COHORT MANAGEMENT PROGRAM OVERVIEW

Version 2018.11.14

CARE COMPASS NETWORK

Table of Contents

Introduction

This document is intended to guide partners through the process of cohort management contracting from beginning to end. It will serve as an educational tool to understand the process and the primary tasks required for working with a cohort population.

Care Compass Network (CCN)'s Cohort Management Program is designed to support the Active Cohort Management of priority Medicaid population cohorts, whereby CCN Partners form Networks of care, integrate services, and are held jointly accountable for population outcomes. This type of collaborative network is not new—there are many small and large-scale networks occurring across New York State. The goal of this formalized program is to help healthcare providers and community-based organizations in our region transition to a new Value-Based Payment (VBP) model where outcomes, rather than fee-for-service, are incentivized.

Background

What is the Cohort Management Program?

A cohort is a group of individuals, defined by their personal, clinical, or social needs; and/or by a triggering event. This program will support the Active Cohort Management of priority Medicaid population cohorts, whereby CCN Partners form Networks, integrate services, and are held jointly accountable for population outcomes.

What's in it For Healthcare Organizations and Community-Based Organizations?

- ✓ Opportunity to develop skills necessary in Managed Care environment
- ✓ New network connections and relationships
- ✓ Learn how to administer funds differently
- ✓ Learn how to work in a new payment model

Program Requirements

Requirements for Networks

- **Network Composition** (roles below are not required to be mutually exclusive)
  - Minimum of four partners
  - One Value-Based Payment Lead Contractor (VLC)*
  - One Tier 1* Community-Based Organization (CBO)
  - One referral source*
  - **see Terminology section for definitions*
- **Relationships**
  - Flow funds, share information
  - Mutually agreed upon expectations for service delivery

Requirements for the VLC

- **Value-Based Payment Lead Contractor (VLC) = Lead Partner**

- VLC serves as the primary contracting entity to CCN on behalf of its Network.
- Ability/Experience to Administer the Network (including Funds Flow, Legal, Network Management, CCN Reporting, Data Exchange, Performance Monitoring of Cohort)
- Intent to contract in a VBP arrangement with a Managed Care Organization as the lead of a Network
- Safety Net Partner*
- Active Phase III Contract for DSRIP Projects w/CCN
- **see Terminology section for definitions*

Requirements for Cohorts

- **What is a cohort?**
  - A group of individuals, defined by their personal, clinical, or social needs; and/or by a triggering event
- **Size and Composition**
  - 100% Medicaid
  - 50-200 Medicaid Members
  - Static or Dynamic, with 6-month reassessment
- **General Characteristics**
  - Groups aligned with DSRIP Performance Metrics
  - Clinically high-needs
  - Probable gaps in appropriate service utilization
  - Probable needs for non-clinical services

Application & Timeline

- Partners form into Networks around cohorts of interest.
- A VLC, on behalf of a Network, must submit a Planning Application to enter the Planning Phase.
- Upon CCN approval of Planning Application, $100,000 in Planning Phase funds will be released to the Value-Based Lead Payment Contractor to carry the Network through the Planning Phase. A minimum of 50% of Planning Funds must be flowed to downstream Network partners.

STEP 1: APPLICATION DUE 12/31/18

- During the Planning Phase, Networks must complete the three Planning Milestones listed in the Planning Phase Section of this Overview to be eligible to move on to the Active Cohort Management Phase.
- Contracts for the Active Management Phase will be executed with the Value-Based Lead Payment Contractor upon completion of all three Planning Milestones.

STEP 2: PLANNING PHASE

- Network begins activities which may include activities such as service integration, process improvement, action plans, case conferencing, facilitation.
- Partners in the Network continue to provide current services to the cohort, which may include outreach, education, engagement, needs assessments, social determinants support, care coordination, primary care, medication adherence, navigation, medical monitoring, nutrition, transportation, and more.

STEP 3: ACTIVE MANAGEMENT PHASE 4/1/19-3/31/20

Step 1: Application

Interested Partners Listing

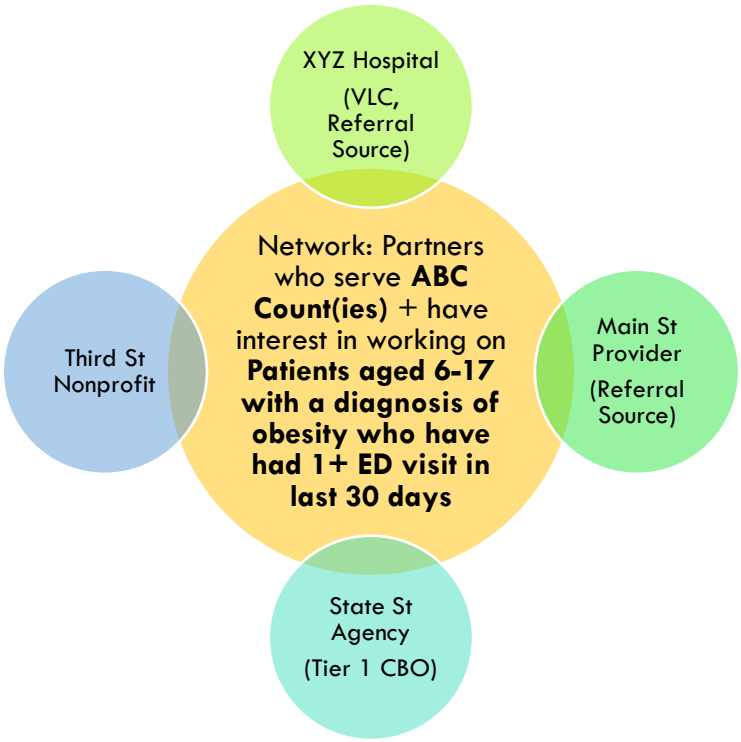
Networks who are looking for partners may find a list of interested partners at www.carecompassnetwork.org/cohort.

Group and Convene

CCN may assist Networks in forming through assignment of a Network Facilitator. Partners that wish to participate but have not found a Network should contact CCN for assistance.

FIGURE 1. ILLUSTRATION OF A POSSIBLE NETWORK

*Minimum of four partners are required, including the VLC.



Applications for Planning Phase

Once Networks are formed and are ready to move to the Planning Phase, the Network VLC will submit a brief application.

- **FORMS REQUIRED: Application for Planning Funds (Form B), and Letter of Participation Template (Form C). These forms are included at the end of this document or you may download them at www.carecompassnetwork.org.**

Application Approval & Contracts

Applications for Planning Phase will be reviewed on an ongoing basis through December 31, 2018 by CCN leadership and CCN will adhere to its standard contracting process. Applicants will be notified within 30 days of a decision regarding their application. Contracts for the Planning Phase are standard Appendix Cs for Cohort Planning, and each Value-Based Lead Payment Contractor of a potential Network will receive

$100,000 in Planning Phase funds. CCN requires that the VLC distribute a minimum of 50% of the Planning Phase funds to its downstream Network partners.

Upon approval and execution of the Appendix C for Cohort Planning, CCN will assign a Network Facilitator for the Network. See CCN Support Services section of the Overview for complete details of the Network Facilitator role.

Step 2: Planning Phase

Planning Phase Milestones

Applications for Planning Phase and Letters of Participation from the Network Partners will be reviewed by CCN leadership for approval. Networks awarded planning funds as a result of their initial proposal will receive $100,000 (payable to the Value-Based Lead Payment Contractor) towards Network planning/development and cohort creation. Once a determination is made based on the Applications, upon contract execution, the network enters the Planning Phase wherein all elements must be completed satisfactorily for the Network to be awarded an Active Cohort Management contract. At the time of contract execution for the Planning Phase, the initial $100,000 will be flowed. CCN requires that the VLC distribute a minimum of 50% of the Planning Phase funds to its downstream Network partners.

The Planning Phase consists of three milestones:

1. Clinical Design Milestone
2. Network Build Milestone
3. Data Reporting Milestone

1. Clinical Design Milestone

During this Milestone, the Networks will define the criteria for their cohort and will be evaluated for clinical appropriateness.

Instructions: Use the Clinical Design Milestone Tool (found online at http://carecompassnetwork.org/about/cohort-management/ under the Toolkit section) to complete your Network's approach for review by the CCN Clinical Governance Committee. The forms can be found on the Cohort Management Program website or from CCN directly. Additional detail regarding requirements can be found in the forms.

Minimum Clinical Requirements:

- 100% Medicaid population
- 50-200 Cohort size

Milestone Requirements:

1) Cohort population
    a. Define the size of the cohort
    b. Define the diagnostic criteria for cohort inclusion
    c. Define the utilization criteria for cohort inclusion
    d. How often will the Cohort refresh?
2) Intervention(s)
    a. Define the core services and interventions to be used during Active Cohort Management of the cohort.
    b. Are all services currently funded through an existing source (billable under Medicaid or other insurance, CCN supported, grant funded, funded under contract, supported with state aid, deficit support, or other NYS or federal funding source)? Identify any core services/interventions which are not funded, provide a cost proposal and justification for consideration by CCN (for clinical appropriateness and reasonableness).
    c. Describe how the clinical and non-clinical services align with a high needs population.
3) Goals and Outcomes
    a. Establish goals for improving patient outcomes, including determining indicators of success.
    b. Choose DSRIP Performance Metrics that are aligned with your network's goals.

Approval:

- Operational Review: Conducted by CCN staff.
- Clinical Review: Conducted by the Clinical Governance Committee.

Clinical Review/Scoring:

The Clinical Governance Committee will review each cohort based on the Needs Assessment Tool and will evaluate to either accept, accept with contingencies, or revise and resubmit. If all of the requirements are accepted, the Milestone would be considered complete. If any of the requirements are accepted with a contingency or if the Network is asked to revise and resubmit, CCN staff will support the Network in any additional work needed to move forward.

2. Network Build Milestone

During this Milestone, Networks will define the partners in their Network, their capacity, and the basic operation of the Network.

Instructions: Use the Network Build Milestone Tool (found online at http://carecompassnetwork.org/about/cohort-management/ under the Toolkit section) to complete your Network's approach for review by the CCN Management. The forms can be found on the Cohort Management Program website or from CCN directly.

Minimum Network Requirements:

- At least 4 partners
- 1 partner must be a Tier 1 Community-Based Organization
- The Value-Based Lead Payment Contractor must be a Safety Net Partner (See definitions page)
- CCN will require notification within 30 days of any changes in the Network membership (additions or removals).
- If, during the Active Management Phase, the Network fails to meet minimum requirements above, payment would be withheld until requirements are once again met.

Milestone Requirements:

1) List of Network partners
    a. For each partner, list the agency name, the core services provided, and FTE breakdown of project staffing.
2) Is there a contractual relationship in place among Network Partners?
3) What are the referral pathways within the Network? (i.e. who encounters the patients first, and refers them to who?)
4) How often does the Network meet, where, and who convenes the meetings?
5) How are decisions made in the Network? (examples: Value-Based Lead Payment Contractor makes decisions, decisions are made by the Network collectively – there are no right or wrong answers)
6) How will new members to the Network be handled?
7) How will poor performance of Network partners be handled?
8) What additional partnerships are needed to serve this cohort?
9) Describe the funds flow to partners in the Network, including:
    a. How much will partners be paid during the Active Cohort Management Phase?
    b. On what schedule will partners be paid during Active Cohort Management?

Approval:

- Operational Review with CCN management.
- Clinical review is not needed for this Milestone.

3. Data Reporting Milestone

During this Milestone, the Networks will identify the reporting mechanisms used to track key leading indicators as well as outline the budget and funds flow model distribution to the participating partners.

Instructions: Use the Data Reporting Milestone Tool (found online at http://carecompassnetwork.org/about/cohort-management/ under the Toolkit section) to complete your Network's approach for review by the CCN Management. The forms can be found on the Cohort Management Program website or from CCN directly.

Minimum Reporting Requirements:

- CCN will require patient names, date of birth, date of service, CIN or Medicaid policy number, needs assessment score, and date the assessment was completed on a monthly basis.

Milestone Requirements:

1) Which indicators will be tracked for the Active Cohort Management of the cohort, and who tracks them?
2) Which systems or databases will be used to track indicators? Do any reports need to be built?
3) How will partners access information about the indicators? (Direct access or generated reports sent to them?)
4) How often will indicators be reviewed and discussed for targeted action by the Network?
5) What mechanisms will be used to track cohort membership?
6) What information will be reported by partners to the Value-Based Lead Payment Contractor and shared among Network Partners?

Approval:

- Operational Review
- Clinical review is not needed for this Milestone.

Needs Assessment

At the completion of all milestones, the panel will be assessed using the Needs Assessment Tool which will take into account both clinical and social needs of the clients/patients in the cohort.

Step 3: Active Cohort Management

Active Cohort Management Phase

What happens during Active Cohort Management Phase?

- During the Active Cohort Management Phase, Networks implement the plan they developed during the Planning Phase. Each Network is expected to communicate with its Network partners on a regular basis to review Cohort Membership, assess the aggregate status of the Cohort (progress, trends, etc.), identify performance gaps, improve process regarding service integration, track patient engagement, coordinate care planning and services for individual Cohort members, and facilitate progress towards closing performance gaps.
- Where applicable, individual Network partners will provide direct services to Cohort Members that align with individual partner mission and business model. Direct services with a funding source are not funded through this program. See table 1 below for details on what activities are funded.

What is the funding structure in the Active Cohort Management Phase?

A. Needs Assessment - $90

❖ Summary

- Reflects Members' individual level of complexity of needs that includes clinical and social determinants of health needs
- Assumes a person with greater complexity of needs requires more effort from the Network to integrate services
- Determines the PMPM for service integration
- Upon determination of eligibility for entry into the cohort (triggering event), the Network will outreach to the patient and complete an assessment form compiled of clinical and social determinants of health needs. The VLC will receive $90 for each completed Needs Assessment that is reported to CCN, and paid out to the Network as determined in the Planning Phase. Note: CCN will pay only for the initial assessment, although it does require unpaid re-assessments every 6 months.

B. Network Activities – Up to $140 Per Member Per Month (PMPM)

❖ Summary

- Network Activities are paid on a Per Member Per Month basis. Networks will report to CCN the cohort members they have identified for inclusion. Networks will be required to conduct a Needs Assessment on each member of the cohort and report to CCN the results. Based on the results of the completed Needs Assessment, each cohort member will be assigned a rate into one of four levels: $40, $60, $100, and $140 for Levels 0, 1, 2, and 3, respectively. The cohort members will be re-assessed every six months and either remain in their respective level or move to a different level. **Note: Level 0 accounts for the time it takes to outreach to cohort members and conduct a Needs Assessment. Networks may be paid for up to three months at a Level 0 per cohort member. If a Needs Assessment is not reported to CCN within three months, CCN will not pay a PMPM for that patient until a Needs Assessment is reported.**
- Network activities include: Ongoing Network Management; Weekly/Monthly Data Review of Cohort Indicators and Service Engagement; Process Improvement regarding Service Integration; and Success stories, progress towards goals, and identification of gaps or issues.

❖ What is covered by the PMPM payment during the Active Management Phase?

What the PMPM will support:	What the PMPM will NOT support:
✓ Service Integration	∅ Direct services to cohort members

✓ Case Conferencing ✓ Process Improvement ✓ Action Plans	∅ Counseling of cohort members ∅ Intake of cohort members ∅ Home visits to cohort members

Table 1. Activities During Active Cohort Management Phase

C. Services without an Existing Funding Source– Maximum 20% of contract value

- Summary
  - Must be requested and approved by CCN's Clinical Governance Committee during the Planning Phase
  - Services requested must:
    - Not be billable under the Medicaid program or other insurance
    - Lack a grant funding source, state aid/deficit funding, or other source of funding.
    - Be mutually agreed upon by Network partners
  - Networks are responsible for submitting a cost proposal for unfunded services to CCN. The service must be assessed for its clinical appropriateness by the Clinical Governance Committee; the cost proposal will be assessed by CCN Management.
  - Opportunity for innovation in the services provided to Members
  - Total Funding for Services without an Existing Funding Source is capped at 20% of the total of A + B (Needs Assessments projected + PMPM Level Expected). Contact your Network Facilitator to request the Active Management Phase Budget Calculator for planning purposes.
- Examples
  - Air Conditioners for cohort members with Asthma/COPD
  - Pet care services for cohort members for which that is a barrier to SUD recovery

What can you request through the "Services without an Existing Funding Source" bucket?	What **CAN'T** you request through the "Services without an Existing Funding Source" bucket?
✓ Non-billable services or equipment ✓ Services or equipment that have no other funding source (including grants, donations, or program revenue) ✓ Services that have a demonstrated or justified clinical need ✓ Services that directly relate to the needs of the cohort members and the Network's interventions	∅ Services or equipment that are billable through Medicaid or other insurance ∅ Services or equipment that are paid for through grant funds, donations, or program revenue ∅ Capital expenses ∅ Services or equipment with no plan for sustainability

Appendix

How are they different? Cohort Management Program Vs. Health Home Model

	Cohort Management Program	Health Home Model
Funding Model	• Assessment $ + adjustable PMPM based on intensity level + proposed amount for unfunded services • Level 0 applies to members of the cohort who have not yet been assessed	• Outreach $ + PMPM based on acuity levels 1-3
Medicaid %	100%	100%
General activities/ description	• Collaborate with a Network of partners to manage the care and social services offered to a targeted cohort population • Objectives: improve health outcomes, reduces cost, improve quality and learning how to operate in a VBP environment. • Eligibility is clinical and social determinants-based.	• Provide outreach and case management to eligible patients. • Objective: connect patients to community resources to support improved engagement and better outcomes. • Eligibility is entirely clinically based.
Resources	• Action Team consisting of members from partners in the Network. • Analyst support (CCN or Network sponsored) to monitor data/progress. • Funding distribution management.	• Care managers + oversight.
Acuity level update frequency	• Complete prior to implementation of cohort and at the 6-month mark.	• Completed annually.

Performance Improvement Payment

As part of the Planning Milestones, the submitting Partner Organization will outline a minimum of 1 (one) DSRIP Performance Metric from a specified list to be improved upon. Metric scores will be calculated for Networks by CCN, using monthly reports of Cohort Members and Medicaid Claims Data.

Upon completion of the Cohort management program efforts and subject to timing of data availability, the final score will be compared against the baseline and the percentage increase will be determined. One improvement point will be awarded for each percentage increase from the baseline score.

> Example: If a baseline score is 80 and the final result is 84, then 5 Improvement points will be awarded ((84-80)/80 * 100 = 5).

The Improvement Points awarded will determine the amount of Incentive payment awarded. In the above example, 50% of the Maximum Potential Incentive Payment will be awarded (10% per Improvement Point), which, relative to the example would be 50% * $141,160, or $70,580. At no time can the actual incentive earned be greater than the maximum available incentive, even if the number of Improvement Points awarded is greater than 10.

Terminology

Cohort

A set of individuals, defined by characteristics or triggering events. May be a static group of individuals or dynamic, meaning the group members change over time.

Community Based Organization (CBO) Tier Levels 1-3

- **Tier 1**: Non-profit, non-Medicaid billing, community-based social and human services organizations.
  Examples: Housing; social services, religious organizations, food banks, mobility management
- **Tier 2**: Non-profit, Medicaid Billing, non-clinical service providers.
  Examples: Transportation, care coordination
- **Tier 3**: Non-profit, Medicaid billing and clinical service providers licensed by the NYS Department of Health (DOH), Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD), Office of Alcoholism and Substance Abuse Services (OASAS), and independently owned primary care.
- **Other**: Any organization that does not meet all characteristics of the definitions above (e.g. a for-profit organization).

Milestones

Milestones are the major tasks that a Network will need to accomplish during the Planning Phase in order to move on to the Active Cohort Management Phase. Within each Milestone there are minimum requirements that must be met. Refer to the Planning Phase section of this Overview for details.

Network

A group of partners/agencies formed for the purpose of providing a core set of services to a defined cohort; establishes service integration.

Network Partners

Members of the Network whose services are integrated with a Value-Based Lead Payment Contractor and/or other Network partners.

Referral Source

A referral source is an agency or organization that has the ability to identify new cohort members who meet the cohort criteria and provide information about the new cohort members to the Network. The referral source may or may not also be a Value-Based Lead Payment Contractor, Tier 1 Community-Based Organization, or another Network member.

Safety Net Providers

SAFETY NET DEFINITION

A Safety Net directly bills Medicaid

AND FITS ONE OF THE CRITERIA BELOW

HOSPITALS

Must be either a public hospital, Critical Access Hospital or Sole Community Hospital

OR

Must pass two tests:

A. At least 35 percent of all patient volume in their outpatient lines of business must be associated with Medicaid, uninsured and Dual Eligible individuals.

B. At least 30 percent of inpatient treatment must be associated with Medicaid, uninsured and Dual Eligible individuals

OR

Must serve at least 30 percent of all Medicaid, uninsured and Dual Eligible members in the proposed county or multi-county community. The state will use Medicaid claims and encounter data as well as other sources to verify this claim.

NON-HOSPITALS

Non-hospital based providers, not participating as part of a state-designated health home, must have at least 35 percent of all patient volume in their primary lines of business and must be associated with Medicaid, uninsured and Dual Eligible individuals.

Social Determinants of Health Categories (SDoH)

The definition of a Social Determinant of Health according to the NYS Department of Health are evidence-based interventions that aim to improve certain social determinants of health. These categories are a starting point for CCN and the State to pave the way to positively affect the social determinants that have a significant negative impact on Medicaid Members in the state of New York.

There are 5 Categories the Department of Health classifies as follows:

1. **Economic Stability:** Housing, employment, food, transportation
2. **Education:** Lack of access to education and English literacy deficiencies; Community Health Advocacy; providing materials on a third-grade reading level for patients can comprehend.
3. **Health and Healthcare:** Lack of access to all types of health care including MH, BH including homecare and advance directive planning.
4. **Neighborhood and Environment:** Safety, physical barriers, substandard housing/living
5. **Social, family and community Context:** Criminal justice, trauma, discrimination issues

Value-Based-Payment Lead Contractor (VLC)

Serves as the Network lead for contracting with CCN. An entity likely to lead contract negotiations with a Managed Care Organization (MCO) on behalf of a Network. Also known as a VLC.

CCN Support Services

Below is a description of services CCN may offer to Networks during the Cohort Management Program.

	Core Services	***Enhanced Services***
Network Facilitator	☐ Serve as the primary contact for assigned Network(s) for the purposes of the Cohort Management Program ☐ Provide direct support for planning and implementation of the Cohort Management Program for assign Network(s) ☐ General mediator/assist in troubleshooting ☐ Relay data requests to Population Health Department ☐ Monitor monthly/quarterly/6-month reports and metrics performance ☐ Help identify and document best practices resulting in the creation of a portfolio at the conclusion of the Network's Cohort Management Program pilot	☐ Assist with convening partners within the Network ☐ Facilitate meetings/record meeting minutes, to include key 'takeaways' ☐ Help identify what is working well and not working well within the Network ☐ Track and drive progress toward milestones, and assist VLC with Milestone documents
Population Health Analyst	☐ Monitor metrics against cohort progress ☐ Provide support and analytic tools to support Cohort Management Program	☐ Upon request, provide specific demographic, analytical, or other information during the Active Cohort Management Phase ☐ Populate cohort membership with CCN-attributed Medicaid members
Compliance & Contracting	☐ Provide guidance to partners about compliance terms ☐ Provide standard/template documents and tools to aid in Network contracting process ☐ Make changes to contracts (if applicable)	☐
IT		☐ Provide information about technologies that could facilitate Network and/or cohort management (on a consultative basis)
Partner Relations or RPU Lead	☐ Will field initial questions during the cohort formation and contraction process. May refer partner(s) to Network Facilitator, depending on request or need	

B: PLANNING APPLICATION FORM

Instructions: VLCs will complete this form in its entirety including the attestation letter and submit with required attachments to cohorts@carecompassnetwork.org for consideration.

VALUE-BASED PAYMENT LEAD CONTRACTOR (VLC)	
LEGAL NAME OF THE NETWORK LEAD (VLC): *Must be a Safety Net organization with the ability to administer a Network.*	

COHORT POPULATION TO BE SERVED
1. GENERAL DESCRIPTION: Please describe diagnostic as well as demographic information about the cohort, geographic area, and any other defining characteristics of the cohort.
Diagnostic information: **Geographic area:** **Other defining characteristics:**
2. TARGET SIZE: Must be between 50-200 Medicaid members
3. INTERVENTIONS: Please briefly summarize the intended interventions that will benefit this cohort.

VLC'S ABILITY TO ADMINISTER NETWORK Describe the VLC's experience and/or ability in each of the following areas.
4. CONTRACTING IN A VALUE-BASED PAYMENT ARRANGEMENT: Please describe what experience the VLC has in contracting in Value-Based Payment arrangements. If none, please write N/A.
5. FLOW FUNDS: Please describe experience of the VLC to distributes funds to one or more organizations for purposes of achieving a shared goal(s).
6. ESTABLISH AND MAINTAIN LEGAL ARRANGEMENTS: Please describe experience of the VLC to enter into one or more legal contracts with another party, providing the legal oversight for stated agreements, either directly or through a contractual arrangement.
7. MANAGE THE NETWORK: Please describe experience of the VLC to regularly monitor performance of partners in the network through reporting and analytics. Also describe experience of the VLC to Implement performance improvement or quality control measures to improve network performance.

8. REPORT TO CCN: Please describe experience of the VLC to submit report(s) to CCN through the appropriate channels to meet Milestones and/or speed and scale commitments as defined by Phase III contracting.
9. SUPPORT EXCHANGE OF DATA: Please describe experience of the VLC to collaborate with partners to integrate population health data, following all HIPAA requirements.
10. MONITOR PERFORMANCE OF THE COHORT: Please describe experience of the VLC to regularly monitor patient-level data to identify opportunities to improve quality, reduce cost of care and improve coordination of care and services.

NETWORK PARTNERS List the legal names of all agencies/organizations in the Network and what role they serve. Please also indicate any partnership that are new and not currently existing.		
VLC		
TIER 1 CBO		New or existing partnership?
REFERRAL SOURCE		New or existing partnership?
OTHER		New or existing partnership?
Add additional rows as needed		

ATTACHMENTS
☐ Include the signed VLC Attestation letter below
☐ Include a signed Letter of Participation for a minimum of ONE Network partner using the template letter (Form C) found on www.carecompassnetwork.org

VLC ATTESTATION LETTER

DATE:

I, [NAME OF PERSON COMPLETING THIS APPLICATION], hereby attest that:

1. [NAME OF VLC AGENCY], agrees to serve as the lead agency, or Value-Based Payment Lead Contractor (VLC), in the above outlined Network; is a Safety Net Provider and understands and accepts the requirements as follows:
   a. Receive and distribute funds to Network Partners. As the VLC, we will work with our Network Partners, as defined in the Cohort Management Program documents, to determine how best to use the Cohort Management Funds in a mutually agreeable manner to the Network Partners.
   b. Communicate with CCN on behalf of the Network.
   c. Coordinate communication for the Network.

2. [NAME OF VLC AGENCY] is committed to current or future participation in a Value-Based Payment arrangement.

Sincerely,
[SIGNATURE]
[TITLE]
[NAME OF VLC AGENCY]

VLC should submit completed application form along with letters of participation to cohorts@carecompassnetwork.org.

C: LETTER OF NETWORK PARTICIPATION

INSTRUCTIONS: Organizations wishing to participate in a Network should complete this letter to accompany a formal Planning Application. This letter should be completed and signed by the representative of the organization participating with the Network. This letter does not need to be completed by a VLC. Completed, signed letters should be scanned and emailed to cohorts@carecompassnetwork.org as part of a VLC's Planning Application.

[Name]
[Title]
[Organization Name]
[Address]
[Address]
[Date]

Mark Ropiecki
Executive Director
Care Compass Network
33 Lewis Road
Binghamton, NY 13905

RE: Letter of Participation

Mr. Ropiecki,

Please accept this letter as confirmation that [Organization Name] is a participant with [VLC Entity Name], a Value-Based Payment Lead Contractor ("VLC"), under the Care Compass Network Cohort Management Program.

It is our intent to engage with the VLC for all activities related to the Cohort Management Program for the entire contracted Cohort Management Program period, ending March 31, 2020.

Sincerely,

SIGN HERE

[Name]
[Title]
[Organization]