



KY SIM August Workgroup

Solicit feedback on draft Value-based Plan

This report is a compilation of direct stakeholder feedback on the Cabinet for Health and Family Services' (CHFS) draft Value-based Health Care Delivery and Payment Methodology Transformation Plan developed as part of Kentucky's State Innovation Model (SIM) Model Design. Feedback on this draft was collected during two three-hour workgroup sessions held on Wednesday, August 26, 2015 and Thursday, August 27, 2015. This compilation of stakeholder input does not reflect the views of CHFS or Deloitte Consulting LLP.

AGENDA

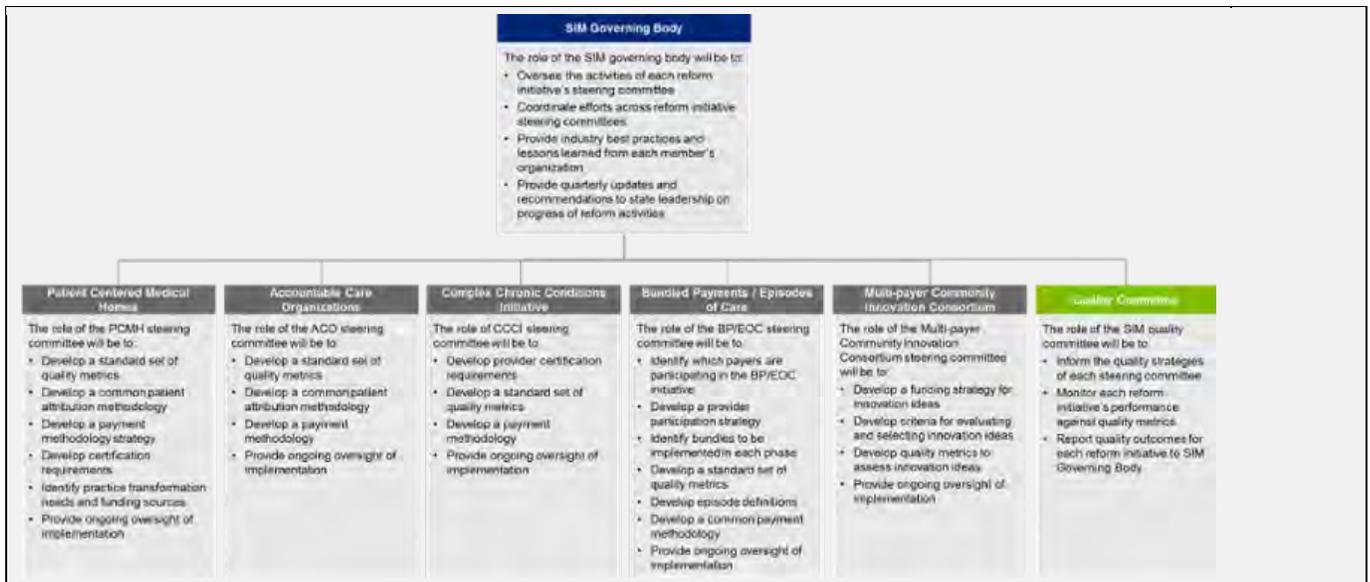
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49	Day 1 Core Elements Feedback - CCC
50	Day 2 Core Elements Feedback - CCC
51	Review CCC Rollout Strategy
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53	Day 2 CCC Rollout Strategy
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90	Multi-payer Innovation Consortium Implementation Roadmap
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REVIEW GOVERNANCE GRAPHIC

Description

Picture 1



DAY 1 GOVERNANCE FEEDBACK

Brainstorm Governing Body makeup



1. What stakeholder types would you like to see represented on the SIM Governing Body (e.g., providers, commercial payers, community organizations, etc.)?

1. Consumers
 - 1.1. Lay consumers
 - 1.2. LTSS/LTC consumers
2. Representation
 - 2.1. Representation across continuum/life span
 - 2.2. Rural health representation

- 1.20. RHCs
- 1.21. CMHC's
- 1.22. Dental
- 1.23. IDNs
- 1.24. Primary Care
- 1.25. Ambulatory providers
- 1.26. doctors/providers
- 1.27. Oral health
- 1.28. Behavioral health providers
- 1.29. Hospitals
 - 1.29.1. Hospital Leaders
 - 1.29.2. Hospitals
 - 1.29.3. hospitals
 - 1.29.4. Hospital CEOs and CFOs
- 2. Patients
 - 2.1. patients
 - 2.2. Lay consumers
 - 2.3. consumers and consumer advocates
 - 2.4. consumers
 - 2.5. Consumer advocates
 - 2.6. lay community consumers
 - 2.7. Consumers
- 3. Other Organizations
 - 3.1. employers
 - 3.2. University and Colleges with Health Professions Education Programs
 - 3.3. Universities
- 4. Provider Organizations
 - 4.1. Kentucky Physical Therapy Association
 - 4.2. KY HOME CARE ASSOC
 - 4.3. Ky Occupational Therapy Association
 - 4.4. Kentucky Hospital Association
- 5. Government
 - 5.1. public health
 - 5.2. DPH
 - 5.3. Government?
- 6. Payers
 - 6.1. Medicare, Medicaid , commercial payers
 - 6.2. Major health plans
 - 6.3. payors
- 7. Community Organizations
 - 7.1. community partners, social service agencies
 - 7.2. council on aging
 - 7.3. Community-based organizations
 - 7.4. public health professionals
 - 7.5. local PH officials
 - 7.6. community based org.
- 8. Minorities
 - 8.1. minorities
 - 8.2. consumer groups, not usually represented: rural, communities of color, immigrants, persons with disabilities, LGBTQ
 - 8.3. persons of low socioeconomic status
- 9. Health Leadership
 - 9.1. Small Rural Hospital Leaders
 - 9.2. leaders experienced in integrated care models
 - 9.3. FQHC Leadership

- 9.4. health related non-profit leadership
- 9.5. local health department directors
- 9.6. ACO Leaders
- 10. Other
 - 10.1. Narcotic Rx Programs
 - 10.2. rural health leaders
 - 10.3. Quality Improvement Organization
 - 10.4. 10
 - 10.5. payers, providers, employers
 - 10.6. pan participants
 - 10.7. Non-Profit stakeholders

TRANSITION TO DELIVERY SYSTEM AND PAYMENT REFORMS

Description

Picture 1



DAY 1 DEFINITIONS - PCMH

Obtain feedback on definition of each reform activity

3.1. NCQA certification does not ensure actual outcomes as PCMH.

3.2. As we pressure test this model, we should also focus on transparency and alignment in methodologies across payers. This can be an overarching theme (KY specific) that stresses aligned measures sets, patient attribution, and risk adjustment methods. Otherwise providers are stuck sifting through a lot of data and expending resources they don't have.

3.3. Is the definition a matter of formality?

3.4. PCMH activity adoption is more important than certification. Readiness surveys are available.

3.5. Require in order to receive any incentives by Ky payers...

2. Leverage a broad care team to coordinate physical, behavioral, and oral health needs

1. KY Specific Definition

1.1. Completely Agree that Ky specific definition is needed

1.2. We had discussions about what the KY definition would be -- more of a Patient Centered Medical Community. And just being accredited by organizations such as NCQA doesn't ensure quality or actual use of appropriate activities by a PCMH.

1.3. How differently will the Kentucky definition for PCMH be from the national NCQA accredited body? Or will it be different?

2. NCQA Standards

2.1. Why not just use the NCQA standard?

2.2. Adopting existing NCQA standards without reinventing the wheel is a good idea.

3. HIT

3.1. many PCPs can't comply with NCQA standards with their existing HIT and can't afford the augment to change the HIT

4. Evidence/Models

4.1. find KY models of this to build on

4.2. who chooses the evidence based models--there appears to be some disagreement as to which models are chosen

4.3. Do we have use cases to show the benefits of adoption?

5. Barriers and Required Changes

5.1. This may include some legislative changes (such as the 10% co-signature rule for PAs) and some policy changes already available but not utilized by some payers (direct access to physical therapy for musculoskeletal management and exercise prescription).

5.2. fix current barriers to making this happen - these have been discussed at previous workgroup mtgs

6. Use of Incentives

6.1. Determine how best to utilize community partners to meet this need. Incentives for primary care providers and PCMH's to collaborate with other community providers such as the school system, social workers and behavioral health providers as well as faith organizations to meet the community needs will be critical to maximize the use of existing resources and control costs.

6.2. define the incentives to change

7. Data Needs

7.1. What is the goal for this implementation in terms of savings, quality improvements, etc? What data is required to measure these goals and how will these be shared or monitored?

8. Care Team

8.1. I think #2 (Leverage a broad care team) is critical but I don't see it in our paper copy.

8.2. Interdisciplinary rather than multidisciplinary teams have proven effective with the medical component overseeing the care plan

9. Communication/Education

9.1. How does this really happen in the humanistic sense? We all know that there are aspects in care that are lost without face-to-face communication, it just seems that there are many ways for this team approach to go wrong if the team never meets in person and always communicates electronically. Will there always be f2f communications?

9.2. Have we thought about how we intend to educate patients about the PCMH model and advantages? There is some confusion regarding definitions in the provider community that need to be worked through before rollout.

10. Oral Health

10.1. better integration of oral health and other health services

10.2. Major challenge will be incorporation of oral health that has separate financing and delivery model, mainly outside of co-located primary delivery sites. Both payment and regulatory changes will be needed

10.3. Regarding oral health, NCQA standards are very early in development process. For SIM in Kentucky, my recommendation is Ky needs to develop a set of Ky. specific measures that incorporate the NCQA oral health standards as

these come on line.

11. Behavioral Health

11.1. IT is a good idea to try to integrate broad care team, but we have a lack of behavioral health professionals and they are not interchangeable

12. Other/Questions

12.1. Isn't PCMH more for chronic care rather than for all patients?

12.2. How will the PCP change their plan for the care of the patient based on social determinants?

12.3. Why do we assume that 1-5 are correct things to do? Is there data to suggest this is proper plan?

12.4. coordination required common systems

3. Increase the number of PCPs who adopt evidence-based PCMH principles in their practices

1. Cost

1.1. Consider the cost to PCPs of adopting a PCMH model

2. Other Provider Types

2.1. Specialists need to also be incorporated into this concept, as coordination between specialty care and PCP's are where care continuum breakdowns can occur. Promoting PCMH for PCPs is only half the battle.

3. Use of Incentives

3.1. Incentives/benefit design to promote PCP's to do PCMH-like activities.

3.2. Are there incentives to mitigate the increased risk of malpractice risk in the PCMH model?

3.3. Adopting evidence based principles is one thing meeting NCQA standards for accreditation is another. Providers need an incentive to start the process

4. Leverage Existing

4.1. PCMH models that are already up and running here such as Norton's already incorporate feedback and cross walks to specialists

4.2. Gain feedback from providers currently implementing the PCMH Model to avoid costly and unintended consequences or outcomes for Kentuckians and the healthcare system.

5. Measurement

5.1. How do you monitor and decrease the variation in the practice's effectiveness in implementing the PCMH model.

There is a difference in checking the boxes and truly adopting the model.

5.2. How would this be measured? How would you determine the baseline?

6. Other

6.1. Doesn't this imply the use of common technology? Change has to be monitored

6.2. I would like to see an emphasis on #3 and #5 as a starting point to for best practice in gaiting to the Triple Aim in the best practice approach to PCMH

4. Increase PCP focus on social determinants of health

1. Operations

1.1. How would this be done? What does this look like?

1.2. This is tied to payment reform and incentives

2. Other Provider Types / Team-base

2.1. Since we're leveraging a team approach, should the terminology refer to a PCP team rather than the individual PCP?

2.2. Agree with comment about care team. PCP's have very little time already so I'd encourage use of the full care team to meet this demand - also would encourage collaboration with existing resources.

2.3. This directly relates to #2 - broadening the team is essential as different providers have different expertise.

2.4. Are PCPs the best team member to focus on social determinants?

2.5. Use kyhealthnow goals and team based approach.

2.6. If this is more of a patient centered medical community, there will be providers in that community that will be appropriate to focus on social determinants.

2.7. Need to incorporate the use of mid-level and nursing staff as well as medical assistants to meet community demand

3. Other

3.1. I suggest adopting the WHO ICF Model (International Classification of Function, Disability and Health) to frame the whole person approach. The rest of the world does this and it will be a key component of the ICD-11 (which is currently in development). It intentionally focuses us on whole person health in the context of his or her individual environment personal factors and external environmental factors.

3.2. Need to provide solutions for providers when a social determinant is identified.

3.3. Considering the number of social determinants that KY ranks worst in, PCP's should already have a fair degree of

focus on this

5. Increase the number of Kentuckians choosing to receive their care through a PCMH provider

1. Access

- 1.1. ensure they are accessible to all so there is choice
- 1.2. Consider the access issues that this initiative may inadvertently cause.
- 1.3. Question -Are there enough number of primary physicians to leverage care?
- 1.4. doctor shopping by patients fragment care ... yet there are issue of access for some areas of the state to a PCMH

physician

2. Patient Education

2.1. How will this be accomplished? There is currently not a lot of patient education on who is PCMH certified and what that means for the patient

- 2.2. Educate Kentuckians regarding the benefits and potential savings by receiving care through a PCMH provider.

3. Payment

- 3.1. This must include economic incentives for providers
- 3.2. rather than just driving the patients choosing the care, how we are looking at payment problems for the providers

4. Other

4.1. Increasing the number of Kentuckians choosing to receive their care through a PCMH can only improve overall health care of patients.

4.2. I do not believe NCQA PCMH certification is a must but a practice must be doing those things that preventing ASC ER visits, keeping patients that were discharged from returning within 60 days, quality measure

- 4.3. Is there a baseline already established that we are working to increase by a certain percentage?

6. Other

1. Other Care Types

1.1. We also need to ensure that we have adequate dental care providers - think about how to increase the availability of providers - dentists, hygienists, other workforce option - mid levels?

2. Other Provider Types

- 2.1. Patient-centered Medical Neighborhood concepts will help bring the specialists along.
- 2.2. agree with #3

3. Workforce/Education

- 3.1. Help lay persons understand what the PCMH model is as implementation evolves.

3.2. We should not leave out the significant issue with KY's workforce challenges. Don't we need to include language that addresses the need to increase the number PCP's in KY?

4. Telecommunication

4.1. I strongly encourage the state to look at telecommunication connectivity across the state to enable utilization of electronic means to meet some of the rural communities and bring additional specialty resources - key is to ensure reimbursement for these services.

5. Other

- 5.1. We put a man on the moon in 1969, why can't something as simple as this work?
- 5.2. Why are we assuming PCMH are correct strategy? Is there data supporting this as best strategy?

DAY 2 DEFINITIONS - PCMH

Obtain feedback on definition of each reform activity

4. Other

- 4.1. have to share common technology
- 4.2. A broad care team will be vital to get the right patient, to the right health care provider at the right time.
- 4.3. 2 this is a concise statement - i like it but social ecological determinants should be included combine 2 and 4
- 4.4. PCMH should include social worker capability to provide resources and advocate for patients
- 4.5. combine this with 4
- 4.6. work on developing networks

3. Increase the number of PCPs who adopt evidence-based PCMH principles in their practices

1. Incentives

- 1.1. Are payment systems supporting and incentivizing PCMH values? need to align
- 1.2. ensure there are monetary incentives to be recognized as PCMH

2. Other

- 2.1. Detect who is / isn't. Insist on best practices
- 2.2. possibly to participate in Medicaid programs must achieve a level of PCMH
- 2.3. Who would support the IT infrastructure required for PCPs to do this?
- 2.4. Does the PCMH actually behave that way
- 2.5. Outcomes vs. "checking the box"

4. Increase PCP focus on social determinants of health

1. Community-based Services/Resources

1.1. Need to have resources lists by community; train providers on SDOH and how to interact with consumers about these issues; need to create incentives for providers to actually DO this; identify and remove barriers to providing support on SDOH. What SDOH will be included and why? Is there a feedback loop to inform policy changes?

1.2. Allow regional providers to bring community leaders to the forefront as the voice of rural/under-served populations, i.e., church leaders, to guide def. /governance of PCMH.

1.3. Have PCP partner with community based services, organizations, and non-profits to link patients to needed support beyond medical visits

1.4. Use of community based services

1.5. this should include identification of community-based resources like legal aid program

2. Payments/Incentives

2.1. who is going to reimburse primary care physicians who are already struggling from reduced payments to try to tackle social determinants of health

2.2. coordinating non-health care related funding with health care funding to address social determinants

2.3. healthcare services being expanded to include social determinants of health would have to include changing payments

2.4. Provide resources for PCP's to address socioeconomic determinants of health, for instance, social work and civil legal aid resources, and reimbursement for providing these services.

2.5. Who pays for the social services pieces...housing, employment, etc?

2.6. Including in Reimbursement this work - including the home visits, advocacy, social workers, etc

2.7. provide incentives

3. Consumer Literacy

3.1. Consumers will need understandable info in order to make this choice. need standards for consumer info and marketing

3.2. Improve health literacy

3.3. Improve mental health literacy.

4. Other

4.1. For example, a commitment to Kentucky having a warrant of habitability (we currently do not outside of the 4 counties and pieces of a few more) - so that people can have healthy homes in which to live to be able to become and stay healthy

4.2. Having PCPs focus on social determinants of health might place an undue burden and expectation on physicians that may not be trained to do this.

4.3. air quality and water quality standards, especially in eastern Kentucky

4.4. This should refer to the PCP office team and not just the PCP

4.5. MCO's must uniformly provide the quality metrics to patients

4.6. Don't you mean increase PCMH focus on social determinants of health?

4.7. Include discussion of the role that proper nutrition plays both in the formative years and as one transition through life

to the end of the life cycle

4.8. Provide PCP's with advanced training on geriatrics and aging. Our country is not prepared to handle the overwhelming amount of aging seniors.

4.9. legal services - medical legal partnerships with primary care/clinics/etc

4.10. make sure kynect links to other public benefits work well ... perhaps include consumer assistance with SNAP and other benefits in kynect contracts

5. Increase the number of Kentuckians choosing to receive their care through a PCMH provider

1. Agreement

1.1. agree

1.2. Agree- maybe make it part of the contracting with providers- PCMH providers be provider of choice when assigning members.

2. Patient/Provider Participation

2.1. Need effective engagement strategies.

2.2. Incent participation

2.3. Develop a health literate educational campaign to educate consumers on the benefits of PCMH and their options for receiving enhanced care

2.4. need to increase number of patients and families that recognize the importance of a medical home for care

2.5. Need engagement strategies that give providers incentive for improvement and moving towards greater risk

3. Other

3.1. need data to identify targets

3.2. We need a measure that is readily available

3.3. There are consumers right now who aren't able to be "accepted" by a primary care provider, so some sense of knowing if consumers truly have adequate networks (including that they are accepting new patients and actual minutes and access to transportation) with their health plans, and cooperation from the providers

6. Other

1. Resources/Reimbursement

1.1. Will there be funds available to help providers put appropriate IT infrastructure to be a PCMH?

1.2. Once the standards are developed, how will it be reimbursed?

1.3. Agree resources are needed to help providers establish PCMH and that reimbursement must support the model

2. Other

2.1. outcomes based improvements in quality

2.2. Call it the health home

2.3. Not about checking box, about changing process/activities to get best results. standards are not unknown, can be monitored and tracked

DAY 1 GOALS - PCMH

Obtain feedback on goals



1. Number of participating sites

1. NCQA

- 1.1. Will we require submission of NCQA documentation to ensure they are certified as a PCMJ?
- 1.2. What is the source? NCQA PCMH or others or all PCMH certifications.
- 1.3. Do we want to confirm that these sites are 'certified'?
- 1.4. And level of recognition...

2. Geography

- 2.1. the goal should indicate geographic dispersion if that's one of the things we're looking for

3. Provider Types

- 3.1. inclusive of different types of sites - inclusive of health system practices and FQHC's

4. Relation to Other Goals

4.1. The goals for numbers has to relate to improvements in care or quality or reduction in cost of providing care. Having these numbers on their own won't achieve the overall objective unless we can prove improvement in care, quality or reduction in cost.

- 4.2. Must increase the number of providers before we commit to increasing the number of participants

5. Other

- 5.1. Build the incentive and ramp up process x% in year one, y% in year 2 etc
- 5.2. Are there going to be state or regional resources available to those practices who may not have resources

(administrative, expertise) to assist in going through the process

2. Number of participating providers

1. Defined Provider Types

- 1.1. How will you count providers? DO you mean only PCP physicians or will other providers count
- 1.2. What is the definition of "provider"?
- 1.3. "provider" meaning clinician by area of specialty within primary care or subspecialty
- 1.4. Is this going to include only PCP's or other types of providers and will they be monitored by site?

2. Rural

2.1. is it more important to push PCMH providers in rural areas since those areas tend to have more access problems than those living in more metro type cities and healthcare/access to other responsibilities aren't such a barrier

3. NCQA

- 3.1. Again, what is the measurement source - NCQA, others, or all

3. Number of Kentuckians receiving care through a PCMH

1. Measurement/Outcomes

- 3.7. plan should provide for geographical reach, demographic reach
- 4. Other
 - 4.1. need provisions for cultural competence, language access
 - 4.2. Share success/failures, maybe collaborate among sites
 - 4.3. What are the quality metrics for a PCMH?
 - 4.4. Is the primary goal for systems integration to transform the system to PCMH only?

2. Number of participating providers

- 1. Specific Provider Types
 - 1.1. PCMH's should be well coordinated to have primary palliative care provider access as well as advanced palliative care referral capability i.e. hospice
 - 1.2. Does the PCMH include inpatient
 - 1.3. Participating providers including mental health, substance abuse counselors, case workers, etc.
- 2. Practices
 - 2.1. This should be practices not providers
 - 2.2. increase number of recognized practices
- 3. Other
 - 3.1. outcomes
 - 3.2. look at service requirement in PCMHs as a condition of medical training in Kentucky Medical Schools
 - 3.3. All providers who participate should achieve PCMH recognition
 - 3.4. additional burden placed on providers who already are dealing with many programs and reporting requirements
 - 3.5. Adequate payment will drive increase participation

3. Number of Kentuckians receiving care through a PCMH

- 1. Agree
 - 1.1. This goal seems more important than the number of sites or providers, because it doesn't have to be driven by that inherently
 - 1.2. Like this better than the number of sites and number of providers
 - 1.3. This would be the best of the three
- 2. Quality/Outcomes
 - 2.1. outcomes
 - 2.2. receiving quality care, not just receiving care
- 3. Other
 - 3.1. so much of this is about transportation and acceptance of new patients, it can't be discussed without discussing phone minutes and all poverty barriers, but it is relevant for those persons not in poverty also having the health insurance literacy to want this
 - 3.2. Have to track retention. Goal is one dimensional
 - 3.3. Initial visit, or ongoing care?
 - 3.4. How do we differentiate between Kentuckians signed up and Kentuckians actually receiving care??

DAY 1 GOALS - PCMH

Brainstorm new goals

6.3. Goals need to insure that providers are not overly burdened with administrative reporting options.

7. Utilization

7.1. Utilization of right person right task activities. Ex: If mental health is primary, early referral should be counted. If musculoskeletal -- quick referral to PT..

7.2. not only number of patients receiving care but are they utilizing the full benefits of the care coordination

7.3. Well visits or non-sick visits can translate into engaged benefic.

7.4. % of well or scheduled visits for benefit. and not just "sick visits"

8. Other Provider Types

8.1. How will Rural Health Clinics and FQHC's be incorporated into these strategies? They clearly meet a need for the Medicaid population as well as treating high incidence of chronic disease patients.

8.2. care coordination and community health workers

9. Advanced Primary Care/Team Approach

9.1. How are we going to use PCMH as the first step in the path toward advanced primary care? (CPC model, advanced primary care, etc.)

9.2. a metric to measure the team approach and inclusion of behavioral and oral health, as well as social determinants, into the PCP's approach

10. Other

10.1. Metric for attainment of the "triple Aim"

10.2. tele-health and virtual networking

10.3. sustainable progress

10.4. Do these previous goals include all of the goals suggested by the workgroups?

10.5. increasing the number of Kentuckians covered by insurance

10.6. Are there incentives for becoming a site during the early years of adoption? These incentives could be used to offset costs associated with converting practices to the PCMH model and also financial risks of participating in the model. These incentives only last for a short period (1-3 years).

10.7. require providers to include PCMH recognition levels in any signage or advertising

10.8. totally agree the IDT

10.9. Will the KHIE be used as part of this process?

10.10. Agree with modification and type of sites

10.11. have a registry of sites following Evidence based practices use the registry to do QI projects in future

10.12. improved access to care through geographic diverse area

DAY 2 GOALS - PCMH

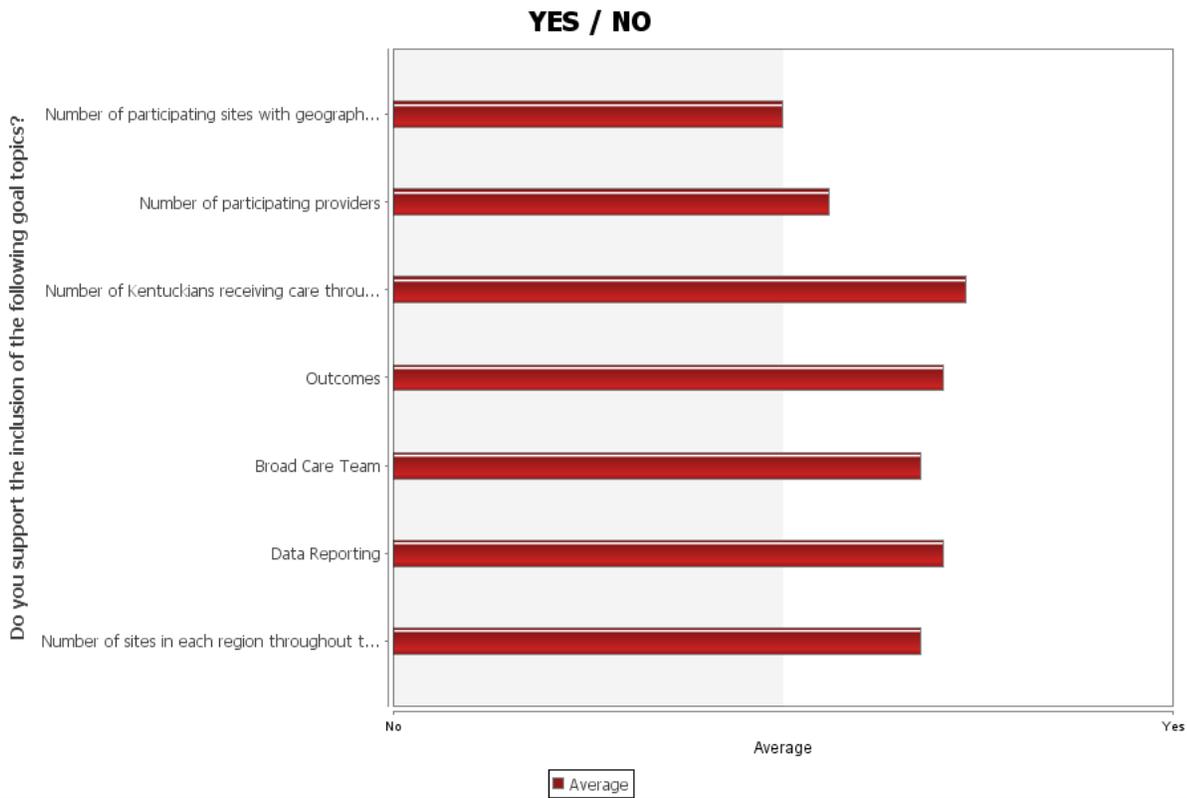
Brainstorm new goals



1. What other goal topics for PCMHs do you think should be included in the draft Value-based Health Care Delivery and Payment Methodology Transformation Plan?

- 1. Outcomes/Value-based
 - 1.1. Whole-Person outcomes
 - 1.2. outcomes vs threshold
 - 1.3. value measures
 - 1.4. provider specific quality outcomes
 - 1.5. quality outcomes
- 2. Payment
 - 2.1. payments reflecting quality of care - which doesn't have to be tied to outcomes - but not fee for service
 - 2.2. Payment based on performance
- 3. Care Coordination
 - 3.1. Coordination of care
 - 3.2. hand off and communication systems standards
 - 3.3. measure person's perception of their care coordination
 - 3.4. measure actual degree of coordination of care
- 4. Patients
 - 4.1. patient engagement
 - 4.2. patients must follow care to keep same level of coverage
 - 4.3. patient adherence
 - 4.4. patient satisfaction
 - 4.5. compliancy of patients
 - 4.6. community engagement, patient centered medical NEIGHBORHOOD
 - 4.7. Health Literacy
 - 4.7.1. Health literacy component - patient accountability
 - 4.7.2. Increased health insurance literacy for consumers
 - 4.7.3. moving from health insurance literacy to health literacy and a culture of health - including schools in value-based health care delivery, to build that culture of health
 - 4.8. Process goals--patient centered
 - 4.9. Patients assigned based on performance
- 5. Other
 - 5.1. goals related to health equity / demographic reach

	YES / NO	Avg.Score	+/-	Std Dev	No	Yes
1	Number of participating sites with geographic dispersion and types of sites	0.50	50.0%	0.50	17	17
2	Number of participating providers	0.56	49.7%	0.50	15	19
3	Number of Kentuckians receiving care through a PCMH	0.74	44.1%	0.44	9	25
4	Outcomes	0.71	45.6%	0.46	10	24
5	Broad Care Team	0.68	46.8%	0.47	11	23
6	Data Reporting	0.71	45.6%	0.46	10	24
7	Number of sites in each region throughout the state	0.68	46.8%	0.47	11	23



Do you support the inclusion of the following goal topics?	Any Comments
Number of participating sites with geographic dispersion and types of sites	1. geographic dispersement with types of sites
Number of participating providers	1. Disburse the certifications state-wide to provide for accessible sites and providers - non-traditional, including FQHCs and Public Health to be sure it is integrated to lower income communities and full access. 2. with a diverse geographic area
Number of Kentuckians receiving care through a PCMH	1. Provide full and state-wide access. 2. with increased compliance with treatment plan 3. with improved consumer experience

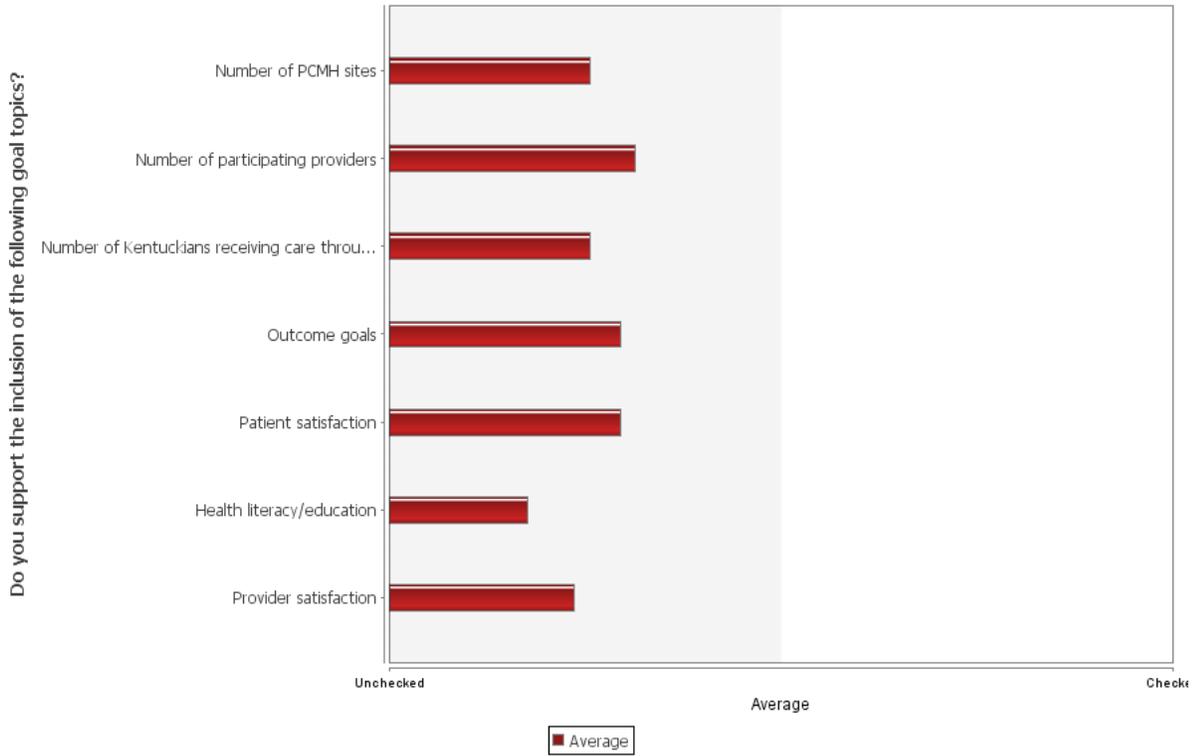
Outcomes	<ol style="list-style-type: none"> 1. What type of outcomes? Provider outcomes or patient outcomes? The patient should have a mechanism to provide feedback on the quality of care. 2. We should measure various incentives to help determine factors that increase participation and result in increased quality. 3. measure compliance with the care plan by the patient to increase quality outcomes 4. How will outcomes be measured?
Broad Care Team	<ol style="list-style-type: none"> 1. We have shortages of personnel, particularly in the rural areas. We should not mandate who must be on the care team 2. team needs to meet to review plan of care of each patient 3. As long as the team meets in person.
Data Reporting	<ol style="list-style-type: none"> 1. We need to identify what data is required for quality and measurements.
Number of sites in each region throughout the state	<ol style="list-style-type: none"> 1. There must be financial incentives to fund the infrastructure needed to have PCPs establish a PCMH throughout the state

DAY 2 YES/NO PCMH GOAL SUPPORT

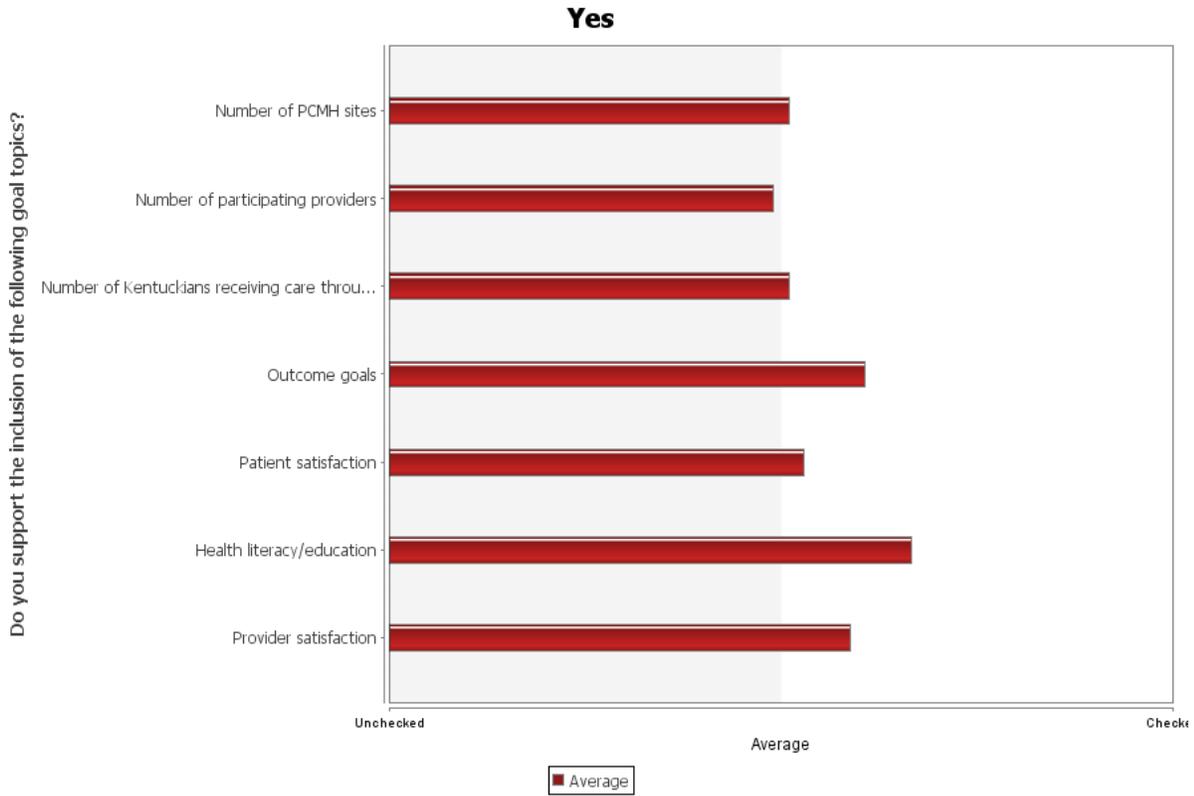
Votes Cast: 51 Abstained: 4

	Yes with Modifications	Avg.Score	+/-	Std Dev	Unchecked	Checked
1	Number of PCMH sites	0.25	43.6%	0.44	38	13
2	Number of participating providers	0.31	46.4%	0.46	35	16
3	Number of Kentuckians receiving care through a PCMH model	0.25	43.6%	0.44	38	13
4	Outcome goals	0.29	45.6%	0.46	36	15
5	Patient satisfaction	0.29	45.6%	0.46	36	15
6	Health literacy/education	0.18	38.1%	0.38	42	9
7	Provider satisfaction	0.24	42.4%	0.42	39	12

Yes with Modifications

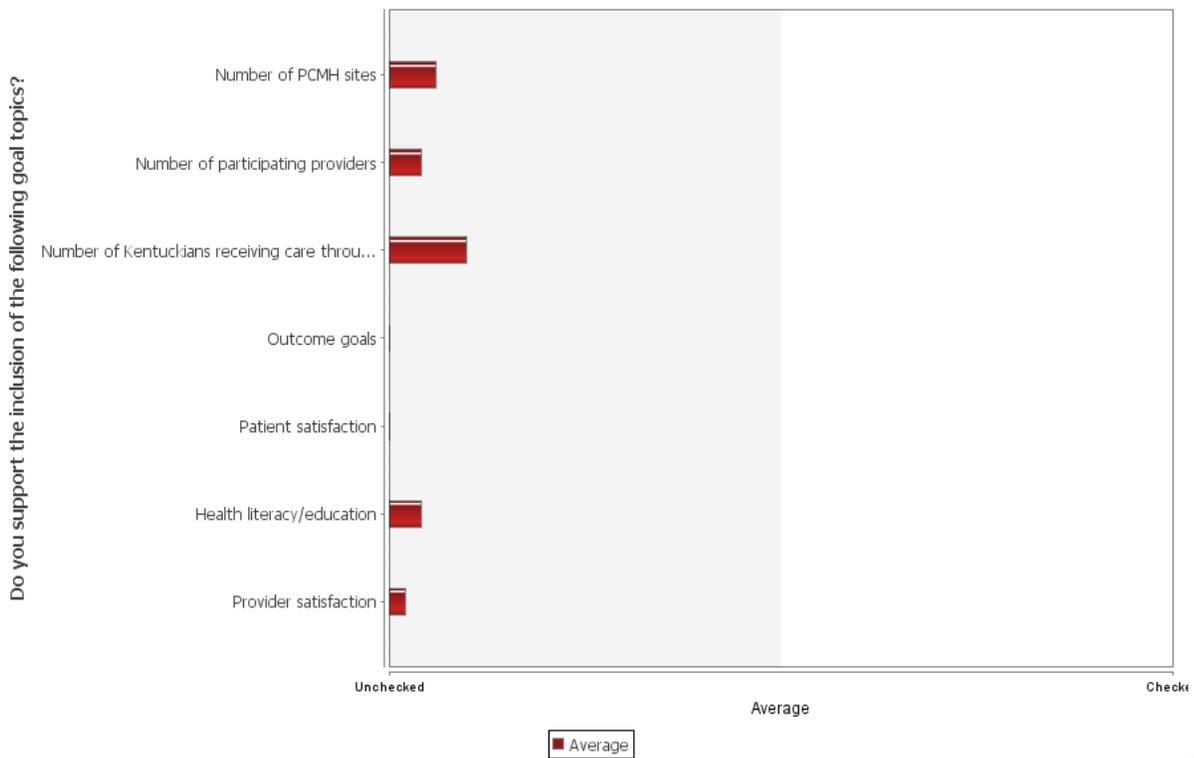


Yes	Avg.Score	+/-	Std Dev	Unchecked	Checked
1 Number of PCMH sites	0.51	50.0%	0.50	25	26
2 Number of participating providers	0.49	50.0%	0.50	26	25
3 Number of Kentuckians receiving care through a PCMH model	0.51	50.0%	0.50	25	26
4 Outcome goals	0.61	48.8%	0.49	20	31
5 Patient satisfaction	0.53	49.9%	0.50	24	27
6 Health literacy/education	0.67	47.1%	0.47	17	34
7 Provider satisfaction	0.59	49.2%	0.49	21	30



No	Avg.Score	+/-	Std Dev	Unchecked	Checked
1 Number of PCMH sites	0.06	23.5%	0.24	48	3
2 Number of participating providers	0.04	19.4%	0.19	49	2
3 Number of Kentuckians receiving care through a PCMH model	0.10	29.7%	0.30	46	5
4 Outcome goals	0.00	00.0%	0.00	51	0
5 Patient satisfaction	0.00	00.0%	0.00	51	0
6 Health literacy/education	0.04	19.4%	0.19	49	2
7 Provider satisfaction	0.02	13.9%	0.14	50	1

No



Do you support the inclusion of the following goal topics?	Any Comments
Number of PCMH sites	1. Location of sites
Number of participating providers	
Number of Kentuckians receiving care through a PCMH model	1. retention 2. long term investment in increasing overall health, not just on a patient list
Outcome goals	
Patient satisfaction	
Health literacy/education	
Provider satisfaction	1. or satisfaction with provider

DAY 1 CORE ELEMENTS FEEDBACK - PCMH

2. Community Resources
 - 2.1. Yes a way to avoid duplication with community resources so they will remain in the community the value of care coordination and not duplication
 - 2.2. These additional providers should be part of the patient centered care community
 - 2.3. We need to ensure that there are adequate community resources, it will do provider and patients no good to identify a need that cannot be filled.
3. Primary Care Coordination
 - 3.1. Needs to be able to maintain continuity with PCP office
 - 3.2. Coordination of public health and primary care is long overdue--need to break these silos down
4. Operations
 - 4.1. This sounds good, but what does it really mean? How would the practices do this?
 - 4.2. Who will compile a list of all community resources?
5. Funding
 - 5.1. Most, if not all, community organizations will also be looking for funding to cover their costs for participation. Need an ability to access funding for program development, either through a grant program or some other form.

3. Develop multi-payer PCMH support by aligning PCMH compensation and measures across all payers.

1. All Payers/Payer Alignment
 - 1.1. Must be all payors
 - 1.2. It is imperative that this work includes ALL Payers
 - 1.3. Align payor measures absolutely. Align payor compensation is a different story...
 - 1.4. Need payors first to get providers to make the change
 - 1.5. Strongly encourage a Steering Committee with all major payors and encourage consistent adoption of basic practices.
 - 1.6. Must be all payers, and must occur first for there to be provider buy-in.
 - 1.7. Need to stop payors each having different methods and policies which increases provider administrative burden
 - 1.8. Must be all payers!
2. Steering Committee
 - 2.1. Will Steering Committee set policy or be advisory only?
 - 2.2. How will this be operationalized? Weekly meetings? Mandates on transparency?
3. Data/Timeliness
 - 3.1. Need to receive data in timely manner and that provides insight on action
 - 3.2. Data needs to be timelier. 2 year old data is useless data
4. Payment Processes
 - 4.1. PCMH is more time consuming appointments therefore less patients in a day, compensation from the insurance companies will have to reflect otherwise, providers will not buy in because of the potential income loss
 - 4.2. Be sure payment systems, including publicly funded payment systems are updated timely and with flexibility to allow for varying compensation methods and incentives. This has historically been a problem in the State Medicaid system and Medicare.
 - 4.3. Will Medicaid increase its compensation levels commensurate with other payors?
 - 4.4. Just because you have a PCMH certification does not mean your patient outcomes are good. Payment should be based on outcomes and not certification alone.
5. Agreement/Priority
 - 5.1. Yes this may be a way to also increase the number of providers participating
 - 5.2. this needs to happen first
 - 5.3. Essential for care coordination
6. Evidence-based
 - 6.1. learn from CPC examples in the US and improve on best practice for Kentucky

4. Encourage employers to promote PCMH primary care for covered employees.

1. Agreement
 - 1.1. YES!
 - 1.2. Agree
2. Encouragement
 - 2.1. "Encourage" is vague. Is there a better term?
 - 2.2. How will you promote this with payers within the state? Payers will vary in willingness to encourage PCMH to

employers.

2.3. agree with changing the vague ness of encourage

3. Value to Employers

3.1. Absolutely with accurate and understandable materials for employers to use in promoting PCMH. They must understand it and the benefits associated with the PCMH.

3.2. any incentive to have this on site for large employers

3.3. Encourage employers to change benefit structure to support PCMH providers.

3.4. I think this will viewed as an intrusion by employees who want to choose their physician

3.5. Demonstrate the value of PCMH to employers....then they will come

4. Network/Access

4.1. Consider the potential access issues.

4.2. some avoid narrow network philosophy

5. Prevention

5.1. Including prevention

5.2. Start with prevention awareness again kyhealthnow.

5.3. PCMH would be of great benefit here due to the focus on PREVENTIVE. This can lower future cost drastically

5.4. Prevention and health promotion/wellness are also key to this.

5. Measure the effectiveness of transitions of care within the PCMH.

1. Agreement

1.1. agree

1.2. Agree! Data driven

2. Transparency

2.1. Transparency is critical for success. Health plans and the Cabinet have all the claims data for their enrollees but providers do not. To enable us to be successful, information must be communicated by and with both parties in a timely fashion to enable change.

2.2. Feedback is vital to providers to measure the effectiveness of transitions of care. Transparency among providers is good feedback

2.3. Agree with transparency, with timely and ease of transition.

3. Defined Transitions

3.1. extremely broad - clear definitions of what will be measured will be necessary

3.2. what/which transitions? define

3.3. Define transitions to include bi-directional. In other words, don't let transition management result in greater referral to inpatient options when outpatient or self-management would be even more appropriate. Example -- joint replacement... instead of following the transition from post-op, why not follow from diagnosis of djd and see if we can prevent the replacement

3.4. include easing the use of SCHOOL BASED health care - how to be collaborative between school based and other providers in the community

4. Operations

4.1. How would this be done? More details are needed

4.2. Will the measurement be by the PCMH or an external; evaluator?

4.3. Will there be a method of sharing payment for transition of care providers?

5. Other

5.1. Our guiding principles do not address the need for coordination of care across the continuum. This core element highlights the critical nature of making successful care transitions across the care delivery system. I believe we should consider addressing the issue of continuity in our guiding principles for the plan and QI measure development.

5.2. have to control quality and adherence

5.3. What can be done to encourage participation from other providers to notify PCMH of admissions and discharges and participate in discharge planning?

5.4. Essential for Triple Aim.....identify needs, goals and objective in engagement of primary care, specialists, patients and the partners in the eco system

6. Develop a targeted consumer education and communication strategy.

1. Agreement/Importance

1.1. Definitely needed. Polls show consumers don't know what PCMH is

1.2. Much needed.

community service and resource providers.

1. Community Health Workers

- 1.1. include community-based community health workers
- 1.2. need to have a primary coordinator, should be CHW or peer specialist from the community and familiar with community resources and social context
- 1.3. and specific ways that we will support the community health worker's time, a way to measure efficacy and impact on individual and population health
- 1.4. reimbursement for community health workers
- 1.5. community health workers

2. Agree

- 2.1. agree
- 2.2. Absolutely - including social factors, social work, piecing together economic stability
- 2.3. Necessary to meet the needs of persons especially those living with chronic diseases

3. Additional Provider Types/Additional Areas of Care

- 3.1. With a holistic view: physical, mental, emotional, volitional, vocational, etc.
- 3.2. Include civil legal aid
- 3.3. Include certification standards and have patient navigators.
- 3.4. Mental Health Care

4. Other

- 4.1. Education is needed regarding available community resources
- 4.2. Make sure resources directly address health issues or chronic problems specific to a patient's family members
- 4.3. include care coordination case management
- 4.4. risk losing focus on the main objective if it becomes too broad
- 4.5. Use quality and time as a measure. i.e. waiting 9 months at the VA
- 4.6. Link multiple service provider types and inventory services provided to prevent those falling through the cracks

2. Expand the reach of PCMHs to coordinate with community programs and resources.

1. Technology

- 1.1. shared technology
- 1.2. With technology, work to increase access to outcomes data.
- 1.3. Telehealth & Teledentistry
- 1.4. health information technology -
- 1.5. electronic connectivity

2. Coordination

- 2.1. this is the most important piece of coordinated care to guide patients to the resources they need to be compliant and able to stay healthy
- 2.2. Coordination does not necessarily mean access to community programs and resources
- 2.3. Convene regularly to share and exchange patient experiences and ways to best address barriers. Include community members and patients in these meetings.
- 2.4. include partnership -- coordination may not be enough to provide community resources to patients when needed
- 2.5. Coordination of patient centered care is important with patient choice related to issues around complex chronic conditions
- 2.6. PCMH need to have reach and involvement with advanced directives and planning for end of life conversations which are difficult but needed to understand what matters most in the end to patients.
- 2.7. Form strong partnerships and COMMUNICATE
- 2.8. coordinate using HIT - encourage and reward use of available resources that allow interoperability
- 2.9. Need for shared care plan

3. Other Community Relationships

- 3.1. Build incentives for community resources outside of the medical profession to engage
- 3.2. Local community initiatives and programs need to be supported.
- 3.3. Legal services! MLP! Medical legal partnerships!
- 3.4. Promote a vision of local community-based stakeholder councils
- 3.5. Many communities have health coalitions - think of ways to partner with existing groups not developing new ones for community resources
- 3.6. Who is paying for community programs and resources?

- 3.7. There needs to be an increase with PCMHs and community programs
- 3.8. Partner with economic development and criminal justice champions
- 4. Other
 - 4.1. yes this requires training of providers
 - 4.2. make sure there are incentives or reasons for the community to work together, maybe potentially negative consequences for lack of willingness to work with others across the continuum
 - 4.3. Make sure community programs and resources include support for family members
 - 4.4. Huge nebulous area of focus; how do you plan to refine this?
 - 4.5. barriers to health are real and are far outside of a doctor's office, addressing those barriers as a part of our health system seems to be a baseline necessity for changing the health of Kentuckians
 - 4.6. Common database to refer patients to needed social services...getting gas turned on, paying an electric bill, etc.
 - 4.7. Holistic view of care team = exactly. Health = a lot of pieces, including housing and economic stability.

3. Develop multi-payer PCMH support by aligning PCMH compensation and measures across all payers.

- 1. Agree
 - 1.1. Agree and require data be shared back with providers
 - 1.2. Agree- but require payers to share quality data with providers and care teams
 - 1.3. In a timely manner.
 - 1.4. This is needed to drive substantial change.
- 2. Technology
 - 2.1. Must have payers full participation and effort in data exchange
 - 2.2. shared data / records
 - 2.3. Electronic health records
- 3. Other
 - 3.1. multi payer PMHC, if standardized, would reduce some of the burden on providers
 - 3.2. We must discipline ourselves to collaborate with others, even if they are out competitors
 - 3.3. payers may have national template
 - 3.4. Ensure compensation for activities that improve health through the PCMH, even if not delivered by a typical health profession (i.e. law).
 - 3.5. practices need to have a high proportion of their payers in order to change
 - 3.6. Community Chronic Disease management
 - 3.7. so much case management
 - 3.8. payers are the driver for so much of the care provided - standardizing payments would help theoretically

4. Encourage employers to promote PCMH primary care for covered employees.

- 1. Agree
 - 1.1. yes
 - 1.2. how about require
- 2. Financial Incentives
 - 2.1. Provide financial incentives for employee participation.
 - 2.2. Show them their ROI
 - 2.3. Develop a method to demonstrate the cost effectiveness of the PCMH model to business leaders
- 3. Encouragement of Others
 - 3.1. Encourage medicaid to promote PCMH
 - 3.2. Encourage employers and Medicaid
 - 3.3. Workplace initiatives with incentives will be able to demonstrate immediate effectiveness of PCMH.
 - 3.4. You need to keep in mind that many employers are self-insured. How are you going to promote this?
 - 3.5. Need to educate employers, who seem to lack knowledge of health resources available in the first place

5. Measure the effectiveness of transitions of care within the PCMH.

- 1. How do you measure effectiveness of transitions of care???
 - 1.1. Readmissions
 - 1.2. duplicate services
 - 1.3. ED visits
 - 1.4. Medication reconciliation

- 1.5. improved outcomes
- 1.6. is anyone healthier
- 1.7. Reduction in ambulatory sensitive condition admissions
- 1.8. improved readmission and mortality rates
- 1.9. readmissions
- 1.10. Define the specific components of transition of care being measured.
- 1.11. Does anyone know how to do this or has this been effectively done anywhere else?
- 1.12. look to the aging community for good models on transitions in care
- 1.13. Difficult measurement
- 2. Technology
 - 2.1. This is a critical portion and awareness of staffing and technology use is needed.
 - 2.2. Dashboards and feedback to the whole team
- 3. Agree
 - 3.1. agree
 - 3.2. Agreed. With increasing complex chronic conditions this is critical for understanding the needs of patients.
- 4. Other
 - 4.1. define measurements early on
 - 4.2. for juveniles, this should include transitions from juvenile justice programs, settings
 - 4.3. Support programs which provide on-going coordinated care into the home for PCMH patients at complex level

6. Develop a targeted consumer education and communication strategy.

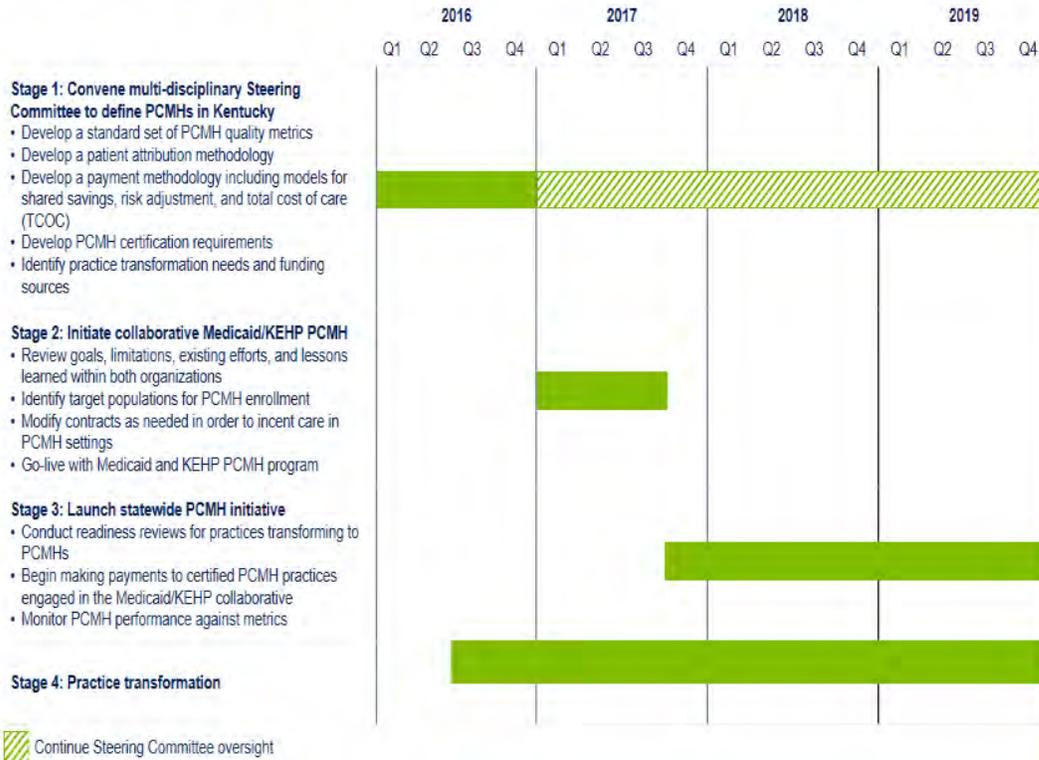
- 1. Provider Education
 - 1.1. need to educate providers as well
 - 1.2. providers and front line staff at care sites need training on health communication and health literacy
 - 1.3. Do you put this burden on the providers
- 2. General Education Comments
 - 2.1. involve patients/consumers in developing
 - 2.2. Can we test the consumers on what they know
 - 2.3. promote education components with school health services
 - 2.4. Cultural Competency
 - 2.4.1. Consumer communication must meet health literacy levels of the state. Include info in multiple languages and with varying messaging strategies. Disseminate to a wide variety of community partners
 - 2.4.2. consumer education needs to be culturally appropriate
 - 2.5. Make clear roles and identify who is responsible for education
 - 2.6. consumer education and communication is important
- 3. Specific Education Needs
 - 3.1. oral health needs to be part of the education
 - 3.2. Wellness
 - 3.3. Agree concerning the ER usage- need to educate patients as to what the other options are
 - 3.4. Target education in the ER setting.
- 4. Other
 - 4.1. Around what? PCMH and encouraging folks to sign up?
 - 4.2. Analytics to guide engagement
 - 4.3. Around the PCMH model to encourage participation? Yes - will probably need to incentivize!
 - 4.4. should we focus on engagement, activation vs education and communication
 - 4.5. Use a motivational interviewing approach which helps the person address his or her concerns
 - 4.6. aggressive concentration of the top 5% of users who costs the majority of costs

REVIEW PCMH ROLLOUT STRATEGY

Review slide

PCMH Rollout Strategy

PCMH Rollout Strategy

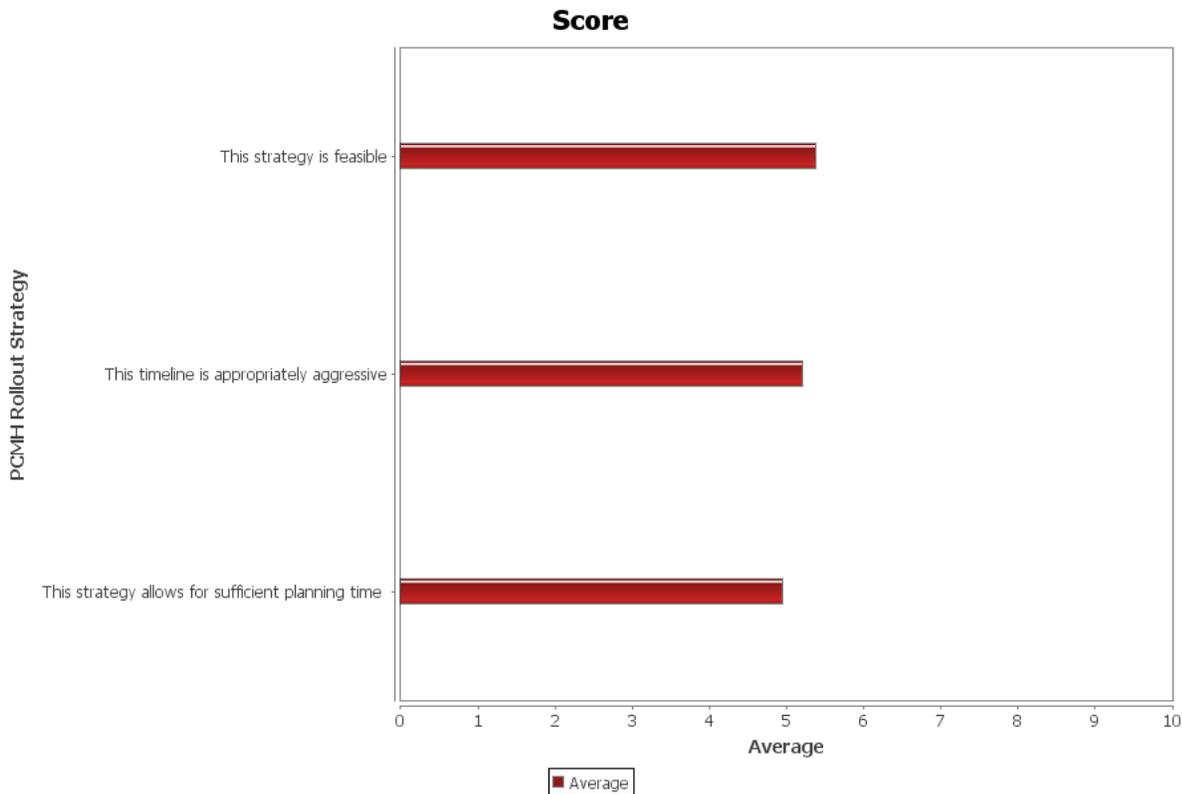


DAY 1 PCMH ROLLOUT STRATEGY

Assess Feasibility

Votes Cast: **44** Abstained: **1**

Score	Avg.Score	+/-	Std Dev	Min	Max
1 This strategy is feasible	5.39	27.3%	2.73	0.00	10.00
2 This timeline is appropriately aggressive	5.20	28.3%	2.83	0.00	10.00
3 This strategy allows for sufficient planning time	4.95	29.8%	2.98	0.00	10.00



PCMH Rollout Strategy	Any Comments
This strategy is feasible	<ol style="list-style-type: none"> 1. This strategy is feasible as it stands on its own but not as a part of a 5 module plan. 2. Depends on the definition of PCMH and if you change from National NCQA to something different. 3. The PCMH should be the first step to transformation and focus of the SIM. The plan goes in way too many directions. Providers should be able to focus on one thing. 4. Didn't see where feedback was gathered. Have to anticipate mid-course corrections 5. PCPs need to be get incentives FIRST or you won't have any PCMH for consumers to attend 6. There needs to be much more time to gather input from affected providers. What do the physicians across the state think they can do and do they support this? 7. Consider allowing different providers to select one or more of the models but consider not requiring all methods of adoption. Would also give the Cabinet an ability to determine success of each of the models.
This timeline is appropriately aggressive	<ol style="list-style-type: none"> 1. Way too aggressive based on actual experience in other states 2. I think this will be aggressive to properly engage and train providers in addition to gaining their collaboration to move forward. 3. Is stage 1 has a lot of foundation work that would be

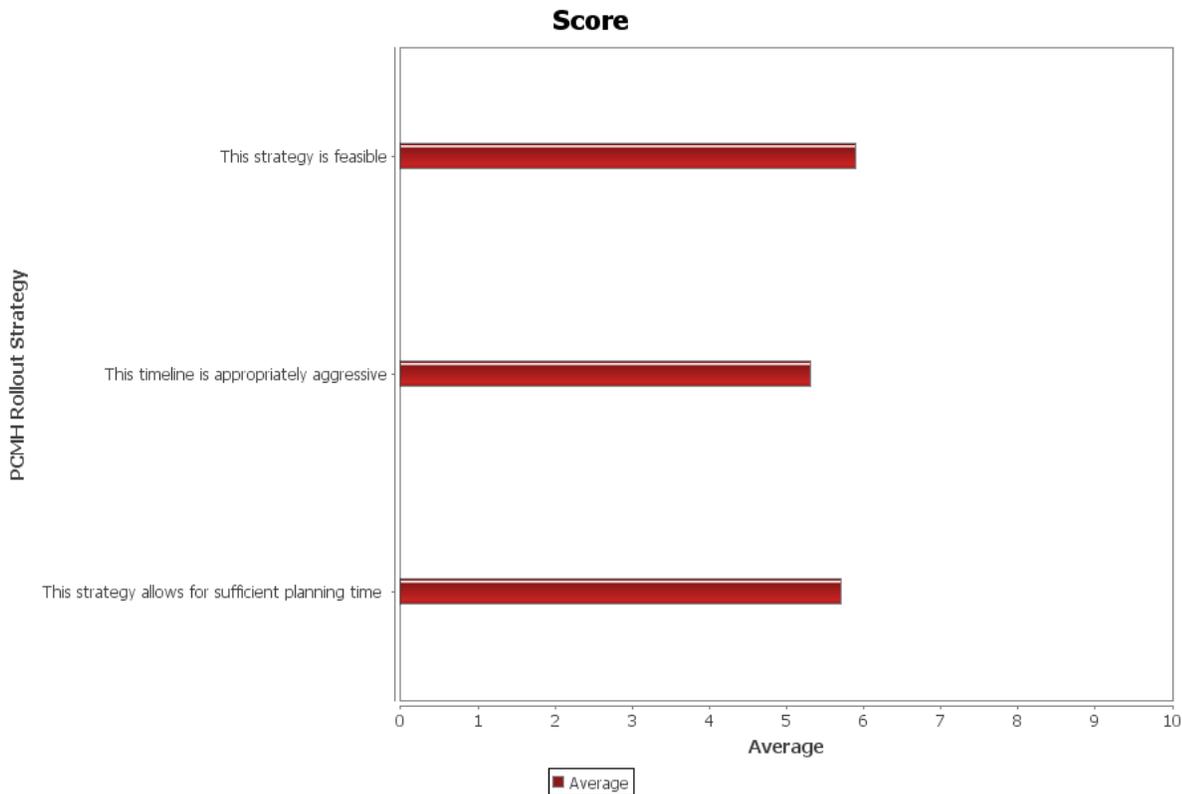
	<p>difficult to complete in, can be done based on regional experience</p> <p>4. It's aggressive for some parts of the State. However, you could roll out different pilots in different geographic areas. For example, Louisville, Lexington and Northern KY probably have more infrastructure already in place merely given the size of the market and the health care providers there.</p>
This strategy allows for sufficient planning time	<p>1. Need to be sure payment systems are well planned and ready to go without delays in payments for providers. This could impact providers greatly and the Commonwealth has a history of implementing projects or systems before they are ready to go and working.</p> <p>2. No, more time is needed</p> <p>3. need remediation time before roll out</p> <p>4. This should have been presented much earlier. Like other issues in SIM, it appears decisions are being made without everyone's input.</p> <p>5. no</p> <p>6. The timeline will be challenging.</p> <p>7. These are extremely aggressive changes to an extremely complicated system. between politics and the complexity of the system it will be a challenge</p>

DAY 2 PCMH ROLLOUT STRATEGY

Assess Feasibility

Votes Cast: 49 Abstained: 6

	Score	Avg.Score	+/-	Std Dev	Min	Max
1	This strategy is feasible	5.90	27.4%	2.74	0.00	10.00
2	This timeline is appropriately aggressive	5.31	29.4%	2.94	0.00	10.00
3	This strategy allows for sufficient planning time	5.71	29.8%	2.98	0.00	10.00



PCMH Rollout Strategy	Any Comments
This strategy is feasible	<ol style="list-style-type: none"> 1. Good to start with Medicaid and KEHP. 2. It's a problem for practices if all payers don't move at the same time - not Medicaid first 3. I am concerned with some of the reports about PCMH results are not the answer to improved outcomes and care 4. Where is the money to fund this? 5. I think it is taking too long. Organizations in the state are already PCMH recognized- let them pilot while the others are receiving recognition
This timeline is appropriately aggressive	<ol style="list-style-type: none"> 1. I believe it needs to be more aggressive 2. Some payers are already moving. do some integration first 3. hard for a practice to shift if majority of population is already moving 4. KPCA has been doing PCMH model for 3 years 5. efforts going on have not been easy 6. UK REC timeline is 18 months with practices 7. need to take into account provider/practice infrastructure
This strategy allows for sufficient planning time	<ol style="list-style-type: none"> 1. I'm not sure I understand the planning time vs the implementation/testing timeline. Testing grants are 4 years - but when would that start and the timeline within that matters more than that 4 year chunk

DAY 1 PCMH ROLLOUT STRATEGY

Benefits and challenges of each stage and overall

PCMH ROLLOUT STRATEGY	Benefits	Challenges
Stage	Benefits associated with this stage and its components	Challenges associated with this stage and its components
<p>1.PCMH Stage 1: Convene Multi-disciplinary Steering Committee to define PCMHs in Kentucky</p>	<ol style="list-style-type: none"> 1. Need to consider the multi-disciplinary part carefully 2. Feel this is very important to set the standards and quality metrics which will be the foundation for the whole process 3. critical first step 4. Develop provider and patient education model 5. make sure this includes a diverse mix of provider, payers, CONSUMERS AND ADVOCATES FOR VULNERABLE GROUPS 6. Will help to improve care and outcomes. 7. This should be attainable by most providers across the state. 8. Needs to begin now 9. Foundation for future work in PCMH, ACO, etc. 10. 2. develop patient satisfaction measures 11. all important...especially multi-payer payment methodology focused on shared quality metrics that take into consideration shared savings, risk adjustments and total cost of care 12. I feel the timeline should be reversed. More years for planning and checklist preparations and gap analysis and less time for actual implementation. More planning time should mean a smoother implementation 13. one set of quality measures for all 	<ol style="list-style-type: none"> 1. Funding <ol style="list-style-type: none"> 1.1. Need to figure out the funding of transformation before we can gain significant momentum with providers 1.2. funding provided by??? 2. Steering Committee <ol style="list-style-type: none"> 2.1. will depend on the makeup of the steering committee 2.2. Need entire stakeholder community engaged and involved 2.3. Need to be sure the entire continuum of care is represented on the steering committee 2.4. Composition of the steering committee is key 3. Data Needs <ol style="list-style-type: none"> 3.1. Do we really have the data necessary to develop a payment methodology including shared shavings, risk adjustment and total cost of care accurately and in a timely, ACTIONABLE manner? 3.2. providing actionable data to providers is as if not more important that analysis on the back end 4. Planning Time <ol style="list-style-type: none"> 4.1. Plan well, carefully and systematically. A well-planned strategy and roll out will result in better implementation. 4.2. One year is not enough time to get involvement statewide of the physicians, align

- 14. Work is happening in this state already
- 15. Develop/ focus patient satisfaction measures.
- 16. KY should be able to achieve standards given the small number of payers in the state compared to other states

- metrics among payors, and develop infrastructure needed in practices throughout the state.
- 5. Education
 - 5.1. need more education on the side of providers as to benefits to their patients, but also to them
- 6. Measure Development
 - 6.1. Metrics need to be developed at this stage so PCMHs will know how they will be measured in Stage 3!
 - 6.2. Getting everyone to agree on the standards and payments tied to them in a manner that does not reduce quality or accessibility.
- 7. Other
 - 7.1. Getting payers on board from the beginning
 - 7.2. DO WE REALLY WANT A STATE AGENCY RUNNING PCMH RECOGNITION?

2.PCMH Stage 2: Initiate collaborative Medicaid/KEHP PCMH

- 1. implement patient experience model and obtain feedback and measures
- 2. Will provide consistency in care for Kentuckians.
- 3. all dependent on positive stage one
- 4. collaborative approach important
- 5. Kentuckians have a history of being able to collaborate.

- 1. Contracting
 - 1.1. Need more time to roll out specifically with contracts
 - 1.2. Contracting takes time.....
- 2. Other
 - 2.1. A better definition of an ACO needs to be first established.
 - 2.2. Uncertain as to how much real collaboration you're going to get here particularly in the KEHP sector
 - 2.3. Challenges may arise around IT infrastructure to be successful at this level.
 - 2.4. If it takes 12-18 months to become certified then more time is needed for sites that have not started.
 - 2.5. LEARN FROM

		<p>OTHER STATES TO AVOID MISTAKES AND UNINTENDED CONSEQUENCES</p> <p>3. Role of Medicaid/MCOs</p> <p>3.1. Its optimistic to think that Medicaid payment will be ready by now</p> <p>3.2. Are the MCOs all going to adopt the same policies and increase reimbursement needed to support this?</p> <p>3.3. Need to plan and implement carefully and consistently across MCOs. This will impact providers greatly if not implemented consistently and fairly.</p> <p>3.4. Medicaid is now where near ready to roll this out to all MCOs.</p> <p>4. Expansion</p> <p>4.1. Expand statewide in one year?</p> <p>4.2. The plan moves from stage 1 into 2 without time for remediation of issues discovered in stage 1</p>
<p>3.PCMH Stage 3: Launch statewide PCMH initiative</p>	<p>1. governance and monitoring of measures and goals</p> <p>2. Patient engagement and communication, patient experience goals and measures,</p>	<p>1. Readiness</p> <p>1.1. What happens to people who are not ready?</p> <p>1.2. assumes alignment between targeted populations and readiness of providers</p> <p>2. New Administration</p> <p>2.1. As 2016 is a major election year, will this impact progress in gaining the necessary support to launch?</p> <p>2.2. what will happen to this with new governor and new administration</p> <p>3. Other</p> <p>3.1. Encourage in what way - benefits and data will be necessary.</p>

<p>4.PCMH Stage 4: Practice Transformation</p>	<p>1. Agree that transformation initiatives need to precede rollout.</p>	<p>1. Operations 1.1. Need details of what this includes 1.2. Have we given considerations on the SGR repeal and MACRA? This is a lot of transformation for practices to undertake by a 2019 penalty deadline. 1.3. Need the incentives in place to allow practice to invest in appropriate resources. 1.4. Need to consider what policy and regulatory changes will need to happen first</p>
<p>5.PCMH Overall</p>	<p>1. Healthier communities in the Commonwealth!!</p>	<p>1. Evidence-based 1.1. This should be the focus of the SIM, but KY should learn from the demonstrations and existing practices that have put in PCMH in expanding this initiative</p>

DAY 2 PCMH ROLLOUT STRATEGY

Benefits and challenges of each stage and overall

<p>PCMH ROLLOUT STRATEGY</p> <p>Stage</p>	<p>Benefits</p> <p>Benefits associated with this stage and its components</p>	<p>Challenges</p> <p>Challenges associated with this stage and its components</p>
<p>1.PCMH Stage 1: Convene Multi-disciplinary Steering Committee to define PCMHs in Kentucky</p>	<p>1. Need to have alignment across payers and self-funded employers which will take time, so this step is important if alignment can be achieved 2. Making sure that all constituencies are well-represented without making the committee too large to be effective 3. Committee members may change the direction of existing</p>	<p>1. Correct people on steering committee 1.1. Getting good/real/lay consumer voices 1.2. having the right people on the bus 1.3. consolidation of steering committees 1.4. make sure consumer voices, especially of more vulnerable populations, are represented 1.5. Having the right kind of leadership - where decisions are made, consensus may not work here</p>

progress
 4. Standardization of approaches and measurement
 5. Getting input from multiple key stakeholders
 6. This is vital for success to have broad group
 7. Good to have broad rep as in kynect advisory bodies
 8. Diversity of knowledgeable members will be important to get patients the right provider at the right time.

1.6. Getting all the necessary stakeholders at the table
 2. Time Commitment
 2.1. the people who would need to be a part of this process don't have the time or flexibility to be at daytime meetings in Frankfort, including those voices, from the whole state
 2.2. Having enough stakeholders and the right ones - including the busy providers and busy patients, not just administrators
 2.3. Not sure that providers will take time out of their practice to serve on this
 3. Other
 3.1. Direction of initiatives may change
 3.2. The group will need a defined time line to get this work done. I can see extended discussions without a decision.

2.PCMH Stage 2: Initiate collaborative Medicaid/KEHP PCMH

1. Have opportunity to impact a large group of individuals
 2. Good opportunity to trial with a large segment of the population
 3. good opportunity, easier to measure possibly
 4. Large group of consumers and providers to draw data from - which there is access to.
 5. Focus on low-income population outcomes
 6. Standardization of quality measures
 7. Good to point state purchasing power in the same direction

1. Different Entities
 1.1. Medicaid and KEHP are different types of entities subject to different rules and limitations. It will be challenging to mesh the different rules and limitations for collaboration purposes.
 1.2. Different types of entities.
 1.3. Difficult to compare populations when benefit design is so different, carrot stick approach may work in one but not the other
 2. Other
 2.1. Funding?
 2.2. Will this approach move practices without many Medicaid patients
 2.3. Does the evidence support PCMH as an effective strategy for ALL primary care practices

3.PCMH Stage 3: Launch statewide PCMH initiative

1. Comparable measurements
 2. Better care for patients
 3. Improved outcomes,

1. Readiness Assessments/Geographic Discrepancies
 1.1. Try to determine the priority locations/areas

reduced cost
 4. an advanced PCMH infrastructure is necessary for all payment reform types
 5. There are many PCMH's across the state. Use their experience to train other like practices. Peer to peer works well.

1.2. Lack of health care providers in certain areas of the state
 1.3. do readiness assessments
 1.4. Not all locations created equal. Start where the need is the greatest
 2. Patient Involvement/Readiness
 2.1. prepare the population of the state for this movement
 2.2. without getting the patient involved, will continue to be challenging
 3. Provider Buy-in/Readiness
 3.1. Smaller practices will face resource challenges, both in staff and financial
 3.2. Buy in from providers who are new to these ideas

4.PCMH Stage 4: Practice Transformation

1. overall health transformation
 2. Long-term rollout
 3. Look to the KY Primary Association and UK partners who have experience - we have experience on this A Real Plus
 4. Practice transformation takes time. Should be a gradual, reasonable timeline
 5. Let Practices who have PCMH certification be Pilot sites or practices, and help steer the others

1. Other
 1.1. I worry about rushing it and, as has already been stated, creates a world where practices just check boxes rather than make meaningful changes. That takes time
 1.2. changing practice patterns
 1.3. There should be a step to evaluate roll out and make needed adjustments or changes
 1.4. Amidst MANY other changes from other stakeholders and payers
 2. Resources/Funding
 2.1. Additional resources likely required
 2.2. Money. Payers.
 3. Payment/Reimbursement
 3.1. must be some incentives and/or penalties for patients
 3.2. need payment to be aligned from the start and work on changing practice and culture of practice ahead of launch
 3.3. Need for CHW reimbursement

5.PCMH Overall

1. Really excited about this feature and was impressed by the draft.

1. Where is the funding?

I think it was a good synthesis of the past year's work
2. Absolutely necessary to gain efficiencies in coordination of care
3. Proven
4. Quality measures form participating providers
5. PCMH is the right direction for everyone.

PCMH IMPLEMENTATION ROADMAP

Description

Picture 1



PCMH IMPLEMENTATION ROADMAP

Categorize comments based upon sections of roadmap

recruitment

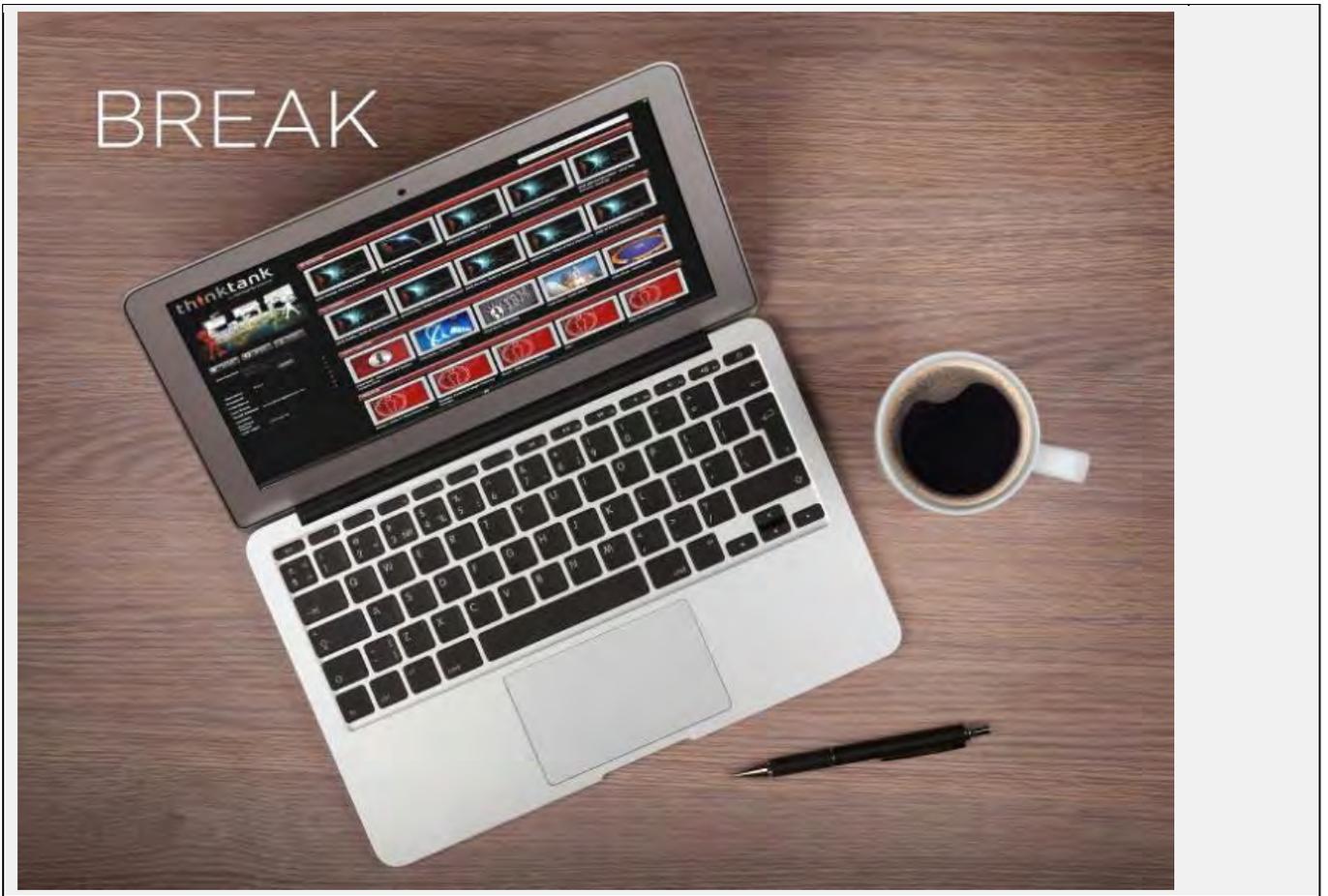
legal
provider **compliance**
communication data
collection
practice **contracting**
monitoring

1. Data Collection and Reporting
2. Provider Recruitment Support/Practice Transformation
3. Contracting
4. Legal/Regulations
5. Workforce
6. Technology
7. Monitoring and Compliance
8. Communication
9. Other

TRANSITION FROM PCMH TO ACO

Description

Picture 1



DAY 1 DEFINITIONS - ACO

Obtain feedback on definition of each reform activity

5.2. Will we look into the Next Generation Model? It is a progression from previous models

2. Reduce administrative and financial barriers to ACO participation by harmonizing participation, attribution, reporting, and measurement

1. Agreement
 - 1.1. Agree with #1 if the goal is to truly go statewide
 - 1.2. Agree with this. We cannot have different sets of rules particularly around data reporting and measurement as this will increase administrative burden and costs to the providers
 - 1.3. Agree with recommending standard ACO measures. multiple standards per payor is not achievable
2. Achievable for all providers
 - 2.1. Administrative reporting for physicians must be achievable.
 - 2.2. Needs to be clearer steps on establishing Value based purchasing contracts and what that means for smaller rural clinicians
3. Outcomes-based
 - 3.1. Have to find a way to share outcomes and practices between ACOs Don't need more silos.
 - 3.2. Need to ensure ACOs are accountable to patient outcomes
4. Existing ACO Structure
 - 4.1. Use existing ACO resources (i.e. ACO 33 metrics)
 - 4.2. Carefully consider ACO governance to include broad participants
5. Technology
 - 5.1. Integrate efficiency in reporting, billing, and payment. This is absolutely necessary.
 - 5.2. Technical systems to help with the component, not hinder. EHR had a huge impact on organizations and continuous roll out of administrative requirements could greatly impact responsiveness.
6. Other
 - 6.1. Are we recommending standard ACO measures and financial incentives?

3. Expand the focus of ACOs to include the social determinants of health, and coordinate with community resources

1. Operations
 - 1.1. Can we include public health? How do we do that?
 - 1.2. Again, I suggest using the WHO ICF as a framework to make this happen. Once understood, it is very intuitive and rich.
 - 1.3. Exclude disincentives to providers for patient non-compliance, when providers have established strategies and tactics that work in the general population.
 - 1.4. Need to consider the continuous decline in available community resources and what this does to this goal.
2. Additional Information Required
 - 2.1. We need to expand this goal with an example as it is not clear how this would be achieved.
 - 2.2. Must then provide a more specific definition and expectations for coordinated care. This is vague.
 - 2.3. Not sure what this really means. The ACOs are incentivized to work with other agencies to lower costs.
3. Agree
 - 3.1. This expansion is critical and should overflow into the PCMH concept.
 - 3.2. Needed.
4. Data Needs
 - 4.1. Data - is it available?
 - 4.2. Need data on social determinants - have to have the right targets. They will change from country to county

4. Expand ACOs to more at-risk populations, such as individuals in long-term care (LTC) and long-term services and supports (LTSS)

1. Technology
 - 1.1. Technology to enable transitions of care amongst vendors will also be an issue if this is to take off
2. Other
 - 2.1. ACO's are required to pay attention to these populations already if they are to be successful
 - 2.2. Completely agree--should be lots of low hanging fruit to harvest , both to improve outcomes and reduce \$
 - 2.3. Agree with #8
3. Operations
 - 3.1. Would ACO provide nonmedical supports to people with IDD who need 24 hour care?

3.2. Change is needed relative to reimbursement and ability to provider long-term care services. For example, the State Health Plan does not facilitate the ability of providers to work in this space. If you expect providers to take risk, they must be allowed to be reimbursement for all types of services across the continuum.

3.3. Why isn't wellness part of the strategy? Delivery model still 'I treat you when ill'.

4. Care Integration

4.1. needs to be more focus on coordination of care in an integrated model across disciplines

4.2. Would be concerned about carving out LTC services as a unique ACO. Would rather see integration across care continuum.

5. Use of Other Models

5.1. I think PCMH is a better way to tackle the at risk chronic population and encourages coordination and consistency of care in a more cohesive fashion.

5.2. This is achievable through the next generation ACO model by allowing the identification of providers that you would include in your ACO and how that relationship is defined

6. Additional Information Required

6.1. This needs more detail and discussion. This is a very costly population and will increase the risk to the ACOs. This will require much more detail of how this would work and protection against high losses for ACOs

6.2. Detail of payment methods need to be discussed and firmly established

5. Increase ACO participation through the use of incentives and benefit design strategies

1. Use and Impact of Incentives

1.1. Are these incentives to patients or ACOs?

1.2. We must consider the bad consequences of incentives.

1.3. Incentives are often good motivators.

1.4. Consider what this "incentive" will do to other things, typically your focus around other important things drops.

1.5. Incentives have to be applicable to both patients and providers. Otherwise the patient participation will lag

1.6. How will incentives be implemented?

1.7. There does need to be ways to keep people in network if they are enrolled in an ACO as that is the only way the ACO can manage the cost and go at risk.

2. Outcomes/Goals

2.1. What about outcomes they produce?

2.2. This appears to be looking for standard measures, financial incentives, etc. What is the vision to achieve this goal with payers?

3. Evidence-based

3.1. We need to show more use cases to demonstrate examples of how this would work and benefit all participants in the process

3.2. What if practices are already involved in these efforts through other initiatives or on their own accord

6. Other

1. Additional Detail Required

1.1. I think that there is still much confusion surrounding the operations of PCMH vs ACO vs etc. The discussions have been too superficial too date

1.2. Agree with #1. However, the paperwork states the "stakeholders" have agreed to this to date. I'm concerned we're way to high level to determine if anyone agrees with this or not.

1.3. There are lots of conversation around ACO's and the various ACO models. That said, there are many challenges relative to implementation with the Pioneer ACO's, for example. The ACO is more of a model to allow payors to shift risk which can be accomplished through a variety of means. I'd like to see additional research around the successful ones before pursuing this too aggressively. They've been around for several years and the success has been very limited.

2. Other

2.1. ACOs need to be held accountable for the amount of help and assistance they offer their practices. Simply submitting data to CMS for me or giving me a CMS isn't going to help my outcomes. They need minimum requirements on how much they are supposed to be hands on and help

2.2. Consider some type of any willing provider participation in ACOs

2.3. Again, there is an assumption that ACO's is a goal. The goal is to increase care models, increase quality of health, access to care and reduce cost. ACO may be one approach but what is the goal for impacting these goals? We anticipate that we can increase X% access to care and reduce chronic condition ER or hospital visits by X%, recue cost by X%. These should be the goals and ACO's PCMH is an approach but unless we can show that we achieve these goals, they are not the

1.3. This is a key element but will require careful consideration in how to make happen. Attribution process should be well defined and reporting expeditious

1.4. needs to prospective attributions

1.5. Attribution definition should be developed with the understanding that the medicaid population is entirely different from Medicaid

1.6. Data capture and patient attribution are critical to success

1.7. The attribution process has to be well defined and rapid. Patients may need to be able to pick an ACO versus a retrospective attribution method

2. Challenges

2.1. This will be a huge problem in Eastern KY. Patients are not compliant.

2.2. timely reimbursement, shared savings payments often come months if not years after performance period

2.3. This sounds magical. Not sure how it actually works

2.4. electronic reporting might be a key hurdle to overcome without financial assistance practice EMR systems

2.5. Administrative and regulatory burdens are one of the biggest drivers of health care costs.

2.6. Cost of infrastructure

2.7. volume of patients

3. Data Needs

3.1. Reduce the administrative burden on providers and provide timely utilization data to providers post implementation

3.2. There needs to be transparency with regard to outcomes for consumers and providers.

3.3. Data management = lots of electronic issues, and travel costs. bringing down costs in one sector may increase them for consumers in another (ie transportation)

3.4. Providers need data up front to determine if they could develop or participate in an ACO effectively and successfully

3.5. Needs to have timely and accurate data to be successful

4. Agree

4.1. Agreed.

4.2. no cost savings without it

5. Additional Ideas

5.1. Partner with existing initiatives in provider practices to determine core issues and barriers to partnering with ACOs

5.2. We must select a few measures which will yield a meaningful increase in health outcomes, not multiple, multiple measures from different payers

5.3. Payments of ACO performance and upside needs to be timelier to support smaller practices and providers.

5.4. Merge with resource access to improve likelihood of compliance

5.5. Billing becomes a part of electronic records that would have to be shared and participation has to be balanced with patient choice, and network adequacy.

5.6. Looking at the settings the patient is in, and identifying the barriers to their ability to become healthy has to be included in a care plan. If a patient goes home to a home filled with mold and heated with open flame, their lung conditions aren't going to improve long term with any amount of medicine, but none of these models guarantee that has a role

3. Expand the focus of ACOs to include the social determinants of health, and coordinate with community resources

1. Care Coordination

1.1. Who is responsible for identifying the appropriate community resources and contacting them?

1.2. Need a vision of local or regional coordinating councils.

2. Reimbursement

2.1. include payment for this work and health changes. For the better.

2.2. Include a reimbursement mechanism to help an ACO focus on the community

2.3. Billing Medicaid for social and legal services for patient health

2.4. How will the community resources be compensated in this model with the limited resources that already exist

3. Types of Community Resources

3.1. Legal aid and Medical Legal partnership--and include a way to pay for the work

3.2. Make sure community resources include the smaller, more nimble groups within the area that are often overlooked. For instance, there may be law student clinic who may help people navigate the legal landscape

3.3. Provide opportunities for, and encourage, formal partnerships between CBOs, non-profits, and other state and local agencies that address, transportation, housing, employment, education, criminal justice, etc. and ACOs

4. Other

- 4.1. create consistent priorities
- 4.2. need to keep in mind purpose of ACOs and not get caught up on the components only...always keep the experience and health outcomes of the community served at the forefront
- 4.3. Behavioral Health has to be a part of the ACO
- 4.4. Need to make sure appropriate person centered care is provided at the patient level

4. Expand ACOs to more at-risk populations, such as individuals in long-term care (LTC) and long-term services and supports (LTSS)

- 1. Additional Items to Consider
 - 1.1. Also included persons with chronic diseases and disabilities
 - 1.2. Include health coaches to empower patient to self-manage their conditions
 - 1.3. Does this include Medicaid waiver participants?
 - 1.4. Including goals for demographic, immigrant, language access
 - 1.5. May need to take a broader approach to housing to address long-term care
 - 1.6. Allow the most disparate populations with the worst health outcomes to benefit first from innovations and expansion of ACO utilization
 - 1.7. Really important to include the LTC and aging in place populations - note that LTC in KY is now includes younger residents with behavioral needs
 - 1.8. Include specific goals for transition management between multiple settings
- 2. Challenges
 - 2.1. A huge target and opportunity but data and system integration problems
- 3. Reimbursement
 - 3.1. Is Medicaid going to revise payment for long-term care?
- 4. Other
 - 4.1. Existing models in some regions that can inform process
 - 4.2. Are there any successful models for this in other states? I would be suspicious
 - 4.3. Make sure that ACOs can handle Medicare populations before you expand to more at-risk populations. Very risky
 - 4.4. Risk sharing should occur to encourage practices to join
 - 4.5. Focused and aggressive ACO expansion is needed to address high cost at-risk segments of the population.
 - 4.6. insure patient protection and choice
 - 4.7. efficiencies of regional vs community

5. Increase ACO participation through the use of incentives and benefit design strategies

- 1. Agree
 - 1.1. Yes, along with benchmarks and timely communication of data
- 2. Incentives/Reimbursement
 - 2.1. Incentives must be geared to insure success of rural providers.
 - 2.2. incentives must be meaningful to the ACO member, use evidence based approaches
 - 2.3. Increase the incentives beyond the MSSP ACO 50/50 split. Liberate more funding for upside performance to incentivize the right behavior of providers to lavish supportive and preventative care. Shift away from duplication of FFS
 - 2.4. Incentives for the patients or the providers. Recruitment to either of these parties to an ACO is hard
 - 2.5. definitely include "bonus" \$
- 3. Quality/Outcomes
 - 3.1. population will grow if/when desired outcomes are achieved
 - 3.2. Aligning the incentives with quality is key
- 4. Other
 - 4.1. ACOs need to become more simplified. Increased participation doesn't solve the complexity of what an ACO currently is.
 - 4.2. Not sure how you can accomplish this if 3 out 4 in an ACO do not qualify for additional benefit
 - 4.3. Has the ACO experience in other states resulted in closure of facilities?
 - 4.4. Coordination and standardization

6. Other

- 1. Technical/Financial Assistance
 - 1.1. where will technical assistance come from
 - 1.2. Where does all the \$\$\$ come from to pay for these additional services

2. General Questions
 - 2.1. Do ACO's include other populations, such as Medicaid, Commercial, and Uninsured?
 - 2.2. How do our definitions relate to National designation of "ACO"?
 - 2.3. Can you have an ACO without being officially recognized by Medicare
3. Provider Impact
 - 3.1. ACO that has a shared saving component there must be reasonable benchmarking to keep providers engaged
 - 3.2. Providers need more education on what to look for in an ACO. We hear a lot about hospitals making the lion's share of the money, but PCPs doing much of the work and not much of the reward. They are scared to participate based on these stories.
4. Education
 - 4.1. Need a way to educate professionals and public about what this is and what it means for them.
 - 4.2. Patients also need education, because we have seen them deny being a part of ACO, because they do not understand.
5. Other
 - 5.1. Establishing an ACO in rural areas can be very difficult in rural areas and by providers who serve a smaller community in comparison to urban
 - 5.2. Concerns about as health plans merge, evolve and change that it will always be hard for us to keep up and change this plan based on their current and future
 - 5.3. Build on existing networks to take advantage of sunk cost in needed infrastructure, data, CM, CC, etc.
 - 5.4. Build in utilization and health outcome goals from the start, even just a few simple ones

DAY 1 GOALS - ACO

Obtain feedback on goals



1. Number of payers involved
2. Number of participating providers
3. Number of Kentuckians receiving care through an ACO

DAY 2 GOALS - ACO

Obtain feedback on goals

- 1.6. Patient education
- 1.7. Must have sound and methodical planning and educational components prepared for streamlined roll out and implementation.
- 2. Outcomes
 - 2.1. Long-term health outcomes: Must make sure that saving money does not simply mean denying care
 - 2.2. Need to use QOL outcomes as part of outcomes, not just typical medical markers
 - 2.3. outcomes produced
 - 2.4. Process. outcomes and models for improvement as we transform to a more robust health eco system
- 3. Evidence-based
 - 3.1. We need to build on what people have already developed, recognizing some providers are more ready than others to move forward with ACOs. Nothing should be mandated.
 - 3.2. use of best practices
- 4. Data Reporting
 - 4.1. develop a consistent quality/utilization metrics. ACO's should be able to tell payers here are the metrics we will report.
 - 4.2. Data reporting requirements and timeframes
 - 4.3. Data reporting is the key to a successful ACO
 - 4.4. If Data reporting is burdensome for physicians, they will not participate
- 5. Provider Impact/Strategies
 - 5.1. Structuring a PMPM for providers to ease the transition into an accountable care model from the start
 - 5.2. consider impact on providers including education and indoctrination
 - 5.3. If ACOs are managing Medicaid patients, we need to eliminate the administrative requirements being imposed by the MCOs
 - 5.4. Break out payers by type and track separately
 - 5.5. ACOs to be given guidelines on how much to help the offices they are responsible for offering
- 6. Integration
 - 6.1. shared knowledge. Don't need more silos. No ACO can get here alone
 - 6.2. seamless integration of care
- 7. Other
 - 7.1. Remember Einstein -- not everything that counts can be counted and not everything that can be counted counts. Don't count those things that really don't matter and consider some qualitative assessment
 - 8. A Medicare ACO goal is to reduce long term cost ... a non-Medicare ACO may be looking at other chronic disease or health issues

DAY 2 GOALS - ACO

Brainstorm new goals

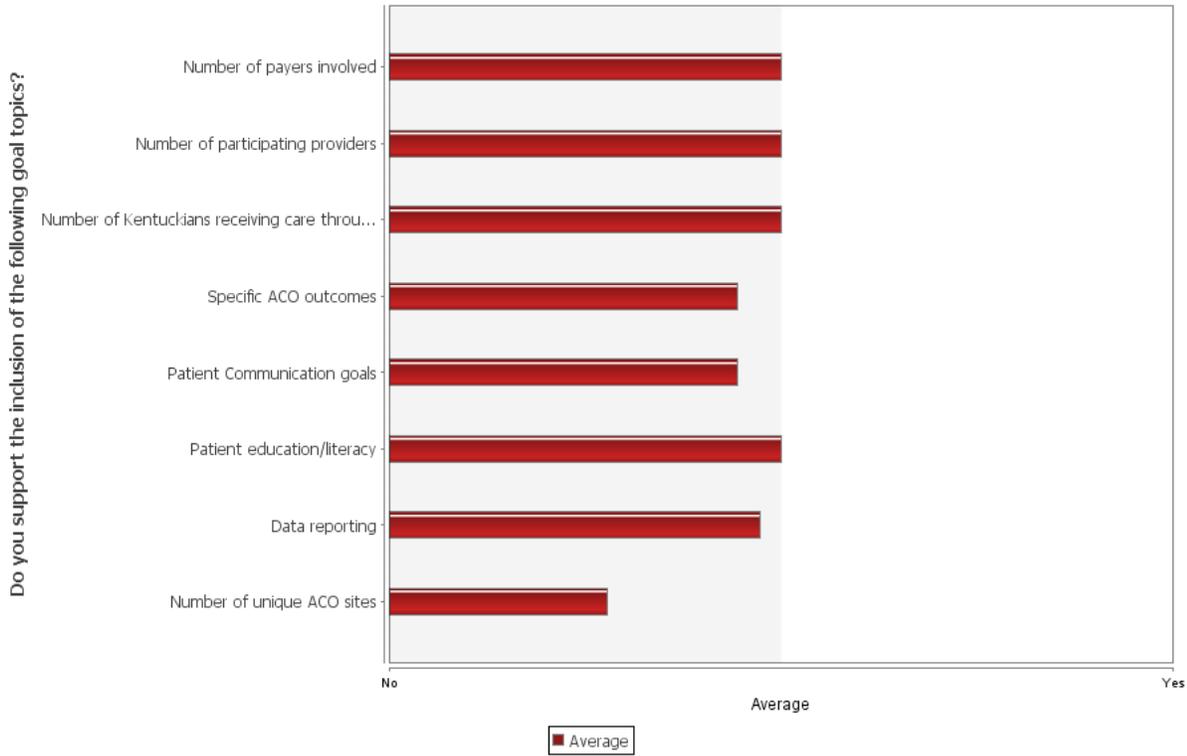
- 8. Transparency/Reporting
 - 8.1. Transparency important for growth
 - 8.2. A central, statewide standardization process may be the most effective way at collecting, comparing, reporting outcomes of ACO's.
 - 8.3. COST transparency is important to me, b/c you can't figure out VALUE without knowing cost and quality
 - 8.4. public reporting
- 9. Payment
 - 9.1. Payment simplification
 - 9.2. equitable shared savings based upon the responsibilities of each ACO member
 - 9.3. Need positive ACO incentives (low or no risk) in the beginning
 - 9.4. Decide who holds the money
 - 9.5. Simplify and coordinate payment to make it easier for providers to practice medicine rather than trying to figure out who pays for what.
- 10. Education
 - 10.1. Demonstrate value of ACO to the person, both in improving health but also reducing out-of-pocket costs to the person
 - 10.2. neutral provider education on why they should join an ACO, to understand structure and transparency, and what it will mean to them and their practice and patients, to join an ACO if you want more participation
 - 10.3. Language accessible for consumers/patients
- 11. Other
 - 11.1. are communities of color being served
 - 11.2. Are community resources inside or outside the ACO?
 - 11.3. specific focus on at-risk populations
 - 11.4. increased access to members, reduced wait time for appt availability
 - 11.5. ooops...increased access for members
 - 11.6. Measure patient engagement levels, ACO's need to facilitate self-management of chronic conditions

DAY 1 YES/NO ACO GOAL SUPPORT

Votes Cast: 36 Abstained: 2

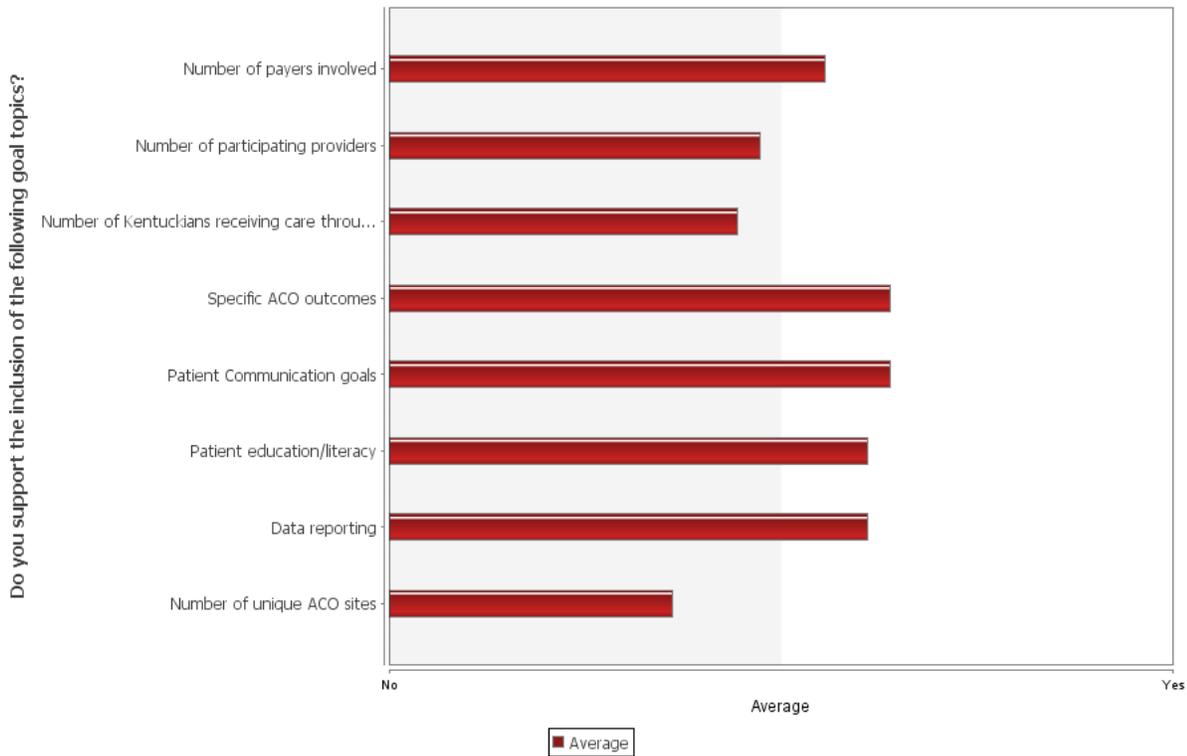
	With Modifications	Avg.Score	+/-	Std Dev	No	Yes
1	Number of payers involved	0.50	50.0%	0.50	18	18
2	Number of participating providers	0.50	50.0%	0.50	18	18
3	Number of Kentuckians receiving care through an ACO	0.50	50.0%	0.50	18	18
4	Specific ACO outcomes	0.44	49.7%	0.50	20	16
5	Patient Communication goals	0.44	49.7%	0.50	20	16
6	Patient education/literacy	0.50	50.0%	0.50	18	18
7	Data reporting	0.47	49.9%	0.50	19	17
8	Number of unique ACO sites	0.28	44.8%	0.45	26	10

With Modifications



YES / NO		Avg.Score	+/-	Std Dev	No	Yes
1	Number of payers involved	0.56	49.7%	0.50	16	20
2	Number of participating providers	0.47	49.9%	0.50	19	17
3	Number of Kentuckians receiving care through an ACO	0.44	49.7%	0.50	20	16
4	Specific ACO outcomes	0.64	48.0%	0.48	13	23
5	Patient Communication goals	0.64	48.0%	0.48	13	23
6	Patient education/literacy	0.61	48.7%	0.49	14	22
7	Data reporting	0.61	48.7%	0.49	14	22
8	Number of unique ACO sites	0.36	48.0%	0.48	23	13

YES / NO



Do you support the inclusion of the following goal topics?	Any Comments
Number of payers involved	<ol style="list-style-type: none"> 1. Payers and provider collaboration is key to the success of this goals 2. needs to be across payers, as multiple rules will cause difficulty 3. Start small and achieve success with Medicaid and State Employee payers 4. More payers should be encouraged to work with providers on their existing ACO initiatives 5. Agree with #4 6. there needs to be transparency
Number of participating providers	<ol style="list-style-type: none"> 1. Agree with #5. Some providers are already in the process of ACOs and PCMH. Take the national guidelines and encourage providers to move at their own pace. 2. TYPES of providers as well 3. Need to evaluate ACO as a broader transformation strategy and how practices can progress through this timeline. 4. Consider rural distribution 5. It takes years to be able to take on this type of risk which does not seem to be recognized in this plan 6. consider attribution of chronic care patients 7. No mandates. Build on existing ACOs. Providers need to move at their own pace

Number of Kentuckians receiving care through an ACO	<ol style="list-style-type: none"> 1. Think we should look at this initiative in connection with PCMH. Not exclusive. 2. Can't penalize small practices in this process that don't have the infrastructure and resources to participate.
Specific ACO outcomes	<ol style="list-style-type: none"> 1. We need to use the same outcome measures as Medicare, not invent new ones 2. Outcomes should be #1 3. Be cautious of selecting meaningful outcomes 4. Outcomes need to be measured and monitored. Also, incentives and measurements needed to be monitored to see what works. 5. include financial viability as an outcome/evaluation measure
Patient Communication goals	<ol style="list-style-type: none"> 1. Not sure what this means. Patients receive communication in all sorts of ways, so sending more mail doesn't always work. 2. really need communications and examples so that patients understand how these will work
Patient education/literacy	<ol style="list-style-type: none"> 1. with provider education and literacy 2. There needs to be some sort of patient accountability. 3. How will this be measured and developed? How do we ensure consistency?
Data reporting	<ol style="list-style-type: none"> 1. Critically important to have consistency in data reporting and reporting in a timely fashion. Some smaller or rural providers may need some support relative to infrastructure and capabilities. 2. Need to define what needs to be measured, how data will be captured, and monitored 3. needs to be in real time 4. Align across ACOs
Number of unique ACO sites	<ol style="list-style-type: none"> 1. distribution across geographic area 2. Need to work with the providers who are ready to implement this or who already have an ACO. It takes time to develop the infrastructure to manage risk. Rural providers are not ready to do this. 3. and distribution thereof

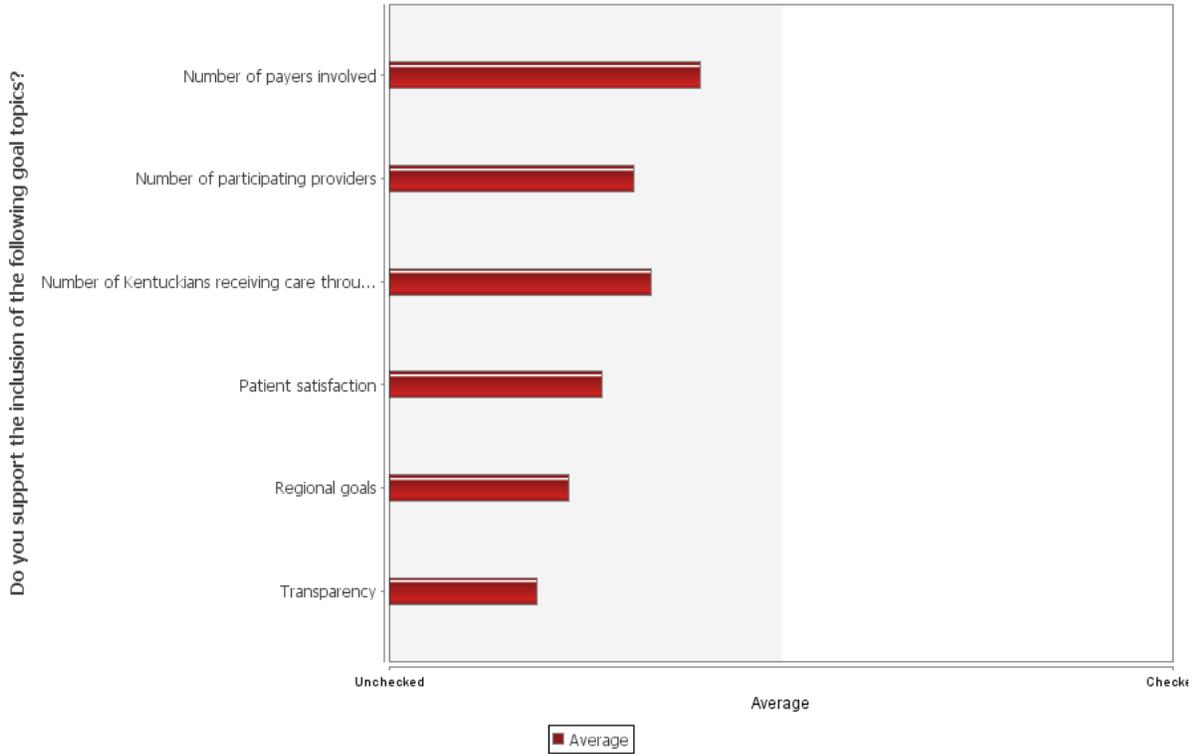
DAY 2 YES/NO ACO GOAL SUPPORT

Votes Cast: 48 Abstained: 4

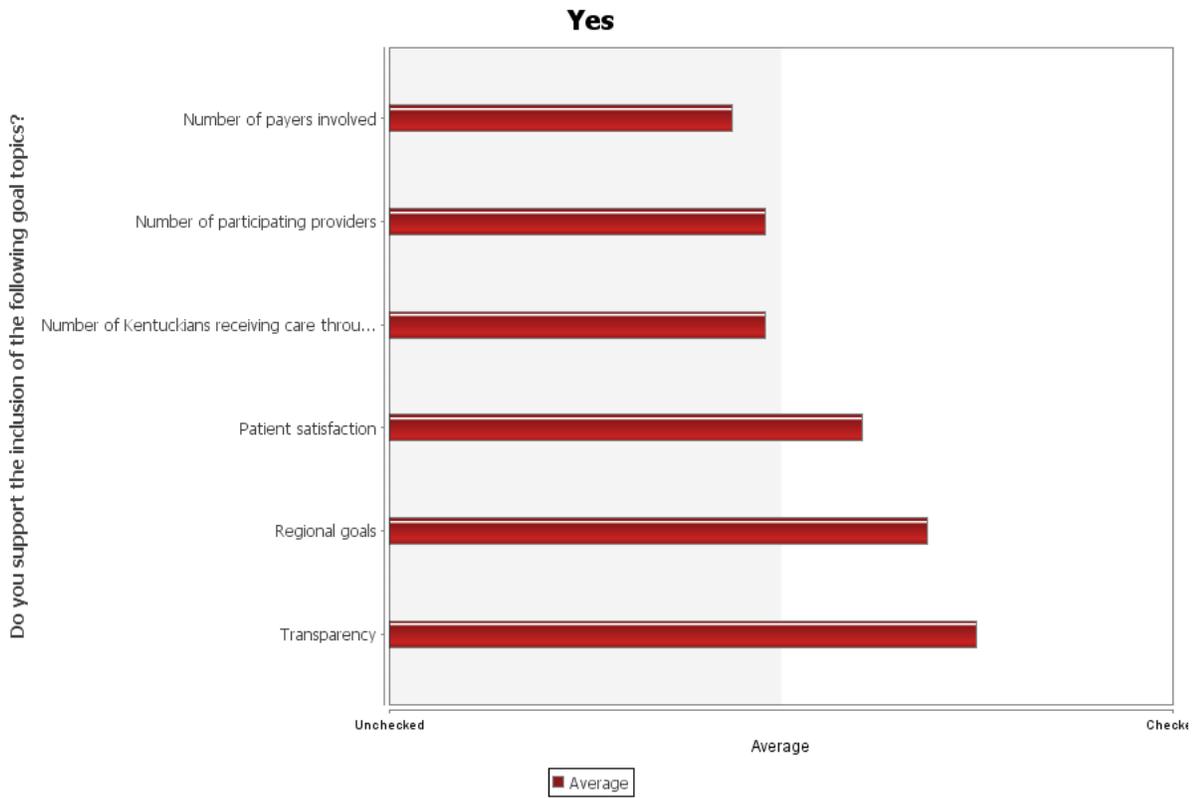
	Yes with Modifications	Avg.Score	+/-	Std Dev	Unchecked	Checked
1	Number of payers involved	0.40	48.9%	0.49	29	19
2	Number of participating providers	0.31	46.4%	0.46	33	15
3	Number of Kentuckians receiving care through an	0.33	47.1%	0.47	32	16

ACO						
4	Patient satisfaction	0.27	44.4%	0.44	35	13
5	Regional goals	0.23	42.0%	0.42	37	11
6	Transparency	0.19	39.0%	0.39	39	9

Yes with Modifications

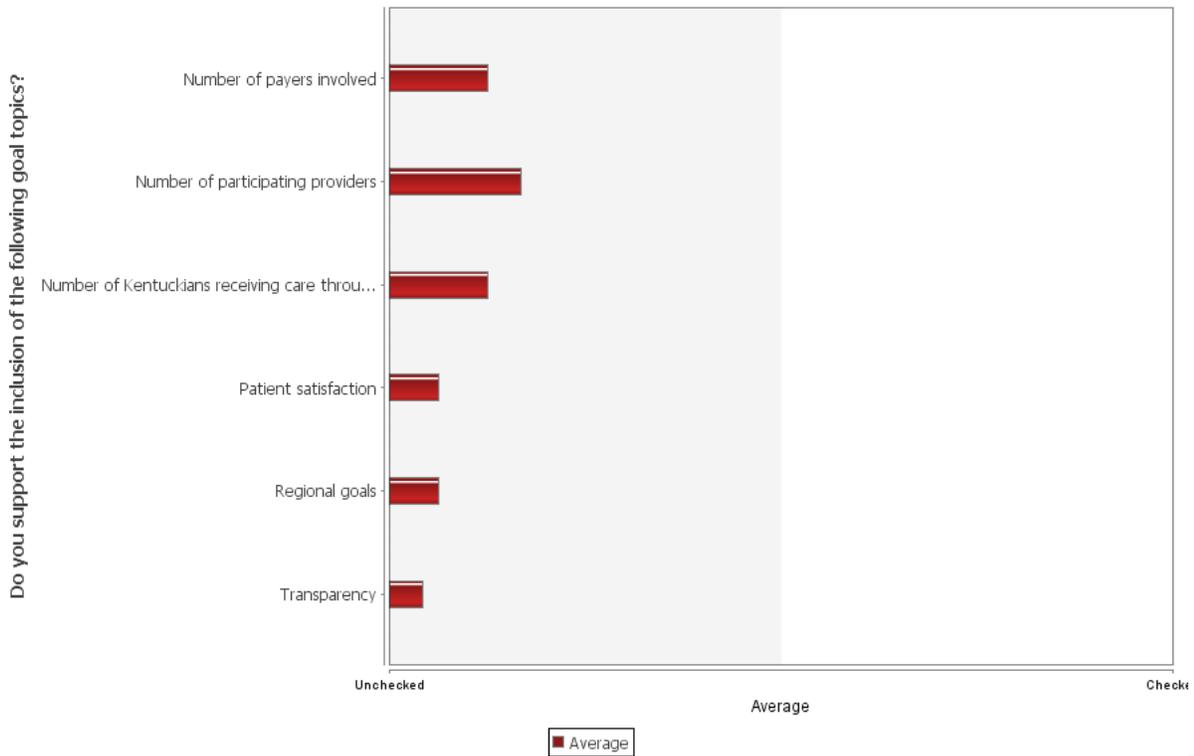


Yes		Avg.Score	+/-	Std Dev	Unchecked	Checked
1	Number of payers involved	0.44	49.6%	0.50	27	21
2	Number of participating providers	0.48	50.0%	0.50	25	23
3	Number of Kentuckians receiving care through an ACO	0.48	50.0%	0.50	25	23
4	Patient satisfaction	0.60	48.9%	0.49	19	29
5	Regional goals	0.69	46.4%	0.46	15	33
6	Transparency	0.75	43.3%	0.43	12	36



No	Avg.Score	+/-	Std Dev	Unchecked	Checked
1 Number of payers involved	0.12	33.1%	0.33	42	6
2 Number of participating providers	0.17	37.3%	0.37	40	8
3 Number of Kentuckians receiving care through an ACO	0.12	33.1%	0.33	42	6
4 Patient satisfaction	0.06	24.2%	0.24	45	3
5 Regional goals	0.06	24.2%	0.24	45	3
6 Transparency	0.04	20.0%	0.20	46	2

No



Do you support the inclusion of the following goal topics?	Any Comments
Number of payers involved	<ol style="list-style-type: none"> 1. This needs flexibility. Perhaps the % of payers involved rather than number 2. More isn't always better - it is the outcome! 3. Is the assumption that more is better?
Number of participating providers	<ol style="list-style-type: none"> 1. Need to make sure efforts align with data - target ACO collaboration to providers who serve marginalized and vulnerable populations. And provide adequate resources to those providers.
Number of Kentuckians receiving care through an ACO	<ol style="list-style-type: none"> 1. patients knowing they are in an ACO 2. Make sure patients who stand to benefit the most are targeted for participation and that the process is made easy.
Patient satisfaction	<ol style="list-style-type: none"> 1. Change to Patient Engagement 2. patient engagement measures better than just patient satisfaction; patients aren't generally satisfied when told they need to lose weight, for example 3. should be patient engagement 4. People don't even read their benefit plans when they sign up for insurance so how can one expect them to competently provide their satisfaction with this concept.
Regional goals	<ol style="list-style-type: none"> 1. Including urban centers and pockets of minority populations
Transparency	<ol style="list-style-type: none"> 1. Need a "dashboard" vision of top indicators to make

2. Other Care Types

- 2.1. Good opportunity to combine BH & PH and to allow same day payments
- 2.2. consider adding vision health
- 2.3. better utilize and incorporate PUBLIC HEALTH departments
- 2.4. add wellness
- 2.5. WHAT ABOUT ADDING ORAL HEALTH

3. Community Resources

- 3.1. How do you plan on building and enabling community resources?
- 3.2. Example of community resources?
- 3.3. Which community resources would you key in on? Would it be a referral, etc?

4. Operations

4.1. Each ACO should be able to establish which patient population and set of services they are able to manage and assume risk for. We should not be mandating this

4.2. Patients need to have skin in the game.

4.3. I think there is a need to discuss does the practice need to participate in all of these activities, or can they choose which one they want to implement and will there be penalties for not participating in 1 vs. the others.

5. Additional Information Required

5.1. I think this is a good goal, but sometimes not feasible for success. For example, many long-term and behavioral health providers don't have the infrastructure or resources to track, measure and report outcomes effectively within an ACO or to the Cabinet.

5.2. Does a community resource include getting more health and oral health providers enrolled and participating in MEDICAID?

5.3. Absolutely and how will the ACO encourage?

5.4. We need use cases to help understand the context

2. Establish a multi-payer, "open-door" policy whereby payers agree to add their populations to an ACO if the ACO desires.

1. Definition of Open Door

1.1. Please clarify open door policy

1.2. Define, "if the ACO desires". How will this decision be made and payers excluded?

1.3. By "open door" do you mean accepting new patients? Need clarification around this.

1.4. not clear regarding intent

1.5. Who makes the final decision? Open door policy?

1.6. Don't really understand this

1.7. Patients may have a difficult time with this concept.

1.8. open door policy?

1.9. 'Open door' and 'if they desire' is like jumbo shrimp. They don't go together

2. Payer Role

2.1. This makes sense -- payers need to be working with the providers who have or are establishing an ACO. This recognizes that many providers are not ready to assume risk

2.2. Would this encourage cherry-picking by some payers

2.3. If there health condition fits within the scope of the ACO

2.4. Agree the difficulty in payers adding population to ACO is going to be patient centered understanding of how the ACO works and how attribution would occur. Some payer systems that are not HMO based don't provide for identifying the PCP provider.

3. Cost

3.1. Wouldn't this tend to negate the cost-saving portion of the ACO? Cost savings is achieved through knowledge and control.

3.2. Agree with #8 these are Very expensive populations with significant co-morbidities that impact this

4. Other

4.1. DPM

4.2. The RFI is a good step forward...

4.3. Is EOL care ie hospice considered its own bundled payment

4.4. Its good to see the inclusion of Public Health and behavioral health. The more provider types improves risk stratification. The key will still be care coordination.

3. Issue a Request for Information (RFI) to include individuals receiving LTSS and/or LTC in an ACO.

1. Agreement
 - 1.1. Agree. This would be good data, if the RFI is well designed to obtain accurate responses desired.
 - 1.2. Agree. May be the only way to continuing providing LTC in the long view
 - 1.3. Would support this idea. Potential for improved quality of care through better coordination.
 - 1.4. agree
 - 1.5. Agree,
 - 1.6. both essential and reasonable
2. RFI Specifics
 - 2.1. RFI is a good idea but what time lines are you looking at and how to pay for these services. They have been limited in payment but the patient population is growing. They are poorly handled now
 - 2.2. Would nonmedical supports be included such as 24 hour residential community based care?
 - 2.3. Would the RFI determine mandatory participation in the future? Additional detail would be needed.
 - 2.4. If individuals receiving LTSS in Medicaid waivers, SCL for example, were to be included in ACOs would current SCL providers be required to become an ACO or contract with an ACO?
 - 2.5. These are very expensive populations. Much more detail on this is needed along with limits on provider financial risk
 - 2.6. for this to be truly effective this should be included
3. Other
 - 3.1. Not sure...
 - 3.2. Consider access, may be limiting

DAY 2 CORE ELEMENTS FEEDBACK - ACO



1. Expand the scope of ACOs to encourage participation across the full continuum of care and focus on behavioral health, public health, and community resources.

1. Care Coordination/Integration
 - 1.1. Meet with organizations addressing health from the aforementioned perspectives and leverage goals and resources to collaborate on joint initiatives
 - 1.2. Good but need guiding models of inclusion and coordination.

- 1.3. Integration of care is crucial. Necessary to treat whole person in their community.
- 1.4. Absolutely. Comprehensive scope of care will be required as not all patients require services at the same time for the same reasons.
- 1.5. Will not achieve goals/outcomes without including the full continuum and community resources
- 1.6. Examine the appropriateness of including end of life hospice patients within potential ACO attribution under traditional Medicare or Medicaid
- 1.7. The full continuum of care is essential for success
- 1.8. Focus on care coordination would include these settings
2. Provider Types to Include
 - 2.1. Oral Health
 - 2.1.1. And oral health as well
 - 2.1.2. DENTAL needs to be included
 - 2.1.3. add Dental
 - 2.1.4. Include oral health, treat the whole patient.
 - 2.1.5. Don't forget dental
 - 2.2. behavioral, public, and social health
 - 2.3. Public health meaning local public health department or population health approaches? if latter, then need a public health professional who understands population health not just a clinician
 - 2.4. Are LTC post-acute providers ready to step up performance and outcomes? Do they have processes in place?
 - 2.5. How do we increase the number of behavioral health providers
 - 2.6. Once again, the behavioral health resources are centered on 4 state hospitals and only one is subjected to any type of managed care pressure. How do you include them?
 - 2.7. It will be important to allow ease of access to all kinds of providers, even if a provider type is under or not represented within a given ACO (mental health, subspecialties, etc).
 - 2.8. Behavioral health services greatly needed, however there is limited access for patients.
3. Reimbursement
 - 3.1. need to look at referral and payment processes; make it seamless for consumers
 - 3.2. Generally, yes. ACOs could expand our current doctor/provider sick-care model to transition to healthcare and a culture of health, but would require payers buying in to payment systems for public health, PREVENTION, legal services, housing, or at least the recognition of all those and more
 - 3.3. Need to provide reimbursement for community resources.
4. Workforce
 - 4.1. I can't imagine there are enough social workers in Kentucky to even start this, but including that data in this planning would be helpful - what professionals do we have and where
 - 4.2. How do we incentivize non-clinical resources?
 - 4.3. this is a great idea, however this in one place where resources are scarce for behavioral, public health and community partners in most areas of KY
 - 4.4. Encourage ACOs to designate resources to hiring professionals knowledgeable of the relationship between public health, SDOH, and community engagement and improved health outcomes
 - 4.5. workforce development
 - 4.6. Will be difficult because there is not an adequate workforce in many settings for behavioral health. Not a one-size-fits all.
5. Community Resources/Community Responsibility
 - 5.1. This depends on the accessibility to these community resources. Don't want to inundate them, or else they may be unable to maintain consistent quality to the population they already serve
 - 5.2. Must embrace community responsibilities on an individual level (e.g. give them
 - 5.3. Participation would drop if community resources become a measurable goal as it is beyond the control of a provider organization and we would just have to give up.
 - 5.4. Define what "participation" means. Does it mean use community resources to serve its patients or to help pay for community resources.
6. Other
 - 6.1. have to have companion / complimentary goal for participants
 - 6.2. Use an information technology platform to facilitate this participation
 - 6.3. Does this mean become person-centered vs provider centered

6.4. Transparency for consumers meaning they have access to cost/outcome data for medical, behavioral, and social interventions.

7. Disagreement

7.1. no.

2. Establish a multi-payer, “open-door” policy whereby payers agree to add their populations to an ACO if the ACO desires.

1. Agree

1.1. I think this is imperative, but only if payers agree to share data and communicate timely, and truly be involved with the practices

1.2. Agree, this will help ACOs achieve the number of members

1.3. Yes.

1.4. Agree

1.5. Difficult to implement, but an appropriate goal

1.6. Multi-payer participation is key to success.

2. Open-Door for Payers

2.1. Door swing both ways. Agree to add also means they and get tossed from the ACO?

2.2. Do payers have some autonomy

2.3. what if the payer wants but the ACO doesn't - open door in reverse

3. Risk/Payment Model

3.1. risk and benefit sharing will need to be determined to do this

3.2. need to have strong payment model to attract providers to ACO and accept new programs

3.3. The payment model needs to attract providers - what is in it for them?

3.4. will need to have a payment model to support this

4. Other

4.1. Communication, collaboration crucial.

4.2. Perhaps even having payers lead this, make it known they are invested in success

4.3. employer groups need flexibility

3. Issue a Request for Information (RFI) to include individuals receiving LTSS and/or LTC in an ACO.

1. agree

1.1. Agree.

1.2. Yes. This is a different sample with different needs.

1.3. agree

1.4. Agree, but with a modifier for risk score factor so cost will not be adversely affected on practices

2. Disagreement

2.1. When does the state run out of money for consultants for all these initiatives? More tax dollars wasted.

2.2. this would not be my first choice very complicated group

3. Additional Information Required

3.1. Are these the only populations to be included in the RFI? Some are being left out!

3.2. Does this mean pulling in medicaid waivers

3.3. At risk?

4. Other

4.1. long term services and supports (LTSS)

4.2. What is LTSS?

4.3. Establish a collaborative to develop effective care models, use the universities to facilitate the process

4.4. Interesting problem with Mental health and state hospitals

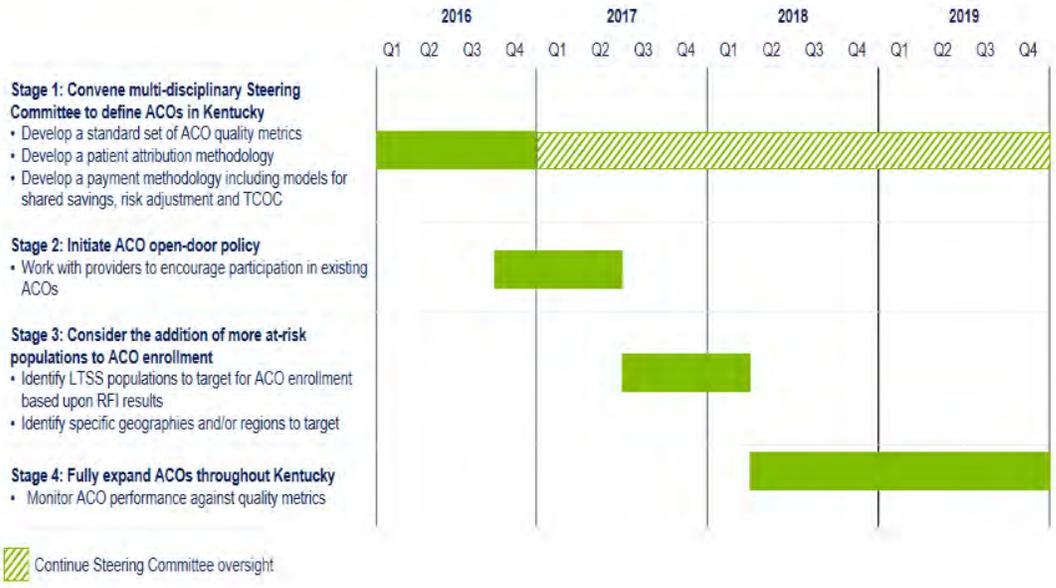
4.5. Effective models exist in other states as models

4.6. Involve the Kentucky Office for Rural Health.

REVIEW ACO ROLLOUT STRATEGY

Review slide

ACO Rollout Strategy



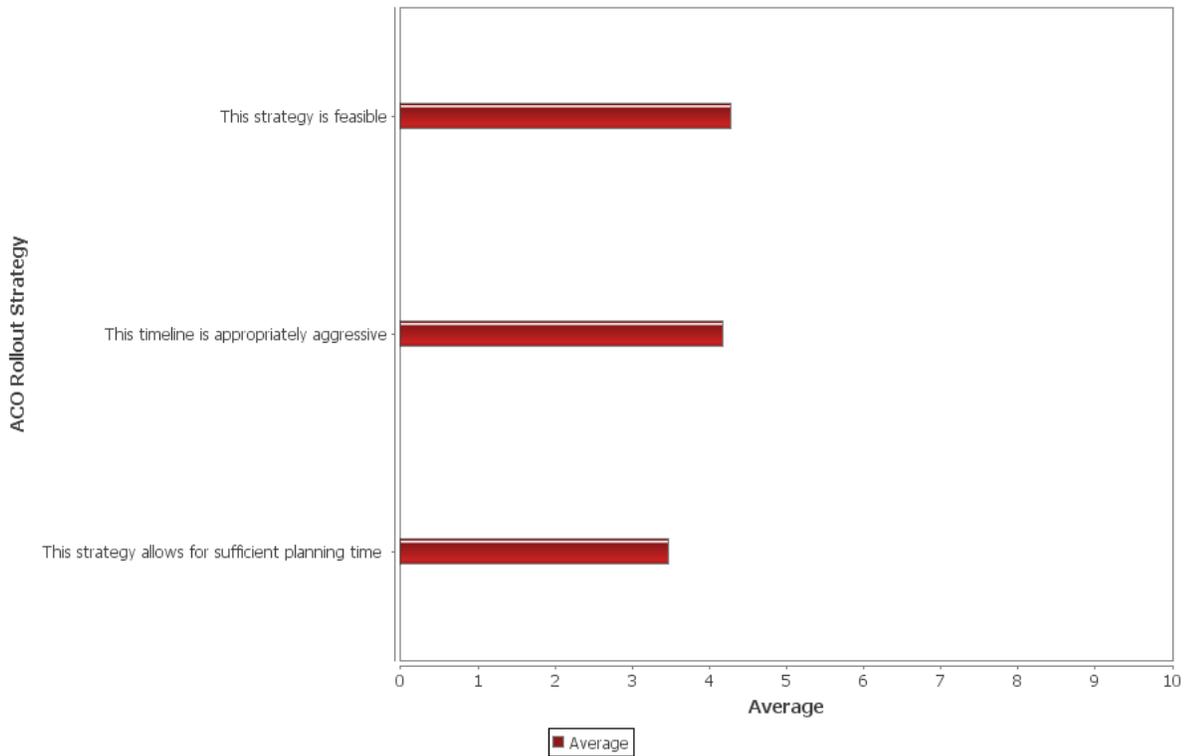
DAY 1 ACO ROLLOUT STRATEGY

Assess Feasibility

Votes Cast: 39 Abstained: 5

	Feasibility	Avg.Score	+/-	Std Dev	Min	Max
1	This strategy is feasible	4.28	25.9%	2.59	0.00	10.00
2	This timeline is appropriately aggressive	4.18	26.8%	2.68	0.00	10.00
3	This strategy allows for sufficient planning time	3.46	29.4%	2.35	0.00	8.00

Feasibility



ACO Rollout Strategy	Any Comments
This strategy is feasible	<ol style="list-style-type: none"> 1. Providers can't take on all these initiatives at once. If a provider can chose one of the 3-4 initiatives then it may be possible 2. too many interdependencies 3. I'm ambivalent about these timelines as there is not enough info to make a sound decision 4. Strategy needs to include communication planning and the development of use cases. 5. Need to revisit the overlapping of the timelines and how they interact. 6. I'm not sure it makes senses to pursue this model of care as an alternative. It's about collaborative and coordinated care but ACO really looks across the continuum. Extremely difficult to manage and be successful due to the lack of information across the continuum. 7. Composition of the steering committee? 8. while separate steering committees may be needed to address the different components, there needs to be some link across these committees 9. The only thing that is feasible is to build on the ACOs that are already out there
This timeline is appropriately aggressive	<ol style="list-style-type: none"> 1. Way too aggressive. It has taken years for providers to develop existing ACOs and be prepared to go at risk 2. Way to aggressive. A successful ACO takes time to

	<p>develop</p> <p>3. Since ACO is a payment methodology how will the providers of care continuum be represented on the steering committee</p> <p>4. Computer system changes always get in the way of good intentions so how long it takes payors of ACO's to adjust will impact this.</p>
This strategy allows for sufficient planning time	<p>1. Agreement</p> <p>1.1. Agree</p> <p>1.2. Agree</p> <p>2. Quality</p> <p>2.1. Can the quality metrics be phased in - in other words report a number of metrics you are already collecting and work toward common metrics - common metrics out the gate is going to be difficult</p> <p>2.2. the quality metric comment applies to all</p> <p>3. Systems</p> <p>3.1. Most provider systems in KY are not ready for this timeline. It is resource heavy and will make other initiatives difficult to achieve.</p> <p>3.2. Planning must include the actual update to payment systems consistent with the methodologies as they are developed. Payment systems, must also be ready to implement and timeline seems to leave this important step out.</p> <p>4. Other</p> <p>4.1. I'd encourage the Cabinet to look at this at a regional level to determine feasibility. Don't feel Kentucky is positioned at all to be successful in this model.</p> <p>4.2. have to collect results feedback</p> <p>4.3. planning time and allow "buy in"</p> <p>4.4. Start with Medicaid to see if it works.</p>

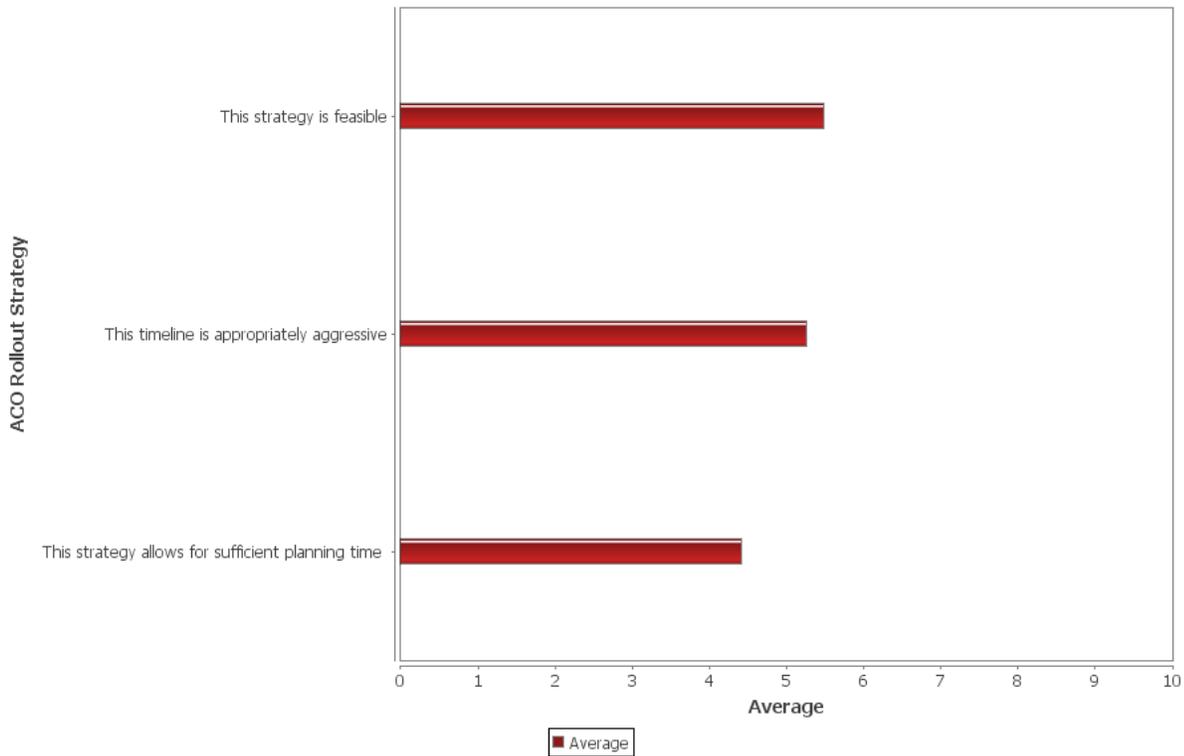
DAY 2 ACO ROLLOUT STRATEGY

Assess Feasibility

Votes Cast: 43 Abstained: 6

	Feasibility	Avg.Score	+/-	Std Dev	Min	Max
1	This strategy is feasible	5.49	30.6%	3.06	0.00	10.00
2	This timeline is appropriately aggressive	5.26	29.7%	2.97	0.00	10.00
3	This strategy allows for sufficient planning time	4.42	32.2%	3.22	0.00	10.00

Feasibility



ACO Rollout Strategy	Any Comments
This strategy is feasible	<ol style="list-style-type: none"> No idea Feasible if we develop a mechanism to make the technology available. It may take a long time to get the technology installed You'd think the activity under Stage 2 would be ongoing. In reality, it's a slow process that takes more than a year to recruit providers. less experience adding these populations LTC population reference in #4
This timeline is appropriately aggressive	<ol style="list-style-type: none"> Will Ky be left behind because of the late implementation?
This strategy allows for sufficient planning time	

DAY 1 ACO ROLLOUT STRATEGY

Benefits and challenges of each stage and overall

ACO ROLLOUT STRATEGY	Benefits	Challenges
Stages	Benefits associated with this stage and its components	Challenges associated with this stage and its components
1.ACO Stage 1: Convene multi-disciplinary Steering Committee to		

define ACOs in Kentucky

2.ACO Stage 2: Initiate ACO open-door policy

3.ACO Stage 3: Consider the addition of more at-risk populations to ACO enrollment

4.ACO Stage 4: Fully expand ACOs throughout Kentucky

5.ACO Overall

DAY 2 ACO ROLLOUT STRATEGY

Benefits and challenges of each stage and overall

ACO ROLLOUT STRATEGY	Benefits	Challenges
Stages	Benefits associated with this stage and its components	Challenges associated with this stage and its components
1.ACO Stage 1: Convene multi-disciplinary Steering Committee to define ACOs in Kentucky	<ol style="list-style-type: none">1. Oversight of this project is key.2. This is the core foundation of everything.3. Yes. Must define participating parties.4. Include members on the steering committee that serve large populations of medicaid members.5. Must be a level playing field for providers and patients.6. Get people with experience in the state on the committee7. Getting key stakeholders asap is key to moving forward	<ol style="list-style-type: none">1. Other<ol style="list-style-type: none">1.1. Confusion between state definitions, national definitions1.2. Getting agreement regarding the definition will be difficult1.3. healthcare is political1.4. unless you have complete buy-in this whole arm of the project will never work1.5. Can the Steering Committee modify the timeline?2. Steering Committee Representation<ol style="list-style-type: none">2.1. Must have representation from small rural providers.2.2. Challenge to include consumers, community-based partners.2.3. Need rural providers on the committee2.4. Choosing the

2.ACO Stage 2: Initiate ACO open-door policy

- 1. Allows ACOs to expand at their own pace
- 2. This will help ACO get members which is needed for sustainability

right members of your steering committee is essential. Please add people who have experience in dealing with ACO's.

- 1. Other
 - 1.1. A payment model with payers to support this will be a challenge
 - 1.2. What would this cost?
 - 1.3. Need wide acceptance of value-based reimbursement
- 2. Timeline Too Aggressive
 - 2.1. Recruiting providers takes a much longer time than a year. In addition, setting up the IT infrastructure will take an even longer time.
 - 2.2. The time line is too short. There is a long learning curve for new providers in an ACO model.
 - 2.3. Must give more time for this group.
 - 2.4. timeline for this is a bit too aggressive - the adoption rate will be slower than indicated here
 - 2.5. timeline too aggressive

3.ACO Stage 3: Consider the addition of more at-risk populations to ACO enrollment

- 1. Need to develop a reasonably priced virtual technology to assist in the management of high resource persons
- 2. Yes since these individuals may be high users of health care services
- 3. Efforts will have more of an impact on the overall health of the Commonwealth
- 4. Create a variety of

- 1. Other
 - 1.1. Also need goals and measures for demographic populations
 - 1.2. Going statewide should be clearly thought-out. Probably best to start in the region with the smallest number of member
 - 1.3. Patient compliance
 - 1.4. may take

care management models which are customized to the needs of persons

regulatory activity
2. Allowances for Risk
2.1. When you have seen one, you have seen one. Risks too varied
2.2. You need to make sure ACOs can manage their current population before exposing them to more at-risk patients.
2.3. Some providers serve higher numbers of at risk, complex and high cost patients. There needs to be adequate protections for the providers and patients served by them to ensure that providers are not penalized by serving those most in need.
3. Too Costly
3.1. payment structure for long term support and care are so adverse to outcomes
3.2. Have to modify the structure for people to take on more expensive at-risk patients
3.3. Costs assigned to patients may affect the practice's overall performance unless a modifier for risk score is used.
3.4. Complex population. Will take a much strategized approach to be successful. Will likely be expensive

4.ACO Stage 4: Fully expand ACOs throughout Kentucky

1. Services available through the ACO will vary based on region of the state.
2. Will be driven by national trends and CMS requirements

1. Other
1.1. Need true incentives for providers to establish an ACO. Positive incentives.
1.2. could negate any cost savings
1.3. Especially for rural areas, you need to

5.ACO Overall

- 1. Based on measures, the patients should experience better care, and the payers should see a reduced cost savings
- 2. Need to follow national trends

make sure you do Stage 3 really well before doing this.

1.4. Lack of awareness is problematic

1.5. Perhaps a schematic combining PCMH and ACO - for example, if member is PCMH recognized, then perhaps a better risk sharing contract

1. Other

1.1. Maine

1.2. Geographic (transportation) challenges for rural populations

1.3. Providers need faster funding and results than the MSSP model where upside payments are delayed considerably

1.4. What is the evidence for ACO success

1.5. If an ACO is the right thing to do why does it require an incentive

1.6. Are you talking of a state specific ACO not using the Medicare definition of ACO ... this could potentially confuse providers ... I would suggest that if the intent is to create a state defined ACO criteria a different name is used ... the potential impact on providers would be high.

2. Outcome Data

2.1. How do providers feel comfortable with providing outcome data and still feel protected legally, financially.

2.2. Are there potential negative

consequences if the providers' outcome data is poor?

ACO IMPLEMENTATION ROADMAP

Description

Picture 1



ACO IMPLEMENTATION ROADMAP

Categorize comments based upon sections of roadmap

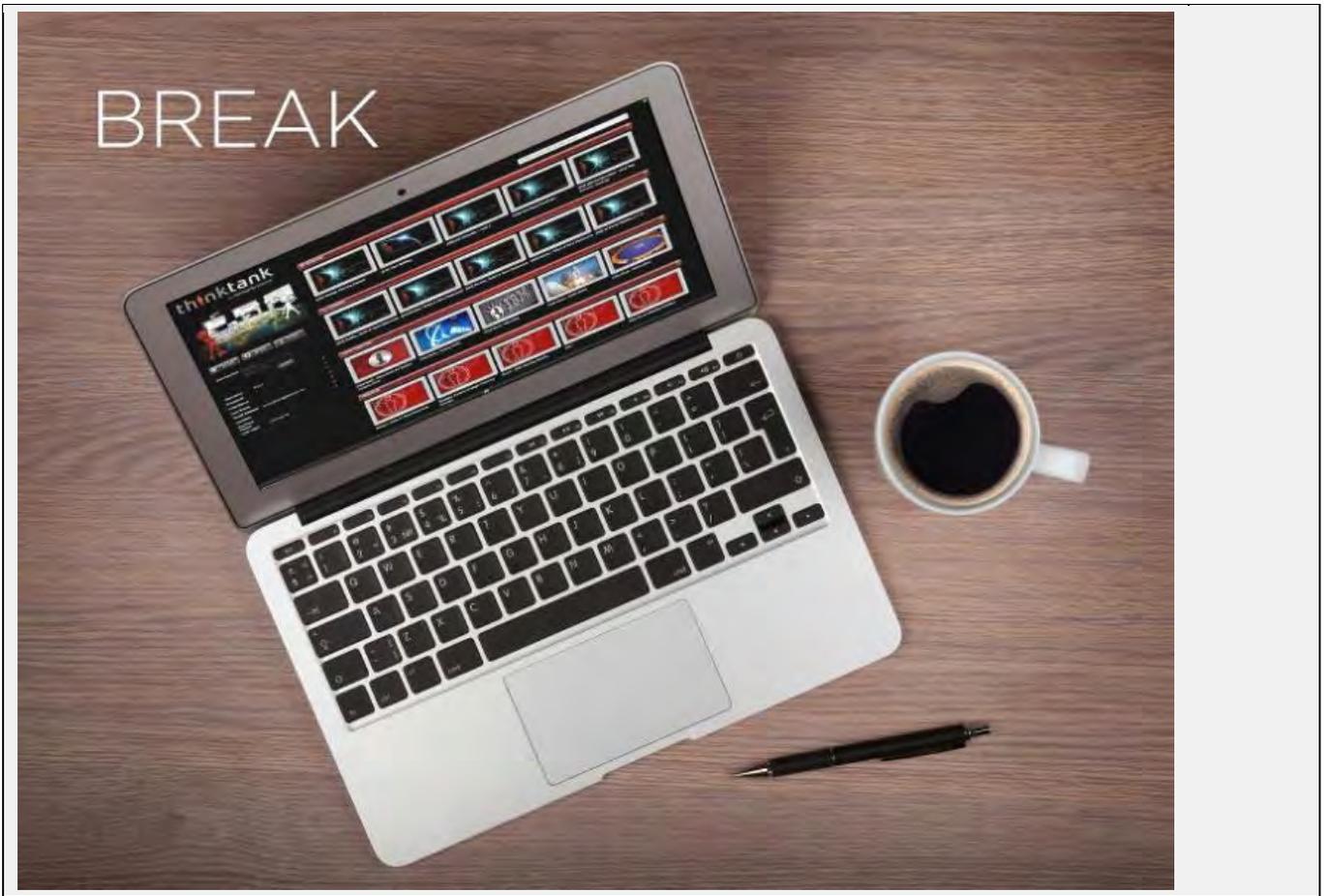
regulations **practice** **provider contracting** **recruitment**
communication
data collection
legal compliance
reporting monitoring

1. Data Collection and Reporting
2. Provider Recruitment Support/Practice Transformation
3. Contracting
4. Legal/Regulations
5. Workforce
6. Technology
7. Monitoring and Compliance
8. Communication
9. Other

TRANSITION FROM ACO TO CCC

Description

Picture 1



DAY 1 DEFINITIONS - CCC

Obtain feedback on definition of each reform activity

- 3.4. Would this include people with IDD?
- 3.5. Don't forget exercise as medicine!
- 3.6. Yes. The CC must include physical, mental, dental, economic
- 3.7. Also oral health
- 3.8. include specific conditions related to children
- 3.9. include the community health worker model under the Case Management to expand the patient education allowing them control of their health going forward
- 3.10. Agree on vision
- 3.11. Add oral health--not sure why it was excluded
- 4. Prevention
 - 4.1. Have any thoughts been given to prevention if the health markers are present for developing chronic conditions: hypertension, obesity, heart disease...ie, patients are close to borderline?
 - 4.2. work to prevent people from getting these conditions in the first place - prevention and social determinants
 - 4.3. Absolutely must start with preventive type care -- Every patient with chronic complex conditions should have a thorough functional assessment by a rehab professional with a follow-up activity plan.
- 5. Consumers
 - 5.1. Chronic conditions require additional measures to ensure patients are adhering to medication and treatment plans - perhaps adding patient incentives?
 - 5.2. We are going to have to have accountability on the consumer/patient side.
 - 5.3. patient accountability
 - 5.4. Really encourage a strong communication program around chronic disease and well-being to drive positive health choices and lifestyle changes.
- 6. Payment/Provider Gaps
 - 6.1. Again payment for these activities don't currently exist if providers know that their payment includes CM and they have to report activities around those activities.
 - 6.2. Agree this is needed but there is a shortage of behavioral health professionals and they are not all interchangeable -- they have different scopes of practice
 - 6.3. concern about behavioral health component and availability of providers in this arena
- 7. Care Management/Coordination
 - 7.1. How will this interface with the care management the MCOs are supposed to be doing?
 - 7.2. need to identify how care coordination would work across practices
 - 7.3. Agree on coordination of care coordination
- 8. Care Team
 - 8.1. CC is a "one" team based concept
 - 8.2. Too many cooks is one problem, but only one cook is a whole different problem.
 - 8.3. make sure no duplication of services - ONLY one Care Coordinator per individual
 - 8.4. Use of an interdisciplinary care team
 - 8.5. Care coordination per INDIVIDUAL or FAMILY
- 9. Other
 - 9.1. Lots of pay-off with broadly based CCC
 - 9.2. All payers included!
 - 9.3. The goal is good

3. Increase the number of qualified individuals receiving services through a CCC initiative.

- 1. Further Definition Needed
 - 1.1. Is this part of the definition or a goal?
 - 1.2. More detail on how this model would be constructed is needed.
 - 1.3. We don't know enough about this model
- 2. Operations
 - 2.1. include palliative care when appropriate- you can only work through the chronic care management cycle so many times until it becomes futile care
 - 2.2. How would there be incentives to ensure the lowest cost of care is provided?
 - 2.3. having a multispecialty practice may be difficult- someone has to be on point for the care coordination BUT THE INFO HAS TO BE SHARED AMONG all specialists or it won't work
- 3. Evidence-base

3.1. Absolutely. All persons with multiple chronic conditions should be enrolled in coordinated care models with providers and payers figuring out how they can make this happen. Technology and fair/timely payment will be necessary.

3.2. Chronic care management is a good method for population health management providing you have the financial resources for care management staff

3.3. We need use cases to demonstrate how coordination would work for orphan types of diseases where specialty knowledge is lacking

4. Education

4.1. education to patients and providers

4.2. 2. Education of patients AND continuing to improve coordination of care with behavioral health should be encouraged by payers and providers alike.

5. Other

5.1. agree

5.2. Integrated approach that can align and be transferable versus a standalone model. This is an important model....would benefit from integrating elements

4. Other

1. Operations

1.1. Are there going to be standards on what defines a complex patient? How will the offices know who qualifies, or does that matter?

1.2. Address community-based care and social determinants to increase health outcomes and reduce barriers to population health.

1.3. While I understand this model and strategy, it's very difficult to implement. One of the challenges we have with our providers is simply they feel burned out by having a full panel of chronic patients every day in their practice. They prefer to have a mix as the chronic patients are extremely resource intensive and mentally draining.

2. Duplication of Effort

2.1. Can the CCC initiative be placed inside the PCMH model? I feel this is a duplication of the same technique

2.2. As it relates to expansion outside Medicaid, confusion is created regarding the potential for duplication of effort as PCMHs are engaged in addressing chronic disease as are ACOs. As these organizations receive value based reimbursement, having the payors responsible for coordinating and offering this program could be problematic. Will ACOs and PCMHs adopt this program after they have already taken steps to implement their own efforts at chronic care mgmt?

DAY 2 DEFINITIONS - CCC

Obtain feedback on definition of each reform activity

- 3.1. Payment models that allow enough time to truly care for the most complex patients.
- 3.2. pay for non-face to face care coordination for these individuals so that they will receive more care and communication, thereby hopefully reducing cost while improving health
- 4. Care Coordination
 - 4.1. Should be a health/social SWAT team to concentrate on the top 5%. this is where you have the potential to get the most bang for your bucks
 - 4.2. create health swat team to target high users
 - 4.3. Build a culture between organizations, even if they are competitors, which supports collaboration to care for people with complex needs
 - 4.4. Care coordination as an identified and reimbursable activity--a good strategy
 - 4.5. connecting and coordinating patients with current evidenced based CDSMP's
 - 4.6. Shared care plans are essential
 - 4.7. Data Sharing and improved communication across all providers serving CCC patients. Less duplication. More patient education.
 - 4.8. I think we will see more focus on care coordination going forward based upon the direction that Medicare is setting ...
 - 4.9. The home is the "New Frontier" for health care. Care coordination of home provided services is vital and must include both licensed and non-licensed providers.
 - 4.10. Is the healthcare community ready to deal with all the care coordination needs of these patients? Where will the resources come from? How creative can health providers be to develop processes and programs?
- 5. Nature of the Initiative
 - 5.1. PCMH on steroids for specific chronic conditions?
 - 5.2. How does this differ from ACO?
 - 5.3. Why not part of the ACO and the PCMH
- 6. Operational Needs
 - 6.1. Make this work evidence-based, look at the research being done in KY and in other states to help identify best practices
 - 6.2. use evidence based or promising practices
- 7. Other
 - 7.1. Time is of the essence for providing interventions with patients with CCC and behavioral health conditions. Waiting for care often ends up in higher costs and worsening conditions.
 - 7.2. Badly needed, not happening in KY although everyone is talking about it!
 - 7.3. Improve resources for transitional staff training/certification/licensure
 - 7.4. requirements for home visits and care management
 - 7.5. Measure hospice utilization for this population.
 - 7.6. Have education on end of life services and support these services.
 - 7.7. our population needs this, however these efforts should not suck all the resources from preventive care and services to youth as it has in the past years
 - 7.8. Once again the state hospitals and mental health providers are not subjected to managed care; will this change?

3. Increase the number of qualified individuals receiving services through a CCC initiative.

- 1. Additional Provider Types
 - 1.1. Would this include hospice?
 - 1.2. need to increase the number of providers and mid-level providers in the care coordination
 - 1.3. Hospice?
 - 1.4. still need medical legal partnerships here as well, perhaps even more so
- 2. Operational Considerations
 - 2.1. Voluntary enrollment by patient choice?
 - 2.2. identify and assign to the proven leaders in care and quality
 - 2.3. lower the standards/requirements
 - 2.4. What is the range of services?
 - 2.5. Would social factors that impact risk be considered or just medical/mental health diagnoses?
 - 2.6. Decision on what conditions driven by current cost? Or poorest outcomes?
 - 2.7. Matching providers to patients -
 - 2.8. How do you define these individuals?
 - 2.9. keep patient qualifying process simple

3. Technology/Data Collection
 - 3.1. Tracking? Data collection -
 - 3.2. would have to include shared records,
4. Patient Incentives
 - 4.1. Provide incentives.
 - 4.2. Incentive for patients to use CCC?
5. Outcomes
 - 5.1. Who is held accountable for outcomes
 - 5.2. Observe outcomes of the MCCM demonstration on providing concurrent hospice team care and curative care.
 - 5.3. Quality of care.
 - 5.4. Make it cost plus quality outcomes
6. Other
 - 6.1. Need another study.
 - 6.2. Raise awareness of eligibility for this initiative through provider and consumer education
 - 6.3. May be difficult to find providers and resources to manage the most complex patients, particularly in rural areas
 - 6.4. "Qualifications" may be problematic when it comes to providing comprehensive care for our citizens.
 - 6.5. Toward targeted specific populations--more targeted and potentially better ROI than generic PCMH

4. Other

1. Duplicate Initiative
 - 1.1. isn't this a core component of and ACO, seems to be a duplication of initiatives
 - 1.2. Isn't a CCC similar to a PCMH that provides specialized care to chronic disease patients?
2. Attribution
 - 2.1. Just make sure the PCP doesn't suffer the attribution of the cost the care!
 - 2.2. Establish protocols for when and member attribution to this model
3. Other
 - 3.1. let's do it first
 - 3.2. would love to see this expand from ccc to also highlight palliative care
 - 3.3. include all MCOs at to drive definitions and implementation. Define separate programs for adults and children -
 - 3.4. Need outcomes measures.
 - 3.5. Focus on cost of care for patients and utilization. Frequent utilization of ER and multiple hospitalizations equals the higher cost.

DAY 1 GOALS - CCC INITIATIVE

Obtain feedback on goals



1. Number of payers involved

- 1. Start with Medicaid

2. Number of participating providers

- 1. Number and TYPES of participating providers
- 2. transitional care should be a piece of this model by providers who have experience - there are evidence based models
- 3. Consider a pilot group

3. Number of Kentuckians receiving care through a Health Home or other CCC model

- 1. need to add a patient outcomes metric to this
- 2. the CCC model needs to address chronic conditions with orphan disease types which typically result in much higher cost and use of care

DAY 2 GOALS - CCC INITIATIVE

Obtain feedback on goals

- 4.2. Start with motivated providers
- 4.3. all medicaid participating providers must be required to manage their patients
- 4.4. Who is the provider if the care is a team effort? Primary care provider?
- 4.5. dental hygienists should be listed as providers

5. Coordination

- 5.1. Broad spectrum of provider across the continuum of care will require coordination of data and communications

3. Number of Kentuckians receiving care through a Health Home or other CCC model

1. Value vs. Volume

- 1.1. we can't just count ducks - volume rather than value-based
- 1.2. Not volume of individuals, but quality of their care
- 1.3. Outcomes of patients (value based)

1.4. make it about value, about minimizing suffering and increasing ability to function in daily activities (not just clinical outcomes, but quality of life outcomes)

2. Agree

- 2.1. This would be the key.
- 2.2. Identified through claims, this could happen sooner than later, and start this level of care now.

3. Workforce

- 3.1. Will there be enough providers in the state to handle CCC patients?

4. Outcomes

4.1. The number of individuals might be very small due to the complexity of their situations. A big change in overall well-being might be a much better measures, that is outcomes not raw numbers

- 4.2. focus on outcomes for those who are receiving ccc care

4.3. Goal should focus on the highest spending segment of the population. Roughly 5% of the population is driving the highest spend; therefore, a shift to tackling this group of the population is critical in reducing spend and improving quality of care.

5. Condition-specific Goals

- 5.1. Will be determined by conditions chosen

5.2. Should be number of qualified individuals since this is directed at chronic disease patients and high utilizers. Need to establish goals specific to most costly diseases and most difficult to manage patients.

6. Patient-centered Goals

- 6.1. raw numbers aren't as meaningful as specific rates of improvement
- 6.2. Feedback on satisfaction of services

7. Retention Goals

- 7.1. Maintain enrollment based of successful participation
- 7.2. have to include retention as an element

8. Other

- 8.1. How do we count? Specifically within a CCC initiative? Or, functional equivalents in other initiatives
- 8.2. Identification of successful pilots
- 8.3. Can I be both considered a CCC and PCMH/ACO?
- 8.4. Reduced readmission rates in geographic region
- 8.5. Coordination of CCCs with those patients who are frequently readmitted to the hospital (HF, COPD, etc)
- 8.6. Must have community buy in/support payers providers cannot do alone. Must change community norms
- 8.7. Measure impact on total spend in corrections, court system, police involvement, emergency Dept utilization
- 8.8. Ensuring patients receiving care through this model are evenly distributed among population most in need

DAY 1 GOALS - CCC INITIATIVE

Brainstorm new goals



1. What other goal topics for the CCC Initiative do you think should be included in the draft Value-based Health Care Delivery and Payment Methodology Transformation Plan?

1. Transitions
 - 1.1. transitional care as a component of CCC
 - 1.2. Transitional care big component of cc, community involvement, patient AND family involvement
 - 1.3. transitions of care
2. CCC Outcomes
 - 2.1. Clinical outcomes that follow a patient, regardless of number of times they may move to other payers.
 - 2.2. long-term health outcomes
 - 2.3. quality of life
 - 2.4. Clinical outcome data
 - 2.5. Outcomes from the clinical and cost perspectives. A cost benefit analysis that includes input from the patient.
 - 2.6. It's about outcomes...not just participation from providers
 - 2.7. quality and cost outcomes
 - 2.8. inpatient and institutional (SNF, incarceration, etc.) recidivism rates
3. Care Team/Services
 - 3.1. community health workers
 - 3.2. strongly encourage utilization of health coaches
 - 3.3. use of community-based services vs medical model services
 - 3.4. Interdisciplinary component of CCC
 - 3.5. behavioral health providers are not all equal and this should be clear
4. Quality of Life
 - 4.1. quality of life
 - 4.2. health, wellness, and quality of life
 - 4.3. Quality of life is important
5. Patient Engagement/Satisfaction/Compliance
 - 5.1. patient satisfaction
 - 5.2. patient compliance
 - 5.3. patient engagement
 - 5.4. Patient non-compliance is a major factor
 - 5.5. Patient centered goal development
 - 5.6. Incentivize patients to adhere to care guidelines and medication compliance - need to ensure programs are in place so

- 2.2. How many individuals have a stable housing setting
- 3. Integrated/Coordinated Care Goals
 - 3.1. Integrated care
 - 3.2. Wraparound health services / care integration
 - 3.3. EHR utilization and sharing information across providers
 - 3.4. Develop strategies to coordinate preventive services in a safe manner - prevent additional complications and comorbidities.
 - 3.5. all components of the delivery model need to be engaged to manage this population
 - 3.6. Timely Communication standardized between payers.
 - 3.7. coordinated data collection at the patient level
 - 3.8. Shared care plan across the continuum
 - 3.9. Coordination of these providers with hospitals to route discharged patients with chronic conditions to the best place for them
 - 3.10. total integration of care
 - 3.11. Integration of Health and Behavioral Health
- 4. Quality/Outcomes
 - 4.1. Patient health status outcomes
 - 4.2. monitoring of positive outcomes vs. \$ spent
 - 4.3. reduce cost of care, while increasing patient's health and wellbeing
 - 4.4. Return on Investment, not just financially but in the quality of life of the individual
 - 4.5. Need dashboard of key outcomes, regular reporting.
 - 4.6. quality of life and barriers to health stability (which often overlap with economic stability)
 - 4.7. quality of life measures
 - 4.8. prevention of deterioration
- 5. Operational Considerations
 - 5.1. how many chronic conditions are covered
 - 5.2. Clearly define high risk/at risk, high cost populations (e.g. older adults with falls risk) with specific focused initiatives (e.g. falls prevention programs).
 - 5.3. Must have an opt-in for all populations.
 - 5.4. what is the definition of success 50% 75% important to set targets for improvement
 - 5.5. Time. Don't be like the VA where it takes months to get an Rx filled.
- 6. Additional Care Types
 - 6.1. Palliative care.
 - 6.2. increased utilization of palliative care services, blended into this model
 - 6.3. Measure costs from a variety of settings, not just medical
 - 6.4. Must include crisis care, which may not be the ER but a Crisis Stabilization Unit
 - 6.5. evidence based palliative care
 - 6.6. Should include pastoral care.
- 7. Prevention
 - 7.1. community level prevention efforts
 - 7.2. Prevention is a key component to decreasing costs
 - 7.3. Prevention science is needed for controlling, managing CCC.
 - 7.4. reduced ed, reduced im, improved self-reported mental health, reduced rx, increased pcp,
 - 7.5. Reduce unnecessary hospitalizations and ER visits for the chronic condition population from a pre/post service aspect
 - 7.6. Prevention of higher-cost care (e.g., hospitalizations) and of negative outcomes (jail)
 - 7.7. make prevention the most important item in the budget
- 8. Patient/Family Involvement
 - 8.1. Patient/Family involvement
 - 8.2. Individual engagement in improving his or her life
 - 8.3. Encourage end of life decision making and support patients in their decision making
- 9. Other
 - 9.1. Community Support
 - 9.2. Health = not just being doctor visit care
 - 9.3. Getting guy in with patients and community leaders to engage a culture of health in Kentucky.

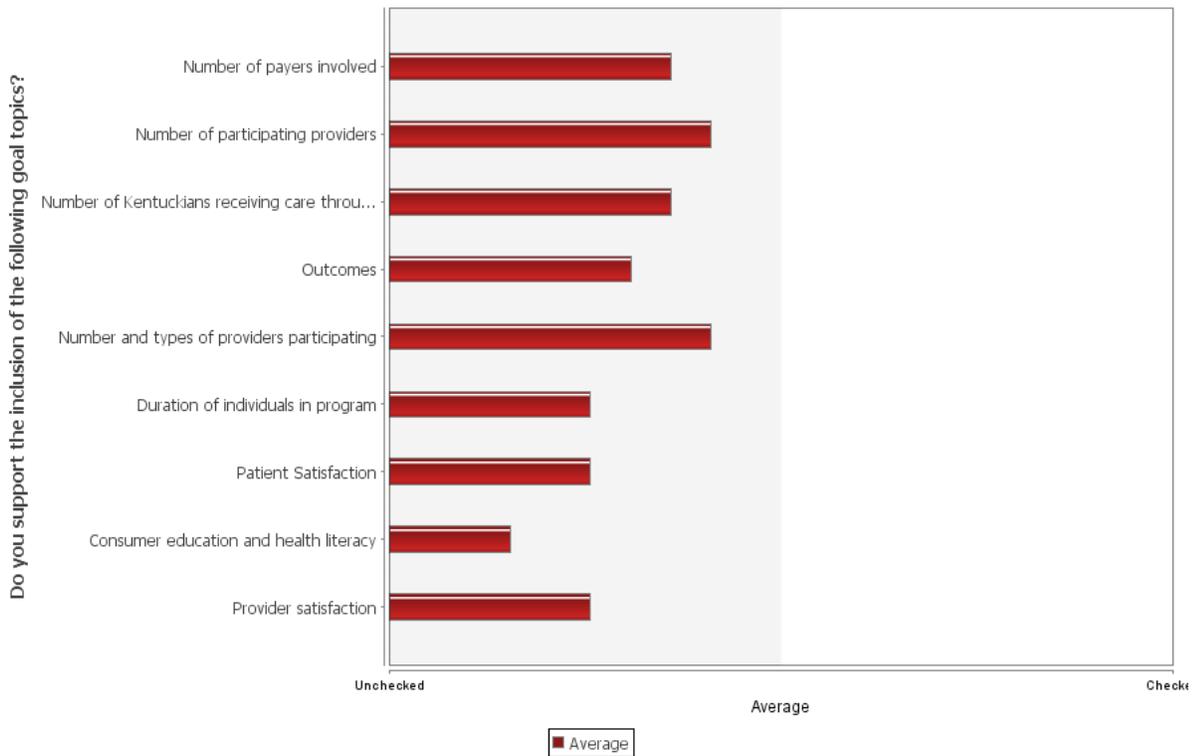
9.4. Reduce admin burden

DAY 1 CCC YES/NO GOALS SUPPORT

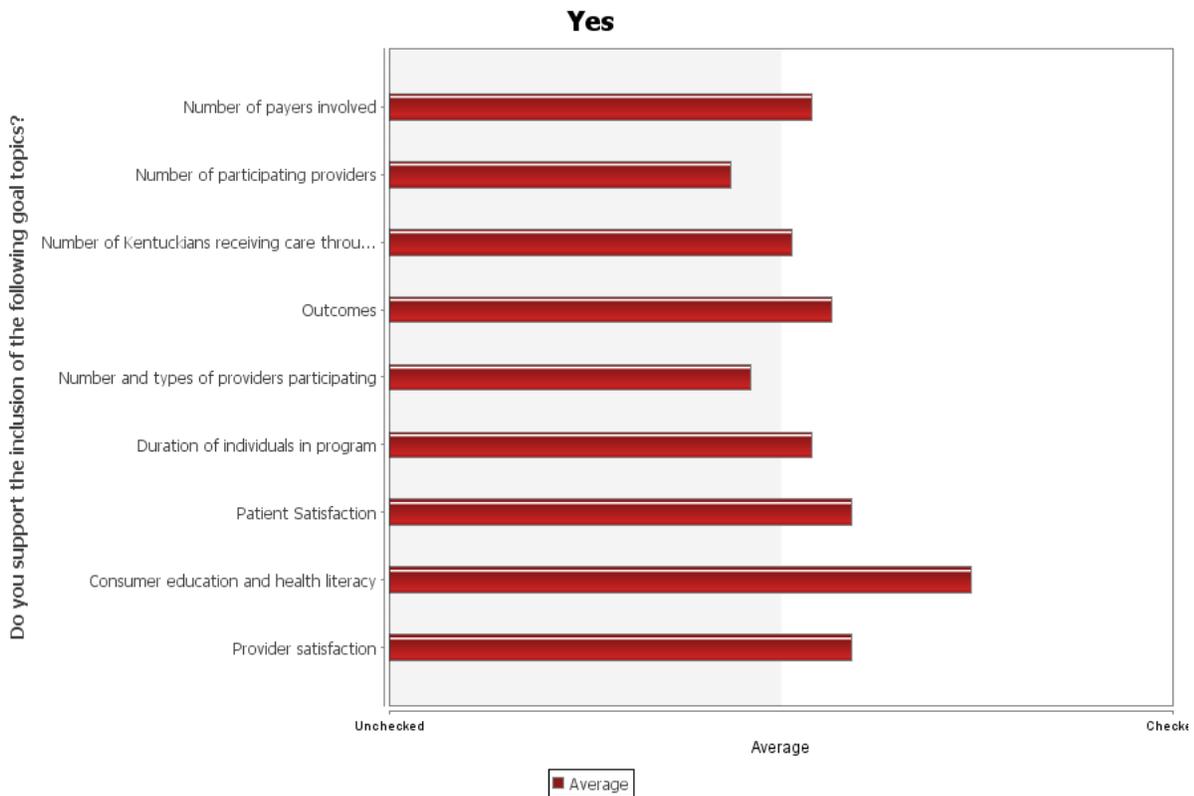
Votes Cast: 39 Abstained: 3

	Yes with Modifications	Avg.Score	+/-	Std Dev	Unchecked	Checked
1	Number of payers involved	0.36	48.0%	0.48	25	14
2	Number of participating providers	0.41	49.2%	0.49	23	16
3	Number of Kentuckians receiving care through a Health Home or other CCC model	0.36	48.0%	0.48	25	14
4	Outcomes	0.31	46.2%	0.46	27	12
5	Number and types of providers participating	0.41	49.2%	0.49	23	16
6	Duration of individuals in program	0.26	43.7%	0.44	29	10
7	Patient Satisfaction	0.26	43.7%	0.44	29	10
8	Consumer education and health literacy	0.15	36.1%	0.36	33	6
9	Provider satisfaction	0.26	43.7%	0.44	29	10

Yes with Modifications

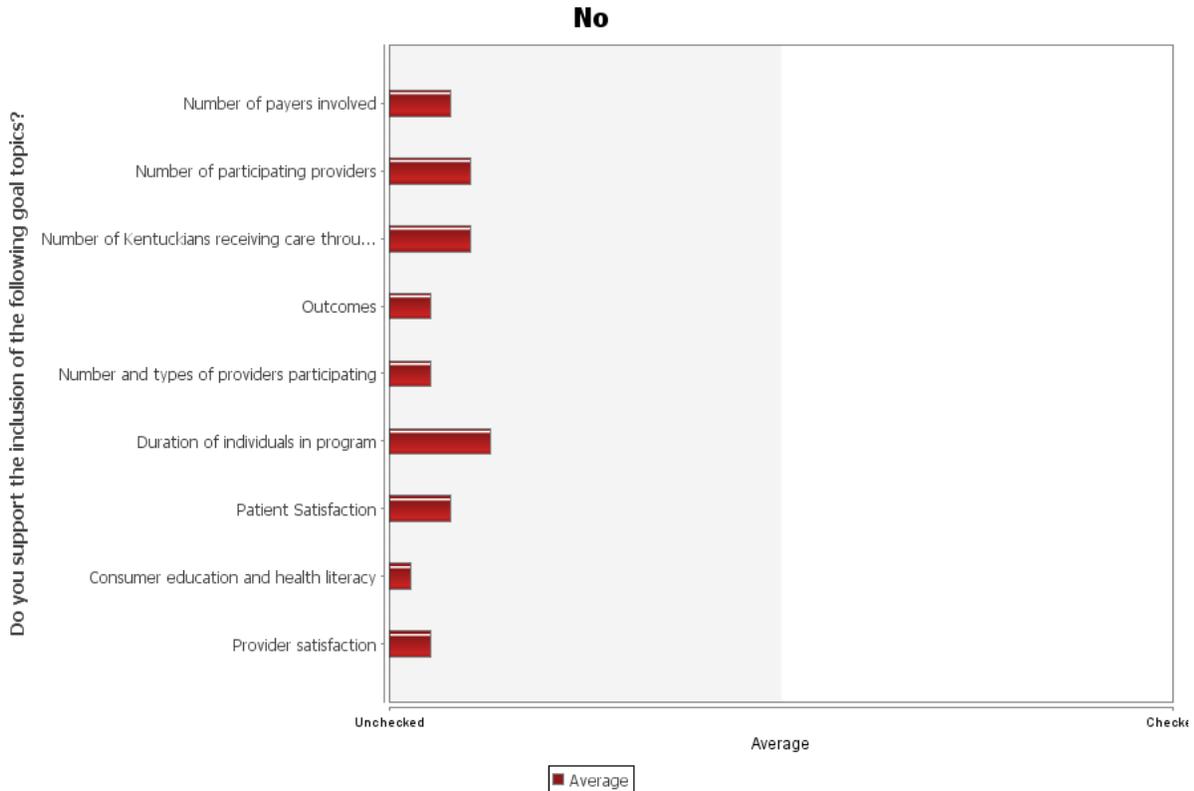


	Yes	Avg.Score	+/-	Std Dev	Unchecked	Checked
1	Number of payers involved	0.54	49.9%	0.50	18	21
2	Number of participating providers	0.44	49.6%	0.50	22	17
3	Number of Kentuckians receiving care through a Health Home or other CCC model	0.51	50.0%	0.50	19	20
4	Outcomes	0.56	49.6%	0.50	17	22
5	Number and types of providers participating	0.46	49.9%	0.50	21	18
6	Duration of individuals in program	0.54	49.9%	0.50	18	21
7	Patient Satisfaction	0.59	49.2%	0.49	16	23
8	Consumer education and health literacy	0.74	43.7%	0.44	10	29
9	Provider satisfaction	0.59	49.2%	0.49	16	23



	No	Avg.Score	+/-	Std Dev	Unchecked	Checked
1	Number of payers involved	0.08	26.6%	0.27	36	3
2	Number of participating providers	0.10	30.3%	0.30	35	4
3	Number of Kentuckians receiving care through a Health Home or other CCC model	0.10	30.3%	0.30	35	4

4	Outcomes	0.05	22.1%	0.22	37	2
5	Number and types of providers participating	0.05	22.1%	0.22	37	2
6	Duration of individuals in program	0.13	33.4%	0.33	34	5
7	Patient Satisfaction	0.08	26.6%	0.27	36	3
8	Consumer education and health literacy	0.03	15.8%	0.16	38	1
9	Provider satisfaction	0.05	22.1%	0.22	37	2



Do you support the inclusion of the following goal topics?	Any Comments
Number of payers involved	1. standardize the payer "requirements" for ccc involvement
Number of participating providers	1. Provider Types 1.1. must provide an approach for engaging specialty providers outside practice group 1.2. including pediatric providers 1.3. And types 2. Other 2.1. need ability to limit the panel size for PCP's for these chronic patients 2.2. collaboration amongst providers is critical for success 2.3. quality of participating providers 2.4. Add number of ACO's participating in CCC programs.

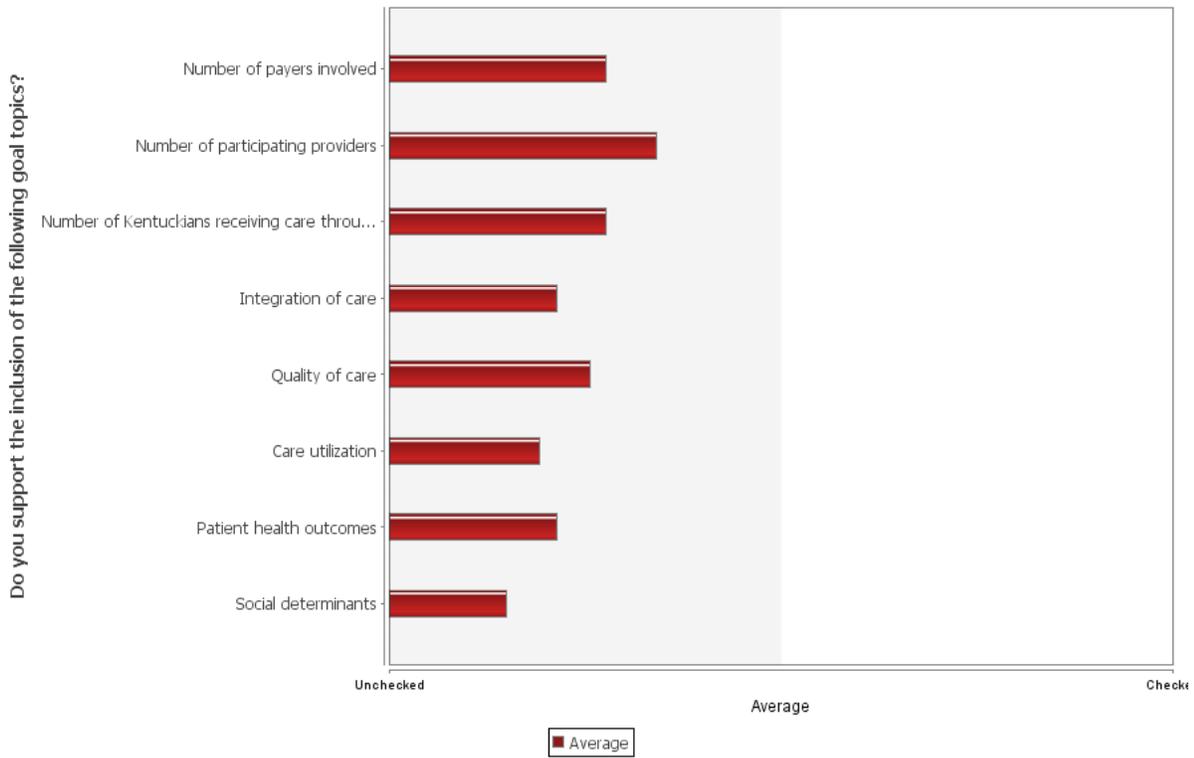
Number of Kentuckians receiving care through a Health Home or other CCC model	<ol style="list-style-type: none"> 1. This number needs to be based on only those with chronic conditions fitting the criteria for those who qualify for CCC care. 2. But need to assure that those who are receiving this care SHOULD be receiving this care or we will be wasting resources
Outcomes	<ol style="list-style-type: none"> 1. Outcomes require measurement. 2. and accurate and up to date data 3. Include QOL
Number and types of providers participating	<ol style="list-style-type: none"> 1. This will vary based on county. Rural/Metro 2. Critical to have broad spectrum of care team to really effectively manage patient - including the role of pharmacists
Duration of individuals in program	<ol style="list-style-type: none"> 1. This varies based on the type of condition and graduation set up of CCC programs 2. Duration can be good or bad-- if the length of care indicates the patient isn't getting what he/she needs, then it's not a great measure
Patient Satisfaction	<ol style="list-style-type: none"> 1. Define patient satisfaction and engagement.
Consumer education and health literacy	<ol style="list-style-type: none"> 1. Extremely important.
Provider satisfaction	<ol style="list-style-type: none"> 1. Don't forget payor satisfaction 2. Very important if we are going to get their buy in 3. Provider satisfaction is key or they will not participate. Education and engagement is key.

DAY 2 CCC YES/NO GOALS SUPPORT

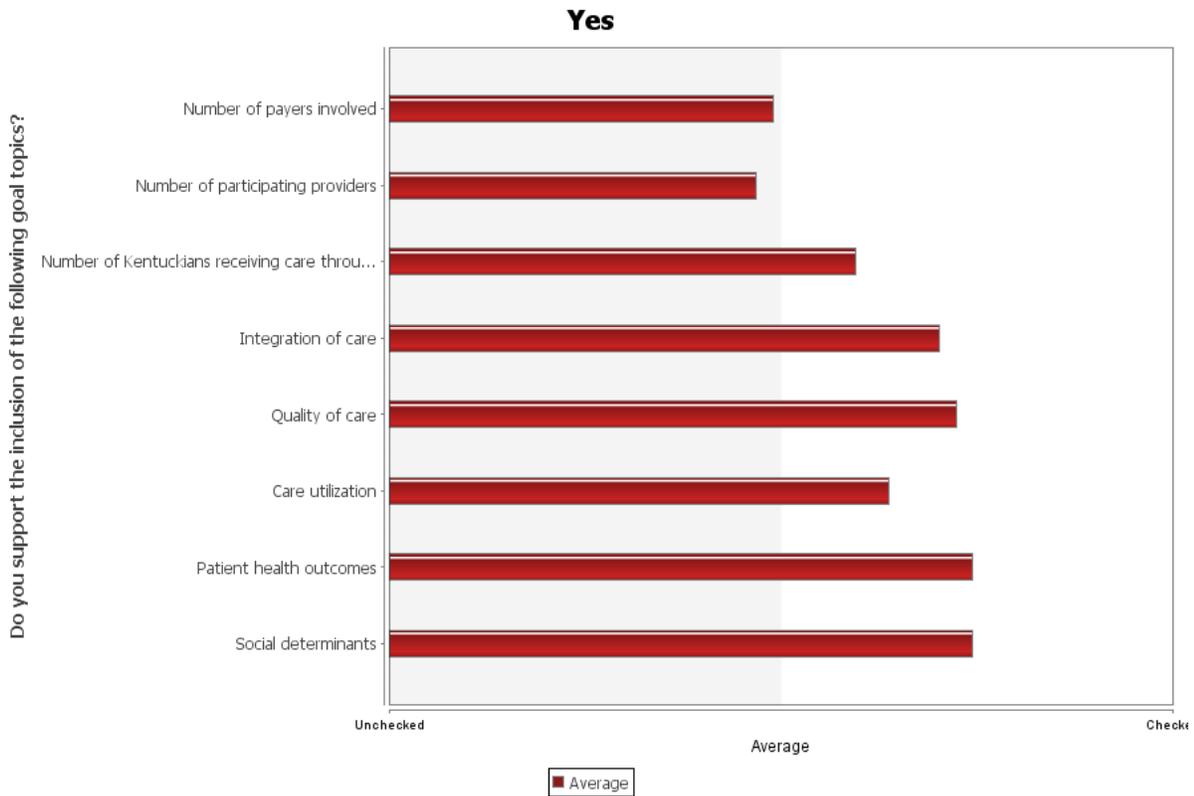
Votes Cast: 47 Abstained: 2

	Yes with Modifications	Avg.Score	+/-	Std Dev	Unchecked	Checked
1	Number of payers involved	0.28	44.7%	0.45	34	13
2	Number of participating providers	0.34	47.4%	0.47	31	16
3	Number of Kentuckians receiving care through a Health Home or other CCC model	0.28	44.7%	0.45	34	13
4	Integration of care	0.21	40.9%	0.41	37	10
5	Quality of care	0.26	43.6%	0.44	35	12
6	Care utilization	0.19	39.3%	0.39	38	9
7	Patient health outcomes	0.21	40.9%	0.41	37	10
8	Social determinants	0.15	35.6%	0.36	40	7

Yes with Modifications

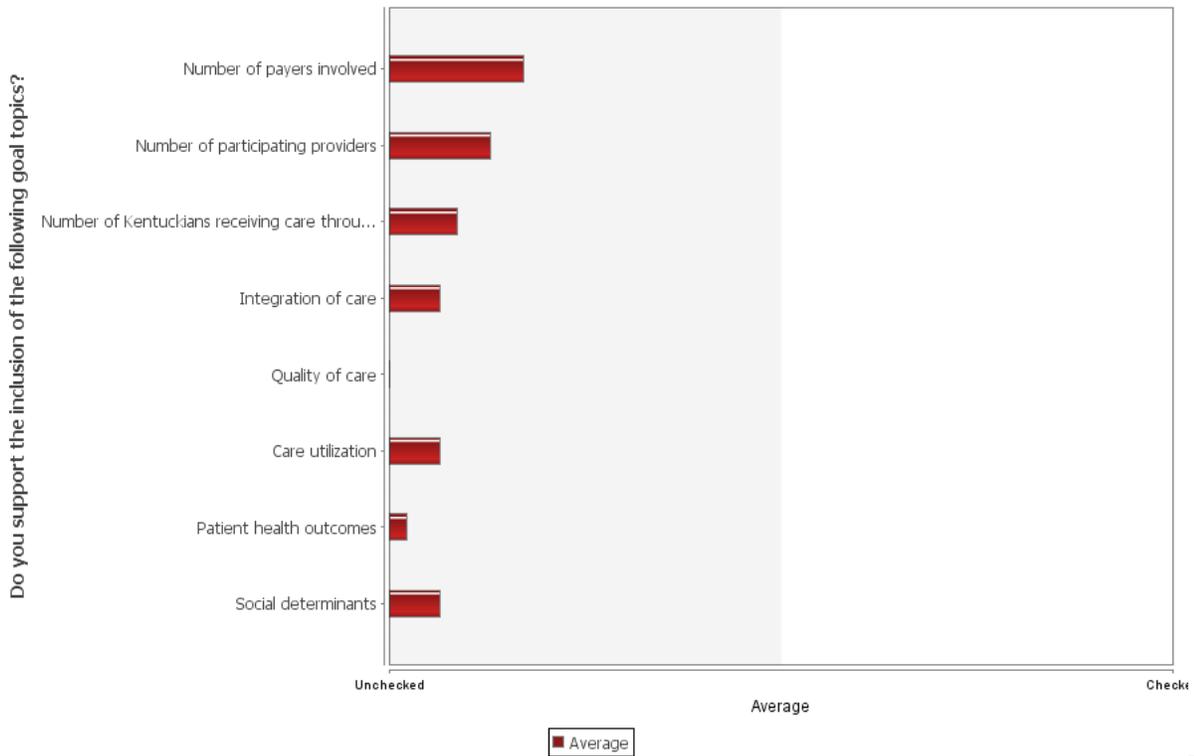


Yes	Avg.Score	+/-	Std Dev	Unchecked	Checked
1 Number of payers involved	0.49	50.0%	0.50	24	23
2 Number of participating providers	0.47	49.9%	0.50	25	22
3 Number of Kentuckians receiving care through a Health Home or other CCC model	0.60	49.1%	0.49	19	28
4 Integration of care	0.70	45.7%	0.46	14	33
5 Quality of care	0.72	44.7%	0.45	13	34
6 Care utilization	0.64	48.0%	0.48	17	30
7 Patient health outcomes	0.74	43.6%	0.44	12	35
8 Social determinants	0.74	43.6%	0.44	12	35



No		Avg.Score	+/-	Std Dev	Unchecked	Checked
1	Number of payers involved	0.17	37.6%	0.38	39	8
2	Number of participating providers	0.13	33.4%	0.33	41	6
3	Number of Kentuckians receiving care through a Health Home or other CCC model	0.09	27.9%	0.28	43	4
4	Integration of care	0.06	24.4%	0.24	44	3
5	Quality of care	0.00	00.0%	0.00	47	0
6	Care utilization	0.06	24.4%	0.24	44	3
7	Patient health outcomes	0.02	14.4%	0.14	46	1
8	Social determinants	0.06	24.4%	0.24	44	3

No



Do you support the inclusion of the following goal topics?	Any Comments
Number of payers involved	
Number of participating providers	1. And type of provider
Number of Kentuckians receiving care through a Health Home or other CCC model	1. Better to use %age of Kentuckians with chronic conditions who are served in a CCC model
Integration of care	1. Individuals perception of how integrated his or her care is 2. Do not restrict discussion of integration to PC and BH. Look at a complete model based on the needs of a community and be creative in how they are licensed. 3. How is it defined? Measured?
Quality of care	1. VALUE of care
Care utilization	
Patient health outcomes	
Social determinants	1. Need a different terms such as social correlates of health

DAY 1 CORE ELEMENTS FEEDBACK - CCC

- 2.1. obvious progression
- 2.2. Agree with pilot testing and systematic roll out. How will expansion accommodate different payment systems outside of MCO and provider support?
- 3. Other Chronic Conditions
 - 3.1. Focus on diabetes
 - 3.2. Focus on respiratory illnesses
- 4. Measurement
 - 4.1. How do we define effectiveness? Just cost reduction, improvement in medical stats, quality of life measures?

3. Encourage other payers to adopt CCC payment and design structure to establish consistency in CCC across payers.

- 1. Agreement
 - 1.1. Without this component I think you will have difficulty expanding statewide
 - 1.2. should happen right out of the box
 - 1.3. Agree--would greatly strengthen
 - 1.4. Agree but we need evidence and measurements to make this work. Currently this is very scarce.
 - 1.5. Agree...
 - 1.6. If nothing else is accomplished but getting payers to work toward common quality measure then 'mission accomplished'
 - 1.7. Payers should adopt CCC
- 2. Define Encouragement
 - 2.1. Encourage payer? What does this mean?
 - 2.2. we've discussed the word "encourage"
- 3. Payer Roles
 - 3.1. Should be across multiple payers
 - 3.2. How will payers differentiate these payments from overall PCMH or ACO payments for accepting risk amongst providers?
- 4. Alignment with Other Initiatives
 - 4.1. Should providers own CCC program if their reimbursement is dependent on medical mgmt. of complex chronic conditions? PMCH and ACOs may already have implemented programs to cover Medicare/commercial enrollees. Could we be duplicating effort? How to we assure standardization without making providers do a great deal of potential 're-work'?
 - 4.2. This might make sense outside of ACOs. We should not have conflicting strategies
 - 4.3. Why not adopt CMS Chronic Care Management program
 - 4.4. Need to consider that in HIX there are members who will cross between MCOs and QHPs sometimes multiple times a year

4. Expand CCC models to include more comorbidities and chronic illnesses.

- 1. Care Types
 - 1.1. Dont forget end of life care
 - 1.2. include physical and behavioral health
 - 1.3. need to include care at the end of life as well
- 2. Consumer Types
 - 2.1. expand to include children
 - 2.2. Special needs children can be a specialized CCC- so is the goal to have specialized CCC or generalized CCC?
 - 2.3. need to define special needs - too broad to use as is
- 3. Expansion of Conditions
 - 3.1. This is extremely difficult to manage amongst multiple providers. I encourage us to focus on wellness and PCMH models to try to balance portfolios for providers.
 - 3.2. 1. This can be done under the right contracting process. We need to start small and build upon success instead of doing a global one step approach with this population.
 - 3.3. Need to start with a small number of comorbidities and chronic conditions, before adding others.
 - 3.4. Cautiously, but yes --
 - 3.5. Start with the most common ccc and add onto that based on population base. Couldn't you obtain data from the CDC?
 - 3.6. This should be done through a demonstration first and proven
 - 3.7. Need to start out focused on a few comorbidities then expand
 - 3.8. Also need to define how CCC conditions that are less common should be addressed.

3.9. Expand the definition and adapt more of a Medicare Care Management code process

3.10. Start with small number of conditions - test for efficacy.

4. Measurement

4.1. Need to develop more evidence based measures for use by providers, payers and population health management.

4.2. Sound and consistent measures for payment.

5. 2. Support

5.1. 3. Support and learn from these conversations. Listen to the communication be in push back or support from the payer community.

5.2. 6. This will be a key piece of the strategy and should be incorporated into each phase of the strategy.

5. Expand the CCC model's care team.

1. Further Definition Required

1.1. Expand to what? be more specific

1.2. Not sure what this means.

1.3. Need to specify

1.4. Not sure what the components for this model are so difficult to know what to expand

2. Importance

2.1. essential

2.2. Absolutely essential - again, right person right task will very likely save money and improve outcomes. This could be tested in demonstration project

2.3. Very essential but need to have the resources to make successful

3. Operations

3.1. all aspects of care should be included here including pharmacy, physical health, BH, specialist care, social barriers, vision, dental, etc

3.2. How will we provide resources to expand?

6. Develop a targeted consumer education and communication strategy.

1. Agreement

1.1. Agreed.

1.2. Agreed.

1.3. So needed!

1.4. Very important

2. Payer/Provide Role

2.1. Not until its refined and all payers are in

2.2. Basic education doesn't need payers. It's the payers that got us into this mess to start with

2.3. Enlist the support of hospital providers and expertise for educational programs as well as faith organizations to reach the diverse population across the state

3. Type of Consumer Engagement

3.1. consider the use of focus groups to ensure all barriers are overcome

3.2. Strongly support - consider working with community organizations to develop support groups of like patients to share experiences.

4. Need more how we plan to educate and communicate. State just rolled out the "if mail comes back with address/patient not found" then member is dropped from plan and provider doesn't get paid. So, if we can't get the members to update their address....how do we expect to communicate?

DAY 2 CORE ELEMENTS FEEDBACK - CCC

- 1.3. This needs to be more than a year in order to determine if it is an effective model and should be expanded
- 1.4. Must have a reasonable implementation time frame.
- 2. Additional Items
 - 2.1. Need a person centered evaluation process.
 - 2.2. What about targeted patient population?
 - 2.3. will need interoperability of IT systems in place
- 3. Proven Outcomes/Evidence-based Decision
 - 3.1. In reality, we really do not know what works well for complex populations. Need a randomized study to demonstrate best methods.
 - 3.2. If well executed and determined to have long term positive outcomes, then Yes. If problematic in design with questionable outcomes (only shorter- "End Result" idea from Codman) then clearly No.
 - 3.3. Proven outcomes are demonstrated
- 4. Agree

3. Encourage other payers to adopt CCC payment and design structure to establish consistency in CCC across payers.

- 1. Agree
 - 1.1. agreed
 - 1.2. Would be helpful - but a long game strategy
- 2. Standardization
 - 2.1. Standardization and coordination is key. As we make these broad sweeping changes we want to also simplify as well
 - 2.2. This is necessary for practices to be able to effectively manage patients. The staff will have the same guidelines that standardization affords.
- 3. Rates/Reimbursement
 - 3.1. financial incentives for cooperation
 - 3.2. Proper incentives need to be established for delivering high quality patient centered care. Outcome performance is key. Baseline PMPM pricing plus pay for performance on quality metrics
 - 3.3. Standardize rates
- 4. Other
 - 4.1. Only if found to be effective in multi-year demonstration project

4. Expand CCC models to include more comorbidities and chronic illnesses.

- 1. Timeframe for Implementing
 - 1.1. Eventually - start simple
 - 1.2. No keep it simple to start off with
 - 1.3. This should come later.
- 2. Evidence-based Decisions
 - 2.1. Only based on data to show that it is an effective model for a particular condition.
 - 2.2. Start small and add as progress is made as determined by proven improvement in outcomes.
 - 2.3. Use data to determine where to expand-- i.e. what condition next
- 3. Additional Information Required
 - 3.1. How would you limit comorbidities and chronic illnesses? if you pick a person you get what they have
 - 3.2. These could be anything - need definitions
- 4. Other
 - 4.1. Independence at Home framework for CMMI is a good place to start with two more comorbidities with recent acute hospitalization
 - 4.2. If you are going to create ACOs then they need to be to focal point of the CCC working in partnership with payors
 - 4.3. This should be a part of ACO model and if Medicaid population is included in ACO model these services should be provided.
 - 4.4. Perhaps do this with Medicaid prior to expansion with other payers
 - 4.5. Set these based on already established core quality measures.
 - 4.6. Do we build education in new models into medical, nursing, social work, chaplain etc. education
 - 4.7. Why exclude commercial payers from the pilot phase? They pay for people with complex needs also

5. Expand the CCC model's care team.

- 1. Provider Types / Additional Members of Care Team

- 1.1. should include dental hygienist- ASPIRATION pneumonia a real problem
- 1.2. Should include peer support specialists for both mental health & SUD
- 1.3. and their communities, community partners, nonprofits, service providers, etc.
- 1.4. Define the person as the quarterback of the care team
- 1.5. agree Add dentistry
- 1.6. Care managers will be integral in the care of these patients.
- 1.7. There should be linkage to hospice and community based palliative care and having the conversation about patient's choice and wishes for advance directives at end of life decisions. Are physicians aware of advance directives are they being shared across providers
- 1.8. include patients and their families in the care team
- 1.9. community health workers, and all mid-level providers need to be included
- 2. Agree
 - 2.1. This could be especially good with transitions. Think juvenile justice.
 - 2.2. This is a critical addition
 - 2.3. Yes.
- 3. Additional Information Required
 - 3.1. Who is part of the CCC model team now?
- 4. Challenges
 - 4.1. State requirements for CHWs could be complicated
 - 4.2. Refer to pertinent disciplines if a CCC member has a not team member care issue
 - 4.3. teams might look different for different conditions

6. Develop a targeted consumer education and communication strategy.

- 1. Agree
 - 1.1. This is a must.
 - 1.2. will be key as generally includes older populations
- 2. Responsibility
 - 2.1. Once again, this is key but cannot fall to the providers to carry this out.
 - 2.2. Who does this? What resources will we make available?
 - 2.3. Great role for CHWs and Patient Navigators
- 3. Communication/Listening Strategies
 - 3.1. Include consumers in development
 - 3.2. use data to target populations
 - 3.3. Listening is more important than just telling through a communication strategy. We test messages without ever listening to the citizen voice
 - 3.4. Patient engagement vs education and communication
 - 3.5. Consumer focused
 - 3.6. A listening strategy
 - 3.7. This will be key for voluntary participation
- 4. Other
 - 4.1. Consumer education especially as it relates to mental health, dual diagnoses issues, and addressing associated stigma.
 - 4.2. Need to know state of the art for consumer info.
 - 4.3. All patients must agree to care after education; it doesn't help anyone if the patient doesn't understand or doesn't want the extra help/care. Then the decision may have to be made about if insurance will be extended to them if not participating,
 - 4.4. Already exists

REVIEW CCC ROLLOUT STRATEGY

Review slide

CCC Rollout Strategy

CCC Rollout Strategy



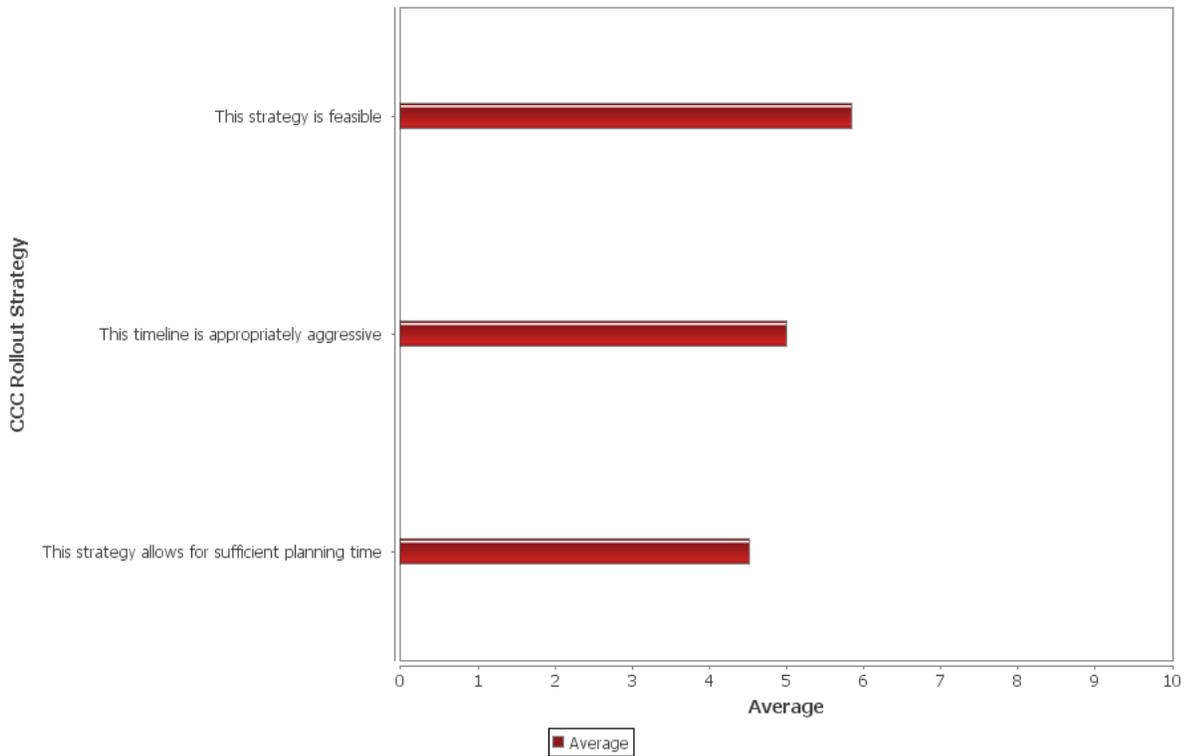
DAY 1 CCC ROLLOUT STRATEGY

Assess Feasibility

Votes Cast: 38 Abstained: 2

	Feasibility	Avg.Score	+/-	Std Dev	Min	Max
1	This strategy is feasible	5.84	27.1%	2.71	0.00	10.00
2	This timeline is appropriately aggressive	5.00	32.0%	3.20	0.00	10.00
3	This strategy allows for sufficient planning time	4.53	29.7%	2.97	0.00	10.00

Feasibility



CCC Rollout Strategy	Any Comments
This strategy is feasible	<ol style="list-style-type: none"> 1. Who IS this steering committee?? 2. Not enough time to review this strategy thoroughly 3. Feasible if done incrementally following a demonstration and proven ROI 4. Are the steering committees on each of these made up of different people or the same? I think this will affect the feasibility
This timeline is appropriately aggressive	<ol style="list-style-type: none"> 1. Too aggressive. We don't know anything about the Medicaid plan 2. Is Medicaid system ready for this so MCO will be paid and MCO systems will be consistent across the pilot areas? 3. Depends on the number of chronic conditions targeted 4. I think the timeline is not aggressive enough or PCMH needs to be pushed back.
This strategy allows for sufficient planning time	<ol style="list-style-type: none"> 1. However, this depends on the willingness of participants to create change. 2. make sure that we can obtain aggregate data 3. make sure steering committee does not just include MCOs - include consumer advocates 4. Depends on the number of conditions 5. No since we don't know anything about the Medicaid plan 6. Steering committee needs to represent the care

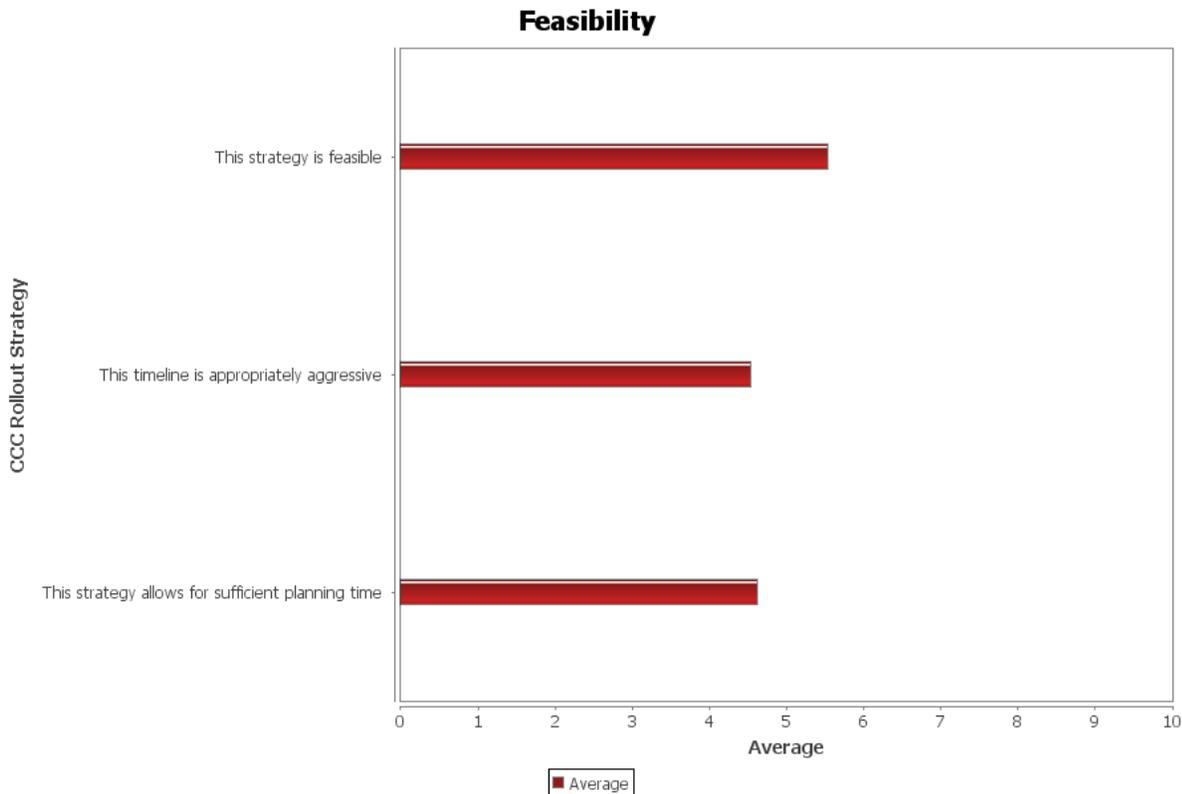
continuum
 7. Technology systems and training must be included in timeline.
 8. Contracting takes time especially since we're still at the straw man phase.

DAY 2 CCC ROLLOUT STRATEGY

Assess Feasibility

Votes Cast: 39 Abstained: 7

	Feasibility	Avg.Score	+/-	Std Dev	Min	Max
1	This strategy is feasible	5.54	29.5%	2.95	0.00	10.00
2	This timeline is appropriately aggressive	4.54	29.6%	2.96	0.00	10.00
3	This strategy allows for sufficient planning time	4.62	29.4%	2.94	0.00	10.00



CCC Rollout Strategy	Any Comments
This strategy is feasible	<ol style="list-style-type: none"> 1. more complex population 2. more complex conditions
This timeline is appropriately aggressive	<ol style="list-style-type: none"> 1. Meaning, it's VERY aggressive! 2. I think elements can start now, and not have to wait so long.

This strategy allows for sufficient planning time

DAY 1 CCC ROLLOUT STRATEGY

Benefits and challenges of each stage and overall

CCC ROLLOUT STRATEGY Stages	Benefits Benefits associated with this stage and its components	Challenges Challenges associated with this stage and its components
1.CCC Stage 1: Convene multi-disciplinary Steering Committee to define CCC demonstration program in Kentucky	<ol style="list-style-type: none"> 1. Keeps the testing focused by limiting number of conditions 2. Definite benefits for patients. Consistency in policies, strategies and education will be necessary. 3. leverages an existing initiative 4. Not offices accept MCO or any type of Medicaid plans 5. 1. This initiative builds on DMS planning efforts and can dovetail with other initiatives underway in the state. 6. Clear benefit to have a steering committee and enlist a broad range of providers. I think this will be challenging to implement 7. Would PCMH transformation encompass this initiative? 	<ol style="list-style-type: none"> 1. Metrics <ol style="list-style-type: none"> 1.1. Where are the metrics to make sure that you have your CCC designed correctly? 1.2. Your metrics should be designed shortly after the program is designed... 2. Payment <ol style="list-style-type: none"> 2.1. Payment methodology changes and contracting of any kind takes time. This piece of the stage is too aggressive... 2.2. Consistency in payment and training. Education is key. 2.3. aggressive payment methodology 3. Planning time <ol style="list-style-type: none"> 3.1. If providers are already PCMH certified, how are they going to know what CCC to focus on? For those practices that are working on the transformation, they need to know what CCC to focus on for planning. 3.2. agree on difficulty of planning multiple developments on similar timelines --major challenge 3.3. short runway for this planning 4. Steering Committee <ol style="list-style-type: none"> 4.1. If separate steering committees for each component of this, there needs to be some coordination between the committees, or the pieces won't necessarily fit together. 4.2. Interesting concept of "master " steering committee 5. Other <ol style="list-style-type: none"> 5.1. finding oral health

2.CCC Stage 2: Implement Medicaid MCO-driven CCC demonstration program

- 1. Defined target audience and limited provider/payor networks
- 2. The state Medicaid contracts have specific control over MCO participation in programs and policies.
- 3. Changes in Medicaid would be good.

providers to take care of these patients

- 5.2. Patient populations for the individual practices are not taken into account.
- 5.3. Coordination and communication regarding implementation and issues with implementation.

- 1. As more patients come into the health care system due to medical coverage I believe we are going to see a significant increase in Chronic illnesses.
- 2. Meaningful outcomes in chronic care management may be more long-term than you have considered. This may need to be re-thought
- 3. Getting all of the MCOs on the same page will need sufficient time
- 4. All MCO's should have the ability to participate at this level due to geographic differences in the commonwealth
- 5. Challenge will be to find adequate coverage of providers to implement such a plan
- 6. Medicaid systems do not change quickly, efficiently or payments. Need to overcome this.

3.CCC Stage 3: Encourage other payers to adopt CCC initiative

- 1. Not sure what this stage means. Payers need to have additional evidence to support initiatives in his arena.
- 2. Not enough info here - are you expanding the area or the payors

1. Linkage to Other Stages

- 1.1. This will largely be dependent upon outcomes from prior stage. If there are benefits seen in demonstration project, more will be motivated to adopt, but that may take time
- 1.2. Success of Stage 2 will likely drive Stage 3 success
- 2. Other
 - 2.1. Needs to take into account that about 12-15% of enrollees in our exchange have household incomes between 127 and 150% of FPL and will bounce between QHP and MCO several times a year which impacts how the CCC program works across payers

		<p>2.2. Patients with chronic conditions that are more specialized don't appear to fit well within this approach.</p> <p>2.3. How will this relate to ACOs which have their own care management strategies</p> <p>2.4. May require re-structuring existing programs by PCMH/ACOs</p>
<p>4.CCC Stage 4: Expand CCC models to include additional chronic conditions</p>	<p>1. Need additional evidence to determine what care and medications are appropriate for expansion or incentives for care.</p> <p>2. Hopefully not all financially driven but care outcome driven</p>	<p>1. need collaboration and standardization across MCOs</p> <p>2. The impact of chronic illness impact maybe more significant than we realize due to the fact that our older population that has been uninsured.</p>
<p>5.CCC Stage 5: Expand CCC models to include more practitioners on the care team</p>		<p>1. Don't have enough info about who is included in the care team to know how to expand it- it needs to be interdisciplinary</p>
<p>6.CCC Overall</p>		<p>1. By limiting condition and payers you will limit participation. Focus should be on paying for care management/coordination services for at-risk or rising risk patients</p>

DAY 2 CCC ROLLOUT STRATEGY

Benefits and challenges of each stage and overall

CCC ROLLOUT STRATEGY	Benefits	Challenges
Stages	Benefits associated with this stage and its components	Challenges associated with this stage and its components
<p>1.CCC Stage 1: Convene multi-disciplinary Steering Committee to define CCC demonstration program in Kentucky</p>	<p>1. Must ensure that appropriate team stakeholders are present (e.g. complex chronic conditions often involve mobility and independence therefore, physical and occupational therapists must be included in this subset).</p> <p>2. Keep it simple to start with</p>	<p>1. inclusion of consumers and community-based partners</p> <p>2. must be well represented of the providers involved in coordination of care</p>

<p>2.CCC Stage 2: Implement Medicaid MCO-driven CCC demonstration program</p>	<p>3. there is already a lot of work already being done in this area</p> <p>1. CCC will yield a great return both in terms of quality of life and financially to the MCOs</p> <p>2. Important to test for efficacy (cost savings and quality outcomes) before expanding!</p>	<p>1. Needs to be at least two years</p> <p>2. Shared risk between MCOs and providers</p> <p>3. How many of these already exist in KY? My working on other designations - don't hear about this one</p> <p>4. How do you elicit, monitor performance?</p>
<p>3.CCC Stage 3: Encourage other payers to adopt CCC initiative</p>		<p>1. Cost risk involved</p>
<p>4.CCC Stage 4: Expand CCC models to include additional chronic conditions</p>		<p>1. Law of diminishing returns...</p>
<p>5.CCC Stage 5: Expand CCC models to include more practitioners on the care team</p>	<p>1. This will allow better transitions and follow-up</p> <p>2. Must ensure the right patients have the right health care providers who can best address their needs with evidence based interventions and in a cost effective manner.</p>	<p>1. Need non-provider community</p> <p>2. will require legislative changes</p> <p>3. Need some of these people before year 3-4 of the process</p>
<p>6.CCC Overall</p>	<p>1. This is the opposite end of the spectrum of Prevention initiatives, and one we have potential to learn a great deal.</p>	

CCC IMPLEMENTATION ROADMAP

Description





CCC IMPLEMENTATION ROADMAP

Categorize comments based upon sections of roadmap

recruitment
monitoring
collection
legal
compliance
data reporting

support

communication

contracting

practice

provider

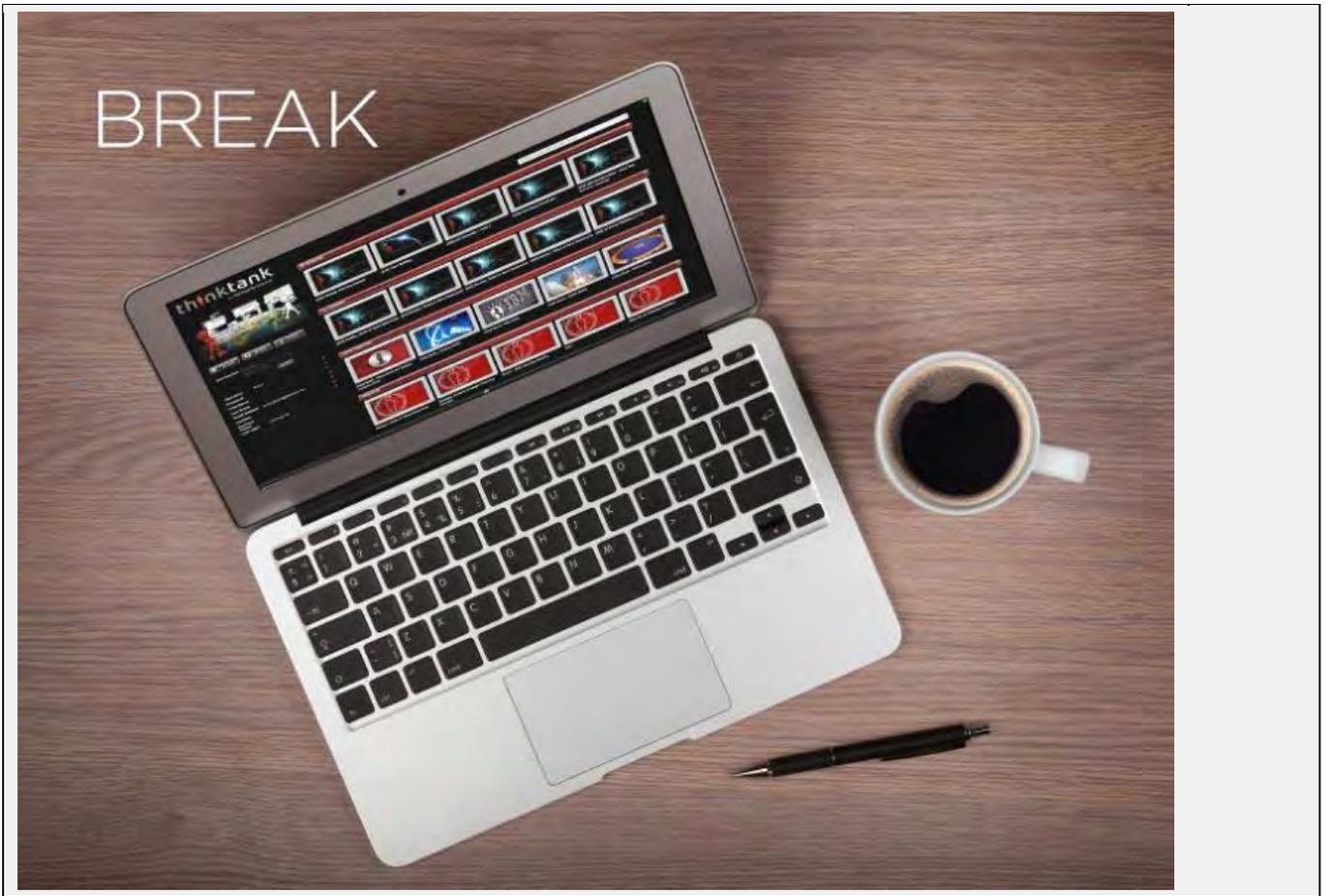
regulations

1. Data Collection and Reporting
2. Provider Recruitment Support/Practice Transformation
3. Contracting
4. Legal/Regulations
5. Workforce
6. Technology
7. Monitoring and Compliance
8. Communication
9. Other

TRANSITION FROM CCC TO BP/EOC

Description

Picture 1



DAY 1 DEFINITIONS - BP/EOC

Obtain feedback on definition of each reform activity

7. Patient Focus

7.1. need to make sure outcomes are improved

7.2. patient protections must be in place to insure quality when trying to hold down cost

8. Other

8.1. CMS has determined 48 areas of BP how will this determine state decisions

8.2. sharing of data / records is key

8.3. You should increase the number of bundles by encouraging providers directly to take on bundles. Every new bundle is a different challenge, and providers need to be on board

2. Harmonize participation, attribution reporting, and measurement requirements across multiple payers.

1. Data

1.1. need timely data on EOC and clear reimbursement models

1.2. Communication and data assimilation is key

1.3. Provide timely data and have the resources to educate the providers on how to use the data to improve outcomes

1.3.1. Real time clinical component

1.3.2. Patients contributing data

1.3.3. Broad range of individuals able to contribute data

2. Measures

2.1. Measures need to be Kentucky specific, when the national offices of payers mandate measures for their KY it creates multiple measures which are expensive and cumbersome for providers

2.2. Reach consensus on a few measures that have a high impact on outcomes

2.3. ID measures that have the largest impact and go with those - we need to be mindful of the reporting burden on patient care

3. Harmonization Requirements

3.1. Do not want to have the same approach as TN with 9 different types of attribution and risk models - this would be very difficult for providers.

3.2. Should be a high standard around how this is operated across payers.

3.3. What's the mechanism for "harmonizing?" The steering committee? The Medicaid/KEHP model as first out of the box?

4. Other

4.1. Important to identify the type of bundle

4.2. If model includes down side risk the participation by independent physician groups. Only large organizations will participate.

3. Increase the use of BPs/EOCs by developing a collaborative Medicaid/Kentucky Employees' Health Plan (KEHP) demonstration.

1. Agree

1.1. Great idea, the number of cases need to be large enough to attract the attention of providers

1.2. This is where I would start, the KEHP would make a great guinea pig.

1.3. Good beginning for demonstration and working out the logistics

2. Medicaid MCOs

2.1. Use of this method has not been proven with MCOs.

2.2. Within reach to start here, but Medicaid is now multiple MCOs. Will they all play?

3. Other

3.1. Do not know enough about KEHP to provide comment.

3.2. Would be interesting to see data

4. Other

1. Other State Concerns

1.1. Tennessee will be using episodes as another means to cut payments to providers by increasing the number of providers being penalized and decreasing the ones receiving incentives. Is this the plan for KY?

1.2. Arkansas is not a Managed Care state and they implemented bundles for cost savings INSTEAD. We have Managed care in Kentucky. Do we want to do both models?

2. Participants

2.1. All of the statements have a verb but no subject. The question of who will innovate and participate is critical. Are

there willing players?

2.2. Beyond Medicaid/KEHP, what are the incentives to be first out of the box?

3. Disagreement/Bundles Not Proven

3.1. Can't do it all at once. Are there a handful of bundles that can establish the content?

3.2. Medicare bundle is DEMONSTRATION

3.3. Episodes/bundles are really a step back from progress nationally.

4. Other

4.1. Ensure that adequate patient protections are in place to ensure that providers that serve higher cost, more complex patients are not penalized for caring for these patients

4.2. would need good information sharing using HIT among providers involved

4.3. Splitting the bundled payment will be difficult for providers not aligned or engaged with each other

4.4. what does bundled do related to quality

4.5. The cost of graduate medical education needs to be included in acute care focused episodes.

DAY 1 GOALS - BP/EOC

Obtain feedback on goals



1. Number of bundles/episodes covered under a BP/EOC initiative

1. Evidence-base

1.1. Is there evidence that BPs provide better quality outcomes prior to including it into the plan?

1.2. The data shown to us earlier identified that more patients were going to SNF than probably warranted - perhaps because they CAN. This requires more thought

2. Operations

2.1. Bundles should be consistent among payers.

2.2. Track quality and outcomes not just cost!

2.3. if you focus on bundles you need to balance the competitive advantage of the payer and provider with the goal of improved quality

3. Other State/Medicare Models

3.1. If we follow Tennessee there will be a lot of push back with providers if this is mandated on them on top of MCOs

3.2. Let's not redesign the wheel, we should investigate TN's (or other state's) approach and adopt a similar model

3.3. We should not be following the footsteps of Tennessee. That program is adding to the administrative burden on

- 1.2. I wouldn't be as concerned with quantity as quality.
- 1.3. feasible numbers and do it well, then move on
- 1.4. Too many bundles/episodes may be burdensome
- 1.5. Start slowly
- 1.6. Large numbers of bundles and episodes is not necessarily the best process!
- 1.7. Start with feasible numbers of bundles
- 1.8. Begin with most prevalent and do not overwhelm with too many
- 1.9. Following the TN model would be wise to begin slowly and then ramp up adoption
- 1.10. start with a small sample to easily monitor and manage
- 1.11. Limit the number of bundles and have a gradual plan for expansion - based on outcomes and cost management
- 1.12. Need cost and quality baselines and goals to know if you're getting anywhere.
- 1.13. Specific, small focus to identify best practices.
- 1.14. It is important to have a small test before rolling out statewide. Therefore these two measures may not be the best metrics. Better would be provider satisfaction, cost savings, improved quality.
2. Evidence-based Selection
 - 2.1. Logically organizing and differentiating the bundles
 - 2.2. Bundles that provide the most value
 - 2.3. Mark milestones that must be reached before taking on new bundles.
 - 2.4. Number of episodes is important, however, they need to be well selected so they have the most impact on improving quality and decreasing cost to Medicaid and commercial payers
3. Disagreement/Bundles are Unproven
 - 3.1. What is the goal of bundles? Decrease cost and increase quality? Is that proven?
 - 3.2. not supporting the whole bundling idea so how many would be zero
4. Additional Information Required
 - 4.1. This definition of bundles is critical
 - 4.2. What's a good start? Are there known bundles that get traction on value (cost and outcomes)?
 - 4.3. The initiative needs to be well defined from the start as to expectations from all perspectives, as well as outlining payments, expected outcomes, etc.
5. Other
 - 5.1. Might this result in the concept of sliding scale bundles?
 - 5.2. Wouldn't all providers have to participate?
 - 5.3. insure coordination of CMS BP as they are introduced

2. Number of participating providers

1. Rollout Strategy
 - 1.1. Will this be implemented regionally? Mandatory for the region? Statewide?
 - 1.2. Start slow
 - 1.3. Pilot on a regional basis
 - 1.4. Needs proving to gain traction
2. Other
 - 2.1. Seems like this will be driven by payors / payments.
 - 2.2. 0-75 seems faster than a ramp up!
 - 2.3. Build a collaborative methodology to spread learning across the state quickly
 - 2.4. Base participating providers on cost. The most cost effective will get priority in choice. This would help deter practices who charge exorbitant pricing. Standardized reimbursement would be key.

DAY 1 GOALS - BP/EOC

Brainstorm new goals

1. What other goal topics for the BPs/EOCs do you think should be included in the draft Value-based Health Care Delivery and Payment Methodology Transformation Plan?

expansion.

4. Payment/Incentives

4.1. Timely payments

4.2. How are facilities paid during implementation period?

4.3. Incentives for those with creative strategies to increase value (cost/quality) equation.

5. Other

5.1. Hospitals should not drive this

5.2. Form partnerships and consortiums based on providers who exhibit increase in quality, and reduction in costs

5.3. Viability of providers under the model.

5.4. Use of episodes defined by state (?)

5.5. folding in community resources into the bundles

DAY 1 BP/EOC YES/NO GOAL SUPPORT

Votes Cast: 0 Abstained: 0

Yes with Modifications	Avg.Score	+/-	Std Dev	Unchecked	Checked
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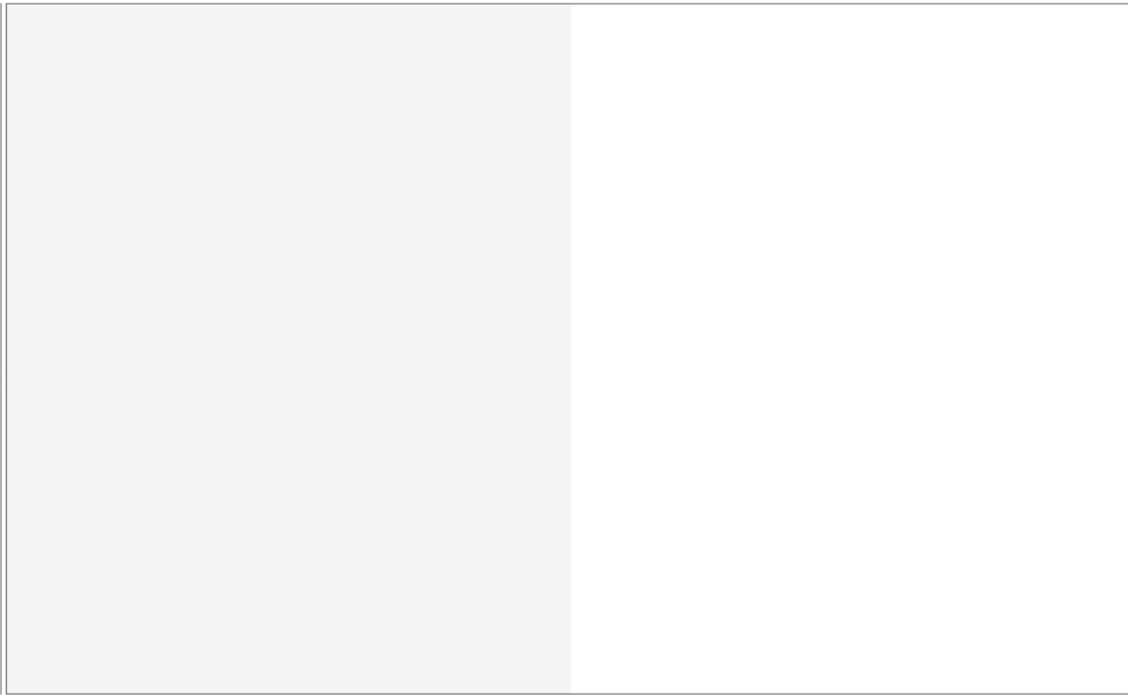
Yes with Modifications



Yes	Avg.Score	+/-	Std Dev	Unchecked	Checked
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Yes

Do you support the inclusion of the following goal topics?



Unchecked

Average

Checked

No

Avg.Score

+/-

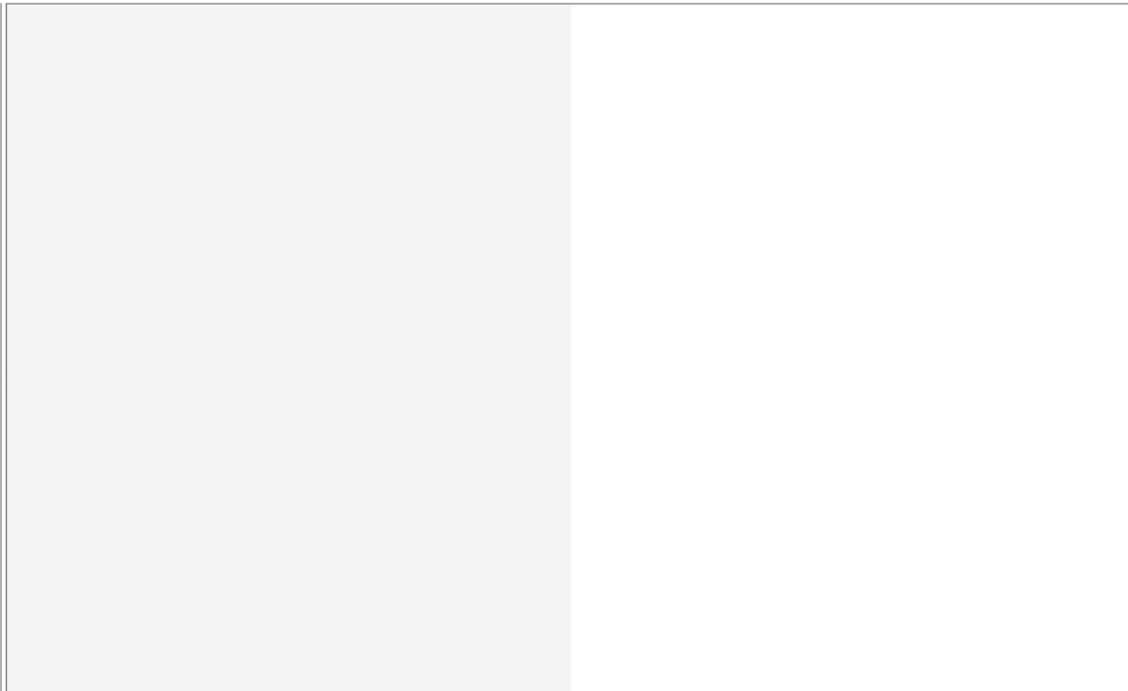
Std Dev

Unchecked

Checked

No

Do you support the inclusion of the following goal topics?



Unchecked

Average

Checked

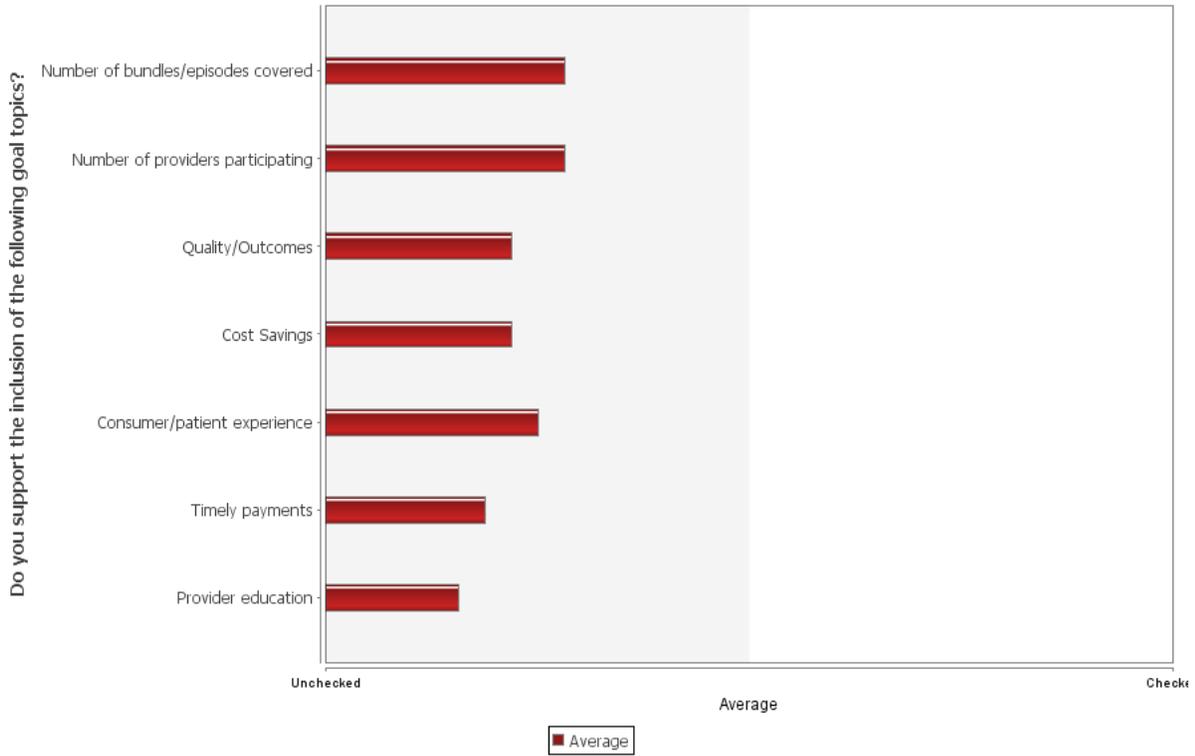
Do you support the inclusion of the following goal topics?	Any Comments
Number of bundles/episodes covered	
Number of providers participating	

DAY 2 BP/EOC YES/NO GOAL SUPPORT

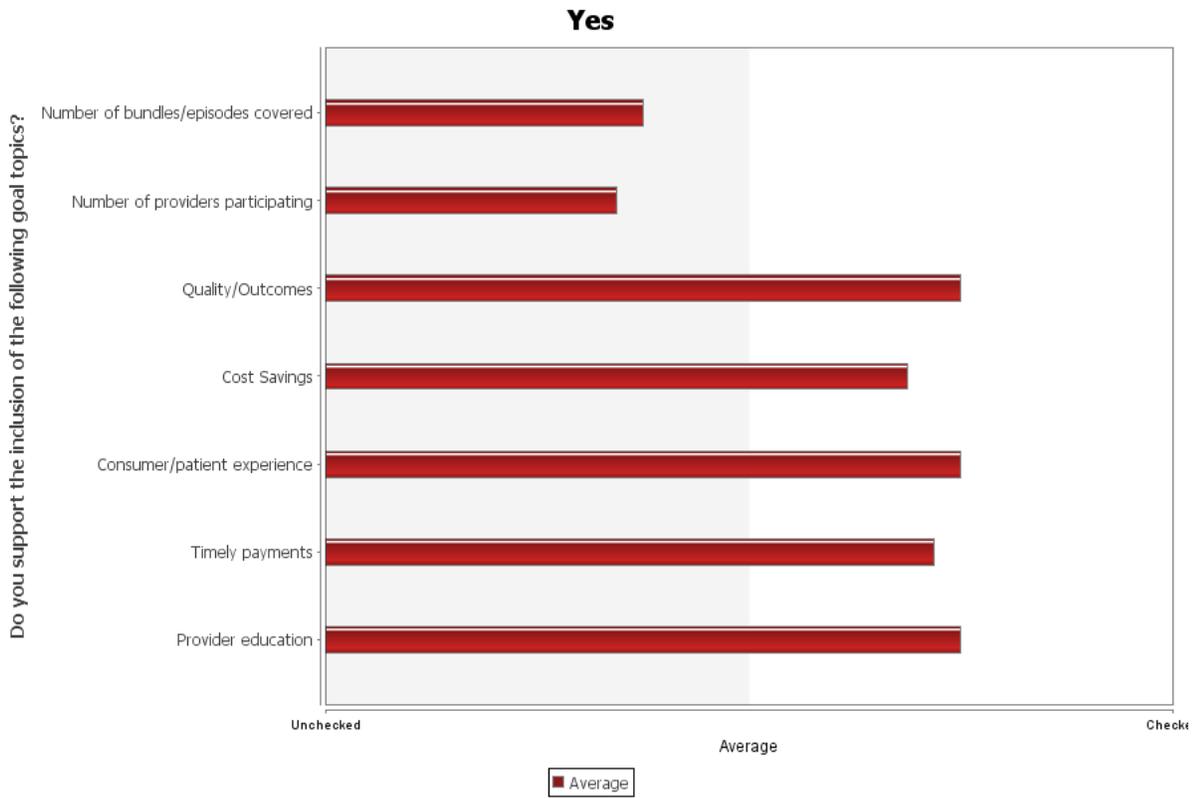
Votes Cast: 32 Abstained: 6

	Yes with Modifications	Avg.Score	+/-	Std Dev	Unchecked	Checked
1	Number of bundles/episodes covered	0.28	45.0%	0.45	23	9
2	Number of providers participating	0.28	45.0%	0.45	23	9
3	Quality/Outcomes	0.22	41.3%	0.41	25	7
4	Cost Savings	0.22	41.3%	0.41	25	7
5	Consumer/patient experience	0.25	43.3%	0.43	24	8
6	Timely payments	0.19	39.0%	0.39	26	6
7	Provider education	0.16	36.3%	0.36	27	5

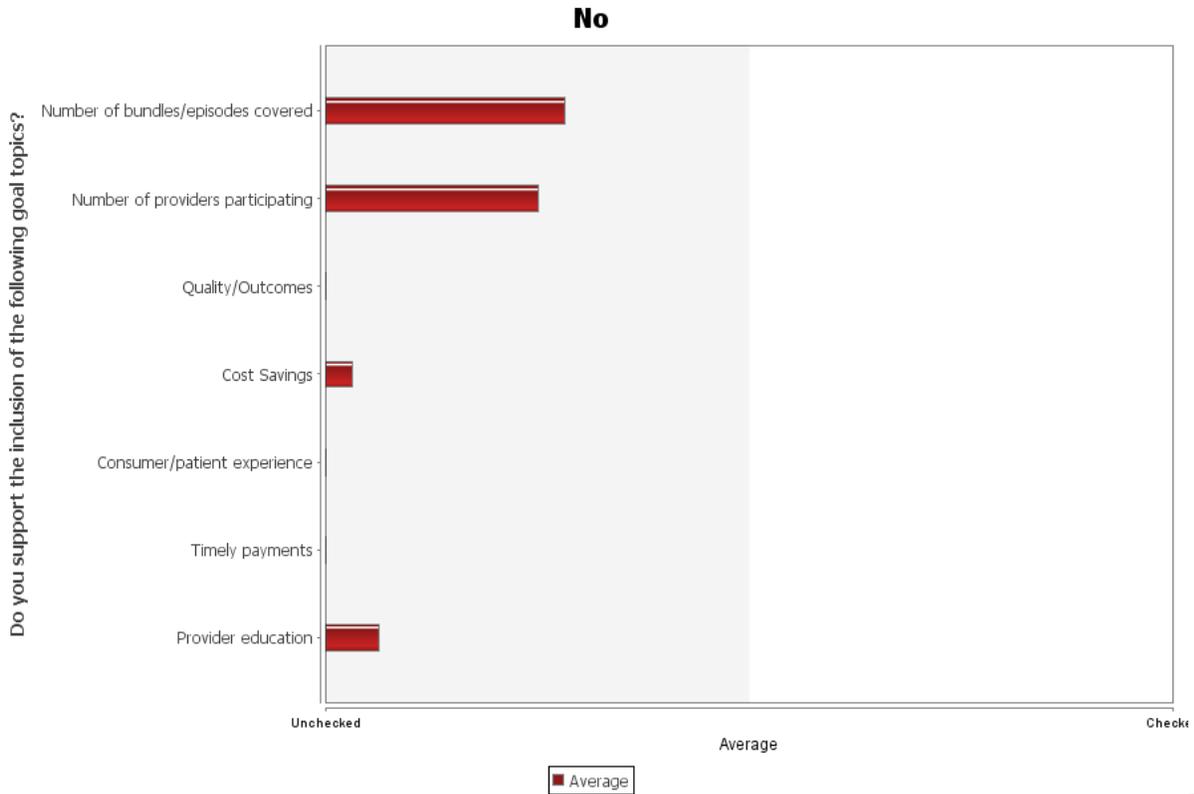
Yes with Modifications



Yes		Avg.Score	+/-	Std Dev	Unchecked	Checked
1	Number of bundles/episodes covered	0.38	48.4%	0.48	20	12
2	Number of providers participating	0.34	47.5%	0.47	21	11
3	Quality/Outcomes	0.75	43.3%	0.43	8	24
4	Cost Savings	0.69	46.4%	0.46	10	22
5	Consumer/patient experience	0.75	43.3%	0.43	8	24
6	Timely payments	0.72	45.0%	0.45	9	23
7	Provider education	0.75	43.3%	0.43	8	24



No	Avg.Score	+/-	Std Dev	Unchecked	Checked
1 Number of bundles/episodes covered	0.28	45.0%	0.45	23	9
2 Number of providers participating	0.25	43.3%	0.43	24	8
3 Quality/Outcomes	0.00	00.0%	0.00	32	0
4 Cost Savings	0.03	17.4%	0.17	31	1
5 Consumer/patient experience	0.00	00.0%	0.00	32	0
6 Timely payments	0.00	00.0%	0.00	32	0
7 Provider education	0.06	24.2%	0.24	30	2



Do you support the inclusion of the following goal topics?	Any Comments
Number of bundles/episodes covered	1. limited number to start
Number of providers participating	1. providers are less important if you have some and cost is competitive
Quality/Outcomes	
Cost Savings	
Consumer/patient experience	1. patient engagement and activation
Timely payments	1. timely payment of shared savings distribution is needed to fund infrastructure
Provider education	

DAY 1 CORE ELEMENTS FEEDBACK - BP/EOC

4.3. Need to prove the risk methodology here

5. Support

5.1. BP/EOC increase quality outcomes and have providers think about the transition of care more than before

6. Provider Impact

6.1. Would consider rolling this out based on community size - may be very difficult for certain providers to implement due to small patient panels as well as challenges around post-acute care (identifying appropriate partners that have capacity and infrastructure to be a good partner)

6.2. If Phys already are hesitant to see patients on Medicaid, wouldn't the newness of bundling make them even more hesitant?

6.3. provides limited benefit for orphan conditions

6.4. Caution needed due to consumers/patients do not understand the impact of letting their providers know where they are getting care which can impact payments to providers. Need data base

7. Operations

7.1. What happens when a patient is referred to a tertiary care center from a rural provider- how are payments dispersed in this model?

7.2. How will data be made available - what stakeholder group would provide this data?

2. Establish a multi-payer, "open-door" policy where payers agree to implement BPs/EOCs at the request of providers.

1. Standardization

1.1. This appears to standardize what is not unique competitive practices how to balance.

1.2. So does that mean if you are a provider and currently have a bundled methodology with one payer you can negotiate for the next payer to accept- that helps the standardization and decrease in admin burden

2. Other

2.1. focus on the high dollar chronic conditions for implementation as a first step

2.2. If providers want to voluntarily develop and market a bundled payment, that is what we should support but not a mandate

2.3. Many payors are already in this space - encourage continued pilot programs

3. Create a collaborative BP/EOC demonstration between the KEHP and Medicaid MCOs.

1. Agreement

1.1. Excellent approach

1.2. Agree.

2. Concerns

2.1. like the approach. Have to bake collaboration into MCO contracts. May not be their nature to play nice with other children

2.2. This will be a problem mandating bundling on top of managed care with the MCOs

2.3. before someone is set up as a model, shouldn't we discuss more of the pros and cons

2.4. Cautiously -- Let's lead with a bundle that goes bi-directionally

DAY 2 CORE ELEMENTS FEEDBACK - BP/EOC

1. Provider Participation
 - 1.1. Agree that providers should have input as lack of participation on their part would not yield success
 - 1.2. Make it profitable for the providers to do it, and they will do it. Pay a bonus to cover infrastructure costs.
 - 1.3. Great idea. However, some providers, because of a variety of reasons, may not be able to provide the same level of quality or price as others. Bundles may cause movement within the market to a smaller number of hospitals.
 - 1.4. Should be voluntary
 - 1.5. Kentucky should be cautious about implementing a statewide rollout of episode based payment without adequate provider input and payer alignment.
 - 1.6. Agree, as long as payers agree to follow the established protocol set up by the Steering Committee
2. Lack of Requests to be Included in BPs/EOCs
 - 2.1. Only integrated systems would most likely be "requesting" bundled payment
 - 2.2. Has this "bottom up" approach worked anywhere . . . or must this change be driven by payers?
 - 2.3. Will people ask or do they need to be made to do this?
 - 2.4. I doubt that many providers will be requesting this
3. Collaboration/Data Sharing
 - 3.1. data sharing is important here and idea that providers will request is probably optimistic
 - 3.2. There would need to be a standard process by payers as well for data sharing, implementation, etc.
4. Other
 - 4.1. The incentives need to be appropriately balanced with the risks to move providers toward value based bundles/episodes
 - 4.2. Is there the potential that providers will be included in bundled payment inadvertently
 - 4.3. Payers are getting experience in other states, but treat each state as if starting from scratch

3. Create a collaborative BP/EOC demonstration between the KEHP and Medicaid MCOs.

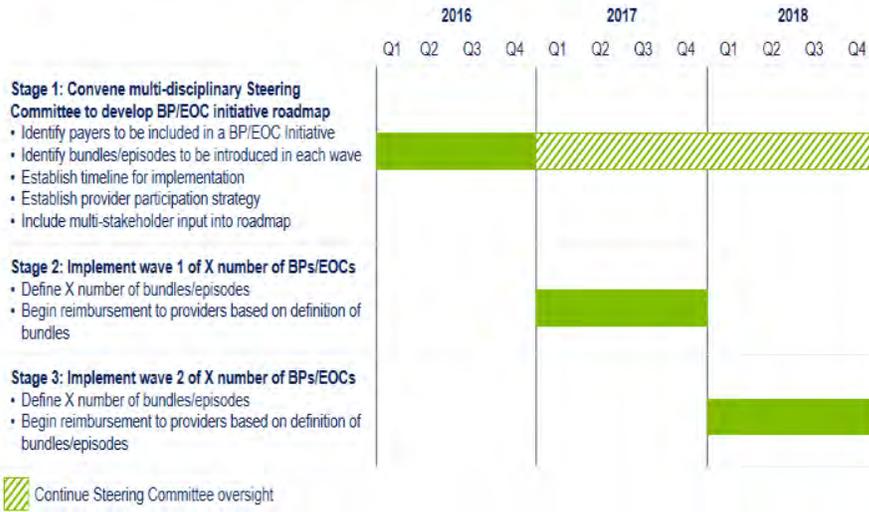
1. Agreement
 - 1.1. Agree that it's good to start here. Are MCOs and their networks ready to go?
 - 1.2. This may help.
 - 1.3. Yes. Collective thoughts and ideas are potentially more powerful than isolated ideas. Sharing of ideas and implementation must have a philosophy of equal partnership.
 - 1.4. Agreed good place to start and trial this
 - 1.5. This would go a long way in providing evidence of success for other providers
2. Challenges
 - 2.1. Complexity in economic regional variation (e.g. salaries/cost of living, instrumentation, device, prosthesis, etc.)
 - 2.2. difficult to coordinate between populations due to a lack of Medicaid participation by certain providers
3. Other
 - 3.1. Have we given up on multi payer solution
 - 3.2. the collaborative needs an evaluation component to uncover promising practices and actual evidence
 - 3.3. employers have to have flexibility to determine what bundles are appropriate for their population
 - 3.4. A mechanism to spread the learning from this collaborative between all providers in the state.
 - 3.5. Must have uniformity among the MCOs

REVIEW BP/EOC ROLLOUT STRATEGY

Review slide

Episodes of Care Rollout Strategy

Episodes of Care Rollout Strategy



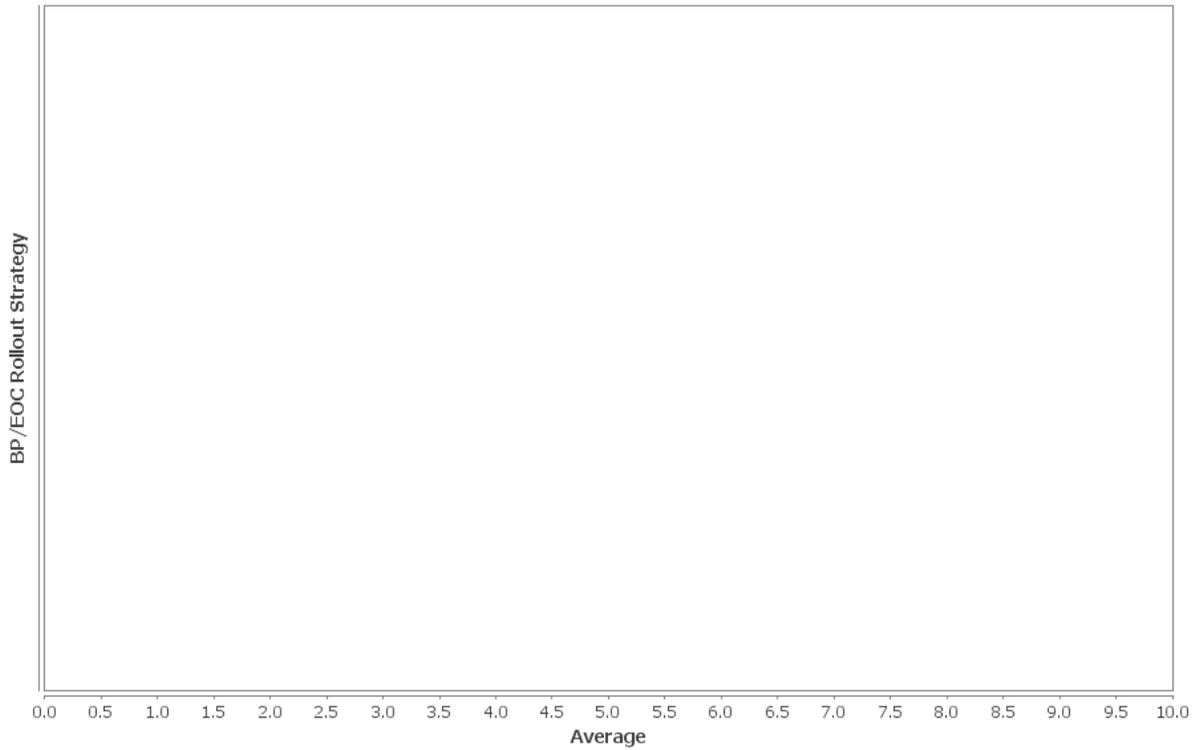
DAY 1 BP/EOC ROLLOUT STRATEGY

Assess Feasibility

Votes Cast: 0 Abstained: 0

Feasibility	Avg.Score	+/-	Std Dev	Min	Max
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Feasibility



BP/EOC Rollout Strategy	Any Comments
This strategy is feasible	
This timeline is appropriately aggressive	
This strategy allows for sufficient planning time	

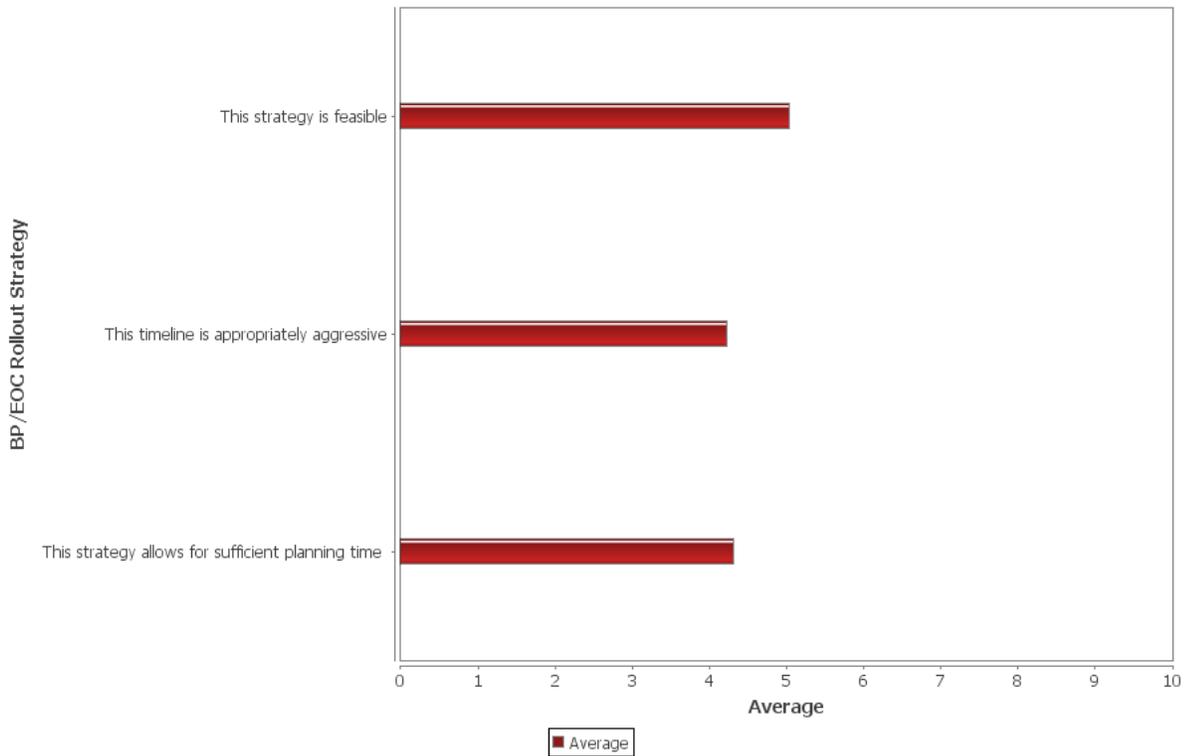
DAY 2 BP/EOC ROLLOUT STRATEGY

Assess Feasibility

Votes Cast: 32 Abstained: 4

	Feasibility	Avg.Score	+/-	Std Dev	Min	Max
1	This strategy is feasible	5.03	32.5%	3.25	0.00	10.00
2	This timeline is appropriately aggressive	4.22	37.2%	2.98	0.00	8.00
3	This strategy allows for sufficient planning time	4.31	31.5%	2.83	0.00	9.00

Feasibility



BP/EOC Rollout Strategy	Any Comments
This strategy is feasible	<ol style="list-style-type: none"> 1. highly dependent on the numbers and types of episodes 2. depends on organizations as well
This timeline is appropriately aggressive	<ol style="list-style-type: none"> 1. too slow 2. need to be able to compare as soon as possible, can't do so without BP 3. mirror amount of Medicare bundles 4. follow Medicare 5. start with handful of episodes implemented with a year of planning time and over a year of implementation
This strategy allows for sufficient planning time	<ol style="list-style-type: none"> 1. Doesn't Medicaid usually follow Medicare? Why wouldn't we just use that strategy instead of working out the details 2. I think in this climate where health plans are in such chaos, it might be hard to fit within this time frame

DAY 1 BP/EOC ROLLOUT STRATEGY

Benefits and challenges of each stage and overall

BP/EOC ROLLOUT STRATEGY	Benefits	Challenges
Stages	Benefits associated with this stage and its components	Challenges associated with this stage and its components

1.BP/EOC Stage 1: Convene multi-disciplinary Steering Committee to develop BP/EOC initiative roadmap
2.BP/EOC Stage 2: Implement wave 1 of X number of BPs/EOCs
3.BP/EOC Stage 3: Implement wave 2 of X number of BPs/EOCs
4.BP/EOC Overall

DAY 2 BP/EOC ROLLOUT STRATEGY

Benefits and challenges of each stage and overall

BP/EOC ROLLOUT STRATEGY	Benefits	Challenges
Stages	Benefits associated with this stage and its components	Challenges associated with this stage and its components
1.BP/EOC Stage 1: Convene multi-disciplinary Steering Committee to develop BP/EOC initiative roadmap	<ol style="list-style-type: none"> 1. Develop a good answer to the question, "How much waste is in the system?" The US pays a lot for healthcare 2. Develop a realistic model to assess the change capacity of each organization involved in the episode from physician, patient, SNF, etc. 3. good to have a diverse mix of voices in this process 4. If payers could align policies and measures significantly that could be a powerful driver for change 5. good to assure all stakeholders are involved 6. Must have appropriate stakeholders involved. 7. It does align with CMS initiative. 8. Payers need to align their policies and practices because with multiple CMOs, it is an administrative burden to be forced to comply with many different standards. Also, bundles need to be consistent across payers 	<ol style="list-style-type: none"> 1. Agreement on Episodes <ol style="list-style-type: none"> 1.1. Choosing the appropriate episodes of care to include in project 1.2. Agreement on which BP/EOC 2. Stakeholders to Include on Committee <ol style="list-style-type: none"> 2.1. Physicians need to be included 2.2. Must include all types of providers. 2.3. Same as others - the people who need to be a part of it - also need to be at work, and we need the people who cannot be paid for participating in this planning - providers who work for themselves, lay consumers, to participate, the billing person in a small practice and a non md group 2.4. Include community based partners 3. Administrative

2.BP/EOC Stage 2: Implement wave 1 of X number of BPs/EOCs

1. Baby steps...
2. if limited to 2 bundles that are similar to Medicare, time line looks good
3. Opportunity to play around with different kinds of definition of episodes and ways to arrange bundles
4. Agree with limit bundles and to limit to align with Medicare. providers should be given option to choose to participate

Burden

- 3.1. Providers will choose to not participate due to the administrative burden
- 3.2. figuring out the administrative burden for providers in a way that makes it real and accessible for consumers, easily understandable
4. Other
 - 4.1. As always, challenge to include consumers, community-based partners
 - 4.2. large scope (range) for a committee to have adequate expertise
 - 4.3. Examples need to be seen early on, and time for comments from provider and payer communities, so everyone will have the opportunity to voice their opinion
 - 4.4. Need lots of provider education regarding how the system works and how they can be successful. Give them tools to be successful
 - 4.5. Experience with bundling is not positive. Negative for providers in trying to keep their practice solvent.

1. Other
 - 1.1. Making all these changes at once
 - 1.2. Avoid medical conditions in the first bundle
 - 1.3. Depends on the magnitude of the number of BP/EOC defined. Would propose consideration of the highest and most

	<p>5. Use a lean six sigma approach to implementation, focus on eliminating variation and waste with the goal of having best practice emerge</p>	<p>beneficial bundles/episodes for patient's outcomes to be initiated first.</p> <p>1.4. It seems as though half the feedback is negative for bundles and episodes and more than half feels the timeline is not appropriate, yet we are pushing forward 100%? How will the report reflect concerns?</p> <p>1.5. voluntary/capacity of providers</p> <p>1.6. administrative burden on practice</p> <p>1.7. Population demographics impact the outcomes</p> <p>1.8. How do you determine who is in the program. Can cause a lot of confusion trying to figure out if they are in the program or not</p>
<p>3.BP/EOC Stage 3: Implement wave 2 of X number of BPs/EOCs</p>	<p>1. Waves allow for restructuring/modification</p> <p>2. Lessons learned from first wave</p> <p>3. Agree concept of waves allows for course correction</p>	<p>1. Learn from Wave 1</p> <p>1.1. Only depending on how wave one works</p> <p>1.2. too soon to roll out new bundles</p> <p>1.3. If voluntary - need to make business case from wave 1 very clear to get wave 2 enrollees</p>
<p>4.BP/EOC Overall</p>	<p>1. 1a - YES! (and consumer and provider feedback)</p> <p>2. seems like the evaluation component of the revised system is missing</p> <p>3. Yes. bundles are better for patients</p>	<p>1. Evaluation of Bundles</p> <p>1.1. Don't we need to build in an evaluation component, starting with baselines of utilization, cost, and outcomes?</p> <p>1.2. How is this all being measured for value?</p> <p>2. Other</p> <p>2.1. The challenge will be to determine an equitable amount per</p>

provider, if multiple practices involved in one EOC.

2.2. Complexity of task should not prevent implementation

2.3. I'm think you are throwing a whole lot out there all at once. I understand the need for this but it might be overload

2.4. Determining the cost of care for X bundle is complicated. Standalone hospitals don't have these types of resources.

2.5. What is the distribution of shared risk?

2.6. The cost of graduate medical education should be factored into planning and cost adjustments providers must deal with under PB/EBP.

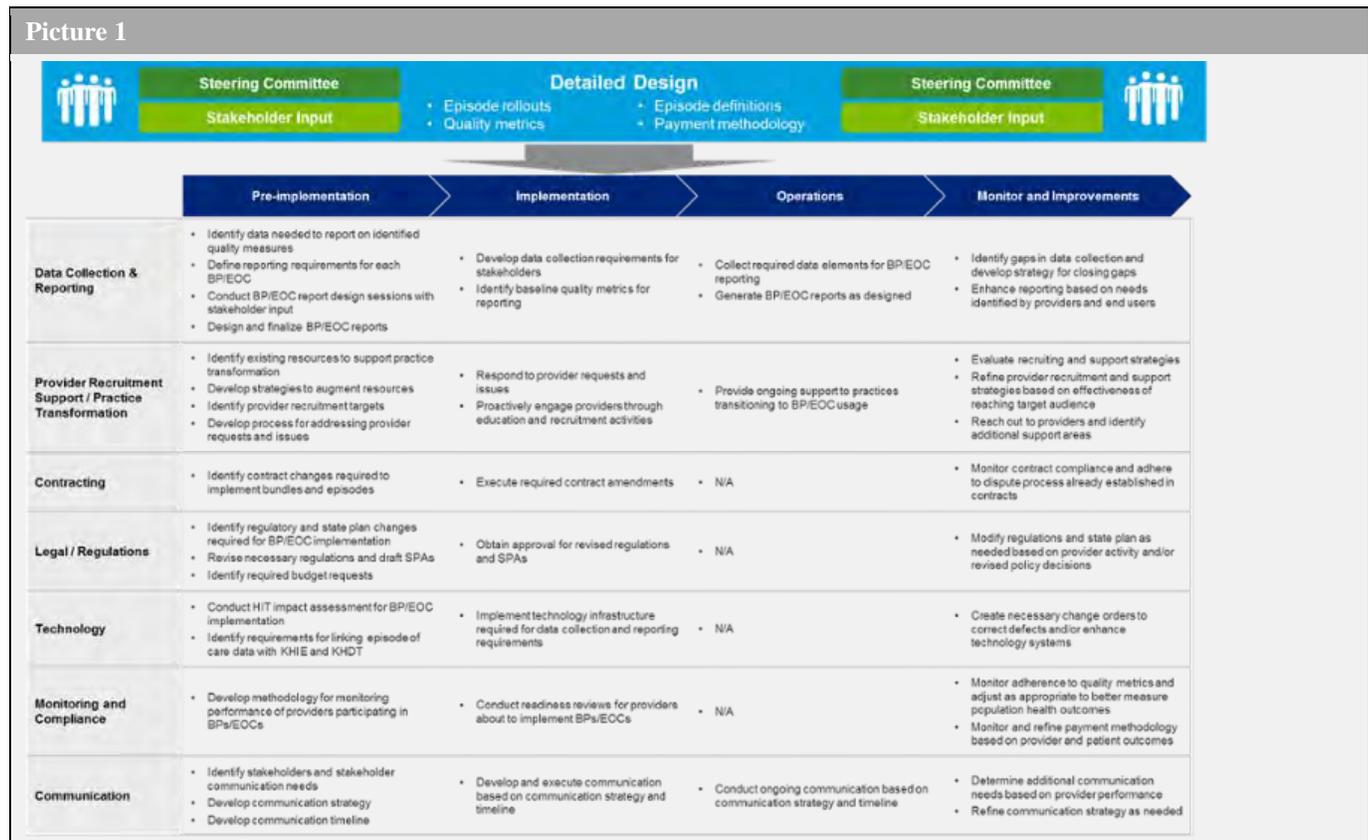
2.7. Just want to mention for all of this, for those that do see Medicare and participate in the incentive programs adding more to their plate will place higher burden on smaller practices. Could see a reduction in access to care if those providers shut their doors. Just an observation

2.8. What is the goal of this process but to have high quality performing organizations which have great outcomes at a low cost? If big facilities cannot adapt to this new environment so be it

BP/EOC IMPLEMENTATION ROADMAP

Description

Picture 1



BP/EOC IMPLEMENTATION ROADMAP

Categorize comments based upon sections of roadmap

recruitment
practice
contracting
collection
legal
monitoring
compliance
communication
data
provider
regulations

1. Data Collection and Reporting
2. Provider Recruitment Support/Practice Transformation
3. Contracting
4. Legal/Regulations
5. Workforce
6. Technology
7. Monitoring and Compliance
8. Communication
9. Other

TRANSITION FROM BP/EOC TO MULTI-PAYER INNOVATION CONSORTIUM

Description

Picture 1



DAY 1 DEFINITIONS - MULTI-PAYER CONSORTIUM

Obtain feedback on definition of each reform activity



1. Create a forum for communities and providers to develop new delivery system and payment model demonstrations focused on achieving PHIP goals with multi-payer leadership and support.

1. Agreement

- 1.1. Great plan
- 1.2. Great idea - difficult to implement and be successful
- 1.3. Agreed
- 1.4. agree
- 1.5. The idea is good. The details are important. The amount of goals you'd like to accomplish is astronomical. Too much....

1.6. This is a great initiative and goal, I think there needs to be a focus on specific goals and outcomes. If left broad in scope it could develop into a tangent that adds to the burden of the program

2. Weaknesses

- 2.1. Clear area of weakness is at it relates to behavioral health needs - consider developing a program whereby these scarce resources provide training programs for laypersons in the community, such as the school, faith organizations, YMCA, etc to garner community support in particular
- 2.2. Include the IT and systems community - tech systems must be designed to work.
- 2.3. You are not giving enough time for comments.....
- 2.4. Communication is good, but concern with governance and how this will affect providers and payors
- 2.5. The goal is good but details on how it will be implemented is key.
- 2.6. What are the data requirements to support this approach?
- 2.7. Yes- data silos still exist
- 2.8. need to include employers

3. Structure

- 3.1. Need funding mechanism to partner and invest jointly in the community with other organizations and support environments to meet patient needs.
- 3.2. It makes sense for providers and payors develop demonstrations at the local level but you don't need a statewide group to control this
- 3.3. We need innovation to address the key aims of the KY SIM effort
- 3.4. Need a definition for "community-based organization" is written in the goals of the section
- 3.5. Providers are already working their local employers on initiatives so this local innovation should be incorporated into the SIM

4. Funding/Payment

- 4.1. Where will funding come from?
- 4.2. What happened to the contract is between the provider and payor.
- 4.3. Many providers are currently paid as a flat fee- how is that currently taken into consideration into the bundled payment

2. Encourage innovations in response to community health needs assessments and other community planning activities.

- 1. Agreement
 - 1.1. Lofty goal but worthy
 - 1.2. This is a great idea
 - 1.3. Critical component for Ky SIM
 - 1.4. Bravo--some true innovation possibilities
 - 1.5. Positive approach - in seeking to understand the needs and meet people where there are. Also addresses community needs with potential for engagement in the transformation process
- 2. Agreement with More Details Needed
 - 2.1. This is wonderful for grass roots initiatives, but need to make sure we know how these will be supported.
 - 2.2. Worthy. Need to recognize limits. Innovation should lead to change - not something so lofty that it isn't funded
 - 2.3. Great. How can this occur reasonably so providers, payers and community-based organizations can all participate and receive adequate compensation to cover costs?
- 3. Funding/Incentives
 - 3.1. Give providers incentives to come up with ideas. There has to be a way to give them some sort of credits, maybe a non-monetary reward?
 - 3.2. Is this a grant opportunity area?
- 4. Leverage Existing Work
 - 4.1. This is already going on in many communities voluntarily so I don't see the need for state oversight
 - 4.2. Part of developing a new model will require patients understand the steps their providers are taking to improve their health. We need to better leverage patient navigators and community health workers here as well
 - 4.3. Clear tie to hospital CHNA requirements and work - strongly encourage collaboration amongst community providers. To the extent the Cabinet can facilitate that around the Medicaid population in particular, this would accelerate providers ability to develop and implement such changes and programs

3. Create a structured forum for leaders of community health initiatives to engage payers to create partnerships that support sustainable transformation at the community and provider level.

- 1. Partnership Types
 - 1.1. Probably will need to start with a team-building process that allows all members of this group to be regarded as peers rather than in a hierarchy of some sort
 - 1.2. Payer and provider collaboration is key
 - 1.3. Require researchers, data analysts, IT, and health providers and payers
 - 1.4. community involvement is key
 - 1.5. Don't forget experts in D and I (Dissemination and Implementation) somewhere in the mix
- 2. Technology
 - 2.1. IT initiatives and the ability to combine wellness tracking and applications?
 - 2.2. Agree and IT must be at the table. Payers also include Medicaid - must be a table and support.
- 3. Employers
 - 3.1. Need to engage employers!
 - 3.2. include employers, mainly the large healthcare systems within the state
- 4. Other
 - 4.1. Not all communities and issues are created equal. Find priorities
 - 4.2. This reads like building a requirement for focused groups into the system which will be key as previously stated and more than we will be here on Wednesday at noon- working people can't take off to add to this
 - 4.3. Offices need to providers to see patients; managers and medical assistants will be the ones connecting the patient with the community services, do not leave that out or increase the burden of the provider
 - 4.4. Open communication and transparency is important

4. Other

6. Other

6.1. careful of being too big to be effective

6.2. Figuring out the barriers to health, and creating a culture of health. Including health in healthcare, not just medicine.

6.3. A must have: this is a living, reactive approach, and the system must have watchful eyes of many stakeholders to redirect if/when needed. Must be able to adapt and move nimbly.

2. Encourage innovations in response to community health needs assessments and other community planning activities.

1. Funding

1.1. Need to provided more funding for this effort.

1.2. Can't do this without funding

1.3. Community wide initiatives will be most useful if provided some resources.

1.4. there need to be grants and other incentives here to mobilize the community

1.5. Notice how everything turns on money. we also need to look at commonsense solutions that do not necessarily depend on more money

2. Agreement

2.1. excellent way to assess pop health needs directly at the source

2.2. Lower costs and better outcomes will drive community engagement and drive solutions

3. Other

3.1. these groups actually have a say in the decisions

3.2. A forum might help us get out of our provider, payer, community organization functional siloes

3.3. What is the engagement of payers at the community level now? Seems lofty

3.4. Hospitals are the ones charged with community needs assessment, not the payers. Not sure why providers are left out of this model.

3.5. Where are the providers in this? Community assessments are provider centered

3. Create a structured forum for leaders of community health initiatives to engage payers to create partnerships that support sustainable transformation at the community and provider level.

1. Communication

1.1. This is key - COMMUNICATION

1.2. Communication, communication, communication, that is the key

2. Provider/Other Participation

2.1. All players should be at the table.

2.2. Again, where are the providers in this?

2.3. might be more important here to have non-providers engaged who could identify the barriers to effective outcomes

3. Other

3.1. Great concept

3.2. There needs to be an agree upon methods for collaboration, what topics are open for discussion, what will we not di

4. Other

1. be sure that you invite all stakeholders to engage in this process. sometimes state "innovation" lead by a political entity in Frankfort (all are political) are a bit incestuous

DAY 1 GOALS MULTI-PAYER COMMUNITY INNOVATION CONSORTIUM

Obtain feedback on goals



1. Number of participating community-based organizations
2. Number of participating payers
3. Number of Kentuckians reached by community health initiatives
4. Explore expanded participation by the Medicaid MCOs, and KEHP in the Greater Louisville Healthcare Transformation Plan
5. Explore specific collaboration among the Medicaid MCOs and KEHP with the seven recipients of the Investing in Kentucky’s Future (IKF) grant to implement their business plan, which addresses key health issues in Kentucky

DAY 2 GOALS MULTI-PAYER COMMUNITY INNOVATION CONSORTIUM

Obtain feedback on goals

- 2.3. How about a "Community Health Innovation Consortium" instead
- 3. Geographic Structure
 - 3.1. Will there be many of these (i.e. local/regional level)? We don't need yet another consortium with all the same players at the table - state level
 - 3.2. Implement by region, or state wide?
- 4. Additional Topics to Consider
 - 4.1. number of providers participating, number of employers
 - 4.2. Will it help improve the health of Kentuckians is a more important question than number
 - 4.3. include prevention and legal services

4. Explore expanded participation by the Medicaid MCOs, and KEHP in the Greater Louisville Healthcare Transformation Plan

- 1. Do you need this here under this Goal?
- 2. Other than Passport is this possible/
- 3. Seems very region specific compared to other parts of the plan

5. Explore specific collaboration among the Medicaid MCOs and KEHP with the seven recipients of the Investing in Kentucky’s Future (IKF) grant to implement their business plan, which addresses key health issues in Kentucky

- 1. Use experiences of efforts being funded as a testing ground
- 2. INCLUDE PREVENTION :)
- 3. It needs to provide value to MCOs and KEHP

DAY 1 GOALS - MULTI-PAYER COMMUNITY INNOVATION CONSORTIUM

Brainstorm new goals

1. What other goal topics for the Multi-payer Community Innovation Consortium initiative do you think should be included in the draft Value-based Health Care Delivery and Payment Methodology Transformation Plan?

DAY 2 GOALS - MULTI-PAYER COMMUNITY INNOVATION CONSORTIUM

Brainstorm new goals



1. What other goal topics for the Multi-payer Community Innovation Consortium initiative do you think should be included in the draft Value-based Health Care Delivery and Payment Methodology Transformation Plan?

1. Qualitative Measurement
 - 1.1. Quality of care measurement
 - 1.2. outcomes measurement, improved population health metrics
 - 1.3. qualitative measures besides outcomes
 - 1.4. Talk about an evaluation methodology upfront
2. Funding/Budget
 - 2.1. Key is funding element and providing enough capacity to test for providers who deliver care
 - 2.2. Add deep evaluation capacity or budget.
 - 2.3. Fund the research needed to develop new care models that yield better outcomes
3. Provider/Payer Involvement
 - 3.1. Provider/payer viability
 - 3.2. number of providers, employers involved not just payers
 - 3.3. Providers must participate
 - 3.4. Providers are most likely to benefit from this initiative as it should result in improved population health. They should have some skin in the game
4. Scale/Capacity
 - 4.1. Number of consortium trying to develop community initiatives
 - 4.2. Large scale, consistent messaging needed to improve Health Literacy.
 - 4.3. Capacity to assist of facilitate consortium
 - 4.4. # of communities
5. Data/Evidence-based
 - 5.1. If we are talking innovations, looking for models that work - each will have its own goal. This may be a moving target. If it doesn't have a goal related to the triple aim, why do it?
 - 5.2. Data on models
6. Participation
 - 6.1. Buy-in to a shared mission.
 - 6.2. participation percentage
7. Regions/Rural Areas
 - 7.1. Need to have a configuration that is regional to promote the community approach with a master oversight

7.2. understanding and directing appropriate resources to the needs for rural communities instead of aimed at municipalities

8. Consumer Role

8.1. Consumers need to have a skin in the game

8.2. Will consumers be involved in forum?

8.3. Consumer/patient involvement

8.4. Education piece, for all the players- Payers, Providers, Patients, so that the value can be understood and created.

9. Other

9.1. Longevity of programs developed and deployed

9.2. Might this be a forum to test new technologies in a neutral space

9.3. must define "community"

DAY 1 MULTI-PAYER CONSORTIUM YES/NO GOAL SUPPORT

Votes Cast: 0 Abstained: 0

Yes with Modifications	Avg.Score	+/-	Std Dev	Unchecked	Checked
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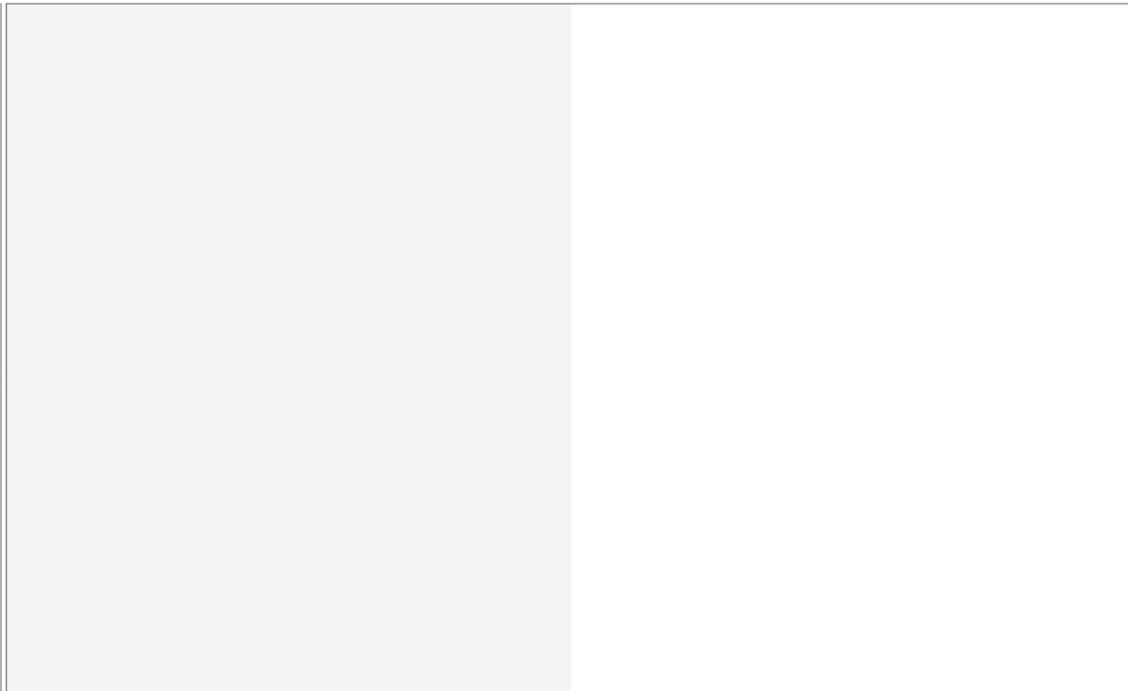
Yes with Modifications



Yes	Avg.Score	+/-	Std Dev	Unchecked	Checked
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Yes

Do you support the inclusion of the following goal topics?



Unchecked

Average

Checked

No

Avg.Score

+/-

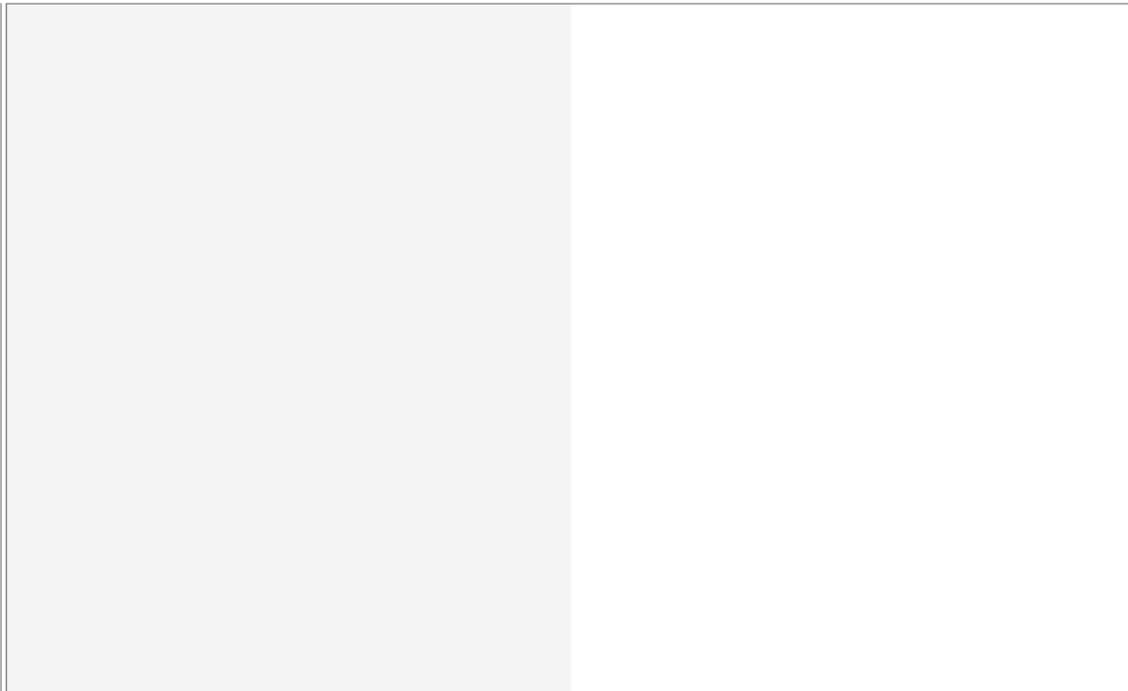
Std Dev

Unchecked

Checked

No

Do you support the inclusion of the following goal topics?



Unchecked

Average

Checked

Do you support the inclusion of the following goal topics?	Any Comments
Number of participating community-based organizations	
Number of participating payers	
Number of Kentuckians reached by community health initiatives	
Explore expanded participation by the Medicaid MCOs and KEHP in the Greater Louisville Healthcare Transformation Plan	
Explore specific collaboration among the Medicaid MCOs and KEHP with the seven recipients of the Investing in Kentucky's Future (IKF) grant	

DAY 2 MULTI-PAYER CONSORTIUM YES/NO GOAL SUPPORT

Votes Cast: 0 Abstained: 0

Yes with Modifications	Avg.Score	+/-	Std Dev	Unchecked	Checked

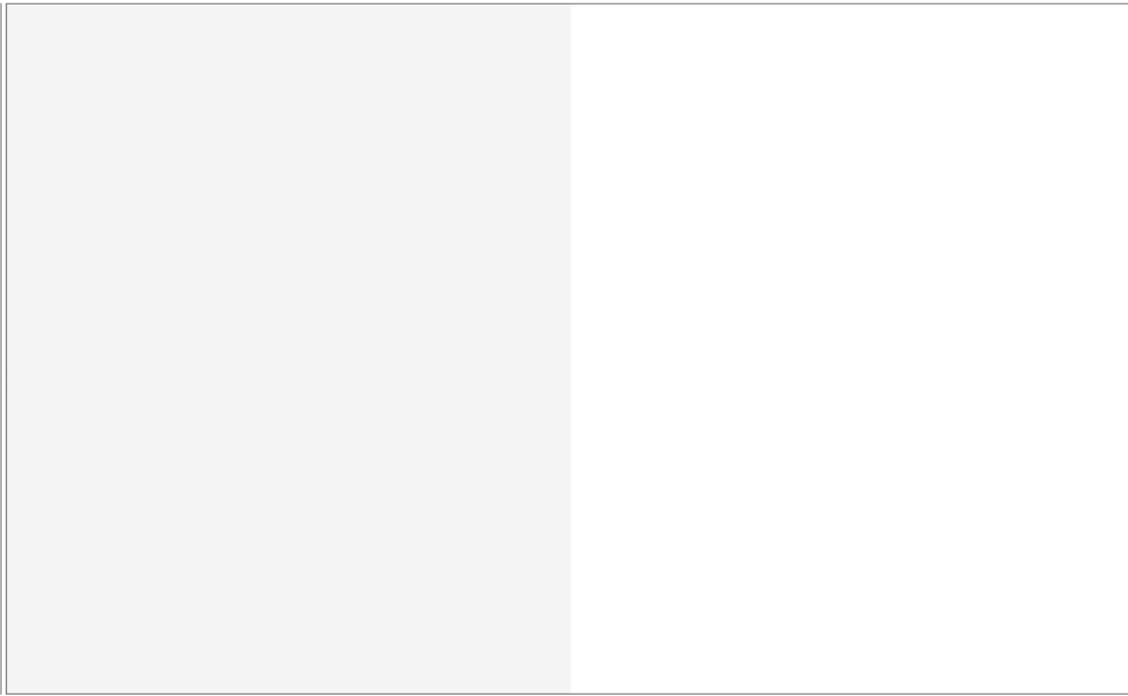
Yes with Modifications



Yes	Avg.Score	+/-	Std Dev	Unchecked	Checked
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Yes

Do you support the inclusion of the following goal topics?



Unchecked

Average

Checked

No

Avg.Score

+/-

Std Dev

Unchecked

Checked

No

Do you support the inclusion of the following goal topics?

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Unchecked

Average

Checked

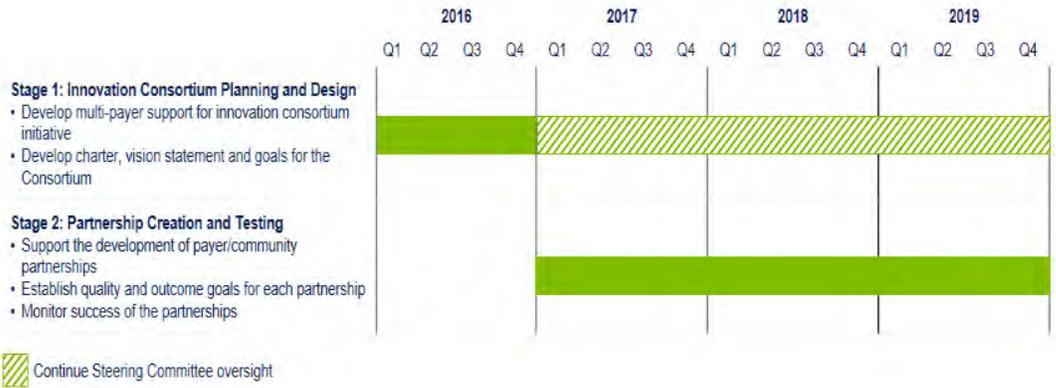
Do you support the inclusion of the following goal topics?	Any Comments
Number of participating community-based organizations	
Number of participating payers	
Number of Kentuckians reached by community health initiatives	
Explore expanded participation by the Medicaid MCOs and KEHP in the Greater Louisville Healthcare Transformation Plan	
Explore specific collaboration among the Medicaid MCOs and KEHP with the seven recipients of the Investing in Kentucky's Future (IKF) grant	
Quality of Care	
Longevity of programs	
Number of providers and employers involved	
Scale across the state	

REVIEW MULTI-PAYER INNOVATION CONSORTIUM ROLLOUT STRATEGY

Review slide

Multi-payer Community Innovation Consortium Rollout Strategy

Multi-payer Community Innovation Consortium Rollout Strategy



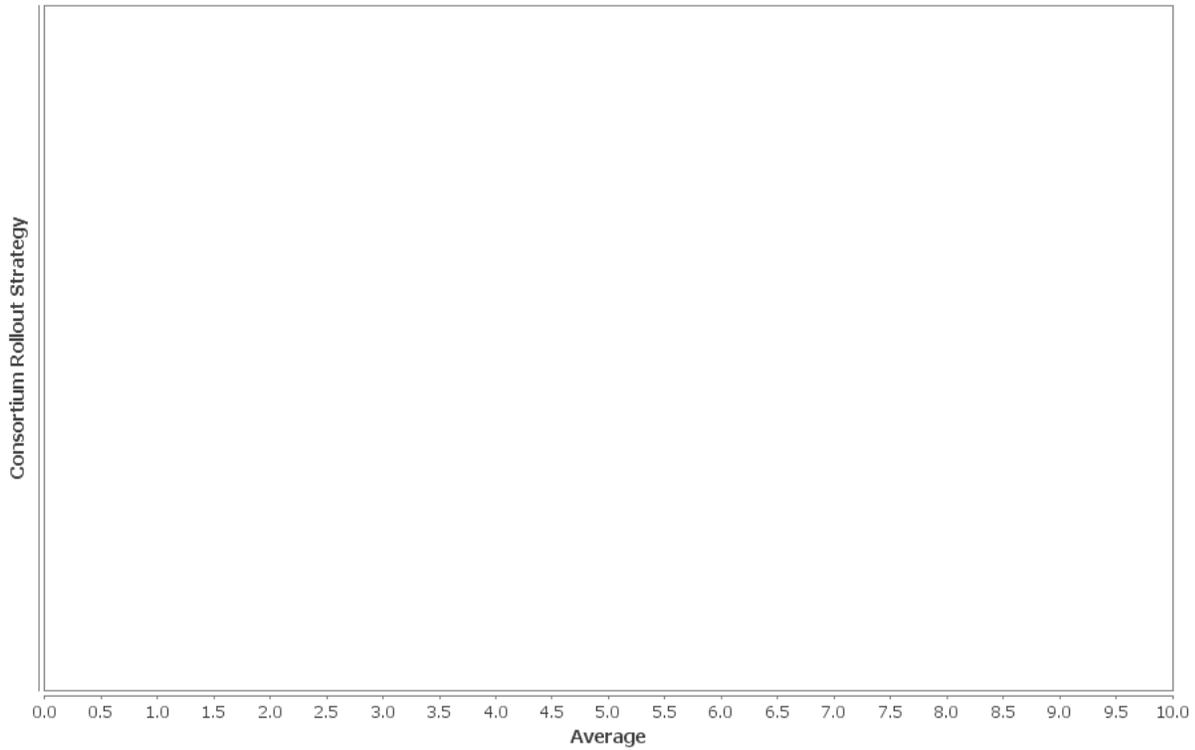
DAY 1 MULTI-PAYER INNOVATION CONSORTIUM ROLLOUT STRATEGY

Assess Feasibility

Votes Cast: 0 Abstained: 0

Feasibility	Avg.Score	+/-	Std Dev	Min	Max
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Feasibility



Consortium Rollout Strategy	Any Comments
This strategy is feasible	
This timeline is appropriately aggressive	
This strategy allows for sufficient planning time	

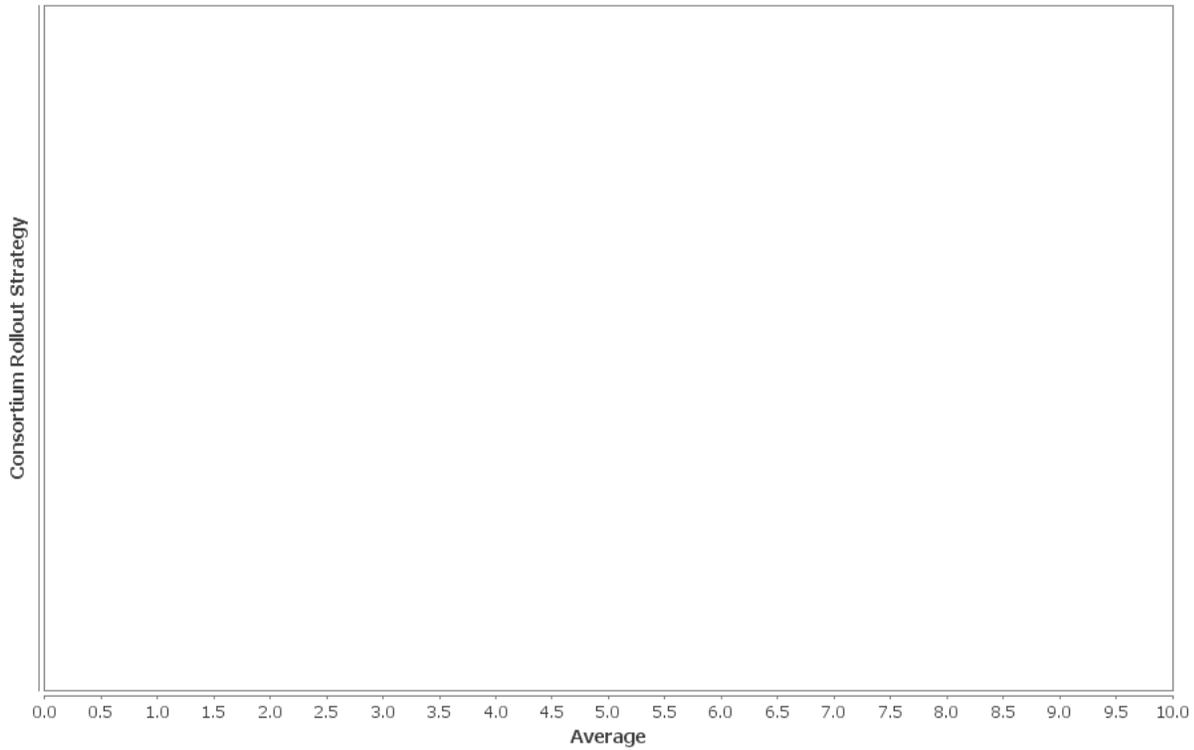
DAY 2 MULTI-PAYER INNOVATION CONSORTIUM ROLLOUT STRATEGY

Assess Feasibility

Votes Cast: **0** **Abstained:** **0**

Feasibility	Avg.Score	+/-	Std Dev	Min	Max
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Feasibility



Consortium Rollout Strategy	Any Comments
This strategy is feasible	
This timeline is appropriately aggressive	
This strategy allows for sufficient planning time	

DAY 1 MULTI-PAYER INNOVATION CONSORTIUM ROLLOUT STRATEGY

Benefits and challenges of each stage and overall

MULTI-PAYER INNOVATION CONSORTIUM ROLLOUT STRATEGY	Benefits	Challenges
Stages	Benefits associated with this stage and its components	Challenges associated with this stage and its components
1. Multi-payer Innovation Consortium Stage 1: Innovation Consortium Planning and Design		
2. Multi-payer Innovation Consortium Stage 2: Partnership Creation and Testing		
3. Multi-payer Innovation Consortium Overall		

DAY 2 MULTI-PAYER INNOVATION CONSORTIUM ROLLOUT STRATEGY

Benefits and challenges of each stage and overall

MULTI-PAYER INNOVATION CONSORTIUM ROLLOUT STRATEGY	Benefits	Challenges
Stages	Benefits associated with this stage and its components	Challenges associated with this stage and its components
<p>1. Multi-payer Innovation Consortium Stage 1: Innovation Consortium Planning and Design</p>	<ol style="list-style-type: none"> 1. Allows local solutions 2. allows community specific focus 3. multi-group "buy-in" 4. Group think to leverage best ideas and strategies, specific to each region/community. 5. Valuable if only for sharing 6. Provides a forum to localize and deploy innovative models rapidly and potentially scale across to similar areas of the state. 7. Community Specific - Physician Leadership 8. Could change the face of reimbursement quickly and allow innovation. 9. utilizing different skill sets should be able to produce a less gap-filled system 	<ol style="list-style-type: none"> 1. Payer Involvement <ol style="list-style-type: none"> 1.1. will be difficult to get competitors (payers and providers) to align 1.2. PAYERS playing 1.3. Getting payers to work together and agree on specifics will be a challenge 1.4. Needs to be balanced process not completely driven by internal agendas at payers but true input from providers and patients 1.5. getting the payers to collaborate is an obstacle 2. Funding <ol style="list-style-type: none"> 2.1. Whose paying? Worried about what these community groups will come up with 2.2. Payments should be timely. 3. Other <ol style="list-style-type: none"> 3.1. Diversity, inclusion, governance. 3.2. so many people, so many voices - the coordination and decision making 3.3. making sure all potential innovators are "at the table"
<p>2. Multi-payer Innovation Consortium Stage 2: Partnership Creation and Testing</p>	<ol style="list-style-type: none"> 1. multi-group "buy in" 2. May actually solve a real community problem 3. Collaboration 4. multi payer would provide a level of standardization for providers 5. Community involvement is essential. 6. Involve consumers from a variety of socioeconomic groups 	<ol style="list-style-type: none"> 1. Existing Efforts <ol style="list-style-type: none"> 1.1. Lots of organizations already work in this space, how do we harmonize all of these different initiatives and organizations 1.2. Confusion in communities may occur if new group formed instead of utilizing existing community health coalitions or groups.

and regions

1.3. duplication of efforts - being flexible enough to adapt to organizations that exist,
 1.4. How do we handle competition

3. Multi-payer Innovation Consortium Overall

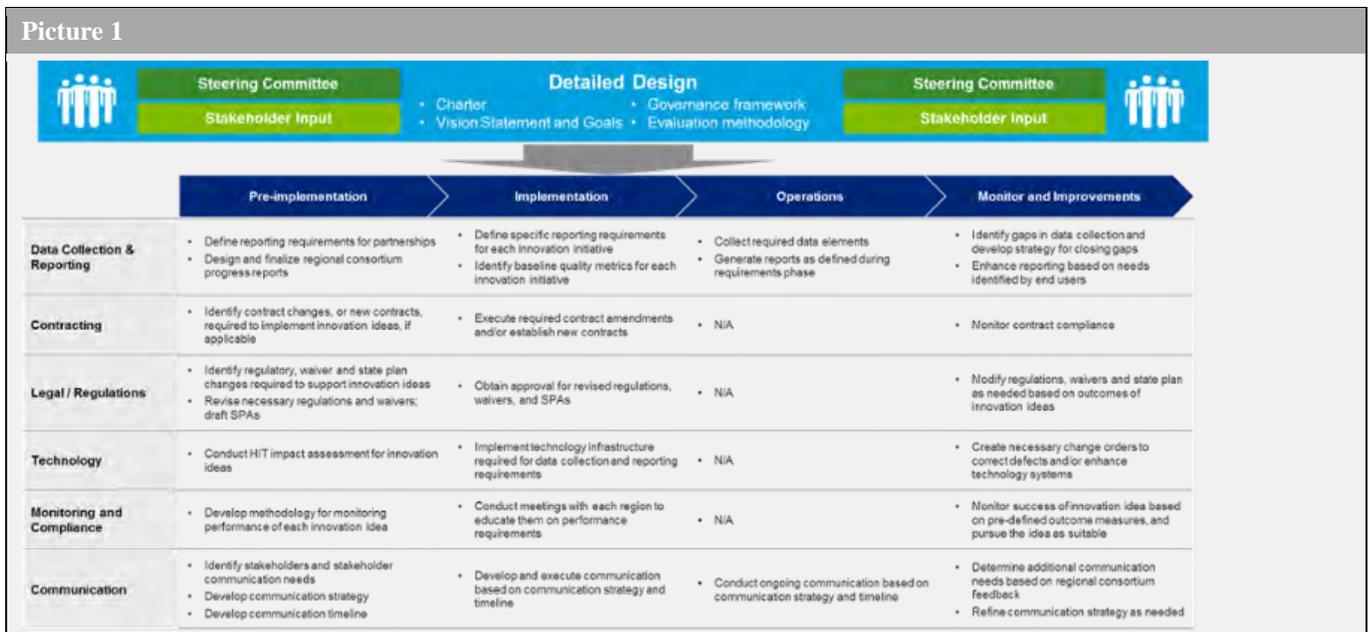
1. Would be a potential home for multi-initiative evaluation capacity.
2. Needs to be regional at the very least ... to account for geographical differences in patients.
3. So is this just a way to continue the work of the SIM group in the long run?
4. The meetings need to be structured to deliver clear outcomes
5. Could offer support to payers and provider with implementing changes on the road to value based care

1. Funding
 - 1.1. This is so nebulous. Just not sure how this will play out and where the funding will come from.
 - 1.2. How would it be sustainable? Payers??

MULTI-PAYER INNOVATION CONSORTIUM IMPLEMENTATION ROADMAP

Description

Picture 1



MULTI-PAYER INNOVATION CONSORTIUM IMPLEMENTATION ROADMAP

Categorize comments based upon sections of roadmap

support monitoring
data compliance
communication
reporting collection
contracting legal
regulations provider
practice
recruitment

1. Data Collection and Reporting
2. Provider Recruitment Support/Practice Transformation
3. Contracting
4. Legal/Regulations
5. Workforce
6. Technology
7. Monitoring and Compliance
8. Communication
9. Other

SESSION NOTES



1. Document any assignments, thoughts, and/or questions that you may need to revisit later

- 1. PCMH feasibility
 - 1.1. feasibility of rollout - can't do all four reforms at a time
 - 1.2. PCMH as a foundation of an ACO, not overlapping/conflicting
 - 1.3. practice transformation
 - 1.3.1. practices need incentives and reducing admin cost, but also need to have a threat/payment reform to be "afraid of it"
 - 1.3.2. need to push practices to transform
 - 1.3.3. encouraging leaves little room for requirement
 - 1.3.4. need provider consequences for not participating
- 2. overall
 - 2.1. need to decide how the four reforms fit together
 - 2.2. need combine timeline
- 3. ACO feasibility
 - 3.1. very feasible but very aggressive
 - 3.2. ACOs will be market drive; forces will encourage ACOs and will take off on its own beyond this timeline; need direction from state - PCMH is different
 - 3.3. need more planning time
 - 3.4. for CPC, have 9 payers and took them two years to agree on quality metrics
 - 3.5. need clarification around a practice who is already offering ACO; if it's a menu or they can fall in using existing structure
- 4. Governance
- 5. Types of Organizations to Include
 - 5.1. Variety of provider types
 - 5.2. Rural health providers
 - 5.3. Representatives across the entire span of care
 - 5.4. Lay consumers
 - 5.5. LTSS/LTC providers
- 6. Add U of L school of public health and information sciences to stakeholder list in plan
- 7. more examples would be helpful
- 8. real life examples
- 9. not enough staff capacity to pull all five reforms off

10. ambitious