New York State Health Innovation Plan

NEWSLETTER || MAY 18, 2016

NEW YORK SIM UPDATES:

- The Innovation Center welcomes Bryan Allinson as its new Director, starting May 31. Bryan comes to the Innovation Center with significant experience and expertise most recently with the SUNY Research Foundation.
- The NYS DOH has received inquiries from health plans regarding the alignment of CPC+ with New York State's Advanced Primary Care (APC) model and with the NYS Medicaid VBP roadmap. In response, NYS DOH sent a letter to health plans providing information describing the alignment of these programs that may help to demonstrate the compatibility of programs with APC, CPC+, and the VBP Roadmap. The letter is attached to this email.
- Slides from the April 4 PPS Webinar on APC have been posted online.
- Materials from the April 11 and May 9 Integrated Care Workgroup meetings have been posted online.
- Slides from the third State Health Innovation Plan Council meeting will be posted to the SIM website soon. A recording of this meeting has been posted online and is available to view until June 10th.

IN THE NEWS:

- **Comprehensive strategy for Primary Care Payment Reform in Medicine: CPC+**
  Strengthening primary care has been a core goal of health care payment reform over the past several years. The most recent effort toward this goal lies at the heart of the recently announced Comprehensive Primary Care Plus (CPC+) program. The full article can be viewed here
- **HANYS Releases Report on Measures**
  Healthcare Association of New York State (HANYS) recently released a comprehensive report calling for healthcare measurement reform. It details the current healthcare measurement environment and how it impacts patient care. The report also provides strategies for providers to manage their measurement programs to prioritize measurement efforts and focus on those that matter most and can drive improvement. The full report can be viewed here
- **Community Perspectives on Advanced Primary Care**
  In January 2015, the New York City Population Health Improvement Program (NYC PHIP) was launched as a collaboration between the Fund for Public Health in New York, the New York City Department of Health and Mental Hygiene (NYCDOHMH), the United Hospital Fund (UHF), and the New York Academy of Medicine (NYAM). Objectives for the first two program years include promotion of increased multi-sector investment in interventions that prevent disease and improve health equity in NYC. Objectives also include the support of a local transition to value-based health care, and development of a plan for expansion of Advanced Primary Care (APC). The NYC PHIP released a report inclusive of patient perspectives to inform ongoing development and implementation of the APC model. The full report can be viewed here

For more information on SHIP/SIM, visit: http://www.health.ny.gov/technology/innovation_plan_initiative/

To subscribe or unsubscribe from this newsletter, email us: sim@health.ny.gov

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HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

May 10, 2016

Dear Colleague:

As you are aware the CMS Center for Innovation (CMMI) recently issued to health plans a request for application (RFA) to participate in its Comprehensive Primary Care Plus (CPC+) model (see https://innovation.cms.gov/Files/x/cpcplus-rfa.pdf). NYS DOH has received inquiries from health plans regarding the alignment of CPC+ with New York State's Advanced Primary Care (APC) model, and within the APC model, regarding the potential alignment with the NYS Medicaid VBP roadmap.

NYS DOH staff have reviewed the CPC+ RFA and met with CMMI to discuss these opportunities for alignment. Upon review, it appears that these two models are similar. We view CPC+ as consistent with our SIM/APC objectives to move towards multi-payer alignment in support of high value primary care services. Further, the APC model can and should serve as the conceptual and operational construct in which multiple private and public payers collectively catalyze the Triple Aim through primary care-based care delivery and payment innovation. The NYS Medicaid VBP Roadmap includes several VBP arrangements, of which one (Integrated Primary Care with the Chronic Bundle) has been developed to fit the APC model. The Medicaid VBP model combines a focus on preventive and routine sick care with the potential for significant shared savings by reducing avoidable complications (e.g. avoidable hospital admissions or ER visits). APC can be seen as the overarching construct incorporating that model as well as for CPC+. All seek to support primary care transformation through a common approach:

- Value-based payments to participating primary care practices, allowing for significant increase in funding and upfront investment
- Focused measurement on costs (e.g., reducing avoidable hospital use) and quality for the practice's population
- A defined, but limited set of quality measures
- Transformation resources to support development of advanced primary care capabilities over time

Therefore, we encourage health plans to seriously consider applying for CPC+ in an effort to engage Medicare in primary care practice transformation in New York. Effectively, CPC+ represents Medicare's potential contribution to the APC model. CMMI estimates that through CPC+, average additional reimbursement to participating CPC+ practices could be significant. However, actualizing that contribution to New York primary care providers requires a concentration of meaningful payer concentration and alignment. In order to support your potential RFA response to CPC+, we suggest below a number of potential points of program

alignment that may help to demonstrate the compatibility of your program with APC, CPC+, and the VBP Roadmap.

Beyond CPC+, NYS DOH and the Department of Financial Services (DFS) encourage payers to participate in multi-payer APC efforts beyond those regions or practices that might be selected by CMMI for CPC+ as we endeavor to create broad access to advanced primary care for patients throughout New York State.

If CMMI awards CPC+ projects to New York State, NYS DOH believes that there are many opportunities to collaborate with CMMI and leverage alignment between the State's APC model and CPC+. Given that CMMI has stated that preference will be given to CPCi, MAPCP, and SIM states, and given that CMS highly values the participation of Medicaid and has endorsed Medicaid's VBP Roadmap, we believe that New York State is in a good position with CPC+. However, now is a moment where payers need to collectively represent to CMMI the meaningful alignment and focus on APC that we have collectively been developing over the past year. If you have questions or would like to discuss, please contact Hope Plavin at NYS DOH at hope.plavin@health.ny.gov

Sincerely,

Hope Plavin, MHCDS, MPA
Director
NYS Health Innovation Center

Foster Gesten, M.D., FACP
Chief Medical Officer
Office of Quality & Patient Safety

Potential points of program alignment that may help to demonstrate the compatibility of private payer programs with APC, CPC+, and the VBP Roadmap

The CPC+ RFA response requires answering 27 questions. Here, we provide draft guidance that may help you to demonstrate alignment with CPC+ within the overarching APC model. You are welcome to use this language as a basis or guide in your response.

- Alignment on regional focus. The incremental impact of the APC model is predicated on achieving regional concentrations of multi-payer focus on primary care delivery and payment innovation. For CPC+, the final definition of a "region" will be based on the overlapping, contiguous geographic service areas of partnering payers. Therefore, we recommend that your selection of regions includes, but is not limited to, regions where providers have experience with the original CPC program, MAPCP, and/or are regions in which your plan would like to create a new multi-payer initiative. *(Relevant questions: #2 and #3 – RFA p. 41.)*
- Attestations to key model components. APC, CPC+, and the Medicaid VBP roadmap each include enhanced support of practice transformation and alternative payment models. For example, payments to providers for NCQA PCMH status provided by Medicaid are analogous to enhanced support for practice transformation. Similarly, the suggested progressive levels of value-based payment in APC, which also tracks with the "levels" described in the VBP roadmap, are approximately aligned with the framework of Track 1 and Track 2 in CPC+. Where possible, we recommend that your proposal directly address how your approach will include financial elements similar to APC and CPC+. Our understanding is that CMMI will view favorably any investments to support care coordination and wraparound services. Further, where possible, we encourage alignment on the approach to performance-based incentives analogous to those in the CPC+ model, with utilization measures approximately aligned with those discussed in both the APC and CPC+ models. With regard to Track 2, our guidance is that you should, at minimum, articulate a willingness to consider and design a Track 2 payment mechanism that represents a partial alternative to FFS. *(Relevant questions: #5, #6, #9, #10, #11, #14 – RFA p. 42)*
- Striking a balance between prospective and performance based payments. The CPC+ model emphasizes upfront payments for practice transformation and care coordination services, and does not include a shared savings or downside risk component. Simultaneously, the CPC+ model is flexible in what counts as payer alignment. The NYS Medicaid primary care VBP arrangement, which uses shared savings models and includes bundled payments, will fit well within the overall context and goals of the CPC+ initiative. Within this broad space, however, our guidance is that you should, at minimum, address how your approach supports practice investments in infrastructure and capabilities to be able to achieve the common goals. This could of course be structured as the CPC+ model itself, but it could for example also consist of upfront payment of expected shared savings with a retrospective reconciliation. For Track 2, a form of capitated payment with or without the possibility to recoup some percentage when specific goals are not met would also be acceptable.
- Alignment on quality measures. We recommend that to the extent possible, you align quality measures to the relevant Medicare measures, including eCQMs, CAHPS and patient-reported outcome measure surveys, as well as to those proposed in the APC model. A greater degree of alignment on measures will demonstrate the collective

willingness of payers to enable providers to approach care delivery transformation in a common, streamlined way, rather than having to deal with an inefficient burden of differing expectations across payers. *(Relevant questions: #19-23 – RFA p. 50-52)*

- Alignment on monitoring and evaluation. We recommend that, where possible, your approach to monitoring and evaluation leverage the APC model approach of the Independent Validation Agent (IVA). The IVA will audit both practices and technical assistance (TA) entities participating in the APC program to ensure consistency across regions and the application of a single statewide standard for achievement of gates and milestones. In addition, the IVA's verification and audit provides unbiased information about practice capabilities and eligibility for value-based payments for both commercial and government payers. We believe that the IVA mechanism can be refined to be able to validate APC progress as well as CPC+ progress. We expect that this synergy will be cost-saving to payers and decrease administrative burden on practices. *(Relevant questions: #24 and #25 – RFA p. 52)*