

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



**State Innovation Model (SIM) Model Design  
Stakeholder Kickoff Meeting**

**March 17, 2015**

# Agenda

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- **Introductions and Agenda** (Emily Parento, Executive Director, Office of Health Policy, Cabinet for Health and Family Services) 1:00 - 1:15 PM
- **Welcome Remarks** (Lieutenant Governor Crit Luallen, Commonwealth of Kentucky) 1:15 - 1:30 PM
- **State Innovation Model (SIM) Overview** (Jim Hardy, Specialist Leader, Deloitte Consulting LLP) 1:30 - 2:00 PM
- **KY SIM Proposal Overview** (Dr. John Langefeld, Chief Medical Officer, Department for Medicaid Services, Cabinet for Health and Family Services) 2:00 - 2:30 PM
- **KY SIM Project Overview** (Jim Hardy, Specialist Leader, Deloitte Consulting LLP) 2:30 – 3:00 PM
- *Break* 3:00 – 3:10 PM
- **Navigating the New Health Care Landscape** (Dr. Lisa Bielowicz, MD, Chief Medical Officer, The Advisory Board Company, Inc.) 3:10 – 3:40 PM
- **Next Steps and Q&A** 3:40 – 4:00 PM

# **Welcome and Introductions**

# **State Innovation Model (SIM) Overview**

# CMS' Goals for the SIM Program

The Centers for Medicare & Medicaid Services (CMS) State Innovation Model (SIM) initiative is focused on testing the ability of state governments to use regulatory and policy levers to accelerate health transformation.

- CMS is providing financial and technical support to states for developing and testing state-led, multi-payer health care payment and service delivery models that will impact all residents of the participating states
- The overall goals of the SIM initiative are to:
  - *Establish public and private collaboration with multi-payer and multi-stakeholder engagement*
  - *Improve population health*
  - *Transform health care payment and delivery systems*
  - *Decrease total per capita health care spending*

Current System	Future System
<ul style="list-style-type: none"> <li>• Uncoordinated, fragmented delivery systems with highly variable quality</li> <li>• Unsupportive of patients and physicians</li> <li>• Unsustainable costs rising at twice the inflation rate</li> </ul>	<ul style="list-style-type: none"> <li>• Affordable</li> <li>• Accessible to care and to information</li> <li>• Seamless and coordinated</li> <li>• High-quality – timely, equitable, and safe</li> <li>• Person- and family-centered</li> <li>• Supportive of clinicians in serving their patient's needs</li> </ul>

Source: CMS SIM Round Two Funding Opportunity Announcement Webinar

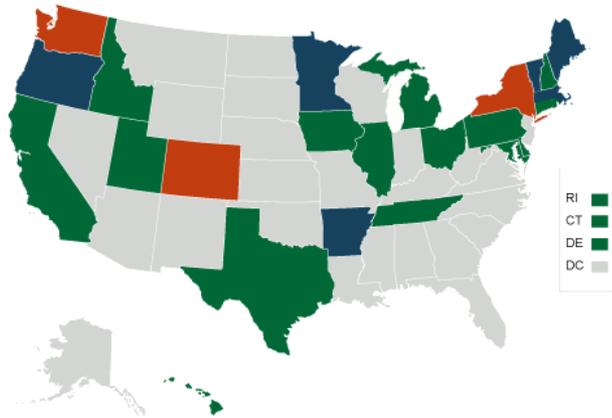
## CMS' Triple Aim Strategy



# Current Landscape of the SIM Program

The Center for Medicare & Medicaid Innovation (CMMI) within CMS awarded states cooperative agreements in two rounds to design and implement strategies for service delivery and payment reform.

■ Model Testing Awards
 ■ Model Pre-Testing Awards
 ■ Model Design Awards

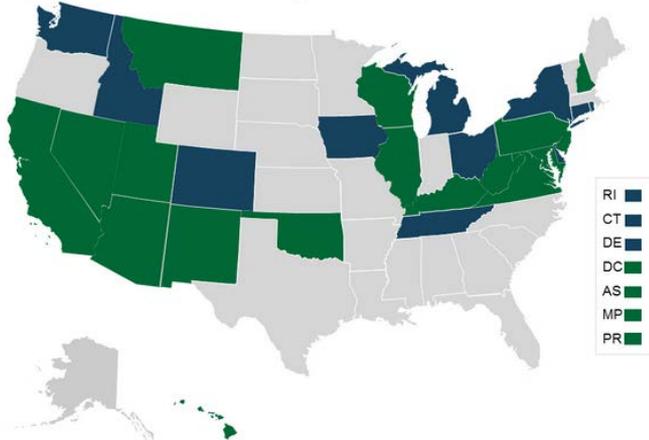


Source: Centers for Medicare & Medicaid Services

## Round 1 SIM Grant Recipients

- Nearly \$300 million was awarded to 25 states in December 2012 to design or test innovative health care payment and service delivery models during Round 1 of the SIM initiative.
- Awardee Breakdown
  - **Model Testing Awards: 6**
  - **Model Pre-Testing Awards: 3**
  - **Model Design Awards: 16**

■ Model Test Awards
 ■ Model Design Awards



Source: Centers for Medicare & Medicaid Services

## Round 2 SIM Grant Recipients

- CMMI added more parameters in Round 2 that better correlate with successful statewide health transformation. It also selected Model Test/Model Design applications based on their potential to impact the health of the entire state population.
- In December 2014, more than \$660 million was provided to 32 awardees (28 states, three territories, and the District of Columbia) for Round 2.
- Awardee Breakdown:
  - **Model Testing Awards: 11**
  - **Model Design Awards: 21**

# National Landscape – Delivery System and Care Linkage Reform

States that received Round 1 Model Testing grants are currently experimenting with several different delivery system and care linkage reform strategies.

## Delivery System Features in SIM Model Testing States

State	Patient-Centered Medical Homes (PCMH)	Health Homes	Behavioral Health Homes	Accountable Care Organizations (ACOs)	New Workforce Models/Team-Based Care
Arkansas	X	X			X
Maine	X	X	X	X	X
Massachusetts	X			X	
Minnesota	X			X	X
Oregon	X			X	X
Vermont	X			X	

Source: Kaiser Family Foundation

## Care Linkages\* in SIM Model Testing States

State	Primary Care & Specialty Care	Primary Care & Behavioral Health	Primary Care & Long-Term Care	Primary Care & Public Health	Primary Care & Community Organizations/Social Services	Primary Care & Oral Health
Arkansas	X					
Maine	X	X	X	X	X	
Massachusetts	X	X		X		
Minnesota	X	X	X	X	X	
Oregon	X	X	X	X	X	X
Vermont	X	X	X		X	

Source: Kaiser Family Foundation

\* Care linkages are defined as relationships between multiple provider organizations

## National Landscape – Payment Model Reform

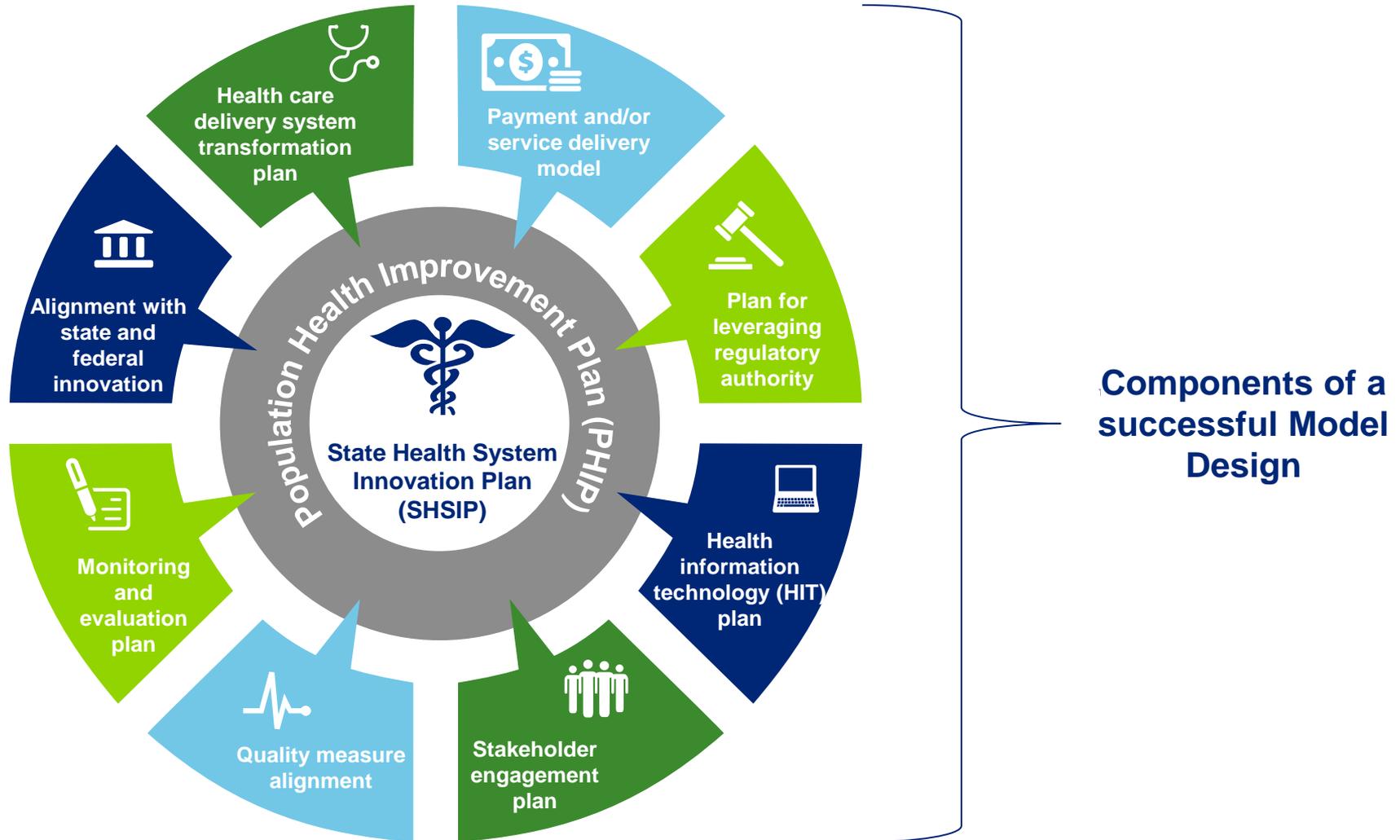
States that received Round 1 Model Testing grants are currently experimenting with several different payment reform strategies.

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

# Components of a SIM Model Design

CMS requires a State Health System Innovation Plan – also referred to as the “Model Design” – as the final deliverable for a SIM Model Design grant.



# **KY SIM Proposal Overview**

## What Is Our Objective?

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**National  
Quality  
Strategy**



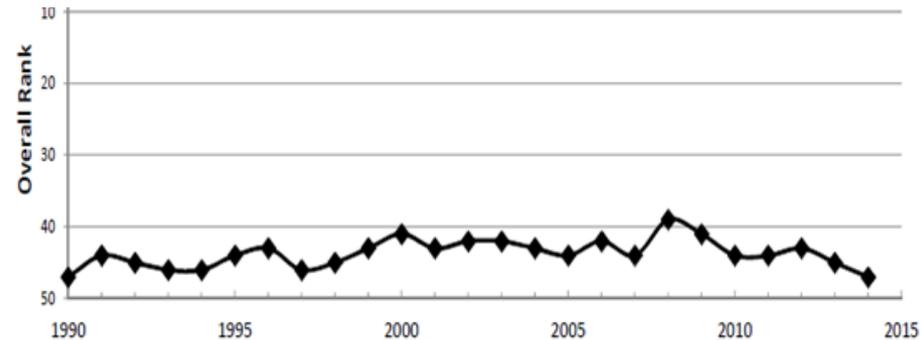
**Triple  
Aim**

# How Are We Doing?

## KENTUCKY

### RANK

POOR MENTAL HEALTH DAYS	50
CANCER DEATHS	50
PREVENTABLE HOSPITALIZATIONS	50
CHILDREN IN POVERTY	50
SMOKING	49
DRUG DEATHS	48
POOR PHYSICAL HEALTH DAYS	47
OBESITY IN ADULTS	46
UNDEREMPLOYMENT RATE	45
PREMATURE DEATH/100,000	44
CARDIOVASCULAR DEATHS/100,000	43
PHYSICAL INACTIVITY	42
LOW BIRTHWEIGHT	38
DIABETES IN ADULTS	33
LACK OF HEALTH INSURANCE	28
HIGH SCHOOL GRADUATION	22



# America's Health Rankings

# 2014

## Definition

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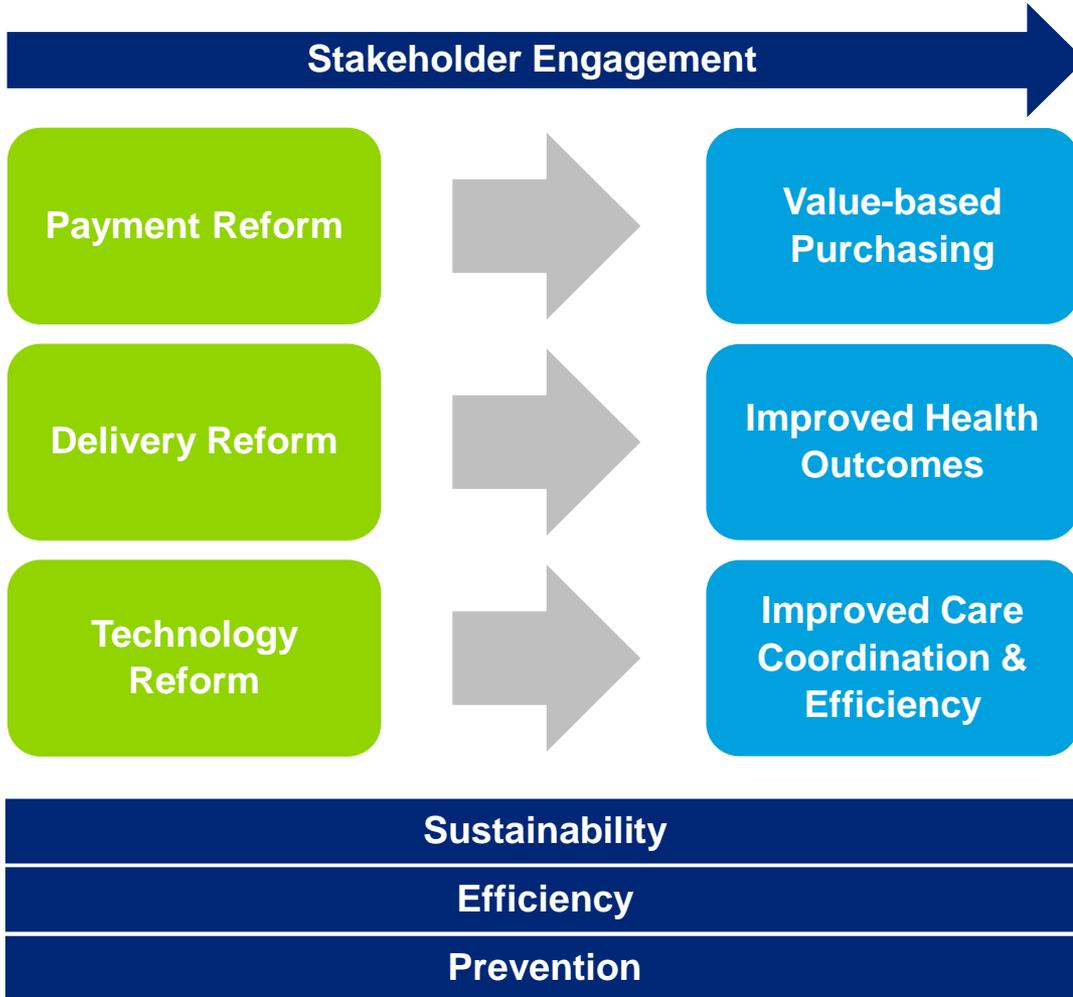
**“*Health* is a state of complete physical, mental and social well-being and not merely the absence of *disease or infirmity.*”**

WHO, 1946

Preamble to the Constitution of the World Health Organization  
as adopted by the International Health Conference,  
New York, June, 1946

# Kentucky's Vision for its SIM Model Design

Kentucky's Model Design will **incorporate multiple payers** including: Medicaid & MCO Partners, Qualified Health Plans (QHPs), the Kentucky Employee Health Plan, other Self-Insured ERISA plans, fully-ensured Health Plans, and Medicare-related payers.



## Goal

KY Annual Health Care Expenditures	\$28.4B
CMS Savings Goal	2%
<b>Estimated Savings</b>	<b>\$568 M</b>



*Kentucky's SIM Model Design application established the goal of reducing health care spending by 2% at the end of the four year implementation period.*

# Kentucky's Goals for Service Delivery Reform

Kentucky has established three primary goals related to health care delivery transformation.

## Increase Access



*Significantly increase access in rural and urban underserved areas, with a focus on primary care and preventive services*

- Maximize use of local resources to help individuals entering and navigating the health care system
- Assess workforce needs strategically by leveraging existing state-level, multi-stakeholder efforts
- Craft delivery options from a consumer service and convenience perspective

## Increase Integrated & Coordinated Care



*Increase population whose care is delivered through integrated and coordinated care models. Patient-centered care should be the rule, not the exception*

- Leverage effective models that are currently in place in KY
- Identify regulatory measures and economic incentive structures
- Explore how workforce measures can support these goals
- Determine impact of consolidation in delivery system
- Emphasize prevention and wellness

## Expand HIT Infrastructure



*Expand HIT infrastructure to enable more efficient and accessible care delivery*

- Optimize technologies that support effective communication
- Develop appropriate databases to support availability and use of actionable data
- Design and track metrics that reflect actual clinical outcomes
- Offer cost and outcome transparency

# Kentucky's Goals for Payment Reform

Kentucky has established four primary goals with respect to payment reform.

## Incentivize Greater Prevention

The starting point for this goal is a KY fee-for-service (FFS) Medicaid initiative that was set to begin in January 2015 to **increase** reimbursement rates for **certain high-value prevention services** that have demonstrated to provide a strong ROI

- Aligns economic incentives of providers with CMS Core Population Health Metrics

## Improve Chronic Disease Prevention & Management

For example, during the Design phase we plan to explore the use of **bundled** or **“episodes”** payment structures for certain defined health populations in Medicaid MCOs as a way to provide cost-effective chronic disease management

- Employ population health measures as part of a gain-share opportunity

## Incentivize Adoption of Integrated and Coordinated Care Models

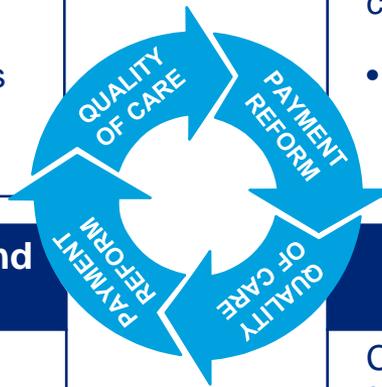
This goal is to employ **Health Homes, PCMH, CPCI, ACOs**, or other similar models, with the possibility of developing a more comprehensive multi-payer gain-share strategy and making integrated and coordinated care make economic sense

- Follow the lead of stakeholders that are leveraging integrated and coordinated care models in the state

## Align Payments with Quality

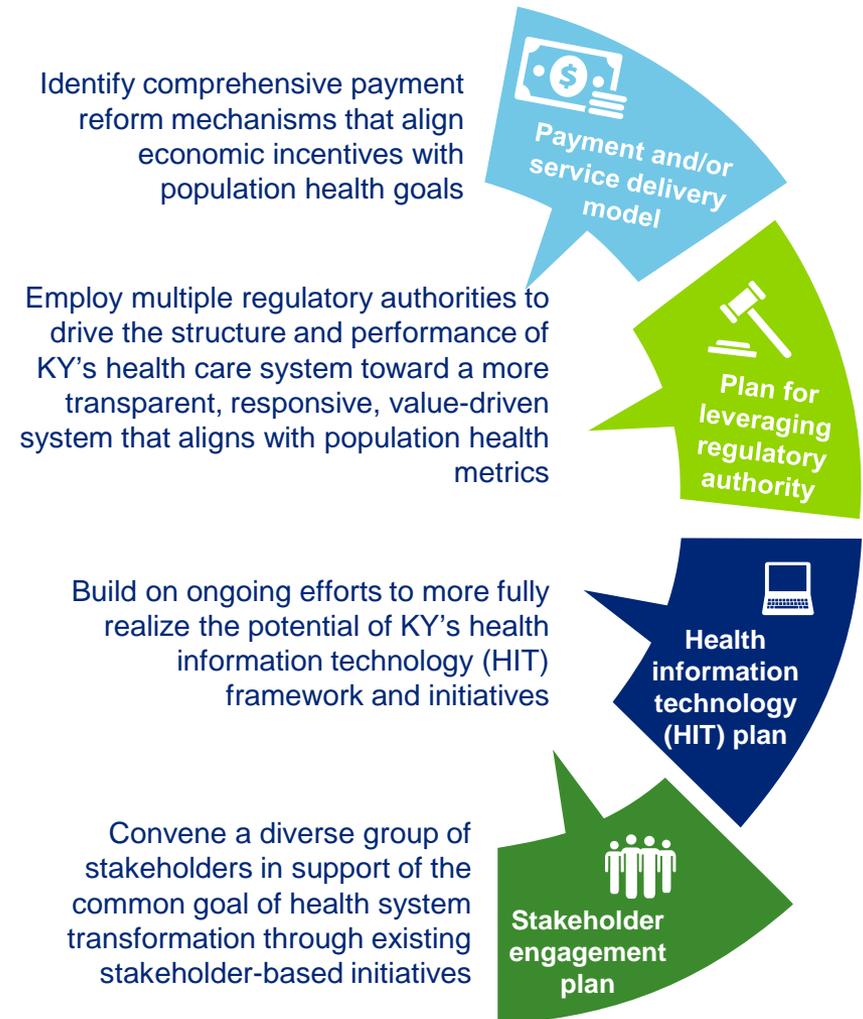
Consideration of financial consequences for **preventable errors, readmissions, and unproductive clinical variations**, which produce unnecessary cost and health burdens

- Examine existing Medicare initiatives (e.g., financial withholdings for certain readmissions) with view toward adopting parallel payment structures in Medicaid and commercial arena



# Kentucky's Vision for the State Health System Innovation Plan

CMS requires a number of work products to **comprise a State Health System Innovation Plan (SHSIP)** as the final deliverable for a SIM Model Design grant.

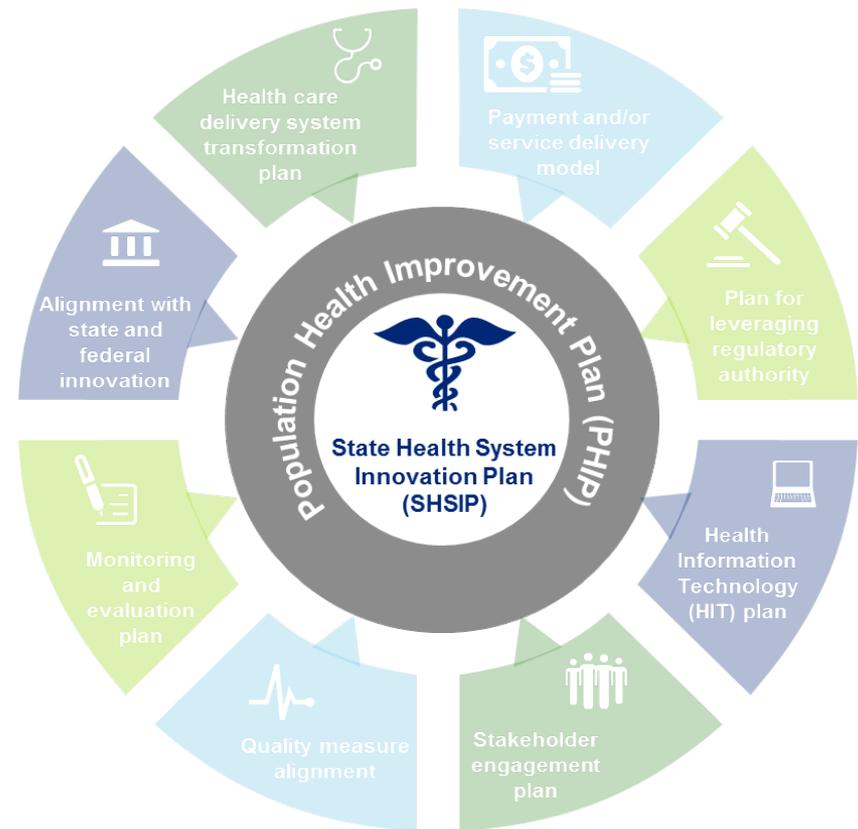


# Kentucky's Vision for the Population Health Improvement Plan

Kentucky will build upon existing health initiatives both within the Commonwealth and at a national level in development of an **integrated, comprehensive Population Health Improvement Plan (PHIP)**.

## PHIP Overview

- The PHIP will help to facilitate the integration of population health strategies and metrics with public health officials and health care delivery systems, with a focus on the following:
  - **Narrowing health disparities**
  - **Expanding access to care at the local level**
  - **Improving chronic disease prevention and management**
- Additionally, the PHIP will be focused on the following core population health metrics:
  - **Tobacco use**
  - **Obesity**
  - **Diabetes**
- The PHIP is central to the overall vision of the SIM project. Themes of the PHIP will be woven throughout other components of the Model Design



# High-Level Model Design Considerations

Kentucky will **propose and discuss with stakeholders multiple key questions** that the respective Model Design components will address and subsequently weave into the final SHSIP.

## Key Questions

<p>How do we infuse a population health focus into payment reform initiatives?</p>	<p>How can we increase the linkages between delivery system reforms and public health initiatives?</p>
<p>How do we build on existing delivery system reform initiatives underway?</p>	<p>How should we align with Medicare's payment reform initiatives?</p>
<p>How do we improve the coordination of services across delivery systems (physical, behavioral, oral health, long-term care)?</p>	<p>How do we increase access to services and care coordination in rural areas of the state?</p>
<p>How can we build consensus and support for initiatives for reforms that require regulatory or statutory changes?</p>	<p>How do we develop robust, multi-payer support for the SIM initiatives?</p>
<p>How do we address the role of consumers in directing and managing the cost of their care?</p>	<p>How will we manage the economic disruption that delivery system and payment reforms will create?</p>

# **KY SIM Project Overview**

# Kentucky's SIM Project Timeline

Strong stakeholder engagement as well as adherence to a thorough project methodology will be critical in the development of a successful SIM Model Design.

Task	2015											2016
	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Jan.
	<b>Stakeholder Engagement</b>											
<b>Phase 1: Define</b> <ul style="list-style-type: none"> <li>Finalize roles and responsibilities</li> <li>Identify goals and objectives</li> <li>Generate innovation ideas for payment and delivery reform</li> </ul>												
<b>Phase 2: Develop Model Design</b> <ul style="list-style-type: none"> <li>Identify components of redesigned system</li> <li>Leverage existing initiatives in support of Model Design</li> <li>Reach consensus on Model Design</li> </ul>												
<b>Phase 3: Develop Financial Model</b> <ul style="list-style-type: none"> <li>Develop financial savings estimate</li> <li>Identify regulatory requirements for supporting new model design</li> <li>Reach consensus on cost savings</li> </ul>												
<b>Phase 4: Finalize State Innovation Model</b> <ul style="list-style-type: none"> <li>Develop implementation strategy</li> <li>Finalize budget for testing</li> <li>Submit Model Design</li> </ul>												

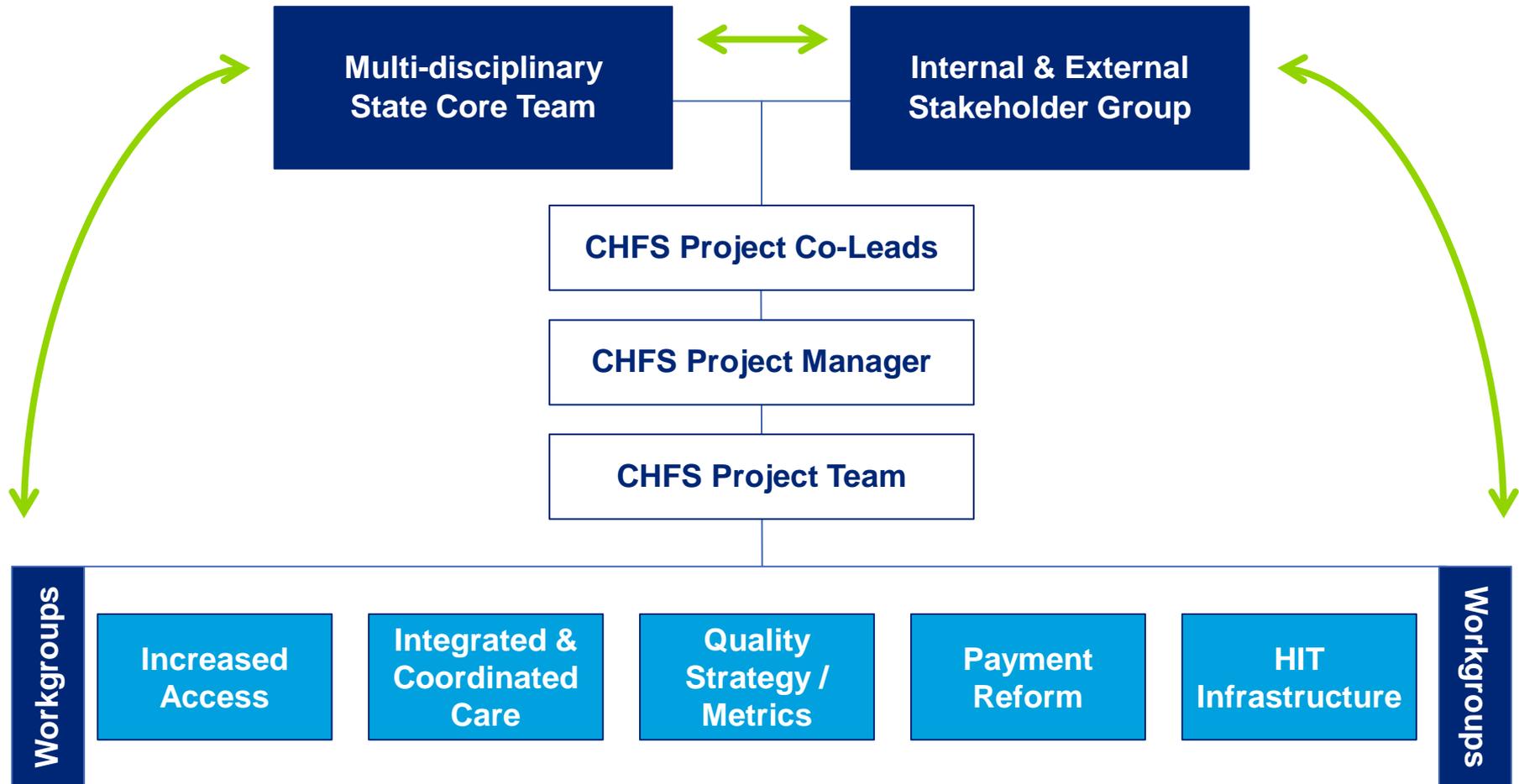
## CMS' SIM Model Design Timeline and Deliverables

CMS has implemented a one-year performance period for the SIM Model Design initiative. Requirements for deliverables are outlined below.

Deliverable	Due Date	Components of Submission
<b>Updated Operational Plan</b>	February 28, 2015	
<b>Stakeholder Engagement Plan</b>	March 30, 2015	
<b>Q1 Quarterly Progress Report</b>	May 30, 2015	<ul style="list-style-type: none"> <li>• Quarterly progress report</li> <li>• Population health plan (Draft)</li> <li>• Driver diagram (Draft)</li> </ul>
<b>Q2 Quarterly Progress Report</b>	August 30, 2015	<ul style="list-style-type: none"> <li>• Quarterly progress report</li> <li>• Value-based health care delivery and payment methodology transformation plan (Draft)</li> </ul>
<b>Q3 Quarterly Progress Report</b>	November 30, 2015	<ul style="list-style-type: none"> <li>• Quarterly progress report</li> <li>• Health information technology plan (Draft)</li> <li>• Operational and sustainability plan (Draft)</li> </ul>
<b>Full Draft State Health System Innovation Plan</b>	December 30, 2015 (Optional)	
<b>Final State Health System Innovation Plan</b>	January 31, 2016	
<b>Final Progress Report</b>	April 30, 2016	

# Kentucky's SIM Project Structure

While the CHFS is the lead applicant agency for Kentucky's SIM Model Design, the process will rely on consistent input from and two-way communication among a multi-disciplinary state Core Team and internal and external stakeholders to develop, implement, and sustain the SIM initiatives.

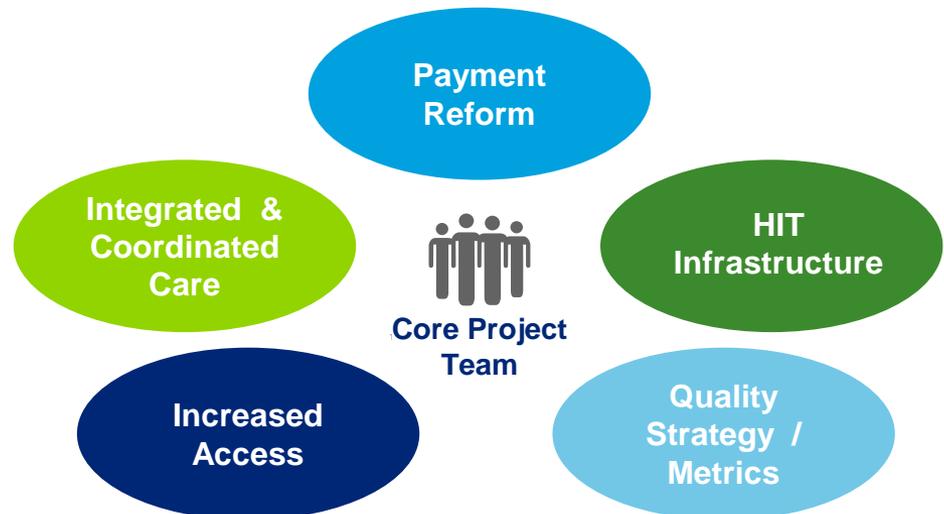


# Kentucky's Stakeholder Workgroup Structure

Workgroups have been created based on key topic areas identified in the SIM application. These workgroups will be responsible for meeting on a monthly basis and working directly with members of the core project team.

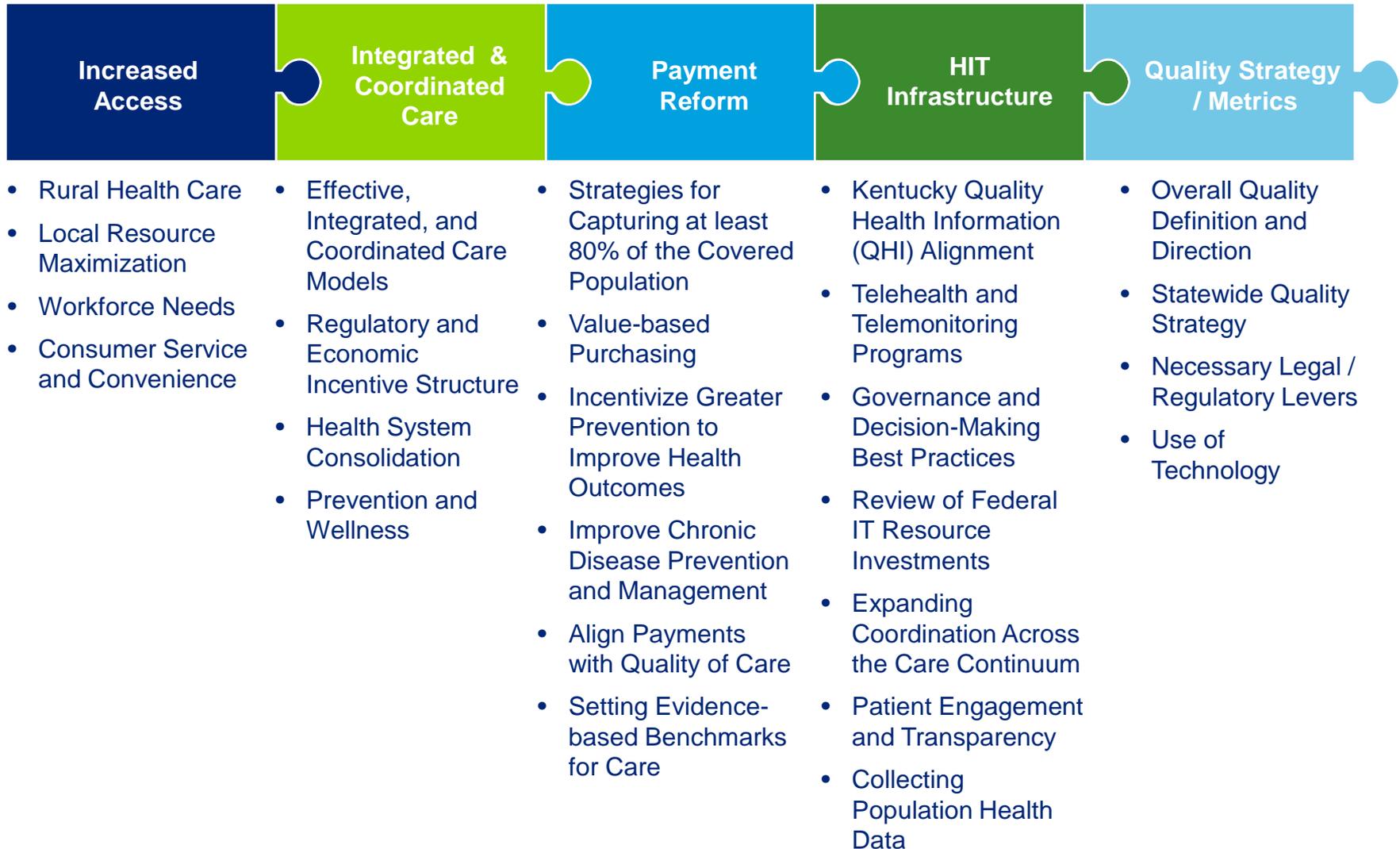
Workgroup Name	Description
<b>Increased Access</b>	Develop strategies that increase access to needed services. Create work force development strategies to support SIM initiatives
<b>Integrated and Coordinated Care</b>	Develop Kentucky-specific model for improving care coordination for individuals with complex needs. Develop strategies to improve coordination across delivery systems
<b>Health Information Technology (HIT) Infrastructure</b>	Leverage Quality Health Information (QHI) framework to implement payment and quality reform strategies
<b>Payment Reform</b>	Identify payment reform strategies that support SIM goals
<b>Quality Strategy/Metrics</b>	Develop a program quality strategy that allows robust measurement of the effectiveness of SIM initiatives

Workgroup Logistics
<ul style="list-style-type: none"> <li>• <b>Frequency:</b> Monthly</li> <li>• <b>Time Commitment:</b> 2.5 – 3 hours per month</li> <li>• <b>How to sign up:</b> Sign up sheets will be posted at the conclusion of the stakeholder session. Additionally, electronic sign-up surveys will be sent via email after the conclusion of stakeholder kickoff meeting.</li> </ul>



# Kentucky's Proposed Stakeholder Workgroup Topics

Each stakeholder workgroup will focus on a set of key topics as part of the overall SIM Model Design and contribute to the development of specific State Health System Innovation Plan components.



# Kentucky's Proposed Stakeholder Meeting Schedule

A monthly meeting of key stakeholders and agreed-upon workgroups will be essential for obtaining buy-in and driving the development of a successful model.

## March 2015

M	T	W	T	F
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27
30	31			

## April 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	

## 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

### Calendar Legend

**Workgroup Meeting**

**Stakeholder Meeting**

*Note: All meeting dates are still proposed at this time. While this schedule represents three months, stakeholder and workgroup meetings will occur throughout the duration of the SIM initiative.*

**Break**

# **Navigating the New Health Care Landscape**

# In Service to Our Health Care Members

## 3,800+

Hospitals and health care organizations in our membership

## 2,500+

Health care professionals employed

## 1,700+

Hospitals using our performance technologies

### RESEARCH AND INSIGHTS

*Memberships Offering Strategic Guidance and Actionable Insights*

- Dedicated to the most pressing issues and concerns in health care
- 300+ industry experts on call
- 200+ customizable forecasting and decision-support tools

### PERFORMANCE TECHNOLOGIES

*National Peer Collaboratives Powered by Web-Based Analytic Platforms*

- Leading provider: Over 60% of inpatient admissions in the United States flow through our technology platforms
- Over 1.6 million user sessions annually
- Key challenges addressed: population health, physician performance, growth, revenue cycle, supply/ service cost, and surgical profitability

### CONSULTING AND MANAGEMENT

*Seasoned, Hands-On Support and Practice Management Services*

- 2,600+ years of “operator” experience in hospital and physician practices
- Principal terrains: hospital-physician alignment/practice management, transition to value-based care, revenue cycle optimization, hospital margin improvement
- Range of engagements from strategy to best practice installation to interim management to fully managed services

### TALENT DEVELOPMENT

*Partnering to Drive Workforce Impact and Engagement*

- Impacted the achievement of 84,000+ executives, physicians, clinical leaders, and managers
- 18,500+ outcomes-driven workshops tailored to partners’ specific needs

*Survey Solutions*

- Customized strategies for improving employee and physician engagement
- National health care-specific benchmarking database of 740,000 respondents

**180,000+**  
health care leaders served globally

**\$700+**  
million in realized value per year

**1,700+**  
engagements completed

**7,700+**  
employee-led improvement projects

# 1 Looking to Bend the Cost Curve

2 Implications for Health Care Providers

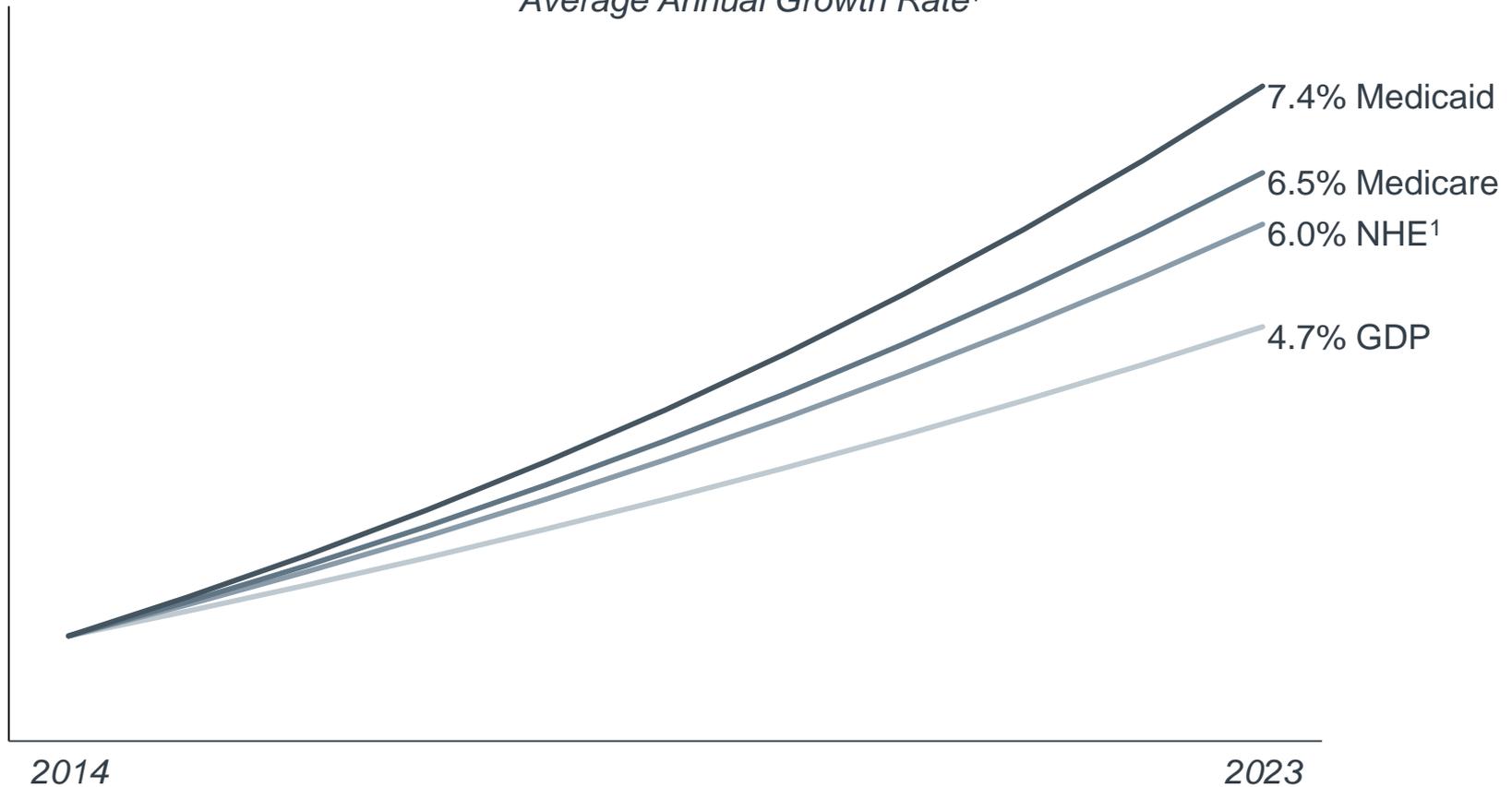
3 Strengthening the State-Provider Partnership

# On the Path to Insolvency

## Unbridled Cost Growth Taking Its Toll

### Projected Health Care Spending

*Average Annual Growth Rate<sup>1</sup>*



1) Includes impacts of the Affordable Care Act and sequestration cuts.

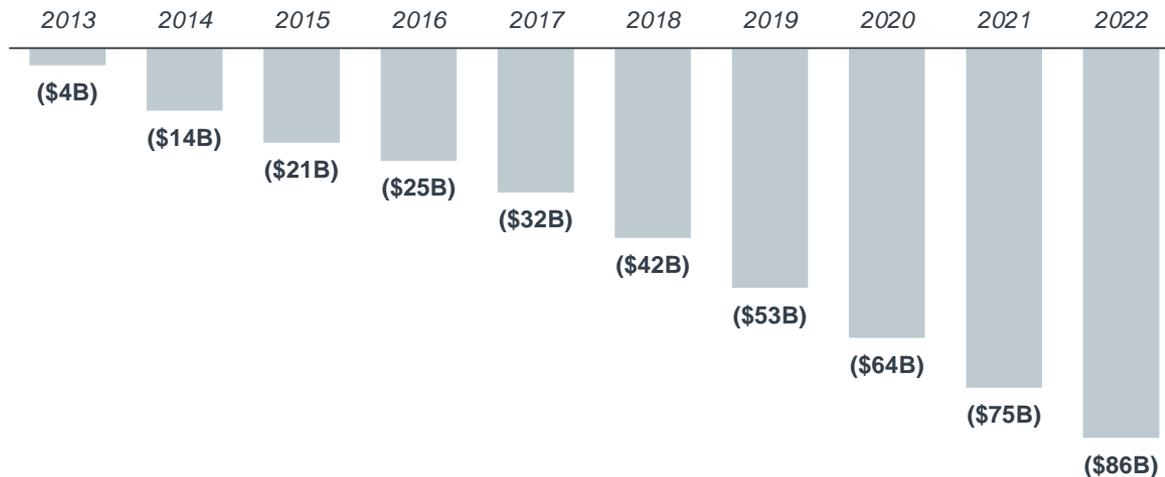
2) National Health Expenditure.

# Public-Payer Reimbursement Still in the Crosshairs

## Medicare Payment Cuts Becoming the Norm

### ACA's Medicare Fee-for-Service Payment Cuts

*Reductions to Annual Payment Rate Increases<sup>1</sup>*



### Not the End of the Story

“Notwithstanding recent favorable developments... Medicare still faces a substantial financial shortfall that will need to be addressed with further legislation”

*Office of the Actuary, CMS*

**\$260B**  
Hospital payment rate cuts, 2013-2022

**\$56B**  
Reduced Medicare and Medicaid DSH<sup>2</sup> payments, 2013-2022

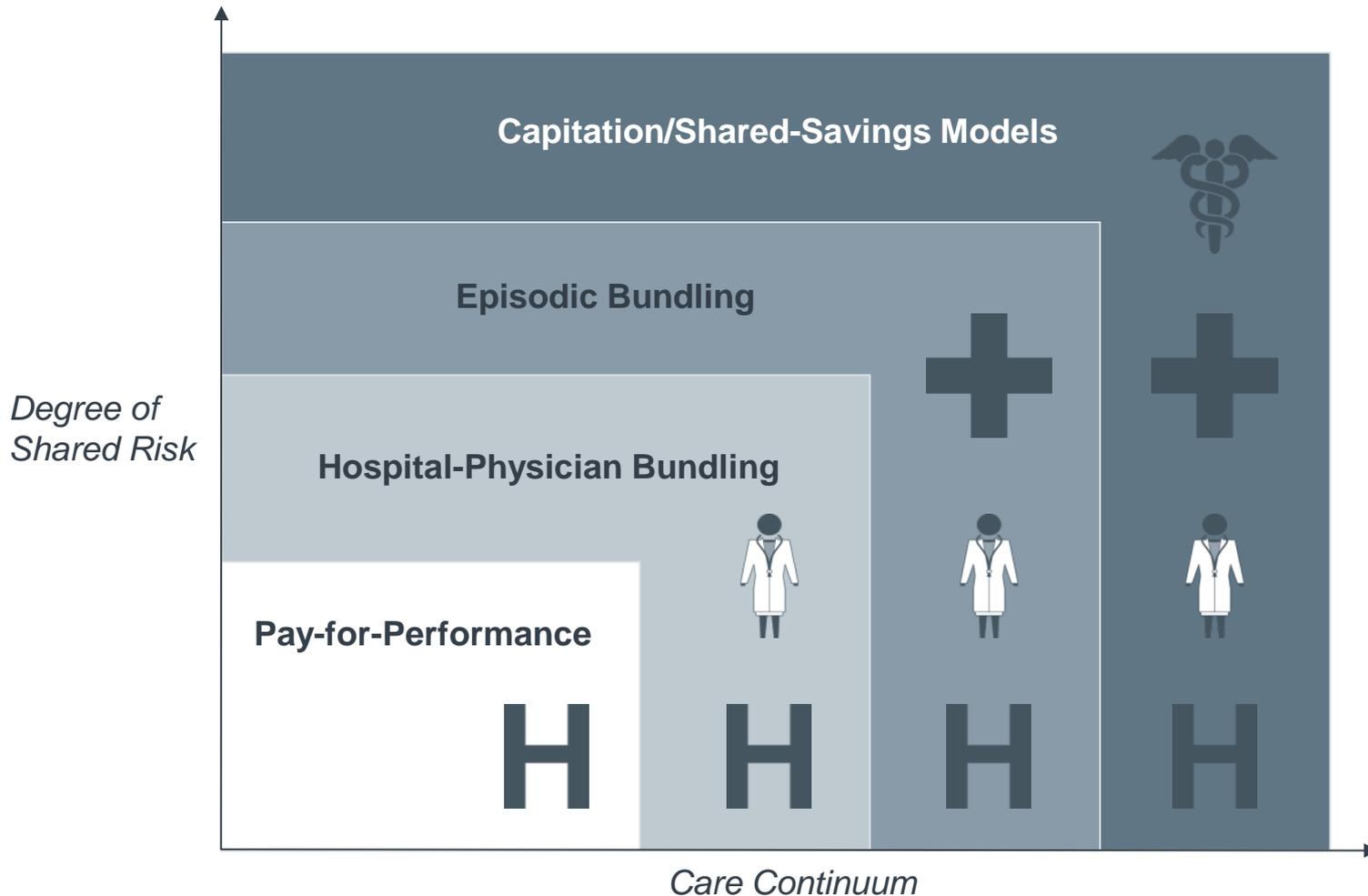
**\$151B**  
Reduced Medicare payments due to sequestration and 2013 budget bill

1) Includes hospital, skilled nursing facility, hospice, and home health services; excludes physician services.  
2) Disproportionate Share Hospital.

1) Source: CBO, "Letter to the Honorable John Boehner Providing an Estimate for H.R.6079, The Repeal of Obamacare Act," July 24, 2012; CBO, "Estimated Impact of Automatic Budget Enforcement Procedures Specified in the Budget Control Act," September 12, 2011; CBO, "Bipartisan Budget Act of 2013," December 11, 2013, all available at: [www.cbo.gov](http://www.cbo.gov); Advisory Board interviews and analysis.

# Shifting Risk and Accountability to Providers

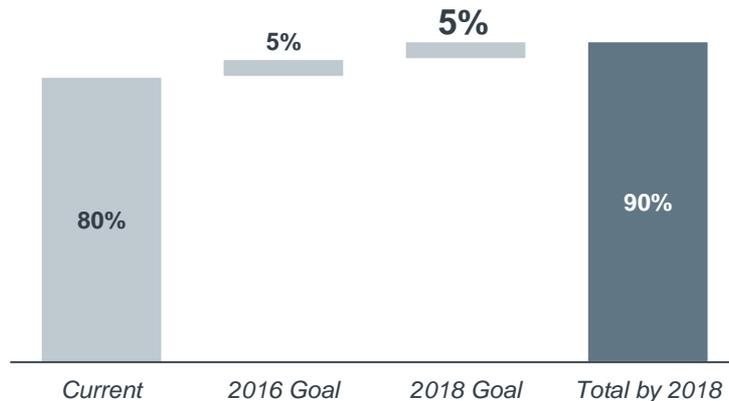
## Providing an Incentive to Remake the Delivery System



# HHS Doubling Down on Value-Based Payment Models

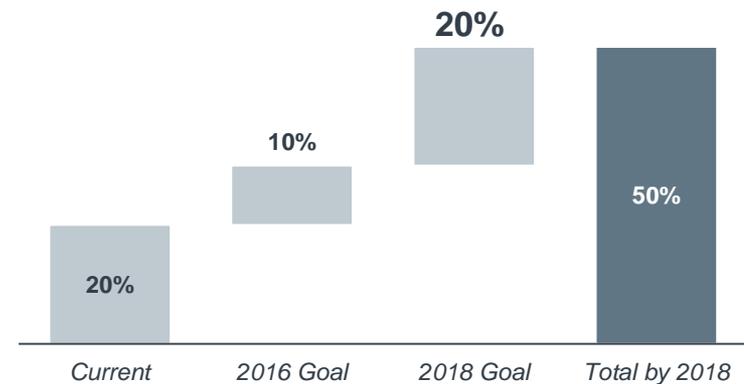
## Aiming to Increase Pay-for-Performance in Traditional FFS

Percentage of Medicare FFS Payments Tied to Quality, Efficiency



## Aggressive Expansion Targets for Alternative Payment Methodologies

Percentage of Medicare Payments Made Through Alternative Payment Models



Hospital-Acquired Condition Reduction Program



Hospital Value-Based Purchasing Program



Hospital Readmissions Reduction Program



Medicare Shared Savings Program



Bundled Payment for Care Initiative



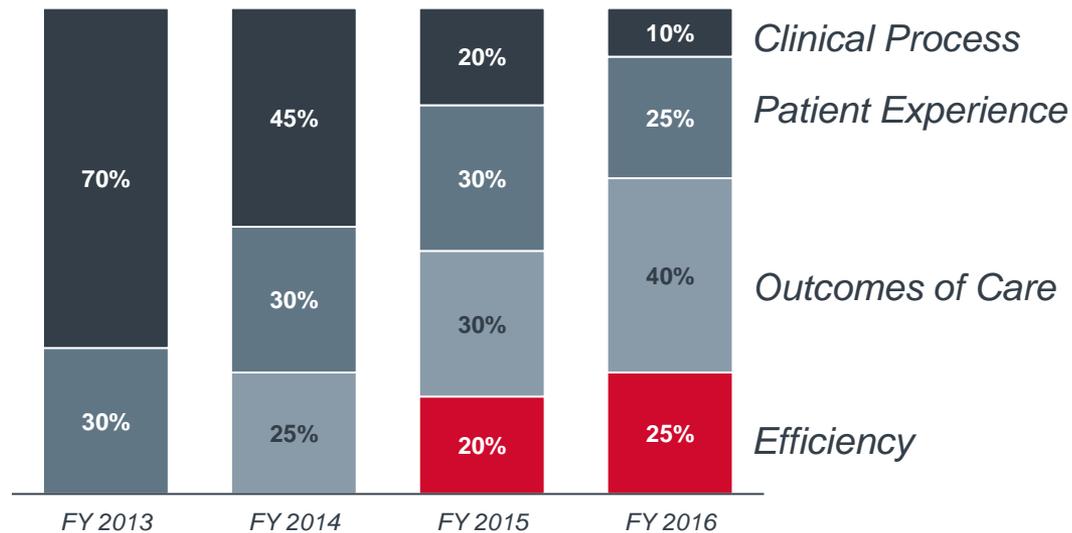
Patient-Centered Medical Home

Source: HHS, "Progress Towards Achieving Better Care, Smarter Spending, Healthier People," available at: <http://www.hhs.gov/>, accessed February 2015; Health Care Advisory Board interviews and analysis.

# Raising the Bar for Value-Based Payment

## More Mandatory Risk On the Horizon

### Medicare VBP<sup>1</sup> Program Domain Weights



**6%**  
 Medicare revenue at risk from mandatory pay-for-performance programs<sup>2</sup>, FY 2017

1) Value-Based Purchasing.  
 2) Includes Value-Based Purchasing Program, Hospital Readmissions Reduction Program, and Hospital-Acquired Conditions Program.

Source: The Advisory Board Company, "Mortality Rates Are Only One of Many VBP Changes to Come," December 4, 2013, available at: [www.advisory.com](http://www.advisory.com); CMS, "Request for Information on Specialty Practitioner Payment Model Opportunities," February 2014, available at: [www.innovation.cms.gov](http://www.innovation.cms.gov); Advisory Board interviews and analysis.

# Redefining the Acute Care Episode

## Bundled Payments Drive Delivery System Integration

### Bundled Payment Framework

*Lump Sum Payments Drive Integration Through Shared Accountability*



Payer



Doctor Services



Hospital Services



Post-Acute Services



### Program in Brief: Medicare's Bundled Payments for Care Improvement

- CMMI<sup>1</sup> initiative offering four voluntary bundled payment models; 6,000+ providers participating as of August 2014
- Models 1-3 provide retrospective reimbursement; Models 2 and 3 include post-episode reconciliation; Model 4 offers single prospective payment
- Acute care hospitals, doctor groups, health systems eligible for all models; post-acute facilities may participate without hospitals in Model 3
- Doctors eligible for gainsharing bonuses up to 50 percent of traditional fee schedule
- For all models, applicants proposed quality measures, which CMS used to develop standardized set of metrics

1) Center for Medicare and Medicaid Innovation.

Source: Centers for Medicare and Medicaid Services; Advisory Board interviews and analysis.

# Large Employers Eying Bundling Models

## Walmart Shopping Carefully for High-Cost Acute Care Services

### Walmart Centers of Excellence Partners

- Cleveland Clinic
- Geisinger Medical Center
- Mayo Clinic
- Mercy Hospital Springfield
- Scott & White Memorial Hospital
- Virginia Mason Medical Center



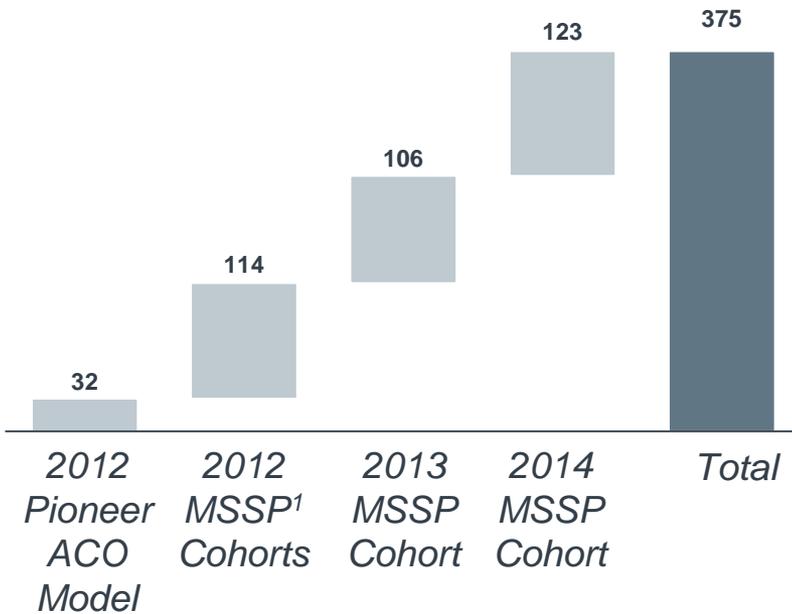
### Case in Brief: Walmart Centers of Excellence

- Walmart entered into bundled payment agreements with six health systems covering heart, spine, and transplant surgeries
- Program launched in January 2013; includes 1.1 million covered lives
- Providers selected based on convenience, quality, and potential for cost savings

# ACOs Reaching a Tipping Point

## Dismal Outlook for Fee-for-Service Motivating a Look at Risk-Based Options

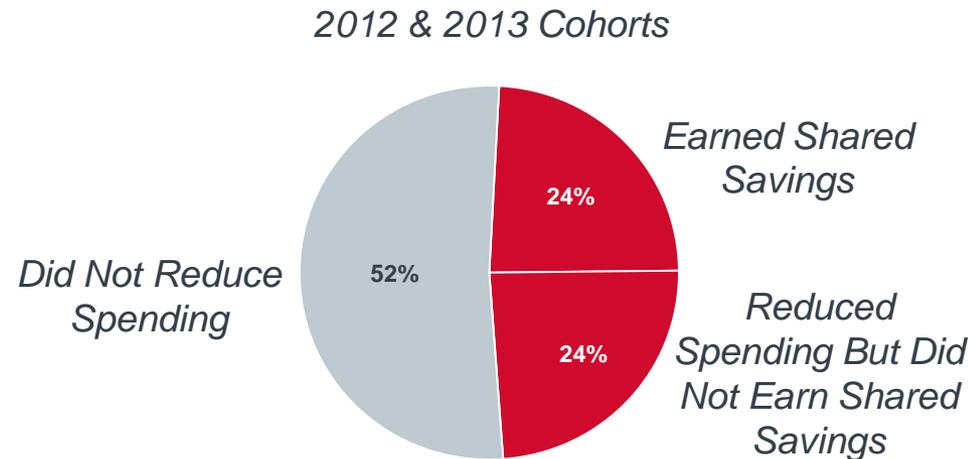
### Medicare ACO Program Entrants



**1 in 10**

Medicare FFS beneficiaries attributed to an ACO

### First-Year Spending Reduction By MSSP<sup>1</sup> ACOs



**\$300M**  
 Shared savings earned by 2012 & 2013 MSSP ACOs in first year

1) Medicare Shared Savings Program.

Source: CMS, "More Partnerships Between Doctors and Hospitals Strengthen Coordinated Care for Medicare Beneficiaries," December 23, 2013; Advisory Board interviews and analysis.

# Applying Total Cost Accountability to Fee-for-Service

## Mechanics of the Medicare Shared Savings Program



### Program in Brief: Medicare Shared Savings Program

- Cohorts launched April 2012, July 2012, January 2013, January 2014, January 2015; contracts to last minimum of three years
- Doctor groups and hospitals eligible to participate, but primary care doctors must be included in any ACO group
- Participating ACOs must serve at least 5,000 Medicare beneficiaries
- Bonus potential depends on Medicare cost savings, quality metrics
- Two payment models available: one with no downside risk, the second with downside risk in all three years

### Shared Savings Payment Cycle

- 1


**Assignment**  
Patients assigned to ACO based on terms of contract
- 2


**Billing**  
Providers bill normally, receive standard fee-for-service payments
- 3


**Comparison**  
Total cost of care for assigned population compared to risk-adjusted target expenditures
- 4


**Shared Savings Payment**  
Bonuses or penalties levied based on variance of expenditures from target
- 5


**Distribution**  
ACO responsible for dividing bonus payments among stakeholders

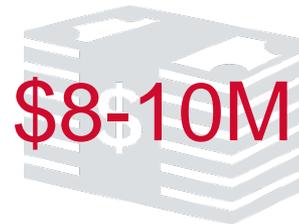
# ACOs Courting Large Employers

## Employers Starting to Shop for Care Management Expertise

### Intel-Presbyterian Partnership



Covered lives in contract



Projected savings, 2013-2017



#### Narrowing of Health Plan Options

Intel reducing number of health plan options from 8 to 4; two remaining plans are narrow networks of PHS<sup>1</sup> providers



#### Shared Accountability

Upside and downside risk for health care spending compared to projected target



#### Customized Care Offerings

Addition of depression screening into customary provider workflow



#### Infrastructure for Care Management

Conversion of Intel's on-site clinic into full service patient-centered medical home



### Case in Brief: Intel Corporation

- Large multinational employer headquartered in Santa Clara, California
- Entered into narrow-network contract with Presbyterian Healthcare Services, an 8-hospital system in New Mexico, for employees at Rio Rancho plant

1) Presbyterian Healthcare Services.

# Employer-Sponsored Insurance at a Crossroads

## Will Employers Maintain Coverage, and How?

### Spectrum of Options for Controlling Health Benefits Expense



Source: Advisory Board interviews and analysis.

# High Deductibles, Narrow Networks on the Rise

## On Exchanges, Consumers Most Often Prioritizing Low-Cost Premiums

### Individual Deductibles Offered On Public Exchanges 2014

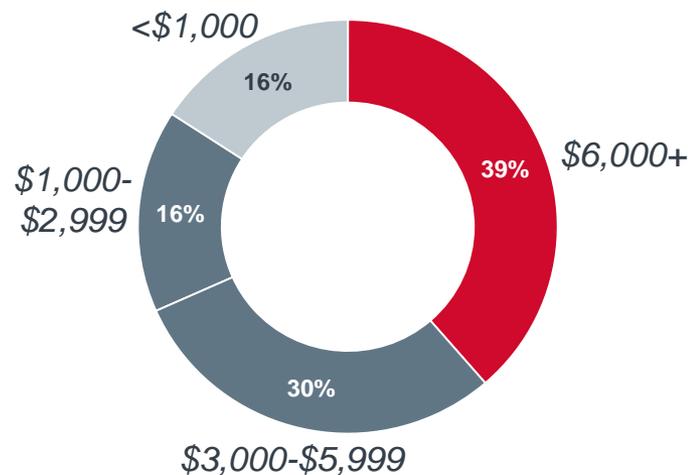
**\$2,500**

**\$6,250**

Median

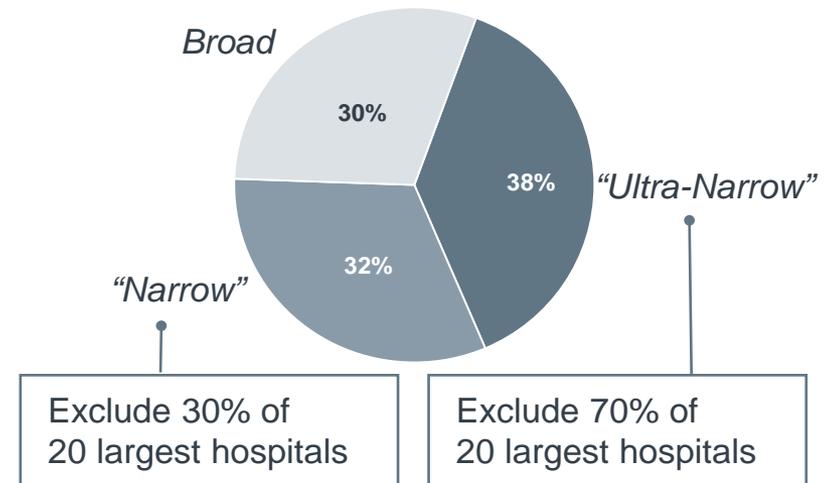
Maximum

### Individual Deductibles Chosen on eHealth Individual Marketplace



### Breadth of Hospital Networks in Exchange Plans

20 Urban Markets, December 2013



**26%**

Median premium reduction directly attributable to network narrowing<sup>1</sup>

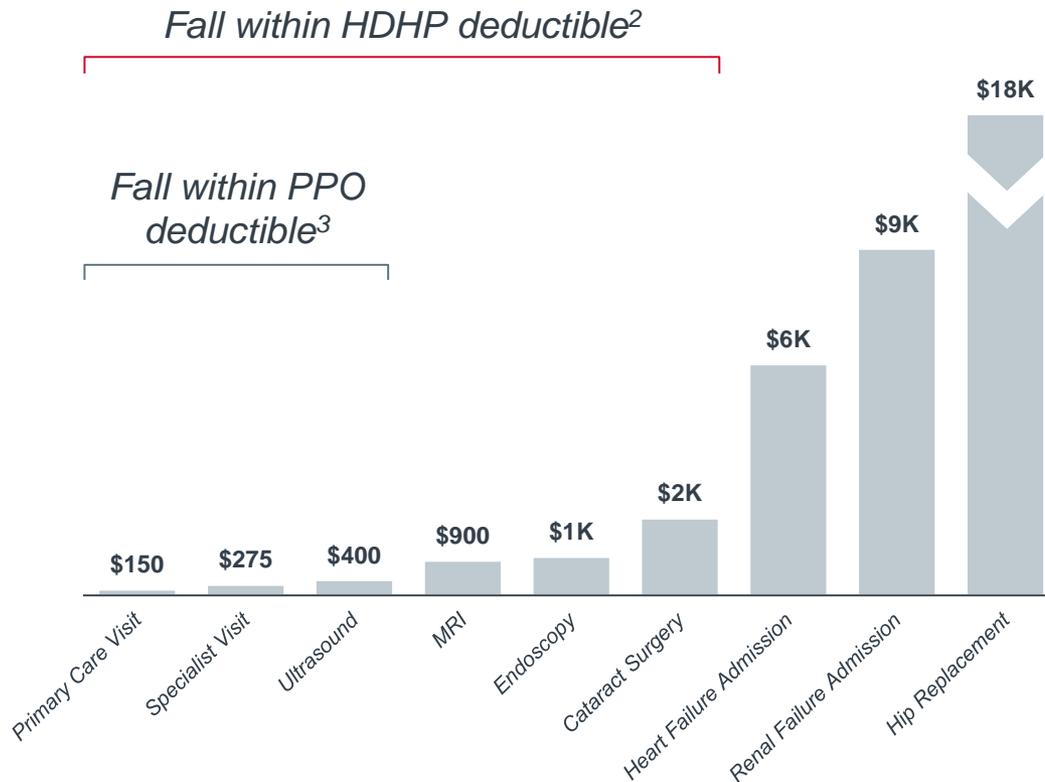
1) Comparing products by the same carrier of the same tier, across 7 carriers.

Source: Breakaway Policy Strategies, "Eight Million and Counting: A Deeper Look at Premiums, Cost Sharing and Benefit Design in the New Health Insurance Marketplaces," May 2014; eHealth, "Health Insurance Price Index Report for Open Enrollment and Q1 2014," May 2014; McKinsey & Company, "Hospital Networks: Configurations on the Exchange and Their Impact on Premiums," December 2013; Advisory Board interviews and analysis.

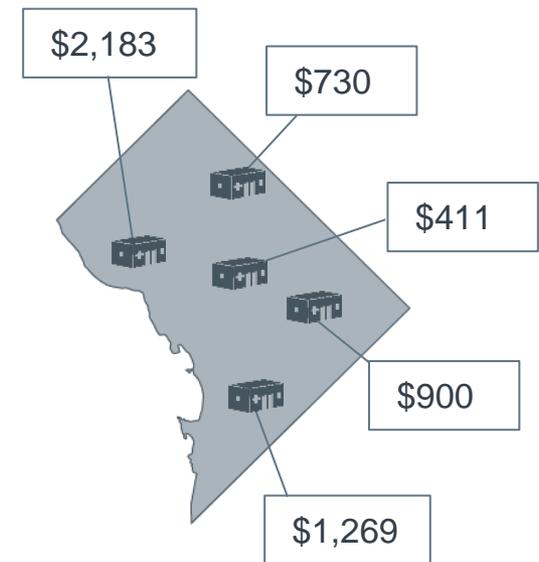
# Price Sensitivity at the Point of Care

## Cost-Conscious Behavior Affecting Pillars of Profitability

### Consumers Paying More Out-of-Pocket



### MRI Price Variation Across Washington, DC



- Price-sensitive shoppers will be acutely aware of price variation
- MRI prices range from \$400 to \$2,183

1) High-deductible health plan.  
 2) \$2,086; based on KFF report of average HDHP deductible.  
 3) \$733; based on KFF report of average PPO deductible.

Source: KFF, "2012 Employer Health Benefits Survey," available at: [www.kff.org](http://www.kff.org); New Choice Health, "New Choice Health Medical Cost Comparison," available at: [www.newchoicehealth.com](http://www.newchoicehealth.com); Healthcare Blue Book, "Healthcare Pricing," available at: [www.healthcarebluebook.com](http://www.healthcarebluebook.com); Kliff S, "How much does an MRI cost? In D.C., anywhere from \$400 to \$1,861," Washington Post, March 13, 2013, available at: [www.washingtonpost.com](http://www.washingtonpost.com); Advisory Board interviews and analysis.

# Walmart Bringing Everyday Low Prices to Health Care

## Low-Cost Access Potentially Just the Beginning

### Care Clinic Model



#### Pricing:

**\$4** For Walmart employees

**\$40** For Walmart customers

#### Hours:

Weekdays	Saturday	Sunday
8AM-8PM	8AM-5PM	10AM-6PM

#### Service:



- Two nurse practitioners provide primary care services on site
- Clinic refers to external specialists, hospitals as appropriate

### Probably Worth Paying Attention



“Our goal is to be the number one health-care provider in the industry.”

*Labeed Diab*  
*President of Health & Wellness*  
**Walmart**

**130M**  
 Annual emergency department visits

**150M**  
 Weekly visits to Walmart stores

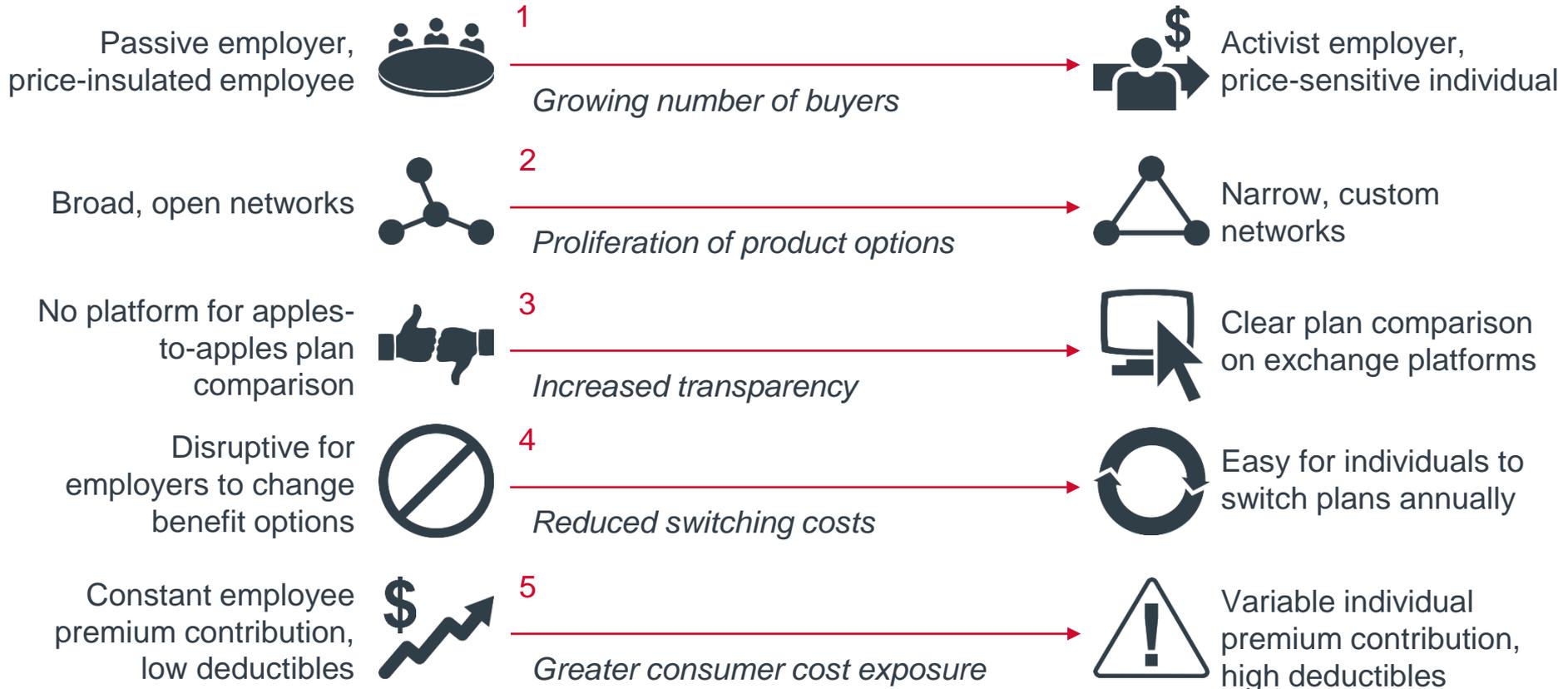
Source: Canales MW, “Wal-Mart Opening Clinic in Cove,” Killeen Daily Herald, April 18, 2014, available at: [www.kdhnews.com](http://www.kdhnews.com); Advisory Board interviews and analysis.

# All Signs Point to a Retail Market

## New Dynamics Unfamiliar in Health Care, But Not in Broader Economy

### Traditional Market

### Retail Market



Source: Advisory Board interviews and analysis.

1

Looking to Bend the Cost Curve

2

Implications for Health Care Providers

3

Strengthening the State-Provider Partnership

# Payer Pressures Not the Only Challenge to Providers

## Financial, Clinical Trends Shifting Dramatically



### Decelerating Price Growth

- Federal, state budget pressures constraining public payer price growth
- Payments subject to quality, cost-based risks
- Commercial cost-shifting stretched to the limit



### Continuing Cost Pressure

- No sign of slower cost growth ahead
- Drivers of new cost growth largely non-accretive

### Shifting Payer Mix

- Baby Boomers entering Medicare rolls
- Coverage expansion likely boosting Medicaid eligibility
  - Disproportionate growth in demand for services from publicly insured patients



### Deteriorating Case Mix

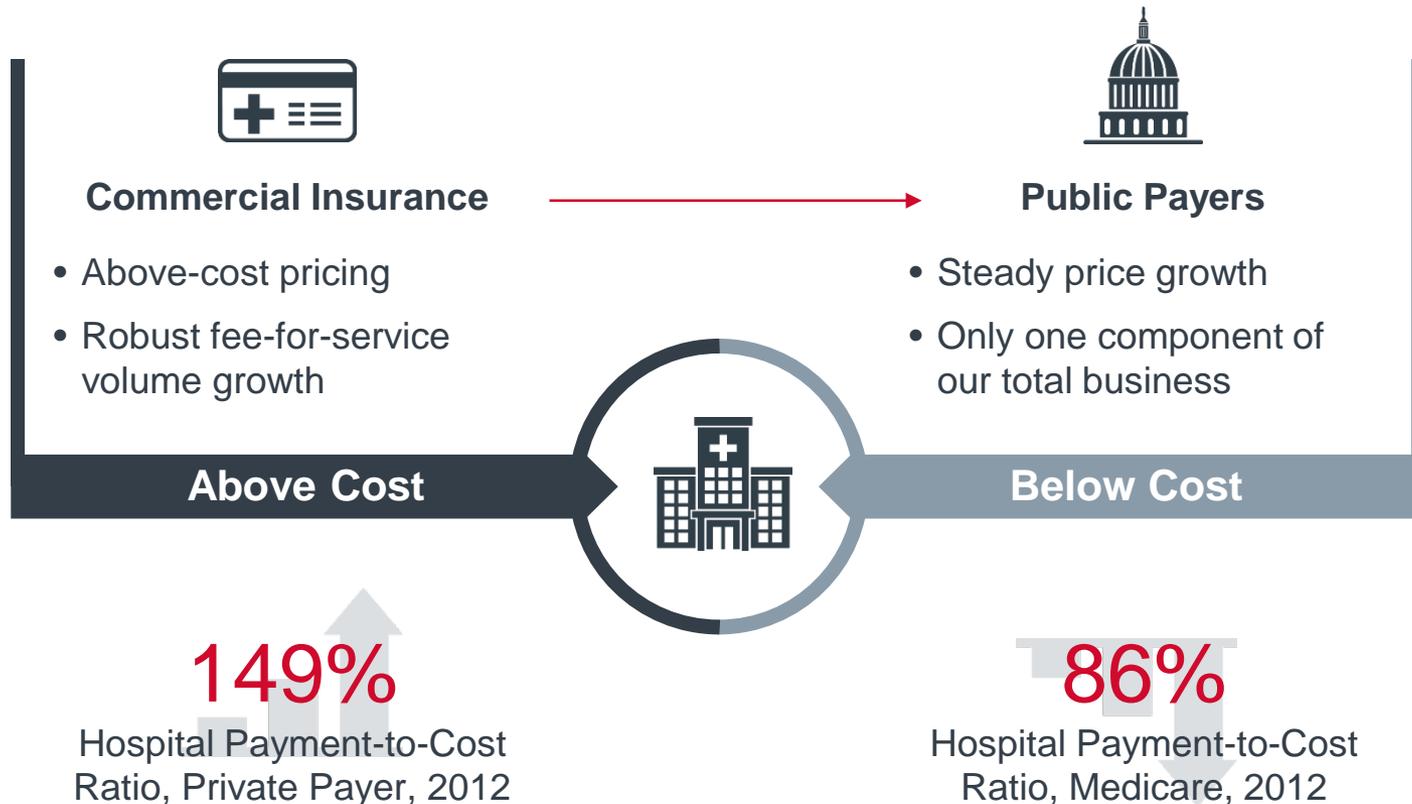
- Growing medical demand from aging population threatens to crowd out capacity for more acute therapies
- Rising incidence of chronic disease and multiple comorbidities



# Threatening a Tenuous Business Model

## Most Hospitals Staying Afloat Through Cross-Subsidization

### Traditional Hospital Cross-Subsidy



Source: American Hospital Association, "Trendwatch Chartbook 2014," available at: [www.aha.org](http://www.aha.org); Advisory Board interviews and analysis.

# Redefining the Value Proposition

## Delivering Desirable Attributes at Low Cost

### Four Imperatives for Health Care Providers

*Low Cost*

*Desirable Attributes*



#### Competitive Unit Prices

*Strategic Imperatives:*

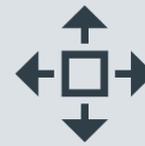
- Avoid reactive position vis-a-vis price cuts, transparency
- Radically restructure cost structures to sustain lower unit prices



#### Total Cost Control

*Strategic Imperatives:*

- Develop population health model to control cost trend
- Clearly communicate total cost advantage to potential purchasers



#### Geographic Reach and Clinical Scope

*Strategic Imperatives:*

- Match service portfolios, footprints to target purchasers
- Explore partnership strategies that strengthen market presence



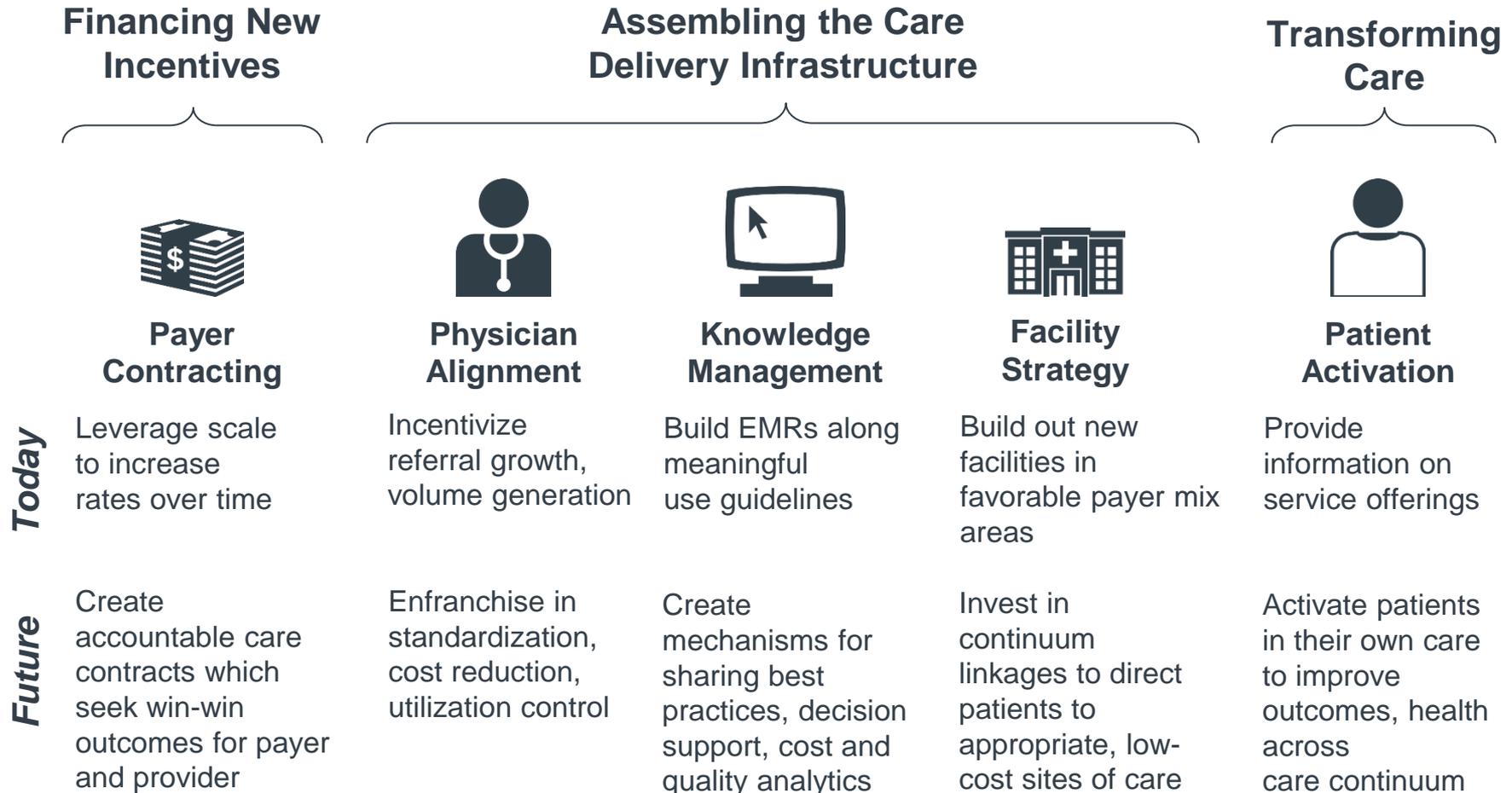
#### Clinical and Service Quality

*Strategic Imperatives:*

- Present unimpeachable clinical credentials to wholesale buyers
- Emphasize access, experience advantages to individual consumers

# Transformation Requires Wholesale Strategy Changes

## Playbook for Accountable Care



# But Transition Is Challenging

## Structural Barriers, Uncertainty Paralyzing Proactive Strategy

### Slowed by Structural Barriers...



#### Persistence of Fee-for-Service

Many health care purchasers continue to pay providers solely based on volume



#### Lack of Clinical and Performance Data

Providers, payers and other stakeholders remain hesitant to share and publish data



#### Complex Regulatory Environment

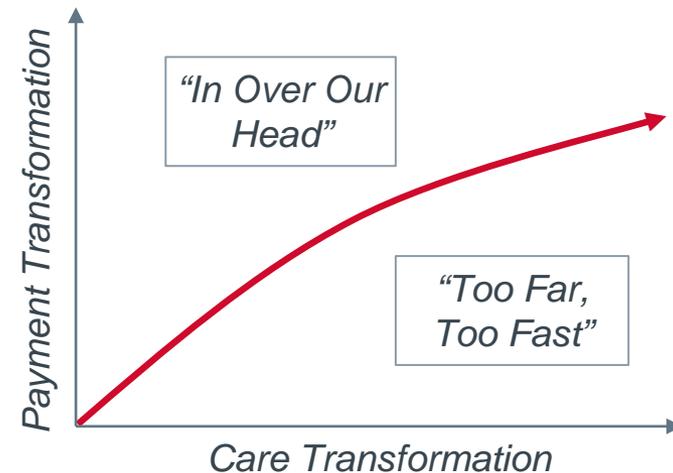
Regulatory environment adjusting to facilitate new care delivery and pay models



#### Balancing Responsibility to Community

Mission, role in community requires conservative decision making

### ...Unclear About Timing Transformation



### Charting the Path Forward

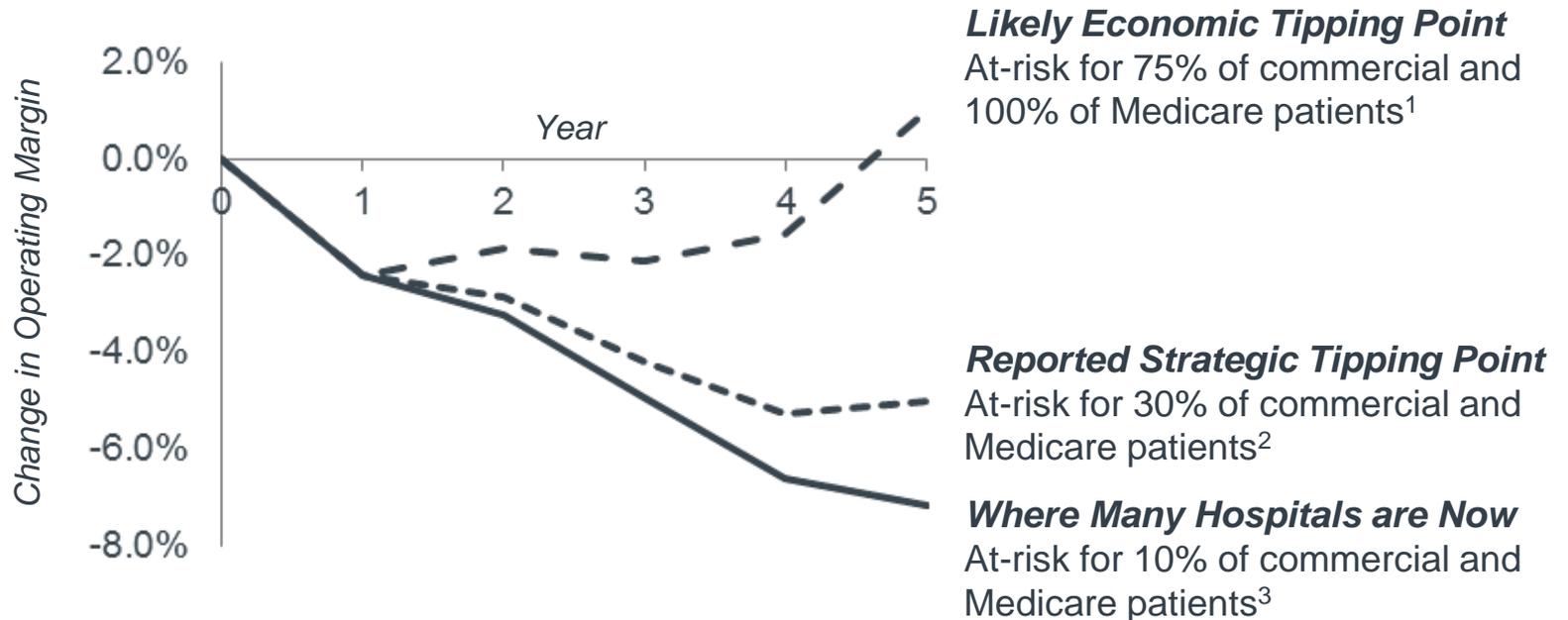
“We have a pretty good idea what the end state looks like. But we don’t know how to time it—how fast to move—and we don’t know the sequence of change or where to start.”

*CEO, Two-Hospital System in Midwest*

# Payment Models Must Align Across Payers

## Population Health Incentives Only Strong Enough When Pervasive

### Impact of Risk-Based Contract Prevalence on Operating Margin



- 1) 75% of commercial and 100% of Medicare patients attributed under shared savings contracts.
- 2) 30% of commercial and 30% of Medicare patients attributed under shared savings contracts.
- 3) 10% of commercial and 10% of Medicare patients attributed under shared savings contracts.

Source: Advisory Board analysis.

1

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Strengthening the State-Provider Partnership

# State Role Critical to Successful Transformation

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## Shared Goals, Incentives Offer Partnership Opportunity

### State Governments Uniquely Positioned to Facilitate Change



#### *Purchaser*

- Use value-based payment for state-funded activity (e.g., shifting Medicaid, state employees, etc. to ACOs, bundles, etc.)
- Address expansion of coverage to uninsured (e.g., Medicaid expansion, state-run programs)
- Establish and expand payments for high-value services (e.g., care management, telehealth, etc.)



#### *Regulator*

- Modernize scope of practice to ensure practice at top of licensure
- Promote data sharing and transparency (e.g., establish or fund HIE, all-payer claims database, etc.)
- Enable framework for value-driven integration by providing clear guidelines on provider partnerships, etc.



#### *Convener*

- Facilitate multi-payer alignment for payment incentives and quality measures incentives (e.g., employer/commercial payer contracting with providers)
- Support clinical workforce development through training, funding, education
- Build community models for integrated social and clinical services (e.g., housing, transportation, nutrition, behavior, etc.)

# Oregon Model for Better Health, Lower Costs

State of Oregon



Coordinated Care Organization (CCO)

- 16 CCOs
- Regional footprints
- Supported by 1115 waiver, SIM<sup>1</sup> grant, etc.



Primary and Specialty Physicians



Hospitals and Health Systems



Behavioral Health Providers



Dental Providers



Community Organizations



Participating Populations

Medicaid | State Employees | Others



1) State Innovation Model.

# Two Years In, Oregon CCOs Generating Results

## Quality, Cost of Care Improving for Medicaid Beneficiaries in Program

### Initial Results Promising

**-5.7%**

Change in inpatient cost, per member per month, 2011-2013

**+55%**

Change in percentage of patients enrolled in PCMH<sup>1</sup>, 2012-2014<sup>2</sup>

**-21%**

Change in ED visits, per capita, 2011-2014<sup>3</sup>

**-48%**

Change in adult inpatient stays for COPD<sup>4</sup>, per capita, 2011-2014<sup>3</sup>

“

### Staying Within Budget

“[F]inancial data indicates coordinated care organizations are continuing to hold down costs. Oregon is staying within the budget that meets its commitment to the Centers for Medicare and Medicaid Services **to reduce the growth in spending by two percentage points** per member, per year.”

*Oregon Health Authority  
“Oregon’s Health System Transformation:  
2014 Mid-Year Report”*

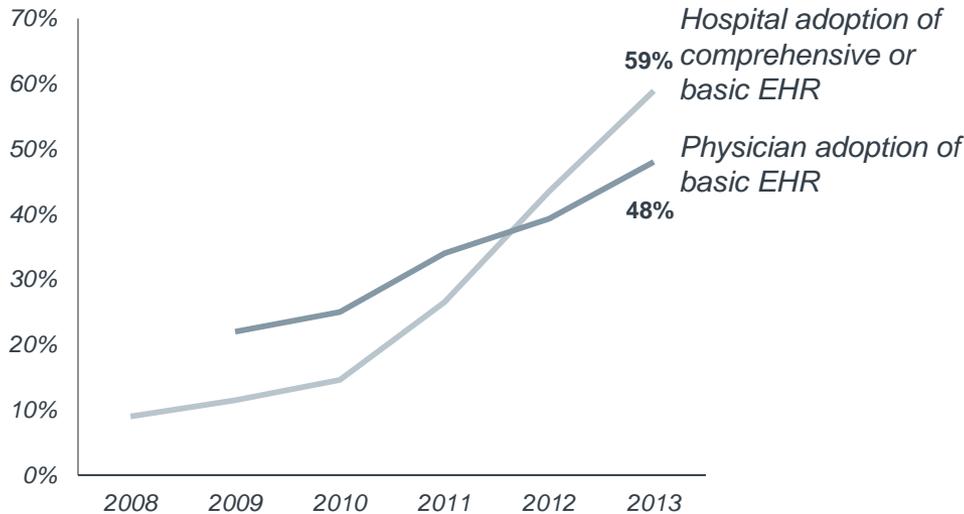
- 1) Patient-center medical home.
- 2) 2014 data as of September 2014.
- 3) Figures compare data from calendar year 2011 to 12-month period from July 2013-June 2014.
- 4) Chronic obstructive pulmonary disease.

Source: Oregon Health Authority, “Oregon’s Health System Transformation: 2014 Mid-Year Report,” available at [www.oregon.gov](http://www.oregon.gov), accessed Jan. 14, 2015; Advisory Board interviews and analysis.

# Federal Incentive Program Driving EHR Adoption

## Kentucky Providers Have Earned Over \$450 Million Under Program

### Provider Adoption of EHR Systems Nationally



### Payments to Kentucky Providers Through EHR Incentive Program

**\$139M** → **5,598**  
 Payments to Kentucky eligible professionals<sup>1</sup>, Jan. 2011-Dec. 2014  
 Kentucky eligible professionals receiving payments

**\$325M** → **94**  
 Payments to Kentucky hospitals, Jan. 2011-Dec. 2014  
 Kentucky hospitals receiving payments

1) Eligible professionals include physicians, dentists, chiropractors, nurse practitioners, nurse-midwives, and certain physician assistants.

Source: Adler-Milstein J, et al., "More Than Half of US Hospitals Have At Least a Basic EHR, But Stage 2 Criteria Remain Challenging for Most," *Health Affairs*, August 2014, available at: [www.healthaffairs.org](http://www.healthaffairs.org); Furukawa M, et al., "Despite Substantial Progress in EHR Adoption, Health Information Exchange and Patient Engagement Remain Low in Office Settings," *Health Affairs*, August 2014, available at: [www.healthaffairs.org](http://www.healthaffairs.org); CMS, "Unique Count of Providers by State," available at: [www.cms.gov](http://www.cms.gov); CMS, "Combined Medicare and Medicaid Payments by State," available at: [www.cms.gov](http://www.cms.gov); Advisory Board analysis.

# Shift to Value Supported by Advances in Health IT

## Improved Access to Data, Interoperability Key to Success of New Models



### Continued EHR Adoption

Shift from incentive payments to penalties and adoption of Stage 3 Meaningful Use rules will drive continued adoption and improvement of EHRs

### Data Exchange/Interoperability

ONC developing Interoperability Roadmap to establish framework for overcoming technical and competitive barriers to flow and use of health information



### Data Transparency

CMS, states, and private insurers pursuing efforts to collect and distribute data on cost and quality of care

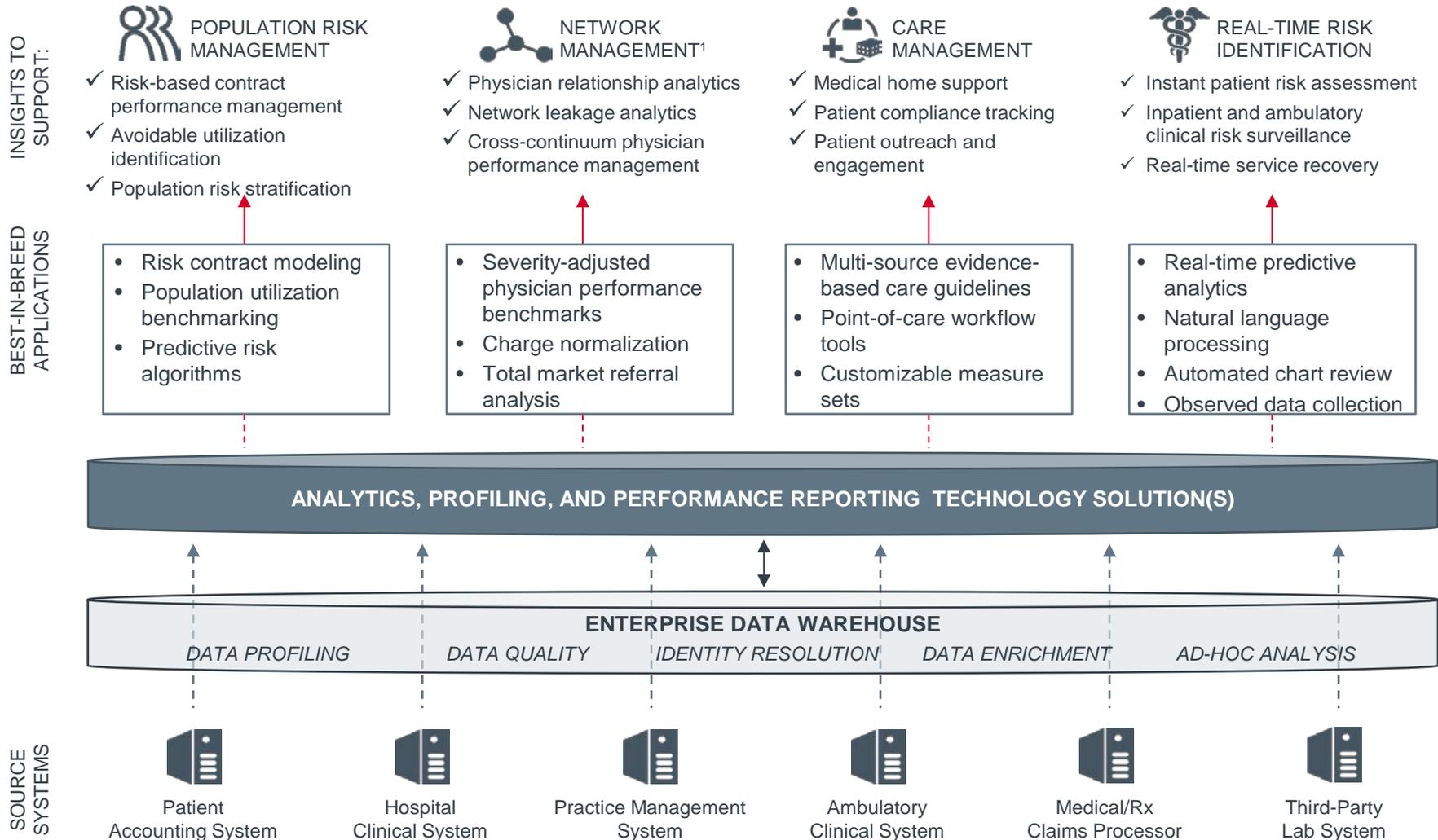
### Improved Quality Metrics

Public- and private- sector stakeholders shifting from process-focused to outcomes-focused measures and seeking to align measures across all payers



# Transformative Information from Multiple Data Sources

*New models requires both different and more comprehensive information*



# Applying results against established Benchmarks

## Leveraging data to derive insights and drive fundamental changes

### Synthesizing Data from Multiple Sources

#### Hospital Financial and Clinical Data

- Inpatient*
- Charges/patient billing
  - Core measures
  - Physician roster

- Outpatient*
- ED
  - Outpatient Surgery
  - Observation

- Ambulatory*
- Office-based PMIS, CPT2 codes
  - Point-of-care registry
  - Office-based EMR

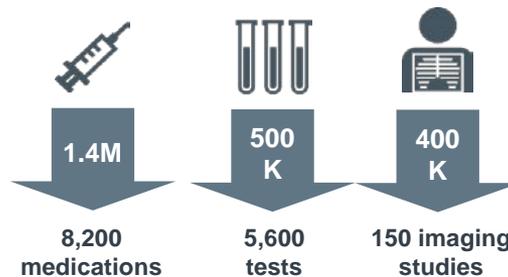
#### Payer and Employer Data

- Medical Claims
- Prescription Drug Claims
- Eligibility Files
- HRA and Biometric Data (Optional)

### Delivering Unparalleled Utilization Benchmarks

**Charge normalization** enabling physician performance comparisons based on treatment of “like” cases

- Benchmark resource utilization of charge items against cohort-wide database with billions of orders



- Drill down to get a detailed view of performance by item and by day of stay
- Compare subspecialist performance to hundreds (even thousands) of physicians nationally
- Push local physicians to elevate performance by comparing to top-decile physicians treating like cases

### Leveraging National Insights to Drive Local Change



#### Treating High-Risk Conditions

*Insight Highlight:* Geriatricians consistently treat CHF patients at lower cost and with better outcomes.

#### Identifying Suboptimal Practice Patterns

*Insight Highlight:* CT is used to diagnose inpatient minor severity simple pneumonia 9% of the time

#### Succeeding Under New Payment Models

*Insight Highlight:* Bundled payment hospitals must look beyond devices for savings – reducing LOS, ICU LOS and readmissions account for as much ROI

# Kentucky State Innovation

**8.57%**

ADVANCE  
PAYMENT ACO

**Advance Payment ACO Models**  
Kentucky operates 3 out of the 35 ACOs participating in the Advance Payment ACO Model; also 2 out of the 72 **Community-Based Care Transitions Program** and 14 out of 479 **Comprehensive Primary Care Initiative** sites

**128**

PILOT SITES

**Bundled Payments for Care Improvement Initiative – Model 3**

Kentucky has 128 pilot sites participating in the **Model 3** of the BPCI initiative (focus on retrospective post-acute care only)

**22**

PILOT SITES

**Bundled Payments for Care Improvement Initiative – Model 2**

Kentucky has 22 pilot sites participating in the **Model 2** of the BPCI initiative (focus on retrospective acute care hospital stay plus post-acute care)

**\$4.2M**

AWARD FUNDING

**Health Care Innovation Awards**

Kentucky received 3 Health Care Innovation Awards from CMMI during Round One of the program: **TransforMED, Vanderbilt University, and Vanderbilt University Medical Center** (represents estimated **\$8.87M** in 3-year savings)

**1.61%**

FQHC ADVANCED  
PRIMARY CARE

**Federally Qualified Health Center Advanced Primary Care Practice Demonstration**

Kentucky operates 7 out of the 434 participating sites involved in the **FQHC Advanced Primary Care Practice Demonstration**; also one of the 15 practice sites operating a CMMI **Independence at Home Demonstration** and operates 5 out of the 182 participating sites in the **Strong Start for Mothers and Newborns Initiative**

Source: Kentucky Cabinet for Health and Family Services State innovation Model (SIM) Model Design Inventory of Other CMMI Projects Operating in Kentucky.

**Q&A**

## Next Steps

- Please sign up for stakeholder workgroups in the lobby after today's meeting. Workgroups will be held on **March 24 – March 26, 2015** in Frankfort, KY
  - Workgroup agendas and any relevant materials will be distributed prior to each workgroup session
- As a reminder, the next full stakeholder meeting is scheduled for **Thursday, April 2, 2015** from **1- 4 PM** at the **Administrative Office of the Courts**, Main Conference Room, 1001 Vandalay Drive, Frankfort, KY 40601
  - An agenda and any relevant materials will be distributed prior to the meeting
- Please visit the dedicated Kentucky SIM Model Design website: <http://chfs.ky.gov/ohp/sim>
  - This website will contain a copy of Kentucky's SIM application, helpful CMS/SIM materials and resources, upcoming meeting dates, etc.
- Please contact the KY SIM mailbox at [sim@ky.gov](mailto:sim@ky.gov) with any comments or questions

### KY SIM Model Design Website



**Thank you!**