

Montana State Innovation Model Design

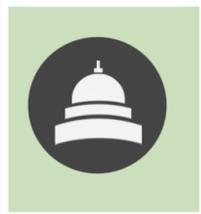
Governor's Council Meeting

May 10, 2016

Agenda

- 10:00 – 10:15 am** ■ Welcome and Meeting Objectives
- 10:15 – 11:10 am** ■ MACRA Briefing
- 11:10 – 11:40 am** ■ SIM Updates
 - State Healthcare Innovation Plan
 - Integrated Behavioral Health Lexicon
 - Next Steps
- 11:40 am – 11:55 pm** ■ *Break, Lunch Served*
- 11:55 am – 2:45 pm** ■ Delivery Model Implementation Working Session
 - Introduction
 - Community Resource Team Pilot
 - Collaborative Care Pilot
 - Pilot Development Next Steps
- 2:45 – 3:00 pm** ■ Other Stakeholder Updates and Public Comment

Meeting Objectives



Briefing on Medicare Access
and CHIP Reauthorization Act
of 2015 (MACRA)



Recap Delivery Model
Consensus



Initiate Delivery Model
Implementation Planning



Reminder:

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



Reminder: Delivery Model Principles

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



Multi-payer



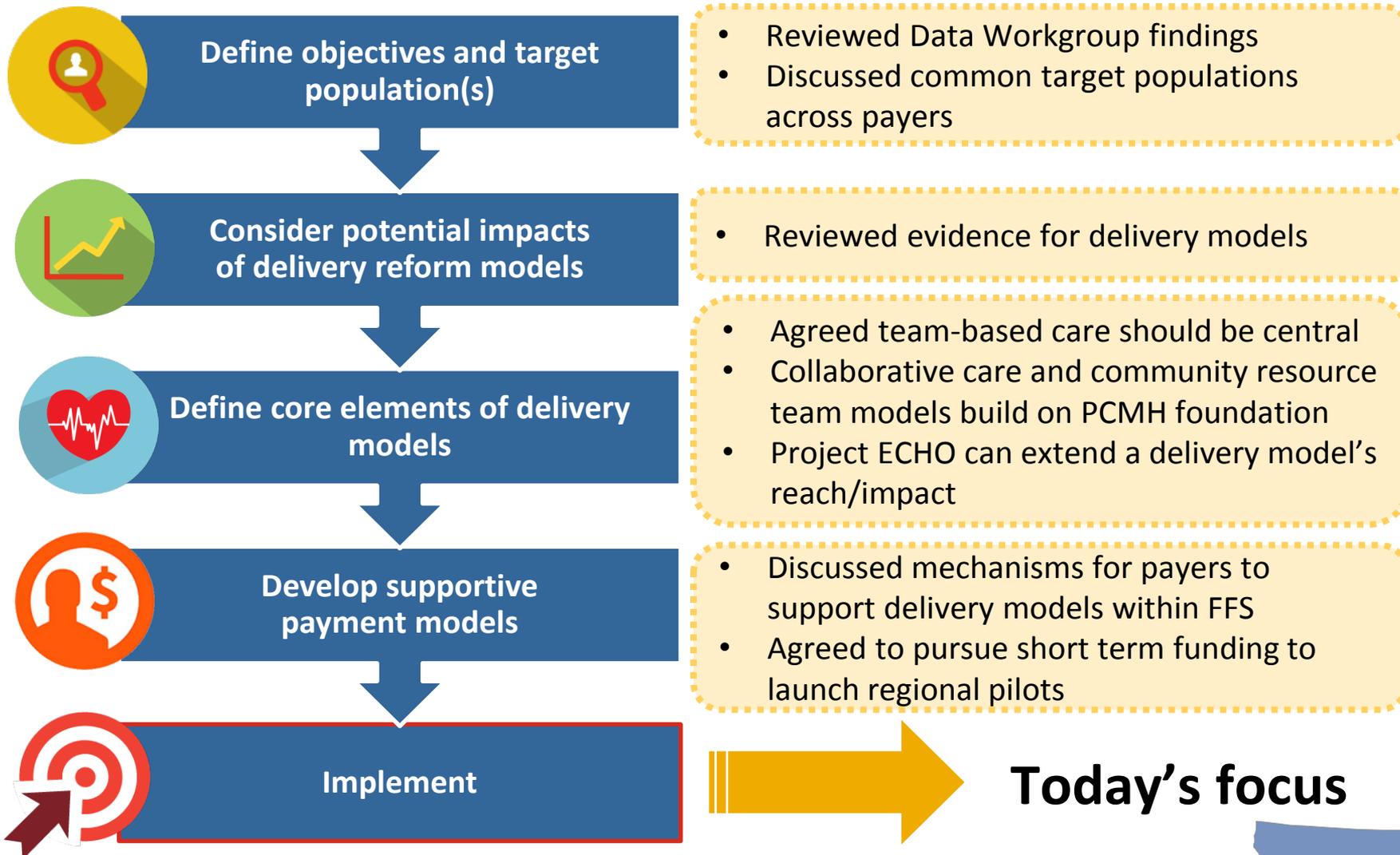
MACRA Briefing



SIM Updates

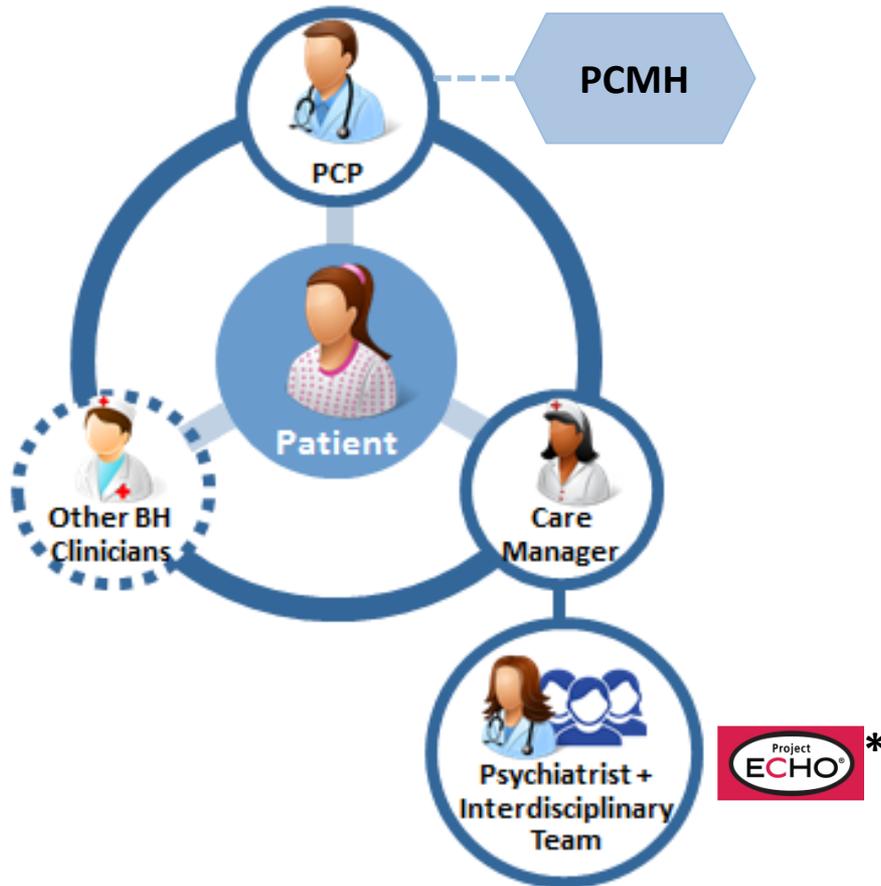


Recap of March Meeting

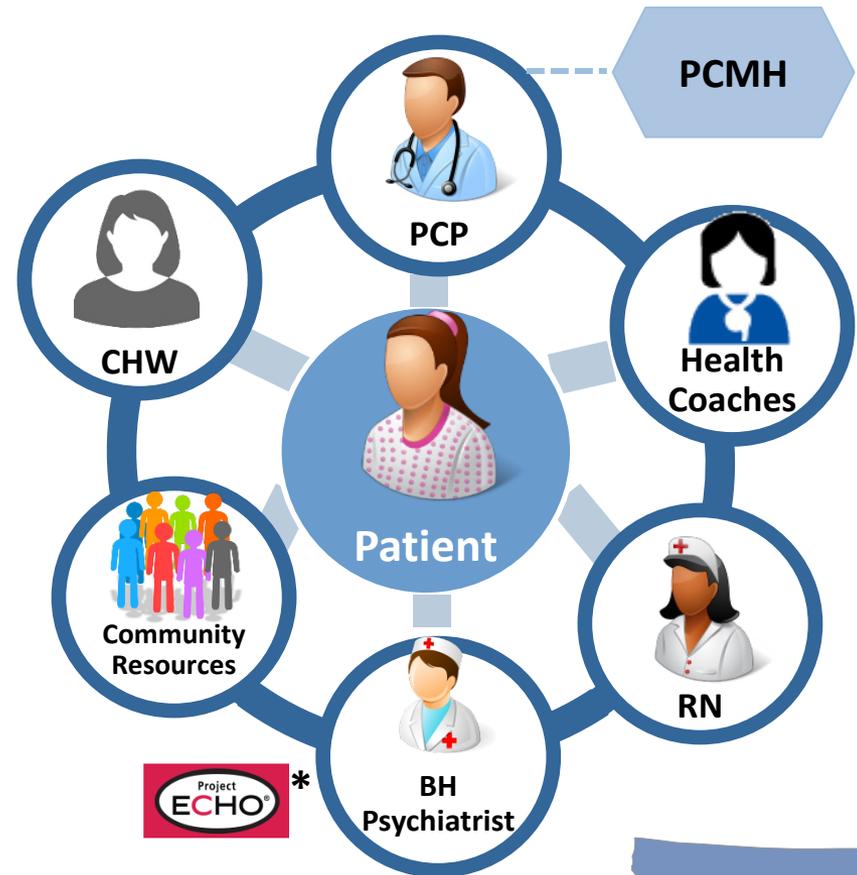


Delivery System Models – Building on the PCMH Foundation

Collaborative Care Model



Hot-Spotting with Community Resource Teams



*Either model could be enhanced through establishment of or access to a Project ECHO Hub.





Integrated Behavioral Health/Collaborative Care

Terminology & examples

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Definitions

“Integrated Behavioral Health” (IBH)

“Integrated Health results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.”

Key elements

- Team-based care: PC and BH providers, psychiatric specialty consultation
- Patient-centered approach
- Care management and coordination
- Population-based, measurement-driven approach: “treatment to a specific target”
- Uses evidence-based treatment
- Reimbursement models typically value-based (quality & outcomes, not pure FFS)

Definitions

“Collaborative care”

Two uses of the term:

1. *“collaborative care”*: general term for collaboration between BH and PC providers
2. *“Collaborative Care”*: a specific approach to IBH, based on the Improving Mood-Promoting Access to Collaborative Treatment for Late-Life Depression (IMPACT) study.

Key elements:

- Patient-Centered Team Care: primary care and behavioral health providers, psychiatric specialty consultation; specific “scope of care” and referral approach
- Population-based care: tracking patients with a specific disease (e.g. diabetes) in a registry
- Applies a specific evidence-based care pathway to each disease
- Measurement-based tracking: “treatment to target”
- Reimbursement models typically value-based (quality and outcomes, not FFS)

Comparing IBH and Collaborative Care

Key elements		“IBH”	“Collaborative Care”
Staffing	<i>Primary Care</i>	✓	✓
	<i>Behavioral health</i>	✓	✓
	<i>Care coordination</i>	✓	✓
	<i>Psychiatric consult.</i>	✓	✓
Operations	<i>Shared space</i>	✓	✓
	<i>Shared chart/data</i>	✓	✓
	<i>“Warm hand off”</i>	✓	✓
Clinical Approach	Measure outcomes, treat to target	✓	✓

DIFFERENCES?

- Policy/systems-level integration
- Whole system/whole patient

- Clinical trials: apply IBH to specific diseases
- Disease-specific protocols, registries

Integrated care in practice

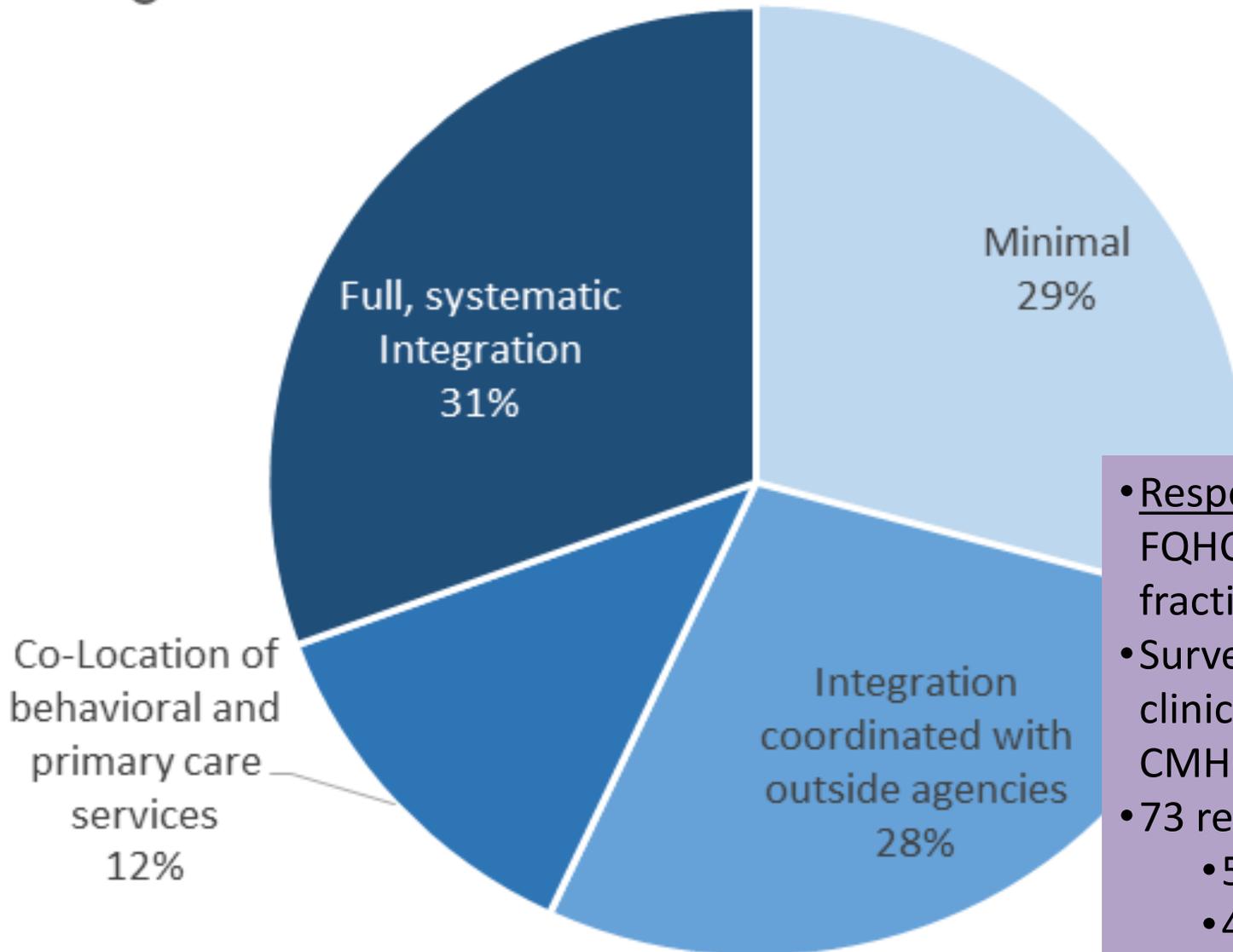
Policy example: Missouri--Medicaid Health Homes

- Created 2 types of health homes: Community Mental Health Centers AND Primary Care
- Medicaid PMPM—annual state review; potential for shared savings
- Results:
 - 9 % reduction in hospitalizations in first year; substantial improvements in high blood pressure, diabetes, and cholesterol
 - CMHC PMPM cost decreased by \$76.33; PC PMPM decreased by \$30.79

Delivery system example: Cherokee Health Systems

- FQHC-CMHC: runs a network of 45 integrated primary care/BH clinics across TN
- Results:
 - 18/1,000 quarterly admissions, compared to 32/1000 for TN
 - Fewer specialty referrals, ER visits, and costs than avg. utilization level in their region

Self-reported level of behavioral health integration at Montana Healthcare Sites, 2015



- Response bias—many FQHCs responded, lower fraction of others.
- Surveyed hospital-based clinics, private practice, CMHCs, CMHCs, CD
- 73 responses
 - 51% primary care
 - 45% BH sites

Take-home points

- Integrated models are used for both “behavioral” (mental illness, SUD), and chronic medical problems (i.e. diabetes, high blood pressure).
- “IBH” means, basically “treat the whole patient” —i.e., integrate primary care, BH, and substance use disorder treatment.
- “Collaborative Care” (the IMPACT version) stems from clinical trials that test IBH-based models for specific illnesses.
- Clinical trials show improved outcomes for chronic physical illnesses like diabetes and high blood pressure as well as for mental illnesses like depression *when all core elements of integration are present*.
- Evaluations also show improved outcomes, and cost savings as a result of lower ER and hospital use, again, *with fully integrated care*.

Bottom line for implementation

- Starting out: A practice without a team-based approach to care will have to start with the basics (adding BH and care coordination staff, developing data sharing, implementing hand-off protocol, etc.)
- Spectrum of integration: It's common to have some degree of primary care and BH collaboration but are still missing key elements of full integration/ 'collaborative care.'
- Patient Centered Medical Homes (PCMH): contain some elements of IBH: team-based care, population analytics, care planning, care coordination. PCMHs may be well-positioned to implement IBH.

MHCF Integrated behavioral health initiative

- IBH report—(available from Council staff, or www.mthcf.org)
- Training and in-depth technical assistance by National Council for Behavioral Health; collaborating with DPHHS to provide TA for Health Home pilot
- Early stages of bringing together a work group to look at how to support more widespread use of IBH in MT.
- Grant making to support innovation and mitigate the risk in making a transition toward IBH:
 - *Planning grants*: one year grants; tailored training by National Council
 - *Implementation grants*: two year grants; tailored training, TA, evaluation by National Council

Thank you

Join our mailing list: <http://www.mthcf.org/newsletter>

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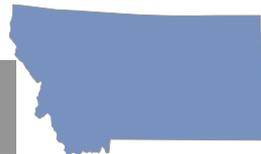
Update: State Healthcare Innovation Plan

Montana State Healthcare Innovation Plan

- I. Introduction
- II. Healthcare Landscape
- III. State Health Improvement Plan
- IV. Stakeholder Engagement
- V. Montana's Flexibility and Opportunity for Innovation
- VI. Delivery Model Framework
- VII. Monitoring and Evaluation
- VIII. Health IT Plan
- IX. Workforce Development
- X. Sustainability
- XI. Financial Analysis
- XII. Appendices



- Required under SIM Design Grant
- Describes Montana's healthcare landscape and foundation for delivery system reform
- Details delivery models and plan for pilot
- Includes initial financial analysis of pilots and plans to seek funding
- Coordinated approach to address integrated behavioral health & address disparities



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
<ul style="list-style-type: none"> Review needs assessment Develop consensus on Gov. Council common agenda and approach Discuss potential models for physical, behavioral health integration HIT/HIE approach 	<ul style="list-style-type: none"> Continue delivery system discussions and obtain consensus on models Begin to review payment models Review driver diagram HIT/HIE update 	<ul style="list-style-type: none"> MACRA briefing Update on State Innovation Plan Integrated behavioral health lexicon Pilot/ Implementation working session 	<ul style="list-style-type: none"> American Indian health presentation and discussion Implementation working sessions by model HIT/HIE update 	<ul style="list-style-type: none"> Planning and implementation team report outs to full Gov. Council Continue implementation planning HIT/HIE update 	<ul style="list-style-type: none"> Obtain consensus on pilot details Begin developing report to Governor HIT/HIE update

Fall Planning & Implementation Team Meetings as Needed



Delivery Model Implementation Working Session

Introduction



Pilot Components



**Target
Population**



**Delivery
Model**



**Providers and
Geography**



**Payment and
Evaluation**



Key Questions for Today



What information do you need, as a representative of your organization, to inform potential participation in a pilot?



**Do we agree on target populations for the pilots?
What is a reasonable population size for the pilots?**



**Do we agree on the high level delivery models for the pilots?
Do we agree on the basic staffing model and respective staff roles for each model?**



**Which providers should be included in the pilots?
In what regions should the pilots be implemented?**



**How should payers contribute to and support the pilots? How can pilot costs be effectively and fairly shared across payers?
How should providers contribute to and support pilots?
How can the pilots inform and initiate the transition to value-based payment?**

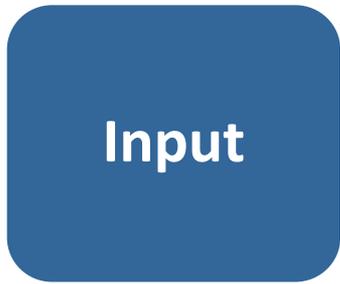




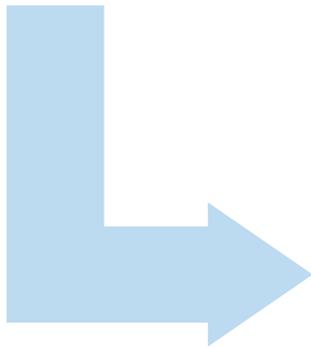
Approach

To inform implementation planning, the following includes new Montana payer data and research on the evidence of each model's costs and savings

The draft analysis will be refined as pilot details are refined.



- Montana payer data and analysis
- Evidence documented in literature regarding delivery models'
 - Costs
 - Savings
 - Staffing models and ratios



- Estimates of target population size
- Rough costs and savings estimates

Key Variables

- Size of the target population
- Acuity of the target population
- Average cost of the target population
- Key model characteristics (e.g., scope, duration)
- Cost of model implementation and evaluation (pilot and scaled)
- Evidence of model's impact with similar population





Defining the Target Population: Payer Data Recap

At the March Governor's Council meeting, payers presented data on high cost/high need populations. Across payers, several groups emerged as potential areas of focus:

- ✓ Behavioral health, especially depression and substance abuse
- ✓ Chronic disease, especially:
 - Diabetes
 - Heart disease
 - Kidney disease
- ✓ Low birth weight babies
- ✓ Cancer
- ✓ Musculoskeletal conditions

The Collaborative Care and Community Resource Team pilots should be designed to build on existing reforms (e.g. PCMHs) and target people with some of the above conditions, especially those with access barriers and disparities.





Defining the Target Population: Updated Data

Since the March Governor's Council meeting, payers have continued to refine their analyses of target populations

Co-occurring Behavioral and Medical Diagnoses:

- Pacific Source: Co-occurring depression in more than 40% of enrollees with: Hemophilia, MS, Serious Mental Illness, HIV, COPD
 - AI/AN twice as likely to have co-occurring depression/asthma than others
(*note small sample size)

Clarifications on Previously Identified Populations:

- Medicaid: There are few commonalities in clinical indicators for those with “other neurology”
- BCBS: Common musculoskeletal conditions include intervertebral disk disorders, spinal stenosis, osteoarthritis of knees and hip, shoulder joint disorders, and back pain; common co-occurring chronic conditions in this population are angina, cerebrovascular disease, depression, diabetes, and hypertension



Delivery Model Implementation Working Session

Community Resource Teams





Defining the Target Population: CRTs

Montana payers report that individuals with elevated risk scores make up 2% – 12% of their enrollees (5% on average)

Sizing the Population

- A pilot targeting 5% of those with elevated risk scores would serve 1,700 Montanans across payers per year

Allegiance: 525	Emp. Health Plan: 80
BCBSMT: 435	PacificSource: 10
Medicare: 400	CHIP: 5
Medicaid: 250	

- A multi-payer pilot would provide sufficient sample size for evaluation – separate pilots would not for all payers

Straw Model for Discussion

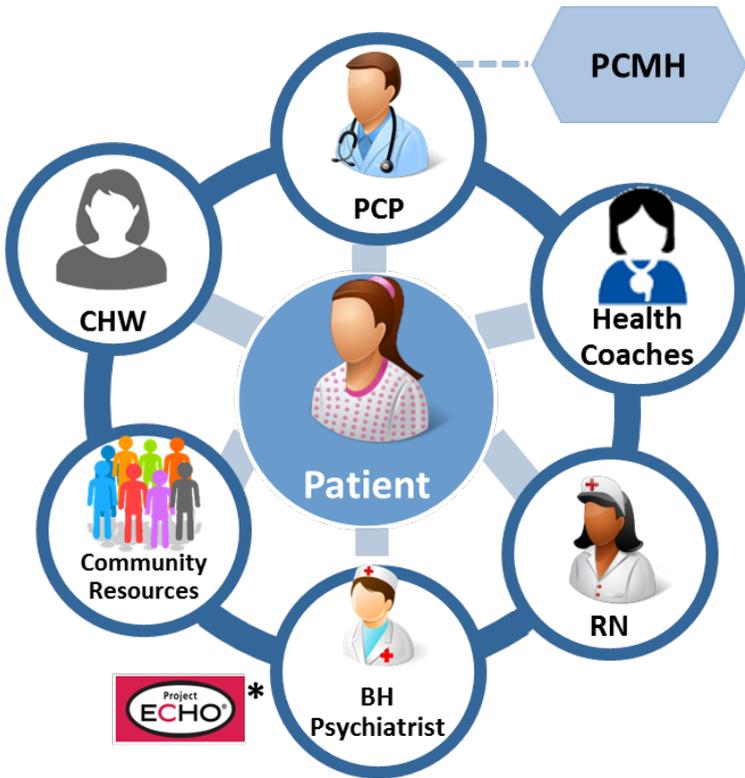
- Each payer selects 2 - 5% of total population who meet all of the following criteria:
 - Two or more hospital inpatient admissions in six months
 - Multiple chronic conditions
 - Would benefit from additional primary care
- Selection also informed by participating providers and geography
- Patients to be identified via analysis of claims data or provider referral





Community Resource Team Roles and Responsibilities

Hot-Spotting with Community Resource Teams



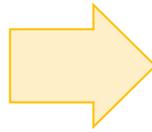
Role	Description
Patient	<ul style="list-style-type: none"> Member of identified target population, focusing on higher need populations Active participant in treatment
PCP	<ul style="list-style-type: none"> Patient identification and referral Care plan development/care management strategy May be embedded in a PCMH
RN Coordinator	<ul style="list-style-type: none"> Embedded in PCP office Clinical team leadership/quarterback across care settings and team
CHW	<ul style="list-style-type: none"> Located in the field Care coordination services Link patients' health and social needs
BH Consultant	<ul style="list-style-type: none"> Behavioral health therapy Consult and coordinate with RN and PCP on overall care plan
Coaches	<ul style="list-style-type: none"> Life skills and self-management coaching Partnerships with social services and community resources Creative solutions
Community Resources	<ul style="list-style-type: none"> Volunteers serve as care extenders to enhance relationships
Other	<ul style="list-style-type: none"> Training on appropriate use of CMS billing codes

*The model could be enhanced through establishment of or access to a Project ECHO Hub.

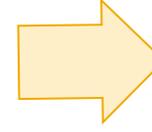


Community Resource Team Workflow

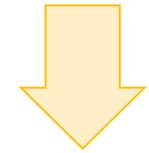
Payers and providers analyze claims and utilization data to identify members of the target population; members may also be referred at the site of care or upon discharge



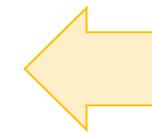
Resource Team meets patient in care setting or at the patient's home and conducts initial assessment; Resource Team immediately begins connecting patient with community resources



Resource Team visits patient in home setting and develops care plan with patient, conducts medication reconciliation, and follows up on community resource referrals



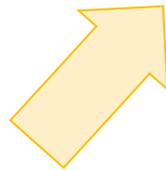
Resource Team arranges and facilitates PCP and specialty visits as needed to review patient status and participate in care planning



Resource Team continues home visits and assesses patients at 30, 60, and 90 days for program graduation or continued support



Upon graduation, patient is transitioned to PCP
Patient claims are monitored subsequent to graduation to identify relapse or need for continued support





Community Resource Team Staffing Model

For illustrative purposes only

Role	Typical Active Caseload for 1 FTE	FTE Ratio per 100 unique patients
PCP	1,500	0.07 FTE
RN Coordinator	60	1.7 FTEs
Community Health Worker	40	2.5 FTEs
Behavioral Health Consultant	165	0.6 FTE
Coaches/Volunteers	5	20 coaches/volunteers

Source: Adapted from Mountain-Pacific's Special Innovation Project. Behavioral health consultant ratio was informed by the University of Washington AIMS Center Collaborative Care staffing model.





Providers/Geography: Criteria for Selection



Potential criteria for selecting pilot providers:

- ✓ Focus on certified PCMH practices and FQHCs that can build on experience implementing related reforms
- ✓ Include some providers with less historical experience/support
- ✓ Serve significant number of target populations
- ✓ Serve tribal or urban Indian communities
- ✓ Serve other populations with significant health disparities



Potential criteria for selecting pilot locations:

- ✓ Rural areas/areas with access barriers
 -  Can help extend access in rural areas
- ✓ Geographically diverse
- ✓ Areas with high concentration of target populations
- ✓ Areas with Indian populations and other sub-populations facing disparities





Providers/Geography: CRTs

Potential Pilot Providers?



Hospitals



IHS/Tribal Health



FQHCs,
PCMHs

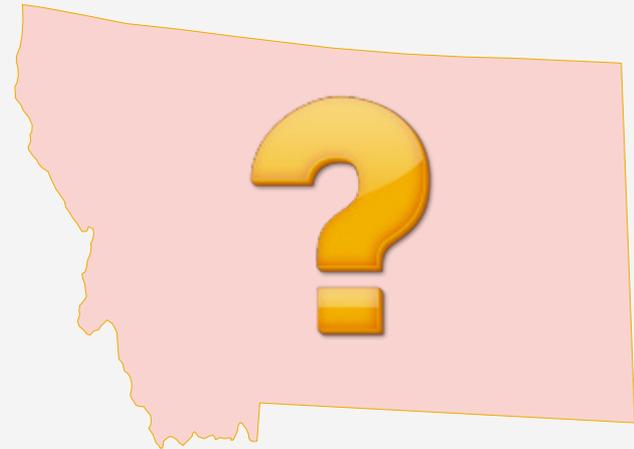


Community
Mental Health
Centers



Other
Community
Services

Potential Pilot Locations?



Can help extend access
in rural areas





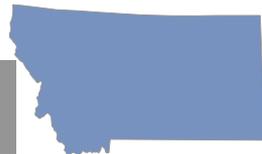
Payment and Payer Participation: CRTs

There is limited evidence on costs and impacts of the Community Resource Team model; early results on savings are promising

The estimates below use implementation costs from MPQH's hot-spotting grant application, and assume a conservative ROI of 1.20 based on Medicaid outcomes in Vermont's CRT model.

Community Resource Team Model: Estimated Cost and Impact		
	Average Per Year (2 Year Window)	Total (2 Year Window)
Implementation Cost/Patient	\$3,333	\$6,667
Savings/Patient	\$4,000	\$8,000
Net Impact	\$667	\$1,333
ROI	1.20	1.20

A CRT Pilot serving 1,700 people could cost \$5.7 million/year to implement. On net, the pilot could save approximately \$1.1 million/year

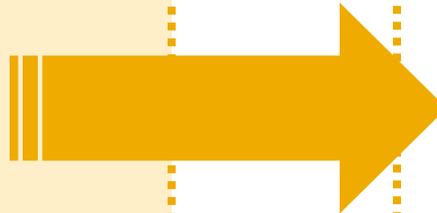




Pilot Funding

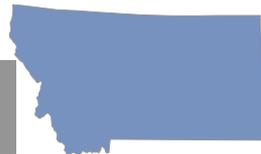
Cost Categories

- Staffing
- Training
- Data collection/
reporting
- Technology
(if needed)
- Evaluation
- Administrative
costs/overhead
- Other?



Key Considerations

- What costs can be shared/spread across payers and pilot participants?
- To what extent can existing staff be repurposed and trained to serve in care manager/RN and community health worker roles?
- Are payers with target population members in the same communities/assigned to the same providers willing/able to pool resources to jointly fund new staff?
 - Under this model, costs may be divided evenly or proportionally according to each payer's member volume in a certain geography or provider
 - In rural areas where members are spread across providers, staff may be shared across providers
- Should providers be required to contribute resources to participate in a pilot?





Measurement for Pilot Evaluation

Model	Care Coordination Process Measures	Clinical/Utilization/Outcome Measures
Both Models	Enrolled patients Graduated patients Relapsed patients Transition of care measures (e.g. referrals and follow ups) Patient satisfaction Provider satisfaction	Required PCMH measures (when applicable) Inpatient admissions/cost Hospital readmissions/cost Emergency department visits/cost Outpatient utilization/cost Pharmacy utilization/cost Total cost of care
Community Resource Team	Volunteer participation Duration of team-patient relationship Social issues addressed	<ul style="list-style-type: none">• Blood pressure control• Tobacco use and intervention• A1c control• Age-appropriate immunization for children• Depression screening





Ensuring Value Based Payment Pathway

Secure Payment for Enhanced Services



Pilot launch with commitments from payers and provider participants

Pay-for-Reporting



Pilot measures for evaluation to be reported by providers and payers, could inform future funding

Pay-for-Performance (P4P) & Shared Savings



Using pilot experience, transition to value-based payment models which may include P4P, bundled payments, shared savings and others



Delivery Model Implementation Working Session

Collaborative Care





Defining the Target Population: Collaborative Care

Montana payers report that individuals with mental health and substance use disorders make up 6% – 11% of their enrollees (8% on average)

Sizing the Population

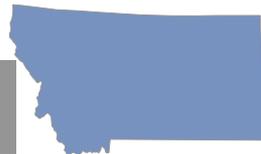
- A pilot targeting 5% of people with MH/SUD conditions would serve about 2,500 Montanans across payers per year

Allegiance: 415	Emp. Health Plan: 115
BCBSMT: 630	PacificSource: 45
Medicare: 845	CHIP: 65
Medicaid: 390	

- A multi-payer pilot would provide sufficient sample size for evaluation – separate pilots would not for all payers

Straw Model for Discussion

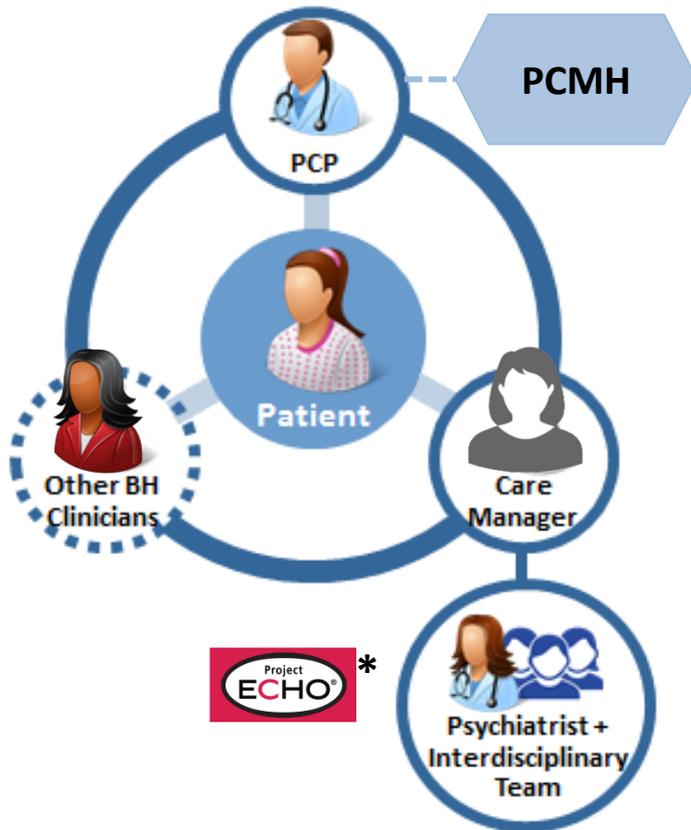
- Each payer selects up to 5 - 10% of their MH/SUD populations for pilot
- Selection informed by participating providers and geography
- Payers may each select a subcategory of focus (e.g. depression, SUD, or serious mental illness),
- Or, payers may choose not to narrow by condition





Collaborative Care Team Roles and Responsibilities

Collaborative Care Model (Could be ECHO-Enhanced)

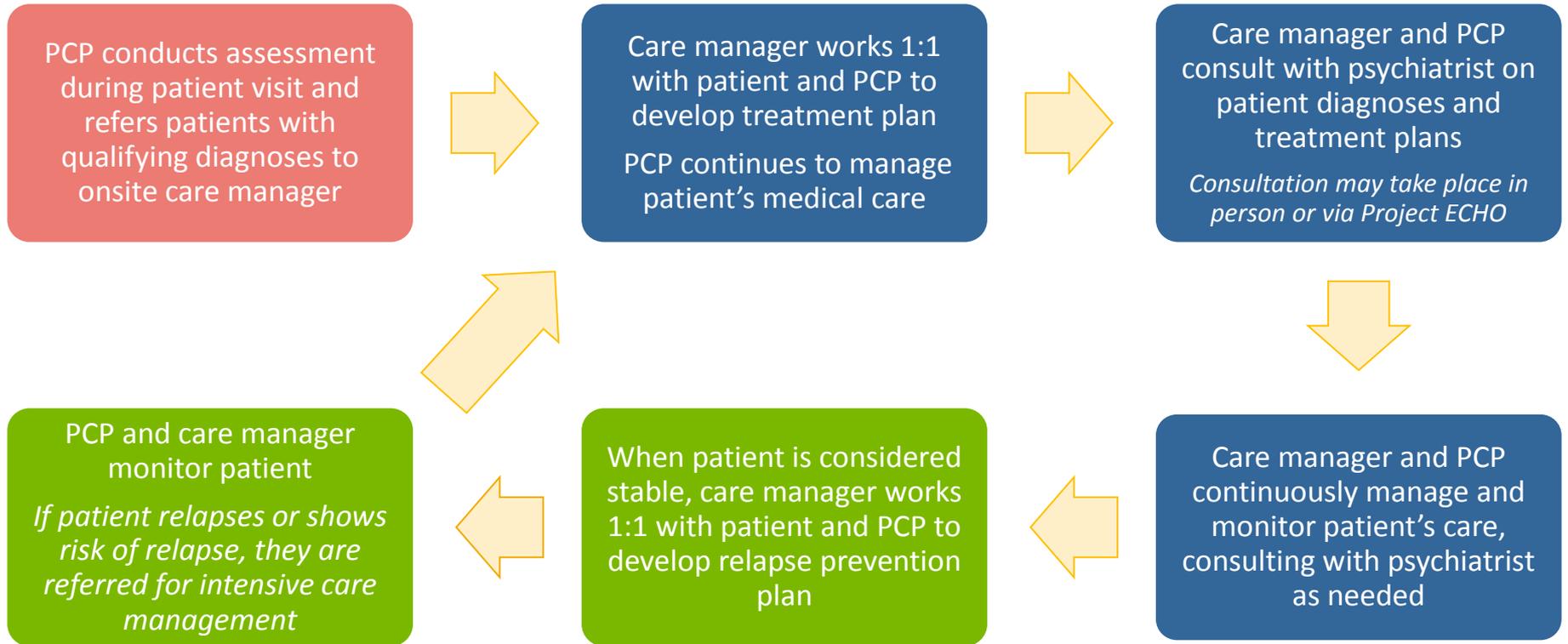


Role	Description
Patient	<ul style="list-style-type: none"> Member of identified target population, focusing on higher need populations Active participant in treatment
PCP	<ul style="list-style-type: none"> Patient identification and referral Works in consultation with care manager Oversees all aspect of patient's care May be embedded in a PCMH
Care Manager	<ul style="list-style-type: none"> Behavioral health professional embedded in PCP office Coordinates Collaborative Care Team Performs all care management tasks Offers psychotherapy when part of the treatment plan
Psychiatrist + Interdisciplinary Team	<ul style="list-style-type: none"> Supports and collaborates with PCP and care manager Consults on patients who are clinically challenging or need specialty behavioral health services
Other BH Clinicians	<ul style="list-style-type: none"> Embedded in PCP office or in community Supports PCP and care manager May see patients for in-person consultations

*The model could be enhanced through establishment of or access to a Project ECHO Hub.



Collaborative Care Workflow





Collaborative Care Staffing Model

Patient Population	Typical Active Caseload* for 1 FTE Care Manager	Total Clinic Patients <i>Proxy for PCP ratio</i>	Ratio per 1,000 unique primary care patients	
			FTE Care Manager	FTE Psychiatric Consultant
Low need (e.g., insured, employed)	100 - 125	5,000	0.2	0.05 (2 hours/week)
Medium need** (e.g., co-morbid medical needs/chronic pain/substance use)	65 - 85	1,500	0.7	0.07 (3 hours/week)
High need (e.g., homeless with substance use disorder)	50	333	3	0.3 (12 hours/week)

*Active Caseload: Active caseload includes patients in acute treatment and follow-up maintenance prior to relapse prevention planning.

**Most FQHCs are considered medium need.

Source: University of Washington AIMS Center.





Providers/Geography: Criteria for Selection



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- ✓ Include some providers with less historical experience/support
- ✓ Serve significant number of target populations
- ✓ Serve tribal or urban Indian communities
- ✓ Serve other populations with significant health disparities



Potential criteria for selecting pilot locations:

- ✓ Rural areas/areas with access barriers



Can help extend access in these areas

- ✓ Geographically diverse
- ✓ Areas with high concentration of target populations
- ✓ Areas with Indian populations and other sub-populations facing disparities





Providers/Geography: Collaborative Care

Potential Pilot Providers?



Hospitals



IHS/Tribal
Health



Community
Mental Health
Centers



FQHCs,
PCMHS

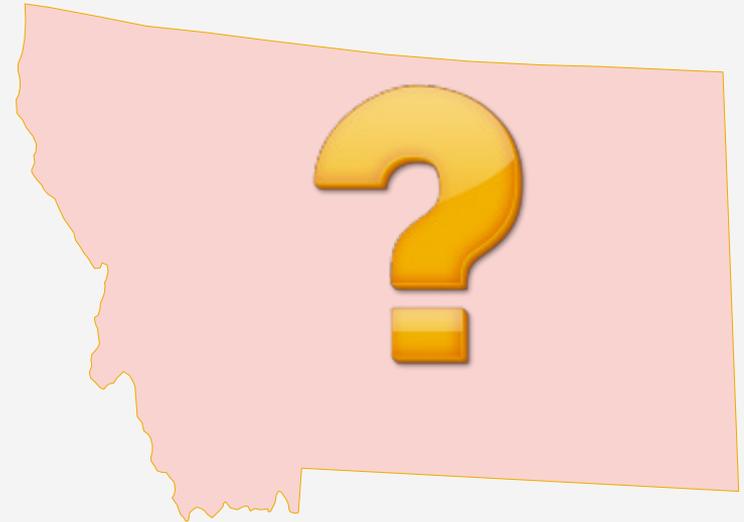


SUD Treatment



Primary Care
Practices

Potential Pilot Locations?



Can help extend access
in rural areas





Payment and Payer Participation: Collaborative Care

The Collaborative Care Model has been tested in 70+ randomized control trials
A CMS issue brief* estimated the cost/impact of the model shown below,
based on experience across payers, conditions, and settings.

Collaborative Care Model: Cost and Impact in Literature		
	Average Per Year (4 Year Window)	Total (4 Year Window)
Implementation Cost/Patient	\$225	\$900
Savings/Patient	\$1,300	\$5,200
Net Impact	\$1,075	\$4,300
ROI	5.78	5.78

A Collaborative Care Pilot serving 2,500 people could cost \$560 thousand/year to implement. On net, the pilot could save approximately \$2.7 million/year

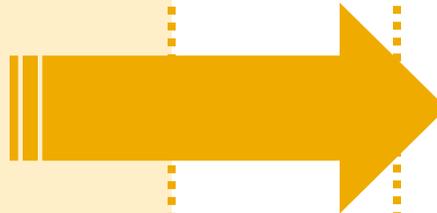




Pilot Funding

Cost Categories

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- Training
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(if needed)
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- Administrative
costs/overhead
- Other?



Key Considerations

- What costs can be shared/spread across payers and pilot participants?
- To what extent can existing staff be repurposed and trained to serve in care manager/RN and community health worker roles?
- Are payers with target population members in the same communities/assigned to the same providers willing and able to pool resources to jointly fund new staff?
 - Under this model, costs may be divided evenly or proportionally according to each payer's member volume in a certain geography or provider
 - In rural areas where members are spread across providers, staff may be shared across providers
- Should providers be required to contribute resources to participate in a pilot?





Measurement for Pilot Evaluation

Model	Care Coordination Process Measures	Clinical/Utilization/Outcome Measures
Both Models	Enrolled patients Graduated patients Relapsed patients Transition of care measures (e.g. referrals and follow ups) Patient satisfaction Provider satisfaction	Required PCMH measures (when applicable) Inpatient admissions/cost Hospital readmissions/cost Emergency department visits/cost Outpatient utilization/cost Pharmacy utilization/cost Total cost of care
Collaborative Care	Depression/SUD assessments BH referrals/consultations Access to BH services	

- Blood pressure control
- Tobacco use and intervention
- A1c control
- Age-appropriate immunization for children
- Depression screening





Ensuring Value Based Payment Pathway

Secure Payment for Enhanced Services



Pilot launch with commitments from payers and provider participants

Pay-for-Reporting



Pilot measures for evaluation to be reported by providers and payers, could inform future funding and payment models

Pay-for-Performance (P4P) & Shared Savings



Using pilot experience, transition to value-based payment models which may include P4P, bundled payments, shared savings and others



Delivery Model Implementation Working Session

Pilot Development Next Steps



Pilot/Implementation Planning Next Steps

Target Population

- Refine target population and refine payer-based analyses to size pilot population
- Determine methodology for individual patient identification and assignment to providers

Delivery Model

- Review delivery model with target providers and conduct gap analysis to identify required resources to implement model
- Identify key protocols and review/refine with participating providers (note: free resources available online)

Providers and Geography

- Identify regions that meet criteria
- Develop terms of provider pilot participation
- Identify specific providers – hospitals, FQHCs, small group and individual practices – and enroll in pilot
- Recruit key staff needed to implement delivery model

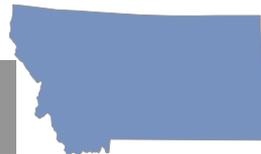
Payment and Evaluation

- Refine estimate of pilot costs
- Develop per provider and per payer cost estimates
- Seek funding to support start-up costs of pilot
- Determine provider payment model and review with providers
- Calculate total cost of care for target population pre-intervention
- Collect baseline data for target population



Pilot Phases

Pilot Planning	Pilot Launch & Implementation	Pilot Evaluation	Expansion
6 – 9 Months	12 – 36 Months	Pre/Post/During Pilot	End of Pilot/Post-Pilot
<ul style="list-style-type: none">• Obtain funding• Define and refine target populations for each model• Finalize core components of delivery models• Identify provider participants• Recruit additional staff as needed• Begin training• Determine provider payment model	<ul style="list-style-type: none">• Launch pilots• Continue training as needed• Provide technical assistance to providers• Report to Governor’s Council on pilot progress• Refine pilots in light of evaluation findings	<ul style="list-style-type: none">• Determine measures and sources• Collect baseline data (pre-pilot)• Review and analyze data on regular basis (to extent possible) to inform pilot approach	<ul style="list-style-type: none">• Review evaluation findings• Develop report on pilots and outcomes• Decide whether pilots will be expanded• If pilots will be expanded, refine models and address key components for new target populations, providers, and geographies• Refine evaluation approach as needed



Pilot Planning Next Steps

Kick off mid-May



Establish Work Groups

- Leadership
- Participants
- Support

Convene Work Groups

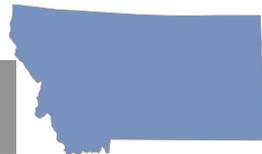
- Refine pilot design
- Continue funding discussions
- Identify requirements for pilot participants

Report Out to Gov. Council

- Update on pilot design, funding, and participation
- Secure participant and Gov. Council buy-in
- Seek Gov. Council feedback on outstanding ?s



Update at July meeting



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

- 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

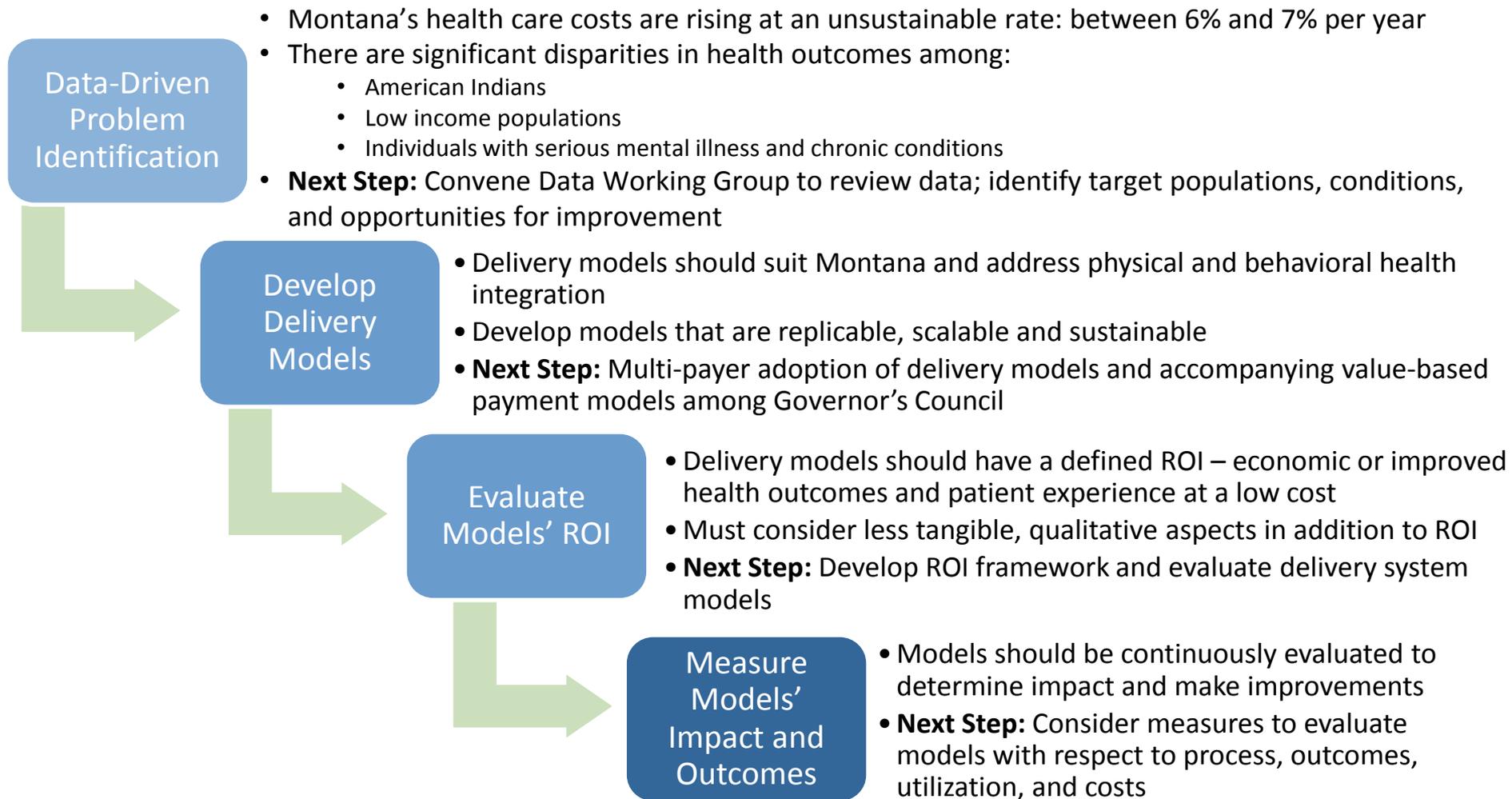


Opportunities & Solutions

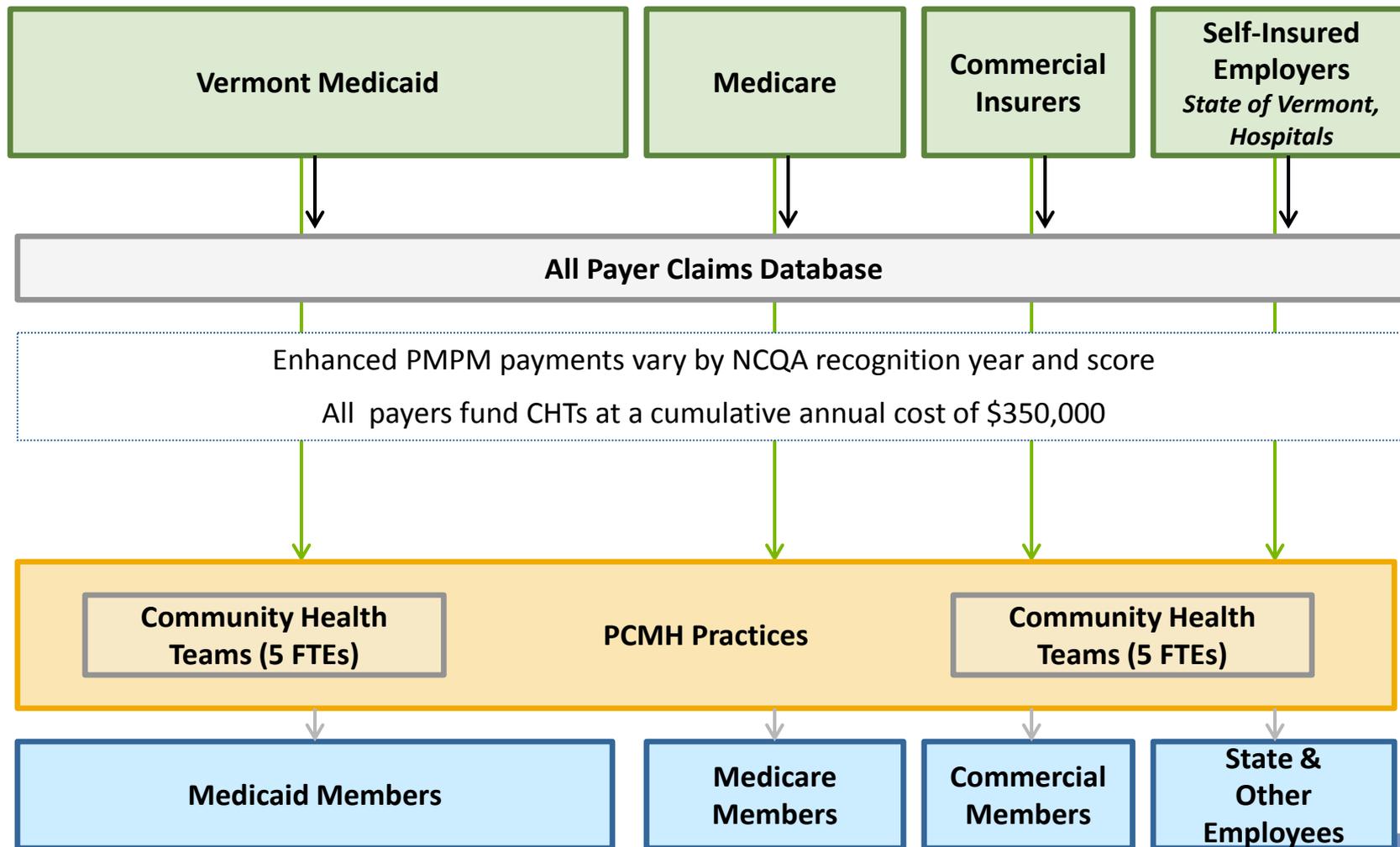
- Health IT services and workforce initiatives:
 - Administrative claims data aggregation
 - Telehealth
 - Health information exchange
 - Project ECHO
- PCMH, Health Homes, ACOs and Collaborative Care Teams
- Greater alignment: public and private sectors
- Alternative, value-based payment models

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



Vermont Blueprint for Health



Vermont Community Health Teams



In Vermont, community health teams provide support to citizens to ensure access to coordinated preventive health and social support services

CHT Design

- Multidisciplinary team that partners with primary care offices, hospitals, and health and social service organizations
- The CHT has flexible staffing, design, scheduling, and site of operation, driven by local leadership
- Design:
 - Address regional health improvement authorities
 - Fill gaps in care
 - Developed through inclusive process including medical and community-based service organizations
- CHT services are available to all patients with no eligibility requirements, prior authorizations, referrals or copays

Vermont CHT Roles:

- Care Coordinator
- Case Manager
- Certified Diabetic Educator
- Community Health Worker
- Health Educator
- Mental Health Clinician
- Substance Abuse Treatment Clinician
- Nutrition Specialist
- Social Worker
- CHT Manager
- CHT Administrator



Vermont Community Health Teams



Funding to support local CHTs is proportional to the population served by the PCMH in the health service area (HSA)

- Set at \$350,000 per year for 20,000 individuals: (\$17,500 per year for every 1,000 patients)
- CHT costs were divided evenly among five major insurers, with some adjustment for market share
- The Blueprint recently proposed aligning each insurer's share of CHT costs to their share of the attributed population

Results for Calendar Year 2013	Medicaid	Commercial
Number of Participating Beneficiaries	83,939	143,961
Total Medical Home Payments	\$2,085,035	\$3,576,002
Total CHT Payments	\$2,343,603	\$5,182,633
Total Investment Annual	\$4,428,638	\$8,758,635
Total Expenditures per Capita (participants)	\$7,776	\$4,954
Total Expenditures per Capita (comparison)	\$7,877	\$5,519
Differential per Capita (participant vs. comparison)	\$101	\$565
Total Differential (participants vs. comparison)	\$8,477,839*	\$81,337,965

*Includes expenditures for special Medicaid services (SMS)

