

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



State Innovation Model (SIM) Model Design
April Payment Reform Workgroup

April 14, 2015
9 AM – 12 PM

Agenda

- **Welcome and Introductions** 9:00 – 9:10 AM
 - **Value-Based Purchasing Overview** 9:10 – 9:30 AM
 - **SWOT Analysis** 9:30 – 10:10 AM
 - **Current State Review and Exercise** 10:10 – 10:40 AM
 - *Break* 10:40 – 10:50 AM
 - **Medicare & Delivery System Continuum Exercise** 10:50 – 11:50 AM
 - **Next Steps and Q&A** 11:50 AM – 12:00 PM
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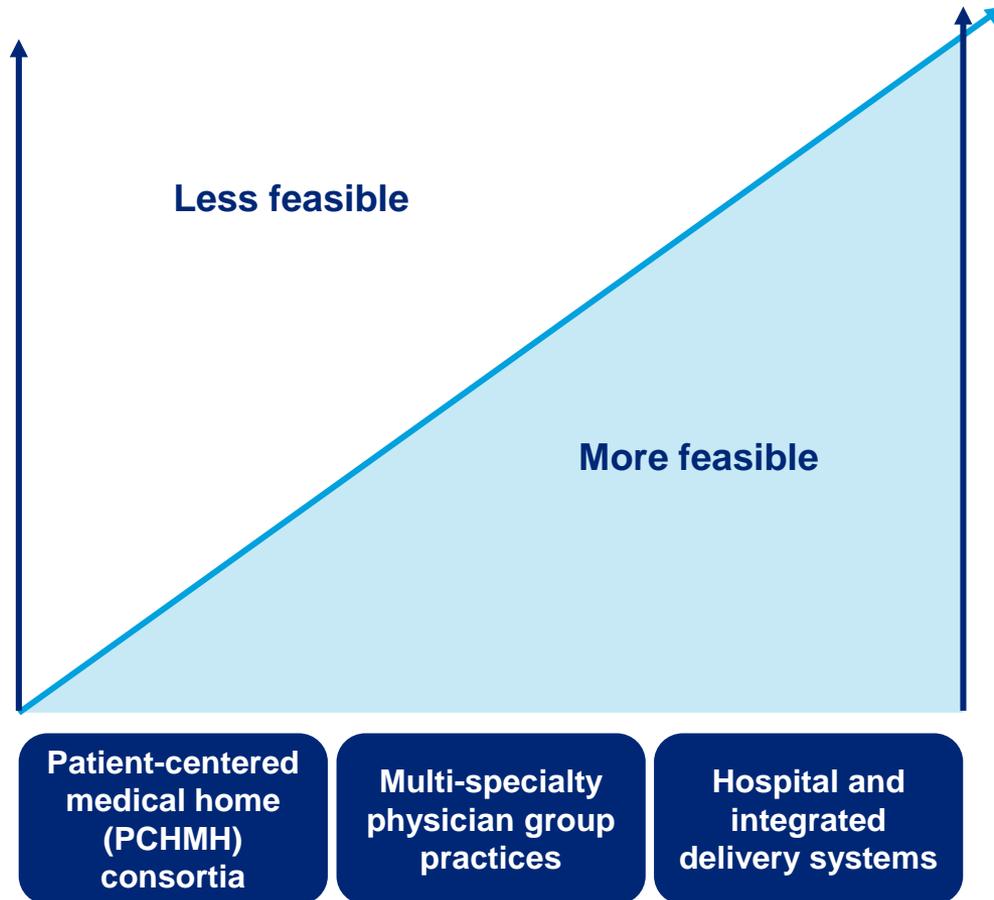
Welcome and Introductions

Value-Based Purchasing Overview

Value Based Care Models

One of the workgroup’s tasks over the Model Design period is to define a payment methodology that rewards value, or quality and cost effectiveness, to support the care delivery model that is developed. This task is in line with the Centers for Medicare & Medicaid Services’ (CMS) goals for SIM and the shifting market dynamic from one focused on volume to one focused on value.

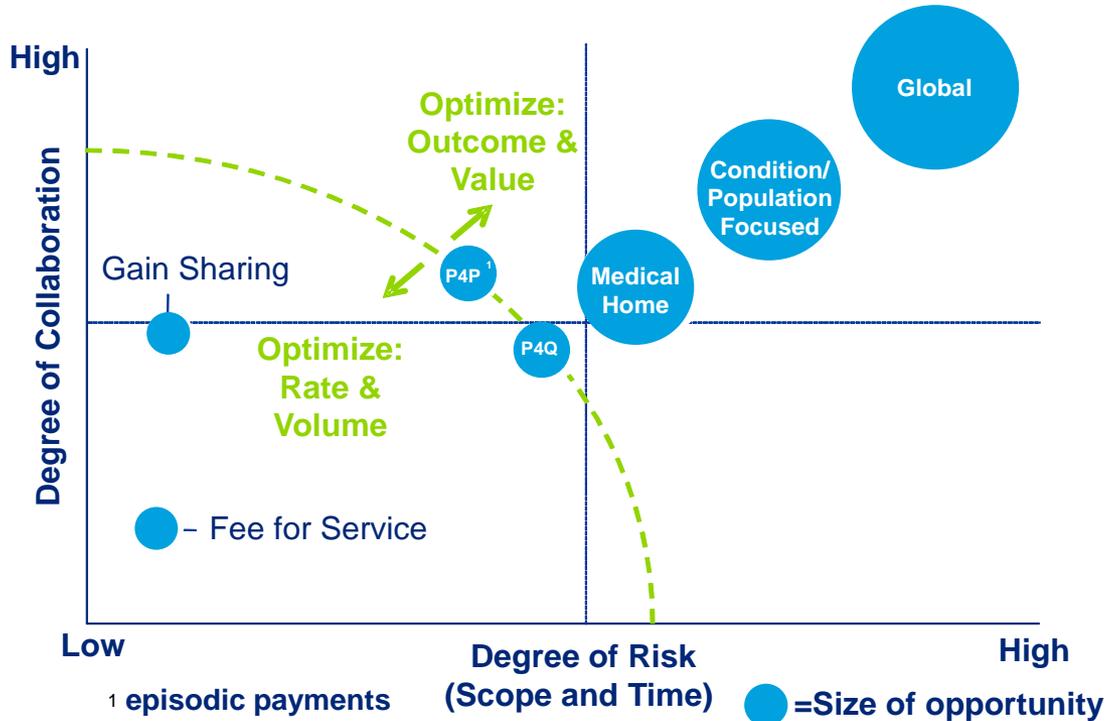
- Risk-adjusted global fee with risk mitigation (e.g., reinsurance)
- Global ambulatory care fees and bundled acute case rates
- Global primary care fees and bundled acute case rates
- Global primary care fees
- Blended fee-for-service (FFS) and medical home fees



- Quality bonuses for patient outcomes; large percent of shared savings; some shared risk
- Quality bonuses for care coordination and intermediate outcome measures; moderate percent of shared savings
- Quality bonuses for preventive care; management of chronic conditions measures; small percent of shared savings

Transition from Volume to Value is Fundamentally Challenging

An accountable care solution, an example of value-based purchasing, aligns clinical and financial performance of stakeholders resulting in improved quality and outcomes.



How do we capture value?

- Transition from FFS to value-based payment model (i.e., potentially get paid more for doing less)
- Manage population health by preventing disease progression and driving appropriate utilization
- Manage premiums to benefit the health system and population, not just the insurer, to potentially offset lower volume
- Coordinate care across delivery systems for patients with complex needs
- Focus on operational cost reduction
 - Gaining efficiency by adjusting fixed costs to patient consumption

- Accountable care is using performance risk to achieve clinical integration and improve service quality
 - Performance risk includes value-based payment model transformation
 - Clinical integration enables care that is coordinated, interdependent, and information driven
- Accountable care achieves sustainable and effective population health management through decreased cost and improved quality and outcomes

National Landscape – Payment Model Reform

States that received Round One Model Testing grants are currently experimenting with several different payment reform strategies, including Arkansas and its Health Care Payment Improvement Initiative.

Payment Models in SIM Model Testing States						
State	Per-Member-Per-Month (PMPM) Payment	Shared Savings	Shared Savings and Risk	Episode-Based/Bundled Payment	Prospective Payment or Partial/Global Capitation	Bonus Payments
Arkansas	X	X		X		
Maine		X	X		X	
Massachusetts	X		X			X
Minnesota	X	X	X		X	
Oregon	X	X	X	X	X	X
Vermont	X	X	X	X		X

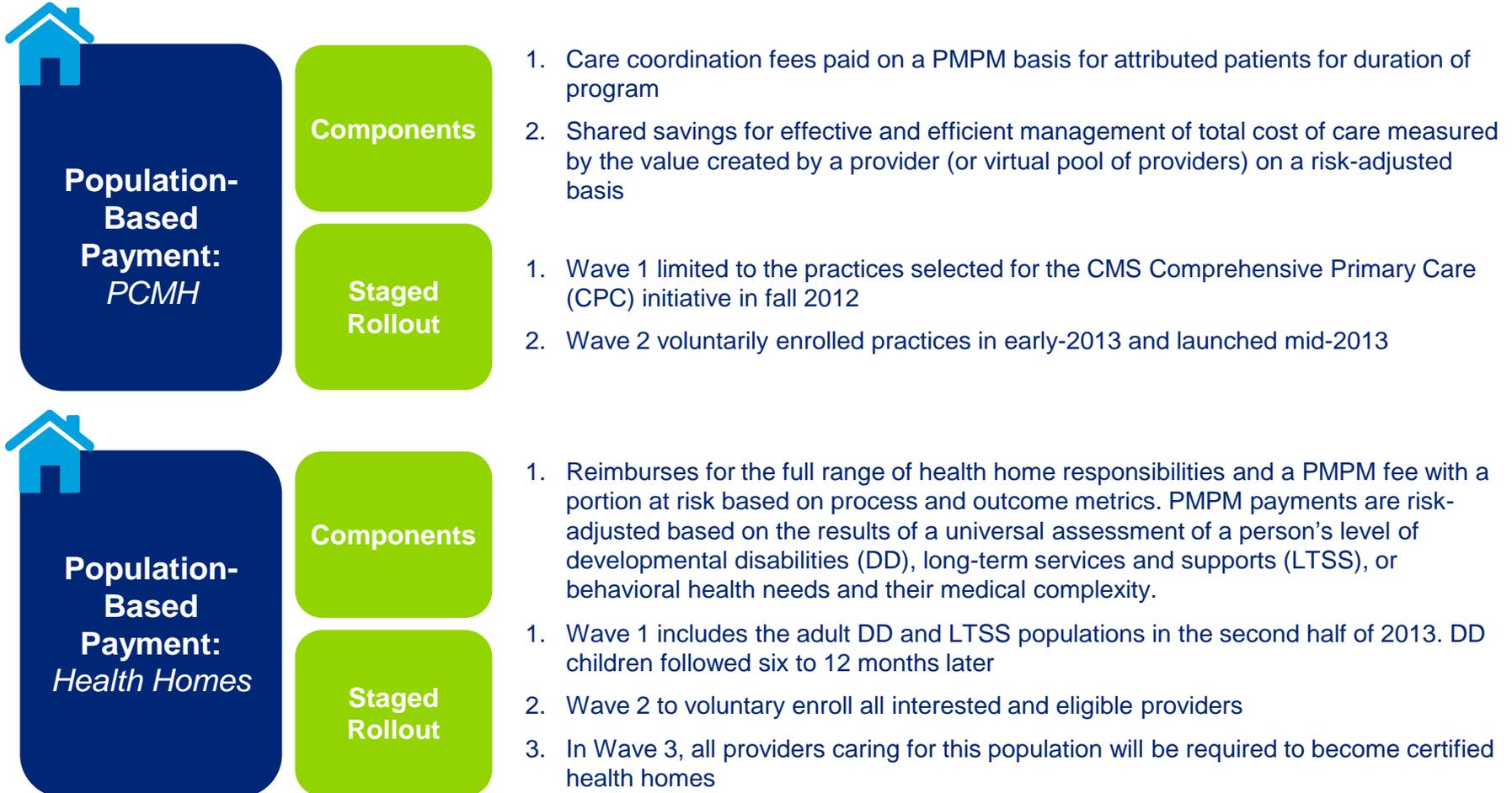
Source: Kaiser Family Foundation

Arkansas expanded its payment reform model during its Round One Model Test:

- Focuses on improving care, not just saving money
- Protects physician discretion and keeps clinical decision-making with providers
- Rewards high-quality providers while also creating a financial incentive for ineffective providers to improve
- Encourages physicians to coordinate their patients' care, which should lead to better health outcomes for Arkansans
- Acknowledges that poor performance is a reality and should not be rewarded
- Aims to improve the status quo and protect Arkansans from alternatives such as “intrusive” managed care
- Allows Medicaid to avoid making drastic cuts to the rates it uses to reimburse doctors or to programs on which tens of thousands of Arkansans depend

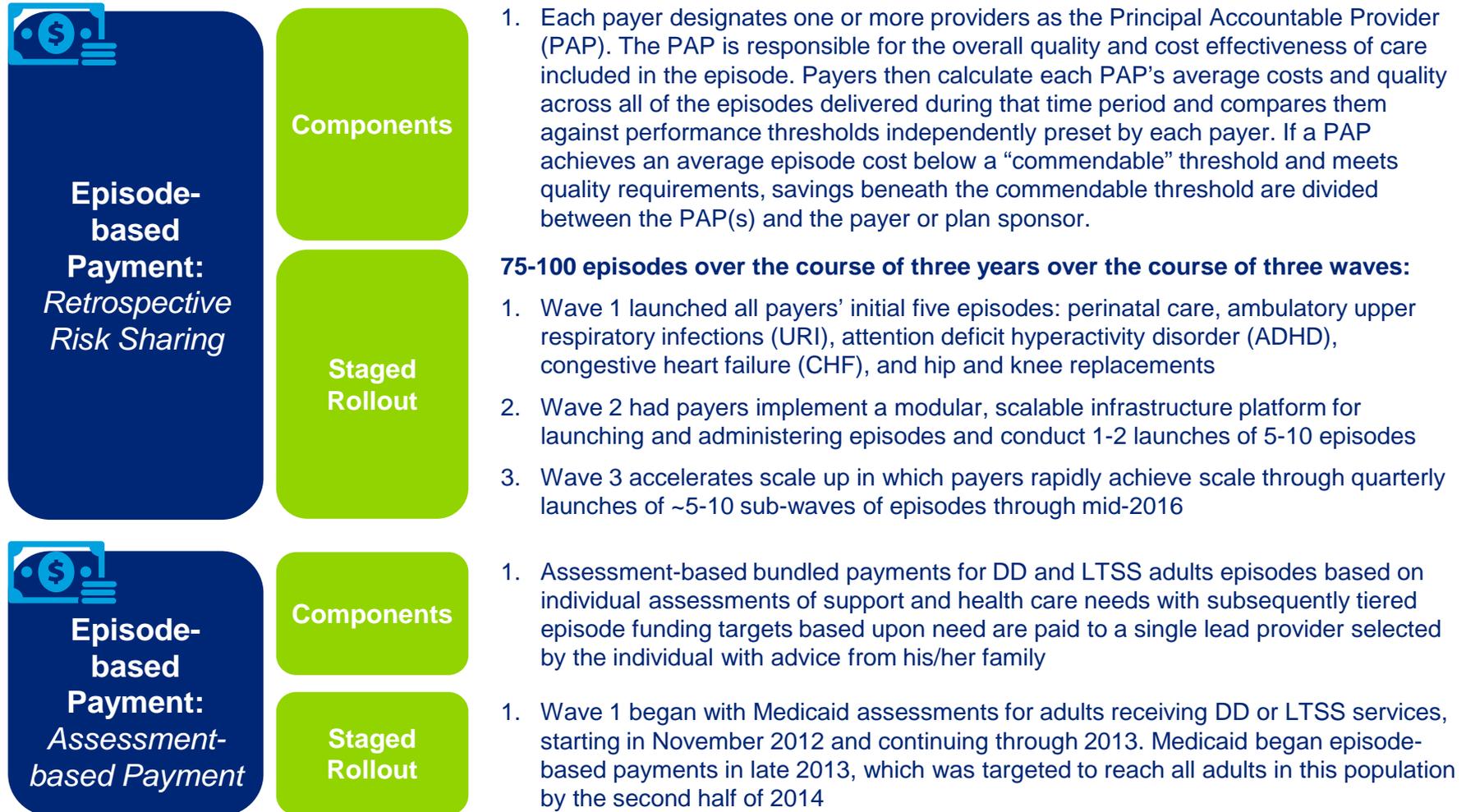
A Closer Look at Arkansas

Using a SIM Model Test grant, Arkansas Medicaid, the Arkansas Department of Human Services, Arkansas Blue Cross and Blue Shield, and QualChoice of Arkansas partnered to transform the state's health care and payment system. The collaboration is called the Arkansas Health Care Payment Improvement Initiative.



A Closer Look at Arkansas (Continued)

In addition to population-based payment models, the Arkansas Health Care Payment Improvement Initiative includes two episode-based payment models.



First Year Results in Arkansas

Year 1 data from the first wave of implementation is available with respect to the two-sided episodic payment model for the URI, ADHD, Perinatal, Hip and Knee Replacement, and CHF episodes of care

Quarterly Performance Reporting

- Once the performance period began, providers began receiving performance reports for each episode type, including detailed cost and quality information, patient names, and patient-level episode ID numbers for each individual episode.
- As of third quarter 2014, more than **5,300** of these quarterly performance reports have been distributed to nearly **2,000*** distinct PAPs.
- To generate these reports, approximately **226.5** million claims have been processed through the engine, resulting in just under **2.67 million** episodes before exclusions.

**Note: Arkansas has 6,340 active licensed physicians and 93 hospitals*

489

Number of providers who were potentially eligible to receive gain sharing payments totaling \$396,103

Number of providers who were required to submit quality data before receiving gain sharing in Year 1

176

\$594,191

Amount paid back to Medicaid by the 278 providers who were penalized after Year 1**

Number of providers with average episode costs above the acceptable threshold who asked for penalty reconsideration

15

Arkansas Medicaid also highlights certain changes in practice patterns that have been gleaned from episode claims and quality data including a 19 percent decrease in antibiotic prescriptions for URI, an increase in guideline concordant care in ADHD with a dramatic reduction in therapy visits combined with recognition of additional co-morbidities, a cost stabilization in hip and knee replacement and CHF, and greater screening of pregnant women for Hepatitis B, HIV, and diabetes.

SWOT Analysis

Exercise: Strengths and Challenges of the Current System

In the following exercise, participants will assess the current state of Kentucky's existing public and private payment strategies and value-based purchasing landscape using a SWOT analysis.



S What are the advantages and **strengths** of existing payment strategies?

Notes:

W What do you believe are the current **weaknesses**?

Notes:

O Are there **opportunities** that could benefit the existing strategies?

Notes:

T Are there **threats** to the current value-based purchasing initiatives – financial and/ or competitive?

Notes:

Proposed Value-based Purchasing Changes

Based upon the results of the SWOT analysis, what changes to the current array of value-based purchasing strategies should we consider making through SIM?

	Reimbursement Methodology	Description	Examples	
Support better performance	Fee-for-Service	Payment for specific services rendered by provider to patient	-Percent of charges -Fee schedule (RBRVS)	LOW LEVEL OF RISK SHARING HIGH
	Per Diem	Payment per day of inpatient care	-Medical/surgical: Maternity -ICU/CCU, NICU	
Pay for better performance	Bundled Payments	Case payment for a particular case based on DRG or case rate	-Case rate -MS-DRG	
	Pay for Performance	Provider payments tied to one or more objective metrics of performance	-Guidelines-based payment -Non-payment for preventable complications	
	Episode-Based Payment	Case payment for a particular procedure or condition(s) based on quality and cost	-Osteoarthritis -Coronary Artery Disease	
Pay for higher value	Service Defined Capitation	Per-person payment for a specific specialty service	-PCP visit -Lab work	
	Condition Specific Capitation	Per-person payment for a specific condition or group of conditions	-Diabetes -Cancer cases	
	Provider Defined Capitation	Per-person payment regardless of volume of care for patient	-Managed care/HMO payment model	
Value-Based Models	ACOs	Capitation to an Integrated Delivery System for full risk of all services of a member group	-Global payment -ACO shared savings program -Medical home -Hospital-physician gain sharing	

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

Current State Review & Alignment Exercise

State Landscape – Existing State Initiatives

Both public and private payers for health care in Kentucky have made advances in reforming the way that payments to providers are being made.

Hospital Pay for Performance

- The Anthem Quality-In-Sights® Hospital Incentive Program (Q-HIP®) is fully implemented and available to all intended/applicable providers/members in Kentucky
- This program evaluates hospitals based on patient safety, health outcomes, and patient satisfaction, and aligns with the hospital's full capitation model with added quality incentives, also referred to as a global payment model

Increased Reimbursement for Prevention Services

- The Kentucky Department for Medicaid Services (DMS) launched an initiative for its FFS program in January 2015 to increase reimbursement rates for certain high-value prevention services that have been demonstrated to provide a strong return on investment (ROI)
- This program aligns economic incentives of providers with CMS Core Population Health Metrics for FFS Medicaid recipients.

Value-based Enhanced Personal Health Care

- The Anthem Enhanced Personal Health Care Program empowers primary care providers (PCP) to engage in comprehensive primary care functions to move toward a coordinated, evidence-based care model
- The program contains value-based payment, aligns financial incentives, and provides financial support for activities and resources that focus on care coordination, individual patient care planning, patient outreach, and quality improvement

Pay-for-Performance Primary Care Program

- The Passport Health Plan enhanced primary care program offers enhanced payments to all of the PCPs who participate in Passport's network in Kentucky
- This program extends the enhanced payments made since 2013 under the Affordable Care Act (ACA) past December 31, 2014, and became effective January 1, 2015 with the first enhanced payment distribution from Passport projected to be in the month of April 2015

State Landscape – Existing Federal Initiatives

In addition to operating state-based payment reform initiatives, providers and payers in Kentucky participate in multiple national programs funded through CMS.

Comprehensive Primary Care Initiative (CPCI)

- Kentucky operates **14** CPC practice sites within the St. Elizabeth Physicians group in the Cincinnati-Dayton Region as part of **479** CPC total practice sites distributed across **seven** CPC regions
- CMS, in collaboration with the commercial health insurance plans in Kentucky, offers population-based care management fees and shared savings opportunities to participating primary care practices to support the provision of a core set of five “Comprehensive” primary care functions

Medicare Advanced Payment ACO Models

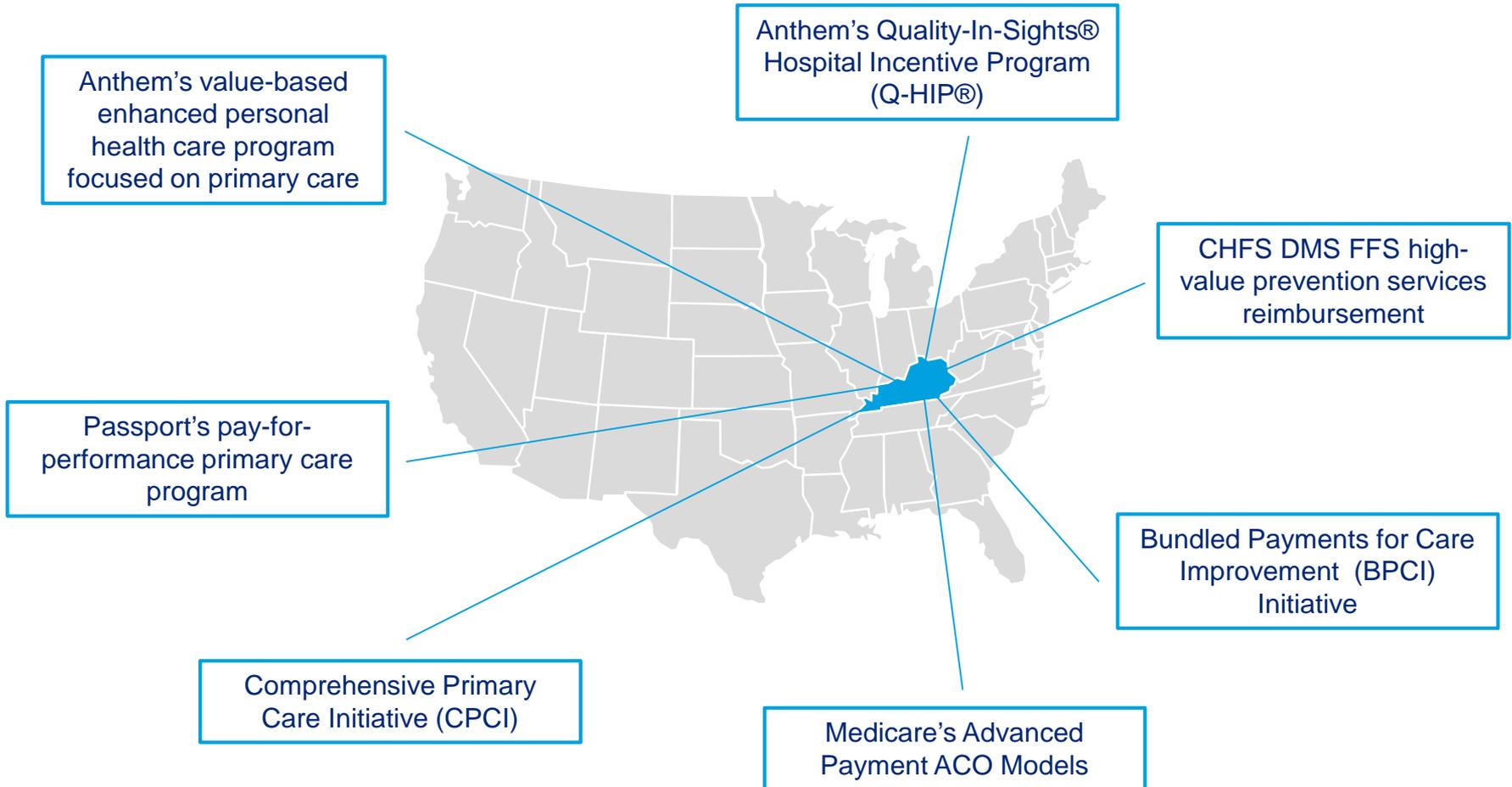
- Kentucky operates three of the **35** ACOs participating in the Advance Payment ACO Model funded by the Center for Medicare & Medicaid Innovation (CMMI): Jackson Purchase Medical Associates PSC, Owensboro ACO LLC, and Quality Independent Physicians LLC
- The Advance Payment Model is designed for physician-based and rural providers who have come together voluntarily to provide coordinated, high-quality care to their Medicare patients
- Kentucky’s selected participants receive upfront and monthly payments, which they can use to make important investments in their care coordination infrastructure

Bundled Payments for Care Improvement (BPCI) Initiative

- Kentucky has **22** pilot sites participating in Model 2 of the BPCI initiative, a program in which organizations enter into payment arrangements that include financial and performance accountability for episodes of care. The specific focus of Model 2 is on Retrospective Acute Care Hospital Stay plus Post-Acute Care
- In addition to Model 2, Kentucky has **128** pilot sites participating in the Model 3 of the BPCI initiative. The specific focus of Model 3 is on Retrospective Post-Acute Care Only

Exercise: Proposed Value-based Purchasing Alignment

How can we align the current value-based purchasing strategies used by the various payers/purchasers in Kentucky? In the following exercise, participants will use the current strategies from existing value-based care models in Kentucky to establish goals for value-based purchasing in SIM.



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

Medicare & Delivery System Continuum

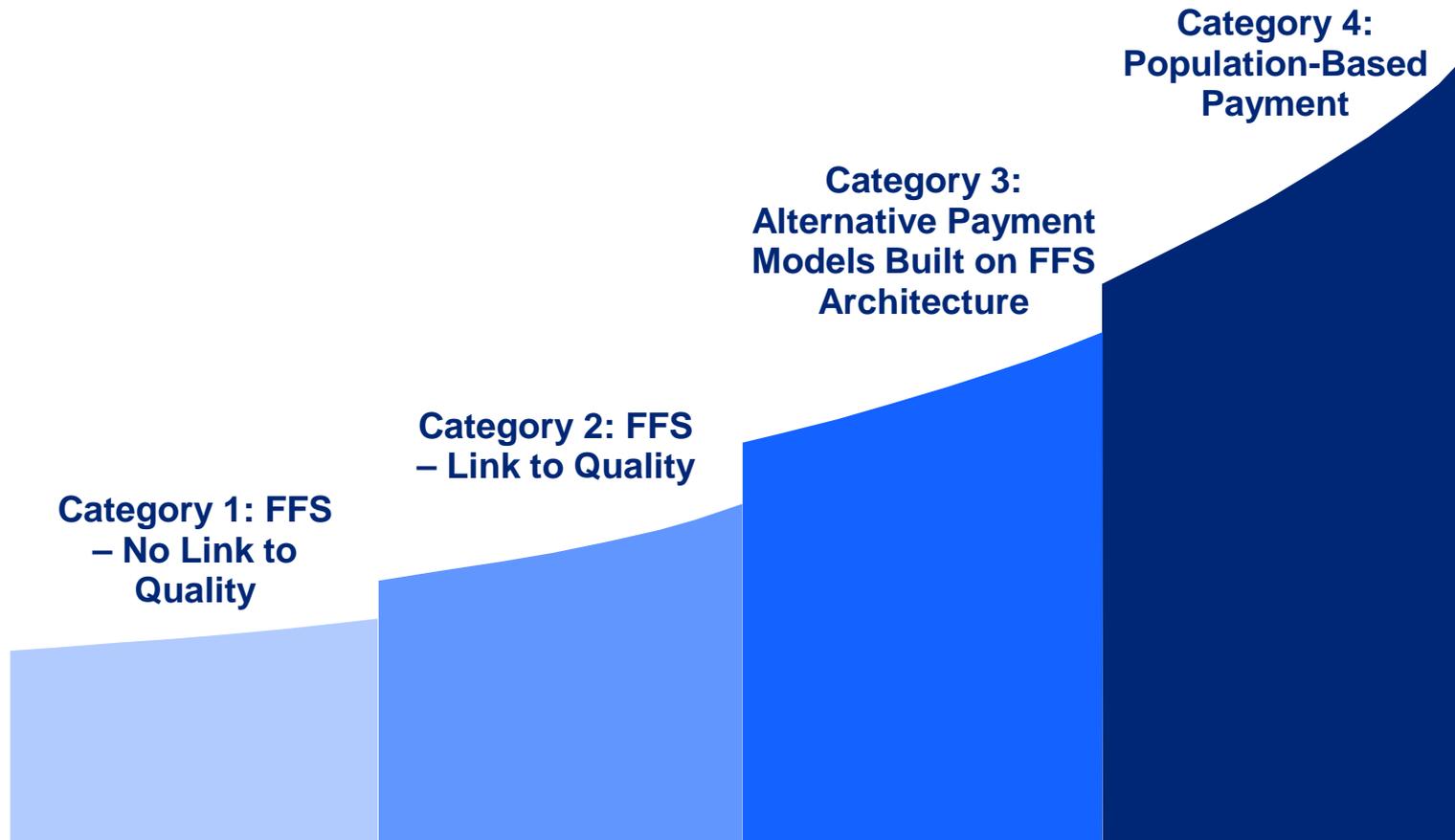
Alignment with CMS Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value

In January 2015, CMS established a goal to have 30 percent of Medicare payments in alternative to FFS payment models (Categories 3 and 4 below) by the end of 2016 and 50 percent by the end of 2018.

CMS Medicare Payment Taxonomy Framework				
	Category 1: FFS – No Link to Quality	Category 2: FFS – Link to Quality	Category 3: Alternative Payment Models Built on FFS Architecture	Category 4: Population-Based Payment
Description of Payment Method	Payments are based on volume of services and not linked to quality of efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or two-sided risk	Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., more than one year)
Medicare FFS	<ul style="list-style-type: none"> Limited in Medicare FFS Majority of Medicare payments now are linked to quality 	<ul style="list-style-type: none"> Hospital value-based purchasing Physician Value-Based Modifier Readmissions/Hospital Acquired Condition Reduction Program 	<ul style="list-style-type: none"> ACOs Medical homes Bundled payments Comprehensive primary care initiatives Comprehensive End-Stage Renal Disease Medicare-Medicaid Financial Alignment Initiative FFS Model 	<ul style="list-style-type: none"> Eligible Pioneer ACOs in years 3-5

Exercise: Medicare Value-Based Reimbursements

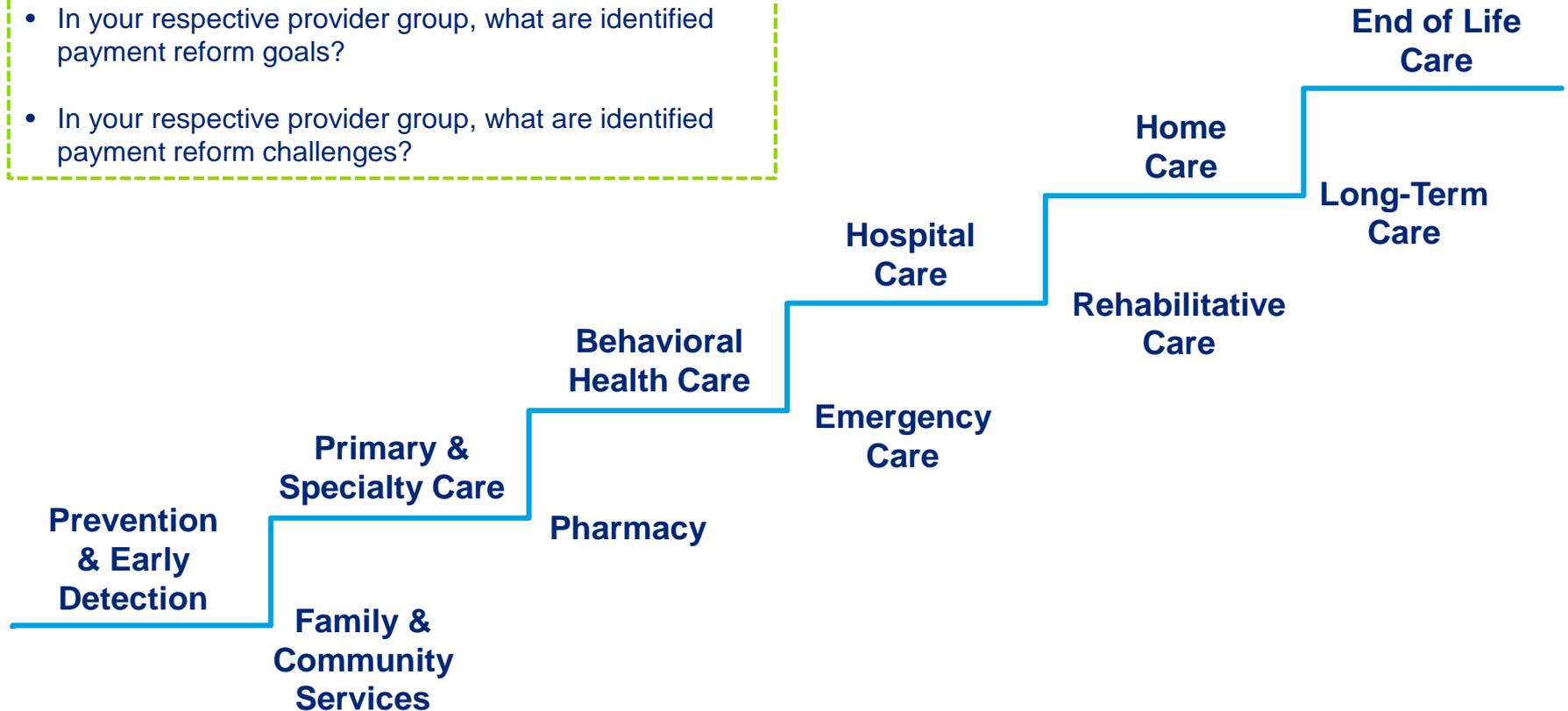
In the following exercise, participants will discuss where on the spectrum from Category 1 FFS payments to Category 4 alternative, population-based payments, Kentucky's SIM Model Design payment methodology should fall.



Exercise: Payment Reforms Along the Delivery System Continuum

Each provider and/or organization that falls on the health care delivery system continuum has different stakeholders and opportunities for both quality improvement and cost reductions. The potential payment reforms/reimbursement models for each level of this continuum should consider these individual factors. In the following exercise, participants will discuss these factors in individual provider-type groups.

- In your respective provider group, what are identified payment reform goals?
- In your respective provider group, what are identified payment reform challenges?



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

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 Payment Reform 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 a Payment Reform 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