Central New York Care Collaborative

All PPS Meeting:
VBRA Findings and Future State Options

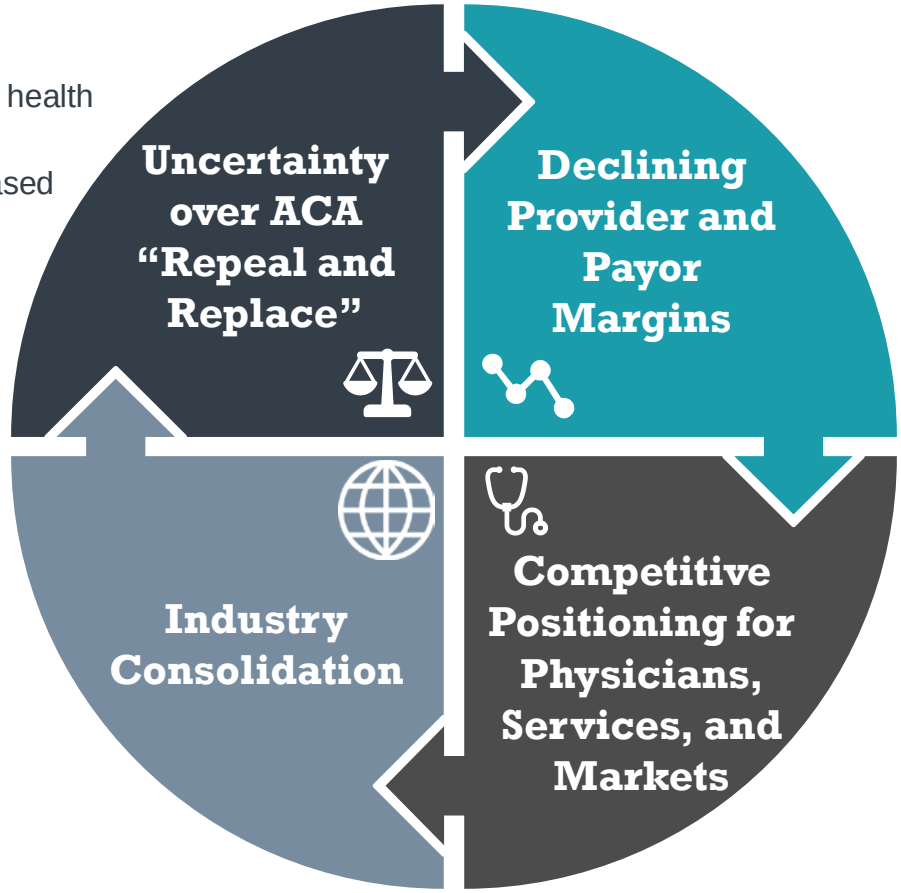
November 6, 2017

CONFIDENTIAL

Market Trends

The regional and national healthcare landscape continues to experience material pressure to improve value and promote network formation and performance.

Implications for CNYCC



- Clinical integration/population health management
- Payment reform and value-based care strategy
- Medicare and Medicaid payor pressures
- Value-based readiness
- Care delivery transformation

- Importance of MCO contracting
- Focus on expense reductions/efficiencies
- Payor mix diversification
- Employee health plan strategies

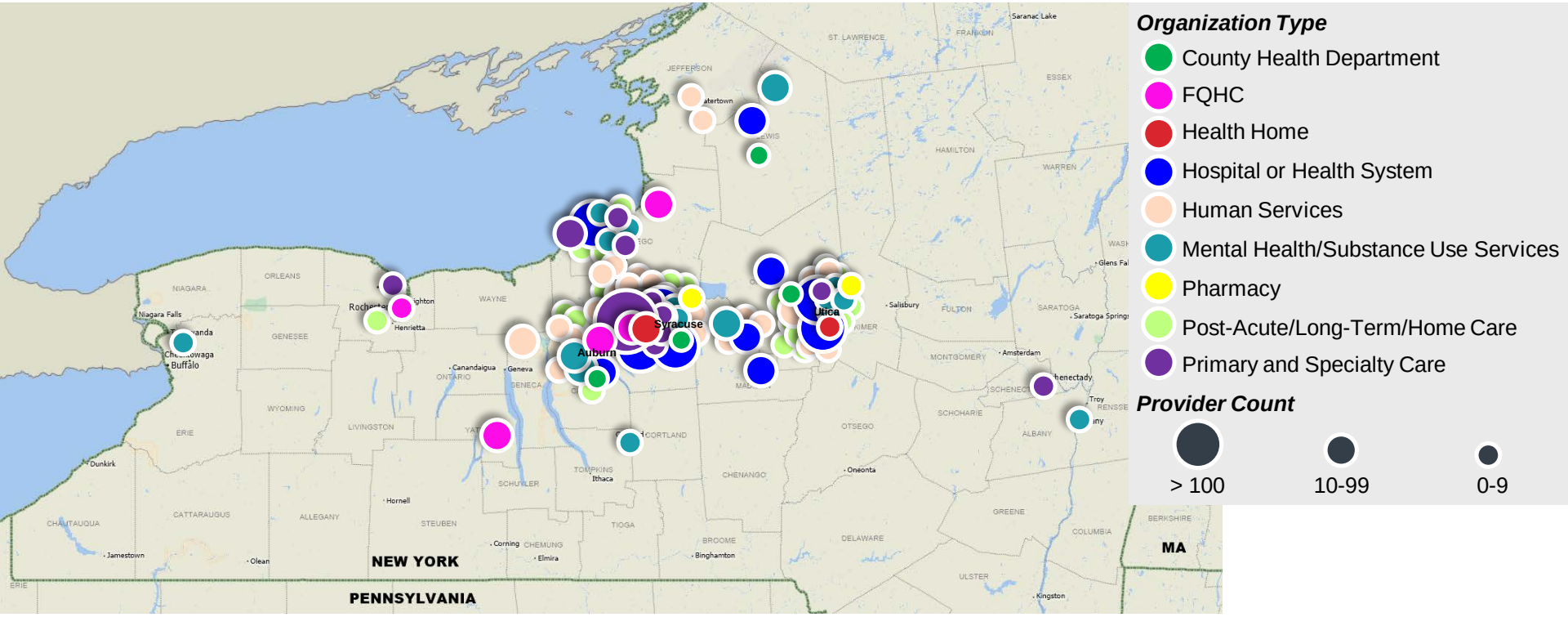
- Payor and provider partnerships
- Hospital/physician financial and incentive alignment
- Network performance and optimization
- Behavioral health integration
- Community based service integration

- Clinical integration and innovative alignment between hospitals and physicians
- CMS ACO waiver opportunities
- PHM technology strategies

PPS Network

Size, Scope, and Geographic Reach

CNYCC has created a comprehensive network that connects more than 2,000 healthcare and community based service providers in six counties across Central New York — Cayuga, Lewis, Madison, Oneida, Onondaga and Oswego.



Notes:

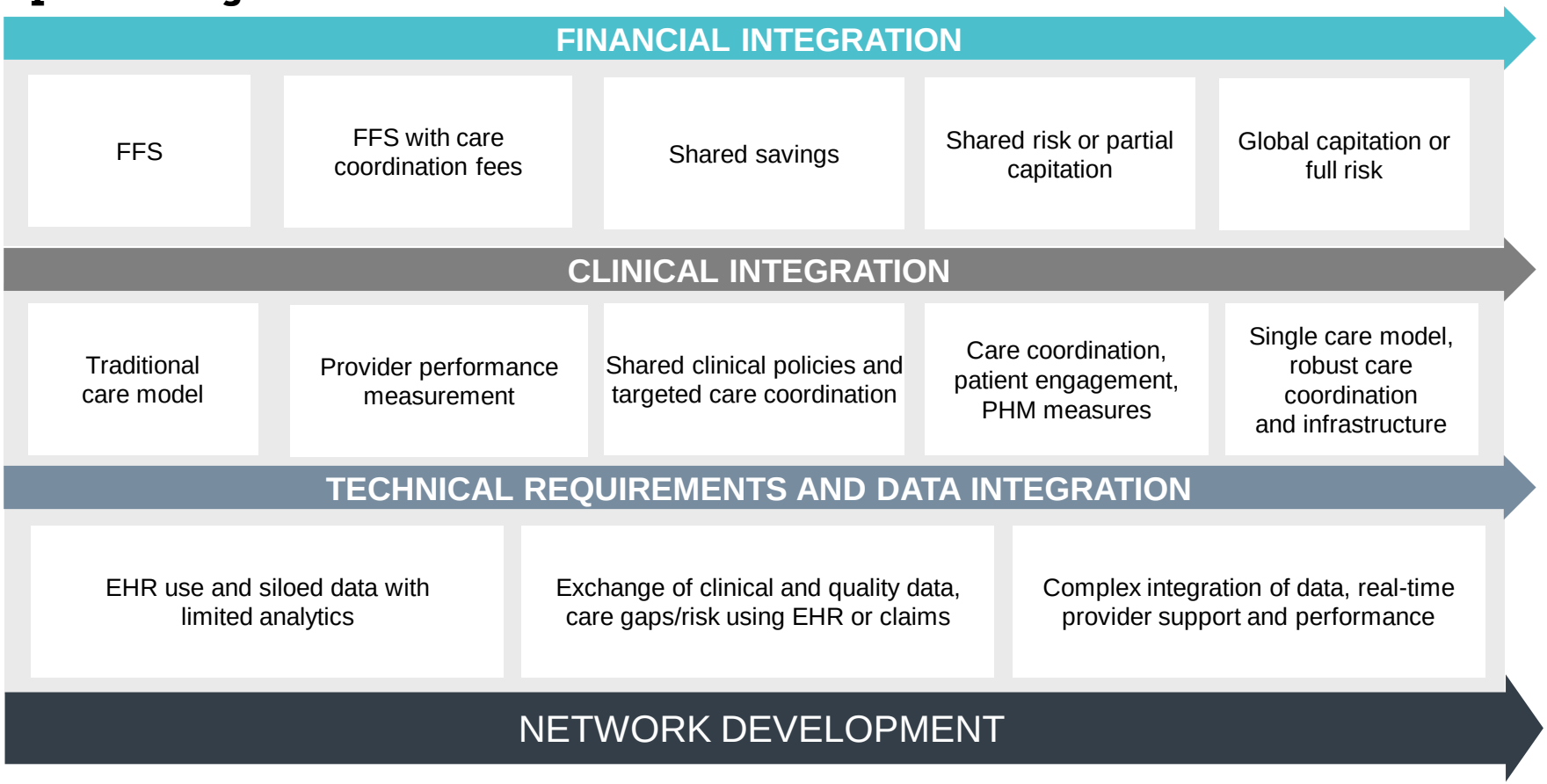
1 "Organization Type" categories were created by cross-walking CNYCC Salesforce organization service type data with self-reported narrative organizational descriptions. Organizations that provide multiple services are categorized under the dominant service offering. For example, St. Joseph's Hospital Health Center is included in the "Hospital or Health System" category as opposed to the "Health Home" category.

2 Providers are defined by CNYCC as those with an NPI or MMIS number.

High Performing Networks

Integration and Scale

Clinical, financial, and data integration are key tenets of the development of a high performing network.



A high-performing network creates material value and scale.

Agenda

I VBRA Process

II Strengths and Gaps

III Service Opportunities

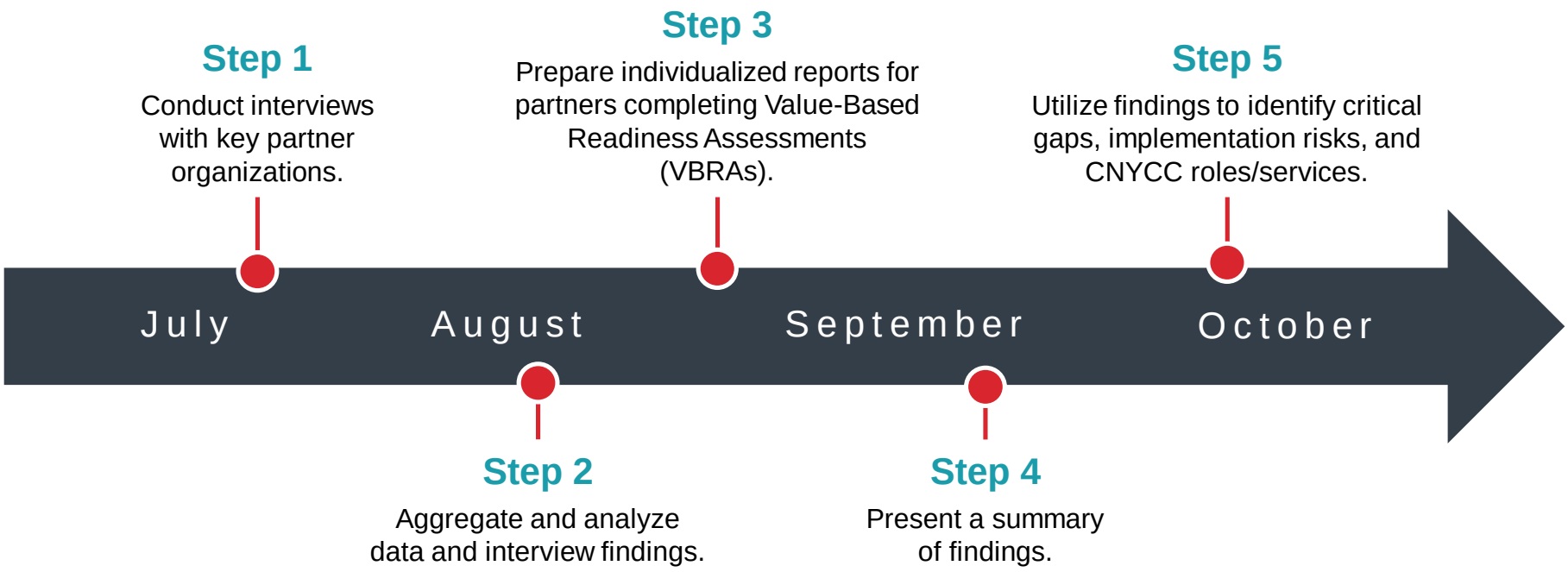
IV Centralized Services Model

V Q&A

I. VBRA Process

Overview

Over the past few months, ECG conducted various interviews with key stakeholders from a sample of Central New York Care Collaborative's (CNYCC's) partner organizations. The purpose of this document is to aggregate key findings in order to identify critical gaps, implementation risks, and additional ways in which CNYCC can support its partners.



I. VBRA Process

Organizations Involved

ECG conducted interviews with 40 of CNYCC's partner organizations during summer 2017 in order to better understand partners' readiness for value-based reimbursement and identify potential obstacles that could affect CNYCC's work.

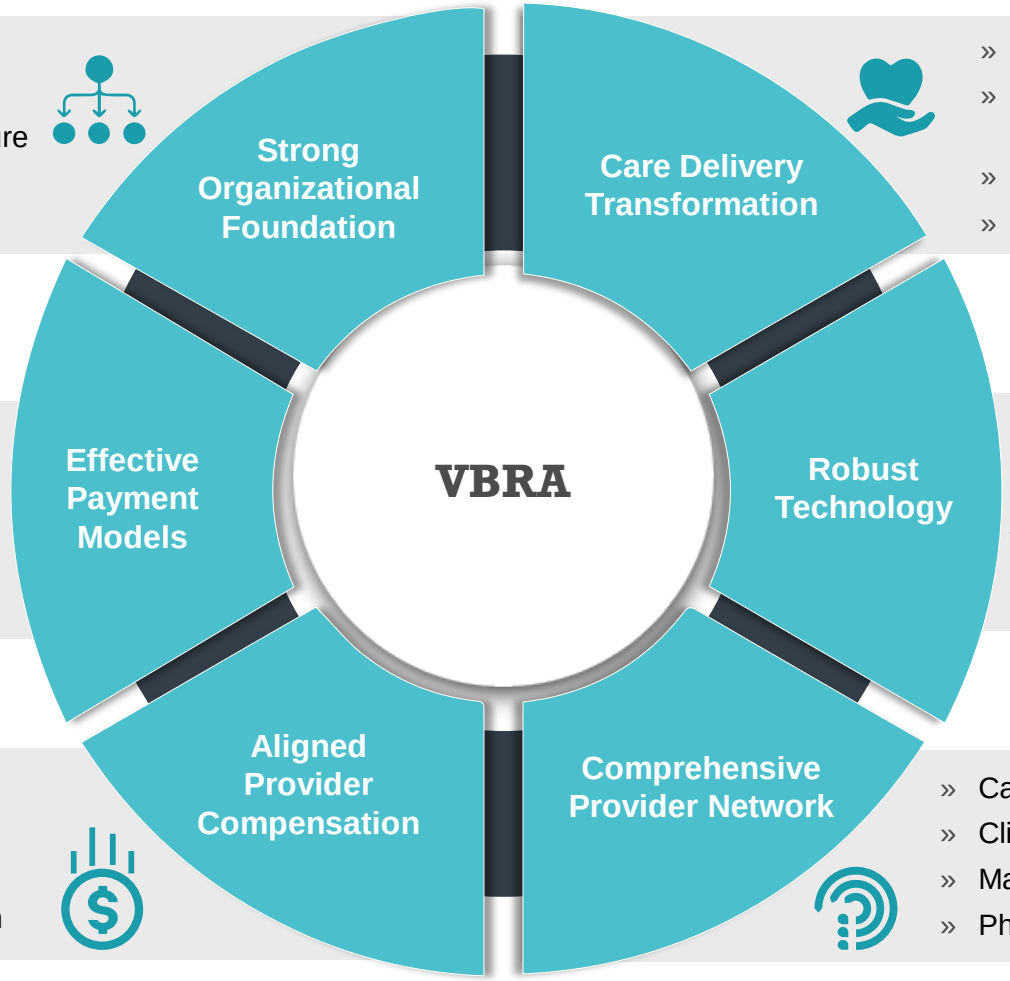
Organization Type	Number Interviewed
Hospital and/or Health System	7
Federally Qualified Health Center (FQHC)	6
Medical Group	1
Long-Term and/or Post-Acute Care Provider	5
Behavioral Health (BH) and/or Health Home	3
Community-Based Human Services Organization	9
Developmental Disability (DD) Organization	9
Total	**40**

Organizations participated in individual interviews, focus groups, and full-day VBRAs.

I. VBRA Process

Areas of Assessment

ECG utilized its VBRA (full and modified) to evaluate CNYCC partners' likelihood of success under Value-Based Payment (VBP) based on each organization's positioning related to six key domains.



- Supportive Culture
- Appropriate Legal Structure
- Effective Organizational Structure
- Financial Strength
- Committed Leadership

- Care Coordination/Integration
- Clinical Standards and Protocols
- Clinical Innovation
- Patient Care and Engagement

- Payor/Employer Collaboration
- Risk-Sharing Experience
- Population Management

- Infrastructure
- Information Exchange and Integration
- Performance Reporting

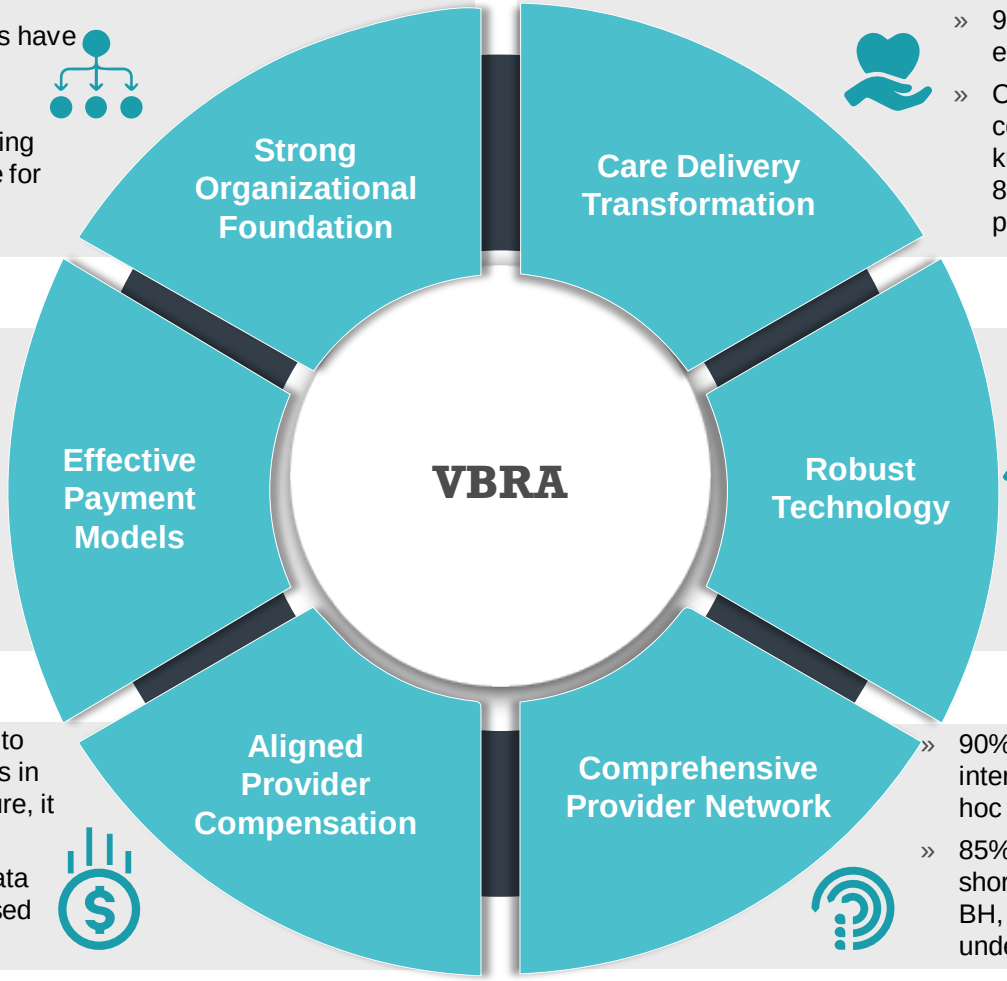
- Plan Design and Structure
- Performance Expectations and Measurement
- Governance and Administration

- Care Continuum
- Clinical Scope
- Market Presence
- Physician Engagement

II. Strengths and Gaps

PPS-Level Findings by Domain

Interviews with a sample of partner organizations suggest that the PPS is in a developing stage of VBR maturity.



- The majority of interviewed partners have not developed a comprehensive VBP strategy.
- Most interviewees have thin operating margins, limiting reserves available for downside risk engagements.

- 90% of clinical partners have some experience with quality measurement.
- Care management and care coordination resources (e.g., staff, knowledge, tools, funds) are limited in 85% of partner organizations, and care planning is largely ad hoc.

- While 30% of organizations have experience with pay-for-performance (P4P) arrangements, most are still in a fee-for-service (FFS) model.
- 95% of partners do not have experience with downside risk.

- The technology landscape is varied: while some partners (22%) have a unified EHR, most operate across disparate systems.
- 95% lack robust population health management (PHM)/business analytics experience.

- While 20% of partners have begun to include a performance-based bonus in their provider compensation structure, it is typically minimal (<10%–15%).
- Partners noted that they lack the data or the clout to implement value-based compensation plans.

- 90% of partners noted that interorganizational collaboration is ad hoc and largely manual.
- 85% of clinical partners noted workforce shortages in primary care (PC) and/or BH, and most lack a comprehensive understanding of CBO service offerings.

II. Strengths and Gaps

By Organization Type

ECG also examined key strengths and gaps by organization type. Notable findings are emphasized in blue.

Organization Type	Strengths	Gaps
Hospital or Health System	» **Significant IT investments (EHR and personnel) to support enterprise-wide solutions** » Longitudinal tracking of physician quality performance » Innovative practices to improve population health, such as a part-time employer-based primary care practice and a cafeteria redesign initiative to promote healthy eating » Movement toward value-based compensation structures in select organizations	» **Lack of value-based vision; payor contracts remain largely FFS, and there is minimal participation in accountable care organizations (ACOs), clinically integrated networks (CINs), and integrated delivery systems (IDSs)** » Limited risk readiness; according to ECG's VBRA, most partner organizations are not yet ready to successfully engage in VBP » Insufficient primary care resources; near-full panels result in access challenges » Limited staff to support care management » Inconsistent use of the RHIO due to variability in accuracy and actionability of information » Thin operating margins » Highly manual data processes (analysis, reporting, and measurement) » Largely productivity-based compensation structures; where performance-based bonuses are in place, they are relatively small in size (<10%–15%) » Underdeveloped physician training and education infrastructure

II. Strengths and Gaps

By Organization Type *(continued)*

Organization Type	Strengths	Gaps
FQHC	» **Comprehensive, well-established, integrated service offerings, including primary care, behavioral health, dental, pharmacy, laboratory, nutrition, and other services** » PCMH accreditation; provision of patient-centered team-based care » Strong interest in pursuing VBP; buy-in from leadership » Innovative practices (telehealth, Plan-Do-Study-Act [PDSA] rapid-cycle improvement processes) » Enterprise-wide use of certified EHRs	» Minimal payor interest in VBP; FQHCs struggle to engage in P4P and shared savings arrangements » **FQHC IPAs created to support contract negotiations are immature with minimal joint contracting** » Lack of medical and behavioral health documentation integration » Communication with external organizations remains a challenge and is largely manual; as a result, care transitions are not well coordinated

II. Strengths and Gaps

By Organization Type *(continued)*

Organization Type	Strengths	Gaps
Health Home and Behavioral Health	» Comprehensive mental health and substance use disorder treatment offerings, including inpatient detox and rehab beds, outpatient individual and group programs, crisis stabilization initiatives, and medication-assisted treatment (MAT) » **Colocation of behavioral health and primary care** » Use of evidence-based protocols (trauma training, SBIRT, MAT, etc.) » Willingness to assume risk; buy-in from organizational leadership » Strong hospital/health system partnerships to streamline referrals and improve care transitions	» External care is poorly coordinated and care plans are not communicated across provider organizations; limited interorganizational data sharing systems in place. » **Payment is largely FFS; minimal experience with VBP outside of capitated care management payments: "MCOs are not ready for behavioral health VBP."** » Risk stratification tools are lacking. » **Multiple, distinct documentation systems are used internally; medical and behavioral health platforms often cannot communicate with one another.** » Use of the RHIO is inconsistent. » Significant behavioral health staff shortages result in a highly leveraged APC model

II. Strengths and Gaps

By Organization Type *(continued)*

Organization Type	Strengths	Gaps
Post-Acute Care (PAC) and LTC	» **Extensive experience in and comfort with palliative care and end-of-life discussions** » **Ability to leverage administrative (front desk) staff to pull information from the RHIO to maximize efficiency and practice at top of license** » Success using telehealth remote psychiatry in select organizations	» Financial instability; operating margins are <1%, and facilities have been closed. » Due to delayed and limited payment from managed LTC payors, LTC and PAC providers cannot afford to invest in VBP (care management, analytics, etc.). » Providers and payors are not ready to engage in VBP. » Compensation is not aligned with value-based goals. » **Partners utilize a hybrid of paper documentation and EHRs**. » **The LTC IPA does not yet provide defined services (contracting or other).** » Significant workforce shortages exist, including nurses, medical assistants, therapists, home health providers, and DD providers.

II. Strengths and Gaps

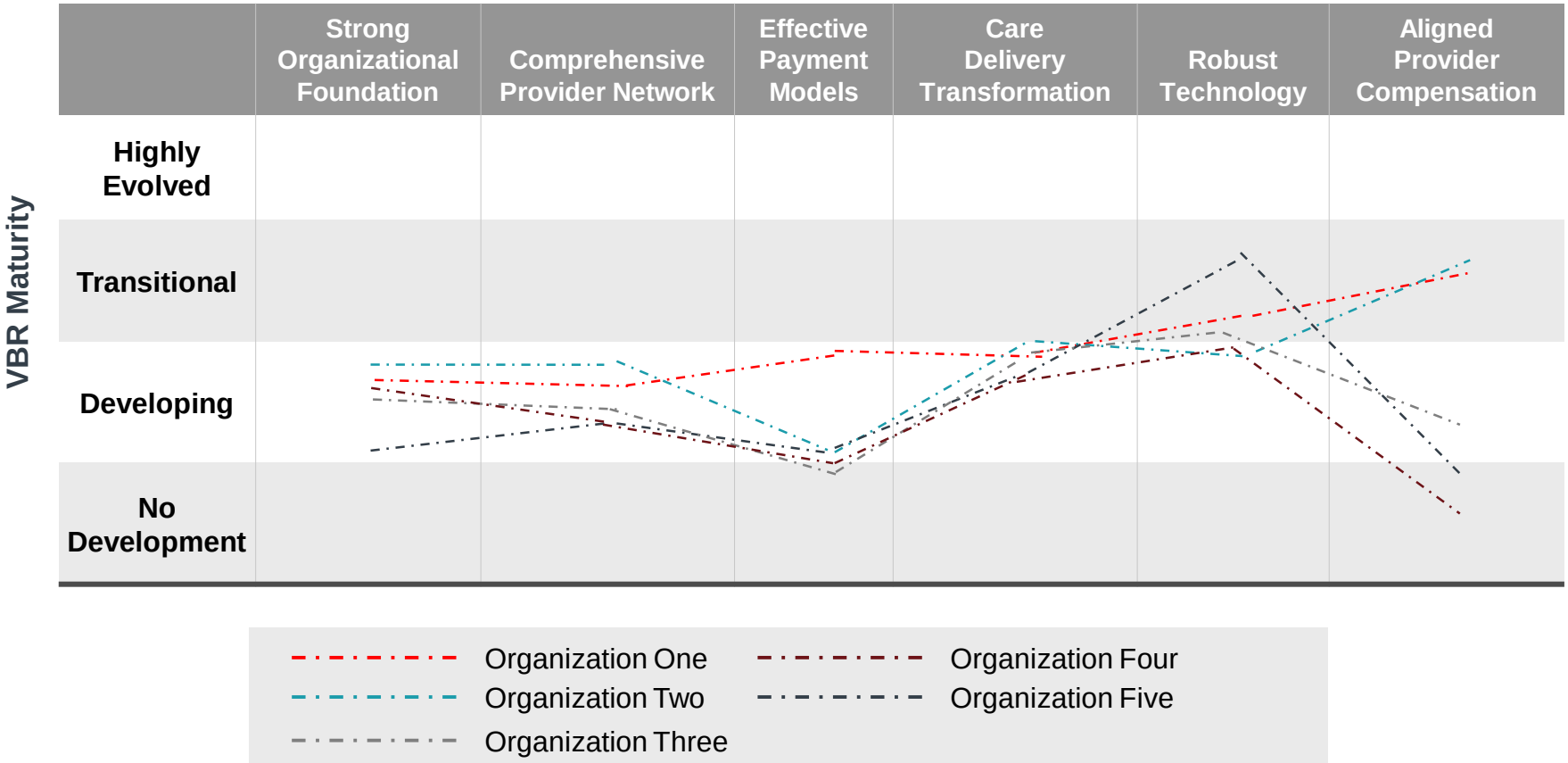
By Organization Type *(continued)*

Organization Type	Strengths	Gaps
CBO	» Extensive utilization of community health workers, navigators, and case managers » **Belief that the partnerships created through CNYCC have the ability to support long-term sustainability**	» The majority of interviewed CBOs feel that they lack the capacity and resources to engage in VBP › Most CBOs lack the skill sets to collect and measure quality and cost performance in the context of the social determinants of health › Most do not have a granular understanding of costs of services › Most lack sustainable business models and funding structures › Compensation is not value-based » **There is a lack of understanding regarding the role of CBOs under VBP** » CBOs articulated that there is a cultural disconnect between clinical providers and CBOs, limiting collaboration

II. Strengths and Gaps

Summary Results: Comparative Analysis

Comparing organizational scores provides insight into CNYCC's partner organizations' value-based market competitiveness.



Each organization above will receive an individualized VBRA report with additional detail and recommendations for closing high-priority gaps.

III. Service Opportunities

Partner Feedback

ECG requested partner input to help shape CNYCC's future service offerings and promote value-based readiness. Potential services have been segmented by role: care coordination, population health management, and service aggregation.

Care Coordination

- **Consider the provision of centralized care coordination resources** to fill gaps where they exist.
- **Focus on functional gap areas** such as transportation management to reduce no-show rates.
- Facilitate **electronic, interorganizational care coordination and planning** through the provision of tools and best practices via IBM Watson.

III. Service Opportunities

Partner Feedback *(continued)*

Population Health Management

- **Partners do not have a good understanding of IBM Watson's functionality.** Provide comprehensive education (demonstrations and trainings) surrounding IBM Watson, including the benefits it will offer to each partner organization.

- **Offer a comprehensive analytics service**, including:
  - Data aggregation and integrity.
  - Data analysis, including benchmarking and predictive modeling.
  - Synthesis of findings and identification of areas for improvement.
  - Reporting that can be sent to payors to support VBP.
  - Provision of services to address needs.

- Serve as a communication platform to **enhance the referral process**.

- Support total cost of care analytics via the **provision of claims data and analytic insight**.

III. Service Opportunities

Partner Feedback *(continued)*

Service Aggregation

- **Offer analytics, tools, and services to support strategic planning.** If organizations are not incorporating value-based goals into the highest level of planning, it is unlikely that they will be engaged in day-to-day transformation efforts, such as improving quality performance and attending PPS events.
- **Promote cultural changes required for medical providers (acute and long term) and CBOs to work collaboratively.** Medical providers have limited knowledge of CBO services. Organize opportunities for medical providers to better understand the services offered by CBOs (e.g., meet and greets, educational materials).
- **Provide VBP innovation resources to pilot ideas, initiatives, and tools.** Such resources could take the form of small grants, offering resource-constrained organizations a low-risk environment to succeed and fail.
- Serve as a VBP advocate, working to **align performance metrics across payors**, including the state.

IV. Centralized Services Model

Goals

Key Objectives

CNYCC must plan for the future in order to:

- ***Optimize the performance of the partners under the DSRIP program and beyond by supporting their transition to operate successfully in a value-based environment.***
- Create a ***financially sustainable support model*** that provides short- and long-term ***strategic benefits to the partners***.
- Establish a vehicle for partners to access other ***network-based opportunities and fill network gaps***.
- Target the ***BH market for initial expansion***, drawing on CNYCC's reputation, capabilities, and model established for the DSRIP program.
- ***Subsequently expand services*** and offer them to other ***payors and providers***.

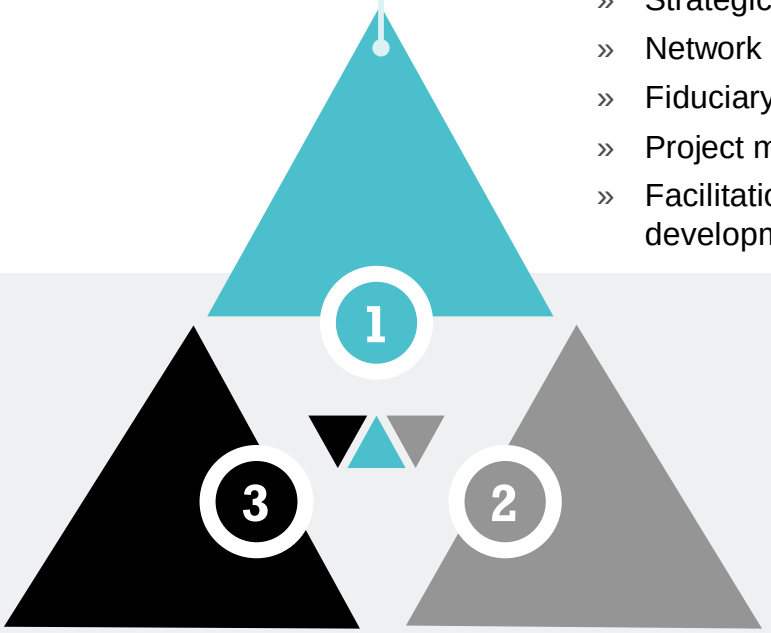
IV. Centralized Services Model

Centralized Offerings

To support value-based readiness and the region's long-term goal of achieving more coordinated care, CNYCC can work to develop centralized service offerings to benefit its community of partners and patients.

Strategy and Operations

- » Strategic planning
- » Network planning
- » Fiduciary responsibilities
- » Project management
- » Facilitation of collaborative care model development



Optional

- » Access to IBM Watson
- » Analytics and reports
- » Referral management

(Keepage & Leakage)

- » Navigation/ coordination services
- » Care management services
- » BH staffing

PHM System and Analytics

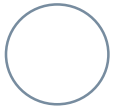
Care Coordination and Management

CNYCC and ECG are in the process of further developing this offering, including an analysis of staffing and related finances.

IV. Centralized Services Model

Implementation Phasing

We recommend phasing the implementation of service offerings, focusing on Medicaid programs first, adding-on Medicare and Commercial payers at a future state.

	Year One (2018)	Year Two (2019)	Year Three (2020)
Medicaid			
Medicare			
Commercial			

Legend: Uptake Assumptions

0% **25%** **50%** **75%** **100%**

Questions & Discussion

Appendix A
Care Model

Care Model

Overview

The initial care model for CNYCC broadly defines the way that services should be delivered across the PPS network. Services that CNYCC can accomplish centrally are on slide 9.

Standards and Protocols

- Develop and standardize the use of disease management, referral, utilization, and care management protocols.
- Enable Clinical Decision Support (CDS) at the point of care and monitor adherence to standards through quality metrics and other means.

Care Coordination

- Implement a care gap program and conduct outreach to patients to close care gaps.
- Conduct outreach to patients for Transitional Care Management (TCM) per the Medicare TCM guidelines.
- Link patients to needed social services available through community partners.
- Utilize the services of health homes.
- Conduct outreach to ED “frequent fliers.”
- Offer a central triage service.

Care Management

- Implement a Chronic Care Management (CCM) program per Medicare CCM guidelines.
- Implement a high-risk patient management program.
- Implement care plan development for some or all patients.
- Enable behavioral health and primary care integration.

Technology

- Conduct quality, cost, and utilization reporting.
- Generate registries for care gaps, high-risk patients, CCM patients, Annual Wellness Visits (AWVs), and ED frequent fliers.
- Develop care plans and document activity of care managers.
- Utilize HIT to improve the care transitions process.
- Participate in HIEs with ADT notifications and secure messaging enabled.

Care Model

Standards and Protocols

This initial care model is intended to roll up discrete DSRIP requirements into broader components that support all value-based contracts.

Standards and Protocols

- **Develop and standardize the use of disease management, referral, utilization, and care management standards and protocols.**
  - DSRIP Evidence-Based Medicine/Standards Requirements
    - 2.a.iii: Implement evidence-based medicine to address risk factor reduction (smoking cessation, immunizations, etc.) and chronic diseases.
    - 3.a.i: Develop evidence-based standards of care with behavioral health providers.
    - 4.d.i: Provide timely, continuous, and comprehensive prenatal care services to pregnant women in accordance with NYS Medicaid prenatal care standards and other professional guidelines.
  - DSRIP Protocol Requirements
    - 2.b.iv: Develop standardized protocols for assisting patients in addressing the key causes of readmissions, including diagnosis, social concerns, and access to PCPs.
    - 3.a.i: Implement behavioral health screenings as part of preventive care screenings.
    - 3.a.ii: Develop close linkages with HHs, ED, and hospital services to develop and implement protocols for ED and inpatient diversion (for BH patients).
    - 3.a.ii: Develop community and facility consensus on behavioral health treatment protocols.
    - 3.b.i: Engage PCPs in actions to optimize patient reminders and supports, including development of protocols for home monitoring.
    - 4.d.i: Ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for smokers.
  - DSRIP Guideline Requirements
    - 3.b.i: Engage at least 80% of PCPs in Million Hearts Hypertension Control Challenge guidelines, including actions to improve medication adherence such as use of once-daily regimens or fixed-dose combinations.
    - 3.g.i: Develop clinical guidelines agreed to by all partners, including services and eligibility such as implementation of the MOLST DOH-5003 form and engagement of staff in palliative care competence training.
- **Enable Clinical Decision Support (CDS) at the point of care and monitor adherence to standards through quality metrics and other means.**
  - DSRIP Requirements
    - 3.b.i: Engage at least 80% of PCPs in Million Hearts Hypertension Control Challenge guidelines, including EHR-based tobacco counseling.

Care Model

Care Coordination

This initial care model is intended to roll up discrete DSRIP requirements into broader components that support all value-based contracts.

Care Coordination

- **Implement a care gap program and conduct outreach to patients to close care gaps. The care gap program may focus on: Annual Wellness Visits (Medicare), routine preventive visits (Medicaid/DSRIP), and visits for patients with specific conditions/health states such as hypertension, elevated BP, pregnancy, or non-utilizing/low-utilizing status (Medicaid/DSRIP).**
  - DSRIP Requirements:
    - Supports all registry- and condition-management DSRIP requirements highlighted in the Care Management and Technology sections. For example:
    - 3.b.i: Engage PCPs in actions to optimize patient reminders and supports, including generating lists of patients needing visits.
    - 2.d.i: Work with MCOs to engage non-utilizing (NU) and low-utilizing (LU) enrollees.
- **Conduct outreach to patients for Transitional Care Management (TCM) per the Medicare TCM guidelines.**
  - DSRIP Requirements: N/A
- **Link patients to needed social services available through community partners.**
  - DSRIP Requirements
    - 4.d.i: Refer high-risk pregnant women to home-visiting services in the community.
    - 4.d.i: Reinforce health education and healthcare service utilization, and enhance social support to high-risk pregnant women from partners throughout the care continuum.
    - 2.a.i: Utilize community health workers, peers, and community-based organizations to help with outreach and navigation.
    - 3.b.i: Engage PCPs in actions to optimize patient reminders and supports, including referrals to community-based programs.

Care Model

Care Coordination *(continued)*

This initial care model is intended to roll up discrete DSRIP requirements into broader components that support all value-based contracts.

Care Coordination *(continued)*

- **Utilize the services of health homes.**
  - DSRIP Requirements:
    - 2.b.iv: Develop transition protocols to include processes for patients eligible for HHs, coordination of social services, early notification of planned discharges, and ability for transitional case manager to develop care plans with the patient during the hospital stay, including care record transitions and timely updates by the PCP and others.
    - 3.a.ii: Develop close linkages with HHs, ED, and hospital services to develop and implement protocols for ED and inpatient diversion (for BH patients).
- **Conduct outreach to ED "frequent fliers."**
  - DSRIP Requirements
    - 2.b.iii: Use patient navigators to help patients in emergency departments (EDs) find and make appointments with primary care providers (PCPs) and community resources.
- **Offer a central triage service.**
  - DSRIP Requirements
    - 3.a.ii: Offer central triage service utilizing a concurrence of community providers.

Care Model

Care Management

This initial care model is intended to roll up discrete DSRIP requirements into broader components that support all value-based contracts.

Care Management

- **Implement a Chronic Care Management (CCM) program according to Medicare guidelines.**
  - DSRIP Requirements: N/A
- **Implement a high-risk patient management program.**
  - DSRIP Requirements
    - 3.a.i: Implement the specific elements of the IMPACT program, including integrated care managers, depression care managers, designated psychiatrists, outcome measurements, and step treatment.
    - 3.b.i: Engage at least 80% of PCPs in Million Hearts Hypertension Control Challenge guidelines, including actions to improve delivery system design such as use of care coordination teams.
    - 4.d.i: Implement innovative models of prenatal care such as CenteringPregnancy that are demonstrated to improve preterm birth rates and other adverse pregnancy outcomes.
    - 4.d.i: Provide clinical management of preterm labor in accordance with current clinical guidelines.
- **Implement care plan development for some or all patients.**
  - DSRIP Requirements
    - 2.a.iii: Develop comprehensive care plans for high-risk patients.
    - 3.a.i: Utilize care managers to integrate care planning between primary care and mental health providers.
- **Enable behavioral health and primary care integration.**
  - DSRIP Requirements
    - 3.a.i: Develop BH services on site at 2014 NCQA Level 3 PCMH or Advanced Primary Care models and primary care services at BH practices by identifying BH providers interested in collaborating and conducting a community assessment of the most efficient care delivery plan.
    - 4.a.iii: Expand efforts with DOH and OMH to implement "Collaborative Care" in primary care settings throughout NYS.

Care Model

Technology

This initial care model is intended to roll up discrete DSRIP requirements into broader components that support all value-based contracts.

Technology

- **Routinely conduct quality, cost, and utilization reporting.**
  - DSRIP Requirements
    - 2.a.iii: Utilize a dashboard of outcome metrics to monitor care provision and implement rapid cycle improvements.
- **Generate registries for care gaps, high-risk patients, CCM patients, AWVs, and ED frequent fliers.**
  - DSRIP Requirements
    - 2.a.iii: Use EHR registries and other community data to identify high-risk patients.
    - 3.b.i: Engage at least 80% of PCPs in Million Hearts Hypertension Control Challenge guidelines, including actions to improve delivery system design such as use of registries.
- **Develop care plans and document activity of care managers.**
    - 3.b.i: Engage at least 80% of PCPs in Million Hearts Hypertension Control Challenge guidelines, including actions to optimize patient reminders and supports, such as documentation of patient self-management goals in the EHR.
- **Utilize HIT to improve the care transitions process.**
  - DSRIP Requirements
    - 3.a.i: Utilize a shared EHR for primary care and BH.
    - 3.a.ii: Utilize EHR and HIE connectivity to exchange information for behavioral health crisis patients.
    - 4.d.i: Utilize HIT to facilitate more robust intake/enrollment, screening/risk assessment, referral, follow-up, and care coordination practices across health and human service providers, including HHs where applicable.
    - 2.b.iii: Establish linkages between participating EDs and PCPs.
- **Participate in HIEs with ADT notifications and secure messaging enabled.**
  - DSRIP Requirements
    - 2.a.i: Participate in local HIE, RHIOs, and SHIN-NY, including supporting notifications and secure messaging by year three.
    - 2.a.iii.: Implement instant messaging and alerts to share clinical information across the PPS.