

10/3/16

State of West Virginia:

Thank you for the submission of the State Health System Innovation Plan (SHSIP) for the SIM Model Design Cooperative Agreement on 6/30/16.

In reviewing your submission, we have found that the State has provided the requested documentation and information to meet with the requirements outlined in the SHSIP Guidance. Below is a summary of the State Innovation Models Team's (SIM) assessment of your SHSIP's strengths and areas for improvement.

Overall Feedback for West Virginia:

Vision for Transformation

Summary: The WV SHSIP includes a concise and clearly written description of the state's vision for health care system transformation. The plan states the following:

West Virginia will improve the health of our population, enhance quality and access to health care and moderate health care spending. During the next five years, the state will:

- Establish a highly coordinated care delivery system built upon a comprehensive primary care model.
- Implement payment systems developed to enhance value for consumers.
- Adopt population health improvement strategies that address existing health disparities, modifiable risk factors and preventable conditions.
- Expand the use of information technologies to provide better intelligence to providers and other stakeholders.
- Address workforce infrastructure and sustainability by developing strategies and solutions to assure an adequate and well-trained workforce to participate in the new health care models and to effectively use health IT (HIT) tools.

Authority Employed

Summary: The section detailing authorities that have been (or could be) employed to achieve transformation is clearly written and informative. The state used The Commonwealth Fund Commission on a High Performance Health System and the CMS Quality Strategy recommendations as a framework to outline the policy strategies that could be employed to promote high-value health care.

The SHSIP details a number of policy levers that could be used to encourage high-value health care services in West Virginia. The inclusion of the HiAP concept as one of the first levers mentioned in the SHSIP presents a good framing for how policy levers not directly related to health can impact the health of the state population.

The SHSIP also identifies opportunities to leverage the state's role as a regulator of insurance products, as an insurer through Medicaid, CHIP and the Public Employees Insurance Agency and through CON and rate setting authorities. It may also be beneficial for the state to think about opportunities to leverage all-payer Advanced Alternative Payment Model provisions within MACRA once the final rule is released. The all-payer AAPMs could provide a strong argument to expand the use of alternative payment models in both Medicaid and commercial insurance products. The SHSIP identifies the potential impacts of MACRA under the HIT section but this could also be explicitly included as a policy lever.

Broad Multi-Payer Commitment

Summary: The state details the challenges it has faced in getting broad multi-payer commitment to investments in VBP/APMs due to commercial payers need to find ROI and the lack of a ROI in earlier work. It is understandable that this has been a challenge given the potentially long time horizons to see a ROI on efforts that focus on improving primary care/population health. In driver four the SHSIP details the states focus on promoting APMs and the intention to start by working through Medicaid. Medicaid is a good and logical starting point for this transformation but there are few details on what the specific strategy(s) will be to expand this effort into the commercial market beyond encouragement to adopt APMs by the state.

The SHSIP also provides good information on strategies to improve and align the data reporting infrastructure so that providers can receive better data and experience a reduced reporting burden. Given the limitations in multi-payer alignment around APMs this is a great area to focus on.

Description of State Health Care Environment

Summary: The WV SHSIP does an excellent job of describing the current health care environment including detailed information on population health issues, high priority chronic conditions and behaviors (obesity, cardiovascular disease, tobacco use, behavioral health, etc.) and the health care delivery environment broken down by level of care (primary, secondary and tertiary). The health care environment section of the SHSIP also goes one step further in referencing specific interventions to address the major focus areas for the state.

This section contained a number of diagrams that very effectively communicated the areas of concern for the state and associated upstream contributors and downstream impacts. The diagram under section 3.2 is especially useful in depicting the three major focus areas (obesity, tobacco use and behavioral health) and negative downstream health impacts. Diagram 3.3 details the social determinants and provides strong support for the Health in All Policies concept detailed later in the SHSIP.

Report on Stakeholder Engagement and Design Process Deliberations

Summary: The section detailing the SHSIP development process includes a good overview of the five workgroups (better health, better care, better value, HIT and workforce development) that convened to inform the steering committee. This section of the SHSIP states that there was a failure to reach consensus on a few important issues:

- Specific models for care delivery and associated payment reform had not been proposed by the workgroups.
- There was no consensus reached on the need, desirability or approach to regional care coordination.
- Providers and consumers expressed frustration with the current approach to quality measure identification and reporting.

- IT and workforce planning are, in part, dependent upon the approaches taken toward specific models of care/payment and quality measure reporting.

It was not clear if final consensus was ever reached on these points and I would be helpful if the SHSIP identified how/if the stakeholder engagement and workgroup process would be sustained after the end of SIM so that these issues can continue to be worked on.

Value-Based Payment and/or Service Delivery Model

Summary: Driver four explicitly mentioned the need to advance value based purchasing models in the state and highlights the state's role as a Medicaid payer through MCOs and regulator of the commercial market in this work. What is not clear in this section of the SHSIP what specific VBP arrangements the state felt would be most feasible to implement in the immediate future. While the SHSIP does discuss payment approaches in other areas of the document it would be helpful to have a clear and concise discussion of potential VBP/APM approaches in a single section of the document.

Plan for Health Care Delivery System Transformation

Summary: The SHSIP clearly states a vision for improved health care access, the promotion of patient centered approaches to care, and stronger linkages between primary care, behavioral health and specialty care, however, the connection between these goals and specific payment reform activities is not totally clear. It would be beneficial to connect the delivery system transformation goals directly to payment reform efforts across payers as more specifics about feasible payment reforms are developed.

Plan for Improving Population Health

Summary: (Feedback from CDC): This is a well thought-out plan to provide health services to the state's most vulnerable population. You have provided an excellent description of how to use community health workers in your state for various health care needs. The development of care management teams is a good way to have a workforce responsible for a region, a County, or a quadrant to provide supportive services that are typically reimbursed in a fee-for-service environment.

Placing a focus on the "Super Utilizer" will not only reduce the cost of health care, but it will also provide your most vulnerable population with quality health care. It is evident in your plan that you are attempting to address the basic needs of this vulnerable population by including community partners and providing opportunities for them to explore life style change activities through the Try This West Virginia. We all know that this vulnerable population will continue to tax the health care system unless they can experience positive life style changes and improvements in the social determinants that effect their lives.

Your continued collaboration with the Division of Health Promotion and Chronic Disease (HPCD) and the evaluation of these program activities will guide you in your efforts to transform the health care delivery system in your state. CDC will continue to provide technical assistance through the HPCD as needed.

Health Information Technology

Summary: (Feedback from ONC): Impressive on the educational value of the document for stakeholders; however, much of the document was justification rather than a tool to move forward to implementation. Organizationally the document did not always incorporate health IT into the sections and/or align the health IT with the other policy timelines, particularly note comments on timeline.

HIT Plan Overall: The state has done a good job of justifying the need for health care delivery transformation and payment reform to address population health and referencing approaches (e.g., AHIMA data quality framework, ONC's HIE governance framework), but further clarity on tactics will

make the document useful for actually moving forward on implementation (see detail comments below in areas to address). Organizationally some things were in multiple places and it would have been easier to get the complete picture if they had been grouped more together, particularly the driver diagram and details. The driver diagram sections, while providing excellent information was confusing and the two sections could have been combined and clarified - pages 107 through 120 and starting on 139 should be consolidated. The state will need a strategy to assure this document is used for operational/implementation planning rather than a deliverable for the SIM Design effort. The more the state can provide concrete action steps the more useful the document becomes. In some areas health IT was referenced and in other areas it was not. Even though there is an HIT section, it is important to incorporate the health IT into the other sections so stakeholders understand the health IT implications. It is also easier for the state to avoid missing critical health IT.

Areas to Address:

- The state acknowledged that because Sections 3.8 and 12.0 were developed in parallel, their contents somewhat overlap and that the SIM project management team is working to consolidate the content from these two sections; therefore ONC recognizes that this issue is being addressed.(pg 68). The state also acknowledges for multi-payer, further information needed In prevalence of Fee-for-Service, Cost-Based and Other Payment Models and Alternative Payment Models (by payer) (pg 84).
- HIT Tactic to achieve strategy 5 of driver 1: Progress toward meaningful use and integration of health information technology and HIE to assist in health improvement efforts. Use population health-level data for risk stratification, targeting high-risk subpopulations and assessing levels of intervention and care management (starting pg. 107 through 120 and starting pg. 139).
 - Implicit to “encourage care management resources that are shared across organizations, such as care teams or virtual care teams” is the need for health IT; however, not stated
- HIT tactic to achieve strategy 1 of driver 2 (starting pg. 107 through 120 and starting pg. 139).
 - Implicit to authorize up to six community paramedicine demonstration projects is the need for health IT; however, not stated
- HIT tactic to achieve strategy 1 of driver 2 (starting pg. 107 through 120 and starting pg. 139).
 - Implicit to focusing on addressing the high costs of health care super-utilizers is the need for health IT; however, not stated.
- HIT tactic to achieve strategy 2 of driver 2 (starting pg. 107 through 120 and starting pg. 139).
 - Implicit to the funding opportunity through CMS to demonstrate Accountable Health Communities (see Section 3.2) for navigation services is the need for health IT; however, not stated.
- HIT Tactic to achieve strategy 3 of driver 2 (starting pg. 107 through 120 and starting pg. 139).
 - Implicit to creating regional centers of excellence in the management of obesity as a resource to medical providers in bringing the best evidence-based approaches to complex obesity cases is the need for health IT; however, not stated.
- HIT tactic to achieve strategy 4 of driver 2 (starting pg. 107 through 120 and starting pg. 139).
 - Implicit to promoting the collaborative care/consulting psychiatrist model to improve treatment of common, less serious behavioral health disorders in primary care, is the need for health IT; however, not stated.
- HIT tactic to achieve strategy 3 of driver 3 (starting pg. 107 through 120 and starting pg. 139).
 - Implicit to quality measure vetting and promote quality measure alignment across payers, is the need for health IT; however, not stated.
- HIT tactic to achieve strategy 1 of driver 4:
 - Potentially better utilizing the Medicaid MCO quality withhold to drive quality improvement or requiring that a certain percentage of payments to providers have a

link to value will require some health IT; however, not stated

- HIT tactic to achieve strategy 2 of driver 4:
 - Implicit to optimizing financial models to reward providers to be cost-effective and focused on wellness is the need for health IT; however, not stated
- HIT tactic to achieve strategy 3 of driver 4:
 - Implicit to align resources and build economies of scale where possible to avoid unnecessary duplication is the need for health it; however, not stated

Additional HIT Comments:

- HIT Tactic to achieve strategy 1 of driver 1: The WVHTA will create voluntary HIE-based patient registries for PCP affiliation where patients could elect to declare a PCP (starting pg. 107 through 120 and starting pg. 139);
 - ONC would recommend that with expanded care team, the state might wish to consider the need for patient attribution and provider directory to address expanded care team
- HIT tactic to achieve strategy 1 of driver 2 (starting pg. 107 through 120 and starting pg. 139).
 - West VA University Health System developing a pilot in Monogaia County where the organization has fully integrated EHR and care coordination infrastructure is a limited pilot as other organizations will not have integrated EHR and care coordination infrastructure.
- HIT tactic to achieve strategy 4 of driver 3 (starting pg. 107 through 120 and starting pg. 139).
 - It is unclear what the tactic is to develop capacity to align quality measures and compile claims data in a centralized repository; will WVHTA have a role in compiling claims data in a centralized repository?
- HIT tactic to achieve strategy 4 of driver 5:
 - ONC would recommend that West VA consider in their geriatric-specific Project ECHO model curriculum development that a focus on health IT be included to assure the skills and knowledge of how to optimize a digitized environment is included
- HIT timeline implications: focus is on end dates but timeline should indicate some policy and technical start dates
 - i. If 2019 HIT and data systems will be aligned to identify patients unaffiliated with a PCP or affiliated with advanced primary care delivery system (as applicable) state may wish to consider working on this starting in 2016-2017
 - ii. The HIT guidance group will develop a plan for creating voluntary, HIE-based patient registries for PCP affiliation to cross-reference against payer members lists in 2019, which may be late to meet provider's needs in both medical home models and APMs so state may wish to consider an earlier start.
 - iii. Address patient attribution issues to increase PCP affiliation rates is listed for 2018 and state might want to consider sooner
 - iv. Finalize the health home and submit for CMS approval is listed as Spring 2017 subject to approval, recruit providers and identify specific populations to participate in the health home so state may wish to work on HIT for health home SPA and leverage Medicaid funding opportunity
 - v. Phase 1 cohort's 90-10 match expires; these Medicaid beneficiaries will be converted to the MCO-designed health home look in summer 2019 so state may need to start in 2017/18 on MCO contract requirements, including HIT (not on timeline)
 - vi. 2016 the state will develop parameters and design of a health home program for high-need Medicaid individuals and the state may wish to include HIT explicitly
 - vii. See additional comments under (4) timeline
- HIT starting pg 213 is excellent.
 - i. What is missing is the alignment this section with other sections of the document where having knowledge of this information could impact other policy decisions.

Workforce Development Strategy

Summary: The SHSIP presents data on the workforce shortage areas in the state as well pertinent information from four reports by the West Virginia Rural Health Association (WVRHA) and the Graham Center analysis of the anticipated workforce need from 2010-2030. The SHSIP also clearly indicates the emphasis the state is placing on improved workforce data collection with the passage of House Bill 4245 mandating annual reporting (starting in 2016) by six state health care licensing boards on their memberships' anticipated retirement dates, age, gender, percentage of time working direct services, percentage of time working administration and county of practice. The SHSIP also details the formation of a health care workforce workgroup under SIM as well as a plan to sustain the workgroup after the end of SIM and table 8.4 summarizes the various workforce areas of concern to the state and strategies to build capacity.

Alignment with Existing Initiatives

Summary: No major comments on this section.

Financial Analysis

Summary: The financial analysis section of the SHSIP details cost estimates for the impact of improvements in population health and behavioral health factors as well as estimates for overall health care cost growth in WV and nationally. Moving forward it would be helpful to align a financial analysis to the proposed VBP/APM and population health reforms to provide a overall assessment of the impact of full scale reforms on the state.

Monitoring and Evaluation Plan

Summary: No major comments on this section.

Operational Plan

Summary: The transformation timeline included in the SHSIP acts as an overview of the drivers, goals and strategies to accomplish the health care system transformation in the state. The timeline also cites the specific entity tasked with working on each strategy year to year. It would be helpful to have a narrative operational plan section that highlights the priorities risks and next steps required to achieve the goals described.

If you wish to discuss this feedback, please contact me to set up a call. Keep this notice with your records to document that the Awardee is in compliance with the programmatic implementation requirement to submit a State Health System Innovation Plan.

Regards,

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