WORKING TOGETHER FOR BETTER HEALTH

Central New York Care Collaborative – 2016 Annual Meeting – November 1, 2016

TIME	SESSION	DESCRIPTION
8:00AM - 8:45AM	**Registration**	Breakfast Served
8:45AM-9:00AM	**Welcome & Introductions**	
9:00AM-9:45AM *Finger Lakes Ballroom*	**Keynote Address** Jason Helgerson Medicaid Director at State of New York DOH	Jason will provide an overview of the NY State DSRIP Program and the transition to Value Based Payment care delivery
9:45AM-10:45AM *Finger Lakes Ballroom*	**Transitions in Care** Thomas Graf, MD National Director of Population Health Management, Chartis Group	Dr. Graf will give an overview of organizations that have successfully transitioned to VBP Care delivery models
10:45AM-11:00AM	**Break**	
11:00AM- 12:00PM *Finger Lakes Ballroom*	**Community Based Partnerships** Rebecca Bostwick Program Director, Lerner Center for Public Health Promotion Panel Discussion Paula Cerio, Salvation Army Constance Gregory, Healthy Neighbors Partnership Gale Grunert, Lewis County Sharon Owens, Syracuse Model Neighborhood Facility, Inc.	Discussion on the importance of building community relationships to help support the healthcare needs of a diverse population Moderated Q & A session to discuss the impact of building community-level engagement opportunities to address healthcare needs

Central New York Care Collaborative – 2016 Annual Meeting – November 1, 2016

TIME	SESSION	DESCRIPTION
12:00PM-1:00PM	**Lunch**	
1:00PM-2:00PM *Finger Lakes Ballroom*	**Managed Care Perspective** Heather Radliff Director DSRIP Network Management, UnitedHealthcare	An overview of VBP model development from the perspective of a Managed Care Organization
2:15PM-3:00PM	**Concurrent Breakout Sessions**	
Hemlock Room	Role of Primary Care in the PPS Tricia Peter-Clark & Nancy Deavers Northern Oswego County Health Services, Inc. (NOCHSI)	Discussion on DSRIP Project Implementation in a Primary Care setting
Finger Lakes Ballroom	Screening, Brief Intervention, and Referral to Treatment (SBIRT) Danielle Olsen & Gerry King, OASAS	Overview of an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs
Conesus Room	CNYCC Population Health Management Integration Joseph Reilly, CNYCC	An overview of CNYCC's planning for PHM System Integration
Canandaigua Room	Care Coordination Delivery Model Brian McKee, Liberty Resources	Outline on the benefits of Care Coordination (Care Management) in the care delivery model
3:15PM-3:45PM Finger Lakes Ballroom	**Closing Remarks** Virginia Opipare Executive Director, CNYCC	Closing remarks by CNYCC's Executive Director that highlights the future outlook of the PPS
4:00PM *Cavalier Room*	**Networking Reception (Cash Bar)**	

NEW YORK STATE | Department of Health | Medicaid Redesign Team

DSRIP & Value Based Payment: A True Opportunity to Transfer Health Care Delivery

Central New York Care Collaborative Annual Meeting
November 1, 2016

Jason Helgerson, Medicaid Director
Office of Health Insurance Programs
NYS Department of Health

Overview

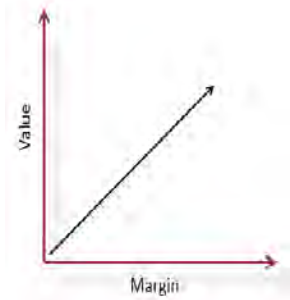
- Background on MRT
- Where Are We Now?
- Moving Forward – Role of Providers Within the PPS
- Closing Thoughts

New York State Medicaid Transformation Since 2011

2011: Governor Cuomo created the Medicaid Redesign Team (MRT) which developed a series of recommendations to lower immediate spending and propose future reforms

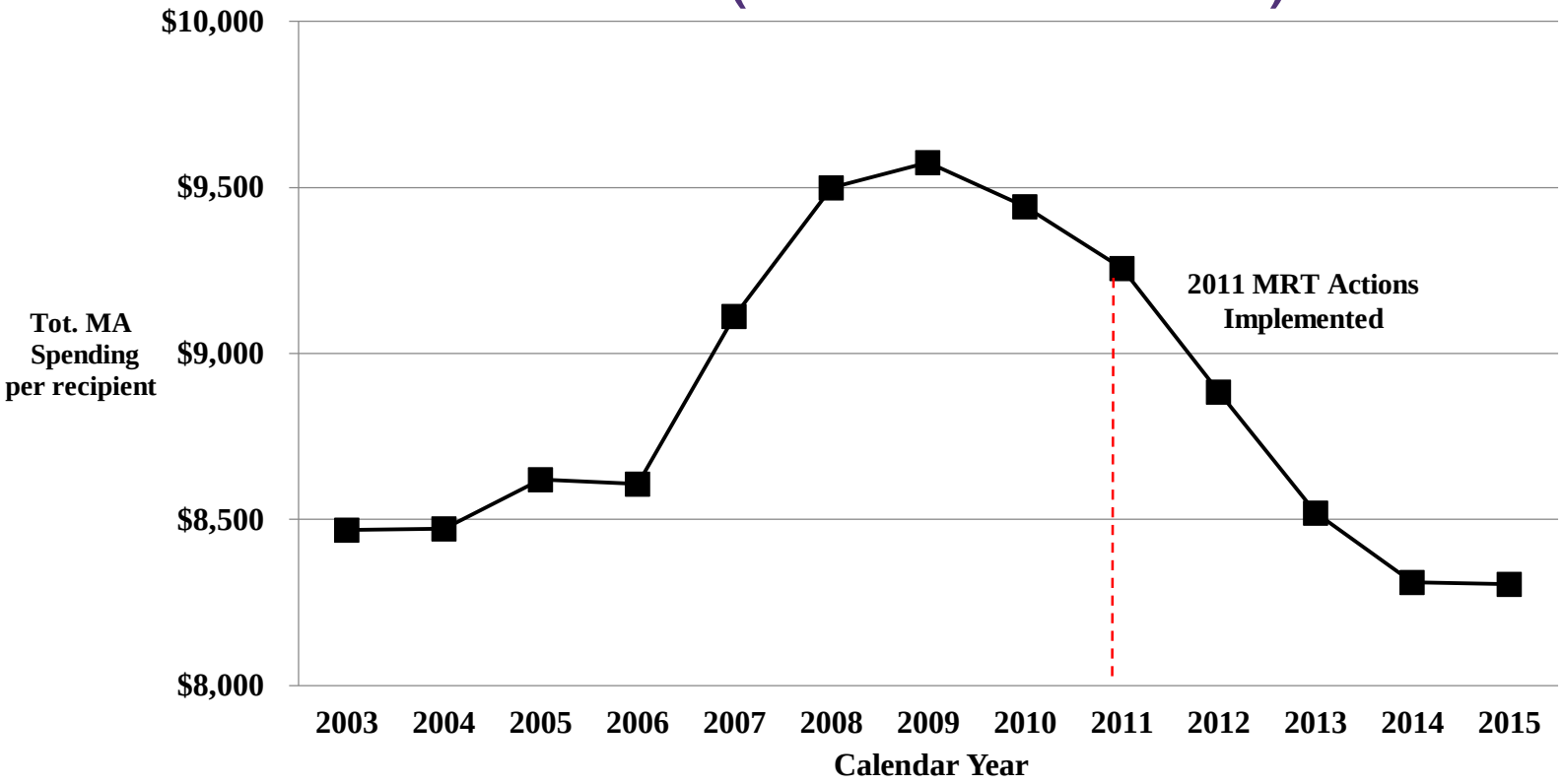
2014: As part of the MRT plan NYS obtained a 1115 Waiver which would reinvest MRT generated federal savings back into redesigning New York's health care delivery system known as **DSRIP**

NEW YORK STATE DSRIP



2015: As part of DSRIP, NYS undertakes an ambitious payment reform plan working towards 80% value based payments by the end of the waiver period

NYS Statewide Total Medicaid Spending per Recipient (CY2003-2015)



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
# of Recipients	4,267,573	4,594,667	4,733,617	4,730,167	4,622,782	4,657,242	4,911,408	5,212,444	5,398,722	5,598,237	5,805,282	6,327,708	6,7,00,524
Cost per Recipient	$8,469	$8,472	$8,620	$8,607	$9,113	$9,499	$9,574	$9,443	$9,257	$8,884	$8,520	$8,312	$8,305

Source: NYS DOH OHIP DataMart (based on claims paid through June 2016)

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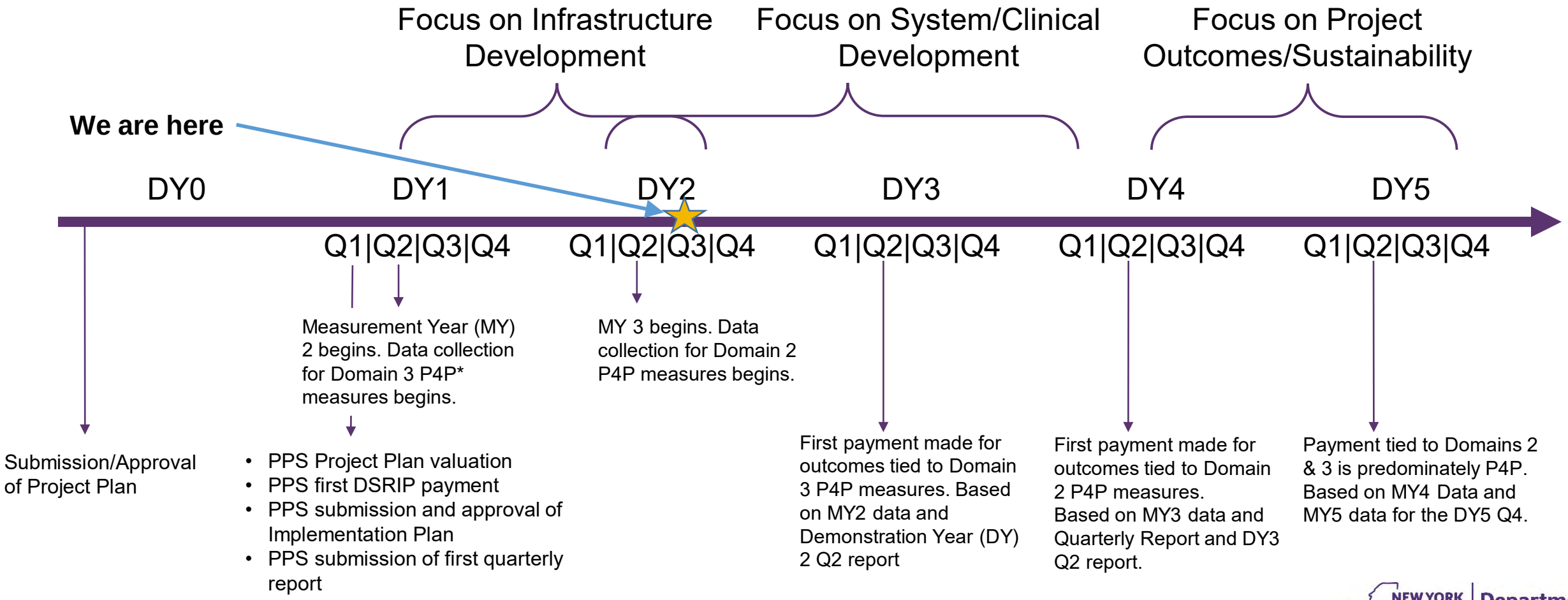
Where Are We Now?

An Important Turning Point

Performing Provider Systems (PPS) have transitioned from planning to implementing projects.



Source: Based on Independent Assessor Project Approval and Oversight Panel Presentation. Nov 9 – 10, 2015. NYS DSRIP Website

** P4P = pay for performance*

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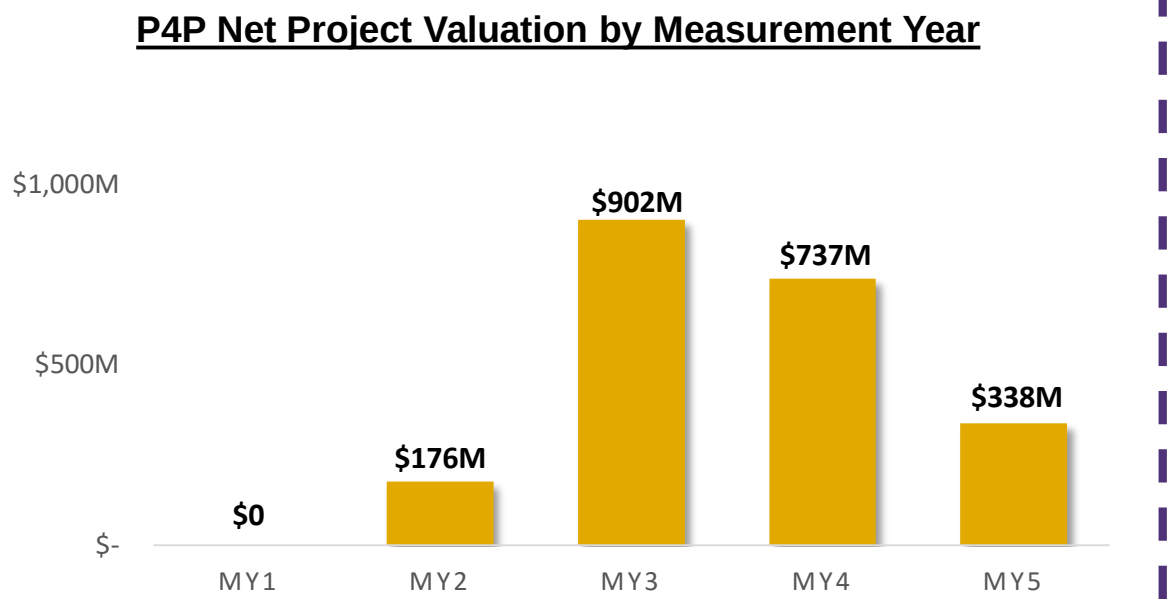
☐ Pay for Reporting ☑ Pay for Performance

Measurement Year 3 (MY3) results = $902M in net project valuation

- MY3 P4P payments are split between payments in Demonstration Year 3 (DY3) (payment 2 - $502M) and DY4 (payment 1 - $400M).
- This represents **42%** of all P4P dollars available through the five years of DSRIP.



We are Making Progress!

The North Country Initiative PPS used DSRIP funds to recruit 23 health care professionals including a dentist to serve a very rural community where they haven't had a dentist in over 5 years.

Ellenville, a critical access hospital Emergency Department (ED), is seeing impressive reductions in opioid seeking utilization (-73%) and a reduction in ED visits (-34%) among their selected cohort as a result of Medicaid Accelerated eXchange (MAX) participation and DSRIP interventions.

Catholic Health System is using claims data to set ED frequency thresholds and then design workflows around high frequency ED patients that are low to non Utilizers of their plan assigned Primary Care Physician (PCP) .

Staten Island PPS developed a new Community Health Worker training program in partnership with 1199 TEF and the College of Staten Island. The program lasts 26 weeks and results in college credits and a Community Health Worker certification.

Central New York Care Collaborative, Inc. (CNYCC)

Major Accomplishments

- **Development of Robust Governance and Partner Network Infrastructure**
  - Board of Directors
  - Committees
  - Partner Contracting
- **Extensive Partner Engagement Efforts**
  - Regional Project Advisory Committee(s)
  - Learning Collaboratives
  - Community Engagement (Human Services Leadership Council; Housing & Homeless Coalition of Syracuse & Onondaga County etc.)
- **Comprehensive Population Health Management System Platform:**
  - Integrated infrastructure to support, People (CNYCC Partner Organizations); Process (Project Implementation); and Technology (Integrated PHM Platform)
  - Focus on impact of Value Based Payment (VBP) approach to PHM Strategy including: Economies of Scale; Care Coordination; and Reporting/Analytics
  - Exploring regional collaboration with other payees & VBP initiatives

DSRIP Year 2: How are PPS performing so far?

PPSs have earned 99.4% of all available funds to date!

$1.2B Total!

There is more work to do!

Moving Forward --
Role of Providers Within the PPS

What You Are Doing Is Beautiful!

Proceed With Fact-Based Optimism

What is Fact-based Optimism?

We live in exciting times and DSRIP is a tremendous opportunity to transform the health care system in NYS.

Optimism is essential for such demanding work and to solve the great challenges ahead.

No time for Pollyanna – fully understand current conditions and focus on the possible.

What is Fact-based Optimism? Cont.

Pessimism = Self-fulfilling Prophecy

Stakeholders can't be told that this is too hard or dwell entirely on problems

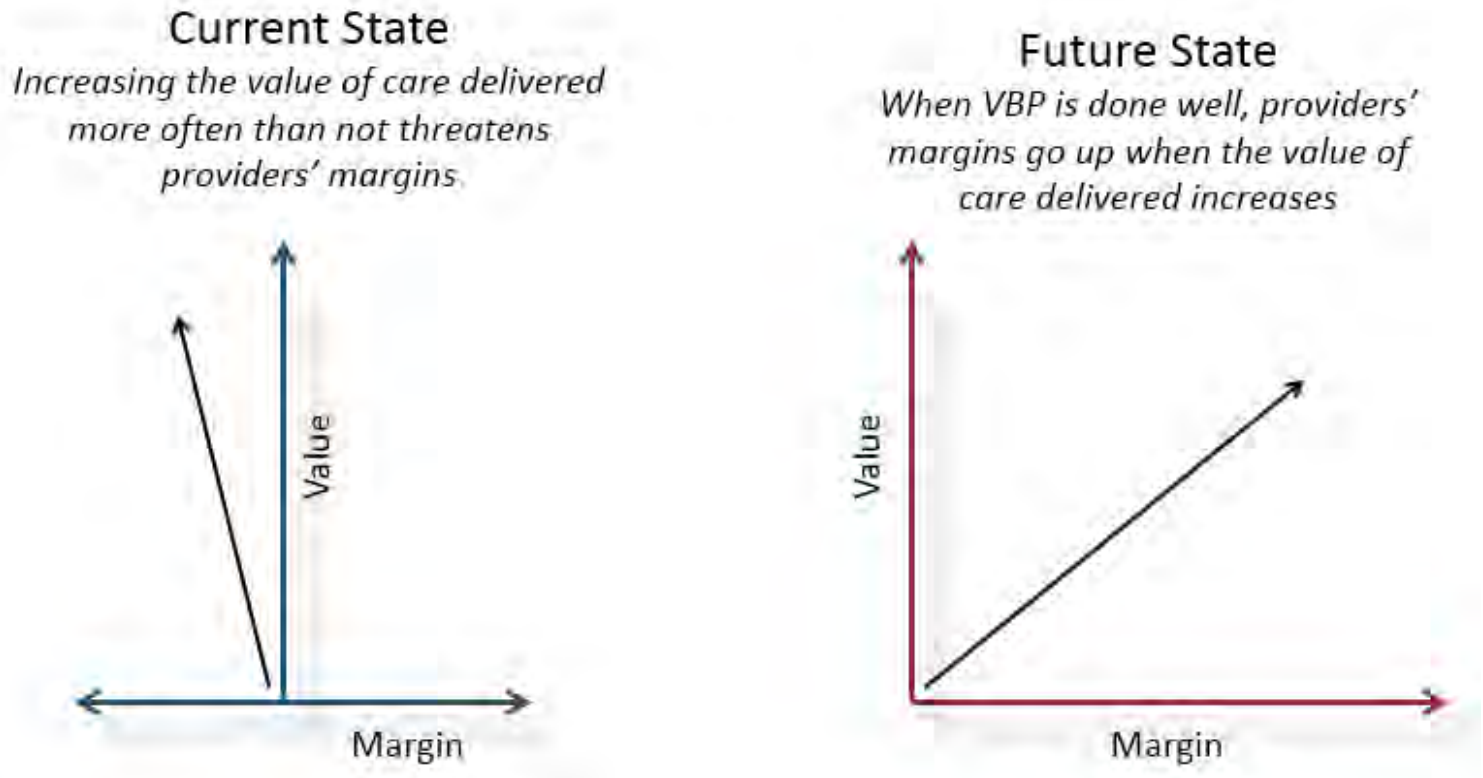
Work to create a "culture of possibility" in which DSRIP goals are seen as achievable and celebrate success.

Building such a culture requires – effective communication and inclusive decision-making

Participate in Value Based Payment

Learning from Earlier Attempts:
VBP as the Path to a Stronger System

VBP arrangements are not intended primarily to save money for the State, but to allow providers to increase their margins **by realizing value**

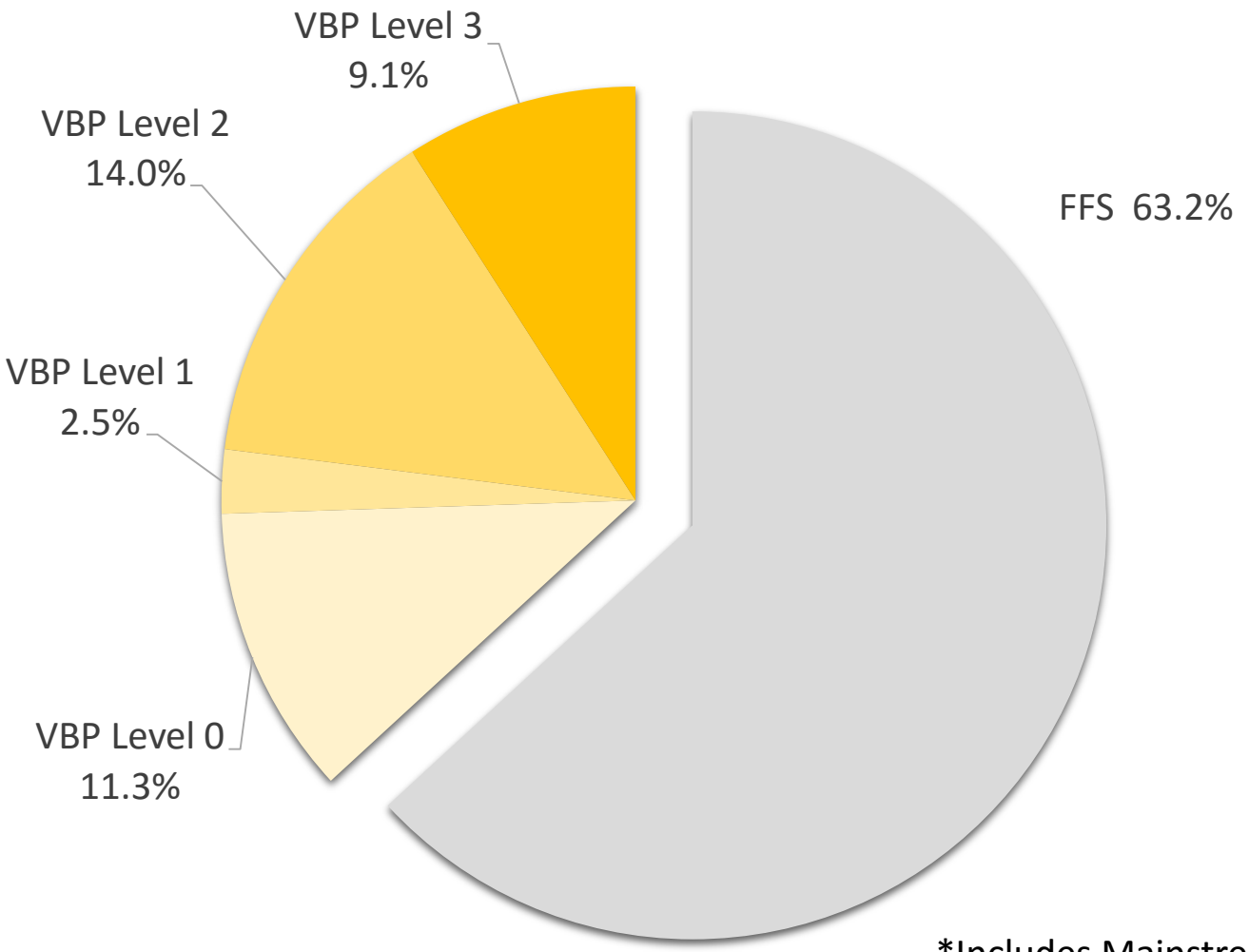


Goal – Pay for Value not Volume

How DSRIP and VBP Work Together

Today: >25% of Medicaid Spend is in VBP Level 1 or Higher

Per Survey, VBP Baseline of Levels 1 - 3 for CY 2014: **25.5%***



VBP Level	Spending or %
Total Spending	$ 22,741 M
FFS	$ 14,372 M 63.2%
VBP Level 0	$ 2,576 M 11.3%
VBP Level 0 Quality	$ 2,036 M 9%
VBP Level 0 No Quality	$ 539 M 2.4%
VBP Level 1	$ 567.5 M 2.5%
VBP Level 2	$ 3,172 M 14%
VBP Level 3	$ 2,062 M 9.1%

*Includes Mainstream, MLTC, MAP, and HIV SNP plans.

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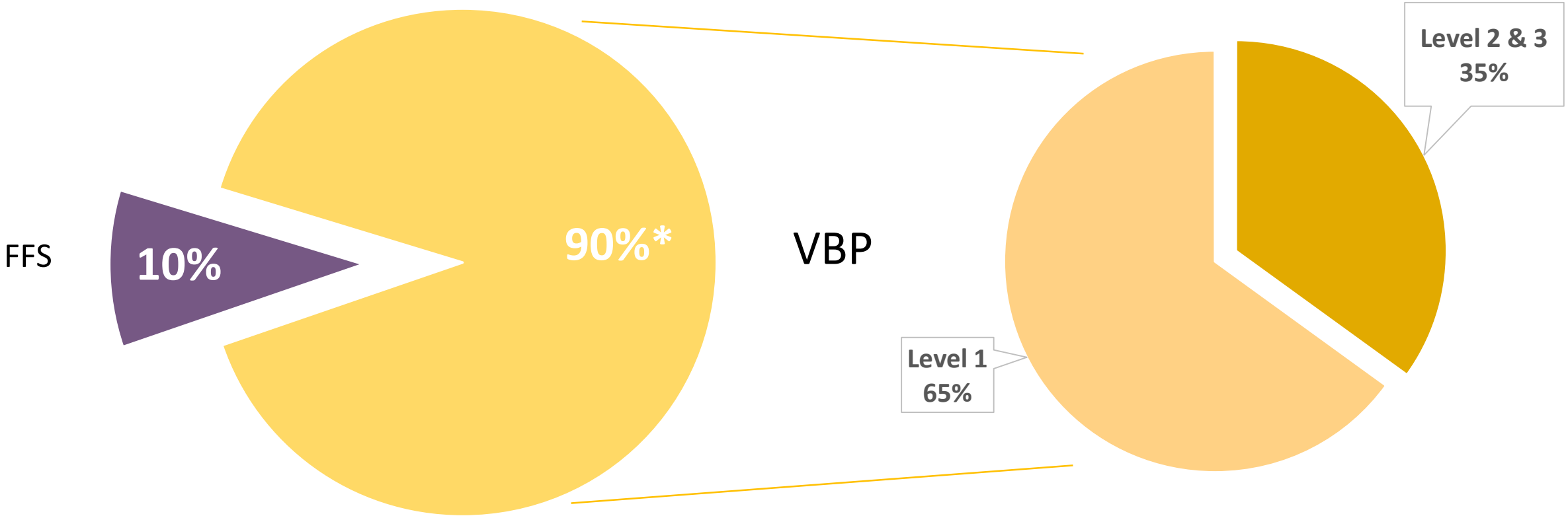
VBP Goals

By April 2020, 80-90%* of Medicaid Managed Care Spend (Plan to Provider Payments) Will Be in VBP Level 1 and Higher



*Minimum of 80%; includes MLTC and (depending on move to Managed Care) I/DD

VBP Implementation Efforts

The State is providing additional financial incentives and support for early adoption of Value Based Payment as well as for execution of higher-risk contracts through:

VBP Pilot Program

- The goal of the Pilots is to help the State and its participating organizations learn how VBP transformation will work in practice as well as to incentivize early adoption of VBP. This is a voluntary 2-year program. DOH reserves the right to restrict enrollment to those pilots that it deems to be most relevant.

Ongoing Subcommittees

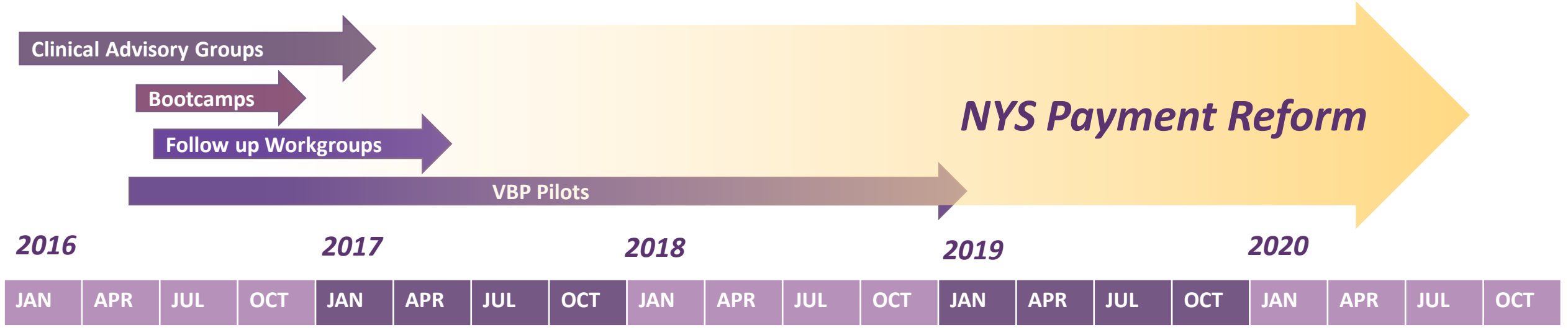
- As VBP is implemented, the State will continue to explore the need for the development of new subcommittees, like a Subcommittee on Children's Health, and reconvene existing groups as needed.

VBP Innovator Program

- The goal of the Innovator Program is to recognize providers that contract high risk Level 2 or Level 3 total cost of care for general and subpopulation arrangements by allowing up to 95% premium pass through.

VBP Transformation: Overall Goals and Timeline

To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.



DSRIP Goals

DY2 – April 2017

PPS requested to submit growth plan outlining path to 90% VBP

DY3 - April 2018

≥ 10% of total MCO expenditure in Level 1 VBP or above

DY4 – April 2019

≥ 50% of total MCO expenditure in Level 1 VBP or above.
≥ 15% of total payments contracted in Level 2 or higher

DY5 – April 2020

80-90% of total MCO expenditure in Level 1 VBP or above
≥ 35% of total payments contracted in Level 2 or higher

DSRIP → VBP → Beyond: True System Alignment

- DSRIP and VBP break down siloes within health care and build relationships to other sectors
- NYS is thinking even more broadly about the systems that serve our communities
- NYS is developing an ecosystem designed to achieve the most important outcomes to a community
- Engaging HHs are a critical part of developing this ecosystem and reaching system alignment

Source: Presentations from "Medicaid in New York: Progressing to Value-Based Payment". United Fund Hospital Website. Published July 2016.

Closing thoughts…

- We are in this together
- What you are doing is making a difference
- You CAN do it!
  - ✓ What you are doing is beautiful
  - ✓ Proceed with fact-based optimism
  - ✓ Embrace VBP


WHAT IS
HAPPENING
HERE IS
AWESOME!

Questions?

Additional information available at:

https://www.health.ny.gov/mrt

https://www.health.ny.gov/dsrip

Contact:

Jason.Helgerson@health.ny.gov

Follow me on Twitter!

@policywonk1

Follow MRT on Twitter!

@NewYorkMRT

THE CHARTIS GROUP

CNYCC

Transitions in Care: Real Life Examples of VBP In Action

November 1, 2016

Today's Discussion

- Review the population health landscape and the imperative for improvement
- Discuss proven value-based care models and their implications for us
- Understand the role of PHM tools in creating success
- Understand how connectivity across the continuum is critical to long term success in Population Health

An Ongoing Crisis of Quality and Cost

The current healthcare industry faces an ongoing crisis of quality and cost. While some would argue that a transformation of our system is well underway, the reality is that we continue to struggle with profound challenges we have faced for years.

People are getting **sicker…**

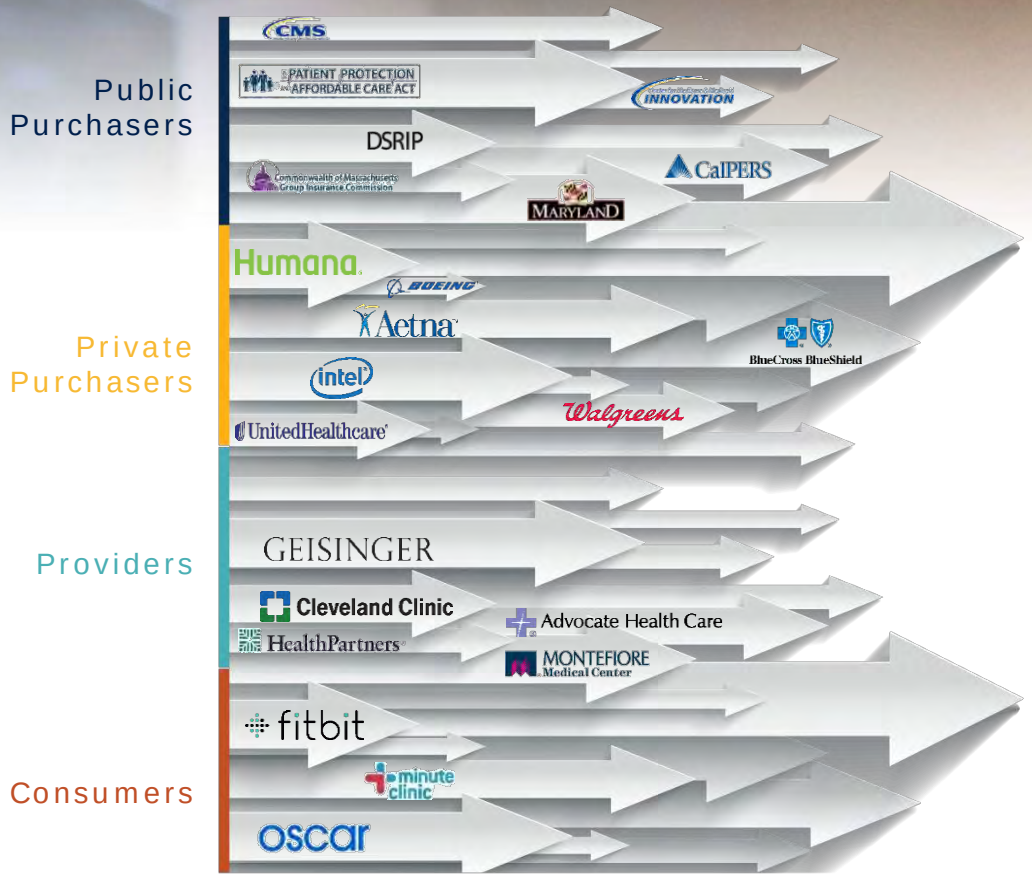
Health disparities **persist…**

Access to care remains a **challenge…**

Personal medical expenses are **increasing…**

… and our healthcare system is ill*-equipped to respond to these crisis-level challenges in its current form.*

Multiple Forces Pushing Towards Structural Change



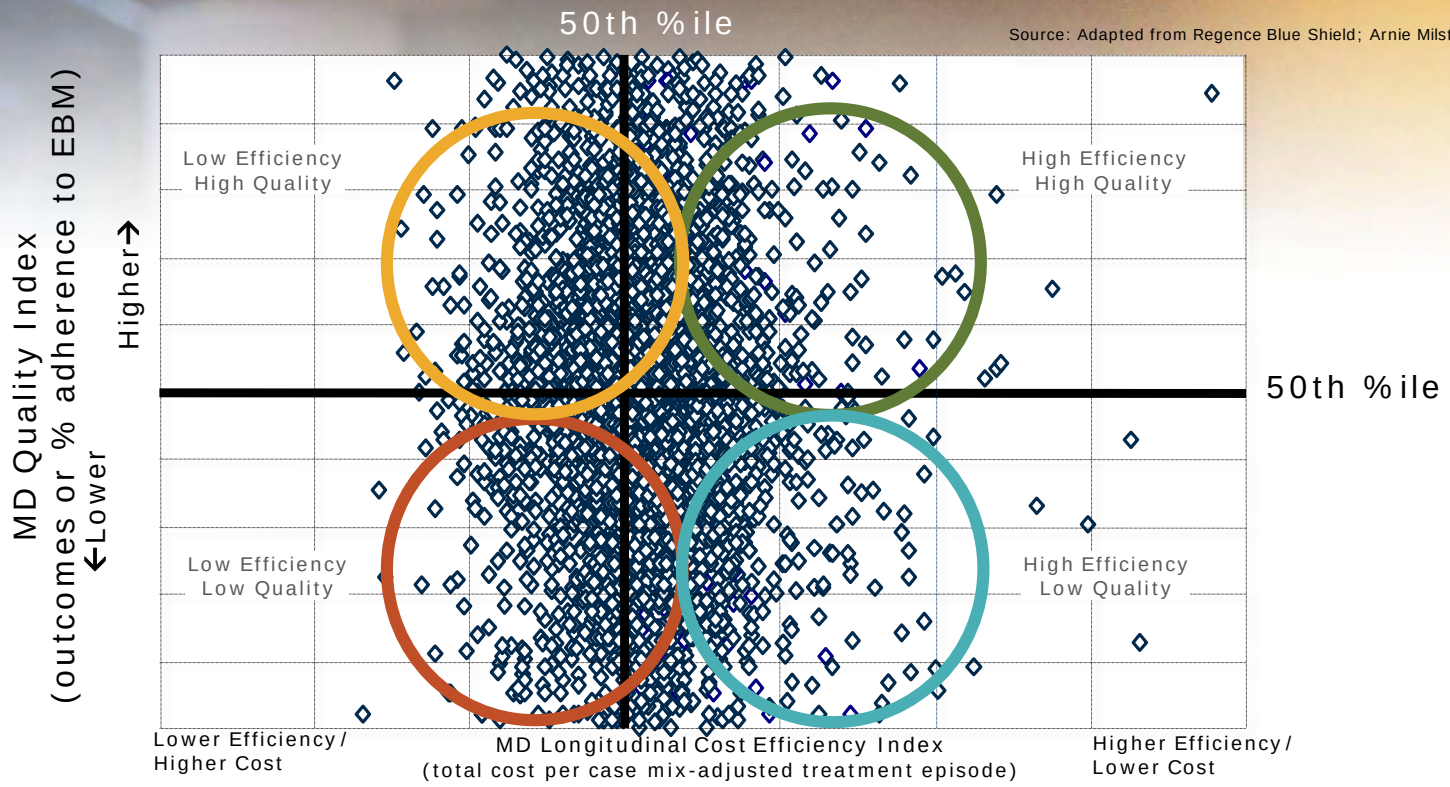
Driving increased accountability for value to providers to:

1. *Curb cost growth and bend the cost curve.*
2. *Improve the health of individuals and groups.*

Illustrative

A Need for Value

High quality and low cost should not be at odds with one another.



The Structural Change is Accelerating

Consolidation of Healthcare Systems

We are witnessing significant growth both in traditional merger and acquisition activity and in the development of ACOs and integrated network partnerships.

Traditional M&A: *The number of hospitals involved has continued to climb related to several recent mega-mergers*

Proliferation of ACOs: *In many markets, traditionally competitive systems are coming together to participate in value-based contracts*

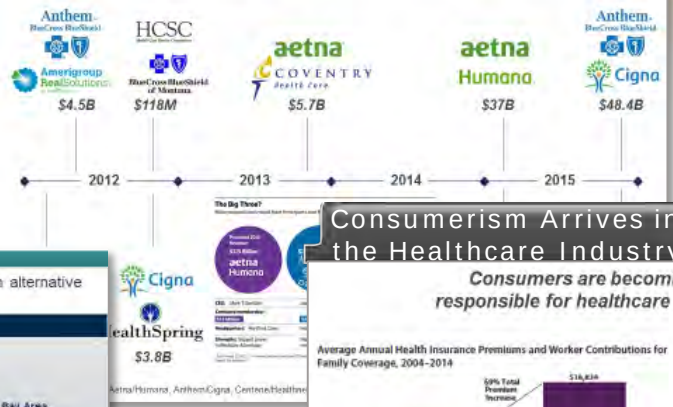
Multi-Hospital Systems and Percentage of Hospitals in Systems 1990 - 2013

Government and Commercial ACOs, 2012 and 2015

Sources: American Hospital Association (left); http://w...

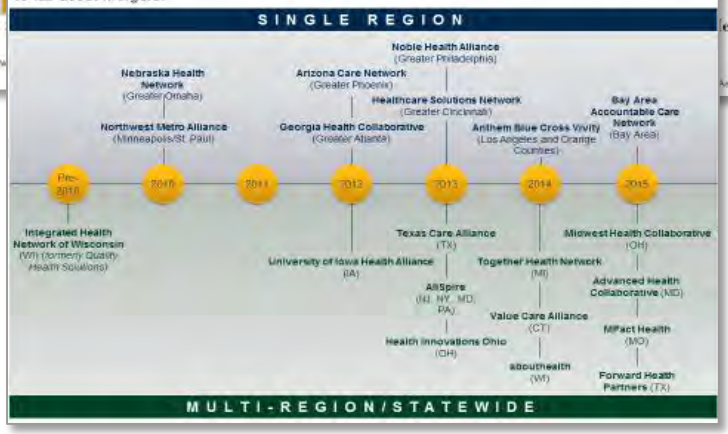
Mega-mergers of Commercial Giants

Notable health plan acquisitions[1] have appropriately raised questions as to what the future of the industry may look like



Regional Consortiums to Deliver Value

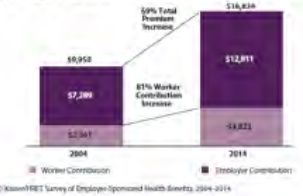
Single and multi-region collaborative entities have increased in recent years as an alternative to full asset mergers.



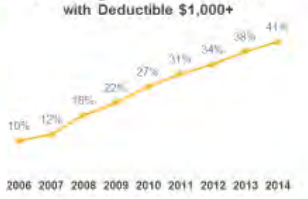
Consumerism Arrives in the Healthcare Industry

Consumers are becoming more directly responsible for healthcare costs and payments

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2004-2014



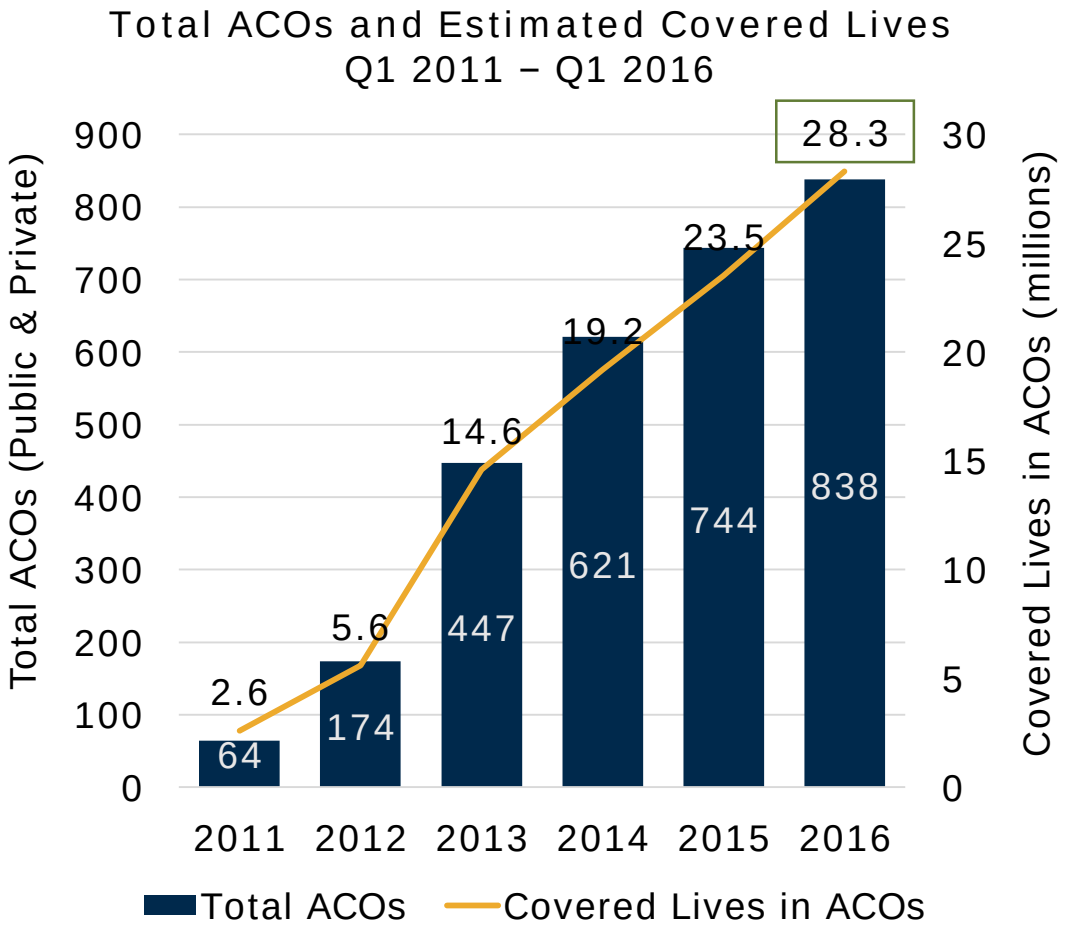
Percentage of Covered Workers with Deductible $1,000+

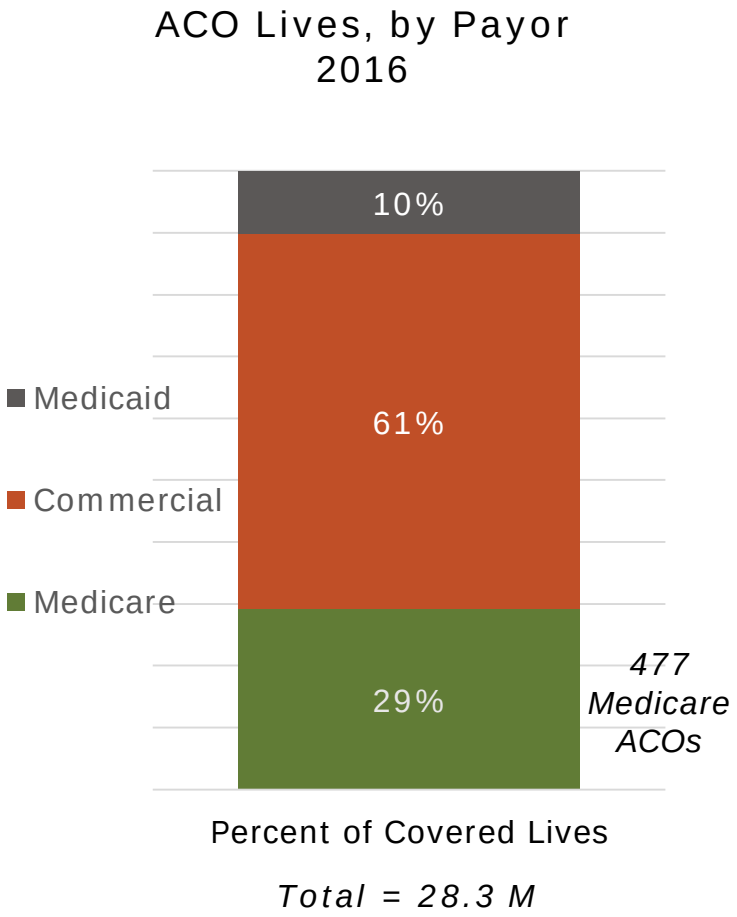


Greater individual responsibility for the cost of care has resulted in more engagement in healthcare decisions, moving patients towards more consumer-like behaviors.

Commercial Payors are Bringing Significant Scale to ACO Adoption

The ACO model has seen tremendous growth, currently covering approximately 9% of the population. Well over half of ACOs participate in Medicare, but commercial ACOs are larger, accounting for 61% of covered lives.





Source: (L) Muhlestein, David and Mark McClellan, "Accountable Care Organizations In 2016: Private And Public-Sector Growth And Dispersion," Health Affairs Blog. April 21, 2016; past reports by Muhlestein et al. (R) Chartis estimate based on Muhlestein et al plus CMS data. Note that while 54% of ACOs are estimated to participate in a Medicare program, they may also have commercial ACO programs.

But Does It Work?

REUTERS

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Press Release | Wed Jun 25, 2014 8:00am EDT

NYUPN Clinically Integrated Network and UnitedHealthcare Collaborate to Enhance Care Quality, Launch Largest Shared Savings Initiative in Region to Reduce Costs

* Reuters is not responsible for the content in this press release.

NYUPN Clinically Integrated Network and UnitedHealthcare Collaborate to Enhance Care Quality, Launch Largest Shared Savings Initiative in Region to Reduce Costs

- *70,000 UnitedHealthcare employer-sponsored health plan participants in New York to have access to improved care coordination and enhanced health services*
- *Physician-led approach designed to reduce cost, improve quality outcomes and increase patient satisfaction through performance incentives and analytical tools*

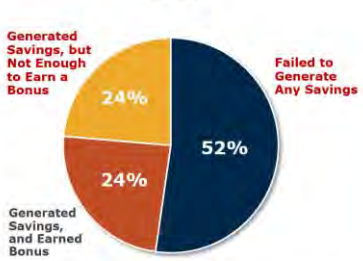
ACOs fail to create value?

Although it's still early, the first-year results of the Medicare Shared Savings Program indicate that few participants have the ability to significantly bend the cost curve...

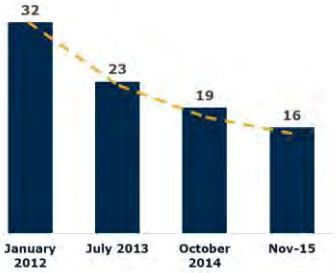
...and participation in the Pioneer ACO program has dwindled as several organizations found the risks of participation outweighed the benefits.

Results of Medicare Shared Savings Program

Year One



Medicare Pioneer ACO Program Participants



Source: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-PY1-Final-Performance-ACO.pdf

 December 2015 Page 7

Medicare is Testing and Spreading a Range of Payment Models

Medicare is exploring a range of value-based purchasing options as well as alternative payment models – and in effect setting a stage for commercial payors and Medicaid to follow suit.

Increasing Degree of Risk/Reward

	Pay for Performance	Bundled Payment	Upside only Shared Savings	Upside/ Downside with corridors	Capitated payment / % of Premium
Payment Model *Note: fixed payments may be added to any model (e.g., pmpm care mgmt. fee)*	Financial incentives and penalties tied to performance metrics	Fixed payment for a grouping of services around a longitudinal episode	Actual spend compared to target spend for defined population over a set period, where any positive delta (savings) is shared based on pre-negotiated terms.	Same concept as upside only shared savings, except provider assumes some accountability for negative delta between actual and target; provider gains/losses typically capped.	Fixed PMPM payment for defined population where provider assumes full responsibility for managing costs to set amount. Partial cap limits to specific services.
CMS Mandatory Examples:	*Merit-based Incentive Payment System (MIPS); Readmissions Reduction Program*	*Comprehensive Joint Replacement (CJR)*		*N/A*	
CMS Voluntary Examples:	*Comprehensive Primary Care Initiative (CPCI)*	*Oncology Care Model; Bundled Payments for Care Improvement (BPCI)*	*Medicare Shared Savings Program (MSSP) Track 1*	• *NextGen ACO* • *MSSP Track 2/3*	*Medicare Advantage and Managed Medicaid (Select States)*

MACRA Brings Additional Focus on Physician Performance

Spotlight on: MACRA

Physicians will fall into two MACRA Tracks*

MACRA Track 1:
Merit-Based Incentive Program
(MIPS)

Non-APMs

APMs that do not qualify as "advanced"

An estimated
760k+
clinicians will be on this track

MACRA Track 2:
Advanced Alternative Payment Model
(APM)

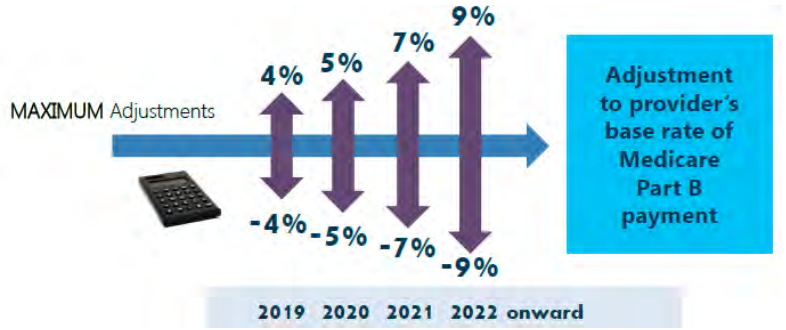
Qualifying Advanced APMs will be "models with more than nominal financial risk"

75% of attributed Medicare patients must be in such a payment model by 2023

Track 1 of the Medicare Shared Savings Program will not qualify; Tracks 2 and 3, with downside risk, may qualify

An estimated
30k-90k
clinicians will qualify for this track

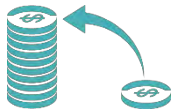
Physicians will be subject to bonuses or penalties based on performance



MACRA Track 1:
Merit-Based Incentive Program (MIPS) Measures

- ❑ Quality (replaces PQRS)
- ❑ Clinical Practice Improvement Activities (new)
- ❑ Advancing Care Information (replaces Meaningful Use)
- ❑ Resource Use (replaces "cost" within the existing Value Modifier Program)

Through its budget-neutral design, MIPS bonuses for high-performers...



... will come at the expense of MIPS penalties for under-performers.

- *CMS estimates that 87% of solo practices will be penalized in 2019 while 81% of large practices (100 or more physicians) will receive a bonus*

Defining Population Health Management

We define population health management as the following:

Population Health Management

*The advancement of the **health** of a defined or specific **population** through coordinated programs and activities that address medical and/or social determinants of health and are supported by an **aligned payment model** that rewards improvement of the population's health and the delivery of high-value care.*

Health + Population + Aligned Payment Model

Healthcare is a Clinical Activity

Whether improving performance for a narrow population, a site of service or an entire community, the most successful organizations will advance core competencies across their system of care.

Harnessing the power of data, analytics, and technology to drive care transformation solutions and improve clinical care delivery

Embedding disciplined care planning and patient progression to ensure a seamless care process for each individual across space and time

Developing & deploying leading practice care models – people, tools, and processes – to address the clinical needs of specific patient populations

Organizing population cohorts to deliver purposeful care to meet care needs and preferences

Determining optimal clinical interventions, utilizing evidence-based medicine and leading practices, to deliver highly reliable care

Engaging with individuals in their health, providing timely and convenient access to services and information, and helping patients navigate to the right modality

Transforming Care to Improve Performance

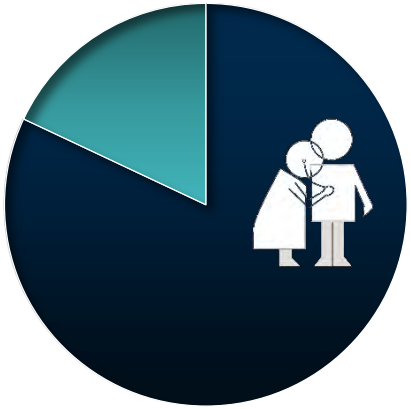
The only way for healthcare providers to truly impact cost and quality performance is to transform clinical care delivery.

Cost

% of Total Cost of Care related to clinical care delivery based on Medicare Cost Report data for the Truven Top 100 Hospitals

68% Clinical

Experience



% of HCAHPS questions impacted by clinical care delivery

82% Clinical

Health Outcomes

% of The Joint Commission's Top Performance on Key Quality Measures impacted by clinical care delivery

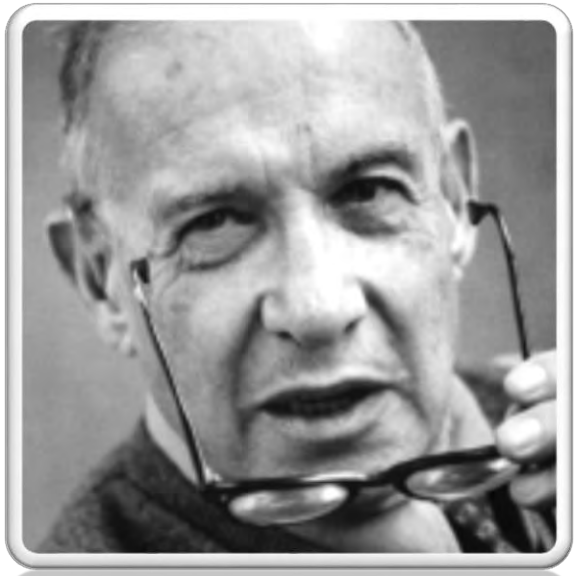
100% Clinical

The Triple Aim but also…

The Triple Aim is critical but may be impossible to achieve if professional experience is not incorporated into the equation.

What Does This Look Like Once Achieved?
(at least partially)

Peter Drucker



November 19, 1909 - November 11, 2005

> *Work implies not only that somebody is supposed to do the job, but also accountability, a deadline and, finally, the measurement of results —that is, feedback from results on the work and on the planning process itself.*

Creating Care Systems at Geisinger

The Geisinger transformation experience included focused change across multiple dimensions.

Comprehensive disease management driven by all-or-none measures

Redesign mantra:

- Streamline
- Team delegation, including IT
- Evolution of the innovation to standard practice
- Engage patients and families

Targeted, active clinical decision making

Proactive outreach

Engaged patients

Compensation

Achieving Results: Better Care

If done well, the results can be spectacular.

IMPACT ON QUALITY

Diabetes Mellitus (DM) ProvenCare Bundle

Reduction in the risk of MI, stroke and retinopathy in a 3-year period

Outcomes	Hazard Ratio	Number of Patients Needed to Treat to Prevent 1 Event over 3 Years
Myocardial Infarction	0.77	82
Stroke	0.79	178
Retinopathy	0.81	151

Source: Bloom, Graf et al. "Primary Care Diabetes Bundle Management: 3-Year Outcomes for Microvascular and Macrovascular Events." *Am J Manag Care*. 2014;20(6):e175-e182. Note: 95% CI for MI: Hazard Ratio: 0.65-0.90, NNT: 37-133; Stroke: Hazard Ratio: 0.65-0.97, NNT: 57-681; Retinopathy: Hazard Ratio: 0.68-0.97, NNT: 47-510)

Achieving Results:
Better Care at Lower Cost

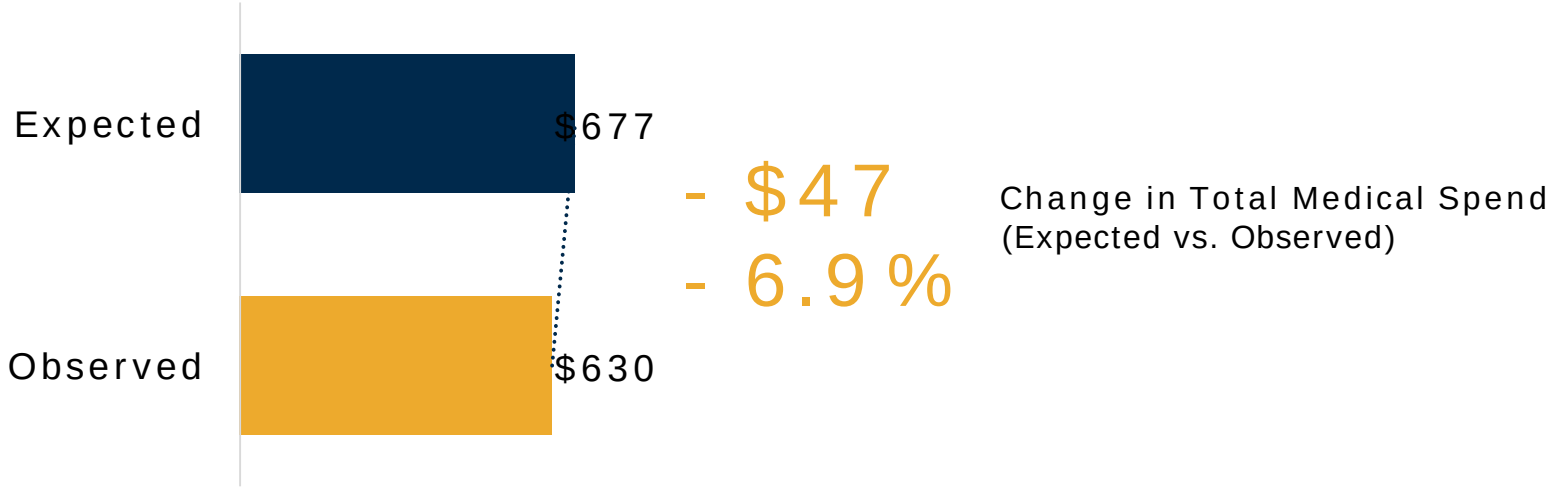
The experience reinforced the fact that better quality and lower cost are mutually attainable – and often may be directly related.

IMPACT ON COST

Diabetes Mellitus (DM) ProvenCare Bundle

Reduction in Total Medical Spend

- Year one: Higher outpatient and professional costs
- Subsequent years: Reductions in total spend driven by lower inpatient costs

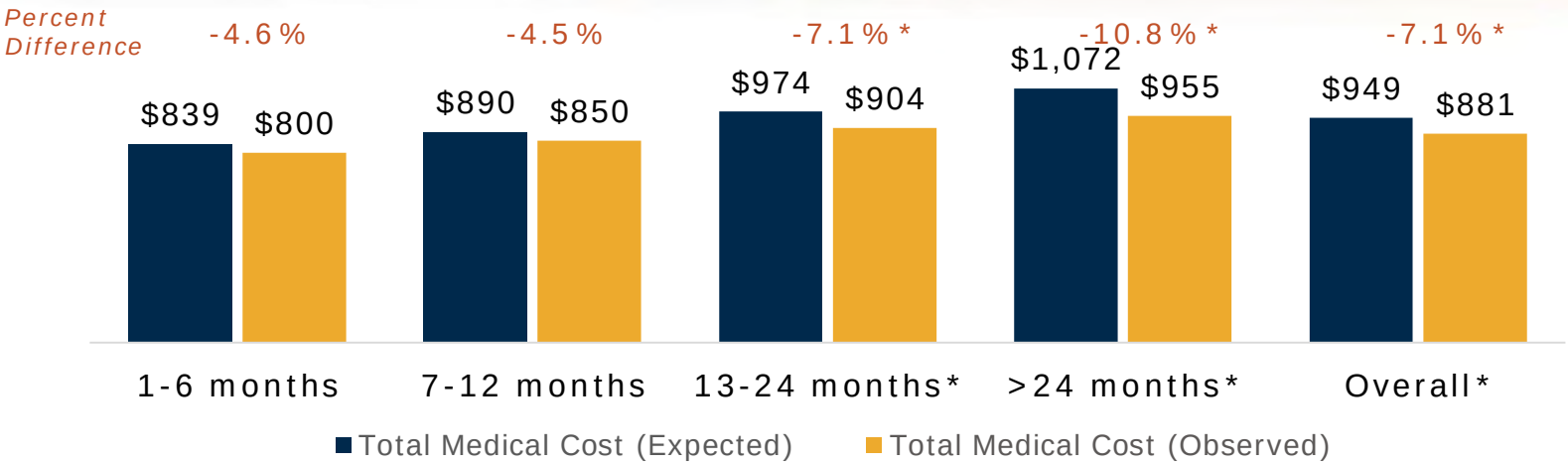


Source: Maeng, Yan, Graf, Steele. "Value of Primary Care Diabetes Management: Impacts on Long-Term Cost of Care." Note: analysis based on claims data covering period 1/1/2005 to 12/31/2013, with construction of a 1-to-1 propensity score matching method to construct comparison group of individuals that received care from PCP practices that had not adopted the DM Bundle.

Achieving Results:
Widespread Impact of Change

Geisinger achieved similarly positive results across multiple areas that implemented focused transformation efforts through the ProvenHealth Navigator (PHN) system.

ProvenHealth Navigator System Observed vs. Expected Cost by Length of Exposure, with Prescription Interaction



*Statistically significant at p<0.01
Source: Geisinger Health System; Note: reflects analysis of PHN effect with prescription interaction. Analysis completed assuming PHN effect is independent of drug coverage found statistically significant results at p<0.05 for >24 months and overall results.

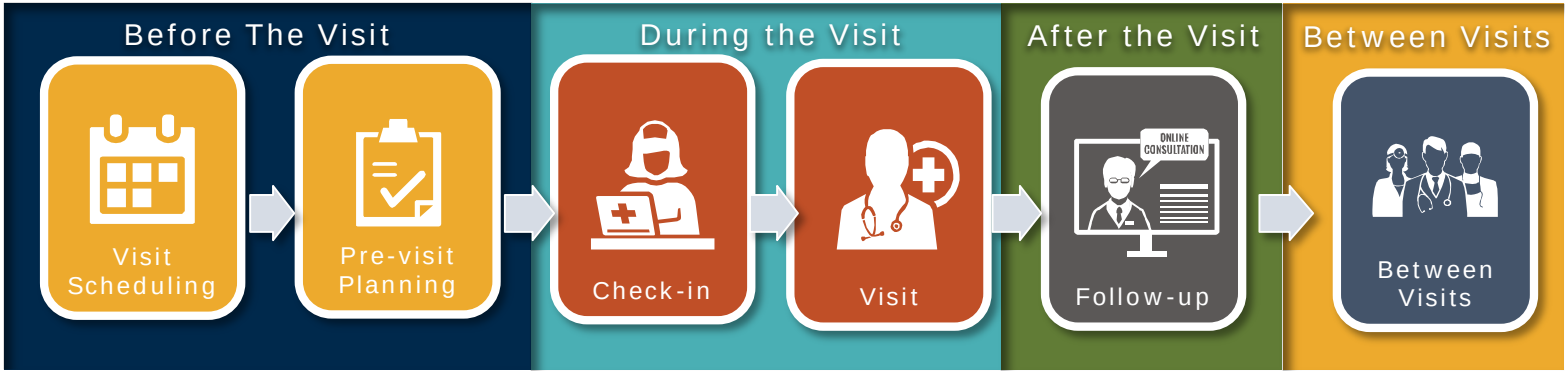
Care Design Principles

HealthPartners uses the following design principles to ensure our care achieves Triple Aim results.

Four Care Design Principles

HealthPartners Redesign Principles in Action

Reliability Care Model Process Visit Cycle

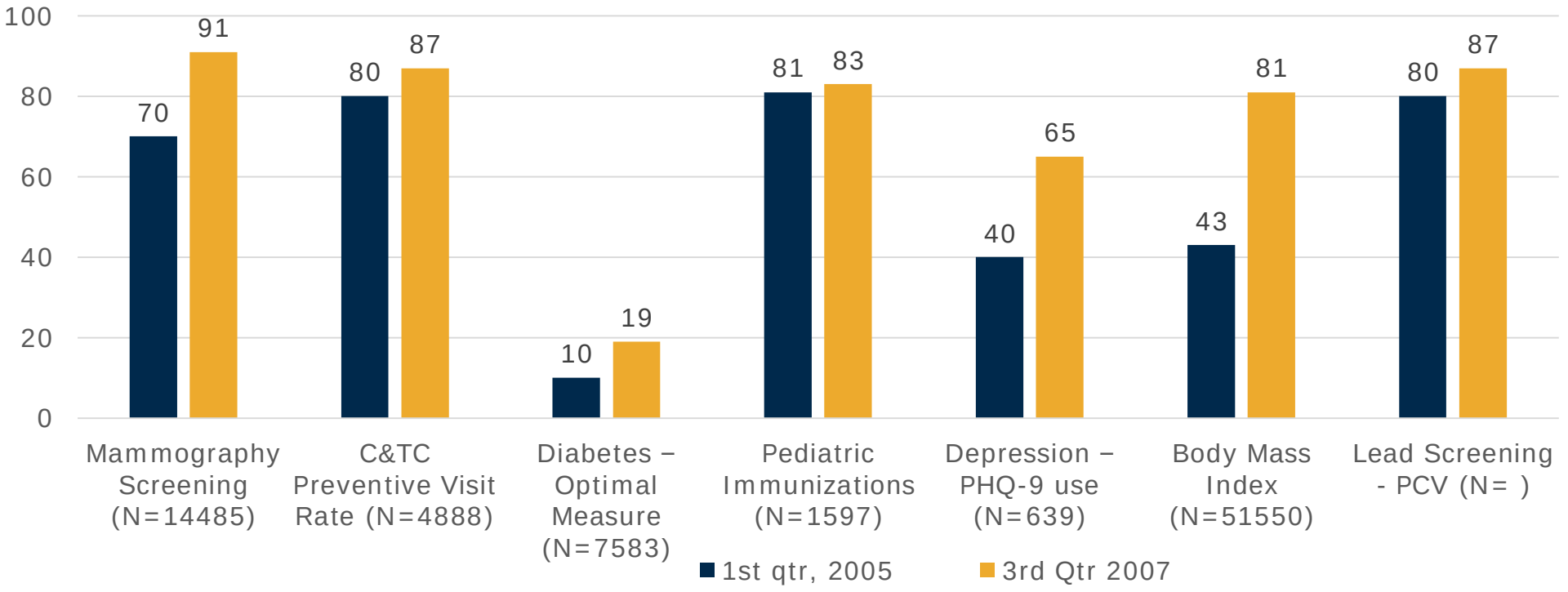


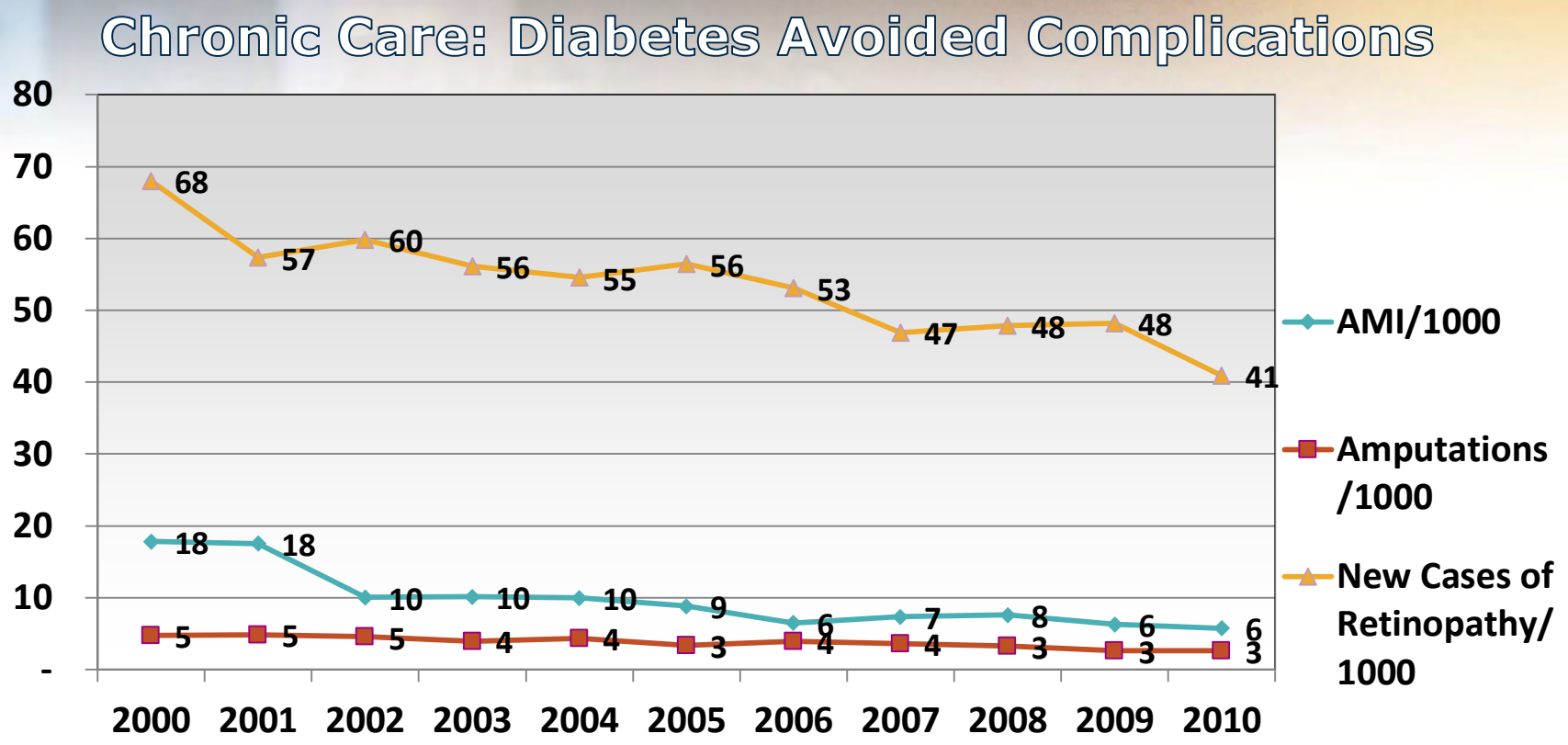
Determined for each workflow:

- WHAT – must be done – the task
- WHERE – where will the task be done
- WHO – appropriate role to complete the task
- HOW – tools needed to support the task
- WHEN – what part of the visit

HealthPartners Outcomes

System Clinical Results
Improvement from 1st Qtr. 2005 to 3rd Qtr. 2007

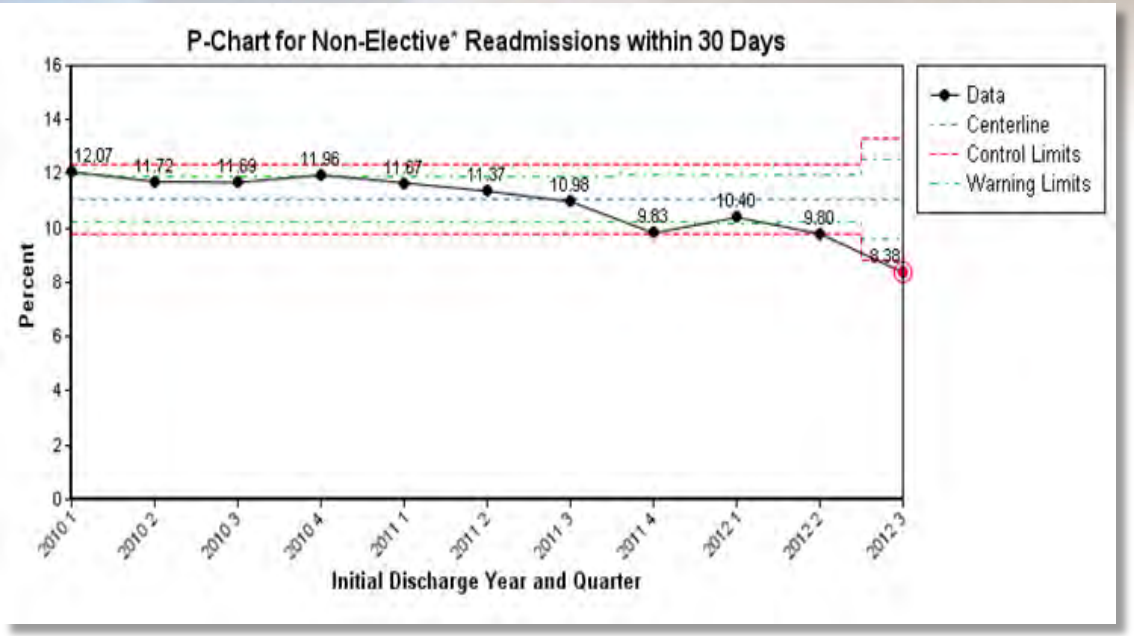




HealthPartners Outcomes

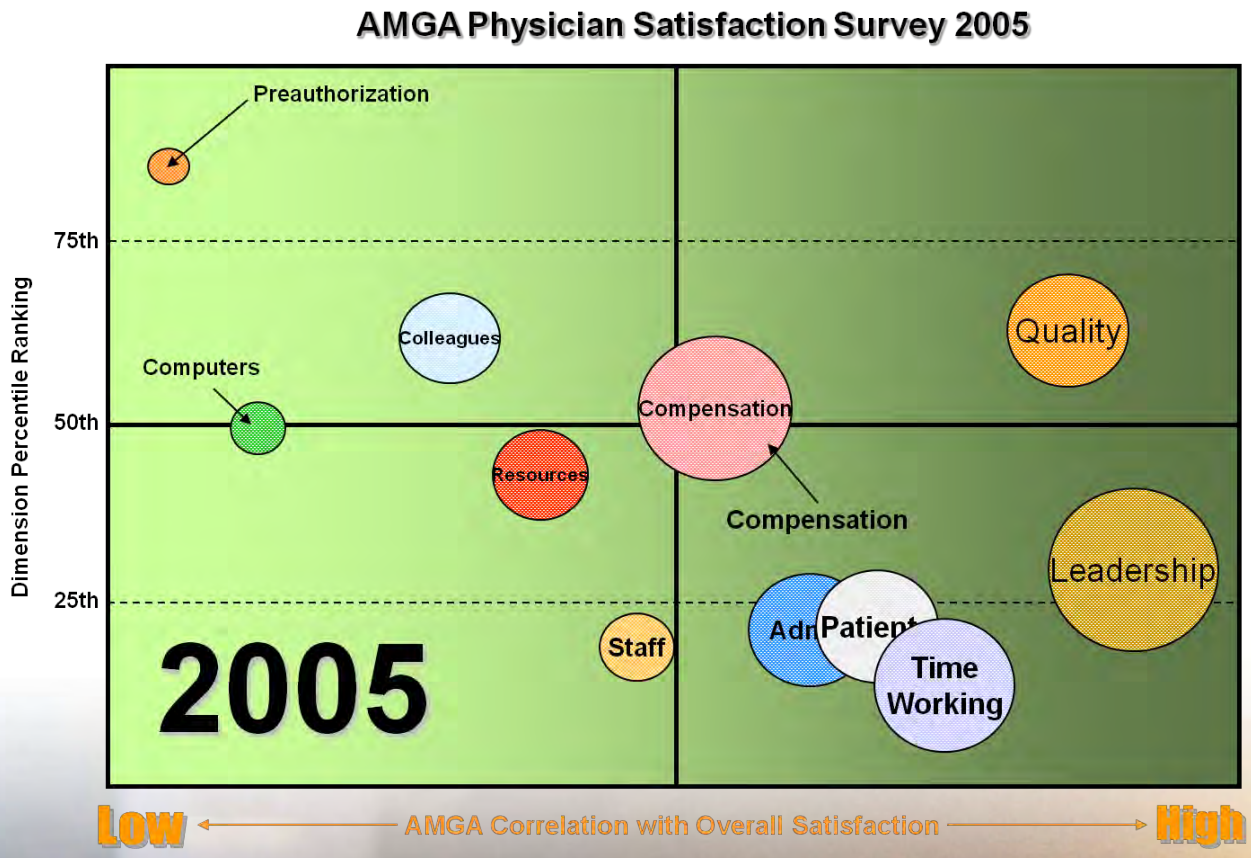
Reduce readmissions through collaboration of our hospital, clinics, care management and pharmacy services:

Reducing Readmissions

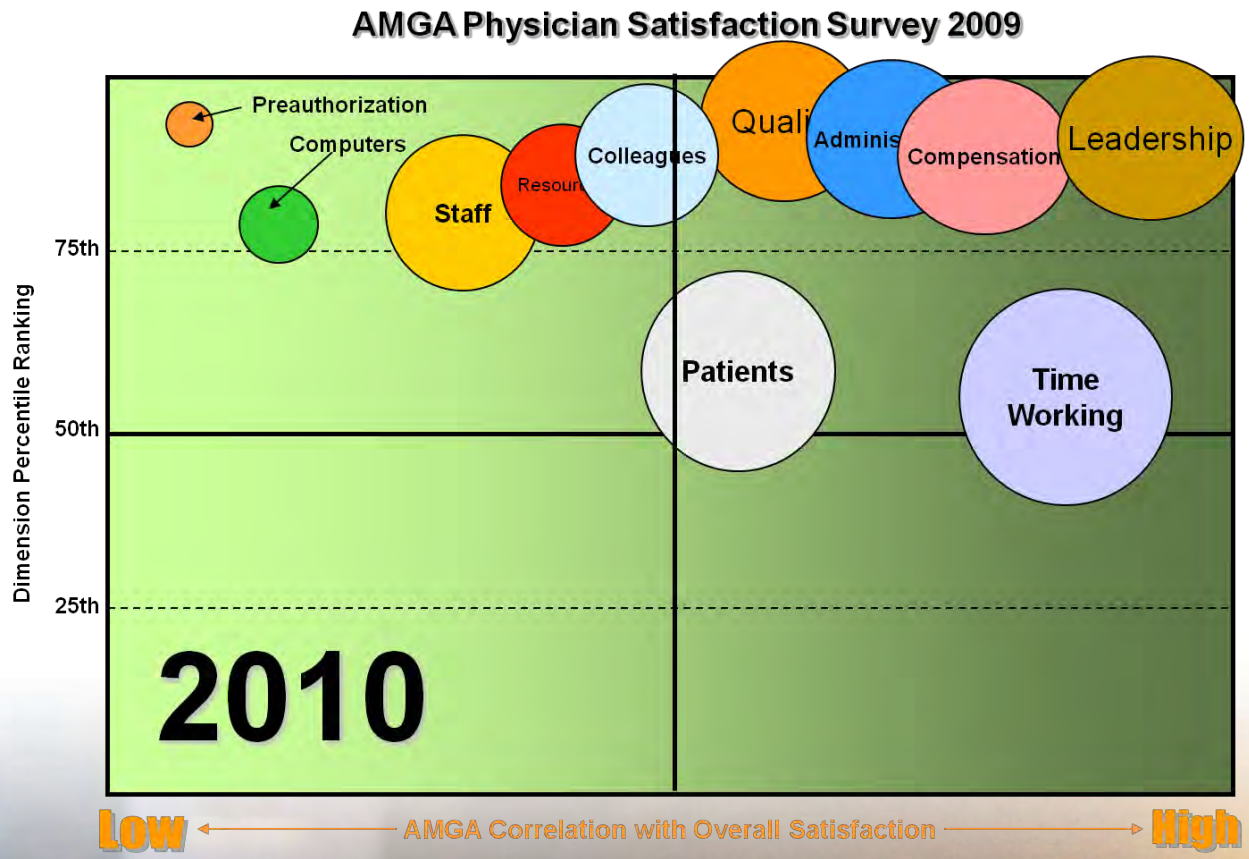


- Identify high risk patients
- Create care plans and implement health coaching
- Participate in medication "boot camp"
- Schedule orders for follow-up clinic appointment
- Coordinate care with home care and other resources
- Simplify patient discharge instructions
- Engage patients in "teach back" methods
- Call patients post discharge

HealthPartners Outcomes



HealthPartners Outcomes



The Path Forward

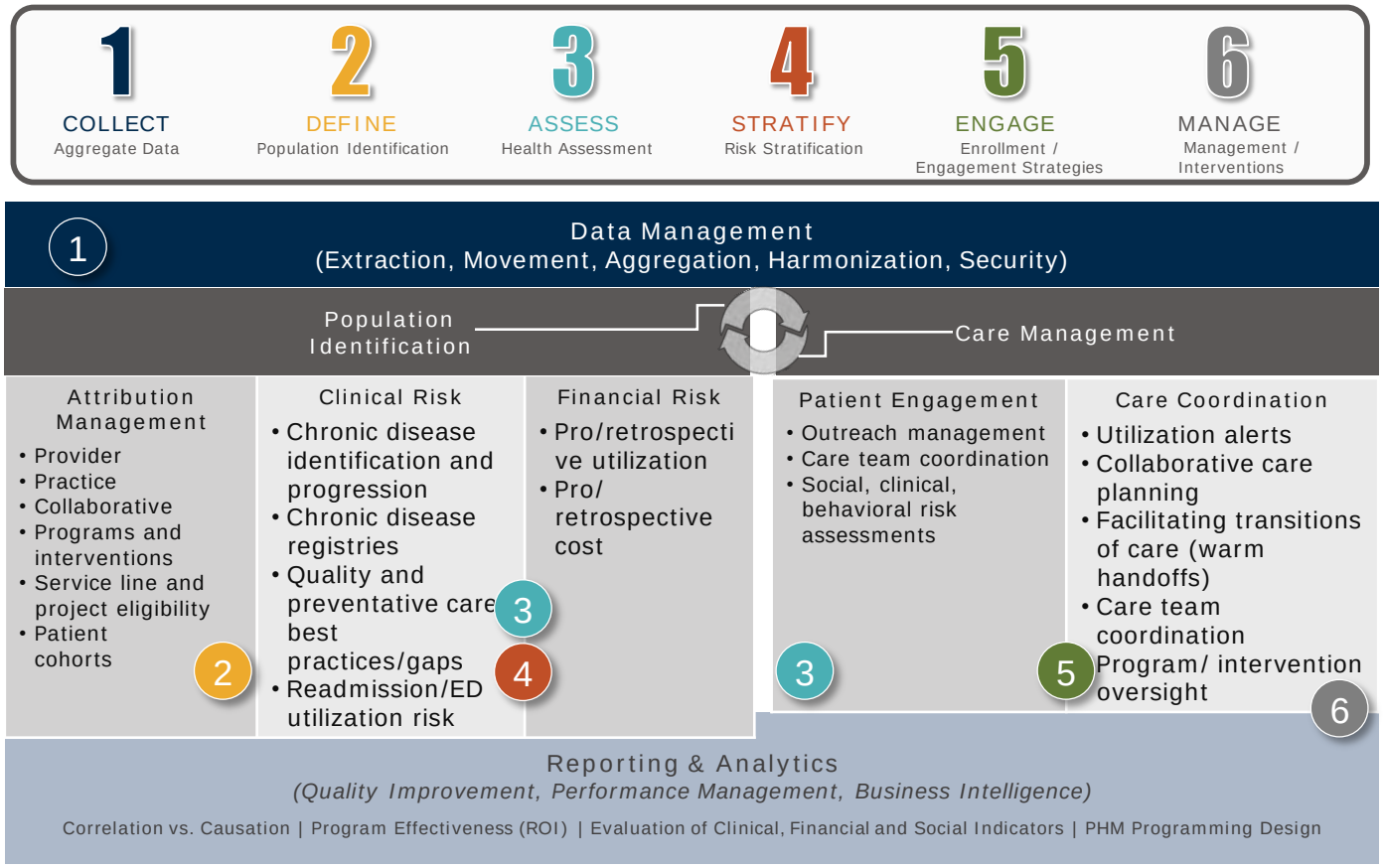
Requires the accelerated advancement in 4 critical areas:

1. Information and Technology Tools
2. Physician Leadership
3. Clinical Re-design
4. Informed Consumerism and Syngergistic Continuum integration

Data Transformed by Advanced Analytics into Actionable Information is the Substrate of Reliable Delivery of Measurably Better Care

- Actuarial informatics allow you to fully understand your population and its individuals and their health related needs and divide them into clinically meaningful different groups.
- Operational informatics allow you to easily provide optimized care to each individual and thereby, the overall population.

Integrated PHM Infrastructure: Components



Understand Populations Across Multiple Dimensions

Leading providers understand their populations along multiple dimensions – and use different definitions to direct various activities and priorities.

SEGMENT & STRATIFY POPULATIONS

Along different dimensions

Disease Condition / Health Status	*Utilization Patterns*	*Risk Factors*	*Geography*	*Socio-Economic Status*	*Social Needs*	*Preferences and Attitudes*

At different levels

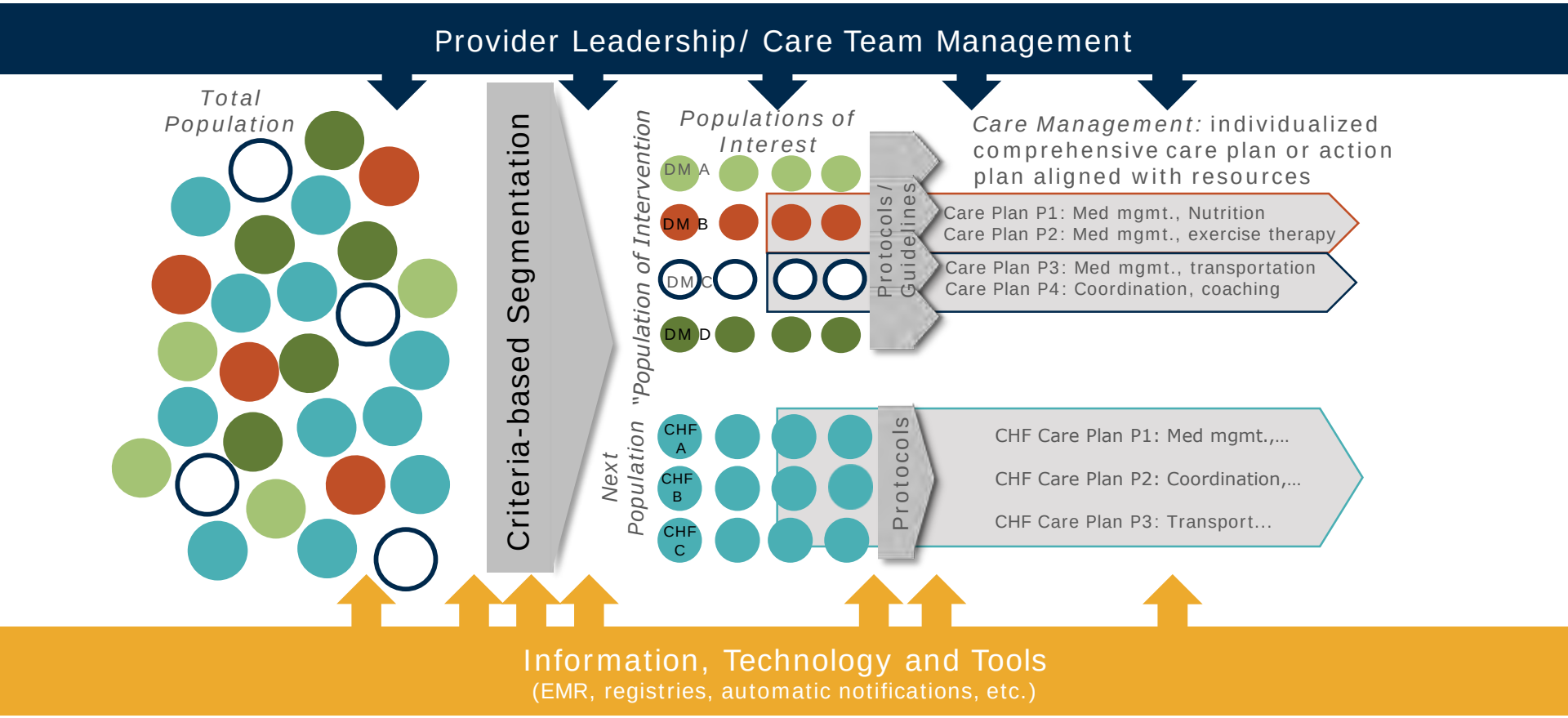
Example Definitions

- *All patients the system touched in the last three years*
- *All lives in a particular geography*

- *Individuals admitted more than once in the past 12 months*
- *Individuals with Heart Failure*
- *Medicare beneficiaries attributed to ACO via primary care*
- *Individuals with multiple chronic conditions*

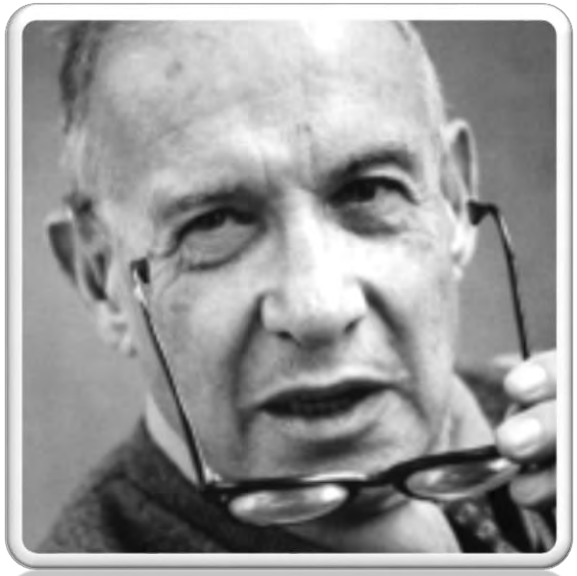
- *Patients with Heart Failure at risk for treatment non-adherence*
- *Individuals from a specific geography with multiple chronic conditions and social needs, e.g., transportation*
- *Individuals with COPD who actively seek services and information online*

Future Model: Care Management



Physician Leadership Drives These Efforts

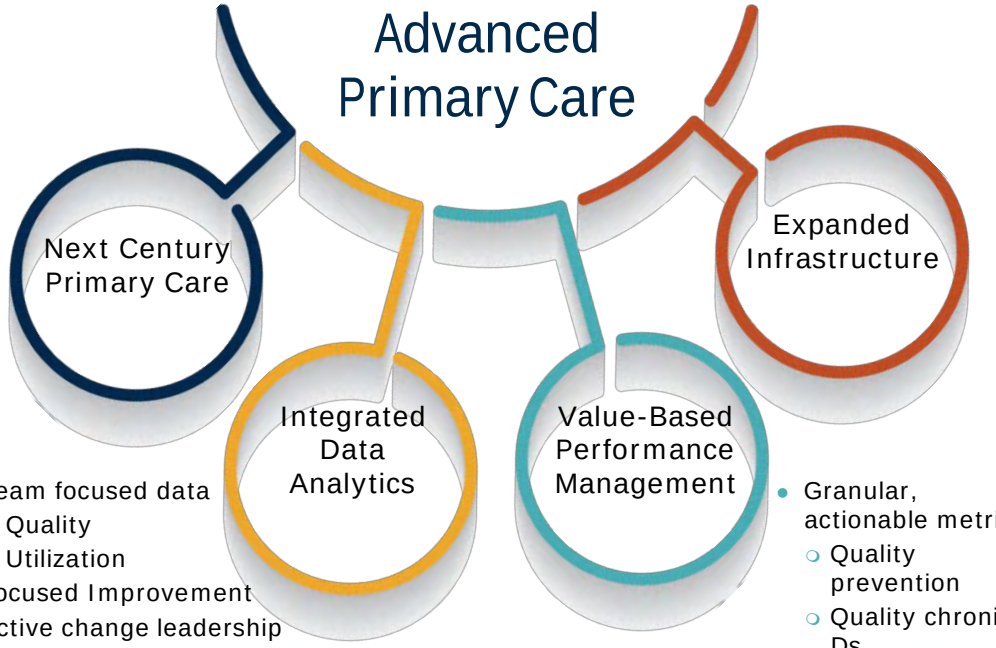
Peter Drucker



November 19, 1909 - November 11, 2005

Your first role…is the personal one,…It is the relationship with people, the development of mutual confidence, the identification of people, the creation of a community. This is something only you can do. It cannot be measured or easily defined. But it is not only a key function.
It is one only you can perform.

Core Elements of Advanced Primary Care



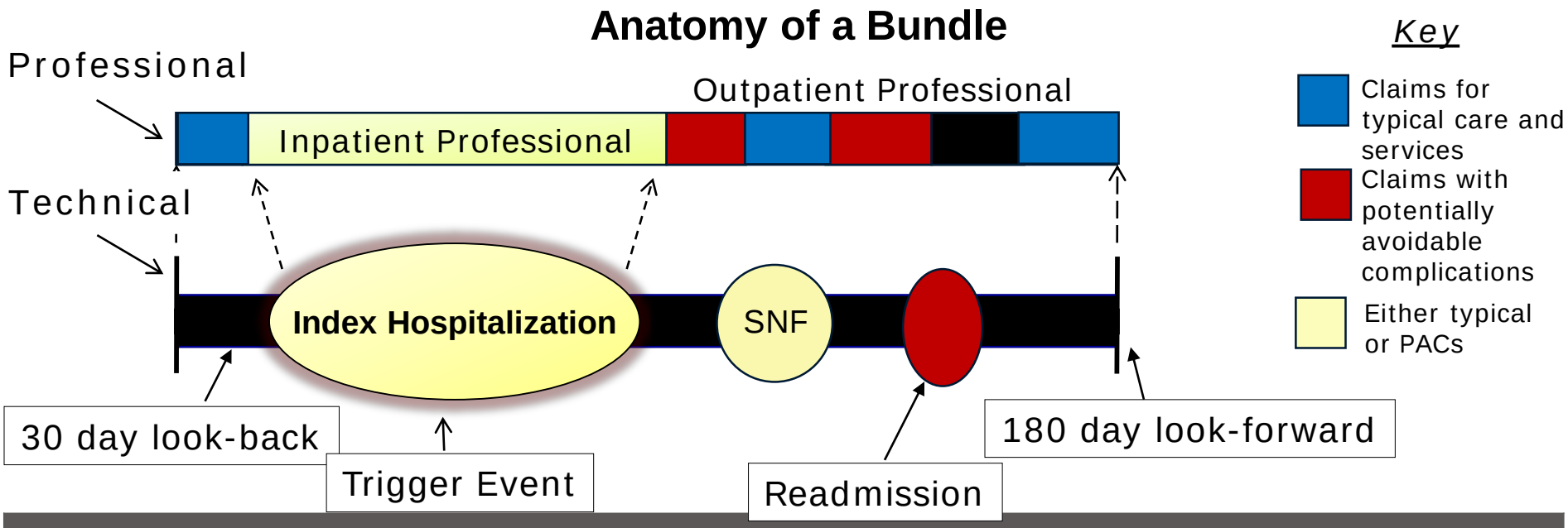
- Physician directed, team delivered care
- Expanded office teams
  - Embedded care management
  - Active electronics
  - Engaged patients/families
- Proactive care connectivity
- Medical neighborhood connections

- Team focused data
  - Quality
  - Utilization
- Focused Improvement
- Active change leadership
  - Physician
  - Administrative
- Programmed innovation
  - Creation
  - Refinement
  - Dissemination

- Granular, actionable metrics
  - Quality prevention
  - Quality chronic Ds
  - Utilization
- Supportive revenue stream

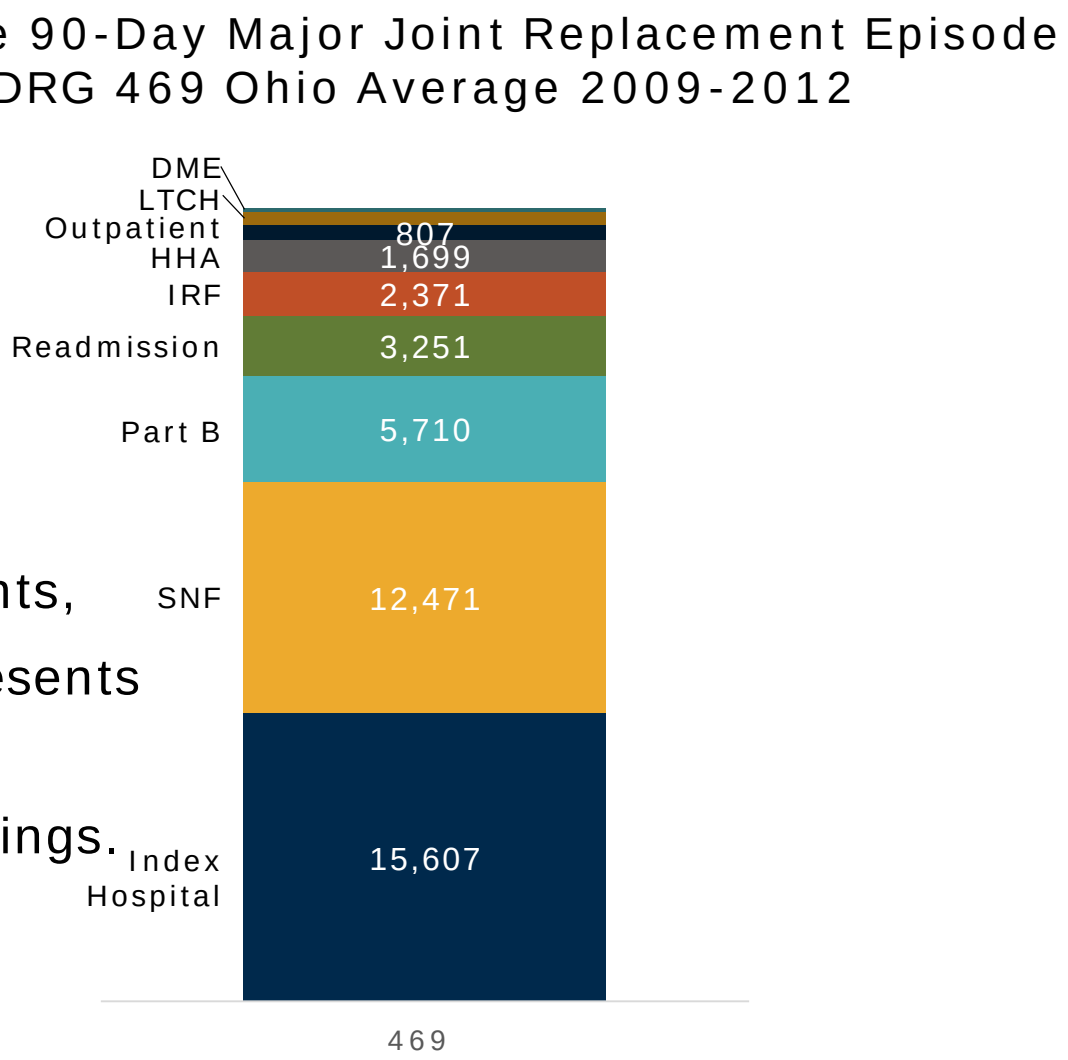
- Active proximal leadership
  - Physician
  - Administrative
- Operational informatics optimization
  - Physician directed
  - Flow enhancing
  - Ease of use
- Programmed innovation
  - Creation
  - Refinement
  - Dissemination

Care Bundles Illustrates the need for connectivity across the continuum



Example	PROMETHEUS ECR for Knee Replacement
Trigger codes	ICD-9 procedure code for knee arthroplasty or ICD-9 diagnosis codes (specified) as primary diagnosis
Patient exclusions	In-hospital death; discharge status left against medical advice; index stay for double knee replacement.
PAC	Readmission; adverse effects of drugs; overdose; complications of implanted device; complications of surgical procedure; revision procedures; vascular catheter associated infection; septicemia; perioperative hematoma; hemorrhage; stroke; coma; syncope; delirium; AMI; shock; cardiac arrest; air embolism; pneumonia; respiratory failure; lung complications; urinary tract infections.

Identifying the Opportunity within Specific Bundles



For Medicare patients, post acute care presents an important opportunity for savings.

True Community Integration

Requires not just aggregation, or functional connectivity, but full synergistic integration of cross continuum services.

- Many systems are approaching healthcare reform via merely aggregating targeted services to expand their footprint in the continuum in an opportunistic fashion.
- Others are working to improve the functional connectivity amongst the elements they have connect with.
- Optimal care of the community requires a far more effective and proactive orientation, synergistic integration. This approach optimizes not just the function, but also the use of all continuum elements and has a disciplined approach to both ongoing management of current processes, iteration of minor improvements, and revolutionary innovation of the model.
- This synergistic integration is grounded in the needs and issues of the community, and is designed to improve Population Health.

"Informed" Consumerism tied to synergistic integration
as a Durable Strategic Differentiator

Customer service alone is not enough:

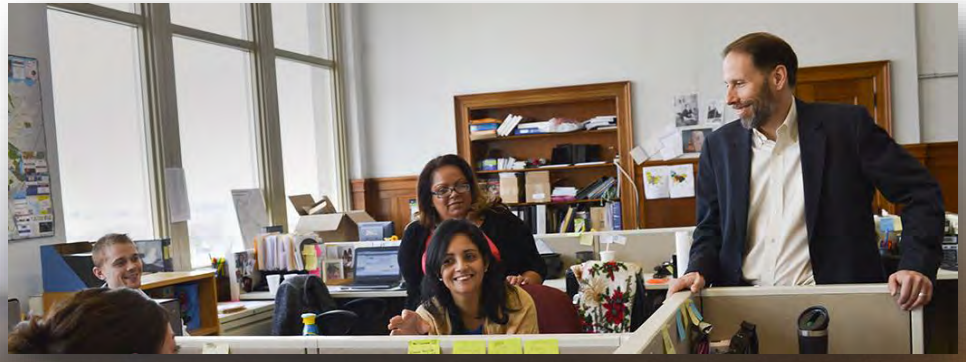
- Deep understanding of the community and its needs, family and its needs and the individual and needs
- New era of competition based on real differences in performance created by convergence of accountability and consensus
  - Feb. 16 — Seventy percent of commercial payer enrollees—including those covered by UnitedHealth Group, Aetna, Anthem, Cigna, Health Care Service Corp., Humana, Kaiser Permanente and the Blue Cross Blue Shield Association—as well as Medicare patients will be covered by new quality measures announced Feb. 16 by the CMS and America's Health Insurance Plans (AHIP).
- ***"Informed consumerism" is the complete transparency of*** *quality, cost, and performance information.*
- Linking this to a synergistic integration with your community yields exceptional results

Camden Coalition

National center to help communities to improve care for patients with complex needs.

National Center for Complex Health and Social Needs

- The Camden Coalition of Healthcare Providers has announced plans to establish a national center to improve care for high-need patients who experience poor outcomes despite extreme patterns of hospitalizations or emergency care. Inefficient and ineffective care of these patients has been identified as a driver of unnecessary health care spending in the United States. AARP, The Atlantic Philanthropies, and the Robert Wood Johnson Foundation are collectively providing $8.7 million to fund the center.
- The Camden Coalition has been a leader in identifying these patients and working to improve their care through coordinated, data-driven, and patient-centered approaches—including addressing needs that have traditionally been considered "non-medical," such as addiction, housing, transportation, hunger, mental health, and emotional and educational support. The national center will bring together practitioners working with these patients around the country and serve as a hub to unite and advance the nascent field.



ProvenWellness Neighborhood – Geisinger

ProvenWellness Neighborhood (PWN) is a free program that helps individuals who are uninsured or underinsured achieve better health and wellness close to home. Staff members identify needs and coordinate resources for individuals and families that include patient advocacy, transportation, prevention coaching, healthy lifestyle education and direct care/monitoring of chronic diseases. PWN operates in five northeastern Pennsylvania counties (Lackawanna, Wayne, Susquehanna, Wyoming and Pike.

Our team includes doctors, nurses, licensed social workers, physical therapists, and nutritionists who work with adults. Our services are free of charge.

Participating Agencies Include:

American Red Cross

CARENET

The Edward R. Leahy Jr. Center Clinic for the Uninsured at the University of Scranton

Friends of the Poor

Marywood University

MFHS Maternal and Family Health Services, Inc.

Northeast Regional Cancer Institute Quarterly Newsletter

theClinics at Scranton Primary Health Care Center

The University of Scranton A Jesuit University

United Neighborhood Centers of Northeastern Pennsylvania

Peter Drucker

November 19, 1909 - November 11, 2005

CHANGE

> Every few hundred years, throughout Western history, a sharp transformation has occurred. In a matter of decades, society altogether rearranges itself: its world view, its basic values, its social and political structures, its arts, its key institutions. Fifty years later, a new world exists, and the people born into that world cannot even imagine the world in which their grandparents lived and into which their own parents were born. Our age is such a period of transformation.

Contact Information

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National Director of Population Health

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The MCO Role in Value Based Payments

Central New York Care Collaborative 2016 Annual Meeting

November 1, 2016

UnitedHealthcare®
COMMUNITY & STATE

What is Managed Care?

UnitedHealthcare COMMUNITY & STATE

...intended to reduce unnecessary health care costs through a variety of mechanisms, including: economic incentives for physicians and patients to select less costly forms of care; programs for reviewing the medical necessity of specific services; increased beneficiary cost sharing; controls on inpatient admissions and lengths of stay; the establishment of cost-sharing incentives for outpatient surgery; selective contracting with health care providers; and the intensive management of high-cost health care cases.

www.wikipedia.com

Reform Projects: DSRIP

UnitedHealthcare COMMUNITY & STATE

5 MCO related measures

2ai, Milestone 9: Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform

2biv, Milestone 2: Engage with the MCOs and HH to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed

2di, Milestone 6: Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP.

UnitedHealthcare COMMUNITY & STATE

3bi, Milestone 19: Form agreements with the Medicaid MCOs serving the affected population to coordinate services under this project

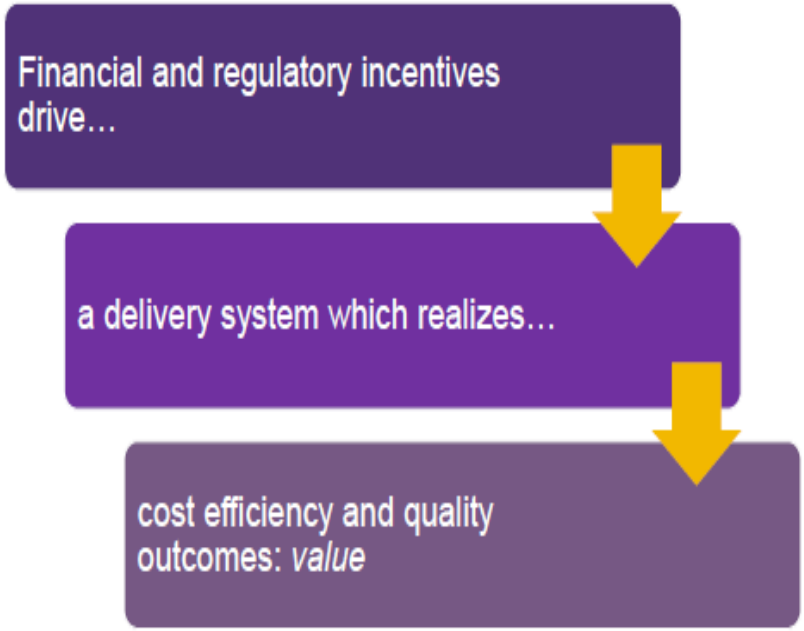
2ai, Milestone 8: Contract with Medicaid MCOs and other payers as an integrated system and establish *value-based payment* arrangements

Delivery Reform and Payment Reform: Two Sides of the Same Coin

UnitedHealthcare COMMUNITY & STATE

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

- Many of NYS system's problems (fragmentation, high re-admission rates) are rooted in how the State pays for services
  - Fee For Service (FFS) pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care
  - Current payment systems do not adequately incentivize prevention, coordination, or integration



Value Based Contracting Goals

UnitedHealthcare COMMUNITY & STATE

New York State has committed to reaching 80-90% value based payments (VBP) by the end of the waiver period (end of Q1 2020).

NY DSRIP Goals and Penalties			
	Level 1+ Target	Level 2+ Target	Penalty*
CY 2017	10%	N/A	0.50%
CY 2018	50%	15%	1.00%
CY 2019	80%	35%	1.50%

* Penalty will be marginal difference between Goal% of Medicaid Managed Care expenditure and total expenditure on Level 1/2 or above VBP contracts

NY DSRIP VBC Models

UnitedHealthcare COMMUNITY & STATE

Total Care for the General Population (TCGP)	VBP contractor assumes responsibility for the total care of its total attributed population. The default method for attribution is MCO-assigned PCP.
Integrated Primary Care (IPC)	MCO contracts Patient Centered Medical Homes (PCMH) or Advance Primary Care (APC) arrangements and rewards the VBP contractor based on the savings and quality outcomes achieved. IPC contracts can include additional payments for practice transformation, care management, and can tie additional rewards to progression towards APC status, for example. All attributed members are included.
Bundles of Care	VBP contractor assumes responsibility for both the outcomes and the costs of the care across the continuum of the patient's trajectory. NYS has prioritized two key bundles: Maternity Care (spanning the pregnancy, delivery and first month of the baby's care) and the Chronic Care Bundle (including the chronic conditions with the highest prevalence in NYS).
Total Care for Special Needs Populations	For these subpopulations, a capitated model (a per member per month (PMPM) payment) is best suited. HIV/AIDS, HARP, Managed Long-Term Care, Care for the Developmentally Disabled (DD). When members are eligible for more than one subpopulation (e.g. HARP and HIV/AIDS), the MCO/SNP decides with the VBP contractor(s) which VBP subpopulation prevails.

VBC Level Definitions

UnitedHealthcare COMMUNITY & STATE

	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature VBP contractor)
Total Care for General Population	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when quality scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	Global capitation (with quality-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM subsidy) with upside- only shared savings based on total cost of care (savings available when quality scores are sufficient)	FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	PMPM capitated payment for primary care services (with quality-based component)
Bundles	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when quality scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	Prospective bundled payment (with quality-based component)
Total Care for Subpopulation	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on subpopulation capitation (savings available when quality scores are sufficient)	FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	PMPM capitated payment for Total Care for Subpopulation (with quality-based component

Big Data

UnitedHealthcare COMMUNITY & STATE

A Value Based Payment deal cannot effectively be negotiated without sound data

- determination of **baseline**
  - *utilization
  - *cost
  - *quality

A Value Based Payment deal cannot effectively be monitored without robust data

- determination of potential for **shared savings or losses**
  - *utilization
  - *cost
  - *quality

Who are the players? What types of data are available? What is the capacity to send/receive data? HIPPA/Security concerns? What analytics are available?

Partnering on Value Based Initiatives

UnitedHealthcare COMMUNITY & STATE

To achieve success, all components of the New York State Medicaid program must understand the fundamental shift that DSRIP and VBP represent.

PPS, Health Systems, Providers, CBO's

PPS no longer the contracting entity

Contracting with Health Systems

Options for individual Providers

CBO involvement

Food for thought

UnitedHealthcare COMMUNITY & STATE

~ What is the Provider's current ability to take on VBC?

- What is the population you want to contract for?
- consider how many members in that population and how you have built an infrastructure to drive down costs in that population
- think about shared savings and losses; what are you ready for?
- stop loss
- risk corridors
- performance against quality measures, how are you doing?
- risk adjustment
- care coordination and other fees

~ What are the data exchange capabilities of the entity to support VBC risk deals?

- flat files
- interactive tools/dashboards
- ability to build or buy analytics
- ability to share data

Food for thought

UnitedHealthcare COMMUNITY & STATE

~ How is the CBO partnered with the provider to bring more to the table in an MCO negotiation?

~ How well do partner providers understand the CBO's admissions/intake/program requirements? Is there an opportunity to train or be part of the provider care management team?

~ How are the CBO and the MCO Community Outreach team working together?

~ Does the MCO have a good understanding of the program, services, and how to refer? Are printed materials available? In a variety of languages etc?

Partnering for success!

UnitedHealthcare COMMUNITY & STATE

Providers/provider networks and MCOs should invest in ***effective*** interventions that have a ***meaningful*** impact on the overall population health and the overall wellbeing of the community in which it serves.

The nature of the intervention(s) should be negotiated between the VBP contractor and MCO, taking into account population health and preventative health needs identified by the community. Providers/provider networks and MCOs may wish to collaborate with CBOs to support, develop, and broaden their reach to more communities.

Networks may want to consider larger partnerships and advocate for systemic improvements that might not be easily quantified on the individual member level immediately or in the short-term. Ultimately the goal should be to track the impact of interventions, not just on an individual level, but on a population level.

Leading the way

UnitedHealthcare COMMUNITY & STATE

The Camden Coalition

www.camdenhealth.org

Super Utilizer Program

Goal: improve quality of care received, quality of life, reduce preventable ED and Inpatient care

Composition: Physician or advanced practice nurse, nursing, pharmacy, behavioral health, social worker and community health worker

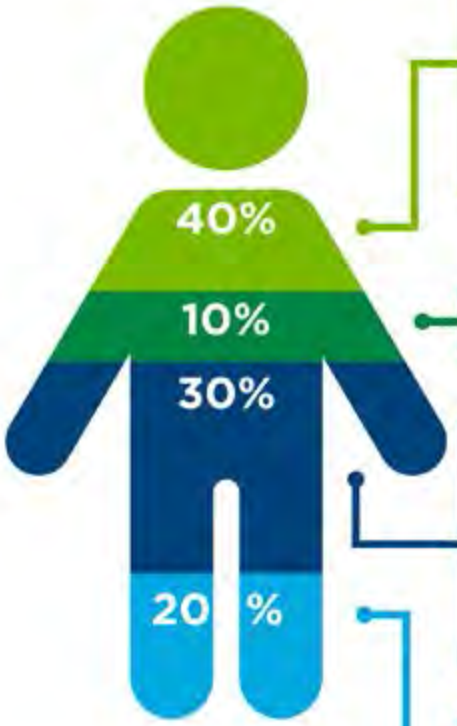
Structure: intensive team-based and relationship centered care, outreach, coordination of care, community engagement, foundation of high quality shared data

The Importance of Building Relationships Across the Continuum of Care

Rebecca Bostwick, MPA
Program Director, Lerner Center for Public Health Promotion

CNY CARE Collaborative Annual Meeting 2016

What Goes Into Your Health?



Socioeconomic Factors

Education | Job Status | Family/ Social Support | Income | Community Safety

Physical Environment

Health Behaviors

Tobacco Use | Diet & Exercise | Alcohol Use | Sexual Activity

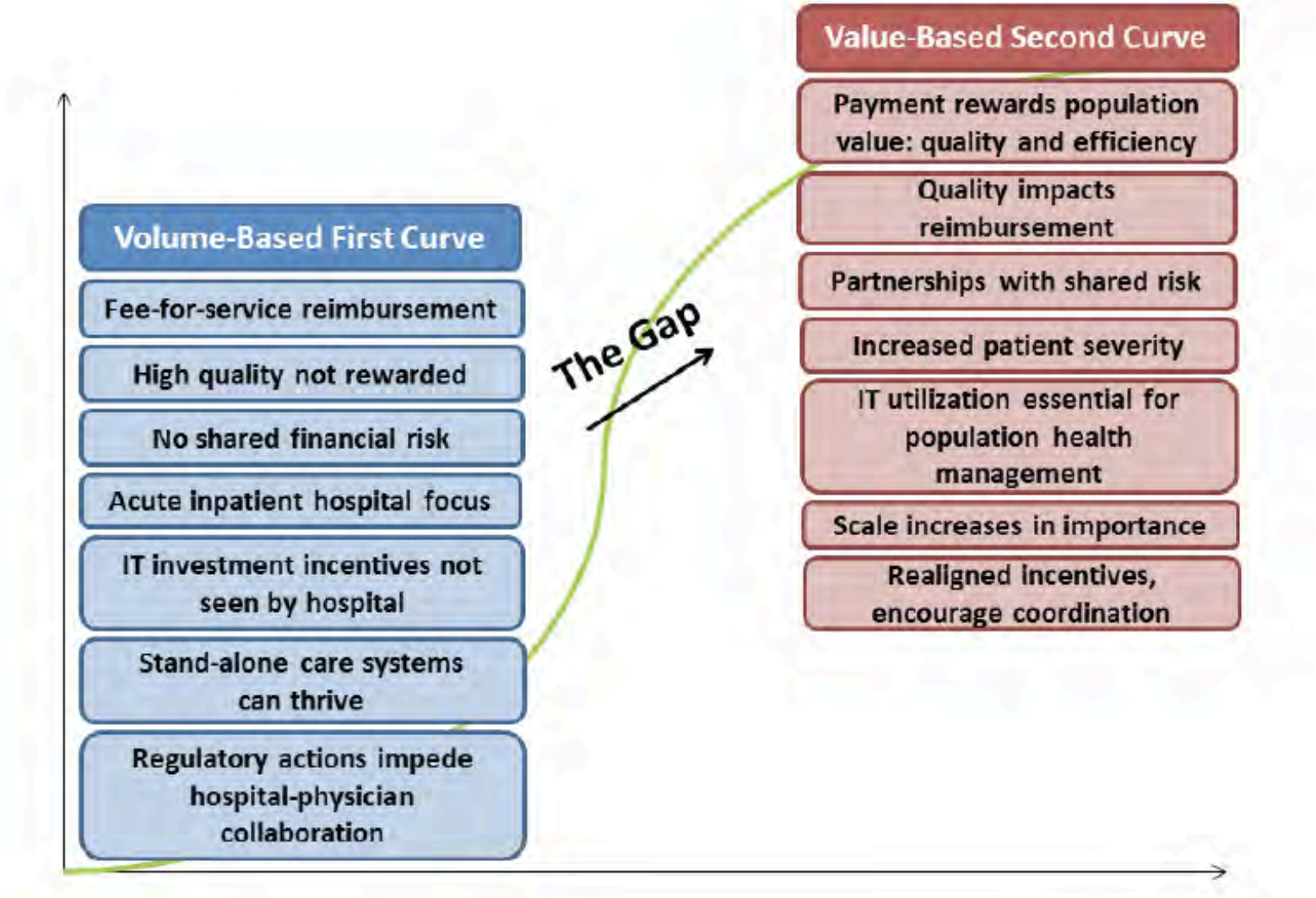
Health Care

Access to Care
Quality of Care

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

The Bridgespan Group

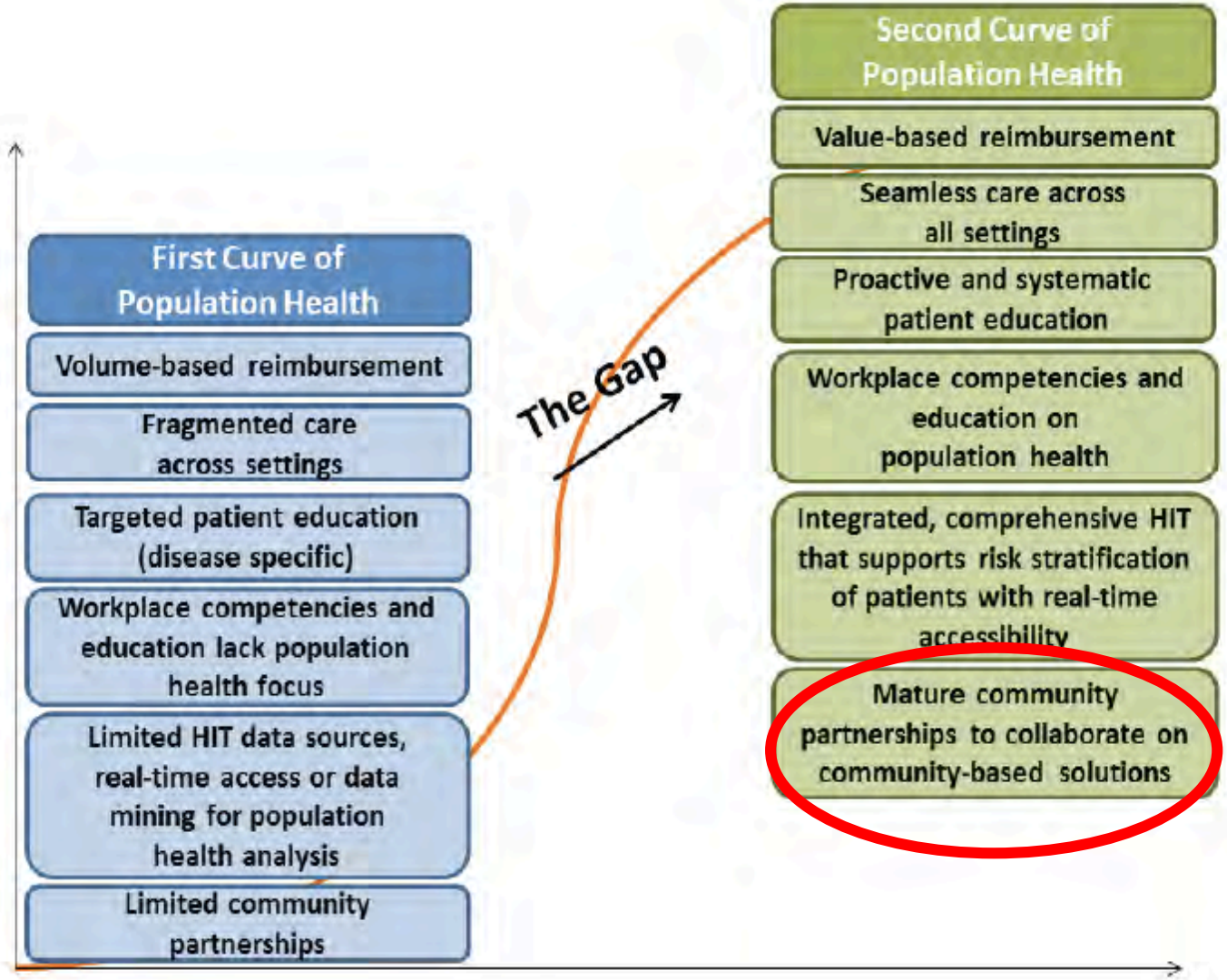
First Curve to Second Curve of Health Care



Source: Health Education and Research Trust: *The Second Curve of Population Health, 2014.*

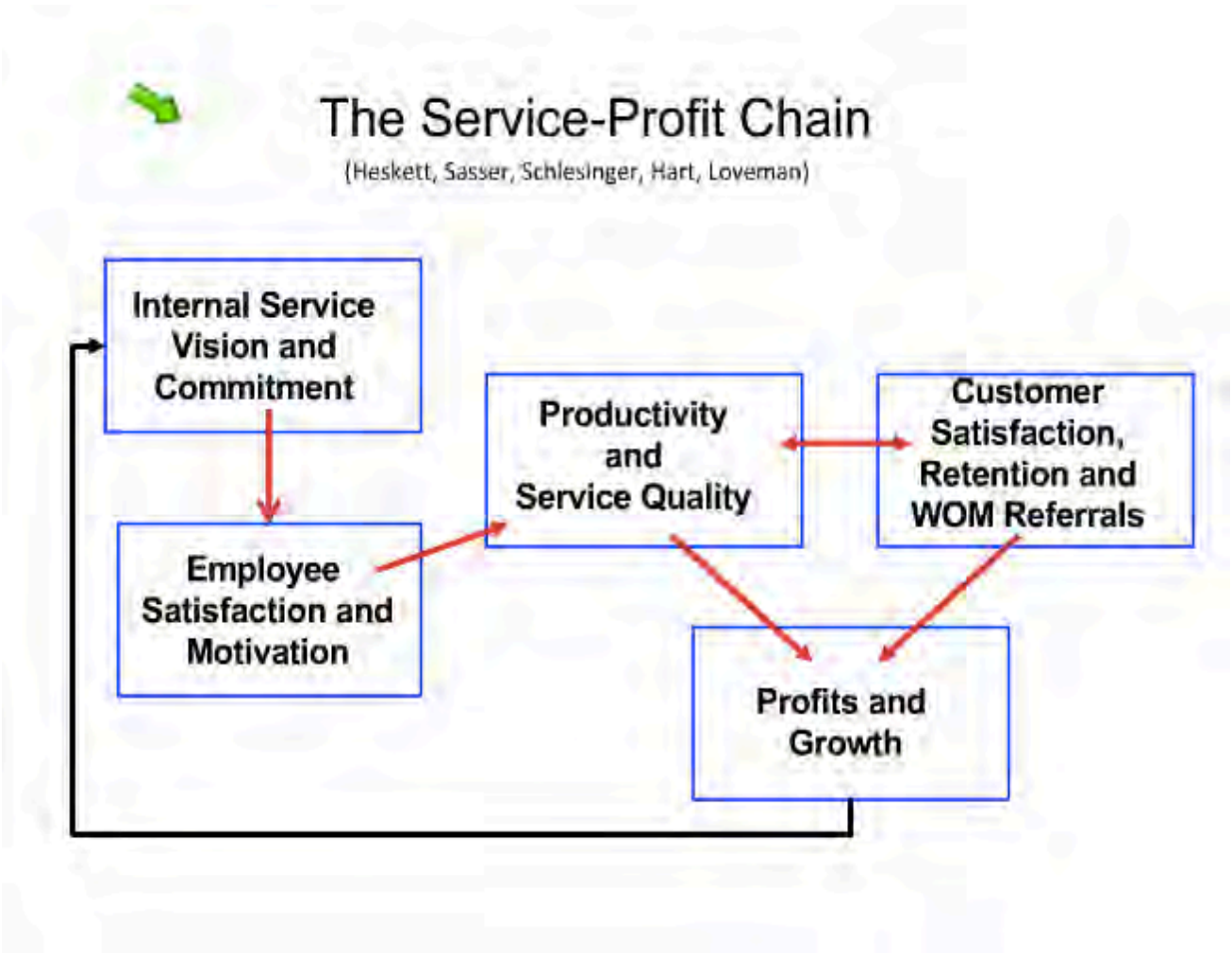
Adapted from Ian Morrison 2011

First Curve to Second Curve of Population Health



Source: Health Education and Research Trust: *The Second Curve of Population Health, 2014.*

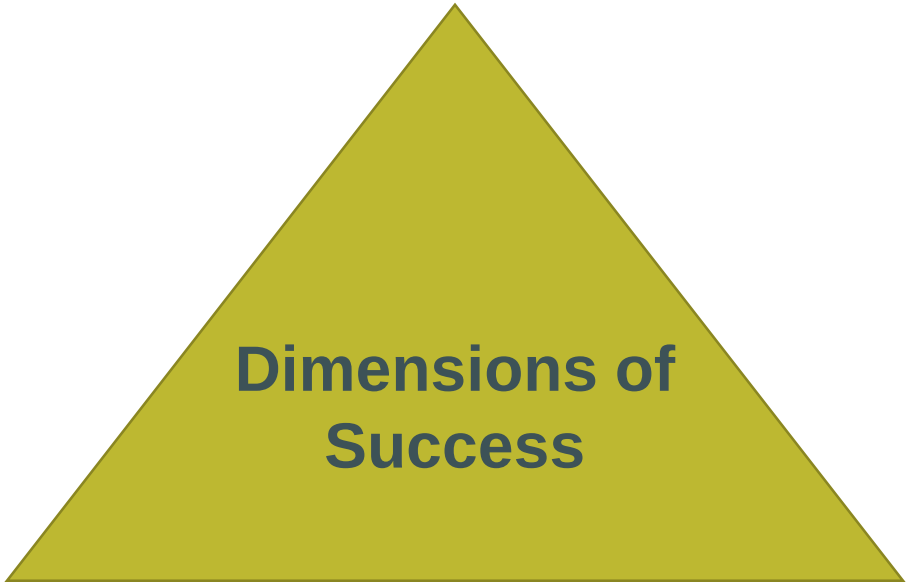
But what about the bottom line?



Our Common Approach

Results

Goal or task accomplished



Relationships

The quality of the connections between the people engaged in the work

Process

The way or spirit in which work is carried out

Source: IHI; Interaction Institute for Social Change

Network Leadership & Collective Impact Principles

Network Leadership

- Mission, Not Organization
- Node, Not Hub
- Humility, Not Brand
- Trust, Not Control

Collective Impact

- Common Agenda
- Shared Measurement
- Mutually Reinforcing Activities
- Continuous Communication
- Backbone Organization

Stanford SOCIAL INNOVATION REVIEW

Informing and inspiring leaders of social change

Essential Mindset Shifts for Collective Impact

- By their very nature, complex problems cannot be solved by any single organization or sector alone.
- Look for silver buckshot instead of the silver bullet.
- Align mission, organizational culture, and services.
- Reach outside the hospital walls, where health happens.
- Seat at the community table- and not always at the head of it.

"Culture eats strategy for lunch."

(Attributed to Peter Drucker)

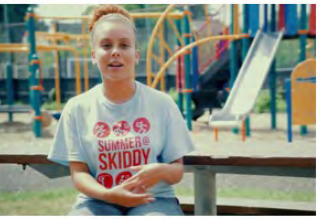
"Every system is perfectly designed to get the results it gets."

(Don Berwick, Past President of IHI)

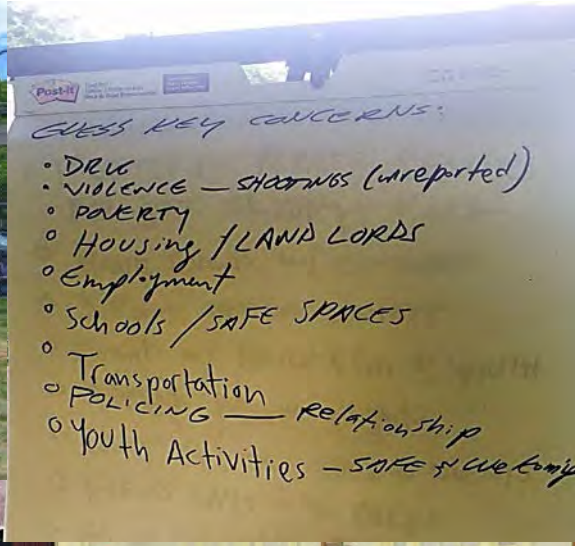

SUMMER@
SKIDDY


SCORING


EXIT


SUMMER@
SKIDDY


TAKE BACK
THE STREETS


Post-it
GUESS KEY CONCERNS:
• DRUG
• VIOLENCE — SHOOTINGS (unreported)
• POVERTY
• HOUSING / LANDLORDS
• Employment
• Schools / SAFE SPACES
• Transportation
• POLICING — Relationship
• Youth Activities — SAFE &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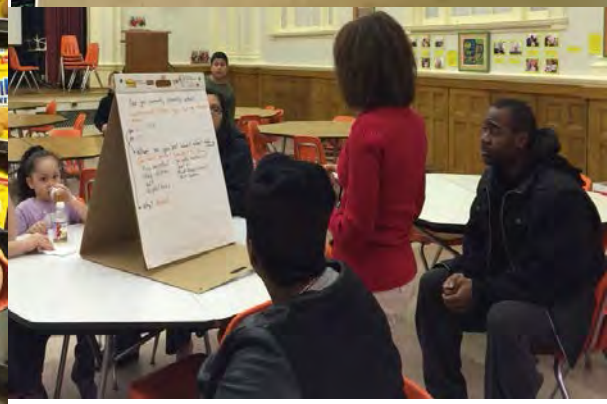

Central New York Care Collaborative (CNYCC)

2016 Annual Meeting

Closing Remarks

Virginia Opipare
Executive Director, CNYCC

"Working Together for Better Health"

Annual Meeting – What We've Learned?

- Themes of the Day
  - VBP & DSRIP – "Two Sides of the Same Coin"
  - A PHM System to Provide Data and Analytics
  - Building Community Partnerships
  - Care Coordination

Our Partnership – “We Can Do This!”

- **Diverse Group of Partner Organizations**
  - Partners Vary in Size, Complexity, & Provider Types
  - 1,400 Healthcare And Community- Based Service Providers
- **Span Across 6 Counties** (Cayuga, Lewis, Madison, Oneida, Onondaga, and Oswego)
  - 6,000 Square Miles
  - Urban Centers (Syracuse, Utica)
  - Rural Settings
- **200,000 Attribute Medicaid Lives Regionally**

Challenges of Transformation

- Data for Quality Improvement and VBC
- Value Based Contracting Vehicle(s)
- Understanding Your Value Based Contracting Readiness
- Developing Partnerships
- Limited Resource Environment

Enabling Tools & Structures

- Data Analytics and Care Coordination Platform (PHM System)
- Communication Vehicles
  - CNYCC Weekly Newsletter
  - CNYCC Website
  - Webinar Series
  - “Partner Spotlight Series”
- Central “Backbone” Organization and Governance Structure
- PPS Wide Outcome Measurement and Improvement
- Venues for Partner Networking & Benchmarking
  - RPAC
  - Learning Collaborative
- Participation in VBP QIP Program

Network Accomplishments

- Partner Network Development
  - 130+ Partner Organizations Currently Under Contract
- Governance
- More than 30K Actively Engaged Patients Across Projects in DSRIP Year 2
- Partner Payment Process with $6 Million Distributed
  - Board Approved Payment Policies
  - Accelerated Payment Program
  - Actively Engaged Patient Payments

Our Future Together….

- Add Value to Our Partners
- Assist Partners in Transition to Value Based Payment
- Provide & Share Data to Measure Our Success
- Implement Population Health Management System
  - Community Wide Data Analytics
  - Combined Clinical & Claims Data
  - Central Care Management Module

Our Future Together….

- Care Coordination Strategy for the Network
- Provide Quality Improvement Tools & Training to Enable the Acceleration of Change Process
  - Rapid Cycle Improvement Methods
- Serve as a Convener to Facilitate & Coordinate Meaningful Connections Across Partner Network

Making A Difference Together…

- Integrate Services
- Collaborate on Patient Care
- Focus on Quality
- Patient-Centered Approach to Care Delivery

THANK YOU

Thank you to CNY Care Collaborative Partner Organizations for everything you do to transform the healthcare system and improve the quality of care for our community.

CNY CARE COLLABORATIVE