

Commonwealth of Kentucky
Cabinet for Health and Family Services
Office of Health Policy (OHP)



State Innovation Model (SIM) Model Design
Integrated and Coordinated Care
April 14, 2015

Agenda

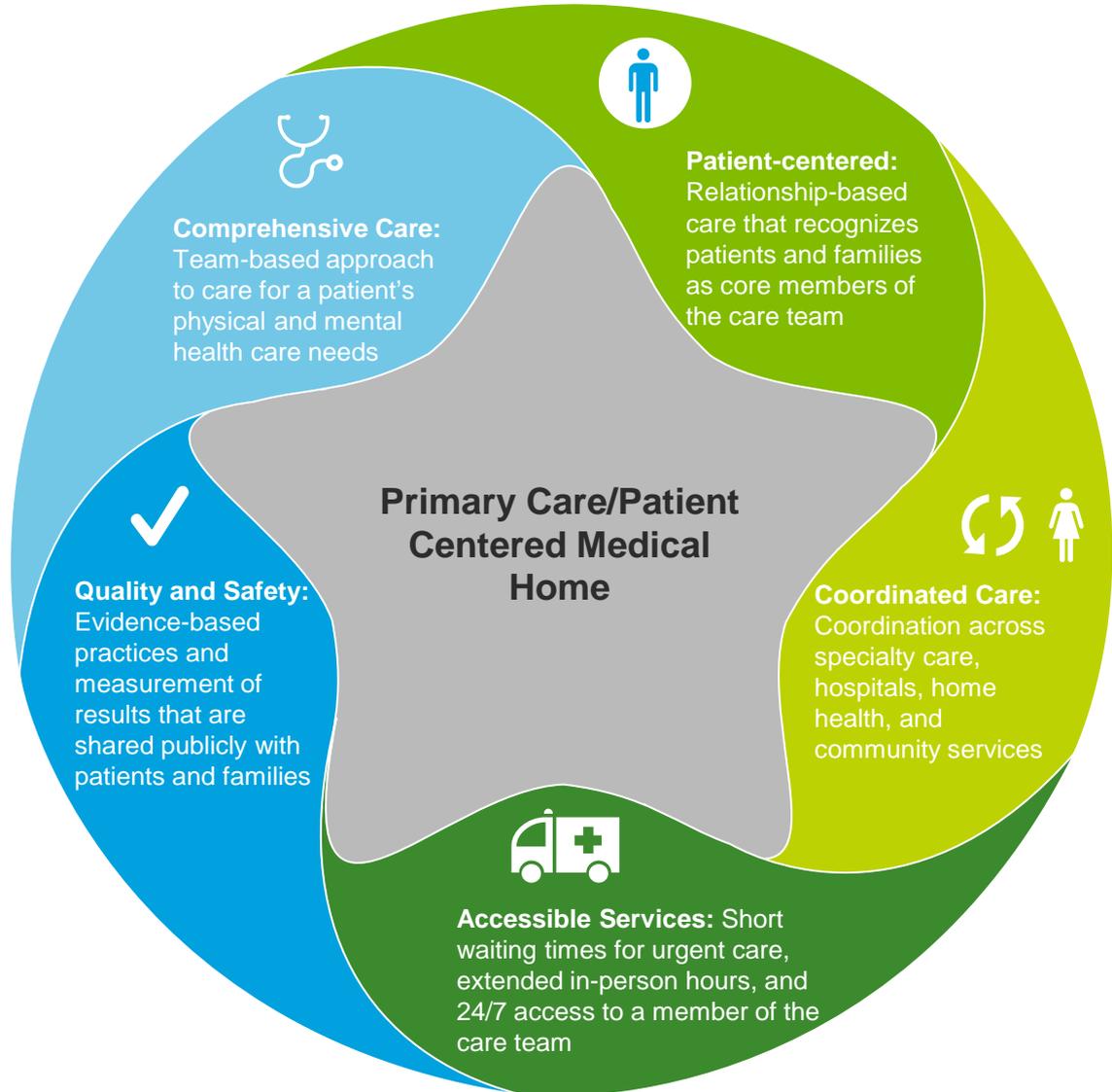
- **Welcome and Introductions** 1:00 – 1:10 PM
 - **Background of Service Delivery Options** 1:10 – 1:30 PM
 - **Approach to Care Coordination Exercise** 1:30 – 1:40 PM
 - **Care Coordination Exercise** 1:40 – 2:30 PM
 - *Break* 2:30 – 2:45 PM
 - **Care Coordination Exercise (continued)** 2:45 – 3:50 PM
 - **Next Steps and Q&A** 3:50 – 4:00 PM
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Welcome and Introductions

Background of Service Delivery Options

Definitions: Patient Centered Medical Home

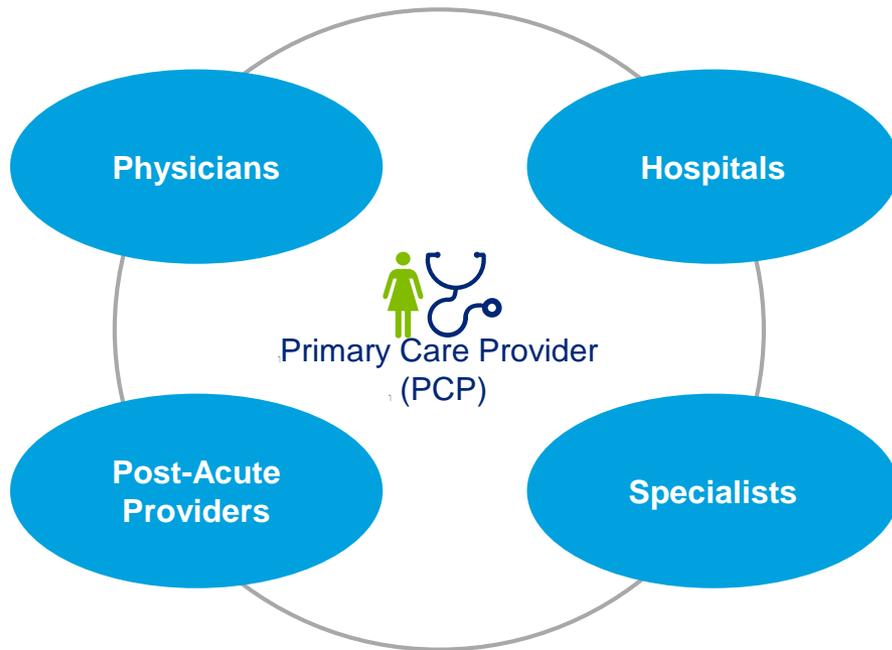
The Patient Centered Medical Home (PCMH) model seeks to transform the method of primary care delivery.



Definitions: Accountable Care Organization

Accountable Care Organizations (ACO) share financial and medical responsibility for their members in an effort to provide coordinated care, reduce unnecessary services, increase the timeliness of treatment, and improve the overall health outcomes of their patients.

ACO Model



Key Elements

Comprehensive Provider Network

ACOs include physicians, hospitals, and other health care providers. PCPs are a required element of the ACO model

Quality Measures

The performance of ACOs is typically tied to certain quality measures and cost savings targets. For example, Medicare groups the quality measures into four categories:

- Patient/caregiver experience
- Care coordination/patient safety
- Preventive health
- At-risk population

Shared Savings

Providers within an ACO network share in the savings that result from meeting or exceeding defined measures and sometimes share in the risk

Definitions: Health Home

Health homes offer coordinated care to individuals with multiple chronic health conditions. Health home providers will integrate and coordinate all primary, acute, behavioral health, and long term services and supports to treat the “whole-person” across the lifespan. As of November 2014, 16 states have a total of 20 approved Medicaid health home models.

Health Home Eligibility
<ul style="list-style-type: none"> • Have two or more chronic conditions • Have one chronic condition and are at-risk for a second • Have one serious and persistent mental health condition

Health Home Services
<ul style="list-style-type: none"> • Comprehensive care management • Care coordination • Health promotion • Comprehensive transitional care/follow-up • Patient and family support • Referral to community and social support services

Health Home Providers	Definition
Designated Provider	May be a physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, or other provider
Team of Health Professionals	May include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, and can be free-standing, virtual, hospital-based, or a community mental health center
Health Team	Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractors, and licensed complementary and alternative practitioners

Delivery System Comparison

While health homes, PCMHs, and ACOs share many similar characteristics, there are variations across the three models.

Health Home, PCMH, and ACO Comparison

Characteristic	Health Home	Patient-Centered Medical Home	Accountable Care Organization
Target Population	Individuals with chronic conditions	All populations across the lifespan	All populations across the lifespan
Typical Providers	May include primary care practices, community mental health organizations, addiction treatment providers, federally qualified health centers, and other safety-net providers	Typically defined as physician-led primary care practices, but may include some mid-level practitioners such as nurse practitioners	Mainly comprised of physician groups and hospitals, with PCPs acting as the central health care authority for members
Payer(s)	Currently a Medicaid-only construct	Exist for multiple payers (e.g., Medicaid, commercial insurance)	Exist for multiple payers (e.g., Medicaid, commercial insurance)
How Care is Organized	Team-based, whole-person orientation with explicit focus on integration of behavioral health and primary care	Team-based, whole person orientation achieved through coordinated care	Team-based, whole person orientation achieved through coordinated care
Provider Requirements	State Medicaid determined	State Medicaid and NCQA determined	Provider requirements vary by ACO arrangement
Payment	Usually PMPM for six required services with more intensive care coordination and patient activation	Payment is in line with added value; usually small PMPM	Shared savings, based on quality, outcomes, and cost metrics, are distributed to participating providers

Definitions: Episodes of Care/Bundled Payment Initiatives

Bundled and/or episodic payments are combined payments to cover services delivered by multiple providers for one episode of care (e.g., bundling pre-op testing, surgery, and inpatient stay, and immediate post-op care).

Definition

- A bundled/episodic payment is the reimbursement to healthcare providers, such as hospitals and physicians, on the basis of expected costs for clinically-defined episodes of care

Key Elements

- Episodes of care included in the bundled payment need to be well defined
- Target rate/discount for the defined episodes of care needs to be calculated
- Gain-sharing mechanisms need to be established amongst various providers

Outcome

- Increased care coordination can be achieved amongst hospitals, post-acute care providers, physicians, and other practitioners by encouraging them to work together
- Higher quality of care and lower costs can be achieved by incentivizing providers through bundled/episodic payments

Key Needs

Technology Needs

- Web-enabled provider collaboration system
- Clinical care plan and workflow system

Analytical Needs

- Episodes of care identification
- Pricing desired episodes of care
- Gain-sharing mechanism establishment
- Financial impact analysis

Approach to Coordinated Care Exercise

Strategy Analysis Overview

In the following exercise, participants will identify strategies for consideration in addressing key integration and coordination of care questions. Participants will rank each strategy based on four factors.

Alignment with SIM Goals

Does the strategy align with the core tenets of the kyhealthnow (and therefore SIM) initiative?

Implementation Effort

How difficult will it be to implement the strategy from a political and operational perspective?

Financial Impact

What will be the cost of implementing the strategy?

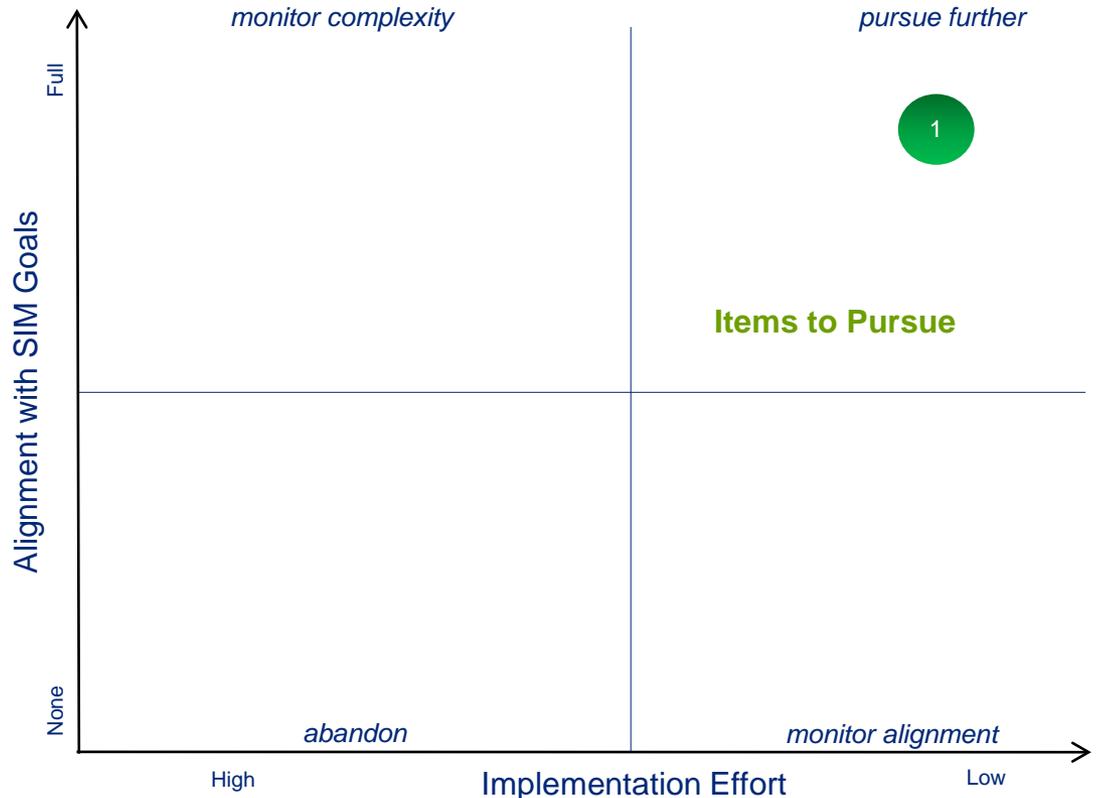


Length of Time to Implement

How long will it take to fully implement the strategy?



Strategy Analysis Map



Example Strategy 1: Full alignment with kyhealthnow goals, low implementation effort, low cost, and quick to implement

Note: All exercises were conducted in real time. Results will be compiled and posted at a later date.

Coordinated Care Exercise

Arkansas PCMH Example

Arkansas is implementing the PCMH model by providing monthly beneficiary payments for practice support. In order to receive practice support, providers must maintain a minimum number of beneficiaries and adhere to pre-defined practice support activities and metrics.



Practice Support Guidelines

1. Identify top 10% of high priority beneficiaries (reviewed annually)
2. Assess operations of practice and opportunities to improve
3. Develop strategy to implement care coordination and practice transformation improvements
4. Identify and address medical neighborhood barriers to coordinated care at the practice level
5. Provide 24/7 access to care
6. Document approach to expanding access to same-day appointments

Monthly Beneficiary Risk Payments

Risk Profile	Monthly Payment
Lower	\$3
Median	\$4
Higher	\$5

PCMHs: Physical/Behavioral Health Coordination

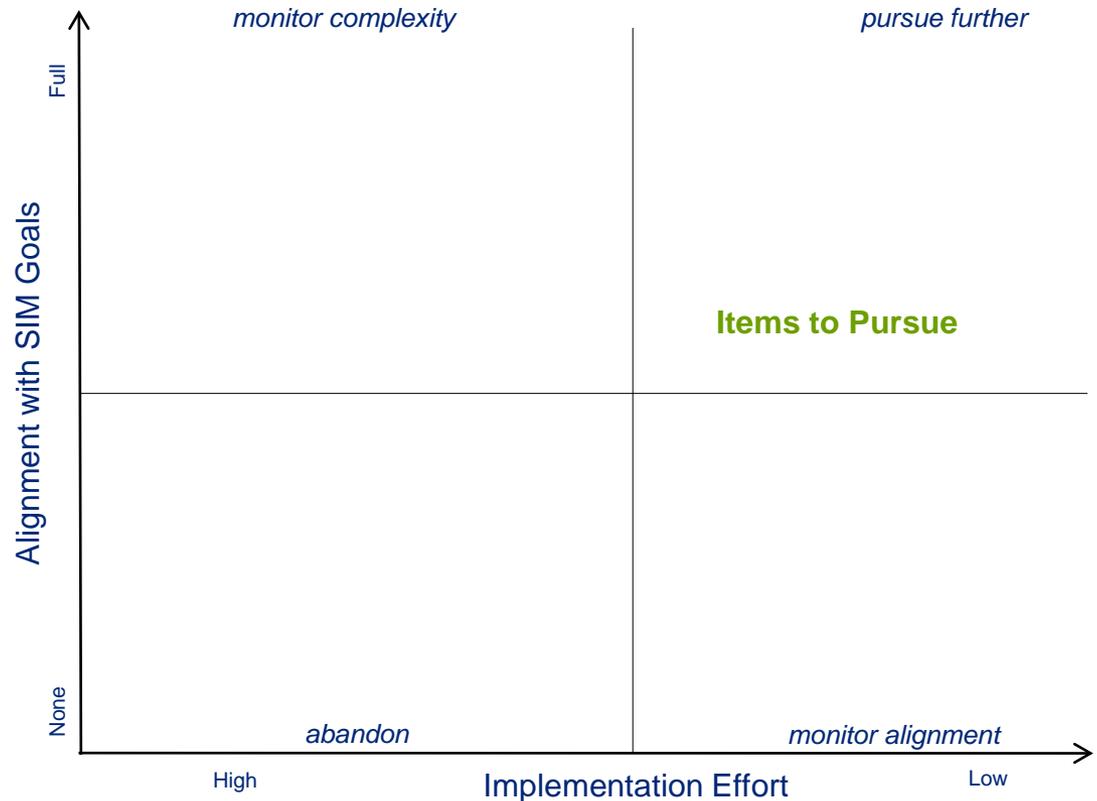
How can the coordination between physical and behavioral health be improved through the use of PCMHs?

Strategy Analysis Map

Strategies

1. XX

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Financial Impact



Length of Time to Implement



PCMHS: Physical/Behavioral & Public Health Coordination

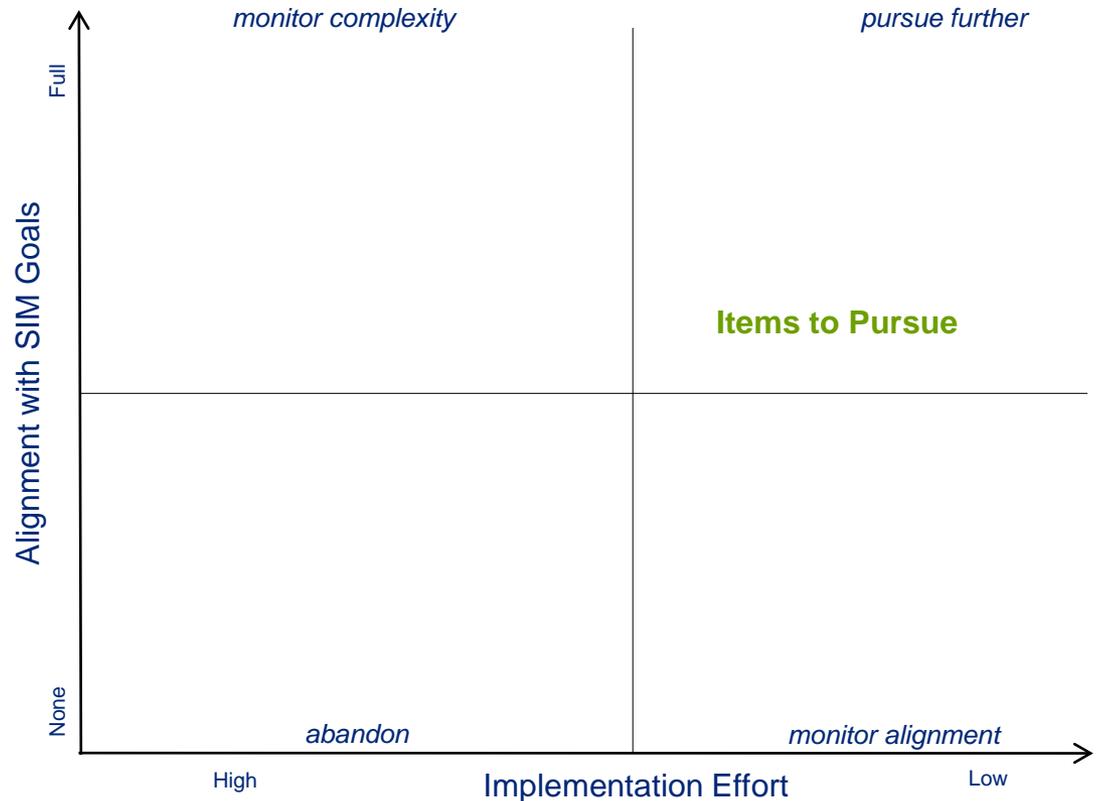
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Strategy Analysis Map

Strategies

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Financial Impact



Length of Time to Implement



PCMHs: Physical/Behavioral and Oral Health Coordination

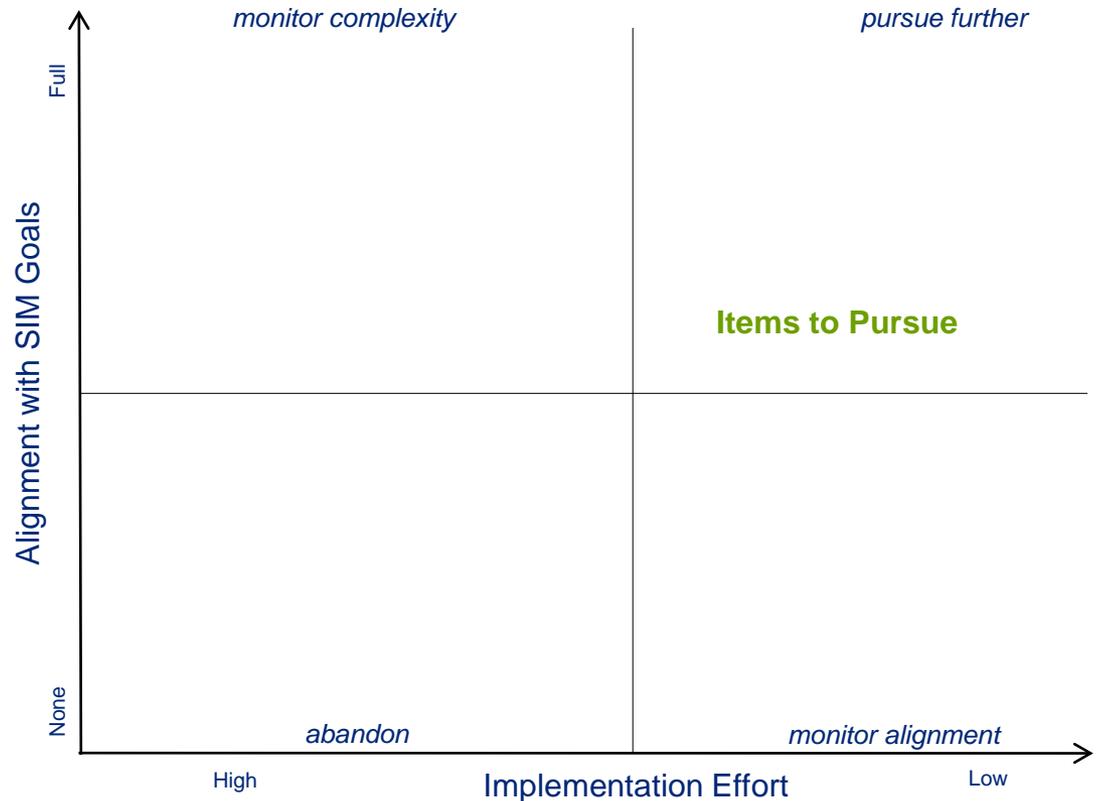
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Financial Impact



Length of Time to Implement



Examples of Coordinating Physical and Behavioral Health with ACOs

Minnesota, Maine, and Vermont are encouraging the integrated delivery of physical and behavioral health services. The Center for Health Care Strategies (CHCS) has identified five focus areas that are key to achieving this integration.

01
Financial incentives and sustainability

Shared savings models tied to appropriate behavioral health metrics sets a foundation for integration sustainability

02
Confidentiality of data sharing and provider support for Health Information Exchange

Timely access to shared patient data is critical between physical and behavioral health providers. Key issues, such as differences in documentation requirements, need to be addressed

03
Quality measurement

Appropriate behavioral health metrics tied to improved quality of care encourage greater coordination between physical and behavioral health

04
Alignment with existing behavioral health initiatives

Leveraging existing integration initiatives is crucial to building a foundation for behavioral health integration with ACOs

05
Potential regulatory and policy levers to overcome barriers to integration

Overcoming existing policy obstacles, such as same-day billing restrictions for primary care and behavioral health services, is critical to service integration

ACOs: Physical/Behavioral Health Coordination

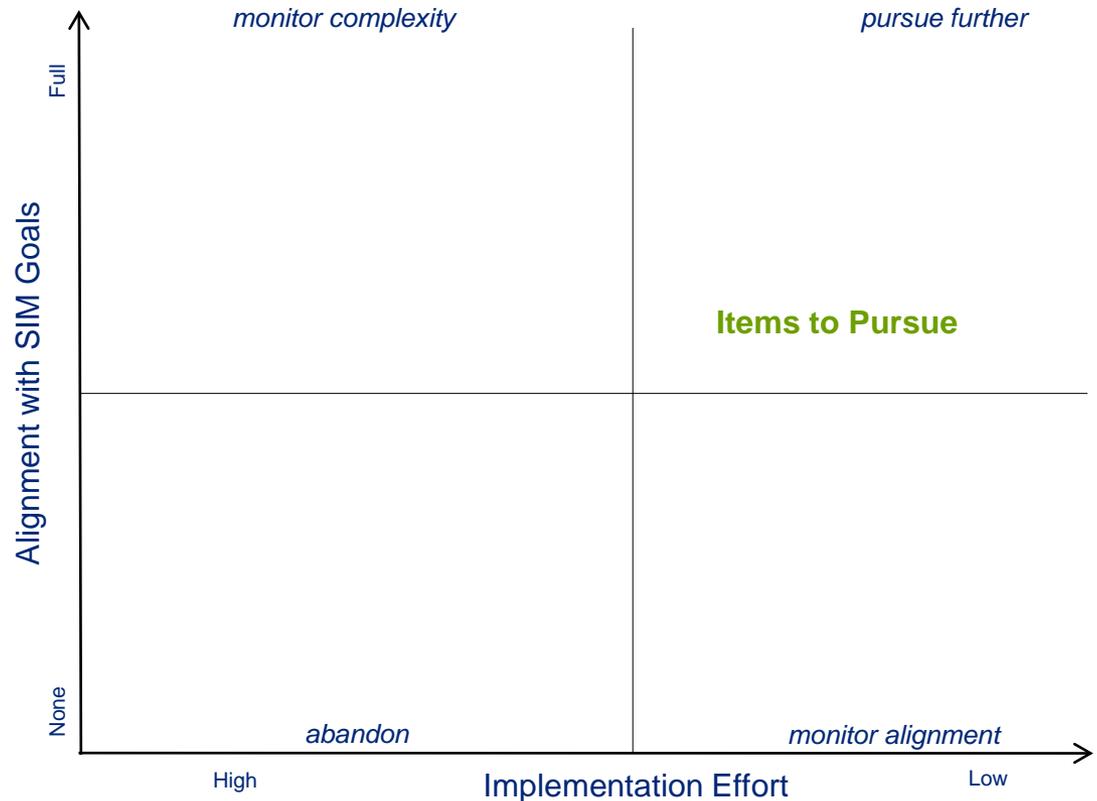
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Financial Impact



Length of Time to Implement



ACOs: Physical/Behavioral & Public Health Coordination

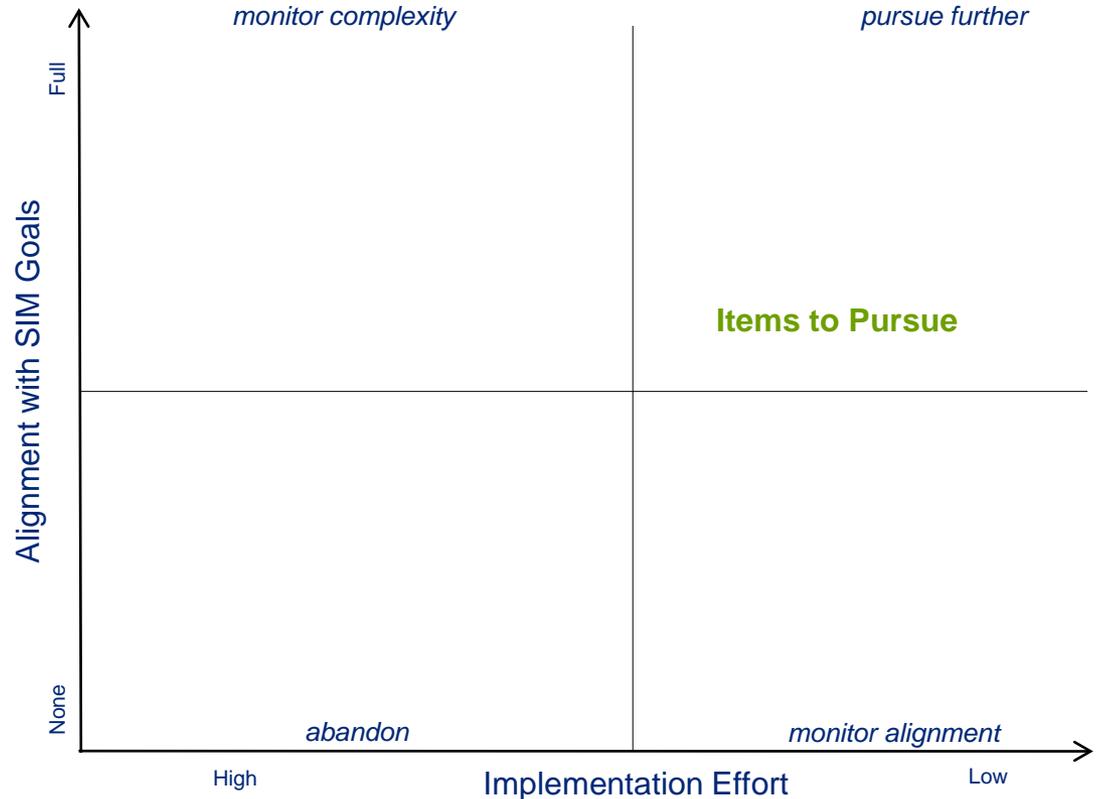
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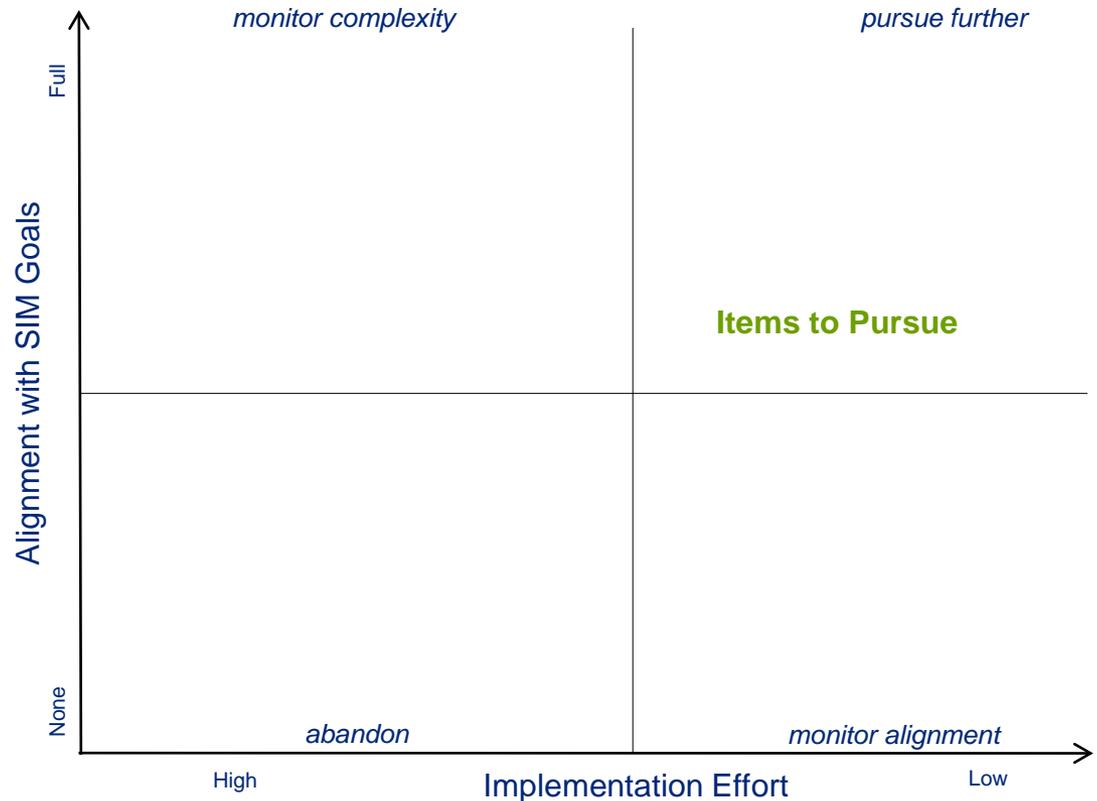
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Financial Impact



Length of Time to Implement



Break

Tennessee Health Home Example

As part of its SIM testing grant, Tennessee is leveraging the federal government's enhanced match to expand the use of Health Homes throughout the state.

Tennessee Health Home Strategy

Prospective Payments

Tennessee will leverage the enhanced federal match to provide prospective payments for care coordination and case management for two years

Cost and Quality Reporting

Participating Health Homes will be required to report on pre-defined quality and cost metrics on a quarterly basis



Network and Workforce Development

A portion of the enhanced federal match will go towards training providers on requirements for Health Homes, as well as building a sustainable network of participants

Health Homes: Physical/Behavioral Health Coordination

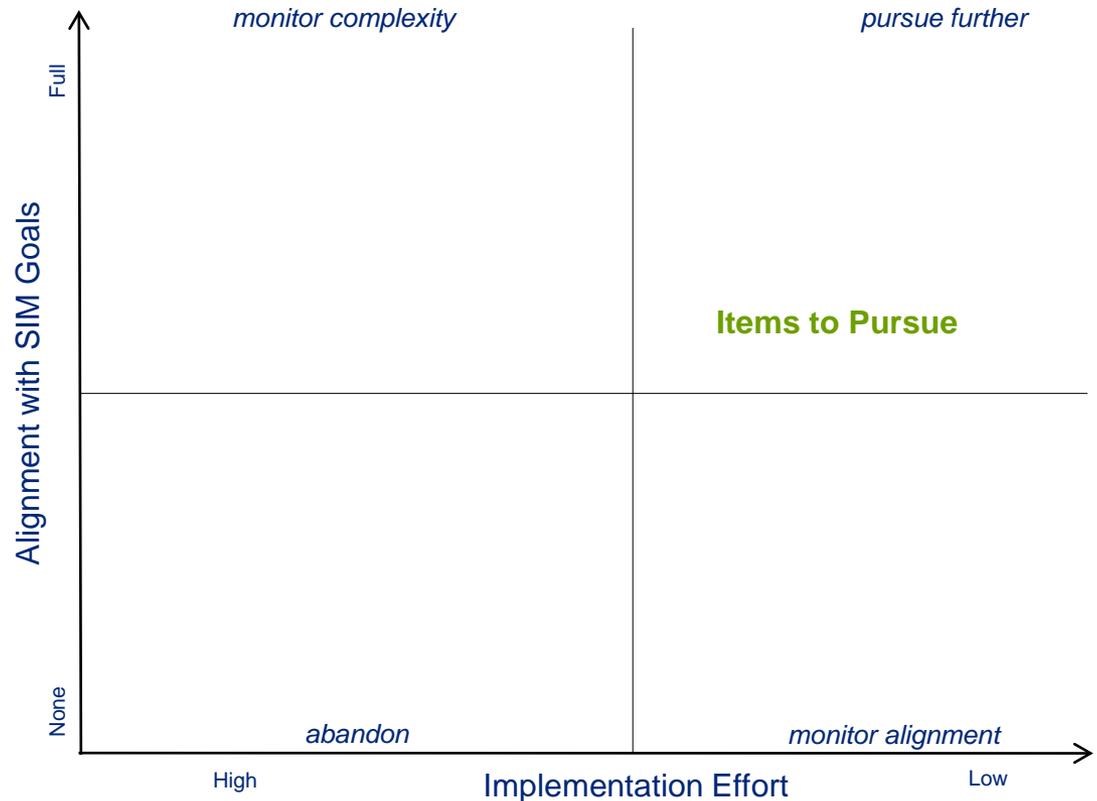
How can the coordination between physical and behavioral health be improved through the use of Health Homes?

Strategy Analysis Map

Strategies

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Financial Impact



Length of Time to Implement



Health Homes: Physical/Behavioral & Public Health Coordination



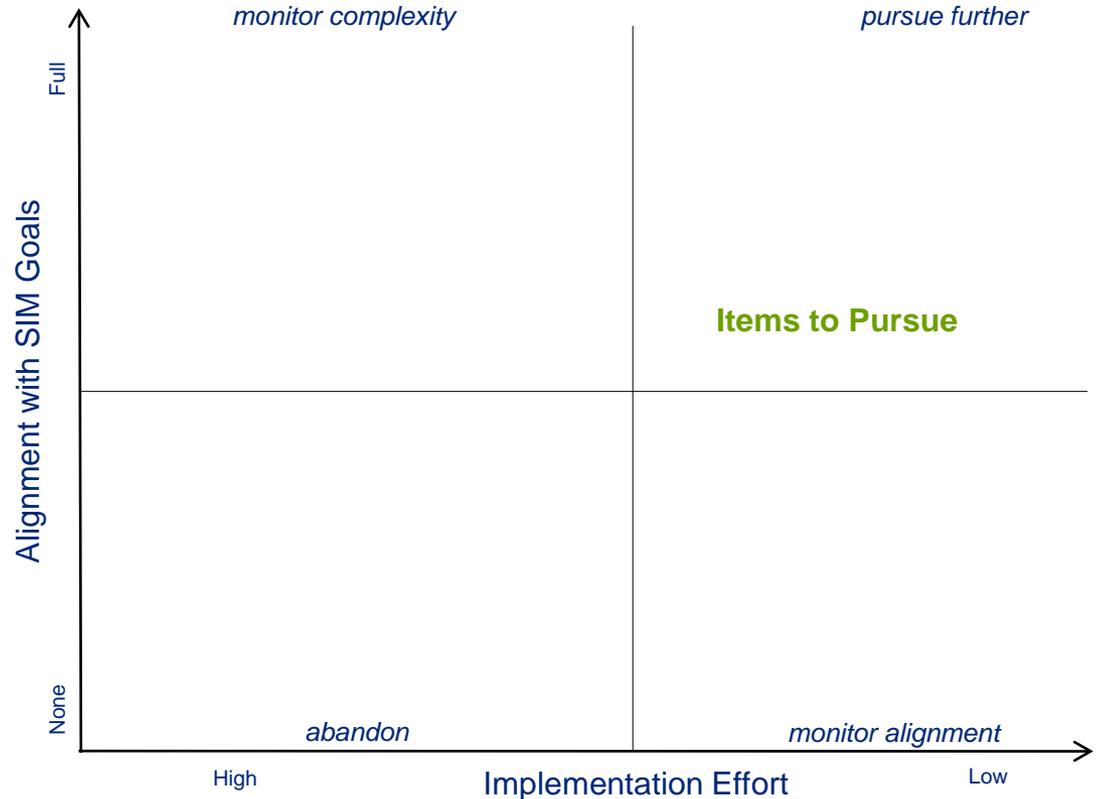
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Financial Impact



Length of Time to Implement



Health Homes: Physical/Behavioral and Oral Health Coordination



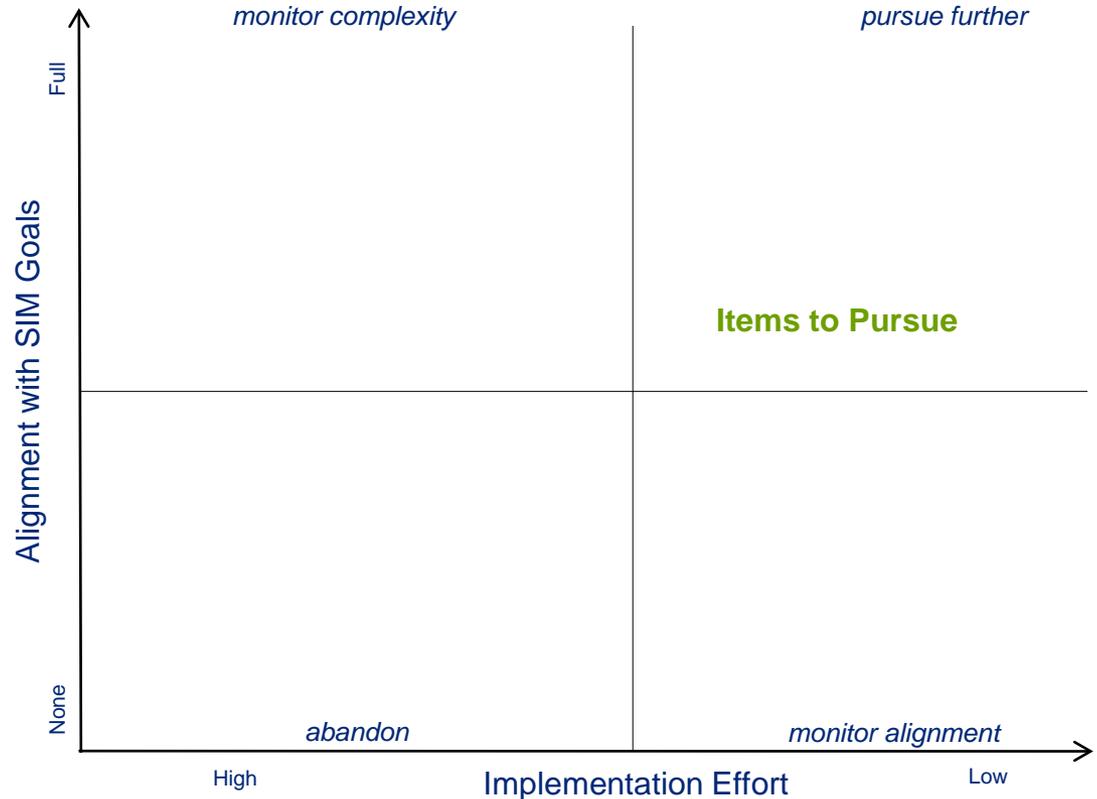
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Financial Impact

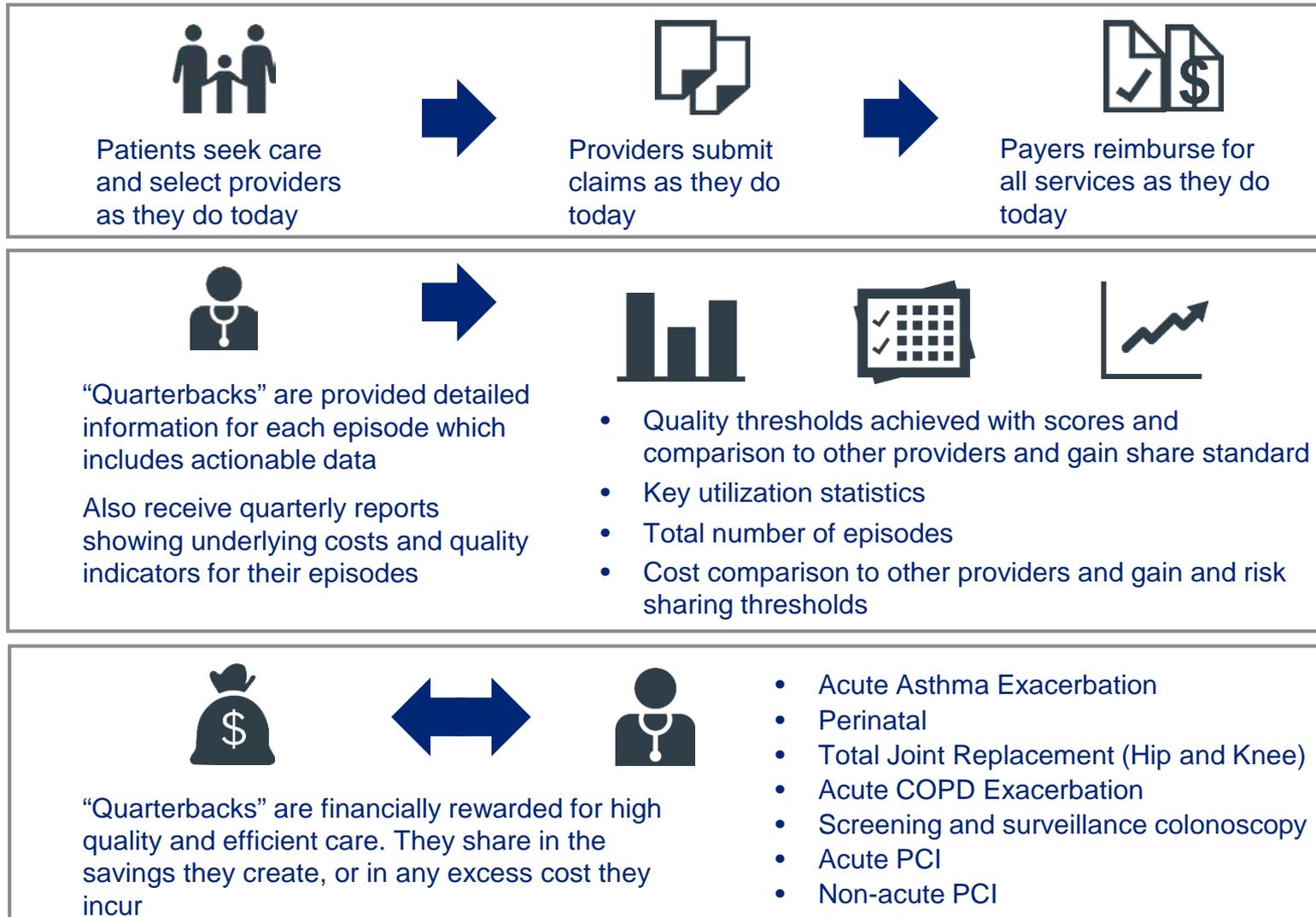


Length of Time to Implement



Tennessee Episode of Care Example

How can the coordination between physical/behavioral health and oral health be improved through the use of Health Homes?



Episodes of Care/Bundled Payments: Physical/Behavioral Health Coordination



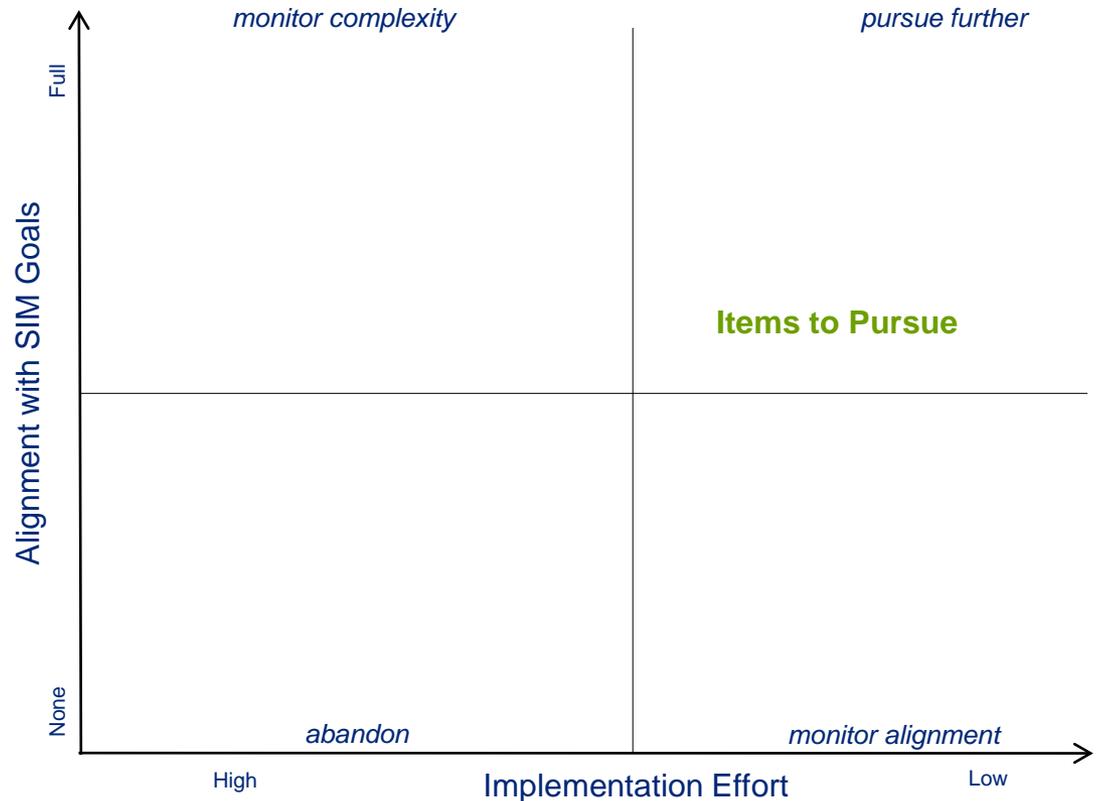
How can the coordination between physical and behavioral health be improved through the use of episodes of care/bundled payments?

Strategy Analysis Map

Strategies

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Financial Impact



Length of Time to Implement



Episodes of Care/Bundled Payments: Physical/Behavioral & Public Health Coordination



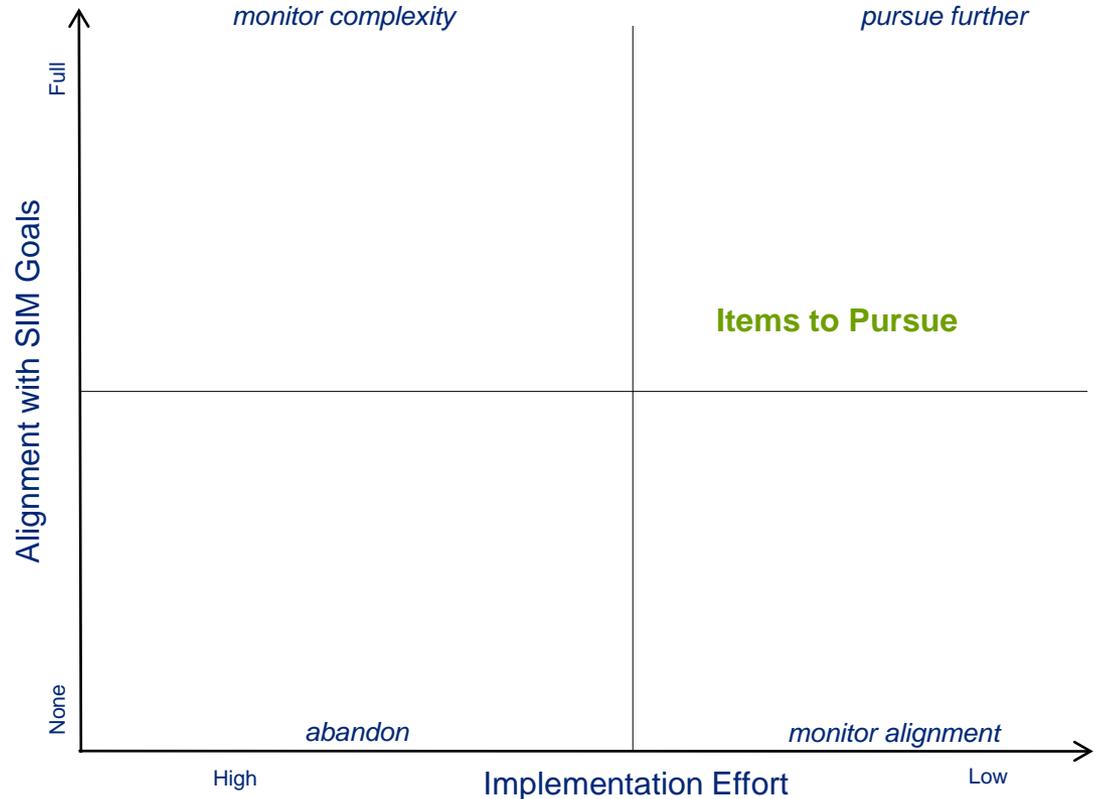
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Length of Time to Implement



Episodes of Care/Bundled Payments: Physical/Behavioral & Oral Health Coordination



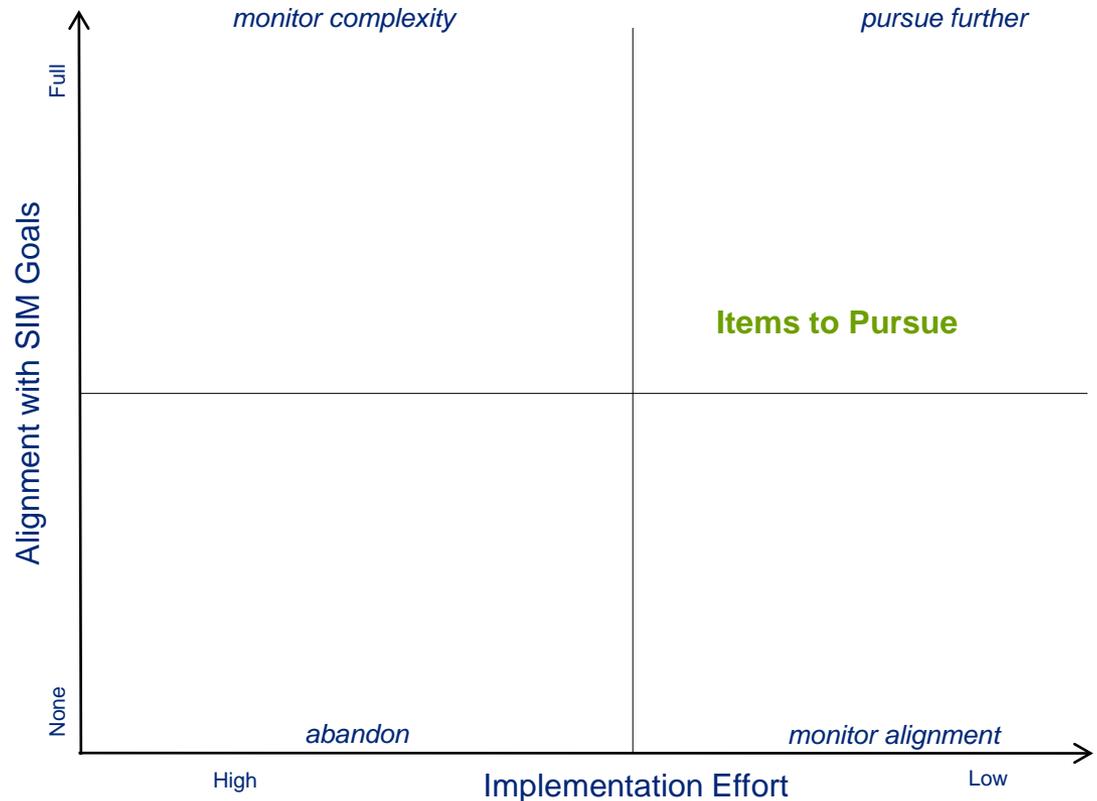
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Financial Impact



Length of Time to Implement



Next Steps

Upcoming Schedule

A monthly workgroup meeting will be essential for discussing key topics, reaching consensus, and driving the development of a successful Model Design. The exact meeting dates, times, and locations for the workgroups will be communicated in advance of each session.

May 2015

M	T	W	T	F
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

June 2015

M	T	W	T	F
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30			

July 2015

M	T	W	T	F
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	31

Calendar Legend

Workgroup Meeting

Stakeholder Meeting

Next Steps

- As a reminder, the next full stakeholder meeting is scheduled for **Wednesday May 6, 2015** from **1 – 4 PM** at the **Administrative Office of the Courts**, Main Conference Room, 1001 Vandalay Drive, Frankfort, KY 40601
- Mark your calendars! The next Integrated & Coordinated Care workgroup will be held on **May 19, 2015**.

Workgroup	May Date	May Time	Location
Payment Reform	Tuesday, May 19, 2015	9AM to 12PM	KY Department for Public Health (DPH), Conference Suites A-C , 275 E Main St, Frankfort, KY 40601
Integrated & Coordinated Care	Tuesday, May 19, 2015	1PM to 4PM	KY Department for Public Health (DPH), Conference Suites A-C , 275 E Main St, Frankfort, KY 40601
Increased Access	Wednesday, May 20, 2015	9AM to 12PM	KY Department for Public Health (DPH), Conference Suites A-C , 275 E Main St, Frankfort, KY 40601
Quality Strategy / Metrics	Wednesday, May 20, 2015	1PM to 4PM	KY Department for Public Health (DPH), Conference Suites A-C , 275 E Main St, Frankfort, KY 40601
HIT Infrastructure	Thursday, May 21, 2015	9:30AM to 12:30PM	KY Department for Public Health (DPH), Conference Suites B-C , 275 E Main St, Frankfort, KY 40601

- Please visit the dedicated Kentucky SIM Model Design website: <http://chfs.ky.gov/ohp/sim/simhome>
 - This website contains an Integrated & Coordinated Care workgroup section that will contain meeting presentations, outputs, and additional resources
- Please contact the KY SIM mailbox at sim@ky.gov with any comments or questions

Thank you!

Q&A