

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



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

July 8, 2015

Meeting Agenda

- **Welcome and Introductions** (Eric Friedlander, Deputy Secretary, Kentucky Cabinet for Health and Family Services) 1:00 PM – 1:10 PM
- **June Workgroup Meetings: Recap and Report Out** (Jim Hardy, Specialist Leader, Deloitte Consulting LLP) 1:10 PM – 1:30 PM
- **Lessons from Tennessee SIM** (Brooks Daverman, Director of Strategic Planning and Innovation, Tennessee Division of Health Care Finance and Administration) 1:30 PM – 2:45 PM
- *Break* 2:45 PM – 3:00 PM
- **Innovation and Reform Led by the Commonwealth**
 - **Managed Care Contracting and SIM** (Lisa Lee, Commissioner & Dr. John Langefeld, Chief Medical Officer, Department for Medicaid Services (DMS)) 3:00 PM – 3:40 PM
 - **The Kentucky Employees' Health Plan (KEHP)** (Joe Cowles, Commissioner, Department of Employee Insurance)
- **Next Steps** (Jim Hardy, Specialist Leader, Deloitte Consulting LLP) 3:40 PM – 4:00 PM

Welcome and Introductions

June Workgroup Meetings: Recap and Report Out

June Workgroups Overview

During the June workgroup meetings, participants reviewed and discussed the core and supporting design elements for each section of the KY SIM Straw Person.

June 2015 SIM Workgroup Calendar

Tuesday 18th	Wednesday 19th	Thursday 20th
9 AM to 12 PM	9 AM to 12 PM	9:30 AM to 12:30 PM
Payment Reform Workgroup – KY Department for Public Health (DPH)	Increased Access Workgroup – KY DPH	HIT Infrastructure Workgroup – KY DPH
1 PM to 4 PM	1 PM to 4 PM	
Integrated & Coordinated Care Workgroup – KY DPH	Quality Strategy/Metrics Workgroup – KY DPH	

49 Stakeholders attended the June Payment Reform Workgroup

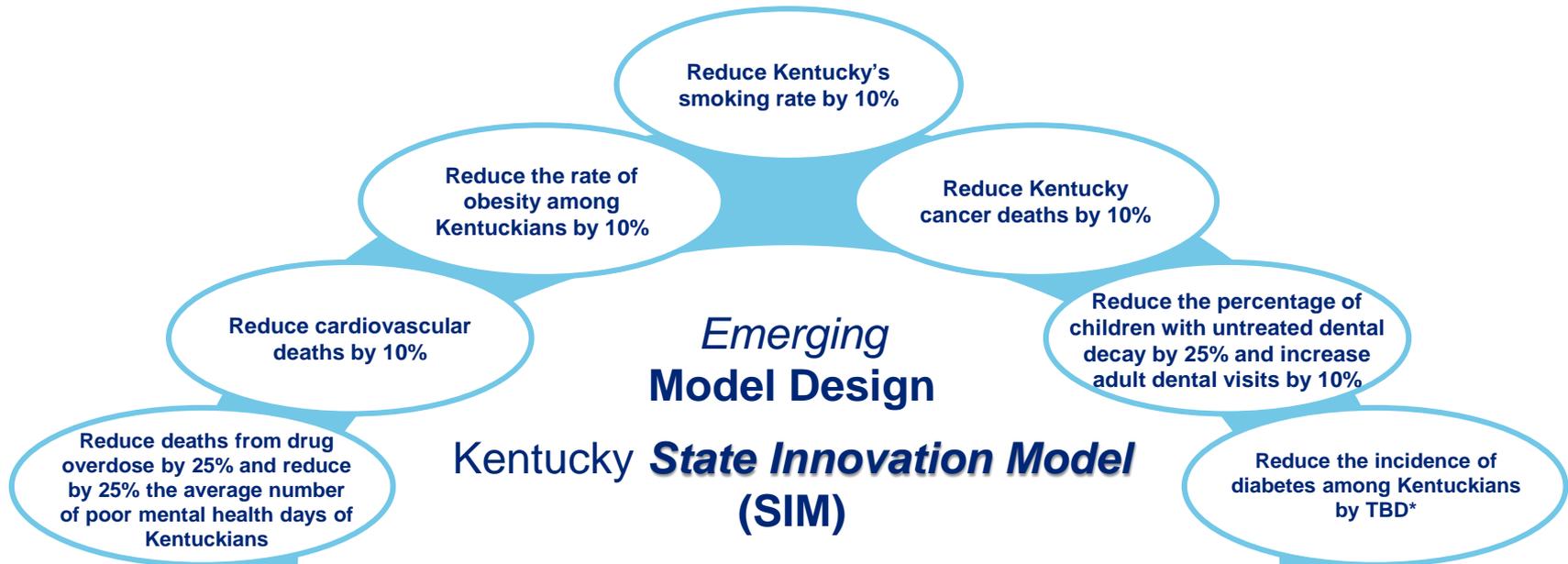
Stakeholders attended the June Integrated & Coordinated Care Workgroup **39**

35 Stakeholders attended the June Increased Access Workgroup

Stakeholders attended the June Quality Strategy/Metrics Workgroup **43**

80 Stakeholders attended the June HIT Infrastructure Workgroup

Reminder: KY's Health Care Delivery System Transformation Plan



Potential Reform Initiatives (based on workgroup input and guiding principles to date)

Expanded Patient Centered Medical Homes (PCMH)

Expanded Accountable Care Organizations (ACO)

Expanded Health Homes

Expanded Bundled Payment Initiatives/Episodes of Care

A Multi-payer Community Innovation Support Center

A program for providers and communities to develop new delivery model & payment reform pilots with multi-payer support

Increased Access Strategies

Quality Strategies

HIT Strategies

Other Supporting Strategies

*The current goals included with kyhealthnow and therefore the PHIP do not contain a specified reduction goal for diabetes. Over the course of the Model Design process, CHFS will work alongside key stakeholders to develop this target for inclusion in the final PHIP.

June Workgroup Recap

Each workgroup provided input on and recommendations for the core and supporting design elements proposed in the KY SIM Straw Person. This information is being used to update and further develop the draft.

Topic Area	Feedback
Consumer Engagement	<ul style="list-style-type: none"> • Recognize the importance of increasing consumer health literacy and cultural competency • Include a consumer-specific strategy for health reform <ul style="list-style-type: none"> – Use benefit design strategies to encourage consumers to engage in healthier lifestyles – Focus benefit design strategies on individuals with or at risk of developing a chronic condition to encourage more active engagement and self-management of health issues • Develop targeted consumer education and communications strategies for each component of the Model Design • Explore the role of registries in consumer education and/or provider access to information
Provider	<ul style="list-style-type: none"> • Redefine “equal risk” to be “proportional risk” amongst providers across the proposed care delivery reforms • Examine the role of a broader range of provider types as “owners” of episodes of care • Recognize the need for a small provider strategy that encompasses approaches to savings distributions and transition planning • Offer a broader definition of the care team for PCMH and ACO beyond the specific provider types mentioned

June Workgroup Recap (*continued*)

Each workgroup provided input on and recommendations for the core and supporting design elements proposed in the KY SIM Straw Person. This information is being used to update and further develop the draft.

Topic Area	Feedback
Quality	<ul style="list-style-type: none"> • Include rapid-cycle evaluation and monitoring within the quality strategy • Clearly distinguish between the overall quality strategy and quality strategies for each reform initiative • Identify clear measures for transitions of care within PCMHs
Workforce	<ul style="list-style-type: none"> • Include a workforce-specific strategy in the final Model Design
Other	<ul style="list-style-type: none"> • Eliminate clinical and/or business process variation wherever possible* <ul style="list-style-type: none"> – Reduce implementation and operational complexity related to each initiative • Recognize the potential impact of the new administration after this fall's election • Identify strategies to overcome cultural/linguistic barriers to delivering high quality care

* Identified as overall SIM guiding principle

Health Information Technology (HIT) Recap

The HIT Infrastructure workgroup began to think conceptually about the core areas that will need to be addressed in the HIT Plan, which is a final component of the State Health System Innovation Plan (SHSIP).



Information, analytics, and reporting:

How can data collection and analytics support the goals of payment and service delivery reform?



Engagement technologies:

How can technology be used by providers to engage consumers and make them more responsible for attaining health goals?



Workflow and core application environments:

How can the capabilities of existing technology infrastructure be used to support the transition to value-based care models?

HIT Plan Strategy

Population health management: How can technology play a role in improving population health?



Interoperability/integration: What is the best use of technology in integrating and coordinating care? How can shared information be transmitted and stored securely?



Workforce Recap

The Increased Access workgroup provided feedback on a workforce development strategy as part of the SHSIP.

Leverage Area Health Education Center (AHEC) programs to reduce disparities among physicians, APRNs, PAs, etc.

Leverage the National Governor's Association (NGA) data collection strategy

Encourage providers to practice to the full extent of their scope

Encourage community-based health professional training and recruitment programs that encourage local young people to pursue health professional training and return to their communities

Address the difficulty of clinical placements by promoting health centers as teaching centers

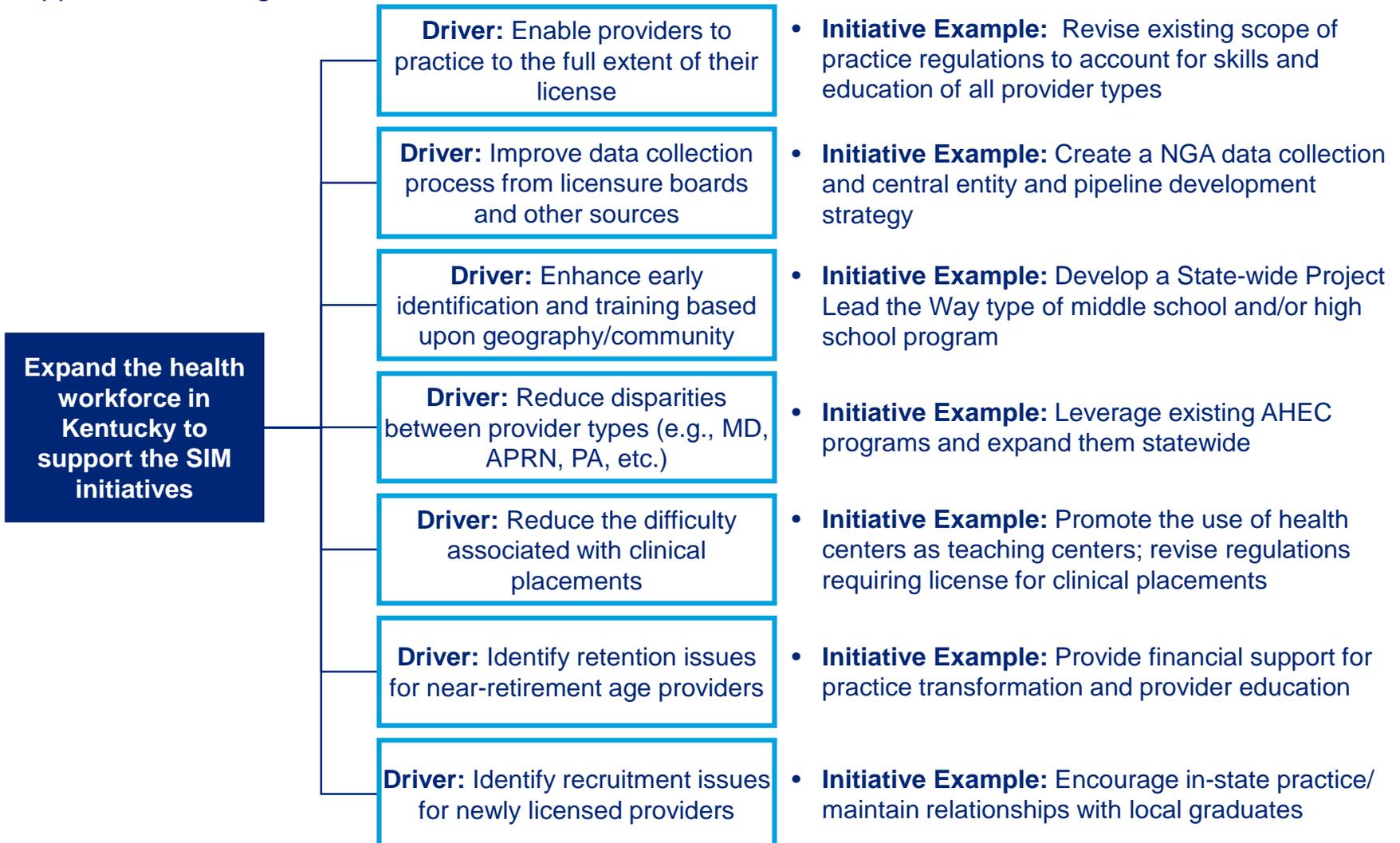
Provide financial support for practice transformation for providers "at-risk" of retirement

Expand loan forgiveness to other professions (e.g., behavioral health providers)

Implement early training based upon geographic location and/or communities

Workforce Recap (*continued*)

Based on the workforce development feedback from the Increased Access workgroup, a driver diagram was created to show the existing barriers to workforce development, as well as potential initiatives to support overcoming each barrier.





Division of
**Health Care
Finance & Administration**

Health Care
Innovation Initiative

Kentucky Stakeholder Meeting
July 8, 2015

Tennessee Health Care Innovation Initiative



“It’s my hope that we can provide quality health care for more Tennesseans while transforming the relationship among health care users, providers and payers. If Tennessee can do that, we all win.”

– Governor Haslam’s address to a joint session of the state Legislature, March 2013

We are **deeply committed** to reforming the way that we pay for healthcare in Tennessee

Our goal is to **pay for outcomes and for quality care**, and to reward strongly performing physicians

We plan to have value-based payment account for the **majority of healthcare spend** within the next three to five years

By **aligning on common approaches** we will see greater impact and ease the transition for providers

We appreciate that hospitals, medical providers, and payers have all demonstrated a **sincere willingness** to move toward payment reform

By working together, we can make significant progress toward **reducing medical costs and improving care**

Stakeholder Process

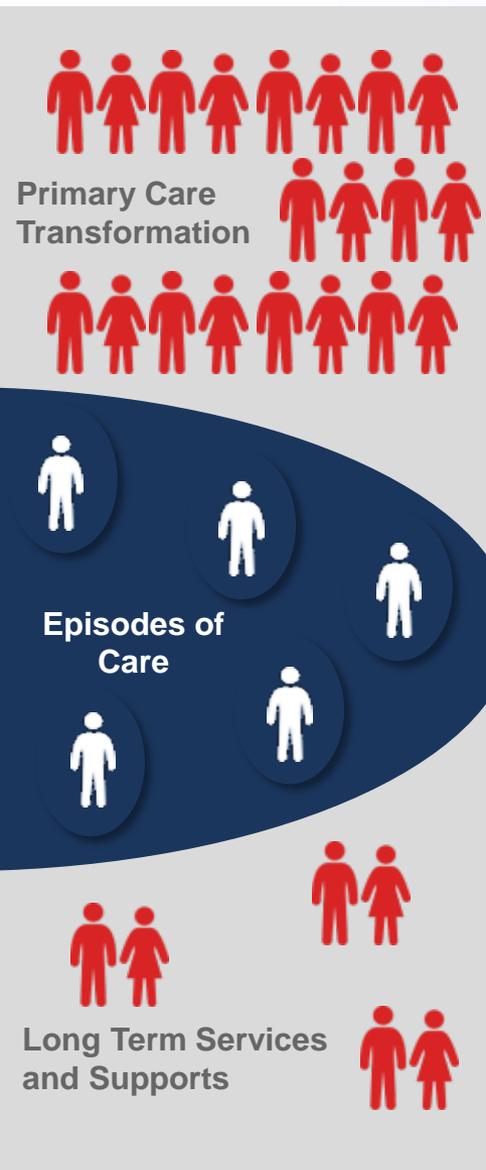
Stakeholder group	Provider Stakeholder Group	Payer Coalition	Quality Improvement in Long-Term Services and Supports	Technical Advisory Groups	Employer Stakeholders
Stakeholders involved	<p>Select providers meet regularly to advise on overall initiative implementation.</p>	<p>State health care purchasers (TennCare, Benefits Administration) and major commercial insurers meet regularly to advise on overall implementation.</p>	<p>Regional Community Forums hosted twice in each of the 9 regions across the state for consumers, family members, and providers.</p>	<p>Select clinicians meet to provide clinical advice on each strategy</p>	<p>Periodic engagement with employers and employer associations.</p>
Meeting frequency	<p>Monthly</p>	<p>2 per month</p>	<p>2 per region</p>	<p>3-6 per group</p>	<p>As needed</p>



How Tennessee Selected Its Strategies

- Strategies must **compliment each other** to comprehensively address the areas of health care
- Strategies must work for all **types of providers**: Urban and rural, individual practitioners and integrated systems, specialists and primary care practitioners
- Strategies must allow for **rapid statewide adoption** so that the majority of health care spending in Tennessee will be paid using value based approaches within five years—including commercial, Medicaid, and Medicare

Tennessee's Three Strategies



Source of value	Strategy elements	Examples
<ul style="list-style-type: none"> Maintaining a person's health overtime Coordinating care by specialists Avoiding episode events when appropriate 	<ul style="list-style-type: none"> Patient Centered Medical Homes Health homes for people with serious and persistent mental illness Care coordination tool with Hospital and ED admission provider alerts 	<ul style="list-style-type: none"> Encouraging primary prevention for healthy consumers and coordinated care for the chronically ill Coordinating primary and behavioral health for people with SPMI
<ul style="list-style-type: none"> Achieving a specific patient objective, including associated upstream and downstream cost and quality 	<ul style="list-style-type: none"> Retrospective Episodes of Care 	<ul style="list-style-type: none"> Wave 1: Perinatal, joint replacement, asthma exacerbation Wave 2: COPD, colonoscopy, cholecystectomy, PCI 75 episodes by 2019
<ul style="list-style-type: none"> Provide long-term services and supports (LTSS) that are high quality in the areas that matter most to recipients 	<ul style="list-style-type: none"> Quality and acuity adjusted payments for LTSS services Value-based purchasing for enhanced respiratory care Workforce development 	<ul style="list-style-type: none"> Aligning payment with value and quality for nursing facilities (NFs) and home and community based care (HCBS) Training for providers



PRIMARY CARE TRANSFORMATION



Primary Care Transformation: Strategy

Most medical costs occur outside of the office of a primary care physician (PCP), but PCPs can guide many decisions that impact those broader costs, improving cost efficiency and care quality.

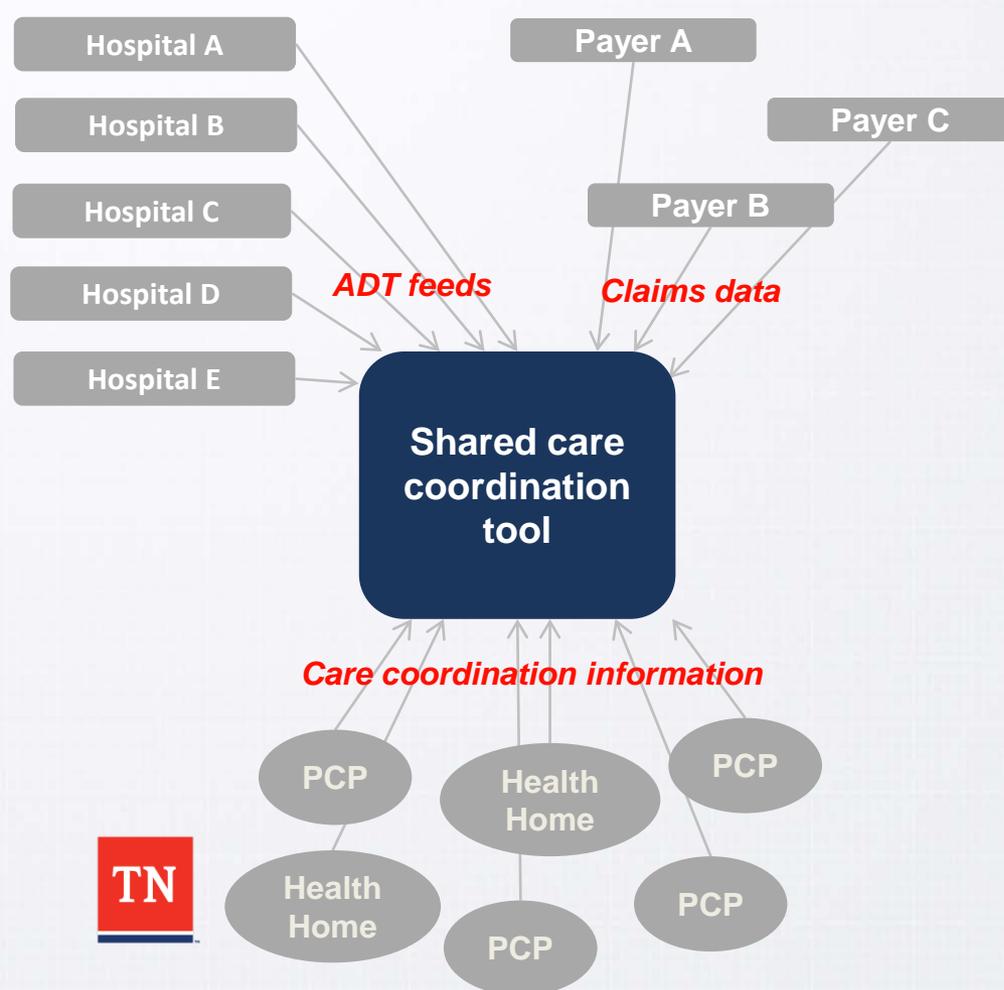
Patient Centered Medical Homes focus on prevention and management of chronic disease, seek to increase coordinated and integrated care across multidisciplinary provider teams, and improved wellness and preventive care. Health Homes will further incorporate behavioral care for TennCare members with severe and persistent mental illness.



- Primary care providers are responsible for proactively managing their attributed patient's health care.
- Rewards for reduced avoidable ED visits and hospitalizations, more coordinated care, and improved quality of care.
- Training and technical assistance supports to providers.
- Regular reports to providers on the quality and efficiency of the care their attributed patients receive.
- Primary care providers are alerted when their attributed patients are admitted, discharged, or transferred to the hospital or emergency department.

Primary Care Transformation: Strategy

A multi-payer shared care coordination tool will allow primary care providers to implement better care coordination in their offices.



- Alerts providers of any of their attributed patients' hospital admissions, discharges, and transfers (ADT feeds)
- Identifies patients risk scores
- Generates and displays gaps-in-care and creates prioritized workflows for the care team
- Maintains, executes and tracks activities against patient-specific care plans
- Displays prescription fills, with alerts on polypharma and gaps in medication adherence

Primary Care Transformation: Timeline

Tennessee's timeline for PCMH and Health Home rollout:

2015	2016	2017	2018
<ul style="list-style-type: none"> July 30- November 19: PCMH and Health Home TAGs meet to advise on design elements of the program 	<ul style="list-style-type: none"> Jan -March: Pilot of ADT feed March - June: Pilot of Care Coordination Tool ~May: Practice transformation training begins July: Launch multi-payer PCMH pilot for a minimum of 12 practices October: Launch SPMI Health Homes statewide (2 years enhanced prospective payment) 	<ul style="list-style-type: none"> July: Expand multi-payer PCMH to pilot practices plus one grand region 	<ul style="list-style-type: none"> July: Expand multi-payer PCMH statewide October: Outcomes-based payment begins SPMI Health Homes

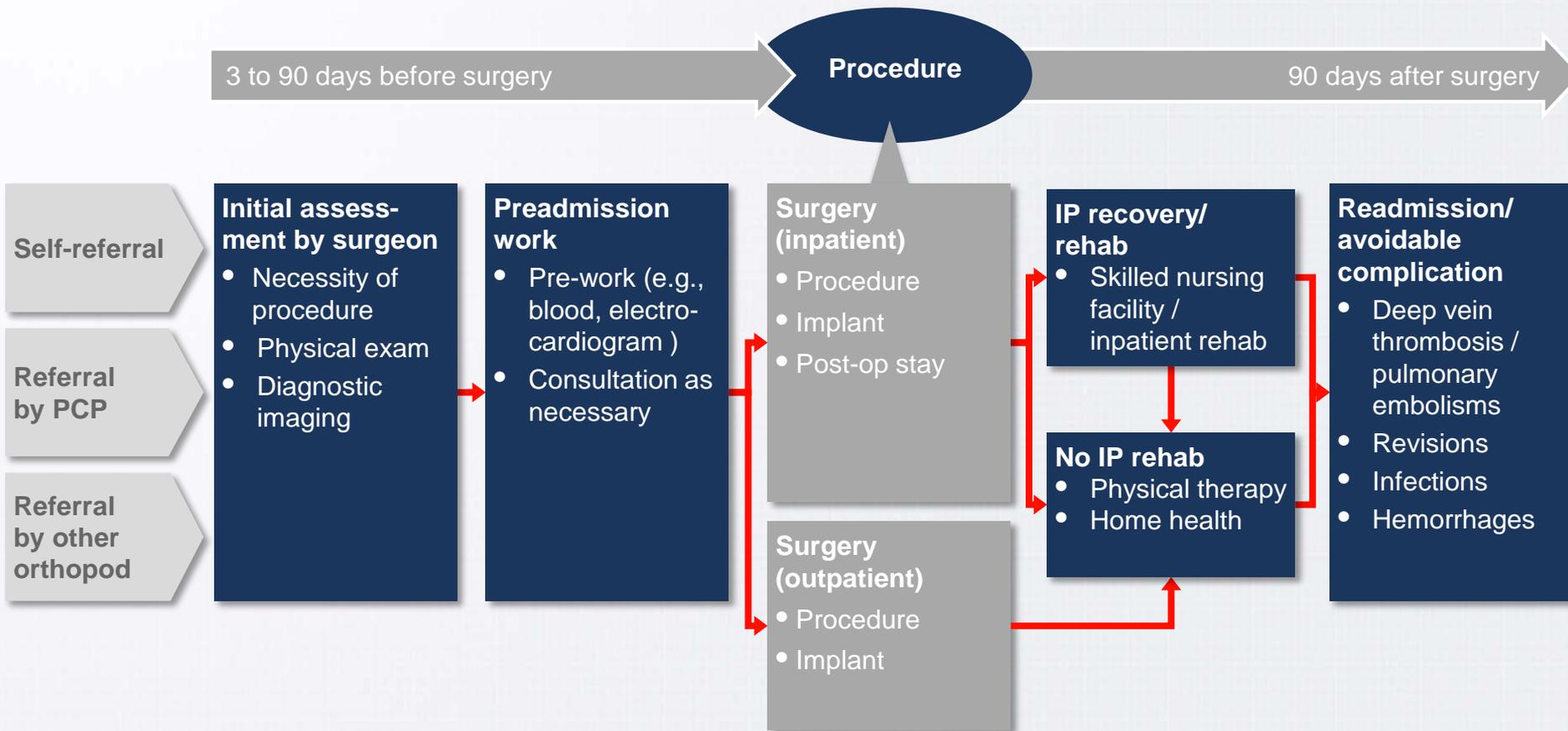


EPISODES OF CARE



Episodes of Care: Definition

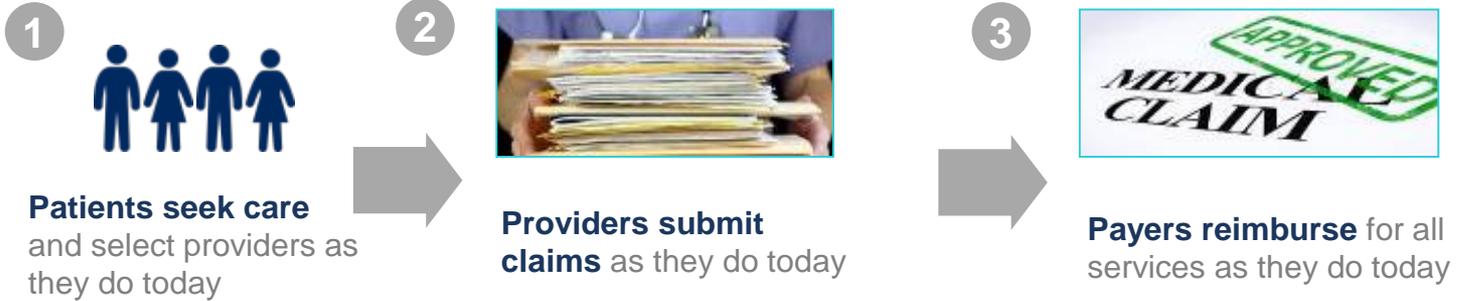
Example patient journey for hip & knee replacement



Episodes include services from multiple providers

Episodes of Care: Process

Unchanged Billing Process



New Information



'Quarterbacks' are provided detailed information for each episode which includes actionable data

Payer Name [TennCare/Commercial] Provider Name Provider Code Report Date: July 2013

[1. Perinatal] B. Episode quality and utilization details

Quality and utilization (selected) comparison with applicable base

You selected selected quality metrics linked to gain sharing

Percentile of Providers

Quality metrics linked to gain sharing	0	25	50	75	100
HIV screening rate	0%	50%	65%	80%	94%
Group B strep screening rate	0%	62%	83%	91%	95%
Chlamydia screening rate	0%	62%	84%	87%	94%
Gestational diabetes screening rate	0%	42%	50%	62%	81%
Asymptomatic bacteriuria screening rate	0%	42%	62%	75%	81%
Hepatitis B screening rate	0%	42%	62%	75%	81%

Payer Name [TennCare/Commercial] Provider Name Provider Code Report Date: July 2013

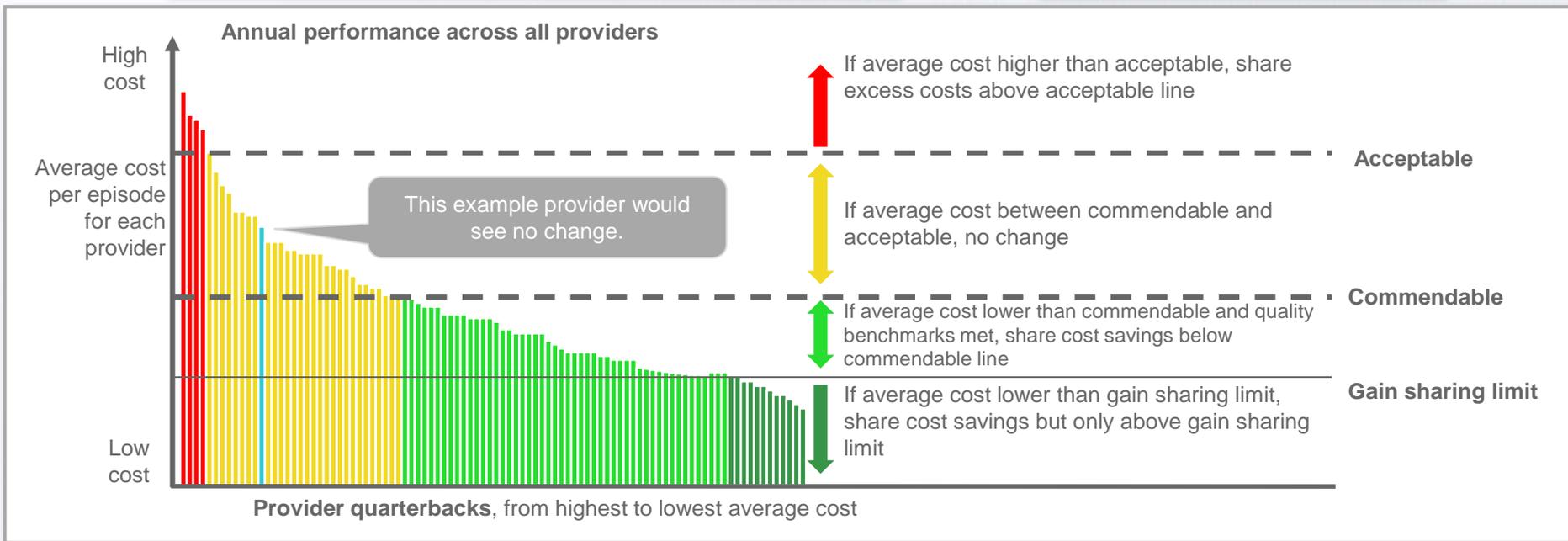
[1. Perinatal] C. Episode cost details

Episode cost breakdown by care category

Care category	# of episodes with claims in care category	% of episodes with claims in care category	Average risk adj. cost per episode when care category utilized (\$)
Outpatient professional	195	84%	120
Pharmacy	11	5%	50
Emergency department	90	39%	235
Outpatient lab	220	96%	190
Outpatient radiology/procedures	215	94%	320



Episodes of Care: Incentives



Episodes of Care: Quality metrics

- Some quality metrics will be linked to gain sharing, while others will be reported for information only
 - Quality metrics linked to gain sharing incentivize cost improvements without compromising on quality
 - Quality metrics for information only emphasize and highlight some known challenges to the State
- Each provider report will include provider performance on key quality metrics specific to that episode

Example of quality metrics from episodes in prior waves

ASTHMA EXACERBATION

- **Linked to gain-sharing:**
 - Follow-up visit rate (42%)
 - Percent of patients on an appropriate medication (82%)
- **Informational only:**
 - Repeat asthma exacerbation rate
 - Inpatient admission rate
 - Percent of episodes with chest x-ray
 - Rate of patient self-management education
 - Percent of episodes with smoking cessation counseling offered

PERINATAL

- **Linked to gain-sharing:**
 - HIV screening rate (85%)
 - Group B streptococcus screening rate (85%)
 - Overall C-section rate (41%)
- **Informational only:**
 - Gestational diabetes screening rate
 - Asymptomatic bacteriuria screening rate
 - Hepatitis B screening rate
 - Tdap vaccination rate

SCREENING AND SURVEILLANCE COLONOSCOPY

- **Linked to gain-sharing:**
 - Participating in a Qualified Clinical Data Registry (e.g., GIQuIC)
- **Informational only:**
 - Perforation of colon rate
 - Post-polypectomy/biopsy bleed rate
 - Prior colonoscopy rate
 - Repeat colonoscopy rate

The quality metric 'Participating in a Qualified Clinical Data Registry' is a first attempt at using quality metrics based on other information sources than medical claims

Episodes of Care: Comparison across states

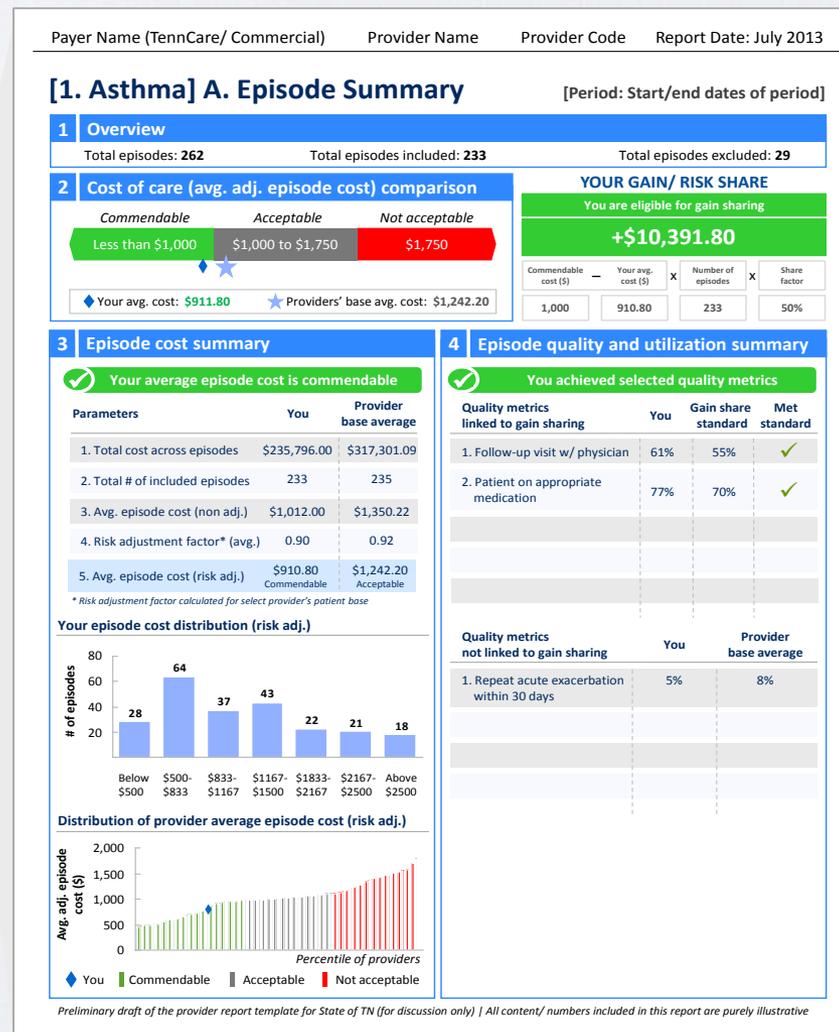
Episodes designed to date:	Tennessee	Arkansas	Ohio
Perinatal			
Total Joint Replacement			
Asthma exacerbation			
COPD exacerbation			
Colonoscopy			Planned
Cholecystectomy			Planned
Acute PCI			
Non-acute PCI			
URI			Planned
Pneumonia			
Inpatient UTI			
Outpatient UTI			Planned
GI Hemorrhage			Planned
EGD			Planned
ADHD	Planned		
ODD	Planned		
CHF exacerbation	Planned		
Tonsillectomy	Planned		
CABG	Planned		
Neonatal	Planned		
ADHD/ODD Comorbid			
Appendectomy			Planned



Episodes of Care: Reporting

Quarterbacks will receive quarterly report from payers:

- **Performance summary**
 - Total number of episodes (included and excluded)
 - Quality thresholds achieved
 - Average non-risk adjusted and risk adjusted cost of care
 - Cost comparison to other providers and gain and risk sharing thresholds
 - Gain sharing and risk sharing eligibility and calculated amounts
 - Key utilization statistics
- **Quality detail:** Scores for each quality metric with comparison to gain share standard or provider base average
- **Cost detail:**
 - Breakdown of episode cost by care category
 - Benchmarks against provider base average
- **Episode detail:**
 - Cost detail by care category for each individual episode a provider treats
 - Reason for any episode exclusions

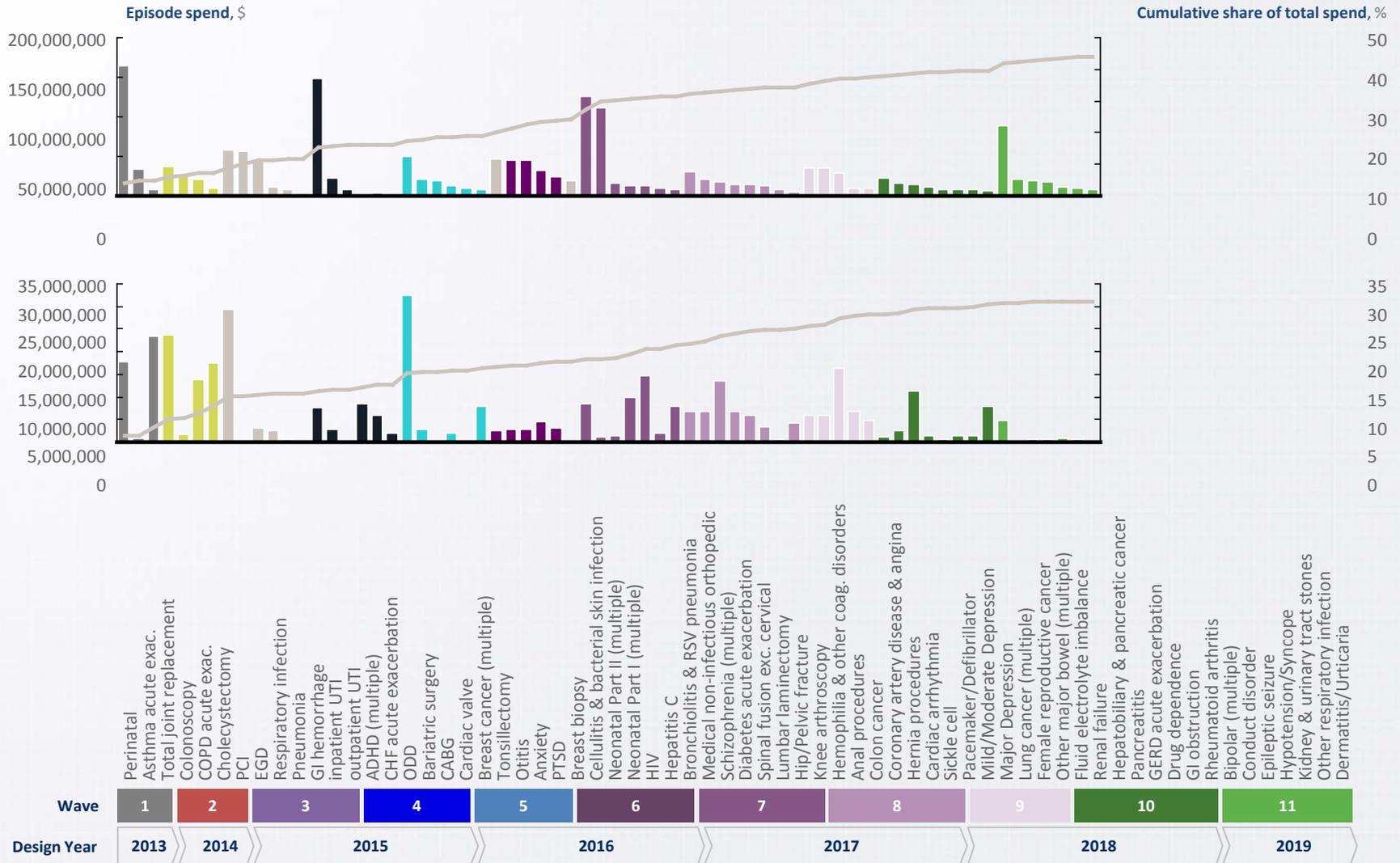


Episodes of Care: 75 in 5 years

\$ 4,125,011,076.65
 \$ 1,259,718,441.88

Tenn-Care

State Commercial Plans



Note: Tennessee may want to assess benefits of securing additional Tennessee Commercial Data with which to design and localize certain episodes (multiple) indication identifies episodes in which more than one episode may be designed
 Source: TennCare and State Commercial Plans claims data, episode diagnostic model, team analysis

Arkansas Results (Jan 2015)

- A 17% drop in unnecessary antibiotic prescribing for non-specific URI
- Across the board improvements in perinatal screening rates
- AR BCBS hip/knee replacement costs were reduced by 1.4% (7% below projected costs)
- 73% of Medicaid and 60% of AR BCBS Principal Accountable Providers (PAPs) improved costs or remained in a commendable or acceptable cost range

Partnerships with Provider Associations

We work with our stakeholders both during design and implementation.



Tennessee Hospital Association

- Analytics to support hospitals in identifying opportunities for improvement in quality and efficiency



Tennessee Medical Association

- Provider Outreach specialist will travel to providers to inform them of initiative strategies and collect questions and concerns to report to the state



Tennessee Chapter of the American Academy of Pediatrics

- Will engage pediatricians in quality improvement projects.

Managed Care Contracting and the State Innovation Model

Managed Care Contracts

- Kentucky Medicaid issued a Request for Proposal (RFP) in May 2015 for managed care organizations (MCOs) to bid for Medicaid business
- On July 1, 2015 the Department for Medicaid Services renewed contracts for all 5 MCOs currently providing services to the Medicaid population based on terms outlined in the RFP
- New provisions that focus on quality and access to care and are directly related to advancing the purpose of the SIM

Managed Care Contract Amendments

- There will be one contract draft rather than negotiating individual requests for each MCO
- State-wide Coverage for all MCOs
- Imposing a Medical Loss Ratio Requirement
- CMS mandated “risk corridor” for the ACA expanded Medicaid
- HEDIS Measures Incentive Program
- The new contract requires using specifically named national standards to determine “medical necessity”
- Department for Medicaid Services will provide ONE FORM for a Member or a Provider to file an appeal with the MCO

Managed Care Contract Amendments (continued)

- Department for Medicaid Services will provide ONE FORM for request for Prior Authorization by the MCO
- MCO Credentialing of Providers must follow National Committee for Quality Assurance standards (NCQA)
- Increases access standards for behavioral health services
- In order to be counted when determining whether an MCO's network meets access standards, the Provider must accept Medicaid Patients
- MCOs must update their on-line provider networks within 10 days of a change
- Mandates more aggressive involvement of MCOs when persons with Severe Mental Illness (SMI) are being discharged from mental health hospitals

Managed Care Contract Amendments (continued)

- Tightened up the penalties section
- Improvement to Fraud recovery requirements
- Retro Eligibility and Prior Authorizations

The Kentucky Employees' Health Plan (KEHP)

The Kentucky Employees' Health Plan

Joe R. Cowles
Commissioner
Kentucky Employees' Health Plan (KEHP)



Discussion Topics: KEHP & SIM

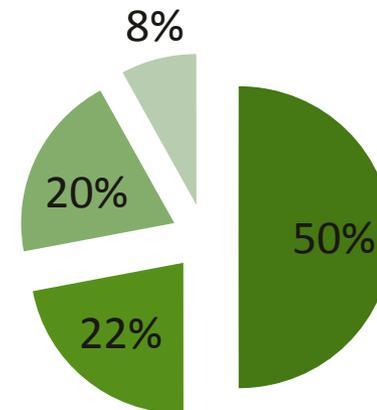
- **KEHP Background**
- **Diabetes Prevention Plan (DPP):** An example of a payment reform (as a fully covered benefit) that is aimed at a key SIM population health goal, serving the SIM principles of population health improvement and chronic disease prevention.
- **Live Health Online program:** An example of both a payment reform (as a fully covered benefit) and a care delivery reform aimed at increasing access and convenience for our members, both of which are key SIM principles.
- **2014 Norton/Humana/KEHP Accountable Care Organization (ACO):** An example of a delivery system reform included in the SIM draft model design, with the goals of increased quality and lower cost, both of which are key SIM principles.

KEHP Background

- Self-Insured since 2006
- \$1.6 Billion total plan annual spend
- 153,000 Planholders (266,000 covered lives), made up of active employees and pre-65 retirees
- Largest employer in every county of state
- Mostly Kentucky residents – some retired members living outside of Kentucky

KEHP

- School Boards (50%)
- Early Retirees (22%)
- State Agencies (20%)
- Quasi (8%)

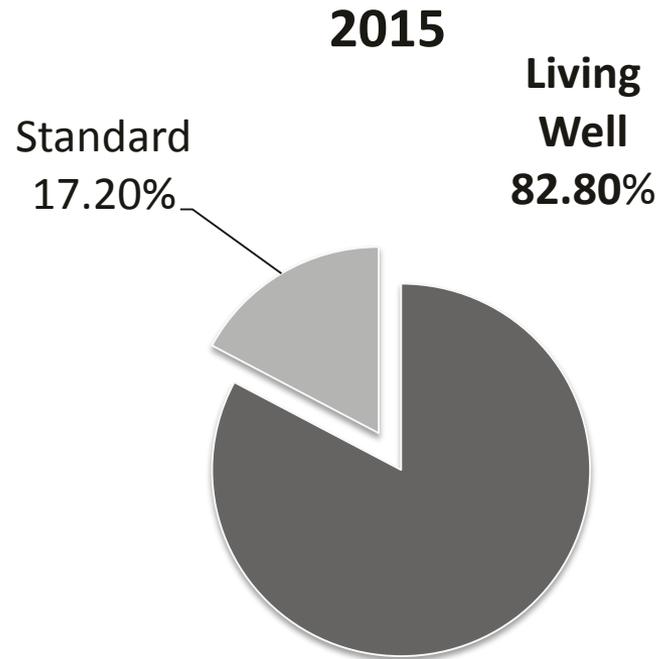
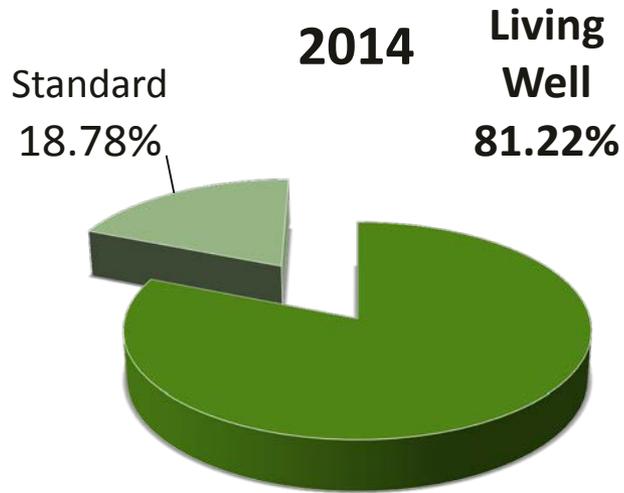




2014/2015 KEHP Options

- **LivingWell Consumer Driven Health Plan (CDHP)** 
 - LivingWell Promise required
 - Highest actuarial value plan
- **LivingWell Preferred Provider Organization (PPO)** 
 - LivingWell Promise required
 - 2nd highest actuarial value plan
- **Standard Preferred Provider Organization (PPO)**
 - No LivingWell Promise required
 - 3rd highest actuarial value plan
- **Standard Consumer Driven Health Plan (CDHP)**
 - No LivingWell Promise required
 - 4th highest actuarial value plan

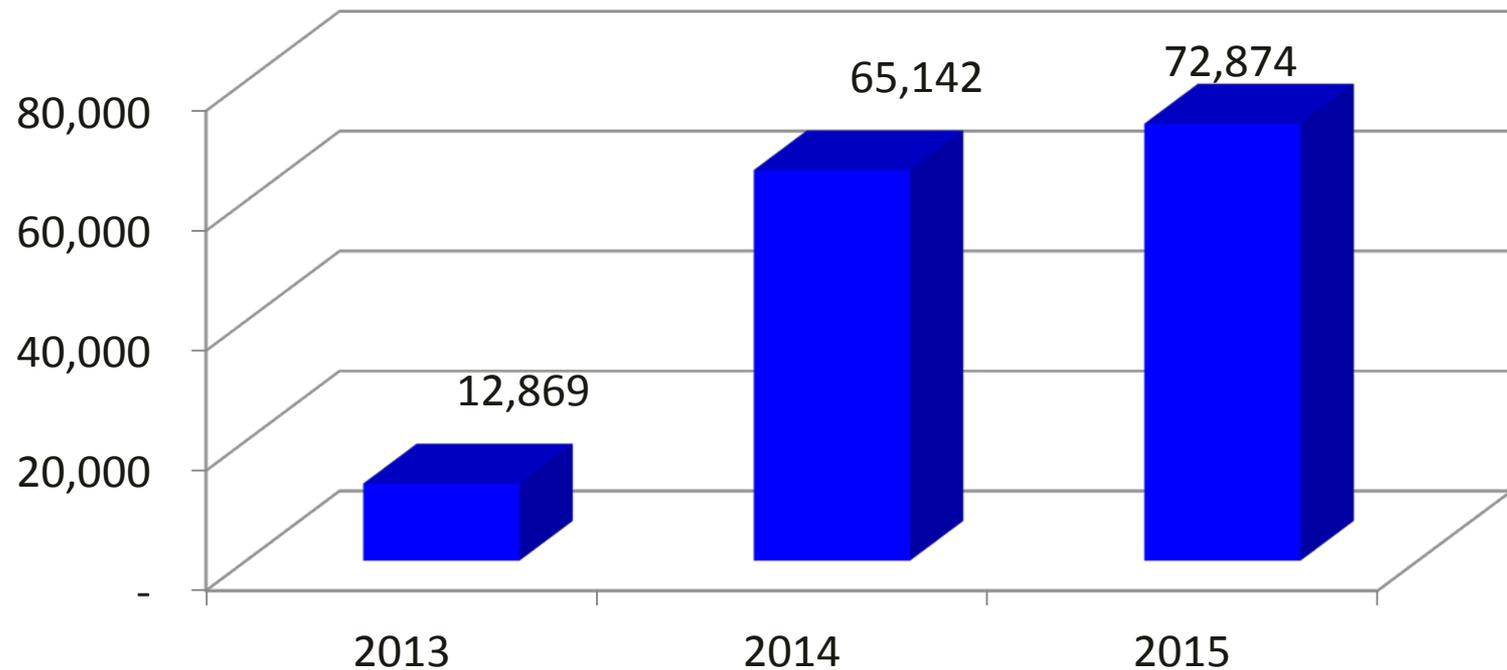
2014/2015 KEHP Enrollment Statistics



Living Well Promise

Dramatic Increase in CDHP Enrollment

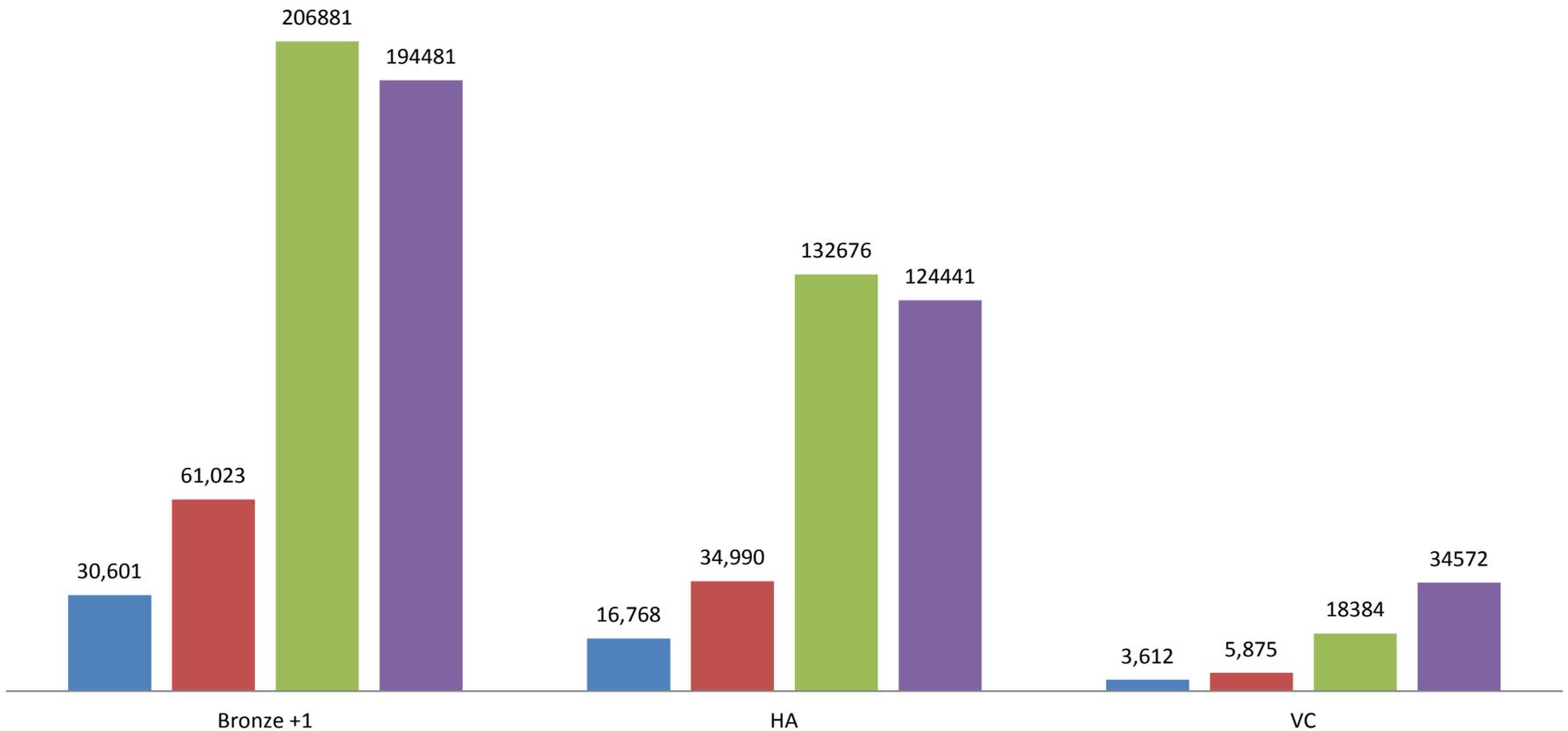
Planholders



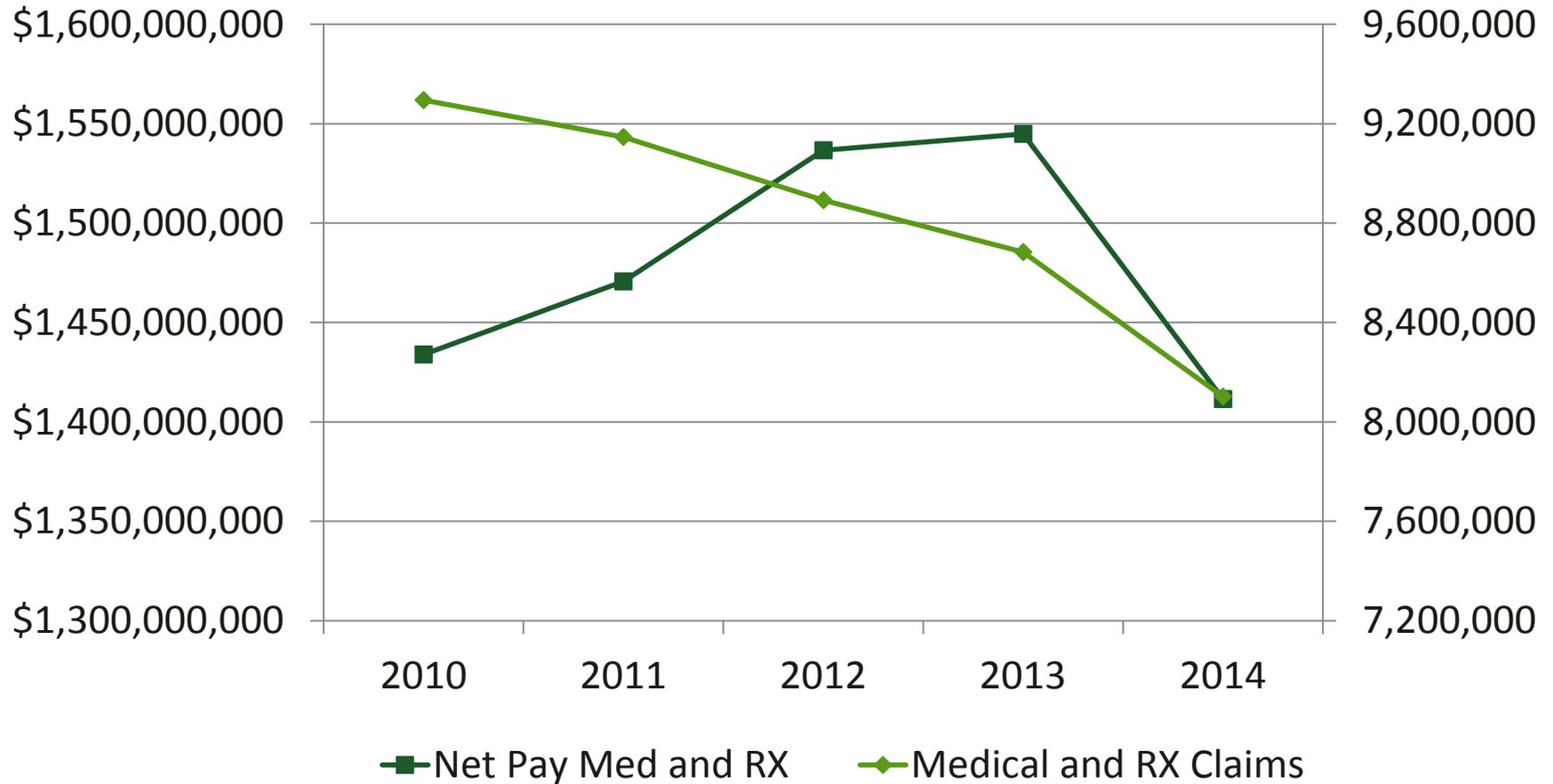
	2013	2014	2015
Covered Lives in CDHP	28,565	125,358	140,292

Annual Wellness Growth (as of 5/20/15)

■ 2012 ■ 2013 ■ 2014 ■ 6/24/2015



2010-2014 Medical & RX Claims & Net Pay



Discussion Topics

- KEHP Background
- **Diabetes Prevention Plan (DPP)**
- Live Health Online program
- 2014 Norton/Humana/KEHP Accountable Care Organization (ACO)

What is Diabetes Prevention Program (DPP)

- Program based on a 2002 study led by the National Institutes of Health with support from the Centers for Disease Control (CDC).
- The CDC-led National Diabetes Prevention Program is an evidence-based lifestyle change program for preventing type 2 diabetes.
- In 2011-12 CDC began a Diabetes Prevention Recognition Program – where all “recognized” DPP organizations report their data ongoing to CDC.
- Recognized organizations report their ongoing data to CDC. To maintain recognition, CDC assures same outcomes for diabetes prevention are maintained with the original DPP research.
- The Diabetes Prevention Program research study showed that making modest behavior changes, including 150 minutes of physical activity per week, helped participants lose 5% to 7% of their body weight.
- DPP helps cut risk of developing type 2 diabetes in half.

DPP Overview

- DPP is designed for people who are overweight/obese (BMI >24) and have prediabetes or at high risk of developing diabetes.
- A DPP lifestyle coaches at recognized KY providers works with a class of participants.
- Recognized providers include hospitals, YMCAs, health departments, pharmacies, private practice groups, doctor's offices, etc.
- Some programs are provided through a CDC grant, while others cost \$300-\$429.
- The DPP participants meet in person as a group with a lifestyle coach, once a week for 16 weeks and once a month for 6-8 months.
- Goals are losing weight, being more physically active, and managing stress

Prevalence and Cost of Diabetes to KEHP

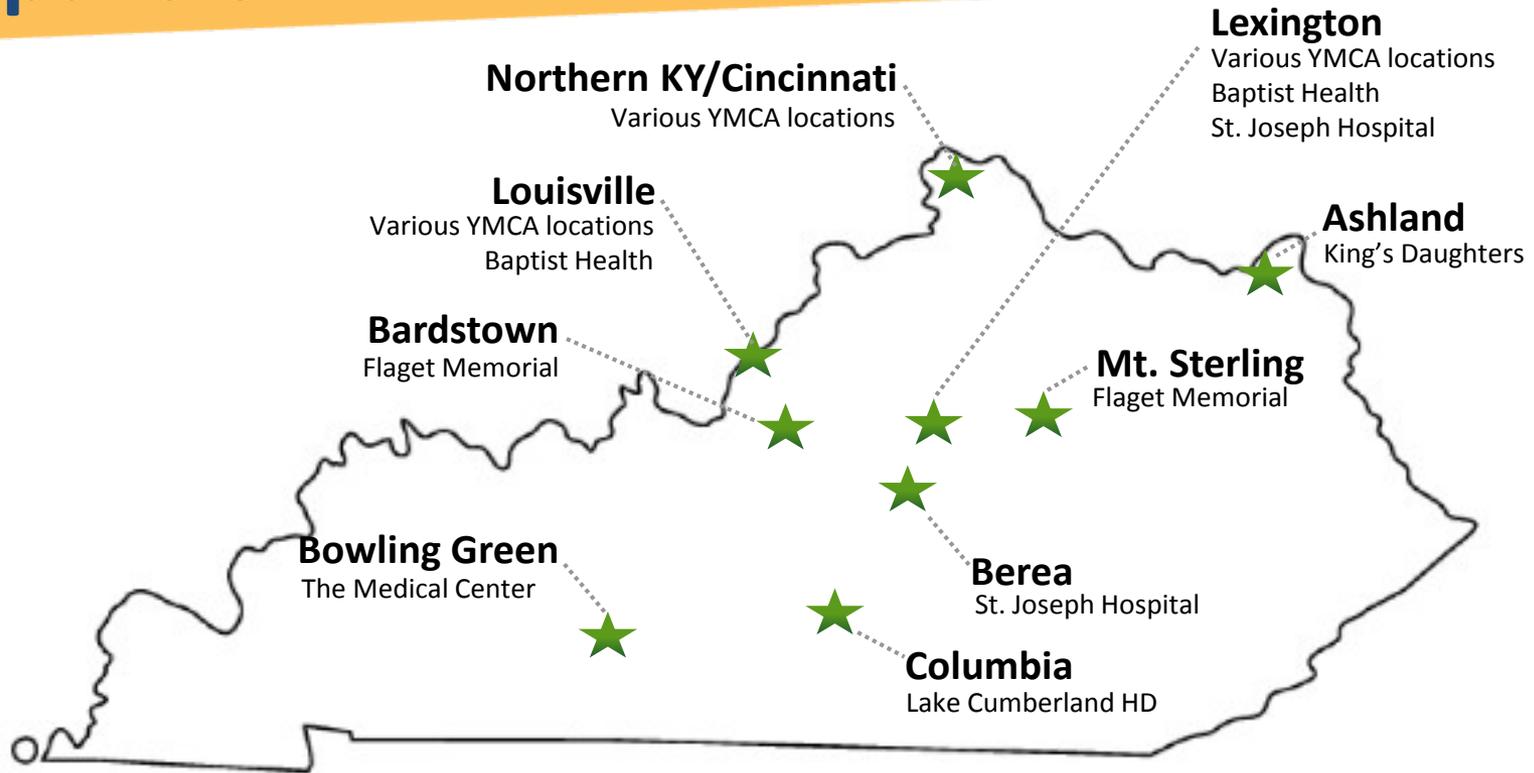
- CDC estimate – 1 in 3 adult Americans have prediabetes (1 in 2 adults aged 65 and older).
- CDC estimates as many as 1 million Kentuckians could be prediabetic – 289,000 Kentuckians have been diagnosed as prediabetic.
- Without intervention 15 -30% of people with prediabetes will develop type 2 diabetes within 5 years.
- Costs Data – Medical expenditures 2.3 times higher in people with diabetes than without diabetes.
- KEHP – diabetes is the second most costly chronic condition for both active and early retirees at **\$66 million** (combined medical and prescription drug costs 2013). Approximately 24,000 KEHP members are diagnosed as diabetic.

The KEHP Experience – 2013 DPP Pilot

*12 KEHP members referred
4 KEHP members participated in 2013*

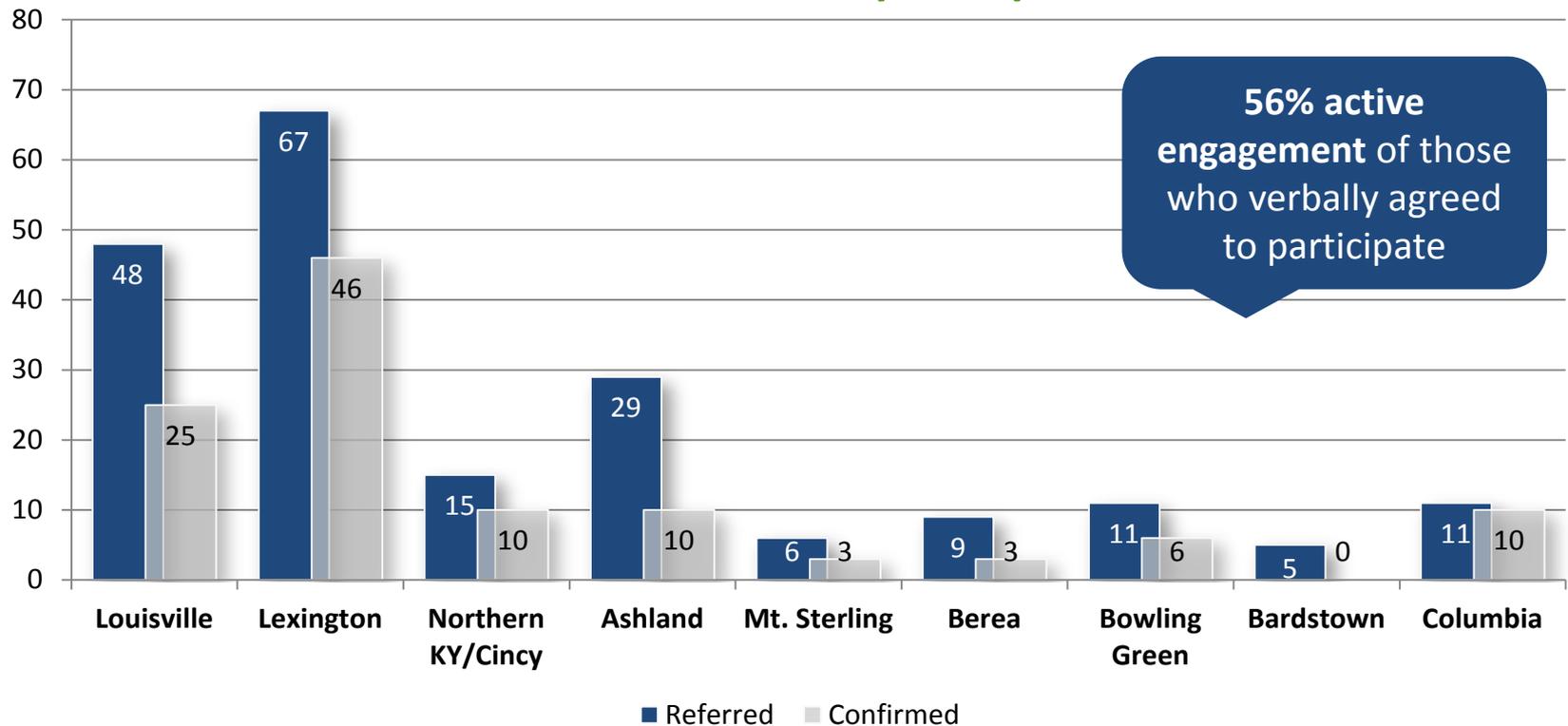
- Partnered with **King's Daughters Medical Center in Ashland**
- Began November 2013, provided **free of charge** through a CDC grant
- Local **YMCA offered free membership** for participants
- Participants received **350 Vitality Points** upon DPP completion
- Participants who completed program met and maintained program goals – lost 5-7% of body weight and increased physical activity to 150 minutes per week:
 - **Average attendance:** 94%
 - **Average weight loss:** 23 lbs.
 - **Average physical activity:** 168.5 minutes per week

The KEHP Experience – 2014 DPP Pilot Expansion



The KEHP Experience – 2014 DPP Pilot Expansion

*31 individual DPP classes
201 KEHP members referred
113 KEHP members participated*



The KEHP Experience – 2014 Aggregate Results

Location:	# of DPPs:	Session Type:	Average Attendance:	Average Weight Loss:	Average Physical Activity:
Louisville	8	Core	90%	11.3 lbs.	81.8 minutes per week
Lexington	12	Core	82%	11.2 lbs.	132.9 minutes per week
Northern KY/Cincy	4	Core	83%	6.9 lbs.	162.5 minutes per week
Ashland	4	Core	78%	15.4 lbs.	134 minutes per week
Mt. Sterling	1	Core	91%	17.0 lbs.	329 minutes per week
Berea	1	Core	82%	11.0 lbs.	575 minutes per week
Bowling Green	1	Core	81%	13.5 lbs.	45 minutes per week
Columbia	1	Core	84%	14.7 lbs.	119 minutes per week



The KEHP Experience – 2014 Participant Testimonials

Theresa



- Stopped drinking soft drinks, drinking more water
- Choosing low fat/low calories options and increasing physical activity
- Finds the DPP beneficial because “...it has changed my life. I feel better and am a happier person.”
- After DPP completion, will miss interactions with fellow participants and hopes to continue progress she has made thus far, on her own

- Increased mobility after losing 41 lbs. – fishing, mowing the yard, enjoying vacations with family
- Has changed the way he shops for food and consumes food – taking time to make informed decisions
- Finds the DPP beneficial because it “...improves the quality of your life.”
- After DPP completion, looking forward to his future, improved quality of life and watching his grandchildren graduate

Henry



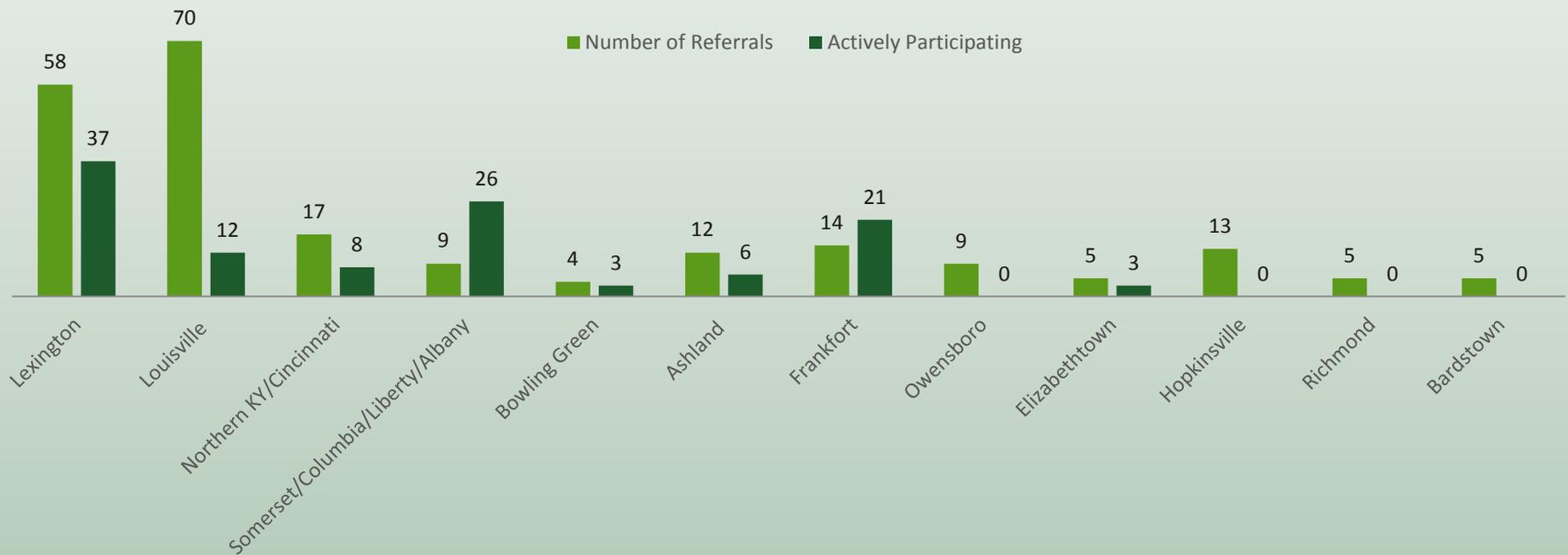
The KEHP Experience - 2015 DPP Participation

214 KEHP members referred as of June 30, 2015

119 KEHP members reported actively participating in a DPP class

Referrals and Participation

■ Number of Referrals ■ Actively Participating



The KEHP Experience – Early 2015 DPP Reporting

Location	City	Start Date	# of Sessions to date	# of KEHP Participants	Average Attendance (%)	Average Weight Loss	Average Physical Activity
						(in lbs.)	(in minutes per week)
Central KY YMCA	North Lexington	28-Jan	13	5	66%	5.2	31
	North Lexington	02-Feb	14	5	68%	2.4	65
	Beaumont Centre	03-Feb	14	6	72%	4.8	89
YMCA of Greater Cincinnati	Cincinnati- Blue Ash	20-Jan	16	1	56%	1	10
	Cincinnati - Powell Crosley	24-Mar	11	1	100%	18.4	52
	Burlington- RC Durr	27-Jan	16	3	100%	10.5	104
	Fort Thomas- Campbell County	23-Mar	10	1	100%	7.5	67.5
	Burlington- RC Durr	15-Apr	8	1	88%	6	32.5
Lake Cumberland District Health	Columbia	22-Jan	14	6	78%	11.33	140.5
	Liberty	21-Jan	13	10	70%	3.2	96.1
	Albany	22-Jan	13	10	86%	16.3	94.8
YMCA of Greater Louisville	Louisville - Downtown	26-Mar	10	2	90%	22.1	182.5
	Louisville - Southwest	30-Apr	5	1	75%	14.2	0
	Louisville - Northeast	23-Feb	13	1	46%	3.4	9
	Louisville - Chestnut St	13-May	4	2	100%	2.6	271.5
The Medical Center Health & Wellness Center	Bowling Green	13-Apr	8	3	92%	5.3	152
KDMC	Ashland	16-Apr	8	6	85%	7.8	76
Lewis County Extension	Lewis	13-May	3	2	50%	3	152
TOTALS			193	66	79%	145	1625
CUMM. AVERAGE						7.85	96.48

Discussion Topics

- KEHP Background
- Diabetes Prevention Plan (DPP)
- **Live Health Online program**
- 2014 Norton/Humana/KEHP Accountable Care Organization (ACO)

LiveHealth Online-Launched by KEHP June 1, 2015

Telemedicine offered at no cost to KEHP members in 2015

Why KEHP launched telemedicine

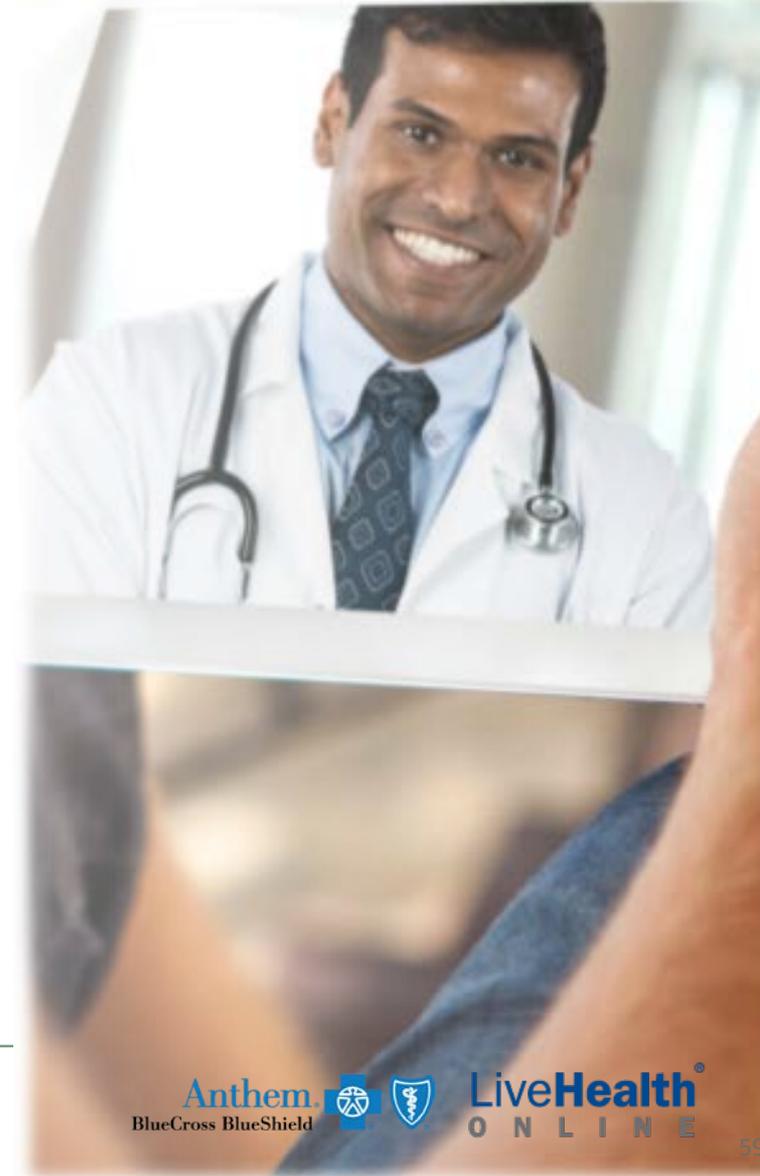
- Acknowledge and embrace technology that has dramatically changed the landscape of the healthcare industry.
- Socio-economics and demographics of KEHP membership.
- Improve access for rural KEHP members.
- Reduce the time an individual employee has to wait to get a doctor's appointment.
- Create a viable and perhaps more appropriate site for medical service alternative.
- Reduce lost productivity when employees are forced to leave work to go to the doctor.
- Enhance member satisfaction.
- KEHP cost savings:
 - 2014 average PCP visit cost was \$122. The plan paid \$88 on average. With \$0 copay, the net plan cost per LiveHealth Online visit will be \$49, which is ~\$40 lower than a regular PCP visit.
 - If ER visits are avoided as opposed to PCP – savings increase considerably.



Visit with a doctor online, anytime. From work, at home or on the go.

LiveHealth Online:

- Is available anywhere you have a computer or mobile device with Internet access (at home, in the office or on the go)
- Is available in most states including DC*
- Is available 24 hours a day, 7 days a week, 365 days a year
- Provides access to in-network, board-certified doctors
- Allows doctors to ePrescribe** utilizing local pharmacies (where applicable)
- Is secure, convenient and easy-to-use



*LHO is not yet available in the following states: AK, TX, LA, AR, AL and NH.

**In certain states, prescriptions cannot be issued as a result of an online interaction with a doctor.

For state telehealth availability, check the map on

www.LiveHealthOnline.com.

KEHP: Registration and Utilization since June 1, 2015 Launch

4,701 KEHP/LHO
registered
members

1

141 KEHP/LHO
visits

2

Next LHO email
communication
Scheduled for July 8th

3

Continue to report
registration and
utilization

4



KEHP: Registration and Utilization Details

- 4,701 LHO registrations and 141 visits, 96% of which were in KY
- 62% of visits are taking place via smart phone or tablet
- 71% of visits resulted in a prescription (most written amoxicillin and azithromycin)
- 71% of visits were completed by a female
- Utilization by Age:
 - 27% age 30-39
 - 25% age 50-64
 - 17% age 40-49
 - 12% age 18-29

KEHP: Registration and Utilization Details

- Average length of visit = 8:12 minutes
- Average member rating of provider = 4.8 (out of 5)
- Reported alternative place of service: 50% PCP, 29% Urgent Care, 10% no where and 4% ER
- Top 5 Diagnosis:
 - Acute maxillary sinusitis
 - Contact dermatitis & other eczema
 - Acute laryngopharyngitis
 - Allergic rhinitis due to pollen
 - Acute pharyngitis

Discussion Topics

- KEHP Background
- Diabetes Prevention Plan (DPP)
- Live Health Online program
- **2014 Norton/Humana/KEHP Accountable Care Organization (ACO)**

2014 ACO Humana, Norton, and KEHP

- In 2013 KEHP Plan joined the Humana/Norton ACO. The first year of participation served to create the base-line for quality and cost trending for KEHP attributed members.
- Development of ACO included an effective payer–provider relationship (including a joint ACO committee), a focus on performance measurement and reporting, an expanding health information technology infrastructure, and an integrated system that facilitates communication and collaboration across the continuum of care to accomplish true patient centered care.
- Norton, Humana, and KEHP reached an agreement on how to attribute
- Methodology
 - Based on 36 month retrospective review of claims
 - Seeks to identify a PCP by either the most recent Wellness Visit or the majority of Sick Visits incurred

ACO – Quality Component

- For the attributed population, mutually agreed upon Quality Measures are in alignment to Chronic Disease Management initiatives of Group, Payor, and Provider
- The following Quality Measures were deemed to be in scope (based on HEDIS):

Diabetes – A1c Management (testing)	Appropriate Treatment for Children with Upper Respiratory Infection
Diabetes – Cholesterol Management (testing)	Avoidance of Antibiotic Treatment for Adults with Bronchitis
Use of Appropriate Medications for People with Asthma	Persistence of Beta Blocker Treatment after Heart Attack
Cholesterol Management for Patient with Cardiovascular Conditions (testing)	Cervical Cancer Screening
Use of Imaging Studies for Low Back Pain	Breast Cancer Screening
Appropriate Testing for Children with Pharyngitis	Colorectal Cancer Screening
Annual Monitoring for Patients on Persistent Medication	

ACO - Financial Component

- Attributed Membership utilized to obtain a yearly PMPM expense target based on prior year's claims experience
- To determine savings, current year's PMPM Expense compared to PMPM Expense Target
- Mutually agree to share in any savings realized thru the ACO relationship – allocation to Group and Provider

ACO – Value Based Payment

- Both the 1) Financial Experience and 2) Quality Experience of the Attributed Membership are utilized for determination of a Final Reward Payment
- After application of the agreed upon Shared Savings allocation, Provider's Final Reward Payment is adjusted based on Quality Performance



Next Steps

Next Steps

- The August full stakeholder meeting is scheduled for **Tuesday, August 4, 2015** from **1:00PM – 4:00PM** at the **Kentucky Historical Society** (100 W. Broadway Street, Frankfort, KY 40601). No advance registration is required.

SIM Workgroup	July Date	July Time	July Location
HIT Infrastructure	Tuesday, July 21, 2015	9:00 AM to 12:00 PM	KY Department for Public Health (DPH), Conference Suite A , 275 E Main St, Frankfort, KY 40601
Integrated & Coordinated Care, Payment Reform, Quality Strategy / Metrics	Wednesday, July 22, 2015	9:30 AM to 3:30 PM	KY Department for Public Health (DPH), Conference Suites B-C , 275 E Main St, Frankfort, KY 40601
Increased Access	Thursday, July 23, 2015	1:00 PM to 4:00 PM	KY Department for Public Health (DPH), Conference Suites B-C , 275 E Main St, Frankfort, KY 40601

- All stakeholder meeting materials and workgroup information is posted on the Cabinet's dedicated Kentucky SIM Model Design website here: <http://chfs.ky.gov/ohp/sim>
- Please contact the KY SIM mailbox at sim@ky.gov with any comments or questions

Thank you!