challenges

- Lack of commitment from payers to date
  - Makes the "pitch" to providers very difficult
- Complicated health reform landscape
  - Multiple models for advancing primary care causes confusion
- Additional challenges for providers:
  - How to select
  - How to avoid unintentional "double dipping," (multiple models with overlapping objectives)
- Delays in implementation of APC
  - Attributed to staffing issues at DOH (i.e., turnover, vacancies, sporadic reliance on high-priced consultants)

Result: Timeline and objectives for practice transformation unrealistic; shift in responsibilities

Key Stakeholder Recommendations

- To facilitate more rapid engagement:
  - List of practices to target (with accurate contact information), specifically where multiple transformation agents are working in a specific region and may end up reaching out to the same practices.

- Suggested adaptations to the Practice Transformation Tracking System:
  - State outreach and marketing to include print and electronic materials targeting DSRIP PPS's
  - More (and more usable) information regarding practices to outreach to

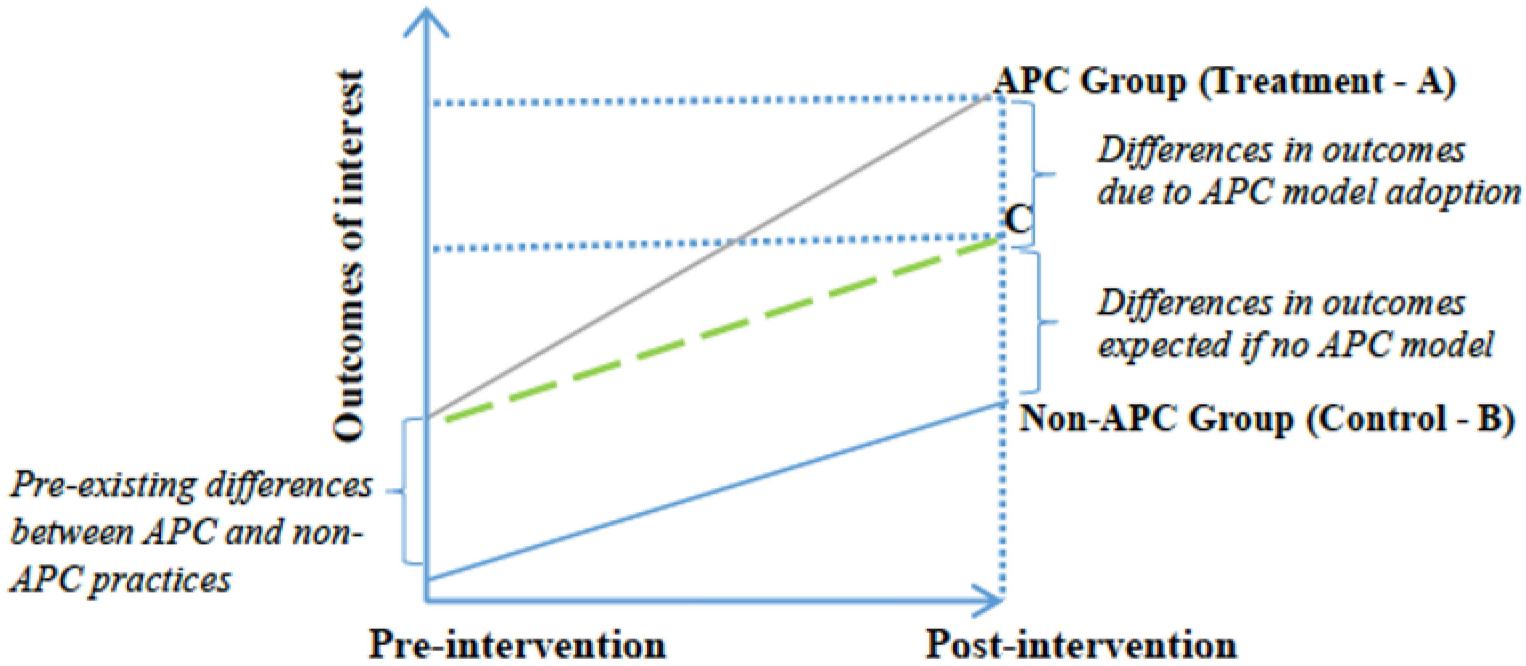
Quantitative Approach and Preliminary Findings

Assessing APC Model Performance & Implementation: Quantitative

- Comparing different levels and stages of APC implementation
  - APC vs. APC-like (e.g., PCMH) vs. control
  - Account for regional roll-out strategy

- Measures of performance
  - Measures calculated from multi-payer data using FAIR Health claims warehouse
    - HCI3 Episode of Care Measures for Chronic Conditions (cost and quality)
    - Total cost of care, hospitalizations, emergency department use
  - APC scorecard measures

Quantitative Analysis: Proposed Approach



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Proposed Metrics

Custom measures for primary care providers calculated from the FAIR Health database, supplemented with Medicare and Medicaid (pending) claims data, including:

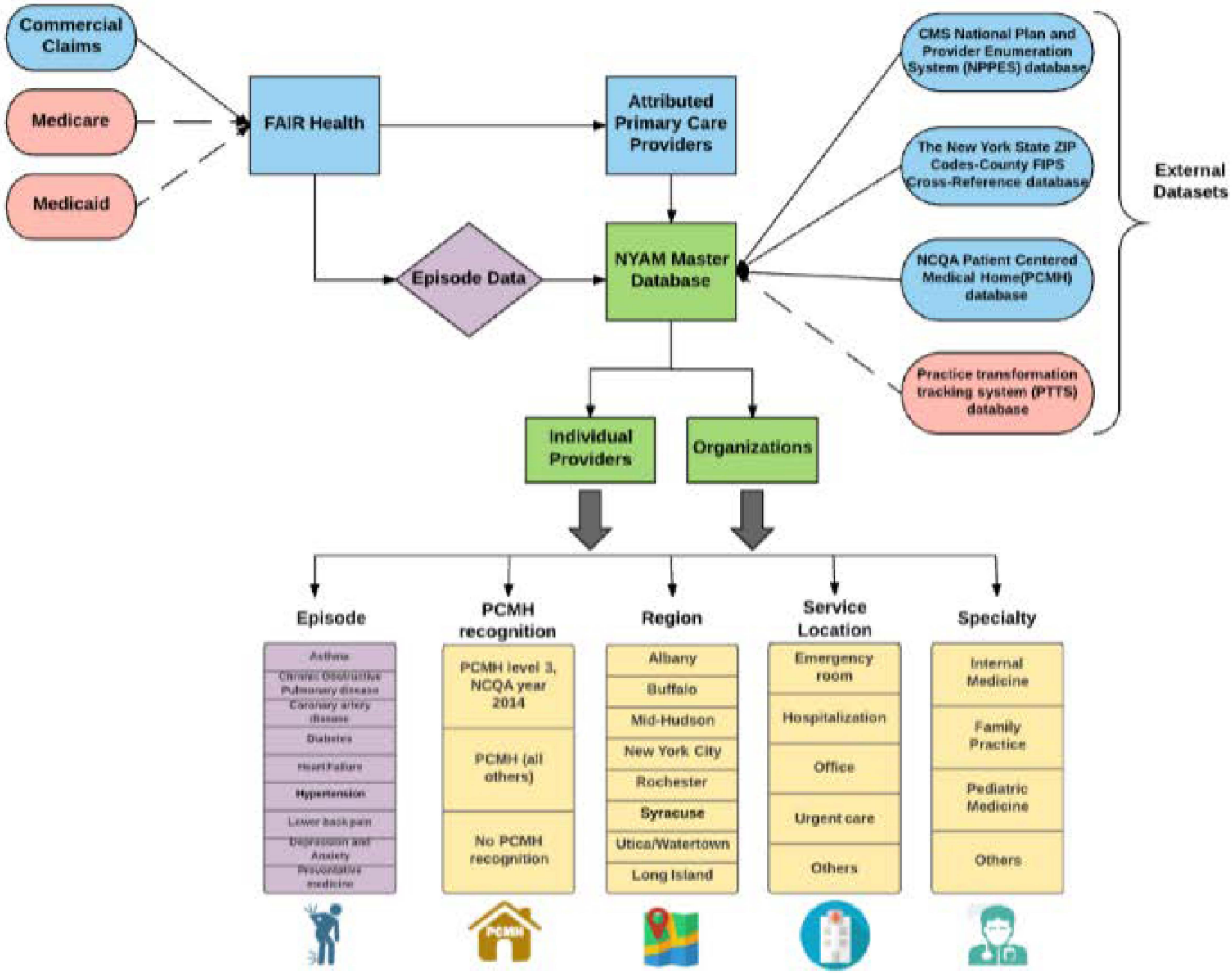
- Total cost of care
- Hospital admissions
- ED utilization
- Primary care utilization

Proposed Metrics (Cont'd)

HCI3 Episodes of Care sensitive to changes in primary care. Each episode measure encompasses cost and quality:

Episode of Care Measure	**Variable Name**	**#**
Asthma	ASTHMA	EC0401
Chronic Obstructive Pulmonary Disease	COPD	EC0402
Coronary Artery Disease	CAD	EC0508
Depression & Anxiety	DEPANX	EC1909
Diabetes	DIAB	EC1001
Heart Failure	HF	EC0521
Hypertension	HTN	EC0511
Low Back Pain	LBP	EC0801
Preventive Care	PREVNT	EX9901

Claims database and analytical approach



Preliminary Findings

	Overall	No PCMH	PCMH LEVEL 3, 2014	All other PCMH
Unique providers & members				
Total # of providers	11,239	7,306	2,347	1,586
Total # of unique members with at least 1 encounter	2,173,335	1,505,566	368,009	299,760
Total # of unique members with at least 1 emergency room visit	106,427	69,817	17,215	19,395
Total # of unique members with at least 1 hospitalization	133,996	97,063.00	20,080	16,853
Healthcare Encounters				
Total # of emergency room visits	249,056	164,074	40,139	44,843
Total # of hospitalizations	941,849	694,643	134,178	113,028
Total # of office visits	19,172,080	13,892,727	2,822,544	2,456,809
Total # of urgent care visits	211,821	145,434	33,262	33,125
***Provider's average encounters per member**				
Average emergency room visits	0.12	0.11	0.12	0.16
Average hospitalizations	0.55	0.64	0.4	0.39
Average office visits	8.79	9.44	7.38	7.91
Average urgent care visits	0.08	0.07	0.08	0.1
****Provider's average charges per member**				
Overall average charges/member	$6,293.22	$7,163.61	$4,482.35	$4,963.53
Average emergency room charges/member	$17.46	$16.26	$18.35	$21.66
Average hospitalization charges/member	$2,261.15	$2,713.91	$1,442.17	$1,387.45
Average office charges/member	$1,586.44	$1,740.43	$1,243.25	$1,384.98
Average urgent care charges/member	$10.03	$9.85	$9.31	$11.96
Average of all other charges/member	$2,418.13	$2,683.15	$1,769.26	$2,157.48

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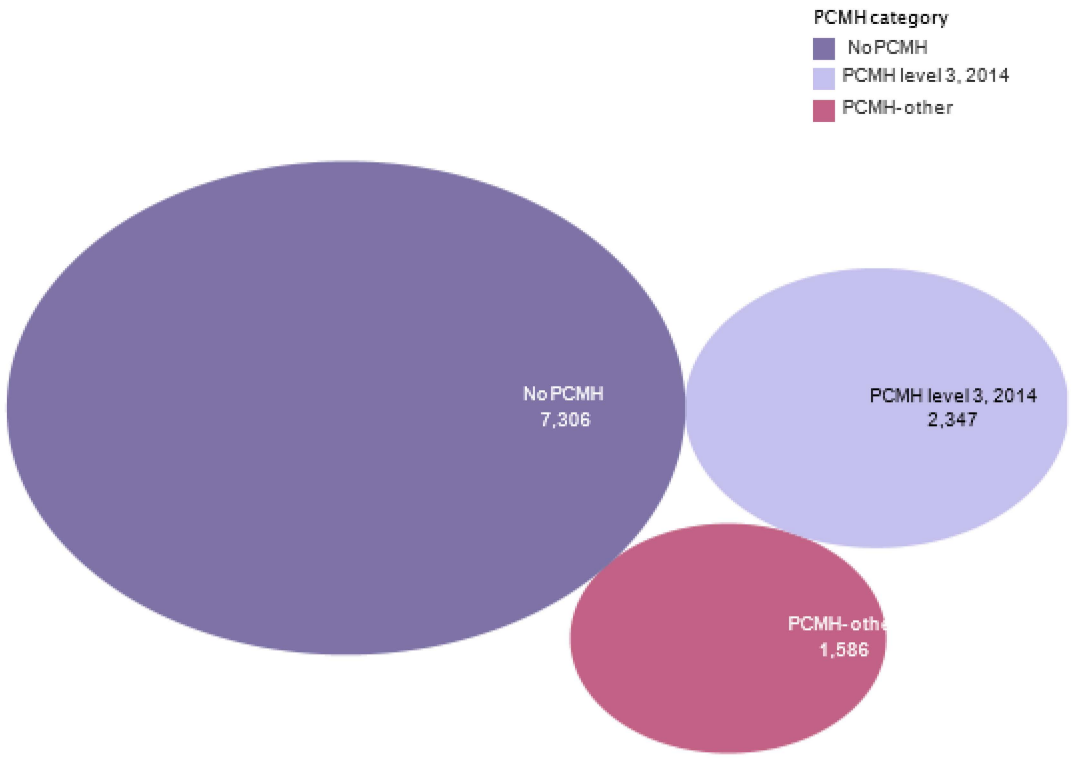
This tables includes all individual providers in New York State for whom data was made available through the Fair Health database for the calendar year 2016.
This table includes data from individual providers only.
*Unweighted average encounters per member for an average provider.
**Unweighted average allowed charges per member for an average provider.

Descriptive statistics for NY State and by region

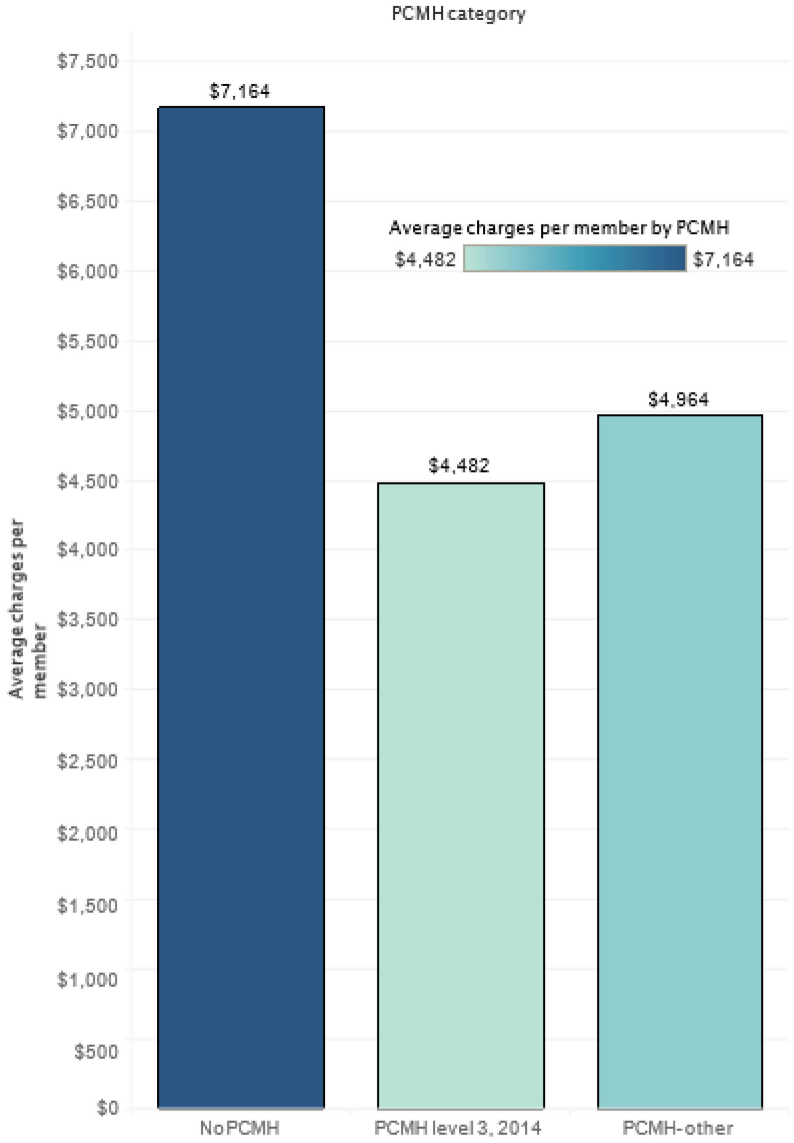
	Overall NY State	Albany Area	Buffalo Area	Mid-Hudson Area	New York City Area	Rochester Area	Syracuse Area	Utica/Watertown Area	Long Island Area
Unique providers and members									
Total number of providers	11,239	754	766	649	4,396	1,090	879	773	1,897
Total number of unique members with at least one encounter	2,173,335	114,475	55,402	135,803	759,458	324,094	245,785	157,810	377,384
Total number of unique members with at least one emergency room visit	106,427	2,176	6,656	1,550	7,242	32,540	29,181	23,055	3,859
Total number of unique members with at least one hospitalization	133,996	6,908	3,294	8,255	50,629	16,001	13,414	8,509	26,723
Healthcare encounters									
Total number of emergency room visits	249,056	5,282	15,597	3,822	17,345	74,132	67,482	55,090	9,932
Total number of hospitalizations	941,849	45,323	21,041	59,339	358,380	90,750	82,112	51,354	231,583
Total number of office visits	19,172,080	896,217	402,038	1,370,856	6,732,890	2,502,761	2,151,696	1,234,671	3,855,626
Total number of urgent care visits	211,821	2,367	5,959	1,204	20,517	69,146	78,139	23,734	10,571
Providers' average encounters per member*									
Average emergency room visits	0.12	0.06	0.29	0.04	0.02	0.28	0.31	0.38	0.03
Average hospitalizations	0.55	0.49	0.39	0.59	0.59	0.31	0.36	0.34	0.86
Average office visits	8.79	7.86	7.40	10.30	8.80	7.32	8.44	7.37	10.80
Average urgent care visits	0.08	0.02	0.10	0.01	0.02	0.20	0.31	0.16	0.03
Providers' average charges per member**									
Overall average charges per member	$6,293.22	$5,165.63	$4,884.21	$6,709.27	$7,092.78	$3,653.96	$4,671.02	$4,959.94	$8,134.55
Average emergency room charges per member	$17.46	$10.10	$46.73	$5.02	$4.21	$40.04	$40.53	$46.78	$8.02
Average hospitalization charges per member	$2,261.15	$1,816.76	$1,640.46	$2,267.58	$2,806.01	$876.09	$1,051.72	$921.82	$3,320.72
Average office charges per member	$1,586.44	$1,132.94	$1,320.36	$1,796.56	$1,737.25	$1,100.39	$1,265.49	$1,033.39	$2,110.57
Average urgent care charges per member	$10.03	$2.96	$12.52	$1.53	$4.08	$24.15	$37.10	$16.34	$5.41
Average of all other charges per member	$2,418.13	$2,202.87	$1,864.14	$2,638.58	$2,541.24	$1,613.29	$2,276.19	$2,941.62	$2,689.82

This tables includes all individual providers in New York State for whom data was made available through the Fair Health database for the calendar year 2016.*Unweighted average encounters per member for an average provider.**Unweighted average allowed charges per member for an average provider.

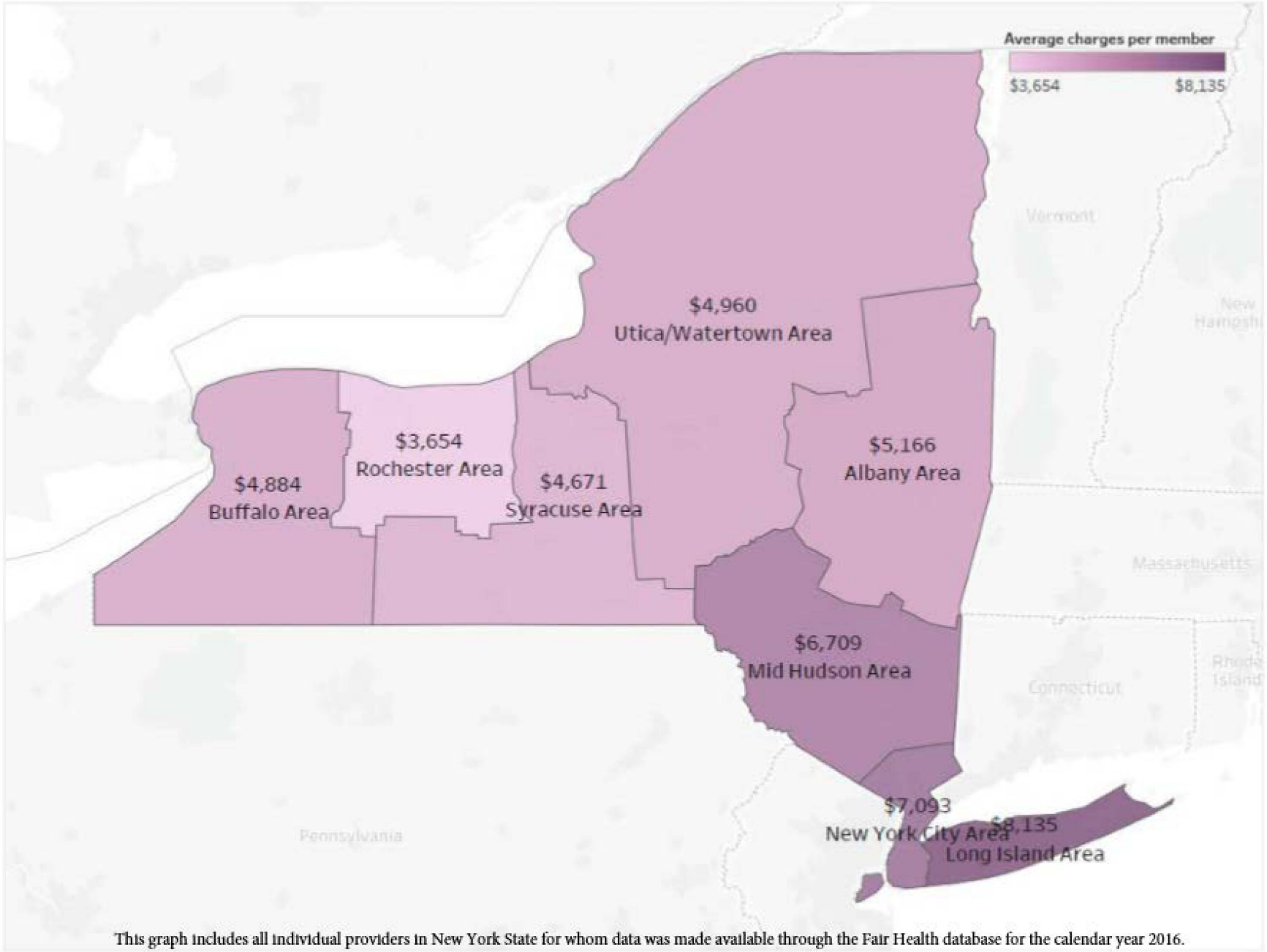
Number of providers in each PCMH category



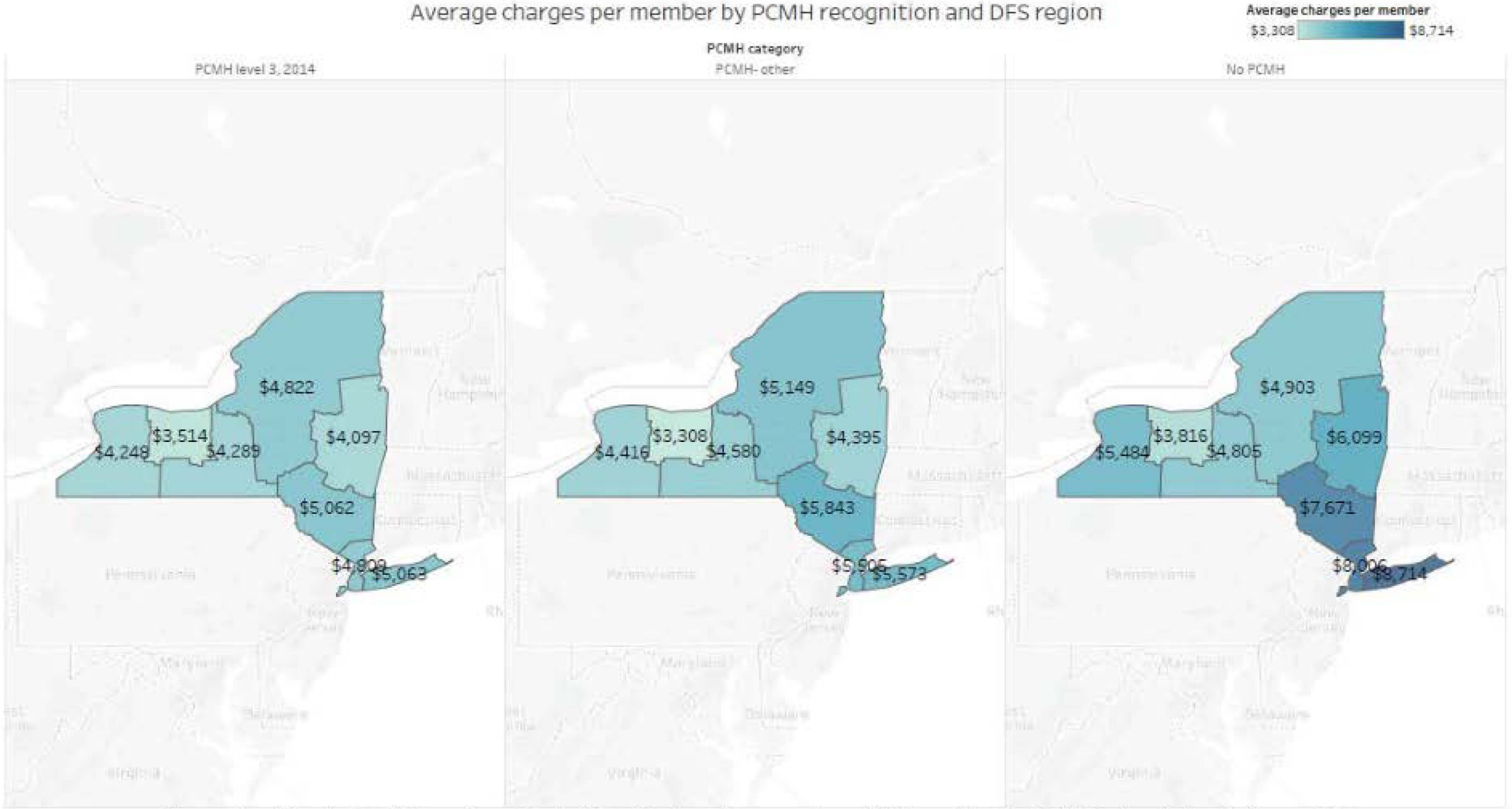
Average charges per member by PCMH category



Average charges per member by DFS region



This graph includes all individual providers in New York State for whom data was made available through the Fair Health database for the calendar year 2016.



This graph includes all individual providers in New York State for whom data was made available through the Fair Health database for the calendar year 2016.

Next Steps and Closing Thoughts

- Focus on generating useful information as SIM is being implemented (vs. seeing if "CMMI SIM program works overall")
- Flexible evaluation strategy as implementation strategy changes over time—responsive to questions as they arise
- Support sustainability planning for NY SIM

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Regional Oversight and Management Committee Progress

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Finger Lakes ROMC Activities

To date

- Two meetings held since the last SSC Meeting (7/11 and 8/14)
- Millennials Consumer Meeting held 8/28
- Shared local ACO's value base support activities for PCPs
- Scheduled Individual Meetings with health plans to discuss opportunities to support and sustain PCP transition to APC

Future activities

- Report back on Millennials focus group feedback
- Discuss the potential to leverage CGCAHPS
- Report back on discussions with insures on opportunities to support and sustain PCP transition to APC
- Analysis of the cost to practices to implement the APC model of care

Seeking the Consumer Voice- Focus Groups

Cornerstone of Primary Care

A Trusted and Caring Relationship with PCP

Compassion, Coordination, Communicate "with me"

Baby Boomers

- Present options in an easy to understand manner
- I am not an invisible voice – communicate with me
- No labeling – be culturally relevant.
- Seeking health care options. Know me and provide relevant options.
- ROMC quality measures resonated with the group but more interested in addressing a trusted and caring relationship

Millennials

- Embrace technology, and welcome its integration into health care services and support.
- Lack of cost transparency is a key concern for accessing services, specially those in high deductible plans.
- Seek health care options. There is a preference for natural vs pharmaceutical remedies. View PCP as needing to be knowledgeable and provide options.
- ROMC quality measures did not resonate with the group.

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NYC ROMC Update

How is NYC different?

- Physician practices
- Area covered
- National versus regional payers
- Facilitator transition

Activity focused on meeting with health plans with goal of bringing back a concrete offer to practices

- Health plans have been engaged and responsive
- All-health plan meetings and one-on-ones

Progress to Date

- Payment Models
  - Focus on PCPs who currently don't have "accountable payment" contracts with health plans
  - Unified payment approach across payers is unlikely. Meet plans "where they are"
- Practice path to transformation
  - Limit program to practices who need transformation
  - NYS PCMH will be the pathway to payment and recognition
- Quality Measures
  - Agreement to work towards a common set of metrics
  - Create crosswalk of current health plan measure sets
  - Where does NYC want to focus?

Still Ahead

- Agree on core measure set
  - Create crosswalk of current health plan measure sets
  - Where does NYC want to focus?
- Agree on payment model for each plan
- Identify practices
  - Who is eligible?
  - Where do plans want to focus?

Capital Hudson ROMC

- As of last update to APC Steering Committee, ROMC was about to embark on a quality measure alignment discussion
- Payers commandeered that June 14 meeting (in a good way) and started a good faith discussion regarding a voluntary multi-payer APC payment model targeted at small practices in region
- Payers met three times in July and August to flesh out this concept
- Next payer meeting is September 14 prior to APC Steering Committee

Draft Concept

To support small primary care practices achieve transformation and improve outcomes, Capital-Hudson region payers are exploring a voluntary multi-payer collaboration to achieve high-level alignment on an APC payment model.

Key attributes:

- Voluntary multi-payer effort
- Targeting small primary care practices with only one to two sites
- Focus on high-level alignment of payment model, but not requiring uniformity
- Anti-trust protection with state supervision
- Use/prefer APC core measures for payment, and utilize IPRO created APC scorecard to monitor progress of small practices

Closing Remarks & Next Meeting