Suffolk Care Collaborative

PAYING FOR PERFORMANCE

NCM-NYS LEARNING SESSION
JULY 18, 2017

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Introduction to the Suffolk Care Collaborative

Our vision to become a highly effective, accountable, integrated, patient-centric delivery system has positioned us well to make an important contribution to the DSRIP program.

Some of the many goals will include the capacity to enhance patients' self-care abilities, improve access to community-based resources, break down care silos and reduce avoidable hospital admissions and emergency room visits.

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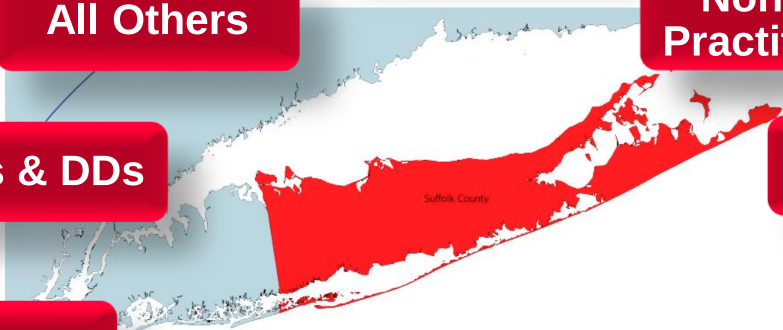
SCC PARTNER COMPOSITION



- Primary Care Practitioners
- Non-PCP Practitioners
- ALL Hospitals
- Clinics
- ALL Health Homes
- Behavioral Health
- Substance Use Disorder
- Skilled Nursing Facilities
- Pharmacy
- Hospice
- CBOs & DDs
- All Others

Approximately 5,000 NPI Enrollments to date

Over 500+ Partner Organizations in the Suffolk PPS

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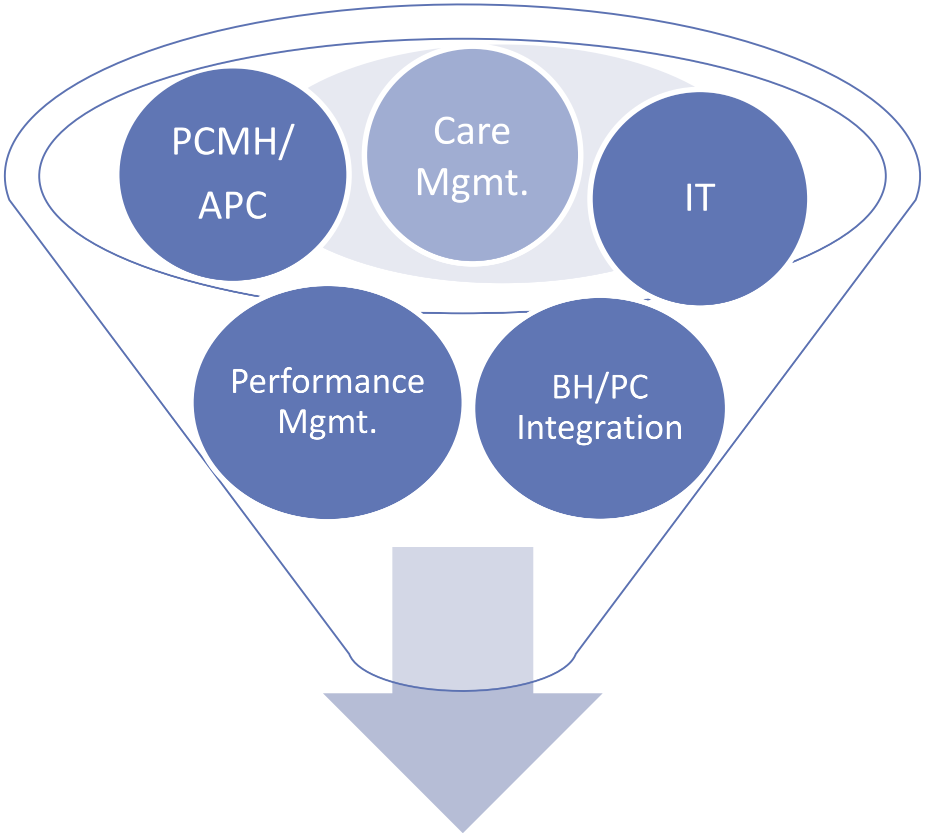
PRIMARY CARE PROVIDER SUPPORT



SUPPORTING TRANSITION FROM FEE-FOR-SERVICE (FFS) TO ADVANCED PAYMENT MODEL (APM)

- Primary Care focused, patient centered model, as the core of a successful Value Based Payment (VBP) Model
- More than just changing provider contracts and compensation - Real change must occur
- Requires a proactive clinical focus, in which patients at high risk for disease progression are identified for early intervention
- Requires ongoing provider & patient engagement and education
- Coordination with Community Based Organizations (CBO's) to address Social Determinants is a must

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LEVERAGING DSRIP AS A CATALYST

DSRIP has created capabilities for Medicaid, most of which can be leveraged across multiple lines of business.

Population Health Service Organization (PHSO) *(Foundation)*

- Population Health IT Platform
- Risk Stratification/Data Analysis
- Care Management/Coordination
- Performance Measurement
- Patient Engagement
- Provider Engagement

Clinical and Financial Model (re)Design

- Aligned, High Performing Network (IDS)
- MCO Alignment
- Medicare/Commercial expansion
- Clinically Integrated Network

Health Plan Operations

- PHSO Expansion
- Patient Enrollment
- Utilization Management
- Claims Payment
- Provider Sponsored Health Plan

P4R

P4P

Shared Savings

Bundle Payment

CMS / Payor Collaboration

Other Lines of Business

5-year Performance-based Funds Flow Model for Participating Providers & Organizations is Operational and included in all SCC Participation Agreements

Funds flow distribution example: Primary care providers

Performance Factor	Description
Engagement Payment	Complete SCC On-boarding documentation as outlined in the SCC Contracting Plan Agreement to ongoing: Good citizenship, Timely and complete quarterly Domain 1 patient engagement reporting , Data sharing, Participation in Population-wide-prevention programs (D4), Updates towards successful completion of the Domain 1 Process Measures & Participation in Project 2ai Integrated Delivery System program & SCC Care Coordination program.
Technical On-boarding	1. Complete Technical On-boarding, i.e. technical data integration and system interoperability between the Partner's source system and the HUB data-warehouse, which will then feed the Suffolk PPS Population Health Platform. 2. EHR meets connectivity to RHIO's HIE and SHIN-NY requirements
Clinical Improvement Programs	Meet requirements of Primary & Behavioral Health Integrated Care Program
	Meet requirements of Cardiovascular Health Wellness & Self-Management Program
	Meet requirements of Diabetes Wellness & Self-Management Program
	Meet requirements of Promoting Asthma Self-Management Program
PCMH Certification	Receipt of NCQA 2014 Level 3 PCMH Certification
Performance Measurement	Adhere to the Performance Reporting and Improvement Plan establishes a planned, systematic, organization-wide approach to performance reporting, performance measurement, analysis and improvement for the healthcare services provided.

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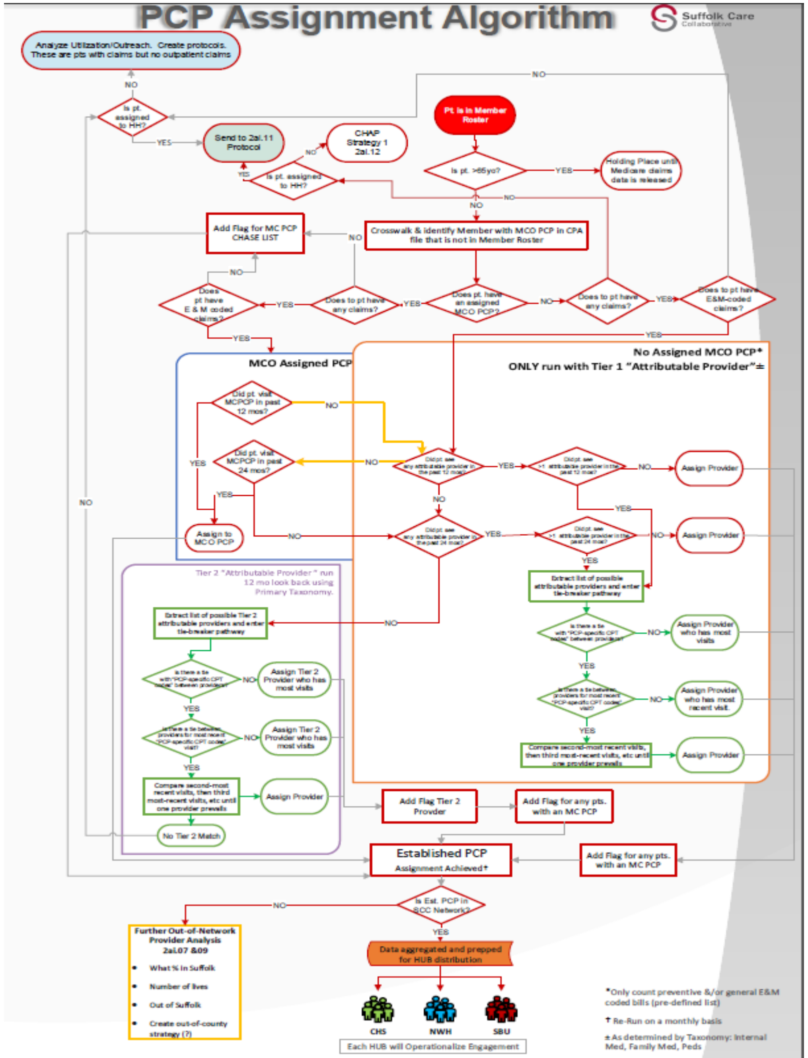
ADDRESSING PROVIDER ATTRIBUTION



- **Goal**
  - Create a Pay for Performance model and Performance Improvement strategies

- **Initial Analysis of Member Roster: May 2016**
  - 54% of attributed population do not have an assigned MCO PCP*

- **Observed Challenges:**
  - Attributing performance at a provider level when a Medicaid member is not assigned to an MCO PCP (54%)
  - Accuracy of performance attribution to MCO assigned PCP

*MCO PCP – Managed Care Assigned Primary Care Physician

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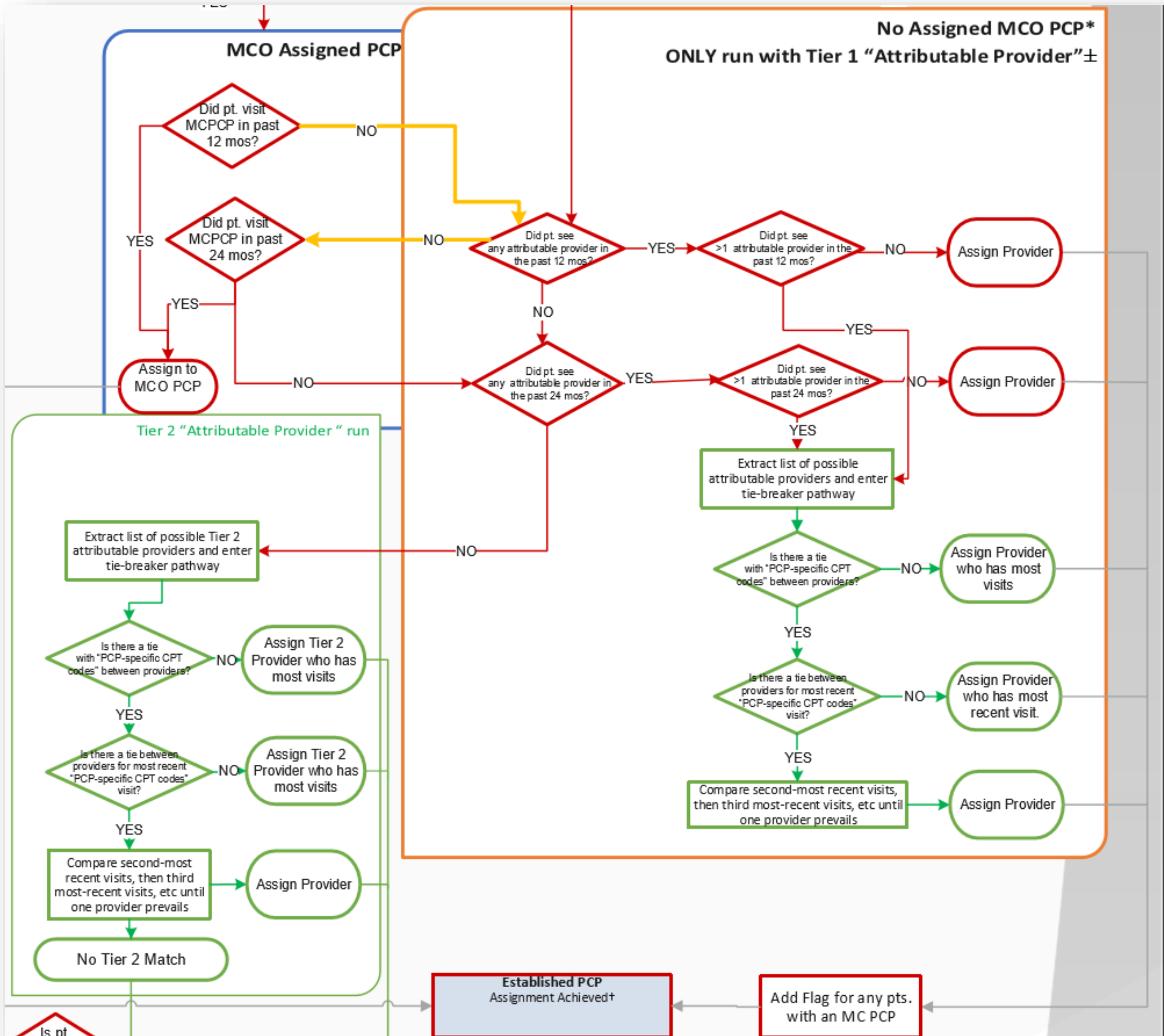
LOYALTY BASED ATTRIBUTION

- How do we define a "primary care visit"?
- Three possible loyalty algorithms to an established PCP
  - Managed Care assigned Primary care Physician (MCO PCP)
  - SCC defined Primary Care Physician
  - Specialist acting as Primary Care Physician



PAY-FOR-PERFORMANCE (P4P) GUIDING PRINCIPLES

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Only incentivize what you can measure

- Survey and clinical abstraction metrics rely on random sampling by DOH, and therefore can only be tied to a PPS.

Right measures to right providers

- Make sure incentivized provider can actually affect measure performance

Organize metrics by categories to make it easier for providers to understand

- Categorize metrics by the type of action incentivized

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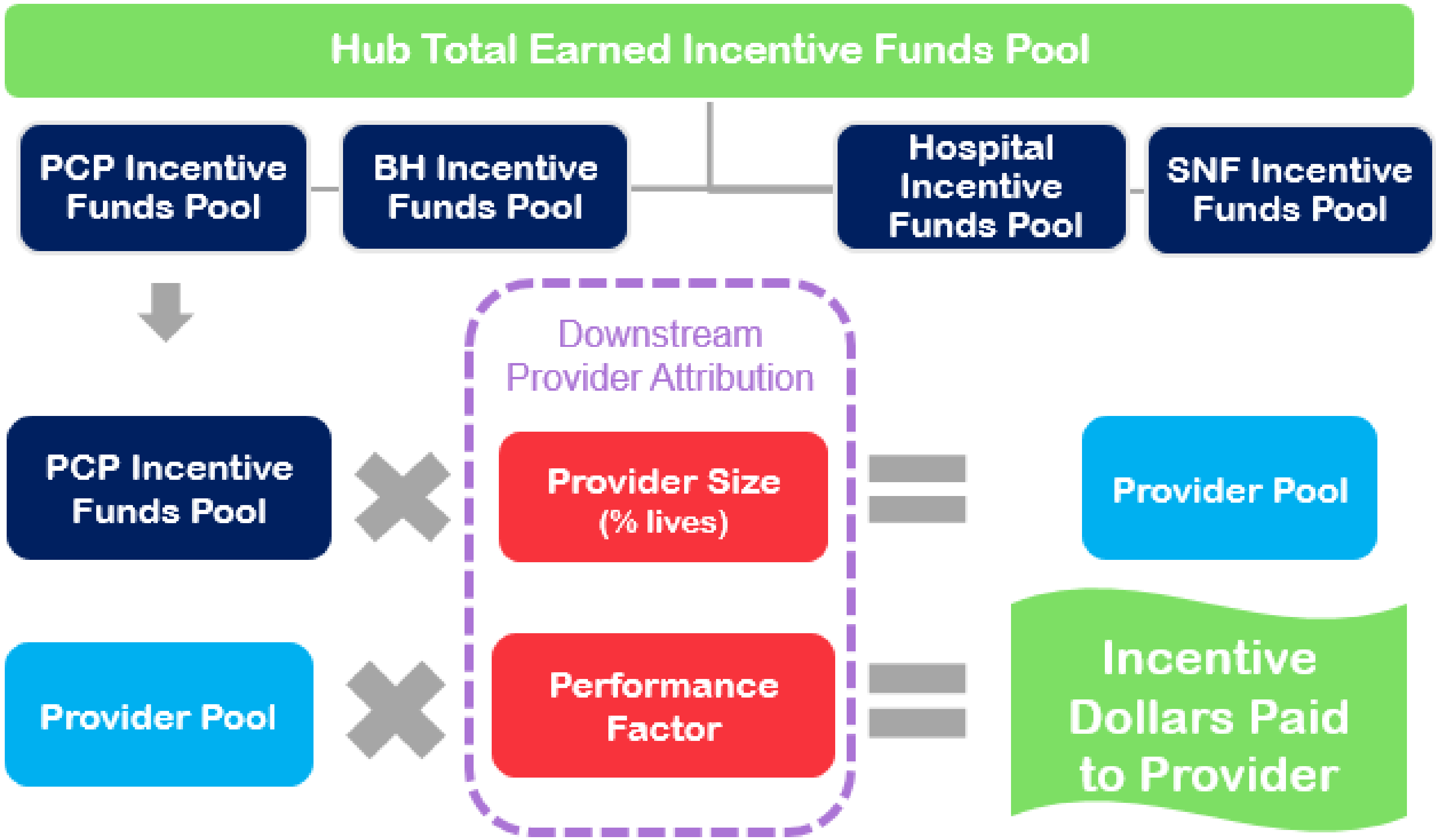
P4P METRICS ASSIGNED BY PROVIDER TYPE

Metric	PCP	BH	Hospital	SNF
Potentially Preventable Emergency Department Visits (for persons with BH diagnosis)	X	X	X	X
Potentially Preventable Emergency Department Visits	X	-	X	X
Potentially Preventable Readmissions	X	-	X	X
Adherence to Antipsychotic Medications for People with Schizophrenia	X	X	-	-
Antidepressant Medication Management - Effective Acute Phase Treatment	X	X	-	-
Antidepressant Medication Management - Effective Continuation Phase Treatment	X	X	-	-
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	X	X	-	-
Diabetes Monitoring for People with Diabetes and Schizophrenia	X	X	-	-
Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication	X	X	-	-
Follow-up care for Children Prescribed ADHD Medications - Continuation Phase	X	X	-	-
Follow-up care for Children Prescribed ADHD Medications - Initiation Phase	X	X	-	-
PDI 90 - Composite of all measures	X	-	X	-
Pediatric Quality Indicator # 14 Pediatric Asthma	X	-	X	-
PQI 90 - Composite of all measures	X	-	X	-
Prevention Quality Indicator # 1 (DM Short term complication)	X	-	X	-
Prevention Quality Indicator # 15 Younger Adult Asthma	X	-	X	-
Prevention Quality Indicator # 7 (HTN)	X	-	X	-
Prevention Quality Indicator # 8 (Heart Failure)	X	-	X	-
Follow-up after hospitalization for Mental Illness - within 30 days	-	X	X	-
Follow-up after hospitalization for Mental Illness - within 7 days	-	X	X	-
H-CAHPS - Care Transition Metrics (Q23, 24, and 25)	-	-	X	-
Adult Access to Preventive or Ambulatory Care - 20 to 44 years	X	-	-	-
Adult Access to Preventive or Ambulatory Care - 45 to 64 years	X	-	-	-
Adult Access to Preventive or Ambulatory Care - 65 and older	X	-	-	-
Asthma Medication Ratio (5 - 64 Years)	X	-	-	-
Children's Access to Primary Care - 12 to 19 years	X	-	-	-
Children's Access to Primary Care - 12 to 24 Months	X	-	-	-
Children's Access to Primary Care - 25 months to 6 years	X	-	-	-
Children's Access to Primary Care - 7 to 11 years	X	-	-	-
Medication Management for People with Asthma (5 - 64 Years) - 50% of Treatment Days Covered	X	-	-	-
Medication Management for People with Asthma (5 - 64 Years) - 75% of Treatment Days Covered	X	-	-	-

DETERMINING INCENTIVE POOL PAYMENT



The SCC is comprised of three distinct “HUB” Networks i.e. Catholic Health Services of Long Island, Northwell Health System and Stony Brook University Hospital. All SCC partners have been aligned to one of the three HUB Networks.

Business Rules

- Each measure will be assigned a point value derived from relative dollar value of each metric within a given payment period

- Point values will be recalculated each payment period and may fluctuate based on DOH's payment schedule for each metric.

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DERIVING METRIC POINT VALUES: BUSINESS RULES

Metric Name	Payment Dollar Value	Payment Point Value
Antidepressant Medication Management - Effective Acute Phase Treatment	$150	60 pts
Potentially Preventable Emergency Department Visits - BH	$50	20 pts
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	$50	20 pts
Total	$250	100 pts

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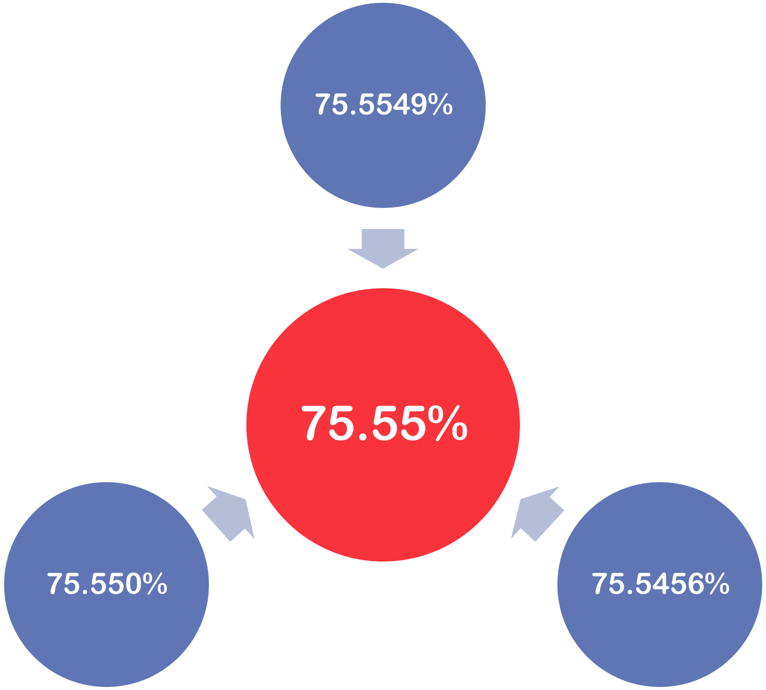
PERFORMANCE PRECISION: BUSINESS RULES

- PPS Target will be rounded to the nearest “hundredth” of a percent.
  - **Example:** If the gap-to-goal for the PPS is 75.556%, the target used will be 75.56%
- Hub performance will also be rounded to the nearest hundredth of a percent.
- Performance that is **equal to target** will be awarded (“tie goes to the runner”)



SCC CORRECTIVE ACTION PLANNING TRIGGERS

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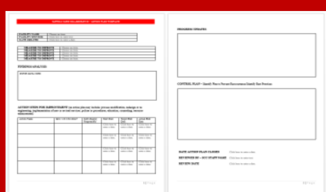
"In variance" refers to when a partner falls below the agreed-upon standard for one or more metrics

The SCC PI toolkit includes:
Action planning Template
PDSA Cycle Template
Data Collection Plan



Trigger: Partner is in variance for 2 consecutive quarters

Corrective Action Plan

Action plans may include:
- Process Redesign
- Further Trending
- Implementation of new service or procedure
- Education
- Counseling
- Focused Audit

Is the metric out of Variance for 2 consecutive quarters?

YES

Action Plan Closed and Completed

NO

Clinical Committee determines next steps

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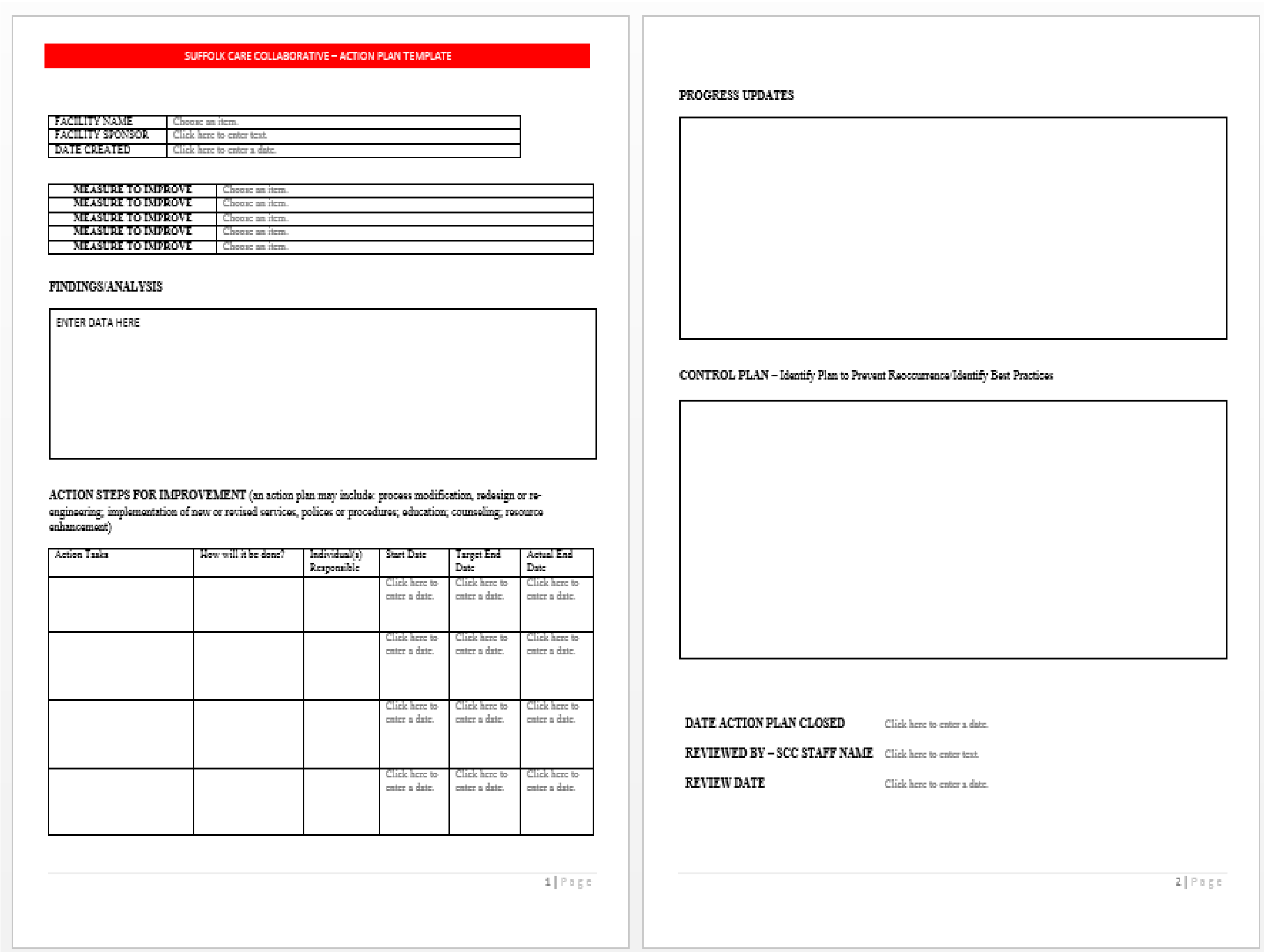
SCC CORRECTIVE ACTION PLAN



SUFFOLK CARE COLLABORATIVE – ACTION PLAN TEMPLATE

FACILITY NAME	Choose an item.
FACILITY SPONSOR	Click here to enter text.
DATE CREATED	Click here to enter a date.

MEASURE TO IMPROVE	Choose an item.
MEASURE TO IMPROVE	Choose an item.
MEASURE TO IMPROVE	Choose an item.
MEASURE TO IMPROVE	Choose an item.
MEASURE TO IMPROVE	Choose an item.

FINDINGS/ANALYSIS

ENTER DATA HERE

ACTION STEPS FOR IMPROVEMENT (an action plan may include: process modification, redesign or re-engineering; implementation of new or revised services, polices or procedures; education; counseling; resource enhancement)

Action Tasks	How will it be done?	Individual(s) Responsible	Start Date	Target End Date	Actual End Date
			Click here to enter a date.	Click here to enter a date.	Click here to enter a date.
			Click here to enter a date.	Click here to enter a date.	Click here to enter a date.
			Click here to enter a date.	Click here to enter a date.	Click here to enter a date.
			Click here to enter a date.	Click here to enter a date.	Click here to enter a date.

1 | Page

PROGRESS UPDATES

CONTROL PLAN – Identify Plan to Prevent Reoccurrence/Identify Best Practices

DATE ACTION PLAN CLOSED	Click here to enter a date.
REVIEWED BY – SCC STAFF NAME	Click here to enter text.
REVIEW DATE	Click here to enter a date.

2 | Page

- Assures accountability across the PPS for improving performance
- Facilitates a process for sharing “Best Practices” at SCC Project Committee Meetings
- Provides opportunity to identify similar trends across SCC PPS partners and then strategize opportunities for Gap closure