Funds Flow Overview

All Partner Meeting: April 10, 2015

Presented by:

Jim Vielkind, Finance Committee

Dan Crowell, Finance Committee

Sue van der Sommen, Senior Director, DSRIP

Finance Committee Members

- Tony Partenza, Co-Chair, Senior Director, Hospital Services, Bassett
- Christa Serafin, Co-Chair, CEO, Sitrin
- Dan Crowell, Otsego County Treasurer
- Len Lindenmuth, Executive Director, Bassett Health Plan
- Jim Vielkind, CFO, Little Falls Hospital
- Mark Wright, CFO, AO Fox Memorial Hospital
- Kurt Apthorpe, CEO, Focus

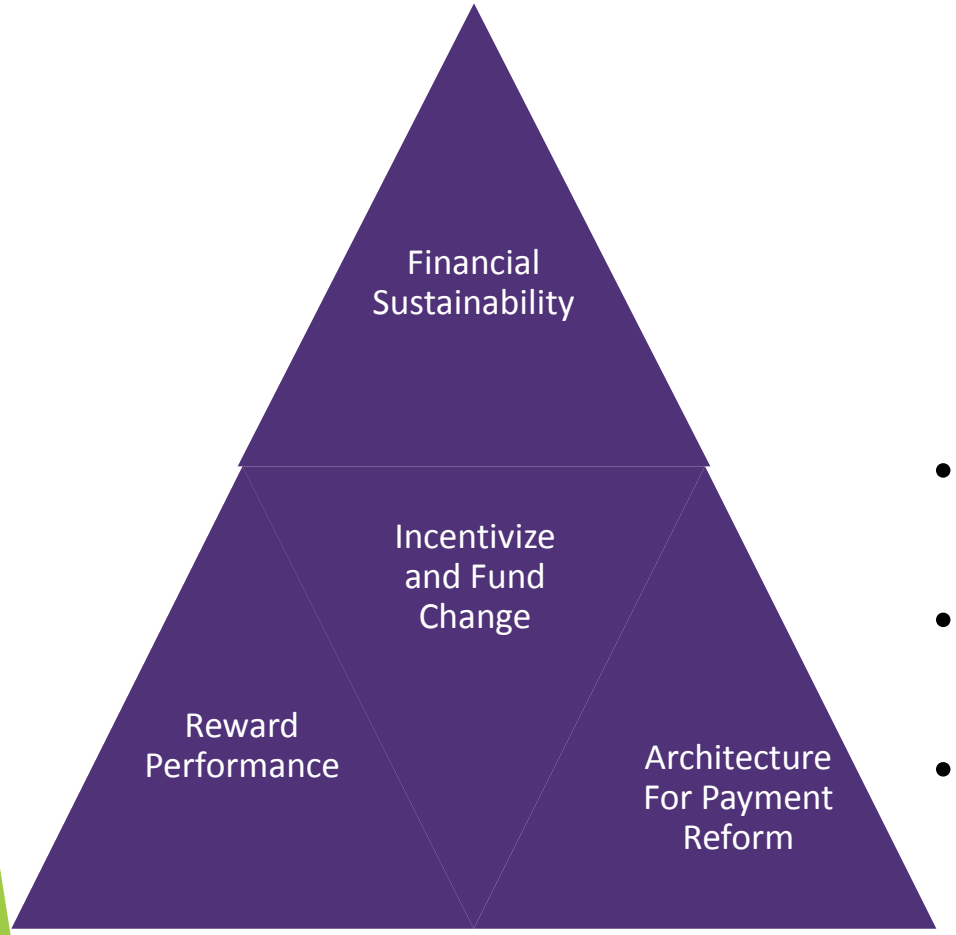
Challenges

- Funds Available
  - Not a grant.
  - Not sufficient to cover the costs of transformation (a statewide phenomenon).
- Governance Structure
  - Planning, oversight and monitoring for transition to population health management approach. What binds us?

Funds Flow Principles

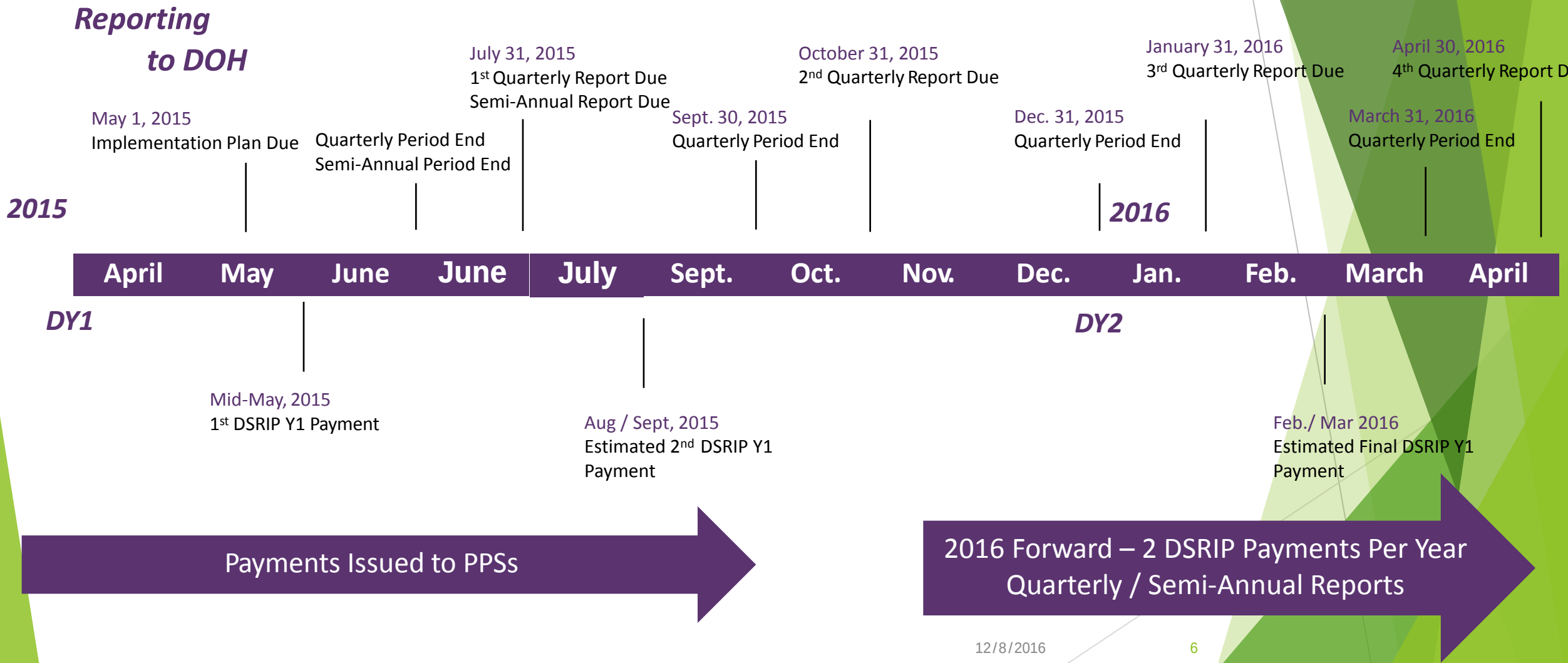
- During DY1-5, LCHP will receive payments from DOH based on the PPS' performance in achieving milestones outlined in the implementation plan
- DSRIP funds are paid for achieving project goals – not for providing services
- Metrics will shift over the DSRIP years from P4R to P4P
- Funds flow design should be able to handle variability in DSRIP funding based on the state and/or PPS achieving its goals
- Funds flow model must be transparent to all partners in PPS
- Funds flow is a critical aspect of the functioning of the PPS ~ and is very complex
- Deliberative oversight of funds flow is required – must be managed extremely carefully with discretion / judgment
- Community Based Organizations (CBOs)

Defining the Funds Flow Plan – Guiding Principles



- An effective funds flow plan will help enable the PPS to accomplish the following:
  - Ensure Financial Sustainability of the PPS
  - Incentivize and Fund change
  - Reward Performance and Incent Behavior
  - Establish architecture for payment reform models
- Buy-in of the funds plan by the providers is a key factor in the PPS's ability to achieve the DSRIP goal.
- Designing an effective funds flow plan requires an understanding of the requirements and impacts of the projects.
- Incentive metrics should be clearly defined and aligned with factors that affect the PPSs DSRIP payments.

DSRIP Payment and Reporting Calendar

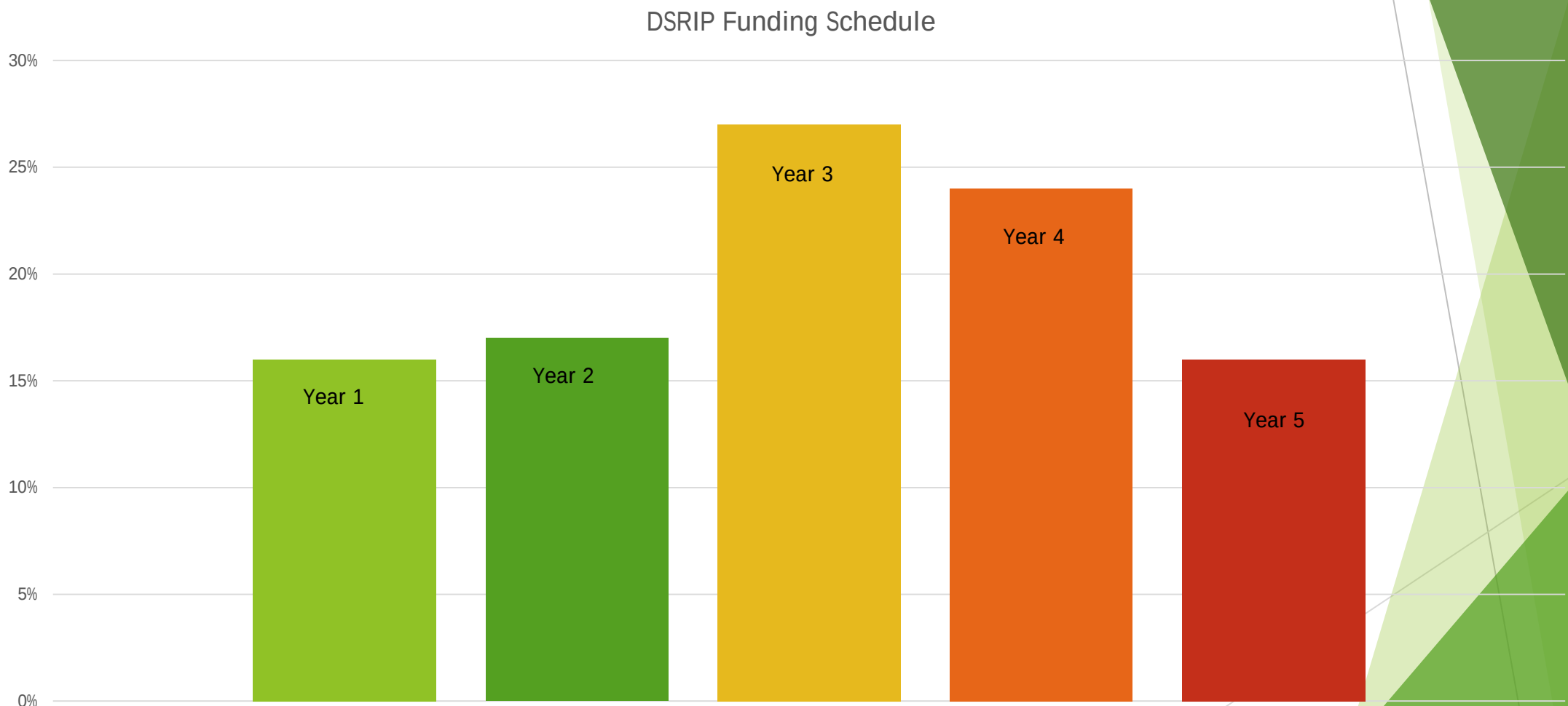


Source: https://www.health.ny.gov/health_care/medicaid/redesign/docs/program_funding_and_mechanics.pdf

Domain Projects/Metrics

- Domain 1 Metrics – Project Milestones
  - Project narrative on status and challenges
  - Percent of providers that are reporting relevant DSRIP project data
- Domain 2 Metrics - System Transformation/Financial Stability
  - Percent of Eligible Providers with participating agreements with RHIO's
  - Meeting MU Criteria and able to participate in bidirectional exchange
- Domain 3 Metrics - Clinical Improvement Milestones
  - Screening for Clinical Depression and follow-up
  - Percent of Long Stay Residents who have Depressive Symptoms
- Domain 4 Metrics - Population Health Outcomes
  - Asthma emergency department visit rate per 10,000
  - Age-adjusted percentage of adult binge drinking during the past month

Anticipated Payments per Year (%)

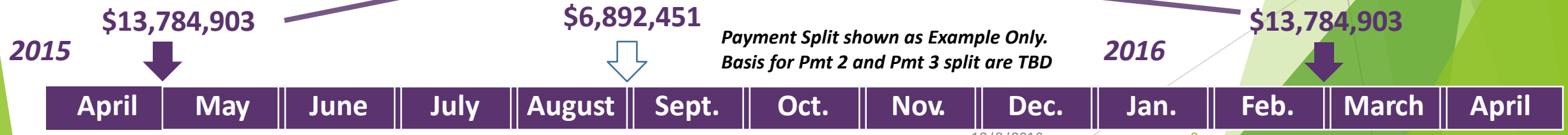


DSRIP Payments are Variable Over Time

- DSRIP payments will be calculated initially based on the progress of process milestones/metrics but will progressively transition to higher amounts being allocated for meeting project outcomes.
- Initially payments are based upon progress – including meeting scale and speed targets and other Domain 1 metrics. Domain 1 payments represent 39% of total payments.
- DOH will issue three DSRIP payments to distribute the CY 2015 funds. Two payments in each subsequent year.

Dependence upon meeting outcome metrics increases

Metrics/Milestons/Domains	Domain		CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	Total
Project Progress Milestones	Domain 1	P4R/P4P	$27,569,805	$22,034,958	$23,740,666	$10,512,729	$ -	$ 83,858,157
System Transformation and Financial Stability	Domain 2	P4P	$0	$ -	$11,870,333	$18,397,275	$17,231,128	$ 47,498,736
		P4R	$3,446,226	$ 3,672,493	$ 2,967,583	$ 2,628,182	$ 1,723,113	$ 14,437,597
Clinical Improvement Milestones	Domain 3	P4P	$0	$ 5,508,739	$14,837,916	$15,769,093	$12,061,790	$ 48,177,538
		P4R	$1,723,113	$ 3,672,493	$ 2,967,583	$ 2,628,182	$ 1,723,113	$ 12,714,484
Population Health Outcomes	Domain 4	P4R	$1,723,113	$ 1,836,246	$ 2,967,583	$ 2,628,182	$ 1,723,113	$ 10,878,238
			$34,462,256	$36,724,930	$59,351,664	$52,563,644	$34,462,256	$ 217,564,750



Domain Characteristics

PROJECT DOMAIN	DOMAIN LEVEL MEASURES	PROCESS MEASURES AND MILESTONES	DY 1&2	DY 3-5
DOMAIN 1	IMPLEMENTATION PLAN - Semi-Annual Updates - Project Narrative on Status - Financial Sustainability - Governance - Workforce - Provider Engagement - Payment Reformt - Learning Collaborative	Financial Sustainability - 3 milestone updates Value Based Strategy - 5 milestone updates	P4R P4R	P4R P4R
		Governance - 4 milestone updates	P4R	P4R
		Cultural Competency Health Literacy - 2 milestone updates	P4R	P4R
		Workforce Strategy Workforce Impact New Hire Updates	P4R P4R P4R	P4R P4R P4R
	Domain 4	Population Health Project Milestones (2)	P4R	P4R
	Domain 2 Projects Domain 3 Projects	Speed of Implementation - Define Data Sources - Support Required *NYDOH Domain 1 Milestones*	P4R P4R	P4R P4R
	Domain 2 Projects Domain 3 Projects	Speed of Engagement - Annual Percent - Milestone for 100% *NYDOH Domain 1 Milestones*	P4R P4R	P4R P4R
Domain 2	System Transformation Metrics	Statewide Measures Spend PMPM is based on project population *18 Measures in Domain 2*	P4R	P4R (5) P4P (13)
Domain 3	Behavioral Health Outomes Other Clinical Outcomes	Data Source is Identified as - NYDOH or PPS - Claims or Med Rec for PPS - Member Detail File TBD	P4R	P4R (1) P4P
Domain 4	Population Health Project Metrics	Project metrics are tied to Focus and Goals defined in the NY Prevention Agenda *(i.e. Focus Area 1, Goals 2 & 3)*	P4R	P4R

Recommended Budget Categories

- Project Implementation & Administration
  - Management office & project implementation
- Cost of Services not Covered
  - “Health Coach” – i.e., services that will provide value to meeting project metrics
  - Goal is to have insurance companies reimburse services in value-based model
- Bonus/incentive payments
  - Meeting metrics
- High Performance Payments
  - Exceeding metrics
- Revenue Loss
  - Reduction in hospital services, particularly “fee for service” reimbursement model

Recommended Budget Categories (continued)

- Contingency
  - i.e., If NY State does not meet milestones
- Sustain Fragile Providers
  - Particularly those who are key to meeting project metrics/transforming health care system
- Innovation/Pilot Programs – "The Lassie Fund"
  - Focus on pilot projects – particularly for institutions without "metrics" that provide value to transformational change
    - i.e., Heroin Task Force
- Undistributed Revenue
  - Funds awaiting distribution
- Other
  - The category we haven't considered …

Variability ~ Areas for Discussion

- Estimated percentage allocation targets
  - Some more fixed in nature (i.e., project management office, implementation costs)
  - Others variable (Cost of services not covered, fragile providers, contingencies)
  - Anticipated revenue loss
- Timing of distribution payments
  - Payment received – allocation formula preparations
- Balance between partner incentive and project management office requirements

Variability ~ Areas for Discussion (continued)

- Model for incentive/bonus payments
  - Project index scores vary significantly
  - Certain projects command a higher return on investment
  - Certain projects drive higher performance payments
  - Develop our model recognizing Domain PPS performance dependencies result from indirect and direct partner collaboration in maximization of performance for Metric success

DSRIP is about SYSTEM TRANSFORMATION!

What binds us?

- The stronger our collective delivery system is as a PPS, the greater our leverage with the MCOs.

The DSRIP Challenge –Transforming the Payment System

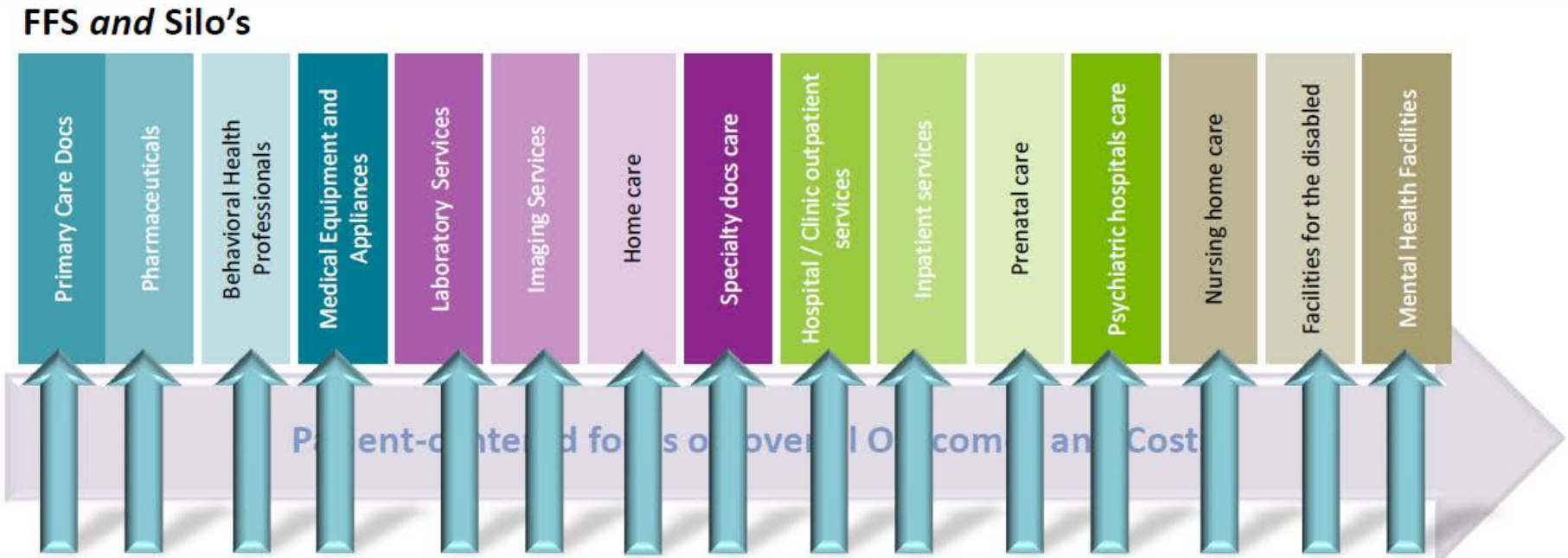
A thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well

Many of our system's problems (fragmentation, high (re)admission rates, poor primary care infrastructure, lack of behavioral and physical health integration) are rooted in how we pay for services

- Paying providers Fee For Service incentivizes volume over value, pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care

- Our current payment system does not adequately incentivize prevention, coordination or integration

Current Fee For Service –deeply embedded, double fragmentation



Challenge to change:

Providers, Payers and Governments have embedded this fragmentation in their culture, organization & systems

The DSRIP Challenge –Transforming the Payment System

DSRIP will be as much about payment reform as about delivery reform