

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

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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.

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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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Promote access as defined by affordability, availability, accessibility, and acceptability of care across all patient populations
HIT	<ul style="list-style-type: none"> Use health information technology to deliver better care that is evidence-based, coordinated, and efficient
Payment model	<ul style="list-style-type: none"> Participate in outcomes-based payment models, based on quality and cost performance, for over 60% of the practice's patient panel
Quality and performance	<ul style="list-style-type: none"> 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:

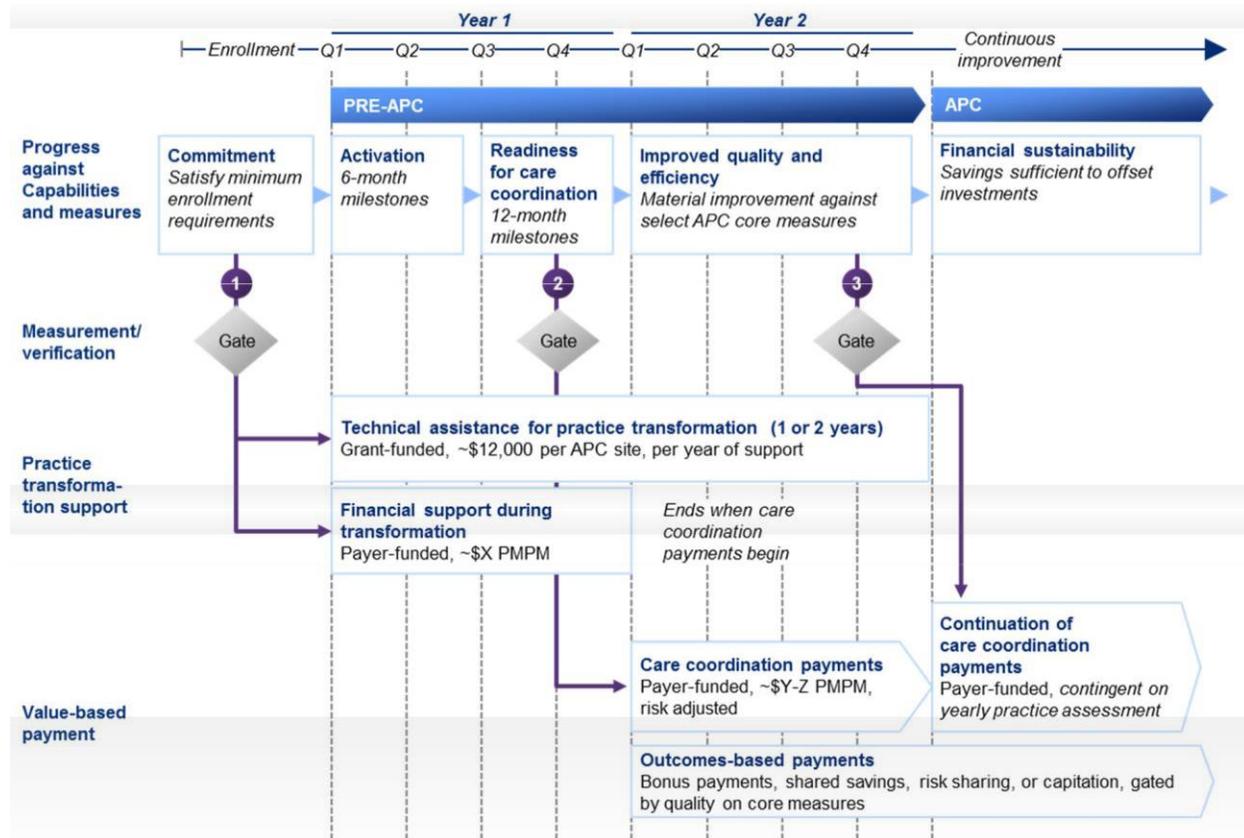
- The ability to identify high-risk patients and successfully measure and report the Core Measures derived from practice data.
- Capacity to provide care coordination for high-risk patients within one year.
- Infrastructure and commitment to use results from APC Core measures for improvement.

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 network¹. 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 on 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

- **Will Medicaid expect all Medicaid primary care practices to participate in APC?**
 - PPSs PCPs must become 'PCMH (NCQA 2014) or APC'. At this point participation in APC specifically is not required.
- **Will all Medicaid primary care practices receiving the PCMH NCQA 'bump' be expected to eventually participate in APC in order to continue to receive the 'bump'?**
 - The PCMH NCQA 'bump' today has no conditions for performance, but in the future these practices will likely have a performance requirement. Consistent with APC, this may take the form of successfully passing Gate 3 within one year and meeting performance requirements, otherwise the PCMH NCQA 'bump' will cease.
- **How will Medicaid measure performance in primary care?**
 - Medicaid primary care practices will increasingly be measured using the APC core measure set. For those practices involved in chronic bundles, there will also be bundle-specific measures.
- **How will Medicaid support practice transformation?**
 - Medicaid primary care practices part of PPSs will receive DSRIP payments to support their transformation toward NCQA (which earns them APC Gate 2) or toward their transformation to APC Gate 2 without NCQA.
- **What kind of outcomes-based payments will be available for primary care?**
 - Medicaid primary care practices will have flexibility to choose from the VBP roadmap (Level 1 and above), including the option of doing chronic bundles or a professional-led ACO. Being an PCMH NCQA or APC will not be a requirement for entering VBP arrangements.

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

