

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



State Innovation Model (SIM) Model Design
July Combined Integrated & Coordinated Care, Payment
Reform, and Quality Strategy / Metrics Workgroups

July 22, 2015
9:30 AM – 3:30 PM

Workgroup Agenda

- **Opening Remarks** 9:30 AM – 9:45 AM
 - **Introductions and Agenda Overview** 9:45 AM – 10:00 AM
 - **Multi-Payer Community Innovation Support Center Panel** 10:00 AM – 11:00 AM
 - **Patient Centered Medical Homes (PCMHs) and Health Homes Panel** 11:00 AM – 12:00 PM
 - *Break/Lunch* 12:00 PM – 1:00 PM
 - **Accountable Care Organizations (ACOs) Panel** 1:00 PM – 2:00 PM
 - **Bundled Payment Initiatives (BPIs) / Episodes of Care Panel** 2:00 PM – 3:00 PM
 - **Closing Remarks and Next Steps** 3:00 PM – 3:30 PM
-

Multi-Payer Community Innovation Support Center Panel

Greater Louisville Healthcare Transformation Plan

Kentucky State Innovation Model

- ***Teresa Couts, EdD:*** Executive Co-Director, KHC and UAW Director, UAW/Ford Community Healthcare Initiative
- ***Randa Deaton, MA:*** Executive Co-Director, KHC and Corporate Director, UAW/Ford Community Healthcare Initiative



Kentuckiana
Health Collaborative

Building a Bridge to Better Health, Better Care and Better Value

KHC Leadership & Staff

**Co-Chairperson:**

Larry Caruso, MBA, Retired GE Senior HR Executive

**Co-Chairperson:**

Diana Han, MD, Medical Director, General Electric

**Co-Chairperson:**

Ken Wilson, MD, System VP - Clinical Effectiveness & Quality, Norton Healthcare

**Treasurer:**

Jason Scherzinger, Community Healthcare Initiatives Consultant, Anthem

**Secretary:**

Reita Jones, RN, KY Diabetes Network & KY Dept. of Public Health
Diabetes Prevention & Control

**Executive Co-Director:**

Teresa Couts, EdD, UAW Director, UAW/Ford Community Healthcare Initiative

**Executive Co-Director:**

Randa Deaton, Corporate Director, UAW/Ford Community Healthcare Initiative

**Membership Director:**

Ken Mudd, JD, Director Human Resources, LG&E KU Services Co.

**Public Reporting Workgroup Chairperson:**

Lisa Steele, RN, Clinical Services Coordinator, Baptist Health Employer Solutions

**Executive Coordinator:**

Michele Ganote, BS

Greater Louisville Healthcare Transformation (GLHT) Plan

To create a shared vision among key community stakeholders to reach Triple Aim Goals of improving quality of care and population health, reducing cost trends, and improving experience for patients and their healthcare teams in the Greater Louisville area. Get consensus on common approaches for:

- DELIVERY SYSTEM REDESIGN: parameters & milestones for program
- COMMON MEASURES: measures and target goals
- DATA SHARING: methods for data sharing, transparency, and reporting
- ALIGNED INCENTIVES: for providers & patients (i.e., thru benefit designs)
- CONSUMER ENGAGEMENT: shared decision-making, empowered consensus



GLHT Key Stakeholders

Abbie	Susan Moser	Kentucky Primary Care Association	Emily Beauregard
All Children Pediatrics	Patti Bingham	Kentucky Primary Care Association	David Bolt
Anthem	Dr. Divya Cantor	KentuckyOne Health	Adonna Wickliffe
Anthem	Michael Lorch	KentuckyOne Health	Don Lovasz
Anthem	Jason Scherzinger	KentuckyOne Health	Tom Walton
Baptist Health	Dr. Kenneth Anderson	KHC	Teresa Coutts
Baptist Health	David Gray	KHC	Randa Deaton
Baptist Health	Lisa Steele	Louisville Gas & Electric (LG&E-KU)	Ken Mudd
CHFS Dept. for Medicaid Services	Dr. John Langefeld	Louisville Gas & Electric (LG&E-KU)	Deanna Hall
CHFS Office of Health policy	Karen Cantrell	Louisville Dept. of Health & Wellness	Dr. Laquandra Nesbitt
Family Health Centers	Bill Wagner	Louisville Dept. of Health & Wellness	Dr. Fairouz "Faye" Saad
Foundation for a Healthy Kentucky	Gabriela Alcade	Louisville Govt - Economic Growth & Innovation	Ted Smith
General Electric (GE)	Dr. Diana Han	Norton Healthcare	Dr. Kenneth Wilson
Greater Louisville Medical Society	Lelan Woodmansee	Norton Healthcare	Ben Yandell
Greater Louisville Project	Christen Boone	Park DuValle Health Center	Anthony Omojasola
Humana, Inc.	Dr. Bryan Loy	Passport Health Plan	Jill Joseph Bell
Humana, Inc.	Jeff Bringardner	Passport Health Plan	Dr. Stephen Houghland
Humana, Inc.	Cynthia Hobbs	UL- Kent School of Social Work	Joe D'Ambrosio
Kentucky Benefit Exchange (Kynect)	Carrie Banahan	UL - Kent School of Social Work	Anna Faul
KY Department of Public Health	Sue Thomas-Cox	ULSPHIS	Dean Craig Blakely
KY Health Information Exchange (KHIE)	Polly Mullins-Bentley	ULSPHIS	Dr. Rob Steiner

It Takes A Region



GLHT Overview

Select 20-40 primary care practices to participate in the following:

- Practice Coaching – on-site and remote to learn new models of care
- Shared learning activities with peers and national experts
- Access to and training on how to use data to drive improvement in value-based care settings
- Care Coordination/Care Management Training (optional)
- Data aggregation and other data services
- Enhanced payment to provide care coordination and care management services, provide services not covered by FFS (i.e., secure email), and defray infrastructure costs
- NCQA Application Reviews (optional)

Engage Consumers

- Healthy Living is as Easy as 1-2-3
- Detailed Campaign TBD: ED Utilization, Smoking, & Obesity

GLHT Preliminary Quality Metrics

BETTER CARE

Prevention

- Tobacco Assessment and Counseling
- Adult Weight Screening & Follow-Up (BMI)
- Breast Cancer
- Colorectal Cancer
- Cervical Cancer

Chronic Disease

- Diabetes – HgA1c >9% - Poor Control
- Diabetes - BP<140/90
- Diabetes - LDL documented and LDL control <100
- Asthma – Use of Appropriate Meds
- IVD – Complete Lipid Profile and LDL Control
- Hypertension - BP<140/9

Mental/Behavioral Health

- Clinical Depression Screening & Follow-Up Plan
- SBIRT – Screening for drug and alcohol use

Pediatrics

- Pediatric Weight Assessment & Counseling (BMI)
- Childhood Immunizations (MMR)

BETTER EXPERIENCE

- Patient Satisfaction
- Provider/Staff Satisfaction

BETTER VALUE

- Preventable ED Visits
- Preventable Hospital Admissions
- All cause 30-day Readmissions
- Total Cost of Care
- Smart Referrals

*All measures were aligned to Kentucky Health Now & Louisville Healthy 2020

GLHT Payment Reform Options

- **Meet Advanced Primary Care Practices Where They Are**
 - Early PCMH: FFS + PMPM + P4P
 - Advanced PCMH: Combined FFS/PMPM + Shared Savings
 - PCMH able to take risk: Combined FFS/PMPM + Higher P4P/Shared Savings with risk
 - ACO - Able to share risk across neighborhood Combined FFS/PMPM + Higher P4P/Shared Savings with and without risk
- **Medical Neighborhood**
 - Bundled Payments
 - Episodes of care
 - Risk-adjusted global payment – Accountable Care Organization (ACO)

GLHT Preliminary Health Outcomes

MEASURES	TARGET GOALS AT PRACTICES	COMMUNITY GOALS BY 2019
SMOKING CESSATION - Tobacco Assessment and Counseling – (Ask, Advise, Refer to the Quitline)	≥ 80%	*Reduce Kentucky’s smoking rate by 10%
ADULT OBESITY - Adult weight screening/follow up	≥ 80%	*Reduce the rate of obesity among Kentuckians by 10%
CHILDHOOD OBESITY - WT Assessment & Counseling for nutrition and physical activity in children ages 3 – 17 yo.	≥ 80%	*Reduce the rate of obesity among Kentuckians by 10%
POTENTIALLY AVOIDABLE ED VISITS	TBD	Reduce inappropriate ED visits by x percent
USUAL SOURCE OF CARE	NA	Increase percent of people with PCP from 89.7% to 99% or more of the Louisville Metro population (PCMH or Advanced Primary Care)
EXCHANGE OF HEALTH INFORMATION AMONG VARIOUS ENTITIES	NA	Increase percent/number by 10% of providers/practices actively exchanging a Continuity Care Document (CCD) or other data (to be defined) through KHIE
HAPPINESS INDEX MEASURE	NA	Increase Happiness Index from baseline by ≥ 3%

GLHT STATUS

- Statements of Intent signed by several key stakeholders (plans, systems, & employers)
- Paused effort to ensure alignment with Major State Efforts
 - Alignment to Kentucky Medicaid SIM
 - Alignment to Kentucky REC TCPI grant
- Next Steps – Assessment of Needs



Kentuckiana Health Collaborative

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Louisville, KY 40218

www.khcollaborative.org

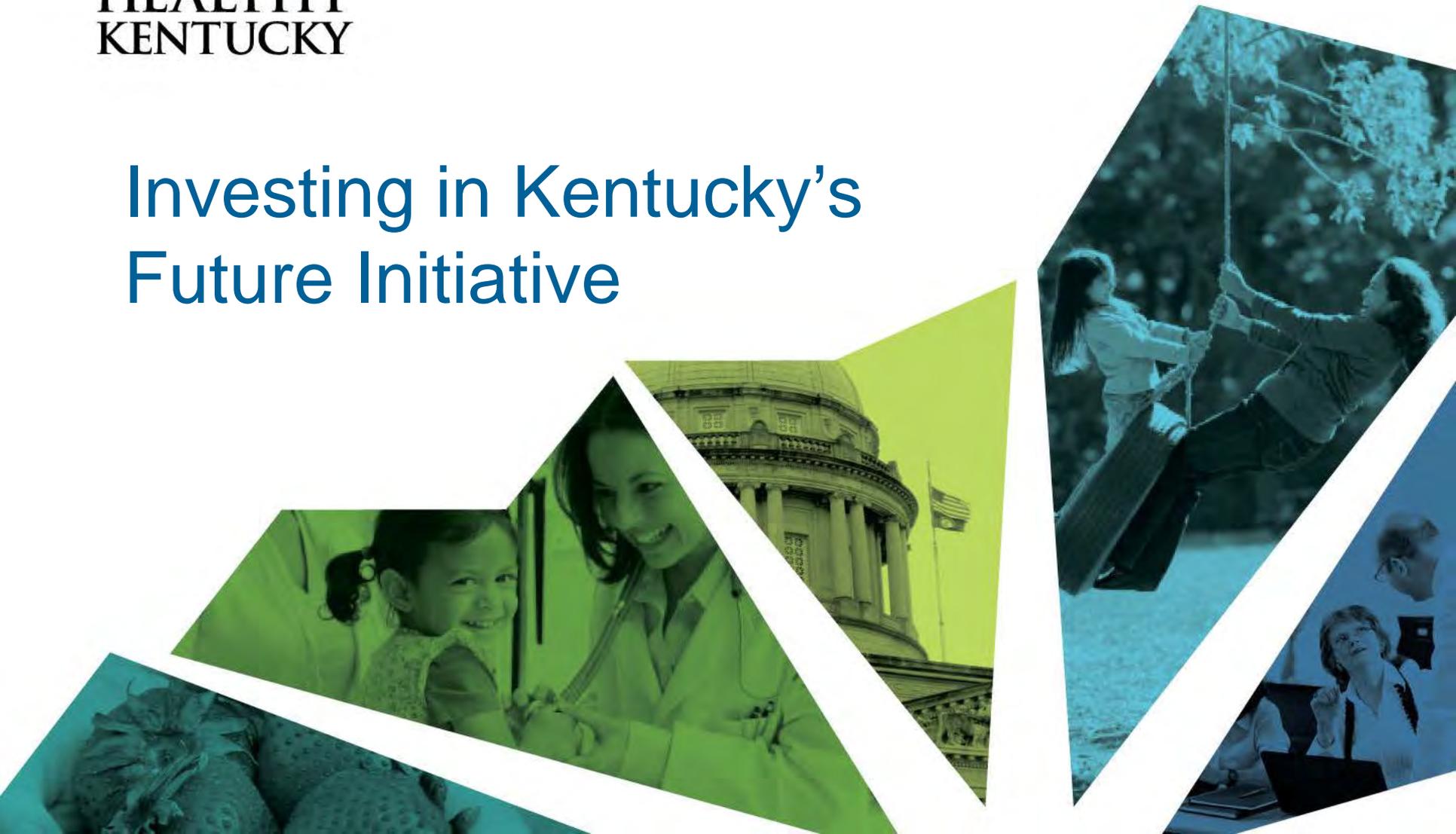
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Executive Co-Directors, Kentuckiana Health Collaborative

- Randa Deaton: rdeaton@ford.com
- Teresa Coutts: tcouts@ford.com



Investing in Kentucky's Future Initiative



Mission

To address the unmet health care needs of
Kentuckians

Investing in communities.

Informing health policy.

Investing in Kentucky's Future

Aim: To improve the health of Kentucky's children by engaging communities in testing innovative strategies.

Investing in Kentucky's Future

- **Grants**
 - **Cross-sector health coalitions**
 - **Pilot innovative strategies with children 5-18, to reduce their adult risk of chronic disease**
 - **7 KY communities:**
 - Self identify priority issue: Obesity prevention/reduction, Adverse Childhood Experiences (ACEs).
 - Planning and Implementation Phases.
- **Training and Technical Assistance**
- **Capture and communicate policy needs**
- **Evaluation**

Investing in Kentucky's Future

What Does Success Look Like in 2017?

- Strength & durability of community partnerships
- Systems and policy changes
- Health behavior change

Planning Phase Evaluation: Lessons Learned

1. Increased **understanding** of children's health issues, community assets
 - Completed assessment/prioritization
 - Quality data
 - Collaborative, data-driven decision-making
2. Increased community **engagement** around children's health issues
 - Strengthened partnerships
 - Expanded membership and engagement
 - Youth involvement
3. Increased **capacity** to identify and address children's health issues
 - **Coalition:** focus; momentum; formal structure; satisfaction with coalition functioning
 - **Individual:** relationships; connections; experience; increased confidence in ability to improve children's health

Planning Phase Evaluation: Lessons Learned

Key Findings from Planning Phase

1. Successful partner engagement - community needs and assets
2. Locally-driven approach, funding for planning/assessment → increased local ownership
3. Challenges - cash match, business plan; varied by community
4. Technical assistance valued, level of needed support varies
5. Understanding/commitment to evaluation for own use varies

Patient Centered
Medical Homes
(PCMHs) and Health
Homes Panel

Transforming Healthcare Across the Medical Neighborhood

Trudi Matthews
Managing Director
Kentucky REC



A journey of a thousand miles begins with a single step...



Meaningful Use: The Foundation

- Kentucky REC has helped 1000+ providers with Meaningful Use (MU) of Health IT
- NCQA's 2014 PCMH Standards align with MU requirements
- PCMH standards assume use of Health IT - facilitated by EHR, registries, HIE

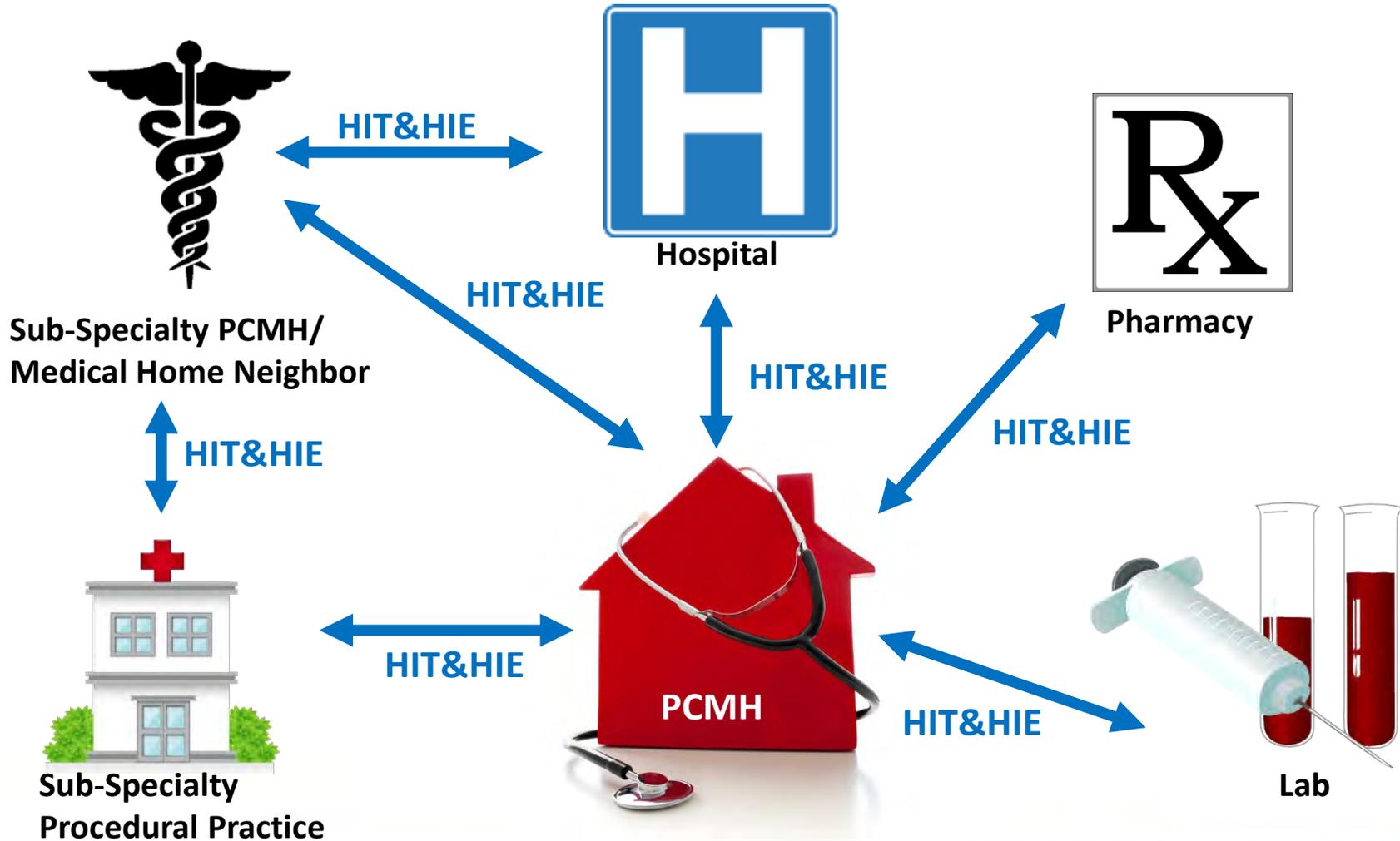


Kentucky REC PCMH Successes

- Supporting practices since 2013; 3,000+ hours content and educational material development
- NCQA PCMH Recognition:
 - Level 3: 5 organizations/8 practice sites
 - Level 2: 2 organizations/4 practice sites
 - Many major health system contracts
- Current PCMH Cohort (March 2015):
 - 12 organizations/25 practice sites
 - 2 Patient-Centered Specialty Practices
 - Behavioral Health & AIDS Clinic
- Upcoming Cohorts:
 - Kentucky Primary Care Association (KPCA),
 - Fall 2015 Cohort Planned



Patient Centered Medical Homes are Just One Part of a Connected Medical Neighborhood



Practice Transformation Network

Funding Overview:

- **Purpose:** A new 4 yr. funding opportunity from CMS to help 150,000 clinicians nationwide transform practice and prepare for new payment models
- University of Kentucky was the Prime for a 5-state proposal aimed at helping 5,700 clinicians – applied in Feb 2015
- Estimated Award Date: July/August, 2015
- SIM, PTN and PCMH projects are mutually beneficial ways to support practice transformation.

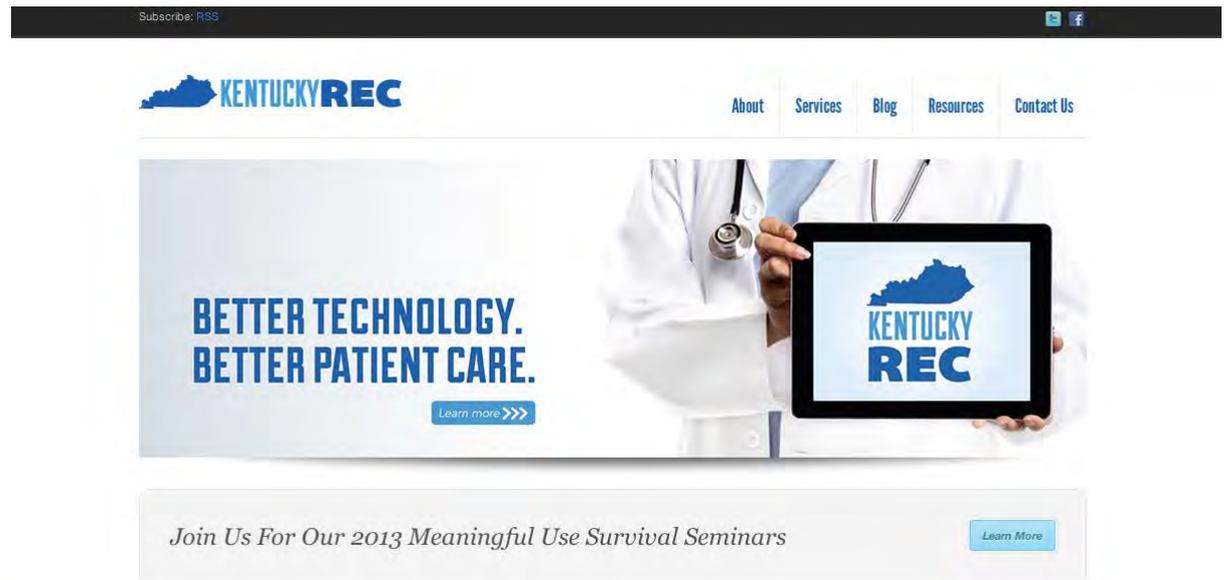
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Like us on Facebook: facebook.com/EHRResource

Follow us on LinkedIn: linkedin.com/company/kentucky-rec

Check out our website: www.kentuckyrec.com

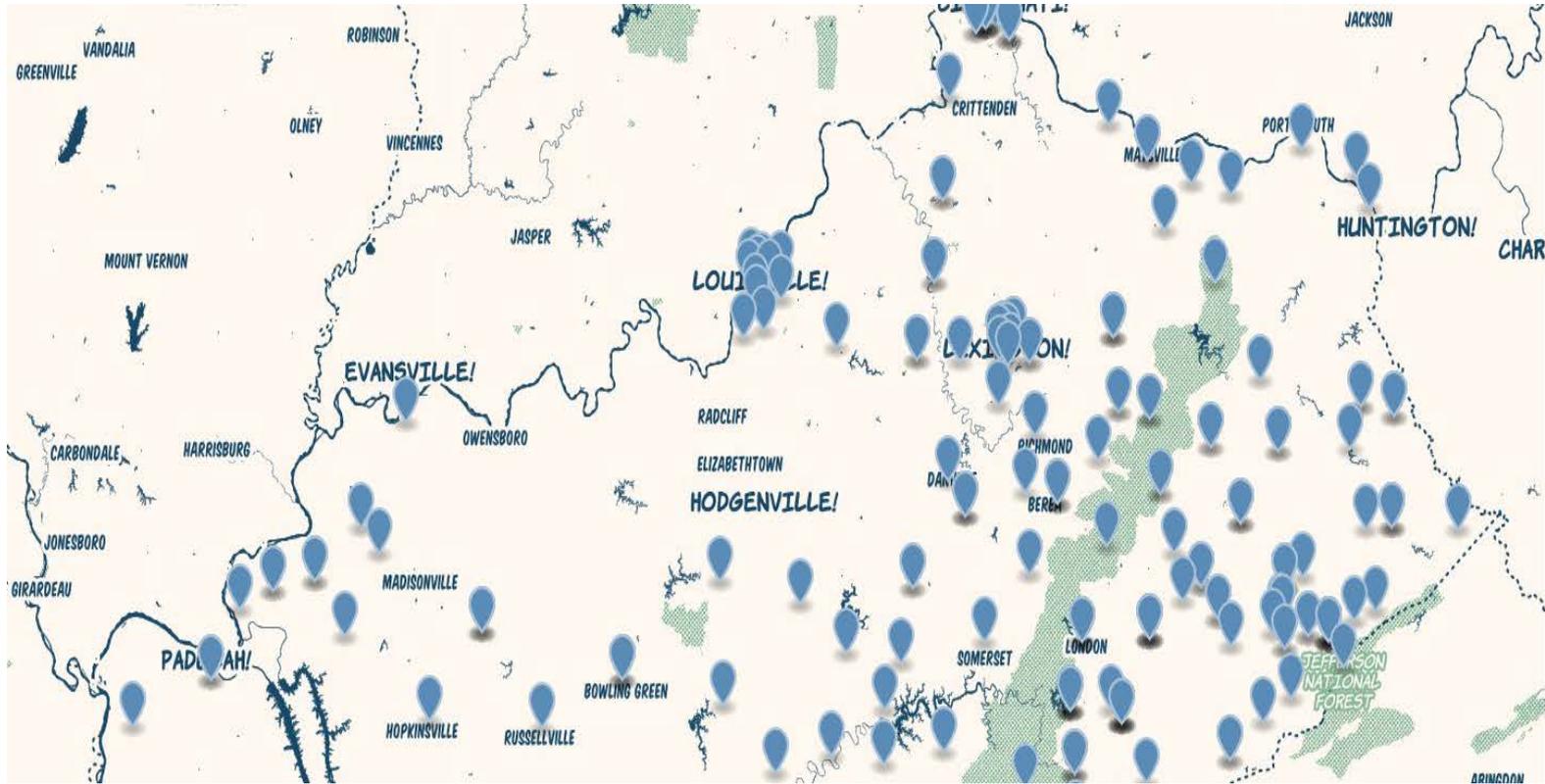


Our Mission

To promote access to comprehensive, community-oriented primary health care services for the underserved.

To develop primary health care as a vital component of a comprehensive health care system within the Commonwealth of Kentucky.

Our Membership



Kentucky Primary Care Association

IPA and ACO Development

Messenger-style IPA

- 4 Medicaid MCOs
- 3 Commercial
- 1 Medicare Advantage

Primary Objectives...

1. Negotiating power
2. Administrative support
3. Health informatics & QI infrastructure
4. Training & TA to drive practice transformation
5. Align payment incentives



Our Vision

To create a high performing preferred provider network with financially stable membership providing cost effective, high quality, patient centered primary care.



Kentucky Primary Care Association

PCMH

- 18 member organizations recognized
- Primarily FQHCs, but RHCs are beginning to get on board
- Starting a PCMH Cohort in partnership with the KyREC



Lessons learned

- PCMH recognition is not transformation
- Data is key
- Payment must support true population health
- We need community-based systems of care



ROADMAP TO TRANSFORMATION

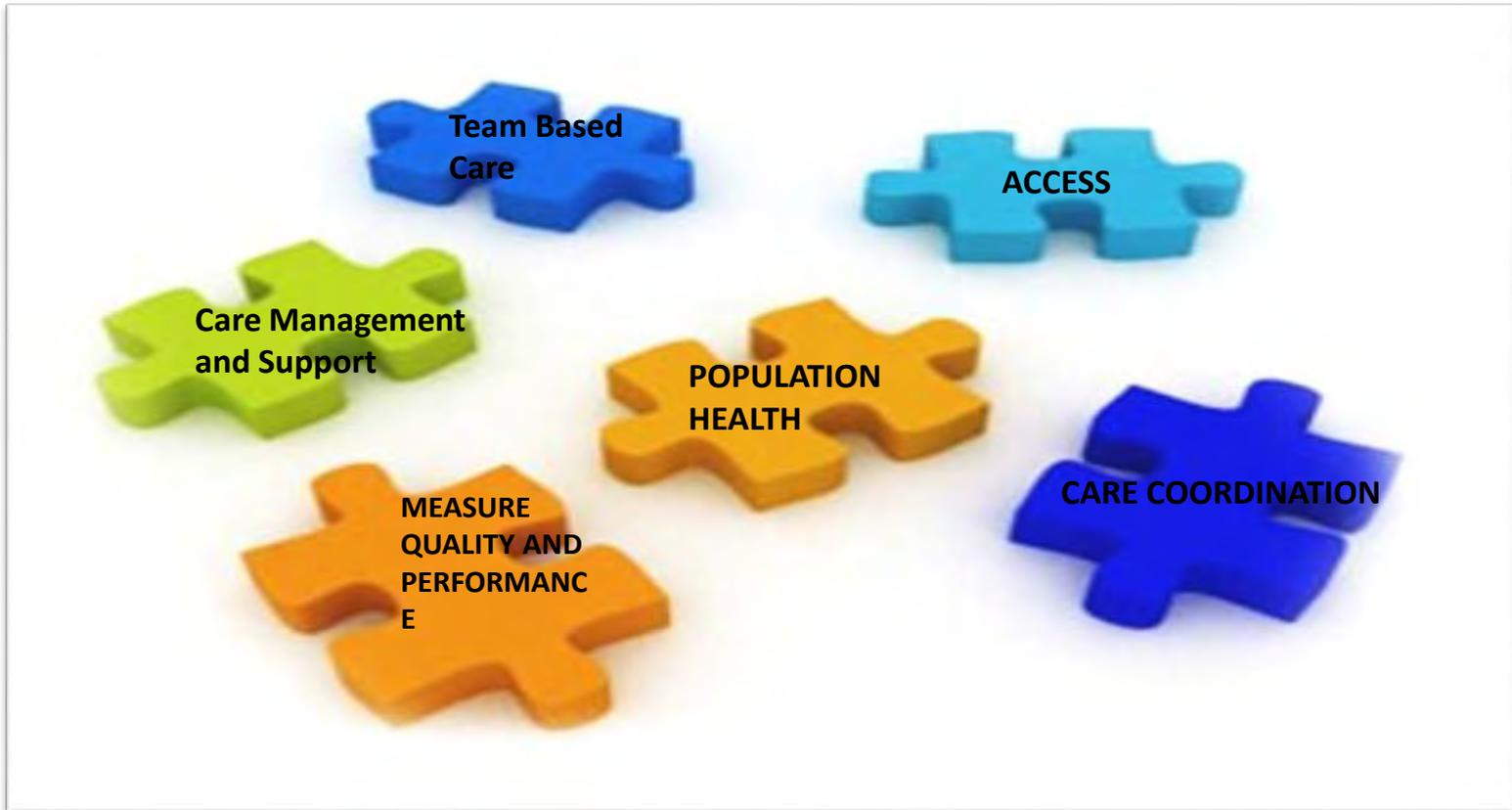
MERCY MEDICAL CLINIC – POWELL COUNTY

MERCY MEDICAL CLINIC – LEE COUNTY

MERCY PRIMARY CARE – IRVINE

Angie Ross, RN

...ONE PIECE AT A TIME



Standard 1 – Patient Centered Access

- Patients have access to routine/urgent care & clinical advice during/after hours
- Same Day Appointment
- Electronic access through MYChart, our patient Portal



Standard 2 – Team Based Care

- Defined our care team and hold regular meetings
- Process to orient new patients to the practice – Welcome Letter



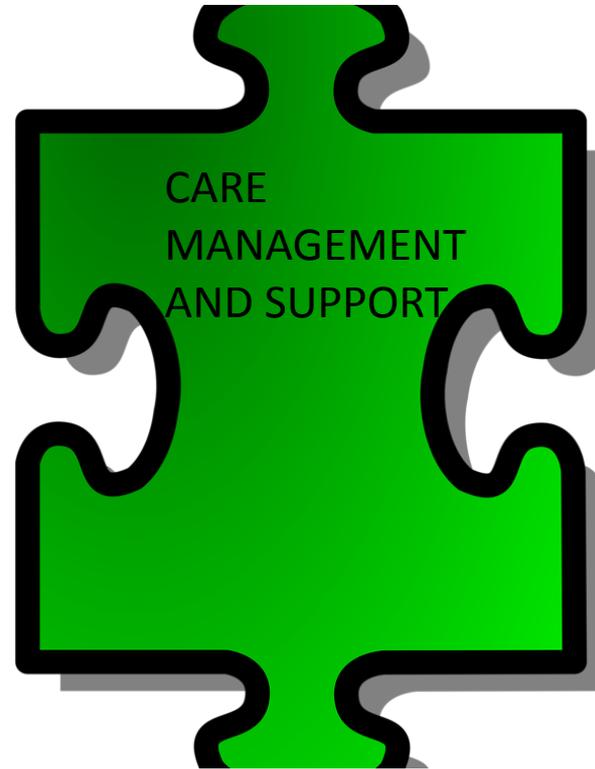
Standard 3 – Population Health Management

- Implemented evidence-based guidelines
- Implemented Pre-Visit Planning
- Developed plan and treatment goals



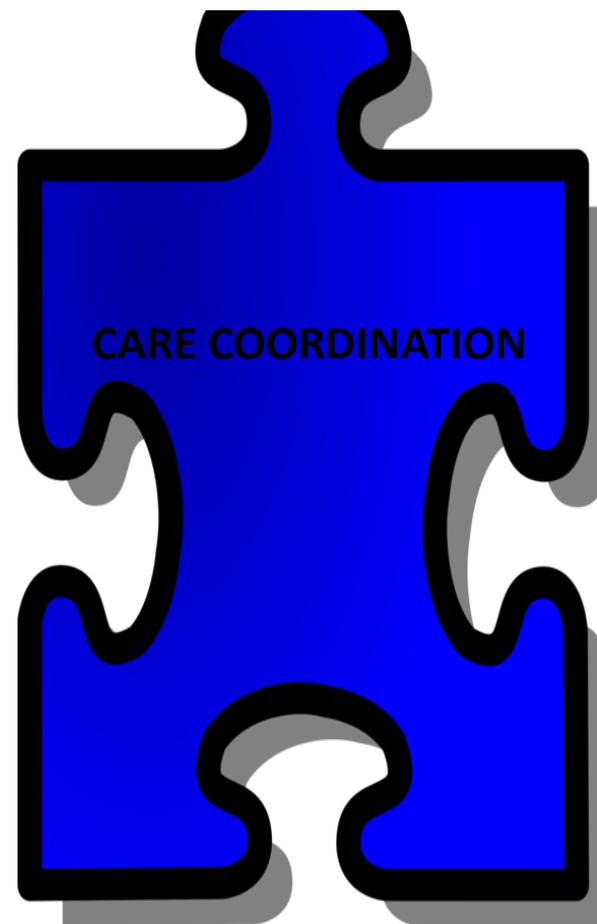
Standard 4 – Care Management and Support

- Developed process to identify and monitor patients who require Care Management (High Risk Patients)
- Ability to prescribe prescriptions electronically



Standard 5 – Care Coordination and Care Transition

- Track and follow-up on lab/imaging results
- Coordinate care received at hospitals and other facilities
- Share and receive clinical information with admitting hospitals and ER departments



Standard 6 – Quality Measure & Improve Performance

- Measure preventive, chronic and acute care
Explorys – Our patient clinical data reporting application (Information is pulled from our EMR)
- Set patient goals and act to improve performance



BENEFITS

- PATIENTS

- Enjoy healthier lifestyles
- Share in their health care decisions
- Assured better access

- PHYSICIANS

- Focus on delivering high quality medical care to patients who really need it

- PRACTICES

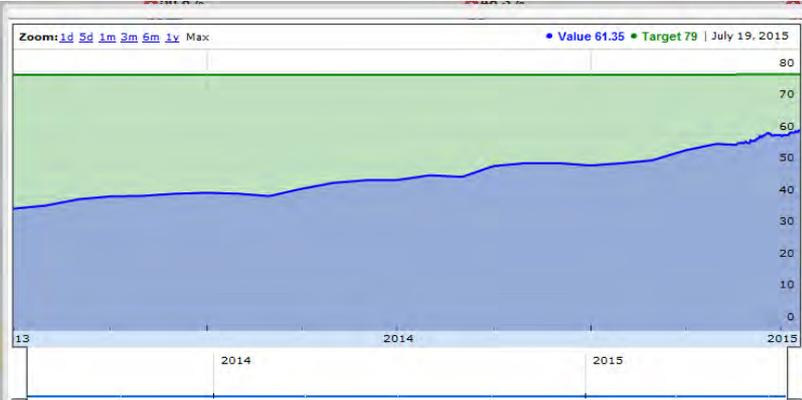
- Team works effectively together
- Work smarter not harder

- PAYORS AND EMPLOYERS

- In the future, physicians and hospitals will be paid based on outcomes – and not fee for service. So the focus will shift from quantity to quality. By becoming a Patient Centered Medical Home – this puts us ahead of the curve . We're already focusing on quality and value – as opposed to volume and production.

PCMH Outcome Data – Explorys Report:

- ACO 14a - Influenza Immunization (Current Season)
- ACO 14b - Influenza Immunization (Previous Season)
- ACO 14c - Influenza Immunization (Annual)
- ACO 15 - Pneumonia Vaccination Status for Older Adults
- ACO 17 - Tobacco Use Screening and Cessation Intervention
- ACO 18 - Screening for Clinical Depression and Follow-Up Plan
- ACO 19 - Colorectal Cancer Screening
- ACO 20 - Breast Cancer Screening
- ACO 22 - DM - Controlled A1c



Population Health -- Breast Cancer Screenings: July 2013 -- 36.74% ---- July 2015 -- 61.29%

- MERCYHEALTH Measure
- The D5 Prime Report / The D5 Prime Report
- Name
- 1. D5c: Controlled A1c (NQF 0729c)
 - 2. D5a: Controlled BP (NQF 0729a)
 - 3. D5d: Non-Smoking Status (NQF 0729d)
 - 4. D5e: Appropriate Aspirin Use (NQF 0729e)
 - 5. High or Moderate Intensity Statin or Exception
 - 6. D5 Prime: Composite Measure for Optimal Diabetes Care (Custom)

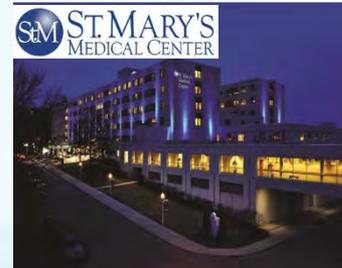


High Risk Condition -- Diabetes: July 2013 -- 18.91% ---- July 2015 -- 32.31%

Accountable Care Organizations (ACOs) Panel



EASTERN KENTUCKY HEALTHCARE COALITION



Mission and Goals

Mission:

To develop a clinically-integrated network that has a focus on Quality, Cost, Patient Satisfaction and Physician Leadership while engaging the communities we serve in an accountable and responsible manner .

Goals:

- Clinical Integration
- High Performing Network
- Development of Physician Leadership
- Physician Engagement
- Triple Aim plus One
- Integrated I.T. platform



Background

- Leaders from OLBH, SCR and HRMC brought together in 2011.
- EKHC formed as a Limited Liability Company “Super PHO” August, 2012
- St. Mary’s and UK Healthcare join EKHC Spring 2013



Adding it all Together



- 214 total beds
- 277 physicians
- 900+ employees



- 166 total beds
- 100+ physicians
- 600 employees

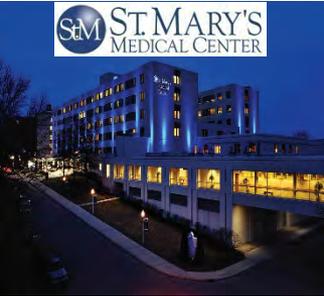


- 149 total beds
- 100+ medical staff
- 1,300+ employees

Adding it all Together



St. Mary's
MEDICAL CENTER



- 463 total beds
- 333 physicians
- 2600 employees



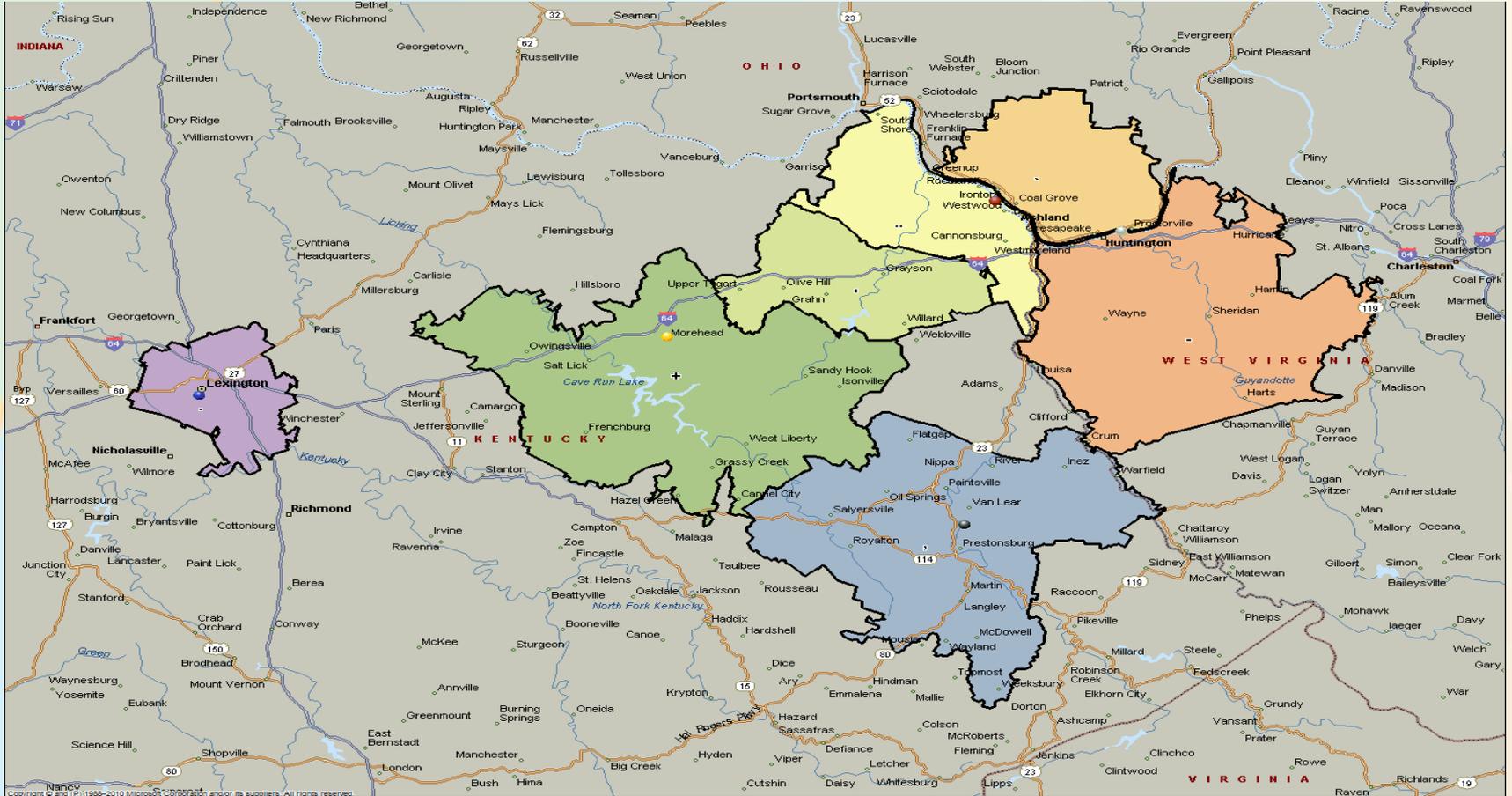
UK HealthCare



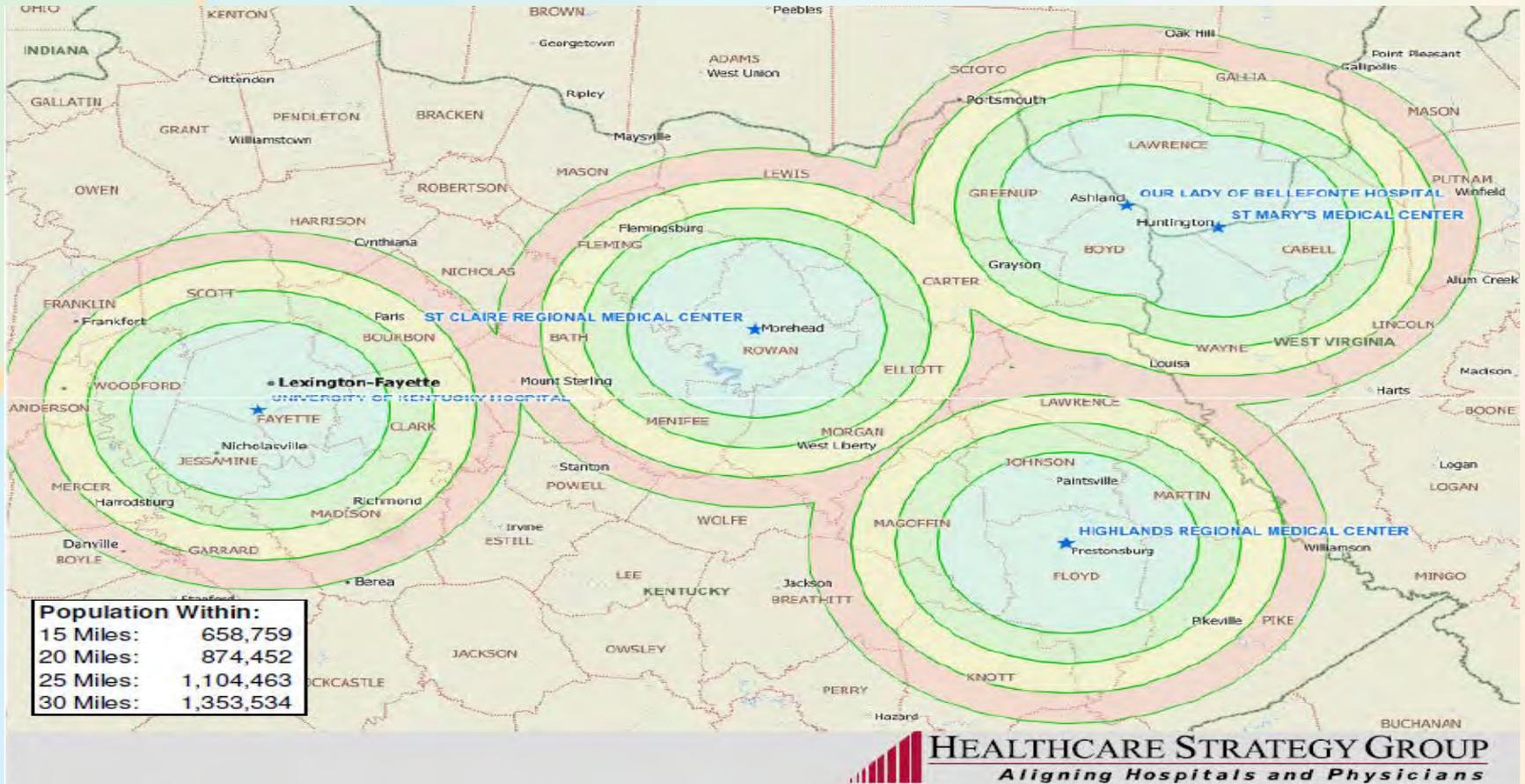
- 791 total beds
- 950 physicians
- 9000 employees

COALITION = **1,783 total beds**
TOTAL = **14,400 employees**
= **1,780+ physicians**

EKHC Primary Service Area



Potential Population Impact



EASTERN KENTUCKY
HEALTHCARE COALITION

Advantages

- **Retain individuality**
- **Trust between partners**
- **Communication and collaboration**
- **Development of high quality network attractive to payers**
- **Strategically aligned for healthcare reform**



Current Payment Models Within EKHC

- Medicare MSSP- No down side risk. 31 Quality Metrics around attributed panel. 7200 lives within Kentucky
- Gain Share Model- Medicaid MCO's. Metrics are set around HEDIS Measures
- Pay for Performance- Commercial Payor. Metrics are around Utilization and HEDIS measures.
- Bundled Payments- Medicare arrangement focusing on Orthopedics.
- Shared Savings Model Development- Shared Savings model developed in conjunction with one MCO.





KentuckyOne Health Partners

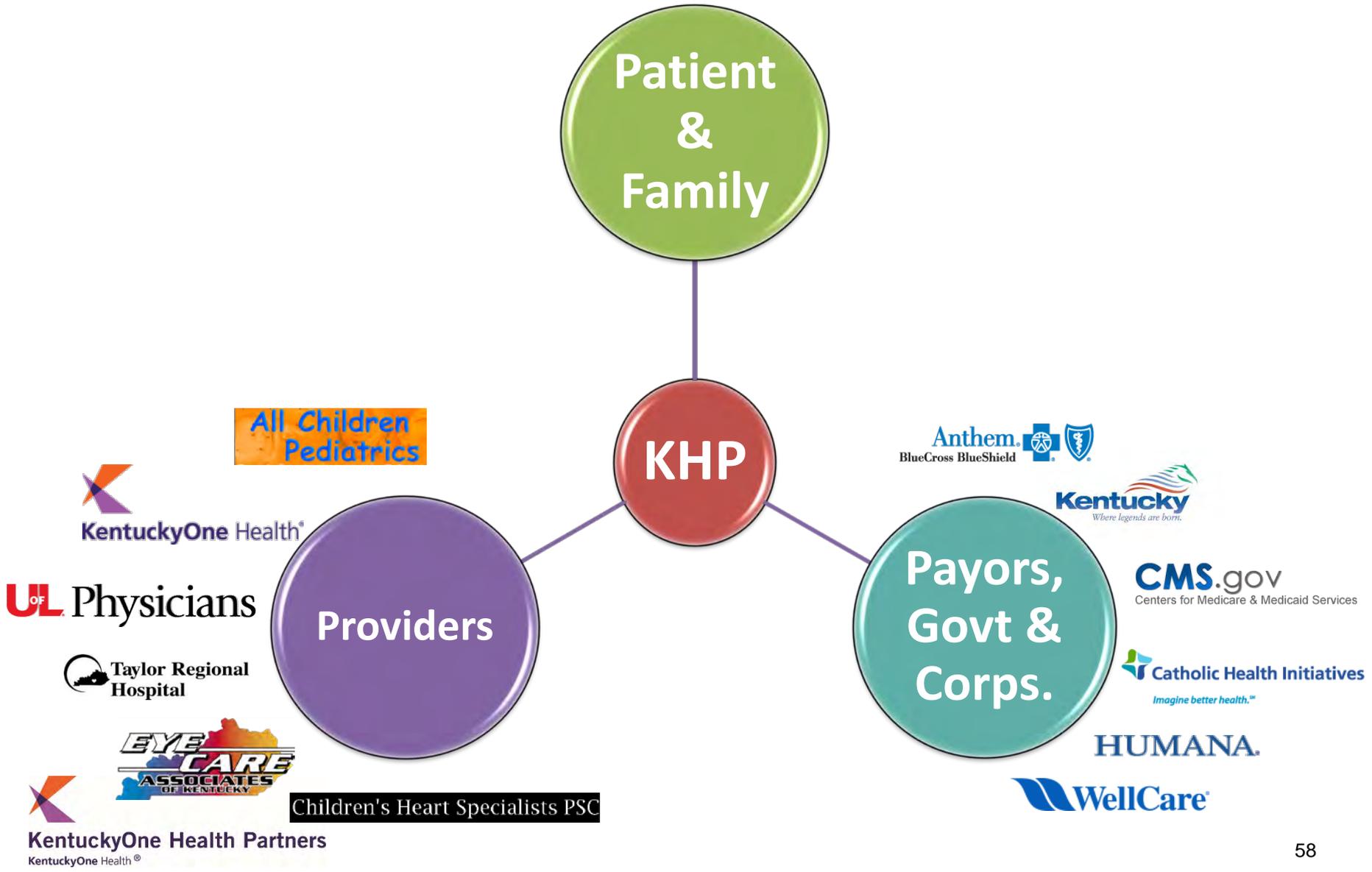
KentuckyOne Health®



State Innovation Model: ACO Panel

July 22, 2015

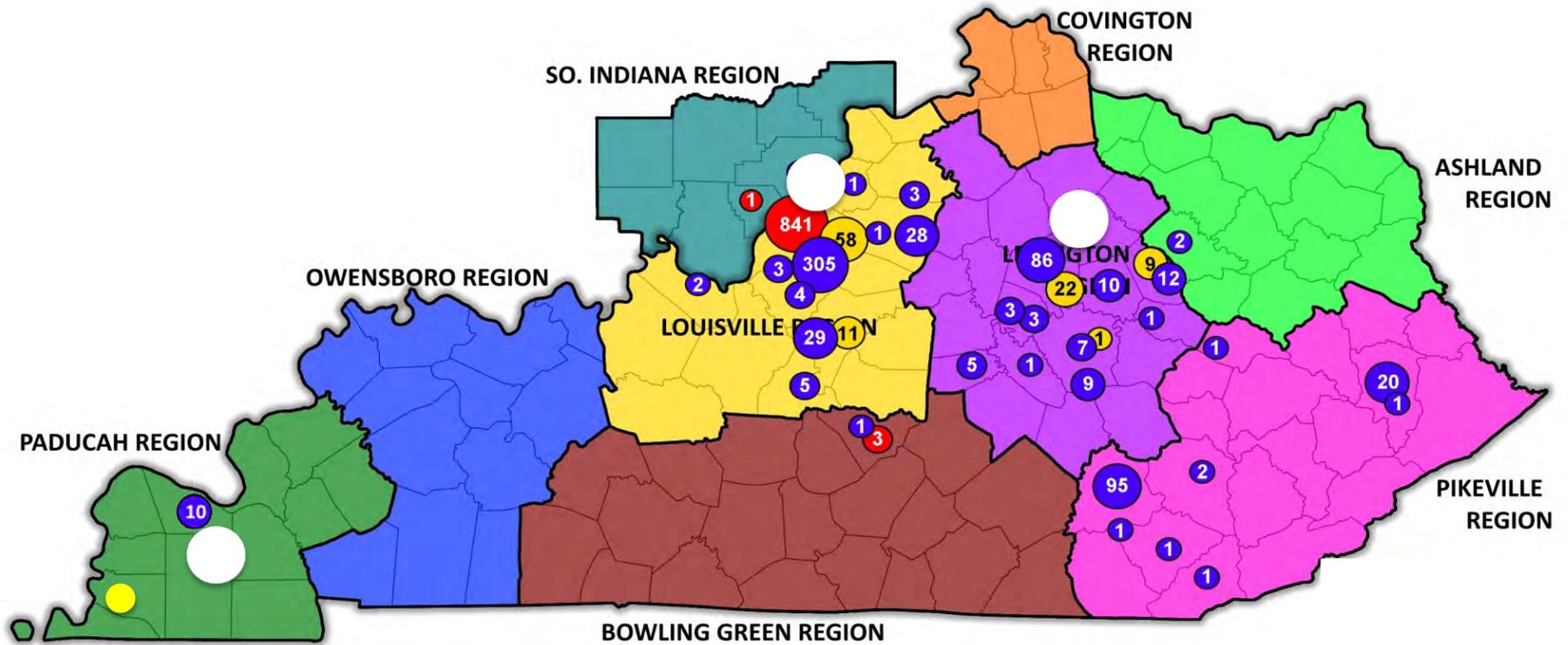
The Role of KentuckyOne Health Partners



Outcomes

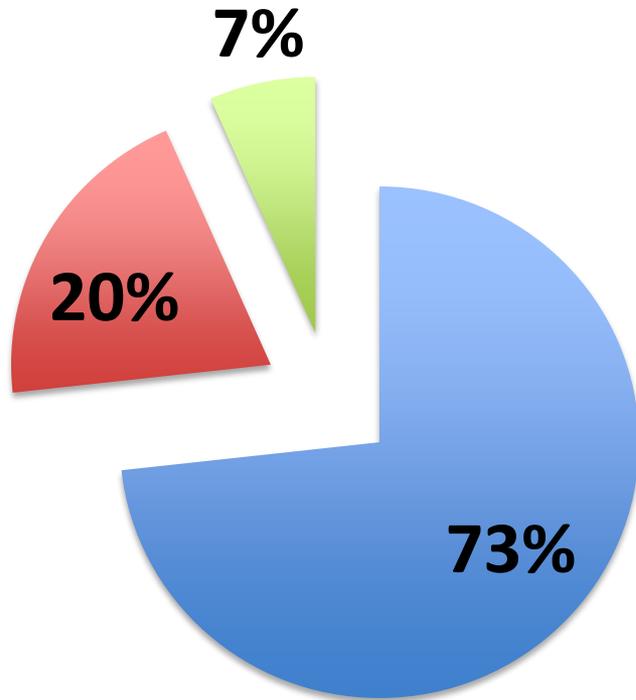
Better Health	Better Care	Better Experience	Lower Cost
Health Knowledge	Protocol Adherence	Patient Satisfaction	Medical Spend
Preventive Screenings	In-Network Care	Participant Satisfaction	Episodes of Care
Mobility	Utilization <ul style="list-style-type: none">• ED• Inpatient Readmission	Client Satisfaction	

2014 Provider Map



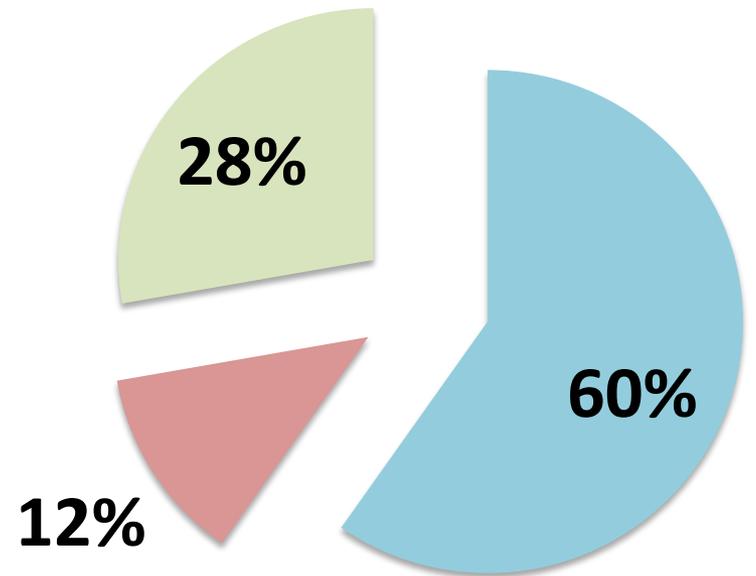
KHP Network

1,700 Providers



■ Physicians ■ APCs ■ Other

72,000 Lives & 1,000 Episodes



■ Medicare ■ Medicaid ■ Commercial

Contract Types

1. Care Coordination (PMPM)
2. Pay-For-Performance (P4P)
3. Hospital Efficiency (Projects)
4. Episode-of-Care (90-day Bundles)
5. Disease Management (Gain Share)
6. Population Health Management (Risk Share)

Provider Portal: Longitudinal Care Record

Provider Portal

Include Network(s): KY Out of Network

Employer: Plan:

Patient Lookup ?

Show me Results for: PCP | My Patients | My Practice | All Enrollees Lookback:

Last Name: First Name: DOB:

<< < > >> Displaying records : 1 through 50 of 70

Name ?	Address	Date of Birth	Employer/Plan	View ?
1 E XXXXXXXXXXXX, XXXXXXX	✘ XXX XXXXXXXXXX XXXXXX, XX	07/21/1940	CMS Kentucky Medicare	Chart Referrals Claims Enrollment
2 E XXXXXXXXXXXX, XXXXXXX	✘ XXX XXXXXXXXXX XXXXXX, XX	05/31/1924	CMS Kentucky Medicare	Chart Referrals Claims Enrollment
3 E XXXXXXXXXXXX, XXXXXXX	✘ XXX XXXXXXXXXX XXXXXX, XX	08/28/1928	CMS Kentucky Medicare	Chart Referrals Claims Enrollment
4 E XXXXXXXXXXXX, XXXXXXX	✘ XXX XXXXXXXXXX XXXXXX, XX	04/03/1931	CMS Kentucky Medicare	Chart Referrals Claims Enrollment
5 E XXXXXXXXXXXX, XXXXXXX	✘ XXX XXXXXXXXXX XXXXXX, XX	02/04/1942	CMS Kentucky Medicare	Chart Referrals Claims Enrollment

My Population's Management Needs ? Toggle View

Risk Level	Total	Nurse Assigned	No Nurse Assigned
Priority	0 0%	0 0%	0 0%
High	30 43%	1 3%	29 97%
Moderate	33 47%	0 0%	33 100%
Low	7 10%	0 0%	7 100%
No known risk	0 0%	0 0%	0 0%
Total	70 100%	1 1%	69 99%

My Population's Conditions ? Toggle View

Emergency medicine	0 0%	0 0%	0 0%
Epilepsy	1 1%	1 100%	0 0%
Glaucoma Screening in Older Adults (National Standard)	65 93%	37 57%	28 43%
Global Rules	35 50%	33 94%	4 11%
Heart Failure - ACE and Acceptable Alternatives	10 14%	2 20%	8 80%
Hyperlipidemia	57 81%	50 88%	14 25%
Hypertension	69 99%	67 97%	13 19%
Total Unique Patients	70	100%	100%
Total Unique Rules	236	78%	62%

Background on Shared Savings Methodology

The MaineCare Accountable Communities (“AC”) program aims to promote better coordination, higher quality, and greater efficiency of care through implementation of a shared savings methodology.

What is Shared Savings

- A shared savings methodology typically comprises four important concepts:
 - Total cost of care (TCOC) PMPM benchmark and care quality metrics
 - Provider payment incentives for improved care quality and more efficient care
 - A performance period to monitor changes
 - An evaluation to determine cost savings achieved in performance period and assess improvements of care quality

Goal of Shared Savings Methodology

- Shared savings methodology shall encourage care coordination and practice transformation activities
- Shared savings methodology shall incorporate reasonable parameters to ensure that incentive payments are based on true savings, and not random data volatility
- Shared savings methodology shall improve care quality

A Shared Savings Methodology is a means to promote higher quality and more efficient care

Maine's Two Shared Savings Models

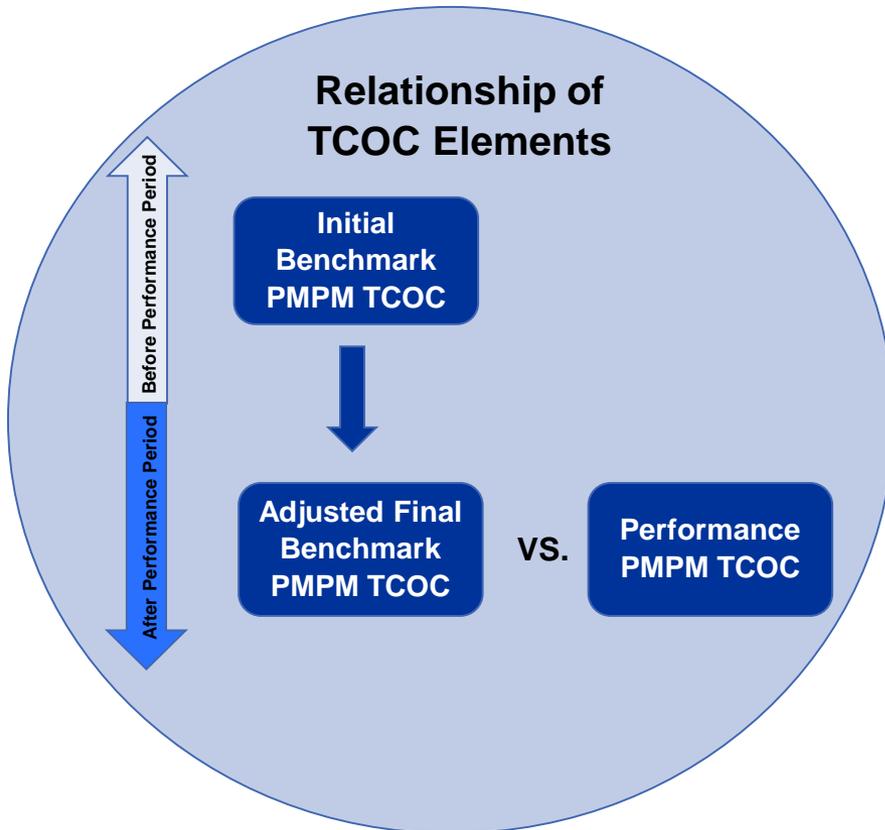
ACs can choose to participate under Model 1, a one-sided shared savings only model, or Model 2 a two-sided shared savings and losses model.

	Model I: Shared Savings Only	Model II: Shared Savings and Losses
Minimum Attributed Members	<ul style="list-style-type: none"> 1,000 	<ul style="list-style-type: none"> 2,000
Minimum Savings/Loss Rate (MSR)	<ul style="list-style-type: none"> -2.5% for Population Size of 1,000 to 4,999 -2.0% for Population Size of 5,000+ 	<ul style="list-style-type: none"> +/-2.5% for Population Size of 1,000 to 4,999 +/-2.0% for Population Size of 5,000+
Maximum Shared Savings Rate	<ul style="list-style-type: none"> Up to 50% back to first dollar Actual shared savings rate dependent on quality scores 	<ul style="list-style-type: none"> Up to 60% back to first dollar Actual shared savings rate dependent on quality scores
Performance Payment Cap	<ul style="list-style-type: none"> 10% of Benchmark PMPM TCOC 	<ul style="list-style-type: none"> 15% of Benchmark PMPM TCOC
Shared Loss Rate	<ul style="list-style-type: none"> No Downside Risk 	<ul style="list-style-type: none"> 40%-60% (Equals 1 – shared savings rate with a 60% cap, and actual shared loss rate is dependent on quality scores)
Loss Recoupment Cap	<ul style="list-style-type: none"> No Downside Risk 	<ul style="list-style-type: none"> Year 1: No Downside Risk Year 2: Risk capped at 5% of Benchmark PMPM TCOC Year 3: Risk capped at 10% of Benchmark PMPM TCOC
Claim Cap	<ul style="list-style-type: none"> \$50,000 for Population Size of 1,000 to 1,999 \$200,000 for Population Size of 2,000 to 4,999 \$500,000 for Population Size of 5,000 + 	<ul style="list-style-type: none"> \$50,000 for Population Size of 1,000 to 1,999 \$200,000 for Population Size of 2,000 to 4,999 \$500,000 for Population Size of 5,000 +

ACs that choose to become accountable for shared losses under Model II will have the opportunity to receive a greater portion of shared savings

Recap of Key Elements of the MaineCare AC Program

The initial benchmark, adjusted final benchmark, and the performance PMPM TCOC are key elements in the MaineCare Accountable Communities Program. Below shows the relationship amongst these items.



Initial Benchmark PMPM TCOC

- Serves as an estimate of the adjusted final benchmark PMPM TCOC
- Uses State Fiscal Year 2013 data with 2-months run-out with adjustments for policy change, completion, trend and claims cap
- Shared before the performance period begins

Adjusted Final Benchmark PMPM TCOC

- Uses State Fiscal Year 2013 data with 30-months run-out for interim calculation and 41-months run-out for final calculation
- Adjusted for policy change, completion (if needed), trend, risk and claims cap

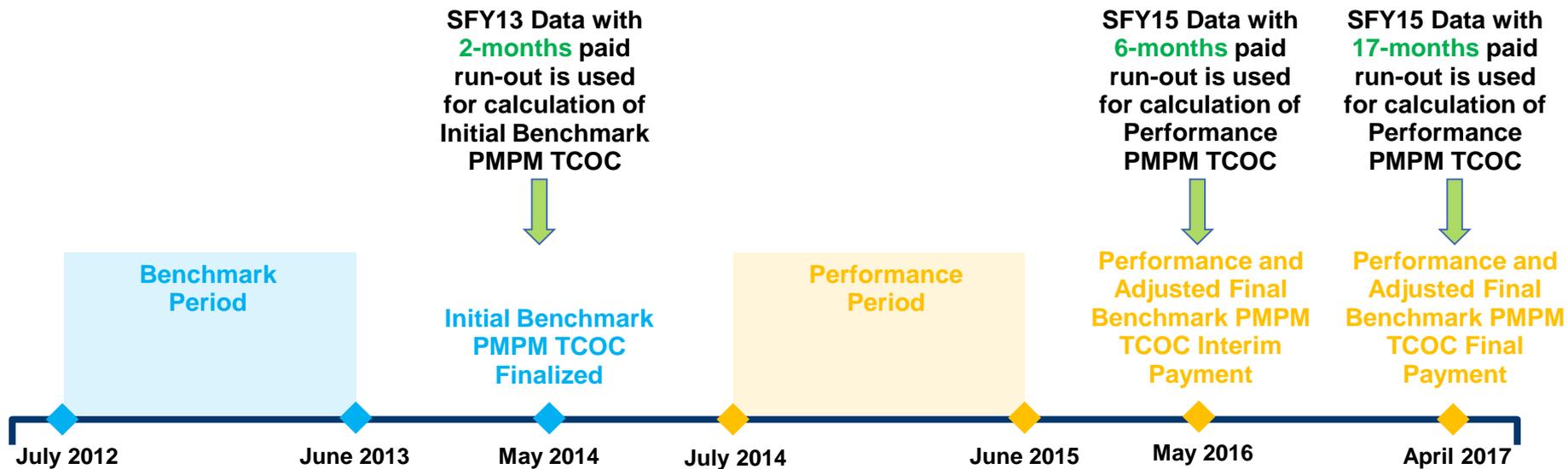
Performance PMPM TCOC

- Uses State Fiscal Year 2015 data with 6-month run-out for interim calculation and 17-month run-out for final calculation
- Adjusted for completion (if needed) and claims cap
- Interim savings will be determined by May 2016 and final savings by April 2017. Allows 1 month for DHHS to receive data and 3 months for calculations. Payments will be made within 30 days of reports.

Recap of Timeline for MaineCare Accountable Communities Program

The timeline for the shared savings calculation in performance year 1 is discussed below.

Performance Year 1 Timeline:



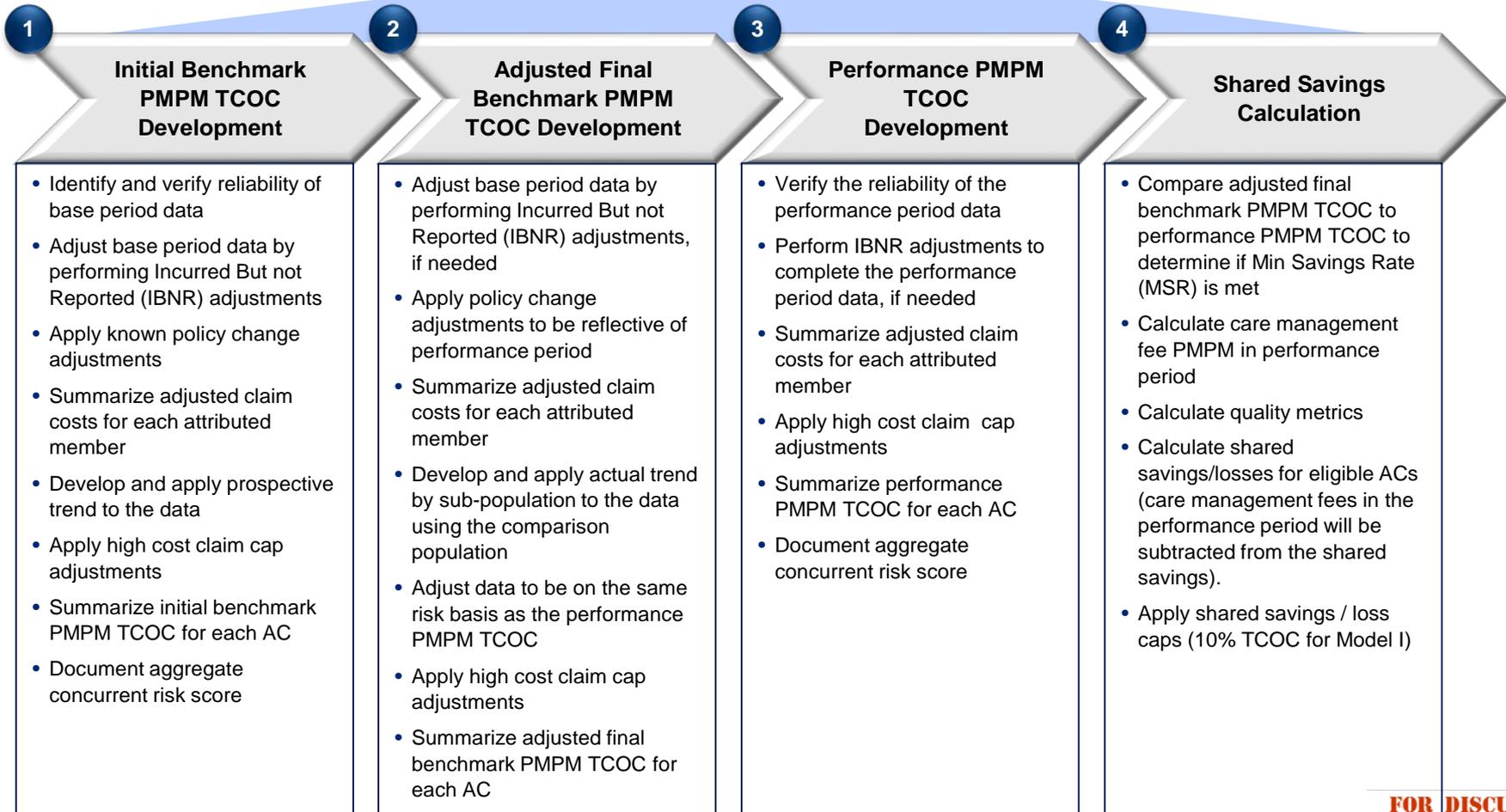
Rebasing

- Benchmark PMPM TCOCs will only be rebased after the initial 3 year test period
- The Benchmark PMPM TCOC for Performance Years 2 and 3 will be based on the Base Year TCOC adjusted for policy, risk, trend, and claims cap between the Base Year and the end of each Performance Year.

Recap of Steps in Shared Savings Calculation

The main steps to calculate shared savings are listed below.

Shared Savings Calculation Steps



**FOR DISCUSSION
DRAFT
PURPOSES ONLY**

Bundled Payment Initiatives (BPIs) / Episodes of Care Panel



KentuckyOne Health Partners

KentuckyOne Health®



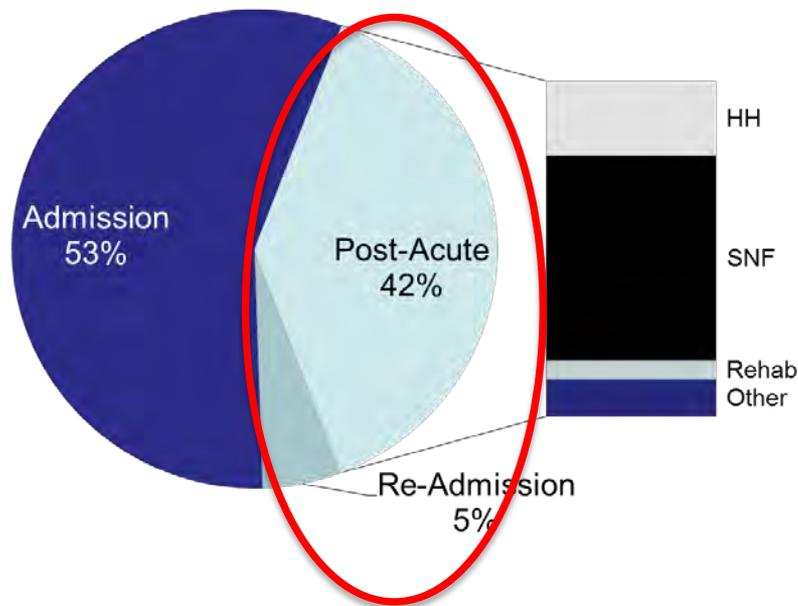
State Innovation Model: Episodes of Care Panel

July 22, 2015

The Opportunity – Medical Spend Reduction

Typical Medicare Charges:
\$1.2K / Ortho Surgeon
\$12K / per hospital

Overall Sample Episode
Medical Spend



INP Rehab Utilization

- Reduce overall utilization
 - From INP Rehab to SNF

SNF Utilization

- Realign from low to high performers
- Reduce SNF LOS of low performers
- Reduce overall utilization
 - From SNF to HH

Home Health

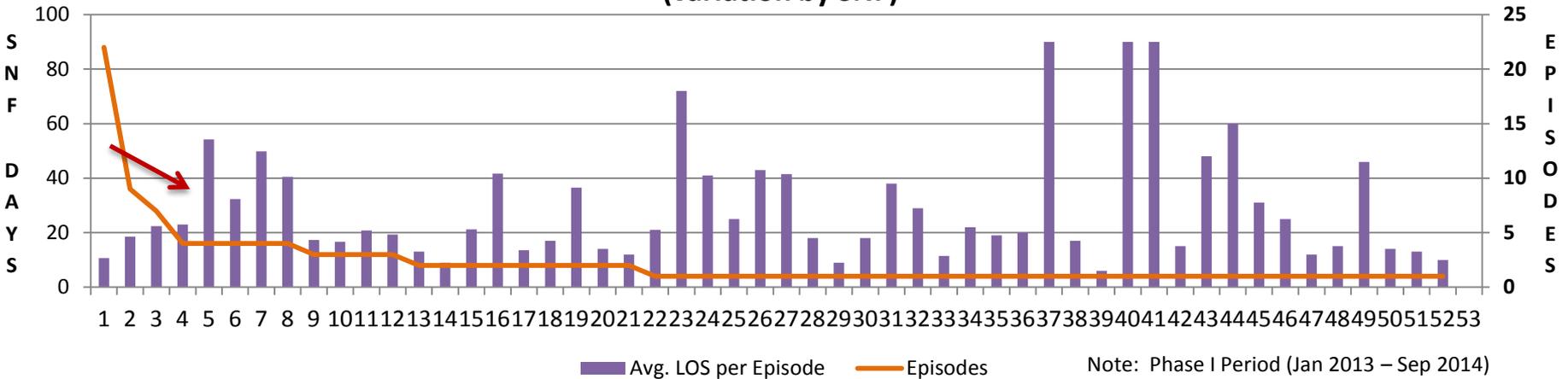
- Reduce overall utilization
 - From HH to Outpatient

Readmissions

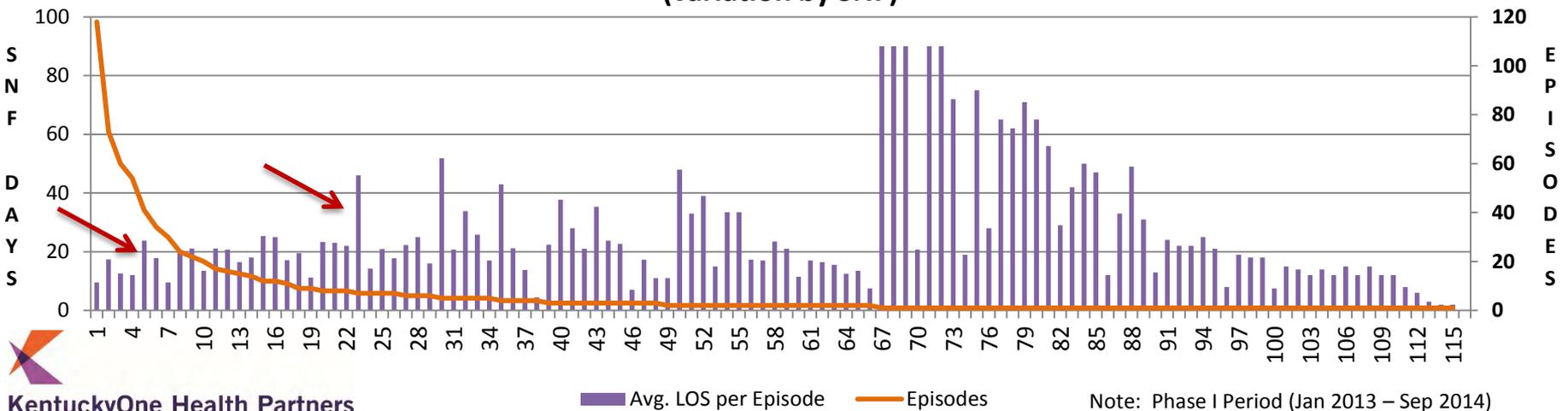
- Discharge planning
- Post-discharge follow-up
- Readmission reduction

The Opportunity – Variation (SNF Avg. LOS)

**DRG 469 - MJR of the lower extremity w MCC
(variation by SNF)**

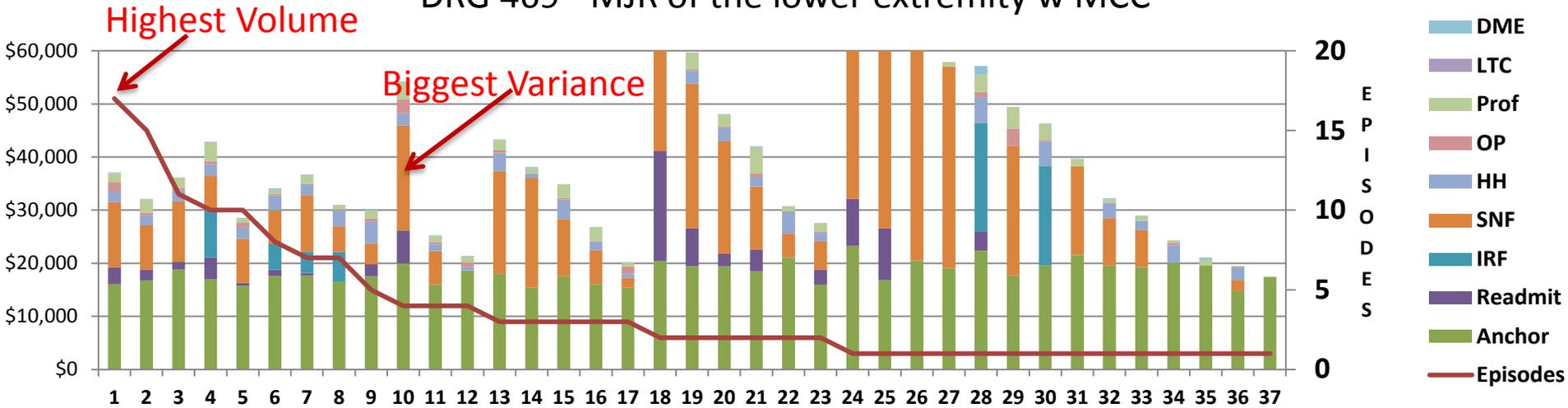


**DRG 470 - MJR of the lower extremity wo MCC
(variation by SNF)**

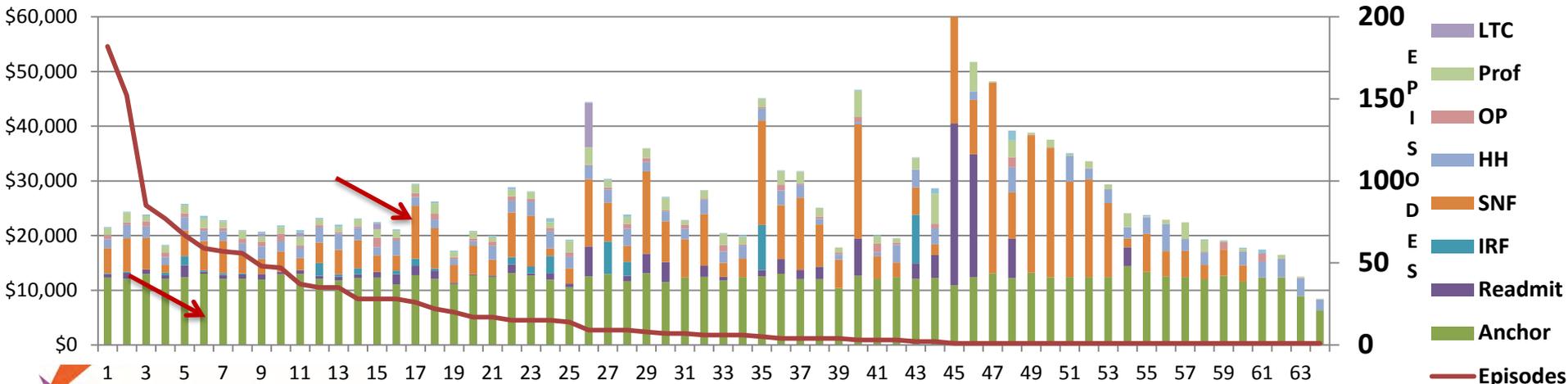


The Opportunity – Physician Variation (Spend)

DRG 469 - MJR of the lower extremity w MCC



DRG 470 - MJR of the lower extremity wo MCC



Episode Management model for Major Joint Replacement

Pre-op

- Necessity of procedure
- Agreement to meet terms
- Enrollment in program
- Joint Academy
- Care Coordination begins with KHP staff, facility staff, MD, and post acute

DRG Admit

- Day of Procedure and Ortho floor placement
- Post-op day 1
- Post-op day 2
- Care Coordination Continues

Post Acute

- Transition lead to RN Ortho Population Health Nurse
- Care Coordination Continues with focus on primary DRG and other co-morbid

Prepare for Surgery and Discharge

Conduct Surgery with reduced LOS

Home is the goal



Comprehensive Care for Joint Replacement (CCJR) Model

CMS announced that it plans on testing mandatory bundled payments for hip and knee replacements through the Comprehensive Care for Joint Replacement (CCJR) model over a five year demonstration period.

Who is impacted?

- 75 geographic areas were chosen through the Comprehensive Care for Joint Replacement (CCJR) model over a five year demonstration period.
- The geographic areas proposed by CMS include two portions of Kentucky - in the greater Cincinnati, OH area and in the greater Evansville, IN area

Why start with hip and knee replacements

- This is likely due to the fact that they are the two most common services received by Medicare beneficiaries.
- In 2013, there were more than 400,000 inpatient primary procedures in Medicare, costing more than \$7 billion for hospitalization alone.
- The average Medicare expenditure for surgery, hospitalization and recovery ranges from \$16,500 to \$33,000 across geographic areas.

How does this relate to the BPCI Initiative?

- This model would be in addition to the Bundled Payments for Care Improvement initiative.
- CMS is running the models concurrently to test the payment model in different hospitals.
- Participation in the BPCI initiative is voluntary, whereas select hospitals would be required to participate in this new CCJR initiative.

How will it affect payments?

- The CCJR payment model proposes to hold participant hospitals financially accountable for the quality and cost care they deliver to Medicare fee-for-service beneficiaries for hip and knee replacements from surgery through recovery (90 days following discharge).

How the CCJR Model Works

1

- Every year the model would set Medicare episode prices for each participant hospital.
- That price includes payment for all related services received by eligible Medicare fee-for-service beneficiaries who have LEJR procedures at that hospital.

2

- A LEJR episode would be defined by the admission of an eligible Medicare fee-for-service beneficiary to a hospital paid under the Inpatient Prospective Payment System (IPPS) that results in a discharge paid under MS-DRG 469 or 470.

3

- All providers would continue to be paid under existing Medicare payment systems throughout a performance year.
- Following the end of a model performance year, actual spending for the episode would be compared to the Medicare episode price for the responsible hospital
- Depending on the participant hospital's quality and episode spending performance, the hospital may receive an additional payment from Medicare or be required to repay Medicare for a portion of the episode spending.

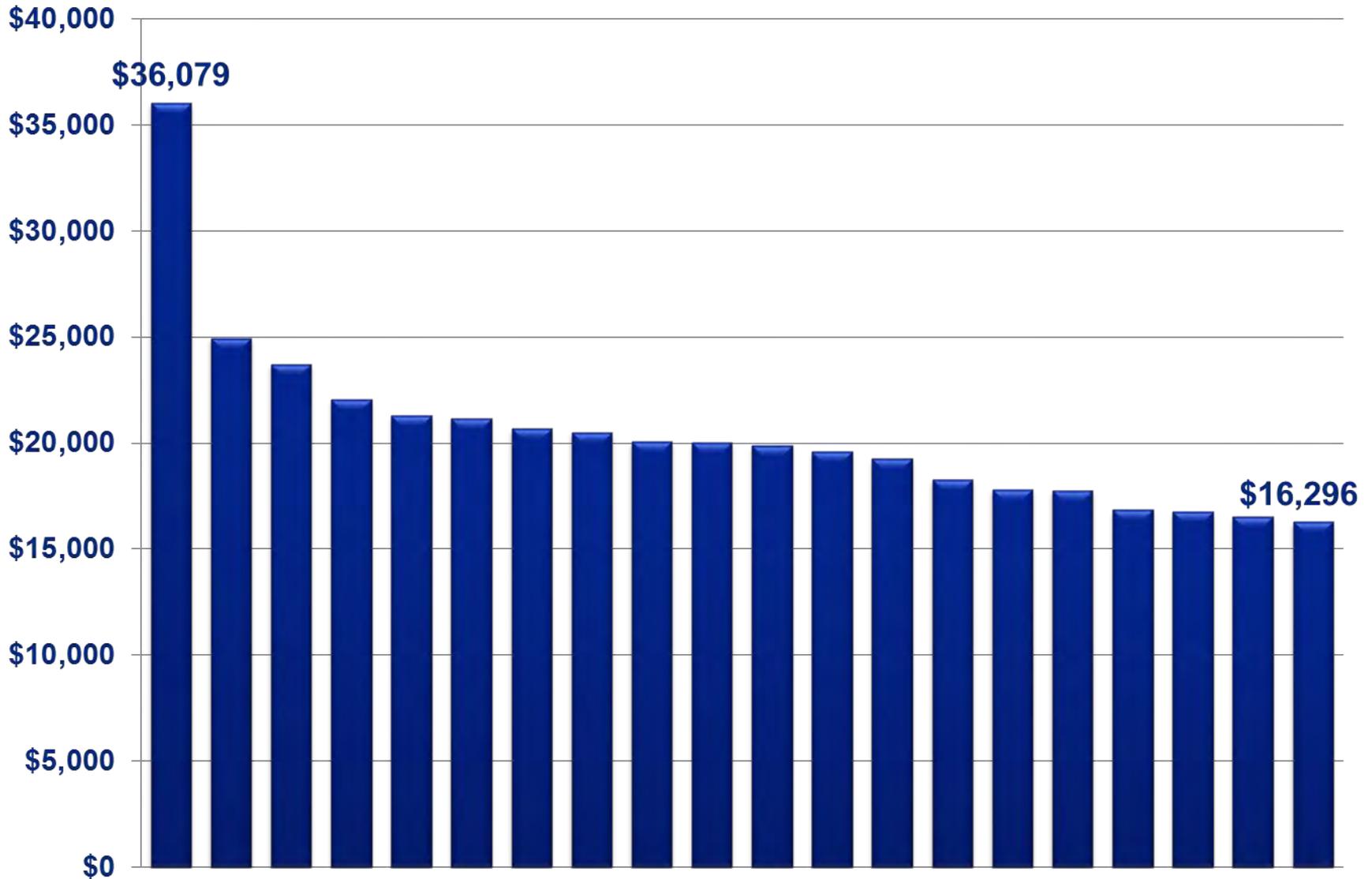
4

- There is no downside risk in the first year of the program.
- Hospitals would receive tools, such as spending and utilization data and sharing of best practices, to improve the effectiveness of care coordination.

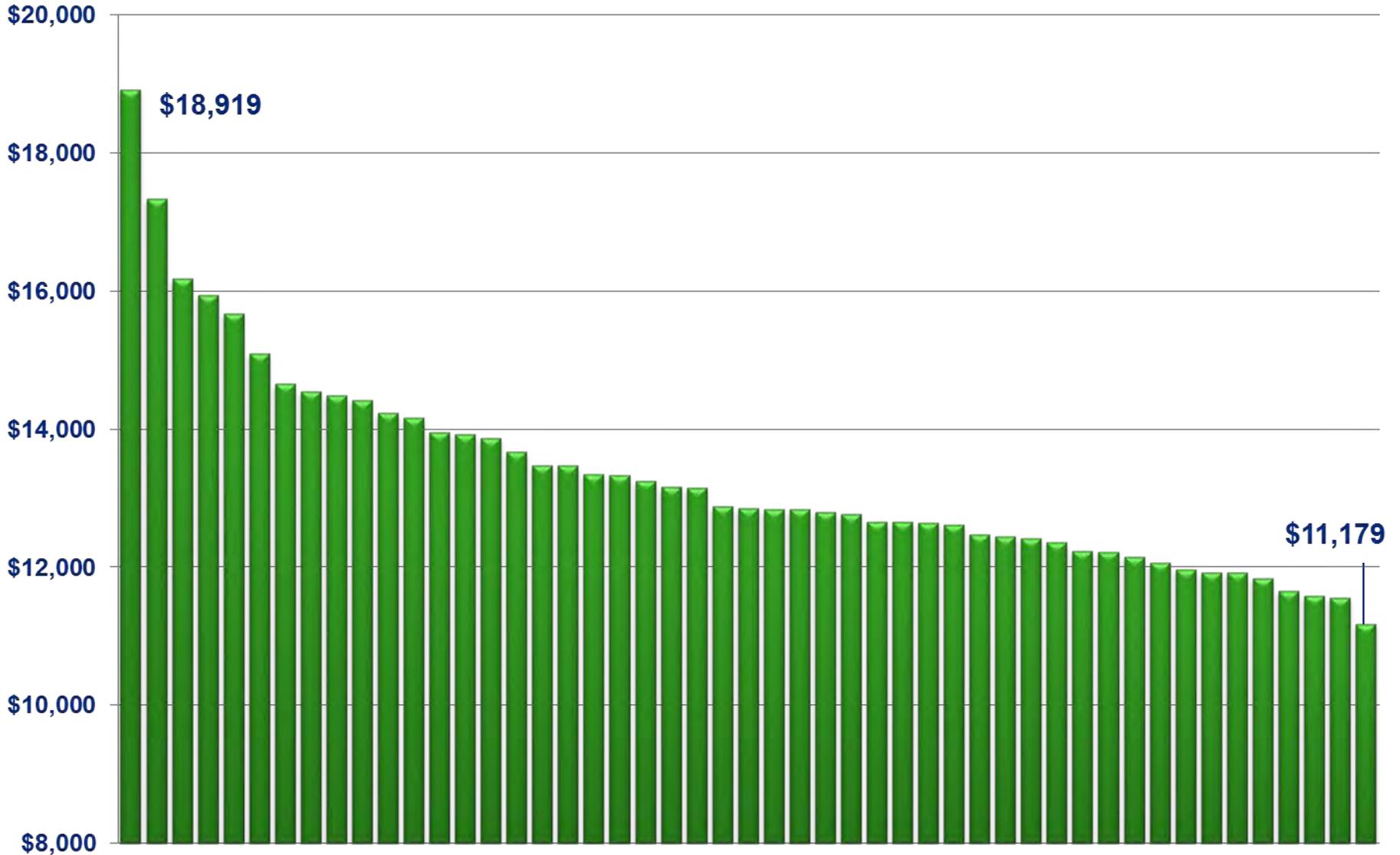
Scope of CCJR Model Proposal

- According to Medicare inpatient charge data for FFY 2013:
 - 16 hospitals and 6 provider groups are currently participating in the BPCI initiative: Model 2 and have included LEJR in their phase 1 bundles
 - 126 Providers are participating in the BPCI initiative: Model 3 (post-acute only) and have included LEJR in their phase 1 bundles
 - 7,977 inpatient discharges fell under the two DRG codes that would trigger the CCJR bundle
 - 61% of those procedures were performed at 1 Baptist East, Norton Inc., University of Kentucky, Jewish Hospital & St Mary's, Lourdes, St. Elizabeth Medical Center, Pikeville Medical Center, Hardin Memorial, Owensboro Health Regional, Greenview Regional
 - In Kentucky, LEJR without complications had total billed charges ranging from \$28,000 at the least expensive hospital to \$117,00 at the most expensive. Average payments ranged from \$11,000 to \$19,000
 - LEJR with complications had total billed charges ranging from \$36,000 to \$110,000. Average payments ranged from \$16,000 to \$36,000
- 1 – Hospitals are listed in descending order by the number of procedures

Average Cost of LEJR with Complications or Comorbidities at Kentucky Hospitals



Average Cost of LEJR without Complications or Comorbidities at Kentucky Hospitals



Next Steps

Next Steps

- The August full stakeholder meeting is scheduled for **Tuesday, August 4, 2015** from **1:00 PM – 4:00 PM** at the **Kentucky Historical Society** (100 W. Broadway Street, Frankfort, KY 40601). No advance registration is required. This meeting will feature a presentation from **Christopher Koller**, President of the **Milbank Memorial Fund (MMF)**.
- The August workgroups will differ from previous months. We will use the August workgroup sessions to solicit stakeholder feedback on the draft **Value-based Health Care Delivery and Payment Methodology Transformation Plan** to be submitted to CMS in mid-September. The draft plan will be circulated in advance of two identical feedback sessions to provide stakeholders with review time and options for providing input.

Workgroup	August Date	August Time	August Location
August KY SIM Workgroup Session #1	Wednesday, August 26 th	9AM – 12PM (lunch 12-1PM)	Kentucky Historical Society, 100 W Broadway St, Frankfort, KY 40601
August KY SIM Workgroup Session #2	Thursday, August 27 th	12PM – 4PM (lunch 12-1PM)	Kentucky Historical Society, 100 W Broadway St, Frankfort, KY 40601

- Also, please **SAVE THE DATE!** The KY SIM team is planning a **KY SIM Innovation Summit** scheduled for **Tuesday, September 29th** from **12 – 5PM** at the **Sloan Convention Center** in **Bowling Green, KY** before the annual **KHIE eHealth Summit**. Additional details and registration information is forthcoming.
- Please visit the dedicated Kentucky SIM Model Design website: <http://chfs.ky.gov/ohp/sim/simhome>
- Please contact the KY SIM mailbox at sim@ky.gov with any comments or questions

Thank you!

Q&A