Montana State Innovation Model Design

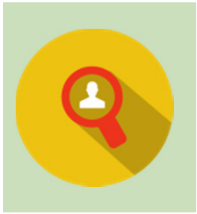
Governor's Council Meeting

March 8, 2016

Agenda

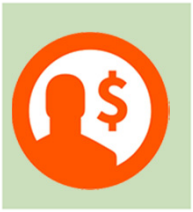
10:00 – 10:10 am	Welcome and Meeting Objectives
10:10 – 10:30 am	Governor's Council Charge and Key Principles
10:30 – 11:45 am	**Delivery System Models Working Session** ▪ Data Working Group Report Out and Discussion ▪ Feasibility/Impact
11:45 – 12:00 pm	*Break, Lunch Served*
12:00 – 2:45 pm	**Delivery System Models Working Session, Continued** ▪ Montana Case Study: PCMH Presentation by RiverStone Health ▪ Defining the Models ▪ Supportive Payment Models
2:45 – 3:00 pm	*Break*
3:00 – 3:40 pm	HIE and HIT Updates ▪ SIM HIT Plan ▪ Billings Pilot Update
3:40 – 3:50 pm	Other Stakeholder Updates
3:50 – 4:00 pm	Next Steps
4:00 pm	Public Comment

Meeting Objectives



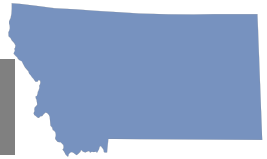
Identify Target Populations

Obtain Consensus on Delivery Models



Discuss Payment Models and Path to Value-Based Payment

Discuss SIM Health IT Plan



Governor's Council on Health Care Innovation and Reform

Governor Bullock appointed an advisory council of private and public payers, providers, regulators, and patient advocates to guide the development of Montana's statewide health transformation plan.

Charge

1. Identify opportunities to improve care delivery and control costs in Montana's healthcare system
2. Explore opportunities to coordinate between public and private sectors to improve health system performance and population health

GOAL: Obtain **consensus** among public and private stakeholders – payers and providers – to **implement** one or more delivery system models and accompanying value-based payment methodologies to advance the triple aim in Montana of improved patient experience, improved population health, and reduced costs

Delivery Model Principles – *For Discussion*

As the Council considers and evaluates delivery models, it should assess the extent to which each model supports a set of core principles

Patient-centered

Replicable for different conditions

Data-driven and measurable

Scalable

Simple and flexible for providers to rollout

Sustainable and tied to payment reform

Collaborative

Multipayer

Delivery System Model Development Framework

Key Elements

Define objectives and target population(s)

- Data Working Group findings
- Target populations and conditions

Consider potential impacts of delivery reform models

- Return on investment (ROI)
- Scalability and sustainability
- Measures

Define core elements of delivery models

- Care model definition
- Existing resources

Develop supportive payment models

- Funding sources
- Payer commitment
- Value-based payment

Implement

- Stakeholder commitment
- Work plan
- Evaluation and refinement

Governor's Council Data Working Group

Membership	• **Allegiance** • **BCBS MT** • **Medicaid** • **Montana Health Care Foundation** • **Mountain-Pacific** • **PacificSource** • **Reiter Foundation** • **State Employee Health Plan**
Immediate Charge	• Identify data needs • Review available data , review/revise problem statement • Define target populations and conditions • Present recommendation at the March 2016 Governor's Council meeting Note: In the future, the Working Group may be asked to consider and evaluate measures to evaluate the impact of selected delivery system reforms
Inputs	• Dr. Arzubi's analysis on the impact of mental illness in Montana • Public health and Medicaid data (as available) • Commercial payer data (as available)
Commitment	• Approximately two, 1 – 1.5 hour meetings and associated prep time • Members will be asked to share and analyze data in response to the Working Group's identified data needs
Duration	• February and March 2016 • If additional data needs are identified during the March 2016 Governor's Council meeting, the Working Group may be asked to extend its work into the Spring
Staff	• DPHHS, Manatt

Medicaid Target Populations

Medicaid Population: Top 5% by Risk Score

Group	Member Count	Average Age	Average Risk Score	Average Prior Total Costs (Annualized) (includes Rx)	Average Prior Rx Costs (Annualized)	Primary Risk Category, Percentage of Total Cost
All Members	5018	41	8.93	$31,616	$9,997	42%
Self Selected Race Non White	1200	40	9.77	$37,053	$8,956	44%
Self Selected Race White	3818	41	8.67	$29,908	$10,324	42%

Medicaid Target Populations

Primary Risk Categories of Top 5% of Risk Score Population

Primary Risk Category	Member Count	Average Age	Average Risk Score	Average Prior Total Costs (Annualized) (includes Rx)	Average Prior Rx Costs (Annualized)	Primary Risk Category, % of Total Cost
Other neurology	1717	44	7.28	$19,326	$5,754	37%
Mood disorder, bipolar	416	39	6.83	$26,254	$7,286	40 %
Psychotic/schizophrenic disorders	350	41	7.5	$35,596	$10,766	47%
Mood disorder, depression	235	42	6.73	$21,266	$6,900	34%
Other pulmonology	224	51	8.85	$26,373	$8,335	33%
Diabetes	162	44	8.24	$30,038	$9,078	33%
Other hepatology	144	50	12.92	$41,314	$12,348	49%
Acute and chronic renal failure	141	44	24.24	$62,199	$7,140	54%
Adult rheumatoid arthritis	129	48	9.16	$25,006	$13,785	43%
Hereditary degenerative & Congenital CNS disorders	126	16	8.58	$31,695	$5,785	57%

STATE OF MONTANA EMPLOYEE HEALTH PLAN

Demographics

Employees	12,535
Retirees	377
Medicare Retirees	1,871
Spouse/Dependents	16,740
Total Members	**31,523**

Age Groups	***% Census***	***% Medical/RX Spend***
0-19	22%	10%
20-44	31%	21%
45-64	35%	51%
65-Plus	12%	18%
	100%	100%
Average Member Age		*42.3*
Average Employee Age		*53.3*

HEALTH CONDITIONS FROM MEDICAL CLAIMS

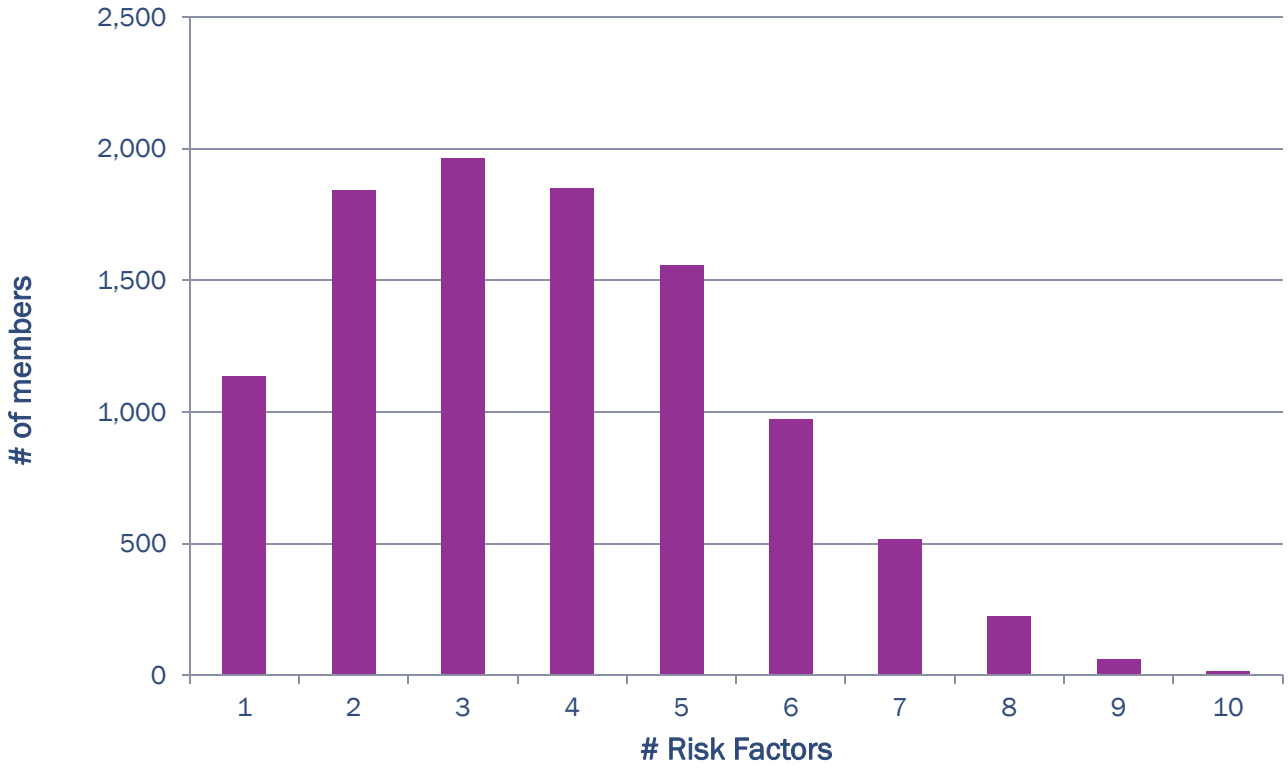
Top Conditions with Highest Charges

	% Plan Spend	*% Members*
Musculoskeletal	23%	3%
Cancer	14%	2%
Circulatory	11%	1%
Gastrointestinal	7%	1%
Neurological	7%	1%
	61%	**9%**

Top Conditions by Member Count

Disease Diagnosis	*# Members*
Hypertension	4,836
Hyperlipidemia	3,481
Diabetes	2,232
Osteoarthritis	2,182
Asthma	1,330
Coronary Artery Disea	860
COPD	644

MONTANA HEALTH CENTERS



HCBD HEALTH CARE & BENEFITS DIVISION

BCBSMT
Target Condition Recommendations

RISK STRATIFIED ANALYSIS

- Narrowed to high risk members
- Ambulatory sensitive conditions
- Highest cost conditions
- Highest ER and hospital use
- Greatest disproportionate volume/cost

RECOMMENDATIONS

HIGH INCIDENCE

- Mental health conditions:
  - Depression, bipolar, anxiety, PTSD, schizophrenia
- Drug & alcohol dependence/withdrawal

HIGH INCIDENCE & HIGH COST

- Musculoskeletal conditions

LOW INCIDENCE & HIGH COST

- Low birthweight infants

PacificSource Target Populations

Highest Cost Conditions

In MT Individual and Small Groups, the top 2.4% of members contributed to half of the total paid cost in 2015.

Top 10 claims cost categories for individual and small group:

- Cancer
- Heart Conditions
- Osteoarthritis and other non-traumatic joint disorders
- Trauma-related disorders
- Complications of surgery or device
- Back problems
- Mental disorders
- Non-malignant neoplasm
- COPD, Asthma
- External causes of injury

Most Prevalent Conditions

Chronic conditions with the highest prevalence:

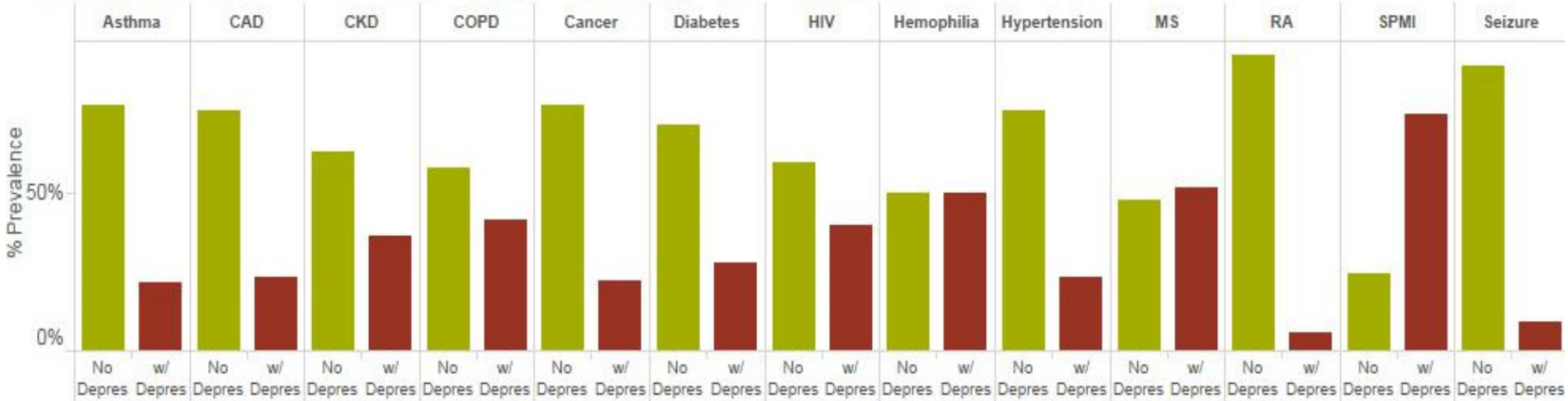
- Depression
- SPMI
- Asthma
- Diabetes
- Cancer
- Hypertension

Lower income enrollees (on cost sharing reduction plans) have higher rates of all of these chronic conditions. For example, the rate of depression is nearly twice as high among lower income enrollees and SPMI is more than twice as high.

Utilization Trends

- Specialty drug users concentrated in members with MS, HIV/AIDS, Rheumatoid Arthritis and Hemophilia
- Mental health and substance abuse admissions increasing in both volume and costs per admission

PacificSource: Condition Prevalence – Comorbidity with MH (Depression)

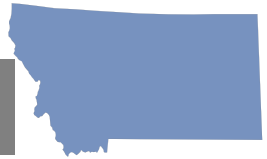


	Asthma		CAD		CKD		COPD		Cancer		Diabetes		HIV		Hemophilia		Hypertension		MS		RA		SPMI		Seizure	
% preva	78.0%	22.0%	76.4%	23.6%	63.6%	36.4%	58.3%	41.7%	78.0%	22.0%	72.2%	27.8%	60.0%	40.0%	50.0%	50.0%	76.6%	23.4%	48.0%	52.0%	94.1%	5.9%	24.8%	75.2%	90.9%	9.1%
Member cnt	181	51	42	13	7	4	14	10	85	24	148	57	12	8	1	1	108	33	12	13	16	1	74	224	10	1

MT small group and individual LOBs

Depression is most prevalent in members with these conditions:

- MS
- COPD
- Chronic Kidney Disease



Allegiance: Prevalent Conditions and Target Populations

For members employed by Montana-based companies (88,331 total):

Category	# Members	% Total
Members with elevated relative risk scores	10,516	11.9%
Members with Diabetes	2448	2.8%
Members with Asthma	2,005	2.3%
Members with CAD/MI	921	1.0%
Members with COPD	555	0.6%
Members with CHF	277	0.3%
Members with likelihood of hospitalization > 0.3	264	0.3%

THE CHALLENGES TO ACCESSING HEALTHCARE FOR AMERICAN INDIANS

- The lack of healthcare available through Indian Health Service and lack of healthcare coverage to pay for healthcare services.
- When Indians do get healthcare coverage, they lack the knowledge needed to navigate through the complicated healthcare system.
- Healthcare providers deny care to Indians based on decades of IHS denying patient care.

Nearly two-thirds of Indian residents in Montana live in medically underserved counties, and more frequently report barriers to care access than white residents.

- The lack of access to preventative services:
  - Screening, testing, check-ups, ect.
- The lack of primary healthcare.
- Creates a tolerance of inadequate basic care which results in Indians dying a generation younger than non-Indians.

Delivery System Model Development Framework

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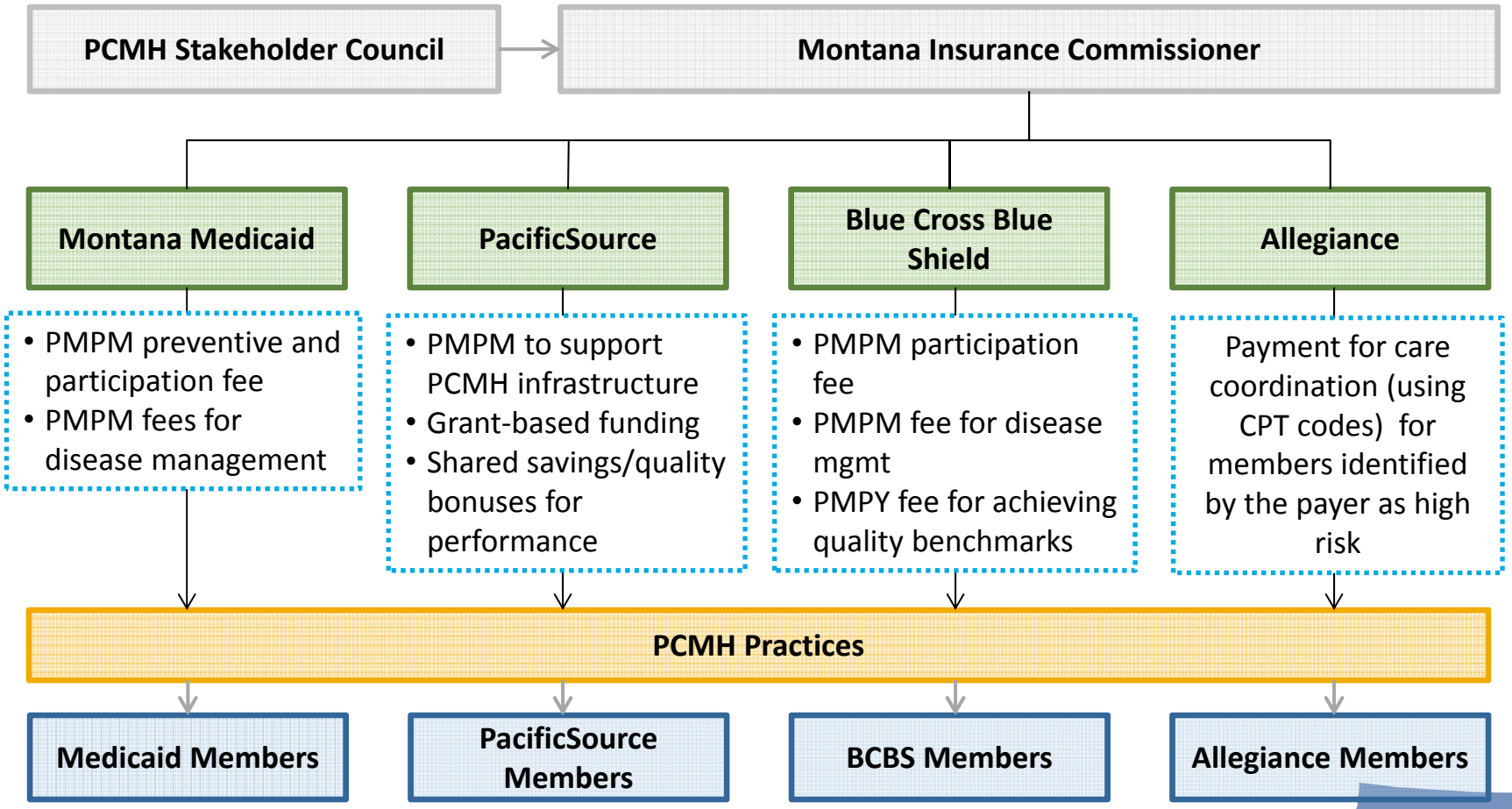
Implement	• Stakeholder commitment • Work plan • Evaluation and refinement

PCMH as a Foundation for Reform

Montana's existing PCMH program should serve as the foundation for participating providers



PCMH as a Foundation for Reform

Participants

- Participating clinics must:
  - Submit a Comprehensive Application
  - Be accredited by one of three national accrediting agencies
  - Report on 3 out of 4 quality of care metrics

Governance

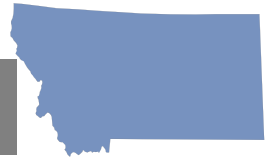
- The Insurance Commissioner and a 15-member PCMH Stakeholder Council consulting on program decisions

Quality

- PCMHs must report on four quality measures: blood pressure control, diabetes control, tobacco cessation, and childhood immunizations
- Depression screening will be added to the program's quality measures for 2016
  - For the 2016 measurement year, PCMH's will report on 4 out of 5 quality measures

2014 At-a-Glance

- 70 PCMHs participated
- Popular elements of practice transformation included:
  - Same day appointments
  - Patient portals
  - Clinical advice outside of office hours
- Initial quality results are promising
  - Rates of hypertension, diabetes, and tobacco use were close to or lower than national and Montana targets
  - Several childhood immunizations met national targets



Evidence for PCMHs

The most recent evidence on PCMHs, including more than 30 published studies and evaluations, points to clear trends in reduced costs and utilization, and improved quality.

PCMHs are designed to provide a strong foundation for delivery system and payment reform.

Improved Outcomes

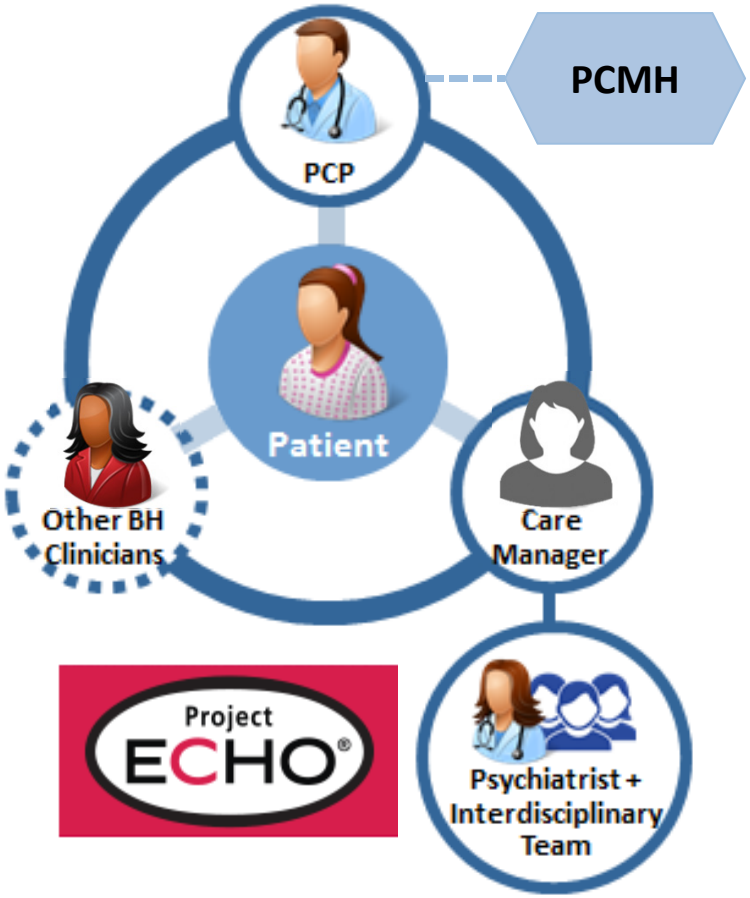
- ✓ Recent studies have found:
  - Better quality of care for diabetes, vascular, asthma, depression, kidney disease, and hypertension
  - Higher rates of cancer and substance abuse screening
  - Improved measures of patient experience, including access to care, doctor rating, and continuity of care
  - Physician support for program and augmented services

Reduced Utilization and Costs

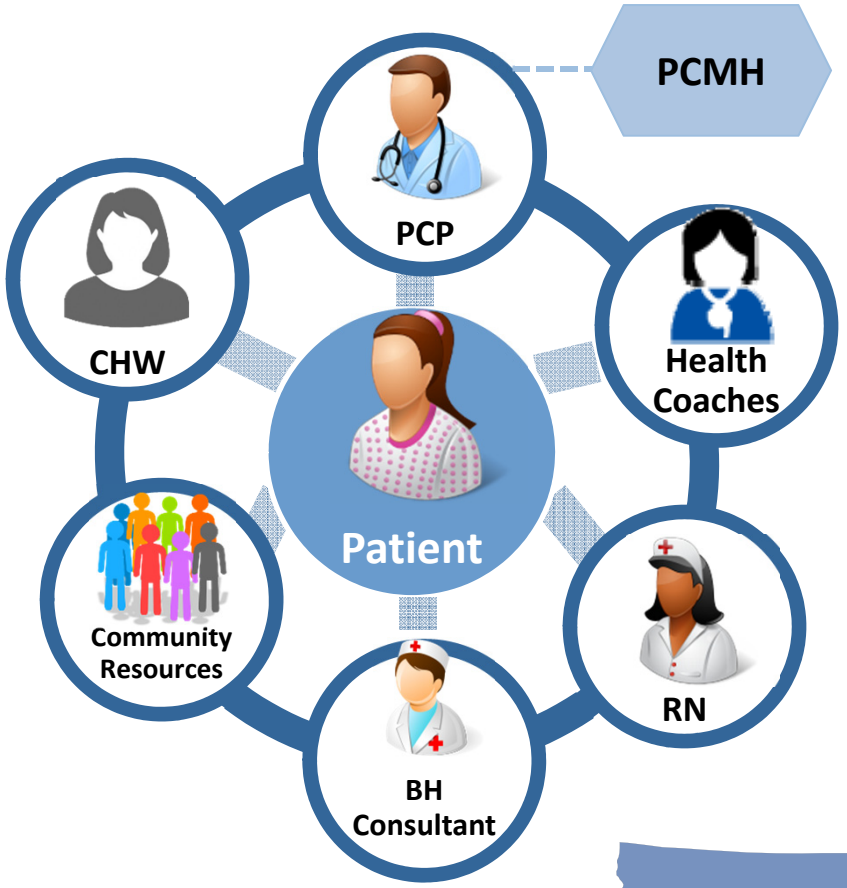
- ✓ Recent studies have found reductions in ED visits, hospitalizations, specialty visits, prescription drug use and related costs
- ✓ By year 3, most programs see cost reductions:
  - Geisinger Health System saved $53 PMPM (others cited PMPM savings of $9-40)
  - BCBS Rhode Island PCMH program had ROI of 250%
  - Minnesota multi-payer PCMH program saved an estimated $1 billion over 4 years
    - Nearly all Medicaid savings
    - Driven by reductions in hospital visits

Delivery System Models – Building on the PCMH Foundation

Collaborative Care Model (Could be Echo-Enhanced)



Hot-Spotting with Community Resource Teams



Introduction: Evidence for Interdisciplinary Care Teams

Improved Outcomes

- Interdisciplinary care team models for complex patients ***improve quality of life and care***
- Interdisciplinary primary care ***improves rates of survival***
- Mental health treatment ***increases workplace stability and productivity***

Reduced Utilization and Costs

- Mixed evidence on utilization and costs; some models have been shown to reduce costs and utilization
- Common features of successful models:
  - Target highest cost enrollees
  - Employ evidence-based care protocols and design

Other Benefits

- Increased community engagement in care
- Increased patient satisfaction
- Enables providers to practice at top of license
- Additional support and training for physicians
- Improved retention of health care providers
- Addressing social determinants of health

Spotlight on Evidence/ROI for Collaborative Care

The Collaborative Care Model has been tested in more than 70 randomized controlled trials in diverse settings, with different provider types and patient populations.

The model is recognized as strongly evidence-based.

Positive Health Impacts:

- ✓ More effective than usual care across diverse populations for range of mental health conditions
- ✓ Demonstrated improvement in health disparities in low-income, ethnic minority populations
- ✓ Strong endorsement from patients, primary care providers, and psychiatrists

Return on Investment:

- ✓ Largest study: ROI of $6.50 for each dollar spent
- ✓ Net savings in every category of health care costs examined:
  - Pharmacy
  - Inpatient and outpatient medical
  - Mental health
  - Specialty care

https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-irc-collaborative-5-13.pdf

Spotlight on Evidence/ROI for Project ECHO

"Project ECHO expands access to best-practice care for underserved populations, builds communities of practice to enhance the professional development and satisfaction of primary care clinicians, and expands sustainable capacity for care by building local centers of excellence." – Health Affairs Study

Positive Impacts for Patients and Providers:

- ✓ As safe and effective as usual care
- ✓ Increases number of patients treated by specialists (expanding workforce)
- ✓ Increases access in rural areas
- ✓ Improves physician-reported measures of knowledge, skills, professional satisfaction, practice recognition
- ✓ Promotes provider retention in rural and underserved communities

Return on Investment:

- ✓ Hub costs estimated about $300,000 per year – first hub launched in Billings
- ✓ Free technology works with laptop, webcam, tablet, smart phone
- ✓ Expands ROI/reach of other proven models (e.g. Collaborative Care)

Spotlight on Evidence/ROI for Hotspotting

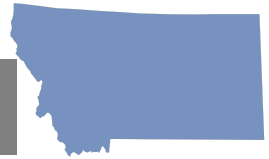
Camden Coalition model, on which the Mountain-Pacific model is based, is widely recognized as a promising model for a selection of the highest cost, highest need patients fitting into a patient typology. The first randomized control trial evaluating the model is underway.

Positive Health Impacts:

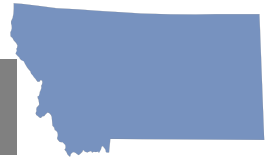
- ✓ Increases security, genuineness, continuity of care
- ✓ Associated with improved patient motivation and active health management and improved patient perception of quality of life
- ✓ Improves care coordination by wrapping services around the patient
- ✓ Extends healthcare beyond the walls of the hospital and clinic to patient's home
- ✓ Addresses physical, situational, emotional and social barriers to health
- ✓ May help reduce hospital readmissions and improve coordination of fragmented care
- ✓ Integration of a behavioral health professional into the provider team treatment approaches

Return on Investment:

- ✓ Camden model reduced ED visits by 40% for the first 36 patients, and costs dropped by 60%
- ✓ Vermont Community Health Team model had net savings of nearly $90 million in 2013
- ✓ Vermont ROI was larger in commercial populations than in Medicaid



Montana Case Study:
PCMH Presentation by RiverStone Health



Garth Brand, M.D.

Carla Cobb, Pharm.D., BCPP

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Connecting you to a better life

RiverStone Health Clinic

- FQHC
- NCQA Level 3
  Patient-Centered Medical Home
- Montana Family Medicine Residency
- Integrated behavioral health and clinical pharmacy

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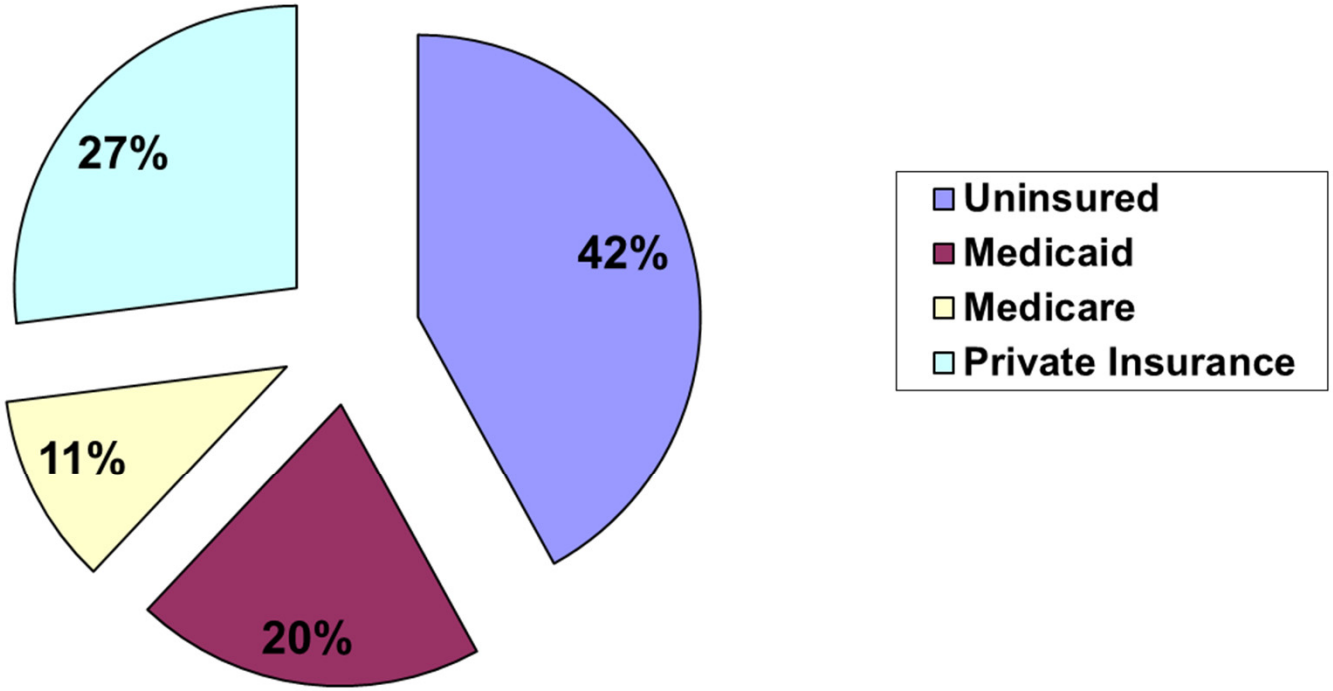
RSHC Patient By Payer Source



Source: RiverStone Health 2015 UDS Report

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Services Provided

- Acute, chronic & well child and adult
- Prenatal care
- Procedures
- Group visits – Centering Pregnancy, Wellness, Diabetes, BH groups
- Chronic pain and Diabetes Pathways
- CLIA Waived Lab, Xray

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Patient #1

- 56 years old
- Working as independent carpenter
- Had a stroke in 2014, recovered well
- Did not have insurance so avoided follow up care and did not refill medications due to cost
- Repeat stroke in February 2015
- 3 weeks in hospital and acute rehab
- Scheduled follow up at RiverStone Health

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The Patient-Centered Medical Home

Changing Health Care Delivery - A Team Approach to Care

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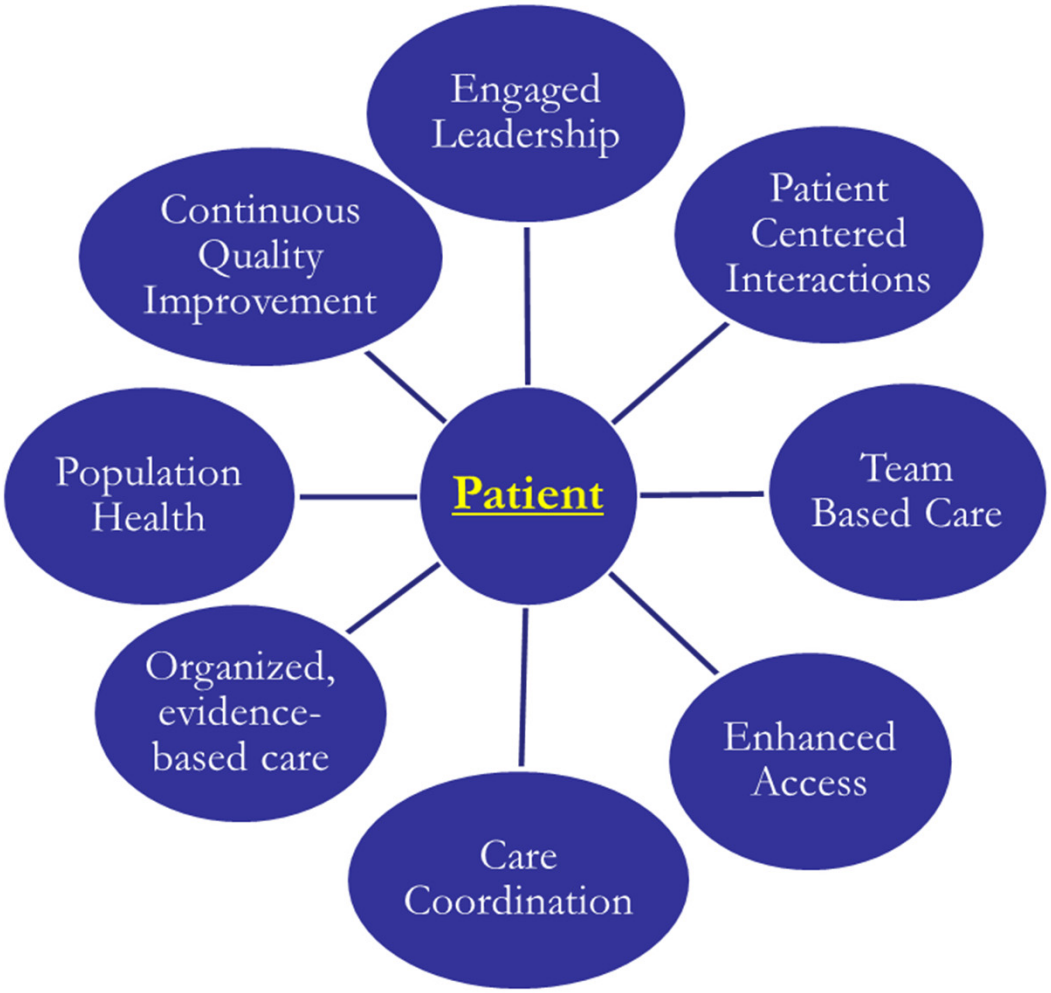
PCMH Principles



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Patient Centered

Meet patients where they are…

- Whole person orientation
- Communicate in a culturally appropriate manner
- Systems that encourage patient engagement and self-management
- Use of patient portals or apps to access health information

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Continuous Quality Improvement

- Helps drive implementation and refinement of PCMH principles
- All staff engagement in regular performance measures and improvement
- Establish and monitor metrics to evaluate improvement efforts and outcomes
- Share quality data

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Continuous & Team-Based Relationships

- Patient has a relationship with a team of care providers
- Different members of the team provide different expertise
- Continuity is emphasized

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Our Teams

- **Providers**
  - Physicians
  - Non-Physician (PAs)
  - Residents
- **Staff**
  - RNs, LPNs and MAs
  - Administrative – pre-visit planners, phones, front desk
  - Care Coordinators – community resources, insurance enrollment
- **Additional Services**
  - Behavioral Health
  - Clinical Pharmacy
  - Diabetes Nurse Educator
  - Dietician

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Enhanced Access

- Established & New Patients
- Advanced access
  - Half of appointments are open until 48 hours prior
  - 48 Hour (scheduled in advance)
  - Same Day (open access)
  - Acute (minor urgent care)
- Evening and Saturday clinics, group visits
- 24/7 call coverage

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Population Health Management

- Manage the panel, not just the patient
- Proactive outreach
  - preventative care reminders
  - patients with high risk conditions
- EHR allows for organized and accurate data management

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Organized, Evidence-based Care

- Make every visit count!
- Use clinical decision support system (CDSS)
- Pre-plan visits
- Leverage team members
- Huddle time
- EHR has built in alerts, CDSS

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PCMH Implementation Team

- Interdisciplinary Team
- Meets twice each month
- Identifies, tests and implements work flow changes to embrace PCMH model
- Feedback loop for continuous improvement

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Patient #1

- Hospital follow up (prior to provider)
  - Receives confirmation call from AA
  - Hospital records printed and reviewed by chart prep
  - Scheduled with Clinical Pharmacist for med rec
    - Made recommendations based on hospital diagnosis
  - Nurse identifies lack of insurance; patient meets with Care Coordinator
  - Nurse also identifies he is still smoking

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Integrated Behavioral Health

- 6.5 FTEs at various sites
  - LCPCs and LCSWs
  - Licensed addiction counselors
- Appointment based and point-of-care access
- Care provided within the scope of primary care
- Referral out for patients needing specialty care

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Behavioral Health Services

- Resource questions
- Emergent concerns
- Diagnostic clarification
- Brief therapy - 6 to 8 sessions
- Lifestyle modification (smoking cessation, weight management, sleep hygiene, stress management)
- Chronic pain care planning
- Substance use issues

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Integrated Clinical Pharmacy Services

- Patient appointments in clinic
- Point-of-care services
- Collaborative practice agreements
- Pharmacy student rotations
- Comprehensive Medication Reviews
- Diabetes education
- Hospital follow-up

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Psychiatric Pharmacy Services

- Medication management for patients with mental illnesses
- Integrated Care Clinic
  - Visits with BH and pharmacist together
  - Develop care plan prior to PCP visit
- Monthly consultations with community psychiatrist
- Residency education and didactics

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PCMH Payment Options

Fee for service for recognized providers

PMPM for care coordination

Diabetes education codes

Preventive Services

Shared savings – ACO models

Transitions of care, chronic care management

Education stipends

Decreasing unnecessary care

Incentive payments for quality measures

340B Drug Pricing Program

"Incident to" billing

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Patient #2

- Depression, diabetes, COPD
- PCP - preventive care, cancer screenings, diabetes care
- BH provider - diagnostic clarification and therapy
- Care coordinator - enrolled in Medicaid HELP Act
- Pharmacist – Adjusted antidepressants, inhalers, diabetes education
- Patient - Quit smoking

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Contact Information

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Delivery System Model Development Framework

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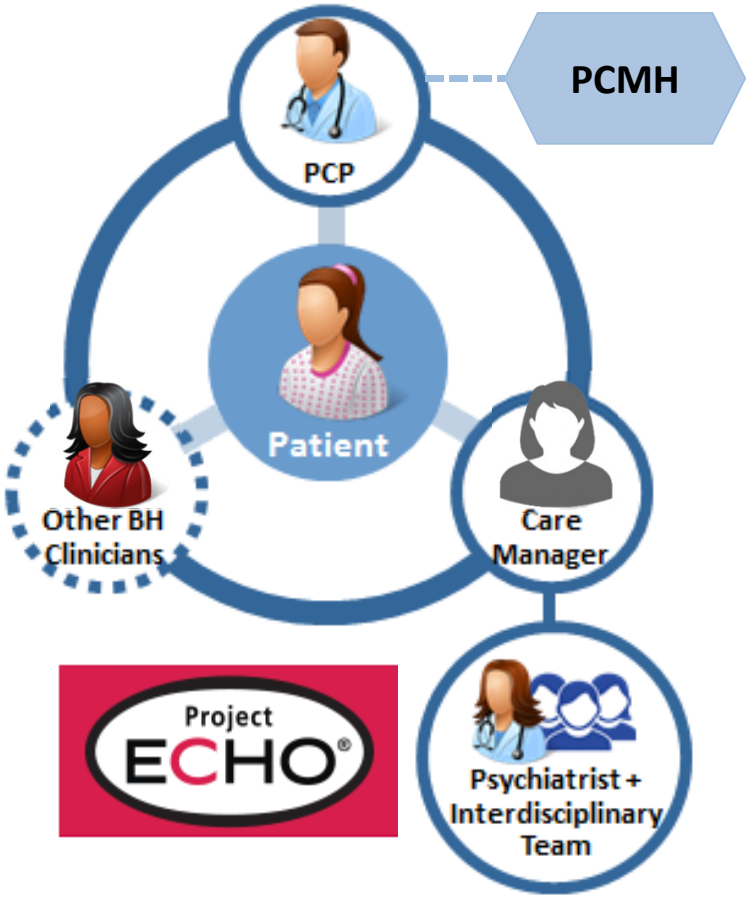
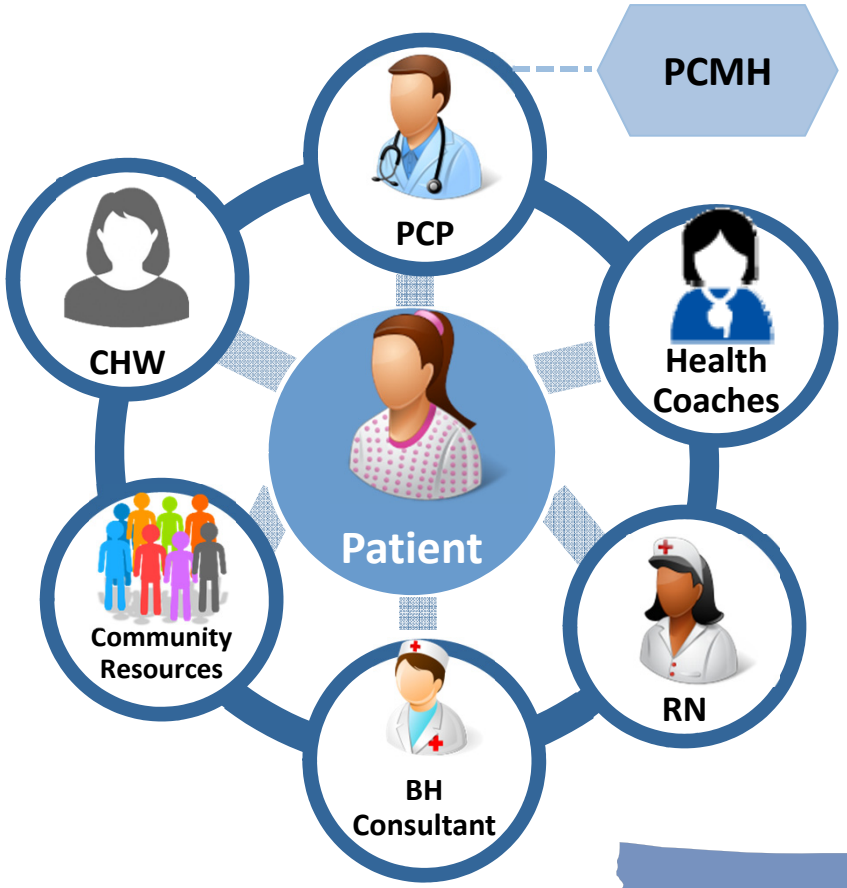
Delivery System Models – Overview

Collaborative Care Model (Could be Echo-Enhanced)



Hot-Spotting with Community Resource Teams

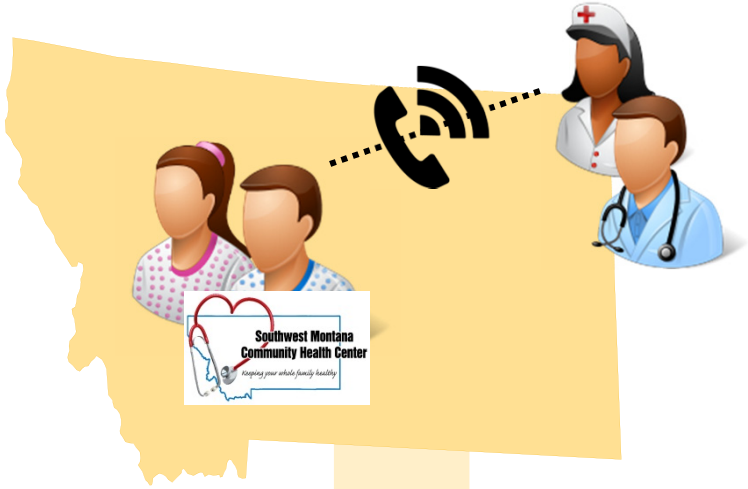


Example – Southwest Montana Community Health Center

Southwest Montana Community Health Center

Leveraging grant funding and FFS payments for provider and therapy visits

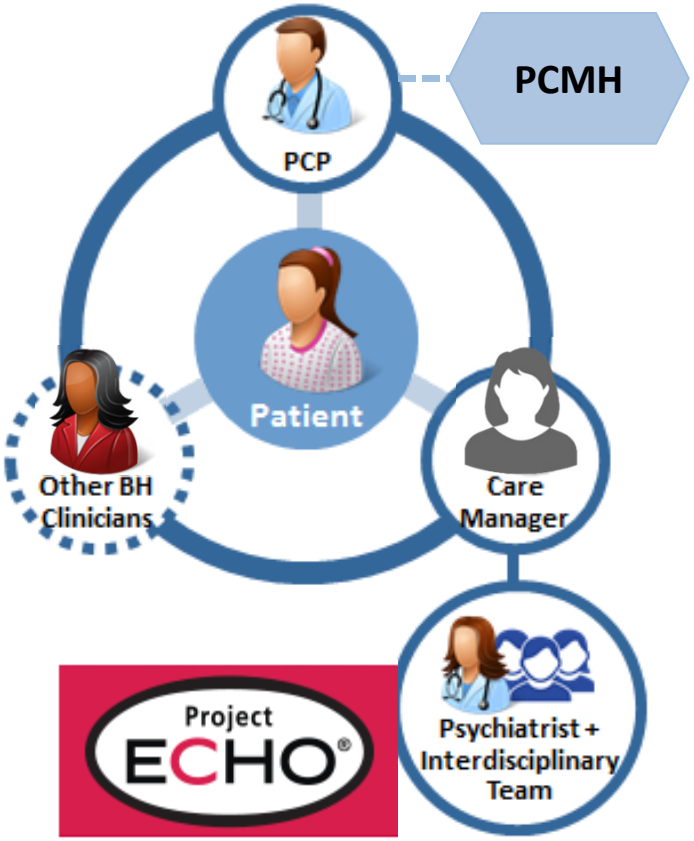
- Collaborative Care (IMPACT) model with stepped care approach
- Targeting all adults with depression and/or anxiety
- Interdisciplinary care team includes: PCP, depression care managers, consulting psychiatrist, and behavioral health specialists
- Psychiatrist services are delivered telephonically and PCP continues to oversee all patient care
- Services include assessment, development of treatment plans and self-management goals, medication management, and problem solving therapy



Expand collaborative care model to care for mental and behavioral health target populations/conditions in additional settings and regardless of payer status

Collaborative Care Team Roles and Responsibilities

Collaborative Care Model (Could be Echo-Enhanced)



Role	Description
Patient	• Member of identified target population, focusing on higher need populations • Active participant in treatment
PCP	• Patient identification and referral • Works in consultation with care manager • Oversees all aspect of patient's care • May be embedded in a PCMH
Care Manager	• Behavioral health professional embedded in PCP office • Coordinates Collaborative Care Team • Performs all care management tasks
Psychiatrist + Interdisciplinary Team	• Supports and collaborates with PCP and care manager • Consults on patients who are clinically challenging or need specialty behavioral health services
Other BH Clinicians	• Embedded in PCP office or in community • Supports PCP and care manager • May see patients for in-person consultations

Collaborative Care Team Intervention – *Overview*

PCP conducts initial assessments and identifies patients in need of behavioral health therapy and enhanced care management

Care manager works with patient and PCP to develop treatment plan; PCP continues to manage patient's medical care

PCP and care manager consult and collaborate with a psychiatrist and interdisciplinary team on patient diagnoses and treatment plans

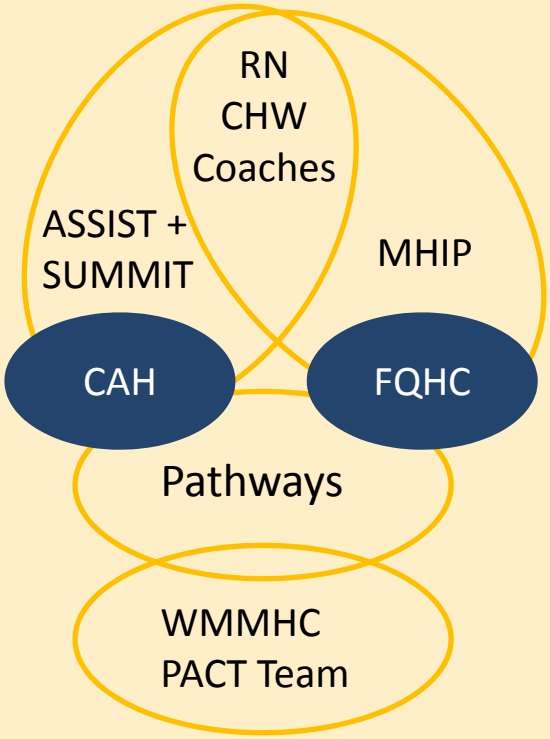
PCP, care manager, and onsite behavioral health providers continue to manage and monitor patient's care, consulting psychiatrist and interdisciplinary team weekly or as needed

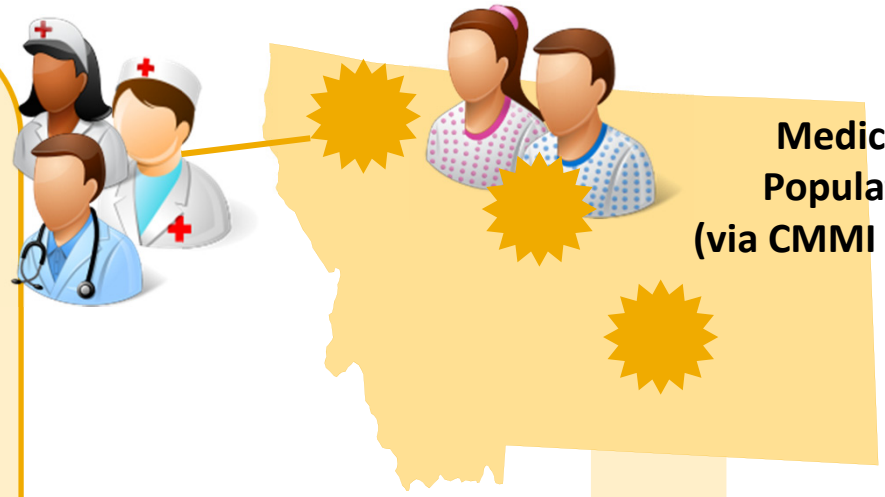
Once patient is considered stable, PCP and care manager work together to develop relapse prevention plan and continuously monitor patient

Example – Mountain-Pacific Community Resource Teams

Kalispell Community Resource Team

Leveraging CMS innovation funding, FFS payments/codes, potential grants, and other existing resources and investments





Medicare Population (via CMMI Project)

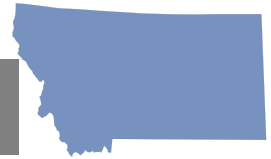
Expand scope of Community Resource Teams (or create new Teams) to include target populations/conditions, regardless of payer status

Medicaid

IHS, Tribal & Urban

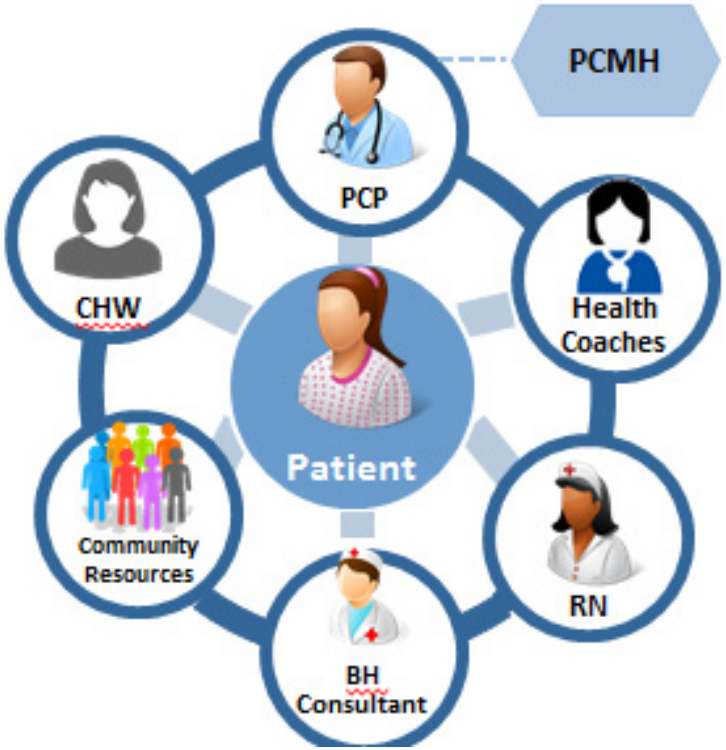
Commercial

Medicare



Community Resource Team Roles and Responsibilities

Hot-Spotting with Community Resource Teams



Role	Description
Patient	• Member of identified target population, focusing on higher need populations • Active participant in treatment
PCP	• Patient identification and referral • Care plan development/care management strategy • May be embedded in a PCMH
RN	• Embedded in PCP office • Clinical team leadership/quarterback across care settings and team
CHW	• Located in the field • Care coordination services • Link patients' health and social needs
BH Consultant	• Behavioral health therapy • Consult and coordinate with RN and PCP on overall care plan
Coaches	• Life skills and self-management coaching • Partnerships with social services and community resources • Creative solutions
Community Resources	• Volunteers serve as care extenders to enhance relationships
Other	• Training on appropriate use of CMS billing codes

Community Resource Team Intervention – *Overview*

ReSource Team connects with patient at hospital bedside, PCP office, behavioral health provider office, or other care setting

ReSource Team conducts patient assessment and begins connecting patient with relevant community resources

Home visits by RN, CHW, and coaches to evaluate patient and develop care plan , conduct medication reconciliation, make and follow up on community resource referrals, etc.

Continued involvement of behavioral health providers as needed

PCP and specialty visits (if needed) to review patient status and participate in care planning

Continued home visits and assessments at 30, 60, and 90 days for program graduation or continued support

Upon graduation, patient is handed off to PCP

Patient claims are monitored subsequent to graduation to identify relapse or need for continued support

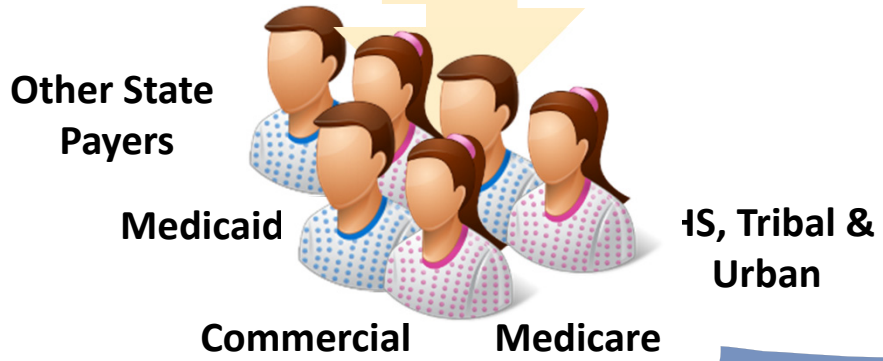
Example – Billings Clinic Project ECHO Hub

Billings Clinic
Project ECHO Hub

Leveraging grant funding and in kind provider contributions

- Billings Clinic launched the first Montana-based Project ECHO hub in January 2016
- Addictions and behavioral health collaborative to support clinicians within Department of Corrections (DOC)
- Interdisciplinary team includes: Psychiatrist, pharmacist, nurse, social worker, and DOC
- Weekly educational support and up to 40 case presentations and consultations
- Formal program evaluation

Expand Billings Clinic Project ECHO Hub – or create a new Hub – to serve the target population, regardless of payer status, giving providers around the State access to experienced psychiatrists and interdisciplinary teams



Delivery System Model Development Framework

	Key Elements
Define objectives and target population(s)	• Data Working Group findings • Target populations and conditions
Consider potential impacts of delivery reform models	• Return on investment (ROI) • Scalability and sustainability • Measures
Define core elements of delivery models	• Care model definition • Existing resources
Develop supportive payment models	• Funding sources • Payer commitment • Value-based payment
Implement	• Stakeholder commitment • Work plan • Evaluation and refinement

Pathway to Value-Based Payment Models

Secure Payment for Enhanced Services

- Develop initial funding models for new delivery models:
  - "Lump sum" grant or payer funding for pilots
  - Enhanced FFS PMPM payments
  - PCMH payments
  - FFS care coordination, disease mgmt, telehealth codes
  - Health home payments
- Secure payer support of models and encourage tiered payment for providers in new delivery models
- Ensure payment for telehealth under parity law

Pay-for-Reporting

- Initiate pay for reporting in new delivery models within one year of implementation
- Continue and expand pay-for-reporting efforts within Montana PCMH and other programs
- Continue FFS reimbursement
- Develop value-based payment transition plan

Pay-for-Performance (P4P) & Shared Savings

- Encourage payers participating in new delivery models to incorporate P4P in payment model
- Encourage payers participating in the PCMH program to incorporate P4P into PCMH payment model
- Continue fee-for-service reimbursement, but encourage payers to move to value-based payment models that incorporate shared savings for defined population
- Begin with shared savings models and graduate to shared risk over time

Securing Payment Sources for Delivery Reform Models

Telehealth Payment

- State law requires private payers to cover certain telehealth services from physicians and other qualified providers in a manner equivalent to in-person coverage; providers receive reimbursement for telehealth at the same level as in-person services.
- Montana Medicaid will currently reimburse a provider enrolled in Medicaid who delivers services via live video services. They are open to looking at additional reimbursement models.

PCMH Payments

- Under the PCMH program, payers could agree to provide enhanced PMPM FFS payments or develop shared savings arrangements to support many of the enhanced team-based care coordination services provided under the models.

Medicaid Health Home Payments

- Under the Health Home program, the State would be eligible for 90% enhanced federal match for first two years of care coordination services provided to certain enrollees with multiple chronic conditions or SMI; services include the use of HIT to link patients to services.

Medicare Care Coordination Codes

- Medicare care coordination codes, particularly the transition care management code, allow for telehealth consultations and support care coordination upon discharge

Enhanced PMPM Payments

- Payers could also agree to provide other enhanced PMPM FFS payments to support these models , for example to support rural or tribal providers using Medicaid Integrated Care authority or private payer arrangements.

Example –Medicaid Health Home Funding Model

Community Resource Teams or Project ECHO Collaborative Care Providers (enrolled in Medicaid)

Target Medicaid Populations with SMI or Multiple Chronic Conditions

Funding Source

State eligible for 90% enhanced federal match for first two years of health home services:

- ✓ Care management and coordination
- ✓ Individual/family support
- ✓ Referral to community support services
- ✓ Use of health information technology to link services across settings

Funding Model

- State has flexibility to design payment methodology
- Range of payment methodologies available, from retaining current FFS model with PMPM care coordination to models with shared savings or upside risk.

Example – Commercial Shared Savings Funding Model

Commercial payer attributes patient populations to CR or Collaborative Care Teams

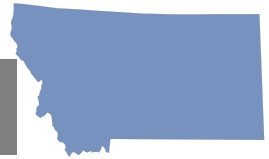
Total Cost of Care < Baseline Cost

Payer makes retrospective shared savings payment to providers

Shared Savings Funding Model

- ✓ No downside risk
- ✓ Value-based model based on total cost of care
- ✓ Could also include quality incentives
- ✓ Successfully deployed in other States for ECHO and Collaborative Care

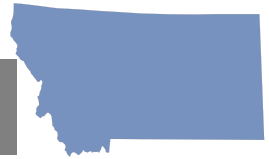
SIM HIT Plan



SIM HIT Plan – *DRAFT*

This SIM HIT Plan reviews Montana's health information landscape, and discusses key health information technology (IT) and exchange (HIE) initiatives that may be expanded in support of the Montana State Healthcare Innovation Plan.

- Administrative data
- Telehealth
- Health information exchange (HIE)



Overview of Administrative Data

State Employee Health Plan

✓ **Building "in house" data warehouse, to be launched July 1, 2016**

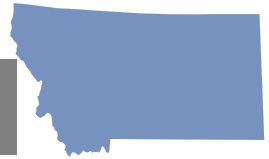
- Plan terminated a previous external data management contract
- Warehouse may eventually house other state medical data (Medicaid, State hospitals, Corrections)
- Aim to include data analytics, predictive modeling to support population health management – already, plan has identified some members with diabetes for outreach and care management services

Medicaid

× **Multiple siloed administrative data systems in use**

✓ **Building data warehouse for expansion claims from TPA (BCBS MT)**

… **Considering compiling all Medicaid and CHIP claims in single Medicaid warehouse** as part of MMIS replacement plan



Current Medicaid Claims Infrastructure

Current Medicaid claims management infrastructure consists of several siloed systems that limit State's ability to aggregate and analyze claims.

Legacy claims system for historical Medicaid populations

Data repository for Medicaid expansion TPA claims

System is currently under construction; users will be able to query systems for reporting and fiscal forecasting

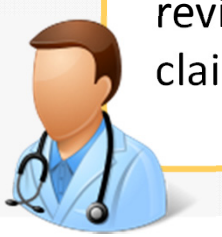
CHIP claims data system

NEMT claims

Waiver claims

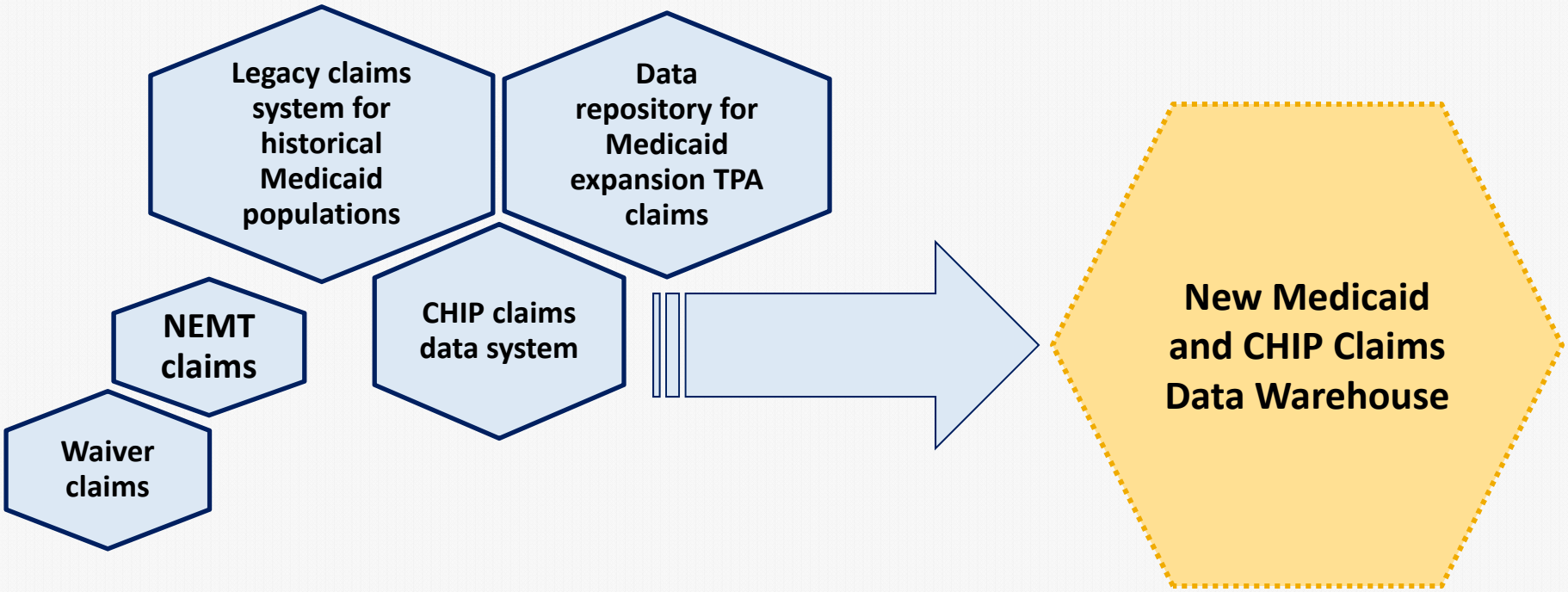
Transportation, waiver, and other special categories of Medicaid services are managed separately

Medicaid's CyberAccess system allows providers to review patients' claims



Streamlining Medicaid Claims Management

Medicaid's modular MMIS replacement plan may include replacing the legacy systems, and a data warehouse for all Medicaid and CHIP claims.



Linking Statewide Multi-Payer Claims Infrastructure

The State is currently developing a database for state employee claims; the database could be expanded to Medicaid.

State Employee Claims Data Warehouse (under development)

Claims Data from Other Payers

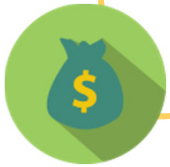
Public Health

Medicaid and CHIP Claims Data Warehouse

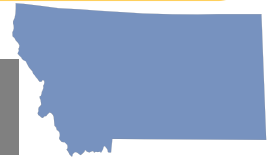
State Hospital and Chemical Dependency Center

Combined State Claims Database?

Additional data analytics capacity could be added to support population health management functions



Some of the development cost could be supported by Medicaid 90/10 funding



Administrative Claims Data Considerations

Opportunity

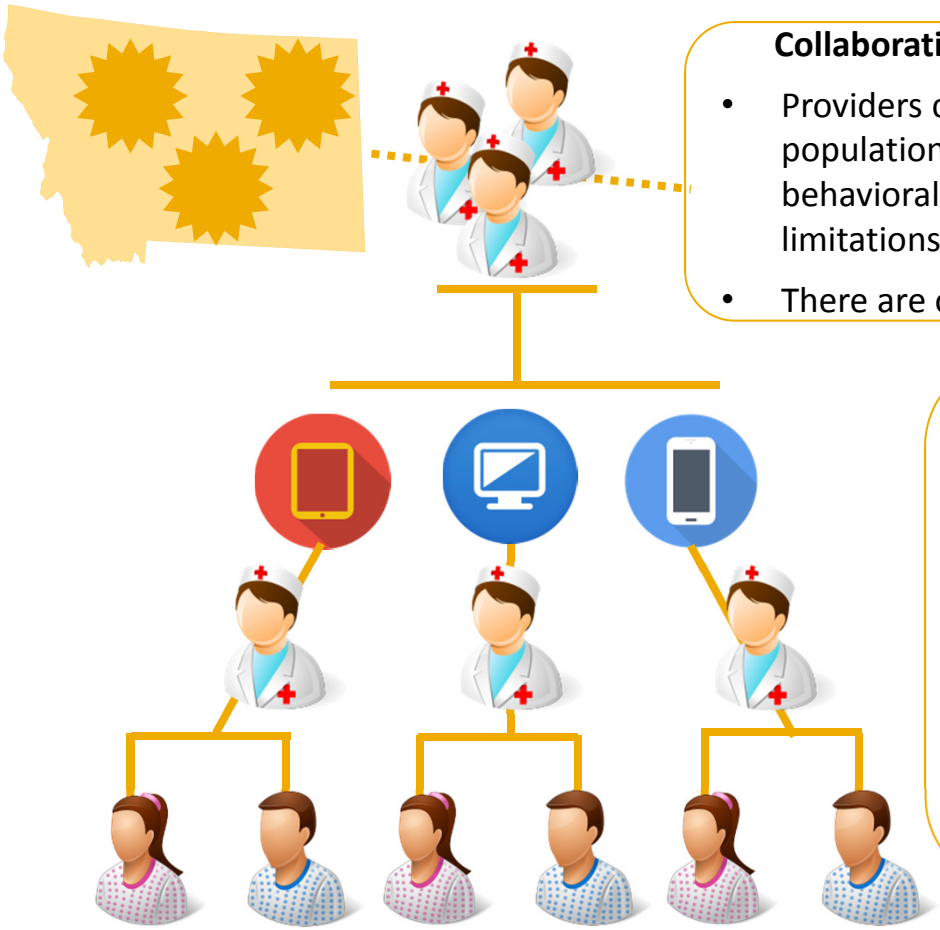
- There is significant opportunity for the State to streamline the centralized collection and storage of claims data
  - Over 240,000 lives could be represented in the contemplated data warehouse, including approximately 30,000 State employees, 205,000 Medicaid and CHIP, and 4,000 corrections
  - The development of analytics "on top" of the data warehouse will enhance the State's ability to effectively engage in population health management and improve health outcomes through targeted care management and interventions

Funding

- Medicaid could consider whether it would be appropriate to draw down 90/10 funding to support further development of the data warehouse to support Medicaid's needs, including the development of population health management tools
- The exemption to A87 allows Medicaid to purchase tools and allow for appropriate re-use for other parties

Expansion of Project ECHO Deployment

ECHO technology and software could be expanded in Montana to address workforce challenges and support delivery reform efforts



Collaborative Interdisciplinary Care Team at ECHO Hub(s)

- Providers can access ECHO Hubs to support care for target populations (e.g. patients with co-occurring physical and behavioral health disorders, health disparities or access limitations)
- There are over 39 ECHO Hubs open to providers

Designated Professionals Work with Patients in Community

- Designated health care professionals in the community (e.g. care managers, physicians, tribal health facilities, community health workers) could consult independently or as a team with ECHO Hub when delivering care
- Could be used with a specific care model (e.g. Collaborative Care) or to generally integrate services across behavioral/physical health

Project Leadership: Dr. Eric Arzubi is leading the Billings Clinic ECHO project and serves on Montana's Governor's Council for Health Care Improvement

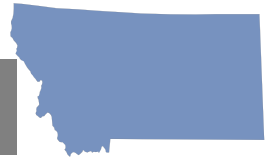
Telehealth Considerations

Opportunity

- Telehealth may help Montana address persistent workforce issues due to the rural nature and size of the state
  - Lack of psychiatrists and other specialists
  - Difficulty retaining primary care providers/family docs who feel unsupported without access to specialists
- Telehealth may ease the burden on patients with complex or chronic conditions who today must travel long distances to see a specialist or may even forego care
- The Project ECHO model has been met with considerable enthusiasm and is grounded in a tested innovation; the Governor's Council is in the process of reviewing the model's ROI

Funding

- Current Billings Clinic ECHO project is grant funded, and has been provided in kind support from participating providers
- State law requires private payers to cover certain telehealth services; providers receive reimbursement for telehealth at the same level as in-person services
- Montana Medicaid will currently reimburse a provider enrolled in Medicaid who delivers services via live video services. They are open to looking at additional reimbursement models.



Billings Pilot Update

BILLINGS HIE PILOT

Participants

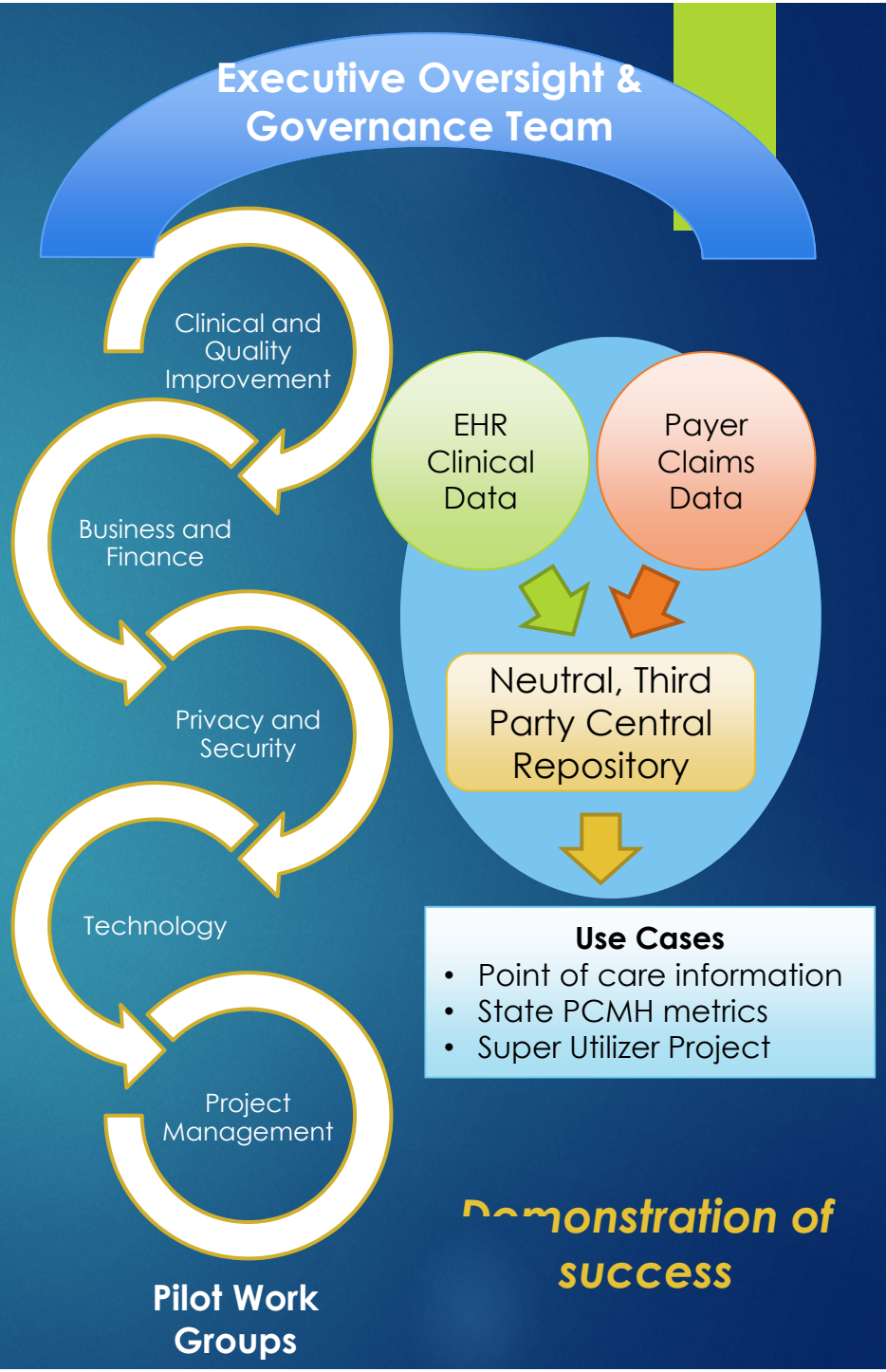
- Billings Clinic
- Blue Cross Blue Shield of Montana
- RiverStone Health
- St. Vincent Healthcare

Guiding Principles

- Voluntary pilot project, participants are "all in" and equal.
- No one organization will assume "ownership" of the pilot project.
- All pilot organizations will invest necessary resources to achieve project objectives.

Objectives

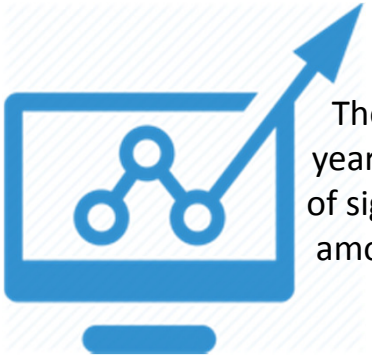
- Share information to improve patient care and population health in the Billings community.
- Enhance community-based healthcare services coordination.
- Build and implement an automated reporting platform for quality improvement efforts.
- Model a governance, operational, technological and sustainability framework for a statewide HIE organization.



HIE

HIE planning will require collaboration among key stakeholders

- Document current health IT landscape
- Convene Steering Committee to advise on approach to HIE planning
- Support statewide planning process
- participate in Billings Pilot
- Provide regular updates to Governor's Council and evaluate success and scalability of Billings Pilot



The Billings Pilot will run for one year and is currently in the process of signing Participation Agreements among providers, plans, and other participants

Updates on Related Initiatives

Next Steps

Draft Updated Driver Diagram

Aim

Improved health of Montanans by:

- Preventing, identifying and managing chronic conditions and communicable diseases
- Promoting the health of mothers, infants and children
- Supporting high-risk, vulnerable patient population and reducing health disparities (e.g. tribal health)

Improved Montana Healthcare System by:

- Improving physical and behavioral health integration
- Improving access to primary, specialty and behavioral health services

Control Healthcare Costs in Montana by:

- Reducing preventable use of ED and inpatient services
- Paying for value

Specific metrics will measure success for each sub-aim

Primary Drivers

Consider and test delivery models such as the Collaborative Care Model, Community Health Teams, patient-centered medical homes (PCMH) and health homes that support physical & behavioral health integration and disease management and improve **patient engagement**

Examine enabling **infrastructure** needs including data sharing & HIT and analytics to allow outcomes measurement and improve care coordination

Consider ways to leverage **policy and payment** authority to implement and spread value-based payment models

Secondary Drivers

Identify target populations for delivery models reflecting State needs, including a focus high utilizers with chronic conditions and behavioral health needs

Consider and obtain consensus on multi-payer delivery model reforms, with a focus on the use of interdisciplinary care teams and extending workforce

Leverage existing capabilities and infrastructure (including PCMH program, Mountain-Pacific CMMI grant, Billings Project Echo) and expand to other populations and payers

Evaluate ways to create or enhance administrative data initiatives to support population health

Explore use of telehealth capabilities to extend reach of delivery models and improve access

Support stakeholder collaboration around health information exchange

Explore leveraging State Medicaid purchasing power, including through Health Home program, to advance alternate payment models

Explore leveraging State Employee Plan, University Plan, and other Government plan purchasing power to advance alternate payment models

Explore collaborative models with commercial and tribal /IHS/urban payers to advance alternate payment models

Measures

Qualitative process measures can be used to document progress on these secondary drivers (e.g. SIM Plan Development, Governor's Council meetings, HIE Steering Committee meetings)

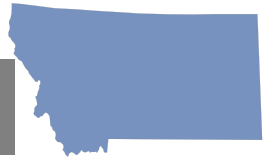
2016 Calendar

Common Agenda and Next Steps	Delivery System Transformation	Transformation Plan	Launch Planning & Implementation Teams	Presentations on Recommended Reforms	Develop Recommendations to Governor
January 2016	**March 8**	**May 10**	**July 12**	**September 13**	**November 15**
• Review needs assessment • Develop consensus on Gov. Council common agenda and approach • Discuss potential models for physical, behavioral health integration • HIT/HIE approach	• Continue delivery system discussions and obtain consensus on models • Begin to review payment models • Review driver diagram and discuss measurement • HIT/HIE update	• American Indian health leaders roundtable/ panel • Update on State Innovation Plan • Continued discussion of financing/transition to value-based payment • Begin to discuss implementation • HIT/HIE update	• Launch planning & implementation teams on: HIE, delivery system, and payment reform • Teams to develop implementation recommendations on specific reforms	• Planning and implementation team report outs to full Gov. Council • Expert panels/ speakers on recommended reforms	• Agree on recommended reform proposals for Montana • Begin developing report to Governor

Spring Webinar:

Medicare Value-Based Payment Approach

Fall Planning & Implementation Team Meetings



Appendix

Governor's Council Themes – *Refined per discussion on 1/19*

Takeaway: Stakeholders want to be part of the change and need a common agenda

Initial Issues to be Addressed

1. Physical and behavioral health integration, including substance use, chemical dependency and mental health integration
2. Social determinants of health and disparities among American Indians and other populations
3. Health information exchange (HIE) and telehealth

Challenges	Opportunities & Solutions

• Workforce
• Rural nature of the state → limited access to care
• Lack of comprehensive patient data
• Integration of direct patient service environment and public health services
• Limited funding for new initiatives
• Fee-for-service payment environment
	• Health IT services and workforce initiatives:
	  • Administrative claims data aggregation
	  • Telehealth
	  • Health information exchange
	  • Project ECHO
	• PCMH, Health Homes, ACOs and Collaborative Care Teams
	• Greater alignment: public and private sectors
	• Alternative, value-based payment models

Delivery System Reform Next Steps

Takeaway: The Governor's Council should use a systematic approach to identify and evaluate delivery system reforms to advance physical and behavioral health integration

Data-Driven Problem Identification

- Montana's health care costs are rising at an unsustainable rate: between 6% and 7% per year
- There are significant disparities in health outcomes among:
  - American Indians
  - Low income populations
  - Individuals with serious mental illness and chronic conditions
- **Next Step:** Convene Data Working Group to review data; identify target populations, conditions, and opportunities for improvement

Develop Delivery Models

- Delivery models should suit Montana and address physical and behavioral health integration
- Develop models that are replicable, scalable and sustainable
- **Next Step:** Multi-payer adoption of delivery models and accompanying value-based payment models among Governor's Council

Evaluate Models' ROI

- Delivery models should have a defined ROI – economic or improved health outcomes and patient experience at a low cost
- Must consider less tangible, qualitative aspects in addition to ROI
- **Next Step:** Develop ROI framework and evaluate delivery system models

Measure Models' Impact and Outcomes

- Models should be continuously evaluated to determine impact and make improvements
- **Next Step:** Consider measures to evaluate models with respect to process, outcomes, utilization, and costs