The Advanced Medical Home Conference

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Opening Remarks

- **Mark Schaefer**, Director, Healthcare Innovation

- **Jeffrey A. Gordon, MD**, Connecticut State Medical Society

- **Kate McEvoy**, Director, Division of Health Services, CT Department of Social Services
Keynote

- Marci Nielsen, PhD, MPH, President & CEO of the Patient-Centered Primary Care Collaborative
Primary care, medical homes, and payment reform: where we are and where we're headed

Marci Nielsen, PhD, MPH
President & CEO
@Marci_PCPCC
MY AGENDA FOR THIS EVENING

Where we’ve been...
• Key elements of transformed person-centered primary care

Where we are...
• Evidence for patient-centered medical home (PCMH)
• Model for care versus certification for payment

Where we are going ...
• Payment reform: MACRA & alternative payment models
• PCMH and changing landscape
PATIENT-CENTERED PRIMARY CARE COLLABORATIVE

*Unifying* for a better health system - by better investing in *team-based* patient-centered primary care

**PUBLIC:**
Patients, Families, Caregivers, Communities

**PAYERS:**
Employers, Government, Health plans, Consumers

**Collaborative:**
- Convene
- Communicate
- Advocate

**HEALTH CARE PROVIDERS:** People who take care of patients/families
An increase of **ONE** primary care physician per **10,000** people can generate:

- **55%** of medical visits are for **primary care** but only **5%** of health care spending.
- **5.5%** fewer hospital visits
- **11%** fewer E.D. visits
- **7%** fewer surgeries

**23%** of Americans do not have a usual primary care provider.

(71 million, almost 1 in 4)

Infographic References
TRANSFORMATION: Where we have been ...

[http://bipartisanpolicy.org/library/what-makes-us-healthy-vs-what-we-spend-on-being-healthy/]
MILESTONES IN PCMH DEVELOPMENT

1967-2006

- Medical Home Term in *Standards of Child Health Care* by Council on Ped. Practice
- Medical Home and Hawaii Child Health Plan (Calvin Sia, MD)
- Future of Family Medicine
- ACP & Advanced Medical Home
- PCPCC Founded

1967
- Alma Alta Declaration

1978

1979
- AAFP & TransforMED

1989

2004

2006
MILESTONES IN PCMH DEVELOPMENT

2006-Present

- National Business Group on Health Award
- Commonwealth Fund PCMH Programs
- Recognition or accreditation of medical homes begins
- Various multi-payer initiatives tested (CPC, MAPCP, IAH)

2007
- Joint Principles of PCMH

2008
- State & Local PCMH Pilots

2010
- Affordable Care Act passed

2015
- Medicare Access & CHIP Reauthorization Act (MACRA) Passes
THERE IS NO “I” IN PCMH

Community Centers
Public Health
Schools
Employers
Faith-Based Organizations

Patient-Centered Medical Home

Health IT

Home Health
Hospital
Pharmacy
Oral Health
Mental Health
Specialty & Subspecialty
Skilled Nursing Facility

Health IT

$
COMMON ELEMENTS OF SUCCESSFUL TEAM-BASED INITIATIVES

• Focus on patient-centered care
• Cultural sensitivity and community focus
• Continuous quality improvement
• Development of effective team practice
• Dispersed team leadership
• Integration of behavioral health
EVIDENCE: Where we are now ...

Figure 1

Medical Home Models

- Multi-Payer Advanced Primary Care Practice (MAPCP)
- Comprehensive Primary Care (CPC)
- Federally-Qualified Health Center (FQHC) Advanced Primary Care Practice (APCP)
- Independence at Home

SOURCE: Map data downloaded January 19, 2016 from CMS: https://innovation.cms.gov/initiatives/map/index.html. Participant counts in this dataset are updated periodically. See Table 3 for official counts in most recently-available CMS documents and webpages.
BEGINS WITH THE DEFINITION: WHAT IS A PCMH?

Is it a “Good Housekeeping” Seal of Approval for the Public?

Is it a quality improvement process for practices?

Is it a recognition or certification process for payers and purchasers?

Is it a payment model for government and/or commercial plans?
PCMH as a “recognition”

- External validation
- “Short term” view of model
- Focused more on process measures
- Role in practice transformation & increased reimbursement
- Role in assessing value by payers

PCMH as ideal practice transformation

- “North star” – aspirational guide
- “Long term” view of model
- Focused more on outcomes
- What’s most important to patients, families, caregivers & consumers?
GROWING BODY OF PCMH EVIDENCE

• 2015 Annual Evidence Report:
  • What we studied & what we learned
  • 30 independent studies
  • Peer reviewed, government, and industry

• Paying for Value
  • Where delivery reform meets payment reform
  • MACRA
FOR POLICYMAKERS ROI IS KEY

(n₁ = Improvement in measure/n₂ = Measure assessed by study)

Aggregated Outcomes from the 30 Studies

21 of 23 studies that reported on cost measures found reductions in one or more measures.

23 of 25 studies that reported on utilization measures found reductions in one or more measures.
KEY FINDING

- **CONTROLLING COSTS BY PROVIDING THE RIGHT CARE**

- **POSITIVE CONSISTENT TRENDS:**
  - By providing the right primary care “upstream,” we change how care is used “downstream”
  - Consistent reductions in high-cost (and many times avoidable) care, such as: emergency department (ED) use and hospitalization, etc
  - Cost savings evident – but assessment of total cost of care required (while assessing quality, health outcomes, patient engagement, & provider satisfaction)
KEY FINDING

ALIGNING PAYMENT AND PERFORMANCE

BEST OUTCOMES FOR MULTI-PAYER EFFORTS:

- Most impressive cost & utilization outcomes among multi-payer collaboratives with incentives/performance measures linked to quality, utilization, patient engagement, or cost savings ... more mature PCMHs had better outcomes
- No single best payment model emerged, but extended beyond fee-for-service
KEY FINDING

ASSESSING AND PROMOTING VALUE

• BETTER MEASURES & DEFINITIONS:
  • Variation across study measures -- and PCMH initiatives – make for challenging evaluations and expectations (patients, providers, payers)

Payment Reform to Define PCMH

The Centers for Medicare and Medicaid Services (CMS) will define PCMH certification for the purpose of payment incentives as part of the Medicare Access and CHIP Reauthorization Act (MACRA). This provides an important opportunity to unify around a clear PCMH definition and recognition process that offers measurable value and impact to patients, providers, and payers, as well as to researchers evaluating the model.
Since 2012, *Comprehensive Primary Care (CPC) initiative* brings together Medicare fee-for-service and *38 payer partners* across *7 regions* to support primary care practice transformation.

- **95% of payers** continue to partner in CPC into its 4th year.
- **Lines of business**: commercial, Medicare Advantage, Medicaid managed care, self-insured clients (TPA/ASO).
- Partnership with **4 State Medicaid agencies**.
Figure 3.6. Practice-reported CPC spending across regions for selected cost categories, in millions

- Labor, $117
- EHR/IT/portals, $7
- Consulting/ vendors, $4
- Office space, $2
- Training/travel, $2
- Non-IT equipment, $1

Figure 3.10. Percentage of practices rating their RLF as excellent, very good, good, fair, or poor in meeting their CPC-related needs

Source: CPC practice survey, administered between April and July 2014.

Note: Some columns do not add up to 100 percent due to rounding. Practices in New Jersey were asked to rate the New Jersey Academy of Family Physicians, because it provides support to all but two New Jersey practices. (These two practices are supported by TransforMED.)

SUMMARY OF EARLY RESULTS: UP NEXT CPC+

IMPROVEMENTS

• GREATEST: Risk stratified care management & expanded access to care

• PATIENT EXPERIENCE: Small statistically significant improvements in timely appointments, information & care; engaging patients in their care; shared decision making)

• EXPENDITURES: Reduction of $11 PBPM (w/o care management fees of $18 PBPM)

• UTILIZATION: Hospitalizations, SNFs

CHALLENGES

• Changing workflows & procedures

• Incorporating new staff roles into primary care work flow

• Communicating without interoperable EHRs

• Data reports from payers hard to interpret
FINANCING (AKA PAYMENT REFORM): Where we are going ...

- **Health expenditures vs. GDP**
  - Per capita, 2010, PPP
  - United States
  - All other OECD countries
  - Circles proportional to size of population

- **Health expenditures as a percentage of GDP**
  - Per capita, 1960-2014
  - United States: 16.9%
  - OECD average*: 8.6%
  - Countries: 5.0%, 3.6%

*Limited to OECD countries with historical data from 1960
“EACH SYSTEM PERFECTLY DESIGNED TO ACHIEVE RESULTS IT GETS”

<table>
<thead>
<tr>
<th>Confronting a Changing Paradigm: The Evolution of Incentives for Providers</th>
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<tbody>
<tr>
<td><strong>Fee for Service</strong></td>
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<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Patient Volume</td>
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<tr>
<td>Length of Stay</td>
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<td>Ancillary Testing</td>
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<table>
<thead>
<tr>
<th>Health Care Environmental Paradigm</th>
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<tbody>
<tr>
<td>• System formation and expansion, market consolidation</td>
</tr>
<tr>
<td>• Volume driven primary and specialty care</td>
</tr>
<tr>
<td>• Continued expansion</td>
</tr>
<tr>
<td>• Emergence of quality and safety processes and metrics</td>
</tr>
<tr>
<td>• Increased transparency on pricing and outcomes</td>
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<tr>
<td>The “Triple Aim” (Value)</td>
</tr>
<tr>
<td>• Improve the experience of care</td>
</tr>
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<td>• Improve the health of populations</td>
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<tr>
<td>• Reduce the per capita costs of health care</td>
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<tr>
<td>• Accept “integrator” role</td>
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<tr>
<td>• Two-way risk sharing</td>
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<tr>
<td>• Appropriate utilization</td>
</tr>
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</table>

http://www.dartmouth-hitchcock.org/about_dh/new_reimbursement_models.html
EMERGING PAYMENT REFORM TRENDS

- Fee-For-Service
- Volume-based reimbursement
- Value-based reimbursement
- Bundled payments
- Global budget contracts
- ACOs
TRAJECTORY TO VALUE-BASED PURCHASING:
PCMH part of a larger framework

HIT Infrastructure: EHRs and population health management tools

Primary Care Capacity: PCMH or advanced primary care

Care Coordination: Coordination of care across medical neighborhood & community supports for patient, families, & caregivers

Value/Outcome Measurement Reporting of quality, utilization and patient engagement & population health measures

Value-Based Purchasing: Reimbursement tied to performance on value

Alternative Payment Models (APMs): Supporting ACOs, PCMH, & other value based arrangements

Source: THINC - Taconic Health Information Network and Community
AVERAGE SAVINGS FOR ACOs BY STATE

NATIONAL ACO TRENDS

• Substantial variation in financial performance and quality results.

• Payment reform alone is not enough to improve quality and reduce costs
  • organizations must also transform the way care is delivered.

• Care transformation is difficult and takes time to get right.
  • Consistent with the 2014 results, this year’s data confirms that the most experienced ACOs have a greater likelihood of achieving shared savings.

• Consolidated ACOs did not necessarily achieve the best performance.
  • Smaller, physician-led ACOs were more likely to improve quality and lower cost enough to earn shared savings.
  • Consolidation and larger size do not necessarily lead to the functional integration and efficiency needed to succeed under alternative payment models.

PREVENTING THE CRASH

“Payment reform and delivery reform are like a pair of skis. Policymakers often want to see immediate results and try to push the policy ski as far forward as possible, but forget about the lagging delivery ski. If progress in payment reform is not matched by progress in delivery reform, the misaligned skis will cause a crash, or, in this case, it will cause ACOs to leave the voluntary program and revert to non-value-based models.”

MACRA: TYING DELIVERY & PAYMENT REFORM IN ONE EASY SLIDE

### MIPS and APMs begin operating

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<th>Year</th>
<th>MIPS</th>
<th>APMs</th>
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<tr>
<td>2016</td>
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<tr>
<td>2017</td>
<td>0.5%</td>
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<tr>
<td>2018</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>2020</td>
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<td>2021</td>
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<tr>
<td>2022</td>
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#### MIPS Maximum Bonus or Penalty (+/-)

- **2016**: -4%
- **2017**: -5%
- **2018**: 4%
- **2019**: 5%
- **2020**: 7%
- **2021**: 9%

#### APMs Across-the-Board Bonus

- **2016**: 5%
- **2017**: 5%
- **2018**: 5%
- **2019**: 5%

#### Additional Funding

- $15 million available every year for measure development
- $20 million available every year for technical assistance to small practices

Up to $500 million authorized every year for MIPS bonuses of up to 10% for exceptional performance (2019–24)
• “The joy of practicing medicine is gone.”
• “I hate being a doctor...I can’t wait to get out.”
• “I can’t tell you how defeated I feel...The feeling of being punished for delivering good care is nerve-racking.”
• “I am no longer a physician but the data manager, data entry clerk and steno girl... I became a doctor to take care of patients. I have become the typist.”

Bodenheimer & Sinsky (2014) From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider http://www.annfammed.org/content/12/6/573.full
Physicians See Effect Of Health IT As Positive, Quality Metrics and Financial Penalties As Negative, For Overall Quality Of Care

**AMONG PRIMARY CARE PHYSICIANS:** Do you think each of the following is having a positive, negative, or no impact on primary care providers’ ability to provide quality care to their patients?

- **Increased use of health information technology:**
  - Positive: 50%
  - No impact: 10%
  - Negative: 28%
  - Not sure: 11%

- **Increased use of quality metrics to assess provider performance:**
  - Positive: 22%
  - No impact: 17%
  - Negative: 50%
  - Not sure: 10%

- **Programs that include financial penalties for unnecessary hospital admissions or readmissions:**
  - Positive: 12%
  - No impact: 14%
  - Negative: 52%
  - Not sure: 21%

**SOURCE:** The Kaiser Family Foundation/Commonwealth Fund 2015 National Survey of Primary Care Providers (conducted January 5 – March 30, 2015)
### Reporting Quality Measures

#### Mean hours spent per physician per week in dealing with external quality measures, 2014-15

<table>
<thead>
<tr>
<th>Physicians and Staff</th>
<th>Total Effort</th>
<th>Entering Information</th>
<th>Reviewing Quality Reports from External Entities</th>
<th>Tracking Quality Measure Specifications</th>
<th>Developing and Implementing Processes to Collect Data</th>
<th>Collecting and Transmitting Data to be Used in Quality Measurement</th>
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<td>Primary Care</td>
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<td>15.3</td>
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<td>0.3</td>
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<td>Multispecialty</td>
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<td>14.7</td>
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<td>0.8</td>
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<td>0.7</td>
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<th>Physicians Only</th>
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<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
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EXPLAINING PHYSICIAN BURNOUT

• 87% of physicians named leading cause of work-related stress and burnout as **paperwork and administration**, with 63% indicating that stress is increasing.\(^8\)

• 43% of physicians surveyed in 2014 reported spending over 30% of their day on administrative tasks.\(^9\)

• Physicians spend **more time on non–face-to-face activities** (eg, letters, in-box management, and medication refills) **than with patients**.\(^{10}\)

• Even when in the exam room with patients, primary care physicians spend from 25% to 50% of the time **attending to the computer**.\(^{11}\)

Bodenheimer & Sinsky (2014) *From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider* http://www.annfammed.org/content/12/6/573.full
RELATING STAFF TO PHYSICIAN BURNOUT

• 60% of employees report job burnout and 34% planned to look for a different job. Complaints included heavy patient loads, small staffs, and high stress levels. ¹⁹

• Physician and staff dissatisfaction feed on each other. “It’s really rough to be around a burned-out doctor. They’re cynical, sarcastic, and wonder, ‘what’s the use anymore?’” It can go the other way, too. A burned-out staff member may not be doing his or her job, resulting in more stress for the already overworked doctor. ²⁰

• Adequate numbers of well-trained, trusted, and capable support staff with low turnover predict greater physician satisfaction. ⁷

Bodenheimer & Sinsky (2014) From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider http://www.annfammed.org/content/12/6/573.ful
ADDING JOY – THE EVIDENCE SO FAR

• Implement team documentation:
  • Team documentation has been associated with greater physician and staff satisfaction, improved revenues, and the capacity of the team to manage a larger panel of patients while going home earlier.33,34

• Use pre-visit planning and pre-appointment laboratory testing:

• Expand roles:
  • allowing nurses and medical assistants to assume responsibility for preventive care and chronic care health coaching under physician-written standing orders33,36

Bodenheimer & Sinsky (2014) *From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider* http://www.annfammed.org/content/12/6/573.ful
ADDING JOY – THE EVIDENCE SO FAR

• Standardize and synchronize workflows for prescription refills
  • an approach which can save physicians 5 hours per week while providing better care

• Co-locate teams:
  • When physicians work in the same space as their team members, increase in efficiency of 30 minutes of physician time per day

• Ensure that staff who assume new responsibilities are well-trained
  • Understand staff contribute to health of patients; re-engineer unnecessary work out of the practice

• Dedicate more financial and personnel resources to primary care
  • One study estimates that a 59% increase in staffing, to 4.25 FTE staff per physician, is needed to achieve the patient-centered medical home.

Bodenheimer & Sinsky (2014) From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider http://www.annfammed.org/content/12/6/573.full
NATIONAL IMPERATIVE: “TRIPLE AIM”
“QUADRUPLE AIM”

Better Patient Experience

QUADRUPLE AIM

Lower Per Capita Health Care Costs

Improved Quality (better outcomes)

“Joy in Practice”

NEW ADMINISTRATION & CONGRESS

• Affordable Care Act: “Repeal & Replace” … process, process, process

• Insurance reforms: Ditch individual mandate but keep pre-existing conditions exclusion, purchase HI across state lines …

• Medicare: Modernize … battle lines already drawn

• Medicaid: Block grants

• MACRA – so far, so good
MY AGENDA FOR THIS EVENING

Where we’ve been...
• Key elements of transformed person-centered primary care MUST BE ACCOMPANIED BY PAYMENT REFORM

Where we are...
• Evidence for patient-centered medical home (PCMH) is clear but TRANSFORMATION TAKES TIME, INCENTIVES, DATA, AND A TEAM

Where we are going ...
• Payment reform: MACRA & alternative payment models ARE HERE TO STAY, BUT DIVERSIONS MAY BE SIGNIFICANT
PRECONDITION FOR PCMH: LEADERSHIP

“It takes leadership, and leadership of a particular kind. The creation of integrated, comprehensive primary care is not a technical proposition. Clinicians are not line workers who produce bits of health care, and clinics are not factories where health care is made. ... Health is personal ...”

J Am Board Fam Med September-October 2015 vol. 28no. Supplement 1 S107-S110
THANK YOU!

(Tell Rod Bremby I said hello!!!((
Panel Discussion: The PCMH Experience

- **Joseph L. Quaranta, MD**, Community Medical Group
- **Adam Dworkin**, Practice Administrator, Griffin Family Physicians
- **Alice Nelson Ferguson**, Patient Voice, SIM Consumer Advisory Board
- **Irene Furlong**, Director of Clinical Services, Stamford Health Medical Center
- **David R. Howlett, MD**, Family Physician, East Granby Family Practice
- **Barbara Ziogas, MD**, Pediatrician
East Granby Family Practice

Staff

• David Howlett, MD
  o PCMH/MU/EMR Project Director for EGFP for 11 years
  o Partner & Full Time Clinical Physician for 33 years
  o Board of Directors, Saint Francis HealthCare Partners & SFHCP ACO
    • Regional Medical Director - SFHCP
  o Past President & Current Board Member of Connecticut Academy of Family Physicians for 20 years
  o Advisory Board, Connecticut Institute of Primary Care Innovation (CIPCI)
  o Past Board Member - Qualidigm
  o Assistant Clinical Professor – UConn School of Medicine
  o Assistant Clinical Professor – Quinnipiac School of Medicine
East Granby Family Practice

“It takes a team”

• Physicians & APRNs
  o Edward Ewald, MD            Elizabeth Freedman, MD          Anne Reiher, MD
  o Neena Pursani, MD            Khuran Ghumman, MD            Daniel Lemer, DO
  o Jeannie Crabtree, APRN       Mary Ann Webster, APRN        Kate Taylor, APRN

• Nursing Staff
  o Ellen Baltronis, RN (Dept.Head)    Tamara Smart, RN (NC)           Cindy Henry, RN (NC)           Krista Pochron, RN (NC)
  o Lucinda Sweeney, LPN              Kim Koistinen, LPN             Tasha Dunn, LPN                   Yanna Wills, LPN
  o Samantha JessopCooper, MA        Kathy Donaldson, MA            Lisa Turcotte, MA                Heather Corley, MA
  o Mary Ann Hath, RT                    Ingrid Walczyk , MA

• Front Office Staff
  o Lynne DuPerry, Office Manager
  o Daniel Eichner, Billing & IT Specialist
  o Cissy Bogli                      Chelsea Burrows               Kate McDunnah
  o MaryAnn Grasso                  Laurie Nash                    Peggy Mannion
  o Cathy Howlett (PMH)
East Granby Family Practice

Characteristics

• Patients from suburban & rural communities
  o East Granby, Granby, Windsor, Windsor Locks, Enfield & others
  o ~16,000 registered patients ~10,000 active (seen within last 2 years)
  o ~26,000 patient visits per year

• Insurances (% of receipts)
  o Private (~62%)
  o Medicare (~12%)
  o Medicaid (~8%)
  o Cash/ High deductible/None (~18%)

• Age Distribution
  o Newborn -10 (8%)  Ages 11-21 (15%)
  o Ages 22-40 (16%)  Ages 41-64 (39%)
  o Ages 65-75 (13%)  Ages 76 & up (7%)
East Granby Family Practice

**Characteristics**

- **EMR – McKesson’s Practice Partner**
  - Go live date - 4/1/2005
  - Able to modify & create templates “on the run”

- **PCMH – “It takes a team to certify”**
  - 2011 - Level 3 - helped by Qualidigm & SFHCP
  - 2014 - Level 3 - helped by SFHCP (Saint Francis HealthCare Partners)
  - 2017 - recertification in progress - CHN (Community Health Network)

- **Meaningful Use**
  - Satisfied the requirements & received payment
  - PQRS reporting (Now through SFHCP ACO)
  - Quality Metrics Reporting & Identify gaps in care

- **ACO**
  - Prepared
East Granby Family Practice

Why did we do it?

- Philosophy of family medicine is concordant with the tenets of the patient centered medical home &
- It’s the right thing to do – improves patient care
- Already had extended hours (some evenings & weekends) from our experiences managing walk-in centers in the 1980’s
- NCQA certification requirements were similar to many of those required for Meaningful Use ($)
- We had already enrolled in a number of study projects through PPRNet to improve patient care
- Might get P4P bonuses (True for Medicaid – PCMH Level 3 = 24% increase in certain E&M codes)
- In alignment with value-based payments (ACO) & in position to legitimize data from insurer’s claims data
Completed Research

Improving Recognition and Management of Chronic Kidney Disease in Primary Care
(7/01/2011 - 6/30/2015)

Learning from Primary Care Meaningful Use Exemplars
(09/01/2013 - 05/31/2014)

Dissemination of the PPReNet Model for Improving Medication Safety in Primary Care
(PPReNet-MS-2 10/01/2010 - 09/30/2013)

Implementation of Alcohol Screening, Intervention and Treatment in Primary Care
(AMTRIP 09/20/2008 - 09/19/2013)

Enhancing Comparative Effectiveness Research Capabilities in PPReNet
(06/01/2010 – 07/31/2012)

Reducing Inappropriate Prescribing of Antibiotics by Primary Care Clinicians
(ABX-TRIP 08/24/2009 - 07/22/2012)

Medication Safety in Primary Care Practice : Translating Research into Practice
(09/30/2007 - 09/30/2010)

Colorectal Cancer Screening in Primary Care Practice (C-TRIP)
(06/01/2006 - 04/30/2010)

Implementation and Evaluation of Standing Orders Using Health Information Technology
(SOTRIP 07/01/2008 - 06/30/2010)

Facilitating Alcohol Screening of Hypertensive Patients - AATRP
(07/01/2004 - 06/31/2007)

Accelerating Translation of Research into Practice - ATRIP
(06/30/2002 - 09/30/2006)

Primary and Secondary Prevention of CHD and Stroke (TRIP II Project)
(10/01/2000 - 09/30/2003)
How did EGFP meet the requirement?

• **Appointment Access**
  - Blocked slots daily for acute & some chronic (pre-op)
  - Extended evening and weekend hours
  - Physician extenders & per diem staff for overflow

• **Telephone Advice Access**
  - 24/7 physician coverage for our group only with access to electronic records at home
  - 2 full-time triage/nurse coordinators for all clinical calls during office hours

• **Electronic Access**
  - Webview - patient have access to all their medical record
  - Can e-message physician for non-urgent care
  - Can request appointment
How did EGFP meet the requirement?

- Inform patients about the practice
  - Website and handouts
  - Result letter re-enforces medications, instructions & contact information

- Roles of staff members – becomes office manual

- Team huddle
  - Patient summary document – outlines what services are needed
  - Standing orders – i.e. flu vaccine, micro-albumens, foot exam

- Meetings – Need to keep minutes
  - Physicians and providers every 2 weeks
  - Management staff every 2 weeks
  - Nursing and front office quarterly and as needed
How did EGFP meet the requirement?

- **Clinical elements/data/health maintenance – discrete retrievable data**
  - Consultants names & telephone numbers
  - Smoking, Alcohol, Depression, Fall, Cognitive Screens, Advanced Directives
  - Special needs: vision, hearing, language, DME, POA
  - Immunizations, MCHAT, CCM, Vulnerable

- **Data – PPRNet reports**
  - Preventive services (Colon, Breast, Cervical screens)
  - Immunizations
  - Chronic or acute services
  - Medication (Beers list in elderly)

- **Evidence based guideline implementation**
  - Patient summary
  - Results letter
  - Clinical summary (from office visit template & Quick-text)
## PPRNet Clinical Quality Reports

### PPRNet Performance Measures
- Practice Performance on Individual Measures
- Provider Performance on Individual Measures

### PPRNet Measure Groupings
- CMS MU Clinical Quality Measures
- CMS ACO Clinical Quality Measures
- U.S. Preventive Services Task Force Recommendations
- CDC Advisory Committee on Immunization Practices Recommendations
- NIAAA Alcohol Screening and Intervention Recommendations
- CDC Get Smart Treatment Guidelines for URI’s
- CMS PQRS Clinical Quality Measure Groupings (DM, IVD, CVD Prevention)

### PPRNet Patient Level Reports
- PLR Registry
- CKD Risk Registry
- CMS PQRS-Diabetes Mellitus Measure Group
- CMS Chronic Care Management
- ACC/AHA Cholesterol Guidelines for ASCVD Risk Reduction in Adults

Note: PPRNet measure definitions may slightly differ from those of others, e.g., CMS electronic clinical quality measure specifications.

Submit all report comments/questions @

https://mecra.musc.edu/surveys/7s-3CALTTCNT

To download the most up-to-date PPRNet Report Guide- please visit our webpage:
<table>
<thead>
<tr>
<th>CMS MU Clinical Quality Measures (2014):</th>
<th>Number of eligible patients</th>
<th>Percent meeting criterion</th>
<th>Number not meeting criterion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Mellitus: Hemoglobin A1c Poor Control</td>
<td>752</td>
<td>71.28%</td>
<td>216</td>
</tr>
<tr>
<td>Diabetes Mellitus: Foot Exam</td>
<td>752</td>
<td>24.47%</td>
<td>568</td>
</tr>
<tr>
<td>Diabetes Mellitus: Dilated Eye Exam</td>
<td>752</td>
<td>19.66%</td>
<td>604</td>
</tr>
<tr>
<td>Controlling High Blood Pressure (BP)</td>
<td>2334</td>
<td>60.11%</td>
<td>931</td>
</tr>
<tr>
<td>Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic</td>
<td>493</td>
<td>82.15%</td>
<td>88</td>
</tr>
<tr>
<td>Heart Failure (HF): ACE Inhibitor or ARB Therapy</td>
<td>47</td>
<td>57.45%</td>
<td>20</td>
</tr>
<tr>
<td>Heart Failure (HF): Beta-Blocker Therapy</td>
<td>47</td>
<td>44.68%</td>
<td>26</td>
</tr>
<tr>
<td>Chlamydia Screening for Women</td>
<td>593</td>
<td>0.00%</td>
<td>593</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>3436</td>
<td>26.89%</td>
<td>2512</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>2231</td>
<td>61.05%</td>
<td>869</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>4342</td>
<td>59.93%</td>
<td>1740</td>
</tr>
<tr>
<td>Influenza Immunization</td>
<td>9659</td>
<td>34.94%</td>
<td>6284</td>
</tr>
<tr>
<td>Pneumonia Vaccination Status for Older Adults</td>
<td>1893</td>
<td>82.09%</td>
<td>339</td>
</tr>
<tr>
<td>Depression screening (adults)</td>
<td>8496</td>
<td>77.48%</td>
<td>1913</td>
</tr>
<tr>
<td>Anti-depressant Medication Management</td>
<td>1535</td>
<td>61.24%</td>
<td>595</td>
</tr>
<tr>
<td>Tobacco Use Screening and Cessation Intervention</td>
<td>8496</td>
<td>88.56%</td>
<td>972</td>
</tr>
<tr>
<td>Use of Appropriate Medications for Asthma</td>
<td>964</td>
<td>39.94%</td>
<td>579</td>
</tr>
<tr>
<td>Appropriate Treatment for Children with Upper Respiratory Infection (URI)</td>
<td>25</td>
<td>76.00%</td>
<td>6</td>
</tr>
<tr>
<td>Use of High-Risk Medications in the Elderly</td>
<td>1760</td>
<td>89.77%</td>
<td>180</td>
</tr>
<tr>
<td>Warfarin Time in Therapeutic Range</td>
<td>61</td>
<td>16.39%</td>
<td>51</td>
</tr>
</tbody>
</table>
PCMH #4 - Care Management & Support

How did EGFP meet the requirement?

• Identify Vulnerable Population
  o ICM-10 codes for 19 chronic conditions from CMS.gov (PPRNet reports)
  o Frequent ER use & Hospitalizations
  o Multiple complex conditions (PPRnet reports)
  o Identified by providers and others (SFHCP – nurse navigators)
  o Behavioral codes – Alcohol, Smoking, Drug Abuse, Prescription Overuse
  o Financial (from billing department)

• Chronic Care Management
  o Built into our templates and QuickText
  o Support from our nurse coordinators and SFHCP nurse navigators

• Medication management
  o Reconciles @ visit – (nursing then provider)
  o Reconciles from consults and hospitalizations (physicians and APRNs)
  o Electronic prescribing
PCMH #5 – Track & Coordinate Care

How did EGFP meet the requirement?

• Order entry
  o Tracks labs
  o Tracks radiology
  o Tracks referrals

• E-message to the future
  o Order due procedures (colonoscopy, mammograms, blood tests, consults)
  o Overdue office visits
  o Cancelled visits

• Must make follow up appointment at sign out
  o If not – e-message to future

• Consult/test tracking & entry
  o Providers enter to Past Medical History section & check discrete data box
  o PMH specialist as additional staff to interpret and enter results
PCMH #6 – Quality Improvement

How did EGFP meet the requirement?

• PPRNet reports
  o Review data as group – provider & patient specific
  o Implement office work flow to improve metrics (webview – flu clinic)
  o Standing orders
  o Demonstrate improvement

• Patient Survey
  o Qualidigm & SFHCP

• Share performance

• Certified EMR
Common Quality Metrics

Cancer Screening
- Breast
- Colorectal
- Cervical

Diabetes:
- HbA1c < 9%
- Retinopathy screening
- Nephropathy screening

Medication Adherence:
- Statins
- ACEI/ARBs
- Diabetes

BMI
- All Patients

Pediatrics:
- Pharyngitis – strep test prior to Abx
- URI – No Abx for 3 days
- Immunizations – variable by payer

BMI
Challenges

• Data management
  o Must be retrievable
  o Everyone needs to put in correct data in correct data field
  o Templates can do a lot automatically, but look busy

• Incomplete “buy-in” to the PCMH concept
  o Not everyone conscientious about entering proper data
  o Team concept & nursing support to overcome some of the barriers

• There is a lot to do – but your ACO will also require it
  o Screening questionnaires, medication reconciliation, standing orders
  o Chronic, acute and preventive care in one visit

• Cost
  o Extra staff - nurse coordinators
  o See fewer patients (but perhaps higher E&M codes)

• Onerous time consuming certification process
  o Like writing a thesis/requirements are choppy/work book is challenging
Costs 2014

- $3.8 trillion
  - Top ½% of population accounts for 20% of expenditures
  - Top 1% of population accounts for 30% of expenditures
  - Top 2% of population accounts for 40% of expenditures
  - Top 3% of population accounts for 50% of expenditures
  - The other 97% of population accounts for the other 50%

- Our Mission
  - Excellent quality care to top 3% sick population
  - Excellent preventive care to the 97% population to prevent them from becoming the top 3% sick population

  • Forbes, Feb. 2014
Benefits

• Patient Satisfaction – getting good care
• Staff Satisfaction – giving good care
• Pride and reputation
• Understanding the practice performance
• Understanding the individual provider performance
• Finding and filling the gaps in care
• Cost effective and non fragmented care
• Aligned with future Value Based Payment Model
• Some current financial benefit
Good Luck
Panel Discussion: The PCMH Experience

- Joseph L. Quaranta, MD, Community Medical Group
- Adam Dworkin, Practice Administrator, Griffin Family Physicians
- Alice Nelson Ferguson, Patient Voice, SIM Consumer Advisory Board
- Irene Furlong, Director of Clinical Services, Stamford Health Medical Center
- David R. Howlett, MD, Family Physician, East Granby Family Practice
- Barbara Ziogas, MD, Pediatrician
Advanced Medical Home Program

Department of Social Services
PCMH Program, with enhanced Medicaid rates

NCQA PCMH recognition (at discounted cost)

Better performance under MIPS (Medicare payment reform)

Improved patient experience and health equity
Are you ready to join the AMH Program?

☐ Yes! I would like to receive free technical assistance through the Advanced Medical Home program.

☐ I would like to learn more. We are happy to provide further information about the Advance Medical Home program to help you make the right decision for your practice.

OR Email Shiu-Yu.Schilling@ct.gov
## Making it Easy: Benefits of PCMH are Within Reach

<table>
<thead>
<tr>
<th>Topic</th>
<th>Speaker/Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Key to Financial Success Under MIPS</td>
<td>Robert McClean, MD, NEMG</td>
</tr>
<tr>
<td>AMH Program: Help is on the Way!</td>
<td>Qualidigm: Anne Elwell, Michele Kelvey-Albert</td>
</tr>
<tr>
<td>Get Rewarded for Improving Care</td>
<td>Robert Zavoski, Medical Director, Connecticut Medicaid</td>
</tr>
<tr>
<td>Simplifying 2017 NCQA PCMH Recognition</td>
<td>William Tulloch, NCQA</td>
</tr>
</tbody>
</table>
PCMH: The Key to Financial Success under MIPS

Robert McLean, M.D.
DECIPHERING THE ALPHABET SOUP

MACRA – Medicare Access & CHIP Reauthorization Act
MIPS – Merit-based Incentive Payment System
APM – Alternative Payment Model

QPP - Quality Payment Program
SGR – Sustainable Growth Rate
RBRVS – Resource–Based Relative Value Scale
SIM – State Innovation Model
GOALS TO UNDERSTAND:

How did we get here?

How does Medicare pay for clinician services?

What changes occurred in the past decade?

How does the alphabet soup fit in?
WHAT TO REALLY CONSIDER:

How does PCMH fit into MIPS?

How does the Nov 8 outcome affect this?
HOW DID WE GET HERE?

1. Science & the biomedical paradigm
2. The rise of hospitals & 3rd party payment in 1930s-40s
3. WW II & postwar dominance of specialists
4. Hard-wiring of payment to procedures: the rise of the “relative value unit”
HOW DOES MEDICARE PAY FOR CLINICIAN SERVICES?

1989 law established
Resource-Based Relative Value Scale (RBRVS)

Work RVU + Practice expense RVU + Professional Liability Insurance RVU
= Total RVU

X conversion factor = payment $
MEDICARE’S CONVERSION FACTOR

1992 initial conversion factor $31.001

2012 $34.037

2016 $35.8279

Included
+0.5% update from MACRA & -0.02% budget neutrality adjustment
WHAT CHANGES OCCURRED OVER THE PAST DECADE?

PCMH movement – Tax Relief and Healthcare Act of 2006 outlined Medicare medical home demonstration project

Public and Legislator awareness of need for:

*Health care that is affordable, accessible, delivered efficiently, and safe*
NEW TOOLS IN THE CMS TOOLBOX TO INCENTIVIZE CHANGES AND ENCOURAGE PRIMARY CARE

• Medical Homes
• Bonus Payments – For Good Results.
• Reducing Fraud, Waste & Abuse
• Medicare Shared Saving Program

• Offer Medicare patient’s free annual physicals and free preventive care services.
• Federal Coordinated Health Care Office
• Innovation Center
MACRA

• Legislation passed in April 2015 repealing the Sustainable Growth Rate (SGR), including 4/1/15 cut of 21%

• Unlike SGR, which cuts all physicians no matter what they do, physicians will have more control over their own conversion factor updates

• Locks provider reimbursement rates at near-zero growth for 3 years

• Stipulates the development of two new payment tracks for the Quality Payment Program (QPP): The Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) tracks

• Payment adjustments will impact Medicare Physician Fee Schedule payment starting Jan 1, 2019
HOW WILL CLINICIANS BE SCORED UNDER MIPS? FINAL RULE FOR 2019

A single MIPS composite performance score will factor in performance in 4 weighted performance categories:

- **Quality**: 60%
- **Advancing Care Information**: 25%
- **Clinical practice improvement activities**: 15%
- **Cost**: 0%

*Based on reporting data in 2017*
Certified PCMHs and PCMH specialty practices will get highest possible scores for clinical practice improvement under MIPS (15% of total)
**TIMING OF QPP IMPLEMENTATION**

- **Performance**: The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, record quality data and how you used technology to support your practice. If an Advanced APM fits your practice, then you can provide care during the year through that model.

- **Send in performance data**: To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology in 2017 to MIPS by the deadline, March 31, 2018. In order to earn the 5% incentive payment for participating in an Advanced APM, just send quality data through your Advanced APM.

- **Feedback**: Medicare gives you feedback about your performance after you send your data.

- **Payment**: You may earn a positive MIPS payment adjustment beginning January 1, 2019 if you submit 2017 data by March 31, 2018. If you participate in an Advanced APM in 2017, then you may earn a 5% incentive payment in 2019.

Source: https://qpp.cms.gov/
PICK YOUR PACE — MACRA/QPP

FINAL RULE FOR 2017 REPORTING

Don’t Participate

- %

Not participating in the Quality Payment Program:
If you don’t send in any 2017 data, then you receive a negative 4% payment adjustment.

Submit Something

0

Test:
If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.

Submit a Partial Year

+ %

Partial:
If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

Submit a Full Year

+ %

Full:
If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

Participate in the Advanced APM path:

+5%

If you receive 25% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% incentive payment in 2019.

Source: https://qpp.cms.gov/
MIPS FINAL RULE: OVERVIEW OF QUALITY PERFORMANCE CATEGORY

- **Most participants:** Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.
  - Three population measures automatically calculated, but only one used for performance score.

- **Groups using the web interface:** Report 15 quality measures for a full year.

- **NOTE:** Key Change from Current Program (PQRS): reduced from 9 measures to up to 6 measures with no domain requirement

- Year 1 Weight: 60%

Source: https://qpp.cms.gov/
MIPS FINAL RULE:
CLINICAL PRACTICE IMPROVEMENT ACTIVITIES*

- **Most participants:** Attest that you completed up to 4 improvement activities for a minimum of 90 days.

- **Groups with fewer than 15 participants or if you are in a rural or health professional shortage area:** Attest that you completed up to 2 activities for a minimum of 90 days.

- **Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model:** You will automatically earn full credit.

- **Year 1 Weight:** 15%

* Now simply called Improvement Activities
MIPS FINAL RULE: ADVANCING CARE INFORMATION

- Fulfill the required (i.e., base) measures for a minimum of 90 days:
  - Security Risk Analysis
  - e-Prescribing
  - Provide Patient Access
  - Send Summary of Care
  - Request/Accept Summary of Care

- Choose to submit up to 9 measures (minimum 5) for a minimum of 90 days for additional credit.

- For bonus credit, you can:
  - Report Public Health and Clinical Data Registry Reporting measures
  - Use certified EHR technology to complete certain improvement activities in the improvement activities performance category

Year 1 Weight: 25%
MIPS FINAL RULE: COST (AKA RESOURCE USE)

- No data submission required. Calculated from adjudicated claims.
- Year 1 Weight: 0%
HOW MUCH CAN MIPS ADJUST PAYMENTS?

- Based on the MIPS composite performance score, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.

- MIPS adjustments are **budget neutral**.

Those who score in top 25% are eligible for an additional annual performance adjustment of up to 10%, 2019-24 (NOT budget neutral)

Adjustment to provider’s base rate of Medicare Part B payment

2019 2020 2021 2022 onward

Merit-Based Incentive Payment System (MIPS)
WHAT TO REALLY CONSIDER:

How does PCMH fit into MIPS?
*Automatic full credit for clinical practice improvement (15%)
*Creates structure to fulfill advancing care information (25%) and to measure clinical quality (60%)

How does the Nov 8 outcome affect this?
The great unknown…
Failure is not fatal, but failure to change might be.
- John Wooden
Demystifying MACRA: Prepare Yourself for MIPS and AMPs in 2017

Join us for this live CME event, which will provide you with the details of the Medicare Access and CHIP Reauthorization Act (MACRA) program, including the two payment pathways for physicians, alternative payment models (APMs) and the Merit-Based Incentive Payment System (MIPS). This program will help you understand the reporting requirements of MACRA as well as help you maximize your payments for 2017.

Register Now
Get Rewarded for Improving Care: The DSS Medicaid PCMH and PCMH+ Programs

Robert Zavoski, MD
Department of Social Services
DSS Person-Centered Medical Home Program

- Based upon American Academy of Pediatrics’ model
- Team-based approach to care
  - NCQA or Joint Commission recognition
- In-office and financial supports
  - Glide path
  - Enhanced fee-for service rates
  - Incentive payments
  - Community Practice Transformation Specialists
Practice Assistance
With a PCMH Approved Practice

- Practice had previously achieved NCQA PCMH Level 2 recognition under the NCQA PCMH 2011 Standards.
- The Quality Assurance Annual Review (QAAR) is used to assess how much assistance a practice may need with their renewal on specific NCQA PCMH elements.
- This practice had multiple opportunities for improvement and areas which could be strengthened.
- The CPTS began working with the practice on their NCQA PCMH renewal in March 2015.
Practice Assistance
With a PCMH Approved Practice

The CPTS assisted the practice with the following NCQA PCMH requirements:
- Review and revision of practice policies and processes
- Identifying patients for Care Management
- Care Plans and Self-Management Support
- Medication Management
- Treatment Goals
- Patient Care Coordination
- Utilizing the practice’s EHR to gather data for Population Management
- Integrating Behavioral Health

Practice achieved **NCQA PCMH Level 3** recognition under the **2014 Standards** in February 2016.
### Financial rewards: details

<table>
<thead>
<tr>
<th>Component</th>
<th>Timing of Payment</th>
<th>Type/Basis for Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. While transforming (Glide Path)</td>
<td>Concurrent to assist with ongoing PCMH costs</td>
<td>Fee-for-Service (FFS) Add-on</td>
</tr>
<tr>
<td>2. Incentive Payments after obtaining NCQA PCMH</td>
<td>Retrospective for certain quality and outcome targets</td>
<td>Per Member Per Month (PMPM) payments</td>
</tr>
<tr>
<td>3. Improvement Payments after obtaining NCQA PCMH</td>
<td>Retrospective for certain quality and outcome improvement targets</td>
<td>Per Member Per Month (PMPM) payments</td>
</tr>
</tbody>
</table>

- Selected primary care service codes for all individuals seen by PCPs within PCMH using Evaluation and Management (E&M) codes including sick and well visits

- FFS Add-on amount varies by:
  - Glide Path - 14%
  - Level 2 - 20%
  - Level 3 - 24%
Financial rewards: Performance Incentive Payments

- PCMH Practices with NCQA Level 2 or 3, which provide services in one full calendar year receive a retrospective lump sum per member per month (PMPM) payment based on their performance results of PCMH Adult and Pediatric Quality measures.
- Performance incentive payment for each practice is awarded based on the annualized number of continuously attributed members, determined by the level of the mean performance percentile shown in the table below:

<table>
<thead>
<tr>
<th>Mean Performance Percentile</th>
<th>Level of Incentive Payment</th>
<th>PMPM Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 25th percentile</td>
<td>No Payment</td>
<td>$0</td>
</tr>
<tr>
<td>25th-50th percentile</td>
<td>25% of possible payment</td>
<td>$0.15</td>
</tr>
<tr>
<td>51st-75th percentile</td>
<td>50% of possible payment</td>
<td>$0.30</td>
</tr>
<tr>
<td>76th-90th percentile</td>
<td>75% of possible payment</td>
<td>$0.45</td>
</tr>
<tr>
<td>91st-100th percentile</td>
<td>100% of possible payment</td>
<td>$0.60</td>
</tr>
</tbody>
</table>
PCMH Practices with NCQA Level 2 or 3, which provide services in two full consecutive calendar years receive an additional retrospective lump sum PMPM payment based on their improved performance results of PCMH Adult and Pediatric Quality measures compared with the prior year’s results.

Performance improvement payment for each practice is awarded based on the annualized number of continuously attributed members, determined by the level of improvement percentage shown in the table below:

<table>
<thead>
<tr>
<th>Improvement Percentage</th>
<th>Level of Improvement Payment</th>
<th>PMPM Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 10%</td>
<td>25% of possible payment</td>
<td>$0.17</td>
</tr>
<tr>
<td>&gt; 10 – 25%</td>
<td>50% of possible payment</td>
<td>$0.34</td>
</tr>
<tr>
<td>&gt; 25 – 35%</td>
<td>75% of possible payment</td>
<td>$0.51</td>
</tr>
<tr>
<td>&gt; 35% or more</td>
<td>100% of possible payment</td>
<td>$0.68</td>
</tr>
</tbody>
</table>
**DSS PCMH Program Growth**

DSS PCMH Practices and Sites Growth by Quarter
January 2012 through September 2016

---

**Total Number of PCMH Unique Participating Practices**

**Total Number of Practice Sites**
60% of attributed Medicaid members now receive their care from a DSS PCMH - Over 1500 providers participate

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>203,718</td>
<td>205,774</td>
<td>226,764</td>
<td>211,206</td>
<td>240,892</td>
<td>250,216</td>
<td>273,012</td>
<td>240,892</td>
<td>533,372</td>
<td>546,668</td>
<td>516,421</td>
<td>540,570</td>
<td>535,628</td>
<td>546,402</td>
<td>550,945</td>
</tr>
<tr>
<td>48.4%</td>
<td>48.6%</td>
<td>51.2%</td>
<td>48.6%</td>
<td>52.4%</td>
<td>50.2%</td>
<td>51.2%</td>
<td>49.7%</td>
<td>49.8%</td>
<td>51.2%</td>
<td>51.7%</td>
<td>282,366</td>
<td>269,339</td>
<td>274,338</td>
<td>287,244</td>
</tr>
</tbody>
</table>

Total PCMH Attributed Members Vs. Total Members Attributed to a PCP
By Quarter from January 2013 through September 2016

Source: Data Warehouse
<table>
<thead>
<tr>
<th>Health Quality Measures - Higher Rate Indicates a Better Result</th>
<th>CY 2013 Admin Rate</th>
<th>CY 2014 Admin Rate</th>
<th>Difference</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressant Medication Management - Acute Phase Treatment</td>
<td>67.6%</td>
<td>69.4%</td>
<td>1.8%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Antidepressant Medication Management - Continuation Phase Treatment</td>
<td>50.9%</td>
<td>55.2%</td>
<td>4.2%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care – Eye Exam¹</td>
<td>56.9%</td>
<td>54.6%</td>
<td>-2.3%</td>
<td>-4.1%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Testing¹</td>
<td>85.1%</td>
<td>87.9%</td>
<td>2.7%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Medical Attention for Nephropathy¹</td>
<td>79.6%</td>
<td>77.4%</td>
<td>-2.3%</td>
<td>-2.8%</td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life - 6 or More Visits¹</td>
<td>76.5%</td>
<td>80.7%</td>
<td>4.3%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life¹</td>
<td>85.1%</td>
<td>85.9%</td>
<td>0.8%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Adolescent Well Care Visits¹</td>
<td>71.0%</td>
<td>70.9%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

8 out of 12 Health Quality Measures improved or stayed the same from CY 2013 to CY 2014 in the PCMH practice setting

A Lower Rate Indicates a Better Result for the Measures shown below

<table>
<thead>
<tr>
<th>Measure</th>
<th>CY 2013 Admin Rate</th>
<th>CY 2014 Admin Rate</th>
<th>Difference</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma Patients with One or More Asthma-Related Emergency Room Visits</td>
<td>8.0%</td>
<td>7.8%</td>
<td>-0.2%</td>
<td>-2.4%</td>
</tr>
<tr>
<td>Ambulatory Care - ED Visits per 1,000 MM</td>
<td>64.80</td>
<td>63.70</td>
<td>-1.10</td>
<td>-1.7%</td>
</tr>
<tr>
<td>Readmissions within 30 Days - Physical Health Only</td>
<td>9.05%</td>
<td>9.90%</td>
<td>0.8%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Readmissions within 30 Days - Physical Health and Behavioral Health</td>
<td>10.08%</td>
<td>11.03%</td>
<td>1.0%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

¹ Hybrid measure is reported using only administrative claims data.
## PCMH Practices* vs. Non-PCMH** CY 2014 Results Comparison

<table>
<thead>
<tr>
<th>Selected Health Quality Measures</th>
<th>PMCH CY 2014 Admin Rate</th>
<th>Number of Qualifying Members (Denominator)</th>
<th>Non-PCMH CY 2014 Admin Rate</th>
<th>Number of Qualifying Members (Denominator)</th>
<th>Rate Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressant Medication Management - Acute Phase Treatment</td>
<td>69.4%</td>
<td>1,715</td>
<td>66.9%</td>
<td>3,036</td>
<td>2.5%</td>
</tr>
<tr>
<td>Antidepressant Medication Management - Continuation Phase Treatment</td>
<td>55.2%</td>
<td>1,715</td>
<td>52.9%</td>
<td>3,036</td>
<td>2.3%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Eye Exam*</td>
<td>54.6%</td>
<td>3,296</td>
<td>52.5%</td>
<td>8,672</td>
<td>2.1%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) testing†</td>
<td>87.9%</td>
<td>3,296</td>
<td>84.3%</td>
<td>8,672</td>
<td>3.6%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Medical Attention for Nephropathy†</td>
<td>77.4%</td>
<td>3,296</td>
<td>75.7%</td>
<td>8,672</td>
<td>1.7%</td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life - 6 or More Visits†</td>
<td>80.7%</td>
<td>2,612</td>
<td>70.3%</td>
<td>6,954</td>
<td>10.4%</td>
</tr>
<tr>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life†</td>
<td>85.9%</td>
<td>10,532</td>
<td>82.2%</td>
<td>27,404</td>
<td>3.7%</td>
</tr>
<tr>
<td>Adolescent Well Care Visits†</td>
<td>70.9%</td>
<td>17,599</td>
<td>69.2%</td>
<td>42,269</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

**Ambulatory Care - ED Visits per 1,000 MM**

<table>
<thead>
<tr>
<th></th>
<th>PMCH CY 2014 Admin Rate</th>
<th>Number of Qualifying Members (Denominator)</th>
<th>Non-PCMH CY 2014 Admin Rate</th>
<th>Number of Qualifying Members (Denominator)</th>
<th>Rate Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care - ED Visits per 1,000 MM‡</td>
<td>63.67</td>
<td>1,060,693</td>
<td>70.18</td>
<td>2,479,949</td>
<td>-6.51</td>
</tr>
<tr>
<td>Asthma Patients with One or More Asthma-Related Emergency Room Visits</td>
<td>7.8%</td>
<td>7,889</td>
<td>12.3%</td>
<td>16,769</td>
<td>-4.5%</td>
</tr>
<tr>
<td>Readmissions within 30 Days - Physical Health Only</td>
<td>9.90%</td>
<td>8,720</td>
<td>12.56%</td>
<td>24,251</td>
<td>-2.66%</td>
</tr>
<tr>
<td>Readmissions within 30 Days - Physical Health and Behavioral Health</td>
<td>11.03%</td>
<td>10,340</td>
<td>13.22%</td>
<td>27,844</td>
<td>-2.19%</td>
</tr>
</tbody>
</table>

1 Hybrid measure is reported using only administrative data.
2 This measure utilizes member months as the denominator.

*PCMH includes community practices and one hospital clinic which have achieved NCQA PCMH Level 2 or 3 recognition status
**Non-PCMH includes all community practices and hospital clinics which have not achieved NCQA PCMH Level 2 or 3 recognition status (Glide Path and FQHC practices are not included in these metrics)

The PCMH practice setting out-performed the non-PCMH practice setting for all 12 measures

Source: CY 2014 Annual Provider Profile Report
Patient satisfaction is high in PCMHs:

95% patient satisfaction rate for routine care in PCMHs in 2014

This is an increase from 2013 and higher than in non-PCMHs
The AMH Program gives you access to the DSS PCMH program

Advanced Medical Home Program

Transformation vendor Qualidigm will help you meet all requirements for the DSS PCMH program/or you have access to the DSS medical ASO – Community Health Network of CT

DSS PCMH Program

✓ Enhanced Medicaid fees during and after transformation

✓ Additional support from CHNCT after you become NCQA recognized
After you become a PCMH you become eligible for a new Medicaid shared savings program called “PCMH+”

**PCMH+ Program**

- Builds on PCMH competencies and other current Medicaid programs
- Eligible to share in savings that result from improving quality and reducing costs
- Next application projected to open in summer of 2018
Questions?

Robert Zavoski, MD, MPH
Medical Director
robert.zavoski@ct.gov
Simplifying 2017 NCQA PCMH Recognition

William F. Tulloch
Director Government Recognition Initiatives
National Committee for Quality Assurance
PCMH Redesign: Improving the experience of the practice and the value of Recognition
We’ve heard...

Reduce
non-value added work, increase practice engagement

Strengthen
the link between PCMH recognition, performance

PCMH transformation is hard. Becoming a recognized PCMH shouldn’t be.

Align
with other reporting requirements

Leverage
practices’ investment in HIT to support PCMH recognition
NCQA PCMH redesign

**Now**
Self-guide to recognition

**Now**
Submit documents all at once

**Now**
Cumbersome survey tool

**Now**
Recognition is a 3-year cycle, has 3 levels

**Soon**
NCQA representative to guide you

**Soon**
Gradual submissions, steady feedback

**Soon**
More intuitive tool, with user tips

**Soon**
Yearly check-ins, more frequent help, no levels
3 Parts to the new system

Commit
Practice completes an online guided assessment.
Practice works with an NCQA representative to develop an evaluation schedule.
Practice works with NCQA representative to identify support and education for transformation.
New NCQA PCMH online education resources support the transformation process.

Transform
Practice submits initial documentation and checks in with its evaluator.
Practice submits additional documentation and checks in with its Evaluator.
Practice submits final documentation to complete submission and begin NCQA evaluation process.
Practice earns NCQA Recognition.

Succeed
Practice is prepared for new payment environment (value-based payment, MACRA MIPS/APMs).
Practice demonstrates continued readiness and high quality performance through annual check-ins with NCQA.

• NCQA PCMH Recognition redesign: The future recognition process
PCMH redesign offers...

- Flexibility
- Personalized service
- User-friendly approach
- Continuous improvement
- Alignment with changes in health care
New recognition platform

“Turbo-Tax” wizard or criteria/task

One online system does it all

Messaging between NCQA, customers, external reviewers

Different access for different roles
Timeline

2015
- Clarify redesign process through pilots with practices
- Finalize process, policies, staffing, training
- Identify requirements for new web-based platform
- Develop new interactive platform
- Test capacity to receive data from aggregators

2016
- Develop staffing model, pricing strategy, revenue/cost projections
- Refine model based on feedback
- Start transition of practices to Sustaining phase of new model
- Pilot & test new platform (V1) mid-2016
- Complete staff training and implement new platform internally.

2017+
- Update & revise PCMH program for 2017
- Go live with PCMH in March 2017
- Bring PCSP and other recognition programs into new process (2018+)
- Expand clinical quality measure data collection
- Test collection of operational metrics from health information technology
<table>
<thead>
<tr>
<th>Category</th>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Team-Based Care and Practice Organization</td>
<td>Practice leadership, Care team responsibilities and Orientation of patient/families/caregivers</td>
<td></td>
</tr>
<tr>
<td>2. Knowing and Managing Your Patients</td>
<td>Comprehensive data collection, Medication reconciliation, Evidence-based clinical decision support, Connection with community resources</td>
<td></td>
</tr>
<tr>
<td>3. Patient-Centered Access and Continuity</td>
<td>Access to practice and clinical advice, Care continuity/empanelment</td>
<td></td>
</tr>
<tr>
<td>4. Care Management and Support</td>
<td>Identifying patients for care management, Person-centered care plan development</td>
<td></td>
</tr>
<tr>
<td>5. Care Coordination and Care Transitions</td>
<td>Management of lab/imaging results, Tracking and managing patient referrals/care transitions</td>
<td></td>
</tr>
<tr>
<td>6. Performance Measurement and Quality Improvement</td>
<td>Collection of performance data and analysis, Setting goals and acting to improve practice performance, Sharing practice performance data and analysis</td>
<td></td>
</tr>
</tbody>
</table>
PCMH 2017 Status Decision

Recognition Level

• Single recognition level for all practices

Scoring Requirements

• All Core Requirements
• Electives
  • Complete 25 credits
  • Must complete at least 1 credit in 5 of the 6 categories
Future Program Additions

- Behavioral Health
- eCQM Reporting
- Patient Experience
- Practice Distinctions
- Oncology Medical Home
Sustaining Recognition

Engage practices in an annual check-in providing confirmation of continuing commitment and performance.

Each practice demonstrates that changes made during the initial recognition effort are part of their culture, and practice is becoming more patient-centered.
Advanced Medical Home Program: Help is on the Way!

AMH Conference
December 8, 2016
Meet the Qualidigm Practice Transformation Team

• Anne Elwell MPH, RN- Project Director
• Michele Kelvey-Albert, MPH- Project Manager
• Abigail Dancause, BS- Project Coordinator
• Rose Stamilio, MSN- Project Coordinator
• Erika Edlund, MBA- Project Assistant
AMH Pilot Updates

• Advanced Networks & Independent Offices

• Five Cohorts- 91 Participating Offices
  – 33 PCMH Level 3 Recognized Offices
  – 58 Offices Pending Submission/Recognition
Advanced Medical Home Components

- **Required “Areas Of Emphasis”**
- **NCQA**
- **SIM Critical Factors**
- **Additional SIM Must Pass Elements**

Advanced Medical Home
Benefits of Participation

**Technical Assistance** from Qualidigm staff designated as NCQA PCMH content experts related to:

- PCMH templates, policies and procedures
- Preparation for MACRA and other physician incentive programs
- Workflow and Team Care Activities
Office Requirements

• Microsoft Office Capabilities

• EHR Capabilities

• Patient Portal Capabilities

• Dedicated Staff
Contact

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860-632-6322

Michele Kelvey-Albert, MPH, PCMH CCE
MAlbert@qualidigm.org
860-632-6367
Closing Remarks

Victoria Veltri, JD, LLM, Chief Health Policy Advisor, Office of Lt. Governor Nancy Wyman