DSRIP Funds Flow Webinar

DST Support - Finance

MEDICAID REDESIGN TEAM
NEW YORK STATE

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Agenda

Starting Points
Funding Valuation and Realization
Five Budget Categories
Guiding Principles per Budget Category
Funds Flow – Aligned to Governance
Illustrative Model

DSRIP Funds Flow - Starting Points

- During DY1-5, the PPS will receive payments from DOH based upon the PPS' performance in achieving the measurable goals of the DSRIP projects.
- DSRIP funds are paid for achieving project goals not for providing services. The Medicaid claims process must be followed to receive payment from Medicaid for services provided.
- The PPS must establish a plan that specifies how the DSRIP funds received will be distributed among the participating providers in the PPS to cover costs and incent the desired behaviors.
- The plan should be designed to be able to handle variability in DSRIP funding due to variability in performance of the PPS or the State as a whole and should reward all PPS Partners when the PPS successfully meets its DSRIP goals.
- The PPS will be required to issue scheduled reports to the DOH on the actual distribution of DSRIP payments by provider and project that also identifies the basis for the distribution.
- The Funds Flow methodology needs to be anchored in the PPS Governance structure and reporting by the PPS should make the flow of funds, and the basis for the flow, transparent to all PPS partners.

Funds Flow is arguably one of the most critical aspects of the functioning of the PPS to get right from the start

DSRIP Funds Received

- **The Maximum Application Value is the maximum amount of DSRIP dollars the PPS can receive from the DOH (excluding high performance fund payments)**
- **This Value is based on:**
  - The Project Index Scores for the projects selected (known)
  - A generic Valuation Benchmark (published when Applications are awarded)
  - # Medicaid Beneficiaries (final attribution numbers will be released 12/10/2014)
  - Project Plan Application Score from Independent Assessor (published when Applications are awarded)

Example:

Project	Value	Project Index Score	Valuation Benchmark	Project PMPM	Medicaid Members	Project Plan Application Score	DSRIP Months	Max. Project Value
2.a.i Create Integrated Delivery Systems that are focused on Evidence Based Medicine / Population Health Management	56	0.93	$6.80	$ 6.32	100,000	0.9	60	$ 34,149,600
2.a.iv Create a medical village using existing hospital infrastructure	54	0.9	$6.80	$ 6.12	100,000	0.9	60	$ 33,048,000
2.b.v Care transitions intervention for skilled nursing facility residents	43	0.68	$6.80	$ 4.62	100,000	0.9	60	$ 24,969,600
3.a.i Integration of primary care services and behavioral health	39	0.65	$6.80	$ 4.42	100,000	0.9	60	$ 23,868,000
3.b.i Evidence based strategies for disease management in high risk /affected populations (adult only)(cardiovascular)	30	0.5	$6.80	$ 3.40	100,000	0.9	60	$ 18,360,000
3.d/ii Expansion of asthma home-based self-management program	31	0.52	$6.80	$ 3.54	100,000	0.9	60	$ 19,094,400
4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health	23	0.38	$6.80	$ 2.58	100,000	0.9	60	$ 13,953,600
					Maximum Application Value			$ 167,443,200

Example – only limited number of projects included

DSRIP Funds Received

- **The *real* amounts received will be determined based on performance of the providers engaged on each approved project and the PPS's overall performance in achieving project goals for each of the Years 1 – 5**
  - This can result in significant reductions in payments, even during the first year of DSRIP – missing 1 out of 5 milestones, for example, could lead to 20% reduction in funding for that DY.

- **The PPS may also receive additional funds from the High Performance Fund if achieved performance meets certain "high performance" levels**
  - Tier 1 is met when the PPS closes the gap in their DSRIP project plan by 20% between current and high performance levels as defined by DOH
  - Tier 2 is met when the PPS' performance meets or exceeds the 90th percentile of statewide performance for a specific measure

- **The PPS funds received may be reduced for missed milestones Statewide.**
  - The reduction is applied proportionately to all PPSs
  - High Performance Fund payments are not subject to the reduction.

The challenge: handling variable, performance-based DSRIP payments

The PPS will initially be compensated for project and infrastructure development, with a gradual transition to payment for achieving outcomes

- *From the start, however, payments are based on realizing milestones*

- **Incentive payments will initially be calculated based on the progress of process milestones / metrics:**
  - ✓ *Approval of DSRIP plan; semi-annual reports*
  - ✓ *Meeting scale and speed targets set in the Project Application per project*
  - ✓ *Meeting other project-specific Domain 1 metrics*

Project Valuation from DSRIP Program

Fee for Service and "Pay for Reporting" (P4R) → Pay for Performance (P4P)

	Performance Payment*	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
Project progress milestones (Domain 1)	P4R	80%	60%	40%	20%	0%
System Transformation and Financial Stability Milestones (Domain 2)	P4P	0%	0%	20%	35%	50%
	P4R	10%	10%	5%	5%	5%
Clinical Improvement Milestones (Domain 3)	P4P	0%	15%	25%	30%	35%
	P4R	5%	10%	5%	5%	5%
Population Health Outcome Milestones (Domain 4)	P4R	5%	5%	5%	5%	5%
PPS Infrastructure Development	P4R	100%	85%	55%	35%	15%
Clinical Improvement and Health Outcomes	P4P	0%	15%	45%	65%	85%

- *P4P is pay for performance; P4R is pay for reporting*
- *Note project progress is counted as P4R for the purpose of subtotals shown.*

- **As the projects progresses, less payment will be allocated to achieving process milestones and more will be allocated to meeting outcome milestones**
  - ✓ *Preventable (re)admissions and ER visits*
  - ✓ *Patient experience measures (CAHPS)*
  - ✓ *Project-specific clinical improvement and health outcome metrics (see measure-specification guide)*

Source: NYC DOH

Within the funds flow model, PPSs must account for 5 different budget categories

1. Cover project implementation costs

- This cost bucket covers three separate project implementation cost types:

A. Costs for PPS administration and PPS-level PMO

B. Project implementation costs relevant to more than one project (e.g. supporting PCMH achievement for example, which is a requirement for several projects, or introducing disease management and population health capabilities)

C. Project-specific costs implementation and organizational transformation costs: salaries and benefits; contractor costs; materials and supplies

2. Cover costs for the delivery of services currently not or under-reimbursed by Medicaid

- These can be both care or community based services or services to facilitate access to needed services.
- These services should become reimbursed through the introduction of value-based payments before the end of the DSRIP project.

3. Pay Provider Bonus Payments

- Bonus payments to partners for meeting and exceeding their goals as part of achieving the overall PPS' DSRIP goals and metrics.

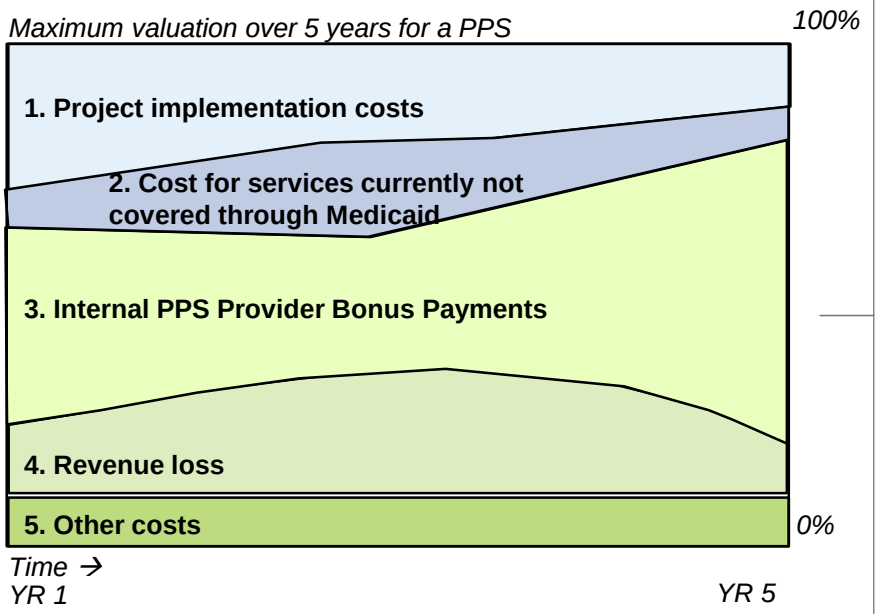
4. Compensate Revenue Loss

- Reduction in bed capacity, closure of a clinic site or other significant changes in existing business models can result in revenue losses that may be compensated through DSRIP funds.
- Funding to sustain financially fragile Safety Net providers (e.g., IAAF funds stop per April 1st)

5. Other

- This category may cover several different types of cost not covered in the other four categories, such as a contingency fund for unexpected items, an innovations or ideas fund, or an award or recognition fund.

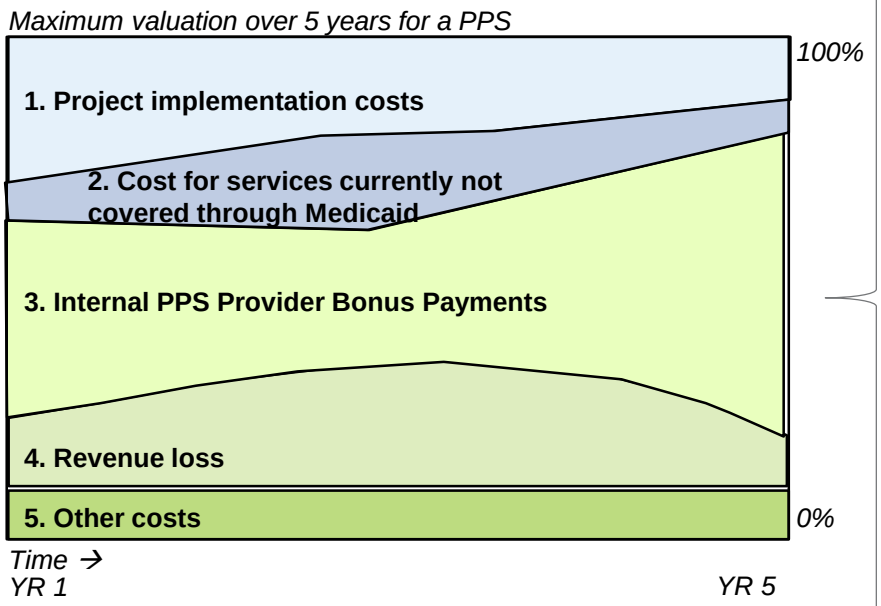
The allocation per budget category should vary over time and depend in part on the speed of introducing value based reimbursements



For explanatory purposes, we first assume that total DSRIP Funding does not fluctuate

1. **Project implementation costs** should be front loaded and will decrease over time as more milestones are met, transformation efforts are realized and new care models become standard practice
2. **Costs for services currently not (sufficiently) covered** through Medicaid will first increase as volume grows and then decrease as the reimbursement mechanisms for services change (incorporating the services previously not covered)
3. **Bonus payments** fluctuate with need for more payments on 2) and 4), but increase significantly during second half of DSRIP
4. It is expected that **revenue loss compensation** will start low and then peak midway through DSRIP as the effects of project implementation start to take hold. These must taper off as new organizational models are realized, costs are brought in line with future expected revenues, and shared savings (VBP) arrangements are introduced. Support for Financially Fragile Safety Net providers should similarly decrease over time.
5. **Other costs (contingencies)** are assumed to stay steady over time

How to handle the fluctuations in total DSRIP funding per category?



Funds in budgets that are not spent (such as missed bonuses etc.) can be allocated to either the Contingency category or remain in the bonus payments budget

1. **Project implementation costs** are likely to be mostly fixed and should therefore in principle not be affected by changes in total DSRIP PPS funding (with the exception of individual partners not achieving milestones)
2. **Costs for services currently not (sufficiently) covered** through Medicaid will most likely remain relatively fixed to the degree that they vary with the number of patients actively using them. If DSRIP is not successful in introducing these new services (and thus perform less well on the DSRIP metrics), less compensation may be needed, and vice versa
3. **Internal PPS provider bonus payments** may be made completely dependent on total DSRIP PPS funding as this optimally aligns internal with external performance
4. It is expected that **less revenue loss compensation** is necessary in the case that DSRIP goals are not met since the patient streams will then be less affected, and vice versa. These could, therefore, be made dependent on DSRIP performance payouts (less DSRIP payouts = less revenue loss compensation)
5. **Other costs (contingencies)** are assumed to stay steady over time

Guiding principles for setting the total budgets for each category

Project Implementation Costs

- Central PMO and Administration costs will be relatively stable over time
- Implementation and transformation costs that cover multiple projects are likely to be significant investments (introduction of disease management capabilities, trans-organizational care pathways, and so forth)
- Project-specific budgets should be created with continuous attention to potential synergies between the individual project implementation strategies
- Project-specific costs do not necessarily have a direct relation with the project valuation: the most important consideration should be the investments required to realize the goals
- To control Project Implementation Costs, it is advisable to work with pre-determined project-specific resource estimates, or by e.g. having PPS partners bid for (sub)tasks.
  - Experience shows that project management and 'coordination' costs can otherwise grow relatively unchecked
- Project Implementation Cost payments to providers should be conditional upon meeting project implementation provider-specific milestones

Costs for services currently not (sufficiently) covered

- The individual project plans should be the starting point to determine which services could be considered for being subsidized through this cost category
- The starting point of negotiations to pay for or add to current reimbursements for services should be the expectation of value added to realizing the promised outcomes. I.e., does this service indeed contribute to reduced (re)admissions and ER visits. Ultimately, would these services find a natural place in novel Value-Based Payment arrangements?
  - Housing is a perfect example here, or care-navigation services
- The payments the PPS makes to these care, community and social services providers should be directly linked to the realization of targets deemed crucial to meet overall DSRIP goals (while being careful to not create perverse incentives).
  - For e.g. housing services, payments should be linked to the number of homeless beneficiaries who successfully avoided care costs by having found a place to live
  - For e.g. care-navigation services, payments could be directly linked to a reduction in ER visits in the communities the navigators are active.

Guiding principles for setting the total budgets for each category

Bonus payments

It is advisable to design separate bonus payment flows. For example:

1. Bonus payments for <u>all</u> participating partners at achieving DSRIP goals. This is an essential stimulus for cooperation and a sense of having skin in the game as a collective.
2. Bonus payments for <u>individual</u> partners that achieve goals vital for the realization of the core DSRIP milestones and outcomes, for example:
    - individual PCMH practices that realize NCQA Level 3 PCMH standards; high scores on H-CAHPS and other provider-specific metrics.
    - PCMHs realizing fewer hospital admissions through e.g. better care-management; hospitals and Home Health Agencies reducing readmissions through better discharge-management and post-discharge outreach)

These bonus payments should be significant to adequately incentivize the desired partners' behaviors. When well organized, these payments can be seen as a first step towards creating a value-based payment mindset within the PPS.

3. Additional bonus payments for those <u>individual</u> partners that exceed their targets and thus increase the opportunity for the PPS to obtain high performance payments
4. Finally, Bonus payments may be awarded for achieving goals related to enhancing the financial stability of the provider/ the PPS and increasing sustainability:
    - PCPs, Health Homes or other PPS providers engaging in value-based contracts with MCOs. This would encourage PPS providers to make a coordinated and planned effort to expand on the DSRIP programs and initiatives and to sustain those beyond the DSRIP period
    - Bonus payments for individual partners that realize milestones or metrics established by the PPS to drive operational and behavior changes focused on the financial stability and health of the provider (e.g. cost objectives or defined financial restructure objectives

- Bonus payments must be well aligned with the mechanisms governing DSRIP performance payments to the PPS as a whole. Reduced payments to the PPS due to not meeting DSRIP goals should directly translate in reduced payments to those providers primarily responsible for the lower performance and vice versa.

Guiding principles for setting the total budgets for each category

Revenue loss

As the PPS is formed and projects are implemented, various forms of currently received revenues will begin to decline. DSRIP funds should be used to cover these losses during the transition periods

- It is to be expected that revenue loss will be needed most for providers that supply inpatient services: successful DSRIP projects will cause reductions in patient volumes that will lead to revenue reductions faster than costs reductions may be realized
- To ensure objectivity, it is advisable to tie revenue loss compensation directly to provider-specific reductions in (re)admissions and ER visits or to other indicators that can be directly attributed to the DSRIP projects.
- Revenue loss compensation should be explicitly drawn upon as a *temporary* measure, facilitating the process of bed-reductions, workforce changes, closure of sites and, where necessary, the overall reconstruction of the business model. costs related to workforce changes.
- Providers who are under a restructuring or a Distressed Provider Plan may also need assistance from this category during the initial transition period. This should be considered *temporary* assistance and require oversight of the Finance Committee to ensure that the provider is meeting the metrics and milestones defined in the plan.
- Financially fragile providers may need supportive funds from this category during the initial DSRIP period in order to achieve defined restructure objectives. This may be necessary to ensure certain provider are sustainable for the entire DSRIP period and should be considered for providers who demonstrate progress on their PPS approved Financial Stability plans.
- In addition, fragile safety net providers may need additional support to transition to new business models that – at the end of the DSRIP period – will be aligned with new Value Based Payment mechanisms. Much like the VAP program, the PPS is advised to require that partners who need this assistance submit a thorough restructuring plan and demonstrate progress on this plan.

Guiding principles for setting the total budgets for each category

Other Considerations

There are other funding considerations that could be utilized by a PPS to effectively incentivize desired behavior or achievement of objectives or to help ensure that variances in year-to-year performance do not affect the PPSs access to required funds.

1. Establish a contingency or reserve for unexpected items or events
   - To help ensure availability of funds to protect against overages in expenditures or to provide a reserve fund in the event additional funding is needed for unanticipated events or conditions. The fund may also provide an additional source of funds to support a worsening condition for a safety net provider.
   - A potential set-aside for providers within an acceptable variance of their DSRIP goals to incentivize them to "catch up" in the next subsequent reporting
   - Reductions due to Statewide missed DSRIP goals can be partially offset from this contingency amount.
2. A mechanism to stimulate new and innovative ideas across the PPS and the community
   - Incentive fund to stimulate thought and engage providers and community regarding new and innovative ideas – possibly ideas solicited via an RFP process within the PPS or across the community via the PPS website – for programs or services.
3. Recognition of contribution(s) toward achievement of High Performance
   - High Performance payments received from DOH should be directed to the high performing partner(s) and to continuum providers that contributed to the project(s) performance.
   - Special recognition of high performance, or exceptional contribution, by a provider organization or individual could be recognized via a nomination process established by the PPS.

Guiding principles for distributing funds to providers

Community based organizations

- Anticipate working with more patients than before due to DSRIP (more patients in preventative, community-based services).
- Depending on how they are currently reimbursed, it is important to reimburse these providers for the costs incurred to run projects as well as for extra volume of patients treated

Primary care providers

- In the event of successful implementation of DSRIP projects, it is expected that these providers receive more patients, with concurrent increased reimbursements
- Simultaneously, these reimbursements will not be sufficient to strengthen the PCP and PCMH infrastructure and adequately handle these increased patient flows. The most important funds categories to consider here are the project implementation costs, bonus payments and reimbursement for new services currently not covered by Medicaid.
- Primary care providers are the key to the success of an integrated delivery network. Funds flow and compensation approaches will need to provide for appropriate incentives and rewards for performance

Secondary and tertiary care providers

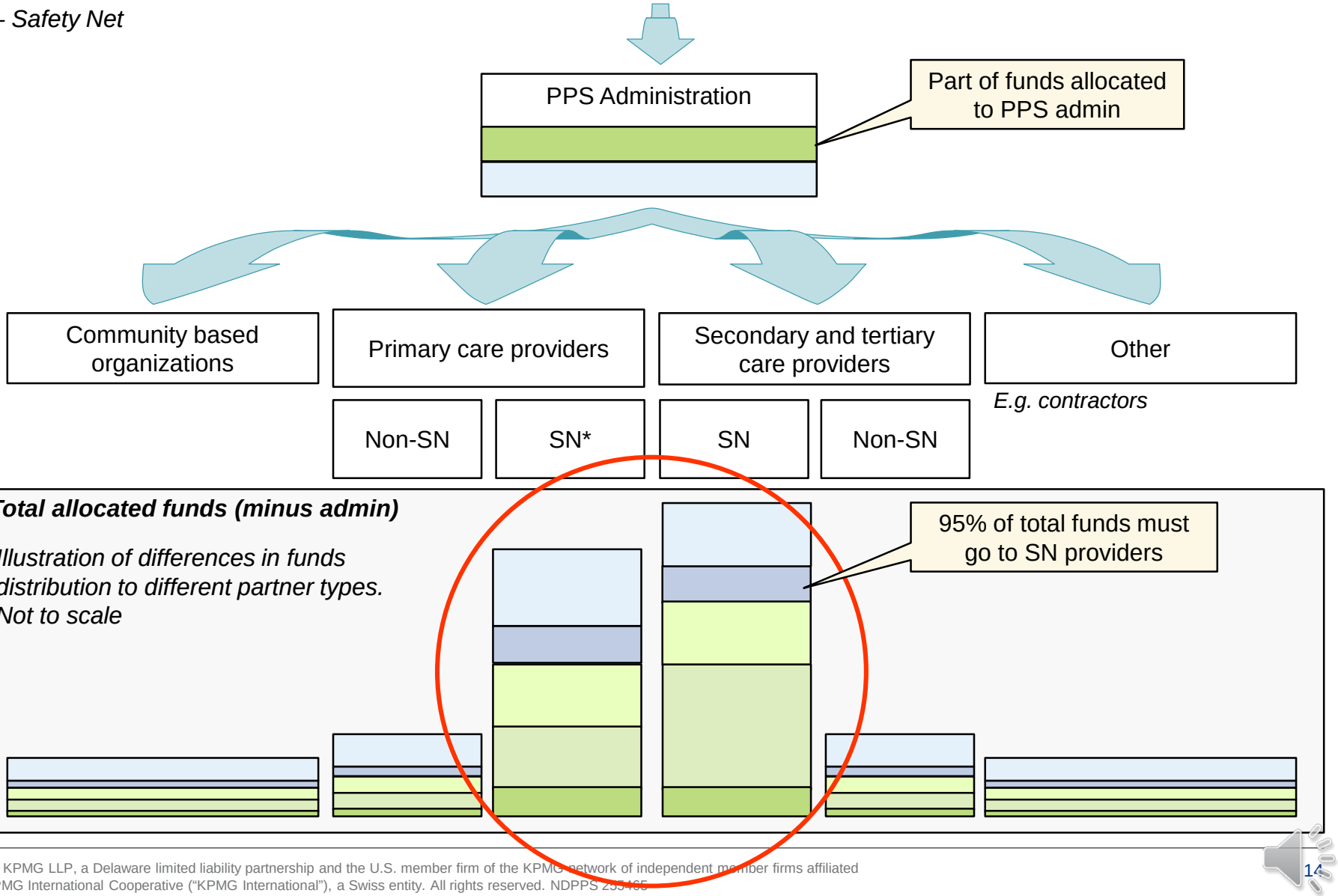
- Inpatient focused providers such as hospitals and nursing homes stand to lose patient streams and revenue in the event of successful implementation of DSRIP projects – see under revenue loss above.

All

- All Funds Flow Methodologies should include a mechanism of progressive sanctions for low- or non-performing partners.
    - After tapering down bonus payments, it is advisable to taper down *all* payments to such a provider as part of a structured process to increase sanctions and prepare for a potential request for partner removal (see also the Governance How-To-Guide).

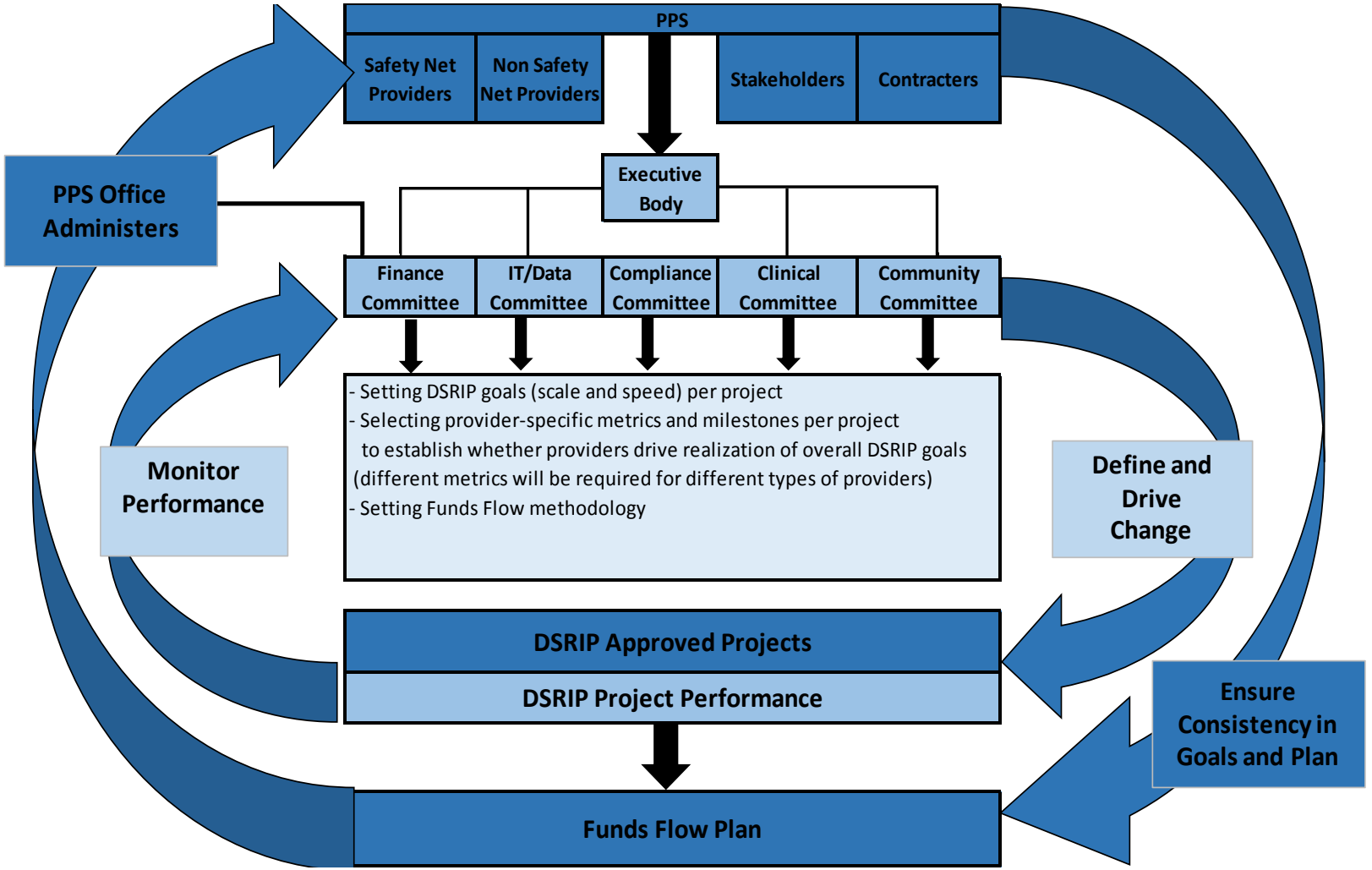
The dynamics for allocating funds for each type of cost category to each (type of) provider within the PPS may create rather different total funds receive per provider

**SN – Safety Net*



DSRIP Funds Flow – Guiding Principles

Governance provides oversight to align incentives, oversee performance and subsequent fund distributions



Funds Flow Example

DSRIP Funds Flow Example – Background on the PPS in our Example

The Forestland Health Provider Partnership (FHPP) is a PPS that will operate under a Delegated Governance Model. The PPS is comprised of 180 partners and 346 vendors.

- There are three capital contributing partners to FHPP. Their roles include serving on the Executive Body where a unanimous vote from all three is required for approved decisions.
  - Forestland Hospital Center – FHC is also the PPS Lead
  - Blackbark Medical and Mental Health Center (25%)
  - Greater Forestland Methodist Hospital (25%)
- FHPP has established their PMO as an LLC – FHPP Project Management Office – with responsibilities to include management of the vendor relationships for the PPS and oversight of the PPS initiatives and projects.
- The FHPP provider partners have each provided FHPP with financial and narrative responses to the survey instrument submitted by FHC to obtain information pertaining to their DSRIP project participation. The responses included their expectations regarding project implementation costs, workforce strategies and costs, as well as impacts that DSRIP might have on their current revenue streams and patient process. These will be considered by FHPP as part of their project planning.
- The Finance Committee of the FHPP is currently working with the Executive Body and with FHC to finalize their policies for managing the DSRIP funds and to develop an initial framework for the funds flow model that will guide the distribution of DSRIP funds to the individual providers.

DSRIP Funds Flow Example – The Providers

The Forestland Hospital Center (FHC) is the PPS Lead for the Forestland Health Provider Partnership (FHPP) PPS. FHC will participate in all DSRIP Projects.

- **Initiatives expected to result in loss of revenue in ED and Inpatient programs**
- **Workforce costs are also expected to be impacted during the transition**
- **The Medical Village project has major financial and organizational repercussions for FHC**
- **The Funds flow model reflects these assumptions and timing**

Within the PPS, FHC has agreed to PPS-internal performance metrics that are aligned to the realization of the overall goals of the PPS, amongst others:

- Closing 16 beds by the end of 2016
- Actively reducing ER visits and avoidable admissions by ensuring all patients visiting the ER are navigated to more appropriate care settings where possible (in close cooperation with the local PCPs and HHA). A yearly goal of 7% reduction in ER visits and 8% in ER related admissions is agreed upon.

DSRIP Funds Flow Example – The Providers

- **FHC project budgets include:**
  - Expected impact of the projects on revenue as inpatient and ED visits decline
  - Costs related to implementing disease management and other prevention services
  - Costs related to closing beds and creating a Medical Village environment, including retraining of staff
  - Costs to transport patients when needed to access primary care and community provider locations

- **As experience begins to materialize, FHC realizes**
  - In Year 3, FHC reported slightly higher amounts of revenue loss and services not covered due to better than expected project performance in areas that affected these metrics
  - These amounts (revenue loss) were covered with the higher than expected funds received from DOH.
  - FHC's performance on their projects exceeded the higher performance metrics established by the PPS at the beginning of Year 3.
  - This qualified them for consideration in the FHPP High Performance Bonus pool for which they were selected to receive a share of the payment in a vote by the Finance and Clinical Committees.

DSRIP Funds Flow Example – The Providers (continued)

- **The Greater Forest Primary Care practice is a large primary care group practice and a provider partner in the Forestland Health Provider Partnership (FHPP) PPS. The group will participate in these DSRIP Projects:**

Project
2.a.i Create Integrated Delivery Systems that are focused on Evidence Based Medicine / Population Health Management
3.a.i Integration of primary care services and behavioral health
3.d.ii Expansion of asthma home-based self-management program
4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health

Within the PPS, the GFPC practice has agreed to PPS-internal performance metrics that are aligned to the realization of the overall goals of the PPS, amongst others:

- Expanding opening hours for urgent care visits to include evenings and weekends
- Actively engaging 25% of eligible children with Asthma in GFPC's service area in home-based self-management program by end of 2016 and 50% by end of 2017

DSRIP Funds Flow Example – The Providers (continued)

- **The GFPC practice submitted a budget model for their projects to FHPP that included**
  - Costs associated with implementing initiatives that require additional workforce to complete additional patient services and protocols and to follow-up with patients.
  - Costs associated with implementing other new prevention and care management services (such as the home-based asthma self-management program)
  - Supporting statistics that relate to current practice volumes and staffing and the gap.

- **As with FHC, Year 3 performance for the GFPC practice is illustrated to be better than expected**
  - The new opening hours have led to higher volumes than expected, and roll out of a self-management program is ahead of schedule. Overall hospital admissions in the region show a sharper than expected downward trend, which is likely due to GFPC's success.
  - Assumed to incur slightly higher than expected number of services not covered due to certain disease management and lifestyle counseling services not being reimbursed.
  - Workforce costs assumed to be on track even though the volume of services provided by the new staff exceeded the projected visits.

DSRIP Funds Flow Example – Defining the Budget (continued)

- **The Maximum Application Value is used as the basis for the PPS to develop a Funds Flow Model**

DSRIP Projects - Determine Maximum Value For PPS Projects			
DSRIP Project	Project Score	Attributed Lives	Max Application Value
2.a.i			$ 34,149,600
2.a.iv			$ 33,048,000
2.b.v			$ 24,969,600
3.a.i			$ 23,868,000
3.b.i			$ 18,360,000
3.d.ii			$ 19,094,400
4.b.i			$ 13,953,600
Total			$ 167,443,200

- **Estimated payments expected to be received from DOH are allocated to the budget categories**
- **FHPP allocates based upon its initial project level budgets**
- **An iterative process: the Initial view of funds by category given the plan approved by the PPS governance structure**
- **The funds flow model includes a provider specific view for each of the budget categories as applicable**

The DSRIP Max Value is allocated into the budget categories to estimate funds that may be available for distribution.

Budget	Yr 1		Yr 2		Yr 3		Yr 4		Yr 5	
Project implementation costs	25%	$8,372,160	20%	$6,697,728	20%	$6,697,728	15%	$5,023,296	10%	$3,348,864
Costs services not covered	5%	$1,674,432	10%	$3,348,864	15%	$5,023,296	10%	$3,348,864	5%	$1,674,432
Bonus payments	50%	$16,744,320	40%	$13,395,456	30%	$10,046,592	45%	$15,069,888	65%	$21,767,616
Revenue loss compensation	10%	$3,348,864	20%	$6,697,728	25%	$8,372,160	20%	$6,697,728	10%	$3,348,864
Other (contingencies)	10%	$3,348,864	10%	$3,348,864	10%	$3,348,864	10%	$3,348,864	10%	$3,348,864

DSRIP Funds Flow Example – Defining The Budget (continued)

- **PPS-level funds flow model is expanded to develop a 5 year provider specific budgets that reflect the expected distribution for each category as appropriate**

BUDGET		Yr 3
Project implementation costs	20%	$6,697,728
Costs services not covered	15%	$5,023,296
Bonus payments	30%	$10,046,592
Revenue loss compensation	25%	$8,372,160
Other (contingencies)	10%	$3,348,864
Total		$ 33,488,640

Forestland Medical Center	Budget	
Budgeted DSRIP Funds		Yr3
Project implementation costs	20%	$1,828,480
Costs services not covered	12%	$1,097,088
Bonus payments	40%	$3,656,960
Revenue loss compensation	18%	$1,645,632
Other (contingencies)	10%	$914,240
Total		$9,142,399

Primary Care Associates	Budget	
Budgeted DSRIP Funds		Yr3
Project implementation costs	29%	$135,964
Costs services not covered	9%	$42,196
Bonus payments	55%	$257,863
Revenue loss compensation	0%	$0
Other (contingencies)	7%	$32,819
Total	$	468,841

- **Budget at provider level, and per category, will depend on the provider-specific projects and project-specific budgets**
  - The budgeted funds flow model reflects the approved costs for items such as implementation and workforce strategies
  - Costs to implement programs and services to meet DSRIP objectives, such as disease management protocols or follow-up, are also approved by the FHPP PPS
  - For example, the primary care group (GFPC) expected to incur costs to develop certain project specific programs that included workforce and care management services
  - Actual amount will also reflect impact to PPS-level performance metrics but will need to make allocation
- **According to FHPP bylaws, services which are necessary to meet goals, but that are not covered by Medicaid, such as transportation or specific healthcare services, are also part of budgeted provider payments.**
- **Bonus payments are budgeted in anticipation of rewarding achievement of project goals as well as specific metrics and goals essential for the PPS overall.**

DSRIP Funds Flow Example - Actual Funds Received (continued)

- PPS (FHPP) submits semiannual reports to DOH that DOH relies on to determine the DSRIP distributions
- DOH distribution includes incentive payments for achieving the required milestones or metrics defined for each project.
- In this example, FHPP received a higher payment than budgeted for Year 3

DOH Funds Distribution Calculation - Year 3			
DSRIP Project	Project Description	Percent Achieved	DSRIP Funds Eligible
2.a.i		100%	$ 6,829,920
2.a.iv		100%	$ 6,609,600
2.b.v		80%	$ 3,995,136
3.a.i		100%	$ 4,773,600
3.b.i		100%	$ 3,672,000
3.d.ii		100%	$ 3,818,880
4.b.i		90%	$ 2,511,648
Total Calculated DSRIP Funds			**$ 32,210,784**
Additional Payments - High Performance Fund			
For Tier 1 Criteria Met			$ 3,543,186
For Tier 2 Criteria Met			$ 1,610,539
Less: Reductions			
Statewide Miss			$ -
Net DOH Funds Issued To PPS			**$ 37,364,509**

- The Percent Achieved Value is the basis for determining the full or partial payment that may be made. Additional payments may also be issued by DOH if the PPS meets High Performance Criteria.

DSRIP Funds Flow Example - Actual Funds Received (continued)

- **The Funds issued by DOH to the PPS are allocated by the PPS Lead or assigned committee into Budget Categories based on initial Funds Flow Model estimates as a first step; PPS has flexibility in determining final distribution**

DOH Funds Distribution Calculation - Year 3			
DSRIP Project	Project Description	Percent Achieved	DSRIP Funds Eligible
2.a.i		100%	$ 6,829,920
2.a.iv		100%	$ 6,609,600
2.b.v		80%	$ 3,995,136
3.a.i		100%	$ 4,773,600
3.b.i		100%	$ 3,672,000
3.d.ii		100%	$ 3,818,880
4.b.i		90%	$ 2,511,648
Total Calculated DSRIP Funds			**$ 32,210,784**
Additional Payments - High Performance Fund			
For Tier 1 Criteria Met			$ 3,543,186
For Tier 2 Criteria Met			$ 1,610,539
Less: Reductions			
Statewide Miss			$ -
Net DOH Funds Issued To PPS			**$ 37,364,509**

- From the budget category level, further allocation and distribution to providers needs to be determined
- The distribution of funds down to the provider level is guided by the project-specific budget that was approved by the PPS governing body and also reflects provider's performance

- Allocating the *actual* amount of funds received from DOH into the budget categories may be prorata based on the initial category estimates
- Allocation methodologies should allow for certain categories, such as implementation expenses, to be more fixed in nature and not fluctuate with changes in the DOH payment received – whether higher or lower than expected

Actual Received	Yr 3			
Compared to Budget	Budget		Actual	
Project implementation costs	20%	$6,697,728	18%	$6,725,612
Costs services not covered	10%	$3,348,864	8%	$2,989,161
Bonus payments	40%	$13,395,456	45%	$16,814,029
Revenue loss compensation	20%	$6,697,728	18%	$6,725,612
Other (contingencies)	10%	$3,348,864	11%	$4,110,096
Total	$33,488,640		$37,364,509	

DSRIP Funds Flow Example – Actual Funds Received (continued)

Illustration of the amount of the DSRIP payment that the provider is eligible to receive based on their share per budget category

- **FHPP performed above expectations, and received higher-than expected disbursements as a result, including funds from the High Performance Bonus pool**
  - Allocation to each provider considers what expense categories are less variable, e.g. staffing or capability implementation; Non covered services may be less variable depending on nature of service
  - Other categories are allocated based on the provider's achievement of objectives in those categories as compared to their goals
  - Final distribution in year 3 to FHC absorbs greater than expected revenue loss with bonus pool funds
  - GFPC non-covered service distribution also higher as were there bonus payments attributed to higher than expected integration between primary care and behavioral health professionals

Actual Received	Yr 3			
Compared to Budget	Budget		Actual	
Project implementation costs	20%	$6,697,728	18%	$6,725,612
Costs services not covered	10%	$3,348,864	8%	$2,989,161
Bonus payments	40%	$13,395,456	45%	$16,814,029
Revenue loss compensation	20%	$6,697,728	18%	$6,725,612
Other (contingencies)	10%	$3,348,864	11%	$4,110,096
Total	$33,488,640		$37,364,509	

Forestland Medical Center	Budget		Actual	
Budgeted DSRIP Funds	Yr3		Yr3	
Project implementation costs	20%	$1,828,480	16%	$ 1,828,480
Costs services not covered	12%	$1,097,088	10%	$ 1,206,797
Bonus payments	40%	$3,656,960	51%	$ 5,978,322
Revenue loss compensation	18%	$1,645,632	15%	$ 1,727,913
Other (contingencies)	10%	$914,240	9%	$ 1,051,376
Total	$9,142,399		$ 11,792,887	

FHC Expected $9.1 M; Actual $11.8M

Primary Care Associates	Budget		Actual	
Budgeted DSRIP Funds	Yr3		Yr3	
Project implementation costs	29%	$135,964	26%	$ 135,964
Costs services not covered	9%	$42,196	10%	$ 50,635
Bonus payments	55%	$257,863	57%	$ 296,542
Revenue loss compensation	0%	$0	0%	$ -
Other (contingencies)	7%	$32,819	6%	$ 33,475
Total	$ 468,841		$ 516,616	

GFPC Expected $470K; Actual $516K

DSRIP Funds Flow Example – Actual Funds Received (continued)

What if performance does not meet expectations?

- **Important for the PPS to prioritize the distribution; these considerations should be established by the governance process.**
  - Costs that are fixed, or less variable, should receive first consideration even if funded for lesser amounts
  - Providers who miss their performance goals should expect to receive a downward adjustment in the funds that they receive – especially for categories that are performance based.

DOH Funds Distribution Calculation - Year 3			
DSRIP Project	Project	Percent	DSRIP Funds
2.a.i		75%	$ 5,122,440
2.a.iv		100%	$ 6,609,600
2.b.v		80%	$ 3,995,136
3.a.i		100%	$ 4,773,600
3.b.i		80%	$ 2,937,600
3.d.ii		100%	$ 3,818,880
4.b.i		90%	$ 2,511,648
Total Calculated DSRIP Funds			**$ 29,768,904**
Additional Payments - High Performance Fund			
For Tier 1 Criteria Met		0%	$ -
For Tier 2 Criteria Met		0%	$ -
Less: Reductions			
Statewide Miss		0%	$ -
Net DOH Funds Issued To PPS			**$ 29,768,904**

Forestland Medical Center	Budget		Actual	
Budgeted DSRIP Funds	Yr 3		Yr 3	
Project implementation costs	18%	$1,674,432	12%	$ 1,506,989
Costs services not covered	2%	$167,443	1%	$ 150,699
Bonus payments	59%	$5,358,182	34%	$ 4,286,546
Revenue loss compensation	11%	$1,004,659	6%	$ 803,727
Other (contingencies)	10%	$937,682	8%	$ 1,078,334
Total			$	7,826,295

Primary Care Associates	Budget		Actual	
Budgeted DSRIP Funds	Yr 3		Yr 3	
Project implementation costs	29%	$133,955	24%	$ 120,559
Costs services not covered	1%	$33,489	6%	$ 30,810
Bonus payments	2%	$267,909	47%	$ 241,118
Revenue loss compensation	0%	$0	0%	$ -
Other (contingencies)	1%	$33,489	6%	$ 30,810
Total			$	423,296

What’s Next

DSRIP Project Readiness – Now Through December 22

There are a number of essential steps that must be completed by the PPS prior to December 22, 2014

• Conceptual Design Funds Flow; define Guiding Principles	• Provider Strategies and Incentives Plan
• Outline how Funds Flow is linked to Governance Structure and Process and review with finance committee	• Develop initial framework of the Data Analytics model and provider requirements

• Agree on Budget Categories	• Funds Flow Process – Draft
	  • PPS Lead Process
	  • Bank and Other Structure required

• Outline Funds Flow Polices and Procedures	• Develop Project Matrix

• Determine Roles and Responsibilities of Providers
  • Pool Groups / Types
  • Individual Providers
	• Obtain financial and other information required for PPS provider

• Develop PPS Governance and DOH Reporting Schedule	• Complete Initial Financial Analysis on PPS Providers for Financial Stability
• Develop and agree on Drivers for Funds Allocation	• Develop Funds Flow PPS Provider Communication Plan

DSRIP Project Readiness – December 23 To April 1

There are a number of essential steps that must be completed by the PPS prior to April 1, 2015

• Funds Flow Process – Finalize
  • PPS Lead Process
  • Bank and Other Structure required
	• Finalize PPS Financial Governance and DOH Reporting Schedule

• Build Simulated Model
  • Simulate Project Results Reporting
  • Simulate Funds Receipt from DOH
  • Simulate Funds Distribution
	• Data Analytics – Finalize
	• Reports and Data requirements
	• Distribution and Access
	• Map processes to data needs and define controls

• Polices and Procedures – develop details and Finalize	• Finalize Financial Stability evaluations
• Re-verify Alignment of Funds Flow Model and Approach with the PPS Objectives and Strategies	• Provider Strategies and Incentives Plan - Final
• Governance Process Review of Simulated Model and Funds Flow Model	• Implement Funds Flow PPS Provider Communication Plan

DSRIP Funds Flow Example – Summary Thoughts

- **Governance structure and agreement determines approach to funds distribution, considering positive as well as under-performance situations.**
- **Funds distribution looks first at the individual project budget and within that, the individual physician or care giver expected contribution and performance.**
- **Budgeted amounts over the 5 year span of the DSRIP project need to reflect expected timing impacts (e.g. reduction in readmissions impact not likely to be felt in Year 1).**
- **Budgets should consider the maximum value as a parameter but provide for the potential that the PPS will not achieve 100% for all projects in all years.**
- **Performance based distributions, including the high performance bonus pool, should be heavily publicized to encourage adoption of emerging leading practices.**
- **Transparency in funds flow mechanics, analytics and communications is critical to developing trust.**
- **PPS leadership and participating providers within the PPS should apply lessons learned in identifying opportunities to expand and apply this initiative toward other books of business in order to leverage the investment.**

Disclaimers

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