APRIL
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Value Based Payment Toolkit for Community Based Providers

PREPARED BY

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Overview of Toolkit: How to Use This Guide

In Spring 2020, Adirondack Health Institute (AHI) engaged Helgerson Solutions Group (HSG) to develop a Learning Series for community-based organizations to support their learning & readiness for value-based payment. Over the course of two webinars and two day-long training sessions, providers were given the opportunity to discover how the changing healthcare ecosystem in New York has opened the door for social care providers to become paid providers in the emerging new value ecosystem. This toolkit is meant to support the learning that happened and continue to inform the efforts of service providers in the AHI catchment area.

We have designed this toolkit to be an easy-to-use guide for you as you begin your journey into the value ecosystem that is emerging in New York State. We use the word "journey" because it is exactly that—there is no shortcut, no set of easy steps. You will have to venture out into the wilderness—the very edges of your organization and what you currently do—to find what you are looking for.

We highly suggest you read through this guide from start-to-finish, so that you can absorb the whole picture of the new landscape & then revisit the appropriate sections as needed.

Many resources we have provided to you within this document are "live," meaning they will inevitably be updated as time goes on. In these cases, we have selected to simply provide you with the link to the website, so that you can have access to the most up-to-date information as you reference these resources.

We specifically built this toolkit for providers within the AHI catchment area, so you will find extensive data analysis & maps that detail regional data available to you towards the back of the document.

We wish you the best of luck as you begin your journey towards value. We know that so many social care providers are providing high levels of value today—may this journey towards value bring your community to new heights through the invaluable work you do.

About the Playbook Authors

Juliette Price

Juliette Price is working to bring health care and social sector partners together in new ways to deliver results for end users.

Juliette previously served as the director of The Albany Promise, a cross-sector, collective impact partnership of 100+ organizations in Albany, New York that focused on improving economic mobility for the city's most vulnerable youth and families using shared vision, collective action, and rigorous continuous improvement. The partnership was widely recognized as leading the nation in the field of collective impact. Juliette was awarded the White House Champion of Change award in 2016 from the President Barack Obama Administration for her work in this field.

Previously, she worked for the Chancellor of the State University of New York, the nation's largest, most comprehensive system of higher education, managing various aspects of the education pipeline and multiple initiatives related to teacher education, statewide education policy, and led the development and implementation of the New York State Master Teacher Program, a program which created a state-wide network of the highest-performing STEM teachers that are dedicated to sharing expertise with peers and attracting the brightest minds to a career in STEM. She staffed Governor Andrew M. Cuomo's New NY Education Reform Commission, which brought together nationally-recognized education, community, and business leaders to recommend reforms to the state's education system in order to improve performance in the classroom so that all of New York's students are fully prepared for their futures.

Kalin Scott

Kalin Scott brings extensive background in public policy, specializing in areas including strategic planning, project management, Medicaid redesign, cross-sector initiatives, delivery system reform and value based payment. Kalin's previous experience includes more than ten years in various health policy roles with New York State. Most recently, Kalin served in a dual role as Director of New York's Medicaid Redesign Project Management Office and Assistant Director for Medical, Dental and Pharmacy policy. Over her eight years with New York's Medicaid program, Kalin served on the senior leadership team, responsible for nationally-recognized policy development and implementation strategies to ensure alignment and execution of the Medicaid program's key priorities. Prior to joining NYS DOH, Kalin worked in the New York State's Executive Chamber.

PART 1:

Understanding the Health Care Landscape Today

Health Care in 2020: Industry Context

The health care ecosystem is rapidly changing and with it the way services are paid for, but in order to deeply understand the opportunities and threats that exist in this new ecosystem, it is important to understand the context of the changes to and within the ecosystem.

1 Macro/Societal Trends

The macro/societal view includes forces that will shape all institutions and aspects of society. This view can include economic, political, environmental, social, demographic, and technological trends.

U.S. demographics are profoundly affecting society and social policy.

- The nation continues to grow more racially, ethnically, and culturally diverse.
- The recent three-year downturn in life expectancy in the U.S. is the longest decline in a century and is marked by disparities based on race, class, income, geography, and education.
- Health care and biomedical research are dependent on international students, trainees, and professionals, yet overall documented immigration is declining. Proposed policy changes would remove protections for the grown children of undocumented families.
- By 2030, Americans age 65 and older will make up 21% of the U.S. population, up from 15% today.
- Supreme Court decisions on immigration, race-conscious admissions, DACA, reproductive rights, and other areas may be disruptive.

Rising health care costs are unsustainable.

- Controlling for inflation, health care spending per capita has increased from $1,700 in 1970 to more than $10,700 in 2018.
- Policymakers, the press, and the public continue to express grave concerns about excessive costs and increasing doubts about value.
- Tomorrow's patients and payers will increasingly demand access to care at lower cost and greater convenience.
- Corporate interests are increasingly entering the marketplace (e.g., Amazon Care), creating potential threats and opportunities for traditional health care providers and the public.

A technological revolution has the potential to change education, research, and clinical care.

- Technological revolutions are occurring in five areas: gene editing, artificial intelligence (AI) and automation, quantum information science, brain-computer interfaces and augmented reality, and blockchain and cryptocurrencies.
- As precision medicine therapies and AI clinical decision support systems become more prevalent, the expectations of clinicians and the settings in which care is delivered will change.
- Such trends will require different skill sets from the ones physicians and researchers have now, with greater emphasis on data science, mathematics, statistics, and computational skills.
- Increasing use of technology may only heighten existing disparities and introduces new and more menacing security vulnerabilities.

2 The Environment for Patients, Families, and Communities

There is growing recognition that patient, family, and community engagement is important for the overall improvement and transformation of the health care system.

The cost of access is too high, and deficits persist in access and coverage.

- The cost of accessing health care remains out of reach for many Americans, particularly those in underserved and under-resourced communities and populations.
- Despite decades of attention, deficits in both access and coverage persist. This is especially true among people with the most severe socioeconomic challenges and in rural/frontier settings.

Health inequities are increasing; racism and bias are major factors.

- Increasing health inequities are adversely affecting low-income communities, rural/frontier communities, racial and ethnic minorities, sexual and gender minorities, veterans, and people with disabilities, among other groups.
- A growing corpus of research shows that racism, bias, and segregation are major factors in health care inequities.

Health care institutions are not sufficiently diverse.

- Recent research suggests teams that are more diverse are more effective.
- American health care, and particularly the leadership (including in academic health centers), remains insufficiently diverse.

Patient, family, and community perspectives and engagement contribute to innovation; partnerships with these groups are increasing across all academic medicine missions.

- Engagement and partnerships with patients, families, and communities can improve health equity, physician education, research, care experiences, quality, safety, and health outcomes.
- The number of meaningful partnerships in health care delivery and improvement is increasing among health care professionals, patients, families, and other caregivers.

Social risks and determinants of health cannot be ignored.

- Patient-level health-related social needs (HRSNs) and community-level social determinants of health (SDOHs) are potent forces in health.
- Of the factors that affect Americans' health, 60% are unrelated to health care or an individual's behavior and genetics but are, rather, related to social determinants of health.

Gun violence, the maternal mortality rate of women of color, the opioid epidemic, and the lack of mental health parity are national crises.

- The rate of gun-related deaths, the maternal mortality rate of women of color, and the climbing number of daily opioid-related overdoses are examples of public health crises.
- Awareness of the role of the medical community in both perpetuating and addressing these issues is increasing throughout the nation.
- Substance use disorders and the rising rate of suicides have increased attention to and concern about the need for more work toward mental health parity.

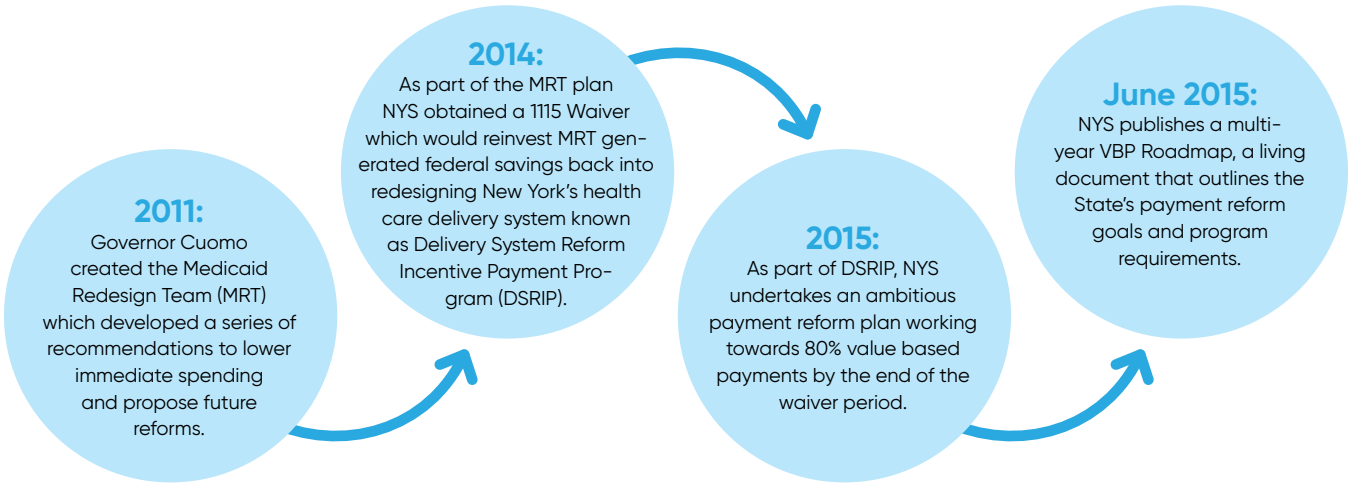
Patients and families want access to medical records and interoperability.

- The availability of medical information and patient records online has led to increasing demands for access to these records by patients and families (with the patient's permission).
- The proliferation of electronic health record systems has increased the desire for interoperability among them.

Adapted from the American Association of Medical Colleges.

New York State Context: Medicaid Redesign Team and Delivery System Reform Incentive Payment Program (DSRIP) & the Associated Learnings & Results

New York's current Delivery System Reform Incentive Payment (DSRIP) program, which ends March 31, 2020, focuses on transforming the state's health care delivery system and rewarding value over volume by reducing avoidable hospital use across the state, creating integrated delivery systems, and supporting the move toward value-based payment arrangements. New York based its first DSRIP request on the demonstrated success of the state's Medicaid program in bending the cost curve after the state generated $17 billion in federal savings and improved quality outcomes through Medicaid Redesign Team (MRT) initiatives dating back to 2011. CMS approved the initial DSRIP request in April 2014 and committed $8 billion of federal investment to DSRIP and DSRIP-related programs through March 2020.



25 Performing Provider Systems (PPS) – collaboratives of providers and community-based organizations assigned to specific regions in the state – are currently implementing population health, clinical improvement, and system transformation projects at a local level. The PPS earn performance payments once they achieve and report specific milestones and metrics. In addition, New York committed to shift 80–90% of all Medicaid managed care payments to value-based arrangements by March 202), as outlined in the state's VBP Roadmap. The program included a planning year (Year 0), five years of DSRIP program implementation, and ends in just a few months, in March 2020. Over the course of its implementation, New York worked with other states interested in implementing and expanding delivery reform system efforts, and Washington, Massachusetts, North Carolina, New Hampshire and Rhode Island have since received federal approval to implement similar programs.

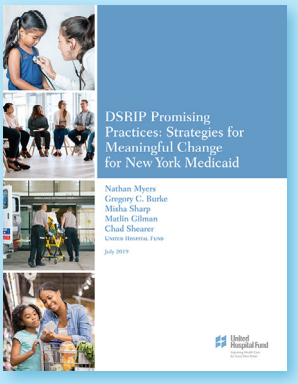
DSRIP has been successful in incentivizing local, place-based collaboratives of health and social care providers and moving to value. These efforts have resulted in improved outcomes for Medicaid members, reshaped New York's health care delivery system, and garnered attention from across the world. Best practices and success stories from New York's DSRIP program are catalogued in the United Hosptial Fund's DSRIP Promising Practices report, linked below.

DSRIP Program Objectives

Reduce avoidable hospital use (Emergency Department and Inpatient) by 25% over the 5 years of DSRIP

- Break down silos
- Develop integrated delivery systems
- Integrate behavioral and physical health
- Enhance primary care and community-based services

In the box to the right you will find a link to a report published by the Medicaid Institute at United Hospital Fund (UHF) - which discusses promising project-level demonstrations that have come from a few choice PPS's. The purpose of this analysis was to review PPS projects while assessing common themes. Through this, UHF identified key lessons that can potentially serve to inform the future of DSRIP. The document examines several key features of lead PPS's that have subsequently led to their success. Topics such as infrastructure, as well as specific PPS project examples, are covered. This report is useful since it asses projects based on their ability to have positive effects of trackable DSRIP measures.



DSRIP Promising Practices: Strategies for Meaningful Change for New York Medicaid

PDF READ MORE

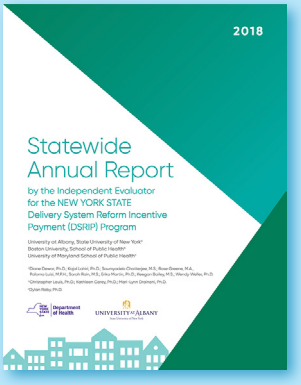
Regional PPS Members

Due to the fluid and complex nature of the health care system today, it has been imperative for AHI to be composed of a large number of stakeholders to ensure adequate health for the community. AHI works in tandem with 5 health delivery partners. The goal of these partnerships is to improve access to care while aiding in developing payment reform.

- Adirondack Health
- Glens Falls Hospital
- Hudson Headwaters Health
- St. Lawrence Health System
- The University of Vermont Health Network - Champlain Valley Physicians Hospital

DSRIP Results

In 2018 NYS DOH and the University at Albany jointly published an annual report evaluating DSRIP. This report will be linked in the box to the right. A mixed-methods strategy was employed to address whether the goals of the program were met. Focus groups collected numerical data, and detailed interviews were used to gather credible evidence during the evaluation. The report below includes a summary of the literature and as well as the activities of the evaluation research teams, as well as the main findings. Evaluations of organizational development, organization, and performance of the PPSs are summarized in the document.



Statewide Annual Report by the Independent Evaluator for the New York State Delivery System Reform Incentive Payment (DSRIP) Program

PDF READ MORE

New York has been incredibly successful in achieving the main goals set out in the state's DSRIP program: reducing avoidable hospital use and shifting Medicaid managed care from fee-for-service to value-based payment. Recent results indicate a statewide 21% reduction in avoidable hospital use, and many PPS have seen greater success. 11 PPS have seen more than a 25% reduction of avoidable admissions and readmissions, and 5 PPS have reduced potentially preventable admissions by 38%.

Holistic Approach to Systems Transformation

Quality

Tracking quality measurement at all levels of care

Key Subpopulations

Develop initiatives targeting populations with high cost of care (ex. HIV/AIDS, superutilizers, developmentally disabled, etc.)

Investing in Primary Care

Boost quality and access to primary care by investing in technology and patient centered medical home

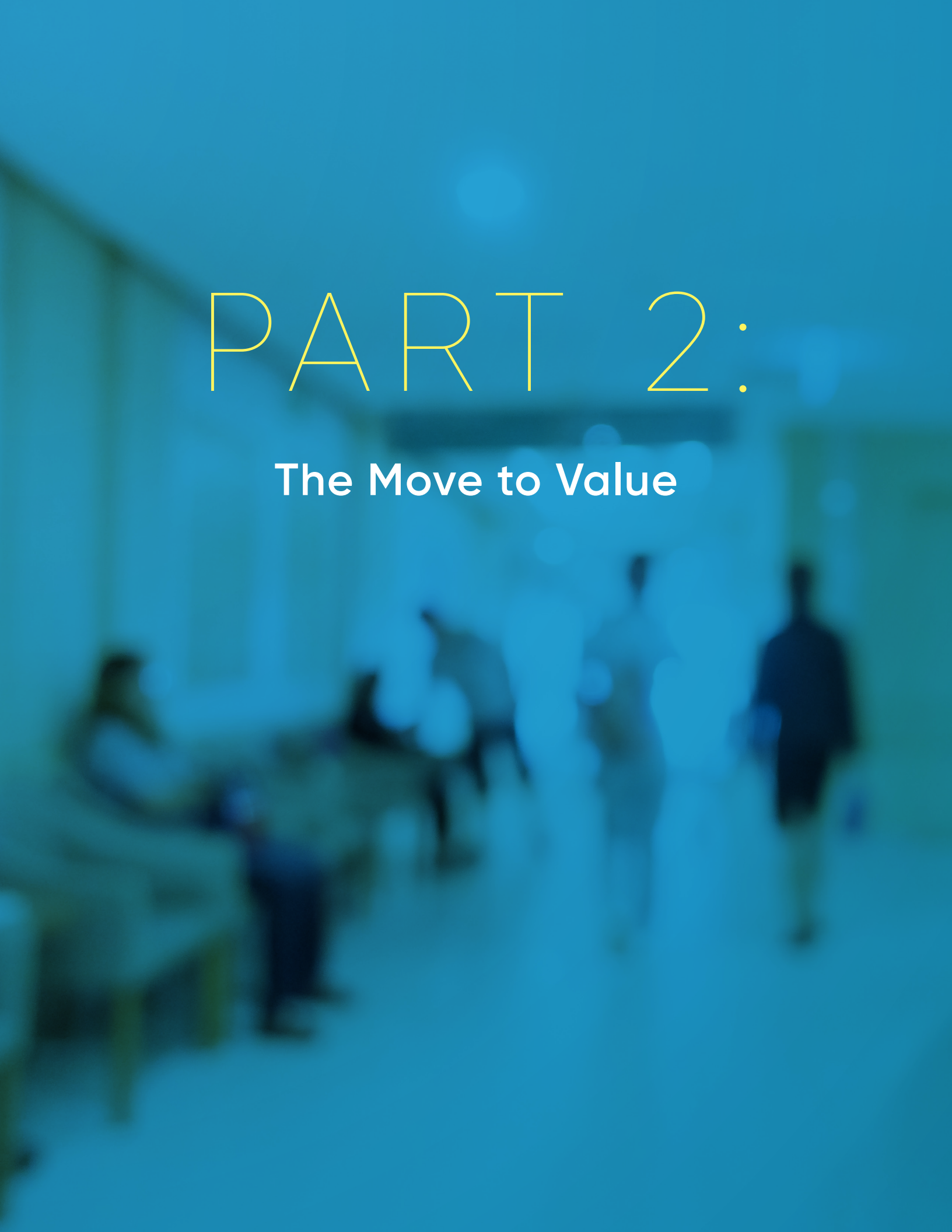
Introducing "Systemness" into Health Care

Integrate providers, share data in real time, make health care a team sport

Address the Social Determinants of Health

Integrate Social care providers into the care ecosystem

Also significant, the state reports that nearly eighty percent of the state's Medicaid managed care funding is in VBP arrangements — with roughly 45% contracted in higher-level risk-sharing arrangements. As required by the state's VBP Roadmap, these higher-level arrangements all include SDoH interventions and engagement of community-based organizations. The adoption of these arrangements serve as a path to sustainability for the DSRIP efforts to date.



PART 2:

The Move to Value

What is Value?: Understanding What a Value Ecosystem Is

Too often, conversations about the move to value jump into the nuances of value-based payment contracting and risk reserves—we say Hold Up! Let's explore the forest of value before we focus in on the trees of VBP contracts.

So what is *value* and what do we mean by it? Value traditionally defined focuses on one of two things—cost and the relative worth, utility, or importance of something. We think the true definition is somewhere in the middle—of course cost is important, but so is the relative impact that services/goods have. But establishing the *value* of something when we use this second part of the definition of "relative worth," relies on defining the relationship. As the saying goes, one man's trash is another man's treasure—what matters not in this fable is the object, but rather the relationship between the object and the person making the assessment of its *value*.

Value, in the context we will be discussing, isn't a fixed dollar amount or relationship—it's about defining and finding that value between entities, and creating value where there previously may not have been any.

Broadly defined in health care, value-based care is the concept by which purchasers of health care (such as government, employers, and consumers) and payers (public and private) hold the delivery system at large accountable for both quality and cost of care. The relationship becomes between what you pay into the system and the outcomes you receive. This is vastly different from the system we have now, often referred to as fee-for service, where there is no relationship between the services rendered and outcomes.

Value-based payment (VBP) is simply the financial methods used to arrive at these kinds of arrangements. It is necessary to deeply understand the concepts of value and value-based care [theoretical concepts] before going on to understand the intricates of value-based payment [technical concepts].

This video was produced by New York State Department of Health and outlines the broad concepts of value-based payment. This is a great tool to use with those who are less familiar with the concept and need a high-level understanding of the concept.

Learning More About Value in Health:

There are lots of schools of thought on how to measure, implement, pay for value in health care, and we encourage you to stay connected to the robust dialogue happening in real time. There is no singular value equation that can be applied to solve our system's expansive needs, but the conversation continues to push us forward.

Addressing the Social Determinants of Health in a Value-Based Payment World

The following two playbooks are written specifically for social care providers to begin their work in engaging health care partners to build value based arrangements. Both are included together, but can be used separately, depending on where you are in your journey to value. The two playbooks are:

1. Laying the Foundation for Health and Social Care Partnership
2. Building a Value Proposition

Addressing the Social Determinants of Health in a Value-Based Payment World: A Playbook for Social Care Providers

Volume 1: Laying the Foundation for Health and Social Care Partnership

Juliette C. Price
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Helgerson Solutions Group

What We Promise to You in this Playbook:

As in all emerging fields, jargon, acronyms, and complexity creep in as we attempt to name and frame concepts to move the field forward. While that can be helpful, it can also do us a disservice as we race towards progress, so here are some ground rules we'll use in our playbook series to help cut down on complexity:

- Spell out acronyms every time. EVERY time. No one likes to read word soup.
- Simplify complex topics and link to other resources where possible to help build your knowledge base where needed.
- Give you some rough-sketch examples of concepts as we go along to paint a picture for you. These should be taken for exactly what they are—examples. Don't focus too much on the details of them, but on how they illustrate a concept. They are not case studies.

Introduction & Setting Context:

The call for the health care sector to recognize that the social determinants of health are overwhelming factors in the health outcomes of populations has never been louder. All across the world, the field of health care is moving towards better understanding, quantifying, and ultimately paying for interventions that address these underlying root causes of health outcomes and inequity.

While on its own a cause for celebration, we find ourselves in a more complicated place—**understanding exactly how health and social care partnerships can work together to deliver outsized results**. Early adopters have begun to pave the way, but these brave organizations would tell you just how complex the process has been, and just how much further we have to go to see these kinds of partnerships in every community.

Our aim in this playbook is to distill down from what we are seeing across the field of health and social care partnerships into an actionable set of recommendations, key questions, and concepts. We seek to accelerate the pace of change by demystifying how health and social care can work together.

We believe a few things about this area of work:

- We believe that health and social care providers are united in their mission to deliver better outcomes for populations, especially vulnerable and historically marginalized groups
- We believe that health and social care providers are split by sector-specific divides, such as nomenclature, fiscal modeling of each respective system, and general misunderstanding about how the other sector works
- We believe that both health and social care sees the problem through a distinct lens, but is missing mission-critical insight that the other sector possesses
- We believe that the answer to some of our greatest collective challenges lays in cross-sector collaboration

This playbook is written specifically through the lens of social care providers and follows our belief that the work of cross-sector partnership begins with singular organizations engaging in deep introspection regarding their own organization. This organizational development lens is uncommon, but draws from over 10 years in the field of cross-sector partnership building.

Key Definitions for this Playbook:

- **Health care:** In this context, when we refer to "health care," we are referring to the general sector that encompasses the prevention, diagnosis, and treatment of disease, illness, injury, and impairments. We're generally referencing the health care system, made up of providers, payors, health care systems, and hospitals and clinics.

- **Social care:** We are deliberately moving away from using terms such as "community based organization" and "non-profit," as it is unhelpful to lead discussions based on an organization's tax-status. Borrowing from the international community, we seek to use the term "social care" when referring to services that can be described as non-medical, personal care and practical assistance, generally focused on children and adults who need extra support. The aim of social care is generally to prevent deterioration of physical or mental health, promote independence and social inclusion, improve opportunities and life chances, strengthen families and protect human rights in relation to people's social needs (NHS definition, 1990).

- **Cross-sector:** In this playbook, when we reference "cross-sector" and "cross-sector partnership," we are referring to any partnership, project, or conversation that includes two or more individuals or organizations that are from different sectors. For example, if a clinic CEO and a social care provider CEO come together to discuss a project, we would label it a "cross-sector" conversation. There is no technicality to this term as we use it here.

How this Playbook is Structured:

In this volume, we've broken down how social care organizations can begin moving towards engaging in cross-sector partnership with health care, through value-based contracting into three key steps. These aren't the only three steps that social care organizations will need to work through, but we believe it's the foundation for the rest of the journey.

We've framed these steps as questions for an organization to answer, as these are a series of sequential issues an organization will need to address in order to be successful in a value-based world.

1. *What problem are you trying to solve and How do you propose solving it?*
2. *Who is your target population?*
3. *How do you measure your impact?*

Key Question 1:

What Problem Are You Trying to Solve and How Do You Propose Solving It?

Addressing Mental Models & Gaining Clarity About the Problem

Passion about the work that your organization does is a must in the social sector—without it, leaders burn out and can't forge ahead through the complexity and scale of the problems at hand. But often, passion can render us blind to how others perceive the issue we are working on or how others understand how we're doing our work. We can find ourselves 15 feet deep in the minutia of a very complex issue and not realize that we're talking past people and not with people.

A key difference when working across sectors is that people working in health care and people working in social care may have the same end goal in mind (ex. Improve outcomes for vulnerable populations), but be working with different **mental models**. Mental models help explain how someone's thought process works and how they view what happens in the world. It can be modeled or visualized and it deeply shapes our behavior and approach to solving problems—so much so, that most of us don't even realize we hold mental models.

In many cases, we mostly share the same mental models—say we showed a room full of people a photo of a child about to touch a hot stove. Without explaining what happens next, you probably already conjured up an image in your head about what happens next. You're ready to explain what's about to happen given what you've observed in the world—and hopefully make an informed strategic decision about what to do next (i.e. move the child away from the hot stove).

The same concept applies to health and social care work—the difference is that due to the complexity, often there are competing mental models amongst potential partners. In the same room full of people, not everyone would agree on how to best serve a complex patient with multiple co-morbidities who is chronically homeless and unengaged in their care plan. Some people's mental models would sketch out a process where engaging the patient's social care needs first would lead to better health outcomes, while others may see it the other way around.

When working across sectors, it is imperative to understand your cross-sector partner's mental model and work together to form a collective mental model that you both can agree on to move the work forward. The focus should not be on whose mental model is "correct," but rather on how cross-sector groups can build collective mental models that produce outcomes for patients/clients.

Translating Care Models Across Sectors

As social care begins to interact and ultimately integrate with health care, we must remember that we're crossing sectors—health care is used to talking about its work in a certain way, with a specific vocabulary, throwing around references to EMRs, CHHAs, LOS, ADLs, bundled payments, fee schedules, PMPMs…the list goes on.

Social care is just as nuanced, with its own set of acronyms. What's needed is clear, concise language that both sectors can understand. A good place to start practicing this habit is to **craft a single sentence that summarizes what problem you are trying to solve and how you approach the issue at hand**.

Question Zero: What Problem Are You Trying To Solve?

Herman Leonard, a professor at Harvard Business School, refers to this as Question Zero—the question you need to ask before any other question. It feels simple, but pushing your organization to answer this question in a singular sentence can help other sectors such as health care better understand what your intervention is seeking to improve and whether it fits into health care's set of challenges as well.

Brevity As the Soul of Cross-Sector Partnership

Once the problem has been succinctly defined, continue to push towards a single-sentence summary of the intervention(s) that the social care organization provides to solve for the stated problem. Attempt to remove all jargon (no industry-specific vocabulary) and keep the details minimal. Additional detail is always able to be added once someone grasps the outlines of the concept, but is much harder to take away once confusion has been sown.

Key Question 2:

Who is your target population?

For whom does this intervention work & in what context.

Social care interventions are rarely universal—most target a specific population in order to be effective or for the intervention to be applicable. While sometimes it may appear self-evident in the description of the intervention (prenatal support interventions require that the participant is pregnant, after all), it is rarely that clear.

Being clear about which population(s) are best suited for your intervention to be effective is paramount. This clarity will help shape how the health care sector understands your intervention and identify how the intervention fits into the population's needs.

> *"Being clear about which population(s) are best suited for your intervention to be effective is paramount."*

There are generally two main frames social care providers use to define target population:

1. **Eligibility criteria:** The intervention has specific eligibility requirements, most commonly tied to its funding source or service design
   a. Ex. An eviction prevention program funded by a city government to serve residents within specific census tracts who have been served an eviction notice.
2. **Evidence base:** Research on an intervention's impact has identified specific populations who benefit most from the intervention
   a. Ex. A home visiting program for moms-to-be have shown to be most effective when mothers are enrolled prior to giving birth

Common constraints for defining populations:

- Age
- Sex
- Gender identity
- Race/Ethnicity
- Income
- Geography (residence in certain cities/blocks or rural areas)
- Medical condition (presence of chronic disease, pregnancy, etc.)

Know Your Number:

When you attain specificity in identifying which population is best served by your intervention, it is best to cross-reference this with the local population that you aim to serve in order to understand your universe of impact.

For example, if your intervention's target population are children under age 5 with asthma, how many children under age 5 live in your service footprint? How many children under age 5 with asthma live in your service footprint? How many children under age 5 with asthma does your intervention currently serve?

What matters here is not the exact number, but the order of magnitude. Are there 10 people that may need this service? 100? 1,000? 10,000? This information will help you and your health care partner understand what kind of impact your collaboration is likely to have, as well as the need that your community or health care provider faces.

As a social care organization, you should also use this data to be reflective on your ability to scale. If you currently serve 100 children but the number of children in need and presumably eligible is 1,000, how could you scale your intervention? Is your intervention scalable without losing impact? These are all questions that a cross-sector partnership with health care will need to surface and investigate.

Key Question 3:

How do you measure your impact?

How to Build Data Infrastructure to Best Serve Your Needs

Social care has perhaps borne the greatest burden of the data age, with an ever-growing list of stakeholders (such as funders, board members, donors, clients, reporters, etc.) demanding to see proof of impact or answers to incredibly specific questions that the data management systems put in place 10-20 years ago have no shot of answering. Adding insult to injury, unlike health care, no dollars are readily available to pull down in order to build out the types of data systems needed, nor are dollars available to invest in data analysts or scientists to help remedy the situation. While the field works to adjust for these structural issues, we recommend that social care providers stick to simple measurement frameworks.

> *"The age of big data has washed over us and we have been left drowning in data and starving for insight."*

Building Measurement Frameworks:

Selecting one outcome measure and a few (three to five) process measures for an intervention is usually plenty to get started. Some programs may have measurement frameworks handed down by funders or other sources, which may require careful review to see if they are really the best way to measure success. Programs may need to build additional metrics if those assigned to them are inappropriate or unhelpful.

Becoming a data-driven social care provider requires time and practice. Using data and building insight is like building muscle; take it slow, train for a 5k before signing up for a marathon.

Using the SMART Framework to Ensure Quality Measurement

The SMART framework can help you assess your measurement framework to ensure that it will be successful in its implementation. For each measurement, think through the following constraints:

S **Specific:** Draw a clear line to define success. Eliminate gray areas. Any outside individual who reads the metric should understand it exactly the same way. Operationalize all terms – words like "improve," "quality," or "effective" need to be quantified.

M **Measurable:** Not just can it be measured, but do you have infrastructure and protocols in place to be able to measure consistently over time? When will you measure, who will gather, enter, analyze and report data? How often? Make your measurement useful by tying it to program improvement. How will organization respond to positive or negative information? Both are valuable.

A **Attainable:** Mistakes here are almost never in the direction of underestimating program impact. Two issues: first, are you pursuing an outcome that flows logically from your intervention? Resist temptation to shoot for moon, or jump from A to Z. Just connect A to B. Second, what effect size is reasonable to expect? Errors often involve underestimating the complexity of context and the interplay of multiple factors that lead to social/economic/health inequities. You should aim to set expectations of change at a meaningful, but respectful level.

R **Relevant:** Seems obvious, but metric needs to capture the change you describe as succinctly as possible. Consider two primary aspects of data quality: validity and reliability. There are different types of validity, but the basic question is does your metric measure what it is intended to measure? Reliability is what it sounds like – if you administer a measure over time, it should perform consistently.

T **Time-framed:** Put dates on your expectations of change—will it take six months or six years? It is critical to build in check points along the way to track progress towards a long-term goal. Define how many, and/or how much over exact periods of time.

Understanding Social Care's Opportunity

The move towards universal understanding of the impact that the social determinants of health have on a patient's individual health outcomes and population health has initiated a shift in power—the traditional health care sector must now partner, collaborate, or even integrate with the social care sector.

However, it can be easy to over-emphasize the size of this power shift. Health care still overwhelmingly holds the power in this evolving relationship—it retains the greatest dollar flow, holds the most amount of data, and has the largest infrastructure. It is still the social sector's responsibility to demonstrate the role that social care can play in improving health outcomes. Waiting for health care to set the rules of engagement will only disserve the social care sector.

> *"It is still the social sector's responsibility to demonstrate the role that social care can play in improving health outcomes."*

Assessing whether the social care interventions your organization provides is a good fit for pursuing value-based contracting with the health care sector is a process that social care providers must go into with an open mind. **Value-based contracting is not a panacea and will not be the right fit for all social care providers**. Viewing the move to value as solely a funding opportunity will blindside social care providers from the challenges associated with it. We urge social care providers to carefully consider this decision before moving forward with pursuing value-based contracting.

Next Step: Approaching a Partnership with Health Care by Building Your Value Proposition

In the new value environment, monetary emphasis is placed on health care achieving very specific outcomes related to quality measures and financial targets. Once you have worked your way through clarifying answers to the three questions outlined in this playbook and believe that your social care organization is prepared to move forward with partnering with health care, you must now build your value proposition.

Building a compelling value proposition to take to a health care partner requires a deep understanding of how the health care system works and which actors face which challenges, so that you can best line up your intervention or solution to the correct actor.

We will explore these next questions in the following volume.

Want to Chat?

We'd love to hear from you—what resonated with you? Have you seen any models you'd like to share? What other information would be helpful for us to share with you?

Are you a provider of social determinants of health strategies or interventions that needs help finding your way in this new VBP world? Or maybe you're a managed care organization or provider looking to find SDOH strategies. Drop me a line and let's find a way to work together: **juliette@helgersonsolutions.com**

About the Author

Juliette serves as Solutions Architect focused on the social determinants of health for Helgerson Solutions Group, working to bring health care and social sector partners come together in new ways to deliver results for end users.

Juliette previously served as the director of The Albany Promise, a cross-sector, collective impact partnership of 100+ organizations in Albany, New York that focused on improving economic mobility for the city's most vulnerable youth and families using shared vision, collective action, and rigorous continuous improvement. The partnership was widely recognized as leading the nation in the field of collective impact. Juliette was awarded the White House Champion of Change award in 2016 from the President Barack Obama Administration for her work in this field.

Previously, she worked for the Chancellor of the State University of New York, the nation's largest, most comprehensive system of higher education, managing various aspects of the education pipeline and multiple initiatives related to teacher education, statewide education policy, and led the development and implementation of the New York State Master Teacher Program, a program which created a state-wide network of the highest-performing STEM teachers that are dedicated to sharing expertise with peers and attracting the brightest minds to a career in STEM. She staffed Governor Andrew M. Cuomo's New NY Education Reform Commission, which brought together nationally-recognized education, community, and business leaders to recommend reforms to the state's education system in order to improve performance in the classroom so that all of New York's students are fully prepared for their futures.

Addressing the Social Determinants of Health in a Value-Based Payment World: A Playbook for Social Care Providers

Volume 2: Building a Value Proposition

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What We Promise to You in this Playbook:

As in all emerging fields, jargon, acronyms, and complexity creep in as we attempt to name and frame concepts to move the field forward. While that can be helpful, it can also do us a disservice as we race towards progress, so here are some ground rules we'll use in our playbook series to help cut down on complexity:

- Spell out acronyms every time. EVERY time. No one likes to read word soup.
- Simplify complex topics and link to other resources where possible to help build your knowledge base where needed.
- Give you some rough-sketch examples of concepts as we go along to paint a picture for you. These should be taken for exactly what they are—examples. Don't focus too much on the details of them, but on how they illustrate a concept. They are not case studies.

Introduction & Setting Context:

In this volume, we will explore what social care providers need to do to develop a value proposition that is compelling enough that it leads to contract to provide services in partnership with health care. A value proposition is a comprehensive proposal that describes in detail how a social care provider will offer a service.

It's important to start the value proposition discussion by first noting that there is a big difference between value-based contracting and grant- or philanthropic-funded programs. Value-based contracting requires proof of a tangible return-on-investment for the health care partner, while grants need only demonstrate that they will effectively address a public need.

While government and private grants are important and fund vital public services, the opportunity presented by value-based payment is one in which social care providers must demonstrate a value proposition that is compelling enough that a private entity is willing to pay for that service. VBP contracts are agreements between two private entities—both parties must see measurable value (most often measured in financial terms) from the agreement. There are many services that social care organizations provide that are simply not a good match for value-based contracting for this reason. If the health care partner cannot see a measurable return-on-investment, it will be hard for them to enter into a value-based contract for this service.

How this Playbook is Structured:

In this volume we will address the three key elements of developing a compelling value proposition. We've framed these steps as questions for an organization to answer:

1. Who is your customer?
2. What does your customer need?
3. What elements must the value proposition include in order for it to be compelling?

Each of these questions must be answered by a social care provider to be successful in value-based payment.

Key Question 1:

Who Is Your Customer?

Understanding Your Customer and Their Needs, Constraints

Most social care organizations rarely use the word "customer," usually referring to people they serve as clients, members, or beneficiaries. In value-based payment arrangements, a social care provider's *customer* is the entity who is willing to pay a social care organization to provide a service.

> *"Each potential customer has their own set of needs and pain points."*

While most social care providers focus their value-based payment efforts on health plans, there are many additional potential customers. Each potential customer has their own set of needs and pain points. Each has the potential to see a social care provider as a value partner who is essential to success.

Who are these potential customers? Provided below is a list of who social care providers can consider potential customers when developing their value propositions:

- Health plans
  - » Medicaid managed care
  - » Medicare Advantage
  - » Managed long-term care
  - » Special needs plans
  - » Commercial insurance
- At-risk health systems
- Hospital systems
- Independent physician association (IPA)
- Health and social care disrupters
- Government

Each customer type has their own unique needs and pain points and it's essential that social care providers understand these so that you can craft a value proposition that is responsive and compelling. Below are two examples of how various customers view the world and what constraints they face.

Example 1 – Medicaid Managed Care Plan

Health plans – especially Medicaid managed care plans – are often the primary contracting target for social care providers. This makes sense because they are at-risk for total cost of care and quality metrics for a population frequently served by social care providers. On the surface, it seems very straight forward that these plans would be interested in contracting with effective social care providers to help them achieve their goals.

While overall, the interests of social care providers and plans are aligned there are some key aspects to the plan's reality that are often misunderstood and often lead to contracting challenges. First, Medicaid plans have very short time horizons. Member churn—the concept that members enroll and disenroll, become ineligible, or choose a different plan—in Medicaid is significant and as a result a plan is never certain that a current member will be enrolled with them next year. As a result, any intervention that requires more then 12 months to generate a return-on-investment is unlikely to be compelling. This is a frequent sticking point in negotiations and has made some social care organizations very frustrated with value-based contracting.

State governments are beginning to address the time horizon challenge by requiring plans to do more with social care providers, which forces plans to think longer term. The hope is that eventually plans will be less shortsighted

but in the meantime, we need to understand the reality faced by plans and explore other partners if the project's return-on-investment requires a long-term timeline to materialize.

Another key factor to understand is that many states require that health plans list investments in non-Medicaid covered services as administrative expenses as opposed to medical expenses. Currently, plans have a legal requirement to spend 85% of each premium dollar on medical expenses—this is known as the medical-loss ratio. This leaves 15% of the premium dollar to spend on overhead, administration, and care management efforts.

This distinction is important, because it means that plans will view many social care interventions as a trade-off against their own care management efforts as well as their profit. While this line of thinking is slowly changing, and states are using tools such as "in lieu of service" designations (a process under which a non-covered service gains approval from the state Medicaid agency as an alternative to a covered service under the Medicaid state plan) as a way out of this box, this challenge can be difficult to overcome. There are however alternative payment arrangements that can be used to address this problem even if a state's policy isn't as progressive as it needs to be.

While Medicaid managed care plans remain an important potential customer, they are not a panacea. Social care providers need to understand the limits and focus on these plans only if they have a value proposition that aligns with the plan's reality. Plans make ideal customers when the value proposition offers relatively short return-on-investment timelines and the plan functions in a state with a more progressive "in lieu of service" policy.

Example 2 – At-Risk Health Systems

An under-appreciated aspect of the value ecosystem is that health insurance risk is rapidly shifting from insurance companies to providers. Most large health systems in the U.S. now have a risk-based contracting strategy and are pushing plans to shift ever more amounts of risk and premium to them to manage. As this trend continues the list of potential customers for social providers will grow.

At-risk health systems are a very compelling customer for social care providers. They are place-based, which means that they serve a population regardless of which insurer the population may be enrolled in at the moment. These systems have longer time horizons—they are heavily invested in their communities and are unlikely to move except under extreme financial hardship. These factors make them more attractive customers then health plans in many ways.

The challenge with health systems–most of which are hospital-led—is that unlike plans who want to reduce costs, these systems have a clear incentive in preserving and growing system revenue. For many of these systems, the move to value-based payment is a defensive move, designed to help them protect the revenue they currently have, especially as technology, clinical advancements, and patient preference drive more of the health care spend out of the four walls of a hospital.

While hospital revenue preservation is a reality, it doesn't preclude partnerships with social care providers. The key reason is that systems understand that if they are to be successful in both the short and long term in value-based payment, they will need to address the social determinants of health for their population and many realize they aren't the right institution to do so. They need partners who aren't considered threats or competitors who can help them manage the health of the local population.

In addition to helping them control costs and improve outcomes, there are other tangible value propositions that social care providers can offer these health systems. These additional issues can be added into the mix and create a compelling value proposition that will be hard to ignore. These include:

- Enrolling patients into Medicaid or other insurance programs – Health systems want to minimize uninsured rates and maximize coverage. Social care providers are often will positioned to help with this especially during renewal periods when members are at risk of paperwork hurdles interrupting coverage.

- Hospital Consumer Assessment of Healthcare Providers (HCAHPS) – This routine survey is used to measure patient's perception of their hospital experience. Hospitals, like health plans, are penalized for low patient satisfaction. Social care providers might be able to help with this.
- Readmission penalties – Medicare penalizes hospitals for high re-admission rates. These penalties are meaningful and are often linked to poor care transitions and social determinants of health. Social care providers, in the community and even in a patient's home, could prevent unnecessary readmissions and reduce costs.

Overall, at-risk health systems are a good potential customer for social care providers. The key is understanding what is most important to them and then fashioning a value proposition that matches those essential needs.

These are just two examples of potential clients that social care providers must think about and evaluate to find the right fit for contracting.

Key Question 2:

What Does Your Customer Need?

What do they care about and how can you help?

Like any business proposition, social care providers need to understand what their customers need and then figure out what they can do to help address those needs. This is often a major challenge for social care providers. Far too often, providers think that because they do good work and have data to show they are improving outcomes, it will be enough to land them a contract. In reality, social care providers need to offer something – a service or a product – that the customer needs and views as valuable. This the hallmark of a great value proposition.

> *"Far too often, providers think that because they do good work and have data to show they are improving outcomes, it will be enough to land them a contract."*

First and foremost, you need to understand how your potential customers view the world. As previous section described, potential customers have generalizable needs but that doesn't replace the need for a more detailed analysis of what individual potential customers need. Bottomline; you need to do your research.

While every customer will be different there are some standard questions you can seek to answer that can help you better understand their issues, challenges, and pain points. Some of these questions are presented below:

How does the customer perform in standard outcome metrics?

Health plans and health care providers are held accountable for standard measures of performance. In the case of plans, the Healthcare Effectiveness Data and Information Set (known as HEDIS) is the standard measurement tool. With over 90 measures over 6 domains of care, the data set is managed by the National Committee for Quality Assurance (NCQA) and is publicly available. In the case of providers, such as hospital systems, you could look at Hospital Consumer Assessment of Healthcare Providers (HCAHPS), avoidable readmissions, and other metrics. Medicare Advantage plans are rated by the Center for Medicare and Medicaid Services (CMS) on a Star Rating System.

Many of these metrics are publicly available which means you can look up your potential customers to see where they perform well and where they are falling behind. Crafting a value proposition that addresses their areas of poor performance are more likely to be well received.

How is the customer doing financially?

The financial condition of a customer is crucial to understand. Many hospital systems are in the red and health plans often go through periods of financial challenge. Financially challenged customers have their own unique needs—going to them with value propositions designed purely to improve outcomes and add services will often fall flat. For those in fiscal distress, you will need a proposal that will help their bottom line. For instance, could you help a plan increase enrollment or reduce member churn which could be the root cause of their distress? Perhaps the health system is seeing significant Medicare readmission penalties and needs help reducing those penalties. Perhaps the Medicare Advance Plan has a low Star Rating and needs your help improving it so that their rate of reimbursement rises.

It important to present your value proposition in a way that is financially responsive to the needs of the customer.

How has the customer been covered by the media?

An under-appreciated reality is that large health care organizations seek positive press and fear negative press. Their reputations as providers and plans are essential to their short and long-term success and they will protect that reputation at all cost. This is also the case if a government agency is your potential customer.

An absolute must in developing a detailed value proposition is doing an analysis of all press coverage of the potential customer over the last three years. Have they had any problems or issues written about in the local press? Have they been highlighted as a regional or national leader in a specific field? Are they considered a good actor in their community? The answers to any and all of these questions can provide valuable insight into the customer and help you prepare a value proposition that helps them either change or enhance their current public narrative. Never underestimate the importance of prestige and reputation in health care. It drives many important decisions and social care providers are uniquely positioned to help make a difference in this important area.

Collecting the Right Information

Often, the amount of information needed to get you started is publicly available, on government websites or other information sources. Social care providers are best served to have do as much work as possible *before* beginning conversations with the potential customer, as you want to be on solid footing to begin your series of negotiations. It is not in your best interest to await their release of information to you.

As discussed earlier in the volume, volumes of information on plans, providers, hospitals, etc. are available online, on various federal and state websites. There are also publications put out by think tanks or good government groups that can help. If your agency belongs to any trade associations, this is another good avenue to pursue information. There are also often local/regional resources that are available to you to help answer some basic questions.

Key Question 3:

What Elements Must the Value Proposition Include in Order for it to be Compelling?

Building a Detailed Case to Bring to a Customer

A value proposition is the final form that your value-based contracting proposal will take, once all the necessary research and development has been done. The term "value proposition" is often overused and conflated with a general strategy document. In reality, a well-crafted value proposition will help accelerate your partnership with health care and ideally lead to a contract more rapidly. It is finely attuned to your customer's needs and tailored to reflect that.

In working with social care providers, Helgerson Solutions Group has developed a value proposition tool comprised of 14 specific sections. This helps social care providers accurately represent their proposal and leads to productive conversations with their selected customer.

Presented below are a subset of the key elements in a high-quality value proposition:

Overview of the Proposed Intervention:
A clear, well-written overview of what the intervention or series of services will be and what results the customer can expect.

Key Partners/Roles:
Who are you going to partner with to accomplish this objective? Do you work alone? Value-based care is about making health care a team sport—teams rarely succeed if they have only one member.

Target Population:
Who will you serve? Seems obvious, but often under-appreciate in terms of importance. How will patients be attributed? Not all members are reachable in the same way—are you certain you can impact their outcomes?

Episode:
What is the measurement period? Is there a clear start and end to your intervention/service? When will the positive outcome occur?

Problem To Solve/Address:
You need to be very clear about what you will solve or fix. Most of the other key components of the value proposition will flow out of this answer.

Metrics:
How do you propose to measure success? Are your proposed metrics easy to collect or do they require new infrastructure? Do these metrics tie to pain points felt by the customer?

Customer/Payer:
Finally, we get to customer. We specifically push this question back because most social care organizations pick their customer long before they know what they are selling.

Base Payment Model:
How will you get paid for the services you provide? Is the payment going to be a rate add-on or a separate Per Member Per Month payment? Will there be a withhold? All of these questions need to be answered in your value proposition. It also important to understand what if any impact your base payment model may have on the customers accounting structure. For instance, will your service need to be considered administrative expense for a plan customer? Accounting details really matter in the value-based payment world.

Risk Sharing Arrangement:

Are you willing to take on risk based on your performance? If not, you may not be ready for value-based contracting. Risk doesn't have to be downside, but there must be a consequence (positive and negative) for your performance.

Risk Adjustment Methodology:

Do you need or want to have your rates of payment or your performance to be risk adjusted? The right answer will depend on other key factors in the value proposition.

As mentioned, the above are only a subset of the elements that must be included in a proposed value proposition. Compelling value propositions take time to craft and are not a quick document to compose. Each element must fit into the larger whole and any one change will unbalance the rest, making the task of ushering a value proposition into contract a long journey.

Looking for Help?

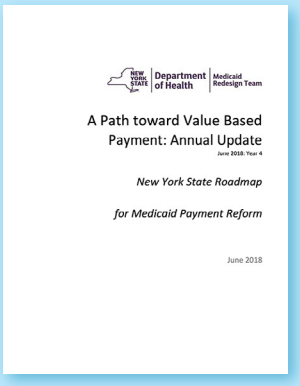
Even with a deep understanding of who you are and what your organization does, building a compelling value proposition is tricky and requires a lot of insider knowledge about the health care industry. Each value proposition is uniquely different and must be built-to-fit in order to be effective and move you towards contract with a health care partner.

We know this work is not easy — and we stand ready to help social care providers who are taking the leap towards value based payment. Contact us if we can help you accelerate your forward momentum: connect@helgersonsolutions.com

Key NYS Department of Health Resources

VBP Roadmap

In order to outline the proposed transition to VBP, under the Medicaid waiver, NYS must submit a multi-year roadmap for comprehensive Payment Reform. These roadmaps help to ensure the long term stability of the program. This document linked below describes the fidelity to the initial plan as well as new updates.



A Path toward Value-Based Payment: Annual Update - 2018

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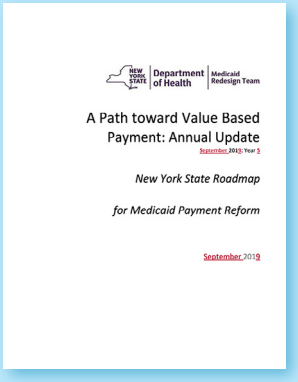

A Path toward Value Based Payment: Annual Update - 2019

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VBP University

VBP U - or the Value-Based Payment Reform University - is yet another tool that can be useful to further your understanding of VBP. Published by the State, this tool uses a combination of videos and text-based documents to educate stakeholders. The ultimate goal of VBP U is to expand the knowledge of stakeholders in order to facilitate the State's transition to VBP. Key terminology and concepts are discussed in-depth. At the conclusion of each semester, you will be able to test your knowledge on topics discussed.

Value-Based Payment Reform University (VBP U)

Quality Measures

Below you will find a variety of links detailing the quality measures for VBP in 2020. Quality measures, which have been established by the state and informed by national standards are especially useful when working in the field of VBP. These measures are meant to educate Medicaid Managed Care Organizations (MCOs) participating in the New York State (NYS) Medicaid VBP program on reporting requirements.

- Total Care for General Population (TCGP) Value-Based Payment Quality Measure Set - 2020
- Maternity Care Value-Based Payment Quality Measure Set - 2020
- Integrated Primary Care (IPC) Value-Based Payment Quality Measure Set - 2020
- HIV/AIDS Subpopulation Value-Based Payment Quality Measure Set - 2020
- Behavioral Health/Health and Recovery Plan (HARP) Value-Based Payment Quality Measure Set - 2020
- Children's Value-Based Payment Quality Measure Set - 2020
- Managed Long Term Care Partial Subpopulation Value-Based Payment Quality Measure Set - 2020
- Medicaid Advantage Plus Value-Based Payment Quality Measure Set - 2020
- Programs of All-Inclusive Care for the Elderly Value-Based Payment Quality Measure Set - 2020

VBP Arrangement Factsheets

The links provided below are meant to be used as a resource to better understand some of the NYS Medicaid VBP arrangements. Within each link, you will find both a general overview and a high-level description. These links detail the unique types of care included in the arrangement as well as a discussion of the methods which were used to define the attributed population. Additionally, you will find information regarding the calculation of associated costs as well as recommendations for quality measures.

- HARP - 2020 Fact Sheet
- HIV/AIDS - 2020 Fact Sheet
- TCGP - 2020 Fact Sheet

VBP Managed Long Term Care (MLTC)

VBP contracting within the sphere of MLTC is incredibly important to fully understand, when the population of a region is aging. Below you will find a resource that discusses this topic in-depth. Through the information provided, you will understand how to the process of implementing VBP in MLTC. Quality measures relevant to MLTC, and contracting materials are included. Additionally, data such as Clinical Advisory Group publications, and relevant surveys can be found.

Value-Based Payment For Managed Long Term Care Plans

In-lieu of Services Guidance

NYS DOH has outlined the state's 'in lieu of services' process. MCOs may propose alternate services and settings that can be justified as medically-appropriate, cost-effective care, not covered under New York's State plan. Formal guidance is linked below:

Cost-Effective Alternative Services (In Lieu of)

VBP Glossary

Use the glossary here to ensure that you are using the correct verbiage when communicating about VBP. Continue to add to this list as your conversations about value unfold.

Term	Acronym	Description
Affordable Care Act	ACA	The comprehensive health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, or "Obamacare"). There are three main aspects of this law: Make affordable health insurance available to more people; expand the Medicaid program to cover all adults with income below 138% of the federal poverty level; support innovative medical care delivery methods.
Accountable Care Organization	ACO	A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.
Agency for Healthcare Research and Quality	AHRQ	The lead Federal agency charged with improving the safety and quality of America's health care system.
Clinical Advisory Groups	CAGs	Created to review the care bundle design and subpopulation definitions most relevant to NYS Medicaid.
Consumer Assessment of Healthcare Providers and Systems	CAHPS	Set of surveys that ask patients to report on their health care experiences.
Community-Based Organizations	CBO	Nonprofit groups that work at a local level to improve life for residents.
Centers for Medicare and Medicaid Services	CMS	A federal agency that administers the nation's major health care programs including Medicare, Medicaid, and CHIP.
Continuous Quality Improvement	CQI	An ongoing process that evaluates how an organization works and ways to improve its processes.
Department of Financial Services	DFS	A department that incorporated both the NYS Banking Department and the NYS Insurance Department. DFS regulates financial services in the state.
Delivery System Reform Incentive Payment Program	DSRIP	A program designed to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospitable use by 25% over 5 years. The program is $8 Billion+ in funding and includes a VBP requirement.
Electronic Health Records	EHR	The systematized collection of patient and population health information which is stored in a digital format.
Fee-for-Service	FFS	Payment model where services are unbundled and paid for separately
Federally Qualified Health Centers	FQHC	Outpatient clinics that qualify for specific reimbursement under Medicare and Medicaid.
Health and Recovery Plan	HARP	Managed care product that manages physical health, mental health, and substance use services in an integrated way for adults with significant behavioral health needs.
Healthcare Effectiveness Data and Information System	HEDIS	The tool used by health plans to measure performance on important dimensions of care and service.
Health Home	HH	Coordinated care provided to individuals with multiple chronic health conditions, including mental health and substance use disorders.

Health Information Technology	HIT	Information technology applied to health and health care. Management of this information utilizes a computerized systems as well as the secure exchange of health information between consumers, providers, payers, and quality monitors.
Incurred but not reported	IBNR	The amount owed by an insurer to all valid claimants who have had a covered loss but have not yet reported it.
Independent Practice Association	IPA	An association of independent physicians, or other organizations that contracts with independent care delivery organizations, and provides services to managed care organizations on a negotiated per capita rate, flat retainer fee, or negotiated fee-for-service.
Integrated Primary Care	IPC	Organizational principle for care delivery with the aim of achieving improved patient care through better coordination of services.
Medicaid Analytics Performance Portal	MAPP	The performance management system that will provide tools to the Health Home network to support providing care management for the Health Home population
Managed Care Organization	MCO	Group of activities intended to reduce the cost of providing for-profit health care and providing health insurance while improving the quality of that care
Managed Long-Term Care	MLTC	A system that streamlines the delivery of long–term services to people who are chronically ill or disabled and who wish to stay in their homes and communities.
Medicaid Redesign Team	MRT	Established as a means of finding new ways to lower Medicaid spending in New York State. It is comprised of stakeholders and health care experts from throughout NYS.
National Committee for Quality Assurance	NCQA	Independent 501 nonprofit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.
National Provider Identifier	NPI	A unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS)
Nulliparous Singleton Term Vertex	NSTV	A measure which identifies the proportion of live babies born at or beyond 37.0 weeks gestation to women in their first pregnancy, that are singleton (no twins or beyond) and in the vertex presentation
Office of Alcohol and Substance Abuse Services	OASAS	An office within the NYS Department of health that focuses on preventing and treating alcohol and substance abuse.
Office of Health Insurance Programs	OHIP	An office within the NYS Department of Health that is responsible for Medicaid Administration and reimbursement.
Office of Patient Quality and Safety	OQPS	An office within the NYS Department of Health, dealing with Patient Quality and Safety across the state.
Potentially Avoidable Complications	PAC	Deficiencies in care that cause harm to the patient, and might have been prevented with more effective treatment.
Pay for Reporting	PRF VBP Measures	A more extensive set of measures that is predominantly process-based and required for monitoring and process improvement.
Pay for Performance	P4P	An umbrella term for initiatives aimed at improving the quality, efficiency, and overall value of health care. These arrangements provide financial incentives to hospitals, physicians, and other health care providers to carry out such improvements and achieve optimal outcomes for patients.
Pediatric Quality Indicator	PDI	A set of measures that focus on children's health care quality using routinely collected hospital discharge data as the basis for indicator specification.
Per Member Per Month	PMPM	A revenue or cost for each member enrolled in a specific health plan each month.

Per Member Per Year	PMPY	The dollar amount paid to MCOs each year by NYS.
Prenatal and Postpartum Care	PPC	The monitoring health prior, during, and after birth of both the mother and child.
Potentially Preventable Readmissions	PPR	Readmission that is clinically-related to the initial hospital admission.
Performing Provider System	PPS	Entities that are responsible for performing a DSRIP project. DSRIP eligible providers, which include both major public general hospitals and safety net providers, collaborating together, with a designated lead provider for the group.
Prevention Quality Indicators	PQI	A set of measures that can be used with hospital inpatient discharge data to identify the quality of care for "ambulatory care sensitive conditions.."
Quality Assurance Reporting Requirements	QARR	A set of indicators used by the New York State Department of Health to monitor health plan performance. Data collection method used dictates how the statewide averages are represented for each measure. QARR consists of measures from the NCQA's HEDIAS, CMS QRS Technical Specifications and New York State-specific measures. The major areas of performance included in the 2017 QARR are: 1) Effectiveness of Care 2) Access to/ Availability of Care 3) Satisfaction with the Experience of Care 4) Use of Services 5) Health Plan Descriptive Information 6) NYS–specific measures.
Quality Improvement Program	VBP QIP	Distressed facilities that receive extra funds from NYS to ensure they remain open. They are required to enter into Level 1 VBP arrangements and develop sustainable plans to remain eligible for funding.
Quality Incentive Program	QIP	A NYS incentive program that incentivizes health plans and their providers to improve the measurement and delivery of health care to Medicaid managed care enrollees.
Regional Health Information Organization	RHIO	A multistakeholder organization created to facilitate the exchange of health information – the transfer of healthcare information electronically across organizations and relevant stakeholders.
Social Determinant of Health	SDH	The conditions in which people are born, grow, live, work and age - which have a direct impact on the physical and mental well being of the individual.
Total Care for General Population	TCGP	A VBP arrangement by which party(ies) contracted with the MCO assumes responsibility for the total care of its attributed population.
Value-Based Payment	VBP	A payment system which incentivize the value and quality of care, in contrast to the current arrangement of incentivizing quantity of care.
Value-Based Payments Level 0	VBP Level 0	The initial level of value-based Payments. This level consists of FFSwith bonuses and/or withhold based on quality scores.
Value-Based Payments Level 1	VBP Level 1	FFS with upside–only shared savings when outcome scores are sufficient.
Value-Based Payments Level 2	VBP Level 2	FFS with risk-sharing (upside available when outcome scores are sufficient; the downside is reduced when outcomes scores are high)
Value Based Payments Level 3	VBP Level 3	Only feasible after experience; requires a mature PPS. This level consists of Global capitation. (with an outcome–based component).

PART 3:

North Country Context: Key Data Sets

Data Analysis for AHI Geographic Footprint

Medicaid Managed Care by County

Medicaid Manage Care Plans	Clinton	Essex	Franklin	Fulton	Hamilton	Saratoga	St Lawrence	Warren	Washington	Total Enrolled by Plan	Market % by Plan compared to NYS
Fidelis Care	10737	4686	7781	9636	592	9799	13378	7959	7242	71810	1.71%
Capital District Physicians Health Plan	201	106	115	1172		10470		671	2845	15580	0.37%
United Healthcare Plan of NY	831	261	269	176			4131	415		6083	0.14%
MVP Health Plan						1912		761	500	3173	0.08%
Recipients enrolled in mainstream Medicaid managed care by county	11769	5053	8165	10984	592	22181	17509	9806	10587	96646	2.30%

Medicare Penetration By County

	Clinton	Essex	Franklin	Fulton
County	State	Total Eligible Beneficiaries	Enrolled	Penetration
Fulton	NY	13,425	6,565	49%
Saratoga	NY	48,589	22,658	47%
Warren	NY	18,062	7,921	44%
Washington	NY	14,206	6,183	44%
Hamilton	NY	1,647	551	33%
St. Lawrence	NY	23,852	6,839	29%
Franklin	NY	11,424	2,993	26%
Essex	NY	9,639	2,494	26%
Clinton	NY	18,639	4,563	24%
Penetration by region	AHI	159,483	60,767	38.10%

Largest Plan By County

COUNTY	MEDICARE ADVANTAGE PLAN	ENROLLMENT BY COUNTY	MARKET % BY COUNTY
Clinton	UNITEDHEALTHCARE	1,811	39.69%
Clinton	AMERICAN PROGRESSIVE LIFE & HLTH INS COMPANY OF NY	1,520	33.31%
Clinton	SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.	536	11.75%
Essex	UNITEDHEALTHCARE	1,052	42.18%
Essex	AMERICAN PROGRESSIVE LIFE & HLTH INS COMPANY OF NY	585	23.46%
Essex	EXCELLUS HEALTH PLAN, INC.	229	9.18%
Franklin	AMERICAN PROGRESSIVE LIFE & HLTH INS COMPANY OF NY	1,506	50.32%
Franklin	UNITEDHEALTHCARE	905	30.24%
Franklin	EXCELLUS HEALTH PLAN, INC.	203	6.78%
Hamilton	UNITEDHEALTHCARE	161	29.22%
Hamilton	MVP HEALTH PLAN, INC.	105	19.06%
Hamilton	AMERICAN PROGRESSIVE LIFE & HLTH INS COMPANY OF NY	89	16.15%
Saratoga	CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.	7,787	34.37%
Saratoga	MVP HEALTH PLAN, INC.	3,277	14.46%
Saratoga	UNITEDHEALTHCARE	2,920	12.89%
Warren	HUMANA	1,483	18.72%
Warren	UNITEDHEALTHCARE	1,307	16.50%
Warren	AMERICAN PROGRESSIVE LIFE & HLTH INS COMPANY OF NY	1,214	15.33%
Washington	AMERICAN PROGRESSIVE LIFE & HLTH INS COMPANY OF NY	1,302	21.06%
Washington	UNITEDHEALTHCARE	1,275	20.62%
Washington	HUMANA	987	15.96%
Fulton	AMERICAN PROGRESSIVE LIFE & HLTH INS COMPANY OF NY	2,509	38.22%
Fulton	HEALTHNOW NEW YORK INC.	1,080	16.45%
Fulton	MVP HEALTH PLAN, INC.	792	12.06%
St. Lawrence	AMERICAN PROGRESSIVE LIFE & HLTH INS COMPANY OF NY	2,451	35.84%
St. Lawrence	UNITEDHEALTHCARE	1,760	25.73%
St. Lawrence	EXCELLUS HEALTH PLAN, INC.	979	14.31%

Enrollment by Plan

COUNTY	CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.	UNITED HEALTHCARE	AMERICAN PROGRESSIVE LIFE & HEALTH INS. COMPANY OF NY	MVP HEALTH PLAN, INC.	HUMANA	HEALTHNOW NEW YORK INC.	SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.	CDPHP UNIVERSAL BENEFITS, INC.	AETNA HEALTH INC.	THE NEW YORK STATE CATHOLIC HEALTH PLAN, INC.	EXCELLUS HEALTH PLAN, INC.	EMPIRE HEALTHCHOICE ASSURANCE, INC.	ANTHEM	CARE IMPROVEMENT PLUS SOUTH CENTRAL INSURANCE CO	WELLCARE OF NEW YORK, INC.	OXFORD HEALTH INSURANCE, INC.	TOTAL Enrollment by County/ Region
Clinton	17	1,811	1,520	22	19		536		251	187	200						4,563
Essex	133	1,052	585	192	15		101	23	81	83	229						2,494
Franklin	11	905	1,506	15			85		191	77	203						2,993
MVP Health Plan						1912		761	500	3173	0.08%						
Recipients enrolled in mainstream Medicaid managed care by county	11769	5053	8165	10984	592	22181	17509	9806	10587	96646	2.30%						
Fulton	590	702	2,509	792	102	1,080	126	78	42	256	32		256				6,565
Hamilton	73	161	89	105		16	30		25		40		12				551
Saratoga	7,787	2,920	1,482	3,277	1,803	1,759	802	833	559	277	21	322	183	254	212	167	22,658
St. Lawrence		1,760	2,451	22	11		257		601	758	979						6,839
Warren	1,127	1,307	1,214	711	1,483	1,055	302	275	130	226			91				7,921
Washington	841	1,275	1,302	497	987	622	176	194	62	195			19	13			6,183
TOTAL Enrollment by Plan	10,579	11,893	12,658	5,633	4,420	4,532	2,415	1,403	1,942	1,872	1,704	322	561	267	212	167	60,767
Market % by Region	17.41%	19.57%	20.83%	9.27%	7.27%	7.46%	3.97%	2.31%	3.20%	3.08%	2.80%	0.53%	0.92%	0.44%	0.35%	0.27%	

Hospital Penalties

Hospitals part of AHI PPS		**Medicare IP Revenue FY 2019**	**Estimated P4P Net Impact FY 2019**		**Hospital Readmission Reduction Program (HRRP)**	**Value Based Purchasing (VBP)**	**Hospital Acquired Conditions (HAC)**
Provider Name	Provider ID	($)	Total Impact ($)	Total Impact (%)	Readmission Impact ($) FY 2019	VBP Impact ($) FY 2019	HAC Impact ($) FY 2019
Adirondack Medical Center at Saranac Lake	330079	$ 11,139,773	-$ 34,991	-0.31%	-$ 3,562	$ 80,740	-$ 112,170
Nathan Littauer Hospital	330276	$ 6,911,721	-$ 44,276	-0.64%	-$ 10,813	$ 35,905	-$ 69,368
Glens Falls Hospital	330191	$ 33,632,727	-$ 123,344	-0.37%	-$ 55,082	-$ 68,261	N
Nathan Littauer Hospital	330276	$ 6,911,721	-$ 44,276	-0.64%	-$ 10,813	$ 35,905	-$ 69,368
Canton Potsdam Hospital	330197	$ 15,657,257	-$ 78,669	-0.50%	-$ 120,953	$ 199,643	-$ 157,359

Demographic Profiles of AHI Geographic Region

Clinton County Demographic Profile	Estimate	%
Total Population	**80,794**	
Age Categories		
Under 5 years	3,945	5%
Under 18 years	14,535	18%
65 years and over	12,853	16%
Sex		
Female	39,295	49%
Male	41,499	51%
Poverty (# individuals at or below)		
50% of poverty line	5,914	7%
100% of poverty line	11,182	14%
125% of poverty line	13,986	17%
150% of poverty line	16,715	21%
185% of poverty line	21,451	27%
200% of poverty line	23,298	29%
Median HH Income	$55,178	
% High School Graduate	X	88%
Disability Status		
% Total Population	X	16%
% Age 65+	X	37%
% No Health Insurance	X	5%
Sources:		
American Community Survey (2017, 2018)		
Small Area Health Insurance Estimates (2017)		

Essex County Demographic Profile	Estimate	%
Total Population	**37,751**	
Age Categories		
Under 5 years	1,495	4%
Under 18 years	6,325	17%
65 years and over	8,322	22%
Sex		
Female	18,129	48%
Male	19,622	52%
Poverty (# individuals at or below)		
50% of poverty line	1,574	4%
100% of poverty line	3,323	9%
125% of poverty line	4,842	13%
150% of poverty line	6,350	17%
185% of poverty line	9,293	25%
200% of poverty line	10,275	27%
Median HH Income	$56,196	
% High School Graduate	X	91%
Disability Status		
% Total Population	X	17%
% Age 65+	X	36%
% No Health Insurance	X	5%
Sources:		
American Community Survey (2017, 2018)		
Small Area Health Insurance Estimates (2017)		

Franklin County Demographic Profile	Estimate	%
Total Population	**50,692**	
Age Categories		
Under 5 years	2,463	5%
Under 18 years	9,912	20%
65 years and over	8,081	16%
Sex		
Female	22,876	45%
Male	27,816	55%
Poverty (# individuals at or below)		
50% of poverty line	4,261	8%
100% of poverty line	8,195	16%
125% of poverty line	10,449	21%
150% of poverty line	12,054	24%
185% of poverty line	15,793	31%
200% of poverty line	16,914	33%
Median HH Income	$52,500	
% High School Graduate	X	87%
Disability Status		
% Total Population	X	15%
% Age 65+	X	33%
% No Health Insurance	X	7%
Sources:		
American Community Survey (2017, 2018)		
Small Area Health Insurance Estimates (2017)		

Fulton County Demographic Profile	Estimate	%
Total Population	**53,743**	
Age Categories		
Under 5 years	2,677	5%
Under 18 years	10,977	20%
65 years and over	9,981	19%
Sex		
Female	26,896	50%
Male	26,847	50%
Poverty (# individuals at or below)		
50% of poverty line	3,693	7%
100% of poverty line	8,119	15%
125% of poverty line	10,717	20%
150% of poverty line	13,314	25%
185% of poverty line	17,974	33%
200% of poverty line	19,378	36%
Median HH Income	$50,248	
% High School Graduate	X	87%
Disability Status		
% Total Population	X	16%
% Age 65+	X	32%
% No Health Insurance	X	7%
Sources:		
American Community Survey (2017, 2018)		
Small Area Health Insurance Estimates (2017)		

Hamilton County Demographic Profile	Estimate	%
Total Population	**4,575**	
Age Categories		
Under 5 years	147	3%
Under 18 years	633	14%
65 years and over	1,319	29%
Sex		
Female	2,228	49%
Male	2,347	51%
Poverty (# individuals at or below)		
50% of poverty line	139	3%
100% of poverty line	315	7%
125% of poverty line	725	16%
150% of poverty line	920	20%
185% of poverty line	1,156	25%
200% of poverty line	1,223	27%
Median HH Income	$57,552	
% High School Graduate	X	83%
Disability Status		
% Total Population	X	26%
% Age 65+	X	56%
% No Health Insurance	X	12%
Sources:		
American Community Survey (2017, 2018)		
Small Area Health Insurance Estimates (2017)		

Saratoga County Demographic Profile	Estimate	%
Total Population	**227,377**	
Age Categories		
Under 5 years	11,778	5%
Under 18 years	46,969	21%
65 years and over	38,737	17%
Sex		
Female	114,909	51%
Male	112,468	49%
Poverty (# individuals at or below)		
50% of poverty line	6,132	3%
100% of poverty line	13,797	6%
125% of poverty line	19,759	9%
150% of poverty line	25,235	11%
185% of poverty line	34,177	15%
200% of poverty line	38,529	17%
Median HH Income	$80,839	
% High School Graduate	X	94%
Disability Status		
% Total Population	X	11%
% Age 65+	X	29%
% No Health Insurance	X	4%
Sources:		
American Community Survey (2017, 2018)		
Small Area Health Insurance Estimates (2017)		

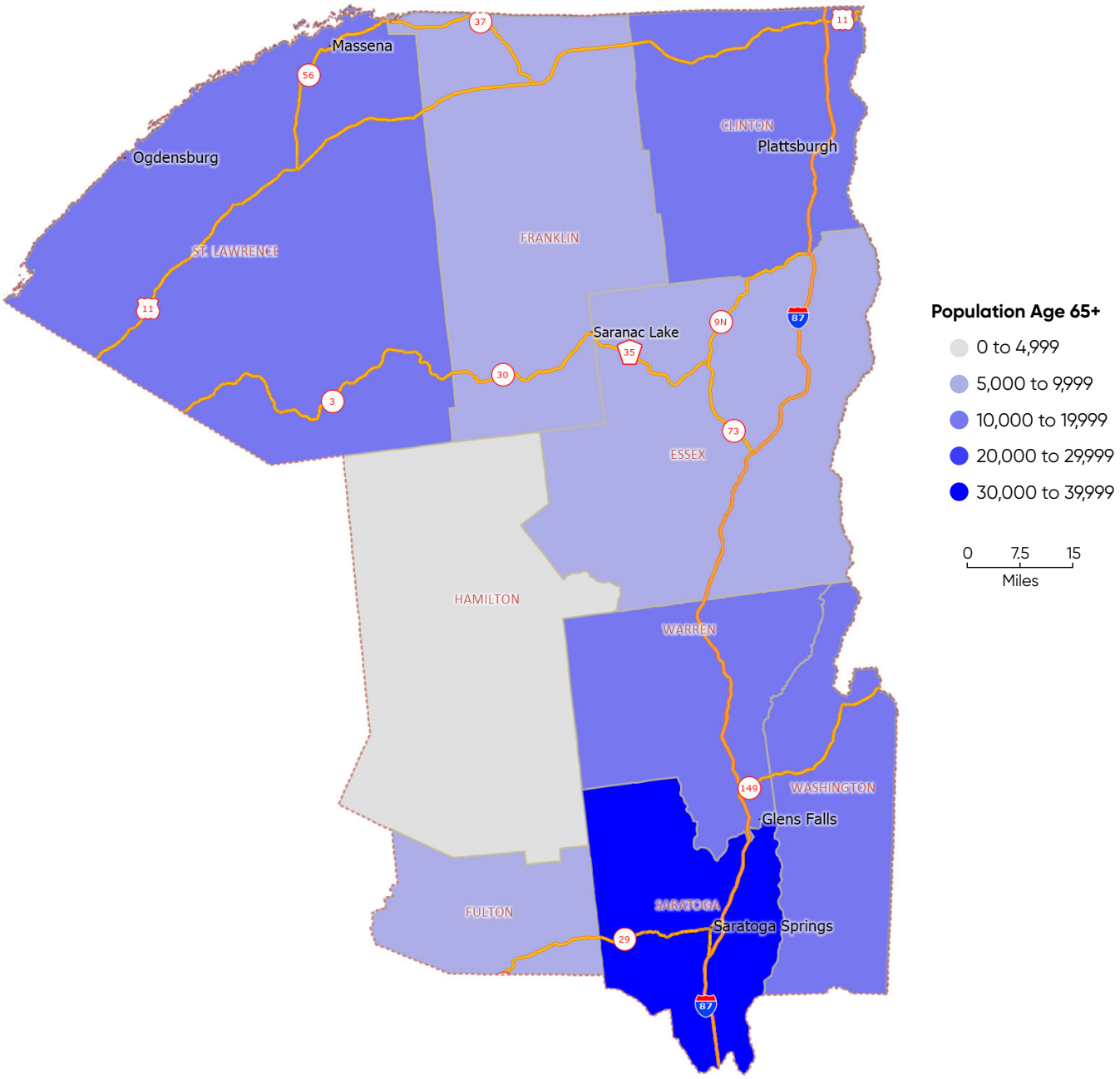
St Lawrence County Demographic Profile	Estimate	%
Total Population	**109,558**	
Age Categories		
Under 5 years	5,814	5%
Under 18 years	22,418	20%
65 years and over	17,884	16%
Sex		
Female	53,778	49%
Male	55,780	51%
Poverty (# individuals at or below)		
50% of poverty line	7,651	7%
100% of poverty line	17,248	16%
125% of poverty line	22,412	20%
150% of poverty line	26,951	25%
185% of poverty line	34,141	31%
200% of poverty line	36,312	33%
Median HH Income	$49,305	
% High School Graduate	X	89%
Disability Status		
% Total Population	X	16%
% Age 65+	X	42%
% No Health Insurance	X	8%
Sources:		
American Community Survey (2017, 2018)		
Small Area Health Insurance Estimates (2017)		

Warren County Demographic Profile	Estimate	%
Total Population	**64,480**	
Age Categories		
Under 5 years	2,836	4%
Under 18 years	11,956	19%
65 years and over	13,493	21%
Sex		
Female	32,782	51%
Male	31,698	49%
Poverty (# individuals at or below)		
50% of poverty line	2,387	4%
100% of poverty line	6,656	10%
125% of poverty line	8,764	14%
150% of poverty line	10,830	17%
185% of poverty line	14,917	23%
200% of poverty line	16,625	26%
Median HH Income	$59,813	
% High School Graduate	X	92%
Disability Status		
% Total Population	X	15%
% Age 65+	X	29%
% No Health Insurance	X	5.9%
Sources:		
American Community Survey (2017, 2018)		
Small Area Health Insurance Estimates (2017)		

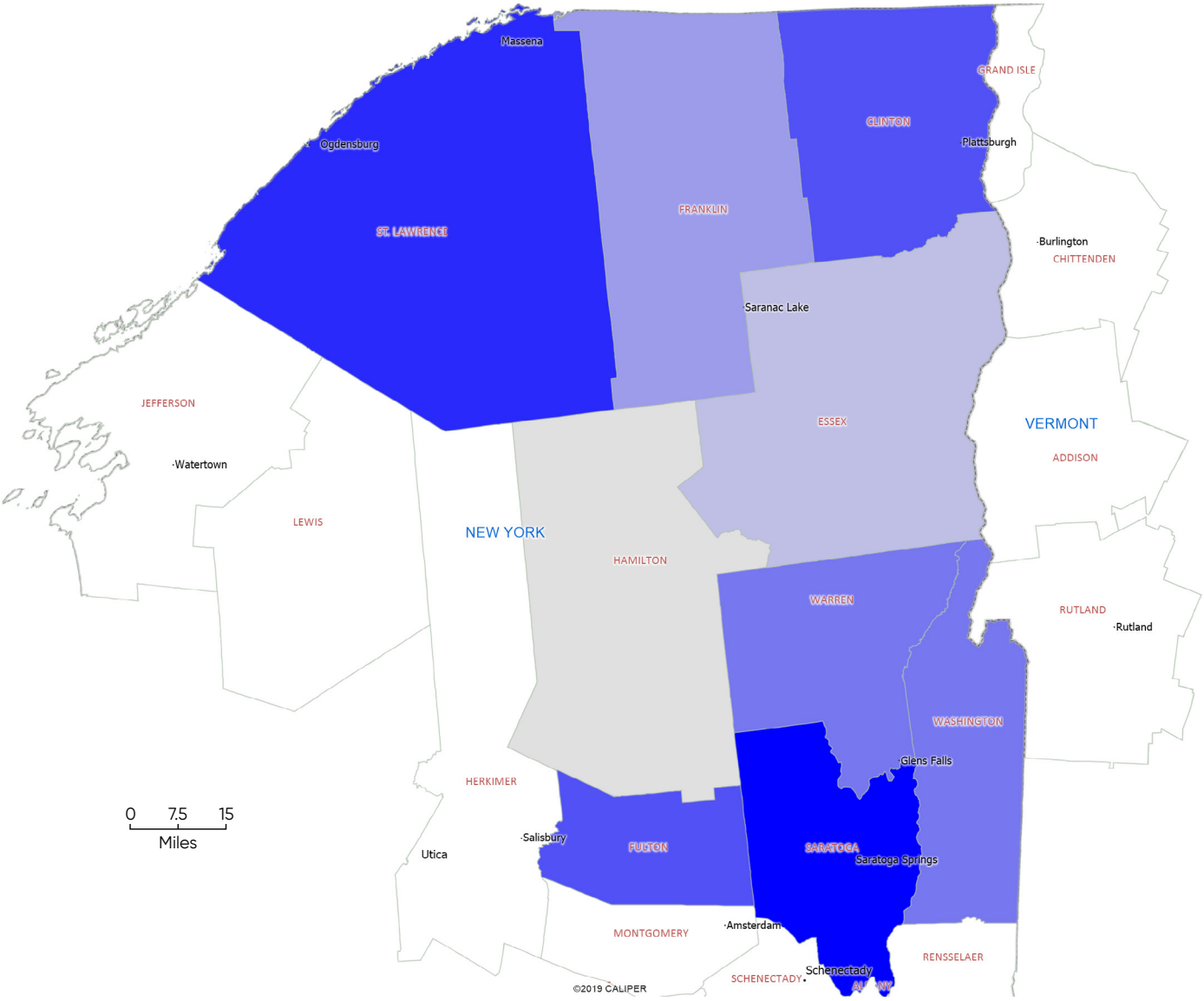
Washington County Demographic Profile		
	Estimate	**%**
Total Population	**61,828**	
Age Categories		
Under 5 years	2,935	5%
Under 18 years	11,910	19%
65 years and over	11,288	18%
Sex		
Female	29,826	48%
Male	32,002	52%
Poverty (# individuals at or below)		
50% of poverty line	2,432	4%
100% of poverty line	7,055	11%
125% of poverty line	9,963	16%
150% of poverty line	12,920	21%
185% of poverty line	17,296	28%
200% of poverty line	18,769	30%
Median HH Income	$54,114	
% High School Graduate	X	88%
Disability Status		
% Total Population	X	15%
% Age 65+	X	33%
% No Health Insurance	X	7.0%
Sources:		
American Community Survey (2017, 2018)		
Small Area Health Insurance Estimates (2017)		

AHI Region Maps

Population 65+



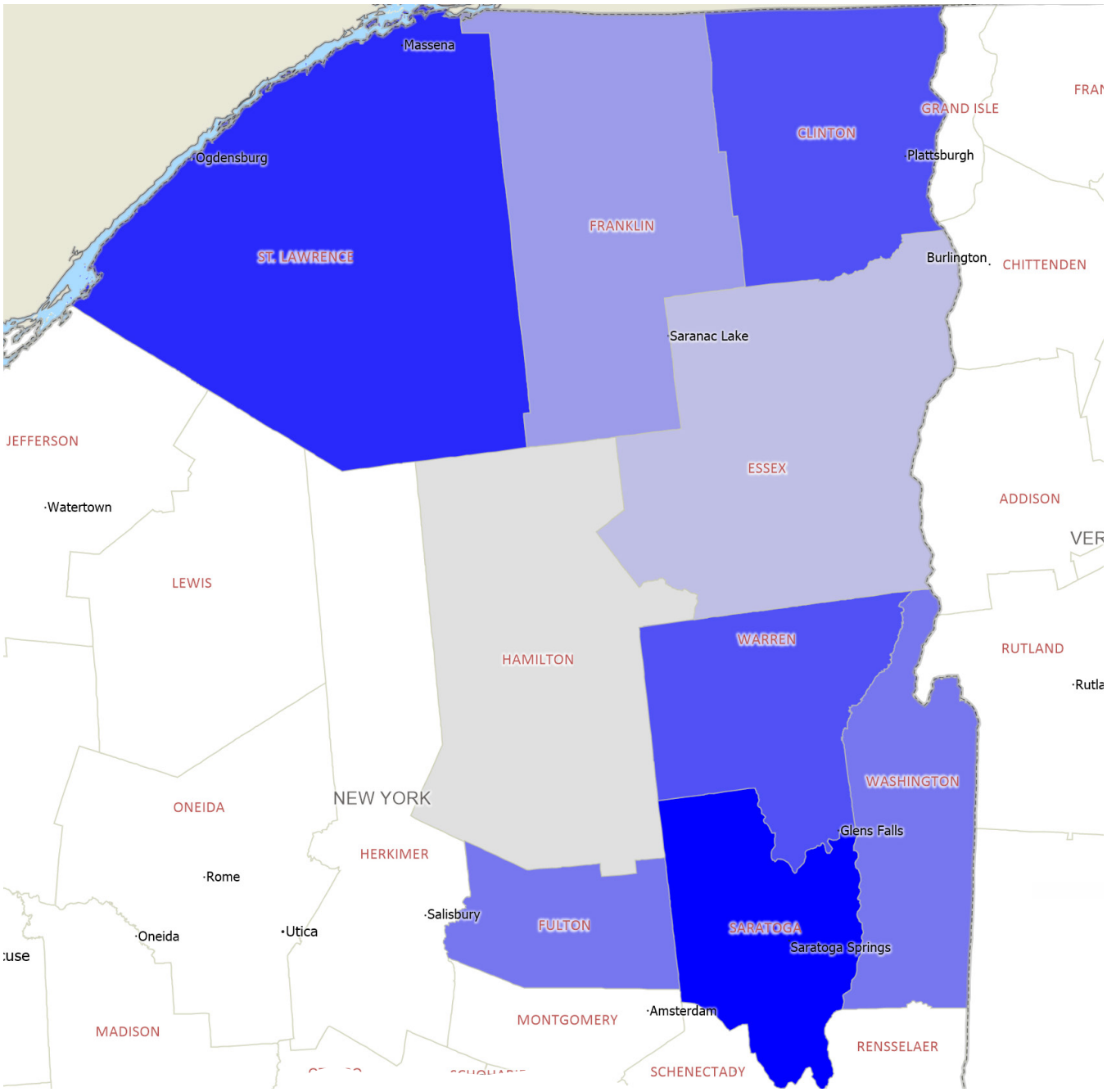
Enrolled in Medicaid Managed Care



Enrolled Medicaid Managed Care

- 4,999 and below
- 5,000 to 7,999
- 8,000 to 8,999
- 9,000 to 10,899
- 10,900 to 16,999
- 17,000 to 19,999
- 20,000 and above
- Other

Medicaid Advantage Eligible Beneficiaries by County

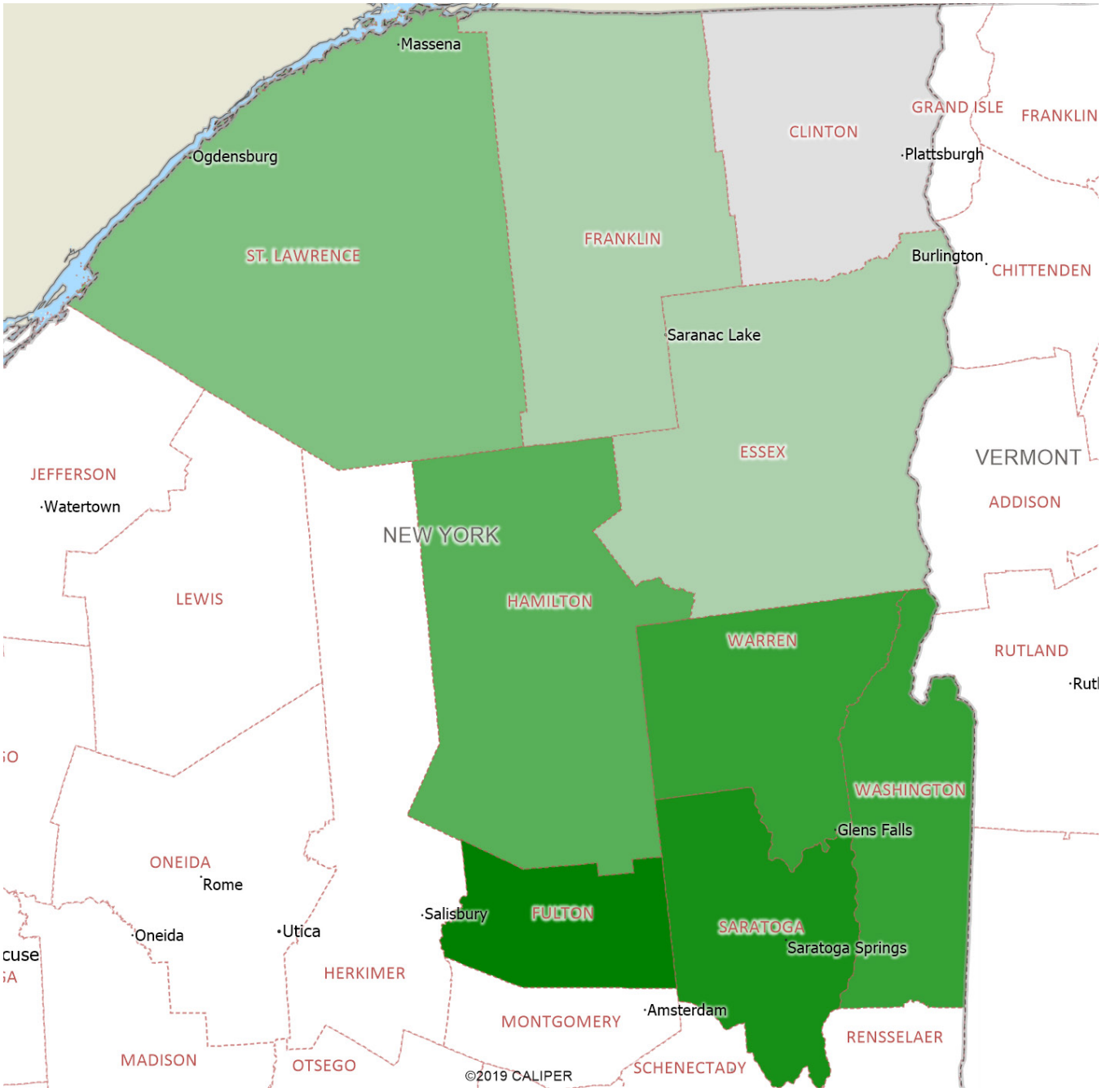


Total Eligible Beneficiaries

- 8,999 and below
- 9,000 to 9,999
- 10,000 to 12,999
- 13,000 to 17,999
- 18,000 to 19,999
- 20,000 to 39,999
- 40,000 and above
- Other

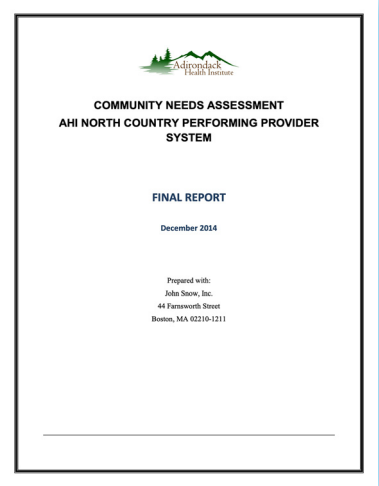
0 15 30
Miles

Medicare Advantage Penetration by County



Appendix: Community Needs Assessment

The following needs assessment was published in 2014 and details the main health and health service challenges faced by the community. This assessment was informed by community participation as well as vital demographic information. Additionally, preexisting community infrastructure was analyzed along with recommendations of new processes to benefit the health of the priority population. Finally, a summary of 11 proposed projects to be implemented is discussed. This serves as an excellent resource for understanding community needs and as a roadmap towards positive community change.


Adirondack Health Institute

COMMUNITY NEEDS ASSESSMENT
AHI NORTH COUNTRY PERFORMING PROVIDER SYSTEM

FINAL REPORT

December 2014

Prepared with:
John Snow, Inc.
44 Farnsworth Street
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Community Needs Assessment AHI North Country Performing Provider System

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