**Summary of PPS Responses to PAOP Standard Modification**

This document has been developed to provide a summary of the PPS responses to the PAOP Standard Modification related to the Partner Engagement and Funds Flow strategies of the PPS. The full details of the PPS responses have been posted to the DSRIP website at, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/midpoint/index.htm.

The Standard Modification was included as a recommendation for 14 of the 25 PPS. The full content of the Standard Modification is as follows:

> The PPS must develop a detailed plan for engaging partners across all projects with specific focus on Primary Care, Mental Health, Substance Used Disorder providers as well as Community Based Organizations (CBOs). The Plan must outline a detailed timeline for meaningful engagement.
>
> The Plan must also include a description of how the PPS will flow funds to partners so as to ensure success in DSRIP.
>
> The PPS must also submit a detailed report on how the PPS will ensure successful project implementation efforts with special focus on projects identified by the IA as being at risk.
>
> These reports will be reviewed and approved by the IA with feedback from the PAOP prior to April 1, 2017.

The IA is currently reviewing the PPS response to this recommendation as well as the PPS responses to all other Mid-Point Assessment Recommendations to provide feedback to the PPS by April 7, 2017.

**Adirondack Health Institute**
The Adirondack Health Institute (AHI) response to the PAOP Standard Modification indicated that the PPS is using its contracting processes to confirm and secure partner participation in Master Participation Agreements (MPAs) and associated project addendums. The response also noted that the PPS has been restructured geographically through the formation of five regional Population Health Networks (PHNs) that have helped the PPS to identify and address the needs of each community it serves.

AHI also developed a 'Meaningful Engagement Timeline' to reflect their plans for achieving meaningful partner engagement. Highlights of this timeline include:

- **April 2017:** first round of Innovation Grants that align with and accelerate IDS formation and DSRIP goal achievement will be awarded and funded. Funds flow to partners in the P4R phase continues.
- **May 2017:** P4R Cycle 4 funds flow will distribute earned funds to partners to support continued implementation efforts.
- **August 2017:** P4R Cycle 5 funds flow will distribute earned funds to partners for continued engagement.

The PPS funds flow strategy is described as having two phases – pay for reporting (P4R) and pay for performance (P4P). Funds flow to partners in the P4R phase is driven by the completion of payment activities by the PPS partners. The project addenda define the threshold for payment for each payment activity. The completion of payment activities, designed to ensure the advancement of DSRIP projects, drives the funds flow to partners. The P4R payments follow a quarterly cycle to facilitate orderly cash flow to partners. The P4P phase of the funds flow plan will be deigned to align partner funds flow with performance outcomes.

AHI also noted that the leadership of each PHN was tasked with reassessing the provider network in their region to identify any provider gaps that may hinder their region from reaching DSRIP program goals. The PPS is working to finalize contracting with identified providers to fill the gaps.

The PPS reported that it dramatically increased funds flow to partners since the Mid-Point Assessment, releasing more than $4.5 million to partners based on the completion of payment activities by the partners.

The following table indicates the planned distributions to partner categories through the end of DY2 and the projected distributions of earned dollars for DY3 and DY4-5.

| | | Funds Flow (all funds) | | | |
|---|---|---|---|---|---|
| **Partner Category** | | ***Funds Flow through DY2, Q3*** | ***Projected Funds Flow through DY2*** | ***% of Earned Dollars Planned for Distribution DY3*** | ***% of Earned Dollars Planned for Distribution DY4 - DY5*** |
| Practitioner - Primary Care | | $ 437,444 | $ 497,884 | 2.50% | 2.00% |
| Practitioner - Non-Primary Care | | $ - | $ - | | |
| Hospital - Inpatient/ED | | $ 4,123,100 | $ 6,692,375 | 25.00% | 22.50% |
| Hospital - Ambulatory | | $ - | $ - | 6.33% | 5.00% |
| Clinic | | $ 1,324,403 | $ 1,833,376 | 10.00% | 11.00% |
| Mental Health | | $ 758,166 | $ 933,661 | 4.00% | 4.50% |
| Substance Abuse | | $ 659,979 | $ 810,121 | 3.75% | 4.00% |
| Case Management | | $ 185,552 | $ 236,739 | 1.00% | 1.00% |
| Health Home | | $ 294,860 | $ 418,315 | 2.00% | 2.00% |
| Community Based Organization (Tier 1) | | $ 688,736 | $ 949,098 | 4.00% | 4.00% |
| Nursing Home | | $ 260,480 | $ 528,408 | 2.25% | 2.25% |
| Pharmacy | | $ - | $ - | | |
| Hospice | | $ 314,650 | $ 365,650 | 2.00% | 2.00% |
| Home Care | | $ 609,087 | $ 961,035 | 5.00% | 5.00% |
| Other (PPS PMO) | | $ 6,078,236 | $ 7,578,804 | 20.17% | 25.92% |
| Other (Uncategorized) | | $ 128,980 | $ 230,980 | 1.00% | 1.02% |
| Other (Uncategorized - County Agency) | | $ 173,130 | $ 176,091 | 1.00% | 1.00% |
| **Total** | | $ 16,036,804 | $ 22,212,536 | 90.00% | 93.19% |

**Advocate Community Providers**
The Advocate Community Providers (ACP) response to the PAOP Standard Modification focused on the PPS' need to engage more Primary Care Physicians (PCPs) in order to meet their commitment from the DSRIP project Plan Application. The response discusses plans for various projects where PCP engagement is behind. The plans indicate a reliance on the creation of reports to better track patients. For project 3.a.i., the integration of behavioral health and primary care, ACP describes four main strategies for developing systems to promote the integration of behavioral health and primary care. The PPS further indicated that these strategies are aimed at increasing physician engagement.

For CBO engagement, the ACP response noted that they created a profile form to log the type of services provided by each CBO, created a CBO Directory, an identified gaps in the CBO network. These efforts resulted in ACP targeting an additional 15 CBOs to recruit in to the network.

The ACP response related to funds flow notes that the strategy has been to distribute payments to the ACP network providers based on implementation as well as engagement and reporting in DY0 and DY1. ACP indicated that it will distribute funds to partners based on performance in DY2 through DY5.

The following table indicates the planned distributions to partner categories through the end of DY2 and the projected distributions of earned dollars for DY3 and DY4-5.

| | | Funds Flow (all funds) | | | |
|---|---|---|---|---|---|
| **Partner Category** | | ***Funds Flow through DY2, Q3*** | ***Projected Funds Flow through DY2*** | ***% of Earned Dollars Planned for Distribution DY3**** | ***% of Earned Dollars Planned for Distribution DY4 - DY5**** |
| Practitioner - Primary Care | | $ 5,969,672 | $ 11,602,778 | 22.00% | 22.00% |
| Practitioner - Non-Primary Care | | $ 745,177 | $ 1,324,735 | 5.00% | 5.00% |
| Hospital - Inpatient/ED*** | | *** | *** | *** | *** |
| Hospital - Ambulatory*** | | *** | *** | *** | *** |
| Clinic | | $ 492,509 | $ 492,509 | 1.60% | 1.60% |
| Mental Health | | $ 418,644 | $ 433,153 | 2.00% | 2.00% |
| Substance Abuse | | $ - | $ - | 0.00% | 0.00% |
| Case Management | | $ - | $ - | 0.10% | 0.10% |
| Health Home | | $ - | $ - | 0.00% | 0.00% |
| Community Based Organization (Tier 1) | | $ 314,176 | $ 669,182 | 1.36% | 1.36% |
| Nursing Home | | $ 183,074 | $ 226,110 | 1.08% | 1.08% |
| Pharmacy | | $ 7,176 | $ 7,176 | 0.20% | 0.20% |
| Hospice | | $ 11,952 | $ 11,952 | 0.23% | 0.23% |
| Home Care | | $ - | $ - | 0.00% | 0.00% |
| PMO | | $ 18,004,200 | $ 26,005,600 | 30.00% | 30.00% |
| Hospital | | $ 4,268,757 | $ 7,568,021 | 13.68%** | 13.68%** |
| All Other | | $ 294,951 | $ 356,411 | 1.43% | 1.43% |
| **Total** | | $ 30,710,289 | $ 48,697,627 | | |

**Planned distribution is based on DSRIP PPS Organizational Application Submitted to NYS DOH in 2014*
***Hospitals and other safety net providers – based on achievement of performance metrics related to overall DSRIP and project goals*
****Information under 'Hospital' category (row 23)*

**Albany Medical Center**
Albany Medical Center's response to the PAOP Standard Modification included discussions on the areas of CBO Engagement, Contracting, Care Coordination, Primary Care, Health Homes/Behavioral Health, and Funds Flow.

The CBO Engagement narrative indicated that the PPS has restructured its PMO to include a community relations manager who focuses on the community need, services provided, and additional advocacy as necessary. The PPS notes that it uses the Consumer and Community Affairs Committee to engage CBOs in the PPS through efforts to help the CBOs understand the projects and how the services of the CBOs can align with the overall DSRIP goals. Albany Medical Center further notes that CBO engagement is an ongoing initiative for the PPS and points to the use of CBOs within Project 2.d.i. to provide navigation services, conduct PAM surveys, coach patients, and help patients to engage in care. Lastly, the PPS notes that vendor contracts are being developed for care management and care coordination services under the PPS' Phase II contracting plan.

As part of the narrative on Care Coordination, Albany Medical Center indicated that it is developing a comprehensive Care Coordination Care Management (CCCM) Model to work with health home care management agencies, PCMHs and other partners such as CBOs to strengthen and expand the capabilities of the primary care partners. This program is intended to identify, engage, and link attributed members to appropriate CCCM resources. Further, primary care partners have defined roles that includes the establishment of partnerships with community based behavioral health organizations for referral and care coordination.

The PPS has developed a Clinical Integration/Care Coordination Model (CI/CCM) under which community-based primary care is a critical component of the cyclical continuum of care coordination from acute to community settings. Albany Medical Center also indicated that the PCMH initiative will be a key component of their strategy to engage primary care providers across the PPS. The PPS with the assistance from a vendor will be working to engage up to 78 participating primary care sites in a two tier PCMH certification process. Albany Medical Center PPS also noted that they are in the planning phase of implementing a recruitment and retention fund, similar to that implemented by the AHI PPS. This fund is intended to support participating providers in addressing access to primary care and through the PPS workforce strategy, to recruit and retain primary care practitioners to expand access to primary care services.

*Funds Flow*
Albany Medical Center's response to the funds flow portion of the recommendation indicated that the PPS has developed a multi-phase approach to contracting and funds flow. The first phase was anticipated to cover April 1, 2015 through December 31, 2016 with $9.7 million allocated for distribution to partner organizations. This first phase of contracting was intended to 'engage partners and begin initial steps towards building an integrated delivery system.' The PPS distributed funds to partners for various activities that included attending monthly PAC meetings, completing work stream and project-specific training initiatives, fulfilling data requests, and developing/adopting policies/protocols. These are all efforts that the PPS believes will provide the PPS and its partners with the foundation needed to implement the various work streams and projects across the PPS service area. Through February 2017, the PPS indicated that it had distributed over $5.6 million dollars to partners through the first phase of contracting and that the PPS PMO was continuing to work with partners to complete deliverables that would drive an additional $3.4M in distributions.

The development of the second phase of contracting included the PPS PMO, partner organizations, and the PPS' consultants and relied on the development of draft metrics that were presented to various PPS committees to obtain feedback. The process was intended to allow for the clinicians in the PPS network to lead in the development of the metrics and to facilitate buy-in from partner organizations. The PPS indicates it has allocated $13 million across its partner organizations for this second phase of contracting that is plan to cover January 1, 2017 through March 31, 2018. Consistent with the shift of DSRIP funding, this second phase of contracting has the goal of shifting the funding for partners from activities to outcome measures. Partners will continue to receive funds for activities such as policy and procedure development, meeting participation, and patient engagement efforts but payments are also tied to the PPS achieving its performance goals for outcome measures. This second phase of contracting allocates 75% of the funding to the continued completion of activities with 25% of the funding tied to outcome measures. Phase two contracting also requires partners to complete 'prerequisite' activities such as attending PAC meetings, completing financial sustainability assessments, attending CCHL champion meetings, and attending VBP education sessions in order to be eligible to receive any payments from the PPS.

The PPS indicated that it anticipates that future contracting phases will continue to move more funding from the completion of activities to the achievement of performance goals for outcome metrics.

The following table reflects the funds the PPS projects to distribute to its partners through the end of DY2 as well as its projects for the portion of earned funds it anticipates distributing to partners for DY3 and DYs 4 and 5. The PPS noted that the distributions included in the 'Hospital – Inpatient/ED' category included physician practices associated with the partner hospitals in the PPS and that these practices account for 28% of the PPS network PCPs, 50% of the network non-PCPs, and 10% of the mental health providers.

| | | Funds Flow (all funds) | | | |
|---|---|---|---|---|---|
| **Partner Category** | | ***Funds Flow through DY2, Q3*** | ***Projected Funds Flow through DY2*** | ***% of Earned Dollars Planned for Distribution DY3*** | ***% of Earned Dollars Planned for Distribution DY4/DY5*** |
| Practitioner - Primary Care | | 194,849 | 1,797,243 | 14.02% | 41.69% |
| Practitioner - Non-Primary Care | | | - | 0.00% | 0.00% |
| Hospital - Inpatient/ED | | 2,408,913 | 4,670,545 | 24.68% | 68.70% |
| Hospital - Ambulatory | | | - | 0.00% | 0.00% |
| Clinic | | 100,296 | 224,312 | 0.43% | 1.61% |
| Mental Health | | 264,025 | 363,916 | 2.28% | 14.09% |
| Substance Abuse | | 37,473 | 51,008 | 0.78% | 4.99% |
| Case Management/Health Home | | 131,617 | 172,799 | 1.78% | 10.86% |
| Health Home | | | - | 0.00% | 0.00% |
| Community Based Organization (Tier 1) | | 43,798 | 63,538 | 0.92% | 2.94% |
| Nursing Home | | 30,157 | 50,662 | 0.31% | 1.17% |
| Pharmacy | | | - | 0.00% | 0.00% |
| Hospice | | | - | 0.00% | 0.00% |
| Other - Home Health, OPWDD, other | | 818,013 | 1,130,657 | 0.21% | 0.73% |
| Uncategorized | | 186,265 | 261,847 | 0.00% | 0.00% |
| Additional Providers | | 36,948 | 36,948 | 0.00% | 0.00% |
| PPS PMO | | 6,932,904 | 8,478,606 | 37.88% | 62.31% |
| **Total** | | **11,185,257** | **17,302,080** | **83.28%** | **209.10%** |

*Note: The IA will be asking the PPS to revise the above table for DY4/5 to appropriately reflect 100% of earned funds distributed across partner categories.*

**Alliance for Better Health Care**
The Alliance PPS response to the PAOP Standard Modification acknowledged that the PPS' funds flow strategy was initially limited to a Project Fund that focused on the implementation of projects and completion of specified requirements. The PPS formed Collaborative teams along naturally occurring patient service lines with the financial awards going through those Collaboratives based on several criteria including the depth and breadth of the Collaborative's participation. Payment to providers for the project implementation activity are performance based, focusing on meeting targets including partner and patient engagement.

The PPS indicated that they had completed much of their project implementation contracting in the Fall of 2016 and that the funds flow details provided in the table below reflects contracting completed after DY2, Q2.

Alliance noted that the PPS governance structure reflects the diversity of provider types including committee representation by PCPs, behavioral health providers, and CBOs. Partner engagement in the Board structure consists of member representatives, two independent practitioners, one of the region's largest private physician groups, and a representative from the PAC as well as over 50 different partners who serve on one or more governing committees.

Alliance indicated a continued use of the Collaboratives and workgroups of diverse provider types to implement projects while simultaneously expanding beyond project implementation to directly focus on outcome measures. The shift from project funding to incentive funding is driven by the goal of incetivizing the most effective interventions which emphasize the role of community based providers and physicians while de-emphasizing hospitals. The PPS will also allocate $2 million for incentives to partners that implement a set of initiatives through the end of the current measurement year (June 30, 2017). This short-term incentive program will help inform the long-term incentive program.

The PPS outlined a list of objectives it hopes to accomplish as part of this plan including the creation of positions focused specifically on CBO and PCP engagement, the extension of project fund contracts through DY3, and the implementation of both the short-term and long-term incentive programs.

The following table indicates the planned distributions to partner categories through the end of DY2 and the projected distributions of earned dollars for DY3 and DY4-5.

| Alliance for Better Health Care - PPS # 03 | Funds Flow (all funds) | | | |
|---|---|---|---|---|
| **Partner Category** | *MAPP Funds Flow through DY2, Q3* | *Projected Funds Flow through DY2* | *% of Earned Dollars Planned for Distribution DY3* | *% of Earned Dollars Planned for Distribution DY4 - DY5* |
| Practitioner - Primary Care | $ 2,596,288 | $ 880,918 | 15% | 15% |
| Practitioner - Non-Primary Care | $ - | $ - | | |
| Hospital - Inpatient/ED | $ 4,414,795 | $ 2,755,498 | 10% | 10% |
| Hospital - Ambulatory | $ 1,734,120 | $ - | 5% | 5% |
| Clinic | $ 4,545,269 | $ 1,119,265 | 14% | 14% |
| Mental Health | $ 930,153 | $ 595,998 | 3% | 3% |
| Substance Abuse | $ 1,401,923 | $ 531,760 | 3% | 3% |
| Case Management | $ - | $ - | 3% | 3% |
| Health Home | $ 450,000 | $ - | 1% | 1% |
| Community Based Organization (Tier 1) | $ 380,309 | $ 188,135 | 8% | 8% |
| Nursing Home | $ - | $ - | | |
| Pharmacy | $ - | $ 16,128 | | |
| Hospice | $ 78,502 | $ 14,251 | | |
| Home Care | $ 1,977,141 | $ 1,887,779 | 14% | 14% |
| Community Based Organization (Tier 2) | $ 276,438 | $ 361,508 | 8% | 8% |
| Community Based Organization (Tier 3) | $ 690,768 | $ 396,868 | 8% | 8% |
| | $ - | $ - | | |
| PMO | $ 3,865,891 | | 8% | 8% |
| **Total** | $ 23,341,597 | $ 8,748,108 | 100% | 100% |

**Bronx Health Access**

The Bronx Health Access response to the PAOP Standard Modification described the PPS' partner distribution and engagement methodologies. The partner distribution methodologies, each having a unique purpose and approach, are grouped into the following buckets:

- **Project implementation distributions:** this distribution methodology supports partner needs for start-up funds for implementing DSRIP projects. The project budgets and implementation plans are determined by project workgroups. The PPS indicated that these distributions will continue through the end of DSRIP.
- **Centralized allocations:** This distribution methodology includes expenses such as Information Technology investment, Workforce development/training, and PCMH which benefit partners directly through contracts and indirectly through shared benefits. The payments are a centralized expense of the PPS PMO.
- **Performance distributions:** This distribution methodology is designed to reward participation ad performance PPS wide. The PPS' initial distribution under this methodology was for $3 million and a second distribution for $6 million was made following the Mid-Point Assessment. The PPS noted that it has begun working on evaluating other disbursement methodologies tied to performance, including those recommended by network partners.
- **CBO grant opportunities:** The PPS is in the process of creating a new grant opportunity for CBOs in the PPS network and that provide supportive services to undeserved patients receiving primary care services in the central and south Bronx. These funds, totaling $75,000 per grant for up to 12 CB partners is focused on Tier 1 CBOs with availability for Tier 2 CBOs limited to the non-reimbursable portion of services provided.
- **Stakeholder engagement:** The PPS has organized and funded a stakeholder engagement workgroup designed to actively engage providers and other various community partners.

The following table indicates the planned distributions to partner categories through the end of DY2 and the projected distributions of earned dollars for DY3 and DY4-5.

| | | Funds Flow (all funds) | | | |
|---|---|---|---|---|---|
| **Partner Category** | | *Funds Flow through DY2, Q3* | *Projected Funds Flow through DY2* | *% of Earned Dollars Planned for Distribution DY3* | *% of Earned Dollars Planned for Distribution DY4 - DY5* |
| Practitioner - Primary Care | | $ 21,042 | $ 107,360 | 1.0% | 0.9% |
| Practitioner - Non-Primary Care | | $ 64,157 | $ 170,683 | 1.7% | 1.5% |
| Hospital - Inpatient/ED | | $ 78,608 | $ 235,824 | 2.3% | 2.1% |
| Hospital - Ambulatory | | $ - | $ - | 0.0% | 0.0% |
| Clinic | | $ 1,937,174 | $ 5,883,105 | 57.4% | 51.3% |
| Mental Health | | $ - | $ - | 0.0% | 0.0% |
| Substance Abuse | | $ 45,158 | $ 98,298 | 1.0% | 0.9% |
| Case Management | | $ 212,828 | $ 574,655 | 5.6% | 5.0% |
| Health Home | | $ 32,152 | $ 93,293 | 0.9% | 0.8% |
| Community Based Organization (Tier 1) | | $ 95,036 | $ 300,410 | 2.9% | 2.6% |
| Nursing Home | | $ - | $ - | 0.0% | 0.0% |
| Pharmacy | | $ 13,489 | $ 29,233 | 0.3% | 0.3% |
| Hospice | | $ - | $ - | 0.0% | 0.0% |
| LTC | | $ 13,489 | $ 64,073 | 0.6% | 0.6% |
| Home Health | | $ 26,998 | $ 26,998 | 0.3% | 0.2% |
| PMO | | $ 6,293,070 | $ 6,990,878 | 8.3% | 9.8% |
| **Total** | | $ 8,833,200 | $ 14,574,810 | | |

**Bronx Partners for Healthy Communities**
The Bronx Partners for Healthy Communities response to the PAOP Standard Modification focused primarily on Project 2.a.iii. (Health Home At-Risk Intervention Program), which was the only project identified as having an elevated risk score by the IA. The PPS noted that support for primary care has played a central role in the PPS' partner engagement and fund distribution strategies. The release of funds in DY1 and DY2 was structured around a series of waves that reflected the PPS priorities including ensuring a robust primary care foundation across the PPS, supporting PCMH transformation, and fostering system wide care coordination infrastructure. This approach to distributing funds aims to align local capacity of implementation with the PPS' focus on deliverables that require early adoption to meet DSRIP targets.

The Colaborative Contracting Model was established by the PPS to facilitate partner buy-in during early DSRIP phases while creating accountability as the PPS establishes the systems and relationships needed to transition to risk-based contracting. The six waves of engagement and funding were identified as:

1) **Investing in PPS Expertise:** The PPS worked with partners to identify best practices for care delivery and contracted with select organizations for implementation support.
2) **Implementing Foundational Requirements:** The PPS provided funding to each of its seven largest partner organizations to hire DSRIP Program Directors to oversee DSRIP related transformation projects. These organizations employ over 75% of the PPS' PCPs and deliver over 97% of primary care services to the PPS' patients. The PPS also funded technical assistance and coaching services to support providers in achieving NCQA PCMH 2014 Level 3 recognition.
3) **PCMH and Project Support (Large Primary Care and Behavioral Health Providers):** The PPS funded large Primary Care and Behavioral Health providers to advance team-based care models; care coordination and transitions; connectivity and analytics. The PPS conducted an RFI process to determine baseline staffing and funding needs to achieve DSRIP clinical integration objectives which drove baseline funding decisions.
4) **PCMH and Project Support (Independent providers, ED Care Triage and Care Transitions):** The PPS continued funding independent providers to advance team-based care models; care coordination and transitions; connectivity; analytics; and PCMH implementation.
5) **CBO/CBH Support:** This phase concentrates on deepening engagement with behavioral health and social service providers to improve population health. The PPS has funded CBO/CBH capacity building, interconnectivity and information exchange via the Bronx RHIO, and innovative approaches for advancing DSRIP goals. The PPS has developed projects for meaningful engagement of community-based behavioral health and social service providers. This includes the PPS' Community Health Literacy (CHL) Program that is aimed at improving patient health literacy and healthcare system navigation as well as to connect eligible individuals to primary care, health Homes and other relevant services and programs. Seven selected CBOs receive funds from the PPS including a base allocation and performance incentives to operationalize this program. The PPS also developed a Critical Time Intervention (CTI) program that is a nine month, evidence based, intensive care transitions model designed to prevent homelessness and other adverse outcomes in people with Serious Mental Illness (SMI) following discharge from hospitals and shelters. The PPS has contracted with four providers for CTI services and has aligned funding in three phases. The final program implemented by the PPS is a Community Behavioral Health (CBH) Initiative to develop and implement strategies for sustainable, standardized best practice and evidence-based screening, referral and follow-up practices across systems.
6) **Post-acute and Housing Support:** This wave is currently being developed and is expected to include partner involvement in referral management initiatives and ensuring smooth transitions

between care settings in addition to supporting individuals in community-based care settings and prevent avoidable admissions and ED visits. The PPS estimated a budget of $5 million to support these services.

The PPS also discussed ongoing engagement and support to PPS partners which includes work with the Bronx RHIO to ensure data can be shared in a secure manner among PPS partners through the health information exchange. The PPS also noted its commitment to the development of a care coordination management system that could connect all partners to shared care planning data for higher risk patients. Additional initiatives that the PPS indicated are under development for future partner engagement and funds flow include the development of a PPS-wide referral management system that would be made available to all PPS partners to make referrals among and between community-based service providers, including medical, mental health, substance use, and social service providers.

For specific funds flow details, the PPS provided the following table which indicates the planned distributions to partner categories through the end of DY2 and the projected distributions of earned dollars for DY3 and DY4-5.

| | Funds Flow (all funds) | | | |
|---|---|---|---|---|
| **Partner Category** | ***Funds Flow through DY2, Q3*** | ***Projected Funds Flow through DY2*** | ***% of Earned Dollars Planned for Distribution DY3*** | ***% of Earned Dollars Planned for Distribution DY4 - DY5*** |
| Practitioner - Primary Care | $ 716,486 | $ 770,936.16 | 3.9% | 4.5% |
| Practitioner - Non-Primary Care | $ - | $ - | 0.0% | 0.6% |
| Hospital - Inpatient/ED | $ 1,075,000 | $ 1,020,034.00 | 6.0% | 6.3% |
| Hospital - Ambulatory | $ 2,869,557 | $ 4,221,334.27 | 19.4% | 20.2% |
| Clinic | $ 3,339,019 | $ 4,060,745.12 | 13.5% | 14.0% |
| Mental Health | $ 624,642 | $ 887,455.31 | 2.3% | 2.5% |
| Substance Abuse | $ - | $ - | 2.3% | 2.5% |
| Case Management (CTI and Non Tier 1 CBO) | $ 225,624 | $ 331,256.00 | 2.7% | 3.1% |
| Health Home | $ - | $ - | 1.2% | 1.2% |
| Community Based Organization (Tier 1) | $ 1,206,579 | $ 1,511,327.00 | 1.9% | 2.9% |
| Nursing Home | $ - | $ - | 1.9% | 1.0% |
| Pharmacy | $ - | $ 129,966.00 | 1.0% | 1.0% |
| Hospice | $ - | $ - | 1.9% | 1.0% |
| Home Care | $ - | $ - | 1.9% | 1.0% |
| Population Health Initiatives | | | 1.6% | 1.7% |
| Workforce (TEF, BDO, Backfill, Special HR Funds) | $ 3,810,581 | $ 4,329,322.35 | 5.1% | 3.0% |
| PMO (Salary, PCMH, Indirect Cost, OTPS, Compliance, IT and Consulting) | $ 9,612,372 | $ 10,906,073.01 | 10.4% | 11.6% |
| Consulting (Manatt) | $ 4,218,287 | $ 4,218,286.73 | 2.3% | 1.9% |
| Bronx RHIO | $ 780,845 | $ 1,257,182.53 | 3.6% | 3.7% |
| IT Systems (Salesforce, RMS, GSI) | $ 272,184 | $ 678,612.00 | 5.0% | 3.3% |
| Revenue Loss | $ 4,000,000 | $ 4,000,000.00 | 12.0% | 12.7% |
| **Total** | $ 32,751,177 | $ 38,322,530.48 | 100% | 100% |

**Care Compass Network**

In responding to the PAOP Standard Modification the Care Compass Network PPS categorized their partners in to one of three categories; partners with a contract with the PPS for the implementation of one or more projects, partners that have a contract for a project but have opportunities to contract for more, and partners who have not contracted with the PPS. The PPS further analyzes those partners with which the PPS has contracted to assess why those partners have not fully engaged or performed at the level expected as defined in the contract. The four main reasons cited by the PPS include a burdensome reporting process that caused a backlog of project activity and patient engagement that was not reported, a lack of sufficient funding to accommodate start-up needs, a lack of meaningful funding to provide the project services, and a lack of knowledge or insight in to the workflow issues.

In order to facilitate engagement with those partners that have not contracted with the PPS and to increase the engagement of those partners with a contract, the PPS presented their five dimensions of engagement:

1) The partner needs to see the value and benefit of participating in the PPS.
2) The partner must have a working knowledge of the opportunities available to participate.
3) The partner must see an opportunity they believe they are able to pursue.
4) The partner needs a funds flow methodology and other resources that facilitate start-up and ongoing participation.
5) The partner must receive meaningful data based feedback on performance.

The PPS also outlined specific strategies at increasing engagement of Primary Care, Mental Health, Substance Use Disorder, and CBO partners. These strategies include increasing both financial and non-financial support to these partners as well as increased emphasis on fostering collaboration and partnerships between partner organizations.

In addressing the funds flow portion of this recommendation the PPS noted that flowing funds to partners is dependent on the ability of the PPS to remediate its partner engagement challenges and fostering partner willingness and ability to engage. The PPS also indicates it has organized its funding to support initiatives that will support the achievement of DSRIP goals. The plan presented by the PPS includes the availability of funds to all partners across nine funding streams, as shown in the table below.

| Fund Flow Category | Future $ Allocated |
|---|---|
| Project Implementation | $52.6M |
| Start-up Funds | $3.0M |
| Innovation | $6.9M |
| RPU Performance Management | $3.2M |
| IT Support | $46.4M |
| Workforce Funds | $5.4M |
| High Performance | $17.4M |
| Partner Expertise | $2.5M |
| Revenue Loss | $29.0M |

The PPS also included the following table as part of their response to illustrate the planned distributions of funds across the various partner categories through the end of DY2 as well as the projected distribution percentages of earned dollars in DY3 and DY4-5.

| | | Funds Flow (all funds) | | | |
|---|---|---|---|---|---|
| **Partner Category** | | ***Funds Flow through DY2, Q3*** | ***Projected Funds Flow through DY2*** | ***% of Earned Dollars Planned for Distribution DY3*** | ***% of Earned Dollars Planned for Distribution DY4 - DY5*** |
| Independent Practitioner - Primary Care | | | $150,000 | 3.5% | 4.0% |
| Independent Practitioner - Non-Primary Care | | | | 0.0% | 0.5% |
| Hospital - Inpatient/ED | | $437,991 | $875,983 | 21.0% | 12.5% |
| Hospital - Ambulatory (Article 28 PCP/Specialists) | | $553,663 | $1,107,326 | 25.0% | 25.0% |
| Clinic (Includes FQHC) | | $91,155 | $182,310 | 5.0% | 6.0% |
| Mental Health | | $86,586 | $173,171 | 5.0% | 8.0% |
| Substance Abuse | | $52,720 | $105,440 | 3.0% | 4.0% |
| Case Management | | $37,778 | $75,556 | 2.0% | 3.0% |
| Health Home | | | $10,000 | 0.5% | 1.0% |
| Community Based Organization (Tier 1) | | $139,904 | $279,808 | 8.0% | 10.0% |
| Nursing Home | | $48,495 | $96,990 | 2.5% | 3.0% |
| Pharmacy | | $33,538 | $67,075 | 1.5% | 1.5% |
| Hospice | | $22,052 | $44,104 | 1.5% | 2.0% |
| Home Care | | $11,480 | $22,960 | 1.0% | 1.5% |
| PPS PMO | | $3,764,783 | $5,000,000 | 12.5% | 11.0% |
| All Other | | $63,371 | $126,742 | 3.0% | 3.0% |
| Uncategorized | | $105,769 | $211,538 | 5.0% | 4.0% |
| **Total** | | $5,449,284 | $8,529,003 | 100% | 100% |

**Central New York Care Collaborative**
In their response to the PAOP Standard Modification, CNYCC indicated that it is employing several strategies to connect with various stakeholder and partner groups throughout its network. The PPS specifically cited the following strategies:

- **Regional Project Advisor Committees (RPACs):** quarterly meetings in each of the six PPS counties that provide a forum for partner organizations to provide feedback on PPS activities.
- **Learning Collaboratives:** monthly meetings for Acute Care, Post-Acute Care, Outpatient, and Community-Based Organizations to monitor outcomes, share best practices, and collectively solve implementation challenges.
- **Weekly Newsletter:** weekly communication with updates on PPS activities, DSRIP program updates, upcoming events, and general news and information.
- **CNY Cares Website:** provides general information about CNYCC goals and objectives, web-based platform for public/partners to access resources and information, and source of DSRIP related content and news.
- **Webinar Series:** web-based presentations on a wide-range of CNYCC topics.

The PPS also discussed efforts on partner engagement for specific partner types including:
- **Primary Care:** The Primary Care strategy is focused on increasing access and capacity through the recruitment of more primary care providers. This effort will be led by the Chief Medical Officer for the PPS.
- **Substance Use Treatment:** The PPS acknowledged that while it has contracted with several Substance Use Treatment partners it is not sufficient to meet the commitments made by the PPS. CNYCC indicated that it will rely on the strategies noted above to outreach to and engage more Substance Use Treatment partners to meet its DSRIP goals.
- **Mental Health:** CNYCC noted that they have engaged several Mental Health partners and that this is an area where the PPS has been successful in contracting with partners consistent with their commitments in the DSRIP Project Plan Application.
- **Community Based Organizations:** CNYCC addressed their CBO engagement efforts through their response to the specific recommendations from the IA related to CBO engagement and contracting.
- **Clinics:** CNYCC noted that their partner engagement to date has been insufficient to meet their commitments and that they are actively working to outreach to clinic partners in their network using the five strategies noted above to engage and contract with clinic partners.
- **Nursing Homes:** CNYCC reported that they are working to identify participation opportunities for Nursing Homes and other post-acute partners in their network to support increased contract and engagement efforts.

The PPS response related to funds flow indicated that the distribution of funds for DY1 and DY2 was based on policies that were reviewed and approved by the CNYCC Board of Directors. The PPS indicated that a decision has been made to redesign the funds flow policies to accomplish their strategic objectives and to recognize and incentive all provider types that are contributing to the PPS' ongoing transformational efforts. As part of this redesign, the PPS noted that it will work to better understand the impact each provider type can have on key performance and outcome measures so that payments can be better aligned relative to the contributions of the partners.

The following table indicates the planned distributions to partner categories through the end of DY2 and the projected distributions of earned dollars for DY3 and DY4-5. The PPS noted that the projected

percentages for DY3 and DY4-5 may shift as a result of the ongoing efforts to revise the PPS' funds flow policies.

| | | Funds Flow (all funds) | | | |
|---|---|---|---|---|---|
| **Partner Category** | | ***Funds Flow through DY2, Q3*** | ***Projected Funds Flow through DY2*** | ***% of Earned Dollars Planned for Distribution DY3*** | ***% of Earned Dollars Planned for Distribution DY4 - DY5*** |
| Practitioner - Primary Care | | $0 | $0 | 3.00% | 4.00% |
| Practitioner - Non-Primary Care | | $0 | $0 | 0.00% | 0.00% |
| Hospital - Inpatient/ED | | $6,883,104 | $7,692,600 | 34.50% | 30.00% |
| Hospital - Ambulatory | | $0 | $0 | 10.00% | 10.00% |
| Clinic | | $1,398,363 | $1,496,669 | 10.00% | 10.00% |
| Mental Health | | $350,140 | $405,777 | 7.00% | 8.00% |
| Substance Abuse | | $86,281 | $103,230 | 4.00% | 5.00% |
| Case Management | | $218,083 | $268,213 | 3.00% | 4.00% |
| Health Home | | $0 | $0 | 1.50% | 2.00% |
| Community Based Organization (Tier 1) | | $16,370 | $20,382 | 4.00% | 4.00% |
| Nursing Home | | $334,855 | $412,965 | 5.00% | 6.50% |
| Pharmacy | | $6,102 | $6,905 | 0.50% | 0.50% |
| Hospice | | $29,367 | $36,196 | 0.50% | 0.50% |
| Home Care | | $0 | $0 | 2.00% | 3.50% |
| All Other | | $733,448 | $873,644 | 0.00% | 0.00% |
| PPS PMO | | $3,798,977 | $5,074,977 | 15.00% | 12.00% |
| **Total** | | $13,855,090 | $16,391,558 | 100.00% | 100.00% |

The PPS narrative also indicated that it intends to manage the future funds flow in a manner that provides a stable flow of funds to partners over time and promotes a pay-for-performance operating environment. The PPS' early funds flow policies called for the smoothing of DSRIP funds in to later years of the program as PPS revenue becomes increasingly at risk due to increased P4P funding in an effort to provide stable funds flow to partners. CNYCC indicated that it intends to incorporate a similar approach to their new funds flow policies.

Lastly, CNYCC reported that it is implementing a Population Health Management System at the start of DY3 on behalf of its network partners, with the funding for the system coming from the PPS PMO in order to preserve the available funding for partners. The PPS believes this system will assist partners with data analytics, care management, and risk identification which will hopefully result in the PPS and its partners achieving improved outcomes.

**Leatherstocking Collaborative Health Partners PPS**
Leatherstocking's response to the PAOP Standard Modification indicated that they had begun a process of planning and implementing strategies for increasing their connection with community and non-Bassett partners. These strategies include:

- Refocus and redesign of the Project Advisory Council (PAC), including a feedback session that indicated a lack of presence or voice for community based partners, including CBOs, compared to Bassett. The PPS has revised the charter and the membership roster of the PAC with the updated charter and PAC membership roster planned for presentation to the PPS Executive Governing Body in March.
- Feature non-Bassett speakers at quarterly All-Partner Meetings
- "Spotlight on CBOs" in quarterly newsletter
- Recruitment of full time Network Operations Manager to engage with partners, educate community members, and align resources strategically to meet DSRIP performance measures.
- Transition the position of Director of Partner Engagement from part-time to full-time.
- Partner site visits to learn more about what partners have to offer, to educate partners, recruit additional partners, and inventory resources and best practices across the PPS.
- Community Impact Meetings
- Project Specific Engagement to identify innovative ways of engagement partners across multiple projects.
- Centralized office and meeting space for team and partners to promote greater collaboration for the Leatherstocking team and easier access to PPS resources in a central location.

The Leatherstocking PPS response on funds flow noted that in addition to distributing funds to partners for meeting specific metrics, the PPS has developed a funds flow model to incentivize partners for participation in DSRIP activities through 'citizenship funds'. The current model has encouraged the PPS to take on most of the training expense for clinical and organizational projects. The PPS' Finance Committee is expected to conduct a review of the funds flow policies with the shift of DSRIP funding towards P4P to align payments with performance metrics. The PPS is working with its partner organizations in reviewing the funds flow model to determine the best approach for distributing funds to partners for improving performance metrics while keeping the model simple so it can be easily understood.

The following table indicates the planned distributions to partner categories through the end of DY2 and the projected distributions of earned dollars for DY3 and DY4-5.

| | Recommendation #10: Funds Flow (all funds) | | | |
|---|---|---|---|---|
| **Partner Category** | ***Funds Flow through DY2, Q3*** | ***Projected Funds Flow through DY2*** | ***% of Earned Dollars Planned for Distribution DY3*** | ***% of Earned Dollars Planned for Distribution DY4 - DY5*** |
| Practitioner - Primary Care | $ - | $ - | 0.00% | 0.00% |
| Practitioner - Non-Primary Care | $ - | $ - | 0.00% | 0.00% |
| Hospital - Inpatient/ED | $ 6,008,766.87 | $ 6,008,766.87 | 37.94% | 43.27% |
| Hospital - Ambulatory | | $ - | 0.00% | 0.00% |
| Clinic | $ 134,653.79 | $ 134,653.79 | 0.85% | 0.97% |
| Mental Health | $ 3,131.63 | $ 3,131.63 | 0.02% | 0.02% |
| Substance Abuse | $ 184,804.52 | $ 184,804.52 | 1.17% | 1.33% |
| Case Management | $ 197,493.47 | $ 197,493.47 | 1.25% | 1.42% |
| Health Home | | $ - | 0.00% | 0.00% |
| Community Based Organization (Tier 1) | $ 79,302.86 | $ 79,302.86 | 0.50% | 0.57% |
| Nursing Home | $ 877,207.67 | $ 877,207.67 | 5.54% | 6.32% |
| Pharmacy | $ - | $ - | 0.00% | 0.00% |
| Hospice | $ 63,394.95 | $ 63,394.95 | 0.40% | 0.46% |
| Home Care | $ - | $ - | 0.00% | 0.00% |
| Other Uncategorized | $ 276,166.81 | $ 276,166.81 | 1.74% | 1.99% |
| Other All Other | $ 413,673.82 | $ 413,673.82 | 2.61% | 2.98% |
| Other (Define- Additional Provider) | $ 494.40 | $ 494.40 | 0.00% | 0.00% |
| Other (Define- PPO Admin) | $ 3,066,378.00 | $ 3,066,378.00 | 14.40% | 14.38% |
| Other (Define- Hold for other budget categories) | | | 33.59% | 26.28% |
| **Total** | **$ 11,305,469** | **$ 11,305,468.79** | **100.00%** | **100.00%** |

**Montefiore Hudson Valley Collaborative**

Montefiore's response to the PAOP Standard Modification focused specifically on the PPS' engagement of Community Based Organizations (CBOs) and the distribution of funds to these partners. The PPS referenced the narrative submitted for the Mid-Point Assessment and the CBO survey in noting that they have developed an incremental strategy for CBO integration, with each component including either direct or indirect funds flow to CBO partners through direct payment of funds or the provision of resources such as technical assistance, consulting services, and/or infrastructure. Montefiore outlined a three-tiered strategy that includes the following components:

1. Outreach and Empowerment (DY2-4). As part of this component, Montefiore has leveraged funds to provide technical assistance and consulting services to CBO partners. The PPS has also leveraged relationships with various associations to connect CBO partners with existing resources and to develop new resources and curriculum to support sustainability.
2. Defining Target Interventions (DY3-5). This component will leverage information obtained from the first component to develop targeted CBO contracts based on delivering clearly defined interventions and reporting on key metrics. Funds flow opportunities are to include direct funding through contracts and the ability to earn funding through the PPS' Innovation Fund.
3. Supporting Sustainability (DY3-5). This component serves as a culmination of the work completed in the previous components. Sustainability includes the CBO integration strategy and the strengthening of direct contracting and MSO relationships with CBOs to further sustainability at the network and partner level.

The PPS also noted that it has established a formal work plan/implementation plan for CBO contracting that is aligned with Component 2 of the CBO integration strategy. This plan includes detailed action items for four milestones; Define Core Services for CBO Contracts, Define Initial Focus Areas; Identify Targeted CBOs; and Execute Contracts.

Montefiore's response also included a description of its funds flow approach. The PPS noted that it worked with partners during DY1 and DY2 to develop a funds flow methodology to support DSRIP project implementation success while also acknowledging that the process is highly iterative as DSRIP and the PPS itself evolves and matures. The PPS initiated Phase I contracting and funds flow in 2015 with a focus on those partners that represented over 90% of the PPS' attribution. In July 2016, Montefiore released Phase II contracts that focused on partner roles and responsibilities for program implementation and clinical outcomes. This phase increased the targeted partner list from 50 in Phase I to 69 and increased the available funding from the $5 million in Phase I to 7.2 million. Under the evolving structure, partners are able to earn 75% of the funds for successful completion of project milestones and 25% of the funding based on the PPS' ability to meet clinical outcomes and measures. The PPS noted that it had begun its second performance period under Phase II contracting in March 2017 with $8.7 million of available partner funds. This period includes continued focus on process and outcome measures but assigns metrics and funds at a more discrete level.

The following table indicates the planned distributions to partner categories through the end of DY2 and the projected distributions of earned dollars for DY3 and DY4-5.

| Partner Category | | Funds Flow (all funds) | | | |
|---|---|---|---|---|---|
| | | *Funds Flow through DY2, Q3* | *Projected Funds Flow through DY2* | *% of Earned Dollars Planned for Distribution DY3* | *% of Earned Dollars Planned for Distribution DY4 - DY5* |
| Practitioner - Primary Care | | $ 1,518,047 | $ 2,214,710 | 4.9% | 9.4% |
| Practitioner - Non-Primary Care | | $ 238,162 | $ 316,376 | 0.6% | 1.1% |
| Hospital - Inpatient/ED | | $ 1,934,236 | $ 2,201,547 | 1.9% | 3.6% |
| Clinic | | $ 2,438,777 | $ 3,133,199 | 4.9% | 9.4% |
| Mental Health | | $ 1,941,227 | $ 2,752,016 | 5.8% | 11.0% |
| Substance Abuse | | $ 1,277,176 | $ 1,639,312 | 2.6% | 4.9% |
| Community Based Organization (Tier 1) | | $ 6,000 | $ 6,000 | 2.5% | 2.5% |
| Nursing Home | | $ 128,235 | $ 337,531 | 1.5% | 2.8% |
| Pharmacy | | $ 6,532 | $ 6,532 | 0.0% | 0.0% |
| Hospice | | $ 1,169 | $ 3,296 | 0.0% | 0.0% |
| Community Based Organization | | $ 5,650 | $ 5,650 | 0.0% | 0.0% |
| All Other | | $ 538,976 | $ 722,810 | 1.3% | 2.5% |
| Case Management/Health Home | | $ 538,843 | $ 934,051 | 2.8% | 5.3% |
| **Partner Payments Sub-total** | | **$ 10,573,030** | **$ 14,273,030** | **28.8%** | **52.6%** |
| | | | | | |
| Administration | | $ 2,218,619 | $ 2,748,080 | 5.6% | 5.7% |
| Project Implementation | | $ 12,725,759 | $ 15,196,298 | 36.8% | 26.4% |
| **PPS PMO Sub-total** | | **$ 14,944,378** | **$ 17,944,378** | **42.5%** | **32.1%** |
| | | | | | |
| **Revenue Loss** | | **$ -** | **$ -** | **9.4%** | **12.9%** |
| | | | | | |
| **Innovation** | | **$ -** | **$ -** | **9.7%** | **1.2%** |
| | | | | | |
| **Contingency** | | **$ -** | **$ -** | **9.7%** | **1.2%** |
| | | | | | |
| **Grand Total** | | **$ 25,517,408** | **$ 32,217,408** | **100%** | **100%** |

**Mount Sinai PPS**
The Mount Sinai PPS indicated in its response to PAOP Standard Modification that it has implemented a refined approach to engage partners of all provider types and to implement clinical change across the network through a "Track" based strategy.

Track one is planned for a mid-March launch and is focused on bringing together the acute care facilities, FQHCs, and clinics in the PPS to drive clinical improvement to drive clinical pathways targeting selected priority measures.

Track two is planned for an April launch and will focus on continuing to engage primary care providers, substance use disorder providers, behavioral health practices, health homes and care management agencies, and community based organizations through concerted efforts to impact metrics that address access, screening, and management.

Track three will be focused on improving relationships between hospitals and community providers. The implementation strategy will focus on avoidable hospitalization utilization through initiatives that address barriers to care coordination and care transition between acute care providers and community based providers.

The PPS narrative did not include a description of its strategy for distributing funds to partners to ensure DSRIP success. The PPS did, however, include the following table to illustrate its planned distributions to partner categories through the end of DY2 and the projected distributions of earned dollars for DY3 and DY4-5.

| Partner Category | | Funds Flow (all funds): Funds Flow through DY2, Q3 | Projected Funds Flow through DY2 | % of Earned Dollars Planned for Distribution DY3 | % of Earned Dollars Planned for Distribution DY4 - DY5 |
|---|---|---|---|---|---|
| Practitioner - Primary Care | | $ 1,869,967.26 | $ 1,869,967.26 | 8.9% | 8.9% |
| Practitioner - Non-Primary Care | | $ 2,010,333.61 | $ 2,010,333.61 | 9.6% | 9.6% |
| Hospital - Inpatient/ED | | $ 1,040,237.36 | $ 1,040,237.36 | 5.0% | 5.0% |
| Hospital - Ambulatory | | $ 1,040,237.36 | $ 1,040,237.36 | 5.0% | 5.0% |
| Clinic | | $ 2,180,010.18 | $ 2,180,010.18 | 10.4% | 10.4% |
| Mental Health | | $ 1,966,422.25 | $ 1,966,422.25 | 9.4% | 9.4% |
| Substance Abuse | | $ 1,342,249.06 | $ 1,342,249.06 | 6.4% | 6.4% |
| Case Management | | $ 1,699,966.30 | $ 1,699,966.30 | 8.1% | 8.1% |
| Health Home | | $ 917,108.40 | $ 917,108.40 | 4.4% | 4.4% |
| Community Based Organization (Tier 1) | | $ 118,728.57 | $ 118,728.57 | 0.6% | 0.6% |
| Nursing Home | | $ 1,037,407.35 | $ 1,037,407.35 | 4.9% | 4.9% |
| Pharmacy | | $ 1,325,288.77 | $ 1,325,288.77 | 6.3% | 6.3% |
| Hospice | | $ 83,069.13 | $ 83,069.13 | 0.4% | 0.4% |
| Home Care | | $ 280,628.54 | $ 280,628.54 | 1.3% | 1.3% |
| Other (Community Based Organization, Not Tier 1) | | $ 1,637,223.86 | $ 1,637,223.86 | 7.8% | 7.8% |
| Other (All Other) | | $ 2,442,829.32 | $ 2,442,829.32 | 11.6% | 11.6% |
| **Total*** | | $ 20,991,707.31 | $ 20,991,707.31 | 100.0% | 100.0% |

* Note: this figure does not include funds flowed to partners who are no longer contracted partner organizations with MSPPS. An additional $73,766.99 was flowed to these 12 organizations.

**Nassau Queens PPS**
The Nassau Queens PPS response to PAOP Standard Modification indicated that it is their priority to implement a comprehensive population health management strategy composed of providers across the continuum of care who are dedicated to reducing inpatient care costs, improving quality of care, and eliminating the duplication of services. The PPS has placed the responsibility for contracting with network partners on its three hubs.

The first phase of partner engagement in DY1-2 based partner selection on attribution, location, and the types of services the partners offered that would meet and improve patient outcomes. The hubs established their respective contracting strategy in collaboration with the PPS PMO to target those providers with the highest attribution and to create agreements based on the delivery of services, achieving patient commitments and project requirements.

In their response, the PPS indicated that it has significantly accelerated its contracting efforts and provided data to support that it has seen an increase in provider contracts of 23% since the initial Mid-Point Assessment report was released. In order to expand on its partner engagement strategy, the PPS has created a multi-pronged approach that includes the first phase of contracting with high attribution providers. The PPS conducted an analysis on project opportunities across the PPS and identified areas of need to contract additional providers. The PPS Data Quality Team is also working to improve its business intelligence and analytics to dive deeper in to available data to create focused interventions for better patient care.

The PPS established relationships in January 2017 with two Behavioral Health IPAs who will facilitate conversations with their existing relationships with CBOs to contract the types of services the PPS needs. The PPS has also hired a Director of Behavioral Health to continue execution of its partner engagement strategy and program design. The PPS identified a list of six opportunities to enhance its current engagement for Mental Health, Substance Use Disorder, and Community Based Organization partners specific to mental health and substance abuse services. Nassau Queens identified a list of five additional opportunities for increased CBO engagement.

On funds flow, the PPS noted that percentages for funds flow for the life of DSRIP have been established for each of the PPS hubs for each partner type, with distributions gradually increasing to partners across the network over time. The PPS expects that as contracting continues, those partners that did not have significant funds distributed to them will see increased distributions. Where the PPS has identified projects within its plan, it expects that those projects will be transitional, newly created, or an expansion of service that will be supported by DSRIP funds and subsequently folded under VBP contracts or funded through other government contracts.

The following table indicates the planned distributions to partner categories through the end of DY2 and the projected distributions of earned dollars for DY3 and DY4-5.

| Partner Category | | Funds Flow (all funds) | | | |
|---|---|---|---|---|---|
| | | *Funds Flow through DY2, Q3* | *Projected Funds Flow through DY2* | *% of Earned Dollars Planned for Distribution DY3* | *% of Earned Dollars Planned for Distribution DY4 - DY5* |
| Practitioner - Primary Care | | $ 3,188,379 | $ 4,954,384 | 18.1% | 18.1% |
| Practitioner - Non-Primary Care | | 135,803 | 184,091 | 4.1% | 4.1% |
| Hospital - Inpatient/ED | | 6,479,531 | 6,745,280 | 21.0% | 22.6% |
| Hospital - Ambulatory | | - | - | 5.5% | 5.5% |
| Clinic | | 829,104 | 1,076,021 | 5.2% | 5.2% |
| Mental Health | | 142,835 | 193,622 | 4.0% | 4.0% |
| Substance Abuse | | - | - | 2.5% | 2.5% |
| Case Management | | 1,082,129 | 1,466,902 | 9.1% | 9.1% |
| Health Home | | 31,928 | 43,280 | 2.5% | 2.5% |
| Community Based Organization (Tier 1) | | 355,831 | 482,354 | 3.3% | 3.3% |
| Nursing Home | | 583,654 | 930,847 | 5.5% | 6.1% |
| Pharmacy | | - | - | 0.5% | 0.5% |
| Hospice | | - | - | 0.5% | 0.5% |
| Home Care | | - | - | 0.5% | 0.5% |
| Other - PMO | | 9,479,788 | 13,496,817 | 16.9% | 14.7% |
| Other - Community Based Organization (Tier 2&3) | | 40,000 | 100,000 | 0.9% | 0.9% |
| **Total** | | $ 22,348,981 | $ 29,673,599 | 100% | 100% |

**Suffolk Care Collaborative**

The Suffolk Care Collaborative response to the PAOP Standard Modification described the PPS funds flow model for contracted providers as being driven by two sources of funding; Project Implementation Costs and Performance Incentive Funds. The Project Implementation Costs are defined as costs budgeted and incurred by the PPS on behalf of the provider to help in providing foundational elements and resources to achieve DSRIP project goals. The PPS estimated that Project Implementation Costs represent approximately 60%, or $179 million if 100% achievement is attained, of anticipated revenue over the five years of DSRIP. The Performance Incentive Funds is based on a Performance Payment Incentive Pool and accounts for approximately 40%, or $119 million, of DSRIP funds if 100% achievement is attained. The Performance Incentive Fund payments are spread across the various provider types and released to providers for the achievement of performance factors designed by the PPS and linked to DSRIP performance goals.

In 2015, the PPS designed and operationalized a comprehensive plan to engage all provider types. The performance driven funds flow model was designed to meaningfully engage contracted partners. This was formalized through Performance Payment Distribution Plans outlined in the PPS partner participation agreements. The Round 1 partner contracting plan began in mid-2015 prioritized partners that had specific Domain 1 requirements, patient engagement reporting requirements within DSRIP projects. The Round 2 partner contracting plan is scheduled to begin in April 2017 to engage and formally contract with Pharmacy, Home Care Agency, Hospice, Care Management, and additional CBO partners.

The PPS has made each of the PPS hubs responsible for their networks project implementation costs and performance incentive funds flow contracting, following a consistent approach for supporting providers and managing performance payments.

Suffolk Care Collaborative also included an analysis of its partner engagement efforts for PCP, Hospital, SNF, Behavioral Health, and Non-PCP partners that indicates significant increases in engagement since the completion of the Mid-Point Assessment. The PPS then reported on its assessment of gaps in partner engagement relative to its commitments from the DSRIP Project Plan Application for all partner types. The PPS reported that it did not have gaps in partner engagement for its PCP, Non-PCP, Mental Health, Substance Use Disorder, Nursing Home, Hospital, Hospice Care, or Case Management partners. The PPS did identify gaps in engagement for Pharmacy, and Home Care agency partners.

The PPS reported that it is developing a CBO survey to address gaps in services and further reduce silos. The initial phase of CBO surveys which targeted CBO partners to support implementation of the DSRIP projects, included 139 CBOs, of which about 7% are contracted or in service agreements with the PPS for six of the 11 DSRIP projects. The next phase, which will include a larger pool of CBOs to survey, is expected to allow the PPS to inquire about services provided by the CBOs, the populations served, addressing social determinants of health needs, and updating CBOs' fit in the tiered CBO structure.

The following table indicates the planned distributions to partner categories through the end of DY2 and the projected distributions of earned dollars for DY3 and DY4-5.

| | | Funds Flow (all funds) | | | |
|---|---|---|---|---|---|
| **Partner Category** | | ***Funds Flow through DY2, Q3*** | ***Projected Funds Flow through DY2*** | ***% of Earned Dollars Planned for Distribution DY3*** | ***% of Earned Dollars Planned for Distribution DY4 - DY5*** |
| Practitioner - Primary Care | | $ 5,784,810 | $ 7,252,105 | 32.2% | 31.3% |
| Practitioner - Non-Primary Care | | $ 55,731 | $ 75,965 | 0.6% | 0.6% |
| Hospital - Inpatient/ED/Ambulatory | | $ 6,800,467 | $ 7,772,671 | 35.9% | 36.2% |
| Clinic | | $ 208,964 | $ 284,835 | 2.1% | 2.1% |
| Mental Health and Substance Abuse | | $ 2,896,406 | $ 3,323,404 | 4.7% | 4.7% |
| Case Management | | $ 588,819 | $ 802,608 | 5.8% | 5.8% |
| Health Home | | $ 25,299 | $ 34,485 | 0.3% | 0.3% |
| Community Based Organization (Tier 1) | | $ 64,675 | $ 102,170 | 1.4% | 1.4% |
| Nursing Home | | $ 2,718,648 | $ 3,169,878 | 4.3% | 4.9% |
| Pharmacy | | | | | |
| Hospice | | | | | |
| Home Care | | | | | |
| Other (CBO non-Tier 1) | | $ 847,599 | $ 968,685 | 3.4% | 3.4% |
| Other (PPS PMO Admin.) | | $ 8,491,223 | $ 9,510,328 | 9.4% | 9.4% |
| Other (Define) | | | | | |
| **Total** | | $ 28,482,641 | $ 33,297,132 | 100% | 100% |

**Westchester Medical Center**

The Westchester Medical Center PPS response to the PAOP Standard Modification noted that the PPS has established a schedule for contracting with each type of organization based on the nature of services offered by that organization in addition to their level of project participation. The PPS included a table that outlined the partner types included in each of the seven contracting waves and the estimated timelines for contract distribution. The PPS also provided data to support that it has made progress in contracting with partners including Primary Care, Mental Health, Substance Use Disorder and Community Based partners.

The PPS facilitates project implementation within the framework of seven Medical Neighborhoods Supporting Health Communities (Medical Neighborhoods) operate as hubs within the PPS to highlight and strengthen connections between primary care clinicians and the various partners that support the delivery of integrated, patient-centered care. Westchester Medical Center held nine Medical Neighborhood since September 2016 with the goal of convening diverse provider groups to define challenges to creating an integrated delivery system while identifying solutions to support the further development of IT infrastructure, population health and performance management tools. These Medical Neighborhood meetings resulted in the collaborative creation of patient workflows unique to each Medical Neighborhood that details location specific process for transitioning patients while providing wrap-around supports and services.

Westchester Medical Center indicated it plans to expand its network contracting scope and deepen existing network partner engagement through the deployment of the Medical Village project across a spectrum of provider categories. The conversion of existing hospital space in to medical Villages allows the PPS to attract and diversify participation of partners under broader DSRIP initiatives such as diabetes, behavioral health, and cardiology.

In addition to project specific engagement of PPS partners, the PPS has engaged partners though Key Network Partner Meetings. These meetings include partners with the highest number of attributed lives and related transformation agenda. They allow core PPS and partner staff to meet around DSRIP projects and deliverables. A series of these meetings are slated for DY3 to focus on provider specific milestones and performance goals associated with DSRIP projects.

Westchester Medical Center indicated in their response related to funds flow that their partner contracting commenced by engaging all partners through a Master Services Agreement (MSA). The PPS then executed Schedule B contracts contingent on each partner's DSRIP project involvement. The first category of Schedule B contracts to be executed were the "Threshold Schedule B" which incentive partner participation by providing baseline compensation to organizations that completed a survey or participated in a PPS committee. The majority (53%) of funds distributed have been under "Implementation Schedule B" contracts, which provide direct resources to providers to support DSRIP project implementation. The PPS identified in its response seven types of contracts under which it has distributed funds to partner organizations and noted that it is currently developing additional methodologies for distributing performance incentive payments in a way that maximizes the impact of the funds towards achievement of DSRIP goals.

The PPS also indicated that it tracks Community-Based Partner engagement by identifying partners that meet criteria for one of the three Community-Based Partner definitions provided by the State. As of January 2017, the PPS has given $379,137.93 in funds to 97 community-based partners.

The following table indicates the planned distributions to partner categories through the end of DY2 and the projected distributions of earned dollars for DY3 and DY4-5.

| | | Funds Flow (all funds) | | | |
|---|---|---|---|---|---|
| **Partner Category** | | *Funds Flow through DY2, Q3* | *Projected Funds Flow through DY2* | *% of Earned Dollars Planned for Distribution DY3* | *% of Earned Dollars Planned for Distribution DY4 - DY5* |
| Practitioner - Primary Care | | $ 4,945 | $ 4,965 | 0.2% | 0.4% |
| Practitioner - Non-Primary Care | | $ 37,665 | $ 38,040 | 0.0% | 0.0% |
| Hospital - Inpatient/ED | | $ 976,922 | $ 997,031 | 0.2% | 0.5% |
| Hospital - Ambulatory | | $ 976,922 | $ 997,031 | 0.2% | 0.5% |
| Clinic | | $ 2,472,624 | $ 2,806,446 | 1.9% | 3.9% |
| Mental Health | | $ 1,860,092 | $ 1,942,283 | 2.3% | 4.7% |
| Substance Abuse | | $ 1,806,989 | $ 1,833,342 | 0.3% | 0.7% |
| Case Management | | $ 140,657 | $ 212,692 | 0.5% | 1.1% |
| Health Home | | $ 140,657 | $ 212,692 | 0.5% | 1.1% |
| Community Based Organization (Tier 1) | | $ 84,490 | $ 93,780 | 0.3% | 0.5% |
| Nursing Home | | $ 33,122 | $ 35,747 | 0.1% | 0.1% |
| Pharmacy | | $ 4,899 | $ 4,917 | 0.0% | 0.0% |
| Hospice | | $ 10,256 | $ 11,194 | 0.0% | 0.0% |
| Home Care | | | $ - | 0.0% | 0.0% |
| Other (Define)-All Other & TBD For DY3 to DY5 | | $ 2,654,547 | $ 3,208,287 | 58.5% | 52.8% |
| Other (Define)-Additional Providers | | $ 482,120 | $ 500,742 | 3.4% | 6.8% |
| Other (Define)-Uncategorized | | $ 27,457 | $ 43,207 | 0.5% | 1.0% |
| Other (Define) -PMO & Provider Support Vendors | | $ 34,459,655 | $ 41,678,793 | 31.0% | 26.0% |
| | | | | | |
| **Total** | | $ 46,174,021 | $ 54,621,189.00 | 100.0% | 100.0% |