

SHIP Information Request Background and Q&A

Introduction

This Q&A is intended to clarify the goal and intent of the recently distributed SHIP Information Request (RFI) and to answer questions raised to date.

In addition to the following clarifications, **the due date of responses has been extended to March 18, 2016**. A template for compiling answers will be distributed next week, as will a meeting invitation for the next Q&A conference call. Please continue to submit questions to stefanie.pawluk@health.ny.gov.

RFI Goals and Intent:

- Information collection. The RFI is intended to collect information about payers' current outcome based primary care models. We have had a number of meetings, both in large groups and individually with plans, to discuss the APC model. The RFI allows plans to provide additional detail on specifics of their primary care models in a confidential format. The RFI also allows us to collect the information in a systematic way to allow better analysis on our end.
- Opportunity for you to comment. The RFI allows payers the opportunity to tell us how their primary care models compare with APC. Also, the RFI is intended to allow payers to comment on any of the items addressed in the RFI.
- Identify alignment opportunities. Your responses to the RFI will allow us (collectively) to identify programs or parts of programs that align with and support the APC model.
- Identify hurdles to alignment. Your responses to the RFI will also allow us (collectively) to identify possible hurdles to adoption of the APC model.
- Opportunity for collaborative refinement of APC model. By identifying opportunities for and hurdles to alignment and adoption of the APC model, the Integrated Care Workgroup, payers and other stakeholders will be able to further refine the APC model and strategize about how we move forward to achieve the larger SHIP goals.

What the RFI is NOT:

- The RFI is not a mandate to adopt APC model, nor is it intended to express any policy that payers must adopt the APC model. It is simply a tool to gather information.
- The RFI is not the final version of the APC model. The supplemental materials in the RFI (including the Draft Business Requirements, the Draft Business Case, and the APC Model Components) are *draft* documents. We provided them along with the RFI as information on which to base responses. The draft documents are intended to provide a clearer "point in time" articulation of the APC model against which payers can compare their own programs. We fully anticipate that the APC model, Draft Business Requirements, and Draft Business Case will be further refined with your input.

Feedback on the proposed APC model can continue to be provided through RFI responses or, as always, may be sent to stefanie.pawluk@health.ny.gov.

Questions and Answers (As of 2/26/16)

1. **Q:** What is the benefit to health plans of aligning with APC?

A: Multi-payer alignment with the APC model increases the likelihood of success for practices and, in turn, payers. We understand that plans are currently developing and investing in their own value-based programs and contracts. Our goal is to develop common guidelines that respect ongoing initiatives that align with the APC model while allowing payers to differentiate and innovate. Common guidelines and alignment will allow even greater efficiencies and improvement in the quality of care, population health and savings.

2. **Q:** How does APC fit with existing value-based programs? What does it mean to be “grandfathered” into APC?

A: The purpose of the RFI is to see how the APC model aligns with existing value-based programs. Some existing value-based programs may be very close to the APC model and could be considered “APC consistent” or “grandfathered” for purposes of achieving the ultimate goal: achieving a level of payer participation necessary to improve outcomes and reduce costs. This means a program that has the same core elements as the APC model (e.g., common measures, payment structures, etc.). It does not mean that plans will have to abandon their current programs to adopt the APC model. The RFI is an opportunity for establishing a baseline for continued dialogue and collaboration on APC.

3. **Q:** What does participation in APC mean?

A: The concept of “participation in APC” will be further refined based on the responses to the RFI and collaborative dialogue among stakeholders. But in general, “participation in APC” means that a health plan has a value-based program that is sufficiently aligned with APC to ensure that, from a practice perspective, the supports, goals, and incentives are consistent with APC.

4. **Q:** What is the State's role in APC?

A: The State is acting as a convener and facilitator to build consensus around the APC model and ensure an ability to scale the model. The State, through SIM, is providing ~\$67M for technical assistance to help practices achieve the APC milestones and participate in value-based payment models.

5. **Q:** Will APC be regulated by the state?

A: No. “APC participation” is a voluntary initiative intended to create multi-payer alignment in support of a common model (APC) and guide distribution of SIM-funded practice transformation assistance for practices and providers.

6. **Q:** Why would I provide PT payments?

A: To help improve outcomes and reduce costs: Practices that meet Gate 1 (as confirmed by SIM-funded practice transformation entities) will have committed to make meaningful improvements in care delivery. This will result in losses to the practice due to reduced productivity during the transformation process. Payer support will help offset a portion of those losses, thereby helping practices to successfully navigate transformation to APC which will in turn to improve outcomes and reduce costs.

7. **Q:** Should responses to the RFI be broken down by line of business?

A: Yes – please refer to attachment A, page 2 “Most of the questions below require separate answers for each line of business, including commercial (both fully- and self-insured) and Medicare Advantage, but should not include Medicaid (both managed care and fee-for-service). Please include as applicable any special considerations made or potentially to be made for specific subpopulations, e.g., pediatrics.”

8. **Q:** How can payers be formally defined as “participating in APC”?

A: We are still finalizing the details based on responses to the RFI and subsequent discussions with payers, providers, and other stakeholders.

9. **Q:** When will APC start?

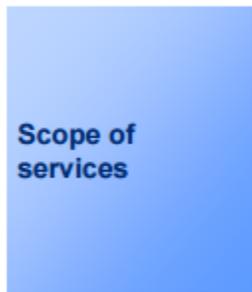
A: Transformation entities will be funded in 2016 to begin work with practices in 2017. Depending on practice maturity, some practices will be defined as “APC Ready” in 2017, some later. As we review the RFI responses, we will be analyzing how plans’ current programs compare with or support the APC model, identify similarities and differences, and discuss opportunities where plans can support the APC model.

10. **Q:** Are Medicaid managed care plans (PHSPs) expected to participate in APC? Does the RFI require data regarding PHSPs?

A: The State is working to ensure alignment of Medicaid and the Transforming Clinical Practice Initiative (TCPI) with the APC model, but this RFI pertains only to commercial and Medicare Advantage lines of business. As set out in Attachment A, page 2: “Most of the questions below require separate answers for each line of business, including commercial (both fully- and self-insured) and Medicare Advantage, but should not include Medicaid (both managed care and fee-for-service). Please include as applicable any special considerations made or potentially to be made for specific subpopulations, e.g., pediatrics.”

11. **Q:** What type of support will SIM-funded practice transformation entities provide to practices? Please provide an example.

A: Please refer to the Integrated Care Workgroup Document #9, page 29, which can be found at https://www.health.ny.gov/technology/innovation_plan_initiative/docs/2015-10-16_integrated_care_presentation.pdf



Scope of services

Scope to include

- Provider engagement, assessment
- Pre-transformational assessment
- In-person and remote interactions
- Multi-practice collaborative
- Curriculum tailored to APC
- **Aid in gathering and reporting of milestone data**

The exact scope of services will be detailed in the forthcoming PT RFA to be released in the coming month.

12. **Q:** Is there a requirement for how many PCPs plans should work with to establish APC?

A: No, however, the State's overarching goal is to ensure that 80% of all New Yorkers are covered or have access to care under an APC model within 5 years.

13. **Q:** Who holds the contract with the provider?

A: Payers will continue to hold contracts with providers.

14. **Q:** If a plan already has an agreement with a group of providers (or practice), would plans have to change existing contracts?

A: No. Plans that have arrangements in place that support advanced primary care (team based care, care coordination, value based payments) are encouraged to continue these initiatives. The goal is alignment and consistency.

15. **Q:** Could you clarify the goals of having 80% of New Yorkers under an alternate payment program. Is the goal to have 80% within an APC setting, or have 80% under the exact APC model?

A: The ultimate goal is to ensure that 80% of all New Yorkers have access to primary care practices that have features of advanced primary care (including care management and care coordination) and are supported by payment models that promote quality, incent value, and use a common set of measures.

16. **Q:** Is there an opportunity for plans to share a template of what plans have in place? It wasn't clear in the instructions if materials could be sent in addition to responses.

A: Yes. We welcome other materials and attachments illustrating and explaining plans' existing arrangements. The intent of the RFI is to understand the programs in place and how

they are consistent or inconsistent with APC. We do not plan to determine that a program is “passing” or “failing” at this time. The RFI is an opportunity for establishing a baseline for continued dialogue and collaboration on APC.

17. **Q:** If we have existing performance based arrangements, including ACOs where we are already collaborating with providers, are we expected to pay a PMPM to those providers and enter into an additional relationship?

A: We do not intend to interfere with existing value-based contracts that support advanced primary care. By understanding how existing arrangements compare and align with the APC model, we can best define the core or foundational set of arrangements and any guidance needed to ensure alignment and achieve common goals and objectives.

18. **Q:** If we have providers on enhanced fee schedules, are we expected to pay additional dollars through APC?

A: In your responses to the RFI, please explain how your enhanced fee schedules align with the APC criteria outlined in the RFI including targeted support for practice transformation and care coordination. By understanding how existing arrangements compare and align with APC, we can best define the core or foundational set of arrangements and any provisions needed to ensure alignment and achieve common goals and objectives.

19. **Q:** Is there an expectation that we pay ALL par providers and also engage and pay providers who are non-par?

A: One of the goals of the RFI is to identify opportunities where plans can adopt the APC model (for example, with practices that do not currently have value-based contracts) or opportunities to align with the APC model (for example, possibly amend current value-based contracts to include components of the APC model). When we receive the responses to the RFI, we will work plans and other stakeholders to identify such opportunities (being sensitive to confidential or proprietary information). The overall goal is multi-payer support of the APC model. Contracting details remain the purview of the individual plans.

We do not expect non-participating providers to engage in the APC model.

20. **Q:** What level of confidentiality will be provided for plan submissions?

A: Payers are invited in the RFI to mark any parts of their submissions as confidential and proprietary as appropriate. DFS and DOH will keep such information confidential and, if we receive a FOIL request for information that a payer has marked as proprietary, we will contact the company to confirm the proprietary nature of the material, as required under the FOIL laws. Proprietary information is exempt from FOIL disclosure.