

C.3. Capitation Payments

- a. Describe proposed approaches for Physician Incentive Plans, including innovative approaches to incent provider behavior and participation.
- b. Provide examples of successful Physician Incentive Plans the Vendor has implemented, including information about their structure, measurable outcomes, challenges and lessons learned.

Passport Highlights: Capitation Payments

How We're Different	Why it Matters	Proof
<p>Passport has taken meaningful steps toward ensuring the provider community has direct input into the evolution of our value-based programs and that providers have the support they need to be successful.</p>	<p>Passport, providers, members and the Commonwealth share a common interest in ensuring that providers are successful in delivering the right care, at the right time, in the right setting. It takes all of us working together to make that happen.</p>	<ul style="list-style-type: none"> • Feedback received through Passport's Partnership Council and Primary Care Workgroup led to the incorporation of an additional earning mechanism for providers in our largest VBP program, HealthPlus. • Passport's team of Population Health Managers has helped to fill critical voids across the state by providing specific, actionable data and guidance for achieving better outcomes.
<p>Passport's programs have generated meaningful results.</p>	<p>Delivery of care with higher quality outcomes at a lower cost benefits all impacted stakeholders. Passport incentivizes the provider community to increase the level of member engagement to make this possible.</p>	<p>The HealthPlus Program generated \$6.7M in shared savings in 2018 and increased the number of formally participating provider organizations from 2 in 2018 to 5 in 2020.</p>
<p>Passport is unique in our commitment to understanding the challenges that providers face in the shift to value-based payment models because providers are in our DNA and we want to support them at whatever stage of the value-based journey they are on.</p>	<p>Not all providers are ready to participate in a shared savings arrangement with up and/or downside risk. Some need an entry-level program that allows them to first build their infrastructure to support more mature models. As the Kentucky provider community matures in its ability to support new models, Passport will be ready with programs that suit their individual needs.</p>	<p>Passport has a variety of Provider Incentive Plans in place with both primary care and behavioral health providers, such as payment for Patient Centered Medical Home (PCMH) practices, care management services and upside-only gainshare with more under development that will support providers' evolution to risk.</p>

C.3.a. Describe proposed approaches for Physician Incentive Plans, including innovative approaches to incent provider behavior and participation.

Passport's Provider-Led History

Passport's entire history reflects deep commitment partnering with providers to meet the needs of our members. In 1997, Passport was founded as a Kentucky-based non-profit organization sponsored by five Louisville hospital and provider organizations. Our goal was to create a unique organization aligning the interests of the Commonwealth, the provider community and Medicaid recipients under the Centers for Medicare & Medicaid Services (CMS) 1115 waiver. In the 22 years that followed, Passport expanded our capabilities and services for our members, collaborated with our providers on health care initiatives to improve quality and supported our advocates in the local communities.

Today, we are the only physician-driven Health Plan solely dedicated to Kentucky. We have grown our membership and now are the second largest Managed Care Organization (MCO) in the Commonwealth serving approximately 300,000 Medicaid beneficiaries.

As the only provider-founded health plan in Kentucky, Passport is deeply rooted in our partnership with our provider community and have offered evolving programs to reflect changing payment arrangements. Specifically, we have substantial experience in value-based payment (VBP) programs, and we are continuing our efforts to reward our providers in offering high-quality care in a cost-effective manner to our members. Our provider philosophy of value complements our model of care in placing our members first and foremost.

A local governance model allows local trends to directly dictate clinical decision-making, rather than a national MCO having to vet any local trend management through a regional/national decision-making process. For example, if local physicians on the local governance committee decide that it is important for the plan to cover a new meningitis vaccine for a specific pediatric population, then that coverage decision is made locally. A national MCO would be required to bring the question to national decision makers and wait for approval from their national Pharmacy and Therapeutics committee.

Since Passport is driven by providers, we achieve greater physician engagement resulting in improvements that not only positively impact Passport's members, but those served by other managed care organizations as well. This system-wide impact creates a greater value to the Commonwealth and its Medicaid recipients. Over the years, providers remain loyal to Passport with continued levels of high satisfaction. In fact, Passport's score increased by 3.9% to an overall satisfaction score of 71.4%, a score that is notably above national benchmark data. Our relationship with our providers is vital, and we strive to maintain strong, collaborative relationships with our network providers and with constituents in the communities we serve.

Provider Involvement in Passport Committees

As a local, provider-driven organization, our providers are not just advisors; multiple key providers have true governance responsibility through participation in the Board of Directors, the Partnership Council, and the

Quality Medical Management Committee (QMMC). Nearly 100 volunteer providers and community members participate in our committee structures.

We also have direct forums to connect feedback of the broader provider community into the committee agendas. For example, the Primary Care Provider (PCP) Workgroup provides important insight and informs the Partnership Council and Passport Health Plan on issues concerning PCPs and their panels of members. The PCP Workgroup also imparts a provider perspective on our efforts to deliver quality services to our membership with the goal of achieving the Department’s stated priorities of transforming the Medicaid program; engaging individuals to improve their health and engage in their healthcare; significantly improving quality of care and healthcare outcomes; and reducing or eliminating health disparities.

Passport’s Historical Approach to Physician Incentive Plans

Background

In September 2011, CMS approved expansion of mandatory Medicaid Managed Care for nearly all beneficiaries throughout the Commonwealth. Since 2013, Medicaid enrollment has increased 97.60 percent from 606,805 enrollees in September 2013, to 1,199,048 in October 2019.¹ Currently 27 percent of Kentucky’s population is enrolled in Medicaid/CHIP, with 44 percent of children covered by Medicaid and 20 percent of Medicare enrollees also covered by Medicaid.² Providing services to eligible members who were not previously enrolled in Medicaid led to an increase in costs. Medicaid expansion necessitated payment reforms to move from volume-driven to value-driven reimbursement that incentivizes high-quality, efficient and cost-effective care.

In a fee-for-service model, overutilization often occurs, and siloed care delivery may unfortunately allow members to “fall through the cracks” within the delivery system. Passport believes that transitioning from fee-for-service (FFS) payment models that pay for volume to capitation and VBP models is critical. Passport offers PCP capitation arrangements to more than 100 providers around the Commonwealth. However, we are also interested in transitioning PCPs to payment arrangements that increasingly recognize the value of services provided and improved health outcomes through Physician Incentive Plans is critical to improving the healthcare system. Aligned financial incentives increase access by ensuring that providers are focused on the members and their challenges that need attention the most.

With the growing number of Medicaid beneficiaries, now more than ever it is essential that Passport help control costs and drive toward efficient use of Medicaid dollars by reducing expenditures on unnecessary, redundant or ineffective care. Paying for value through Physician Incentive Plans also supports improved

¹ <https://www.medicaid.gov/state-overviews/stateprofile.html?state=Kentucky>

² KFF: <http://files.kff.org/attachment/fact-sheet-medicaid-state-KY>

health outcomes by providing financial incentives for performance improvement and penalties and financial risk for poor quality of care and outcomes.

Partnership in Advancing Value-Based Programs

Passport knows that taking on risk is often intimidating for providers and they are therefore hesitant to engage in a shared savings program. We are unique in our commitment to understanding the challenges providers face in the shift to Value Based Payment (VBP) models, as evidenced by Passport taking meaningful steps to ensure the provider community has direct input into the evolution of VBP through forums such as the Partnership Council.

Additionally, we're focused on infrastructure development with providers to support this shift. The majority of providers in our network still need to enhance their population health management capabilities before they will be ready for any shared savings risk that might potentially impact their fee-for-service compensation, let alone a capitated payment that would replace it. As a result, Passport has partnered with providers to administer foundational Provider Incentive Plans that establish population health infrastructure such as a PMPM payment for care management services or Patient Centered Medical Home (PCMH) certification. These programs help providers build core VBP capabilities by allowing for incentives to change behavior.

Passport is committed to helping providers achieve better performance results by delivering specific, actionable data and guidance via our Population Health Manager (PHM) communications and relationships assigned to any provider participating in these programs. This support simultaneously helps providers feel heard, while also assisting in moving providers along the glidepath to risk. For example, one group that received PHM assistance in 2019 felt so supported that they decided to participate in Passport's upside-only VBP program in 2020.

Passport is committed to advancing the progression of the delivery system in Kentucky towards a focus on higher quality and better outcomes. The pages that follow will describe in more detail the following innovative approaches Passport is taking to ensuring the provider community is modifying its behaviors and participating in a meaningful way in our programs that are supporting this evolution towards value:

- Develop, and continue to evolve, a variety of Physician Incentive Plans that “meet the provider where they are” in terms of infrastructure, capabilities, and risk tolerance
- Invest in our providers' ability to advance their population health capabilities by providing financial support for infrastructure buildout
- Incorporate quality measures that can be customized to the needs of a specific practice, such as adjusting for adult primary care or pediatric care
- Provide meaningful, actionable data in a format that is readily available and easily digestible
- Provide frequent on the ground coaching and support through our Population Health Managers (PHMs)
- Hold regular Joint Operating Committees (JOCs) and Care Conferences (CCs) with providers participating in one of our VBP programs

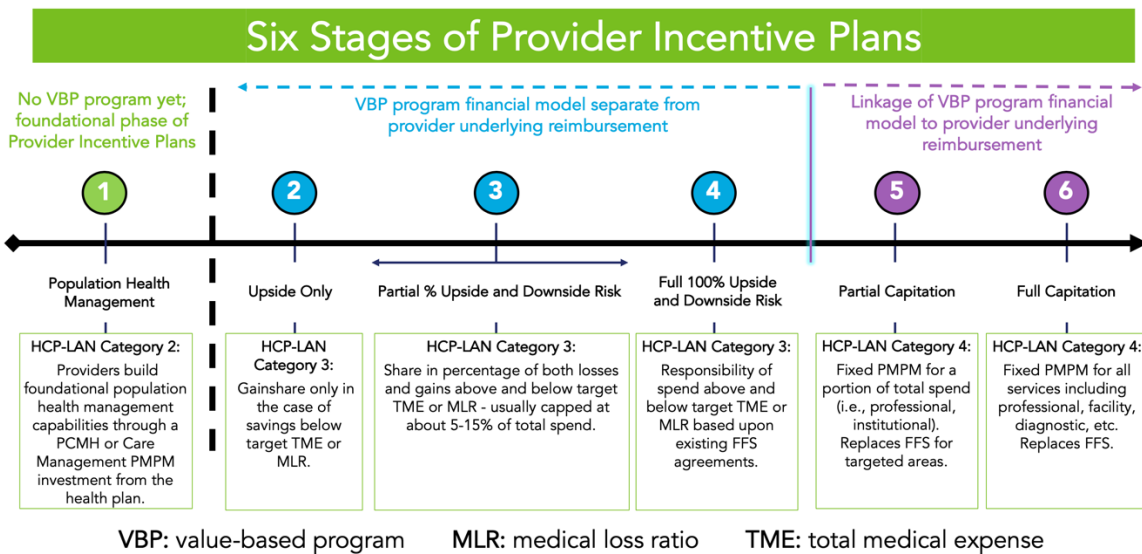
Passport’s Current and Future Approach to Value-Based Programs

Provider Risk and Linkage to Physician Incentive Plans

Passport views capitation and Provider Incentive Plans as two distinct but analogous concepts. Passport defines Provider Incentive Plan to mean any compensation program that rewards providers for improving the quality of patient care and outcomes. While a Provider Incentive Plan is most often implemented in the form of a Value Based Program (VBP), it can also take place through PMPM incentives that help provider establish population health management infrastructure.

The below exhibit depicts the six stages of Physician Incentive Plans. The first phase is a preparation phase, focused on building core population health capabilities through a care management or Patient Centered Medical Home (PCMH) PMPM program. Stages two through six incorporate a VBP program with increasing levels of provider risk. In the case of more advanced risk, such as partial or full capitation, providers may or may not participate in a VBP program as defined by CMS’ Health Care Payment LAN Framework (HCP LAN). Capitation alone does not necessarily improve quality of care, nor does it allow the arrangement to align with CMS’ Health Care Payment LAN Framework. For this reason, when Passport’s providers are ready for capitation arrangements, we intend to incorporate a VBP program. Please refer to **Exhibit: C.3-1** for a Glidepath of Physician Incentive Plans.

Exhibit: C.3-1: Glidepath of Physician Incentive Plans



Passport will use CMS’ HCP LAN Framework which outlines a four-category payment model classification system as our guide for defining Physician Incentive Plans, including VBP programs:

- Category 1 – Fee-for-service with no link of payment to quality
- Category 2 – Fee-for-service with a link of payment to quality and value

- Including: Foundational payments for infrastructure & operations, payment for reporting, rewards for performance, and rewards and penalties for performance.
- Category 3 – Alternative Payment Models (APMs) built on fee-for-service architecture
- Including: APMs (VBPs) with upside gainsharing or APMs (VBPs) with upside gainsharing & downside risk
- Category 4 – Population-based payment
- Including: Condition-specific population-based payment or comprehensive population-based payment.

In addition to leveraging the HCP LAN framework as a guide when developing and refining Physician Incentive Plans, Passport will also continue to ensure that we remain compliant with applicable sections of our contract with the Commonwealth, specifically section 11.5 (Physician Incentive Plans) of the Draft Medicaid Managed Care Contract. Compliance with our contract includes but is not limited to adhering to 42 C.F.R. 422.208 and 42 C.F.R. 422.210; filing templates for compensation agreements (as defined in 42 C.F.R. § 417.479(c)) with the Department; as well as providing information to members, providers, and the Department regarding our Physician Incentive Plans upon request.

Most of Passport’s providers are in the very early stages of VBP program sophistication. Currently our Care Management PMPM and Patient Centered Medical Home PMPM programs align with LAN Framework Category 2. However, Passport’s primary care upside-only Outcome-Based VBP program, HealthPlus, aligns with LAN Framework Category 3. Passport’s goal is to graduate as much of its network into some form of risk sharing through Category 3 (financial model separate from underlying reimbursement) and Category 4 APMs (financial model linked to underlying reimbursement, such as bundled payments).

While Passport is evolving its VBP with an understanding of provider readiness, we have devised a forward-facing strategy to move providers along the risk continuum. Passport recognizes that payment transformation must be done deliberately and incrementally, and as such has developed a tiered VBP program framework that allows for more mature models as providers continually master population health capabilities.

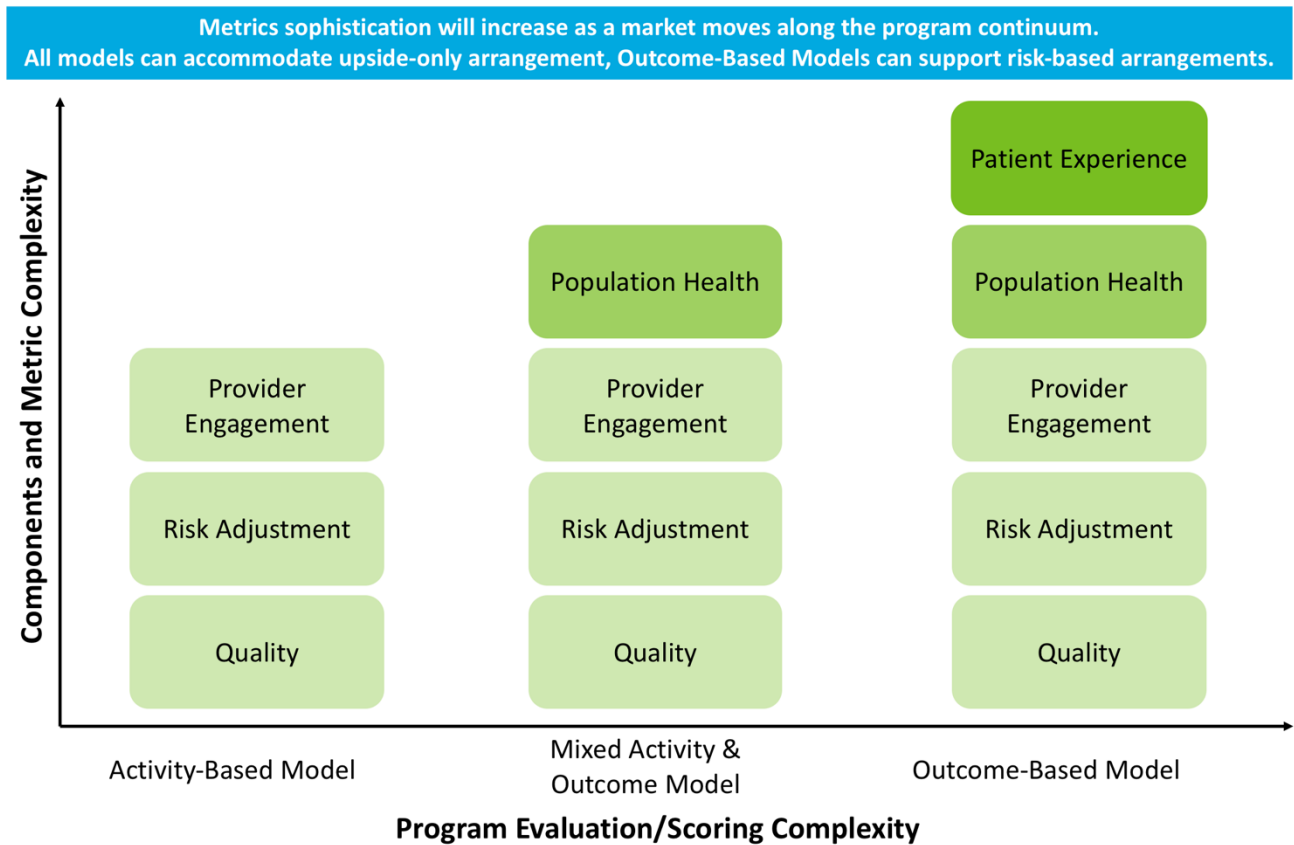
The VBP program strategy has three defined stages.

1. The first stage is an Activity-Based Model in which providers receive a defined payment for completing specific tasks around quality, risk adjustment, and provider engagement (i.e.: submitting Patient Assessment Forms for risk adjustment, attending Joint Operations Committee (JOC) meetings, etc.).
2. The second stage is a Mixed Activity- and Outcome-Based Model in which providers can earn defined dollars by completing specific tasks and performing well on metrics around quality, risk adjustment, provider engagement, and population health (ex: exceeding the HEDIS 50th percentile, reducing Emergency Department utilization by a particular percentage relative to prior year).
3. The third stage is an Outcome-Based Model in which providers can share in savings by performing well on metrics around quality, risk adjustment, provider engagement, population health, and

patient experience. For providers needing encouragement to try an Outcome-Based model, Passport may incorporate additional PMPM earnings to reward high quality scorecard performance even if the Medical Expense Ratio (MER) does not decrease to generate shared savings. Furthermore, we may also offer a PMPM bonus for providers with an already efficient MER, which may be hard to further reduce.

Exhibit C.3-2 provides an overview of our strategy in aligning metric type with program sophistication.

Exhibit C.3-2: Program Evaluation and Scoring Complexity

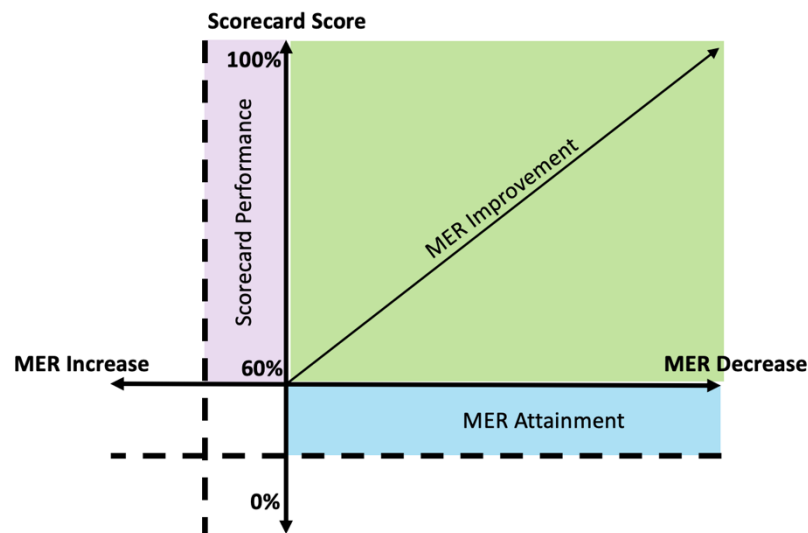


Our VBP models have a sliding scale in program sophistication while covering the full risk continuum. Risk-bearing VBP programs will have proportional upside and downside risk for the providers. Additionally, capitation arrangements with an Outcomes-Based VBP program overlaid offer providers the opportunity to earn additional funds, as shown in Exhibit C.3-3 below.

Exhibit C.3-3: Outcome-Based VBP Program’s Payment Mechanisms

There are 3 separate potential earning mechanisms for a participating provider group; the mechanism with the greatest calculated payout will be the one applied.

- **MER Improvement** earnings potential is generated from their individual cost savings from YoY lower MER. The portion of the incentive shared with the provider group is based on their scorecard performance, minimum of 60%. A group can earn up to 50% of its incentive potential.
- **MER Attainment** earnings rewards provider groups that maintain an MER at or below 85% in the case their MER does not improve. Groups must have at least 60% on the Scorecard. MER Attainment only applies for groups that do not have MER improvement.
- **Scorecard Performance** earnings mechanism rewards providers for achieving at least 80% on their scorecard. This earning mechanism only applies for groups that do not have any MER improvement or MER at or below 85% (MER Attainment).



Measuring Improvements in Health Outcomes Through VBP Arrangements

Provider payment models are not considered “value-based” unless payments have a strong link to improved outcomes and cost savings, requiring dedication and rigor around metric measurement. **Exhibit C.3-4: Quality Metrics** offers a list of “measures that matter” for PCPs, hospitals and specialists that we measure (where and how) and are considered in conjunction with the various domains and quality gates. This is a nonexhaustive list of metrics that support our VBP programs and quality gates.

Exhibit C.3-4: Quality Metrics

Clinical and Efficiency	Population Health, Access, and Satisfaction
<ol style="list-style-type: none"> 1. Follow-up visit made within seven days following post-acute stay 2. Admission rate 3. ER Utilization rate 4. Plan all-cause readmissions (adult & peds) 5. Ambulatory care sensitive ED rate (adult & peds) 6. Use of imaging studies for low back pain (adult only) 7. Completion of screenings such as the PHQ-9 for detection of depression in the primary care setting or completion of the Edinburgh Depression Scale for women with post-partum depression 	<ol style="list-style-type: none"> 8. Expanded office hours outside the hours of 8:00 AM-5:00 PM 9. Member satisfaction (member experience score) 10. Quarterly care plans 11. Transition visit w/in five days of discharge 12. Physician attendance at Physician Engagement programs 13. Pre-visit planning 14. Visit made following stratification of a member into a complex care program 15. Practices adoption and use of our technology platform, Identifi Practice
Adults	Peds
<ol style="list-style-type: none"> 16. Comprehensive diabetes care - nephropathy 17. Antidepressant medication management - acute phase 18. Medication management for people with asthma - appropriate meds for at least 75 percent of treatment period 	<ol style="list-style-type: none"> 19. Medication management for people with asthma appropriate meds for at least 75 percent of treatment period 20. Adolescent well-care visits 21. Immunization status - Combo 2 22. Appropriate treatment of children with upper respiratory infection
Specialists VBP Measures That Matter	Behavioral Health VBP Measures
<p>Many of the PCP metrics and specialist metrics can cross over to the other.</p> <ol style="list-style-type: none"> 23. Hospital readmission at 30, 60, 90, and 180 days (including psych) 24. Follow up after hospitalization (all types) 25. Caesarean section and early elective delivery rates 26. Obstetricians - prenatal care (first trimester prenatal visit, frequency of prenatal care visits, 6-weeks post-partum) 27. Medication management, including follow-up targeting specific types of drugs 	<ol style="list-style-type: none"> 28. Initiation and engagement of alcohol and other drug dependence treatment (IET) 29. Antidepressant medication management (AMM) 30. Follow-up care for children prescribed ADHD medication (ADD) 31. Participation in vocational rehabilitation and other measurable results
Hospitals VBP Measures That Matter	Maternity/OB VBP Measures That Matter
<ol style="list-style-type: none"> 32. All-cause readmission rate 33. Risk-adjusted average length of stay 34. Hospital-acquired conditions/infections 	<p>Regarding OB specialty, our quality gate would focus on OB care using Medicaid HEDIS and Joint Commission measures. We aim for HEDIS 90th percentile as target, with partial points for 50th and</p>

<ul style="list-style-type: none"> 35. Emergency to observation/inpatient escalation rate 36. Radiology service utilization 37. National Patient Safety and National Quality Improvement goals 38. Hospital Consumers Assessment of Healthcare Providers and Systems (HCAHPS) 39. Mortality rate for three conditions present on admission Indicators 40. Admission notifications within 24 hours 	<p>75th. For Joint Commission measures, we use the Healthy People 2020 goal. Three measures we focus on for OB care are: frequency of ongoing prenatal care (FPC); prenatal and postpartum care (PPC); and the Joint Commission: C-section for nulliparous singleton term vertex (NSTV).</p>
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Our VBP programs are designed to reduce potentially preventable events. We have identified several clinical and efficiency measures that directly and indirectly reduce preventable events. To ease the burden of providers participating in multiple VBP programs, we may align our metrics with existing the Commonwealth and managed care organization (MCO) initiatives for potentially preventable events. The following are examples of VBP program metrics that target preventable events as outlined in **Exhibit C.3-5** below:

Exhibit C.3-5: Potentially Preventable Event Measures

PCP Measures	Preventable Events
<ul style="list-style-type: none"> 41. Follow-up visit made within 7 days following post-acute stay 42. Admission rate 43. ER utilization rate 44. Plan all-cause readmissions (Adult & Peds) 45. Ambulatory care sensitive ED rate (Adult & Peds) 46. Use of imaging studies for low back pain (Adult Only) 47. Completion of screenings designed to identify members who need specific interventions such as the PHQ-9 for detection of depression in the primary care setting, or completion of the Edinburgh Depression Scale for women who are identified with post-partum depression 	<ul style="list-style-type: none"> 48. All-Cause readmission rate 49. Risk-adjusted average length of stay 50. Hospital-acquired conditions/infections 51. Emergency to observation/inpatient escalation rate 52. Radiology service utilization 53. National Patient Safety and National Quality Improvement goals 54. Hospital Consumers Assessment of Healthcare Providers and Systems (HCAHPS) 55. Mortality rate for three conditions present on admission indicators 56. Admission notifications within 24 hours

Analysis of these measurements are used as the basis for provider discussion and program planning. Passport’s experience with VBP programs has informed our approach to analyzing performance against targets. We evaluate programs and provide feedback to participating providers on a quarterly basis. We have determined that a quarterly evaluation gives providers sufficient time to impact the metrics, while still providing us the opportunity to adjust program metrics or elements in partnership as needed.

We take a two-tiered approach to physician engagement and scorecard report distribution that offers a comprehensive top-down and bottom-up structure.

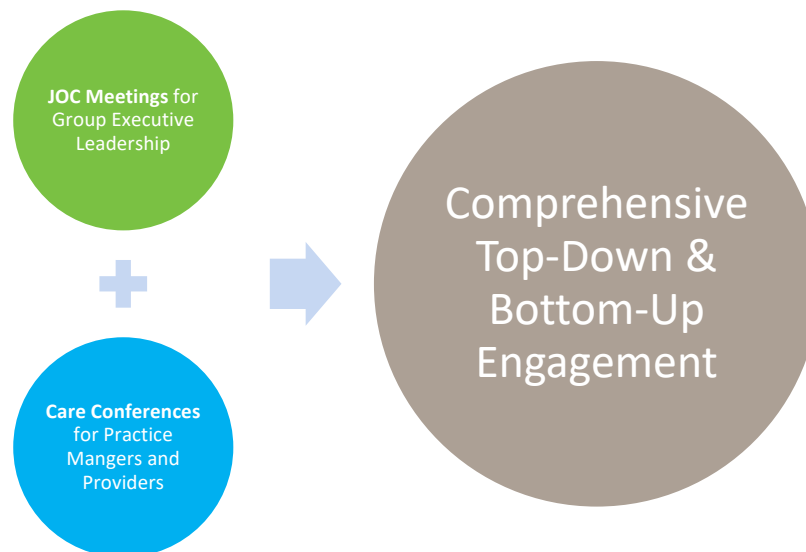
- **Joint Operations Committee (JOC) Meetings:** The purpose of the quarterly in-person JOC meeting is

to work collaboratively with the provider organizations' executive leadership teams to discuss group-level MER and program performance data, best practices, and macro-level areas of focus that ultimately lead toward improved quality and satisfaction for members while reducing unnecessary costs. Passport has an interdisciplinary team that provides comprehensive support for scorecard reports. These meetings allow us to work with the practitioner group leadership to review interventions, and measure progress and jointly determine opportunities for improvement whether that is 1) further root cause drill down for actionable information at a practitioner level, or 2) an opportunity on the practice side including workflow efficiencies, administrative burden, or practitioner engagement.

- **Care Conference (CC) Meetings:** The purpose of the monthly CC meeting is to engage organizations' key practice managers and providers to ensure they understand the VBP program and have the information they need at the point-of-care to successfully participate as well as be able to test and learn from practice level adjustments discussed at the JOC meetings. Passport's PHMs play a critical role in supporting practice-specific performance. PHMs are different than Provider Network Representatives because they are specific subject matter experts around practice transformation, population health, and specifically clinical care management programs and VBP initiatives. Key activities led by PHM with practitioners include:
 - Sharing broad to specific practice-level actionable information on the member panel;
 - Helping providers improve quality, population health, and risk adjustment performance more broadly and specifically around the VBP program elements; and
 - Educating providers on and supporting member engagement in appropriate Passport care management programs.

Please refer to Exhibit C.3-6 for Passport's Multi-faceted Physician Engagement Strategy.

Exhibit C.3-6: Passport's Multi-faceted Physician Engagement Strategy



A major focus of Care Conferences goes beyond just the VBP metrics and elements. We use the opportunity to provide feedback and inform providers about broader HEDIS, EPSDT, quality, and clinical action items that we can work together on to impact member health more broadly as well as improvements in relationships between Passport and our practitioner network. It is this broader support effort that truly responds to provider asks for assistance in strengthening their population health management capabilities, which are needed for them to be successful in VBP programs and risk arrangements.

In-person Care Conference meetings with prioritized practice locations yield the greatest impact on the provider group's overall scorecard performance. Passport's network providers are also equipped with tools like the provider web portal and Identifi Practice to monitor quality and clinical measures.

Methods for Evaluating the Effectiveness of VBP

Passport has the technical capacity and engagement resources to continue to successfully administer VBPs with providers to track and drive improvement outcomes. Both our Joint Operating Committee and Care Conference meeting forums feature customized analytics, guidance, scorecard performance updates, and training to help providers succeed in our VBP programs. Passport adjusts the support at these engagement meetings per the unique needs of the provider groups and what they feel will be most useful to them.

Passport also will grant authorized providers access to our Care Management (CM) and reporting capabilities through our practitioner communication and interactive provider portal, Identifi Practice. This platform documents care gaps and coding accuracy opportunities on a member-by-member basis and enables providers to understand in near real-time precisely how to close the care gap and thereby improve their performance metrics. Practitioner reports are available on Identifi Practice, and providers have the option to submit electronic authorizations via this portal. Passport will continue to work with our practitioners, especially with input from those that serve on the PCP Workgroup, to further develop and test efficiency enhancements to the tool. A few areas where providers will inform improvements include content and workflow and ease of use such as development of easy, single sign-on capabilities. Further, Identifi Practice allows providers to coordinate with members of the Passport CM team through bi-directional communication and the notes functionality.

Our PHM and care management teams also assist the provider office to support individual care gap closure, actionable clinical guidance regarding member health and well-being, and VBP program arrangements and data results. Local medical directors and PHMs will work with physician offices to understand the practice's opportunities and disseminate best local and national best-practice strategies to improve performance in the areas of care gap closure, identifying and confirming suspected diagnoses that will drive our risk stratification program, and engaging the most complex members in our population in the appropriate clinical management programs.

These PHMs are critical assets to provider practices, working hand-in-hand with physicians, care managers, and office staff to ensure they have access to complex member rosters and gaps in care reporting. They are a resource to the practice to enable them to fully utilize the Identifi Practice tools, analytics, and reporting capabilities to better manage the physicians' patient panel. Other supporting elements include strong data

capture, normalization capabilities, and robust standard and customized report generation that align to the performance scorecard. PHMs are also unique to Passport in that they are practice transformation and population health subject matter experts beyond the typical knowledge and experience of traditional provider network representatives and are deployed to all of our VBP program partners and other key network practitioners.

Passport’s PHMs support providers both preparing for and already participating in VBP programs. This customized support not only helps providers feel heard during these evolving times, but is also fruitful in moving providers along the glidepath to risk. For example, a group that received PHM assistance in 2019 felt so supported that they decided to formally participate in Passport’s upside-only VBP program in 2020.

C.3.b. Provide examples of successful Physician Incentive Plans the Vendor has implemented, including information about their structure, measurable outcomes, challenges and lessons learned.

Passport “Meets Providers Where They Are”

A core tenet of Passport’s Physician Incentive Plan philosophy is to “meet providers where they are.” Passport is working in partnership with providers to enhance risk contracting and VBP program sophistication. In response to provider readiness and preference, VBP programs currently are upside-only and overlay FFS arrangements. As aforementioned, Passport has a defined strategy to move providers along the six stages of Provider Incentive Plans. Together, Passport and its affiliate subcontractor Evolent Health (Evolent), have experience deploying VBP programs with varying levels of risk, including capitated models. Passport will continue to evolve alongside providers as they reach a point of readiness for capitated models that incorporate a VBP program.

The Passport VBP strategy includes a suite of models that “meet providers where they are” as they move along Physician Incentive Plan continuum. Early stages are focused on building foundational population health management capabilities. To date, Passport has implemented two Stage One models that provide a PMPM payment to engage providers in VBP and help them build the necessary infrastructure for more advanced models.

Stage One Physician Incentive Program Models:

- **Care Management PassportPlus:** In working with our existing providers, we learned that some need additional practice investment for their infrastructure enhancements in order to participate in HealthPlus. This Program extends compensation for care management services on a semi-annual basis for participating providers who can then plan their resources accordingly.
- **Patient Centered Medical Home (PCMH) PassportPlus:** This program rewards dozens of existing provider groups to incentivize the core tenets of PCMH behavior in their practices. The incentive is paid monthly with a goal of moving these smaller practices closer to risk-readiness and move them along the quality and value continuum at a comfortable pace without the resource jeopardy that risk often signals to small practices.

While Stage One models serve as a great entry to Physician Incentive Plans, our experience is that patient care and cost savings to Kentucky's Medicaid system improve significantly as providers participate in stages further along the continuum. Though administrative challenges associated with administering either of these Stage One models were minimal, recognizing that they do serve a unique purpose in supporting providers in building their infrastructure with the goal of eventually progressing to a more advanced VBP model, Passport has learned the lesson that additional measures must be taken in order to truly produce better outcomes. Accordingly, over the last three years Passport developed and refined a Stage Two model, an upside-only primary care VBP program called HealthPlus. With one full program measurement year and payout complete, Passport is excited to share that HealthPlus is not only effectively driving outcomes, but also expanding to include more provider groups.

Below we detail four VBP programs that progress along the Physician Incentive Plan maturity continuum that: 1) exemplify Passport's VBP diversity of programs with a care management PMPM for a Clinically Integrated Network (CIN); 2) demonstrate Passport's experience launching a provider-centric primary care VBP program; 3) demonstrate our Behavioral Health Shared Saving Model; and 4) highlight a sample capitation arrangement with a VBP program in another market supported by Passport's vendor, Evolent.

VBP Program with Care Management PMPM for Clinically Integrated Network (CIN) Provider

Passport successfully implemented a physician-centric, shared savings program with hospitals and physicians that was clinically integrated across the care continuum to support triple-aim objectives of improving the member experience of care, advancing the health of populations, and minimizing costs for our members. Physicians and hospitals collaborated with shared goals in performance, quality, value and efficiency while adopting enhanced care coordination for our members and their families.

The shared savings VBP program aimed to incentivize providers that deliver high-quality care in an efficient manner and achieve measurable improvements in quality and efficiency for maximizing the impact of preventable care. Existing FFS agreements were not impacted by the CIN contract, and the program was upside only. Unit cost and VBP contracting were separate agreements.

Passport's CIN performed care management for all members assigned to providers who participated in the network. Passport recognized that to shift focus to meaningful outcomes it needed to assist providers in building a foundation with resources that support population health management. Passport paid the CIN administrative PMPM care management fees to help providers fund and integrate population health management to encourage successful participation in the VBP program. The CIN could also earn additional care management PMPM based on scorecard performance. In addition to a care management PMPM, the CIN could earn a portion of the shared savings through the MER Improvement payment mechanism in which their scorecard performance correlated to a percentage of the shared savings split with Passport.

Measurable outcomes were driven by a true partnership between the plan and providers and included sharing information and resources to attain success. Provider engagement and communication were significant elements of the program. Passport shared performance reports in quarterly Joint Operating

Committee meetings to confirm understanding, gather feedback and offer recommendations for improvement. Passport worked collaboratively with our provider organization’s executive, administrative and clinical leadership teams to share data, best practices and areas of focus that lead toward improved quality and satisfaction on their patient panel. We helped providers take action on quality and risk adjustment and educated providers to help them understand and achieve successful outcomes in the value-based program.

Below is a sample performance-based CIN program with a shared savings arrangement for a large Medicaid provider.

The scorecard measures provider performance based on 4 weighted categories for a total of 20 points, as depicted in **Exhibit C.3-7**.

Exhibit C.3-7: VBP Program Scorecard with Care Management PMPM for CIN Provider

Domain	Measure	Points	Weighting
Prevention/ Quality	1. Adolescent well-care visits (12-21 years of age) 2. Chlamydia screening in women (15-24 years of age) 3. Adult BMI Assessment 4. Medication management for people with asthma – appropriate medications for at least 75% of treatment period 5. HbA1C Testing for members with Diabetes (Adults) 6. HbA1C Control less than or equal to 9 for members with Diabetes (Adults)	1 point per measure; Total 6 points	60%
Efficiency	1. Plan all-cause readmissions 2. Ambulatory care sensitive ED rate	1 points max per measure; Total 2 points	20%
Provider Citizenship	1. Attendance at quarterly JOC Meetings	1 points max per measure; Total 1 points	10%
Potential Diagnosis Addressed Rate	1. Office visit with 40% identified population	1 points max per measure; Total 1 points	10%

Passport used intelligent analytic tools to evaluate and support the CIN’s performance through actionable insights that foster improvements in quality, efficiency, cost and utilization. Quarterly evaluation of performance during the measurement year showed improvements in various categories. Final performance evaluation reflected marked reductions in MER. While the CIN generated savings as a result of spending below financial target, performance scorecard criteria were not met and the CIN was not eligible to receive shared saving payment or additional care management PMPM. The lessons learned by Passport regarding the CIN’s challenges to reach the applicable scorecard criteria helped to inform the development of what is now Passport’s leading VBP program for primary care providers, HealthPlus, which is outlined in the following section.

Highlights of measurable outcomes achieved through this particular program include:

- MER reduction of 6%

- Exceeded the target for HbA1C Control > or equal to 9 (adults) by 38%
- Inpatient PMPM decreased 34%
- Outpatient PMPM decreased by 17%
- ED PMPM decreased by 11%

Passport’s Sample Primary Care VBP Program

In 2017, Passport collaborated with our PCP Workgroup to design the 2018 HealthPlus Program. We conducted lengthy, multi-session exercises with our providers to vet the program’s design and metrics. Passport launched its primary care HealthPlus VBP program in 2018 after gaining approval from DMS. Our primary care VBP program was initially designed for multi-site practices covering nearly 120,000 health plan lives across 2,100 contracted primary care providers.

HealthPlus is uniquely physician-centric and is built upon the guiding principles of Passport’s value-based care strategy:

- Ensure the value-based incentive strategy aligns with the plan’s mission and governance from DMS
- Begin by focusing on an (adult/pediatric) PCP incentive program designed to manage quality and cost at the member level. Confirm the program has metrics that are inclusive of all primary care practitioners - pediatric, family medicine, and adult-only internal medicine practitioners. Continually work with providers to iteratively test and improve the program to create the best approach.
- Ensure the value-based incentive program is driven by a true partnership between the plan and providers, including sharing information and resources to attain success. Provider engagement and communication are critical elements of the program.

HealthPlus is an upside only provider gain-share program that rewards providers for improved cost and quality outcomes after a quality gate has been achieved. The program is uniquely physician-centric and rewards incremental progress. In direct response to feedback from our provider community and lessons learned from implementing earlier versions of the program, in 2020 Passport is offering three earning mechanisms as an enhancement to the program as compared to its initial roll-out in 2018 which had only two earning mechanisms.

The three opportunities for gain-share reward include:

- MER Improvement – Providers improve the total cost of care by providing a full range of services to their assigned members.
- MER Attainment – Providers maintain an already-reasonable total cost of care by providing a full range of services to their assigned members.
- Scorecard Performance – Providers achieve high performance on the Passport Quality Scorecard related to the care of their assigned members.

5 PCP Groups

5 Domains:

- Population Health
- Risk Adjustment
- Provider Engagement
- Patient Experience
- Quality

Payer Program Design

The *Passport Quality Scorecard* includes 15 quality measures that can be customized to the needs of the specific practice, such as adjusting for adult primary care or pediatric care, as shown in **Exhibit C.3-9**. Performance is measured on a calendar year and rewards are paid out the following year once claims have matured, creating an accurate measurement of the provider’s performance, as shown in **Exhibit C.3-8**.

Exhibit C.3-8: HealthPlus Outcome-Based Earning Opportunities

3 Outcome-Based Earning Opportunities for 2020 HealthPlus



Exhibit C.3-9: 2020 HealthPlus Scorecard Performance Metrics

Domain	Measure	Weighting
Quality (Adults)	<ol style="list-style-type: none"> 1. Comprehensive Diabetes Care - HbA1c Testing 2. Antidepressant medication management -acute phase 3. Medication management for adults with asthma – appropriate medications for at least 75% of treatment period 	25% Weighted Adult
Quality (Pediatrics)	<ol style="list-style-type: none"> 1. Medication management for children with asthma – appropriate medications for at least 75% of treatment period 2. Adolescent well-care visits 3. Child well-care visits 4. Appropriate treatment of children with upper respiratory infection 	50% Weighted Pediatric
Population Health (Adults)	<ol style="list-style-type: none"> 1. Plan all-cause readmissions 2. Ambulatory care sensitive ED rate 3. Use of imaging studies for low back pain 	25% Weighted Adult

Domain	Measure	Weighting
Provider Engagement	<ol style="list-style-type: none"> 1. Practices’ physician/clinical leadership and administrative leadership attendance at quarterly Joint Operations Meetings 2. Practices’ key location(s) physician/clinical leadership and administrative leadership attendance at monthly Care Conference Meetings 	20% Weighted All
Potential Diagnosis Addressed Rate	<ol style="list-style-type: none"> 1. Medicaid Condition Addressed Rate – The percentage of suspect conditions addressed for patients identified as having an intervention opportunity 	20% Weighted All
Patient Experience	<ol style="list-style-type: none"> 1. Personal doctor explained things 2. Personal Doctor showed respect 	10% Weighted All

The initial launch of HealthPlus in 2018 aimed to strategically improve quality of care, lower costs and engage providers in the pay-for-value paradigm. The program incentivized providers for improvements in quality, costs and patient experience, and ensures the VBP is driven by a true partnership between Passport and its providers. In the spirit of true-partnership and innovation, Passport paused HealthPlus in 2019 to refine the program and to better serve the needs of providers.

Passport has taken meaningful steps towards ensuring the provider community has direct input to the evolution of our value-based programs, and that they have the support they need to be successful. Direct feedback through the Partnership Council led to the incorporation of an additional earning mechanism for providers in HealthPlus, as well as other VBP program revisions.

Of the participating groups, a large practice serving the needs of adult and pediatric patients achieved shared saving incentives resulting from performance in 2018. They demonstrated strengths in improving quality scores in all four measures for adults, and reduced MER by 2.9 percent. Achievements in scorecard performance were less than optimal in the beginning of the program, however a baseline has been established to improve and tailor improvement efforts in 2020. **Exhibit C.3-10** reflects the final performance evaluation for participating groups in 2018.

Exhibit C.3-10: 2018 Final Performance Evaluation

Scorecard Domain	Measure	Percent of Groups that Exceeded Baseline Threshold	Percent of Groups that Exceeded Target Threshold
Quality Adults	Comprehensive Diabetes Care – Medical Attention for Nephropathy	20%	0%
	Antidepressant Medication Management	0%	0%
	Medication Management (Asthma)	80%	20%
Quality Pediatric	Medication Management (Asthma)	86%	0%
	Adolescent Well-Care Visits	29%	14%
	Child Well-Care Visits	29%	14%
	Appropriate Treatment (Respiratory Infection)	86%	43%
Prevention/ Quality Adults	All-Cause Readmissions	20%	0%
	Ambulatory Care Sensitive ED Rate	80%	0%
	Use of Imaging Studies for Low Back	0%	0%
Provider Engagement	Leadership Attendance at JOC Meetings	100%	100%
	Provider Group Use of Identifi Practice	100%	100%
Patient Visit Rate	Medicaid Condition Addressed Rate	43%	43%
Patient Experience	Personal Doctor Explained Things	86%	86%
	Personal Doctor Showed Respect	86%	86%

HealthPlus Program Refinement

After taking 2018 performance and provider feedback into account, Passport has refined the HealthPlus program. Given that HealthPlus remains Passport’s primary mechanism for driving outcomes in primary care, our intent is to continue to scale this program across the network, strategically moving providers along the risk continuum in the coming years. Passport worked with targeted provider groups to vet potential program changes while considering activities to strengthen provider engagement, minimize administrative burden, ensure timely, accurate and actionable reporting and increase provider ability to earn incentives. Passport met with individual provider groups and their key staff members to align on areas of improvement that are appropriately beneficial for Passport and participating groups. Through this series of meetings and collaboration, Passport finalized the 2020 HealthPlus program with five provider groups signing agreements to participate.

A key component of the program in 2020 is support and expertise from the Population Health Management (PHM) team. Provider success in HealthPlus is made possible due to the analytic-based, actionable insights

contributed by PHM. Maximizing patient care quality and population health involves several strategies and tools to identify patients who should be targeted for medical interventions, leading to improved quality scores and/or medical/ED avoidance. PHM helps providers identify and target high-risk patients and research why those patients need help. PHM guidance also helps identify members who may benefit from inclusion in our Care Management programs. Member engagement efforts are realized through targeted data for quality and risk, a variety of reporting capabilities, and hands-on member outreach. Program success in 2020 helps prepare participating providers to move from fee-for-service to risk-based alternative payment models (APM).

Exhibit C.3-11 reflects key program changes from the initial program launch to 2020.

Exhibit C.3-11: 2020 HealthPlus Program Changes

Program Element	2018 HealthPlus	2020 HealthPlus	Rationale for change
Earning mechanisms	2 Payment Elements: Groups can earn MER Improvement and/or MER attainment.	3 Payment Elements: Groups can earn MER Improvement, or MER Attainment, or Scorecard Performance	<ul style="list-style-type: none"> Earning mechanisms revise resulting from provider feedback and desire for more simplified methodology Experience gained administering the program in 2018, direct feedback from providers and effort to “meet providers where they are” prompted the need for the Performance Scorecard payment mechanism. Additionally, MER Improvement was difficult for pediatric practices to attain.
Scorecard Domains	Domain weighting: <ul style="list-style-type: none"> Provider Citizenship – 25% Patient Visit Rate – 15% 	Scorecard weighting <ul style="list-style-type: none"> Provider Citizenship – 20% Patient Visit Rate – 20% 	<ul style="list-style-type: none"> Improving comprehensive care for patients with higher risk factors and more opportunity for providers to achieve points in this category.
Scorecard Measures	Measures: <ul style="list-style-type: none"> Adoption and use of Identifi Practice Comprehensive Diabetes Care - Nephropathy 	Measures: <ul style="list-style-type: none"> Practice attendance at monthly Care Conferences Comprehensive Diabetes Care – HbA1C 	<ul style="list-style-type: none"> Shift focus from provider adoption of a specific tool to ongoing work with the Population Health Management team as trusted advisors at practice level Providers felt they were better positioned to move the needle on HbA1c

Behavioral Health-focused Value-Based Payment Program

Centerstone Kentucky (Seven Counties Services) has been a provider with us since the behavioral health benefit started in 2013. They were paid initially only on a FFS basis. Our first value-based arrangement with

Centerstone Kentucky (Seven Counties Services) was a Pay-for-Performance model, where they had the opportunity to earn additional dollars for demonstrating that they were putting recommended procedures in place and building relationships to increase 7- and 30- day follow-up post hospitalization. Later, the incentive was enhanced to increase the number of discharged members receiving their 7- and 30-day follow-up appointments. Payments were made quarterly for earned incentives.

Our second arrangement with Centerstone Kentucky (Seven Counties Services) was a Blended Case Rate/Bundle of Services. They had the opportunity to bundle a group of services and receive payment for delivery of High-Fidelity Wraparound services in the Foster Care Pilot. They also had an opportunity to earn an incentive on top of this if they achieved their quality performance targets for the two primary goals of the pilot:

1. Percentage of children who maintained their foster care placement or returned to their natural family, and
2. Percentage of children who improved their functioning on a standardized assessment.

Payments on the Blended Case Rate/Bundle of Services arrangement occurred monthly with any earned incentives paid out at the end of the program.

Our current value-based arrangement with Centerstone Kentucky (Seven Counties Services) is a Shared Savings Model. There are two opportunities to earn these Shared Savings Incentives:

- **Population Incentive:** Through our Population Incentive, Centerstone Kentucky (Seven Counties Services)' members are identified and agreed upon before the measurement period begins. Members are then measured for one quarter, and pre-quarter and end-of-quarter expenses per member are compared (after allowing a quarter for claims lag). A pool is created from any savings on medical inpatient stays, behavioral health inpatient stays and emergency department visits. Thirty percent of the savings, over a quarter, for the agreed-upon members is placed into an "incentive pool," which they may earn. Half the pool is awarded for achieving savings. The other half of the pool is tied to the following quality measures:
 - Follow-up after hospitalization
 - Documenting members' BMI and having a plan for addressing if it is outside the normal range
 - Documenting members' tobacco use, and having an intervention if they use tobacco,
 - Documenting of obtaining release and sharing of records with PCP
 - Documenting obtaining of release and sharing of records with referring provider
 - Completing AIC hemoglobin screenings for members with schizophrenia or bipolar disorder
 - Documenting suicide risk assessments for members with major depressive disorder at least every six months
 - Screening members for SUD and linking to treatment if needed.
- **Partners in Wellness Incentive:** Centerstone Kentucky (Seven Counties Services) is provided a list of 200 members (in advance of the quarter), beginning with their members with a severe mental illness and their members with the most expense due to their health care utilization. Centerstone Kentucky (Seven Counties Services) is also provided a list of members (who are not currently with Centerstone Kentucky (Seven Counties Services)) with a severe mental illness and the higher expense rates, but the listed members will not have been engaged in care. They have the opportunity to engage these members into the Partners in Wellness Program, an integrated

behavioral and medical case management model with 24-hour access to nursing. Again, this is a shared savings model with pre- and post-measurement for a quarter before and at the completion of the quarter (after allowing another quarter for claims lag). Thirty percent of any savings over the quarter from medical inpatient stays, behavioral health inpatient stays, and emergency department visits is placed into an “incentive pool”. Seven Counties can earn half of the incentive pool by closing the quarter with a savings. The other half of the pool is tied to specific quality metrics for the intervention’s two primary goals:

- Member activation
- Documentation of member having a health goal with documented progress measured toward achieving the goal

Additional health behaviors and performance on HEDIS targets are documented to possibly use as baseline clinical metrics for future value-based relationships.

The most significant challenge Passport has experienced in implementing the multiple iterations of this highly collaborative VBP arrangement is the investment needed in time, resources, and relationship building in order to optimize this partnership and establish mutual trust. Both Passport and Centerstone Kentucky (Seven Counties Services) have both invested countless hours to ensure that data can be shared bi-directionally in a timely fashion, that processes are working smoothly, and that we are establishing meaningful measures that will truly continue to drive outcomes. As we continue the relationship, our metrics will remain focused on the member receiving whole person integrated care in an effort to improve overall health and wellbeing.

During a Grand Rounds at the University of Louisville, Passport shared its BH program design with Stephen Bartels, MD, MS from the Substance Abuse and Mental Health Administration (SAMHSA) – Health Resources & Services Administration (HRSA) National Center of Excellence for Integrated Health Solutions (CIHS). He strongly supported the idea of focusing on patient activation and focus on physical health goals for outcomes for members with severe mental illness. He also reported they have emerging research that focusing on symptoms of mental illness results in incremental change. Dr. Bartels indicated that for transformative change, the focus needed to be on overall health, even though the program was originally designed for individuals with severe mental illness. The integrated, whole person approach helps members make impactful changes. The results of this value-based experience align with this emerging research (see **Exhibit C.3-12.**)

Exhibit C.3-12: Results from Partners in Wellness Incentive Program

The program served 142 members with severe mental illness for up to 6 months over a 9-month period.

Within that period, we observed the following impact:

- 63% reduction in combined medical inpatient, emergency, and behavioral health inpatient expenses
- 45% reduction in inpatient hospital stays
- 27% reduction in Emergency visits
- 69% reduction in hospital readmissions

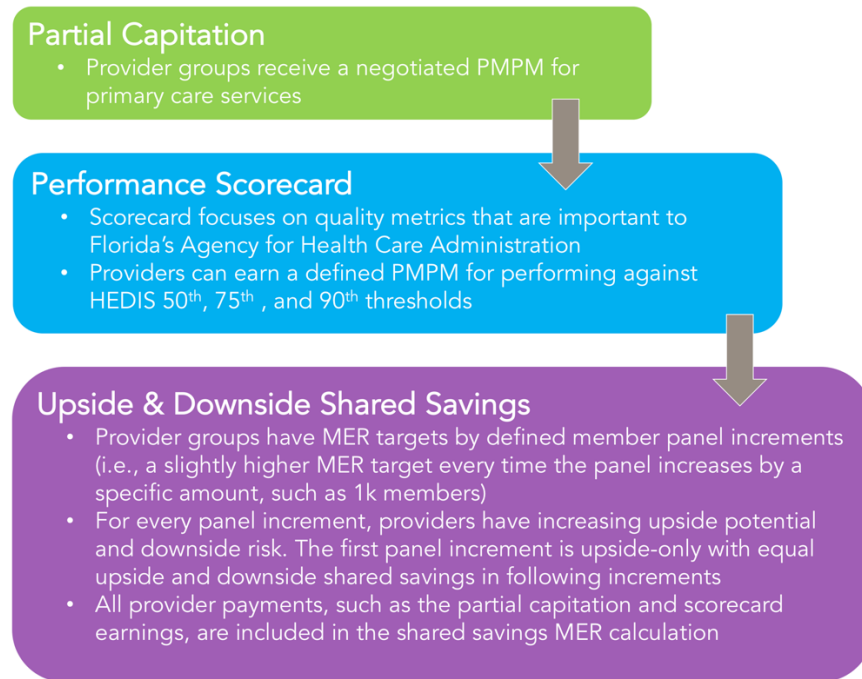
These initial results suggest we have created an integrated program that could bring medical case management into the relationship of trust with the Behavioral Health provider and help us to promote appropriate utilization of intensive care resources

Patients with chronic medical and comorbid mental health or substance use disorders generally experience higher costs. Because of this, savings opportunities exist through VBP programs that address this specific population.

Bringing National Capabilities to Kentucky

Passport has access to industry-leading experience with VBP Models in markets across the nation. As the delivery system in Kentucky continues to evolve towards more sophisticated VBP models, Passport will benefit from these capabilities and experience. An example of a sophisticated HCP LAN Category 4 model that is currently in place at provider-led, Evolent-supported Health Plan in Florida could be implemented in Kentucky when the provider community is ready. One of the models currently in place in south Florida incorporates both differentiated underlying reimbursement (partial capitation) as well as a VBP component, as shown in **Exhibit C.3-13**. Providers participating in this program have partial upside and downside risk, subject to hitting both financial and quality targets. This VBP model itself has gone through multiple iterations over the past two years as the Health Plan has made adjustments based on lessons learned and provider feedback. One specific modification that has been made in order to maximize outcomes are adjustments to specific quality measures. Passport is prepared to implement a model such as this in Kentucky.

Exhibit C.3-13: Example Partial Capitation with Risk-Based VBP Program



Lessons Learned Developing and Implementing VBP Models

Through the process of building our VBP programs, Passport has developed a consistent approach to identifying and building out initiatives for VBP. We begin by identifying gaps or opportunities to enhance care. Next, we review the literature to determine what evidence-based solutions have worked in other settings. Very importantly we then engage providers and members of our advisory groups, such as the PCP Workgroup, or Behavioral Health Advisory Group to provide feedback on the program structure. A detailed proposal is developed for the Passport Executive Leadership Team which defines the risks and benefits, how success will be measured, and expected outcomes. Once approved by leadership, Passport implements the initiative and measures progress according to the established clinical and/or financial metrics.

Passport has identified several key factors in building effective programs that improve performance and outcomes:

- 1. Build VBP program with providers at the table.** To gain buy-in and minimize abrasion among providers, it is essential to work with them from the outset to develop the program. Our provider ownership and provider-driven governance structure is a differentiator for Passport in developing VBP programs because we can work directly with key provider leadership in the design choices and approval of our VBP programming. The PCP Workgroup provides invaluable insight into the best metrics and payment approaches to use to achieve the best outcomes with the highest provider participation. An example of the important and thorough discussion with providers for feedback is

on population health metrics like preventable Emergency Department (ED) utilization. Healthy discussion ensued about the impact Primary Care physicians have on members going to the ED. Early discussion focused on how members have many factors that lead to ED visits including specialists and other factors but as the discussion continued, the majority of PCPs voted in favor citing their role as the member's medical home. Practitioner buy-in is the most important factor to engagement and success in any incentive VBP program. All of Passport's practitioner initiatives are reviewed and approved by the provider-led Partnership Council as a final step before Passport leadership will move forward.

2. Choose measures thoughtfully. With earlier VBP pilot programs, Passport initially selected a larger number of measures to evaluate for payments. As pilots progressed, we determined that it was best to ask providers to focus on fewer performance metrics, so they can best focus their attention on specific key areas leading to improved processes and quality of care for members. Otherwise buy-in was difficult because practitioner feedback was there were too many measures and they had little control over impact on some of them. An example included PCPs saying that are not involved in hospital follow-up after behavioral health hospitalization since that follow-up is almost exclusively done by Psychiatrists and behavioral health specialists. It was very important to build provider buy-in to select metrics they felt they had influence over especially when tying this to compensation and incentives. The narrowed metric focus also helped us be able to focus on the critical elements to measure outcomes and results as accurately as possible and allows Passport to provide more granular-level data and insights providers need to enhance care.
3. There will be data challenges to work through. Practitioner buy-in and confidence is foundational to success, and significant effort is required to resolve data challenges and develop accurate reporting and measurement evaluation. Key areas include member to PCP attribution, developing appropriate rules around each specific measure to incorporate exact data elements both numerator and denominator, ensuring claims data flows to populate those metrics, and serial review and adjustment with each data run. Accurate and timely analytics for participating providers are key to a fruitful VBP program. We are lucky to have strong and loyal relationships with our key practitioner network partners and through regular Joint Operating Committee meetings and practice meetings we can review data with individual practitioners and group leadership to get their feedback on data accuracy for continuous improvement. Our intensive practitioner engagement process that begins with our CMO and Medical Directors personal commitments to meet with practitioners in person and the partnership from PHMs that are unique to Passport have maintained the strong loyalty to Passport from practitioners who have been willing to stick with us as we take their constructive feedback and rework and adjust our data and reports.

Passport welcomes the ability to receive swift feedback and iterate with its network quickly to achieve broad and rapid alignment. Our providers are truly the standard-bearers for these

initiatives, and we work through these provider-oriented governance groups when we experience variable provider acceptance within the network. Passport invests time and resources to address provider data concerns, such as 1) member-PCP attribution logic, 2) appropriate definitions for each specific measure, and 3) ensuring claims data flows to populate metrics appropriately. Passport is building foundations for strong reporting and analytics through internal and provider reviews.

4. Meet the providers where they are. Not all providers are at the same point in their transition to value. Targets in VPBs need to be achievable for providers, regardless of where they are in this transition and must be based upon change over time rather than fixed metrics. “Meeting providers where they are” is multifaceted and we first ensure that we have the right level of provider risk tied to the VBP program, i.e.: upside only, partial risk, full risk, partial capitation or full capitation. We must also ensure that the correct model sophistication is used, i.e.: activity-based, mixed model, or outcome-based. Last, thresholds for metrics must be adjusted incrementally to improve performance and reward providers as they progress year after year.
5. Focus on meaningful outcomes over activity. Passport’s philosophy in “meeting providers where they are” includes helping providers new to value-based care build the infrastructure needed to support future participation in VBP programs (i.e., a CMS Health Care Payment Learning and Action Network (LAN) Category 2 program). For some providers, this took the form of a PMPM care management capitation to help providers fund and integrate population health management that would foster fruitful participation in VBP programs. One of Passport’s largest provider groups began their transition to value-based care with such a PMPM capitation; from there, Passport partnered with the provider group to evolve their participation over several years to that of an upside outcome-based VBP program with analytics and tools to support performance (i.e., a CMS Healthcare LAN Category 3 program). Passport recognizes that to shift focus to meaningful outcomes, it may need to help providers set the foundations with step-wise care management resources that ultimately support more independent population health management.

Potential Challenges

Passport understands that there are often unique regional characteristics that make varying contributions to poor health experienced by Kentuckians across the Commonwealth. This is especially true in the healthcare delivery system where distance and time often have a different meaning, whether that is getting around a range of mountains in Eastern Kentucky, Lake Cumberland in Southeastern Kentucky, or crossing the Land Between the Lakes in far Western Kentucky. There are similar examples through the Commonwealth. Factors such as this contribute to challenges in creating a large program that fits across the entire landscape, a landscape that from the provider perspective is ideally agnostic to payor source. To summarize, the providers would prefer a common system across all Medicaid MCOs as well as commercially insured clients. Passport believes that there is a great opportunity to bring all stakeholders together to create a more uniform solution for all of Kentucky.

Other specific challenges that Passport believes is impacting providers and system development across Kentucky include:

- Limited access to concurrent data
- Wide variance in patient attribution at the provider level
- Wide variance in access to providers
- Variability in community and social supports
- Lack of common approaches by payers

Limited Access to Concurrent Data

The evolution of Kentucky Health Information Exchange (KHIE) offers an outstanding opportunity to connect health records across the Commonwealth, and Passport is ready and willing to work with the Cabinet to support widespread utilization. These methods of interconnectivity offer practitioners and MCOs a unified way to submit or access data in real time or near real time to help populate data fields and metrics and close specific care gaps. It would also help inform immediate hot spots to focus on such as members that are in the hospital or emergency department to ensure those members are contacted by practitioners or plan care managers to ensure safe and smooth transitions and reduce readmissions. Within our own network of contracted providers, we are working to grow connectivity to increase access to “real time” information concerning admission, discharges, and transfers, additional transitions of care, and gaps in care. Passport also understands that many hospitals are electing to participate in a collaborative that allows information to be shared re: ED visits amongst those facilities that are participating.

Wide Variance in Patient Attribution

While not unique to Kentucky, this challenge remains an important issue to address. This is true from the perspective of the provider and the health plan. VBP programs tend to flourish in situations where providers have significant member volume, thereby making certain process and protocol changes needed to drive performance worthwhile. Larger provider groups better able to make these necessary changes and fund the resources needed to support them tend to reside in urban or suburban parts of Kentucky. It is difficult to use VBP programs to drive healthcare improvement in rural settings which tend to have significantly smaller provider groups or independent practitioners.

If the ratio of members on a provider panel is small, it complicates identification of a significant trend, addressing actuarial soundness at the microlevel and creation of an incentive program and pool that is likely to facilitate behavior change.

Wide Variance in Access to Providers

This has obvious impacts on referral to specialists and delays in seeking early preventative services. Issues such as this can disproportionately impact a provider or region due to utilization of high acuity services while solutions are identified and implemented. A less obvious example for some would be the reality that many

counties in Kentucky do not have ready access to “private” ambulance services and might have only one or two ambulances for the entire county supported either by a local hospital or local government. This limitation on ground ambulance transportation can increase the need for use of air transport not only for tertiary or quaternary care but also for initial evaluation at a local facility. These regional variations can have significant impact that must be critically evaluated so that the providers can be assured that any program is not adversely affecting them.

Variability in Community and Social Supports

While the urban areas have greater access to many services in absolute number, it does not always translate into significant improvement at the global level. Passport believes that lack of availability of many of these services will contribute to poor performance in healthcare results, i.e. Quality, and costs. Anything that impacts quality and health care costs will have an impact that has to be considered in a VBP. We understand that community and social supports are important to addressing the holistic needs of members independent of where they live. As a result, we utilize systems to track resources (Healthifi and Unite Us) to assist in resource finding for our members.

Lack of Common Approach by Payers

Passport believes that providers want to primarily focus providing health care, what they were trained to do and what they do best, rather than keep track of multiple programs for various health plans. It is easy to think only about the program that we offer or potentially that another Medicaid MCO’s might offer. From the provider perspective there are these and so many more. Considering the scenario from a much broader view, we understand why there is frustration from the providers and why the results that we all want to achieve have been slower to materialize. As such Passport welcomes the opportunity to participate in a collaborative to reach common ground, potentially following a model like the development of the Kentucky Core Measure Set that was initiated by the Cabinet for Health and Family Services and developed in conjunction with the Kentuckiana Health Collaborative. While there might be unique characteristics that have to be considered, the value is worth the effort.

Nationally, no standardized metrics exist for VBP programs. CMS is currently updating the quality metrics that will be used for MIPS in 2020 and will provide standardized measurement-based care metrics by specialty area. This standardization will simplify VBP on many levels. Providers will know what metrics to work toward for all members, regardless of which plan they have. MCOs will more easily be able to collaborate on achieving statewide improvements in outcomes. Passport is contributing to CMS’s efforts to standardize the metrics and participates on the committee that is developing the new MIPS metrics.

Conclusion

Passport is committed to incorporating alternative payment methods into our provider contracts. We believe that better aligned financial incentives increase access by ensuring that providers are focused on the members and challenges that need their attention the most. Paying for value also supports improved health outcomes by providing financial incentives for performance improvement and eventually, penalties and financial risk for poor quality care. Finally, VBP helps control costs and drives more efficient use of Medicaid dollars by reducing expenditures on unnecessary, redundant or ineffective care.

Passport has been honored to serve the Kentucky Medicaid and foster care populations for 22 years and will continue to comply with all provisions of the Medicaid Managed Care Contract and Appendices (including Kentucky SKY) as we continue to serve them in the future.