Attachment B:

Draft Business Requirements

This draft of the business requirements for payer participation in APC is based on a full year of design work with payers, providers and other stakeholders. It represents input received during the year towards implementing the State's plan to meet the goals of Advanced Primary Care (APC) and the State Health Innovation Plan (SHIP). This section is divided into three components: (A) an overview of Advanced Primary Care, (B) the commitments the State expects payers to make in order to participate in APC and (C) a draft of the detailed minimum guidelines for the contracts and/or contract amendments that participating payers would make with practices as part of those commitments.

A. Overview of Advanced Primary Care

1. The overarching goals of Advanced Primary Care (APC), consistent with the Triple Aim, are to support a care delivery model that results in the following by 2020:
    a. 80 percent of the population is cared for under a primary care model that is paid for through an alternative payment model; and
    b. 80 percent of the population receives care within an APC setting, with a systematic focus on prevention and coordinated behavioral healthcare
2. The APC model promotes the following:
    a. Comprehensive, patient-centric primary care.
    b. Effective collaboration between primary care, other clinical care ("the medical neighborhood") and community-based services.
    c. Deliberate focus on coordinated care for patients with complex needs.
    d. Effective use of health information technology (HIT), including electronic health records, data analytics, and population health tools.
    e. Financial and technical support for primary care practices in the transformation to advanced primary care.
    f. A shift from exclusive encounter-based payment to inclusion of alternative payments that support the services and infrastructure needed for advanced primary care.
    g. Multi-payer participation and alignment.
    h. Performance measurement that is focused, aligned and meaningful to patients, payers and clinicians.
3. Advanced Primary Care (APC) is defined in terms of Practice Capabilities, Milestones (that reflect progress to achieving these Capabilities), a Core Measure Set and alternative or outcome-based payments. Details of each can be found in Attachments C and D (the APC FAQ; Detailed components of APC).
4. Practices will enter the APC program at one of three Gates depending on their ability to meet certain structural, process- and performance-based Milestones that describe their Capabilities. Meeting performance-based milestones will require the practice to make

progress on certain Core Measures. A practice's progress within the APC program is defined by their passage through the three Gates.

5. To remain in the APC program, practices at Gate 1 will need to reach Gate 2 within one year, and practices at Gate 2 will need to reach Gate 3 within one year.
6. Practice Transformation Technical Assistance Entities ("TA Entities") will assist practices participating in the APC program to progress to Gate 2 and to Gate 3 and will certify that each practice has met the required milestones for each Gate through a standardized, on-site Gating assessment tool. The TA Entities will be paid for by the State and will provide on-site coaching and other training. The specific activities of these TA Entities will be described in a RFA to be issued by the State in January.
7. In addition to the TA Entity's assessments, an independent third-party vendor will audit TA Entities and practices (using on-site visits) to ensure that practices are progressing through Gates in accordance with milestones. This vendor is supported by SIM funding for the duration of the grant (see Attachment D, NYS APC FAQ, for more details about SIM funding). The cost of Gating assessments may be shared between the State and the practice. The relationship between practice transformation technical assistance provided through APC and other transformation initiatives ongoing statewide is described in Attachment D: Advanced Primary Care FAQ.
8. Payers are expected to make investments in participating practices that are coordinated with the investments made by the State (TA Entities, practice assessments, oversight and auditing) and with the practices themselves (time spent to learn and implement new care delivery, reporting and payment models). These investments are linked to the Gates reached by practices and are designed to support practices as they incur costs associated with transformation and begin to support care coordination. Detailed descriptions of these payments are provided in part C: Minimum guidelines for APC-qualified contracts.
9. The APC program will be rolled out on both a regional basis and a practice-specific basis according to the following:
    a. There will be up to 11 regions across the state. These regions could be the Population Health Improvement Program (PHIP) regions[1], the New York Geographic Rating Areas, or some other set of regions to be defined by the State.
    b. The roll-out process will "activate" practices and regions as they meet specific payer and practice participation thresholds as detailed below:
        1) The DOH will activate a **region** for APC once 60% of the patients in that region are attributable to payers that have agreed to participate in the APC model[2].
        2) The DOH will activate a **practice** for APC if the practice is within an activated region **and** 60% of its patient panel is attributable to either:

[1] See https://www.health.ny.gov/community/programs/population_health_improvement/

[2] On a preliminary basis, Medicare and Medicaid will be considered as "APC-participating payers" for these purposes

a) APC-qualified contracts of APC-participating payers, or

b) Other qualified outcome-based payment contracts of APC-participating payers. These contracts must meet the criteria described by CMS as Level 3 ("Alternative payment models built on fee-for-service architecture", see Attachment A: Glossary) or Level 4 ("Population-based payment", see Attachment A: Glossary) to be "grandfathered" in to the roll-out process in this way.

For the purposes of this document, payer members include all lines of business (commercial fully-insured, commercial self-insured, and Medicare Advantage).

3) When a practice is activated:

c) Funding for practice transformation support by a TA Entity can be disbursed from the State to the TA Entity.

d) Practice transformation, care coordination, and outcome-based payments specified in the practice's contracts with payers, and as appropriate given the practice's current Gate, should be disbursed from payers to the practice. Payers are welcome to make these payments earlier, but must at least make the appropriate payments based on practice Gate. Payers without APC-qualified or otherwise Gate-dependent contracts with the practice would not be obligated to disburse these payments after practice activation.

4) The State will create a master attribution system, taking into account attribution data and other input from payers and providers, that will serve as a single source of truth for the activation status of regions and practices.

5) Practices within a given region are permitted but not required to enter into APC-qualified contracts with payers before the practice is activated.

B. Commitments necessary to be considered a payer that supports APC

Payers will play a critical role in the success of the APC program. Payers must make the following commitments in order to be considered an APC-participating payer:

1. APC-participating payers should develop contracting arrangements that meet the minimum guidelines of APC. These APC-qualified contracts, defined in detail in Section C, support the transition of practices to APC by offering investments in participating practices as they make cumulative structural and performance improvements. Practice progress will be audited on-site by an independent third-party vendor to ensure that the investments by the payer and the State (through supporting TA Entities) deliver these improvements.
2. APC-participating payers are expected to **offer an option** to be contracted under an APC-qualified contract (see Section C, "Minimum guidelines for APC-qualified contracts") to each practice in their network that has at least 50 payer members in its panel and that will be contracting with a sufficient number of payers such that at least 60% of the practice's panel will be attributed to a participating payer. This option must

be offered whether or not the practice is part of an ACO or otherwise has an outcomes-based payment arrangement with the payer. This option could involve:

a. Amending the practice's current contract so that it satisfies the minimum guidelines,

b. Contracting the practice into a new APC-qualified contract, or

c. Another arrangement that would result in an APC-qualified contract between the payer and the practice.

It is not required that the practice takes the offered option for the payer to be considered APC-participating: as long as the option is offered by the payer, payers and practices are permitted to keep the contracting status that they have.

3. Both APC-participating and non-participating payers will be expected to report to the State data[3] from primary care practices in their network relevant to the Core Measures (see Attachment C, "APC Model Components"), including data from all lines of business and both practices participating and not participating in APC. These data will be used by the State to generate a provider scorecard that will track the performance of practices statewide. Payers are encouraged to be partners in the development, testing and operational planning for this data reporting requirement.

4. APC-participating payers are also encouraged to provide in-kind support to practices, such as supplementary data or tools, to maximize the likelihood of practices' successful transition to outcome-based payment and the APC care delivery model.

C. Minimum guidelines for APC-qualified contracts

To become APC-qualified, a contract must meet the following **minimum** requirements:

1. The Gate status of a practice, as determined by TA Entities contracted by the State, and as audited by an independent third-party vendor, should trigger payments to that practice from the payer and must permit and/or require the practice to enter into outcome-based agreements between the payer and the practice:

Gate threshold	Payment commitment from payer to practice	Outcome-based payment commitment from payer to practice
Gate 1	**Practice transformation payments**: based upon expected productivity losses to a primary care practice (5%) within the first year of its investment in practice transformation, and the contribution of primary care to the total cost of care (6-12%), we estimate that practices incur costs from transformation of approximately 0.3% to 0.6% of the total cost of care. In	Payers are not expected to offer outcome-based agreements with practices at Gate 1

[3] These data would include the numerators and denominators necessary to calculate the Core Measures in the V1.0 Scorecard (see Attachment C)

	Attachment A, we ask payers to propose how they would support the practice in offsetting these costs. This support is not expected to continue for more than one year.	
Gate 2	**Care coordination payments**: practices must be eligible for up-front, rather than retrospective, care coordination payments to offset the cost of hiring or paying for care coordination staff and related practice investments (e.g., technology, specialized resources, etc.) related to care coordination. Although the particulars of each program may be different, payments of between 0.5% and 2% of the total cost of care have been used to offset these costs in different states.	Gate 2 practices must be enrolled, at a minimum, in a CMS Level 2 payment agreement ("Fee for service—link to quality", see Attachment A: Glossary)
Gate 3	**Care coordination payments**: practices are guaranteed up-front care coordination payments for a period of at least one year after meeting Gate 3.	Gate 3 practices must be enrolled, at a minimum, in an upside-only CMS Level 3 or Level 4 payment agreement, with optional enrollment in upside/downside payment agreements (see Attachment A: Glossary).
Ongoing	Payers are expected to continue to provide up-front support for care coordination, but may make this support conditional on additional practice performance requirements that are at the discretion of the individual payer.	The APC program no longer places minimum requirements on the contracts entered into by payers and providers.

The estimates of the magnitude of the support given to practices shown above are to be considered **guidelines only**. In addition, although we have provided these guidelines in terms of the total cost of care, APC-qualified contracts do not need to specify these payments in the same terms, and we ask payers to propose how they envision calculating the size of practice transformation and care coordination payments and how they envision delivering these payments (see Attachment A: part B, "Technical approach to APC implementation").

2. Care coordination and practice transformation payments should be monetary, i.e., they cannot be replaced by in-kind support in expertise, IT, etc., although payers are permitted and encouraged to provide in-kind support in addition to care coordination and practice transformation payments. Examples of acceptable payment mechanisms

include direct payments to practices, increases in reimbursement rates and increased monthly capitation payments.

3. At least 80% (for Medicaid and commercial plans) or 60% (for Medicare Advantage plans) of the total weight of quality and utilization measures used to qualify a provider for outcome-based payment should be weighted on APC core Measures.
4. Payers should not impose additional conditions for disbursement of practice transformation and/or care coordination payments beyond the performance requirements associated with the Gates of the APC program.
5. Practice transformation and care coordination payments, as relevant and appropriate to a given Gate status, are expected to be made so long as the practice remains in good standing, defined as the practice passing to Gate 2 within one year of passing to Gate 1 and passing to Gate 3 within one year of passing to Gate 2.

Attachment C:

APC Model Components

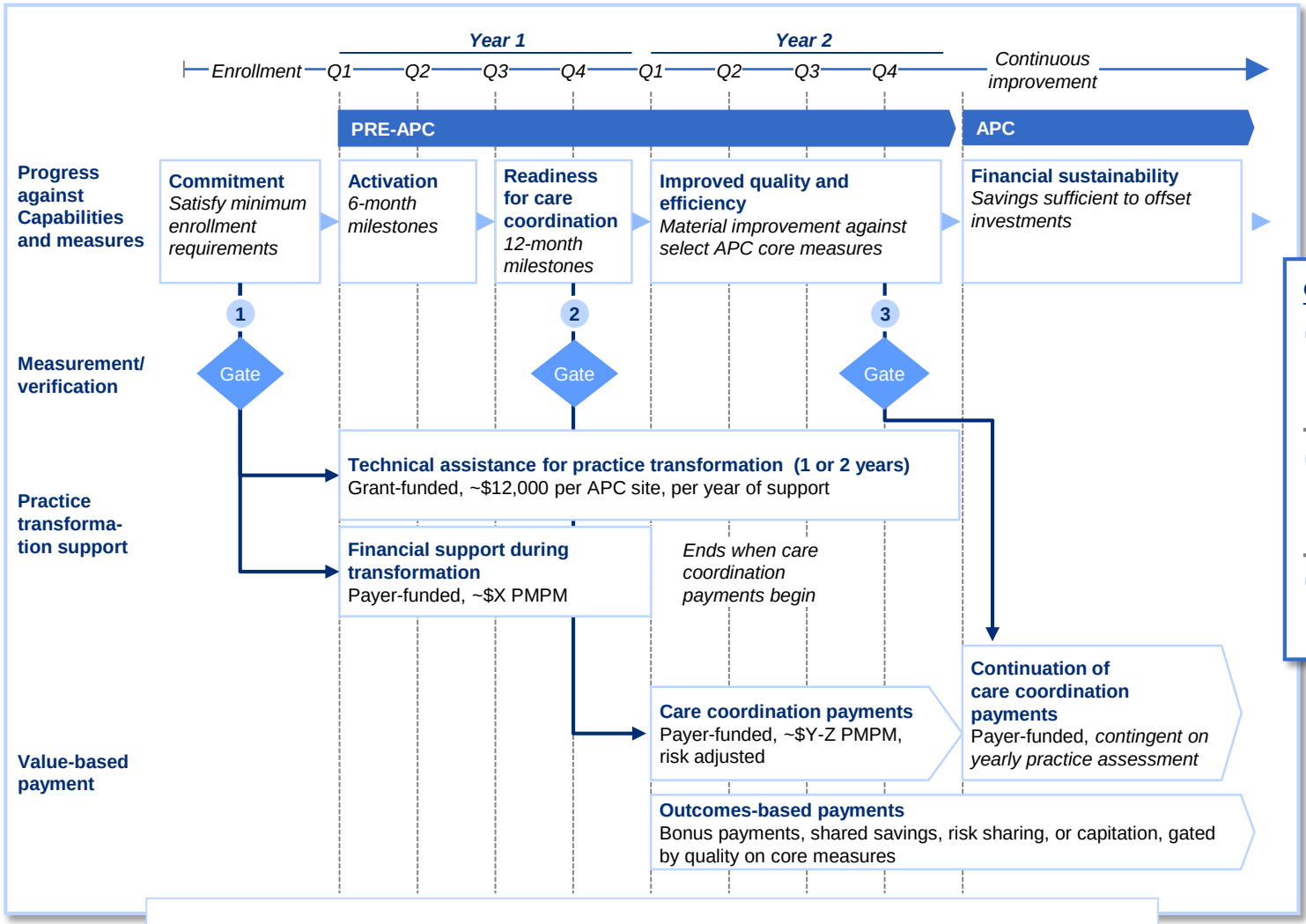
APC Capabilities

DRAFT- January 20, 2016

Category	Description
Patient-centered care	▪ Engage patients as active, informed participants in their own care, and organize structures and workflows to meet the needs of the patient population
Population Health	▪ Actively promote the health of both patient panels and communities through screening, prevention, chronic disease management, and promotion of a healthy and safe environment
Care management/ coordination	▪ Manage and coordinate care across multiple providers and settings by actively tracking the highest-risk patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and tracking and optimizing transitions of care
Access to care	▪ Promote access as defined by affordability, availability, accessibility, and acceptability of care across all patient populations
HIT	▪ Use health information technology to deliver better care that is evidence-based, coordinated, and efficient
Payment model	▪ Participate in outcomes-based payment models, based on quality and cost performance, for over 60% of the practice's patient panel
Quality and performance	▪ Measure and actively improve quality, experience, and cost outcomes as described by the APC core measures in the primary care panel

Path to APC over time for practices starting out

DRAFT- January 20, 2016



Gates

1. Gate to receive TA, eligibility for programmatic and financial support for transformation
2. Gate to receive care coordination payments, early outcomes-based payments
3. Gate to sustain care coordination payments and reach APC tier

- **Practices may enter the program at Gates 1, 2, or 3 depending on a their initial Gating Assessment**
- **Other programs such as NCQA, CPCI, and MAPCP may qualify for advanced Gates**

NEW YORK STATE OF OPPORTUNITY. Department of Health

Practice-wide structural milestones

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	Commitment Gate 1 *What a practice achieves on its own, before any TA or multi-payer financial support*	Readiness for care coordination Gate 2 *What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet* **Prior milestones, plus …**	Demonstrated APC Capabilities Gate 3 *What a practice achieves after 2 years of TA, 1 year of multi-payer financial support, and 1 year of multi-payer-funded care coordination* **Prior milestones, plus …**
Participation	i. Early change plan based on self-assessment tool ii. Designated change agent / champion iii. Participation in TA Entity APC orientation iv. Commitment to achieve gate 2 milestones in 1 year	i. Participation in TA Entity activities and learning (if electing support)	
Patient-centered care	i. Process for Advanced Directive discussions with all patients	i. Plan for patient engagement and integration into workflows within one year	i. Engagement: survey, focus group, advisory council or equivalent, plus QI plan based on results (yearly)
Population health			i. Participate in bimonthly Prevention Agenda calls ii. Annual identification and reach-out to patients due for preventative or chronic care mgmt iii. Process to refer to self-management programs
Care Management/ Coord.	i. Patients empaneled to practice and care teams	i. Tracking system to identify highest risk patients for CM/ CC ii. Ramp-up plan to deliver CM / CC to highest-risk patients within one year iii. Behavioral health: evidence-based process for screening, treatment where appropriate[1], and referral	i. Care plans developed in concert with patient preferences and goals ii. CM delivered to highest-risk patients iii. Referral tracking system iv. Care compacts or collaborative agreements for timely consultations with medical specialists and institutions v. Coordinated care management for behavioral health vi. Post-discharge follow-up process
Access to care	i. 24/7 access to a provider	i. Same-day appointments ii. Culturally and linguistically appropriate services	i. At least 1 session weekly during non-traditional hours
HIT	i. Plan for achieving Gate 2 milestones within one year	i. Tools for quality measurement encompassing all core measures ii. Tools for community care coordination including care planning, secure messaging iii. Attestation to connect to HIE in 1 year	i. 24/7 remote EHR access ii. Secure electronic provider-patient messaging iii. Meet current Meaningful Use standards iv. Connected to local HIE qualified entity and using data for patient care
Payment model	i. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year	i. Minimum FFS with P4P[2] contracts with APC-participating payers representing 60% of panel	i. Minimum FFS + gainsharing[3] contracts with APC-participating payers representing 60% of panel

Measurement and performance milestones to follow

1 Uncomplicated, non-psychotic depression
2 Equivalent to Category 2 in the October 2015 HCP LAN Alternative Payment Model (APM) Framework
3 Equivalent to Category 3 in the APM framework

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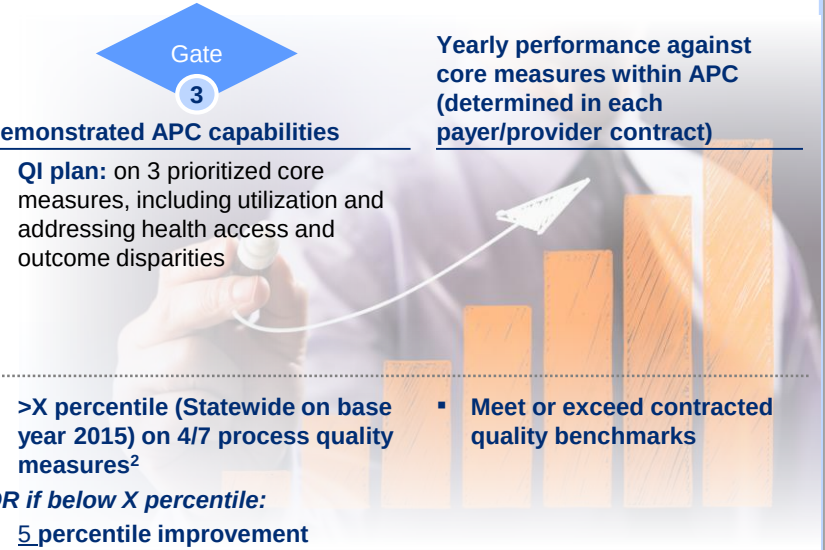
Measurement and performance milestones

DRAFT- January 20, 2016



	Gate 1 Commitment	Gate 2 Readiness for care coordination	Gate 3 Demonstrated APC capabilities	Yearly performance against core measures within APC (determined in each payer/provider contract)
Process	▪ **Data collection plan:** Plan for collecting and reporting non-claims-based data relevant for core measures	▪ **Report and use data** on all core measures[1], including data necessary to assess health disparities ▪ **QI plan:** Plan to achieve performance gate requirements by Gate 3	▪ **QI plan:** on 3 prioritized core measures, including utilization and addressing health access and outcome disparities	
Performance on Quality			▪ **>X percentile (Statewide on base year 2015) on 4/7 process quality measures[2]** ***OR if below X percentile:*** ▪ **5 percentile improvement compared to own prior 2-year rolling baseline, up to 50th percentile, on 4/7 quality process quality measures**	▪ **Meet or exceed contracted quality benchmarks**
Performance on Utilization			▪ **>Y percentile on 2/3 utilization measures (Statewide on base year 2015 hospitalizations, readmissions, and ED use)** ***OR if below Y percentile:*** ▪ **Minimum improvement compared to own prior 2-year rolling baseline in 2/3 of the following measures:** – **Hospitalization: A%** – **Readmission: B%** – **ED utilization: C%**	▪ **Net positive ROI on care management fees** through cost and utilization savings beginning in year three of transformation

1 Of measures being reported at that time (i.e., in 2016 the V1 scorecard will report on a subset of the 20 APC Core Measures)
2 Measures 2, 4, 5, 9, 12, 15, 16 from following page- subject to change on an annual basis and upon roll-out of V2 scorecard

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Scorecard measures with proposed quality & utilization measures DRAFT

- (x) Process quality measures for Performance Gates
- (x) Utilization measures for Performance Gates

✓ Claims-only is possible Candidate V1.0 measures

Categories	Measures	Measure steward	Claims	EHR	Survey
Prevention	1 Colorectal Cancer Screening	HEDIS	✓	✓	
	2 Chlamydia Screening	HEDIS	✓	✓	
	3 Influenza Immunization - all ages	AMA (all ages) or HEDIS (18+)	✓	✓	✓
	4 Childhood Immunization (status)	HEDIS	✓	✓	
	5 Fluoride Varnish Application	CMS (steward), NQF, MU	✓		
Chronic disease	6 Tobacco Use Screening and Intervention	CMS (steward), NQF, MU	✓	✓	
	7 Controlling High Blood Pressure	HEDIS	✓	✓	
	8 Diabetes A1C Poor Control	HEDIS	✓	✓	
	9 Medication Management for People with Asthma	HEDIS	✓	✓	
	10 Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults	*Children*: HEDIS *Adults:* CMS	✓	✓	
BH/Substance abuse	11 Depression screening and management	CMS	✓	✓	
	12 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	HEDIS	✓		
Patient reported	13 Record Advance Directives for 65 and older	HEDIS	✓	✓	✓
	14 CAHPS Access to Care, Getting Care Quickly	HEDIS			✓
Appropriate use	15 Use of Imaging Studies for Low Back Pain	HEDIS	✓		
	16 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	HEDIS	✓		
	17 Hospitalization	HEDIS	✓		
	18 Readmission	HEDIS	✓		
	19 Emergency Dept. Utilization	HEDIS	✓		
Cost	20 Total Cost Per Member Per Month		✓		

Attachment D:

APC FAQ

New York State's Advanced Primary Care Model Frequently Asked Questions

NEW YORK STATE DEPARTMENT OF HEALTH

DECEMBER 2015

NEW YORK STATE'S ADVANCED PRIMARY CARE MODEL

These frequently-asked questions are meant to describe the New York State's Advanced Primary Care Model as of December 28, 2015. Additional information on the model, the working group, and ongoing updates can be found at https://www.health.ny.gov/technology/innovation_plan_initiative/workgroups.htm, under Integrated Care.

Table of Contents

WHAT IS NEW YORK STATE'S ADVANCED PRIMARY CARE MODEL (APC)?

What are the goals of the APC model?

The overarching goals of the APC model, consistent with the Triple Aim, are to support a care delivery model that results in the following by 2020:

- 80 percent of the population is cared for under primary care model that is paid for through an alternative payment model; and
- 80 percent of the population receives care within an APC setting, with a systematic focus on prevention and coordinated healthcare.

The APC model promotes the following:

- Comprehensive, patient-centric primary care
- Effective collaboration between primary care, other clinical care ("the medical neighborhood") and community-based services
- Deliberate focus on coordinated care for patients with complex needs
- Effective use of health information technology (HIT), including electronic health records, data analytics, and population health tools
- Financial and technical support for primary care practices in the transformation to advanced primary care
- A shift from exclusive encounter-based payment to inclusion of alternative payments that support the services and infrastructure needed for advanced primary care
- Multi-payer participation and alignment
- Performance measurement that is focused, aligned and meaningful to patients, payers and clinicians

What are the components of APC?

APC is an integrated care delivery and payment model that ties together a service delivery model and reimbursement to promote improved health and health care outcomes that are financially sustainable (see Figure 1 below for detail).

APC is defined in terms of the following four components:

1. **A defined set of practice capabilities** that promote care coordination for complex patients, support robust connections with the medical neighborhood and community-based services and an administrative infrastructure to be successful in a move from fee-for service to value-driven, population-based care payment.
2. **Core measures:** Common quality, outcome and cost measures across payers and providers that ensure consistent reporting and incentives.
3. **Common milestones and measures:** that define a practice's capabilities over time and that are linked to payment.
4. **Outcome-based payments:** Reimbursement structured to promote and pay for quality and outcomes. APC reimbursement models are designed to support team-based care

delivery team (inclusive of physicians, care providers, care managers and others as needed) to promote high quality comprehensive and coordinated care delivery, and provide opportunities for shared savings.

The APC model describes elements of care delivery that have been shown to enhance patient experience and improve clinical care, while also helping clinicians and practices transition to increased value-based payments.

Figure 1: APC Capabilities

Category	Description
Patient-centered care	▪ Engage patients as active, informed participants in their own care, and organize structures and workflows to meet the needs of the patient population
Population Health	▪ Actively promote the health of both patient panels and communities through screening, prevention, chronic disease management, and promotion of a healthy and safe environment
Care management/ coordination	▪ Manage and coordinate care across multiple providers and settings by actively tracking the sickest patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and tracking and optimizing transitions of care
Access to care	▪ Promote access as defined by affordability, availability, accessibility, and acceptability of care across all patient populations
HIT	▪ Use health information technology to deliver better care that is evidence-based, coordinated, and efficient
Payment model	▪ Participate in outcomes-based payment models, based on quality and cost performance, for over 60% of the practice's patient panel
Quality and performance	▪ Measure and actively improve quality, experience, and cost outcomes as described by the APC core measures in the primary care panel

How was the APC model created?

APC was developed with the input and guidance of a wide array of stakeholders inclusive of payers, providers and consumers from all regions of the state. These stakeholders (members of the SIM Integrated Care Workgroup) met regularly to consider the evidence to date for similar models of care and payment delivery and to craft a model that is designed to achieve stated goals and objectives. Information on this workgroup and its deliberations may be found here: https://www.health.ny.gov/technology/innovation_plan_initiative/workgroups.htm.

What can primary care practices expect from APC?

Practices opting to participate will be provided an initial self-assessment tool to help them understand and document their current competencies and potential areas for development needed to provide care consistent with the goals of APC. With this information, practices will be able to select a SIM-funded transformation vendor to assist them with identified areas. Once engaged in the program, practices must demonstrate progress toward APC capabilities in order to be eligible for continued and expanded financial supports.

Practice transformation advisors (to be funded through a competitive procurement), as well as an independent auditor (to be selected), will evaluate practices to determine whether the practice

has made adequate progress (see detail below - current APC milestones posted at https://www.health.ny.gov/technology/innovation_plan_initiative/workgroups.htm) that will in turn be used by payers to guide reimbursement.

Gate 1: Commitment and preparation

Practices must show evidence of commitment to change as demonstrated by the allocation of appropriate resources and personnel. A shared responsibility between payers and providers in the region is needed to ensure that payers participating in (financially supporting) APC represent a "critical mass" of the practice's panel, currently defined as 60 percent of a practice's patients.

Gate 2: Readiness for care coordination including payment

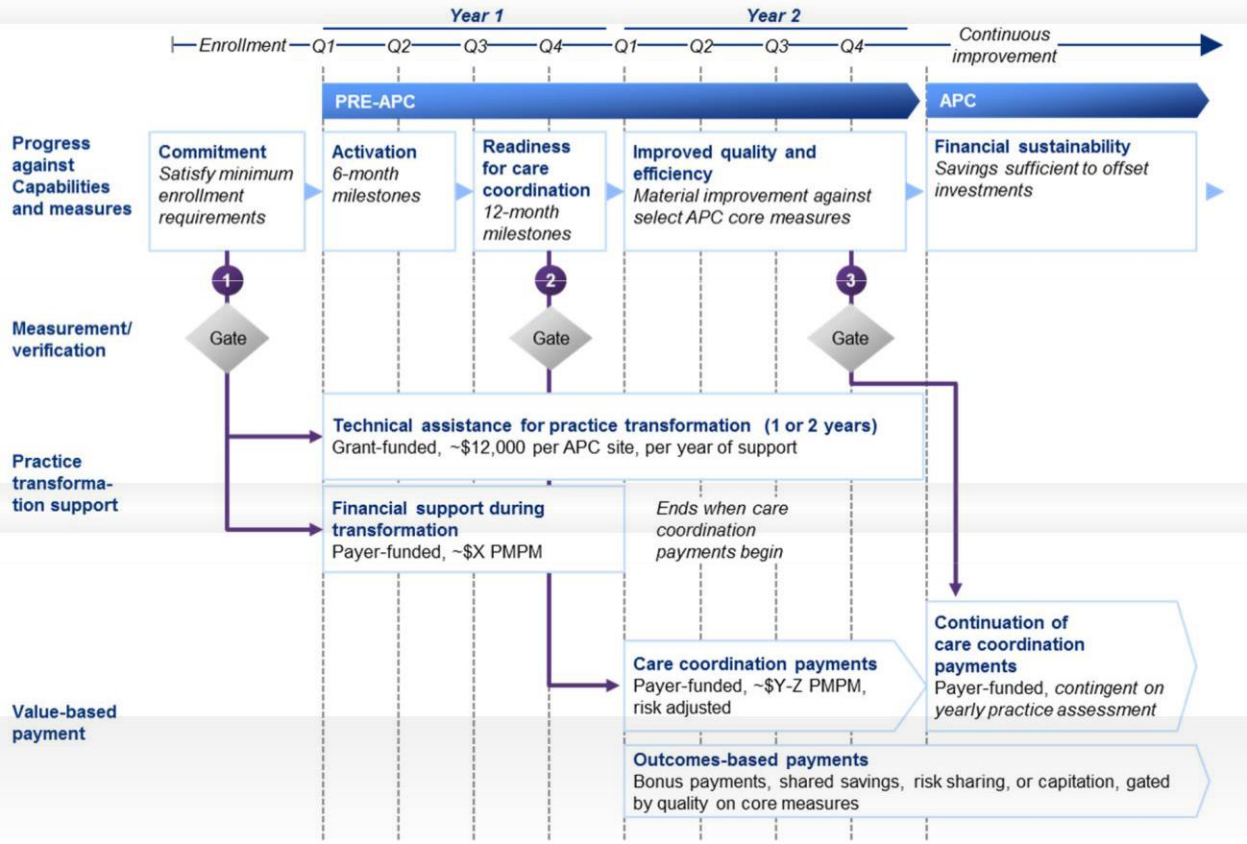
Gate 2, to be achieved at least one year after meeting Gate 1, indicates a practice's readiness to provide effective care coordination. Necessary capabilities at this point include:

- The ability to identify high-risk patients and successfully measure and report the Core Measures derived from practice data.
- Capacity to provide care coordination for high-risk patients within one year.
- Infrastructure and commitment to use results from APC Core measures for improvement.

Gate 3: Demonstration of APC capabilities and performance

One year after meeting Gate 2 (or sooner if ready), practices will have to demonstrate active care management and coordination for a majority of their high-risk patients. At this point, they will be required to connect to their regional health information exchange (RHIO). Importantly, demonstrating APC capabilities implies moving from an ability to measure performance to the ability to demonstrate improvements in quality and reduced preventable costs. APC practices will have to continue to meet defined performance targets after passing Gate 3 in order to remain in the program.

Figure 2: Path to APC



Gate 1: Gate to receive SIM-funded TA and payer financial support for transformation. Gate 2: Gate to receive care coordination payments and begin outcome-based payments. Gate 3: Gate to sustain outcome-based and/or care coordination payments.

Common Measure Set

To ensure alignment and minimize the number of unique measures required to be reported by each plan and practice, a common set of core measures has been developed for use by APC participating payers and practices. APC core measures will be reported as part of an APC provider scorecard, where providers will be able to review data from these measures. These measures are intended to eventually form the basis for outcomes-based payments by payers, bringing greater alignment in measurement, reducing administrative burden, and amplifying the impact of incentive payments.

How will APC practices be reimbursed under APC?

Providers/practices will continue to negotiate payment directly with payers. However, APC will provide a common framework or structure that aims towards greater consistency across payers and aligns incentives to assure support of the following key model components:

1. SIM funded TA support during transformation.
2. Care Management payments to support a care delivery team charged with managing and

coordinating patient care.

3. Outcomes-based payment models that support quality improvement activities and investments and provide incentives to deliver care efficiently and effectively (such as shared savings).

The APC program seeks to promote strategic, coordinated, and aligned investments in practices for a defined period contingent on practices and payers seeing improvements in care and a return on investment. Public funds will be used to provide technical assistance to practices in the process of making these workflow changes.

What is the role of payers?

Participating payers will offer contracts compatible with APC guidelines to providers meeting APC milestones. An independent third-party will be hired by the State to evaluate practices with respect to attainment of milestones that trigger payment and report this information to payers. Payer financial support will vary according to demonstrated practice capabilities as measured by the following three gates:

Meeting Gate 1: Payer-supported transformation support to help offset initial practice investments until care management and outcomes-based payments become active.

Meeting Gate 2: Payer-funded care management payments, and possible initiation of outcomes-based payments.

Meeting Gate 3: Outcome based payments rewarding improved quality and preventable cost reductions will form a significant and increasing source of payments. Payers may fund continued care management payments contingent on continuing to meet APC criteria and meeting performance improvements agreed upon in payer/provider contracts or may "bundle" care management support within other, more global alternative payment approaches.

In addition to supports noted, payers participating in APC will share claims data with the State.

What is the role of practice transformation technical assistance advisors?

Practice transformation technical assistance advisors will help practices succeed in meeting gate specific milestones. Practice transformation in NYS is supported in several ways including through SIM, the Transforming Clinical Practice Initiative and DSRIP. While some practices may be able to transform workflows on their own, technical assistance is expected to help 80-90 percent of all practices in NYS achieve APC.

Specific SIM supported assistance may include the following:

- Technical assistance, including content expertise
- Regular learning sessions, assessments and webinars
- Detailed reports and other feedback
- One-on-one coaching on site-specific practical aspects of implementing APC concepts
- Assist in the implementation of health information technology and health information exchange capacities associated with APC requirements
- Administrative capacities needed to successfully participate in value based payments

TA Goals for Practices:

- Capabilities for team-based care, including care management and coordination
- Quality improvement through application of monthly feedback on Plan-Do-Study-Act cycles
- Capabilities in change management, sustainability planning, and learning and development
- Capabilities for identifying and overcoming patients' barriers to care

BENEFITS OF APC

Why is multi-payer alignment important to the APC program?

Transformation to value-based payments is a goal of CMS and a growing expectations among private payers. Payers are moving away from fee-for-service (FFS) volume-driven health care services to value-based payment models that support providers to delivery high quality, outcomes driven, efficient care. Medicare has noted its intention to move in this direction through the merit-based incentive payment system (MIPs) and alternative payment model framework proposed by the health care payment and learning and action network[1]. Under these payment models the practice is expected to be able to effectively influence utilization and related practice expenses for treatment. Success is based on the practice's ability to demonstrably contribute to the control the healthcare expenses of the patient population. The practice may share in the potential savings, and, in some cases, may also share risk for losses.

Using lessons learned from regional pilot initiatives such as Comprehensive Primary Care initiative (CPCi) and Multi-Payer Advanced Primary Care Practice (MAPCP) APC seeks to align payment, delivery, and measurement premised on a common assumption that providers are more likely to be effective and successful when a "critical mass" of their payments is in the form of aligned outcome-based payments. Increased consistency in payment programs will help practices avoid confusion and inefficiencies related to disparate incentive programs, thereby allowing practices to devote their time to patient-centered care.

What is the role of the State?

The State is convening stakeholders, facilitating the development of the APC model, and administering practice transformation funding. The SIM APC initiative, funded by the CMS

[1] https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network

Innovation Center (CMMI), seeks to engage providers and payers - both commercial and public - to align delivery model and payment methodologies in support of the APC practice model. Within the $100 million CMMI SIM grant, the state has made available $67 million in funding that will be used to support practice transformation technical assistance to work with practices to help them achieve APC milestones and in turn be supported through outcome-based payment models.

In addition, as part of the State Innovation Model (SIM) cooperative agreement, the State is supporting efforts to address training of the healthcare workforce, to provide resources to facilitate practices' connections with local community and population health resources, and to promote health IT tools, including a development of a State all payer database.

Why would a payer participate in APC?

A growing evidence base of successful primary care value-based programs, including patient-centered medical homes (PCMHs), has helped to focus the APC approach. Examples from New York and nationally (e.g., Adirondack MAPCP, Hudson Valley CPCi, CDPHP's Enhanced Primary Care model, Empire BCBS's Enhanced Personal Health Care, Bronx Community Accountable Healthcare Network, MA BCBS's Alternative Quality Contract, Geisinger's ProvenHealth, GroupHealth's Cooperative PCMH and Community Care of NC), have all achieved significant savings on total cost of care in 2 to 4-year timeframes. Success cases show savings o n total costs of care ranging between 6-12 percent, with similar investments to the APC model. Using assumptions from published models, reasonable financial returns would be expected in 2-3 years, with a cumulative return at 5 years of 3-4 times investment. (Details released separately in APC Generalized Financial Business Case.)

The APC model was designed to learn from success cases and avoid common pitfalls where primary care transformation models have failed. APC results-oriented design goals include:

- *Significant panel coverage*- Participating payers comprise a majority of a provider's revenue (and patient panel), and costs of transformation are spread across multiple payers while minimizing "free-riders" for investments
- *Expectations*- Practices must demonstrate interest and progress prior to receiving alternative payments, and progressive milestones designed to ensure progress on both processes and efficiency are communicated up front
- *Improvement strategy*- Including three key features: a clear focus on managing high-risk patients to reduce potentially preventable events, focus on effective use of data and performance, and an expectation that savings will cover the costs of investments including but not limited to care management
- *Improvement mindset*- Practice transformation is conceived as a continual process of improvement based on data, where physicians and office staff "own their own change" as program creators and office champions

Why would a primary care practice want to participate in APC?

The APC model is designed to promote better care and improve the experience of being a

provider through focus on proactive, integrated, population health-focused care. APC is an opportunity for practices to engage in an initiative in which multiple payers are increasingly aligned in their expectations and support. The APC model creates revenue for services that are currently non-billable but of high value to patients and clinicians. Ultimately, non-FFS payments create additional autonomy for practices to design their practices and services to optimally meet the needs of their patients. Successful practices, consistent with published PCMH results, could see a 10-20 percent increase in revenue compared to FFS billing. Specific supports that may be available to participating practices include:

1. Up to *two years of practice transformation technical assistance* funded through the SIM Grant, Transforming Clinical Practices Initiative (TCPI), or other as appropriate at no cost for the practice
2. *Support* from participating payers to offset productivity losses and investments associated with transformation for the first year
3. *Support for care coordination consistent* with having met milestones to qualify for an increased level of payer support
4. *A standardized measure set* applicable across the entire panel of participating payers
5. A *more standard approach to outcomes based payment*, including shared savings or capitation models that may increase provider income.

WILL APC WORK FOR ME?

How can small practices participate in APC?

A majority of practices within the state of New York have fewer than three providers, and the APC support model is designed to enable their success. Small practices may not have sufficient scale for some APC capabilities such as care management on their own. To provide these services while retaining independence, small practices will be encouraged to explore arrangements with similar practices to share resources for these critical functions. For small practices, the Technical Assistance vendors will help facilitate these arrangements where needed and appropriate.

How will TCPI, CPC, PCMH and other transformative initiatives be aligned with APC?

APC milestones are constructed to recognize ongoing practice efforts to address structural, workflow, and performance change as supported by TCPI, CPC, MAPCP, and PCMH. Successful participation in these four programs will constitute substantial demonstrated evidence of practices meeting APC milestones. That said, a practice will still need to make a commitment to meet any additional APC gates and ongoing performance requirements necessary in order to remain in the APC program. Practices will also be obligated to share data on performance, workflow, and infrastructure associated with participation in those programs as part of meeting designated gate requirements linked with payments.

Already transformed practices may enter into the APC model at an advanced gate and be eligible for earlier access to care coordination payments and/or outcomes-based payment.

Technical assistance, however, will be prioritized for those practices that have not already proven advanced-practice through other methods or that are not currently in receipt of alternatively funded practice transformation support.

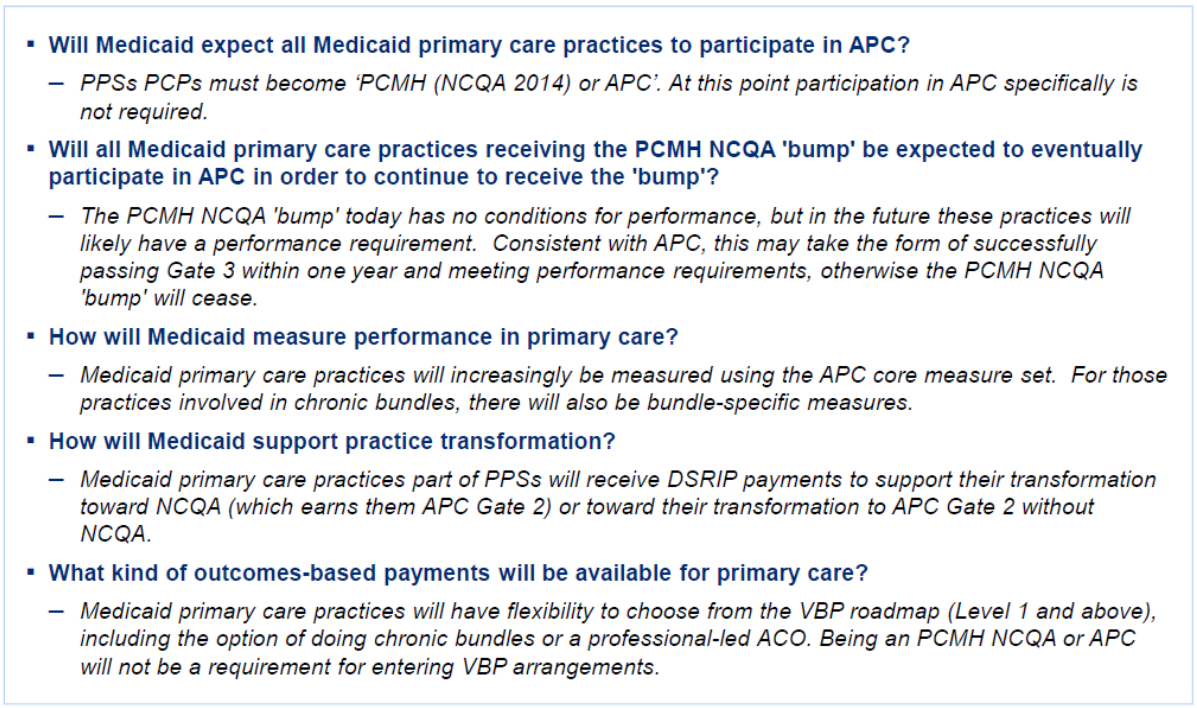
How will APC work with Medicare and Medicaid?

Existing payment programs centered on primary care can help provide a foundation for APC support, though there is work to be done over time to align on key structural and performance components. Ongoing conversations with commercial payers, employers, Medicare, and Medicaid's Delivery System Reform Incentive Payment (DSRIP) program aim to help facilitate operational alignment.

Discussions are ongoing to develop mechanisms to align and integrate SIM with DSRIP to assure that achievement of NCQA PCMH 2014 is consistent with Gate 2 under the APC model. Practice support from Medicaid includes DSRIP funds for transformation, PCMH incentive funds for care management, and VBP that is in development – all of which are consistent with APC.

Future participation in APC by Medicare will continue to be explored. MIPS, MACRA, and current incentive programs for providers like PQRS and MU, and the complex care management payments offered under Medicare FFS align well with APC thus ensuring the providers evolving to APC under SIM will be well positioned for future federal delivery and payment models.

Figure 3: Medicaid and DSRIP Programs are Largely Aligned with APC

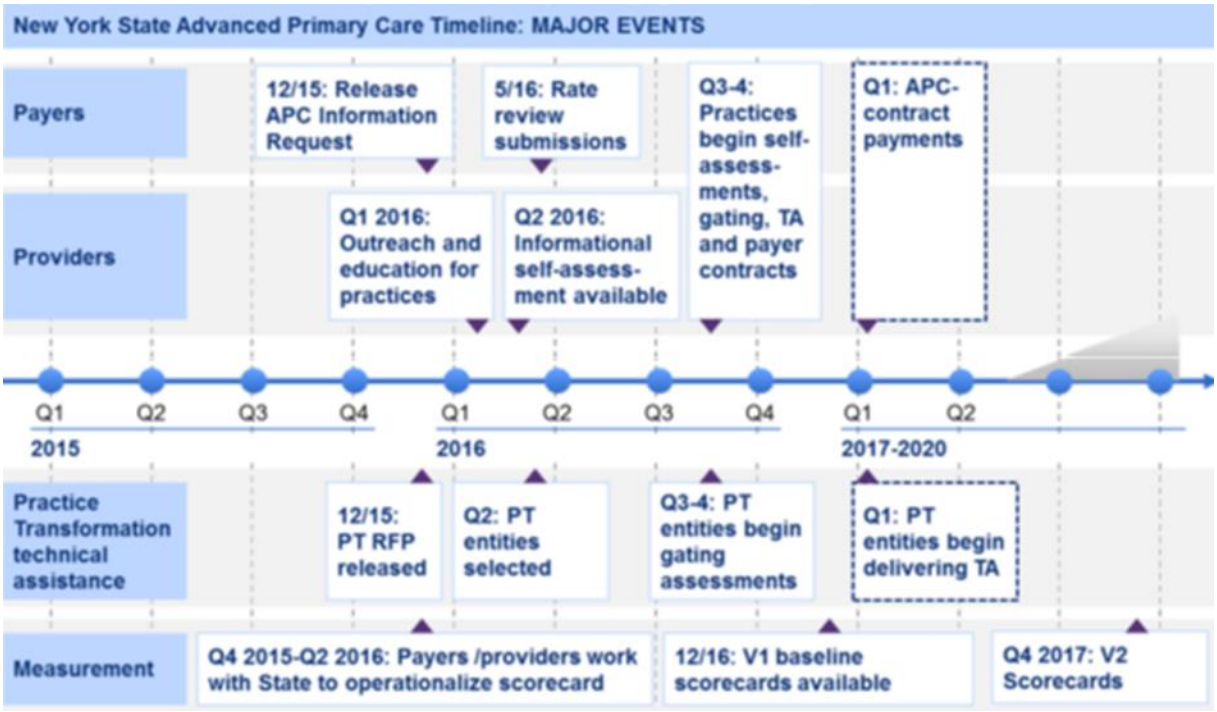


WHAT IS THE TIMELINE FOR APC?

The goal is for 80 percent of New Yorkers to have access to primary care consistent with the APC model by 2020. (See Figure 4). Achieving this ambitious goal will require commitment and support from a variety of stakeholders, most notably a majority of NYS payers and providers.

A Request for Applications (RFA) to select practice transformation vendors will be released early in 2016 with contracts to be completed by Q2 of 2016 and services provided to practices shortly thereafter. The first APC-compatible contracts, embraced by both practices and payers should be available by Q3 of 2016 with the majority beginning in 2017.

Figure 4: Advanced Primary Care Proposed Timeline



Attachment E:

Draft Payer Business Case

Context for Advanced Primary Care financial business case (1/2)

- Over the past several months the NYS State Innovation Model (SIM) project team has been working closely with payers to define the multi-payer APC model and how it would be implemented
- Payers have asked for greater specificity on the expected investments and returns of participating in the APC model
- In parallel the team has been developing the financial requirements and returns to inform the general financial business case
- This document outlines the assumptions and direct financial business case for health plans to customize and discuss as part of their decisions to move forward in support of the APC model
- We encourage payers to review this material internally, incorporating each payer's experience with primary care models and value-based payments

Context for Advanced Primary Care financial business case (2/2)

- **This document focuses on describing the financial business case for APC payers[1], including investments and returns over time**
- **Multiple other sources of value for payers to participate in APC, not described in detail here, are anticipated to include:**
  - Improved quality, outcomes, and patient experience
  - Positive influence on payer brand and reputation
  - Ability to engage more practices in value-based payments, including practices with fewer plan members and smaller practices
  - Capture of quality incentives from Medicare and Medicaid (e.g., MA Stars)

1 The business case for APC providers will be released separately in coming months, and will be based on the same economic principles

Target questions to be answered in financial business case for APC payers

1. What will participation in APC cost for a payer?
   - What investments expected in a practice by year of participation in APC starting at Gate 1?
   - What will payers be expected to invest in each calendar year to participate in APC?
2. What's the return for payers?
   - When should payers expect to see returns on investment for each practice they invest in?
   - What are the expected returns on investment for payers by calendar year?
   - What is the expected financial impact for participating primary care practices?

Executive summary

1 *What will participation in APC cost for a payer?*

- Private payers will be expected to support Advanced Primary Care practices caring for patients in their Commercial and Medicare Advantage service lines
  - **Support to offset 1 year of productivity losses of practice transformation (PT)** ($1.5-3 PMPM) for practices starting at Gate 1
  - **Investment in care coordination (CC) fees** ($4-10 PMPM) after passing Gate 2 for one year, and continued after Gate 3 contingent upon meeting performance requirements
- For a representative payer with 10% market share, this could represent an **investment of ~$10M in 2017 (~$2M in PT support and ~$8M in CC fees)**

2 *What's the return for payers?*

- Success cases from multiple published multi-payer initiatives suggest a **pay-back period of 2-3 years and cumulative return of 3-4x by the end of 5 years** from start at Gate 1
  - In 2017, returns for a payer with 10% market share can be from $15-25M, driven largely by advanced practices who enter APC at Gates 2 and 3
  - By 2019, net returns for a payer with 10% market share can range from $90-135M per year
  - Primary care practices participating and succeeding in APC can see up to 50% increase in take-home pay by their fifth year of participation

Key assumptions (1/2)

Pre-conditions

- **Participating payers:** comprise a majority of provider's revenue (at least 60% of panel)
- **Improvement mindset:** as a process of improvement focused on outcomes, where physicians and office staff are program creators and office champions
- **Improvement strategy:** centered on high-risk patients, data, and performance
- **Expectations:** to demonstrate progress prior to receiving alternative payments

Investments

- **$1.50-3 PMPM ($18-36 PMPY) in financial support during transformation**:
  - Total cost of care (TCC) in NY: $440PMPM (Commercial) to $980PMPM (Medicare)
  - 6-12% of TCC in all settings paid to primary care under FFS ($30-60 PMPM)
  - 5% drop in PCP productivity during 2-year transformation
- **$4-10 PMPM ($48-120 PMPY) payment for care coordination**
  - TCC: $440-980 (as above)
  - Care coordination payments 0.5-2% of TCC
- **Outcomes-based payments** representing 30-70% of savings, net of other investments

Impact on cost of care

Base case consistent with well-executed models

- Fully offset care coordination fees by year 2 (some earlier)
- Progressively improve to achieve 6-12% gross savings by year 5

Minimum case to remain in APC

- Demonstrate improvements in efficiency by year 2
- At least offset care coordination costs by year 3

SOURCE: NYS SIM financial analysis, June 2014, National Academy for State Health Policy

Key assumptions (2/2)

- **Ramp-up:** Very few payers and providers will execute contracts in 2016 (~2%)- though a large proportion will begin in 2017 (35%)- the remainder (toward a target of 80% of attributable members) will finish in 2018 and 2019
- **Business lines**: The following business case illustrates commercial (SI and FI) and Medicare Advantage business lines, where private payers have greatest discretion; the SIM program also anticipates participation of Medicare FFS and Medicaid (MCO and FFS) programs- though these are not illustrated in this case
- **Members reached through APC program:** Only members attributable to PCP (estimated to be 80% for total members[1]) can participate
- **Performance expectations:** 20% of practices will not meet performance requirements to remain in plan each year for the first four years, and will leave the APC program. Subsequently attrition is expected to be minimal.
- **APC gate upon entry into program:** Gate 1- 40%; Gate 2- 55%; and Gate 3- 5%
  - Each practice will undergo a Gating Assessment co-sponsored by the SIM grant and participating practices in order to determine Gate upon entry
  - Allied programs such as NCQA PCMH, DSRIP, TCPI[2] will qualify for Gate 2
  - Practices participating in CPCI and MAPCP will qualify for Gate 3
- **Existing VBP for primary care**: Most payers have existing VBP programs for primary care (assumed in this case to affect ~30% of members). For individual payer examples, only 70% of APC investments are assumed to be new investments, leading to proportionately reduced new returns

1 20% of adults have not seen a provider in the last 12 months, CDC 2014
2 Most TCPI practices are expected to join the APC program in 2017, by which point many will be able to demonstrate Gate 2 milestones

Expected return on investment by calendar year for APC-participating payers (detail to follow)

ILLUSTRATIVE

		2016	2017	2018	2019	Total target
All payers (new and continued investments)	1 **Investments per year,** Millions	$7	$150	$280	$330	$770
	2 **Expected returns per year,** Millions	$-	$200-350	$400-600	$700-950	$1,300-1,950
Sample payer (10% market share, new investments only)	1 **Investments per year[1],** Millions	$<1	$10	$20	$25	$55
	2 **Expected returns[2] per year,** Millions	$-	$15-25	$30-40	$50-65	$90-135

- Returns in in early years are driven by advanced practices joining at Gate 2 or 3
- Subsequent years see returns on practices joining at Gate 1

1 New investments assume 30% of existing VBP for primary care is repurposed for APC (and only 70% is new)
2 For new investments, excluding 30% of VBP already existing

1 Projected ramp-up and budget implications for APC payers[1]

ILLUSTRATIVE

	Line of business	Type of payment	2016	2017	2018	2019	Total target
Ramp-up assumptions by year, % of attributable members[1]	**All**	N/A	2%	35%	28%	15%	80%
Cumulative members remaining in program,all payers '000 members	**Commercial (SI + FI)**	Care coordination (CC)	75	1,700	3,600	4,300	
		Practice Transformation (PT)	50	1,100	900	500	
	Medicare Advantage	Care coordination	<10	190	400	480	
		Practice transformation	<10	120	100	60	
Investments per year, all payers, Millions	**Commercial (SI + FI)**	CC ($60 PMPY example)[2]	$5	$100	$215	$260	$580
		PT ($24 PMPY example)[3]	$1	$25	$25	$10	$60
	Medicare Advantage	CC ($108 PMPY example)	$<1	$20	$45	$50	$115
		PT ($24 PMPY example)	$<1	$3	$3	$1	$7
Total investments per year, all payers, Millions	**Commercial and MA**	All (CC and PT)	**$7**	**$150**	**$280**	**$330**	**$770**
Total new investments[3] per year, sample payer with 10% market share, Millions	**Commercial and MA**	All (CC and PT)	**$<1**	**$10**	**$20**	**$25**	**$55**

1 All numbers rounded for ease of communication and to avoid false precision
2 Care management fees may vary by payer in this range, and are presumed to be annual for all practices in APC
2 PT support may vary by payer in this range
3 New investments assume 30% of existing VBP for primary care is repurposed for APC

SOURCE: Interstudy 2014, CMS, NCQA

NEW YORK STATE OF OPPORTUNITY. Department of Health

2 Returns for payers and providers by year of practice participation in APC

ILLUSTRATIVE

		By year starting after Gate 1[1]				
		Year 1	Year 2	Year 3	Year 4	Year 5
Gross savings (% of TCC)[2]	**Target range**	0-1	2-3	4-5	6-8	6-12
	Minimum	0	0.5	1	2	3
Investments (% of TCC)	**PT support**	(0.5)	--	--	--	--
	CC fees	--	(1)	(1)	(1)	(1)
Net savings based on target range of impact (% of TCC)	**Total surplus**	(0.5)-0.5	1-2	3-4	5-7	5-11
	PCP share[3]	0	0.5-1	1	1-2	0-2
	Payer share[4]	**(0.5)-0.5**	**0.5-1**	**2-3**	**4-5**	**5-9**
PCP impact	As % increment to FFS[3]	0	5-8	10	10-15	0-23
	As % increment to take-home pay[4]	0	15-20	25-30	25-40	0-55

- **Pay-back period in 2-3 years**
- **ROI is 5-9X investments by year 5, and 3-4x cumulative return over 5 years**

1 All numbers rounded for ease of communication
2 Target range = savings demonstrated in successful population health management models. Minimum = necessary to remain in APC program
2 Assumes PCP is paid 50% shared savings relative to two-year historical baseline (similar to 60/30/10-weighted three-year baseline used by MSSP), MSR 2% of gross
3 Assumes PCP base reimbursement is 10% Total Cost of Care in Year 0, growing at 5% per year in base case. Exclusive of CC fees (assuming fee is to cover costs only)
4 PCP take-home is assumed to be 30-40% of PCP reimbursement- 40% used here as a conservative assumption

SOURCE: SHIP financial analysis, IC WG documents

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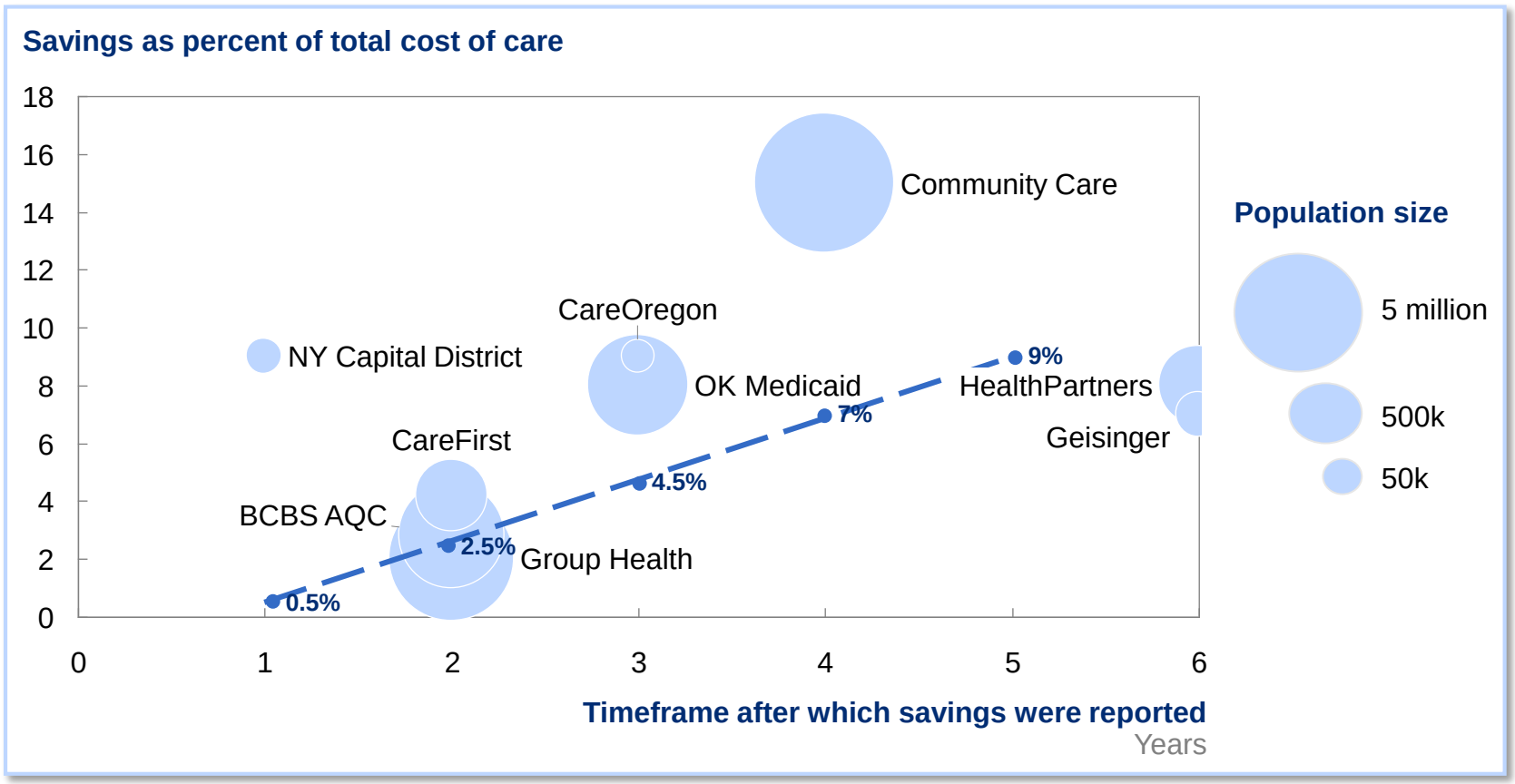
APPENDIX

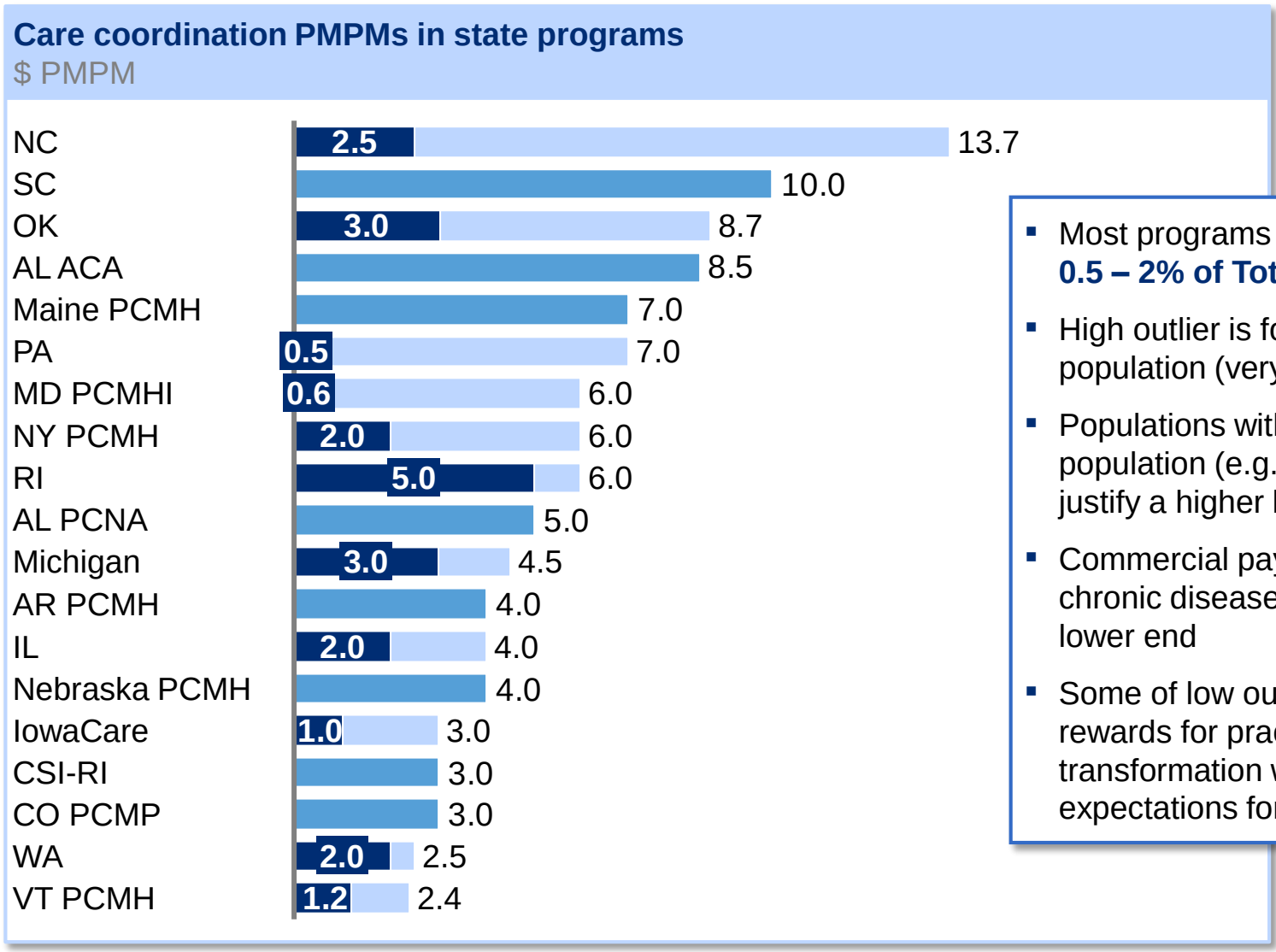
Our financial model assumes conservative savings relative to the ramp up effect evidenced by case studies



SOURCE: Commonwealth Fund, Health Affairs, Milliman, Annals of Family Medicine, Patient-Centered Primary Care Collaborative, Agency for Healthcare Research and Quality

Proposed APC care coordination payments are within the range of similar multi-payer programs

NOT COMPREHENSIVE



- Most programs **average between 0.5 – 2% of Total Cost of Care**
- High outlier is for a special needs population (very high cost)
- Populations with higher chronic population (e.g., Medicare) may justify a higher level of investment
- Commercial payers with lower chronic disease burden cluster at lower end
- Some of low outliers may reflect rewards for practice transformation without specific expectations for coordinating care

SOURCE: National Academy for State Health Policy, 2013

Care coordination cost estimate for technology and services

ILLUSTRATIVE

Illustrative practice with 10,000 patients

Operating assumptions

Number of high-risk patients	1,000
/	
High-risk patients per coordinator[1]	500
=	
# of care coordinators	**2**

Cost assumptions (per CC)

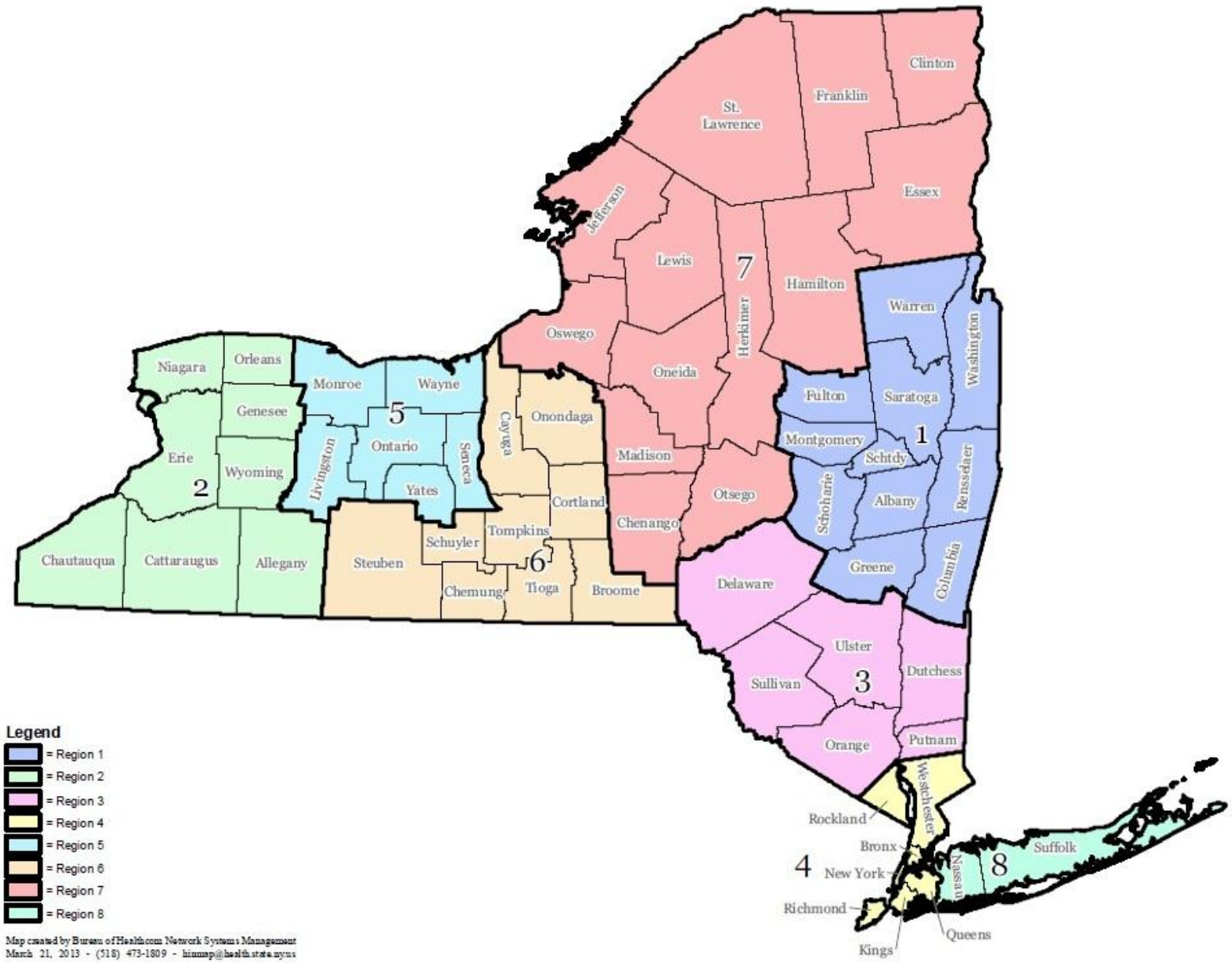
Salary and benefits[2]	$95-120k
+	
Access to specialized resources for high-complexity cases[3]	$25-40k
+	
Management overhead[4]	$30-40k
+	
Technology investment	$70-140k
=	
Total	$220-340k
Total CC investment (2 CC's)	**$440-680k**

- This is a high-level estimate for resources required for an average practice for hiring a care coordinator and related coordination resources
- Although actual approach to care coordination may vary across practices, these estimates are likely still representative
- Many factors affect the actual costs for a practice, including current investment by providers and payers in care coordination resources

1 Total panel size over the course of a year
2 One coordinator at $85-110k/year in salary and benefits
3 One specialty staff per 5-10 care coordinators at $150k/year in salary and benefits (may include PharmD, social workers, other specialty staff)
4 10-15 managers for every 100 care coordinators at $200k/year in salary and benefits

Attachment F:

Map of DFS Rating Regions



Legend

- = Region 1
- = Region 2
- = Region 3
- = Region 4
- = Region 5
- = Region 6
- = Region 7
- = Region 8

Map created by Bureau of Healthcom Network Systems Management
March 21, 2013 - (518) 473-1809 - hinmap@health.state.ny.us