Montana State Innovation Model Design

Governor’s Council Meeting

May 10, 2016
## Agenda

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Identify opportunities to improve care delivery and control costs in Montana’s healthcare system</td>
</tr>
<tr>
<td>2.</td>
<td>Explore opportunities to coordinate between public and private sectors to improve health system performance and population health</td>
</tr>
</tbody>
</table>

**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.
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
- Data-driven and measurable
- Simple and flexible for providers to rollout
- Collaborative
- Replicable for different conditions
- Scalable
- Sustainable and tied to payment reform
- Multi-payer
MACRA Briefing
SIM Updates
Recap of March Meeting

- Reviewed Data Workgroup findings
- Discussed common target populations across payers

Consider potential impacts of delivery reform models

- Reviewed evidence for delivery models
- Agreed team-based care should be central
- Collaborative care and community resource team models build on PCMH foundation
- Project ECHO can extend a delivery model’s reach/impact

Define core elements of delivery models

- Discussed mechanisms for payers to support delivery models within FFS
- Agreed to pursue short term funding to launch regional pilots

Develop supportive payment models

Today’s focus
Delivery System Models – Building on the PCMH Foundation

Collaborative Care Model

- PCP
- Patient
- Care Manager
- Psychiatrist + Interdisciplinary Team
- Other BH Clinicians

Hot-Spotting with Community Resource Teams

- PCP
- CHW
- Health Coaches
- RN
- Patient
- Community Resources
- BH Psychiatrist

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

<table>
<thead>
<tr>
<th>Key elements</th>
<th>“IBH”</th>
<th>“Collaborative Care”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staffing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Primary Care</em></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><em>Behavioral health</em></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><em>Care coordination</em></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><em>Psychiatric consult.</em></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Operations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Shared space</em></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><em>Shared chart/data</em></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><em>“Warm hand off”</em></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Clinical Approach</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure outcomes, treat to target</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

**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
Surveyed hospital-based clinics, private practice, CMHCs, CD
• 73 responses
  • 51% primary care
  • 45% BH sites

Response bias—many FQHCs responded, lower fraction of others.
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

Aaron Wernham, MD, MS
Montana Healthcare Foundation
777 E. Main St
Bozeman, MT 59715
(406) 451-7060
info@mthcf.org
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

<table>
<thead>
<tr>
<th>Common Agenda and Next Steps</th>
<th>Delivery System Transformation</th>
<th>Transformation Plan</th>
<th>Launch Planning &amp; Implementation Teams</th>
<th>Presentations on Recommended Reforms</th>
<th>Develop Recommendations to Governor</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2016</td>
<td>March 8</td>
<td>May 10</td>
<td>July 12</td>
<td>September 13</td>
<td>November 15</td>
</tr>
<tr>
<td>• Review needs assessment</td>
<td>• Continue delivery system</td>
<td>• MACRA briefing</td>
<td>• American Indian health presentation</td>
<td>• Planning and implementation</td>
<td>• Obtain consensus on pilot details</td>
</tr>
<tr>
<td>• Develop consensus on Gov.</td>
<td>discussions and obtain</td>
<td>• Update on State</td>
<td>and discussion</td>
<td>team report outs to full Gov.</td>
<td>• Begin developing report to</td>
</tr>
<tr>
<td>Council common agenda and</td>
<td>consensus on models</td>
<td>Innovation Plan</td>
<td></td>
<td>Council</td>
<td>Governor</td>
</tr>
<tr>
<td>approach</td>
<td>• Begin to review payment</td>
<td>• Integrated</td>
<td></td>
<td></td>
<td>• HIT/HIE update</td>
</tr>
<tr>
<td>• Discuss potential models</td>
<td>models</td>
<td>behavioral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for physical, behavioral</td>
<td>• Review driver diagram</td>
<td>health lexicon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>health integration</td>
<td>• HIT/HIE update</td>
<td>• Pilot/</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• HIT/HIE approach</td>
<td></td>
<td>Implementation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>working session</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fall Planning & Implementation Team Meetings as Needed

2016 Calendar
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?
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.

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

**Output**
- 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 invertebral 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 per year

<table>
<thead>
<tr>
<th>Payer</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allegiance</td>
<td>525</td>
</tr>
<tr>
<td>BCBSMT</td>
<td>435</td>
</tr>
<tr>
<td>Medicare</td>
<td>400</td>
</tr>
<tr>
<td>Medicaid</td>
<td>250</td>
</tr>
<tr>
<td>Emp. Health Plan</td>
<td>80</td>
</tr>
<tr>
<td>PacificSource</td>
<td>10</td>
</tr>
<tr>
<td>CHIP</td>
<td>5</td>
</tr>
</tbody>
</table>

- 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**

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

*The model could be enhanced through establishment of or access to a Project ECHO Hub.*
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 continues home visits and assesses patients at 30, 60, and 90 days for program graduation or continued support.

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

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 Workflow
Community Resource Team Staffing Model

*For illustrative purposes only*

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

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
- Geographically diverse
- Areas with high concentration of target populations
- Areas with Indian populations and other sub-populations facing disparities
Potential Pilot Providers?

- Hospitals
- IHS/Tribal Health
- FQHCs, PCMHs

Potential Pilot Locations?

Community Mental Health Centers

Other Community Services

Can help extend access in rural areas
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.

<table>
<thead>
<tr>
<th>Community Resource Team Model: Estimated Cost and Impact</th>
<th>Average Per Year (2 Year Window)</th>
<th>Total (2 Year Window)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation Cost/Patient</td>
<td>$3,333</td>
<td>$6,667</td>
</tr>
<tr>
<td>Savings/Patient</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Net Impact</td>
<td>$667</td>
<td>$1,333</td>
</tr>
<tr>
<td>ROI</td>
<td>1.20</td>
<td>1.20</td>
</tr>
</tbody>
</table>

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?
<table>
<thead>
<tr>
<th>Model</th>
<th>Care Coordination Process Measures</th>
<th>Clinical/Utilization/Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both Models</td>
<td>Enrolled patients</td>
<td>Required PCMH measures (when applicable)</td>
</tr>
<tr>
<td></td>
<td>Graduated patients</td>
<td>Inpatient admissions/cost</td>
</tr>
<tr>
<td></td>
<td>Relapsed patients</td>
<td>Hospital readmissions/cost</td>
</tr>
<tr>
<td></td>
<td>Transition of care measures (e.g. referrals and follow ups)</td>
<td>Emergency department visits/cost</td>
</tr>
<tr>
<td></td>
<td>Patient satisfaction</td>
<td>Outpatient utilization/cost</td>
</tr>
<tr>
<td></td>
<td>Provider satisfaction</td>
<td>Pharmacy utilization/cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total cost of care</td>
</tr>
<tr>
<td>Community Resource Team</td>
<td>Volunteer participation</td>
<td>• Blood pressure control</td>
</tr>
<tr>
<td></td>
<td>Duration of team-patient relationship</td>
<td>• Tobacco use and intervention</td>
</tr>
<tr>
<td></td>
<td>Social issues addressed</td>
<td>• A1c control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Age-appropriate immunization for children</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Depression screening</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Payer</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allegiance</td>
<td>415</td>
</tr>
<tr>
<td>BCBSMT</td>
<td>630</td>
</tr>
<tr>
<td>Medicare</td>
<td>845</td>
</tr>
<tr>
<td>Medicaid</td>
<td>390</td>
</tr>
<tr>
<td>Emp. Health Plan</td>
<td>115</td>
</tr>
<tr>
<td>PacificSource</td>
<td>45</td>
</tr>
<tr>
<td>CHIP</td>
<td>65</td>
</tr>
</tbody>
</table>

- 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)**

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

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

1. PCP conducts assessment during patient visit and refers patients with qualifying diagnoses to onsite care manager.

2. Care manager works 1:1 with patient and PCP to develop treatment plan. PCP continues to manage patient’s medical care.

3. Care manager and PCP consult with psychiatrist on patient diagnoses and treatment plans. Consultation may take place in person or via Project ECHO.

4. PCP and care manager monitor patient. If patient relapses or shows risk of relapse, they are referred for intensive care management.

5. When patient is considered stable, care manager works 1:1 with patient and PCP to develop relapse prevention plan.

6. Care manager and PCP continuously manage and monitor patient’s care, consulting with psychiatrist as needed.
## Collaborative Care Staffing Model

<table>
<thead>
<tr>
<th>Patient Population</th>
<th>Typical Active Caseload* for 1 FTE Care Manager</th>
<th>Total Clinic Patients Proxy for PCP ratio</th>
<th>Ratio per 1,000 unique primary care patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low need (e.g., insured, employed)</td>
<td>100 - 125</td>
<td>5,000</td>
<td>0.2</td>
</tr>
<tr>
<td>Medium need** (e.g., co-morbid medical needs/chronic pain/substance use)</td>
<td>65 - 85</td>
<td>1,500</td>
<td>0.7</td>
</tr>
<tr>
<td>High need (e.g., homeless with substance use disorder)</td>
<td>50</td>
<td>333</td>
<td>3</td>
</tr>
</tbody>
</table>

*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

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 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
- FQHCs, PCMHs
- Primary Care Practices

Potential Pilot Locations?
- Community Mental Health Centers
- SUD Treatment

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.

<table>
<thead>
<tr>
<th>Collaborative Care Model: Cost and Impact in Literature</th>
<th>Average Per Year (4 Year Window)</th>
<th>Total (4 Year Window)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation Cost/Patient</td>
<td>$225</td>
<td>$900</td>
</tr>
<tr>
<td>Savings/Patient</td>
<td>$1,300</td>
<td>$5,200</td>
</tr>
<tr>
<td>Net Impact</td>
<td>$1,075</td>
<td>$4,300</td>
</tr>
<tr>
<td>ROI</td>
<td>5.78</td>
<td>5.78</td>
</tr>
</tbody>
</table>

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

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?

Cost Categories

• Staffing
• Training
• Data collection/reporting
• Technology (if needed)
• Evaluation
• Administrative costs/overhead
• Other?
### Measurement for Pilot Evaluation

<table>
<thead>
<tr>
<th>Model</th>
<th>Care Coordination Process Measures</th>
<th>Clinical/Utilization/Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both Models</td>
<td>Enrolled patients</td>
<td>Required PCMH measures (when applicable)</td>
</tr>
<tr>
<td></td>
<td>Graduated patients</td>
<td>Inpatient admissions/cost</td>
</tr>
<tr>
<td></td>
<td>Relapsed patients</td>
<td>Hospital readmissions/cost</td>
</tr>
<tr>
<td></td>
<td>Transition of care measures (e.g. referrals and follow ups)</td>
<td>Emergency department visits/cost</td>
</tr>
<tr>
<td></td>
<td>Patient satisfaction</td>
<td>Outpatient utilization/cost</td>
</tr>
<tr>
<td></td>
<td>Provider satisfaction</td>
<td>Pharmacy utilization/cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total cost of care</td>
</tr>
<tr>
<td>Collaborative Care</td>
<td>Depression/SUD assessments</td>
<td>• Blood pressure control</td>
</tr>
<tr>
<td></td>
<td>BH referrals/consultations</td>
<td>• Tobacco use and intervention</td>
</tr>
<tr>
<td></td>
<td>Access to BH services</td>
<td>• A1c control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Age-appropriate immunization for children</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Depression screening</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Delivery Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Refine target population and refine payer-based analyses to size pilot population</td>
<td>• Review delivery model with target providers and conduct gap analysis to identify required resources to implement model</td>
</tr>
<tr>
<td>• Determine methodology for individual patient identification and assignment to providers</td>
<td>• Identify key protocols and review/refine with participating providers (note: free resources available online)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Providers and Geography</th>
<th>Payment and Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify regions that meet criteria</td>
<td>• Refine estimate of pilot costs</td>
</tr>
<tr>
<td>• Develop terms of provider pilot participation</td>
<td>• Develop per provider and per payer cost estimates</td>
</tr>
<tr>
<td>• Identify specific providers – hospitals, FQHCs, small group and individual practices – and enroll in pilot</td>
<td>• Seek funding to support start-up costs of pilot</td>
</tr>
<tr>
<td>• Recruit key staff needed to implement delivery model</td>
<td>• Determine provider payment model and review with providers</td>
</tr>
<tr>
<td></td>
<td>• Calculate total cost of care for target population pre-intervention</td>
</tr>
<tr>
<td></td>
<td>• Collect baseline data for target population</td>
</tr>
</tbody>
</table>
## Pilot Phases

<table>
<thead>
<tr>
<th>Pilot Planning</th>
<th>Pilot Launch &amp; Implementation</th>
<th>Pilot Evaluation</th>
<th>Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6 – 9 Months</strong></td>
<td><strong>12 – 36 Months</strong></td>
<td><strong>Pre/Post/During Pilot</strong></td>
<td><strong>End of Pilot/Post-Pilot</strong></td>
</tr>
<tr>
<td>- Obtain funding</td>
<td>- Launch pilots</td>
<td>- Determine measures and sources</td>
<td>- Review evaluation findings</td>
</tr>
<tr>
<td>- Define and refine target populations for each model</td>
<td>- Continue training as needed</td>
<td>- Collect baseline data (pre-pilot)</td>
<td>- Develop report on pilots and outcomes</td>
</tr>
<tr>
<td>- Finalize core components of delivery models</td>
<td>- Provide technical assistance to providers</td>
<td>- Review and analyze data on regular basis (to extent possible) to inform pilot approach</td>
<td>- Decide whether pilots will be expanded</td>
</tr>
<tr>
<td>- Identify provider participants</td>
<td>- Report to Governor’s Council on pilot progress</td>
<td></td>
<td>- If pilots will be expanded, refine models and address key components for new target populations, providers, and geographies</td>
</tr>
<tr>
<td>- Recruit additional staff as needed</td>
<td>- Refine pilots in light of evaluation findings</td>
<td></td>
<td>- Refine evaluation approach as needed</td>
</tr>
<tr>
<td>- Begin training</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 questions

Update at July meeting
Appendix
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*

- 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

- 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

- 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

- 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
Enhanced PMPM payments vary by NCQA recognition year and score

All payers fund CHTs at a cumulative annual cost of $350,000

Vermont Medicaid
Medicare
Commercial Insurers
Self-Insured Employers
State of Vermont, Hospitals

All Payer Claims Database

Community Health Teams (5 FTEs)
PCMH Practices
Community Health Teams (5 FTEs)

Medicaid Members
Medicare Members
Commercial Members
State & Other Employees
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

<table>
<thead>
<tr>
<th></th>
<th>Medicaid</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Participating Beneficiaries</td>
<td>83,939</td>
<td>143,961</td>
</tr>
<tr>
<td>Total Medical Home Payments</td>
<td>$2,085,035</td>
<td>$3,576,002</td>
</tr>
<tr>
<td><strong>Total CHT Payments</strong></td>
<td>$2,343,603</td>
<td>$5,182,633</td>
</tr>
<tr>
<td>Total Investment Annual</td>
<td>$4,428,638</td>
<td>$8,758,635</td>
</tr>
<tr>
<td>Total Expenditures per Capita (participants)</td>
<td>$7,776</td>
<td>$4,954</td>
</tr>
<tr>
<td>Total Expenditures per Capita (comparison)</td>
<td>$7,877</td>
<td>$5,519</td>
</tr>
<tr>
<td><strong>Differential per Capita (participant vs. comparison)</strong></td>
<td>$101</td>
<td>$565</td>
</tr>
<tr>
<td>Total Differential (participants vs. comparison)</td>
<td>$8,477,839*</td>
<td>$81,337,965</td>
</tr>
</tbody>
</table>

*Includes expenditures for special Medicaid services (SMS)