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Western New York Bridging Gaps in Care for the Medicaid Population

Sponsored by the Health Foundation for Western and Central New York and the P2 Collaborative of Western New York

Dennis R. Horrigan, President and CEO

Michael Edbauer, DO, Chief Medical Officer

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- Betsy Wright

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Community Partners of WNY Leadership Team:

- Dennis Horrigan, President and CEO, Catholic Medical Partners
- Michael Edbauer, DO, CMO Catholic Health
- Carlos Santos, MD, CMO Community Partners of WNY
- Rachael Nees, Director of Grants, Catholic Health
- Thomas Schifferli, DSRIP Interim Director
- Patti Podkulski, Director of Medical Policy and Accreditation
- Dapeng Cao, PhD, Manager of Healthcare Analytics
- Sarah Cotter, Director of Clinical Transformation
- Peggy Smering, Director of Care Management
- Cara Petrucci, Student

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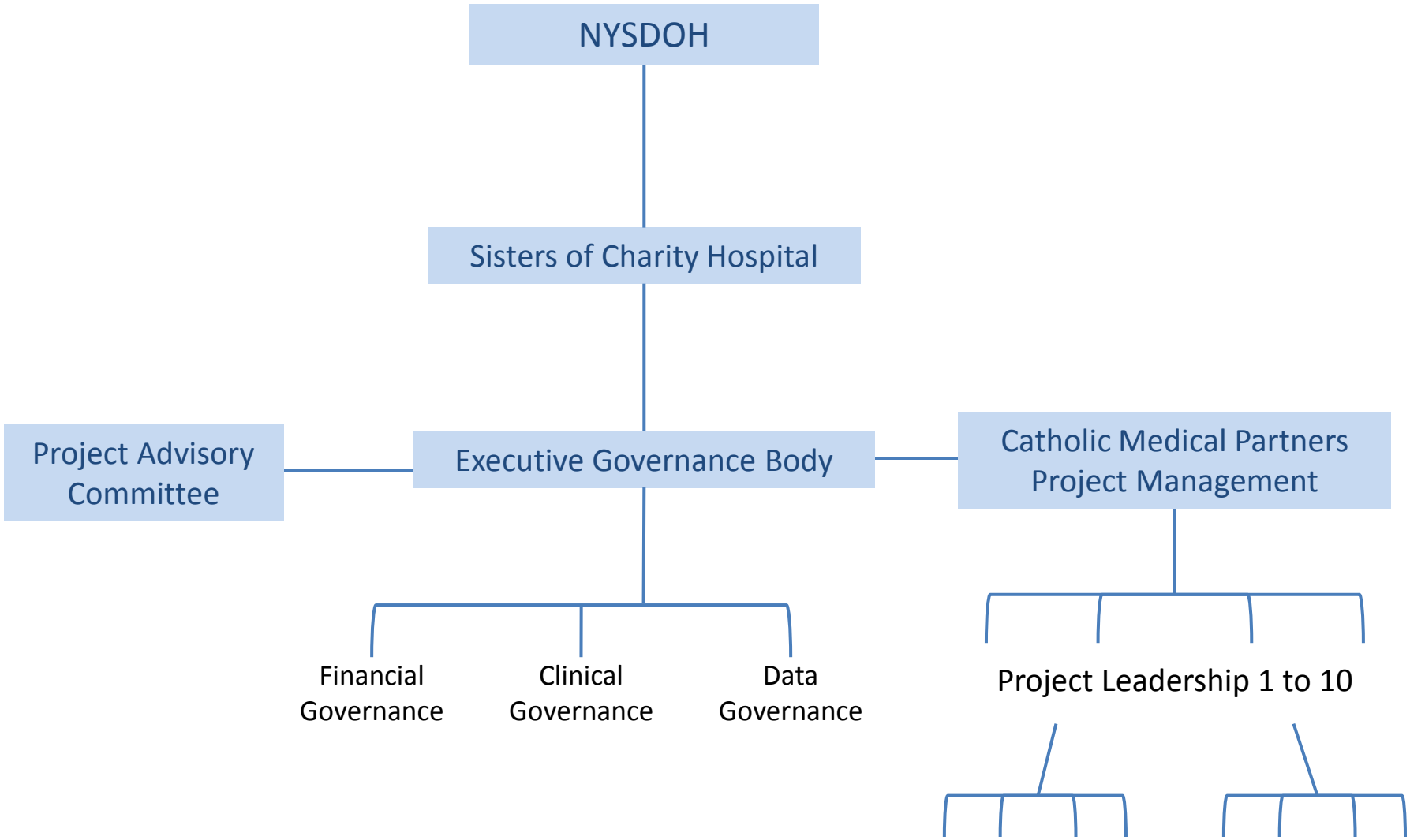
Community Partners of WNY PPS Organizational Structure:



CPWNY DSRIP Project Plan Award

Agreement Period: April 1, 2015 – December 31, 2020
Award Amount: $92,253,402
Population: 85,385

Guaranteed:	$23,856,680	25.86%
At Risk:	$59,298,605	64.28%
At Higher Risk:	$9,098,118	9.86%

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Valuation and Payment

Valuation Bucket	Amount	At Risk	Measurement	# of Payments	Amount & Timing
Safety Net Equity Guarantee	$23,856,680	N	N/A	5	5 equal annual payments, DY1 paid in June 2015
Safety Net Equity Performance	$15,904,454	Y	CPWNY reporting & performance, Domain 1-4 metrics	10	Semi-annual in DY1-DY5, various amount, first payment Jan 2016
Net Project Valuation	$43,394,151	Y		11	3 payments in DY1, semi-annual in DY2-DY5, various amount
Net High Performance Fund (3%)	$5,062,760	Y	CPWNY exceptional performance, metrics unknown	4	4 annual payments in DY2-DY5, on TBD date, unknown amount
Additional Performance Fund (State Only)	$4,035,358	Y	NYS overall performance, metrics unknown	5	5 annual payments in DY1-DY5, on TBD date, unknown amount

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Community Partners of WNY Region

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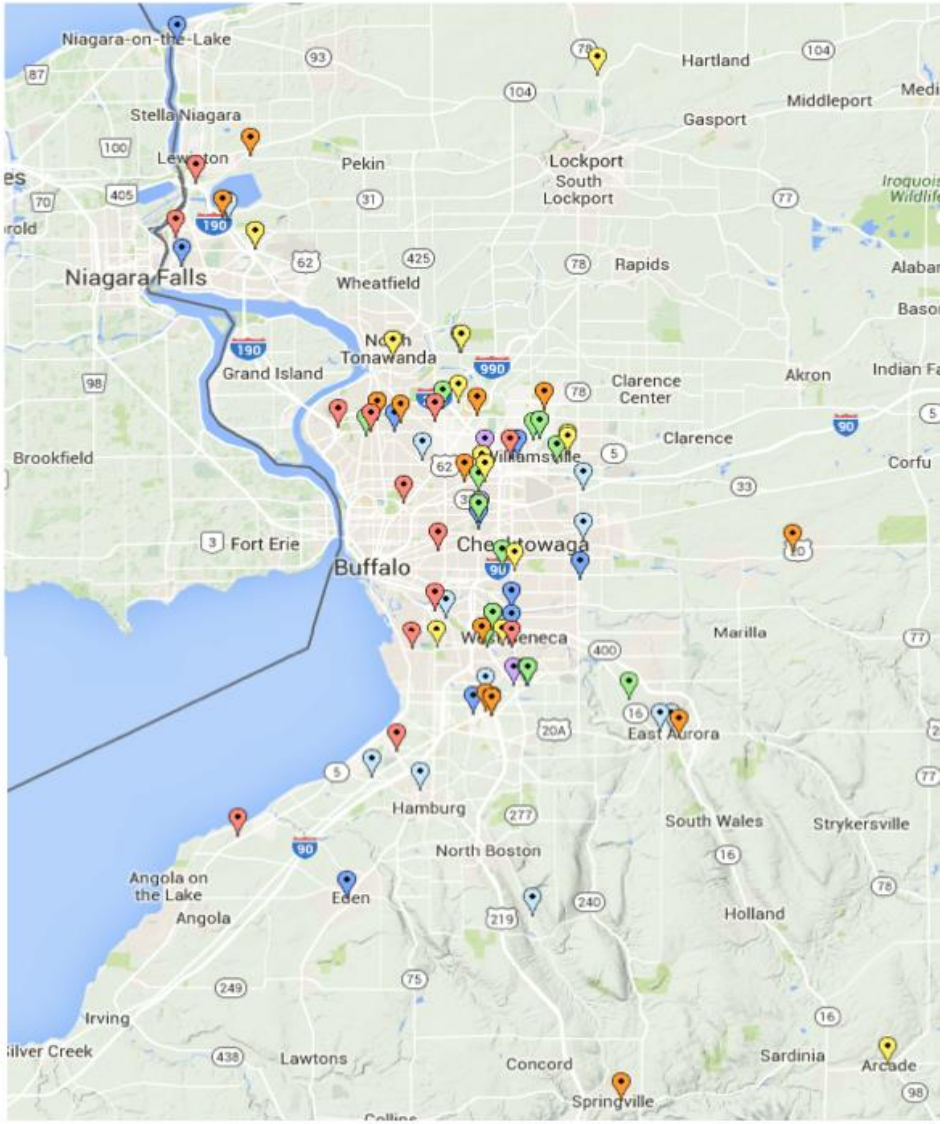
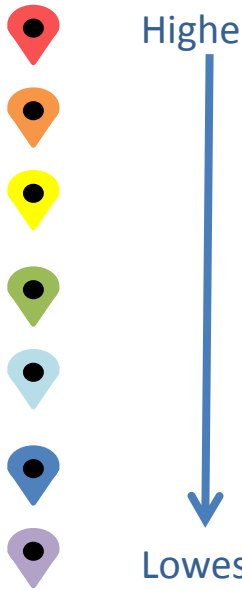
Serving the Medicaid Population

Provider Types:

- Primary Care
- Specialists
- Hospitals
- Clinics
- Health Home
- Care Management
- Behavioral Health
- Substance Abuse
- Skilled Nursing
- Nursing Homes
- Pharmacy
- Hospice
- Community Based Organizations



Number Patients Served:



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Bridging the Gaps in Care

Goal: Reduce health disparities in the Medicaid population in Western New York

Objectives:

1. Reduce unnecessary hospital utilization by 25% over the next five years
2. Improve health status by demonstrating improved preventative care and management of chronic health conditions

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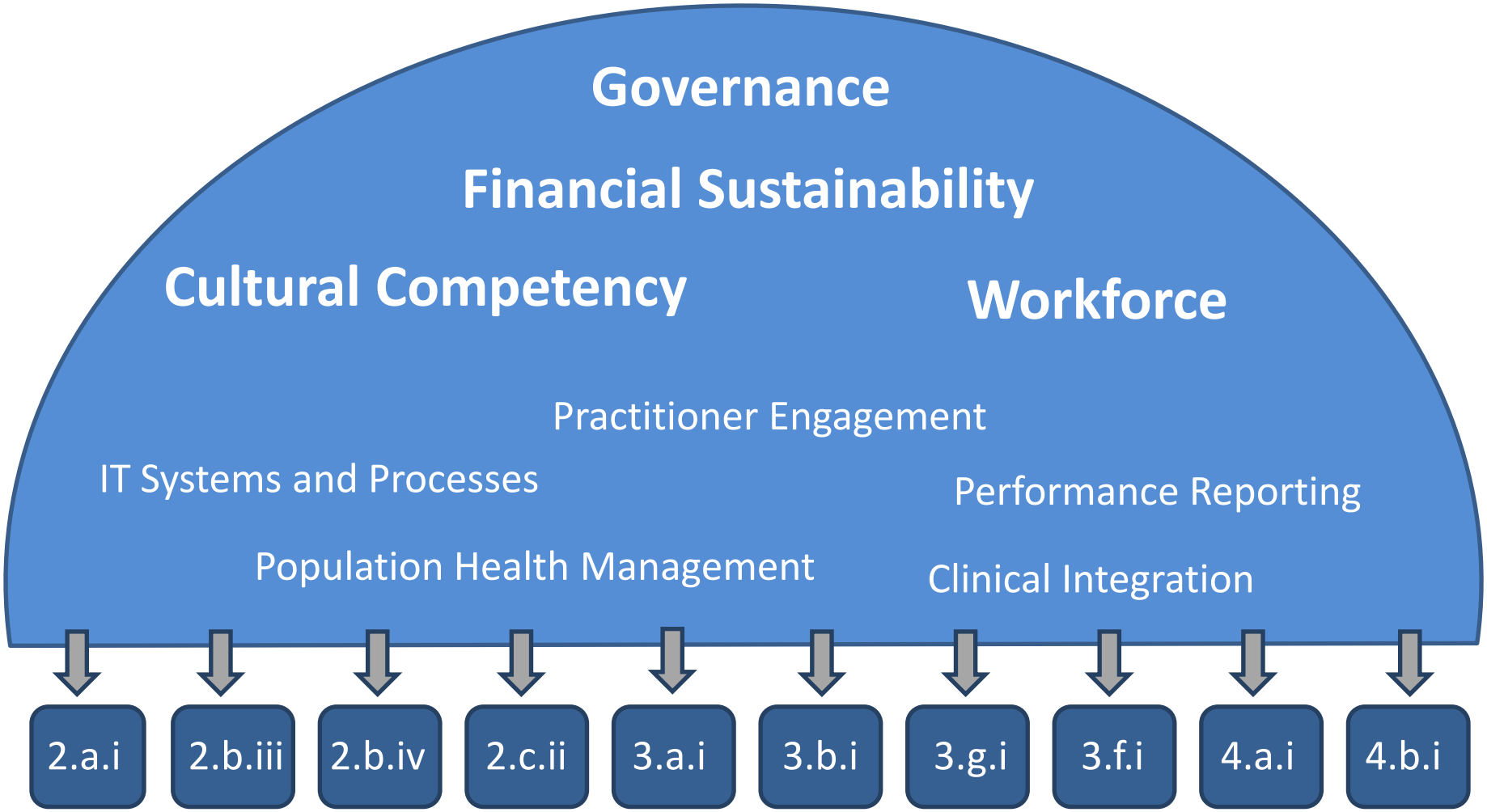
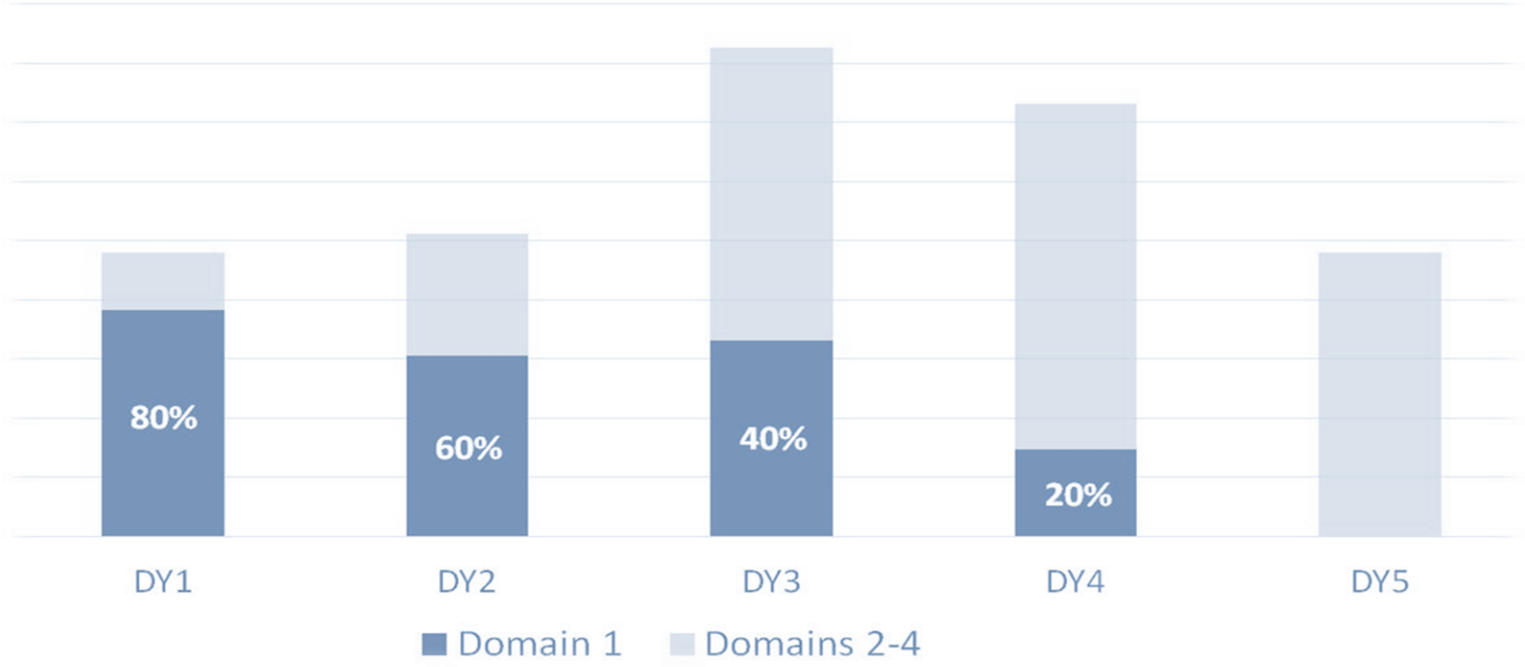
DSRIP Grant Structure



DSRIP Annual Performance Funds – Ratios by Domain Metrics



	DY 1	DY 2	DY 3	DY 4	DY 5	Total
Performance Payment Percentages to be distributed	15.84%	16.88%	27.29%	24.16%	15.84%	100.00%

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Community Partners / Millennium Collaboration

1. Joint Community Needs Assessment
2. Six common initiatives
3. Collaborative work on interoperability with HealtheLink
4. Dr. Edbauer and Dr. Billittier meeting regularly to identify opportunity to maximize success in Western New York

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THE WESTERN NEW YORK POPULATION AT A GLANCE

1,544,000 PEOPLE

MORE THAN 15.8%
OF THE POPULATION IS AGE 65 AND OLDER
(compared to 13.6% in New York State)

11%
OF THE WNY POPULATION HAS A DISABILITY
(almost double the NYS percentage)

WNY HAS A HIGH PREVALENCE OF CARDIOVASCULAR DISEASE-RELATED CONDITIONS

7.6%
CORONARY HEART

9.1%
CARDIOVASCULAR

32.7%
HIGH BLOOD PRESSURE

12.1%
OF BABIES ARE BORN PRE-TERM

MATERNAL MORTALITY RATE
26.8/100,000 BIRTHS IN WNY

10.9% OF HIGH-RISK PREGNANCIES OCCUR IN MEDICAID MOTHERS

Only 69.5%
OF CHILDREN IN GOVERNMENT-SPONSORED INSURANCE PROGRAMS HAVE HAD THE RECOMMENDED NUMBER OF WELL CHILD VISITS

FEDERAL POVERTY LEVEL

15% WNY

10% NYS

MEDIAN HOUSEHOLD INCOME IS
$49,304
(15% Below the NYS median of $58,033)

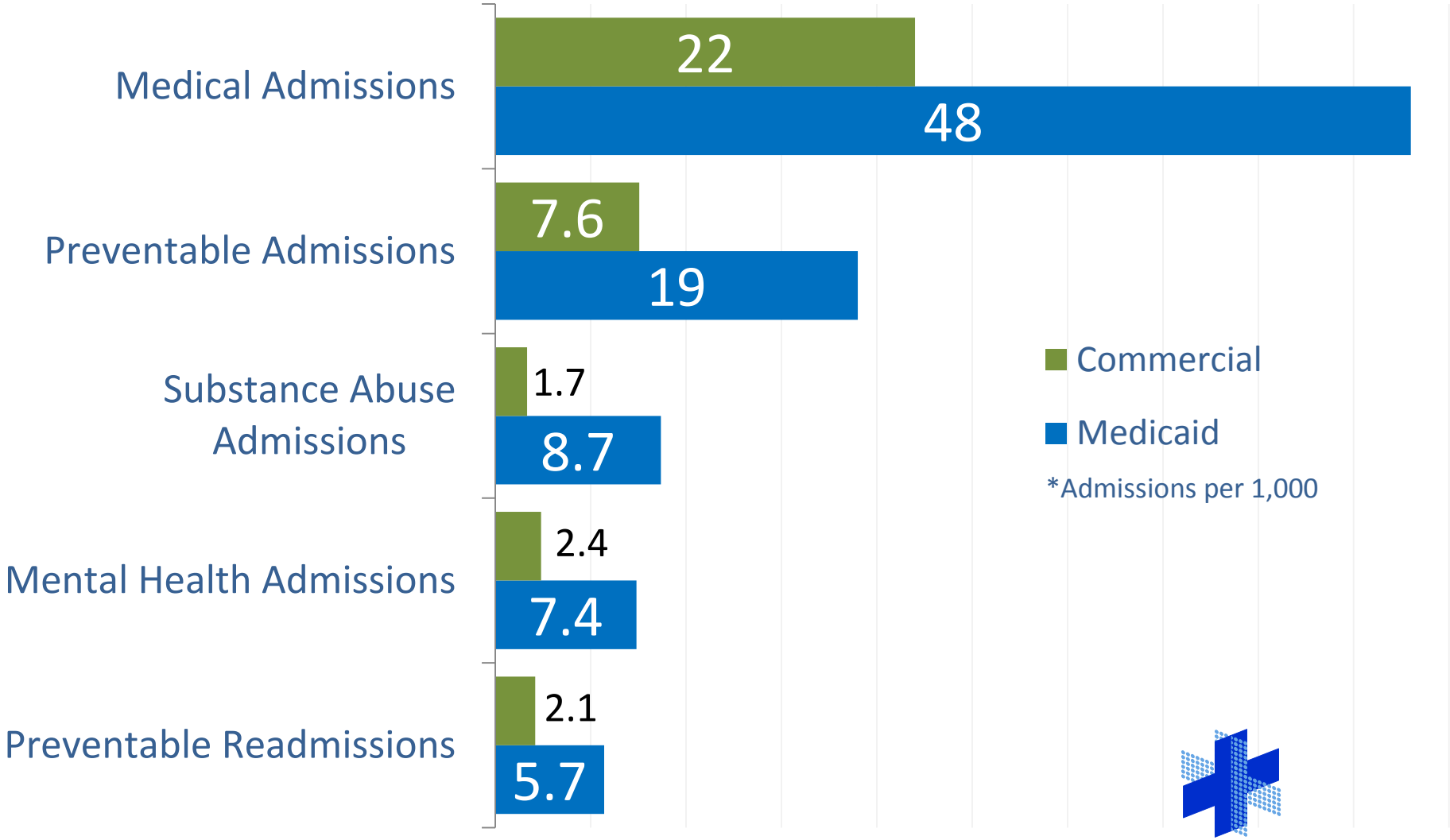
30.2%
OF ADULTS IN WNY ARE OBESE

18.9%
OF ADULTS IN WNY BINGE DRINK

20.8%
OF ADULTS IN WNY SMOKE CIGARETTES

Based on Western New York Community Health Needs Assessment; Delivery System Reform Incentive Payment (DSRIP) Program

Medicaid versus Commercial Admissions



Source: Health Plan actuarial data (2014)

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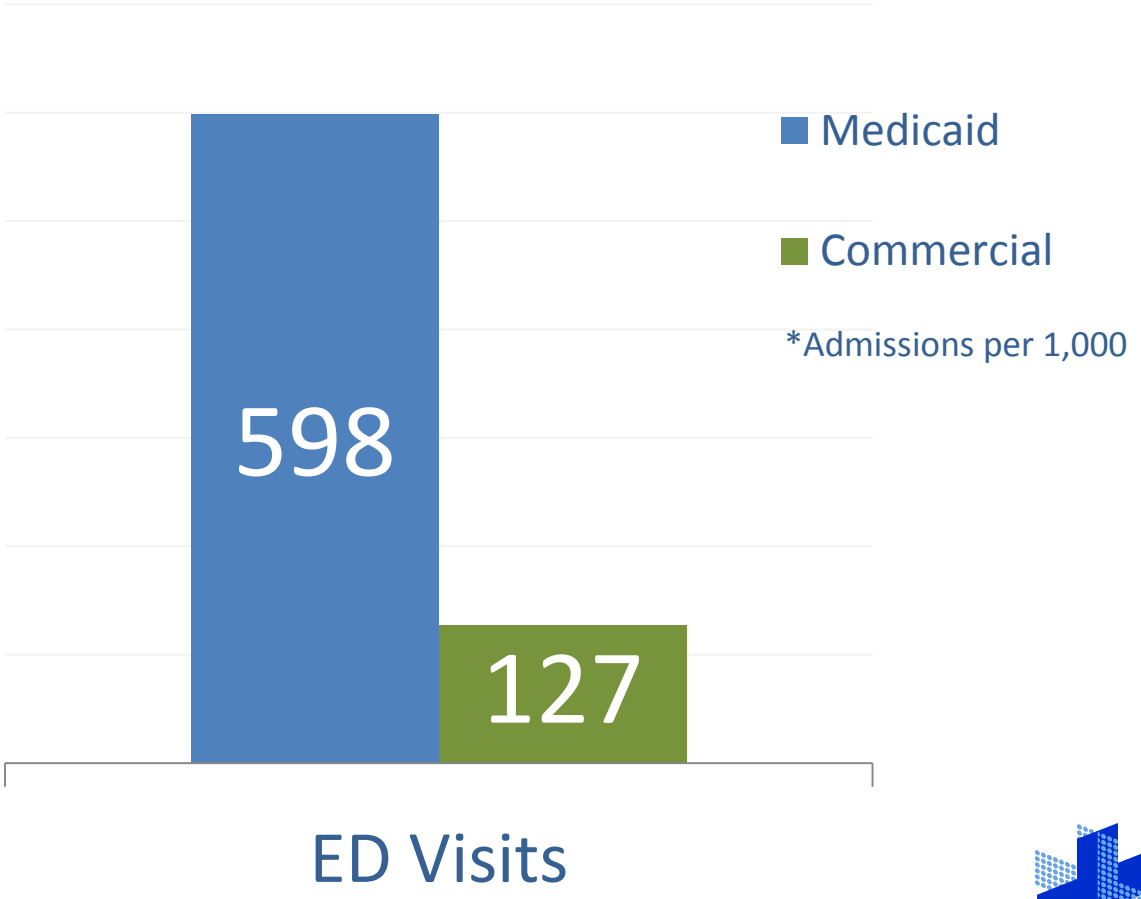
Medicaid versus Commercial Emergency Department Visits



Source: Health Plan actuarial data (2014)

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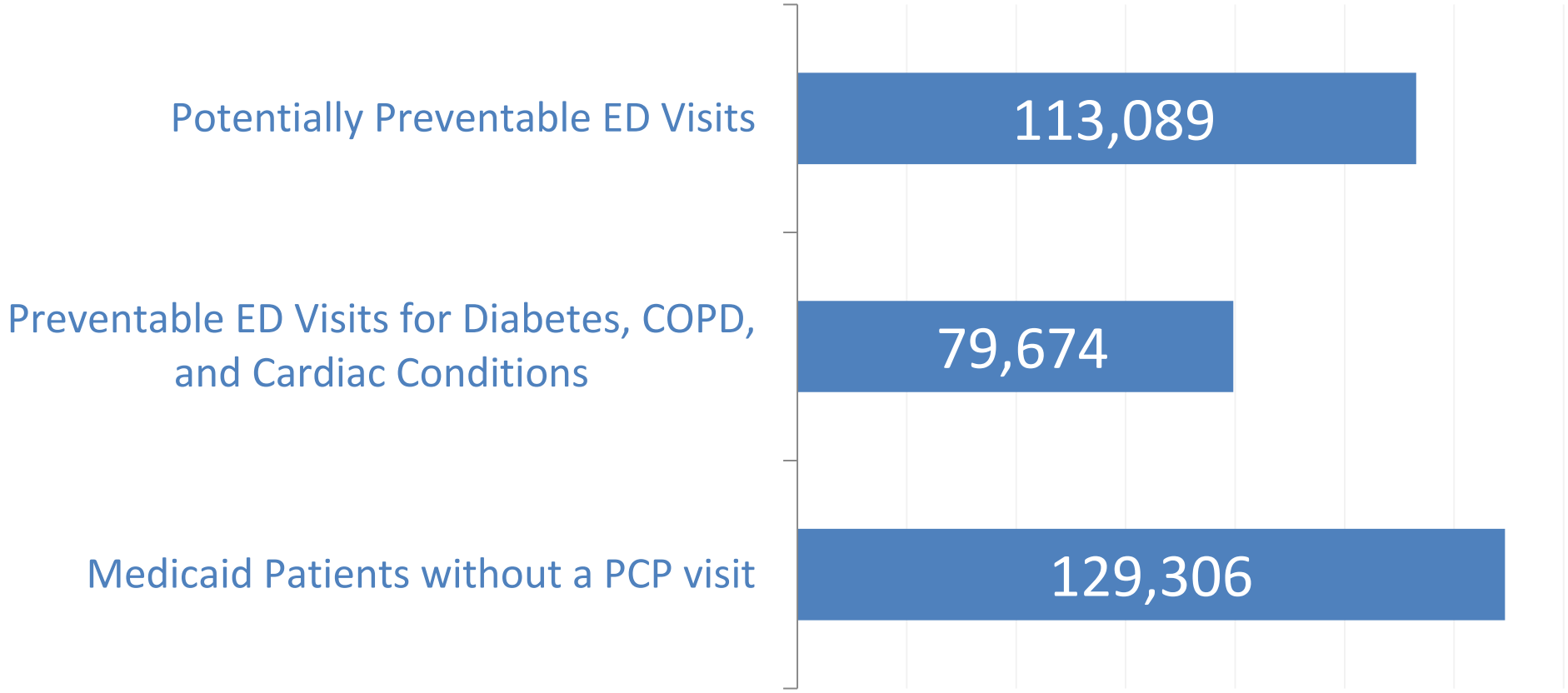
Annual WNY Medicaid Utilization



Source: NYS Department of Health ED PPV by County (2012), total from Erie, Niagara, and Chautauqua.

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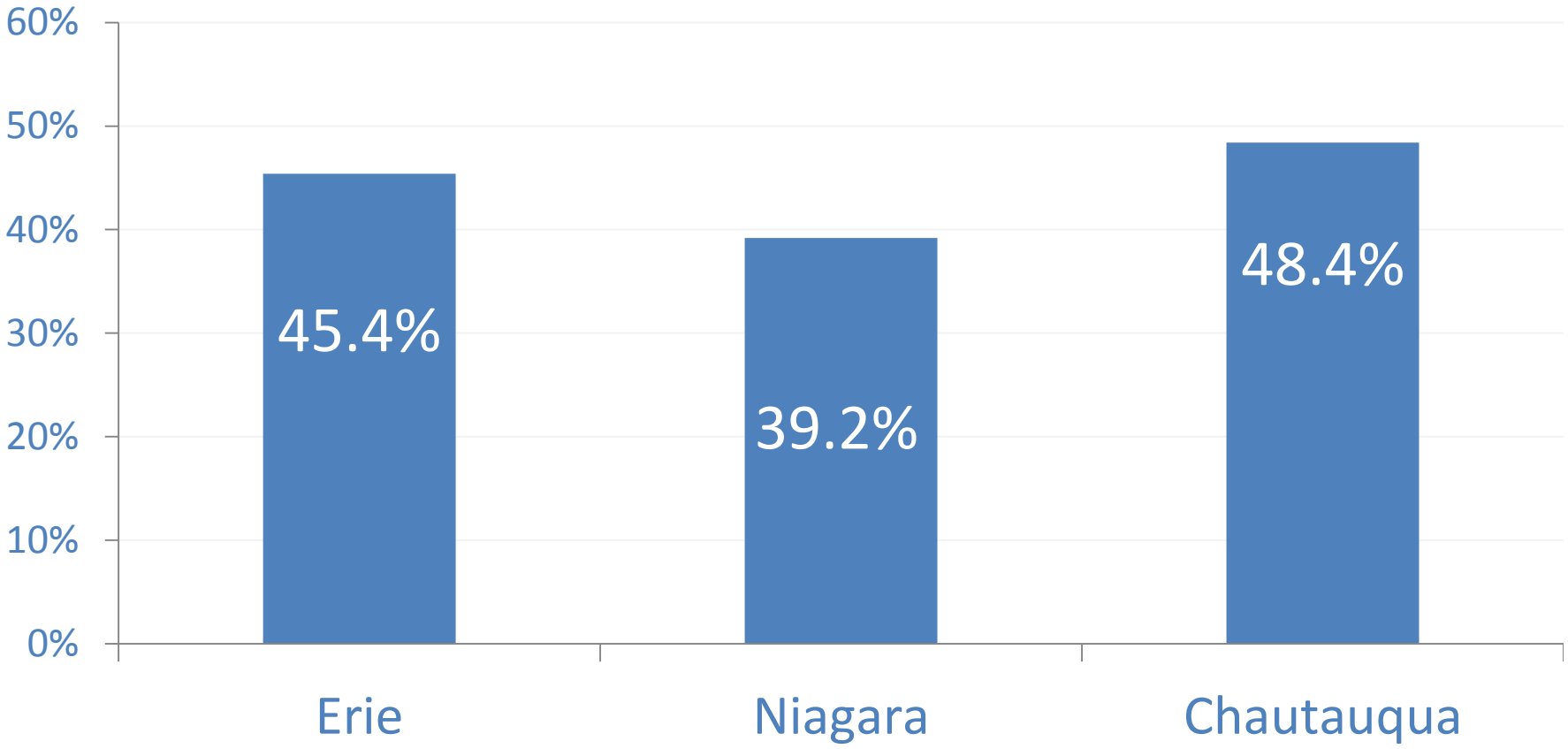
Medicaid Population Accounts for Almost Half of all ED Use



Source: SPARCS outpatient data (2013)

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CPWNY DSRIP Initiatives

- 2.a.i Create Integrated Delivery Systems that are focused on Evidence-based Medicine and Population Health Management (11 Domain 1 Metrics)
  - Example: Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.
- 2.b.iii Emergency Department triage for at-risk patients (5 Domain 1 metrics)
  - Actively Engaged is defined as: The number of participating patients presented at the ED and appropriately referred for medical screening examination and successfully redirected to PCP as demonstrated by a connection with their Health Home care manager for a scheduled appointment.
- 2.b.iv Care transitions model to reduce 30-day readmission for chronic health conditions (7 Domain 1 Metrics)
  - Actively Engaged is defined as: The number of participating patients with a care transition plan developed prior to discharge who are not readmitted within that 30-day period.
- 2.c.ii Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services (7 Domain 1 Metrics)
  - For this project, Actively Engaged is defined as: The number of participating patients who receive telemedicine consultations

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CPWNY DSRIP Initiatives

- 3.a.i Integration of primary care and behavioral health services (4 Domain 1 Metrics)
  - Actively Engaged is defined as: The total of patients engaged per each of the three models in this project, including: A. PCMH Service Site: Number of patients screened (PHQ-9/SBIRT) B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-9/SBIRT).
- 3.b.i Cardiovascular Health- Evidence-based strategies for disease management in high-risk affected populations (20 Domain 1 Metrics)
  - Actively Engaged is defined as: The number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.)
- 3.f.i Increase support programs for maternal and child health through the Nurse Family Partnership Model (4 Domain 1 Metrics)
  - Actively Engaged is defined as: The number of expecting mothers and mothers participating in this program.
- 3.g.i Integration of palliative care into the PCMH model (6 Domain 1 Metrics)
  - Actively Engaged is defined as: The number of participating patients receiving palliative care procedures at a participating sites, as determined by the adopted clinical guidelines.

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CPWNY DSRIP Initiatives

- 4.a.i Promote mental, emotional and behavioral (MEB) well-being in communities
  - No Domain 1 Metrics or Patient Engagement numbers
- 4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health
  - No Domain 1 Metrics or Patient Engagement numbers

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Overall AV Evaluation Matrix

- Organizational AVs (Work streams) carry across all projects
- Domain 2 and 3 Projects: up to 7 AVs per reporting period based on Project Implementation Speed
- Domain 4 projects: 5 AVs in every period

	AV Category	2.a.i		2.b.iii		3.a.i		3.b.i		4.a.i	
		DY1 Q2	DY2 Q4	DY1 Q2	DY2 Q4	DY1 Q2	DY2 Q4	DY1 Q2	DY2 Q4	DY1 Q2	DY2 Q4
Organizational	Governance	1	1	1	1	1	1	1	1	1	1
	Workforce	1	1	1	1	1	1	1	1	1	1
	Cultural Competency / Health Literacy	1	1	1	1	1	1	1	1	1	1
	Financial Sustainability	1	1	1	1	1	1	1	1	1	1
Project	Quarterly Progress Reports/Project Budget/Flow of Funds	1	1	1	1	1	1	1	1	1	1
	Patient Engagement Speed	1	1	1	1	1	1	1	1	N/A	N/A
	Project Implementation Speed	N/A	1	N/A	1	N/A	1	N/A	1	N/A	N/A
	Total Possible AVs	6	7	6	7	6	7	6	7	5	5

Crimson Population Health Key Capabilities

Data Normalization and Aggregation	Population Identification and Stratification	Proactive Patient Care Management	Performance Reporting and Contract Management
•Normalize claims and clinical data from disparate source systems •Match patients and providers across episodes and care settings •Attribute patients to providers	•Stratify populations using Milliman predictive modeling •Identify high-risk patients and chronic condition care gaps using both clinical and claims data •Surface significant and actionable population-level opportunities using Milliman's engineered benchmarks and algorithms	•Monitor Utilization, customize care plans, execute targeted outreach and engage patients •Coordinate cross-continuum care management •Leverage community resources	•Measure impact of interventions on quality, avoidable costs •Track and enforce performance by physicians, groups, practices, networks •Monitor patient adherence •Inform contract negotiations with payers for additional populations

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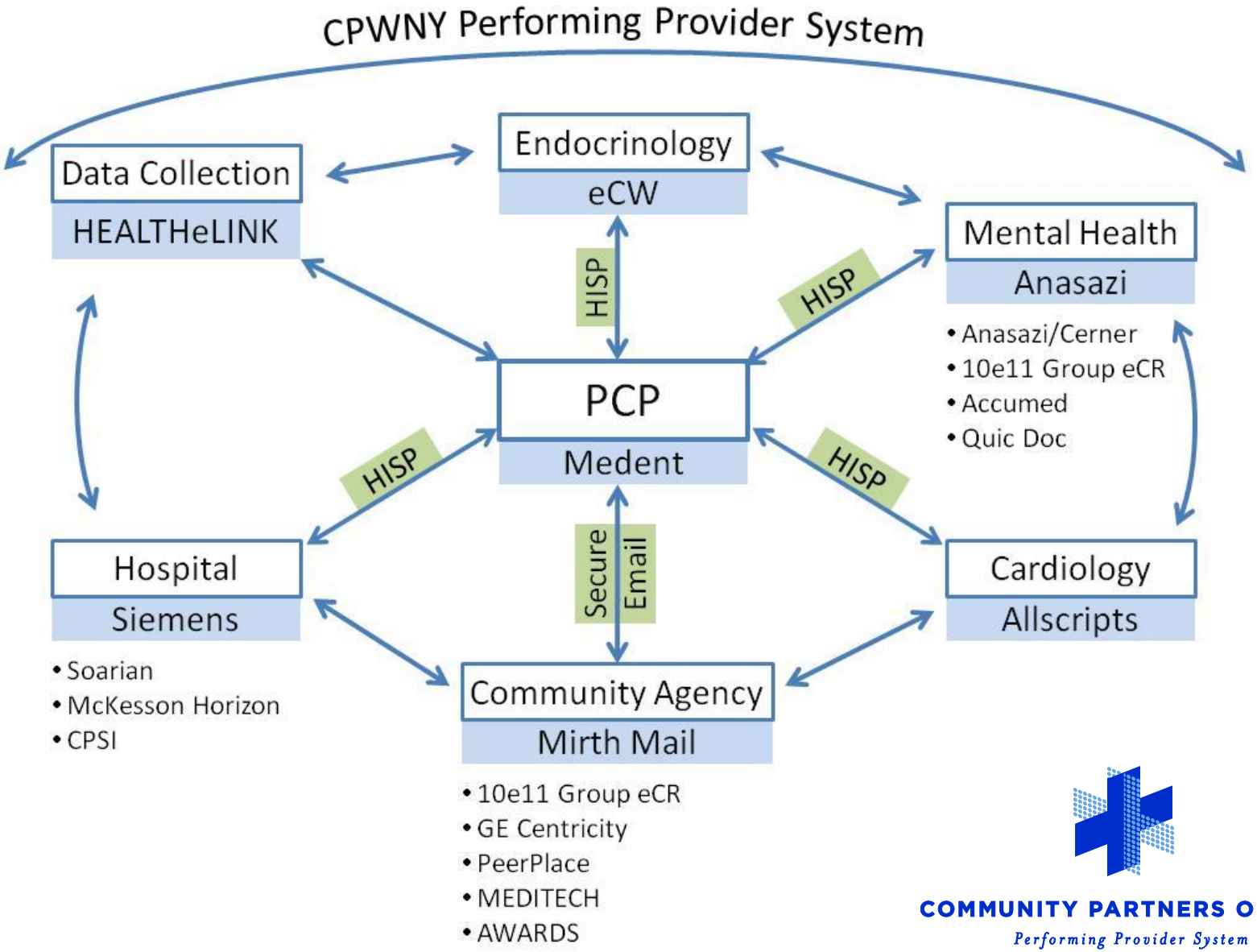
DSRIP HIT (Direct) Infrastructure



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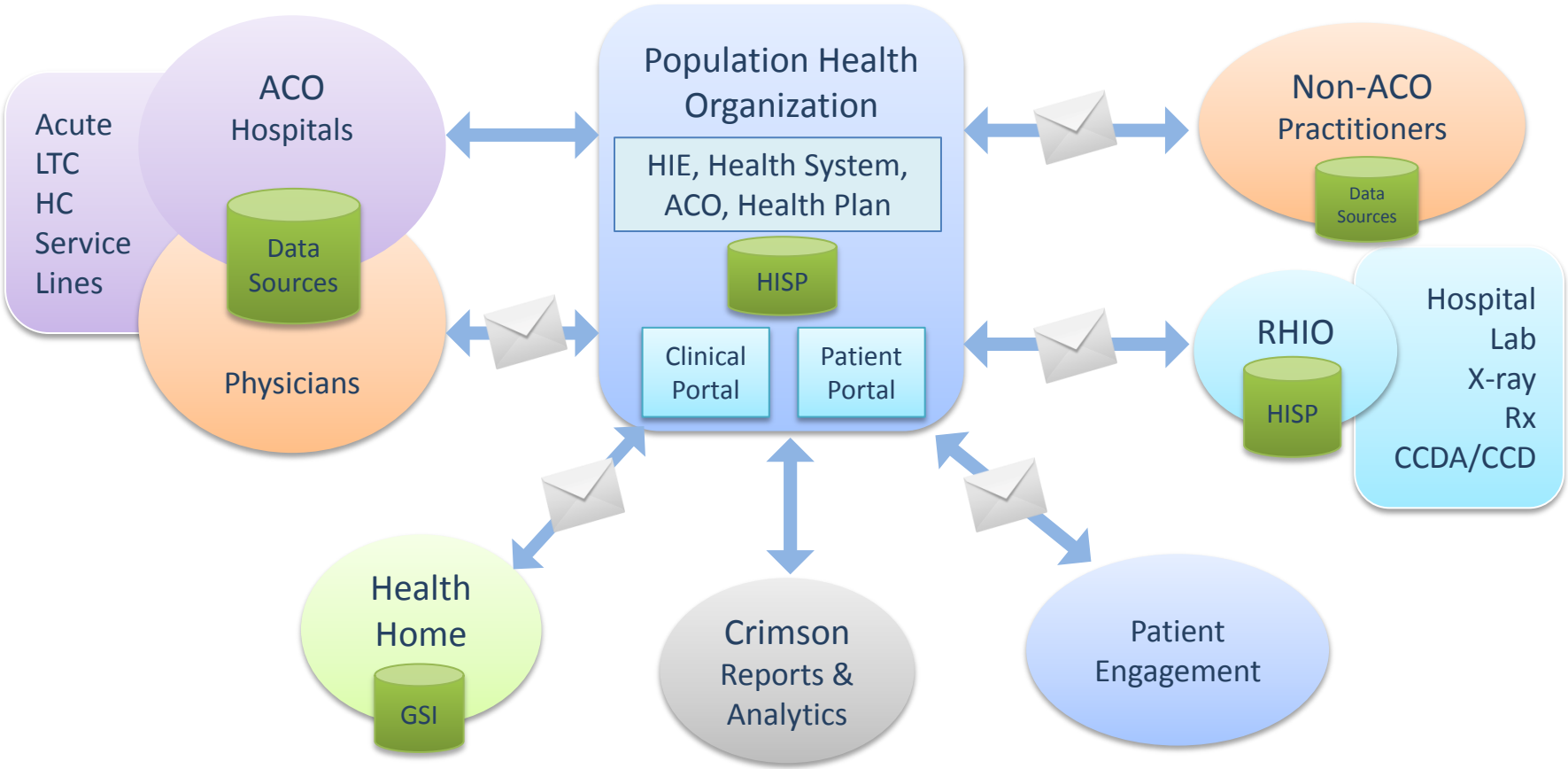
CMP/CHS Population Health Information System



DIRECT (Secure) Message
Data: Push, Pull, and/or Query

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