COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Care Delivery and Payment System Transformation Committee

October 29, 2014

Agenda

- Approval of Minutes from August 13, 2014
- Discussion of the CDPST Committee Priorities & Patient-Centered Medical Homes (PCMH) Certification Program
- Schedule of Next Committee Meeting (December 10, 2014)

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Vote: Approving Minutes

Motion: That the Care Delivery and Payment System Transformation Committee hereby approves the minutes of the Committee meeting held on August 13, 2014, as presented.

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  - CDPST Priorities
  - PCMH Certification Program
- Schedule of Next Committee Meeting (December 10, 2014)

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  - **CDPST Priorities**
  - PCMH Certification Program
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Priority Issue Areas for Care Delivery & Payment Transformation Committee

Care Delivery Transformation

Accountable Care

- ACO certification standards
- "Model" ACO criteria
- Technical assistance & capability building

Primary Care Transformation

- PCMH certification standards
- PCMH payment model
- Technical assistance & capability building

Payment System Transformation

APM Penetration

- Increased APM penetration for:
  - PPO population
  - MassHealth
  - Specialty services (e.g., episode based payments)

Cross-payer alignment

- Standardization of certain contract elements across payers, e.g., attribution, risk adjustment, baseline budget

Key Enablers

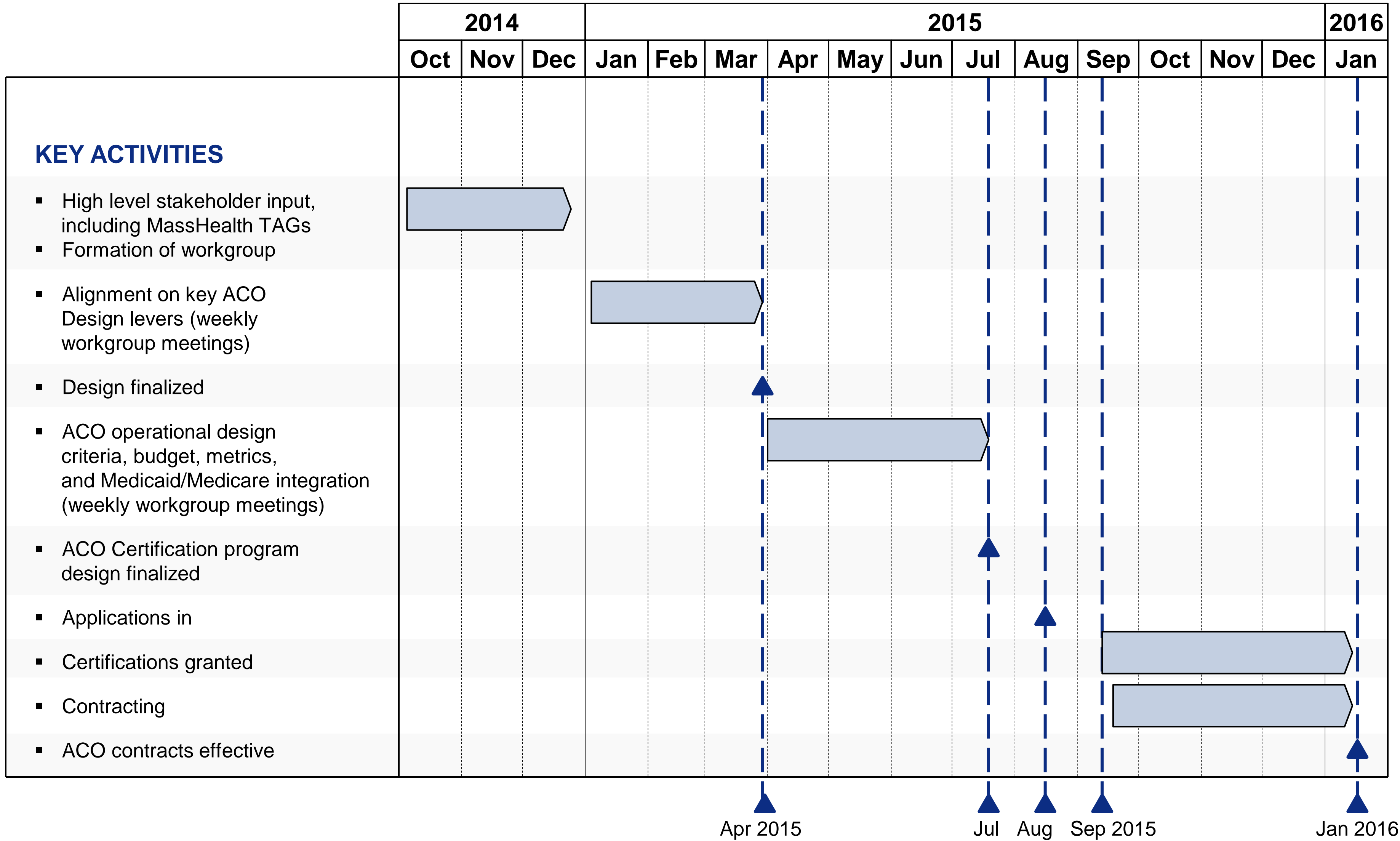
Strategic Vision for Health Care Transformation (incl. CD & PST)

Stakeholder alignment and engagement around the vision

Data Transparency

Behavioral Health a key focus area across all domains

Proposed MA ACO Certification Timeline



Agenda

- Approval of Minutes from August 13, 2014
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  - CDPST priorities
  - **PCMH Certification Program**
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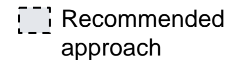
Executive Summary (1/2)

- MA stakeholder community has expressed that HPC's proposed PCMH certification criteria are very similar to those of NCQA and recommended HPC to consider NCQA certification as a proxy
- NCQA has expressed interest to partner with HPC, and help address previously identified drawbacks
- First, it is critical to agree on a **philosophy** governing the PCMH certification program. **HPC staff proposes creating a robust, stringent program acting as a "Stamp of Approval"** (vs. a large scale certification program with low standards that targets capturing 'low hanging fruit' for all practices)
- Next, we need to align on 3 critical design choices:
  - Should/Can we certify **processes/capabilities or outcomes**?
  - How do we **validate capabilities**? (documentation/site visits/both)
  - Should we aim for **standardization or flexibility?**
- Considering stakeholder input as well as data and resource limitations, we propose to:
  - Start with **capabilities**, build in outcomes as data becomes standardized & easily accessible
  - Validate based on **documentation**; layer in site visits selectively for consultative support
  - Focus on **limited number of capabilities**, emphasizing flexibility at practice level beyond must-pass criteria
- Looking at other statewide PCMH programs, we don't see a **correlation between particular criteria included in the program and quality/cost impact**; rather, success depends on other critical elements such as **payment incentives, data transparency, multi-payer alignment, technical assistance**

Executive Summary (2/2)

- **Previously identified issues with NCQA can be eliminated or alleviated:**
  - High value items, i.e., population health management, resource stewardship and behavioral health integration, can be added as additional modules to existing NCQA standards; more tailoring of individual standards possible if needed
  - Validation can be simplified via simpler documentation requirements, user friendly technology solutions and replacing particular measures with MA-wide available outcome measures
- **Overall, partnering with NCQA involves trade-offs, however, benefits outweigh the downsides**
  - NCQA has expressed **flexibility for customization** except for must-pass elements; though we should watch out for 'excessive' customization that will render a partnership meaningless
  - **Higher bar for certification** implies that it will take longer for small/ resource constrained practices to be certified
  - Partnership would enable **faster time to market**, ability to leverage NCQA's **clinical expertise and operational experience**, as well as, easier adoption by MA practices who already have or are in the process of obtaining NCQA certification

PCMH certification should be a mechanism to certify advance primary care in MA, through a robust, stringent program acting as a "Stamp of Approval"



	High bar for Recognition	Low Bar for Recognition
Which practices participate?	Advanced practices that meet stringent criteria	A large number of practices with varied capabilities that all commit to becoming a PCMH
What is the goal?	Provide "Stamp of Approval" for advanced practices, enabling payment incentives from payers	Help all practices make at least modest improvements by focusing on "low-hanging fruit"
When does practice transformation occur?	Before program enrollment	On an ongoing, incremental basis

A high bar approach is a better fit for the MA market because:

- **Health plans** are less willing to alter existing payment rates and/or help fund primary care transformation in the absence of "**meaningful"** stamp of approval from HPC
- Creating an environment where **high value** PCPs are clearly differentiated is critical to enhance community based care, where appropriate
- Majority of PCPs in MA are **affiliated** with physician organizations or health systems, thereby have corporate support to undergo transformation to meet stringent standards

Source: Urban Institute, Team Analysis

Key design elements include certification of capabilities vs outcomes, preferred method for validation, and the level of standardization

	Options	Considerations	Recommendation
1 What are we certifying?	▪ PCMH **capabilities** (e.g., expanded access) ▪ PCMH **outcomes** (e.g., improved HEDIS measures) ▪ A **mix** of capabilities and outcomes	▪ **Limited availability** of standardized outcome data at practice level (e.g., HEDIS measures) ▪ Ability to capture efficiency metrics at practice level using **APCD** at least 18 months away	**Start with capabilities, build in outcomes as data becomes standardized and easily accessible**
2 If capabilities, which method of validation do we prefer to use?	▪ Validation based on **documentation** provided by practices ▪ Validation based on **site visits**	▪ **Limited resources** available at HPC for reviewing documentation and/or conducting site visits ▪ **Administrative burden** on practices higher if HPC requires detailed documentation	**Validation based largely on documentation, layer in site visits for consultative support & learning opportunities selectively**
3 If capabilities, how many capabilities are required for certification?	▪ **Large** number of capabilities, emphasizing clinical **standardization** ▪ **Limited** number of capabilities, emphasizing **flexibility** at practice level beyond must-pass criteria		**Limited number of capabilities, emphasizing flexibility at practice level beyond must-pass criteria**

Design recommendations largely align with NCQA's philosophy, making it worthwhile to consider NCQA as a potential partner

Source: Team Analysis

Statewide PCMH programs have shown mixed results, irrespective of particular certification criteria chosen

Q: Impact on quality*

C: Impact on cost*

NCQA

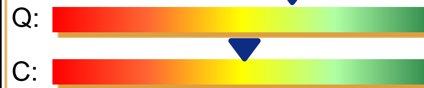
Vermont

Rhode Island (2008)

NCQA++

Maryland (2010)

Pennsylvania (2008)



Maine (2009)

n/a

State-specific: High bar**

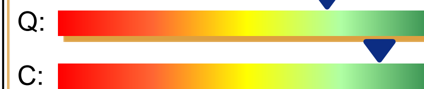
Minnesota (2010)

Illinois (2006)

Oregon (2008)

n/a

Michigan (2008)



State-specific: Low bar

Kansas (2010)

C: n/a

Texas (on hold)

n/a

* Green: Favorable impact; Red: Unfavorable impact

** NCQA level or higher

Source: Literature search

Previously identified issues with NCQA can be eliminated or alleviated

Previously identified issues	Proposed approach to address issue
▪ NCQA criteria do not focus on **high-value elements** – Behavioral health integration – Population health – Resource stewardship	▪ NCQA willing to add **MA-specific criteria / modules** ▪ NCQA willing to partner with HPC to **pilot outcome based certification criteria** (e.g., for patient experience and access) *(see next page)*
▪ **Administrative** burden on practices	▪ NCQA has already addressed some issues in 2014 version. It is also willing to partner with HPC to pilot: ▪ **Replacing particular process measures** with outcome measures if MA can provide the practice-level outcomes data and benchmarks ▪ **Simpler documentation** for particularly administratively burdensome criteria (e.g., chart review) ▪ **User friendly technology** solutions to submit documentation (e.g., shared screens vs. screenshots)
▪ **Cost** burden on practices	▪ HPC can help **support certification payments** for small, resource constrained practices (partially with funds saved by not having to administer the program in house)[1]
▪ NCQA does not perform **on-site validation**	▪ HPC can **add on-site validation** component to the program (through NCQA, another external partner, or via internal resources)
▪ HPC wants to perform an **evaluation** of its PCMH program for supporting continuous improvement initiatives	▪ HPC can contract with NCQA to **obtain the necessary data** to perform the evaluation

Add new criteria

Enhance NCQA criteria/Change to must pass

Change documentation

MA certification have a specific emphasis on behavioral health, resource stewardship and population health

For discussion purposes only

Examples of potential changes to NCQA criteria

Area	Potential changes
Patient Centered Access	▪ Use MHQP data to score practices using outcome metrics, eliminate relevant process metrics ▪ Establish formal mechanism to integrate patient and family as key members of quality and safety improvement
Team Based Care	▪ Make CLAS a must pass standard
Population Health	▪ Enhanced requirements for use of data for population health management, including BH specifically[1] ▪ Implementing risk stratification ▪ Add requirement for clinical decision support for various high risk conditions[2]
Care Coordination & Care Transitions	▪ Cooperative referral process with specialty mental health, substance abuse, or developmental providers including a mechanism for co-management as needed ▪ Co-location either actually or virtually with specialty mental health, substance abuse, or developmental providers ▪ Formal written agreements with hospitals ▪ Coordination of care when patients receive care in specialized settings (hospital, SNF, long term care facility). ▪ Cooperation with community service providers, such as dental, educational, social service, foster care, public health, non-traditional health workers and pharmacy services ▪ Formal process to offer or coordinate hospice and palliative care and counseling ▪ Formal process to engage patients in end-of-life conversations
Performance Measurement & QI	▪ Tracking specified measures (e.g., ambulatory care sensitive utilization, follow up after hospitalization for mental illness) or more measures than NCQA specifies (i.e., two measures) ▪ Require practices to conduct comprehensive quality and utilization assessment annually, and establish annual performance improvement plans

1 NCQA 2014 standards require 50% scoring for: 2 preventive services, 2 immunizations, 3 chronic or acute care services, patients not seen by the practice

2 NCQA 2014 standard 3.E suggests implementing CDS for a MH/SA disorder, a chronic medical condition, an acute condition, a condition related to unhealthy behaviors, well child or adult care and overuse/appropriateness issues. However, this is NOT a must-pass criteria

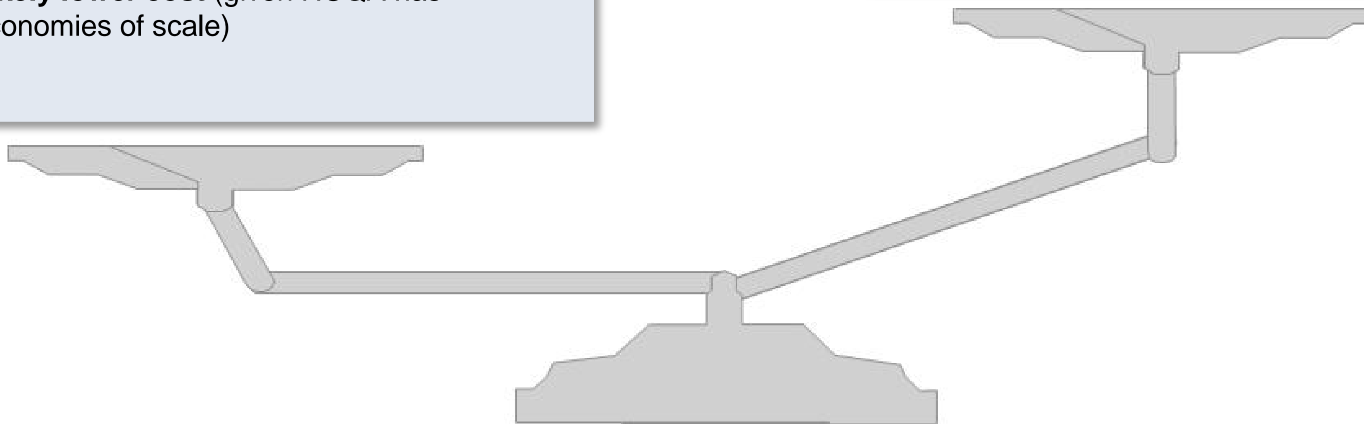
Partnering with NCQA involves trade-offs, however, benefits outweigh the downsides

Pros

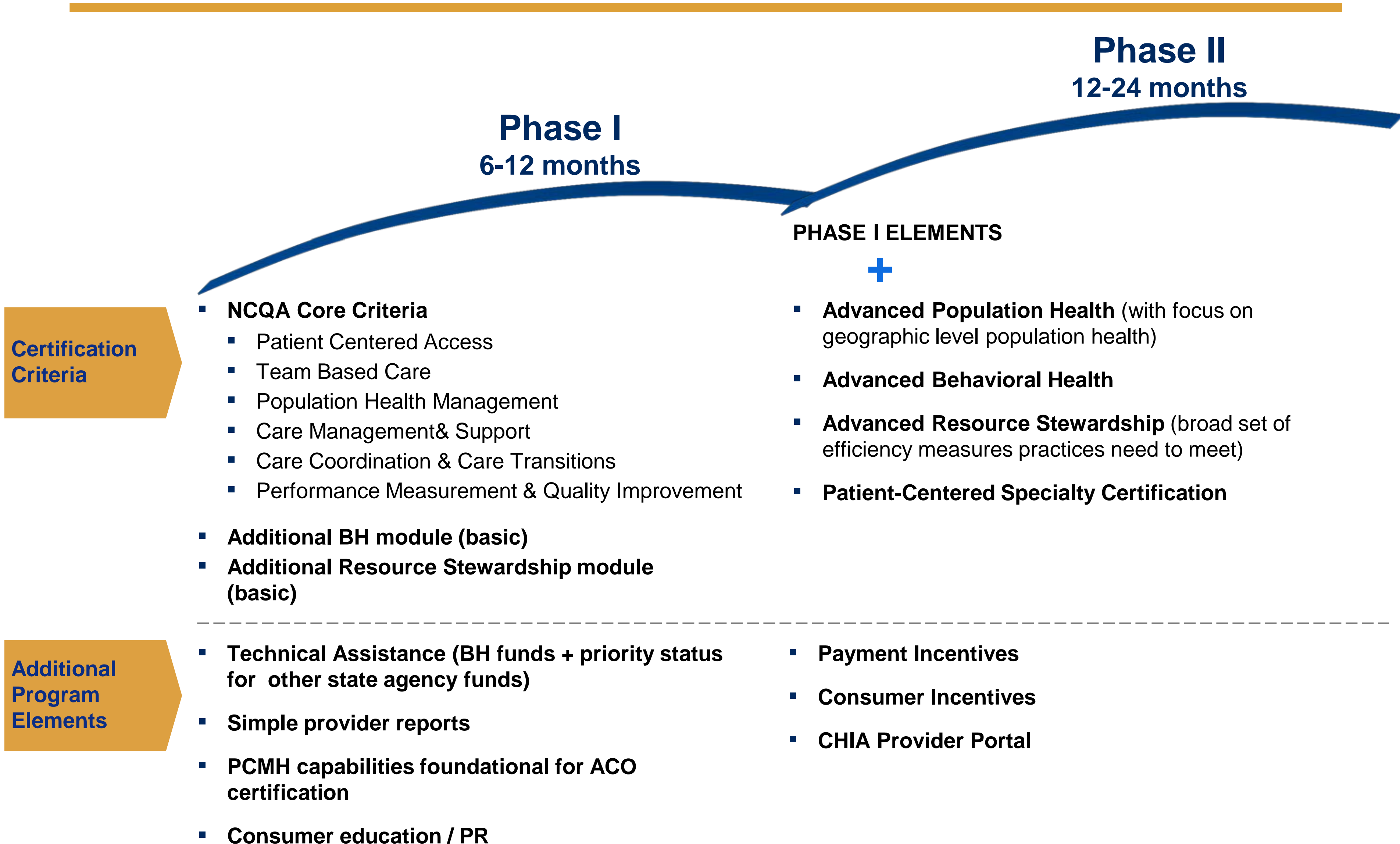
- **Faster time to market**
- Ability to leverage NCQA's **clinical expertise**
- Ability to leverage NCQA's **operational / implementation experience**
- **Recognition** for **~30%** of MA practices who already have or are in the process of obtaining NCQA certification
- Opportunity to influence **national dialogue**
- **Likely lower cost** (given NCQA has economies of scale)

Cons

- Ability to **perfectly customize** it to our wishes is **limited** (although NCQA has expressed flexibility except for must-pass elements)
- **Higher bar** for certification implies that it will take longer for small/ resource constrained practices to be certified



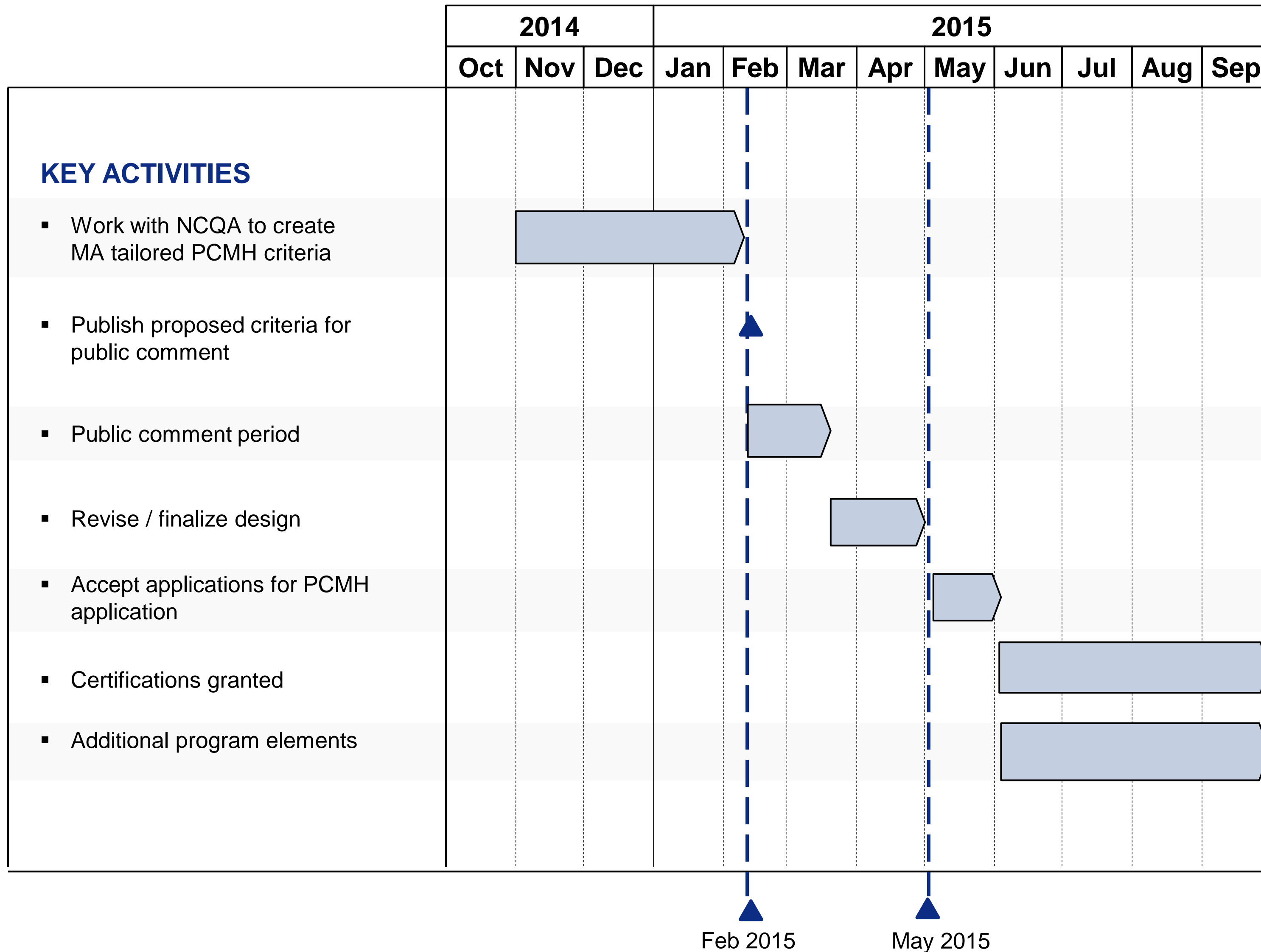
PCMH program could evolve over time to enable more advanced levels of primary care as well as payment and consumer incentives



PCMH Certification process will be tailored to meet the needs of all practices in MA

Non-certified practices	Practices with 2011 certification	Practices in process of transitioning to 2014 standards
▪ Will be required to fulfill HPC standards wholesale	▪ HPC/NCQA will create crosswalk between 2011 NCQA standards and HPC standards ▪ HPC will communicate to practices additional criteria they need to fulfill to be HPC certified	▪ HPC/NCQA will create crosswalk between 2014 NCQA standards and HPC standards ▪ HPC will communicate to practices additional criteria they need to fulfill to be HPC certified

PCMH Certification Timeline



A partnership with NCQA is also projected to result in savings in program administration

($000)	NCQA			Home-grown		
	Yr 1	*Yr 2*	*Yr 3*	*Yr 1*	*Yr 2*	*Yr 3*
Certification Costs for the practices	300[1]	300[1]	300[1]	0	0	0
Administrative Costs	400[2]	100[2]	100[2]	1,200[3]	1,000[3]	1,000[3]
Training / Technical Assistance	500[4]	500[4]	500[4]	500[4]	500[4]	500[4]
Total	**1,200**	**900**	**900**	**1,700**	**1,500**	**1,500**

1 Assumes 50% penetration over a three year period (~2,200 PCPs). Cost per PCP assumed at $500/PCP, subject to 20% state discount.

2 Includes the following: Development cost (fixed cost), modification of technical systems (fixed cost), training of staff (fixed cost), staff review of applications (ongoing)

3 Includes IT investments (fixed cost with maintenance), staff cost (ongoing), marketing and branding (ongoing). Based on CHART program as a benchmark

4 Based on other state examples

NCQA has already taken steps to simplify the documentation requirements based on practice feedback, and is considering piloting new approaches

Steps NCQA has taken to simplify documentation per stakeholder feedback	**Simplified chart review process** ▪ Lower number of criteria to be evaluated through chart review ▪ Focus on elements that can be documented via automatic reporting in EHRs **Simplified corporate application process,** enabling majority of documentation to be submitted at corporate level **Contracted with 18 EHR vendors to pre-validate NCQA requirements** (w/ 20 more in the pipeline, with the exception of EPIC)
Approaches NCQA is currently considering to further simplify documentation	**User friendly technology solutions to submit documentation** (e.g., shared screens vs. screenshots)

Details on select state programs (1/2)

	Michigan	Minnesota	Maryland
Launch date	▪ 2009	▪ 2010	▪ July 2011
Payer involvement	▪ Multi-payer ▪ Led by BCBSM	▪ Multi-payer ▪ Law requires payers to pay PMPM CM fees	▪ Multi-payer, as required by law ▪ Enhanced payment based on population and practice size
Certification criteria	▪ NCQA or BCBS criteria ▪ BCBSM criteria weighted: 50% capabilities, 50% quality and cost metrics ▪ Random site visits for ~25% of practices ▪ Practices ranked and paid accordingly	▪ Home grown certification criteria ▪ Documentation and site visits ▪ New criteria added for re-certification	▪ Modified NCQA criteria:[2] ▪ Elements optional under NCQA, but required in MD include: dedicated staff who work with patients on treatment goals, assess patients' barriers to meeting their goals, and follow-up with patients after visits; providing 24-hour phone response for urgent needs; medication reconciliation at every visit; and maintaining a patient registry
Implementation	▪ State agency sponsors Learning Collaboratives, oversees APCD to provide risk-adjusted reports, high-risk patient lists to facilitate CM; provides financial/operational assistance to develop care mgmt models (6 program staff + 8 APCD staff) ▪ BCBSM has 28 staff: Program (4), Field (10), Development (4), Admin (5), Clinical (5)	▪ State sponsors learning collaboratives, 6 program staff	▪ State sponsors learning collaboratives and practice coaches, uses APCD for practice support and evaluation ▪ 50 sites in phase 1 ▪ Working with Health Resources Commission to train care coordinators
Results	▪ $310M savings over 4 years ($26.37 lower PMPM) ▪ Composite quality scores increased by 3.5%; HEDIS measures for immunization, breast cancer and colorectal screening improved by 5%	▪ PCMH members 9.2% less costly vs non PCMH members ▪ Better quality for colorectal screening, asthma, diabetes, depression follow up, vascular care[1]	▪ 4.2% reduction in PMPM over 2 years ▪ 8% reduction in specialist visits

1 based on statewide quality measurement and reporting system

2 Reasons cited include: familiarity of commercial payers with NCQA, ability to leverage investments made by a widely known, respected, neutral organization, and eliminating the need to devote limited resources to developing and administering a new recognition process

Details on select state programs (2/2)

	Rhode Island	Illinois
Launch date	▪ 2008	▪ 2006
Payer involvement	▪ Multi-payer ▪ Enhanced payment for care management, initially voluntary, subsequently mandated by law	▪ Medicaid
Certification criteria	▪ NCQA criteria	▪ Home grown criteria, in association with PCCCC and AHRQ (implementation preceded national PCMH certification standards)
Implementation	▪ 48 sites, ~300 providers ▪ State sponsors learning collaboratives ▪ Common contract specifications were developed through a consensus process that included plans and providers	▪ Medicaid program provided patient registries, referral support, quality improvement tools, access to claims databases, and physician quality measure profiles
Results	▪ 7% reduction in admissions ▪ 15% reduction in TME (2008-12) ▪ 35% improvement in weight management, 5% improvement in diabetes control, 13% improvement in hypertension control	▪ 7-8% annual savings (varies by program, cumulative savings of $1.5B ▪ IP costs fell by 30%, OP costs rose by 25%, avoidable hospitalizations fell by 17% ▪ Quality improved for nearly all metrics; prevention metrics more than doubled in frequency

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Contact Information

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