CNY CARE COLLABORATIVE

VBP Self-Assessment

Introduction

Thank you for taking the time of complete the CNYCC Value Based Payment (VBP) Self-Assessment Capacity Tool Survey. You are receiving a link to complete this survey because your organization is a contracted partner of CNYCC and your information was provided to us as the DSRIP Coordinator and/or financial point-of-contact for your organization. If you feel you received this survey link in error, please contact CNYCC at info@cnycares.org.

The Value Based Payment (VBP) Self-Assessment Capacity Tool (Assessment Tool) is designed to help providers assess their readiness to enter into risk-based, alternative payment model contracting. Specifically, the tool will focus on the following operational domains and identify key capabilities necessary for VBP arrangements:

1. **Governance and Staffing**
2. **Risk Assumption**
3. **Care Coordination and Care Management Programs**
4. **Data Analytics**
5. **Network Management**
6. **Performance Monitoring**
7. **Quality Improvement**

The risk-based, alternative payment model considered by this Assessment Tool is a population-based payment model under which the provider organization, referred to herein as an Accountable Care Organization (ACO), contracts with a Medicaid Managed Care Organization (MMCO) on a population-based shared savings or shared risk arrangement. As a part of this type of arrangement, savings and losses will be determined by comparing actual costs of care on a per member per month (pmpm) budgeted amount. Additionally, savings and losses are likely to be shared with the MMCO, at varying levels, depending on the ACO's level of readiness.

Thank you again for participating in the VBP Self-Assessment Capacity Survey. If you have any questions pertaining to this survey, please contact us at info@cnycares.org.

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Instructions

To complete the Assessment Tool, please take the following steps:

1. For each Domain, determine which member of your organization is in the best position to lead the assessment of your functional capabilities.

2. As appropriate, ask the "Domain Leader" to work with a cross-functional team of providers and "frontline" administrative staff to review each function and to honestly rate the readiness level, using the three-level rating system.

3. Compile the ratings from each of your teams.

4. Once you are satisfied with the accuracy of the assessment, calculate the percentages of responses within each level by Domain and in aggregate.

5. Review the results with your management team and discuss the implications for organizational planning.

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Contact Information

* 1. What is the name of your company/organization?

* 2. Please complete your contact information.

Name	
Email Address	
Phone Number	

Prerequisite: Financial Resources

3. A recent National Association of ACOs survey of 35 ACOs found that on average ACOs need $2 million of start-up capital during the first 12 months of operation and in total will need $4 million of capital until there is a chance for any recoupment from savings. Does your organization have these resources available for this purpose?

Level 1: currently lack capacity	Level 2: capacity development underway	Level 3: currently have capacity
○	○	○

VBP Self-Assessment

Domain 1: Governance and Staffing

4. An ACO governing body is in place and is structured to incorporate representation from ACO-participating provider organizations and Medicaid beneficiaries.

Level 1: currently lack governing body	Level 2: currently developing governing body	Level 3: currently have governing body
○	○	○

5. The ACO has substantial provider representation, including primary care providers and specialists, on its governing body.

Level 1: currently lack provider representation	Level 2: currently developing capacity for provider representation	Level 3: currently have provider representation
○	○	○

6. The ACO has created governing body committees (at a minimum, finance, clinical and quality improvement) that engages ACO network providers and advises the governing body.

Level 1: currently lack governing body committees	Level 2: currently developing governing body committees	Level 3: currently have governing body committees
○	○	○

7. Legal structures are in place to receive and distribute any MMCO shared savings or performance bonus payments to providers affiliated with the ACO.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

8. The ACO has in-house or contracted personnel experienced in negotiating risk-bearing contracts with payers.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

9. The ACO has developed a budget and financing plans to support the staffing and other operational costs needed to support the start-up (if applicable) and operations of the ACO.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

10. The ACO has staff and contracted personnel to support the full scope of required ACO functions.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

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Domain 2: Risk Assumption

11. The ACO has completed financial modeling for a risk-based contract, with consideration of:
1) total cost of care for which the ACO would be financially responsible
2) levels of risk assumption, including risk sharing and risk cap (if any)
3) percentage of total payments remaining within the ACO's network
4) cost and impact of stop-loss coverage at the individual and aggregate levels
5) impact of quality performance requirements
6) clinical risk adjustment

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

12. The ACO has analyzed a historical utilization and cost for its attributed population and past performance under other Value-Based Payment contracts (e.g., P4P, shared savings) to inform its preparation for risk assumption.

Level 1: currently lack information	Level 2:currently developing information	Level 3: currently have information
○	○	○

13. In negotiating its contract with payers the ACO has adopted risk mitigation strategies, including one or more of the following:
· use of withhold;
· sharing risk with payer;
· beginning with a low level of risk and increasing risk over time;
· delegating risk (and savings) to ACO partners;
· obtaining aggregate-level reinsurance coverage;
· risk-adjusting ACO payment levels based on attributed member clinical and non-clinical attributes, and/or
· excluding high-cost-outlier claims from ACO responsibilities.

Level 1: currently lack strategies	Level 2: currently developing strategies	Level 3: currently have strategies in place
○	○	○

14. The ACO has determined the level of needed reserves and has a plan for financing reserves that has been approved by its governing body.

Level 1: currently lack financial capability	Level 2: currently developing financial capability	Level 3: currently have financial capability
○	○	○

15. The ACO has formal policies defining how participating providers will assume financial responsibility for any losses, as well as how any earned savings will be distributed among ACO network providers.

Level 1: currently lack formal policies	Level 2: currently developing formal policies	Level 3: currently have formal policies in place
○	○	○

16. The ACO tracks actual costs against expected costs on a monthly basis.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

17. The ACO has an effective system for informing participating providers of potential cost overruns and for rapidly developing cost saving initiatives that also protect patient access to needed services and promotes quality of care.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

18. *If the ACO is to accept prospective payments*, the ACO has the capacity to accept payments from the MMCO, to pay providers in accordance with agreed upon payment methodologies (e.g., on basis of encounter forms using a fee schedule, salary, etc.) OR the ACO has contracted with a third party administrator to make payments on behalf of the ACO.
NOTE: Enter N/A if the ACO will not be accepting prospective payments.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity	N/A
○	○	○	○

19. *If the ACO is to accept prospective payments*, the ACO has mapped payment flow and timing against the participating providers' revenue cycle.
NOTE: Enter N/A if the ACO will not be accepting prospective payments.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity	N/A
○	○	○	○

Domain 3: Care Coordination and Care Management Programs

Identifying Patients in Need of and Who Can Benefit from Care Management and Care Coordination Services

20. *Care management:*
· The ACO has developed and implemented a standard methodology for stratifying its patient population identifying patients at high risk for future avoidable use of high cost.
· The methodology minimally draws upon clinical and claim data.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

21. *Care coordination:*
· The ACO has developed and implemented a standard methodology for identifying patients with multiple socioeconomic risk factors and in need of social services.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

22. Using information from a variety of sources, including payers and practice clinicians, has updated its lists of patients prioritized for care management and/or care coordination at least quarterly.

Level 1: currently lack capability	Level 2: currently devellping capability	Level 3: currently have capability
○	○	○

23. The ACO has developed and implemented a process to periodically evaluate the effectiveness of process to prioritize patients for care management and care coordination.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

Domain 3: Care Coordination and Care Management Programs (Service Delivery)

24. The ACO has sufficient designated resource(s) -- including trained licensed Registered Nurse(s), clinical social workers, behavioral health clinicians, pharmacists and peer specialists & community health workers -- to provide care management services to at least 2% of the ACO's attributed population prioritized for care management and with caseloads not in excess of 100.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

25. The ACO has an established methodology for the timely assignment of a) levels of care management or care coordination services and b) type of personnel (e.g., RN, LICSW, CHW) needed to address identified patient needs.
· Such methodology considers clinical information including disease severity level, behavioral health co-morbidities, social determinants of health and whether the patient is receptive to case management or care management support.
· The levels of service consider such factors as patient barriers to accessing services, urgency of need for services, patient's and family's self-management capacity, and social determinants of health that can be ameliorated through intervention.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capabiltiy
○	○	○

26. Within 2 weeks of identifying a patient for services, the care manager or care coordinator completes a patient assessment to identify a) the most significant health issue impacting utilization for the patient; b) patient goals; and c) barriers that impede improved or better managed health and wellbeing and patient goal attainment.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

27. Within 1 week of completing the patient assessment, the care manager or care coordinator, in partnership with the patient's primary care provider, develops a care plan, in conjunction with the patient or the patient's family. This care plan, includes at a minimum: a) patient's self-management plan/activities; b) patient centered goals; c) patient strengths; d) patient resources (care team members and anyone else they want involved in their care); e) barriers to care; f) treatment plan. The care plan respects the patient's preferences regarding personal and treatment goals, therapeutic alternatives and advance directives.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

28. Within 1 week of completing the patient assessment, the care manager or care coordinator, in partnership with the patient's primary care provider, develops a Rescue Plan*, that includes at a minimum, rescue medications, and/or providers to call and other actions to take when in need.

**Rescue Plan - a written plan to carry out if minor exacerbations of chronic diseases develop (E.G. For a COPD patient the Rescue Plan could include a steroid prescription to take at home if their sputum production increases, changes color, or consistency and they are more short of breath. In lieu of going to the ED, they would be instructed to activate the plan.)*

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

29. The care manager or care coordination updates the written care plan on a regular basis, based on patient needs to affect progress towards meeting existing goals or to modify an existing goal, but no less frequently than semi-annually.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capabilty
○	○	○

30. If the patient's hospitalization is not known until after discharge, the care manager contacts the patient within 24 hours of discharge to determine care management and/or care coordination needs.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capbility
○	○	○

31. For every patient contacted as a result of a hospitalization, the care manager completes a medication reconciliation assessment within 24 hours of discharge. To the extent possible, the medication reconciliation is conducted in person.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

32. The care manager or care coordinator contacts every known care-managed patient who has had an Emergency Department visit for a situation or condition that is related to or contributes to the patient's high-risk status within 24 hours of an ED visit.

Level 1: currently lack capacity	Level 2: currently lack capacity	Level 3: currently have capacity
○	○	○

33. The care managers and care coordinators participate in primary care practice team meetings and are viewed as part of the care team.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

34. Care management support is available to care-managed high-risk patients after hours and on weekends to address urgent needs.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

35. The ACO has well-defined systems to manage transitions of care across all practice settings including hospitals, long-term care, behavioral health facilities, home care, and palliative care to minimize avoidable inpatient (re)admissions and/or ED visits.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

36. Care managers have access to real-time inpatient admission, discharge and transfer notifications and ED visit notifications.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

37. Care managers and care coordinators maintain robust relationships with community-based social service organizations that can help address social determinants of health.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

38. The ACO promotes adoption of treatment protocols, such as medication initiation and adjustments and referral initiation, that enable care managers to respond quickly to urgent and emergent situations.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

39. The ACO has the ability to allow all applicable members of a patients' care team to centrally document in a shared care plan

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

Domain 4: Data Analytics

40. The ACO has a formal data and health informatics plan that has been reviewed and approved by the governing body. The plan includes a strategy for collecting and analyzing data, including a clear understanding of the basic data elements needed and the basic requirements needed to perform data analysis to support ACO business strategy and operations.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

41. There is a specific process, including designated leader(s), to review the reports and develop action plans for improvement

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

42. These action plans have resulted in measured improvement in performance

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

43. The ACO operates and/or has purchased the data analytic capacity and skill level needed to receive and analyze administrative data to identify ACO-level and provider-level cost and utilization patterns and quality of care performance for all care for which the ACO is financially and clinically responsible.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

44. The ACO operates and/or has purchased the data analytic capacity and skill level needed to receive and analyze clinical data to identify ACO-level and provider-level utilization patterns and quality of care performance.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

45. The ACO operates and/or has purchased the data analytic capacity and skill level needed to receive and analyze social and behavioral determinants data to identify their impact on cost utilization.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

46. The ACO operates and/or has purchased the data analytic capacity and skill level needed to integrate administrative data and clinical data for analysis purposes.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

47. The ACO operates and/or has purchased the data analytic capacity and skill level needed to integrate administrative data, clinical data, social and behavioral determinants data for analysis purposes.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

48. The ACO has the ability to access key data elements of clinical information from EHRs, including patient problems, medications, tests, demographics, vital signs and care plans to facilitate care management and other ACO clinically related activity.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

49. The ACO has the ability to track and monitor performance management at the provider, practice, and organizational level.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

50. The ACO has access to an HIE(s) and the ability to access key data elements, such as prescription medications, admissions, discharges and transfers, as well as ED visits.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

Domain 5: Network Management

Building the Necessary Network and Services

51. The ACO has an adequate number of physicians, nurse practitioners and physician assistants that have committed or are certain to commit to and contract for ACO participation. These primary care clinicians will attribute a population of at least 10,000 Medicaid patients with at least one MMCO.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

52. The ACO has mapped the specialty and hospital referral patterns of its provider network.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

53. The ACO has identified service delivery needs of its attributed population and has identified service gaps and strategies to bridge those gaps.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

54. The ACO has identified high-value specialists, long-term and post-acute facilities, behavioral health facilities, and ancillary providers and engaged them in ACO activity as ACO members or in formal referral relationships.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

55. The ACO has MOUs with high volume specialists who are outside of the ACO regarding communication and referral protocols. has identified high-value specialists, long-term and post-acute facilities, behavioral health facilities, and ancillary providers and engaged them in ACO activity as ACO members or in formal referral relationships.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

56. The ACO has designed and implemented a formal strategy for:

· value-based compensation for salaried clinicians;

· value-based payment for non-employed primary care and high-volume specialist clinicians, and

· value-based payment for hospitals.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

Domain 5: Network Management (Provider Engagement and Transformation Support)

57. The ACO provides practice coaching, learning collaboratives and/or other forms of technical assistance to ACO network providers to support their efforts to systemize and improve care delivery.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

58. The ACO helps high-volume providers (at a minimum) to understand and apply the data and reports the ACO makes available to the providers.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

59. The ACO clinical leadership meets with providers whose performance does not meet expectations and provides support in terms of skill development to assist the providers in achieving performance goals.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

60. Clinical leadership intervention has resulted in measured improvement in performance of the providers counseled.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

Domain 5: Network Management (Payment Reform to Reinforce Delivery System Redesign)

61. The ACO has designed and implemented a formal strategy for:
· value-based compensation for salaried clinicians (if applicable);
· value-based payment for non-employed primary care and high-volume specialist clinicians, and
· value-based payment for hospitals.
The strategy aligns MMCO-ACO financial incentives with provider incentives.

Level 1: currently lack strategy	Level 2: currently developing strategy	Level 3: currently have strategy
○	○	○

Domain 6: Performance Monitoring

The functions in the table below that address "reporting" refer to reporting to network providers, unless otherwise noted. They anticipate reporting only to those providers that meet a minimum patient attribution or visit/procedure/test/admission volume threshold.

62. The ACO has a methodology for attributing patients to providers for purposes of reporting and regularly reports attribution lists to ACO network primary care providers and to any other providers that have assumed financial and clinical responsibility of a sub-population of ACO patients.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

63. The ACO has analyzed claims and/or clinical data and developed a thorough understanding of the health status and health needs of the population it serves.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

64. The ACO has identified specific areas of overuse, underuse and misuse of services by comparing patterns of care against best care protocol for selected high use and high cost services.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

65. The ACO has adopted measures of quality and efficiency that are evidence-based and aligned with performance incentives required by contracted MMCOs and tracks and reports them at the ACO and provider level.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

66. The ACO has adopted measures of cost and utilization and tracks and reports them at the ACO and provider level.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

67. The ACO has adopted measures of patient experience and tracks and reports them at the ACO level and at the provider level for ambulatory care practices and for hospitals.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

68. The ACO has adopted measures of access to care, including referral services, and tracks and reports them at the ACO level and at the provider level.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

69. The ACO tracks episode-based resource-use metrics for common medical and surgical conditions.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

70. The ACO regularly reports adherence to clinical guidelines to ACO-affiliated providers for whom the guidelines are applicable.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

71. The ACO analyzes and regularly reports on provider performance variation to ACO-affiliated providers.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

72. Data sharing among providers of provider performance is transparent, i.e., includes provider identification.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

73. The ACO analyzes and regularly reports the comparative costs and quality of referral providers within and outside of the ACO.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

74. The ACO regularly produces public reports that compare ACO performance relative to benchmarks for measures of quality, access, patient experience and cost.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

75. The ACO's Chief Medical Officer uses performance data to identify under-performing providers.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

Domain 7: Quality Improvement

76. The ACO has a formally structured and staffed program to improve access, patient experience, clinical quality and cost efficiency where performance measurement and benchmarking indicate there are meaningful opportunities for improvement.

Level 1: currently lack capacity	Level 2: currently developing capacity	Level 3: currently have capacity
○	○	○

77. The ACO is able to deploy rapid cycle improvement tools when significant opportunities for improvement are identified.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

78. The ACO convenes ACO-affiliated clinicians to adopt or defined standard processes for care delivery where performance measure indicates high variability of practice and/or significant opportunity for performance improvement.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○

79. The ACO evaluates the effectiveness of its quality improvement activities at least annually.

Level 1: currently lack capability	Level 2: currently developing capability	Level 3: currently have capability
○	○	○