COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Care Delivery and Payment System Transformation Committee

January 13, 2015

Agenda

- PCMH certification: Modifications to NCQA standards
- PCMH certification: NCQA contract
- ACO Certification: Discussion on key design questions

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- **PCMH certification: Modifications to NCQA standards**
- PCMH certification: NCQA contract
- ACO Certification: Discussion on key design questions

HPC modifications to NCQA PCMH standards focus on Behavioral Health, Resource Stewardship, Population Health and Patient Experience

Examples of modifications (*non exhaustive)**

Behavioral Health

- Additional requirement for **screening for anxiety and substance abuse disorders**
- Added a new factor that requires practices to **annually assess effectiveness of BH partners**

Resource Stewardship

- Enhanced standards that require practices to **measure, assess, and improve utilization measures:**
  - NCQA standards require improvement on only one utilization measure.
  - HPC standards enhance this requirement to 2 and 4 measures for 'Qualified PCMHs' and 'Best Practice' PCMHs respectively

Population Health Management

- **Enhanced immunization standards**, requiring practices to attain certain rates of vaccination/immunization for particular patient groups
- Require **comprehensive health assessment** for all patients on a periodic basis
- Require **managing care transitions**
- Require establishing a **systematic process** and criteria for **identifying high risk patients** that can benefit from care management

Patient Experience

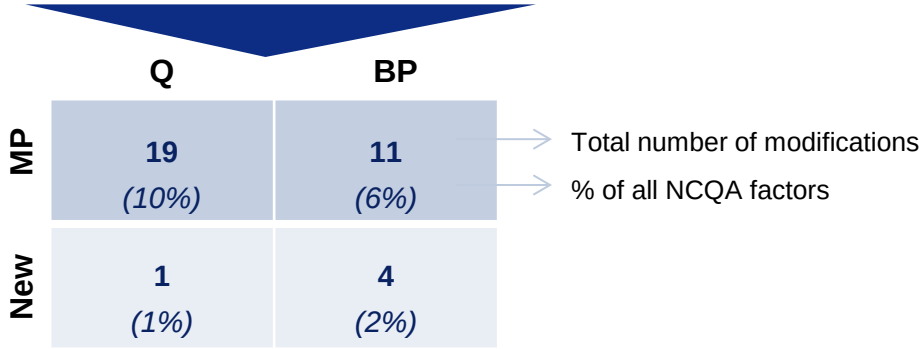
- Require practices to **obtain feedback from patients/families regarding their experience** and satisfaction with care and incorporate results into improvement activities. Attention to vulnerable populations is also required

*** Please refer to Appendix B for complete list of modifications HPC plans to make to existing NCQA PCMH standards**

Overall, HPC certification will require low degree of modifications to existing NCQA criteria

Total number of modifications

	Qualified PCMHs				Best Practice PCMHs only			
	BH	***RS***	***PE***	***PHM***	***BH***	***RS***	***PE***	***PHM***
Existing factors								
2011 factor → HPC MP factor	4	1	3	6***	0	0	1	3
2011 Critical Factor (or part of MP element) → HPC MP factor	3*	0	0	0	0	1	1	0
2014 only → HPC MP factor	0	0	0	0	0	0	0	1
2011 enhanced → HPC MP factor	0	0	0	0	0	0	0	0
2014 enhanced → HPC MP factor	0	2	0	1	0	3	0	1
New Factors								
Part of 2014 NCQA	2**	0	0	0	0	0	0	0
Not part of 2014 NCQA	0	0	0	0	4	0	0	0



* 1 factor would be must-pass as part of HPC modifications for the population health management domain

** 1 factor would be new as part of HPC modifications for the population health management and resource stewardship domains

*** Includes a "modified scoring" factor (Element 5C, factors 1-4 allot double points)

For discussion: Using MHQP data for patient experience

Current State

- Some practices already use the MHQP Patient Experience Survey (collected and refreshed annually) to satisfy the NCQA patient satisfaction standard (6.C.)
- NCQA accepts MHQP results as sufficient evidence only if the MHQP sample represents at least 90% of its patient population

Concerns

- MHQP **currently collects data from commercial plans only** (anticipates capturing additional payer types by 2016)
- Any provider with **significant Medicare and MassHealth volume cannot use MHQP survey** to satisfy NCQA requirement

Considerations

- **Should HPC consider standardizing patient experience measurement for PCMHs in MA through the use of a single patient experience measurement tool (MHQP or some other tool)?**

Agenda

- PCMH certification: Modifications to NCQA standards
- **PCMH certification: NCQA contract**
- ACO Certification: Discussion on key design questions

NCQA is uniquely qualified to partner with the HPC on the Patient-Centered Medical Home Certification Program

Chapter 224

- Chapter 224 directs the HPC to partner with an accrediting organization in developing PCMH standards and **specifically references the existing standards by the National Committee for Quality Assurance** (NCQA)

Qualifications

- NCQA is the most widespread PCMH recognition tool used in Massachusetts
  - More than 1,800 clinicians in 215 practice sites are **already NCQA PCMH recognized**
  - 135 practices in process of becoming NCQA PCMH recognized
  - EOHHS PCMH Initiative required NCQA recognition
- Approximately 15% of all PCPs nationwide deliver care in an NCQA-recognized PCMH
- NCQA has **expertise, IT platform, and training infrastructure** readily available

Alignment with HPC

- NCQA's standards and requirements are **closely aligned** with the goals of the HPC's PCMH certification program
  - Limited additional HPC-specific requirements
  - Only streamlined "upgrade" process will be required for practices already NCQA-recognized, reducing administrative burden and cost

Value

- NCQA will review HPC-specific elements with **no additional cost**
- **20% government discount**
- Customized technical assistance available

For discussion: NCQA – HPC contract

Costs to the HPC

Content Development

- Consulting support for **modifying** existing NCQA standards and **developing new requirements** specific to Massachusetts
- Consulting support to determine the best method by which modifications will be incorporated into the certification process and how **compliance** with new requirements will be assessed

Program Implementation

- Configuration of existing data systems (Interactive Survey System) to meet new HPC requirements
- Training of reviewers on the new HPC requirements
- Creation of a customized "upgrade" process for currently certified practices that will streamline the transition to the 2014 NCQA/HPC standards

Training &Technical Support

- **4 in-person training** sessions (1.5 days each, focused on currently non-certified practices)
- **6 webinars** (2-3 hours each), focused on practices currently certified
- **Phone/email support** for practices to receive guidance and support

- **~185K for 1st year**
- **~100K for subsequent years**

Costs to practices

- Reviews for NCQA and MA-specific requirements can be accomplished under NCQA's **standard fee schedule**
  - Full fee for new practices
  - Upgrade fee for existing practices *[single upgrade fee from 2011 to HPC standards]*

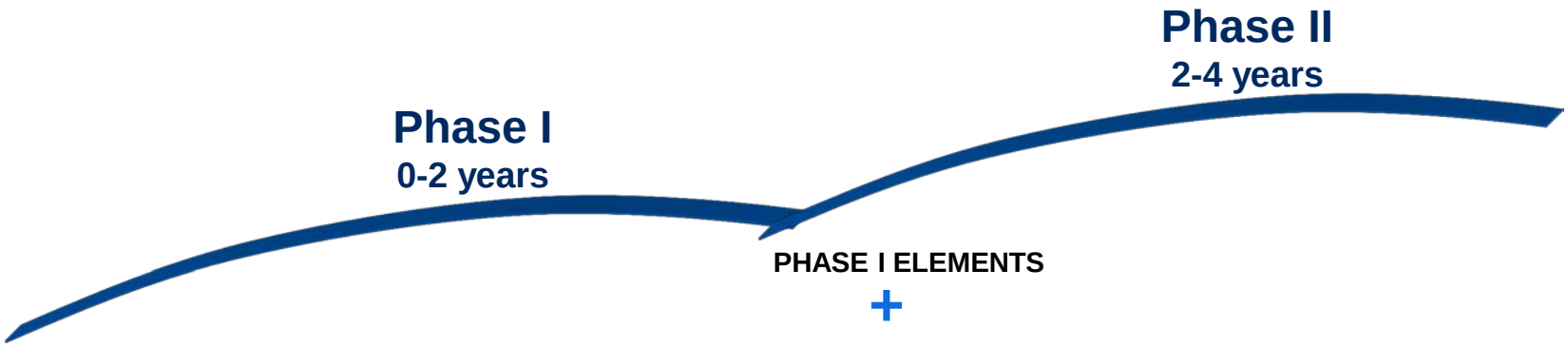
Costs will be based on volume of practices

Source: NCQA estimates

Vote: Endorsement of Proceeding with Contract with NCQA

Motion: That the Care Delivery and Payment System Transformation Committee hereby endorses staff's recommendation to **advance discussions with the National Committee for Quality Assurance (NCQA) to further define potential contract elements** in support of the Patient-Centered Medical Home certification program and recommends that the Commission authorize **proceeding with a contract, including a notice of intent to contract with the NCQA, at the next Commission meeting, on Jan 20, 2015**.

Additional program elements are critical for overall success of the PCMH program; to be discussed at the next CDPST meeting



Certification Criteria

Phase I

- **NCQA Core Criteria**
  - Patient Centered Access
  - Team Based Care
  - Population Health Management
  - Care Management& Support
  - Care Coordination & Care Transitions
  - Performance Measurement & Quality Improvement
- **Modifications for Behavioral Health, Resource Stewardship, Population Health Management and Patient Engagement**

Phase II

PHASE I ELEMENTS

+

- **Advanced Population Health** (with focus on geographic level population health)
- **Advanced Behavioral Health**
- **Advanced Resource Stewardship** (broad set of efficiency measures practices need to meet)
- **Patient-Centered Specialty Certification**

Additional Program Elements

- **Technical Assistance (BH funds + priority status for other state agency funds)**
- **Simple provider reports**
- **Consumer education / PR**
- **Payment Incentives**
- **PCMH capabilities foundational for ACO certification**
- **Payment Incentives**
- **Consumer Incentives**
- **CHIA Provider Portal**

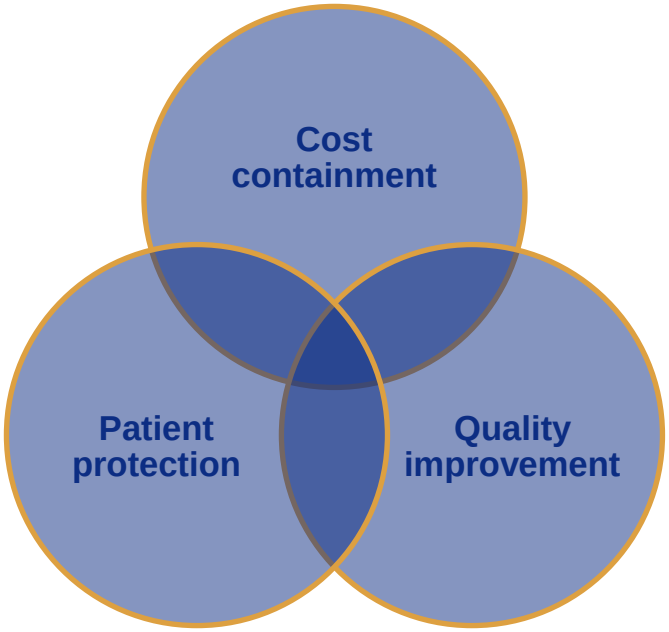
Agenda

- PCMH certification: Modifications to NCQA standards
- PCMH certification: NCQA contract
- **ACO Certification: Discussion on key design questions**

Goals for today's ACO discussion

- Review HPC's **statutory mandate** on ACO certification
- Discuss HPC's **goals** for the ACO certification program
- Discuss certification **approach (outcome vs. capability based)**
- Discuss **framework of functional domains** for ACO certification
- Review **approaches from other state and commercial programs** for each functional domain
- Deliberate over **points of emphasis** for HPC's ACO certification program

Ch. 224 links ACO certification to 3 overarching priorities, and specifies 15 related sub-goals that certification criteria should incentivize



- Reduce growth of health status adjusted **total expenses**
- Improve **quality** of health services using **standardized measures**
- Ensure **access** across care continuum
- Promote **APMs & incentives** to drive quality & care coordination
- Improve **primary care** services
- Improve access for **vulnerable populations**
- Promote **integration of BH services** into primary care
- Promote **patient-centeredness**
- Promote **HIT** uptake
- Promote demonstration of **care coordination & disease mgmt.**
- Promote **protocols for provider integration**
- Promote **community based wellness** programs
- Promote health of **children**
- Promote **worker training** programs
- Adopt **governance structure standards**, including those related to financial COI & transparency

There is considerable ACO/ global risk contract activity in MA; however, comparison across contracts/care models is not feasible due to variability in contract elements

Not exhaustive, based on best available information

	Pioneer	MSSP	Commercial *
Physician only			
Accountable Care Clinical Services		X	
ACO of New England		X	
Acton Medical Associates			X
Atrius Health	X		X
BIDCO/BIDPO	X	X	X
Cape Cod Health Network		X	
Circle Health Alliance		X	
Coastal Medical		X	
Collaborative Health		X	
Harbor Medical Associates		X	
MACIPA	X		X
Physicians of Cape Cod		X	
Saint Vincent Medical Group			X
Southcoast ACO		X	
Hospital only			
Boston Medical Center		X	X
Children's Hospital Boston			X
Mount Auburn Hospital			X
Signature Healthcare Brockton Hospital			X
Sturdy Memorial Hospital			X
Integrated physician-hospital systems			
Baystate Health		X	X
Lahey Health		X	X
Lowell General PHO and Lowell General Hospital			X
NEQCA and Tufts Medical Center		X	X
Partners HS	X		X
Steward HS	X		X
South Shore PHO and South Shore Hospital			X
UMass Memorial ACO, Inc.		X	X

* as of 2012

Source: CMS, MA select commercial payers

Goals for the ACO certification program should be clearly linked to priority areas identified by Ch. 224 and the HPC

FOR DISCUSSION

	Proposed goals: HPC's ACO certification program should:
Fostering a value based market	• Establish **minimum standards** for high quality and efficient care, **to support and promote value based insurance design** • Promote models of provider integration that **support a competitive marketplace**
Promoting an efficient, high quality health care delivery system	• Promote excellence in **identifying population health needs** and implementing **integrated** care delivery models that support those needs, supported by **evidence-based practice guidelines**
Advancing aligned financial incentives and accountability	• Promote adoption of payment models and provider funds flows that provide **sufficient incentive to change provider behavior** to improve quality and efficiency • Establish a **pathway for increased accountability** for quality, cost and patient experience over time
Enhancing transparency	• Promote reliable, standardized, better integrated and progressively more sophisticated **performance measurement and public reporting at the aggregate and individual provider level**, as appropriate
Enhancing patient protection and engagement	• Ensure **patient access** to health care services across the care continuum • Improve access to and quality of health care services for **vulnerable populations**

Principles and process for developing ACO certification standards

Principles

ACO certification standards will:

- **Maintain flexibility** for market innovation while ensuring minimum standards for an efficient and high quality care delivery system
- Be **evidence-based**
- Minimize unnecessary administrative burden on providers

Process

Standards will be determined and refined based on input gathered from:

- MA providers, payers, and consumer advocacy groups
- National and regional subject matter experts
- Other state ACO programs

Most state certification/Medicaid programs are based on capabilities and quality measures; initial experimentation with select outcome measures ongoing in New York and Texas

Eligibility / payment based on:	
No ACO activity	▪ Rhode Island ▪ Pennsylvania ▪ Michigan ▪ Ohio
Capabilities only	▪ Colorado ▪ Illinois
Capabilities Quality measures	▪ Minnesota ▪ Maine
• Capabilities • Quality measures • Reporting on utilization / outcome measures	▪ Oregon ▪ New Jersey
• Capabilities • Select outcome measures (PPEs)	▪ New York ▪ Texas

Certification would ideally be based on statewide agreed upon outcome measures and benchmarks; however, this is not feasible in the short term

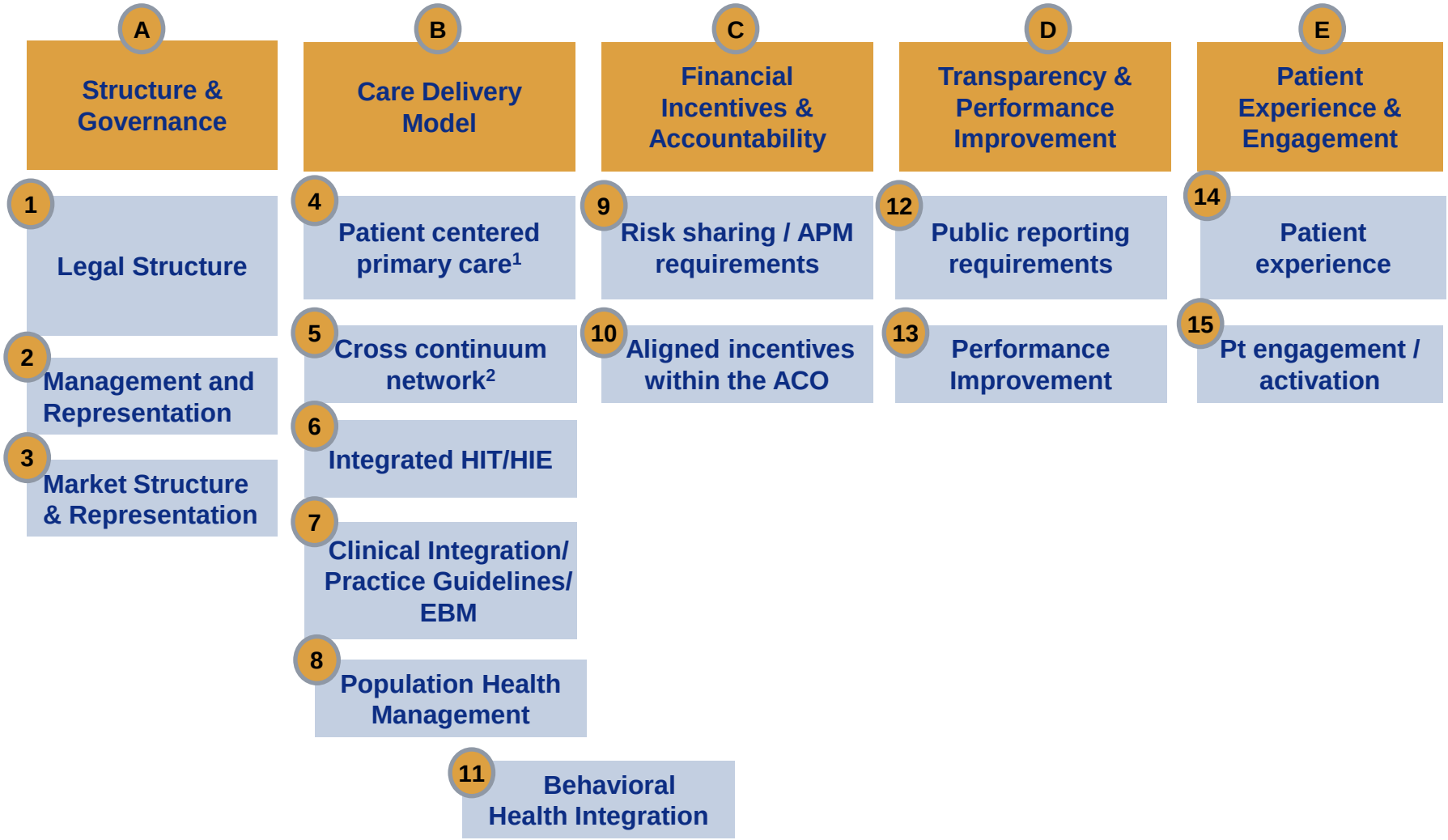
	Description	Feasibility
Certification based on holistic outcome measures	**Certification to include requirements for meeting an agreed upon threshold for:** • Growth in **Total Health Cost Expenditures** • **Quality** measures established by the SQAC • **Patient centeredness/activation**	**Currently not feasible:** • No market agreement on THCE calculation methodology using APCD, time lag associated with APCD • Statewide quality and patient centeredness measurement have significant limitations
Certification based on select outcome measures	**Certification based on meeting specific thresholds on select outcome measures (**e.g., ambulatory sensitive ED visits, potentially preventable readmissions)	**Currently not feasible:** • Proprietary methods exist for select measures (e.g., 3M PPE methodology)[1] • APCD, other data sources (e.g., MHDC, ED outpatient data set) have significant limitations
Certification based on capabilities	**Certification based on capabilities linked to 'intermediate goals' established by the HPC:** • Fostering a value based market • Promoting an efficient, high quality health care delivery system • Advancing APMs • Enhancing transparency • Ensuring patient protection	**Feasible**

Recommendation

- HPC's ACO certification program should be based on capabilities initially, supplemented with the use of select outcome measures for reporting purposes only
- Over time, in 2-4 years, HPC should aim to certify based on agreed upon outcome metrics

[1] Currently being used in New York and Texas Medicaid programs

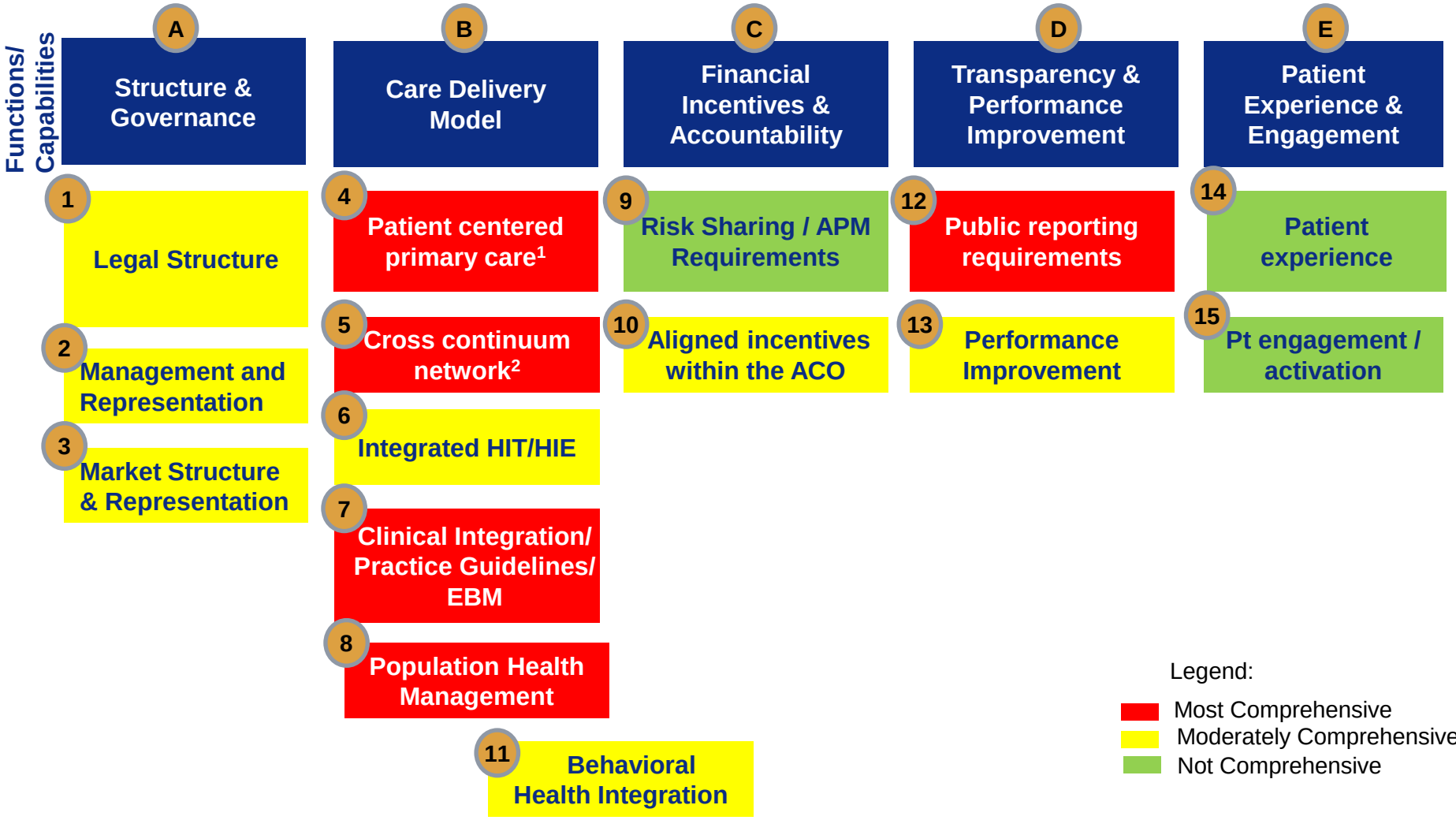
Required functions and capabilities can be categorized across 5 domains, each of which is tightly linked to identified goals



[1] Closely aligned with HPC PCMH requirements

[2] Includes community-based medical and non-medical services

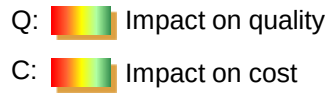
Commercial and state ACO models tend to be most comprehensive with regard to care delivery and transparency requirements

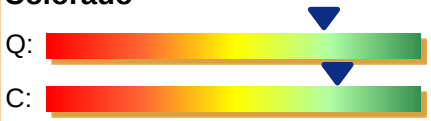
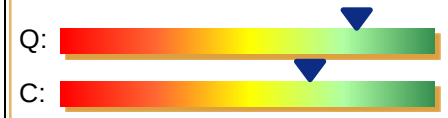


[1] Closely aligned with HPC PCMH requirements

[2] Includes community-based medical and non-medical services

Quality and cost performance data on state ACO programs are limited; outcomes published by more comprehensive ACO programs appear promising*



Less Comprehensive	Moderately Comprehensive	More Comprehensive
New Jersey No results at this time	**Colorado**  **Vermont** No results at this time **Maine** No results at this time	**Minnesota**  **Oregon** 

Source: Literature, State/CMS Reports

* Most states have yet to publish data on Quality or Cost Performance measures. Programs are either still in their 'reporting only' phase, or have yet to publish data

Discussion questions

- What specific points of emphasis should HPC have for the MA ACO certification program?
- How comprehensive should HPC's ACO certification standards be across each of the 15 domains?
- What additional programmatic elements would best enhance HPC's capability to deliver on intended outcomes?

Contact Information

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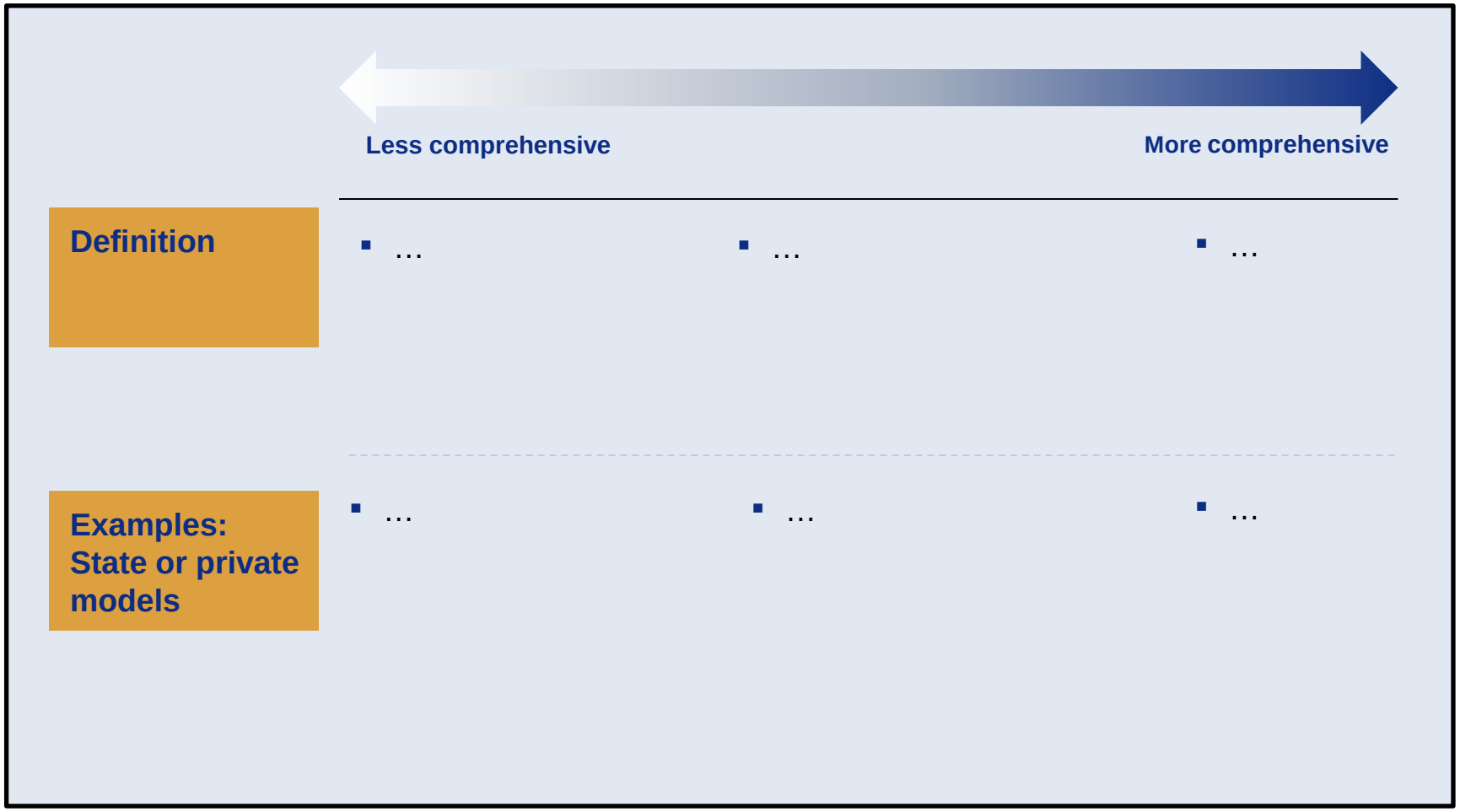
Appendix A:

Definition of ACO capabilities and evidence from other state and commercial ACO models

For each capability, requirements can be more or less comprehensive, based on available evidence from other states and commercial ACOs

Proposed template to help formulate certification standards



A 1 Legal Structure

Less comprehensive → More comprehensive

	Less comprehensive		More comprehensive
Definition Legal entity Lead entity	▪ No/Limited requirements	▪ Specific requirements regarding lead entity	▪ Must be a separate legal entity
Examples: State or private models	▪ **Maine** – Not required to form a new legal or financial entity – Must designate a legal Lead Entity to contract	▪ **Minnesota** – Not required to form a new legal or financial entity – Must be provider led ▪ **Illinois** – Must be provider led – Must have lead entity that has legal responsibility for the ACO	▪ **New Jersey** – Must be registered as a separate non-profit entity ▪ **New York** – Must be a separate legal entity only if it is formed among multiple independent ACO participants – Must be comprised of clinically integrated independent health care providers

[1] Based on comparison between 2011 OR baseline and National Medicaid benchmarks.

A 2 Management and Representation

Less comprehensive → More comprehensive

Definition
Representation and management requirements

- No/Limited requirements
- Specific requirements regarding representation
- Some guidance regarding leadership/management structure
- Specific requirements regarding representation
- Specific guidelines regarding leadership/management structure

Examples: State or private models

- **Colorado:**
  - Regional Collaborative Care Organizations (RCCOs) must create a Performance Improvement Advisory Committee with provider and member representation
  - Must have permanently assigned contract manager, financial manager, and chief medical officer
- **Oregon:**
  - Coordinated Care Organizations; (CCO) governing body must include:
    - Major components of health care delivery system
    - 2+ providers in active practice, including a licensed physician and a BH provider
    - 2+ members from the community
    - 1+ member of the community advisory council
  - Must establish community advisory council in each of the proposed service areas
- **Illinois**
  - If lead entity is single provider, governing body must include providers employed and not employed by lead entity
  - Must demonstrate meaningful involvement of the medical director and front-line providers
- **New Jersey**
  - Board Membership must include:
    - providers, including a PCP and representation from other specialties
    - Social service agencies
    - 2+ consumer organization
  - Must obtain support from providers in the designated area – all of the general hospitals, at least 75% of qualified PCPs, and at least four qualified BH care providers
  - Management structure must include a Quality Committee, Medical Director, or governance structure responsible for overseeing the ACO's quality performance
  - Must designate leadership responsible for public engagement

B 4 Care Delivery: Patient Centered Primary Care

Less comprehensive → **More comprehensive**

Definition
Primary care working towards achieving the triple aim

- 'Basic' PCMH capabilities, flexibility in implementation:
  - Patient Centered Access
  - Team Based Care
  - Population Health Management
  - Care Management & Support
  - Care Coordination & Care Transitions
  - Performance Measurement and Quality Improvement
- Specific requirements/thresholds for implementing basic PCMH capabilities
- Enhanced PCMH capabilities, e.g.,
  - Behavioral Health integration
  - Resource Stewardship
  - Community based population health
  - End of life planning
- Specific requirements to contract with state- or nationally accredited PCMHs

Examples: State or private models

- **Minnesota**:
  - Integrated Health Partnerships (IHPs) need to 'demonstrate' experience with innovative care delivery models, such as MN Health Home certification or other national certifications, community-based or collaborative partnerships
- **Illinois**:
  - Access requirements for specific conditions (e.g., 80% of specialty referrals must be seen within 30 days)
  - Need to meet Health Homes requirements in Sec 2703 of the ACA
- **Oregon**
  - CCOs required to contract with a network of PCMHs recognized under Oregon's standards, including:
    - Concrete plans for increasing the number of enrollees served by certified PCMHs, incl targets
    - Concrete plans for advancing basic PCMHs to more advanced PCMHs

B 5 1 Care Delivery: Cross Continuum Network - Medical Services

Less comprehensive → More comprehensive

Definition
Identification of partners across the care continuum

- Relationships with partners exist but not formalized or set up with incentives
- Formal relationships with partners exist, without aligned incentives
- Formal relationships with partners exist which include aligned incentives

Examples: State or private models

- N/A
- **Illinois**
  - Accountable Care Entity (ACE) applications need to document:
    - ‘Network’ of primary care, specialty, BH and SUD providers and level of commitment (i.e., letter of intent, pending contract, ACE contract etc.)
    - Percentage of services previously provided by the network to expected universe of enrollees
- **Minnesota:**
  - IHPs are not eligible for two sided risk arrangements unless they are an integrated delivery system that provides a spectrum of outpatient and inpatient care as a common financial and organizational entity
- **Oregon**
  - CCOs to have a formal contractual relationship with a dental services organization
  - CCOs shall demonstrate how hospitals and specialty service providers are accountable for achieving successful transitions of care

B 5 2 Care Delivery: Cross continuum network – Community based and public health services

Less comprehensive → **More comprehensive**

Definition
Connecting with patients with support available in the community, including non-clinical services

- ACO works with a select number of community-based organizations, but significant additional resources exist in the community

- ACO has processes and programs in place to connect patients with community-based resources (e.g., public agencies, housing authorities, transportation bodies)
- Process in place to evaluate usefulness of community-based resources and adjust partnership strategy on at least on an annual basis

Examples: State or private models

- **New York**
  - No specific requirements

- **Minnesota:**
  - IHP applications need to describe any *existing or planned partnerships* with community based / public health resources as well as the intended impact of the partnerships on key outcomes of interest
- **Illinois**
  - ACE applications need to describe *plan to coordinate* with state- and community-based social services and transportation to services

B 6 Care Delivery: Integrated HIT/HIE

For the purposes of the ACO certification program, integrated HIT is defined as:

- Majority of clinicians on EMRs, standardization in fields/use
- Ability to integrate inpatient and outpatient data from network and non-network providers including a variety of data sources (e.g., claims, labs, pharmacy, EMR)
- Real rime ADT information exchange amongst network and non-network providers
- Connecting to and transacting on HIE for a sizable portion of patient population (e.g., 20%+)

Less comprehensive — **More comprehensive**

Definition
Ability to share clinical and non-clinical data across care settings

- No/limited requirements for integrated IT
- Limited requirements for integrated IT, however, ACOs need to improve over time
- Extensive requirements for integrated HIT

Examples: State or private models

- **Minnesota:**
  - Physician groups are eligible for upside only arrangements if they are not formally integrated with a hospital or integrated system via aligned financial arrangements and common clinical and information systems
- **Oregon**
  - CCOs are required to:
    - Identify network EHR adoption rates by provider type/geographic region; and develop and implement strategies to increase adoption rates of certified EHR;
    - Identify current capacity and develop and implement a plan for improvement in HIE, including patient engagement through HIT
- **Illinois:**
  - All ACE providers must have the ability to utilize the Illinois Health Information Exchange (ILHIE)
  - Within 18 months of Contract Execution, the ACE must demonstrate real-time care connectivity between the EDs and PCPs.

B 7 Care Delivery: Clinical Integration / Practice Guidelines / Evidence Based Medicine

Less comprehensive → **More comprehensive**

Definition
Evidence based guidelines and best practices that are available at the point of care

▪ Little incorporation of evidence based guidelines into clinician practices	▪ Establish practice guidelines for select services/specialties ▪ Monitor practice pattern variation	▪ Establish practice guidelines for all appropriate services/specialties ▪ Practice and evidence based guidelines are embedded in systems used at the point of care with alerts to support clinical decisions ▪ Monitor practice pattern variation ▪ Provide performance reports to participating providers that detail variation in care patterns ▪ Provide training and education on reducing variation
Examples: State or private models		
▪ **Illinois** – ACE medical director is responsible for developing and implementing a care model, incorporating best practices ▪ **Minnesota** – No specific requirements	▪ **Oregon** – CCOs shall adopt practice guidelines, update them periodically as appropriate, disseminate to all affected providers and use them for utilization management, member education, and coverage of services ▪ **New York** – ACO needs to describe how it will use evidence based health care, and how the ACO will assure that ACO participants adhere to the quality improvement programs and clinical guidelines	▪ **N/A**

B 8 Care Delivery: Population Health Management[1]

Less comprehensive → More comprehensive

Definition
Coordination of care across settings with standardized protocols and interventions

- No/limited program to coordinate care across settings
- Patients are managed in the inpatient setting to ensure effective transition to lower acuity setting
- Comprehensive health assessment
- Process and programs in place to coordinate care across all settings (hospital, long term care, community).
- Protocols in place for intervention in each care setting based on patient profile

Examples: State or private models

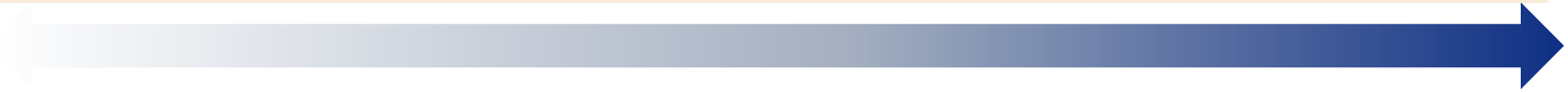
- **N/A**
- **Illinois**
  - ACEs required to demonstrate transitional care coordination utilizing an evidence-based model among all providers including inpatient and ED follow-up
- **Oregon**
  - CCOs as required to conduct Community Health Assessment (CHA) and develop Community Health Improvement Plan (CHP) working with various specified stakeholders[2]
  - CCOs shall collaborate with OHA Office of Equity and Inclusion to develop meaningful baseline data on health disparities[3]
  - CCOs shall conduct the CHA and CHP so that they are transparent and public in process and outcomes
- **Minnesota**
  - IHPs need to define approaches and methods to coordinate care across the spectrum of services, supported by a payment model
  - IHPs will engage and coordinate with other providers, counties, and organizations, including county-based purchasing plans, that provide services to the IHP's patients on issues related to local population health goals

1 Comprehensive health assessment, Care coordination, Care transition elements that go beyond the scope of PCMH activities outlined in B.3
2 Early Learning Council, Youth Development Council, Local Mental Health Authority, oral health care providers, the local public health authority , community based organizations, hospital systems , school health providers
3 Disparities to include those defined by race, ethnicity, language, disability, age, gender, sexual orientation, occupation, culture, class, religion, and other factors in its Service Areas

C 9 Financial Incentives and Accountability: Risk sharing/APM requirements

For the purposes of the ACO certification program, risk sharing / APM requirements is defined by:

- Speed of progression from shared savings to downside risk over time
- Share of total revenue that comes from contracts with accountability for Total Cost of Care
- Share of total revenue that comes from contracts with downside risk accountability for Total Cost of Care
- Share of specialist revenue that comes from APMs (e.g., episode based payments)
- Number of payer classes with which the ACO holds TCOC contracts



	Less comprehensive		More comprehensive
Definition	▪ No specific requirement	▪ Some requirements to transition towards higher levels of risk over time	▪ Specific requirements to transition to higher levels of risk over time, differentiating between upside only and two-sided risk
Examples: State or private models	▪ **Illinois** – ACEs must demonstrate a reimbursement structure **aimed at creating value and savings**	▪ **Minnesota** – Shared savings (SS) for virtual IHPs, downside risk for integrated IHPs – Shared savings kick in after **2% reduction** from baseline cost – Integrated IHPs need to assume **symmetrical** downside risk in Yr 2 ▪ **Oregon** – CCOs need to **implement a schedule of APMs**, with benchmarks and evaluation points identified that demonstrate direct support for transformation of care delivery across the care continuum – CCOs shall assign a high priority to implementing **APMs for PCPs**; such payments shall provide a **sufficient and sustainable level of financial support** necessary to offset costs of PCMH transformation ▪ **Medicare Pioneer Program** – ACOs need to demonstrate that 50% of their revenue will come from 'outcome based contracts'[1] by the end of Year 2 ▪ **Medicare MSSP Program** – ***Current:*** For Track 1 ACOs, 1st agreement period under one-sided model. Subsequent agreement periods under two-sided model. Higher levels of shared savings for ACO who take on two-sided risk – ***Proposed:*** For Track 1, up to 50% shared savings based on quality performance for 1st agreement period, reduced by 10% for each subsequent agreement period under the one-sided model	▪ N/A

1 Defined as contracts that include financial accountability (shared savings and/or financial risk), evaluate patient experiences of care, and include substantial quality performance incentives

C 10 Financial Incentives and Accountability: Financial Incentives with the ACO

Less comprehensive → More comprehensive

Definition
ACO use of financial incentives

- Compensation for participating providers independent of ACO performance
- Bases some portion (<20%+) of the compensation provided to participating providers on the performance of the ACO as a whole, using clinical quality, cost ,and patient experience indicators
- Bases a significant portion (40%+) of the compensation provided to participating providers on the performance of the ACO as a whole, using clinical quality, cost, and patient experience indicators

Examples: State or private models

- **Oregon:**
  - No specific requirements
- **Minnesota**
  - IHPs need to describe how they will distribute shared savings/losses among its component parts or entities. If applicable, the IHP should highlight the direct inclusion of community organizations in the payment model structure
- **Illinois**
  - ACEs must clearly delineate the flow of financial reimbursement among participating providers down to the PCP including sharing in financial savings
- **New York**
  - ACOs must clearly delineate how shared savings will be distributed among ACO participants
- **N/A**

B C 11 Behavioral Health Care Delivery and Payment Models: Definition

Less comprehensive → **More comprehensive**

	Less comprehensive		More comprehensive
Care Delivery:	**Coordinated care** ▪ PCP has phone consult ability with psychiatrist ▪ Record sharing capacity b/w PCP and BHPs[4]	**Co-located care** ▪ Psych MD or NP & PCP in same bldg; LCSW/RN available for immediate consult ▪ Tele-psychiatry capacity (tele-eval of patient, follow-up phone consult w/ PCP)[1] ▪ BH specialist keeps 50% of time unscheduled[5]	**Integrated care** (14% of ACO contracts, 2013)[2] ▪ BH trained LCSW/RN located in PCP office w/ psych MD available for phone consult & to see pts who do not respond to treatment[8] ▪ Ambulatory intensive care team for high-risk pts – MD, care mgr., LCSW, psychologist, pharmacist[12] ▪ Care coordinator case load inversely proportionate to pt risk level[12]
Payment:	**FFS**	**One-sided risk** ▪ BH consultation services (care mgmt., tele-consults) included in global payments or APMs[4] ▪ Some BH included in capitated risk (e.g., care mgmt. & phone consults for depression)[1] ▪ As of 2013, 84% of ACO contracts included MH and/or SUD services (nationally)[2]	**Two sided risk** ▪ Capitated payments include BH ▪ Savings shared with BH providers[8] ▪ Capitated payment to MCO; FFS to provider, all parties share savings & risk of loss (MCO can allocate PMPM funds in creative ways to incentivize care coordination)[9]

1 Kilbourne et al, Sustainable Lifelines: supporting integrated behavioral health services for children and adolescents in the accountable care era, AJAC, Dec. 2014.
2 Lewis et al, Few ACOs pursue innovative models that integrate care for mental illness and substance abuse with primary care, Health Affairs 33, 2014.
3 Fortney et al, Practice-based versus telemedicine-based collaborative care for depression in rural federally qualified health centers: a pragmatic randomized comparative effectiveness trial, Am J Psychiatry 170, 2013.
4 Straus JH & Sarvet B, Behavioral health care for children: the Massachusetts child psychiatry access project, Health Affairs 33:2153-2161 (2014).
5 Essentia Health, Results for depression, 2013, http://www.essentiahealth.org/main/Depression.aspx.
6 Integrated Behavioral Health Project, Phase I Summative Report, June 2009
7 North Country Health Systems Redesign Commission, Primary Health Behavioral Health Collaboration, Jan 21 2014
8 Chung H, Montefiore behavioral health integration & health reform: are we at the tipping point?; Chung H & Schwartz B, The Montefiore ACO & behavioral health: a work in progress; Chung H, The promise & progress of the ACO for behavioral health integration: current status at Montefiore medical center.
9 Sandberg et al, Hennepin Health, Health Affairs 33 (2014)

Behavioral Health Pilots – Coordinated Care

	Care delivery model	Payment model	Outcomes / Evidence base
MA Child Psychiatry Access Project[1]	▪ Psychiatrist, licensed therapist, & care coordinator housed at 6 hubs throughout state for virtual consultation ▪ PCP can receive immediate consult or order expedited face to face with patient (~18% of consults turn into face to face visits) ▪ Care coordinator assists w/ referrals into community BH services ▪ PCPs new to the program receive training on BH resources in their region, insurance coverage, and some education on BH conditions	▪ DMH funds 6 psychiatry "hubs" around state ($3.3 million, or $2.20 / child in 2014) ▪ $200,000 offset by billing for face-to-face visits (2014) ▪ MBHP administers payments to providers	▪ Tele-psychiatry consult w/in PCP office increases access to BH services and proven effective at improving outcomes in children[2] and adults[3] ▪ As of 2012, 50% of referrals not completed, even with care coordinator support ▪ 95% of PCPs in MA enrolled w/in 3 years; 455 practices (2,915 PCPs) as of June 2014 ▪ PCP understanding of BH conditions has increased – 67% reported being able to manage conditions they previously would have referred to a psychiatrist

1 Straus JH & Sarvet B, Behavioral health care for children: the Massachusetts child psychiatry access project, Health Affairs 33:2153-2161 (2014).
2 Kilbourne et al, Sustainable Lifelines: supporting integrated behavioral health services for children and adolescents in the accountable care era, AJAC, Dec. 2014.
3 Fortney et al, Practice-based versus telemedicine-based collaborative care for depression in rural federally qualified health centers: a pragmatic randomized comparative effectiveness trial, Am J Psychiatry 2015.

Behavioral Health Pilots – Co-located Care

	Care delivery model	Payment model	Outcomes / Evidence base
Essentia Health (ND, ID, WI, MN)[1]	▪ BH providers (MA level) & psychiatric NP located in adjacent office to PCP ▪ BH providers assist w/ BH screenings & short term therapy; keep 50% of time unscheduled to facilitate immediate referral ▪ Psychiatric NP assists PCP w/ diagnosis & treatment plan ▪ Off-site consulting psychiatrist for complex cases	▪ Medicaid ACO – 2 sided risk ▪ Medicare ACO – 1 sided risk ▪ Private ACO contracts – risk varies ▪ Bundled payment includes offers outpatient SUD treatment, specialized detox facilities, psychiatric hospital treatment, & BH screenings ▪ Bundled payment does not include outpatient BH treatment	▪ 12% had improved depression scores w/in 6 months compared to 6% comparative group[2]
Crystal Run Healthcare (NY)[1]	▪ 2 FTE BH providers in PCP office ▪ PCP screens for depression, initiates and manages treatment, refers out when necessary ▪ Psychiatrist co-located in building of largest PCP practice to allow for warm hand offs w/ support from social workers ▪ Shared EMR, email, and scheduling systems	▪ 1 sided risk ▪ Payment includes BH screening & outpatient treatment	▪ Warm handoff increases likelihood of follow through on BH referral by 60%[3]

1 Tierney KI, Saunders AL, & Lewis VA, Creating connections: an early look at the integration of behavioral health and primary care in accountable care organizations, Commonwealth Fund, Dec. 2014.
2 Essentia Health, Results for depression, 2013, http://www.essentiahealth.org/main/Depression.aspx.
3 North Country Health Systems Redesign Commission, Primary Health Behavioral Health Collaboration, Jan 21 2014.

Behavioral Health Pilots – Integrated Care

	Care delivery model	Payment model	Outcomes / Evidence base
Hennepin Health (MN)[1]	▪ Clinical social worker ▪ RN care coordinator ▪ Community health workers ▪ Social workers in DPH connect high-risk pts. w/ social services9 ▪ Link community providers to EMR (w/ pt consent)[2] ▪ Sober bed unit to divert SUD pts out of ED[2] ▪ Social worker in ED[2] ▪ Ambulatory intensive care unit (MD, RN, care coordinator, social worker, psychologist, pharmacist)	▪ Capitated payment to MCO; FFS to provider, all parties share savings & risk of loss (MCO can allocate PMPM funds in creative ways to incentivize care coordination)[3] ▪ Flexible PMPM allocation greater than expenditures as of 1st year analysis	**Health Outcomes** ▪ 9.1% decrease in ED over first year ▪ 3.2% decrease in admissions over 1st year[3] ▪ 2.5% increase in PCP visits over first year[3] ▪ 20% fewer crisis visits to ED[2] **Savings** ▪ Care coordinator led to ~10% reduction in cost per pt.[2] ▪ Rx mgmt. for high-risk pts resulted in > 50% savings on medications[2] ▪ Intensive care team for high utilizers reduced costs 40-95% per patient[2,4] ▪ Diverting pts into sober bed unit saved 50% on detox spending & 90% on ED expenditures[2] ▪ Social worker in ED estimated to reduce ED visits and admissions by 50%[2] ▪ Social workers connecting high risk pts to social services resulted in 70% reduction in cost[2]
Montefiore ACO (NY)[5]	▪ BH trained LCSW/RN located in PCP office ▪ Psychiatrist available for phone consult w/ PCP on Rx initiation & management ▪ Psychiatrist available to see pts not responding to treatment ▪ Extend BH EMR to PCP office ▪ RN care mgr. ▪ LCSW BH mgr.	▪ 2 sided risk ▪ Capitated payments include BH ▪ Bonuses to BH providers and PCPs	▪ PHQ-9 score among diabetic pts fell by average of 29% ▪ PHQ-9 score among pts w/ CV risk fell by average of 20% ▪ Mean PHQ-9 decreased 32% ▪ 30-44% in partial reemission (PHQ-9 < 10) ▪ 13% in full remission (PHQ-9 < 5) ▪ 35% had 5 point reduction in GAD-7 score ▪ 22% decrease in PCP utilization

1 Sandberg et al, Hennepin Health, Health Affairs 33 (2014)
2 Hennepin County, Hennepin Health, November 2013
3 Hennepin County, Hennepin Health, June 2014
4 Among the 5% of pts who accounted for 64% of expenditures
5 Chung H, Montefiore behavioral health integration & health reform: are we at the tipping point?; Chung H & Schwartz B, The Montefiore ACO & behavioral health: a work in progress; Chung H, Montefiore experience of the ACO for behavioral health integration: current status at Montefiore medical center.

State ACOs requiring some showing of integration, falling somewhere in the middle of the spectrum

	Care delivery model	Payment model	Outcomes / Evidence base
Oregon[1,2]	▪ Must demonstrate experience & capacity integrated BH & physical health services ▪ Must prioritize pts w/ mental illness/SUD ▪ Must screen for alcohol misuse ▪ Must screen for depression ▪ Must follow-up after hospitalization for mental illness (w/in 7 days)	▪ NA	▪ % pts receiving follow-up w/in 7 days after hospitalization for mental illness increased from 65% to 68% (2011-13) ▪ % pts screened for alcohol misuse and receiving intervention if appropriate increased from 0% to 2% (2011-13)
Louisiana[3]	▪ Must provide referral and coordination for specialized BH services (e.g., MH rehabilitation) & BH drugs	▪ Must cover basic BH services	▪ NA
Colorado[4]	▪ Medicaid ACOs must screen for BH using PHQ-9, GAD-7, and AUDIT ▪ Must enter into participation agreement with state-wide network of BH providers ▪ Must demonstrate coordinated, co-located, or integrated BH	▪ Should be entering into 2 sided risk contracts by 2019	▪ NA
New Jersey[5]	▪ Must develop relationships with PCPs & BH providers to engage pts in treatment, promote mediation adherence, reduce SU, improve access to BH services, and ensure integrated primary & BH care	▪ Gainsharing plans to promote use of open access scheduling in BH care settings and funding interdisciplinary collaboration between PCPs and BH providers	▪ NA
New York[6]	▪ ACOs must obtain participation by BH providers (at least 4 w/in designated area) ▪ Must demonstrate how BH is integrated w/ physical health	▪ NA	▪ NA

1 Oregon Law c. 414 §§ 625 (1)(e), (2)(c), (2)(j), (2)(k)(B) (2013).
2 Oregon Health Authority, Quality and Accountability, 2013 data.
3 Louisiana Code, Title 50, c. 31, sections 3305(D)(11), (F)(7), & (F)(11) (2011).
4 Colorado's State Health Innovation Plan, Dec. 13, 2013
5 New Jersey c. 114, An Act Establishing a Medicaid Accountable Care Organization Demonstration Project and Supplementing Title 30 of the Revised Statutes
6 New York State Dept. of Health, Proposed Rule Making: Addition of Part 1003 and Amendment of Subpart 98-1 of Title 10 NYCRR (Accountable Care Organizations), 2

D 12 Transparency & Performance Improvement: Public Reporting Requirements (1/2)

Less comprehensive → **More comprehensive**

Definition
Tracking of standard and customized metrics, Identification of sources of variability & suggest solutions

- Nationally recognized Quality Measures are tracked and reported at aggregate level
- A formal tool is used to collect measurement data

- Quality Measures are tied to performance/payment as well as those just for reporting purposes only
- Utilization/Cost reporting is transparent and detailed

- Statewide Quality Reporting and Measurement System – or similar program – is used to collect statewide data for monitoring and comparison purposes
- Increasingly more comprehensive measures are collected and utilized (e.g., diabetes, vascular disease)

Louisiana

	mandatory measures	voluntary measures	Mandatory Reporting Only
Q	16/HEDIS/AHRQ		
U/C			Quarterly & Annually
PP			Quarterly reports to Dept. of Health and Hospitals
PE	CAHPS		
SP			Semiannually
SRE	29		

New Jersey

	mandatory measures	voluntary measures	Mandatory Reporting Only
Q	21 mandatory; 6 voluntary	6	6
U/C	Annual savings calculations	6	1 (mental health)
PP			Annually to Dept. Human Services
PE	7 – CAHPS, similar		
SP			
SRE	29		

Minnesota

	mandatory measures	voluntary measures	Mandatory Reporting Only
Q	36		
U/C			At least annually to Commissioner
PP			Yes
PE	14 – CAHPS		
SP	Yes		
SRE	29		

- Q = Quality Measures ; U/C = Utilization/Cost Measures; PP = Patient Protection; PE = Patient Experience ; SP = Strategic/Transformation Plan; SRE = Serious Reportable Events
- Mandatory Measures are most often tied to payment/performance.

D 12 Transparency & Performance Improvement: Public Reporting Requirements (2/2)

Less comprehensive → **More comprehensive**

Definition
Tracking of standard and customized metrics, Identification of sources of variability & suggest solutions

- Nationally recognized Quality Measures are tracked and reported at aggregate level
- A formal tool is used to collect measurement data

- Quality Measures are tied to performance/payment as well as those just for reporting purposes only
- Utilization/Cost reporting is transparent and detailed

- Statewide Quality Reporting and Measurement System – or similar program – is used to collect statewide data for monitoring and comparison purposes
- Increasingly more comprehensive measures are collected and utilized (e.g. diabetes, vascular disease)

Illinois

	mandatory measures	voluntary measures	Mandatory Reporting Only
Q	29		
U/C			Monthly & Annual
PP			Quarterly
PE			Yes
SP			
SRE	29		

Vermont

	mandatory measures	voluntary measures	Mandatory Reporting Only
Q	33		
U/C	15		1
PP			Yes
PE	7-9		
SP			
SRE	29		

Maine

	mandatory measures	voluntary measures	Mandatory Reporting Only
Q	16	2/5	5
U/C	32		
PP			Yes
PE	CAHPS		
SP			
SRE			Yes

- Q = Quality Measures ; U/C = Utilization/Cost Measures; PP = Patient Protection; PE = Patient Experience ; SP = Strategic/Transformation Plan; SRE = Serious Reportable Events
- Mandatory Measures are most often tied to payment/performance.

D 13 Transparency & Performance Improvement: Performance Improvement Requirements

Less comprehensive → More comprehensive

	Less comprehensive		More comprehensive
Definition work flow analysis, benchmarking, and guidance to implement best practice	▪ Operational effectiveness and efficiency benchmarked against the industry occasionally (e.g., biannually)	▪ Operational effectiveness and efficiency benchmarked against the industry annually, select initiatives launched as a result	▪ Regular assessment of how operations can improve (e.g., benchmarking, flow analysis). ACO knows the largest drivers of waste and act on plans to change operations
Examples: State or private models	▪ **New Jersey:** – ACO must explain policies, technical capabilities, and organizational structures it expects to develop to meet goals/objectives, and project benchmarks	▪ **Illinois:** – ACE will use data from Dept. of Health and Family Services to drive quality improvement and health outcomes – ACE must describe internal QI plan/processes	▪ **Minnesota**: – IHPs must develop infrastructure to internally report on quality and cost metrics, monitor performance, and use results to improve care over time – Quality Incentive Payment System (QIPS) – levels based on: ▫ absolute performance, and ▫ improvement over time – Dept. of Health sets benchmarks and improvement targets – Minimum threshold based on lowest rate attained by providers (using historical data); target for improvement is 3% higher than the minimum threshold

E 14 Patient Experience & Engagement: Patient Experience

Less comprehensive → **More comprehensive**

Definition
Patient Experience is measured, compared against a benchmark, and used as a way to improve patient care

- Provider/Practice implements a patient satisfaction survey utilizing a formal tool
- Patient Satisfaction is scored and tied to payment and/or performance measure

- Patient satisfaction/experience results are increasingly valued in the overall QM total
- Survey tool is extensive and comprehensive enough to fully evaluate multiple facets of patient experience

- Patient satisfaction is not only part of the core quality measures, but is given substantial weight of total QM

Examples: State or private models

- **Maine:**
  - 10% of scoring
  - Year 1 &2 → reporting only
  - Year 3 → performance
    - Thresholds will be compared against National CG-CAHPS data
      - ≈ 84% average
  - CAHPS

- **Oregon:**
  - 1 Incentive Measure/16 total Incentive Measures
  - Year 1 → reporting only
  - Minimum Thresholds:[1]
    - 2013: 84%
    - 2014: 89%
    - 2015: 89.6%
  - CAHPS

- **Minnesota:**
  - 25% of scoring
  - Sub-divided into 4 clinic & 10 hospital modules
  - Year 1 → reporting
  - Year 2 & 3 → performance
    - Minimum threshold: 30%
    - Upper threshold: 90%
      - Points awarded for attainment of different thresholds
  - CAHPS

[1] Based on comparison between 2011 OR baseline and National Medicaid benchmarks.

E 15 Patient Experience & Engagement: Patient Engagement/Activation

Less comprehensive → More comprehensive

Definition
Measures the extent to which a patient is knowledgeable, confident, and involved in her/his health care

- Patient engagement is part of discussions or goals among ACOs, but nothing greater or more tangible has been developed

- Recognizes importance of measuring patient engagement
- Has begun process of formalizing inclusion of patient engagement measures within ACO framework, but has yet to fully realize

- Develops and implements a detailed strategy on how to best engage patients and caregivers
- Develops training program, creates cultural/language/age appropriate materials to aid both providers and patients, partners with community-based organizations to strengthen resources available to patients/caregivers
- Utilizes a formal tool to measure level of patient activation within practice

Examples: State or private models

- **Minnesota:**
  - 2014 RFP:
    - IHPs must demonstrate how they will "meaningfully engage patients and families as partners in the care they receive."
    - Must demonstrate capacity to receive data from State and use to identify opportunities for patient engagement

- **Vermont:**
  - Part of the Core Measures, but reporting not required Year 1:
    - "How's Your Health?"
    - Patient Activation Measure (PAM)

- **Oregon:**
  - OHA Published Full Report and Recommendations outlining 5 key strategies to improving "person- and family-centered care" (2013)
  - Encourages use of PAM® assessment tool
  - Other evidence-based tools:
    - Shared-decision making
    - Health literacy
    - Self-management
  - OHA sample CCO contract requires demonstrated measurement and coordination of patient engagement

Appendix B:

HPC modifications to NCQA PCMH standards for:

- Resource Stewardship,
- Population Health Management, and
- Patient Experience

NCQA Modifications: Resource Stewardship (1/2)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Measuring Utilization	**6A: Measure Performance** The practice measures or receives data on the following: ▪ 3. At least two utilization measures affecting health care costs	**6B: Measure Resource Use** The practice measures or receives data on the following: ▪ 2. *Same as 2011 standards*	▪ **Make the following 2014 standards must pass:** – 6.B.2 ▪ ***Enhanced requirement:*** – At least **four utilization measures** affecting health care costs – Including either: ▫ Overuse of imaging, or ▫ Appropriate use of antibiotics	All BP
Action to improve performance	**6C: Implement Continuous Quality Improvement (MUST PASS)** The practice uses an ongoing quality improvement process to: ▪ 1. Set goals and act to improve performance on at least three measures	**6D: Implement Continuous Quality Improvement (MUST PASS)** The practice uses an ongoing quality improvement process to: ▪ 3. Set goals and analyze at least one utilization measure ▪ 4. Act to improve at least one utilization measure	▪ ***Enhanced must pass requirement:***[1] – 6.D.3 ▫ Set goals and analyze at least **two utilization measures** ▫ Set goals and analyze at least **four utilization measures** – 6.D.4 ▫ Act to improve performance on at least **two utilization measures** ▫ Act to improve performance on at least **four utilization measures**	All BP All BP

[1] **Similar measures are implemented in many other states across the country, sample examples are below:**

MD: Pediatrics – assess and report on 3-5 measures within Year 1-2; meet thresholds Year 3.
Adult – assess and report on 12-18 measures Year 1-2; meet thresholds Year 3

MN: Practice must measure, analyze, and track measures related to cost-effectiveness of services

NCQA Modifications: Resource Stewardship (2/2)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Demonstrating improved performance	**6D: Demonstrate Continuous Quality Improvement** The practice demonstrates ongoing monitoring of the effectiveness of its improvement process by: ▪ 1. Tracking results over time ▪ 2. Assessing the effect of its actions ▪ 3. Achieving improved performance on one measure ▪ 4. Achieving improved performance on a second measure	**6E: Demonstrate Continuous Quality Improvement** The practice demonstrates continuous quality improvement by: ▪ 3. Achieving improved performance on one utilization or care coordination measure	▪ **Make the following 2014 standards a critical factor:** – 6.E.3	BP

NCQA Modifications: Population Health Management (1/4)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Evidence-Based Decision Support	**3A: Implement Evidence-Based Guidelines** The practice implements evidence-based guidelines through point-of-care reminder for patients with: ▪ 1. The first important condition ▪ 2. The second important condition ▪ 3. The third condition, related to unhealthy behaviors or mental health or substance abuse	**3E: Implement Evidence-Based Decision Support** The practice implements clinical decision support following evidence-based guidelines for: ▪ 1. A mental health or substance use disorder (CRITICAL FACTOR) ▪ 2. A chronic medical condition ▪ 3. An acute condition ▪ 4. A condition related to unhealthy behaviors ▪ 5. Well child or adult care ▪ 6. Overuse/appropriateness issues	▪ **Make the following 2014 standards must pass:** – 3.E ▪ ***Enhanced requirement:*** – 3.E.6 – At least **two** overuse/appropriateness issues, one of which must be either: ▫ Overuse of imaging, or ▫ Appropriate use of antibiotics	All BP
Identify High-Cost/Utilization Patients	**3B: Identify High-Risk Patients** The practice: ▪ 1. Establishes criteria and a systematic process to identify high-risk or complex patients ▪ 2. Determines the percentage of high-risk or complex patients in its population	**4A: Identify High-Risk Patients** The practice establishes a systematic process and criteria for identifying patients who may benefit from care management, which includes consideration of: ▪ 1. Behavioral health conditions ▪ 2. High cost/high utilization ▪ 3. Poorly controlled or complex conditions ▪ 4. Social determinants of health ▪ 5. Referrals by outside organizations ▪ 6. The practice monitors the percentage of the total patient population identified through its process and criteria (CRITICAL FACTOR)	▪ **Make the following 2014 standards must pass:** – 4.A*	All

* **4.A.1** is also a Must Pass factor under Behavioral Health.

NCQA Modifications: Population Health Management (2/4)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Coordination with Community Resources	**4B: Provide Referrals to Community Resources** The practice supports patients/families that need access to community resources: ▪ 1. Maintains a current resource list on five topics or key community service areas of importance to the patient population ▪ 4. Offers opportunities for health education programs	**4E: Support Self-Care and Shared Decision Making** The practice: ▪ 6. Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offers outside the practice and its affiliates ▪ 7. Assesses usefulness of identified community resources	▪ **Make the following 2014 standards must pass:** – 6.E.6 – 6.E.7	 All BP
Document Advance Care Planning Preferences	**2C: Comprehensive Health Assessment** To understand the health risks and information needs of patients/families, the practice conducts and documents a comprehensive health assessment that includes: ▪ 5. Advance care planning (NA for pediatric practices)	**3C: Comprehensive Health Assessment** ▪ 5. *Same as 2011 standards*	▪ **Make the following 2014 standards must pass:** – 3.C.5	All

* **MN:** requires that practices "demonstrate ongoing partnership(s) with at least one community resource, including training staff on which resources are available and how to refer them to patient population

* **IL:** also emphasizes an ongoing partnership and coordinating care with community resources

NCQA Modifications: Population Health Management (3/4)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Care Transitions	**5C: Coordinate with Facilities and Manage Care Transitions** On its own or in conjunction with an external organization, the practice systematically: ▪ 1. Demonstrates process for identifying patients with a hospital admission / ED visit ▪ 2. Demonstrates process for sharing clinical information with admitting hospitals and EDs ▪ 3. Demonstrates process for consistently obtaining patient discharge summaries ▪ 4. Demonstrates process for contacting patients/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit ▪ 5. Demonstrates process for exchanging patient information with the hospital during a patient's hospitalization ▪ 6. Collaborates with patient/family to develop a written care plan for patients transitioning from pediatric to adult care ▪ 7. Demonstrates the capability for electronic exchange of key clinical information with facilities ▪ 8. Provides an electronic summary-of-care record to another care facility for >50% of transitions of care	**5C: Coordinate Care Transitions** ▪ 1,2,3,4,5,7,8. *Same as 2011 standards* **2A: Continuity** The practice provides continuity of care for patients/families by: ▪ 4. Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care	▪ ***Modified scoring:*** – *5.C.1-4* ▫ double points ▪ **Make the following 2014 standards must pass:** – 5.C ▪ **Make the following 2014 standards must pass:** – 2.A.4*	All BP All

* 2.A.4. from the 2014 standards aligns with 5.C.6. from the 2011 standards.

NCQA Modifications: Population Health Management (4/4)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Performance Improvement	**6A: Measure Performance** The practice measures or receives data on the following: ▪ 1. At least three preventive measures	**6A: Measure and Improve Performance** The practice measures or receives data on: ▪ 1. At least two immunization measures	▪ ***Enhanced requirement:*** – 6.A.1 – Practices must measure/receive immunization data for each population above the specified threshold:[1] ▫ 80% for < 2 year olds ▫ 85% flu vaccination for 6mths-4yrs ▫ 85% for adolescents/pre-college, including - 50% HPV vaccination for females; 30% for males ▫ 70% for pregnant women ▫ 60% for seniors	All
Addressing Disparities	**6C: Implement Continuous Quality Improvement (MUST PASS)** The practice uses an ongoing quality improvement process to: ▪ 3. Set goals and address at least one identified disparity in care or service for vulnerable populations.	**6D: Implement Continuous Quality Improvement (Must Pass)** ▪ 7. *Same as 2011 standards*	▪ **Make the following 2014 standards must pass:** – 6.D.7	BP
Preventive & Follow-Up Care		**6G: Use Certified EHR Technology**[2] The practice uses a certified EHR system: ▪ 10. The practice generates lists of patients, and based on their preferred method of communication, proactively reminds >10% of patients/families about needed preventive/follow-up care+	▪ **Make the following 2014 standards must pass:** – 6G.10[3]	BP

[1] Rates are based on 2011-2013 data for MA-specific immunization rates, in accordance with MA immunization schedules and guidelines.

2 The *2011 standards included preventive/follow-up care standards, but 2014 specifically requires the use of EHR to enhance these standards.*

3 MN & IL: Both states require communication regarding preventive/follow-up care, AAFP strongly recommends communication regarding preventive/follow- up care

NCQA Modifications: Patient Experience (1/2)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
CLAS Requirements	**1F: Culturally and Linguistically Appropriate Services (CLAS)** The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by: ▪ 1. Assessing the racial and ethnic diversity of its population ▪ 2. Assessing the language needs of its population ▪ 3. Providing interpretation or bilingual services to meet the language needs of its population ▪ 4. Providing printed materials in the languages of its population	**2C: Culturally and Linguistically Appropriate Services (CLAS)** *Same as 2011 standards*	▪ **Make the following 2014 standards must pass:**[1] – 2.C.1,2 – 2.C.3,4	 All BP
Measure Patient/Family Experience	**6B: Measure Patient/Family Experience** Practice obtains feedback from patients/families on their experiences with the practice and their care: ▪ 1. The practice evaluates patient/family experiences on at least three of the following: – Access – Communication – Coordination – Whole-person care/self-mgmt support ▪ 2. The practice uses the PCMH CAHPS 3. The practice obtains feedback on the experiences of vulnerable patient grps. ▪ 4. The practice obtains feedback from patients/families through qualitative means	**6C: Measure Patient/Family Experience** *Same as 2011 standards*	▪ **Make the following 2014 standards must pass:**[1] – 6.C.1,2,4	All

[1] Almost every state requires CLAS standards for certification fulfillment. **MN** requires that a practice formulate an availability plan for accessing interpreters.

NCQA Modifications: Patient Experience (2/2)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Continuously Improve Patient Experience	**6C: Implement Continuous Quality Improvement** The practice uses an ongoing quality improvement process to: ▪ 2. Set goals and act to improve on at least one patient/family experience measure	**6E: Demonstrate Continuous Quality Improvement** The practice demonstrates continuous quality improvement by: ▪ 4. Achieving improved performance on at least one patient experience measure	▪ **Make the following 2014 standards must pass:** – 6.E.4	All
Patient Involvement in Continuous Improvement	**6C: Implement Continuous Quality Improvement** The practice uses an ongoing quality improvement process to: ▪ 4. Involve patients/families in quality improvement teams or on the practice's advisory council	**2D: The Practice Team (MUST PASS)** The practice uses a team to provide a range of patient care services by: ▪ 10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council	▪ **Make the following 2014 standards a critical factor:** – 2.D.10	BP