NEW YORK STATE OF OPPORTUNITY. Department of Health

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DOH REVIEW AND EXECUTIVE SUMMARY OF PPS PRIMARY CARE PLAN DECEMBER, 2016

PPS NAME: CARE COMPASS NETWORK (CCN)

CCN services roughly 92,859 Medicaid patients across the nine counties covering a large geographic area in the Southern Tier of the state. Of the nine counties, six counties are Primary Care Health Professional Shortage Areas (HPSAs), making access to primary and preventative care a challenge for these areas. The HPSA counties are Broome, Chenango, Cortland, Delaware, Tioga and Tompkins. The PPS has established four regional planning units RPUs) for local planning and implementation, with the Southern RPU constituting 46% of the Medicaid lives (Binghamton/Broome County) and where 3 of the PPS' 9 hospital systems are located.

There are 85 practice sites in the network with 2% of the sites having achieved PCMH 2014 Level 3 certification, 78% of the sites with PCMH 2011 certification and 20% of the sites without any certification

Overall Assessment: Plan needs specificity and focus. There are general delivery system issues described but discussion does not focus sufficiently or clearly on primary care. Strategies are left to RPUs and health system partners. The plan does not indicate specific progress on projects to indicate implementation is underway except for the MAX action sites.

FUNDAMENTAL #1: Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs

- Capacity is measured by vacancy rates by the major partner systems in the network amidst the 6 counties that are designated as HPSAs.
  - Primary Care Physician 8.5%
  - Primary Care Nurse Practitioners 9%
  - Physician Assistants in Primary Care 6.3
- Strategy is for partners to continue active recruitment and to deploy other positions to allow current providers to perform at the top of their license. RPUs to offer incentives and innovation grants for more mid-levels at CBOs such as MSWs and LCSWs especially in rural areas. Help providers understand staffing to go from FFS model to VBP model.
- Community-based PC Providers - Consultant in NRPU to help rural PCPs (non-safety net) gain PCMH but unclear if these practices will engage.

FUNDAMENTAL #2: How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?

- PPS is funding PCMH efforts with $40k incentive payment and sign-on bonus as well as offering PCMH consultant services.

- PPS deploying CRFP funds to assist PCPs and other providers to obtain EMR and other connectivity including RHIO, telehealth, also spreading screening tools fostering integration across providers. PPS serves as resource to providers to navigate various health initiatives and resources
- No mention on use of workforce budget or other state programs to recruit primary care.

<u>FUNDAMENTAL #3:</u> What is the PPS's strategy for how primary care will play a central role in an integrated delivery system?

- Primary care is described as the spine of the DSRIP implementation plan but no specifics regarding operationalizing the role in the integrated delivery system.
- Primary Care representation in the PPS's governance committees as follows:
  - NRPU – CAP ACO which is also CIN – 215 primary and specialty docs.
  - Other committees of CCN are balance of hospital system and community providers
    1. PPS Clinical – 65% healthcare system vs 34% community-based
    2. PPS Finance – 55% healthcare system v 45% community-based
  - The 4 RPU Quality Committees – majority from community-based

<u>FUNDAMENTAL #4:</u> What is the PPS's strategy to enable primary care to participate effectively in value-based payments?

- Building relationships between CBOs and physician networks and practices so CBOs can cover non-medical needs.
- Regional payer forums – convened United Healthcare in August with mostly CBOs.
- Provide data to help PPS and providers track performance to drive care coordination efforts and support VBP arrangements
- PPS acts as facilitator or convener between partners and MCOs.

<u>FUNDAMENTAL #5:</u> How does your PPS's funds flow support your Primary Care strategies?

- Approach is "flexible" funds flow to evolve over time to incentivize behaviors that are "value".
- Not specific to primary care providers but to the systems for primary care activities where there would be payment for a screening or a warm hand-off.
- Examples of types of payments available or made to partners but no information to distinguish overall allocation or payments for primary care.

<u>FUNDAMENTAL #6:</u> How is the PPS progressing toward integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i)?

- MAX project: shared the experience and practice of the single site
- Hired additional PMO staff person to assist on BH integration
  - Depending on partners to recruit staff - (vacancy rates for Psychiatrist 24%, Psychiatric Nurse Practitioner 10%, Substance Abuse and Behavioral Disorders Counselors 24%)
- No specific plan cited for next action steps or sites for partner implementation except education to broader provider community.
- Formulating incentives and innovation funds for proposals to develop ambulatory detox services and proposals for a psychiatric residency in Broome County based out of Upstate Medical School.