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

State Innovation Model (SIM) Model Design

May Payment Reform Workgroup

May 19, 2015
9 AM – 12 PM

Agenda

▪ **Welcome and Introductions**	9:00 – 9:10 AM
▪ **Review Payment Reform Strategies in Nearby SIM States**	9:10 – 10:10 AM
▪ **Identify Advantages and Disadvantages of Leveraging Payment Reform Strategies in Nearby SIM States**	10:10 – 10:40 AM
▪ *Break*	10:40 – 10:50 AM
▪ **Review Current Status of the PHIP**	10:50 – 11:10 AM
▪ **Discuss Payment Reform Strategies to Improve Population Health in the Context of the PHIP**	11:10 – 11:55 AM
▪ **Next Steps and Q&A**	11:55 AM – 12:00 PM

Welcome and Introductions

Review Payment Reform Strategies in Nearby SIM States

Tennessee's Payment Model – Episodes of Care

In SIM Round Two, Tennessee was awarded a $65 million Testing grant to implement the Tennessee Health Care Innovation Initiative, its plan designed in Round One which consists of three strategies – primary care transformation, use of episodes of care payment methodologies, and reforming how long-term services and supports are paid for.

- Episode-based payments are applicable for most procedures, hospitalizations, acute outpatient care (e.g., broken bones), as well as some forms of treatment for cancer and behavioral health conditions (e.g., ADHD).
- Under the initiative, episode-based payment will be rolled out in waves every six months with the goal of implementing 75 episodes by the end of 2019.

Wave 1: May 2014

- Acute Asthma Exacerbation
- Perinatal
- Total Joint Replacement

- The design of each episode was developed with input from key stakeholders, including Tennessee clinicians and insurance companies.
- The design is consistent across all TennCare Managed Care Organizations, but there may be some variation in commercial payer episode definitions.
- Over 500 providers statewide received reports from TennCare and four commercial payers.

Wave 2: Current

- Acute PCI
- Acute COPD Exacerbation
- Non-Acute PCI
- Screening and Surveillance Colonoscopy
- Outpatient & Non-Acute Inpatient Cholecystectomy

- The initiative plans to begin reporting on these episodes in mid 2015.

Source: Tennessee Health Care Innovation Initiative

Tennessee's Payment Model – Episodes of Care (Continued)

To meet the state's goal of implementing 75 episodes of care by the end of 2019, Tennessee has developed a methodology to arrive at a preliminary recommendation on which episodes to use.

175 identified episodes[1] → 90 initial episodes → 75 episodes for implementation[2] → 19 episodes for waves 3-5

Selection Factors

1. Total **episode spend**
2. **Diversity in provider types** included as Quarterbacks
3. **Variation in average spend** per episode across Quarterbacks
4. Clinical **complexity** of the episode
5. Existence of **similar episode models**
6. Quarterbacks **variation in performance** on quality

Considerations

- **Homogeneity** of episode i.e. one large single opportunity that would not require further stratification
- **Distinctiveness** of episode e.g. episode is not a potential complication of other episode

Considerations

- Potential for **greater near-term impact** based on 6 selection factors
- **Clustering** of Quarterback groups
- **Balance** of TennCare and Commercial importance
- **Even diffusion** of complexity
- System **readiness for change** e.g. longer lead time for sensitive TA[3]
- **Lead time required** to design episodes

1 Based on episodes in existing episode models such as BCPI and Prometheus and additional opportunities through analyzing large spend areas using the episode diagnostic model
2 Including already identified wave 1 and 2 episodes
3 Therapeutic Areas

Source: Tennessee Health Care Innovation Initiative

Tennessee's Payment Model – Long Term Services and Supports

In addition to episodes of care, Tennessee is implementing quality- and acuity-based payment and delivery system reform for LTSS, including Nursing Facility services and Home and Community Based Services (HCBS) for seniors and adults with physical, intellectual and developmental disabilities (I/DD).

Quality- and Acuity-Based Payment for Nursing Facilities and Home and Community Based Services

Components

- Under the Quality Improvement in Long-Term Services and Supports (QuILTSS) initiative, Nursing Facility payment will be based in part on residents' assessed levels of need and adjusted based on quality metrics.
- HCBS payments will be adjusted to incorporate the same quality metrics when they apply across service delivery settings, along with modified and additional quality metrics specific to HCBS.

Impact

- These changes will reward providers that improve the member's experience of care and promote a person-centered care delivery model.
- For individuals with I/DD, Tennessee will apply quality and acuity-based payments to address inequities in the system, encourage appropriate high-quality and efficient care, and increase the number of people who can be served.

Value-Based Purchasing Initiative for Enhanced Respiratory Care

Components

- TennCare will revise its reimbursement structure for ERC services in a Nursing Facility, using a point system to adjust rates based on the facility's performance on key performance indicators.
- Tennessee's extensive stakeholder input process has identified that one of the most critical aspects of LTSS value pertains to the level of training and competency of professionals delivering direct supports. Therefore the initiative will invest in the development of a comprehensive training program for individuals paid to deliver LTSS.

Impact

- Since staff training will be an important quality measure and will also impact a provider's success across other measures, agencies employing better trained and qualified staff will be appropriately compensated for the higher quality of care experienced by individuals they serve.
- The revised reimbursement structure will be combined with strengthened standards of care, and educational programs to promote quality and best practices.

Source: Tennessee Health Care Innovation Initiative

Ohio's Payment Model at a Glance

In SIM Round Two, Ohio was awarded a $75 million Testing grant to rapidly scale the use of patient-centered medical homes (PCMH) and episode-based models for most acute medical events statewide.

Goals

- **Launch** reporting on six episode-based payments across payers statewide in November 2014, tie to payment within one year, and define and launch additional episodes with a goal of 50 or more within four years.
- **Adapt** Southwest Ohio's Comprehensive Primary Care Initiative for statewide rollout of PCMHs to one additional market in 2015, all major markets within two years, and statewide within four years.

Scope

- **Enroll** 80 to 90 percent of the state's population (10.1 million) in some value-based payment model (combination of episode- and population-based payments).
- **Implement** the SIM test models through Medicaid FFS and managed care, state employee benefit programs, and four private payers with 80 percent of the commercial market (Aetna, Anthem, Medical Mutual, and United).
- **Include** all providers within participating payer networks, regardless of size, sophistication, or geographic location (an estimated 90 percent of hospitals, 88 percent of specialists, and 53 percent of primary care practices by 2018).

Timeline

October 2013 – May 2014:
- The multi-payer coalition, with extensive provider input, completed six episode definitions to be used for performance reporting beginning November 2014

Year 1:
- State leads design of six episodes: asthma acute exacerbation, COPD exacerbation, perinatal, acute and non-acute PCI, and joint replacement

Year 2:
- State leads design of seven new episodes: URI, UTI, cholecystectomy, appendectomy, GI hemorrhage, EGD, and colonoscopy

Year 3:
- 20 episodes defined and launched across payers

Year 5:
- 50+ episodes defined and launched across payers

Source: Ohio Governor's Office of Health Transformation

Ohio's Payment Model – Episodes of Care

Ohio has developed an episodes of care model charter with potential degrees of standardization by component.

	"Standardize Approach"	"Align in Principle"	"Differ by Design"
Accountability	• Single accountable provider will be identified for majority of episodes • Type of provider may vary, but payers align on accountable providers for each episode	• Common vision to not categorically exclude unique providers	• Adjustments to episode cost (e.g., cost normalization) may vary by payer
Payment Model Mechanics	• Model follows a retrospective approach; episode costs are calculated at the end of a fixed period time	• Model includes both upside and downside risk sharing • Aligned principle of linking quality metrics to incentives • Agree to evaluate providers against absolute performance thresholds	• Payers may choose to have min number of episodes for provider participation • Type and degree of stop loss may vary
Performance Management	• Commitment to launch reporting period prior to tying payment to performance	• Aligned approach to have episode specific risk adjustment model • Aligned approach to exclude episodes with factors not addressable through risk adjustment	• Payers independently determine method and level for gain sharing • Risk adjustment methodologies may vary across payers
Payment Model Timing and Thresholds		• Performance period length for each episode and launch timings aligned where possible	• Start/ end dates for each episode may vary • Payers each determine approach to thresholding (incl. level of gain/risk sharing) • Outlier determinations will be at discretion of each payer

Source: Ohio Governor's Office of Health Transformation

Ohio's Payment Model – Episodes of Care (Continued)

In addition to a charter for its episodes of care model, Ohio has developed and shared the set of guiding principles that the state used to define its episodes for Year One.

Guiding Principles for Selection:

- Leverage episodes in use elsewhere to reduce **time to launch**
- Prioritize meaningful **spend across payer populations**
- Look for opportunities with **clear sources of value** (e.g., high variance in care)
- Select episodes that incorporate a **diverse mix** of accountable **providers** (e.g., facility, specialists)
- Cover a **diverse set of "patient journeys"** (e.g., acute inpatient, acute procedural)
- Consider **alignment with current priorities** (e.g., perinatal for Medicaid, asthma acute exacerbation for youth)

Working hypothesis for episodes in the first year:

- Perinatal
- Asthma acute exacerbation
- Chronic obstructive pulmonary disease (COPD) exacerbation
- Joint replacement
- Percutaneous coronary intervention (PCI)

Source: Ohio Governor's Office of Health Transformation

Arkansas' Payment Model – PCMH and Health Homes

Using a SIM Model Test grant, Arkansas Medicaid, the Arkansas Department of Human Services, Arkansas Blue Cross and Blue Shield, and QualChoice of Arkansas partnered to transform the state's health care and payment system. The collaboration is called the Arkansas Health Care Payment Improvement Initiative.

Population-Based Payment: *PCMH*

Components

1. Care coordination fees paid on a per-member, per-month (PMPM) basis for attributed patients for duration of program
2. Shared savings for effective and efficient management of total cost of care measured by the value created by a provider (or virtual pool of providers) on a risk-adjusted basis

Staged Rollout

1. Wave 1 limited to the practices selected for the Centers of Medicare & Medicaid Services (CMS) Comprehensive Primary Care (CPC) initiative in fall 2012
2. Wave 2 voluntarily enrolled practices in early 2013 and launched mid 2013

Population-Based Payment: *Health Homes*

Components

1. Reimburses for the full range of health home responsibilities and a PMPM fee with a portion at-risk based on process and outcome metrics. PMPM payments are risk-adjusted based on the results of a universal assessment of a person's level of developmental disabilities (DD), long-term services and supports (LTSS), or behavioral health needs and their medical complexity.

Staged Rollout

1. Wave 1 includes the adult DD and LTSS populations in the second half of 2013. DD children followed six to 12 months later
2. Wave 2 to voluntary enroll all interested and eligible providers
3. In Wave 3, all providers caring for this population will be required to become certified health homes

Source: Arkansas Health Care Payment Improvement Initiative, Arkansas State Innovation Plan

Arkansas' Payment Model – Episode-Based

In addition to population-based payment models, the Arkansas Health Care Payment Improvement Initiative includes two episode-based payment models.

Episode-based Payment: *Retrospective Risk Sharing*

Components

1. Each payer designates one or more providers as the Principal Accountable Provider (PAP). The PAP is responsible for the overall quality and cost effectiveness of care included in the episode. Payers then calculate each PAP's average costs and quality across all of the episodes delivered during that time period and compares them against performance thresholds independently preset by each payer. If a PAP achieves an average episode cost below a "commendable" threshold and meets quality requirements, savings beneath the commendable threshold are divided between the PAP(s) and the payer or plan sponsor.

Staged Rollout

75-100 episodes over the course of three years over the course of three waves:

1. Wave 1 launched all payers' initial five episodes: perinatal care, ambulatory upper respiratory infections (URI), attention deficit hyperactivity disorder (ADHD), congestive heart failure (CHF), and hip and knee replacements
2. Wave 2 had payers implement a modular, scalable infrastructure platform for launching and administering episodes and conduct 1-2 launches of 5-10 episodes
3. Wave 3 accelerates scale up in which payers rapidly achieve scale through quarterly launches of ~5-10 sub-waves of episodes through mid 2016

Episode-based Payment: *Assessment-based Payment*

Components

1. Assessment-based bundled payments for DD and LTSS adults episodes based on individual assessments of support and health care needs with subsequently tiered episode funding targets based upon need are paid to a single lead provider selected by the individual with advice from his/her family

Staged Rollout

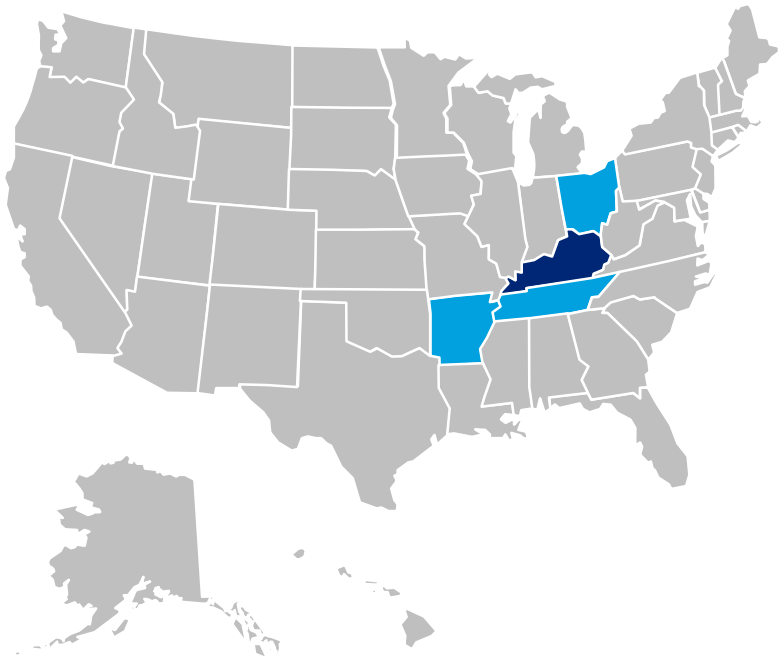
1. Wave 1 began with Medicaid assessments for adults receiving DD or LTSS services, starting in November 2012 and continuing through 2013. Medicaid began episode-based payments in late 2013, which was targeted to reach all adults in this population by the second half of 2014

Source: Arkansas Health Care Payment Improvement Initiative, Arkansas State Innovation Plan

Advantages and Disadvantages of Leveraging Strategies in Nearby SIM States

Advantages Discussion

In your groups, brainstorm the potential advantages of Kentucky leveraging the payment reform strategies already underway in nearby SIM states, including but not limited to Arkansas, Ohio, and Tennessee.

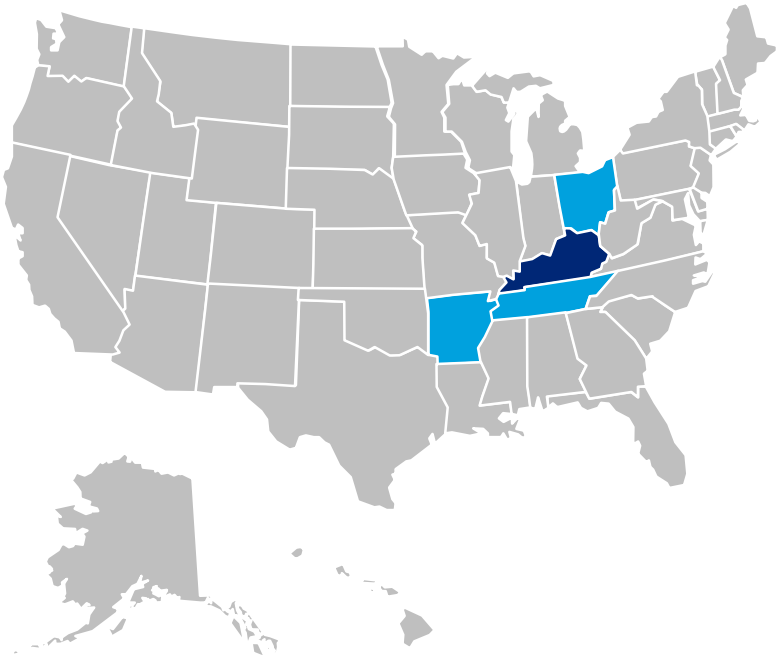


Potential Advantages
• Experience implementing value-based practice changes • Ability to achieve buy-in from multiple commercial payers • Experience achieving alignment amongst public and private payer groups • Strong two-way communication between the state and hospitals/hospital systems • Development of payment policies that benefit smaller, more rural providers • Published, positive year one findings and impact on consumers (Arkansas) **Others?**

The goal of this workgroup activity is to develop lists of potential advantages in smaller groups and then report out ideas to the full workgroup.

Disadvantages Discussion

In your groups, brainstorm the potential disadvantages of Kentucky leveraging the payment reform strategies already underway in nearby SIM states, including but not limited to Arkansas, Ohio, and Tennessee.



Potential Disadvantages

- A different uninsured market as a result of a non-expanded Medicaid population
- Incompatibility between the commercial payers operating in the state(s)
- Already established episodes of care
- Differing legislative structures and political administrations

Others?

The goal of this workgroup activity is to develop lists of potential disadvantages in smaller groups and then report out ideas to the full workgroup.

Review Payment Reform Strategies to Improve Population Health in the Context of the PHIP

PHIP Status Update and Process Overview

CMS has created a project structure that promotes crafting the Population Health Improvement Plan (PHIP) **prior** to developing payment and service delivery reforms with a **first draft due on May 29, 2015**.

PHIP Development Process:

May Draft PHIP		December Final PHIP
Health Needs Assessment	→	Interventions to Improve Population Health
Current Population Health Initiatives	→	Implementation Plan
Stakeholder Engagement Plan	→	Governance Framework

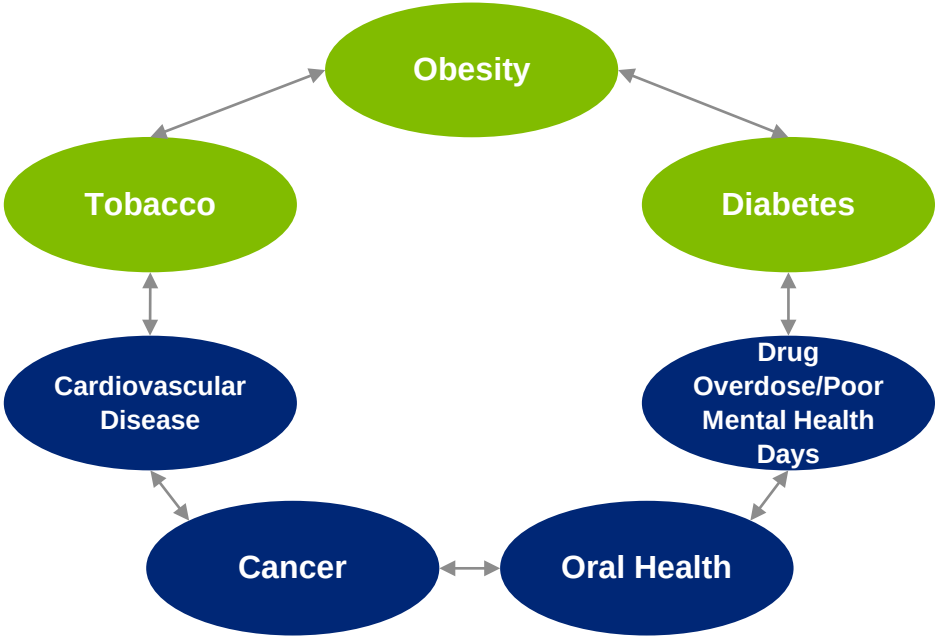
The **May draft of the PHIP** will serve as a **checkpoint** on the unique population health needs that Kentucky is facing, and as **a mechanism to solicit stakeholder input** throughout the remainder of the Model Design process on how to **design payment and service delivery reforms** around these population health needs.

PHIP Section 1: Health Needs Assessment

The draft PHIP contains a health needs assessment for the three CMS/CDC prescribed population health focus areas, plus the additional four focus areas added to promote the PHIP's alignment with and as an extension of **kyhealthnow**.

Health Needs Assessment Outline

- The PHIP draft provides an **initial assessment** of the **gaps in access to care and the health status disparities** that Kentucky seeks to address in the delivery system transformation initiatives designed over the course of the Model Design period.
- For each of the seven population health focus areas, the PHIP describes the current state and its impact on the Commonwealth and its populations, focusing specifically on:
  - **The prevalence of the condition**
  - **The disproportionate populations at risk**
  - **The economic impact**



CMS/CDC & kyhealthnow Focus Areas

Other kyhealthnow Focus Areas

PHIP Section 2: Current Health Initiatives

The second section of the PHIP focuses on describing major ongoing population health-focused initiatives to improve both health outcomes and risk-factors related behavior. While the connection between the PHIP and **kyhealthnow** is inherent throughout, the PHIP describes the work being done in other areas and how stakeholders are playing multiple roles in each.

kyhealthnow

- **kyhealthnow** established seven health goals for the Commonwealth, along with a number of specific strategies to help achieve these goals through 2019.
- These strategies will be implemented through executive and legislative actions and public-private partnerships.
- In addition, an **Oversight Team** was established to monitor and provide oversight of the administration's efforts to meet the kyhealthnow goals and carry out the strategies needed to achieve these goals, which is attached to CHFS.
- The PHIP is using **kyhealthnow** and its goals as its framework to develop new payment and delivery system reforms that work towards reaching each identified goal and a new governance process to provide long term monitoring and oversight.

ER "Super-Utilizer" Initiative

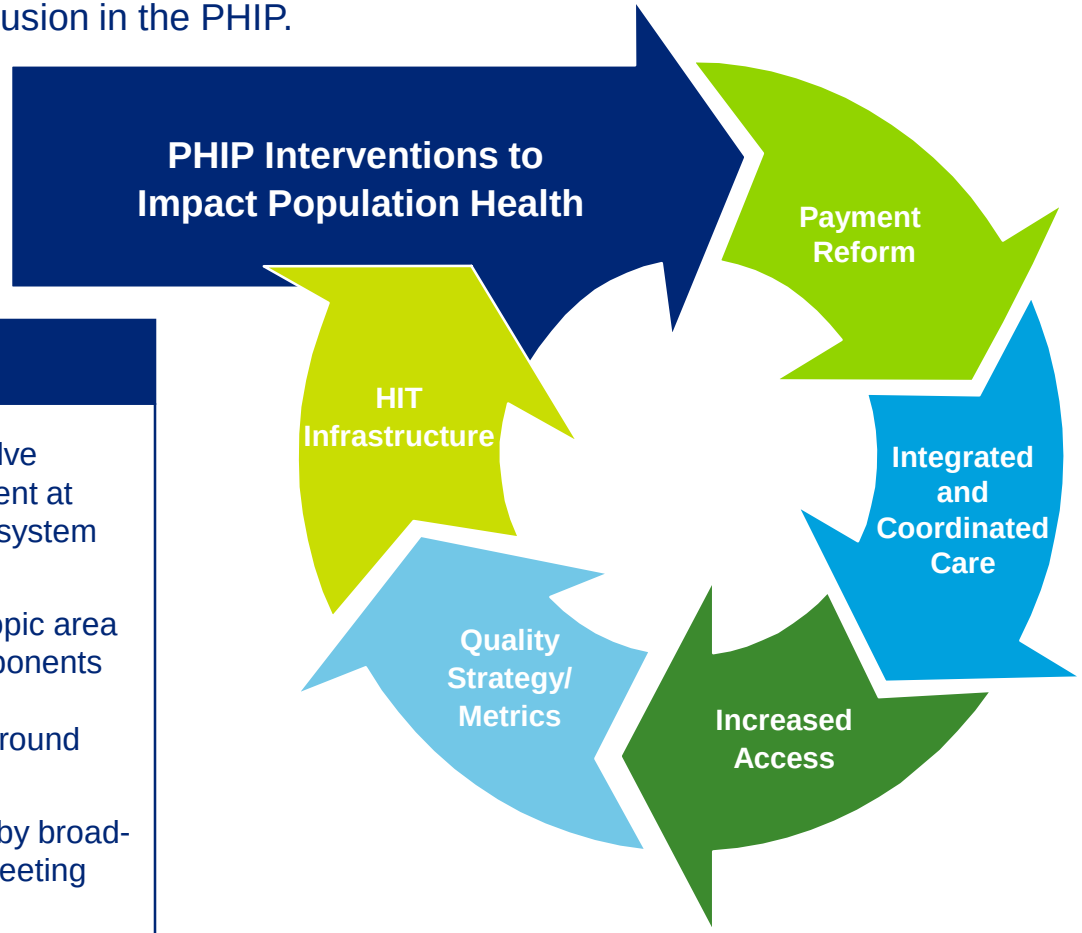
- Kentucky was awarded participation in a National Governor's Association (NGA) Policy Academy to address **emergency department (ED) super-utilization** in July 2013 and expanded the program statewide in August 2014.
- **Phase I** of the project focused on evaluating, recommending, and implementing models that efficiently navigate patients, focusing on decreasing emergency room super-utilization.
- **16 hospital sites** participated in Phase I of the project, and these sites are already seeing success, including active partner engagement and the development of new tools to monitor super-utilization data.
- The **Kentucky Department for Public Health (DPH)** provides assistance to these hospital sites through workgroup conference calls, data analysis, and specific technical expertise.

Unbridled Health

- The Coordinated Chronic Disease Prevention and Health Promotion Plan, or **Unbridled Health**, was completed in August 2013 through the work of more than an 80 member steering committee, a committee that continues to meet on an annual basis to identify synergies around the key initiatives included in the plan.
- **Unbridled Health** provides a framework in which organizations and individuals can unite as one powerful force to reduce the significant chronic disease burden in our state.
- **The framework** includes policy, systems and environmental changes that support healthy choices; expanded access to health screenings and self-management programs; strong linkages among community networks; and research data that are used as a catalyst for change.

PHIP Section 3: Stakeholder Engagement

Throughout the Model Design period, CHFS will use a robust, iterative process with internal and external stakeholders to craft the components of the Model Design, the first component being the PHIP. The team has developed a formal stakeholder engagement approach that will be used to develop the strategies and interventions for future inclusion in the PHIP.



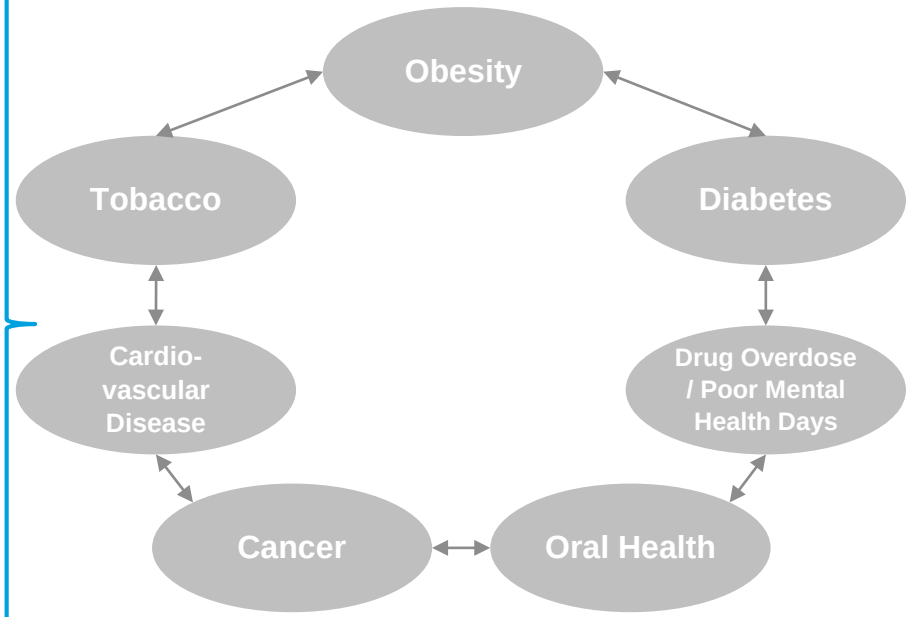
Stakeholder Process

- The development of the final PHIP will involve continuous stakeholder input and involvement at every step of the process across all health system sectors.
- The workgroups have been organized by topic area in order to align with the way in which components of the Model Design must be developed; workgroups will participate in discussions around the interventions included in the PHIP.
- Input by stakeholder workgroups, followed by broad-based report out in the large stakeholder meeting setting, will cultivate and maintain lasting stakeholder support for the PHIP's reforms and interventions.

PHIP Section 4: Interventions to Improve Population Health

Using the health needs assessment and population health focus areas of kyhealthnow, stakeholders will develop interventions to improve population health in the context of the SIM workgroups and their topic areas over the course of the Model Design process.

1. **Service Delivery Model Options**
2. **Payment Methodologies**
3. **Policy and Regulatory Levers**
4. **Workforce Needs Assessment**
5. **Health Information Technology**



These categories of interventions to improve population health and how they apply to the seven focus areas are not comprehensive and lend themselves to expansion, refinement, and discussion with all SIM stakeholders.

PHIP Section 4: A Closer Look

Within the seven kyhealthnow focus areas that the PHIP seeks to address, there are 51 associated strategies to help achieve these population health goals over the next five years. For the purposes of the PHIP, we will explore a subset of these strategies as they relate to payment reform to determine which strategies can be impacted by new value-based payment methods, or which methods would have the most effect on the strategies.

Strategy	Description

The goal of this workgroup activity is to develop a set of key themes to designing payment methods that work towards achieving the kyhealthnow, and therefore the PHIP, population health goals for inclusion in the draft PHIP due at the end of May.

PHIP Strategies Discussion

How can we use payment reform strategies, e.g., incentives, to (1) increase the prescription of smoking cessation therapies by providers and (2) increase the use of these therapies by consumers?

Reduce Kentucky's Smoking Rate by 10%

Strategy #6

Strategy	Description
Increase use of smoking cessation therapy by 50%.	According to preliminary 2014 Kentucky BRFSS data, a slight increase was shown in the use of smoking cessation programs. Among smokers who attempted to quit smoking or quit smoking in the past 12 months, 10.8% used a smoking cessation program. Among smokers who attempted to quit smoking or quit smoking in the past 12 months, 34.3% used some form of nicotine replacement therapy (BRFSS; Preliminary 2014). Due to the expansion of Medicaid and coverage of smoking cessation services via health plans due to the Affordable Care Act, additional increases are anticipated in the future.

PHIP Strategies Discussion (Continued)

How can we use payment reform strategies amongst payers to encourage increased utilization of dental services?

Reduce the Percentage of Children with Untreated Dental Decay by 25% and Increase Adult Dental Visits by 10%

Strategy #2

Strategy	Description
Partner with Managed Care Organizations to encourage increased utilization of dental services.	Over 800,000 total claims were submitted to Medicaid for dental services in 2014. (Medicaid Claims Data). In addition, a total of $18,075,000 was paid in revenue from Medicaid expansion to dental providers, and over 115,000 preventive dental services were provided to over 80,000 Medicaid expansion members in 2014 (Deloitte Medicaid Expansion Report, February 2015).

PHIP Strategies Discussion (Continued)

How can we use payment reform strategies to increase the number and type of providers who can be reimbursed for behavioral health services?

Reduce Deaths from Drug Overdose by 25% and Reduce by 25% the Average Number of Poor Mental Health Days of Kentuckians

Strategy #7

Strategy	Description
Create a more comprehensive and open access behavioral health network and increase by 25% the number of behavioral health providers eligible to seek reimbursement from Medicaid by the end of 2015.	Significant progress has been made on this strategy as more than 300 new behavioral health providers have been added to the Medicaid network. (Deloitte Medicaid Expansion Report, February 2015).

PHIP Strategies Discussion (Continued)

How can we use payment reform strategies, e.g., incentives, to encourage primary care providers to regularly screen both children and adults for depression?

Reduce Deaths from Drug Overdose by 25% and Reduce by 25% the Average Number of Poor Mental Health Days of Kentuckians

Strategy #9

Strategy	Description
Increase the proportion of adults and adolescents who are screened for depression during primary care office visits by 10%.	Medicaid MCO contract language requires that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders (KY Department for Behavioral Health, Developmental and Intellectual Disabilities, 2015). In 2013, there were 419 children and 1,679 adults in the Medicaid program for whom the claim indicated that screening for depression occurred during an office visit. In 2014, there were 1109 children and 5593 adults for whom the claim indicated that screening for depression occurred during an office visit. This represents a 165% increase for children and 233% for adults. (KY Department for Behavioral Health, Developmental and Intellectual Disabilities; 2015).

Next Steps

Upcoming Schedule

A monthly workgroup meeting will be essential for discussing key topics, reaching consensus, and driving the development of a successful Model Design. The exact meeting dates, times, and locations for the workgroups will be communicated in advance of each session.

June 2015

M	T	W	T	F
1	2	3*	4	5
8	9 *Rescheduled	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30			

July 2015

M	T	W	T	F
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	31

August 2015

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				

Calendar Legend

Workgroup Meeting

Stakeholder Meeting

Next Steps

- The June full stakeholder meeting that was scheduled for **Wednesday, June 3, 2015** has been **rescheduled**. It will now take place on **Tuesday, June 9, 2015 from 1 – 4 PM** at the Kentucky Historical Society - 100 W Broadway Street in Frankfort, KY.
- Mark your calendars! The next Payment Reform workgroup will be held on **June 16, 2015.**

Workgroup	June Date	June Time	June Location
Payment Reform	Tuesday, June 16th	9AM to 12PM	KY Department for Public Health (DPH), Conference Suites B-C, 275 E Main St, Frankfort, KY 40601
Integrated & Coordinated Care	Tuesday, June 16th	1PM to 4PM	KY Department for Public Health (DPH), Conference Suites B-C, 275 E Main St, Frankfort, KY 40601
Increased Access	Wednesday, June 17th	9AM to 12PM	KY Department for Public Health (DPH), Conference Suites B-C, 275 E Main St, Frankfort, KY 40601
Quality Strategy / Metrics	Wednesday, June 17th	1PM to 4PM	KY Department for Public Health (DPH), Conference Suites B-C, 275 E Main St, Frankfort, KY 40601
HIT Infrastructure	Thursday, June 18th	9:30AM to 12:30PM	KY Department for Public Health (DPH), Conference Suites B-C, 275 E Main St, Frankfort, KY 40601

- Please visit the dedicated Kentucky SIM Model Design website: http://chfs.ky.gov/ohp/sim/simhome
  - This website contains a Payment Reform workgroup section that will contain meeting presentations, outputs, and additional resources.
- Please contact the KY SIM mailbox at sim@ky.gov with any comments or questions

Thank you!

Q&A

Appendix

This slide is a reporting of facilitated workgroup activities only and does not reflect CHFS-endorsed proposals or policy prescriptions.

Payment Reform Driver Diagram – Tobacco Use

What are the current barriers to reducing tobacco use in Kentucky? What would be the key drivers to reducing those barriers? What initiatives could support those drivers from a payment reform perspective?

Reduce the Rate of Tobacco Use

Driver	Initiative Example
Driver: Remove primary care provider (PCP) disincentives for tobacco cessation services	? **Initiative Example:** Change billing codes to allow payment for both visit and cessation
Driver: More actively engage providers around smoking cessation	? **Initiative Example:** Provide additional information and outcomes information, as well as examples from successful states
Driver: Enable and empower the consumer to make behavioral changes	? **Initiative Example:** N/A
Driver: Increase focus on prevention in children/teens	? **Initiative Example:** Create financial accountability for schools to provide smoking cessation (e.g., link school funding to tobacco prevention performance)
Driver: More actively engage payers in reducing tobacco use	? **Initiative Example:** Link payments to smoking cessation rates
Driver: Engage employers to promote smoking cessation in their workforce	? **Initiative Example:** Incentivize employers who have created worksite policies and host tobacco cessation programs for employees
Driver: Encourage team-based intervention around smoking cessation	? **Initiative Example:** Expand the existing reimbursement structure to encourage smoking cessation activities across multiple provider types

This slide is a reporting of facilitated workgroup activities only and does not reflect CHFS-endorsed proposals or policy prescriptions.

Payment Reform Driver Diagram – Obesity

What are the current barriers to reducing the incidence of obesity in Kentucky? What would be the key drivers to reducing those barriers? What initiatives could support those drivers from a payment reform perspective?

Reduce the Incidence of Obesity

- **Driver:** Promote more consistent reporting of body mass index (BMI) to payers through coding policy
  - ? **Initiative Example:** Incentivize the use of BMI codes for all providers for all visits
- **Driver:** Better identify the root causes of an individual's obesity
  - ? **Initiative Example:** Establish a program that enables community health workers (CHW) to work with at-risk kids identified by schools, and coordinate their therapies
- **Driver:** Increase focus on prevention in children/teens
  - ? **Initiative Example:** Create financial accountability for schools to provide structured physical fitness
- **Driver:** Encourage dietary counseling by a pediatrician or other health care provider
  - ? **Initiative Example:** Develop payment strategies that encourage team-based approaches to delivering treatment options
- **Driver:** Enable and empower the consumer to make behavioral changes
  - ? **Initiative Example:** N/A
- **Driver:** Encourage providers to focus on social determinants to health
  - ? **Initiative Example:** N/A

This slide is a reporting of facilitated workgroup activities only and does not reflect CHFS-endorsed proposals or policy prescriptions.

Payment Reform Driver Diagram – Diabetes

What are the current barriers to reducing the incidence of diabetes in Kentucky? What would be the key drivers to reducing those barriers? What initiatives could support those drivers from a payment reform perspective?

Reduce the Incidence of Diabetes

Driver: Encourage better use of evidence-based protocols

? **Initiative Example:** Harmonize payer formularies and payment policies for diabetes and pre-diabetes care

Driver: Encourage diabetes prevention

? **Initiative Example:** Require payers to adopt a consistent message or approach to diabetes prevention

? **Initiative Example:** Expand to statewide adoption of Diabetes Prevention Program (DPP) using Kentucky Employee Health Plan (KEHP) best practices

? **Initiative Example:** Partner/contract with behavioral health providers in the area with more aggressive rates and payment structures for these providers to help identify pre-diabetes signs

Driver: Encourage stronger coordination between PCPs and public health programs

? **Initiative Example:** Adopt payment reform at the certified diabetes educator (CDE) and PCP levels to incentivize coordination between PCPs and community-based CDEs

Driver: Encourage team-based approaches to diabetes care

? **Initiative Example:** Fund peer mentoring interventions (e.g., peer mentors hired with Type 2 Diabetes themselves and who are managing their disease) to remind the mentees of what to do