Montefiore Hudson Valley Collaborative Financial Stability and Value Based Payment Baseline Assessments

Partner / Organization Name: _____

Notice of Agreement of Financial Stability: MHVC, as a state-designated lead agency, has a contracted obligation to the state to develop a Financial Health Assessment of the MHVC partner network. To support this process MHVC, along with the MHVC Steering Committee, has set up a formal governance structure to advise and provide feedback on the most effective way to meet state requirements. This structure includes a Finance and Sustainability Subcommittee composed of 12 members of MHVC representing our network's stakeholder and geographic diversity. The Finance Subcommittee has worked closely with the MHVC office to design and approve the below assessment. The assessment will allow the Finance Subcommittee to learn more about what defines a financially stable Partner in the MHVC region, as well as to gain an understanding of baseline value based payment readiness and identify the associated risks. With this information MHVC and the Finance Subcommittee will create recommended thresholds for financial sustainability and strategies to guide those organizations in need of strategic financial support. These recommendations will also be presented to the MHVC Steering Committee for review and feedback. Each of these steps will be taken to meet DSRIP requirements established by New York State.

The compilation, review, and analysis of the information you are providing will be conducted by our third-party consultant, COPE Health Solutions (COPE). To the extent possible, COPE will not distribute an individual Partner's sensitive financial information or payer relationships to MHVC and/or the Finance Subcommittee, instead compiling the necessary information into an aggregate report. Moreover, any information you provide in this survey will be used solely for the purpose of advancing DSRIP policies and objectives in order to meet state mandated requirements; no information will be shared with or used by COPE, MHVC, or any Finance Subcommittee member for any other purpose. In the event it is necessary for COPE to share more detailed financial information to MHVC and/or the Finance Subcommittee, it will only be shared with those individuals who have a responsibility to help MHVC meet its state requirements to help guide those organizations in need of strategic financial support, and will only be shared and used for that limited purpose.

By checking this box, you attest that the information provided is accurate based on your best knowledge and that the information provided does not contain any untrue statement of fact or omit a material fact that inhibits your ability to perform your required duties as a DSRIP participant. You also confirm that your organization would be able to provide supporting documentation for PPS review purposes, if requested, for each of the line items stated below.

Failure to provide this information may place your organization in a noncompliant status in MHVC.

If you are unable to provide information on the Financial Stability Assessment Indicators, MHVC reserves the right to request additional information and/or data to determine if your organization is deemed financially fragile. MHVC reserves the right to require that financially fragile Partners develop a Distressed Provider Plan (DPP) in joint effort with MHVC.

1. Please indicate your organization's fiscal year (mm/dd – mm/dd): ___/___ - ___/___
2. What is the year of your organization's last audited financial statements? [Please select a year]
3. For the following data, please provide the 3/31/16 year-to-date (YTD) value and the most recent year end audited value.
    - please include the dollar amount – you can round to the nearest 1000 if desired
    - for ratios, please enter numbers for up to 3 decimal points

Financial Sustainability Indicator	3/31/16 YTD value	Consolidated Last year-end audited value
Operating Income		
Net Revenue		
Operating Margin % **(Operating Income / Net Revenue)**		

Current Assets		
Current Liabilities		
Current Ratio **(Current Assets / Current Liabilities)**		

Cash & Cash Equivalents		
Operating Expenses		
Depreciation		
Days Cash on Hand **(Cash* +Cash Equivalents)/ [(Operating Expenses - Depreciation) / 365]** *Cash = unrestricted cash and investments + unrestricted board designated funds		

Total Debt		
Total Assets		
Debt Ratio **(Total Debt / Total Assets)**		

Long-term Debt		
Total Equity (Net Assets)		
Capitalization ratio **Long-term debt / [Long-term debt + Total equity (net assets)]**		

4. Have any of the following events occurred in your organization or any of its affiliated organizations in the past 12 months?

	Yes	No	Comments
a. Filing of bankruptcy or bankruptcy protection			
b. Received an on-going concern audit opinion from your organizations external audit firm			
c. Foreclosure or involuntary lien filed against any of the assets of the organization			
d. Finding of fault in a fraud investigation by any state or federal agency			
e. Organizational or business changes that could positively or negatively impact your current financial condition and your organization's ability to participate in the DSRIP program (Examples include: significant grant funding that is not expected to last for the entire DSRIP 5-year period, regulatory/reimbursement changes mergers or acquisitions, significant construction or expansion projects, etc.)			

5. Does your organization have access to resources from affiliates, foundations, etc. that can be accessed if required to sustain operations? ☐ Yes ☐ No

6. Please provide your organization's Medicaid Dual Eligible* percentage based on either patient population or service volume:

***Dual Eligible:** Medicaid patient or service with simultaneous coverage from Medicare

	%
% Dual Eligible by Patient Population or Service Volume	

a) b. If you are a hospital, please provide the two most recently available ratios that make up your Medicare Disproportionate Share Hospital (DSH) Patient Percentage:

SSI Ratio (Medicare SSI days / Total Medicare Days): _____

Medicaid Ratio (Medicaid Days / Total Patient Days)_____

7. Please provide your organization's payor mix, in terms of percent and dollars for your **core services** as of the end date corresponding with your **last audited fiscal year**:

Core Services Include (check all that apply):

- ☐ Inpatient
- ☐ Outpatient (Primary Care)
- ☐ Outpatient (Specialty Care)
- ☐ Outpatient (Behavioral Health)
- ☐ SNF/Nursing Home
- ☐ Home Health
- ☐ Pharmacy
- ☐ Other (Please Describe): _____

Payor	Percent of total patient service revenue	Total dollars (in thousands)
Medicaid FFS (state based)		
Medicaid Managed Care		
Medicare FFS (traditional)		
Medicare Managed Care		
Commercial		
Self-pay / Uninsured		
All Other		

Please provide payor mix for any **other services** not included in the revenue listed above as of the end date corresponding with your **last audited fiscal year**:

Other Services Include (check all that apply):

- ☐ Inpatient
- ☐ Outpatient (Primary Care)
- ☐ Outpatient (Specialty Care)
- ☐ Outpatient (Behavioral Health)
- ☐ SNF/Nursing Home
- ☐ Home Health
- ☐ Pharmacy
- ☐ Other (Please Describe): _____

Payor	Percent of total patient service revenue	Total dollars (in thousands)
Medicaid FFS (state based)		
Medicaid Managed Care		
Medicare FFS (traditional)		
Medicare Managed Care		
Commercial		
Self-pay / Uninsured		
All Other		

8. Does your organization have existing Value Based Payment (VPB) agreements with MCO's? ☐ Yes ☐ No

9. If yes, how much of your patient service revenue is attributed to these VBP agreements (i.e. shared savings, capitation, etc.) as of the end date corresponding with your **last audited fiscal year**?

Payor	Total dollars (in thousands)	Attributed Lives
Medicaid		
Medicare FFS (via ACO)		
Medicare HMO		
Commercial		

10. Are you part of a Medicare Shared Savings Plan (MSSP) ACO or Pioneer ACO? If so, please provide the following information:

Name of the ACO: ____

Your role in the ACO: ____

11. Please complete the following section for your organization's three largest managed care payors ranked in size based on total patient service revenue **from last audited fiscal year**. This information will be aggregated by COPE and partners will be de-identified before it is shared with MHVC and/or Finance Subcommittee.
    a) Please select the name of the managed care payor from the drop down menu or select Other and specify the name of the managed care payor if it's not listed. You may select "N/A" if you do not feel comfortable disclosing the MCO name at this time.
    b) For each managed care payor please provide the patient service revenue and the number of attributed lives by line of business as of the end date corresponding with your **last audited fiscal year**.
    c) If you have any existing VBP arrangements, please select all of the VBP contract types associated with each payor and line of business as applicable. Please select most advanced level for which you have a signed contract. Please select "None" if no VBP arrangements exist. If none of the contract types listed apply, please select other and provide an explanation.

Managed care payor #1: *Select Payor*

If other please specify:

Line of business	Medicare	Medicaid	Commercial
Total associated patient service revenue (In thousands)			
Number of lives attributed by MCO			
VBP Contracts Type/Description (check all that apply)	☐ NONE ☐ Level 0: FFS with quality component ☐ Level 1: Shared Savings (Upside Only) ☐ Level 2: Upside and Downside Risk Sharing ☐ Level 3 Capitation (choose one): ☐ Professional/ Primary Care Sub-capitation ☐ Institutional Sub-capitation ☐ Global Sub-capitation ☐ Level 3: Bundled Payments ☐ Other (please explain): ___________	☐ NONE ☐ Level 0: FFS with quality component ☐ Level 1: Shared Savings (Upside Only) ☐ Level 2: Upside and Downside Risk Sharing ☐ Level 3 Capitation (choose one): ☐ Professional/ Primary Care Sub-capitation ☐ Institutional Sub-capitation ☐ Global Sub-capitation ☐ Level 3: Bundled Payments ☐ Other (please explain): ___________	☐ NONE ☐ Level 0: FFS with quality component ☐ Level 1: Shared Savings (Upside Only) ☐ Level 2: Upside and Downside Risk Sharing ☐ Level 3 Capitation (choose one): ☐ Professional/ Primary Care Sub-capitation ☐ Institutional Sub-capitation ☐ Global Sub-capitation ☐ Level 3: Bundled Payments ☐ Other (please explain): ___________

Managed care payor #2: *Select Payor*
If other please specify:

Line of business	Medicare	Medicaid	Commercial
Total associated patient service revenue (In thousands)			
Number of lives attributed by MCO			
VBP Contracts Type/Description (check all that apply)	☐ None ☐ Level 0: FFS with quality component ☐ Level 1: Shared Savings (Upside Only) ☐ Level 2: Upside and Downside Risk Sharing ☐ Level 3 Capitation (choose one): ☐ Professional/ Primary Care Sub-capitation ☐ Institutional Sub-capitation ☐ Global Sub-capitation ☐ Level 3: Bundled Payments ☐ Other (please explain): ___________	☐ None ☐ Level 0: FFS with quality component ☐ Level 1: Shared Savings (Upside Only) ☐ Level 2: Upside and Downside Risk Sharing ☐ Level 3 Capitation (choose one): ☐ Professional/ Primary Care Sub-capitation ☐ Institutional Sub-capitation ☐ Global Sub-capitation ☐ Level 3: Bundled Payments ☐ Other (please explain): ___________	☐ None ☐ Level 0: FFS with quality component ☐ Level 1: Shared Savings (Upside Only) ☐ Level 2: Upside and Downside Risk Sharing ☐ Level 3 Capitation (choose one): ☐ Professional/ Primary Care Sub-capitation ☐ Institutional Sub-capitation ☐ Global Sub-capitation ☐ Level 3: Bundled Payments ☐ Other (please explain): ___________

Managed care payor #3: *Select Payor*
If other please specify:

Line of business	Medicare	Medicaid	Commercial
Total associated patient service revenue (In thousands)			
Number of lives attributed by MCO			
VBP Contracts Type/Description (check all that apply)	☐ None ☐ Level 0: FFS with quality component ☐ Level 1: Shared Savings (Upside Only) ☐ Level 2: Upside and Downside Risk Sharing ☐ Level 3 Capitation (choose one): ☐ Professional/ Primary Care Sub-capitation ☐ Institutional Sub-capitation ☐ Global Sub-capitation ☐ Level 3: Bundled Payments ☐ Other (please explain): ___________	☐ None ☐ Level 0: FFS with quality component ☐ Level 1: Shared Savings (Upside Only) ☐ Level 2: Upside and Downside Risk Sharing ☐ Level 3 Capitation (choose one): ☐ Professional/ Primary Care Sub-capitation ☐ Institutional Sub-capitation ☐ Global Sub-capitation ☐ Level 3: Bundled Payments ☐ Other (please explain): ___________	☐ None ☐ Level 0: FFS with quality component ☐ Level 1: Shared Savings (Upside Only) ☐ Level 2: Upside and Downside Risk Sharing ☐ Level 3 Capitation (choose one): ☐ Professional/ Primary Care Sub-capitation ☐ Institutional Sub-capitation ☐ Global Sub-capitation ☐ Level 3: Bundled Payments ☐ Other (please explain): ___________

12. Based on the services your organization is providing and the population that it is responsible for, please help us understand what you see as being your barriers to success in value-based payment contracting:

	Low Risk	Medium Risk	High Risk	N/A
Patient engagement	☐	☐	☐	☐
EHR	☐	☐	☐	☐
Data analytics	☐	☐	☐	☐
Care coordination	☐	☐	☐	☐
Financial/cost accounting tracking	☐	☐	☐	☐
Patient disparate geography	☐	☐	☐	☐
Physician alignment	☐	☐	☐	☐
Identifying and integrating with community benefit and social services organizations	☐	☐	☐	☐
Chronic disease management	☐	☐	☐	☐
Post-acute care integration	☐	☐	☐	☐
Other (please specify):	☐	☐	☐	☐
Other (please specify):	☐	☐	☐	☐

13. What services, technical assistance and/or other support would you like to see MHVC provide in order to help your organization and other organizations be best prepared for success under value based payment contracting?
    - ☐ Centralized care management
    - ☐ Data analytics
    - ☐ Call Center
    - ☐ Claims Processing
    - ☐ Primary Care Transformation
    - ☐ Data warehousing and data hosting
    - ☐ Clinical decision support
    - ☐ Support building new care models (ex: ED Care Triage, crisis stabilization)
    - ☐ Program design to increase patient engagement and literacy
    - ☐ Other (please specify):
    - ☐ Other (please specify):

    _____

14. Contact information:

Name of individual completing this form:	
Title:	
Phone number:	
Email address:	