Alternative Payment Model Readiness Assessment Survey

Prepared by Health Management Associates

Introduction and Purpose

Welcome to the Alternative Payment Model (APM) Readiness Assessment. This tool was developed by the New Mexico Primary Care Council, the New Mexico Human Services Department (NM HSD), and the State's national partner, Health Management Associates.

The 2021 New Mexico House Bill 67 (Primary Care Council Act) charges HSD to establish a statewide Primary Care Council (PCC) to identify ways primary care investment could increase access to primary care, improve the quality of primary care services, lower the cost of primary care delivery, address the shortage of primary care providers and reduce overall health care costs.

The mission of the PCC is to revolutionize primary care into interprofessional, sustainable teams delivering high-quality, accessible, equitable health care across New Mexico through partnerships with patients, families, and communities.

To advance primary care payment reform in New Mexico, the state would like to know about clinical organizations' capacity to accept risk, and barriers and facilitators to APM implementation. This survey is developed to give New Mexico policymakers and primary care leaders actionable information on primary care providers' readiness to succeed in APMs and to identify critical gaps that need to be addressed. We appreciate your time and cooperation in completing this survey and helping develop the payment model and strategies to support you throughout implementation.

Completing the Survey

We encourage you to work as a team to complete the survey. Working as a team will allow you to explore APM readiness elements together and agree on the status of each element, thereby reducing the likelihood of answers being based on a single person's perceptions.

Throughout the survey you will see references to your "health center/practice." For the purposes of the survey, health center/practice means any provider type, including hospitals, ancillary providers, etc.

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Health Center/Primary Care Practice Name:

Health Center/Primary Care Practice Location:

Section I: Board, Leadership, and Strategic Readiness

Context

Moving to an APM will likely be a significant shift in the way services have traditionally been developed and delivered. Therefore, it is important that your Board and all staff—leadership, frontline clinical and non-clinical staff, and other support staff—understand the reason for change and are willing and able to participate in the planning and execution of strategies that enable your health center to succeed under an APM. In particular, the role of the Board and leadership in supporting the changes is critical as is the need for a performance dashboard that enables you to track and respond to key metrics.

Board Engagement

1. Our health center/practice has engaged in a comprehensive strategic planning process with our Board and other key stakeholders that prepares us for the transition to value-based care while maintaining fidelity to our organization's mission, vision, and values.
2. Our health center/practice has determined the level of risk our organization is willing to take in relation to APMs through a process that included executive leadership and members of the governing Board.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

Executive Data

3. Our health center/practice's leadership team has access to a performance management dashboard that enables it to monitor and respond to critical organizational indicators in real time.
4. Our health center/practice’s management team regularly tracks the results of a patient experience survey.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

Section I: Board, Leadership, and Strategic Readiness

Staff Readiness

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
5. In general, administrative and clinical leadership are knowledgeable about and on board with the movement toward payment reform models.					
6. In general, providers and staff are knowledgeable about and on board with participation in alternative payment models.					
7. In general, providers and staff are active in or willing to participate in practice transformation initiatives.					

Section II: Health Information Technology/Health Information Exchange

Context

Effectively managing patient populations requires health centers to have accurate and comprehensive data about those populations, and those data must be collected and reported in a timely, often real-time, manner. The care team must have actionable data at the point of care in order to make appropriate clinical decisions and avoid duplication or unnecessary tests and services. Transitions of care can be costly, but if managed appropriately with real-time data, they can be an opportunity to control costs and improve outcomes. Providers practicing without this information will be unable to fully contribute to the success of an alternative payment system.

Quality Improvement and Data Monitoring

8. Has your health center/practice undertaken any major chronic disease-specific quality improvement initiatives in the past 3 years (e.g., participated in a learning collaborative, pursued NCQA Diabetes Center of Excellence recognition, etc.)?
   - ☐ No
   - ☐ Yes

9. Our health center/practice has the technology to support retrieving, storing, calculating, and reporting clinical quality metrics.
   - ☐ Strongly disagree
   - ☐ Disagree
   - ☐ Neither agree nor disagree
   - ☐ Agree
   - ☐ Strongly agree

10. As part of your reporting, do you specifically measure and monitor the following?
    - Quality incentive payment provisions of third-party payer contracts
    - Test utilization
11. Are quality and outcome measures reviewed with clinical leadership and providers?

No	Yes

Section II: Health Information Technology/Health Information Exchange

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

12. Our health center/practice utilizes quality data to inform patient outreach when appropriate.
13. Our health center/practice collects race, ethnicity, and language (REAL) data consistently for all patients.
14. Our health center/practice can use member data from payers in conjunction with program data for measures reporting, retrospective analytics, and continuous program improvement purposes.
    This capability is usually found in so-called "business intelligence/decision support/data analytics" applications that work off large, multi-dimensional databases or warehouses.

Provider Alerts, Decision Support Tools, and Registries

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

15. Our health center/practice has evidence-based clinical protocols and decision support tools embedded electronically in our EHR to aid in point-of-service decision-making.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

16. In general, providers use the following automatic prompts about services in our EHR:
    - Reminders for preventative services to be ordered
    - Reminders for tests or services that have been ordered but remain incomplete

Section II: Health Information Technology/Health Information Exchange

	No	Yes
17. Do providers and care team members receive proactive alerts in your EHR for:		
• Emergency room utilization		
• Inpatient hospitalization		
• Automatic ordering of generic prescription drugs		
• Other		
18. Does your health center/practice have a workflow in place to quickly act on real-time admission, discharge and transfer (ADT) alerts received when your patients are registered or discharged from:	**No**	**Yes**
• The hospital		
• The emergency room		
• Other		
19. Does your health center/practice create an actionable list of:	**No**	**Yes**
• "Super utilizers" (e.g., patients who have frequent ED use or hospital readmissions)		
• Other patients at-risk for hospital admission (e.g., recently discharged, children with uncontrolled asthma)		
20. Does your health center/practice have a workflow in place to reach out to patients for ongoing follow-up?		
21. Does your health center/practice have access to a database or data warehouse that serves as an actionable registry and contains patient data for reporting and program improvement purposes?		

22. Our health center/practice utilizes actionable registries to monitor patients (e.g., list of all patients with diabetes, date of their last appointment, and date and result of their last HbA1c test).
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree
    - ☐ Strongly agree

Section III: Care Delivery

Part I: Care Management

Context

A high functioning care team uses all members of the team in specific roles and at the top of their skill set and training. Because payment is based on value rather than provider volume, all team members work directly with patients in identifying needed services and coordinating the care. Patients are assessed for physical, behavioral, and social needs, and a care plan is developed and shared with all members of the care team. Patients and their caregivers are active participants in developing the care plan and setting goals for improvement.

Care Management

23. Do you offer any care management services at your health center/practice?
    - ☐ No
    - ☐ Yes

23a. (If yes to 23) How many FTEs on staff are dedicated to care management activities? Number of FTEs:

23b. (If yes to 23) Care management services are integrated into the care team.
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree
    - ☐ Strongly agree

23b1. (If yes to 23b) How are care management services integrated into the care team? Select all that apply.
    - ☐ Provider referral
    - ☐ ED alerts
    - ☐ Super-utilizer list
    - ☐ Contracted member list
    - ☐ Other (e.g., chronic condition)

24. Our health center/practice uses a care plan as a source for care management.
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree
    - ☐ Strongly agree

Section III: Care Delivery

25. Does your health center/practice use or have access to an electronic care management system for your care plan and related services?
    - ☐ No
    - ☐ Yes

26. Regarding a care plan, every provider within the care team can:
    - Collaborate on the development of a common care plan for a particular patient
    - Work off a common care plan on an ongoing basis (e.g., read each other's notes and collaborate in maintenance and updates to plan)

27. Care plans are informed by real-time intelligence about a patient's status (e.g., potential allergies, evidence gathered from patients with similar conditions, adverse drug reactions and/or drug-to-drug interactions).

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

28. Does your health center/practice regularly conduct the following types of assessments?
    - Initial screenings
    - Health/functional assessments
    - Risk assessments
    - Risk stratification
    - Health related social needs (HRSN) or social determinants of health

28a. (If yes to any item in 28) Does your health center capture the assessment as structured data in your care plan, EHR, or another database (images/paper/PDF do not qualify) for the following types for assessments?
Structured data are data entered into a specific field that can be used to generate statistics, reports, or other information. Information entered as free text in a chart note, contained in images such as PDFs, or otherwise unsearchable information does not qualify as structured data.
    - Initial screenings
    - Health-functional assessments
    - Risk assessments
    - Risk stratification

No	Yes

No	Yes

Section III: Care Delivery

- Health related social needs (HRSN) or social determinants of health

29. Does your health center/practice track external referrals by referring provider at the health center?
30. Does your health center/practice track to which external provider a patient is referred?

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Open text:				

31. Our health center/practice has established relationships and processes with hospitals utilized by our patients for routine communication and handoffs (e.g., with hospital ED care navigators, discharge planners, coordinators).
32. Our clinical organization integrates oral health care into our screening and delivery workflows.
33. How do you refer patients for dental treatment?

No	Yes

34. Do you have a strategy in place to outreach to and engage any managed care members who are assigned to you but have never been seen in your health center/practice?
35. Is your health center/practice using any health information exchange (HIE) service offered by another HIE service provider (such as a query based HIE) to communicate with external providers?

36. It is challenging for our health center/practice to pay for the start-up and/or annual fees to connect to New Mexico's HIE.
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree
    - ☐ Strongly agree

Section III: Care Delivery

Part II: Patient-Centeredness (Patient Centered Medical Home, Patient-Centered Care, Enhanced Access, and Cultural/Linguistic Competency)

Context

The care team must have a thorough understanding of their population, including the language, cultural, and social environments, to provide meaningful care that will help implement improvements in health status. Along with understanding the global population the team serves, each patient should be the center of their care and should be an active contributor to their care plan.

Access to services should be available during and outside traditional business hours to effectively manage urgent concerns and avoid unnecessary ED visits. Experienced nursing staff can assess the urgency of medical complaints and work with another provider, when necessary, to accommodate the appropriate level of care needed.

Patient-Centered Medical Home (PCMH)/Patient-Centered Health Home (PCHH)

	No	Yes
37. Are you currently recognized as a PCMH or PCHH by an authorizing agency such as NCQA or URAC?		
38. Are patients empaneled to a particular primary care provider?		

Providing Patient-Centered Care

39. Do you collect patient satisfaction data through a survey tool?
    - ☐ No
    - ☐ Yes

39a. (If yes to 39) Select the frequency with which you survey patients for satisfaction.

- ☐ At every encounter
- ☐ Quarterly
- ☐ Semi-annually
- ☐ Annually
- ☐ Other, please describe:

Section III: Care Delivery

40. Do you provide use of an electronic patient portal for patient access?
    A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information and other related services from anywhere with an Internet connection.
    - ☐ No
    - ☐ Yes

40a. (If yes to 40) Which of the following resources does the patient portal provide access to? Select all the apply.

- ☐ Patient records
- ☐ Appointments
- ☐ Clinical questions
- ☐ Other information
- ☐ If yes, do more than 50% of patients use it for any reason?

41. Do you use any patient-centered tools such as shared decision-making or decision support tools?
    - ☐ No
    - ☐ Yes
42. Do you track patient visit cycle time (i.e., the amount of time it takes a patient from the time they enter the door to exit with a completed visit)?
    - ☐ No
    - ☐ Yes

Enhanced Access

43. Does your health center/practice have an individual engaged full time in clinical nursing for triage, care coordination, and/or telephone consultation services (less than 20% administrative office work)?
    - ☐ No
    - ☐ Yes

Linguistic and Cultural Competency

44. Our health center/practice has assessed the linguistic needs of the population in our service area within the last three years.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

Section III: Care Delivery

45. Our health center/practice has assessed the cultural needs of the population in our service area within the last three years.					
46. Language translation and interpretation services are easily accessible for all patients.					

47. How often does your health center/practice train providers and staff on cultural competency? Select all that apply.
    - ☐ No training is provided
    - ☐ During orientation
    - ☐ Annually
    - ☐ Other, please describe:
48. How often does your health center/practice train providers and staff on diversity, equity, and inclusion? For example, trainings that explore the role of racism, colonialism, and other forms of oppression in healthcare, bias, privilege, etc. Select all that apply.
    - ☐ No training is provided
    - ☐ During orientation
    - ☐ Annually
    - ☐ Other, please describe:

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
49. Provider demographics and/or experiences are fully reflective of the community in our service area.					
50. Our health center/practice has developed patient education materials and information on tests and procedures in multiple languages and at appropriate health literacy levels.					

Part III: Behavioral Health and Primary Care Integration of Services

Context

Nearly half of patients with one or more of the top five chronic medical conditions treated in primary care also suffer from a co-existing behavioral health issue. Providing primary and behavioral health care in one location by an integrated care team leads to improved outcomes (clinical and financial) for both medical and behavioral health issues as well as significantly lower long-term health care costs. The behavioral health staff should function as a core team member, not ancillary staff.

Section III: Care Delivery

Behavioral Health and Primary Care Integration of Services

	No	Yes
51. Are behavioral health services available to your patients in the same physical facility as the medical care?		
52. Is a behavioral health trained staff member part of the clinical care team, located on-site, and available to confer with the team throughout the day?		
52a. (If yes to 52) Are they available 100% of the time?		

53. If a medical provider refers a patient for behavioral health services (non-urgent), how often can the patient be seen the same day for behavioral health?	Never	Rarely	Sometimes	Always

	No	Yes
54. Do primary care and behavioral health staff document in a shared medical record?		

	No	Yes
54a. (If no to 54) Do they have, at minimum, viewing access in each other's records?		
55. Does your clinical team have time regularly designated to discuss complicated or difficult cases (not including a brief huddle)?		

Section IV: Partnership Readiness

Context

Partnerships with other health care providers along the entire continuum of care are also critical to ensuring that your health center can effectively coordinate and manage health care and costs for the patients for whom you will be responsible.

Partnership Agreements

56. Select the type(s) of social service providers with which your health center/practice has agreements in place (formal arrangements through a memorandum of understanding or contract).
    - ☐ Housing
    - ☐ Food and nutrition services
    - ☐ Tribal services
    - ☐ Disability services
    - ☐ Education/schools
    - ☐ Child welfare
    - ☐ Legal services
    - ☐ Supported employment agencies
    - ☐ Other
    - ☐ None of the above

57. Select the type(s) of medical providers with which your health center/practice has agreements in place (formal arrangements through a memorandum of understanding or contract).
    - ☐ Hospitals
    - ☐ Home health
    - ☐ Skilled nursing/long-term care
    - ☐ Other
    - ☐ None of the above

58. Has your health center/practice conducted an analysis to identify the other service providers in your community from whom your patients receive care?
    - ☐ No
    - ☐ Yes

59. Our health center/practice has agreements in place that enable it to serve people with the entire range of behavioral health disorders (including both mental health and substance use services)?

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

Section V: Financial Operational Readiness

Context

Success in APM arrangements is grounded in improving health outcomes and realizing cost efficiencies, thereby reducing the total healthcare spend. To realize these desired behaviors, alternative payment incorporates various payment models, generally including (1) base compensation (to reimburse for services provided in-house), (2) quality incentive payments, and (3) managing the total cost of care of a patient. As a result, managing and monitoring financial performance will move away from per-visit analyses to quality metrics and patient- and family-centered financial analyses (per patient).

With regards to base compensation, centers will need to become more efficient in the delivery of services so increased emphasis will be placed on managing productivity and capacity levels of provider and non-provider staff, as well as improving business processes with the goal of reducing the average cost per unit (visits and procedures). In addition, centers will need to better understand the utilization of services by patient for both services provided in-house as well as outside its four walls as the underpinning of managing the overall cost per patient. An additional complexity is that patient utilization patterns often vary based on the health (risk) status of a patient and therefore payment is also varied by risk status. Therefore, coding will become even more important for a center to manage a patient's health status, utilization patterns, cost of care, and to access quality incentive payments.

Accordingly, the foundation for success in APMs includes the appropriate coding for services, improvement in cost efficiencies for services provided in-house, management of utilization, and the ensuing overall cost of care by patient while improving health outcomes and quality.

Financial Operational Readiness

	No	Yes
60. Does your health center/practice train providers on proper coding and documentation practices?		
61. Does your health center/practice have coders on staff?		

62. Please provide the following information for 2022:
    - Number of physician or mid-level practitioner (e.g., nurse practitioner or physician assistant) FTEs on staff:
    - Number of coder FTEs on staff:
    - Number of billing staff (excluding coders and front desk) FTEs on staff:

63. Does your health center/practice review provider coding on a regular basis?		
64. Does your health center/practice have an incentive compensation program for providers?		

Section V: Financial Operational Readiness

64a. (If yes to 64) Is the program aligned with existing quality incentive programs in payer contracts?		
65. Does your health center/practice monitor provider productivity (i.e., panel size)?		
66. Does your health center/practice monitor the productivity (i.e., panel size) of non-provider staff?		
67. Does your health center/practice have a roster of attributed members?		
67a. (If yes to 67) Is the member attribution at the physician or practice level?		
☐ Physician		
☐ Practice		
68. Does your health center/practice analyze cost per visit on a regular basis to identify cost efficiencies?		
69. Does your health center/practice utilize a cost-based charge structure?		
70. Does your health center/practice update its fee schedule on an annual basis?		
71. Does your fee schedule include ICD-10 Z codes? *Z codes are the encounter reason codes used to describe factors influencing health status, e.g., Z56 – problems related to employment and unemployment or Z59 – problems related to housing and economic circumstances.*		
72. Does your health center/practice calculate and monitor the total, annual cost per patient for in-house services?		
73. Does your health center/practice monitor the utilization of specific services by patient for in-house services?		
74. Does your health center/practice have partial capitation agreements with MCOs for in-house services (e.g., primary care)? *Capitation is a payment arrangement in which a provider is paid a set amount for each enrolled person assigned to them, per period of time (e.g., per member per month, or PMPM), whether or not that person seeks care.*		

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
75. Our health center/practice has a strategy for assessing the needs of patients regarding social determinants of health,					

	No	Yes
76. Does your health center/practice have agreements with third party payers that include quality incentive		

Section V: Financial Operational Readiness

payments?		
76a. (If yes to 76) Have you been successful in fully accessing quality incentive payments?		
77. Does your health center/practice have surplus-sharing arrangements with third party payers? *This means a payment arrangement in which the provider can share with the payer in the surpluses (savings) of overall healthcare expenditures for members assigned to the provider.*		
78. Does your health center/practice have risk-sharing arrangements with third party payers? *This means a payment arrangement in which the provider can share with the payer in the losses (shortfalls) of overall healthcare expenditures for members assigned to the provider.*		
79. Does your health center/practice have participation agreements with an independent physician association (IPA) or accountable care organization (ACO)?		
79a. (If yes to 79) Do you have any surplus sharing agreements with those entities?		
79b. (If yes to 79) Do you have any risk sharing agreements with those entities?		

80. If your health center/practice is involved in surplus-sharing or risk- sharing arrangements:

- How engaged is your health center/practice in monitoring performance?

Not at all engaged	Minimally engaged	Somewhat engaged	Very engaged

- How successful has your health center/practice been, financially, with receiving payments?

Not at all successful	Minimally successful	Somewhat successful	Very successful

	No	Yes
81. Does your health center/practice actively identify high-cost/high-utilizing patients?		
81a. (If yes to 81) Does your health center/practice identify and monitor high-cost providers?		
82. Does your health center/practice utilize Business Intelligence (BI) software to:		
• Assimilate and report on data from internal systems (EHRs, billing systems, accounting systems)?		
• Assimilate external claims data with internal data?		
• Manipulate third party claims data?		
82a. (If yes to any items in 82) Does the BI software have a flexible architecture that allows for ad hoc reporting, e.g., to respond to reporting requests and requirements from different payers?		

Section V: Financial Operational Readiness

83.	Does your health center/practice meet the HRSA standard for working capital (>30 days)? *HRSA definition: Days in Working Capital = (Current Assets – Current Liabilities)/(Total Annual Operating Expenses/365 days)*	
83a.	(If yes to 83) Does your health center/practice maintain cash > 30 days?	
83b.	(If yes to 83) Has your center/practice met this working capital metric for the past three fiscal years?	
84.	Does your health center/practice have a positive unrestricted net asset position?	
84a.	(If yes to 84) Do you have positive net assets, available for operations? *Positive Net Assets, Available for Operations = Unrestricted Net Assets – (Net Fixed Assets – Capital, Long-term Debt)*	
84b.	(If yes to 84) How many days of operation does your health center/practice's net asset position represent?	
85.	Did your health center/practice generate a positive margin for the three most recent completed fiscal years?	
86.	Did your health center/practice generate a positive operating margin (operating revenue less expenses before depreciation and non-operating revenues and expenses) for the three most recent completed fiscal years?	
87.	Has your health center/practice developed a revenue model to budget the amount and timing of revenue and cash flow of potential alternative payment model arrangements?	
88.	Has your health center/practice evaluated the upfront costs of participating in the alternative payment model arrangement and new skill sets/core competencies?	
89.	Has your health center/practice evaluated reserve requirements and/or the opportunity to partner with other providers?	

Section VI: Areas of Concern when Preparing for Alternative Payment Models

Context

The table below captures broad categories that can influence success in APM adoption. Please indicate your health center/practice's level of concern for each item.

	Very Concerned	Concerned	Not a Concern
Necessary time/staff resources to design and implement APM readiness			
Adequate financial position/reserves			
Establishing partnerships with external providers			
Negotiation with plans			
HIT infrastructure/support needed to implement changes			
Capability/willingness to exchange health information (HIE) with external partners			
Liability/audit risk			
Provider buy-in			
Board of Directors support			
Impact on clinical workflow			
Impact on fiscal workflow			
Impact on operational workflow			
Ability to meet clinical targets/expectations set forth in alternative payment models			