Patient-Centered Medical Home & Delivery System Reform Incentive Payment Program Alignment

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Agenda

Overview of Programs

Shared Goals of PCMH & DSRIP

Resources

Q&A
Why PCMH & DSRIP

Volume
Provider
Practice
System
Value

MU
PCMH
DSRIP

PCMH
DSRIP
Meaningful Use: *Provider* Transformation

**Documentation**
- Record patient demographics, vital signs, problem lists, medications
- Use consistent variables across practices
- Practice workflows for decision support

**Patient engagement**
- Share visit summaries
- Provide electronic access
- Provide patient-specific education materials

**Care coordination**
- Medication reconciliation
- Clinical data exchange
- Patient summaries at transitions of care

2016 is the last year to begin the Medicaid MU program & receive $21,250 for “AIU”

For more information, please visit: www.nycreach.org
Patient-Centered Medical Home (PCMH)

- PCMH Pillars
  - Comprehensive
  - Coordinated
  - Accessible
  - Quality and safety

- Recognition awarded to practices by (NCQA) National Committee for Quality Assurance

- New York State Medicaid reimburses Primary Care Providers

Patient-Centered Specialty Practice (PCSP)
## Potential Yearly Earnings for Primary Care Practices

<table>
<thead>
<tr>
<th># of Medicaid Managed Care Patients</th>
<th>NCQA Level 3 Earnings</th>
</tr>
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<tbody>
<tr>
<td>1000</td>
<td>$72,000</td>
</tr>
<tr>
<td>2000</td>
<td>$144,000</td>
</tr>
<tr>
<td>3000</td>
<td>$216,000</td>
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Medicare Chronic Care Management (CCM)

Medicare pays Per Member Per Month for 20 minutes of non face-to-face care
Transformation to PCMH positions a practice to successfully provide CCM and vice versa

PCMH in Medicare MACRA/MIPS

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing care information

- Comes from PQRS
- Comes from Value Modifier
- New category
- Comes from Meaningful Use EHR incentive

Earn “full credit” in this category for Patient-Centered Medical Home
Standard 1: Patient-Centered Access

Standard 2: Team-Based Care

Standard 3: Population Health Management

Standard 4: Care Management & Support

Standard 5: Care Coordination & Care Transitions

Standard 6: Performance Measurement & Quality Improvement
Role of Community Based Organizations in PCMH

PCMH 2014 Standard 4, Element E: Support Self-Care & Shared Decision Making
The practice supports patients/families/caregivers in self-management and shared decision making:

1. Uses an EHR to identify patient-specific education resources and provide to > 10%
2. Provides educational materials and resources to patients
3. Provides self-management tools to record self-care results
4. Adopts shared decision making aids
5. **Offers or refers patients to structured health education programs**
6. **Maintains a current resource list on five topics or key community service areas**
7. **Assesses usefulness of identified community resources**

Role of Specialists in PCMH

PCMH 2014 Standard 5, Element B: Referral Tracking and Follow-up

1. Considers available performance information on specialists when making referrals
2. Maintains formal/informal agreements with specialists based on established criteria
3. Maintains agreements with behavioral healthcare providers
4. Integrates behavioral healthcare providers within the practice site
5. Gives the consultant/specialist the clinical question, timing and the type of referral
6. Gives the consultant/specialist demographic and clinical data, test results and care plan
7. Has capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for >50% or >10% of referrals
8. Tracks referrals until the consultant/specialist’s report is available, flagging and following up on overdue reports
9. Documents co-management arrangements in the patient’s medical record
10. Asks patients/families about self-referrals and requesting reports from clinicians

DSRIP: System Transformation

Delivery System Reform Incentive Payment (DSRIP)
Attribute geographic populations to Performing Provider Systems (PPS) for care management and coordination across the care continuum.

Timeline: 2014 - 2020

Goals:
• Reduce avoidable hospitalizations by 25% over 5 years
• Transform the Medicaid delivery system to be value-based
• Promote community-level collaboration
• Improve population health

Who: 11 PPSs in NYC, 25 total in NYS, mostly led by hospitals

How: System Integration, Clinical Improvement, and Population Health projects based on Community Needs Assessment

For more information, please visit: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/
## Agenda

- Overview of Programs
- Shared Goals of PCMH & DSRIP
- Resources
- Q&A
PCMH as a Framework for DSRIP: Shared Goals

**PCMH**
- Practice level improvements
- Private accreditation program
- Implemented by NCQA

**DSRIP**
- System level improvements
- State program
- Implemented by NYS Medicaid Redesign Team

- Reduce costs
- Comprehensive approach
- Reduce avoidable hospitalizations
- Minimize fragmentation
- Better coordination between providers
- Incentives
## PCMH & DSRIP Alignment Examples

<table>
<thead>
<tr>
<th>PCMH Standard</th>
<th>DSRIP Project</th>
<th>Description</th>
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</table>
| 1A            | 2.a.i         | **PCMH:** The practice incorporates same-day appointments, extended hours and alternative types of clinical encounters  
**DSRIP:** Create an Integrated Delivery System: Getting Timely Appointments, Care and information |
| 4A            | 3.c.i         | **PCMH:** The practice establishes a systematic process and criteria for identifying patients who may benefit from care management, including those with chronic disease  
**DSRIP:** Chronic care management: Managing patients with diabetes |
| 5B            | 3.a.i         | **PCMH:** The practice maintains agreements with specialists and behavioral healthcare providers, and documents co-management arrangements  
**DSRIP:** Increase coordination between behavioral health and primary care |
PCMH & DSRIP Alignment Examples

PCMH is *required* in many DSRIP projects
2.a.i – v, 2.b.i – iii
3.a.i, 3.b.i, 3.c.i, 3.e.i, 3.f.i, etc.

**PPS Primary Care Providers**

must achieve NCQA PCMH 2014 Level 3 recognition by March 31, 2018.
Adopt PCMH Early

DSRIP Performance

PCMH Recognized

2016 2017 2018 2019 2020

PCMH Recognized

PERFORMANCE & INCENTIVES

Incentives

NYC REACH
Regional Electronic Adoption Center for Health
PCMH and Other Programs

Meaningful Use
PCMH Standards overlap with Meaningful Use

SHIP/SIM
PCMH is a gateway to Advanced Primary Care

Accountable Care Organizations
PCMH is a framework for ACO practices

DSRIP
PCMH is required

Patient Centered Medical Home
Overview of Programs

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Resources

**DSRIP**
- NYS Department of Health DSRIP information: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/
- NYP PPS: http://www.nyp.org/pps

**PCMH**

**Meaningful Use**
- NYC REACH: www.nycreach.org
Thank you!

Q&A