



Alternative Payment Model Design Council
02/25/2020

Participants:

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- Bob Finuf, Children's Mercy Hospital
- Chad Wilkins, Community Care Network of Kansas
- Cynthia Lewis, Kansas Home Care & Hospice Association
- Denise Cyzman, Community Care Network of Kansas
- Dennis Kriesel, Kansas Association of Local Health Departments
- Dr. John Esslinger, KDHE Division of Healthcare Finance
- Dr. Scott Wituk, Wichita State University Community Engagement Institute
- Evan Fisher, KDHE Division of Healthcare Finance
- Jane Kelly, Kansas Home Care & Hospice Association
- Jennifer Pacic, Wichita State University Community Engagement Institute
- Jessica Grubbs, KDHE Division of Healthcare Finance
- Jodi Schmidt, University of Kansas Hospital System
- Kasey Sorell, KDHE Bureau of Family Health
- Lynne Valdivia, Kansas Foundation for Medical Care
- Mark Heim, KDHE Division of Healthcare Finance
- Melissa Hudelson, Kansas Chapter of the American Academy of Pediatrics
- Michelle Ponce, Association of Community Mental Health Centers of Kansas
- Rowena Regeir, KDHE Division of Healthcare Finance
- Samantha Ferencik, KDHE Division of Healthcare Finance
- Scott Pester, University of Kansas Hospital System
- Shanna Peters, Kansas Chapter of the American Academy of Pediatrics
- Sharon Johnson, KDHE Division of Healthcare Finance
- Tarah Remington Brown, Kansas Academy of Family Physicians
- Tawny Smith, KDHE Division of Healthcare Finance
- Tish Hollingsworth, Kansas Hospital Association

Background, History, Purposes

Why Transition? (Slide 7)

- Winding down of Delivery System Reform Incentive Payment (DSRIP) and transitioning to Alternative Payment Model (APM)
- DSRIP was also originally a replacement of another program. Need to be aware of sensitivity around the transitioning of funding.

- Kansas Department of Health and Environment (KDHE) will provide an update of where we are with the deadline each time we meet.
- No states have actually accomplished this transition yet, but we can look at other process examples within in the United States.
- You [stakeholders] are involved because KDHE believes that partnerships are important. No person is going to a single location for Medicaid benefits. KDHE wanted to give all stakeholders the opportunity to attend and make the decision of their involvement on their own.

DSRIP Across the Nation (Slide 8)

- The history of this reform is more developed within Medicare and is not as concrete on the Medicaid side.
- These Centers for Medicaid and Medicare Services (CMS) services tend to be transitioned within Medicare first.
- Movement from volume to value

DSRIP Evolution to APMs (Slide 9)

- This model assumed that performance payments to these facilities would prompt them to form collaborative relationships with community providers, but these connections were not formally specified in waiver documents. Only New York and Texas went appreciably beyond the hospital-oriented model to create regional networks of various kinds of providers to form DSRIPs.
- Even though this may have a hospital component, there is a lot more of a focus on community interventions. An example of this is discharge planning. The hospital is one stop within the whole patient experience.

Key Questions to Answer (Slide 10)

- Mostly focused on process improvement.

Questions of Clarification (Slide 12)

What's something that you heard?

- The models are changing but the funding is the same.
- There are joint issues with home care and hospitals
- Those that were invited are happy to be included because they will be impacted by these changes.
- KDHE is unsure if \$30 million will be the maximum amount but it is definitely the minimum amount.
- There is a desire to increase hospital/provider relationships.
- There are similarities and differences between states.
- There is a "no sooner than" date but not a "no later than" date.
- The funding is not just for hospitals but will be a collaboration with other partners.
- If the state has already determined the \$30 million and it was previously given to 2 hospitals and now will be allocated to other locations, care may be reduced. "If all we do is reallocate the funds, how do we increase care?" Incentives may be necessary.
- The \$30 million is annual and total. This is a minimum amount and has not been finalized yet.
- Need to balance reality of what is happening on the ground and the requirements of CMS.
- The state impact needs to come from organizations that have the capability to do this. (e.g., reporting, health information, process improvement, etc.)
- There are other partners that we need to include.
- There may already be data that is already being reported and can be used (e.g., Social Determinants of Health, intake data, etc.).

What are you curious about or want to learn more about?

- How are we going to distribute this money between the different providers that are represented here?
- Hospital/provider relationships – How can we identify a way to foster this? Stakeholders may have ideas
- We may identify new processes and the questions from Slide 11.

- What are APMs that could benefit this? (e.g., telehealth) This could reduce the cost of care and reduce the burden in aggregate.
- Would the \$30 million change with potential Medicaid Expansion? (Answer: I don't know.)
- Non-DSRIP hospitals currently receive uncompensated be impacted by this? (Answer: Critical Access Hospitals. They will not be impacted by this because their funding is from a different source.)
- Would it help if KDHE separated/line-itemed the information?
- With the \$30 million, is this the current DSRIP amount? (Answer: Yes)
- How do outcomes relate to this?
- Do we have the right people in the room?
 - TO DO: Let Samantha know if you have organizations that are missing. (Answer: More rural folks need to be involved.)

Communications Needs (Slide 15)

[Referencing the charter.]

- Only one *spokesperson* from each organization is allowed on the Design Council. Organizations may have more than one representative is okay but only one spokesperson.
- You want representatives to support in the subgroups. That is fine but in the main design council, this is one spokesperson

Council Discussion (Slide 19)

- Please refer to the Design Council Charter.
- Contact us via email: kdhe.KS-APM@ks.gov
- Community Care Network of Kansas is the organization formally known as Kansas Association for the Medically Underserved.

What questions of clarification do you have related to this component?

- Is it the intent to have the \$30 million paid through the MCOs? (Answer: This is KDHE's intent right now.)
- What is the role of the Managed Care Organizations (MCOs)? (Answer: They will not voting members but may have a representative to stay informed about the changes.)

What do you want to know more about?

- Charter states that the DSRIP representatives. Are there other large hospital representatives? (Answer: Representatives for the subgroups may be listed.)
- It will be important to communicate back to stakeholders who might be impacted. (e.g., MCOs)
- The list of participants were invited but may not have been available to attend.
- Subgroup meetings are happening outside of this large Design Council meeting. There is a possibility of utilizing the formal gathering as times.
- Current MCOs, do they have APM initiatives? (e.g., Two APMs with hospital systems) KDHE is constrained by what is happening with CMS.
- Importance of the charter
- What is the timeline of APM? (Answer: KDHE's hope is to have the pre-print submitted by early fall 2020. The pre-print is the document to CMS explaining Kansas' plans. The Design Council planning must be largely completed before this submission. Between the submission of the document and end of 2020, there may be some update/clarification meetings for the Design Council.
- The Design Council time commitment is six hours, once per month, between now and submission of pre-print.
- Subgroups meet monthly as well. Some of them every other week for an hour and some meet every week for an hour. If you would like to participate, you are welcome to join.

What is interesting, exciting, concerning?

- TO DO: Please share concerns that you may hear from your colleagues with the Design Council as soon as you hear them.
- Other partnerships should be decided early so that organizations know their roles.
- MCOs going to make payments out to providers. Payments have to come through MCOs per CMS. The state is directing how to make the payments.
- Where is a good place for the next meetings? What is the best time and date?
- What and who do we share information?
 - Communication to members/providers: KDHE will forward information out to Design Council members that will say something similar to, “Ask your membership/providers [[insert question here]]? Also pertinent information will be shared to inform them about [[insert topic here]].
 - Concern: Don’t provide too much information as it might seem “random” to the stakeholders/members/non-DC members.
- What class or classes of providers are eligible to participate? Help KDHE understand what to do and who will be doing it.
- Website – The information and products from this group will be housed here.

What are other ideas or suggestions?

Data & Conditions Subgroup

Potential Target Populations (Slide 22)

- Kansas’ approach is looking at chronic conditions
- There is a need for post-discharge specialties. This does not always need to be a provider or hospital. This could be someone who knows them.
 - Transition care is important. Follow-up within the first few days of discharge is essential.

Top Reasons for Hospital Admissions (Slide 23)

- These items were not derived from specific age groups and populations.

NICU Data 2018 (Slide 24)

- Increase in prenatal care increases probability of children getting to full-term birth.

Kansas hospitals w/25+ NICU Medicaid beneficiaries [2018] (Slide 25)

- What is the adequacy of the network of providers that can manage these patients in the home environment in addition to the hospital environment?

Conditions associated with ARF (Slide 26)

- ARF: Acute Respiratory Failure
 - Usually due to an underlying chronic condition.

Conditions associated with sepsis (Slide 27)

- Pneumonia is not necessarily a chronic disease.
- Initial reaction of KDHE is to exclude sepsis due to DSRIP having this focus. This is still under consideration and is not a final decision. There is concern that sepsis being excluded.
 - Sepsis is a result of a chronic condition. What is a condition that has an increased risk to sepsis? for example, diabetes and the resulting conditions (e.g., renal failure, etc.) can increase the risk of sepsis.

Proposal for Targeted Conditions (Slide 28)

- PCP: Primary Care Physicians
- Are PCPs more tied to the hospital physicians for follow-up care?

- Where is the MCO responsibility? Is there an increased responsibility of care coordination? This is not clear. Is it up to the hospitals to enforce the increased care coordination based on relationships with MCOs?
- Where are the teachable moments? (e.g., smoking cessation when a patient is admitted to ICU on ventilator)

Proposal for Targeted Conditions (Slide 29)

- State is planning to pay for diabetic education.
- Currently, Medicaid is not penalizing for readmissions but Medicare is.

Council Discussion (Slide 31)

What questions of clarification do you have related to this component?

What do you want to know more about?

- The team needs to get deeper into the data. What factors that are involved? Understand what is evidence.
- Does the data sync with patients' top 5-10 conditions?
- What is cause of the data? (e.g., low birthweight = inadequate care, smoker = COPD) This type of discussion needs to be held in the subgroups.

What is interesting, exciting, concerning?

- Referrals for home care have been lost. This is something to consider.
- The "cost" is the payment by the state. KDHE is drawing attention in the volume of these chronic diseases.
- What process will be used to narrow this focus?
- What is the timeline? KDHE wants to get input from the Design Council members.
- Chronic Obstructive Pulmonary Disease (COPD) — Look at the hospitals and the size of the hospitals with respect to the number of admissions for the specific hospitals.

What are other ideas or suggestions?

- If there is a difference in the raw claims data and fee for service data? This is data out of the paid claims, then it may not include all unreported costs. These are just inpatient costs not all costs.
- Define the approach then determine what the intervention would be.
- Are there geographic differentials? For example, FQHCs are geographic dependent and if the interventions are going to be truly statewide versus urban focused, need to consider how to reach all areas (e.g., Teaching hospitals, rural hospitals, 124 community hospitals)
- Idea: Design of the initiatives by hospital type. Some hospitals will not participate based on the importance of the initiatives in their communities. There might be an opportunity to support small hospitals to improve care for patients with chronic conditions.
- Decisions document may seem to exclude items. Please recommend items to add to the decisions document. Any points of clarity please share. This document is a "working" document and it is not finalized. Please provide your input and ideas.
- The items on the 2nd page of the Decisions document will be handled by KDHE.
- Are there other agencies' data that we can use? (e.g., Kansas Healthcare Collaborative, Kansas Foundation for Medical Care, etc.)

APM Payments Subgroup

- The basement amount will definitely be the \$30 million but it may be more.
- The specifics of the distribution of this may be difficult to address.

Payment Model Considerations (Slide 34)

- There are items that are more likely to be approved by CMS.

Council Discussion (Slide 39)

What questions of clarification do you have related to this component?

- CMS' goal is to reduce utilization. Consider how to direct payment by their effort has reduced utilization.
 - CMS is moving toward to value-based purchasing
 - Claim add-ons are not the best for measuring impact

What do you want to know more about?

- Preventative care and preventing readmissions
- Community led projects – how do you compensate for that?

What is interesting, exciting, concerning?

What are other ideas or suggestions?

- Payment structured different differently in year 1 and year 2
- All subgroups – can you publish the meeting schedule (Answer: Many are meeting ad hoc. Contact individual subgroup leads.)
- Consider not only the unit of services but the consumption of resources in some fashion

Research & Evaluation Design Subgroup

(Slide 40)

- KDHE is trying to approach project design from a research standpoint.
- There are many documents that CMS have published.
- You can request the copy of the Mercer report if you would like it.

(Slide 41)

- Though APMs exist, Kansas is different. Within the first cohort of mandated DSRIP transition to “something else” (e.g., APM). They include Texas, New Jersey, New York and Kansas. Kansas will be able to see what the sustainability path looks like going forward.
- Mercer wrote a report to summarize what is happening in Research and Evaluation.
- CMS has high volume of requests for APMs.
- 2017 was the inception of APMs

Other States Currently Transitioning (Slide 42)

- These are informative about what CMS is approving.
- In these states, they are all using state directed payments.
- Arizona – all directed payments are quality-based payments (e.g., nursing facilities, community mental health, etc.). Enhance a fee for service based on qualifiers (e.g., using Electronic Health Records, etc.)
- Massachusetts – Quality payments attached to certain items (e.g., robust access to disability accommodations), behavioral health payments (e.g., screenings)
- California – Not as quality based. Pooled into public and private hospitals. Pass-through payments are difficult for this state.
- Rhode Island – Accountable Care Organizations with add-on rates. These are mostly linked to hospitals but may include some behavioral health organizations as well.

States pursuing directed payments under 42 CF4 438.6(c) (Slide 43)

- Washington – DSRIP state, focusing on rural providers \$1 million focusing on rural critical access hospitals for depression screening or follow-up after Emergency Department visit with coordinated care ONLY. Hospital can select their measure.
- Oregon – Quality add-on payments with

- Not like DSRIP in that it can't be for a project, infrastructure, etc.
- Link to current services and quality under the contract.
- Variety of models to look at.
- It is a lot to consider and this can be challenging to identify payment models in specific communities.
- Some states have done a menu set within hospitals. CMS has approved this in other states.
- Explore a menu idea. How many pre-prints are we talking about with CMS? The volume of work is a lot for CMS. The process was changing in 2018. From an administrative perspective, simplicity is likely encouraged. September 2020 is the goal for submission due to likelihood that KS will have some review and revisions that may be required. Ninety days is a good rule of thumb for negotiation.

Research Considerations (Slide 44)

- Perhaps we can learn from the other states.
- What will demonstrate success?
- What is currently being collected/reported? There may be a crossover with the work that is being done
- What will be required in the future within the APMs or outside of Medicaid entirely?
- Are other providers requiring something that KanCare can build off?
- "By [[date]], we will be looking for X, Y, Z." Can KanCare align with these efforts?

Research & Evaluation Design Subgroup (Slide 45)

- What is possible or already being done?
- Infant mortality work in Geary County

Council Discussion (Slide 46)

What do you want to know more about?

- How is this pre-print going to work? Design Council will help design and KDHE will construct.
- What is the timeline for research? Limited in terms of its duration. Quick decisions are essential for six to eight weeks for the subgroup.
- What is the project timeline?
- What measures are Washington looking out? Individual hospitals may not have large enough numbers? How are the providers of the community going to get compensated and measured? How is Geary County measuring their outcomes? How will an incentive payment work if there is not an outcome yet? NOTE: Mercer report is available if you are interested. Sam will have this distributed to all participants.

What is interesting, exciting, concerning?

- Small provider numbers in small hospitals is concerning – How do we put together an evaluation for them? It is possible that CMS will allow the data to be aggregate. There will not be a one-size-fits-all approach. Oregon will be a good place to look for examples.

Next Steps & Homework (Slide 47)

- Do we have the right people in the room? TO DO: Let Samantha know if you have organizations that are missing. (Answer: More rural folks need to be involved.) Who should we add to this list?
- Please send notes and suggestions to email by March 11th for the next meeting.
- Join a subgroup by emailing as well.
- Website will be launched in the next week or so.

Next Meetings & Locations (Slide 48)

- Monday, March 23, 2020 at 10:00 AM – 3:00 PM
- Wednesday, April 29, 2020 at 10:00 AM – 3:00 PM
- Location: Kansas Health Institute