



Commonwealth of Kentucky

State Innovation Model (SIM) Model Design Grant

Value-based Health Care Delivery and Payment Methodology Transformation Plan

Summary of Changes Companion Document

Overview

This document provides a summary of the changes made to the draft *Value-based Health Care Delivery and Payment Methodology Transformation Plan* as a result of the two stakeholder input sessions held on Wednesday, August 26, 2015 and Thursday, August 27, 2015, along with input from the Cabinet for Health and Family Services (CHFS). The changes resulted in an updated version of the draft that was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 15, 2014.

Global Changes

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

Draft Delivery System and Payment Reform Plan (Page 16)

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

Delivery System and Payment Reform Goals (Page 17)

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

SIM Governance Structure (Pages 17 – 18)

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

Consumer Education and Communication Strategy (Page 18)

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

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

1. Confirmed Kentucky's plan to use NCQA-certification as the baseline for the PCMH initiative in response to stakeholder feedback to use national standards
2. Further described how Kentucky-specific components would be included in a phased, transitional payment strategy for PCMH that incentivizes PCMH sites to become NCQA certified and focuses on both process and outcomes measurement strategies

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

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

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

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

1. Recognized the stakeholder feedback on the success of an episodic approach as opposed to bundled payment approach and revised this initiative to focus solely on EOCs
2. Extended the timeline for evaluation phases between Wave 1 and Wave 2 of the Medicaid/KEHP EOC demonstration initiative to allow for the evaluation of effectiveness and inclusion of lessons learned from the first wave of episodes prior to the second wave's implementation
3. Added an additional phase to the EOC rollout strategy to collect and publicly report of the range of episodes identified by the Steering Committee prior to the implementation of Wave 1 to focus on transparency

4. Added the development of additional EOC-specific goals for (1) consumer experience/patient satisfaction (2) quality of care and (3) health outcomes as a responsibility for the EOC Steering Committee
5. Further described the multi-payer “open-door”, focusing on the provider role and benefits to payers, providers, and consumers through this framework
6. Added language to further promote the adoption of the EOC model where providers still receive FFS payments and the "risk" is held by the coordinating entity
7. Clarified inclusion of the development of a harmonized data sharing and reporting process as part of the ACO Steering Committee's role
8. Clarified that the harmonized patient attribution and measurement strategies are also key elements of the Medicaid/KEHP demonstration
9. Recognized stakeholder feedback that an EOC initiative should consider both the successes and criticisms of other state programs by reflecting the review of outcomes, challenges, and successes in Core Element language
10. Described how the quality and/or outcomes-based measurement strategy in other states and within Medicare is used in developing incentives and/or penalties for participating providers

A Community Innovation Consortium (Pages 31 – 33)

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

Appendix II. Glossary of Terms (Page 40)

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