Agenda

• Welcome and Introductions
• Overview of Why We’re Here and What We Plan to Do Today
• Changing Environment - Developing and Validating Shared Assumptions
• FLPPS Today: Sharing a Vision for FLPPS - Current State and Future Potential
• FLPPS Central Services and Value Proposition
• Transformation Via DSRIP $
• Your Role and What This Means to You and Your Organization
• Review Outcomes and Next Steps
Overview

Why We’re Here and the Plan for Today
A unique opportunity

Taking care of our communities requires collaboration.

And improving the health and wellness of our neediest individuals and families demands not just collaboration, but also connectivity, innovation and a shared sense of purpose.

That is why you are here today!

This will require us to work together differently than we have in the past
Journey to Transform Medicaid is Slow and Methodical

**Focus on Maximizing Award**
- Formed Single PPS
- Drove Project Design/Data Collection
- 2nd Highest Score in State

**Engaging/Supporting Organizations**
- Assisted hundreds in VAP applications
- Attestation Signatures

**CNA**
- Understand our community and its core healthcare needs
Destination:
Value-Add Network
Working with Payers
to Create Change for a
Vulnerable Population

Building Relationships
Real Change
Project Success

Implementation Plans
Ensuring Milestones are
Achievable
Dealing with Delays

Informing DOH as Thought Leader
Funds Flow Models
Contracting Models
Promoting Goal of Provider
Alignment and Success

HIT Plan
Understanding Network
Needs and Working to
Help Ensure Value
A unique opportunity

- **History of collaboration** in the Finger Lakes region
  - Health Homes, CMMI
- **A federal investment** that can be leveraged to redesign care delivery and improve the health of our patients who have great needs and often little resources
- **A chance to think outside the box** to solve tough problems
- **Serious challenges**
  - How will we maximize the efficient use of limited resources and develop shared services?
  - How do we consider aggressively reducing and avoiding duplication among the FLPPS network and providers across the region for Medicaid services?
- Uncertain funding
To work differently...

DSRIP and the Performing Provider System structure requires us to jointly:

• Develop a clear decision-making process
• Build trust in the midst of little information and changing landscape
• Increase accountability and transparency when we barely know ourselves
• Establish common goals and initiatives when we all get paid differently
• Build the foundation of a coordinated and integrated delivery network for Medicaid and uninsured across a 13 county region
How do we...?

– Decide what we want FLPPS to be; develop a clear vision for its value proposition and role within the larger ecosystem?

– Ensure the decisions, initiatives and daily activities of FLPPS align with our organizational strategies and visions, and those of our partner organizations?

– Develop the competencies and capacity to transform and continuously improve operations and patient care for the Medicaid population?

– Build the transformation of care delivery, including new administrative and clinical services, into a capitated payment system?

– Effectively measure performance and ensure progress toward the strategy and vision for FLPPS at all levels?
Goals for today

• Further develop **relationships** across the FLPPS providers and CBOs to facilitate collaborative work
• Develop **common assumptions** around how changes to Medicaid, coverage expansion and DSRIP will impact our providers
• **Level the playing field** – understand key decisions and governance requirements and options
• Develop **options** for how the co-leads and the FLPPS region overall may engage in transformation over the next five years
• Prepare for and make **progress** toward the DSRIP Implementation Plan due on March 1st
Environmental Change

Developing and Validating Shared Assumptions
HEALTH REFORM BEGAN BEFORE ACA AND WILL CONTINUE

“The ACA was built on tracks that were already laid down. Who's going to stand in the way of the progress we've made?”

Richard Umbdenstock, President + CEO
American Hospital Association (MGMA-ACGME Panel, San Antonio, TX)
General Environmental Change Assumptions

- Financial/market pressures will make fee for service, fragmented care unsustainable.
- There will be a transition to capitated or alternative value-based payments.
- Safety Net members/patients will churn between charity care/sliding fee scale programs, Medicaid, Basic Health Plan, CHIP and Exchange.
- DSRIP projects will invest significantly in care delivery transformation and new services for safety net providers and patients/members.
- These services must become financially sustainable within a capitated payment arrangement with the state or one or more managed care organizations.
DOH’s Vision for Medicaid Post-DSRIP

Relationships, guidelines, incentives will change:

- **State** – Stable budget via premium payment, improved outcomes and member satisfaction
- **Members** – Empowerment and enhanced access
- **Physicians** – Narrow networks, care coordination, reporting, payment for outcomes/experience
- **Hospitals** – Same as physicians, plus reduced admissions and ED visits, real changes to core business model
- **Long-term care** – Shift to home and community-based services
## Anticipated Market Changes

| Long-term care | Shift to home-based services  
<table>
<thead>
<tr>
<th></th>
<th>Shift to community-based services</th>
</tr>
</thead>
</table>
| Physicians     | Narrow network  
|                | Care coordination  
|                | Payment for outcome |
| Hospitals      | Narrow network  
|                | Care coordination  
|                | Payment for outcome  
|                | Reduced admissions/ED visits  
|                | Changes to core business model |
Perspectives: Patients/Members

- Large increase in covered population may mean pent-up demand, but also less money per member will put pressure on the current high-cost model of care
- Increased diversity and aging population
- Increased choice and empowerment
- Demand for value, ease of use and positive experience
- Expect access to health information
Perspectives: Providers

- Want to be at the front of the food line for $$$
- How do I improve patient/member experience?
- Trying to “capture” lives and taking more risk
- Increasing competition and consolidation – cost reduction and enhanced care coordination/rationalization
- Transition from hospital-based to ambulatory care and moving into more home visits and care models
- More aggressive care management programs
- Traditional physician practices → PCMH
  - Teams practicing at top of license
  - Standardized guidelines, e-consult, telemedicine, centralized processes and tools
- Increased expectation for reporting and documentation to support RAF scores and demonstrate value/quality – and now the move toward more skin in the game for patient/member experience
Perspectives: Health Plans

• Bigger players, more lives, more power, more needs/demands from providers - in FLPPS players with significant market power

• Quality, performance metrics and reporting – shift from risk factors to customer experience for payment

• Large integrated delivery networks – health plans are usually happy to push down clinical risk, especially with delegated groups because those groups’ administrative costs don’t count toward medical loss ratio and they can play with the division of financial responsibility to disadvantage the providers

• Why didn’t the contracting in the ’90s and early 2000s work well for providers?
Perspectives: New York DOH and CMS

• Hey, we really like this whole idea of having budget certainty and projections that are more consistent rather than wondering what fee-for-service claims will look like each year...

• And by the way, we want a share of the savings generated by members, providers and health plans

• Shift in payment toward member experience and quality outcomes, less weight for complexity appears to be a trend

• Increased focus on fraud and abuse

• Incentivizing, and sometimes partnering on, innovations – DSRIP!
What does all this mean for us?

- Payment change is coming—NY spends more than twice as much as California on Medicaid per beneficiary (2012 Total Medicaid Computable Spending)

<table>
<thead>
<tr>
<th>Location (rank)</th>
<th>Aged</th>
<th>Disabled</th>
<th>Adult</th>
<th>Children</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>California (51)</td>
<td>$9,844</td>
<td>$15,891</td>
<td>$1,136</td>
<td>$1,585</td>
<td>$3,441</td>
</tr>
<tr>
<td>New York (2)</td>
<td>$21,931</td>
<td>$30,288</td>
<td>$4,465</td>
<td>$2,580</td>
<td>$8,910</td>
</tr>
</tbody>
</table>

- State and health plans want to put providers at risk and reduce total cost per member for more covered members

- DSRIP performance dollars and the state-funded capital investment dollars represent a one-time opportunity to redesign systems of care and payment

Your mission

Provide higher quality care for
FEWER TOTAL DOLLARS ANNUALLY PER MEMBER
Key Takeaways

Fewer dollars per member per year in the market
Major transition from fee for service to managed care
Care coordination and ability to manage population health are key to success
Reimbursements tied to consistent quality, cost-effective care delivery and member experience
Fierce competition and/or collaboration among health plans, hospitals and medical groups to cover new managed care lives

This is not your parents’ managed care experience
The ’90s were full of wishful thinking capitated experiences. DSRIP can fund the tools and knowledge we need for success in managing risk
FLPPS Service Area

- Western
- Monroe
- Finger Lakes
- Orleans
- Genesee
- Wyoming
- Livingston
- Allegany
- Sullivan
- Chemung
- Elmira
- Rochester
NOCN Workgroup Composition

Care setting spectrum

- Primary Care Physician Representative
- NON-PCP Practitioner (MD, NP, DDS, PA, etc.) Representative
- Hospital (Acute Care) Representative
- Clinic (FQHC) Representative
- Health Home/Care Management Representative
- Behavioral Health and/or County Mental Health Representative
- Substance Abuse Representative
- Skilled Nursing Facility/Nursing Home Representative
- Home Care Representative
- County Health Department Representative
- Pharmacy Representative
- Hospice Representative
- CBO Representative
- Transportation Representative
- Developmental Disabilities Representative
- Housing Representative
- HR Representative (Optional)
- Medicaid Member Representative
- Other
FLPPS NOCN Workgroup Leadership

- **Finger Lakes NOCN**
  - Mary Zelazny, Finger Lakes Community Health
  - Marty Teller, FLACRA

- **Monroe NOCN**
  - Bob Lebman, Huther Doyle
  - Janice Harbin, D.D.S., Anthony Jordan Health Center

- **Southeastern NOCN**
  - Jan Eberhard, M.D., Arnot Health
  - Rosemary Anthony, Arnot Health

- **Southern NOCN**
  - Eva Benedict, Jones Memorial Hospital
  - Andrea Haradon, S2AY Rural Health Network

- **Western NOCN**
  - Dan Ireland, UMMC
  - Jim Cummings, Oak Orchard
FLPPS Operations Committees

• **Finance Committee**
  – Adam Anolik, CFO, Strong Memorial Hospital/URMC
  – Tom Crilly, CFO, Rochester Regional Health System

• **IT Committee**
  – Michael Larche, IT, Rochester Regional Health System
  – Nancy Bales, IT, Strong Memorial Hospital/URMC

• **Clinical Committee**
  – Marc Berliant, M.D., Strong Memorial Hospital/URMC
  – Michael Nazar, M.D., Rochester Regional Health System
FLPPS Operations Workgroups

- **Workforce**
  - Kathy Rideout R.N. Ed.D., UR School of Nursing
  - Daniel Ornt M.D., Rochester Institute of Technology
- **Transportation**
  - Patrick Rogers, Institute for Human Services
  - William McDonald, Medical Motors
- **Cultural Competency and Health Literacy**
  - Lenora Rose, Coordinated Care Services, Inc.
- **Housing**
  - Kelly Luther, URMC
  - Kathy McGuire, Rochester Regional Health System
  - Gloria Harrington, Family Service Communities
Vision for FLPPS

Future Potential
**FLPPS Principles**

- **Focus on the Patient**
  All decisions are weighed against the question – “How will this impact the member/patient’s health care needs and cultural and linguistic preferences, enabling provision of the right care, at the right place, at the right time?”

- **Strong Physician and Provider Leadership**
  Physicians and other practitioners have representation and deep engagement in governance and leadership.

- **Accountability, Transparency and Trusting Partnerships**
  Clear and open partnerships with regular, proactive communication to support the design and implementation of truly cost-effective, best practice care delivery.

- **Adaptability**
  Develop the ability to continually transform based on patient needs and environmental changes. Recognize that there is no best, *there is only better*.

- **Capacity & Capability for Managed Care of a Population**
  Develop the ability to manage members/patients across the continuum of care with varying disease states, health care and social needs
Strategies

• **Leverage DSRIP projects** as a way to invest in key initiatives and the development of a core care coordination infrastructure

• **Transform medical management**, standardize care processes, & share key health information at point of care, reducing duplicative admin and other MSO services and costs to the extent possible

• **Medicaid members identify** FLPPS as a robust health care network

• **User-friendly for providers** – all tools and resources are easy to use, effective and meaningful (value driven)

• **Improve population health and achieve savings** through improved access, higher quality and lower total cost - reducing overall PMPM cost for Medicaid patients

• **Generate savings for FLPPS and providers** to achieve sustainability
Commonwealth Fund’s Attributes of High Performing Health Systems

“Fifteen Care Transformational Leaders”

• Patients’ clinically relevant information is available to ALL providers at the point of care

• Patient care is coordinated among multiple providers, and transitions across care settings are actively managed

• Providers (all members of the care team) both within and across settings have accountability to each other, review each other’s work, and collaborate to reliably deliver high quality, high value care

• Patients have easy access to appropriate care and information; there are multiple points of entry; and providers are culturally competent and responsive

• There is clear accountability for the total care of patients

• The system is continuously innovating and learning in order to improve the quality, value, and patients’ experiences
Additional Critical Success Factors:

- Value-Driven Governance and Leadership
- Physician Leaders Deeply Engaged and Accountable at all Levels
- Transparency and Trust
- Financial Integration, Alignment of Financial Incentives
Transition from Current to Future State

• **DY 1 – DY 3**
  - DSRIP payments serve as new investment funds
  - Separate from current MCO/FFS Medicaid payment streams to providers

• **DY 3 – DY 5/beyond: FISCAL TRANSFORMATION**
  - Traditional Medicaid costs declining due to reduced ED visits and hospitalizations
  - FLPSS contracts with MCOs/NYS for new services that have proven to be successful in containing costs
  - FLPPS, as a provider network, must consider new arrangements with MCOs – shared savings contracts, risk contracts based on total medical spend per Medicaid beneficiary
Build a population health management entity capable of supporting PPS partners in reducing total PMPM cost for Medicaid members and benefiting from the resultant savings across the approximately $1.3 billion spent annually in our region.
FLPPS Core Services

- RHIO Integration/HIE and Bi-Directional Services
- Care Management, Care Coordination Platform and Secure Messaging
- Data Warehouse with Predictive Analytic and Modeling Capabilities
- Call Center and Warmline
- FLPPS User and Member Portal
- Quality Dashboards and DSRIP Reporting
- Customer Relation Management Service
**Level 1:** Partners will support patient care through the implementation of these IT services/capabilities to ensure patients receive appropriate quality, while reporting on individual partner metrics.

**Level 2:** FLPPS will support partners and patients with this array of services to help ensure the entire PPS is able to successfully report on and achieve DSRIP metrics.

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**PARTNER CAPABILITIES**

- Care Coordination
- HIE/RHIO/SHIN-NY (Partner & PPS)
- EMR
- IT Infrastructure
- Consent Management
- Patient Portal

**PPS CAPABILITIES**

- Information Security
- PPS level Patient Portal
- CRM
- Data Management Platform
- Call Center/IT Support
- Analytics Platform
- Performance monitoring
- Dashboards & Registries
- Reporting
- Advanced Analytics
RHIO Integration and HIE

- Single online resource for patient information from multiple sources consolidated into a longitudinal record for each patient
- Makes critical information available so providers can more effectively care for their patients
- Saves time chasing down reports, faxing, and manually logging into multiple portals
- Reduces unnecessary procedures and tests
- Reduces time spent gathering history from patients
Care Management/Care Coordination Platform

- Provider messaging and alerts
  - Provider-to-provider secure messaging
  - Distribution of discharge plans to step-down level of care and PCP
  - ED to clinic/PCP messaging and alerts
  - Inpatient admission to clinic/PCP messaging and alerts
- Secure messaging and e-referral with standardized guidelines
  - Phase II would enable e-authorization
- Care management and care navigation/enrollment
  - Standardized care management processes, protocols, templates and tools specific to Medicaid members and uninsured
    - Chronic disease, high risk and mental health care management
  - Centralized outsourced navigation services, including enrollment processes, protocols, templates, tools and training
  - Health risk assessments and care plan development
Data Warehouse

- Focus on Medicaid and uninsured clinical and claims/administrative data
- Risk stratification
- Modeling for eligibility for high risk, chronic care, other care management
- Pharmacy medication reconciliation/management
- Predictive analytic and modeling capabilities
- Disease registry functionality
  - FLPPS-required data reporting
  - Targeted tracking and management of chronic conditions such as diabetes
Call Center

• Crisis stabilization
• Member relations
• Call center and after-hours warmline
• PPS Resource Directory & Navigation Assistance for CBO, community services, medical care referrals
• Health coverage and special programs eligibility support and referrals
FLPPS
FINGER LAKES PERFORMING PROVIDER SYSTEM

Transformation Via DSRIP $
FLPPS DSRIP Projects

1. Integrated Delivery System
2. ED Triage for At-Risk Populations
3. 30-Day Readmission Care Management
4. Transitional Housing
5. Behavioral Health Integration with PCMH
6. Crisis Stabilization
7. Behavioral Health in Nursing Homes
8. Nurse Family Partnership
9. Overall Health and Wellness
10. Improving Behavioral Health and Substance Abuse Treatment
11. Implementation of Patient Activation Activities to Engage Uninsured and Low Utilizing Medicaid in Community Based Care
Earning DSRIP Payments

• Not distributed evenly from year to year

<table>
<thead>
<tr>
<th>Funding Breakdown</th>
<th>DY 1</th>
<th>DY 2</th>
<th>DY 3</th>
<th>DY 4</th>
<th>DY 5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSRIP Annual Funding %</td>
<td>15.84%</td>
<td>16.88%</td>
<td>27.29%</td>
<td>24.16%</td>
<td>15.84%</td>
<td>100%</td>
</tr>
</tbody>
</table>

• Two types of payments:
  • PPS Infrastructure Development: Pay for Reporting (P4R)
  • Clinical Improvement and Health Outcomes: Pay for Performance (P4P)

• Funding Domains:

<table>
<thead>
<tr>
<th>Domain</th>
<th>P4R</th>
<th>P4P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Project progress milestones</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Domain 2: System transformation and financial stability milestones</td>
<td>7%</td>
<td>21%</td>
</tr>
<tr>
<td>Domain 3: Clinical improvement milestones</td>
<td>6%</td>
<td>21%</td>
</tr>
<tr>
<td>Domain 4: Population health outcome milestones</td>
<td>5%</td>
<td></td>
</tr>
</tbody>
</table>
Project Valuation for the PPS

**Project Value**

\[ \text{Project Value} = \left[ \text{Project PMPM} \right] \times \left[ \# \text{ of beneficiaries} \right] \times \left[ \text{project application score} \right] \times \left[ \text{DSRIP months} \right] \]

<table>
<thead>
<tr>
<th>Projects</th>
<th>Index Score</th>
<th>PPS Attribution Total</th>
<th>DSRIP Project Plan Application Score</th>
<th># of DSRIP Months</th>
<th>Maximum Project Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.a.i</td>
<td>56</td>
<td>250,000</td>
<td>0.95</td>
<td>60</td>
<td>$26,600,000</td>
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<tr>
<td>2.a.iii</td>
<td>46</td>
<td>250,000</td>
<td>0.88</td>
<td>60</td>
<td>$20,240,000</td>
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<tr>
<td>2.b.iii</td>
<td>43</td>
<td>250,000</td>
<td>0.92</td>
<td>60</td>
<td>$19,780,000</td>
</tr>
<tr>
<td>2.b.iv</td>
<td>43</td>
<td>250,000</td>
<td>0.81</td>
<td>60</td>
<td>$17,415,000</td>
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<tr>
<td>3.a.i</td>
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<td>250,000</td>
<td>0.94</td>
<td>60</td>
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<td>3.a.ii</td>
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<tr>
<td>3.b.i</td>
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<td>0.98</td>
<td>60</td>
<td>$14,700,000</td>
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<td>3.c.i</td>
<td>30</td>
<td>250,000</td>
<td>0.81</td>
<td>60</td>
<td>$12,150,000</td>
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<td>4.a.iii</td>
<td>20</td>
<td>250,000</td>
<td>0.83</td>
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<td>$ 8,300,000</td>
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<td>4.b.ii</td>
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<td>250,000</td>
<td>0.80</td>
<td>60</td>
<td>$ 6,800,000</td>
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<td>2.d.i</td>
<td>56</td>
<td>125,000</td>
<td>0.87</td>
<td>60</td>
<td>$12,180,000</td>
</tr>
</tbody>
</table>

| Total DSRIP Project Valuation | $171,665,000 |

*This example PPS can earn $171,665,000 in DSRIP Funding across the five-year demonstration period.*
Plan for Meeting Domain 1 Requirements

Plan

PPSs to specify how many sites will have met all of the Domain 1 requirements

Quarterly Reports

Every quarter the total number of providers for which 100% of the requirements are met should match the quarterly target laid out in the summary plan

Project Implementation Speed from FLPPS Application
Meeting Domain 1 Requirements Quarterly

Every quarter the total number of providers for which 100% of the requirements are met should match the quarterly target laid out in the summary plan.

<table>
<thead>
<tr>
<th>Providers</th>
<th>Current Report</th>
<th>Requirement 1</th>
<th>Requirement 2</th>
<th>Requirement 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Provider A&quot;</td>
<td>&quot;Provider B&quot;</td>
<td>Ensure appropriate location of the co-located primary care services in the ED...</td>
<td>Ensure that new participating PCPs meet NCQA 2014 Level 3 Medical Home standards or......</td>
<td>etc. etc.</td>
</tr>
<tr>
<td>&quot;Provider A&quot;</td>
<td>&quot;Provider B&quot;</td>
<td>Completion Date: DY3, Q4, Status: Not started</td>
<td>Completion Date: DY2, Q4, Status: Complete</td>
<td>% requirements complete: 20%, 100% complete: No</td>
</tr>
<tr>
<td>&quot;Provider C&quot;</td>
<td>&quot;Provider D&quot;</td>
<td>Completion Date: DY1, Q4, Status: Complete</td>
<td>Completion Date: DY2, Q3, Status: Complete</td>
<td>% requirements complete: 60%, 100% complete: No</td>
</tr>
<tr>
<td>etc.</td>
<td>etc.</td>
<td>etc.</td>
<td>etc.</td>
<td>etc.</td>
</tr>
</tbody>
</table>
Patient Engagement Plan

- Required to detail the number of patients who will become ‘actively engaged’ in each quarter
- Performance against these numbers will apply to Domain 1 Process payments
Partners Inform Implementation Planning

• Performing provider contracts will outline shared accountability for success
  – Responses to surveys on provider-specific commitments will be required for contract execution

• Partner survey will be released during the second week of February to understand:
  – When providers anticipate meeting each Domain 1 requirement for each project they are participating in

• In addition to the survey, the PPS will require an implementation plan per provider
## Funds Flow

<table>
<thead>
<tr>
<th>Budget Category</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administrative Costs for FLPPS</strong></td>
<td>15%</td>
</tr>
<tr>
<td>- Staffing the Project Management Office (PMO), PMO operations, running FLPPS and management of centralized services for DSRIP project implementation, and cost of DSRIP project implementation, including the development and management of centralized services.</td>
<td></td>
</tr>
<tr>
<td><strong>Revenue Loss and Sustainability Fund</strong></td>
<td>10%</td>
</tr>
<tr>
<td>- Support FLPPS providers who are essential to FLPPS success but may be at risk for financial losses and have exhausted all other financial resource options</td>
<td></td>
</tr>
<tr>
<td>- Make up for financial losses from unforeseen levels of utilization as we transition to value-based payments</td>
<td></td>
</tr>
<tr>
<td><strong>Contingency Fund</strong></td>
<td>10%</td>
</tr>
<tr>
<td>- Needs such as non-covered services, high costs for niche populations, need for specific population health expertise, termination of state funding streams, and other unforeseen levels of utilization</td>
<td></td>
</tr>
<tr>
<td><strong>Partner Share of Funds</strong></td>
<td>65%</td>
</tr>
<tr>
<td>- 85% based on attributed lives x complexity of chosen projects x performance on project metrics (consistent with distribution methodology to FLPPS but modified to reflect intra-FLPPS relative performance and projects chosen)</td>
<td></td>
</tr>
<tr>
<td>- 10% based on response to surveys, information requests, and engagement in planning and governance</td>
<td></td>
</tr>
<tr>
<td>- 5% for CBOs who do not have attributed lives but provide value-add services</td>
<td></td>
</tr>
<tr>
<td><strong>Bonus Funds</strong></td>
<td></td>
</tr>
<tr>
<td>- If FLPPS receives bonus funds from the state based on performance, those will be distributed to the underlying providers contributing to that performance</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100%</td>
</tr>
</tbody>
</table>
Funds Flow Based on Performance

**Flowchart Description**

- **DSRIP** funds are directed to the **FLPPS** (Finger Lakes Performing Provider System).
- **65%** of the funds go to the **Partner Share of Funds**.
- **10%** go to the **Revenue Loss & Sustainability Fund**.
- **10%** go to the **Contingency Fund**.
- **15%** go to the **Administrative Fund**.
- **FEE-FOR-SERVICE** payments are directed to Performing Provider Contracts.
- Process & Outcome Reports are generated to monitor performance.

**Key Terms**

- Performing Provider Contracts
- Alternate fund-flow mechanism

**FLPPS Performing Providers**
Provider Contracting for DSRIP

Performing Provider Contracts

- Attributed Lives (multiplier)
- Selected Projects (multiplier)
- Outcome achievement score (multiplier)
- Process Achievement Score (multiplier)
- Provider Engagement Score 10%

Domain 1 Process Reporting: Scale & Speed
Domain 2-4 Outcome Measures
Your Role

What Does This Mean to Me and My Organization?
Which DSRIP Project is Right for Me?

• DSRIP projects that can serve as the means to achieve your organization’s mission
• Note: NYS has defined the provider type per project
• Questions to ask when evaluating whether your organization is a good fit for a project:
  – Where does my provider type fit in the FLPPS project plan application (11 projects)?
  – Are the design elements in this project in line with my organization’s mission?
We Are a Network – If One Fails, We All Fail

• We are evaluated as a single unit; thus we must function as a collective
• Participation and engagement of providers is essential
• Learning about a network of 350 organizations will take time – NOCN groups will help with this
• Build on the network’s strengths and leverage opportunities for success
Keep an Open Mind

• Feedback and suggestions welcome
• Offer to get involved and take initiative
• Share best practices: next Summit will focus on learning from one another in a collaborative environment
• Welcome the change and challenge the status quo
Common Questions

• How will funds flow to me?
• What will be required of us in our contracts? When will those contracts be solidified?
• Why should I participate without knowing what funds I will get?
• How do I participate in the shared savings generated by successful implementation of the initiative and reduction in Medicaid costs?
• What do I do if I don't get the CRFP funds I need to succeed and meet speed and scale expectations?
• What is the role of the CBO? We have value but we don't feel like we are valued by FLPPS.
• How will the centralized FLPPS office and the money that is being spent on "administration" work to assist me as your partner?
• How will implementation be handled locally? Will we have local project teams? When will we be given direction on how to organize and do the work locally?
• What is the role of the centralized project team moving forward?
• What level of involvement will community-based healthcare providers have in the development of these implementation plans?
• Will providers still be paid on fee-for-service rates for PPS-eligible enrollees, or will there be some sub-capitation arrangements to achieve the value-based payment objectives?
Summit Breakout Topics

- Community and CBO engagement in System Transformation and Population Health Management
- Workforce Strategy and Impact
- Financial Sustainability and Funds Flow
- IT Systems, Data Sharing
- Performance Reporting
- Physician Engagement in DSRIP Implementation
- Patient-Centered Medical Home
- Health Home and ACO Models in Population Health Management
- 2.b.iii ED Care Triage for At-Risk Populations
- 2.b.iv Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Health Conditions
- 2.b.vi Transitional Supportive Housing Services
- 2.d.i (Project 11) Implementation of Patient Activation Activities to Engage, Educate and Integrate the Uninsured and Low/Non-Utilizing Medicaid Populations into Community-Based Cares
- 3.a.i Integration of Primary Care Services and Behavioral Health
- 3.a.ii Behavioral Health Community Crisis Stabilization Services
- 3.a.v Behavioral Interventions Paradigm in Nursing Homes (BIPNH)
- 3.f.i Increase Support Programs for Maternal & Child Health (including high risk pregnancies) (Example: Nurse Family Partnership)
Transportation Booth

- #1 barrier to access to care
- Submit a 1-page survey (located in folder) regarding challenges and opportunities
- Surveys can be turned into the "Transportation Table" outside the main meeting area