

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



**State Innovation Model (SIM) Model Design
Integrated & Coordinated Care Workgroup Kickoff Meeting**

**March 24, 2015
1 PM – 4 PM**

Agenda

- **Welcome and Introductions** 1:00 – 1:10 PM
 - **“As-Is” Integrated & Coordinated Care National and Kentucky Landscape** 1:10 – 1:30 PM
 - **National and Kentucky SIM Goals** 1:30 – 1:50 PM
 - **Workgroup Charter** 1:50 – 2:20 PM
 - *Break* 2:20 – 2:30 PM
 - **Driver Diagram Exercise** 2:30 – 3:50 PM
 - **Next Steps and Q&A** 3:50 – 4:00 PM
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Welcome and Introductions

**“As-Is” Integrated & Coordinated
Care National and Kentucky
Landscape**

State Landscape – Existing Initiatives

Multiple providers of health care in Kentucky have made advances in reforming the way that care is integrated and coordinated in their practices or system using both state-based and federal funding

Kentucky Emergency Room SMART (Supportive Multidisciplinary Alternatives & Responsible Treatment) Program

- In **September 2013**, under direction from Kentucky Governor Steve Beshear, CHFS launched an initiative within the Medicaid program that aims to reduce over-utilization of Emergency Rooms (ERs) and leverages the Kentucky Health Information Exchange (HIE).
- The state chose **16 hospitals** that ranged from small to large facilities in both urban and rural areas to participate in the program and form coordinated care teams (CCTs) within these communities to better understand and holistically treat ER “super-utilizers”.
- SMART Partners include the Department for Public Health, the Department for Medicaid Services, the Department for Behavioral Health, Developmental, and Intellectual Disabilities, the KY Hospital Association, the KY Health Department Association, and the KY Managed Care Organizations (MCO).

Comprehensive Primary Care Initiative (CPCI)

- Kentucky operates **14** Comprehensive Primary Care (CPC) practice sites within the St. Elizabeth Physicians group in the Cincinnati-Dayton Region as part of the **479** CPC total practice sites distributed across **seven** CPC regions funded by the Centers for Medicare & Medicaid Innovation (CMMI).
- CPC provides resources to help practices work with patients to provide the following five comprehensive primary care functions: (1) Access and Continuity, (2) Planned Care for Chronic Conditions and Preventive Care, (3) Risk-Stratified Care Management, (4) Patients and Caregiver Engagement, and (5) Coordination of Care Across the Medical Neighborhood.
- By participating in this program, practices are working closely with patients’ other health care providers by coordinating and managing care transitions, referrals, and information exchange.

State Landscape – Existing Initiatives (Continued)

Multiple providers of health care in Kentucky have made advances in reforming the way that care is integrated and coordinated in their practices or system using both state-based and federal funding

Medicare Community-based Care Transitions Program (CTTP)

- Kentucky operates **two** of the **72** participating sites involved in the CCTP funded by CMMI: the Green River Area Development District and the Kentucky Appalachian Transitions Services .
- The CCTP created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
- The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measurable savings to the Medicare program.

Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration

- Kentucky operated **seven** of the **434** participating sites involved in the FQHC Advanced Primary Care Practice Demonstration funded by CMMI that concluded on October 31, 2014.
- This demonstration project, operated by CMS in partnership with the Health Resources Services Administration (HRSA), tested the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for up to 195,000 Medicare patients.
- Participating FQHCs were expected to achieve Level 3 patient-centered medical home (PCMH) recognition, help patients manage chronic conditions, as well as actively coordinate care for patients. CMS is presently analyzing the demonstration data and the final results will be published on the CMS website at a later date.

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 and Kentucky SIM Goals

CMS Goals for the SIM Program

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

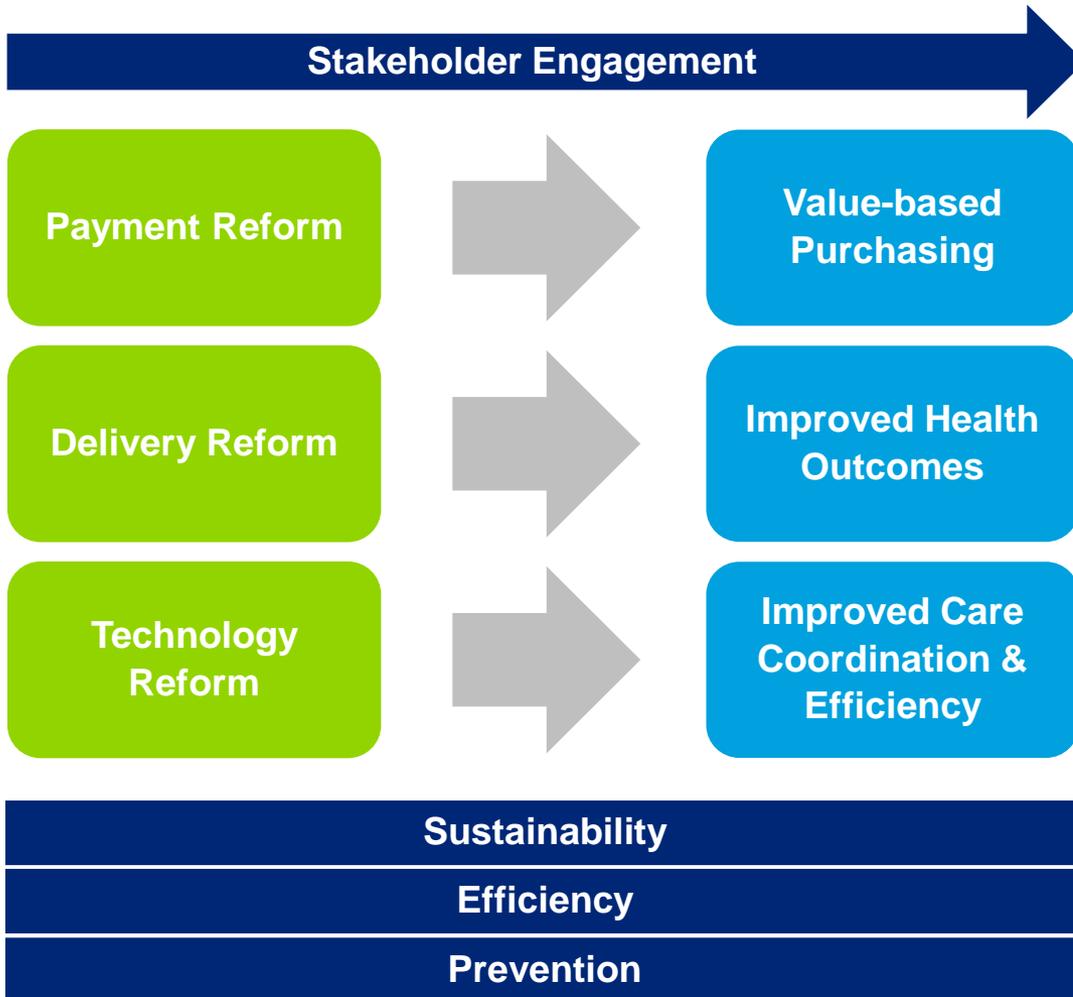
Source: CMS SIM Round Two Funding Opportunity Announcement Webinar

CMS’ Triple Aim Strategy



Kentucky's Vision for its SIM Model Design

Kentucky's Model Design will incorporate multiple payers, including Medicaid managed care organizations (MCOs), the Kentucky Employee Health Plan, insurers offering Qualified Health Plans (QHP) through kynect, and Medicare in an effort to achieve health system transformation



Goal

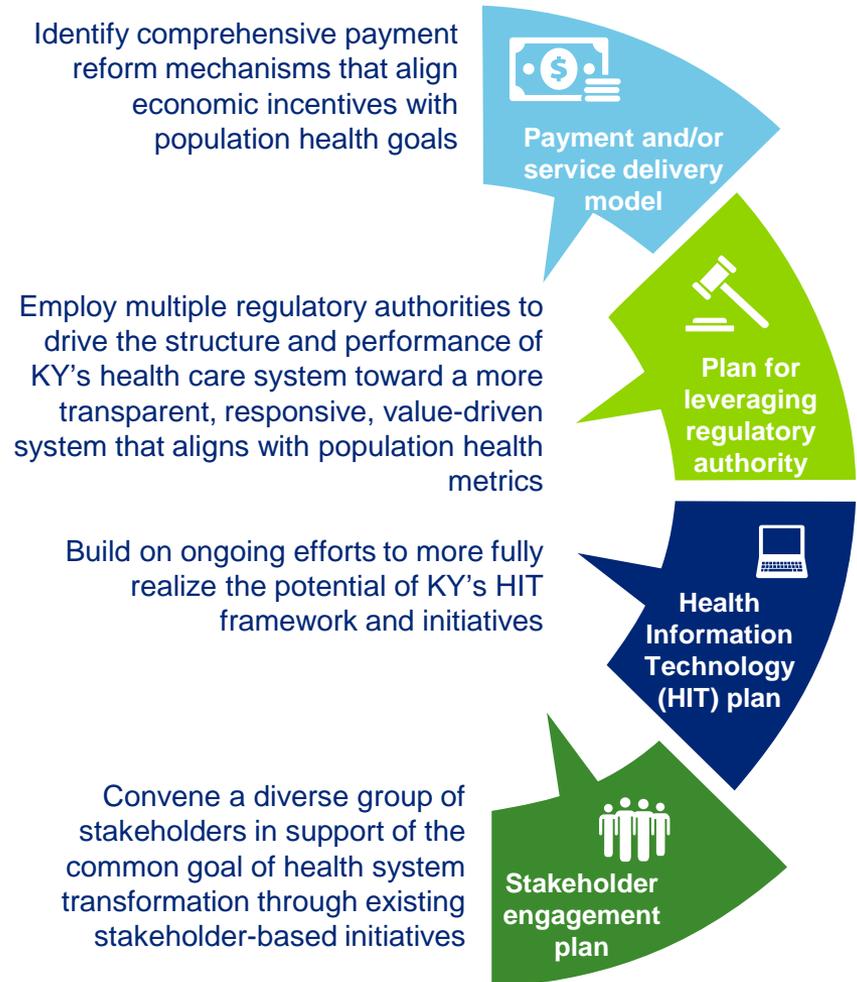
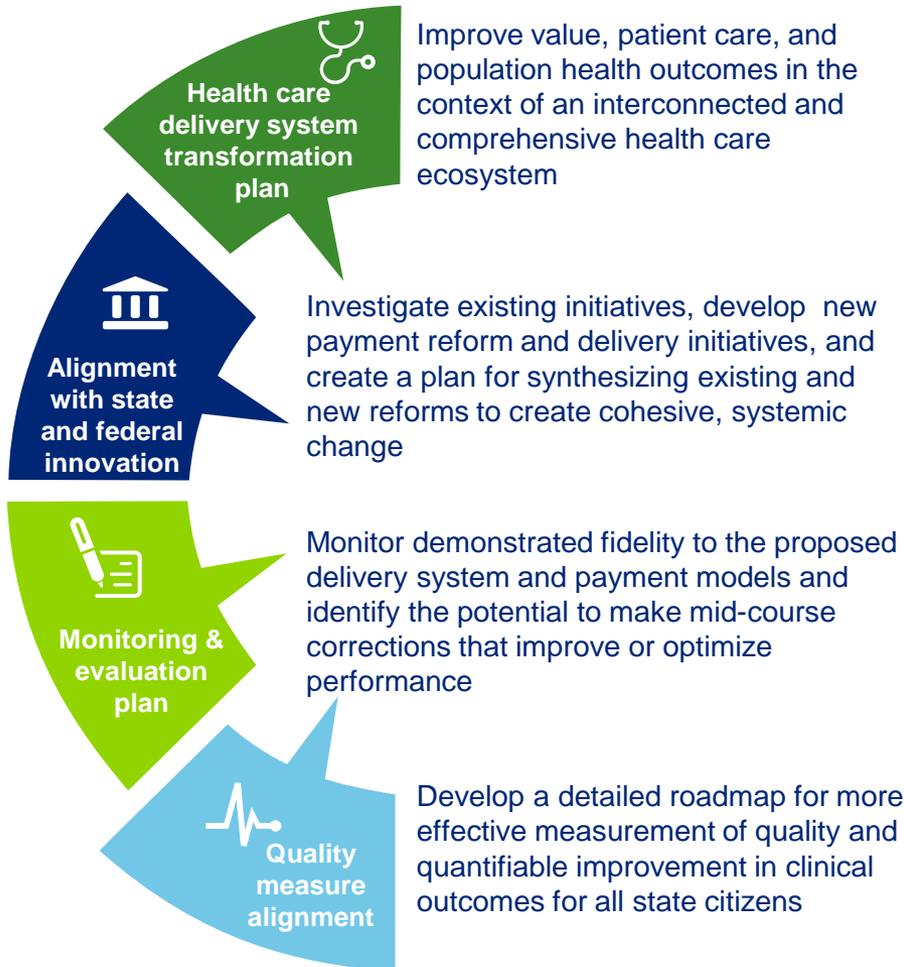
| | |
|------------------------------------|----------------|
| KY Annual Health Care Expenditures | \$28.4 B |
| CMS Savings Goal | 2% |
| Estimated Savings | \$568 M |



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.

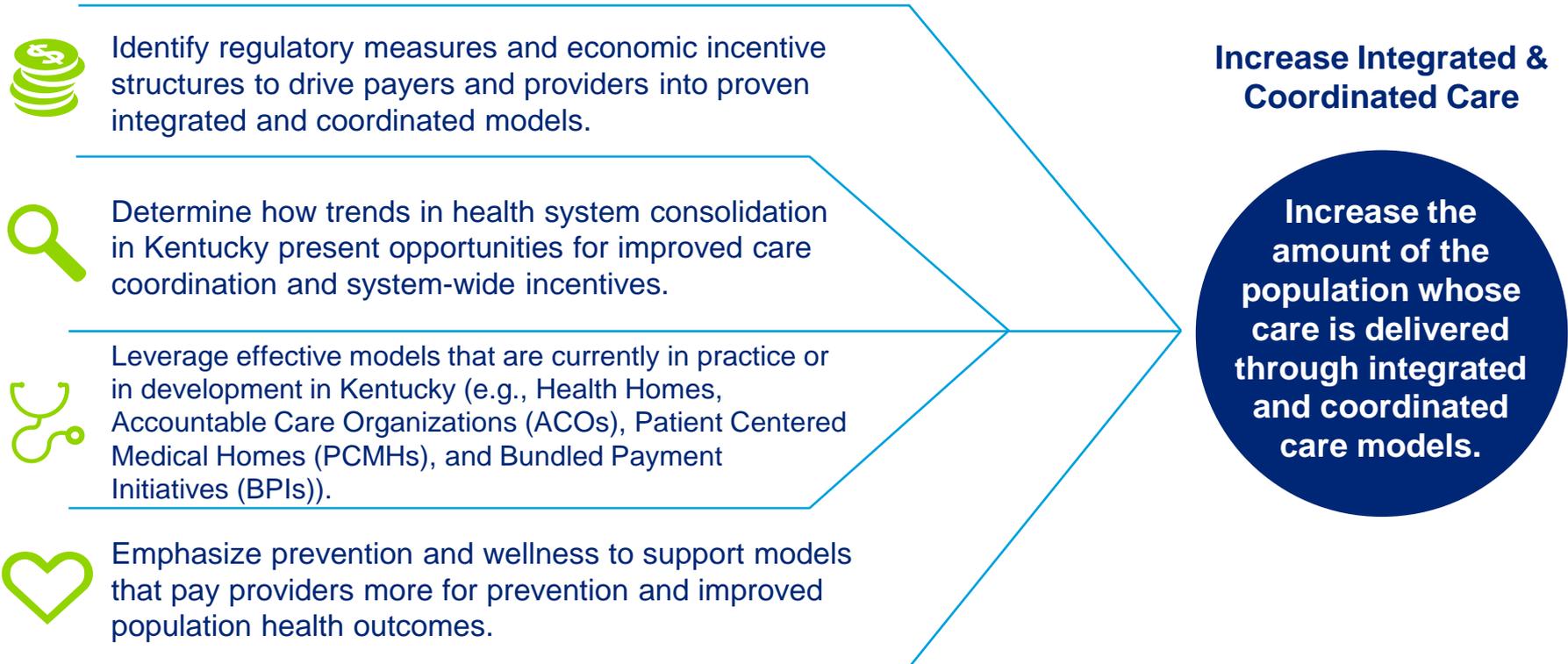
Kentucky's Vision for the State Health System Innovation Plan

The State Health System Innovation Plan (SHSIP) is the final deliverable of the SIM Model Design period and has a number of components. Kentucky will leverage existing state infrastructure and established programs to meet its goals for each plan component



Kentucky's Goals for Service Delivery Reform

Kentucky has established three primary goals with respect to health care delivery transformation, one of which is focused on increasing integrated and coordinated care models in the state

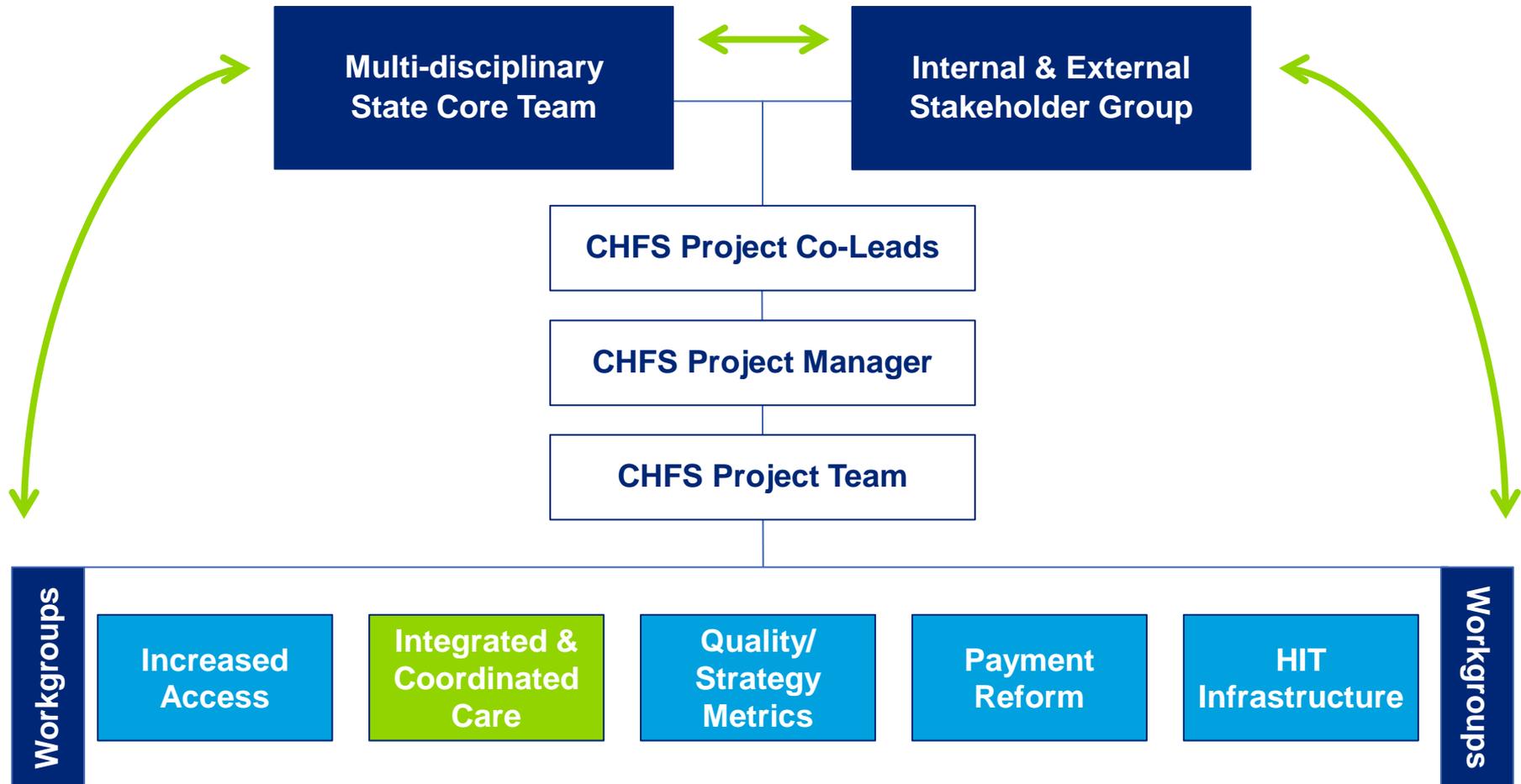


Patient-centered care should be the rule, not the exception.

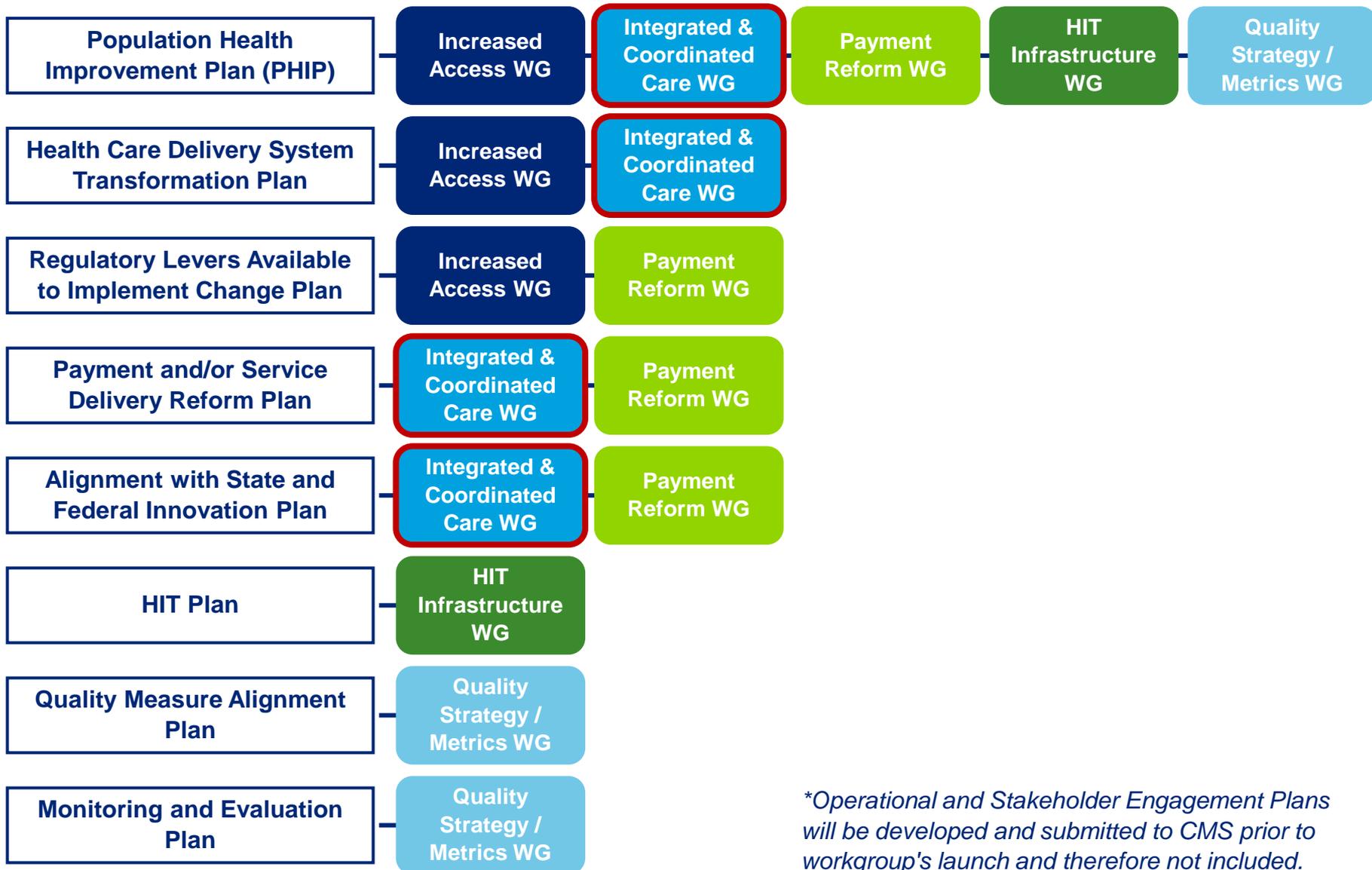
Workgroup Charter

Workgroup Process Overview

The workgroup 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



Workgroup Alignment with SHSIP Sections

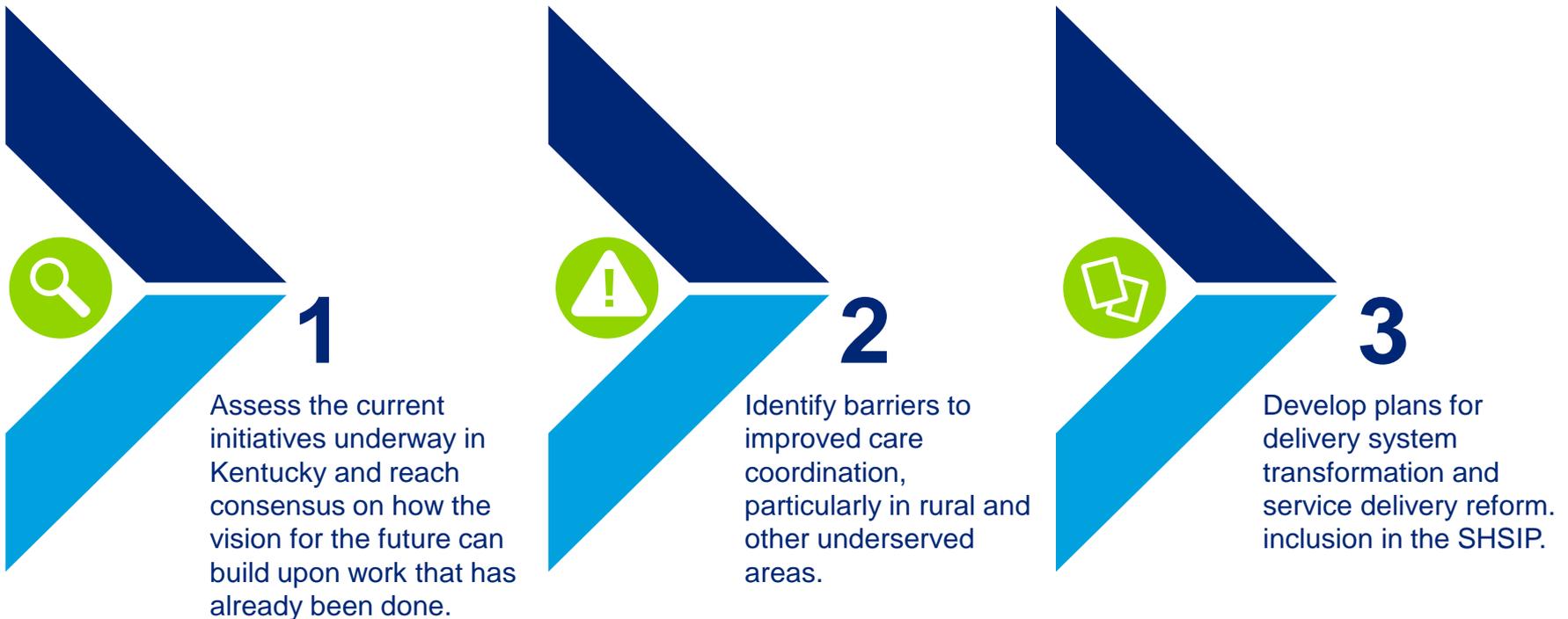


**Operational and Stakeholder Engagement Plans will be developed and submitted to CMS prior to workgroup's launch and therefore not included.*

Workgroup Roles and Responsibilities

The Integrated & Coordinated Care Workgroup will take a consensus-based approach to make recommendations for improving integrated and coordinated care in Kentucky

The primary role of the Integrated & Coordinated Care Workgroup is to develop a plan to increase the percent of the population whose care is delivered through integrated and coordinated care models.



Workgroup Timeline

An organized work plan and adherence to its steps and timeline will be critical in the development of the workgroup’s components of the Model Design

| Task | 2015 | | | | | | | | | |
|---|---------------------------|------|-----|------|------|------|------|------|------|--|
| | Mar. | Apr. | May | Jun. | Jul. | Aug. | Sep. | Oct. | Nov. | |
| | Workgroup Sessions | | | | | | | | | |
| Phase 1: Assess Current Landscape and Discuss Key Topics <ul style="list-style-type: none"> Review workgroup charter Conduct as-is review of current initiatives in Kentucky Conduct driver diagram/goal setting exercise Discuss key topics related to integrated and coordinated care: <ul style="list-style-type: none"> Effective, integrated, and coordinated care models Regulatory and economic incentive structures Health system consolidation Prevention and wellness | | | | | | | | | | |
| Phase 2: Design Plans for Health Care Delivery System Transformation, Payment and/or Service Delivery Reform, and Alignment with State/Federal Innovation <ul style="list-style-type: none"> Develop straw person outlines for relevant SHSIP components Reach consensus on plans for Health Care Delivery System Transformation, Payment and/or Service Delivery Reform, and Alignment with State/Federal Innovation | | | | | | | | | | |
| Phase 3: Review Plans for Health Care Delivery System Transformation, Payment and/or Service Delivery Reform, and Alignment with State/Federal Innovation <ul style="list-style-type: none"> Review draft plans for Health Care Delivery System Transformation, Payment and/or Service Delivery Reform, and Alignment with State/Federal Innovation Incorporate workgroup feedback into SHSIP components | | | | | | | | ★ | | |

Health Care Delivery System Transformation Plan Draft Due



Final Workgroup Meeting

Driver Diagram Exercise

Guidelines for Developing Statewide Integrated and Coordinated Care (ICC) Goals

To facilitate stakeholder commitment to the changes that SIM will require during future testing, Kentucky is taking a consensus-based approach to developing the goals and objectives for its Model Design.

Key components of each goal and objective

- Identify what will be improved, by how much, for whom, and by when
- Be bold yet attainable
- Create a focus and sense of urgency amongst providers and payers
- Derive from a data-driven and evidence-based approach
- Support improved health outcomes related to tobacco, obesity, and diabetes

Key ICC questions to consider

- How do we build on existing delivery system reform initiatives underway in KY?
- How can we increase the linkages between delivery system reforms and public health initiatives?
- How do we improve the coordination of services across delivery systems (physical health, behavioral health, long-term care)?
- How will we manage the economic disruption that delivery system reforms will create?

Specific

Measurable

Attainable

Realistic

Timely

To be successful, the stakeholder-developed goals and objectives for SIM should be consistent with the **SMART** methodology.

Driver Diagram Process Overview

Using a driver diagram exercise to clearly define a goal and its drivers will provide the workgroup with a shared view of the theory of change to Kentucky’s health care system. This “cause and effect” process will set the stage for defining the “how” elements of the SIM Model Design in alignment with CMS’ key three population health goals.

| CMS/CDC Population Health Goals |
|--|
| <ul style="list-style-type: none"> • Reduce the rate of tobacco use statewide • Reduce the incidence of obesity statewide • Reduce the incidence of diabetes statewide |



Current Drivers

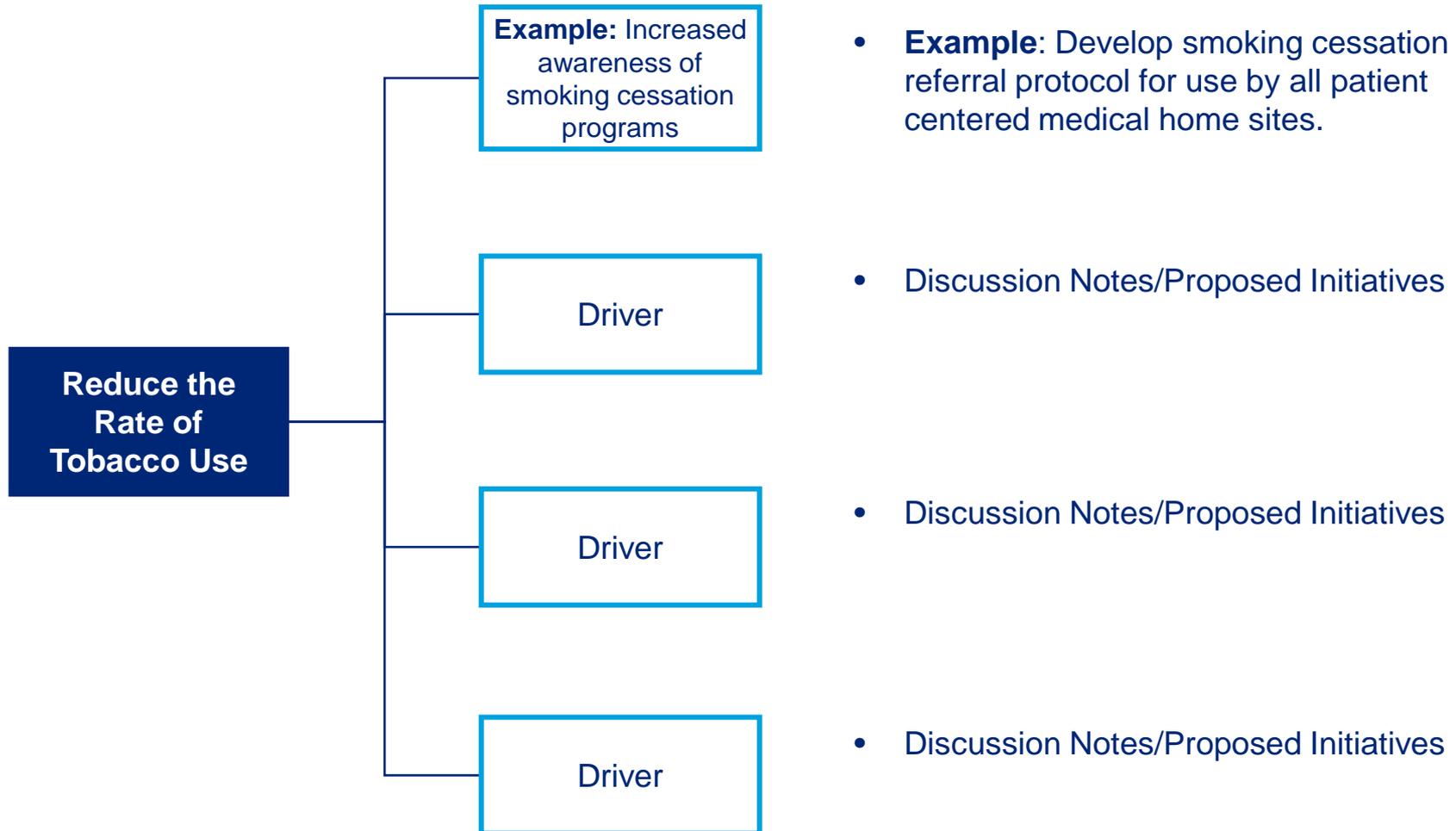
- What are the current drivers of high tobacco use, obesity rates, and diabetes incidences in Kentucky?

SIM Initiatives

- What initiatives can this workgroup develop that would positively impact those drivers from an integrated and coordinated care perspective?

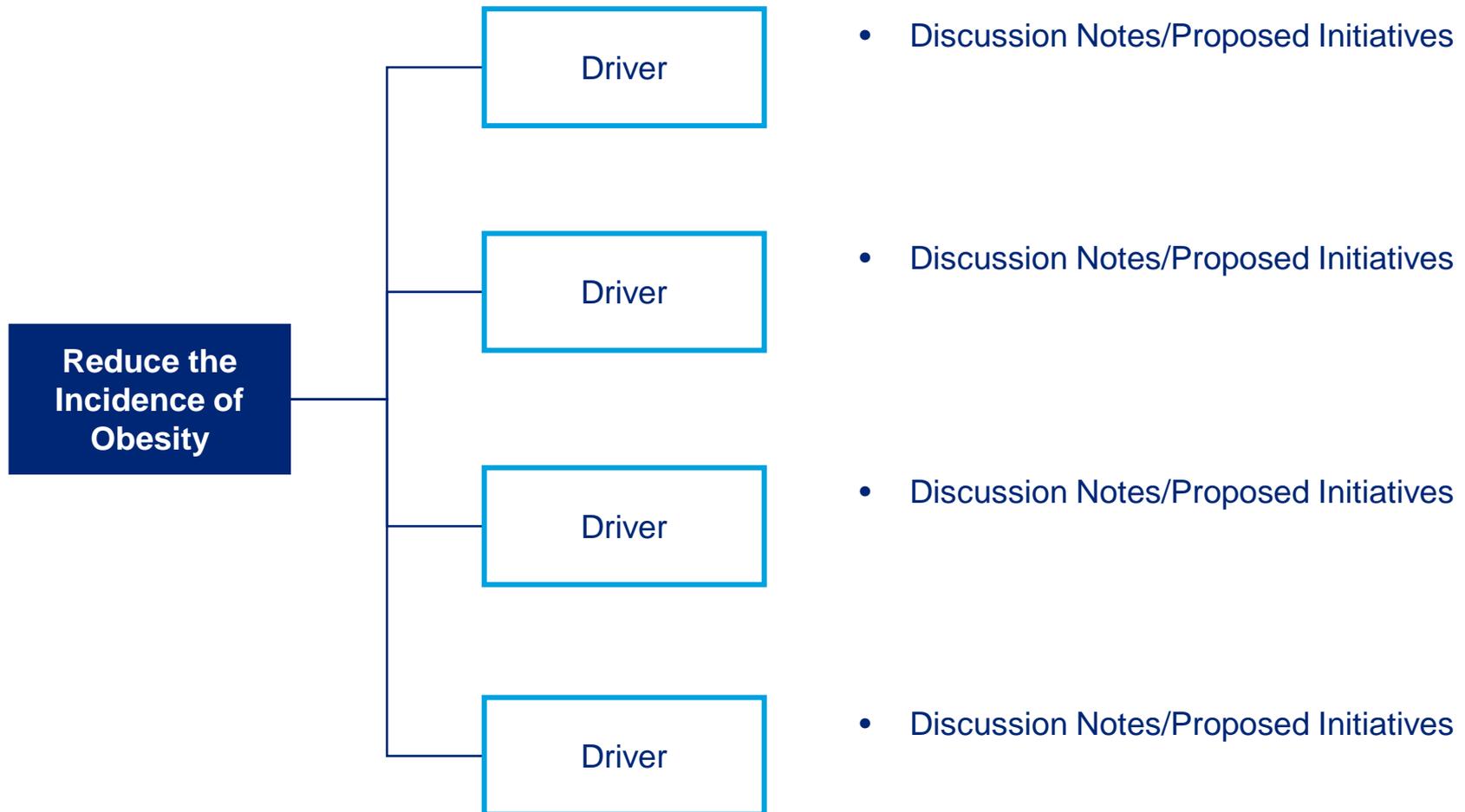
Goal Setting Exercise – Tobacco Use

What are the current barriers to reducing tobacco use in Kentucky? What would be the key drivers to reducing those barriers? What initiatives could support those drivers from an integrated and coordinated care perspective?



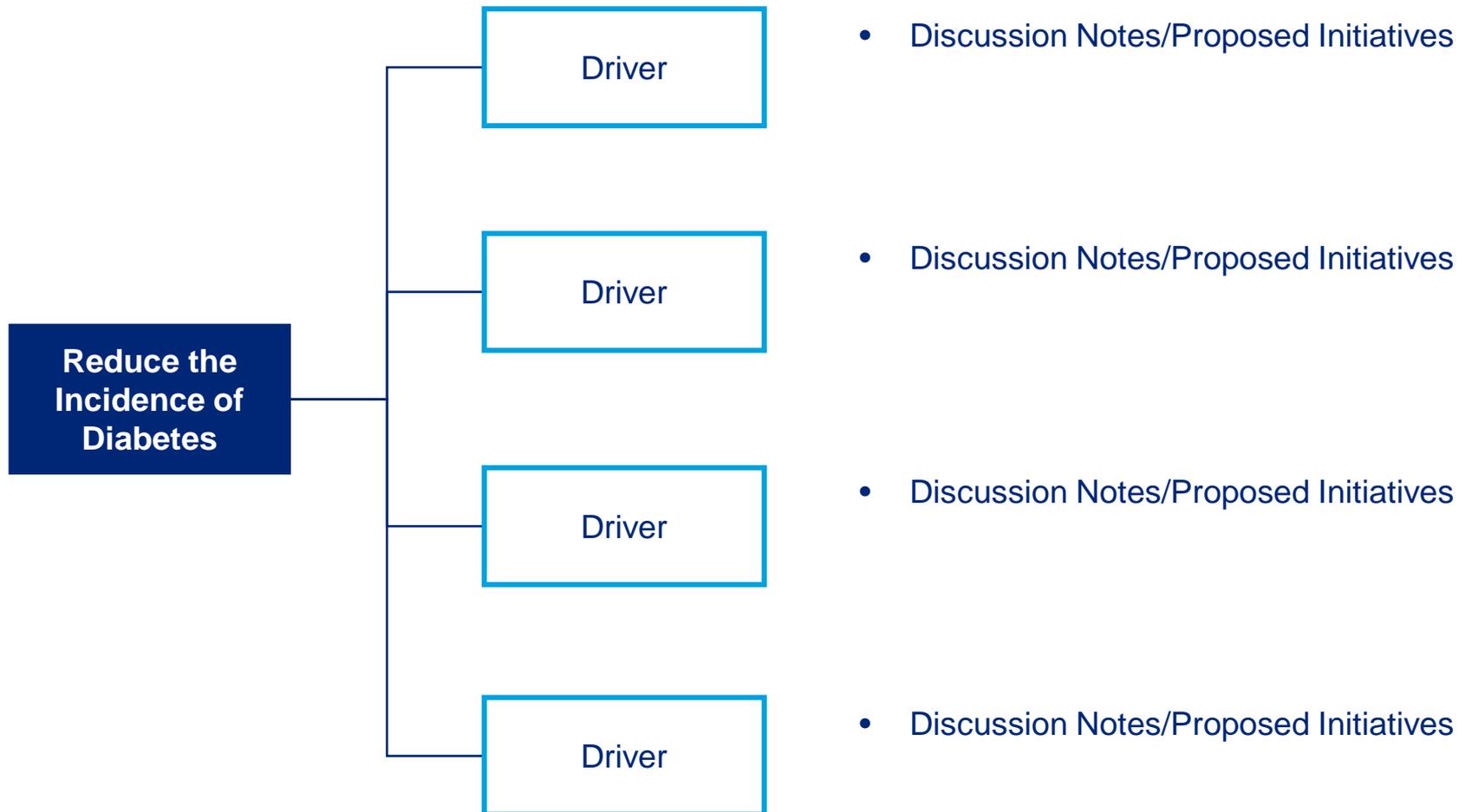
Goal Setting Exercise – Obesity

What are the current barriers to reducing the incidence of obesity in Kentucky? What would be the key drivers to reducing those barriers? What initiatives could support those drivers from an integrated and coordinated care perspective?



Goal Setting Exercise – Diabetes

What are the current barriers to reducing the incidence of diabetes in Kentucky? What would be the key drivers to reducing those barriers? What initiatives could support those drivers from an integrated and coordinated care perspective?



Next Steps

Upcoming Schedule

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

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 |
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| 11 | 12 | 13 | 14 | 15 |
| 18 | 19 | 20 | 21 | 22 |
| 25 | 26 | 27 | 28 | 29 |

June 2015

| M | T | W | T | F |
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| 8 | 9 | 10 | 11 | 12 |
| 15 | 16 | 17 | 18 | 19 |
| 22 | 23 | 24 | 25 | 26 |
| 29 | 30 | | | |

Calendar Legend

Workgroup Meeting

Stakeholder Meeting

Next Steps

- 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
- Mark your calendars! The next two rounds of the Integrated & Coordinated Care workgroup will be held on **April 14, 2015** and on **May 19, 2015**.

| Workgroup | April Date | April Time | May Date | April Time | Location |
|-------------------------------|---------------------------|-------------------|-------------------------|-------------------|---|
| Payment Reform | Tuesday, April 14, 2015 | 9AM to 12PM | Tuesday, May 19, 2015 | 9AM to 12PM | TBA – Frankfort, KY <i>*Please see website</i> |
| Integrated & Coordinated Care | Tuesday, April 14, 2015 | 1PM to 4PM | Tuesday, May 19, 2015 | 1PM to 4PM | TBA – Frankfort, KY <i>*Please see website</i> |
| Increased Access | Wednesday, April 15, 2015 | 9AM to 12PM | Wednesday, May 20, 2015 | 9AM to 12PM | TBA – Frankfort, KY <i>*Please see website</i> |
| Quality Strategy / Metrics | Wednesday, April 15, 2015 | 1PM to 4PM | Wednesday, May 20, 2015 | 1PM to 4PM | TBA – Frankfort, KY <i>*Please see website</i> |
| HIT Infrastructure | Thursday, April 16, 2015 | 9:30AM to 12:30PM | Thursday, May 21, 2015 | 9:30AM to 12:30PM | TBA – Frankfort, KY <i>*Please see website</i> |

- 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

Appendix

SIM Round One Testing State Profiles

Model Testing Activities by State

Arkansas
\$42M

The Arkansas model is based on two complementary strategies—population-based care delivery and episodes-based payment—that are being launched statewide with the support of both public and private insurers. Under the plan, by 2016 a majority of Arkansans will have access to a patient-centered medical home (PCMH). Persons with complex or special needs (e.g., developmental disabilities) will also have access to health homes, which will work with their PCMHs to coordinate medical, community, and social support services. Payments will include performance-based care coordination fees, as well shared savings for PCMHs based on their ability to reduce total cost of care while also achieving goals for quality. Arkansas will also continue to institute and expand its system of episode-based care delivery for acute, procedural, or ongoing specialty care conditions, using a retrospective payment approach that will reward providers who deliver high-quality, cost-effective and team-based care across an entire episode of care. Service for special needs populations will be further enhanced by payments reflecting each client’s assessed level of need. Persons with complex or special needs (e.g., developmental disabilities) will also have access to PCMHs. Payments will include performance-based care coordination fees, as well shared savings for medical homes based on their ability to reduce total cost of care while also achieving goals for quality. Arkansas will also continue to institute and expand its system of episode-based care delivery for acute, procedural, or ongoing specialty care conditions, using a retrospective payment approach that will reward providers who deliver high-quality, cost-effective and team-based care across an entire episode of care. Service for special needs populations will be further enhanced by payments reflecting each client’s assessed level of need.

Maine
\$33M

Maine will test its plan by aligning benefits from MaineCare with benefits from Medicare and commercial payers to achieve and sustain lower costs for the Medicaid, Medicare, and CHIP populations while maintaining access to care, improving care quality, and improving patient satisfaction. The Maine innovation model will support the formation of multi-payer ACOs that commit to providing greater value in return for performance-based payment for high quality care. These ACOs will agree to meet established quality standards for clinical care and publically report on their performance. Through the provisions of the plan, Maine will support and strengthen enhanced primary care; support and strengthen alignments between primary care and public health, behavioral health, and long-term care; support the development of new workforce models for the transformed system; and align measures, data and analytics across providers. In addition, Maine will implement payment reform across public/private payers; spread the PCMH model of enhanced, integrated primary care; and achieve transparent understanding of the costs and quality outcomes of patients across all payers statewide.

SIM Round One Testing State Profiles (Continued)

Model Testing Activities by State

Massachusetts
\$44M

In the Massachusetts model, primary care practices will be supported as they transform themselves into PCMHs—capable of assuming accountability for cost and offering care coordination, care management, enhanced access to primary care, coordination with community and public health resources, and population health management. The Massachusetts model will strengthen primary care through shared savings/shared risk payments with quality incentives based on a statewide set of quality metrics, as well as payments to support practice transformation. This award will be used to support public and private payers in transitioning to the specified model; to enhance data infrastructure for care coordination and accountability; to advance a statewide quality strategy; to integrate primary care with public health and other services; and to create measures and processes for evaluating and disseminating best practices.

Minnesota
\$45M

The Minnesota model will ensure that every citizen of the state has the option to receive team-based, coordinated, patient-centered care that increases and facilitates access to medical care, behavioral health care, long-term care, and other services. The Minnesota Accountable Health Model will test a comprehensive, statewide program to close the current gaps in health information, create a quality improvement infrastructure, and provide the workforce capacity essential for team-based coordinated care. In addition to strengthening clinical health care, the model for health system transformation will emphasize community health, preventive services, behavioral health, and other support services. Minnesota will increase the kinds of care offered through ACOs, including for the first time long-term social services and behavioral health services. It will create linkages between the ACOs and Medicare, Medicaid, and commercial insurers, aligning payments to provide better care coordination, wider access to services, and improved coverage. Minnesota also plans to work with community organizations to create “Accountable Communities for Health” that will integrate medical care with behavioral health services, public health, long-term care, social services, and other forms of care, share accountability for population health, and provide care centered on the needs of individuals and families. This award will enable Minnesota to expand its health information exchange and health information technology infrastructure, develop a workforce of community health workers and care coordinators, and support primary care physicians who wish to transform their practices into Patient-Centered Medical Homes to improve their patients’ overall health.

SIM Round One Testing State Profiles (Continued)

Model Testing Activities by State

**Oregon
\$45M**

The Oregon Coordinated Care Model (CCM) proposes to use the state’s purchasing power to realign health care payment and incentives, so that state employees, Medicare beneficiaries, and those purchasing QHPs on Oregon’s Health Insurance Exchange will have high quality, low cost health insurance options that are sustainable over time. The CCM will focus on integrating and coordinating physical, behavioral, and oral health care; shifting to a payment system that rewards quality care outcomes rather than volume; aligning incentives across medical care and long-term care services and supports; reducing health disparities and partnering with community public health systems to improve health.

Oregon will begin implementing its model test in Medicaid through its system of Coordinated Care Organizations (CCOs) and use the SIM funding to foster the spread of this new model of care to additional populations and payers, including Medicare and private plans. CCOs have the flexibility, within model parameters, to institute their own payment and delivery reforms to achieve the best possible outcomes for their membership. They are accountable for the health and care of the population they serve and are rewarded for improving both the quality of care and health care value. CCOs will transition payment for care from a fully-capitated model to payment that is increasingly based on health care outcomes.

**Vermont
\$45M**

Vermont proposes to develop a high performance health system that achieves full coordination and integration of care throughout a person’s lifespan, ensuring better health care, better health, and lower cost for all Vermonters. Vermont will achieve these goals through three models: a shared-savings ACO model; a bundled payment model; and a pay-for-performance model aimed at improving the quality, performance, and efficiency of individual providers. The award also will fund the following enhancements in health system infrastructure: improved clinical and claims data transmission, integration, analytics, and modeling; expanded measurement of patient experience of care; improved capacity to measure and address health care workforce needs; health system learning activities essential to spreading models and best practices; and enhanced telemedicine and home monitoring capabilities.