

**PROJECT ABSTRACT:** Building upon Kentucky Governor Steve Beshear's strong leadership in expanding Medicaid and creating a highly successful state-run health benefit exchange (**kynect**) - the only Southern Governor to do so - Kentucky is in a unique and important position to benefit from a State Innovation Model Design Award. An award in the amount of \$3 million would greatly enhance Kentucky's ability to holistically tackle its unique population health, care delivery and payment system challenges. The guiding theme of Kentucky's Model Design will be robust payment and delivery reforms that catalyze improved health outcomes, aligning economic incentives with improvements in Core Population Health Metrics identified by the Centers for Medicare & Medicaid Services / Center for Medicare & Medicaid Innovation.

As alluded to above, kynect saw vigorous first period enrollment under the Governor's leadership. As of April 21, 2014, Kentucky has enrolled 413,410 individuals in new health coverage, including Medicaid and private Qualified Health Plans (QHPs) through kynect, of which an estimated 75% were previously uninsured. While a tremendous start, this enrollment success is only the first step toward transformation. Improved population health and cost containment must follow, built on the principles of efficiency, sustainability and prevention.

Kentucky is plagued by poor population health, regularly ranked among the worst states across traditional indicators (45<sup>th</sup> overall; 50<sup>th</sup> in tobacco use; 42<sup>nd</sup> in obesity). Recognizing the need for an aggressive health improvement strategy, Governor Beshear launched the **kyhealthnow** initiative, a series of specific health goals for the Commonwealth to achieve over the next five years, with a strong focus on tobacco use, diabetes, obesity and heart disease. Each goal is expressly designed to capitalize on opportunities presented by the Affordable Care Act, and many are calibrated to match national goals articulated by the Centers for Disease Control.

With a Model Design award, Kentucky will develop structural payment and delivery reforms that target these chronic diseases, as well as the state's unique health disparities and rural access challenges, with the goal of incentivizing desired outcomes and discouraging high-cost, low-yield efforts. We envision a system that more fully incorporates value-based purchasing in health plans to drive population health improvements, with the objective of developing a State Health Care Innovation Plan that can realize approximately 2% in savings on Kentucky's approximately \$28.4 billion in annual state-wide health care expenditures when fully implemented over approximately four years. Kentucky's ultimate goal for health reform is to utilize evidence-based, cost-effective payment and technology reforms to drive better individual and population health.

Kentucky's Model Design will incorporate multiple payers, including a particular focus on the five Medicaid Managed Care Organizations covering approximately 90% of Medicaid enrollees; the Kentucky Employee Health Plan; and insurers offering QHPs through kynect. Further, the Model Design will build on a number of reforms already underway or under discussion in Kentucky in the arenas of coordinated care delivery, chronic disease management and prevention, expanded use of health data and technology and leadership by local health entities. The design process will allow Kentucky to thoroughly examine which existing initiatives are valuable and effective and what new payment and outreach initiatives must be developed (and harmonized with effective existing initiatives) in order to create the kind of transformative yet sustainable change that Kentucky's health care challenges demand. Undergirding this entire process will be the robust, well-coordinated participation of stakeholders across the health care system, dozens of whom have expressed their wholehearted support for the design effort and are already partnering with the Commonwealth on other health initiatives.

## I. PROJECT NARRATIVE

The core principle of Kentucky’s Model Design is *population health improvement catalyzed by strategic payment and delivery reforms*, serving the dual purpose of containing costs and targeting population health metrics that reflect Kentucky’s biggest disease burdens (*i.e.*, tobacco use, obesity, and chronic diseases such as diabetes). To reach this vision, we will use a robust iterative process – below is an abridged version of Kentucky’s Model Design planning approach, as detailed further in the Project Narrative (*see* Figure 8 in Operational Plan).

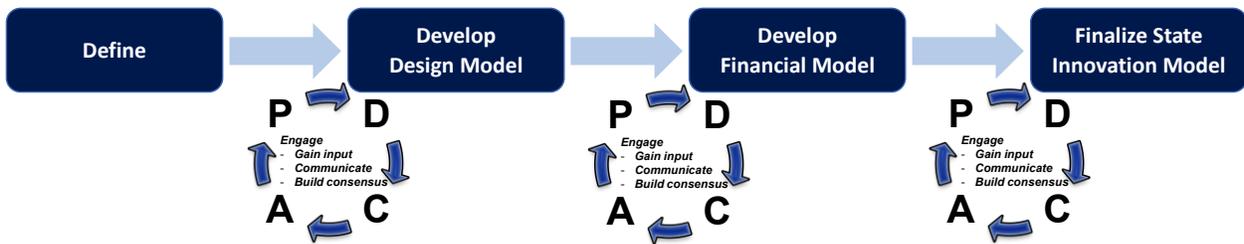


Figure 1: Kentucky’s Model Design Planning Approach (Abridged)

### A. Population Health Plan

Kentucky’s Model Design Population Health Improvement Plan (PHIP) will build upon the Commonwealth’s Affordable Care Act (ACA) implementation, Governor Beshear’s kyhealthnow initiative, and state population health plans in development, all as described below. Given Kentucky’s national health rankings (*see* Table 1 below), the PHIP will form the foundation of any and all progress the Commonwealth makes with health care reform.

<i>Disease / Health Behavior</i>	<i>National Rate</i>	<i>Kentucky Rate &amp; National Ranking</i>
Tobacco Use	19.6%	28.3% of adults, 50 <sup>th</sup> overall
Obesity	27.6%	31.3% of adults, 42 <sup>nd</sup> overall
Diabetes	9.7%	10.7% of adults, 38 <sup>th</sup> overall
Hypertension	30.8%	38% of adults, 46 <sup>th</sup> overall

Source: America’s Health Rankings 2013 Annual Report

Table 1: Select Chronic Disease Burden in Kentucky

Vision: During the Model Design process Kentucky will develop, in close concert with stakeholders, *a population health plan that facilitates integration of population health*

*strategies and metrics with public health officials and health care delivery systems, with particular attention to narrowing health disparities, expanding access to care at the local level and improving chronic disease prevention and management.*

Process: Governor Beshear has already begun to lead on population health through his kyhealthnow initiative, which targets Kentucky's main drivers of poor population health and adopts a Health-in-All-Policies approach to state government, aligning many of the goals therein with national goals identified by U.S. Department of Health & Human Services (HHS) initiatives, such as Healthy People 2020 and the CDC's Winnable Battles. Kyhealthnow thus provides a solid foundation from which to address population health through its Model Design, aligning with CMS/CDC Core Population Health Metrics. Moreover, it bears noting that the Kentucky Department of Public Health (KDPH) has a strong relationship with the CDC, especially regarding primary care, worksite wellness, maternal-child health and chronic disease.

Also noteworthy is that KDPH, together with over 100 stakeholders, recently developed *Unbridled Health: A Plan for Coordinated Chronic Disease Prevention and Health Promotion (2011)* pursuant to a CDC grant, targeting tobacco use, obesity, and diabetes, and other health issues. Building on *Unbridled Health*, KDPH is currently developing a Kentucky State Health Improvement Plan (KSHIP) as part of the accreditation process of the Public Health Accreditation Board (PHAB), aligning the KSHIP with kyhealthnow's priorities.

During the Model Design process, the Commonwealth will harmonize existing population health initiatives to develop *a single, consistent* population health plan. Led by Commissioner Dr. Stephanie Mayfield Gibson, a core team will lead the process of further data gathering and analysis, plan development and ultimate synthesis with existing initiatives (using a process that parallels Kentucky's Model Design Planning Approach in Figure 8) to ensure

alignment and integration with the Health Care Delivery System Transformation and Payment Reform plans. The PHIP team will also leverage the existing, comprehensive stakeholder engagement for other KDPH initiatives; oversee the coordination of Cabinet for Health and Family Services (CHFS) for participants in PHIP development; and explore the best governance structure and policy proposals to support the PHIP’s proposed interventions. The team will work directly within the project structure of the Model Design process (*see* Figure 7) and build upon the existing solid foundation for stakeholder engagement (*see* Section E). Thus, maintaining their engagement to develop the Model Design will be a robust yet familiar process.

A critical element of sustainability of the PHIP will be its full integration and alignment with the Health Care Delivery System Transformation and Payment Reform plans, in addition to full integration of the PHIP at the community level. In order to engage in plan development at the local level, KDPH will build on its ongoing efforts to more fully integrate Local Health Departments (LHDs) in their local communities, positioning them as “health hubs” within the community in a way that is more far-reaching than in the past.<sup>1</sup> LHDs are already working toward integration of the public health and health care delivery systems through programs such as Community Health Workers (CHWs) (per Section 5313 of the ACA), public health dental hygienists, school health programs, and local diabetes education and prevention programs.

PHIP Key Features & Metrics: The PHIP will be centered on the core Population Health Metrics of tobacco use, obesity and diabetes, as they reflect most of Kentucky’s greatest health challenges and align with priorities identified by CMS/CDC. In developing the plan, the core measures will be incorporated as top line metrics against which to evaluate plan performance.

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<sup>1</sup> LHDs worked aggressively to ensure local access to the kynect roll-out and are well-positioned to act as conveners around PHIP development. Three of the first nine LHDs nationwide to receive PAHB accreditation were from KY; six have applied this year, two of which have achieved accreditation. Six more LHDs, as well as the KDPH itself, will apply next year. Most LHDs are using the Mobilizing for Action through Planning and Partnerships (MAPP) community evaluation method from the National Association of County and City Health Officials (NACCHO).

For example, reduction in tobacco use will be a key feature, and strategies must clearly demonstrate effectiveness in order to be included in the plan. Moreover, the PHIP will leverage kyhealthnow's data gathering effort to more accurately assess the Commonwealth's progress toward the goals identified therein.

Kentucky's PHIP will also have a strong focus on child wellness and prevention issues (ongoing work supported in part by a CDC 1305 Grant), particularly prevention of tobacco initiation and childhood obesity, including through ongoing school, childcare and community-based strategies, which will be synthesized with the PHIP. These and additional efforts support the integration of population health metrics into the care delivery system, and the Model Design process will enable KDPH to lead CHFS and stakeholders toward the development of a truly integrated, transformative health improvement plan for a healthier Kentucky.

## **B. Health Care Delivery System Transformation Plan**

Vision: The guiding vision of Kentucky's health care delivery system transformation plan is to *achieve the Triple Aim – improved value, patient care and population health outcomes – in the context of an interconnected and comprehensive health care ecosystem*. While care has traditionally consisted of unconnected silos and a singular, linear relationship between provider and patient (for those who even have access to care), we aim to create a constellation of interconnected, holistic touch-points surrounding each patient – a healthy eco-system that ultimately costs less and delivers more. Kentucky's plan for delivery system transformation will be multi-faceted, involving a mix of policy levers, education efforts and consensus-building to drive system stakeholders toward what works. We will assess which existing efforts are valuable and effective, and what new delivery reforms and strategies we must develop, and then synthesize with existing initiatives, in order to create systemic, sustainable change.

Goals & Strategies: Kentucky’s Model Design will build upon its success with kynect enrollment, recognizing that access to health care is dependent, first, upon access to and quality of insurance coverage. Beyond this foundational objective, we have identified three broad goals for delivery reform and important strategies to support each, as presented in Figure 2 below.



**Figure 2: Kentucky Model Design Health Care Delivery Transformation Goals and Strategies**

Process: Stakeholder engagement in health care delivery transformation will follow the general iterative process detailed in Section F and Figure 8. We will engage at the outset those stakeholders and CHFS representatives invested in care delivery measures and invite representative participation in small workgroups around key goals of increased access to care and coverage, integrated and coordinated care models and expanded HIT infrastructure. The process will be one of organized outreach; meaningful opportunities for stakeholder input at a large scale; substantive stakeholder workgroup consultations at a small scale; presentation of

findings; and then further discussion, negotiation and refinement at identified junctures along the way. For certain final proposals, the Kentucky Employee Health Plan (KEHP) and other payers who have shown a willingness to innovate (e.g., KEHP's coverage of the high-ROI Diabetes Prevention Program for eligible state employees) may offer a testing ground for new initiatives.

### **C. Payment and/or Service Delivery Model**

Vision: Kentucky is well-positioned to move forward on payment reform. Governor Beshear's leadership on Medicaid expansion (unique among Southern governors) has resulted in nearly 25% of the Commonwealth's population now being covered by Medicaid, close to 90% of which is under fully capitated managed care. The Commonwealth's ultimate vision is to implement *comprehensive payment reform mechanisms that align economic incentives with population health goals*, eventually capturing at least 80% of the covered population. Kentucky will formulate a framework for payment reform based on the principles of moving payers and providers toward *value-based purchasing*, setting *evidence-based benchmarks for care* and *capturing and utilizing data in a consistent and actionable manner*.

Process: Arriving at this level of reform and alignment will involve detailed evaluation of appropriate policy levers (both legislative and regulatory); examining the precedent-setting value of Medicaid, Medicare or KEHP models or pilots; and conducting an intensive stakeholder engagement effort. The process will bring together key public and private health system stakeholders and multiple payers, with a particular focus on the Managed Care Organizations (MCOs) that manage almost 90% of Kentucky Medicaid enrollees; the KEHP, which covers more than approximately 300,000 state employees, retirees and their dependents; and the insurers offering QHPs via kynect (Humana, Anthem, and the Kentucky Health Cooperative). Developing feasible and attractive reforms will require extensive discussion and negotiation

among the affected stakeholders at a broad scale and then again at the small workgroup level in the iterative process depicted in Figure 8 in Operational Plan, including presentation of successful payment model reforms and consideration of how different reforms may be customized to meet the needs of Kentucky's payers, providers and patients.

By engaging critical stakeholders across the spectrum, Kentucky will work toward a Model Design that more fully incorporates value-based purchasing in health plans to drive population health improvements, with the objective of developing a plan that will be ready for implementation in January 2016 (following the conclusion of the Design period).

Goals & Strategies: The Model Design process will be a critical time period and opportunity to perform thorough evaluations as to which payment reforms will actually work, and for which stakeholders, to achieve a projected 2% overall cost reduction while improving population health metrics. As with delivery transformation, Kentucky's ultimate payment reform plan will be multi-faceted, addressing different economic and administrative challenges for different patient populations and payer/provider groups. Kentucky's plan will also consider whether and how existing or new waiver programs should be amended or proposed.

Although Kentucky has only recently shifted to managed care (Nov. 2011), and most of the work to date has been to ensure its smooth functioning, the Commonwealth will be at a stage during the Model Design process where it will consider inclusion of performance metrics (reflective of population health goals and payment goals outlined herein) in the contracts of MCOs, with attendant risk and gain-sharing opportunities. In addition, Kentucky will explore mechanisms to promote payer-initiated reforms to realize maximum innovation *and* stakeholder ownership (*i.e.*, "skin in the game"). Accordingly, Kentucky has identified four broad goals for payment reform, as detailed in Figure 3 below.

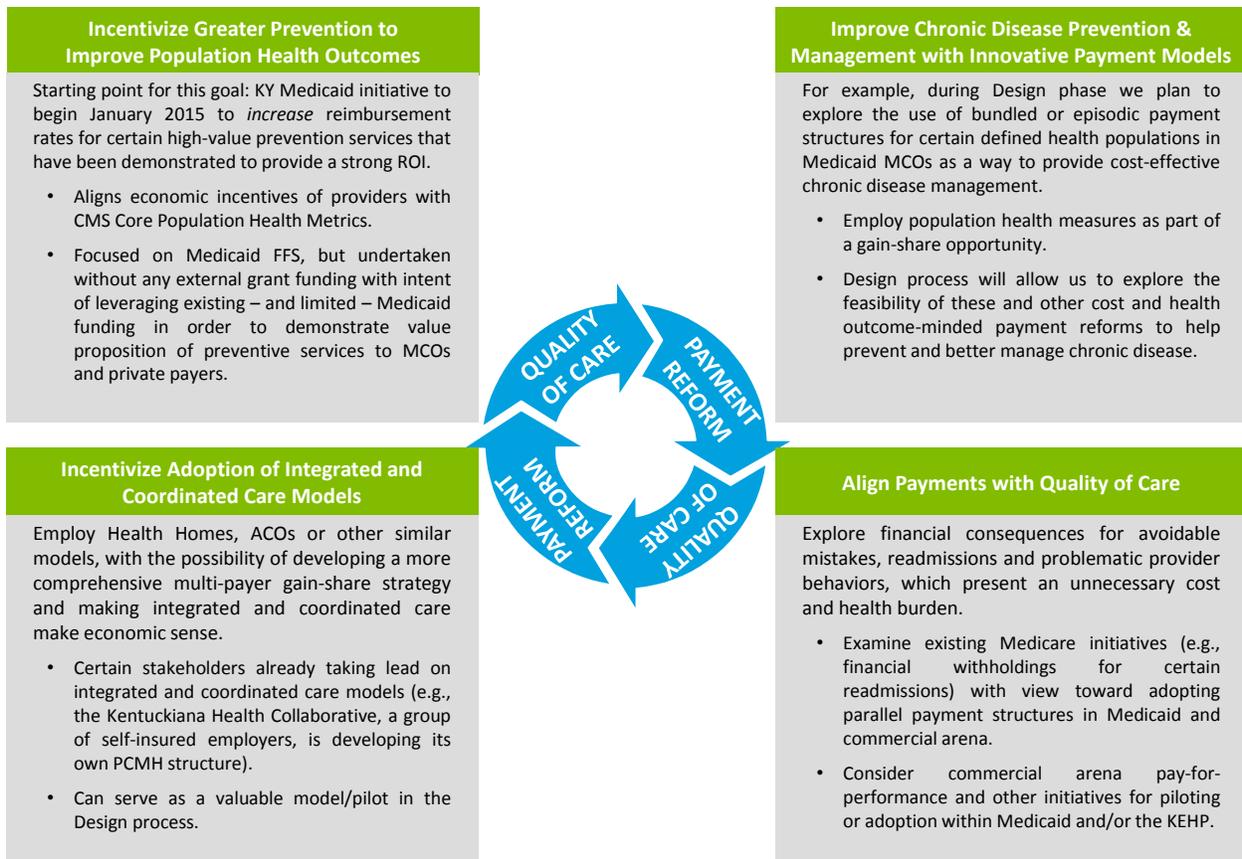


Figure 3: Kentucky Model Design Payment Reform Goals and Strategies

#### D. Leveraging Regulatory Authority

The Commonwealth is committed to employing multiple regulatory authorities to *drive the structure and performance of Kentucky’s health care system toward a more transparent, responsive, value-driven system that aligns with population health metrics*. Examples include leveraging the Certificate of Need program (located in the Office of Health Policy (OHP)) to support systemic innovation, building on existing policy and regulatory efforts to transform the health workforce;<sup>2</sup> incorporating value metrics into plans offered on kynect; moving toward value-based purchasing within the KEHP; more fully integrating value-based principles and a focus on population health metrics into Medicaid MCO contracts; and, in partnership with both

<sup>2</sup> Kentucky was one of seven states selected to participate in the National Governors Association Policy Academy *Building a Transformed Health Care Workforce: Moving From Planning to Implementation*.

state academic medical centers and the Council on Postsecondary Education (CPE), working toward inclusion of transformation-based teachings in medical and other professional curricula.

Beyond these specific policy considerations, Kentucky is strongly committed to using the Model Design process to build deep and broad consensus (internal and external) for additional levers we deem necessary to incent the behavior and create the structures required to produce and sustain systemic changes resulting in both cost containment and improved population health.

### E. Health Information Technology

Kentucky will use the Model Design process to build on ongoing efforts to *more fully realize the potential of its health information technology (HIT) framework and initiatives* in consultation with enthusiastic and invested stakeholders and committed providers. CHFS has developed an overall HIT strategy, known as the Kentucky Quality Health Information (QHI) framework, which facilitates the implementation

of technology standards and approaches for the development of an interoperable, scalable and easily adaptable cross-technology framework. Kentucky views the QHI (*see* Figure 4, right) as a house built on a solid foundation of sharable technical services and a common infrastructure, with various applications as pillars. These QHI initiatives will significantly improve Kentucky’s capacity to continually assess health information,

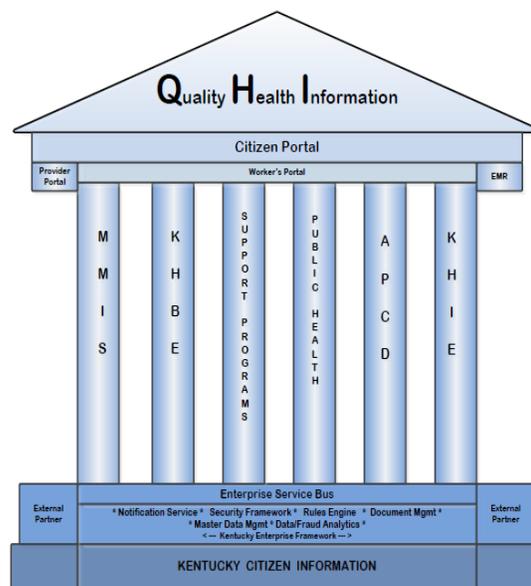


Figure 4: Kentucky Quality Health Information (QHI)

and will be integrated with stakeholder systems in Kentucky’s health care delivery system (*see* Table 2 below).

<i>QHI Initiative</i>	<i>Description</i>
<b>Medicaid Management Information System (MMIS)</b>	New MMS system will be flexible, modular, and provide near real-time interfaces and access to information, and will interface with the other systems within the QHI framework and enable automation of Kentucky’s data reporting to CMS.
<b>Kentucky Health Benefit Exchange (KHBE)</b>	KHBE is comprised of closely integrated Eligibility and Enrollment (E&E) and Plan Maintenance and Billing (PMB) solutions; expanding to include SNAP and TANF.
<b>Support Programs</b>	CHFS maintains a number of systems to support other CHFS programs, <i>e.g.</i> , Child Support, Child Care, Children Welfare, which are being modernized to utilize the QHI framework.
<b>KY DPH</b>	DPH policy and program governance for systems supporting local health departments, communicable disease control, disease and injury surveillance, enforcement of public health regulations, public health education, risk identification and reduction, policy development, and responses to disasters. The QHI will enable the interface of a number of local and national systems, including Kentucky’s Immunization Registry.
<b>All-Payer Claims Database (APCD)</b>	Envisioned as a large-scale database including claims data derived from medical, eligibility, providers, pharmacy, and dental claims from private and public payers. The APCD will support three key objectives: improve public health and quality of care delivery, support health care reform initiatives, and provide a foundation for transparency in cost and delivery of health care. The APCD will provide the necessary information repository to catalog and measure the utilization and outcomes of all health care in Kentucky, and will help integrate predictive modeling capabilities into health care projections.
<b>Kentucky Health Information Exchange (KHIE)</b>	Supports transition to electronic health records (EHRs) within CHFS and with private providers via KHIE. Works with all KY providers to connect their EHR systems to the state for the exchange of patient clinical information. KHIE has on-boarded over 800 provider locations/points of care, and 80% of Kentucky hospitals are currently live on KHIE, which has also successfully completed interfaces to the KY Immunization & Cancer Registries, CDC/BioSense and National Electronic Disease Surveillance System. Forthcoming work of KHIE, which will be incorporated in the Model Design as appropriate, involves development of an individually accessible patient portal/personal health record (PHR).
<b>Telehealth</b>	Plan to leverage telehealth as a mechanism to expand the reach of health professionals, lower costs and improve integration of care. Kentucky’s legal and regulatory environment has led to the development of the Kentucky TeleHealth Network (KTHN), the legislatively-mandated statewide initiative with over 250 member facilities. A number of telehealth projects with potential for significant cost savings are being explored.
<b>Telemonitoring</b>	Support for telemonitoring, which has great potential, particularly in the arena of reducing hospital and nursing facility admissions and readmissions. To build on efforts to keep members in the community, technologies such as remote monitoring of vital signs and access to a nurse will be incorporated in the Model Design. This model can be a successful tool for reducing hospital admissions/ readmissions by emphasizing disease management, rather than acute care treatment.

**Table 2: Kentucky QHI Initiatives**

## F. Stakeholder Engagement

Kentucky already has major building blocks in place to enable the convening of a diverse group of stakeholders in support of the common goal of health system transformation through existing stakeholder-based

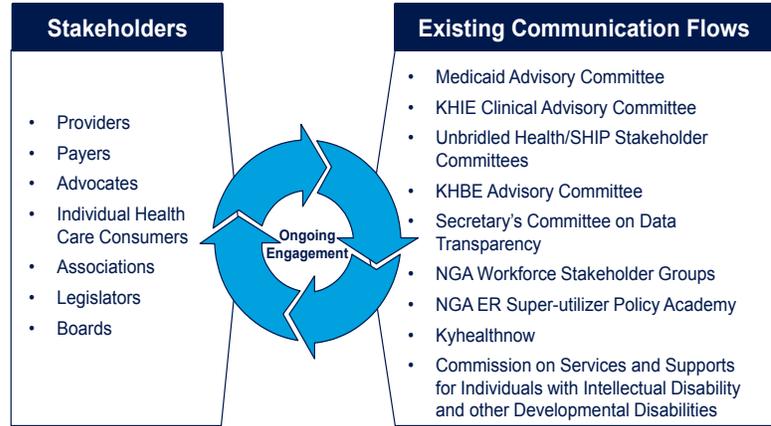


Figure 5: Select KY Initiatives with Major Stakeholder Engagement

initiatives (see Figure 5). These initiatives involve hundreds of stakeholders from state and local government, payer, provider, advocacy and expert groups already deeply involved in projects with CHFS and who have expressed sincere support for this effort.

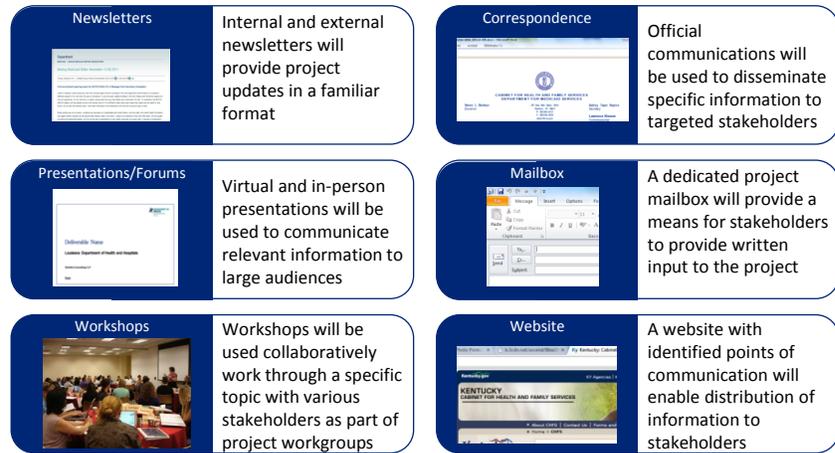


Figure 6: Tools to Facilitate Stakeholder Engagement

As described in Figure 8 in the Operational Plan,

Kentucky's Model Design will involve continuous stakeholder input and involvement at every step of the process across all sectors: government, payers, providers, advocates, individual health care consumers, nonprofit organizations, and others. Figure 6 above describes examples of mechanisms that will be used to support continuous stakeholder involvement.

One of Kentucky's strengths in convening key stakeholders is the nature of the insurance market, which is more concentrated than in many other states (e.g., one insurer holds 80% of the

individual insurance market share).<sup>3</sup> This concentration makes coordination and alignment easier, and the major players have provided letters of support for this project. In addition, there are a number of key stakeholders who have long and deep relationships with both providers and state government officials – for example, Janie Miller (CEO, Kentucky Health Cooperative), and Mark Birdwhistell (VP Admin & External Affairs, UK Healthcare) are both former CHFS Secretaries. Moreover, many of stakeholders are involved in existing CMS-funded Innovation work (see Table 4), including a number of those organizations that have provided letters of support for the Model Design process; for example, Almost Family, Inc., a Kentucky-based provider of home health services that recently acquired a physician-led ACO-management firm and is leveraging that knowledge to support transitions in the long-term care sector.

The institutional knowledge of these individuals and organizations will be invaluable in the Model Design process, and they are only representative examples. Table 3 provides a list of the organizations submitting letters of support, although, as noted, additional stakeholders will be brought into the process as the project begins in earnest.

<ul style="list-style-type: none"> <li>• Almost Family, Inc.</li> <li>• Anthem</li> <li>• Anthem (Medicaid)</li> <li>• Baptist Health</li> <li>• Coventry Cares of Kentucky</li> <li>• Cumberland Family Medical Center</li> <li>• Family Health Centers</li> <li>• Foundation for a Healthy Kentucky</li> <li>• Friedell Committee for Health System Transformation</li> <li>• HealthPoint Family Care</li> </ul>	<ul style="list-style-type: none"> <li>• Humana / Humana CareSource</li> <li>• Kentuckiana Health Collaborative</li> <li>• Kentucky Academy of Family Physicians</li> <li>• Kentucky Cancer Consortium</li> <li>• KY Council on Postsecondary Education</li> <li>• Kentucky Employee Health Plan</li> <li>• Kentucky Health Cooperative</li> <li>• Kentucky Health Dept. Association</li> <li>• Kentucky Medical Association</li> <li>• KentuckyOne Health</li> </ul>	<ul style="list-style-type: none"> <li>• Kentucky Primary Care Association</li> <li>• Kentucky Telecare</li> <li>• Kentucky Voices for Health</li> <li>• Norton Healthcare</li> <li>• Passport Health</li> <li>• University of Louisville School of Public Health &amp; Information Sciences</li> <li>• University of Louisville</li> <li>• University of Kentucky Health Care</li> <li>• WellCare</li> <li>• White House Clinics</li> </ul>
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**Table 3: Letters of Support (as of date of submission): Payers (incl. all Medicaid MCOs), Providers and Advocates**

<sup>3</sup> Kaiser Family Foundation, <http://kff.org/other/state-indicator/individual-insurance-market-competition/> (accessed 7/16/14).

## **G. Quality Measure Alignment**

Kentucky is currently ranked 45th in overall quality (America's Health Rankings 2013). Although the Triple Aim sets forth an elegant vision for a quality strategy, defining and quantifying "quality" has been an ongoing discussion at the national and state levels without clear resolution or harmonization of metrics to date. This absence of national consensus necessitates that Kentucky incorporate in its Model Design a process for reaching agreement among stakeholders on the most critical quality metrics. Accordingly, through the Model Design process, Kentucky intends to provide *a detailed roadmap for more effective measurement of quality and quantifiable improvement in clinical outcomes* for all state citizens. The Commonwealth already possesses or is augmenting the technology infrastructure necessary to support this initiative. Moreover, the Department of Medicaid Services (DMS) has begun an effort to focus quality metrics across the five MCOs, including common metrics for the MCO performance improvement plans. However, Kentucky's Model Design recognizes that this effort is not limited in scope to Medicaid (and MCOs), or Public Health, or even CHFS; this is a "Kentucky" discussion and requires input, engagement and action from a constellation of critical stakeholders. To that end, stakeholder discussions have begun (including many identified in Section E) regarding further development, collection, analysis and reporting of common metrics.

## **H. Monitoring and Evaluation Plan**

Kentucky will work closely with the CMS third party entity on model implementation, testing performance results and outcomes, monitoring beneficiary experiences, early detection of model performance issues, rapid cycle evaluation and other critical Model Design aspects. As data elements are identified for inclusion in monitoring, they will feed into the Evaluation Plan, and Kentucky attests to cooperation for the provision of such data. As stipulated by CMS, the

evaluation strategy will be comprised of three parts: 1) Overall design and data collection phase, 2) Rapid cycle evaluation, and 3) Impact evaluation. Although “CMS has ultimate responsibility for the evaluation process and reports, both for individual states and between state comparisons,” Kentucky will contract with an in-state research entity to assist with the development of methodological and data standards, to conduct monitoring and rapid cycle evaluation to promote real-time program improvement, and to conduct the impact evaluations. This entity has not yet been selected, but preliminary discussions have commenced with state academic institutions. Collectively, Kentucky’s team will provide both CMS’ third party entity and the in-state program evaluation entity with all information necessary to monitor demonstrated fidelity to the proposed delivery system and payment models, thereby identifying the potential to make mid-course corrections that improve or optimize performance based upon process and quantitative feedback. In addition, some groundwork has been laid through the monitoring and evaluation of kyhealthnow goals, which will align with the process herein. Overall, Kentucky will engage stakeholders and work toward monitoring and evaluation of the key outcomes of 1) strengthening population health; 2) transforming the care delivery system; and 3) decreasing per capita health care spending.

### **I. Alignment with State and Federal Innovation**

As mentioned above, key parts of the design process include *investigation* of existing initiatives for their potential to help produce the kind of transformative change outlined here, proposing the *development* of new payment reform and delivery initiatives to address identified needs, and creating a plan for *synthesis* of existing and new reforms to ensure maximum return on investment across all health innovation projects and to create cohesive, systemic change. Kentucky stakeholders are already involved in a number of CMMI funded initiatives (*see* Table

4 below). CHFS will continue to engage these and other key participants in the coming months to maximize alignment and synthesis of existing initiatives with the plan developed.

<i>Name of Program</i>	<i>No. of KY Orgs</i>	<i>Name of Program</i>	<i>No. of KY Orgs</i>
Advance Payment ACO Model	3	Independence at Home Demonstration	1
BPCI Model 2	9	Strong Start for Mothers and Newborns Initiative	5
BPCI Model 3: Retrospective Post-Acute Care Only	50	Health Care Innovation Awards	3
Comprehensive Primary Care Initiative	14	Community-based Care Transitions Program	2
FQHC Advanced Primary Care Practice Demonstration	7	Innovation Advisors Program	1

**Table 4: CMMI Funded Initiatives in Kentucky**

As described in Section A, Kentucky will continue to align closely with HHS goals and programs, including the following:

<i>Program</i>	<i>Description</i>
Aging and Disability Resource Center (ADRC) Enhancement Grants	Provided the impetus to establish a 50/50 admin match agreement between the Dept of Aging and Independent Living and DMS to enhance reimbursement for the ADRC No Wrong Door Medicaid system specific to Medicaid.
Balancing Incentive Program (BIP)	BIP enhanced match rate will fund a total of 1,203 1915(c) waiver slots serving individuals with intellectual or developmental disability, or acquired brain injury.
Health Home Planning Grant	As of April 1, 2014, Kentucky has been developing a Health Home Planning Model and currently plans to include chronic disease(s) and behavioral health.
Medicaid Managed Care	5 Managed Care Organizations (MCOs) in Kentucky receive capitated rate payments for 90% of KY Medicaid enrollees (excepting waiver participants and long-term care).
Money Follows the Person (MFP)	Kentucky Transitions (MFP) continues to offer transition assistance to individuals who are eligible and desire to move from facility placement into the community.
Testing Experience and Functional Tools (TEFT)	Leverages funds to field test an Experience Survey and CARE Assessment, develop PHR systems, and e-LTSS standards for across waivers.
Waiver Case Management System	Kentucky is developing a No Wrong Door/Single Entry Point, on-line, Waiver Case Management portal to be available through Kynect.gov. Eventually, programs such as WIC, TANF, and LIHEAP will also be added.

**Table 5: HHS Programs Underway in Kentucky**

Finally, with respect to ensuring that federal funding will not be used for duplicative activities or to supplant current or state funding, as attested in the Budget Narrative, Innovation Center funds will not supplant funding from other sources. Staff are very well versed in tracking time across various programs and financial staff within CHFS approve expenditure requests, as well as appropriate fund coding, prior to any authorization for purchase.

## II. FINANCIAL ANALYSIS

Kentucky will develop a Model Design that meets two critical goals: moving at least 80% of health insurance payments into a value-based purchasing framework, and establishing outcomes-based payment metrics that achieve approximately 2% overall cost savings.

In designing the financial model, Kentucky will undertake a rigorous analysis of empirical evidence regarding the cost-effectiveness of interventions and the flow-through impact of those interventions on population health metrics, with a particular focus on chronic non-communicable diseases, such as obesity, diabetes, and tobacco-related illnesses. As a first step, Kentucky’s insured population can be broken into the following discrete categories:

<i>Payer</i>	<i>Number</i>	<i>% of Insured Population<sup>4</sup></i>	<i>PMPM Cost</i>
Medicaid	<ul style="list-style-type: none"> <li>• Total: ≈ 1,097,379 (source: DMS)               <ul style="list-style-type: none"> <li>○ Fee-for-Service (Waivers and Long-Term Care): ≈121,682</li> <li>○ Managed Care: ≈ 975,697</li> </ul> </li> </ul>	≈27.5%	<ul style="list-style-type: none"> <li>• ≈ \$539               <ul style="list-style-type: none"> <li>○ ≈ \$1,993</li> <li>○ ≈ \$358</li> </ul> </li> </ul>
Individuals <sup>5</sup>	≈ 135,574 (QHPs: ≈ 84,416)	≈3.4%	<i>TBD during Design Process</i>
Employer-Based <sup>6</sup>	<ul style="list-style-type: none"> <li>• Total: ≈ 2,058,600</li> <li>• Small Group: 190,889</li> <li>• Large Group: 369,903</li> <li>• Self-funded: TBD (KEHP ≈ 300,00)</li> </ul>	≈ 51.6%	<i>TBD</i>
Medicare <sup>6</sup>	≈ 793,271	≈ 19.9%	<i>TBD</i>

**Table 7: Insured Population Categories**

Thus, between Medicaid, the stakeholders who have provided letters of support, and Medicare, this is a considerable portion of insured individuals, and as detailed in the Stakeholder Engagement section, Kentucky will work to engage all key players in the Model Design Process.

*Anticipated Cost Savings.* Kentucky’s Model Design will work toward an overall cost savings of 2%, or \$568 million over a four-year implementation period:

$$\text{(Total Annual Healthcare Cost \$28.4 billion<sup>7</sup>)} \times \text{(0.02)} = \text{(Projected Cost Savings \$568 million)}$$

Moreover, Kentucky’s Model Design will seek to align the cost savings with population health improvements on key metrics such as tobacco use, obesity and diabetes. For example, in recognition of the significant cost and outcome differentials among controlled and uncontrolled

<sup>4</sup> Total insured population est. at 3.988M using most recent data on state uninsured rate (est. at 8.95% post-April 2014), obtained via estimates from multiple sources. Note: total insured population percentages slightly exceed 100%, likely due to data overlap among years and existence of individuals dually eligible for Medicaid/Medicare.

<sup>5</sup> Kaiser Family Foundation, <http://kff.org/state-category/health-insurance-managed-care/insurance-market-competitiveness/> (accessed 7/16/14).

<sup>6</sup> Kaiser Family Foundation, <http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/> (accessed 7/16/14).

<sup>7</sup> Kaiser Family Foundation, <http://kff.org/other/state-indicator/total-health-spending-2/#map> (accessed 7/16/14).

diabetics, Kentucky will work toward a Model Design that rewards improvements in CMS-identified population health metrics such as the percentage of adult diabetics who have had two HbA1c tests and a foot/eye exam in the preceding year. A model for this intervention (*see* Table 8 below) could work as follows, although of course it would be further refined during the Model Design process (*e.g.*, inclusion of co-morbidities as a savings predictor and/or use of predictive analytics to factor in the likelihood of compliance within the intervention design):

<i>Category</i>	<i>Data</i>
<b>Number (%) of Medicaid enrollees who are known diabetics</b>	83,956 (8.3% enrollees) (2013) Controlled vs uncontrolled: TBD
<b>Average annual cost for diabetics</b>	\$16,610 (appr 50% higher than non-diabetics) (source: DMS) <sup>8</sup>
<b>Average cost differential b/w controlled vs Uncontrolled diabetics</b>	\$TBD
<b>Estimated KY diabetic population</b>	4,339,367 (total population) X .093 (Diabetes Prevalence(BRFSS)) = 403,561
<b>Total Cost Burden of Diabetes</b>	403,561 x \$16,610 = \$6,703,148,210
<b>Per Capita Cost of Proposed Diabetes Control Intervention</b>	\$TBD
<b>Success Rate of Proposed Intervention</b>	TBD%
<b>Uptake of Proposed Intervention</b>	TBD%
<b>Cost of Intervention</b>	(Per capita cost of intervention * total uncontrolled diabetics * uptake of proposed intervention)
<b>New # Uncontrolled diabetics</b>	Old # uncontrolled diabetics – (old# uncontrolled * uptake rate * success rate)
<b>Savings</b>	(Pre-intervention # uncontrolled diabetics * PMPM cost) LESS (New# uncontrolled diabetics * PMPM cost) PLUS total cost of intervention

**Table 8: Diabetes Cost Control Savings Analysis**

Similar analyses would be undertaken when considering other broad-based interventions, such as multi-payer implementation of the Diabetes Prevention Program (currently a covered benefit for all KEHP members meeting eligibility criteria), aggressive promotion of tobacco cessation (pursuant to the ACA’s preventive services benefit), interventions to decrease the percentage of individuals with uncontrolled hypertension, and other population-based interventions. Moreover, as part of the analysis of high-priority interventions for implementation, Kentucky’s Model Design process will involve a comprehensive inventory and analysis of existing initiatives among participating stakeholders, along with an analysis of the evidence basis for existing and proposed initiatives and the projected effect of all evaluations on population health metrics of highest impact. In addition, the Model Design will incorporate specific analysis of the projected impact of proposed interventions on health disparities across the Commonwealth.

The Model Design will utilize robust data analytics as the foundation of all financial analyses and the eventual Innovation Plan, with the overall goal of improving population health, lowering costs, improving quality, and reducing health disparities.

<sup>8</sup> Ultimate model projection will use cost figure reflecting state’s entire population, not just Medicaid cohort.

### III. OPERATIONAL PLAN

OHP is the lead applicant agency for the State Innovations Model Design Award and is strategically positioned as an extension of the Office of the Secretary within CHFS. The role of OHP is to coordinate and integrate policy across CHFS, which includes coordinated, timely, efficient, and cost-effective health planning and policy research. Other relevant stakeholder departments within CHFS include, but are not limited to: the Kentucky Health Benefit Exchange (KHBE), Governor's Office of Electronic Health Information (GOEHI)/KHIE, Office of Administrative and Technology Services (OATS), DMS, KDPH, and the Department for Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID). OHP has demonstrated significant capacity to develop, implement, and sustain initiatives. Of recent significance is the development of a state-run benefits information exchange, co-coordination of the Governor's kyhealthnow initiative, Balancing Incentive Program (BIP), Planning and Demonstration Grant for Testing Experience and Functional Tools (TEFT) in Community-Based Long Term Services and Supports (CB-LTSS) grant, National Governor's Association *Building a Transformed Healthcare Workforce: Moving from Planning to Implementation* political academy, and a Health Homes planning grant.

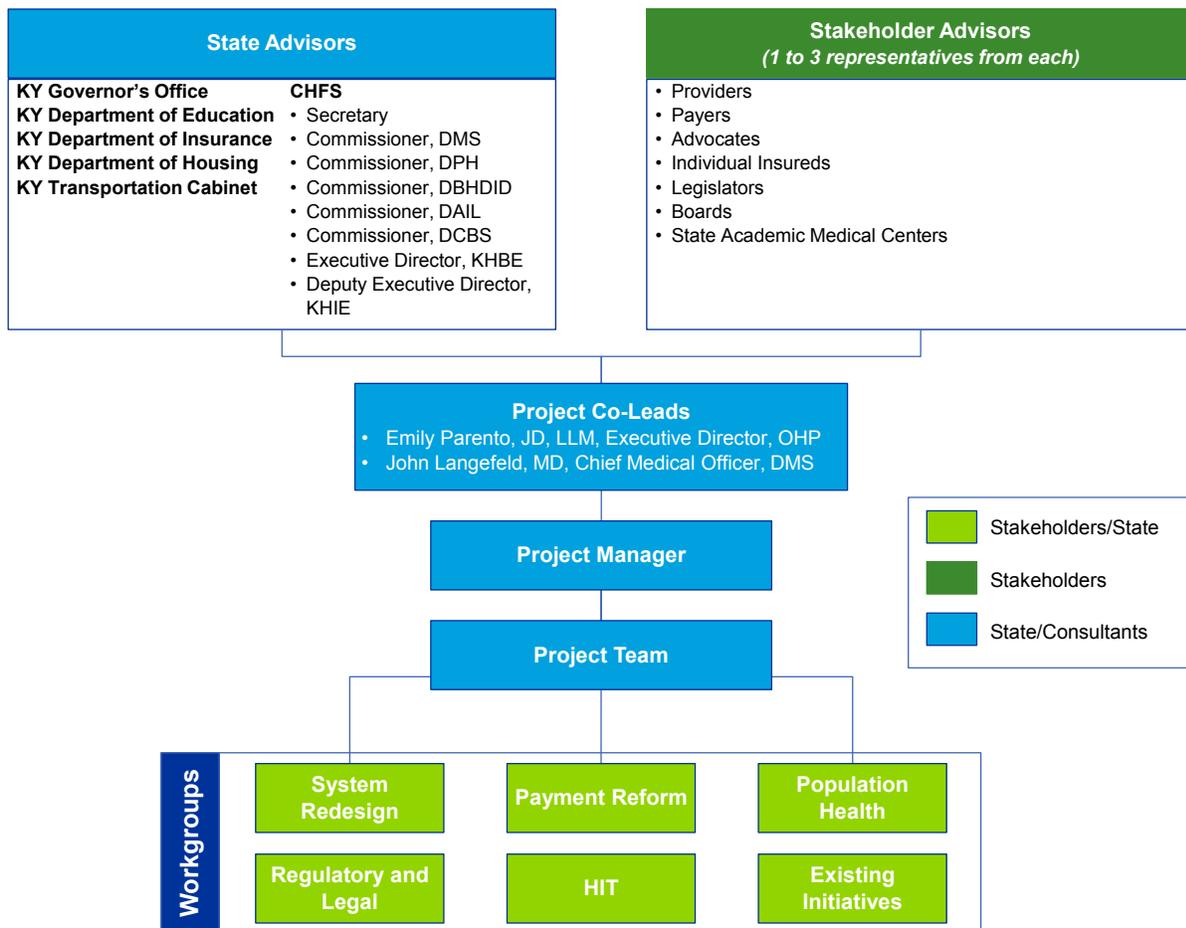
The Executive Director of OHP, Emily Parento, JD, LLM, reports directly to CHFS Secretary Audrey Tayse Haynes to integrate initiatives across CHFS, safeguard against duplicity and ensure integrated sustainability. Ms. Parento holds a Juris Doctor and Master of Law in Global Health Law from Georgetown University Law Center, and a Bachelor of Business Administration in Finance and Business Economics from the University of Notre Dame. Prior to joining CHFS, Ms. Parento was a Fellow at the O'Neill Institute at Georgetown University Law Center; she has also held an appointment as a visiting assistant professor at the University of Louisville Louis D. Brandeis School of Law, teaching courses in health law, administrative law, and food and drug law. Earlier in her career, she served as a judicial clerk to the Honorable John G. Heyburn II, current chair of the Judicial Panel on Multidistrict Litigation, in the United States District Court in Louisville, Kentucky, and practiced law with Davis Polk & Wardwell.

While Ms. Parento will take lead responsibility for researching and developing health policy, an additional key state employee, John Langefeld, MD, Chief Medical Officer for DMS, will serve as co-lead by informing the development of policy through data analytics. A graduate of the University of Louisville School of Medicine, Dr. Langefeld has extensive health care experience in clinical care, provider management, managed care, large employer-sponsored benefit programs, Workers Compensation/Disability, and data analytics and information management. Prior to joining CHFS, Dr. Langefeld served as Chief Medical Officer for Artemetrx, a Tennessee-based company with an office in Lexington, Kentucky specializing in how data analysis can aid in clinical outcomes that has worked with many large employers and public entities. Dr. Langefeld continues his strong interest in using data and technology to support better decision-making in health care. His areas of focus include clinical integration, population health, and medical informatics. As such, his role will include the use of data and technology to support decision-making and electronic system enhancement.

A full-time CHFS Designated Project Manager will be recruited under the joint supervision of Ms. Parento and Dr. Langefeld. The Project Manager will, in concert with outside vendor

partners to be hired, facilitate stakeholder meetings, create and disseminate meeting minutes, research topics identified of importance by the members of the stakeholder group, research and summarize other state innovation planning and testing activities, develop progress reports as required by CMS, and assist the financial manager with tracking expenditures and authorizing payments through Ms. Parento. Finally, the Project Manager will, in concert with Ms. Parento, Dr. Langefeld and outside vendors, develop the Kentucky State Innovation Plan based on outputs from stakeholder meetings and work sessions, which will be the basis for implementation and a possible Model Testing award.

As shown below (see Figure 7), Kentucky’s Model Design Project Structure creates an efficient system to facilitate a smooth Model Design process. Further detail regarding roles and responsibilities is included in the Budget Narrative.



**Figure 7: Kentucky Model Design Project Structure**

Jacob Fouts within the CHFS Office of Policy and Budget (OPB) will serve as the financial manager and will verify appropriate expenses throughout the planning phase. Various leadership staff within the departments and external stakeholders will provide “in-kind” time. Grant funds are appropriately managed through the OPB, which also reports directly to Secretary Haynes.

*Organization/Readiness.* Ms. Parento and Dr. Langefeld will recruit lead staff across the departments and agencies identified above with input from Secretary Haynes and DMS Commissioner Lawrence Kissner. Governor Beshear will remain involved throughout, both in a leadership role on health care reform and through representation from his office (individual to be designated). Moreover, alignment with kyhealthnow and the existing leadership structure in place for that initiative (chaired by the Lt. Governor and with heavy involvement from both OHP and DPH) ensures that the two processes will dovetail closely and remain coordinated, as many of the same individuals will be involved in both. Once the anticipated award announcement is received, a Project Manager will be recruited or identified in order to quickly proceed to the planning phase. Stakeholders will be informed of the status and appropriate meetings will be scheduled. The Project Manager will also work closely with the Co-Leaders and CMS' third party entity to develop more specific Scope of Work for the Contractor agencies.

Kentucky's planning approach includes four phases with cyclical feedback loops, culminating in a final, innovative Model Design (see Figure 8 below). As depicted, stakeholders will be consistently engaged through each phase. The Operational Plan includes the following four phases: 1) Define, 2) Develop Design Model, 3) Develop Financial Model, and 4) Finalize State Innovation Model. Major milestone dates for successful execution of the Operational Plan are presented in Figure 9. The Consultant will provide guidance throughout each phase based upon its experience with SIM planning and testing in other states. The Actuary will primarily be involved in phases two and three or as otherwise needed. The Evaluator will also be involved in each planning phase thereby balancing both stakeholder input and scientific rigor and integrity to inform an evaluation plan for the testing and implementation phase.

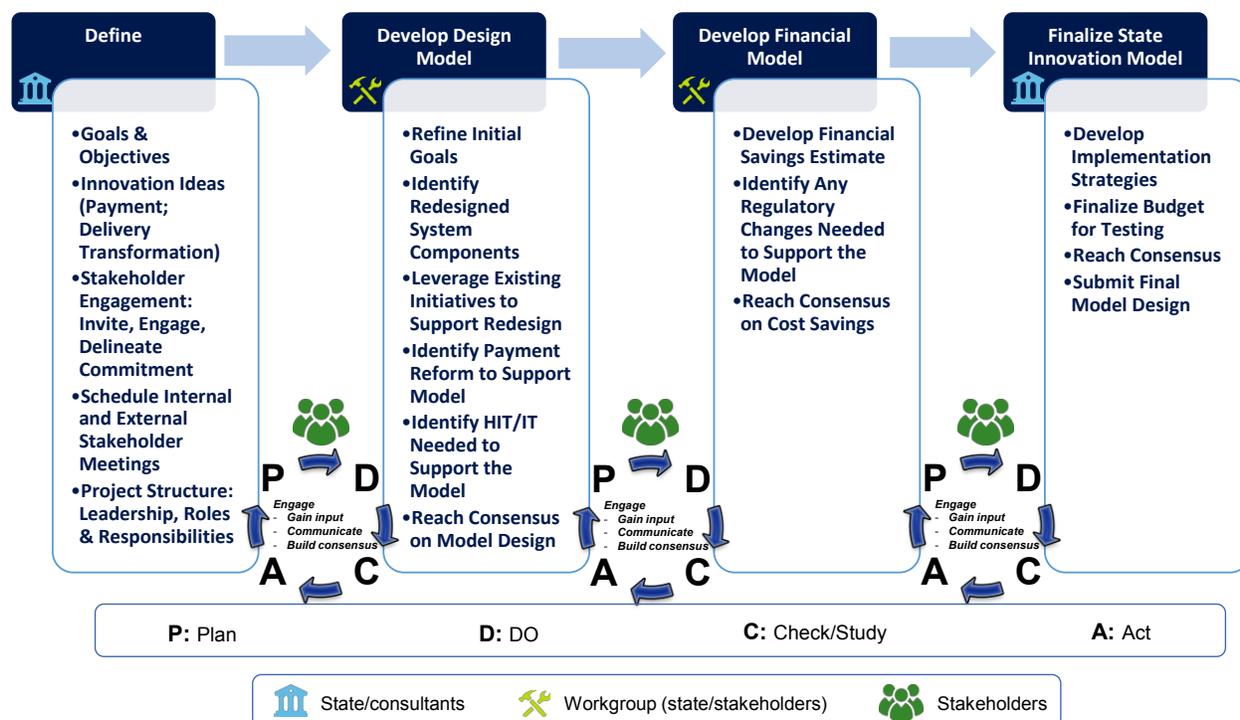


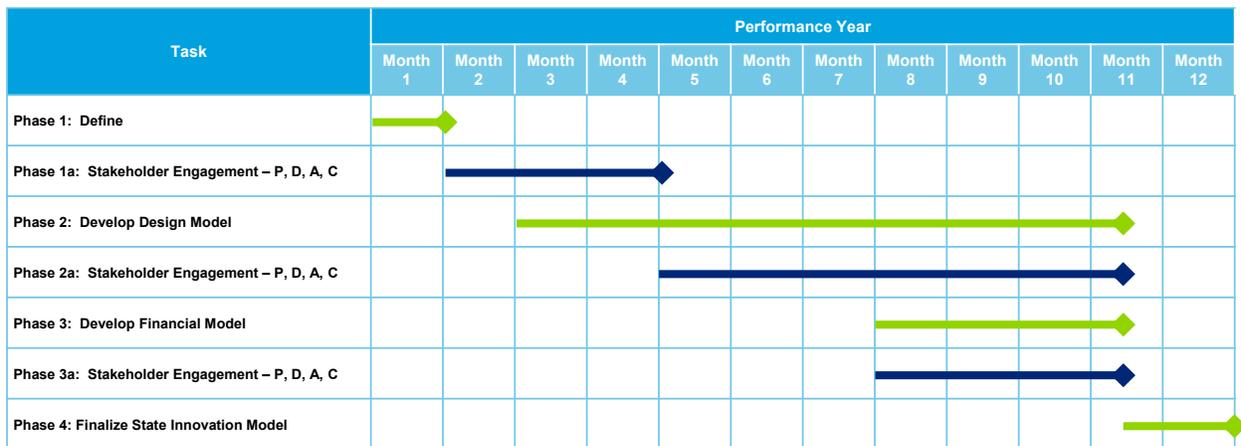
Figure 8: Kentucky Model Design Planning Approach

*Define.* During the Define phase, the Co-Leaders and Project Manager will operationalize the grant proposal by revisiting and further defining goals, objectives, and further explore successful innovative models. Three vendors will be selected with guidance from CMS’s third party entity and stakeholders will be invited to participate in a series of meetings wherein the project structure, leadership, roles and responsibilities will be determined.

*Develop Design Model.* During the Model Design phase lead staff, in conjunction with the Consultant, will refine initial goals based upon feedback from the CMS’ external evaluation contractor. They will also identify other initiatives that may be leveraged to facilitate planning. Collectively, lead staff and stakeholders will reach consensus on a defined model, including delivery transformation, payment reform and health information technology, to support the plan.

*Develop Financial Model.* During the third phase, the Project Leaders will continue to engage stakeholders in the development of a Financial Model to best support the Model Design. The Actuary will provide feedback to include cost savings estimates until the stakeholders reach consensus on a final, comprehensive model. Stakeholders will also determine any regulatory changes that may be needed to support the model and present any additional systems change that may need to occur.

*Finalize Innovations Model.* A comprehensive State Innovation Model plan will be developed during the final phase to include implementation strategies, budget for testing, and an evaluation plan. Finally, the plan will be submitted to CMS for approval.



**Figure 9: Kentucky’ Model Design Planning Timeline**

*Assumptions / Mitigating Identified Risks*

Kentucky has identified the following operational risks and mitigation strategies for the Model Design process.

*Project Complexity.* The Model Design is a large, complex project involving individuals and organizations both within and outside state and federal government. As such, an operational risk is a lack of coordination and structure to the process; however, Kentucky will mitigate this risk by engaging outside consultants with deep expertise in working on Innovation Model

Designs (and Testing awards), as well as ensuring that the CHFS leadership team includes individuals with the expertise and authority to ensure engagement of relevant players.

*Contracts.* Relatedly, another risk is delay in contract finalization with vendors to assist in Kentucky's Model Design; however, given that there are existing relationships with qualified vendors with prior SIM experience, any delays that may arise are unlikely to be significant.

*Personnel.* As in most projects of significant scale, certain personnel will be integral to the success of the effort. A risk to that success is the possibility of change in agency leadership or departure of key personnel during the course of the Model Design. This risk will be mitigated by ensuring continuity of staffing among the core Model Design project team and ongoing dialogue with agency leadership to ensure constant communication. Moreover, Kentucky's Model Design will not rely on any single individual but rather the work of the combined project team. Thus, should a particular individual depart, the team will work to quickly recruit another qualified individual to fill the role.

*Project Timing and Milestones.* Development of a close-to-final Innovation Plan within 12 months will require diligence and constant attention to detail. In order to ensure that the Model Design stays on task, Kentucky will utilize the Project Structure, Planning Approach and Proposed Timeline herein to develop a detailed timeline including key project deliverables. Moreover, the incorporation of project team members, including outside consultants, with expertise in Model Design work in other states, will help Kentucky rapidly scale the work once the Model Design award announcement is made.

*Lack of Participation by Key Stakeholders.* Although Kentucky stakeholders are strongly supportive of the Model Design proposal, it is possible that as the process evolves some may scale back or cease participation; however, it is unlikely that this risk will materialize at a significant scale. Nonetheless, to mitigate this risk the Model Design proposal includes consistent and ongoing stakeholder participation throughout the process to ensure full engagement and buy-in.