

Commonwealth of Kentucky
Cabinet for Health and Family Services (CHFS)
Office of Health Policy (OHP)



**State Innovation Model (SIM) Model Design
September Stakeholder Meeting**

**September 22, 2015
9:00 AM – 12:00 PM**

Meeting Agenda

- **Welcome and Introductions** (Dr. John Langefeld, Chief Medical Officer, Department for Medicaid Services) 9:00 AM – 9:15 AM
- **Update on Consumer Input Process** (Dr. John Langefeld, Chief Medical Officer, Department for Medicaid Services) 9:15 AM – 9:25 PM
- **Using Benefit Design to Drive Patient Engagement** (Dr. Dennis Weaver, Executive Vice President and Chief Medical Officer, The Advisory Board Company, Inc.) 9:25 AM – 10:40 AM
- *Break* 10:40 AM – 10:50 AM
- **Breakout Discussion Activity on Consumer Engagement** 10:50 AM – 11:40 AM
- **Q&A on Draft Value-based Health Care Delivery and Payment Methodology Transformation Plan** (Dr. John Langefeld, Chief Medical Officer, Department for Medicaid Services & Jim Hardy, Specialist Leader, Deloitte Consulting LLP) 11:40 AM – 11:55 AM
- **Next Steps** (Jim Hardy, Specialist Leader, Deloitte Consulting LLP) 11:55 AM – 12:00 PM

The Commonwealth Institute of Kentucky

A transdisciplinary collaborative for population health improvement, policy, and analytics

SIM Consumer Input Project for the Cabinet for Health & Family Services

Purpose

- To collect feedback from Kentuckians regarding their experiences as health care consumers
- To recommend specific direction and targeted resolutions in the design of Kentucky's State Innovation Model

Methods

- Synthesize consumer feedback that has been collected throughout Kentucky in the past five years from relevant and applicable projects led by:
 - consumer advocacy groups
 - private organizations
 - government agencies
- Survey FQHC board members via online questionnaire and phone and in-person interviews

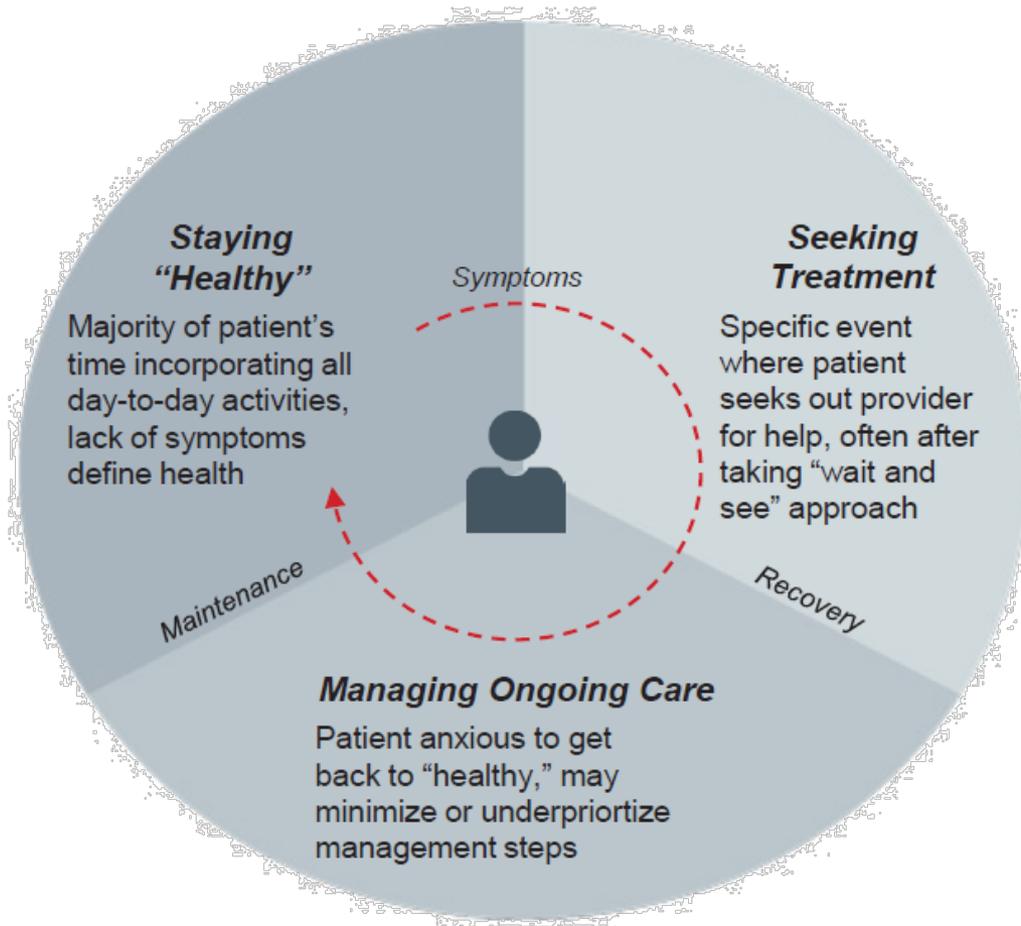
Analysis

- Analyze data into observable themes to inform each of the five SIM Stakeholder Workgroups and the elements of the “straw person” Model Design
- Submit final report to the Office of Health Policy for integration into final SIM Design Plan

Driving Patient Engagement Through Benefit Design

A Patient's View of the Health Care System

Easy for Patients to Become Disconnected



76%
Patients, 50 or older left a physicians or hospital confused about what to do next

50%
Adults have trouble understanding and using health information

40%-80%
Information immediately forgotten by adult learners

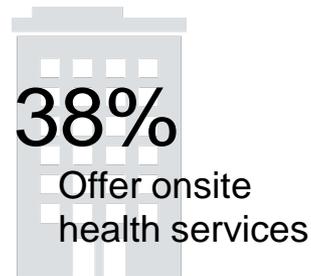
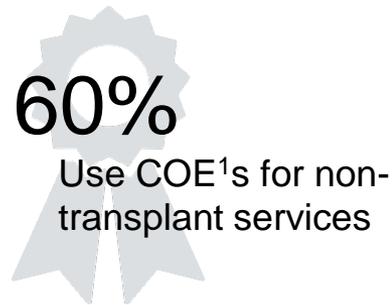
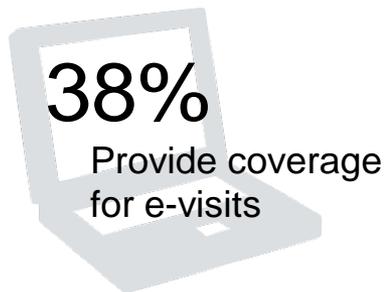
Source: FierceHealthcare, "New Campaign Aims to Focus Health Reform Implementation on Improving, Coordinating Care for Vulnerable Older Adults," available at: www.fiercehealthcare.com, accessed April 12, 2010; Hoffman J, "Awash in Information, Patients Face a Lonely, Uncertain Road," The New York Times, Aug. 14, 2005; McGuire L, "Remembering What the Doctor Said: Organizations and Older Adults' Memory," Experimental Aging Research, 1995, 22: 403-428; Kessels R, "Patients' Memory for Medical Information," Journal of the Royal Society of Medicine, 2003, 96: 219-222; Health Care Advisory Board interviews and analysis.

In Health Care, Customer Focus Now a Mandate

New Customers Exerting Greater Influence Over the Buying Process

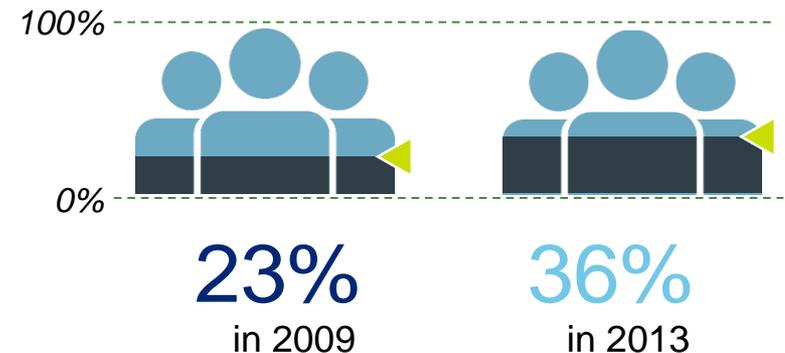
Employers Experimenting with New Services and Purchasing Mechanisms

Percentage of Employers with Strategies In Place or Planned for Next Year



Consumers Increasingly on the Hook for Care Decisions

Percentage of Consumers with HDHPs or CDHPs²



Open to New Options

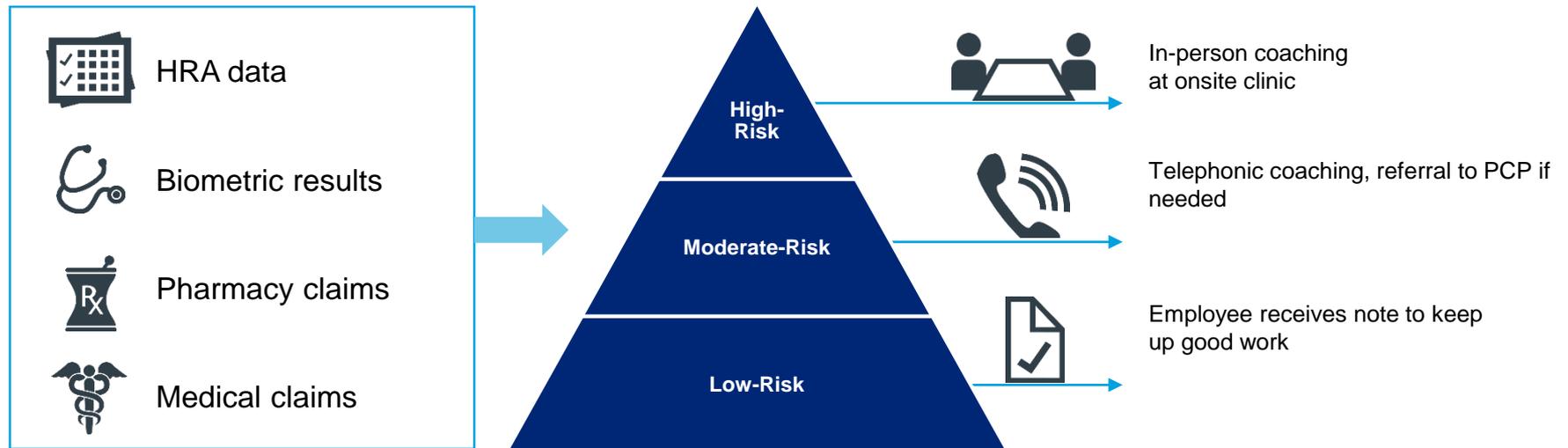
68% Employees who would “definitely travel” to a COE for knee surgery

Source: “The New Health Care Imperative: Driving Performance, Connecting to Value,” Towers Watson/National Business Group on Health, available at: <http://www.towerswatson.com/>; CDC/NCHS, National Health Interview Survey, 2009-2014, available at: <http://www.cdc.gov/nchs/nhis.htm>; National Business Group on Health annual survey, August 13, 2014, available at: <https://www.businessgrouphealth.org/index.cfm>; Health Care Advisory Board interviews and analysis.

Service Where It's Needed Most

Beneficiary-Level Targeting Maximizes Returns

Translating Data Into Actionable Intervention



Case in Brief: Prevea Health

- 250-physician multispecialty group based in Green Bay, Wisconsin
- Partners with employers through LeadWell, a workplace wellness offering that includes onsite clinics, educational services, occupational health, fitness, and medical programming

Current Approaches for Commercial Plan Design

Exchange Enrollees Trading Premiums for Deductibles

Average Public Exchange Deductibles by Tier, 2015

Bronze:

\$5,181	\$5,081
2015	2014

Silver:

\$2,927	\$2,898
2015	2014

Gold:

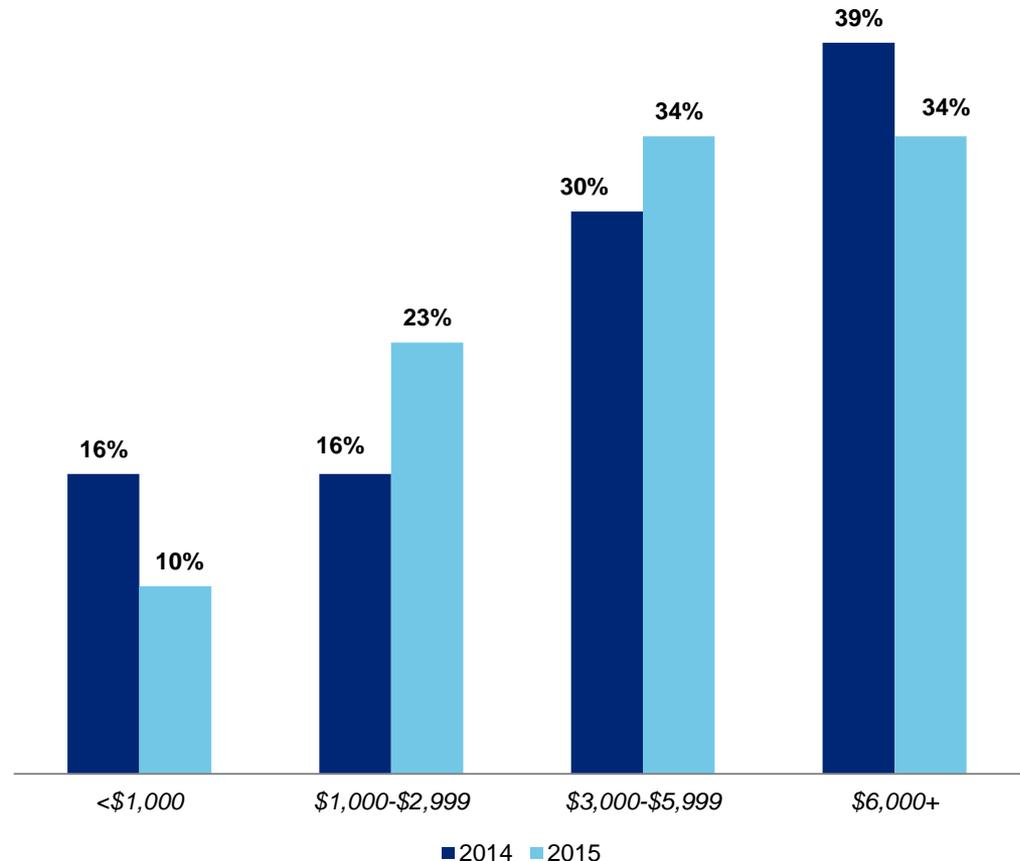
\$1,198	\$1,277
2015	2014

Platinum:

\$243	\$347
2015	2014

2015 Enrollees Favor Higher Deductibles

Annual Deductibles as Percentage of All Individual Plans Selected on eHealth Platform, 2014-2015



Source: eHealth, "Health Insurance Price Index Report for the 2015 Open Enrollment Period," March 2015, available at: www.news.ehealthinsurance.com; HealthPocket.com, "2015 Obamacare Deductibles Remain High but Don't Grow Beyond 2014 Levels," November 20, 2014, available at: www.healthpocket.com; Health Care Advisory Board interviews and analysis.

Employers Moving Away From the Traditional HMO

Looking to Combine Network Advantages with Consumer Accountability

Employers Looking to Narrower Networks, But Not Interested in the Traditional Model

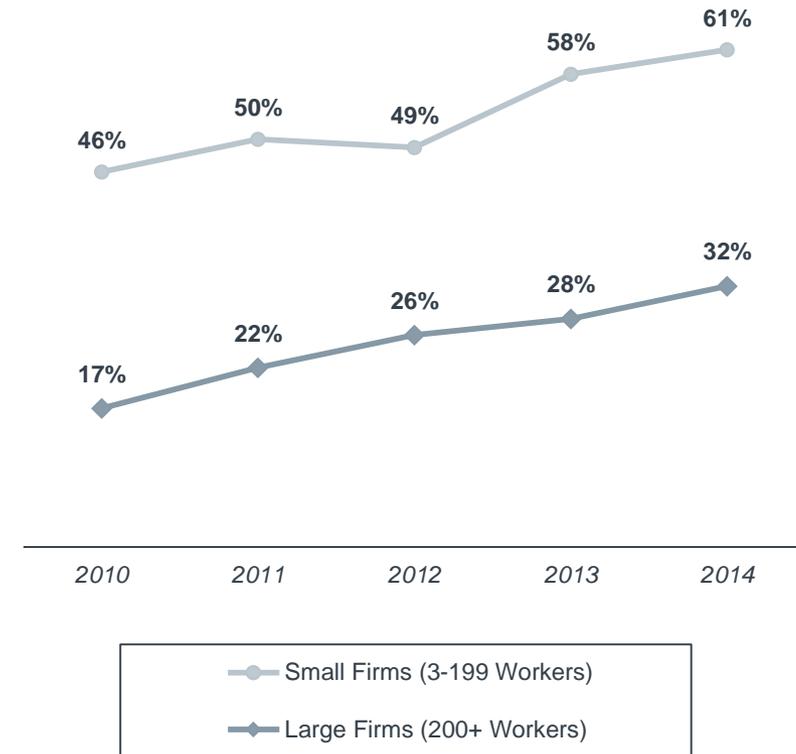
77%

Small employers who would select a high-performance network with >10% cost reduction

36%

Large employers who have eliminated or plan to eliminate all HMO plan options by 2015

Percent of Covered Workers Enrolled in a Plan with a \$1,000+ Deductible



“We’d love to eliminate our HMO options. Not because we’re opposed to narrower networks, but because HMOs isolate individuals from the true cost of health care.”

Director of Benefits, Large National Employer

Source: Bernardo J, “High Performance Networks Entice Health Plan Sponsors,” Society for Human Resource Management, August 18, 2014, available at: www.shrm.org; Kaiser Family Foundation/Health Research & Educational Trust, “Employer Health Benefits 2014 Annual Survey,” September 2014, available at: www.kff.org; Health Care Advisory Board interviews and analysis.

Current Employer Offerings Not Delivering

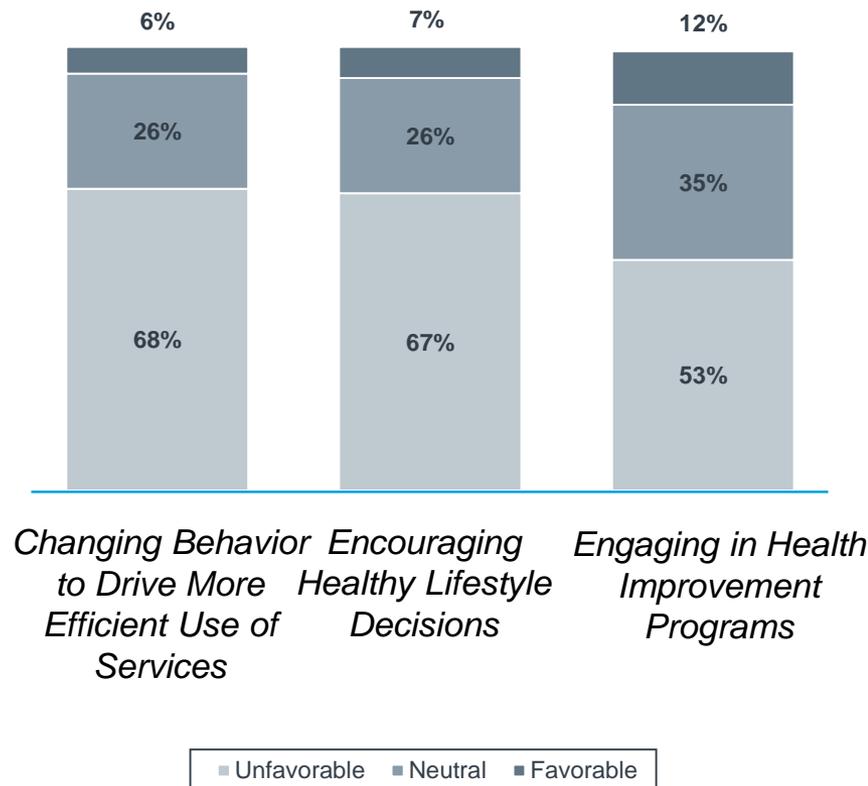
Disappointing Returns on “Wellness,” Other Employer-Based Services

Dissatisfied with Current Offerings

Employer Impressions of Health Plan Vendor Effectiveness; n = 512

Spending on the Wrong Solutions

Most Common Investments Focused on Lifestyle Management



Top Six Sources of Employer Spending	
1	Health Risk Assessments
2	Weight Management
3	Nutrition
4	Screenings
5	Fitness Services
6	Smoking Cessation

Despite Evidence of Limited ROI

\$0.50 Loss on dollar spent on lifestyle management

Source: Towers Watson, “Employer Survey on Purchasing Value in Health Care,” 2012; Son A, “IBISWorld Industry Report OD462: Corporate Wellness Services in the US,” December 2012, IBISWorld; “Do Workplace Wellness Programs Save Employers Money?“, 2014, RAND Corporation, available at: <http://www.rand.org>; Health care Advisory Board interviews and analysis.

Top Performers Solve Specific Employer Problems

Common Elements of Consumer-Oriented Enhanced Management Models



Based around primary care core



Risk segmentation technology



Electronic access to records and care team



Combined lifestyle and disease management



Shorter wait times, longer appointments



Demonstrable results

A Sampling of the Best-in-Class



turntablehealth



QuadMed



Qliance



HEALTHWAYS

MIDVIP



WhiteGlove
HEALTH



MedLion
Direct Primary Care

Match Service Portfolio to Employer Need

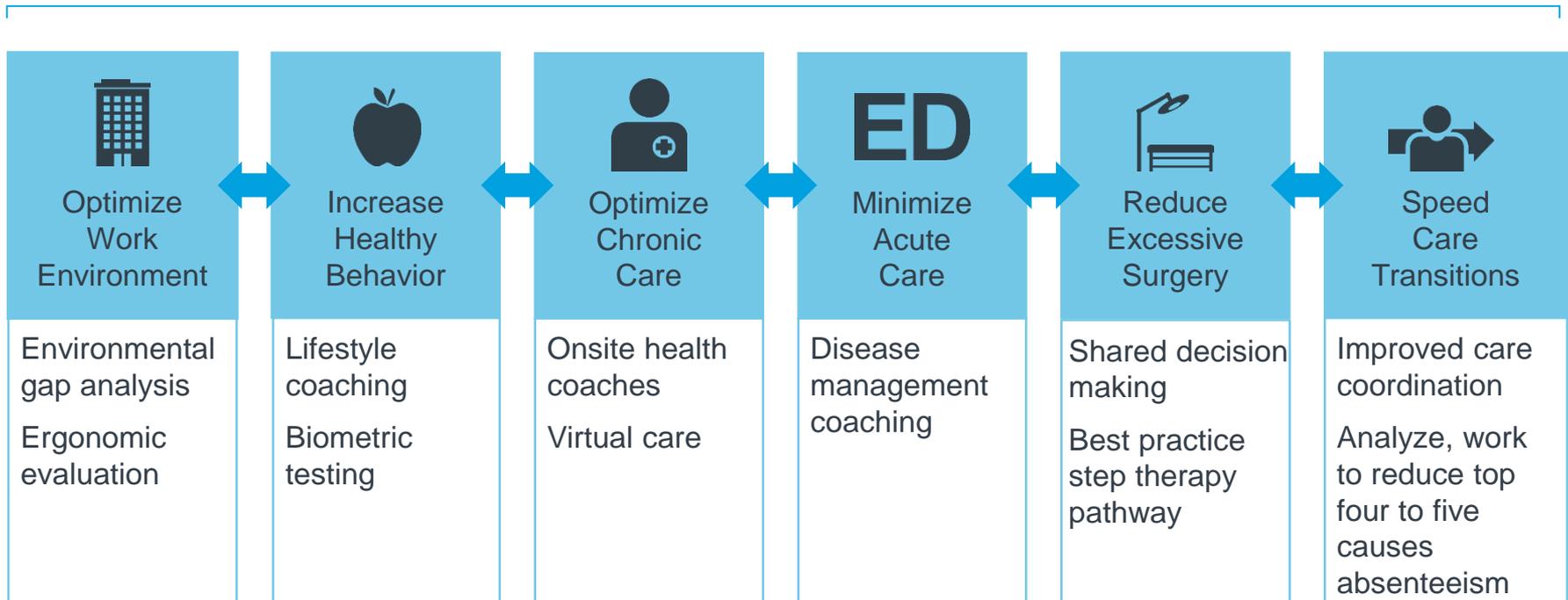
Tying Specific Services to Distinct Goals

Addressing Three Top Employer Concerns

1 Poor Health

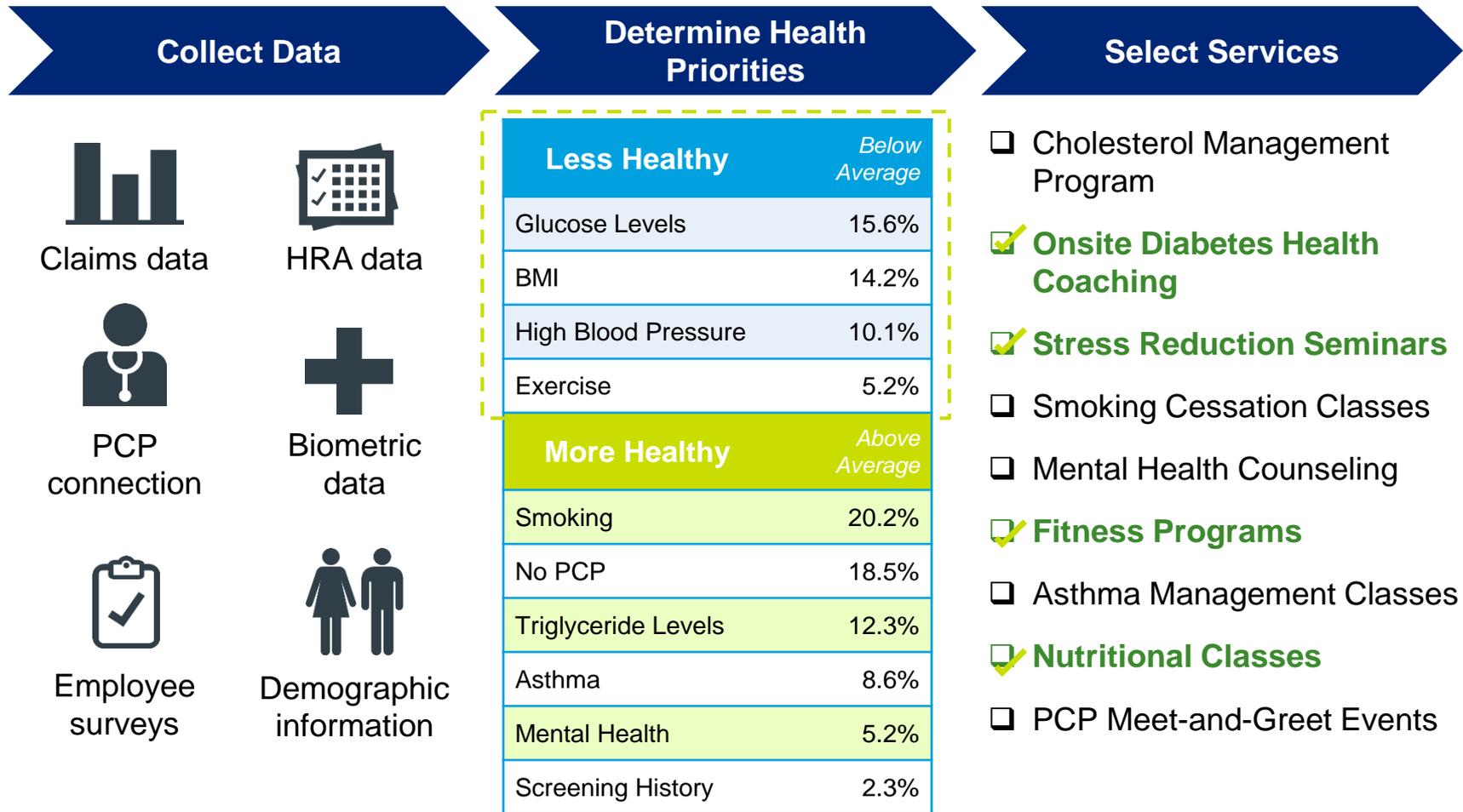
2 Excessive Medical Costs

3 Lost Productivity



A Data-Focused Approach to Product Design

ProHealth Eschewing One-Size-Fits-All Offerings



Employers Critical Stakeholder to Engage

Health Benefit Design Reinforces Ongoing Health Promotion





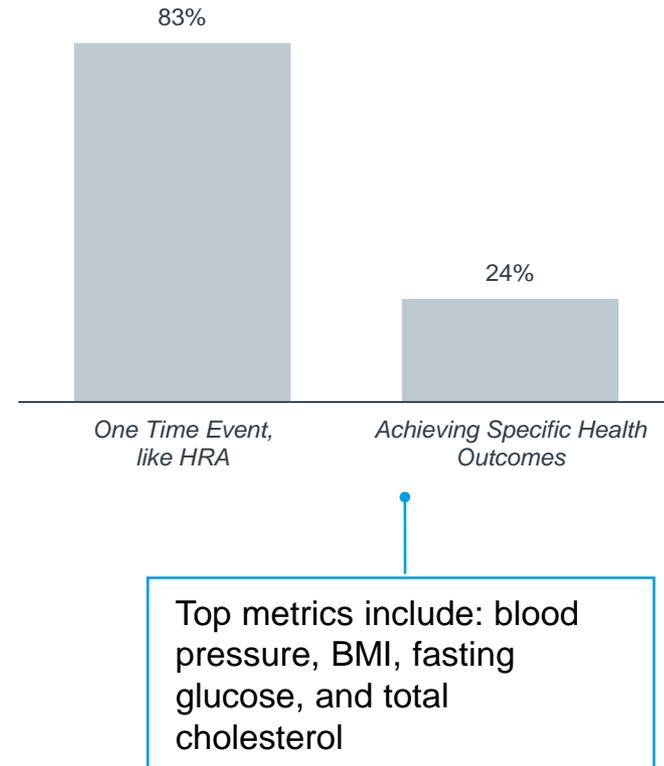
BP Rewarding Steps

1M Steps
Logged on FitBit

500 Points
Points earned by walking 1 million steps

1,000 Points
Needed to reduce deductible, copays and-out of-pocket expenses

Employer Incentives Shifting from Participation to Outcomes



Design Benefits to Encourage Health Promotion

Reduce Financial Obligation of Employees

\$2,000 in Individual Financial Incentives



Steps to Reduce Deductible



Preventive Visits

Attend annual PCP visit



Health Improvement

Learn and improve health measurements



Health Promotion

Participate in fitness challenges and wellness classes



Case in Brief: AtlantiCare

- Two-hospital system headquartered in Egg Harbor Township, NJ
- Employee preventive visit rate increased from 40% to 94%
- Redesigned benefit plan to encourage in-network utilization and health promotion



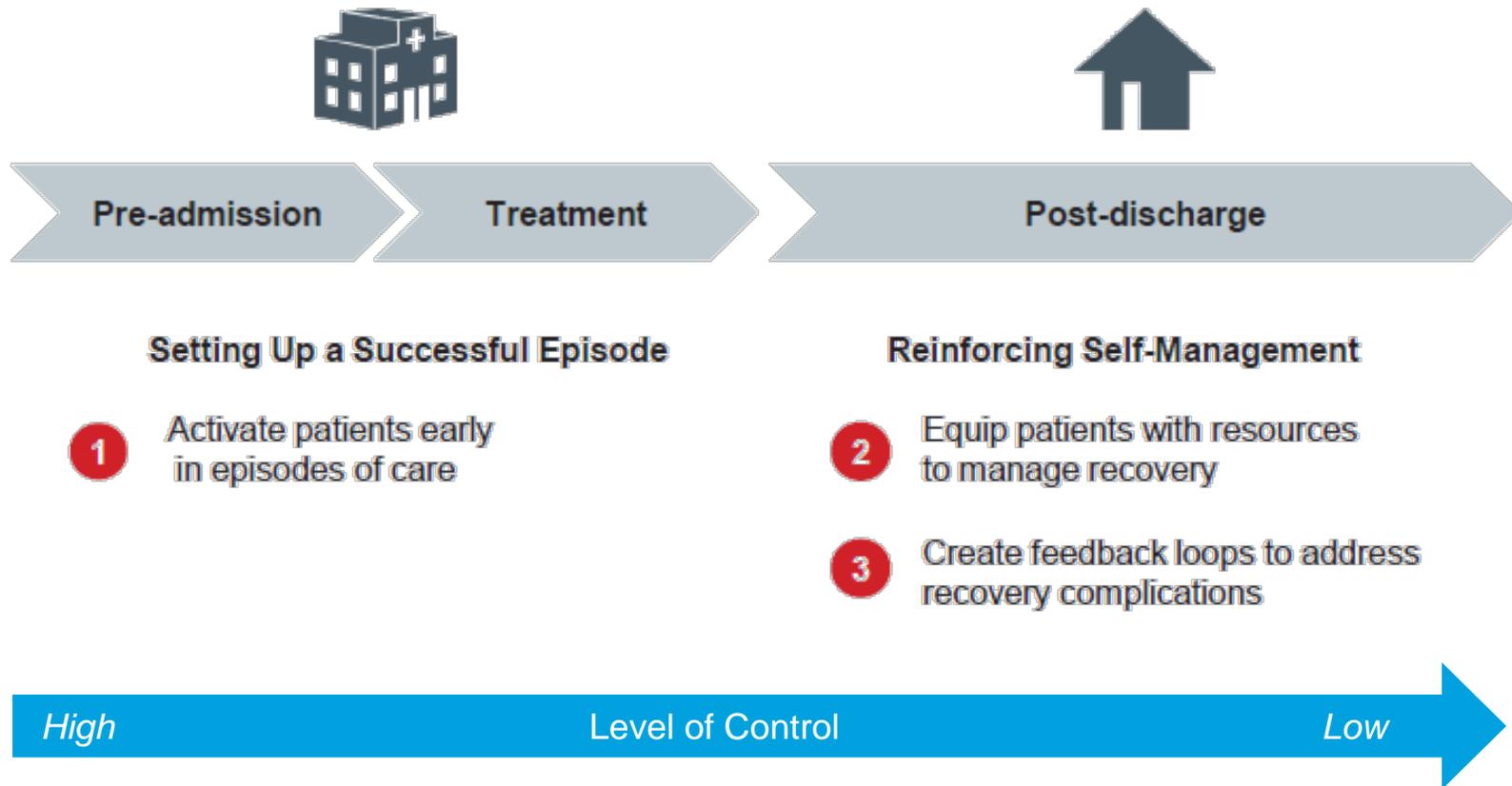
80%

Participants who have reduced deductible to \$0

Applying Plan Design for Medicare and Medicaid Populations

Elevating Engagement in Episodes of Care

Key Engagement Opportunities Across the Care Episode



Use Pricing to Incent the “Right” Utilization

Pricing Not Only a Market Share Play

Value-Based Insurance Design Inflects Utilization to Maximize Total Cost Control

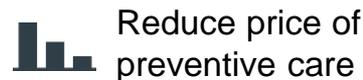
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“We can talk all we want about provider accountability. But as important as that is, it misses an important piece of the puzzle—and that’s **consumer accountability**. There are a lot of things that we need patients to do if we’re going to get this right. And we need to give them the incentives to do all of those things.”

*Greg Poulsen,
Chief Strategy Officer,
Intermountain Healthcare*

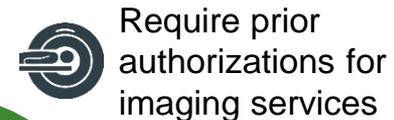
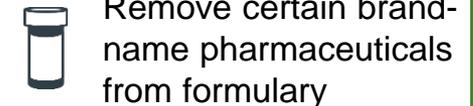
Change Price of Services, Products

Strategies to Consider



Limit Access to Certain Services

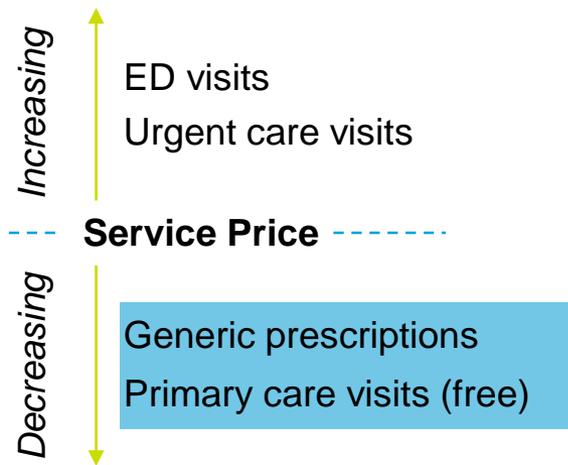
Strategies to Consider



Prioritize influence over benefit design in payer contracts

Incent the “Right Utilization” through Benefit Design

Covenant Health’s Benefit Pricing Strategy



Case in Brief: Covenant Health

- Three-hospital health system based in Lubbock, Texas
- Already at risk for own employees
- Using employees’ health plan benefit design to encourage appropriate utilization of primary care, generic prescriptions to reduce costs

Benefit Design Levers to Inflect Utilization Patterns

1 Change Price of Services, Products

Strategies to Consider:



Differentiate network prices



Raise emergency department copays



Tier pharmaceutical price structure



Reduce price of preventive services

2 Limit Access to Certain Services, Products

Strategies to Consider:



Remove certain brand-name pharmaceuticals from formulary



Require prior authorizations for imaging services

Building Longitudinal Patient Accountability

Fostering Informed Patients Across an Entire Episode of Care

Facilitating Pre-admission Coordination



Patient accesses dashboard with custom content

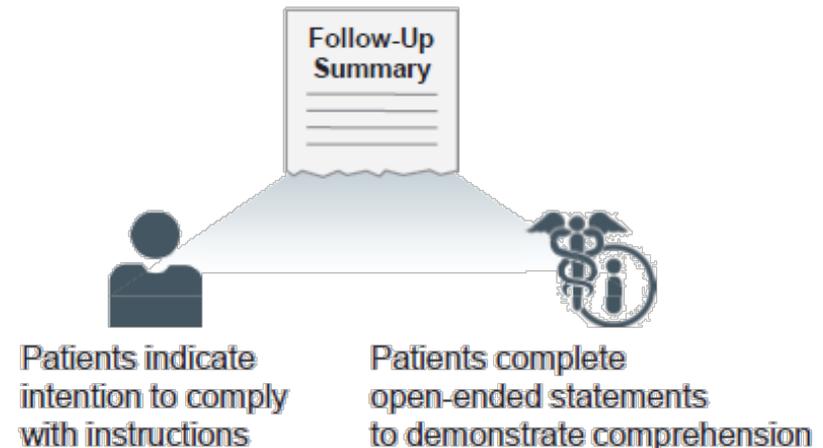


Patient completes all pre-admission forms online



Patient prompted to provide data when necessary

Sharing Post-discharge Responsibilities



Case in Brief: iCarePassport

- Web-based portal providing patients 24/7 access to personalized health education
- Patients receive education, alerts and reminders for upcoming visits and procedures
- Plans and providers access dashboard to monitor, retrieve information at any time

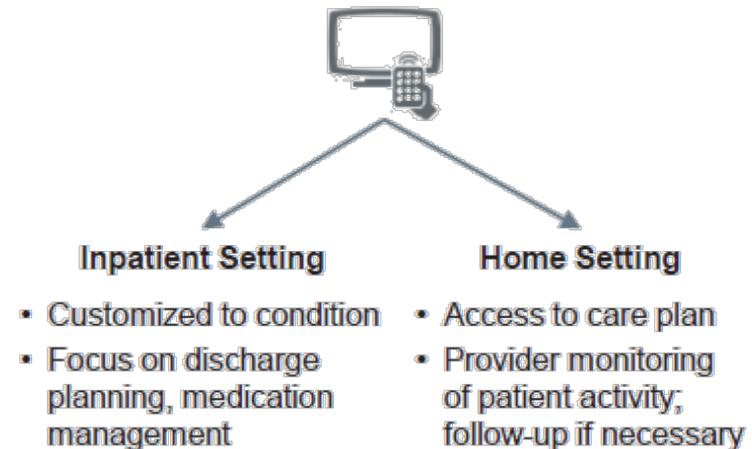
Bridging the Gap Between Care Site and Home

Easy Access to Information to Reinforce Discharge Plan

Supplementing Initial Instructions with Updated Resources

- 1  Provider records audio or visual discharge information
- 2  App organizes content onto personal, secure website
- 3  Provider edits content, uploads supplemental resources

Providing Continuous Access to Information



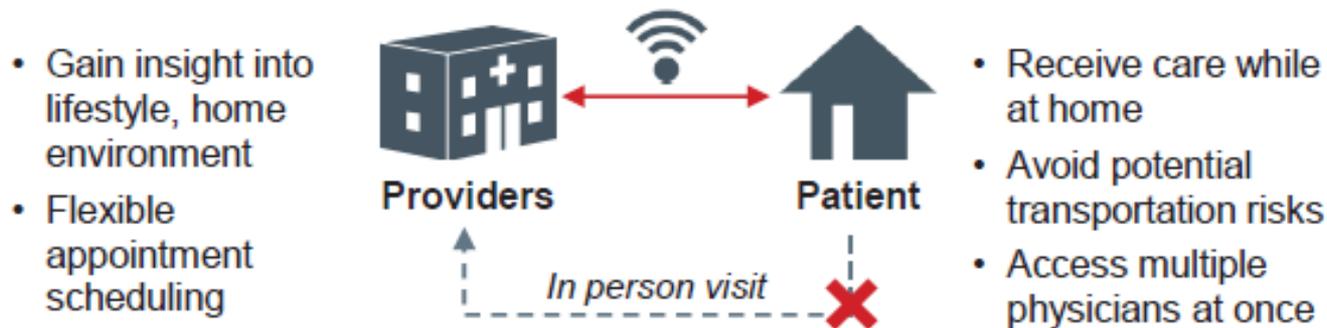
Case in Brief: Postwire

- HIPAA-compliant mobile application transfers discharge instructions recorded via smartphone to personal website. Access limited to patient and provider
- Content organized for easy accessibility by patients, caretakers; resources available for download throughout recovery

Making Follow-Up Easier for Patients and Providers

Finding Innovative Solutions to Support Recovery at Home

Accessing Patients Regardless of Location



Case in Brief: VGo Communications

- Simple, lightweight robotic telepresence solution enables remote physicians to conduct real-time visits. Physician control robot movement and patient interaction
- Providers assign device according to patient risk status; length of time varies from two weeks to two months

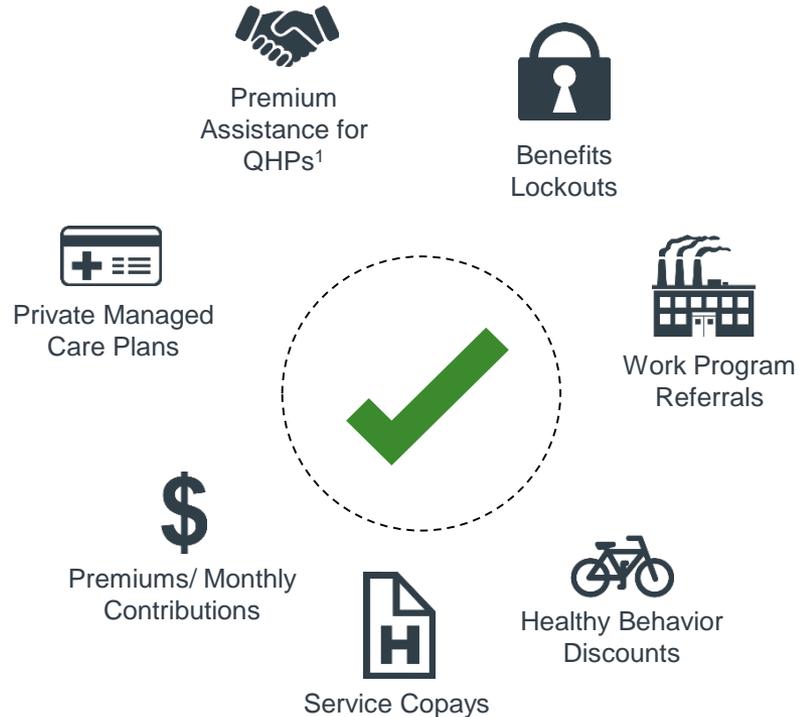
Current Efforts From Around the Country

States Experimenting with Medicaid Benefit Design

States Using Waiver Flexibility to Redesign Benefits, Influence Behavior

Medicaid Waivers Encourage Healthy Behavior, Personal Responsibility

Demonstration Proposals Approved by CMS



Demonstration Proposals Rejected by CMS

- ✘ Work requirements as condition of eligibility
- ✘ Mandated premiums for beneficiaries below 100% FPL²
- ✘ Cost sharing exceeding amounts permitted under federal law

¹ Qualified Health Plans.
² Federal Poverty Level.

Source: Kaiser Family Foundation, "The ACA and Recent Section 1115 Medicaid Demonstration Waivers," November 24, 2014, available at: www.kff.org; Modern Healthcare, "CMS Gives Arkansas, Iowa More Leeway in Medicaid Expansion Waivers," available at: www.modernhealthcare.com, accessed January 5, 2015; Health Care Advisory Board interviews and analysis.

Leveraging ACA Waivers for Benefit Design

Key Themes in ACA Expansion Waivers and Proposals

Approved Waivers							
	Premium assistance	Premiums / Monthly Contribution	Healthy Behavior Incentives	Benefits	Work Referral	Co-Payments	Waivers of Retroactive Eligibility / Reasonable Promptness
AK		✓					
IA		✓	✓	✓			
IN		✓	✓	✓		✓	✓
MI		✓	✓				
PA		✓	✓	✓			

Leveraging ACA Waivers for Benefit Design

Key Themes in ACA Expansion Waivers and Proposals

Proposed Waivers							
	Premium assistance	Premiums / Monthly Contribution	Healthy Behavior Incentives	Benefits	Work Referral	Co-Payments	Waivers of Retroactive Eligibility / Reasonable Promptness
NH	✓				✓		✓
TN	✓	✓	✓			✓	✓
UT	✓	✓	✓				

Medicaid Redesign Proposals at a Glance

Premium Assistance



- 1 CMS will approve limited number of waivers to allow states to use Medicaid funds to purchase coverage for some or all newly eligible beneficiaries in Marketplace Qualified Health Plans (QHPs) as a “private approach to expansion
- 2 These states indicate that they are using premium assistance to test how private coverage works for Medicaid beneficiaries and whether enrolling beneficiaries in Marketplace coverage will increase provider access and reduce churn between Medicaid and Marketplace coverage due to income fluctuations.

Medicaid Redesign Proposals at a Glance

Monthly Contributions and Premiums



- 1 CMS has approved waivers that allow states to charge premiums or monthly contributions primarily for expansion adults between 100% and 138% of the Federal Poverty Line. The consequences of non-payment of premiums for adults with incomes above poverty vary across states, but only Indiana includes a six month lock-out for beneficiaries dis-enrolled due to unpaid premiums.
- 2 Each of the five approved expansion waivers allows the states to impose premiums or monthly contributions for newly eligible beneficiaries with incomes between 101-138% FPL. These premiums (equal to about 2% of income) are about the same level as those allowed for individuals at these incomes who are eligible for tax credits to purchase coverage through the Marketplace in states not expanding Medicaid.

Medicaid Redesign Proposals at a Glance

Healthy Behavior Incentives



- 1 CMS has approved the use of healthy behavior incentives to reduce or eliminate beneficiaries' out-of-pocket expenses. Individuals who complete specified healthy behaviors will have their premiums and cost sharing waived or reduced.
- 2 The protocols are required to: (1) specify the types of healthy behaviors (such as health risk assessments); (2) include a diverse set of behaviors as well as a strategy to measure access to providers to ensure that all beneficiaries have an opportunity to receive healthy behavior incentives; (3) engage stakeholders and the public in developing the healthy behavior standards; (4) show how healthy behaviors will be tracked and monitored at the enrollee and provider level; (5) include a beneficiary and provider education strategy; and (6) include the methodology describing how healthy behavior incentives will be applied to reduce premiums or copayments.

Medicaid Redesign Proposals at a Glance

Waivers of Required Benefits



- 1 CMS has approved limited waivers of required Medicaid benefits that allow states not to cover non-emergency medical transportation
- 2 States must cover the ten ACA-required Essential Health Benefits (EHBs) along with certain other mandatory Medicaid services. States also must meet mental health parity requirements. Beyond these requirements, states have flexibility to choose a benchmark plan for coverage that may include one of several specified private insurance options or “Secretary-Approved Coverage” which can include a state’s current Medicaid benefits package for adults. However, some states have sought waiver approval for greater flexibility in the provision of benefits

Medicaid Redesign Proposals at a Glance

Cost Sharing Waivers



- 1 In July 2013, final regulations were released that final that streamlined and simplified existing rules around premiums and cost-sharing in Medicaid, increased the nominal rate for cost-sharing, and increased allowable cost-sharing amounts for non-preferred drugs and non-emergency use of the emergency room.
- 2 This authority applies to both newly eligible adults and previously eligible parents. By May 1, 2015, the state must establish a control group with a minimum of 5,000 beneficiaries who will not be subject to the increased co-payments; selection of the control group will be detailed in the state's protocol submitted to CMS.

Value-Based Insurance Design in Medicare Advantage Plans

Value Based Insurance Design (VBID)

- VBID plans structure enrollee cost-sharing and other plan characteristics in a way that encourages the enrollees to utilize high-value health care services that are likely to improve their health status
- Plans are typically structured around clinical categories such as chronic diseases, meant to reward the specific use of services by individuals who have been identified as in most need of such interventions
- So far, Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania and Tennessee will be participating - targeting diabetes, congestive heart failure, COPD, past stroke, hypertension, coronary artery disease, and mood disorder.

CMS Requirements

- CMS will permit organizations to design their own VBID interventions so long as they fit into four broad categories
 - Reduced cost sharing for high-value services
 - Reduced cost sharing for high-value providers
 - Reduced cost-sharing for enrollees participating in disease management or related programs and
 - Clinically targeted supplemental benefits
- CMS will require that organizations propose a methodology for identifying high-value providers for each target population, encouraging use of independent external metrics. So far, CMS has provided little guidance on identification of appropriate VBID services

“

VBID relaxes the questionable assumption that when faced with cost sharing, consumers will balance costs and clinical value optimally. The underuse of valuable clinical services when a person is faced with even modest copayments likely represents a range of information issues, including how people understand their medical care, how they make decisions amid uncertainty, and how they make trade-offs over time .

**-Michael E. Chernew,
“Value-based
Insurance Design”**

Main Focuses for Benefit Redesign

Key Components to Understand and Engage Beneficiaries



Fully Understand the Population

Through HRA's and further risk assessment, understand which patients need which specific form of engagement



Financially Incentivize the Right Behaviors

Discounts for good behavior can engage, and adding price-sensitivity can encourage seeking the appropriate care



Leverage IT to Engage at Home

Finding cost-effective and simple technologies can extend the reach of providers and decrease cost of care



Plug Into the Community

Leveraging social networks and community partners can help to spur health activities

General Discussion

Questions and Answers

Break

Breakout Activity Instructions and Brainstorming

During today's meeting, participants will conduct a breakout activity structured around engaging consumers in the value-based care initiatives outlined in Kentucky's draft plan. We will form three groups and rotate to discuss this question in the context of each reform component for 15 minutes each. Please take approximately 5 minutes at the start of each group to brainstorm responses for that group's component and write notes on the index cards you have been given.

Based upon your experience, how can we maximize consumer participation in each of the value-based care initiatives included in the Draft Value-based Health Care Delivery and Payment Methodology Transformation Plan?

Rotate

Patient Centered Medical Homes (PCMH)

1. How can we best incent consumers to utilize providers engaged in a PCMH?
2. How can we best incent consumers to actively engage in managing their health if they are engaged in a PCMH?

Rotate

Accountable Care Organizations (ACO)

1. How can we best incent consumers to utilize providers engaged in an ACO?
2. How can we best incent consumers to actively engage in managing their health if they are engaged in an ACO?

Rotate

Episodes of Care (EOCs)

1. How can we best incent consumers to utilize providers engaged in EOCs?
2. How can we best incent consumers to actively engage in managing their health if they are engaged in EOCs?

Q&A on Draft Value-based Plan

Draft Value-based Plan Outline and Next Steps

In late August, stakeholders had the opportunity to review the draft Value-based Health Care Delivery and Payment Methodology Transformation Plan and provide feedback to the Cabinet for inclusion in the draft submitted to CMS on September 15, 2015.



Document Outline

- **Baseline Health Care Landscape**
 - Existing Reforms
- **Proposed Delivery System and Payment Reforms**
 - Definitions
 - Goals
 - Core elements
 - Targets and Timelines
- **Supporting Strategies**
 - Increased Access
 - Quality Metrics
 - HIT Infrastructure
 - Consumer
 - Workforce
- **Conclusion**

August Workgroup Feedback Sessions

M	T	W	T	F
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28
31				

Draft Value-based Health Care Delivery and Payment Methodology Transformation Plan

August

- The draft plan was circulated to stakeholders on **August 21st**, in advance of two identical feedback sessions held on **August 26th** and **August 27th**. Feedback was collected, synthesized, and posted on the KY SIM website.

September

- The Cabinet incorporated stakeholder feedback into an updated draft plan and submitted it to CMS on **Tuesday, September 15th**. This updated plan as submitted is posted on the KY SIM website.

October – December

- The draft plan, along with the contributions of the workgroups, will serve as a starting point to build the remaining sections of the **SHSIP** and will further evolve over the course of the Model Design period.

Summary of Changes Based Upon Stakeholder Feedback

Global Changes

1. Combined the Definition and Core Elements sections for each reform to improve the plan's structure
2. Rephrased components of the Definition sections previously phrased as goals to address stakeholder feedback that the similarities caused confusion
3. Added additional language to clarify and better address operational comments/questions received by describing the responsibility of the Steering Committees to develop detailed implementation plans, using current roadmaps as the foundation for this continued planning after the Model Design period ends

Draft Delivery System and Payment Reform Plan (Page 16)

1. Clarified that the expectation of the reforms is not that providers, payers, and consumers participate in each, but rather that these groups participate in the value-based models that are applicable to their organization

Delivery System and Payment Reform Goals (Page 17)

1. Developed new overall goals section that revisits and includes the goals from Kentucky's Model Design application and develops comprehensive goals that span across the four reform areas to (1) have a broad population reach of capturing at least 80% of the covered population through the SIM reforms, (2) align with the population health goals of the Population Health Improvement Plan (PHIP), and (3) generate a projected 2% cost savings over a four year implementation period

SIM Governance Structure (Pages 17 – 18)

1. Added general groups of stakeholders as options for the Secretary of CHFS to consider when appointing the SIM Governing Body, based upon stakeholder suggestions
2. Added a responsibility of each Steering Committee to gather input from providers currently participating in their respective reform
3. Revised the Quality Committee's placement in the SIM Governance Structure to show that its role spans across each reform and subsequent Steering Committee

Summary of Changes (Continued)

Consumer Education and Communication Strategy (Page 18)

1. Raised the consumer engagement and communications strategy to a level in the plan that spans the four reforms; this responsibility was added to each Steering Committee role and removed as Core Element within each reform

Patient Centered Medical Homes (PCMH) Initiative (Pages 18 – 23)

1. Confirmed Kentucky's plan to use NCQA-certification as the baseline for the PCMH initiative in response to stakeholder feedback to use national standards
2. Further described how Kentucky-specific components would be included in a phased, transitional payment strategy for PCMH that incentivizes PCMH sites to become NCQA certified and focuses on both process and outcomes measurement strategies
3. Removed the standalone complex chronic conditions (CCC) initiative and merged both CCC principles and Kentucky's Medicaid Health Home effort as a Core Element within a PCMH
4. Updated the PCMH initiative goals to reflect geographic dispersion of providers and include references to tracking PCMH expansion by region and encouraging participation in geographic areas with low participation
5. Removed the number of participating provider types goal as PCMH certification remains at the site level
6. Added the development of additional PCMH-specific goals for (1) consumer experience/patient satisfaction (2) quality of care and (3) health outcomes as a responsibility for the PCMH Steering Committee
7. Updated the language regarding expanding PCMHs to coordinate with community resources to address stakeholder concern around the duplication of efforts for community programs that already exist
8. Updated the language regarding employer promotion of PCMH to address stakeholder concern around the feasibility of this Core Element without payer involvement
9. Incorporated a continuous feedback look into each phase of the rollout strategy
10. Specified the multi-payer nature of the tasks for the PCMH Steering Committee, e.g. payment methodology and patient attribution methodology
11. Included a CCC component phase within the PCMH rollout strategy

Summary of Changes (Continued)

Accountable Care Organizations (ACO) Initiative (Pages 23 – 27)

1. Expand the Medicaid LTSS/LTC RFI effort to the subsequent release of an RFP and launch of a Medicaid ACO for the LTSS/LTC populations
2. Further described the multi-payer “open-door”, focusing on the provider role and benefits to payers, providers, and consumers through this framework
3. Removed the standalone complex chronic conditions (CCC) initiative and merged both CCC principles and population management strategies as a Core Element within an ACO
4. Updated the ACO initiative goals to reflect geographic dispersion of providers and include references to tracking ACO expansion by region and encouraging participation in geographic areas with low participation
5. Updated the ACO initiative goals to reflect the inclusion of multiple provider types as participating providers
6. Added the development of additional ACO-specific goals for (1) consumer experience/patient satisfaction (2) quality of care and (3) health outcomes as a responsibility for the ACO Steering Committee
7. Clarified the prospective nature of the harmonized patient attribution approach to be developed by the ACO Steering Committee
8. Clarified the inclusion of medical services and LTSS/LTC for the Medicaid ACO population in the Core Element description
9. Included oral health as a key care type in the expanded scope of ACOs

Summary of Changes (Continued)

Episodes of Care (EOC) Initiative (Pages 27 – 31)

1. Recognized the stakeholder feedback on the success of an episodic approach as opposed to bundled payment approach and revised this initiative to focus solely on EOCs
2. Extended the timeline for evaluation phases between Wave 1 and Wave 2 of the Medicaid/KEHP EOC demonstration initiative to allow for the evaluation of effectiveness and inclusion of lessons learned from the first wave of episodes prior to the second wave's implementation
3. Added an additional phase to the EOC rollout strategy to collect and publicly report of the range of episodes identified by the Steering Committee prior to the implementation of Wave 1 to focus on transparency
4. Added the development of additional EOC-specific goals for (1) consumer experience/patient satisfaction (2) quality of care and (3) health outcomes as a responsibility for the EOC Steering Committee
5. Further described the multi-payer "open-door", focusing on the provider role and benefits to payers, providers, and consumers through this framework
6. Added language to further promote the adoption of the EOC model where providers still receive FFS payments and the "risk" is held by the coordinating entity
7. Clarified inclusion of the development of a harmonized data sharing and reporting process as part of the ACO Steering Committee's role
8. Clarified that the harmonized patient attribution and measurement strategies are also key elements of the Medicaid/KEHP demonstration
9. Recognized stakeholder feedback that an EOC initiative should consider both the successes and criticisms of other state programs by reflecting the review of outcomes, challenges, and successes in Core Element language
10. Described how the quality and/or outcomes-based measurement strategy in other states and within Medicare is used in developing incentives and/or penalties for participating providers

Summary of Changes (Continued)

A Community Innovation Consortium (Pages 31 – 33)

1. Renamed the initiative to reflect the need to include not only payers but also providers and consumers in the design of the Consortium's initiatives
2. Clarified the intent of the Consortium as not creating a duplication of existing community resources or programs, but rather being flexible in how new innovations are designed to adapt to the current environment; included examples such as the Greater Louisville Health Transformation Plan and Investing in Kentucky's Future grant program
3. Further explained how the payers, providers, and consumers involved will be responsible for developing specific programmatic and/or financial supports and conduct sustainability planning for each initiative designed by the Consortium

Footnotes

1. Better defined the term "community providers" used throughout the draft as non-licensed and/or non-clinical provider types such as community health workers (CHWs) peer support specialists, and patient navigators

Next Steps

Next Steps

- As a follow-up to stakeholder feedback around engaging innovative technologies and leveraging existing efforts within Kentucky as part of the SIM process, we are holding a **SIM HIT Innovation Forum** in partnership with the 2015 KHIE Annual eHealth Summit. The Innovation Forum will take place on **Tuesday, September 29, 2015 from 11:00 a.m. to 5:00 p.m. (CST)** at the **Sloan Convention Center in Bowling Green, Kentucky**. If you would like to attend the SIM HIT Innovation Forum, please register here: <https://prd.chfs.ky.gov/GenRegistration/ClassConf.aspx?AGY=1>.
- The 2015 KHIE Annual eHealth Summit itself will take place the following day, on September 30, 2015 from 8:30 a.m. to 5:00 p.m. (CST) at the Sloan Convention Center as well, for which you can also register through the link provided (please note that you must register separately for the SIM Innovation Forum and the KHIE eHealth Summit).
- In addition to the SIM HIT Innovation Forum, we have **one upcoming KY SIM workgroup** scheduled in October:

Workgroup	October Date	October Time	October Location
October KY SIM Quality Workgroup	Tuesday, October 6 th	1 PM – 4 PM	Kentucky Historical Society (KHS), 100 W Broadway St, Frankfort, KY 40601

- We are working to schedule two additional meetings in late October. Additional details are forthcoming.
- Please visit the dedicated Kentucky SIM Model Design website: <http://chfs.ky.gov/ohp/sim/simhome>
- Please contact the KY SIM mailbox at sim@ky.gov with any comments or questions

Thank you!