## Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00 – 10:10</td>
<td>Welcome and Meeting Objectives</td>
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<tr>
<td>10:10 – 10:50</td>
<td>Montana Health Care Needs Assessment</td>
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<tr>
<td>10:50 – 11:20</td>
<td>Governor’s Council Approach and Common Agenda</td>
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<td>11:20 – 12:20</td>
<td>Montana Case Studies on Physical and Behavioral Health Integration</td>
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<td>12:20 – 12:40</td>
<td><strong>Lunch Break</strong></td>
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<tr>
<td>12:40 – 1:40</td>
<td>Montana Case Studies (continued)</td>
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<tr>
<td>1:40 – 2:40</td>
<td>Discussion of Potential Physical and Behavioral Health Integration Reforms in Montana</td>
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<td>2:40 – 2:55</td>
<td><strong>Afternoon Break</strong></td>
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<td>2:55 – 3:20</td>
<td>Proposed HIE Planning Approach</td>
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<td>3:20 – 3:45</td>
<td>Updates on Related Initiatives</td>
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<td>3:45 – 3:50</td>
<td>Next Steps</td>
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<tr>
<td>3:50 – 4:00</td>
<td>Public Comment</td>
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</table>
Meeting Objectives
Meeting Objectives

Agree to Common Agenda

Discuss Potential Models for Behavioral/Physical Health Integration

Review and Discuss HIE Planning Approach

Confirm 2016 Council Calendar and Objectives
Montana Health Care Needs Assessment
Medicare Care Management Codes

Presented by Patty Kosednar, PMP, CPEHR
Health Technology Services/
Mountain-Pacific Quality Health
Two main categories for care management codes

- **Transitional Care Management (TCM)**
  - Effective since January 2013
  - Used for care transition activities

- **Chronic Care Management (CCM)**
  - Effective since January 2015
  - Used for managing patients with two or more chronic conditions
Transitional Care Management – TCM

• Used to manage the activities and follow up visits for patients after discharge from:
  – Acute care hospitals, rehabilitation hospitals, long-term acute care hospitalization programs, skilled nursing facilities and community mental health partial hospitalization programs

• Two available codes
  – 99495 (moderate complexity – patient seen within 14 days of discharge)
  – 99496 (high complexity – patient seen within 7 days of discharge)
Transitional Care Management – TCM

• Previously established relationship with provider is not required

• Required elements of service
  – Non-face-to-face encounter, contact patient within two days of discharge
  – Face-to-face visit within 7 or 14 days (based on complexity)
  – Medication reconciliation
Transitional Care Management – TCM

• A provider may bill for one unit of 99495 or 99496 services per patient – period = 30 days from discharge

• Claims billing no sooner than 30 days after discharge
  – Claim not paid if there is a readmission within 30 days

• No formal “patient agreement” requirements
TCM Details

• Non-face-to-face must address patient status and needs beyond scheduling follow-up care

• Face-to-face can happen on same day as discharge, but cannot be performed by same professional who bills a discharge day management code

• Face-to-face can be telemedicine (based on CMS telemedicine rules)

• Documentation requirements
  – Timing of initial post-discharge communication
  – Date of face-to-face encounter
  – Complexity of medical decision making

• Face-to-face encountered bundled into TCM payment, subsequent E&M services separately payable
Chronic Care Management – CCM

• Used to manage the non-face-to-face care coordination activities for patients with:
  – Two or more chronic conditions that are expected to last at least 12 months

• Only one code – 99490

• Covers 20 minutes of non-face-to-face activities per month

• Only one practitioner can be paid for each patient’s 99490 per month
Examples of chronic conditions include (but are not limited to):

- Alzheimer’s disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Autism spectrum disorders
- Cancer

- Chronic obstructive pulmonary disease
- Depression
- Diabetes
- Heart failure
- Hypertension
- Ischemic heart disease
- Osteoporosis
CCM Details

- Must have current certified EHR
- Must record structured data in EHR
- Must create patient-centered comprehensive care plan with electronic access (24/7) to plan for patients and other providers
- Must ensure 24/7 access to care
- Must provide managed care services, manage care transitions and coordinate care with home and community based service providers
- Cannot bill both CCM and TCM codes in the same time period
Clinic Feedback Summary

• Transition Care Management – TCM
  – Easy/requires less admin to implement
  – Good revenue source for clinics (both with increased volume and TCM code billing)
  – Good outcome improvement opportunities for both clinics and hospitals
  – Can improve patient engagement
  – No formal “patient consent” requirements

• Chronic Care Management – CCM
  – More difficult/requires more admin to implement
  – Good outcome improvement opportunities for clinic
  – Can improve patient engagement
  – Biggest barrier is patient recruitment
  – Sufficient ROI only with high patient recruitment
Resources

• CMS – Chronic Care Management Fact Sheet:

• CMS – Chronic Care Management FAQs:
  – https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf

• Pershing Yoakey & Associates (PYA) TCM white paper:

• CMS – Transitional Care Management FAQs:
Q&A

• Contact Information
  – Patty Kosednar
    Health Technology Services/Mountain-Pacific Quality Health
    406-461-4410
    pkosednar@mpqhf.org

• Thank You
Governor’s Council Approach and Common Agenda
Takeaway: Stakeholders want to be part of the change and need a common agenda

Key Issues to be Addressed

1. Physical & behavioral health integration; including substance use, chemical dependency and mental health integration
2. Disparities and social determinants of health
3. Health information exchange (HIE) and telehealth

<table>
<thead>
<tr>
<th>Challenges</th>
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<tbody>
<tr>
<td>• Workforce</td>
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<tr>
<td>• Rural nature of the state → access to care</td>
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<td>• Lack of comprehensive patient data</td>
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<td>• Funding &amp; financing for new initiatives</td>
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<thead>
<tr>
<th>Opportunities &amp; Solutions</th>
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<tbody>
<tr>
<td>• PCMH expansion</td>
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<td>• Medicaid Health Homes</td>
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<tr>
<td>• Community health teams</td>
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<tr>
<td>• Telehealth</td>
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<tr>
<td>• Health information exchange</td>
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<td>• Coordination and alignment between public and private sectors</td>
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For Reference –
Hypotheses: Common Agenda & Approach

Engage Governor’s Council
Build trust and foster consensus on a “common agenda”
Utilize members’ expertise to guide planning around need identification and delivery system and payment reform
Establish SIM timeline and the continued role of Gov. Council

Needs Assessment
Review State Health Improvement Plan
Identify target populations
Consider population health components to inform value-based reforms

Focus Delivery System Reform Efforts
Issues with strong support:
• **Focus**: Behavioral health (including mental health and substance abuse) and physical health integration
• **Target**: Disparities identified in needs assessment
• **Programs and Enablers**: For example: community health teams, workforce development, HIE, telehealth, Health Homes, PCMHs, and other models

Address Payment Reform
Discuss payment reform in the context of narrowed delivery system focus
Review Medicare transition to value-based payment as a guidepost
Identify areas of common interest among stakeholders
## Proposed Agendas for 2016 Gov. Council Meetings – For Discussion

### Meeting 1:
**Common Agenda and Next Steps**
*January, 2016*
- Review needs assessment
- Develop consensus on Gov. Council common agenda and approach
- Discuss potential models for physical, behavioral health integration
- HIT/HIE approach

### Meeting 2:
**Delivery System Transformation**
*March, 2016*
- Continue discussion and obtain consensus on delivery system transformation approach
- Discuss measurement
- HIT/HIE update

### Meeting 3:
**Transformation Plan**
*May, 2016*
- Obtain consensus on key elements of transformation plan
- Financing and payment mechanisms to support reforms
- HIT/HIE update

### Meeting 4:
**Launch Planning & Implementation Teams**
*July, 2016*
- Launch planning & implementation teams on: HIE, delivery system, and payment reform
- Teams to develop implementation recommendations on specific reforms
- HIT/HIE update

### Meeting 5:
**Presentations on Recommended Reforms**
*October, 2016*
- Planning and implementation team report outs to full Gov. Council
- Expert panels/speakers on recommended reforms

### Meeting 6:
**Develop Recommendations to Governor**
*December, 2016*
- Agree on recommended reform proposals for Montana
- Begin developing report to Governor

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**Spring Webinar:**
Medicare Value-Based Payment Approach

**Fall Planning & Implementation Team Meetings**
Montana Case Studies:
Physical and Behavioral Health Integration
Discussion: Potential Physical and Behavioral Health Integration Reforms in Montana
Discussion Framework: Delivery Reform in Montana

Common Agenda
- Behavioral and physical health integration
- Social determinants of health
- HIE and telehealth

Montana Health Care Needs
- Disparities and target populations
- Workforce
- Behavioral health

Existing Capacity and Reform Efforts
- Montana case studies
- PCMHs & Health Homes
- Private payer models

Feasibility and Expected Impact
- Multi payer
- Scalability
- Financing
- Timing

Can we develop delivery models that align with and address these areas?
Collaborative Care Model

- **Collaborative Psychiatrist** serves as a consultant to provide diagnostic consultation on difficult cases and is accessible to care manager and PCP.

- **Care manager** educates the patient, provides self-management support and in some cases counseling services, and conducts close follow-up to ensure patients remain engaged in their care.

- **Primary care physician** is directly involved in developing and implementing a treatment plan.

- **Care manager** and patient may also link to substance abuse treatment, vocational rehab, and other community resources.

- **Intake/Assessment**
  - Team uses validated clinical tools - PHQ 2 and PHQ 9 - to identify and monitor at-risk patients.

- **Step 2: Care Approach**
  - Symptoms are measured at the start of treatment and regularly thereafter. Treatment is adjusted based on clinical outcomes and an evidence-based algorithm, and the plan is changed if this reduction is not observed.
Example: Telehealth Enabled Collaborative Care

Project ECHO technology and software could help address workforce challenges and expand scope of delivery reform efforts under SIM

Interdisciplinary Team at ECHO Hub(s)
- Psychiatrist could be connected to and would consult with many care managers via the ECHO technology
- Other specialists (e.g. pharmacist or addictions counselor) could also be added at the ECHO hub(s)

Care Team Works with Patients in Community
- Care manager, PCP, and other care team members would be embedded in community primary care practices
- Teams would each work with patients, using the Collaborative Care Model stepped treatment approach, and consulting via ECHO with a psychiatrist
Vermont Community Health Teams

Community health teams expand the capacity of primary care practices by providing patients with direct access to an enhanced range of services and individualized follow up.

Vermont CHT Design

- Multidisciplinary teams are designed and hired at the community (health service area [HSA]) level
- Local leadership convenes a planning group to determine the most appropriate community health team design
- Community health team design varies based on:
  - Demographics of the community
  - Identified gaps in services
  - Strengths of local partners
- Services are available to all patients with no eligibility requirements, prior authorizations, referrals or copays

Vermont CHT Roles

Teams linked to primary care sites may include:

- 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
Community Health Teams Discussion, Cont.

How can we structure and compose Community Health Teams to best address Montana health care needs?

- **Geography**
  - Urban, Rural, Indian

- **Target Populations**

- **Community Resources and Needs**

- **Other Factors**

Local primary care providers or patient centered medical homes (PCMHs) could be linked to and help lead CHTs.
Proposed HIE Planning Approach
Two Key Drivers for SIM HIT Plan

Value-based reforms will further increase the need to share information, analyze and report outcome data, and improve care coordination and integration.

Create or enhance data sharing and communication capabilities
- All-payer claims database
- Expanded telehealth
- Statewide health information exchange
- Strengthening and expanding community data-sharing arrangements

Improve adoption and use of health IT and information exchange
- Stakeholder collaboration
- Technical assistance
- Focus on supporting PCMHs, other VB models
- Funding and financing
- Data analytics

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Feedback from Gov. Council

• Gov. Council members have expressed support for exploring options to advance HIE and HIT, including telehealth, in Montana to support delivery system reform
• The State will be a key participant in HIE planning, but will not lead the effort

At the Montana Medical Association (MMA) meeting in September, stakeholders discussed and prioritized challenges that may be addressed through access to and exchange of health information.

Top Challenges

• Interoperability:
  • Bidirectional, timely exchange of structured data
  • Access to and exchange of summary care records
  • Workflow → getting data into health information systems
• Population health data & management
• Measuring and reporting value and quality
• Patient engagement & access to information
• Referrals
Proposed SIM HIE Work Plan

- Document current health IT landscape *(in progress)*
- Convene Steering Committee to advises on plan development
- Retain Dr. Kendrick to support 100 Day Planning Process
- Develop plan and vet with the Leadership Committee, stakeholders, and Governor’s Council

HIE planning will require collaboration among key stakeholders
Stakeholder Workgroups will include government, payers, providers, patients and advocates, tribes and other experts.
# 100 Day Planning Process – Proposed Workgroups

<table>
<thead>
<tr>
<th>Workgroup</th>
<th>Key Issues</th>
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<tbody>
<tr>
<td>Governance</td>
<td>• Vision and mission</td>
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<td>• Organizational principles</td>
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<td>• Governance models</td>
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<td>• Leadership/Board of Directors</td>
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<td>• Bylaws</td>
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<td>• Forming a legal entity (if appropriate)</td>
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<td>• Participant representation</td>
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<td>• Decision-making processes</td>
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<td>• Participation agreements</td>
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<tr>
<td>Clinical drivers of HIE/use cases</td>
<td>• Need identification</td>
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<tr>
<td></td>
<td>• Use case definition (inpatient, outpatient, emergency settings, care management, institutional settings, etc.)</td>
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<tr>
<td>Quality</td>
<td>• Quality use cases and measurement priorities</td>
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<td></td>
<td>• Support for value-based payment models</td>
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<td>• Public health reporting</td>
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<td>• Data standards and collection</td>
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<td>Privacy and security</td>
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<td>• HIPAA privacy, security, and breach notification rules</td>
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<td>• Uses of patient health information (PHI)</td>
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<td>• Consent model</td>
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<td>• Data sharing agreements</td>
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<td>• Patient and provider education and engagement</td>
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<td>• Participation agreement, especially Business Associate Agreement (BAA) framework</td>
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<tr>
<td>Finance/Business model</td>
<td>• Revenue models and sustainability</td>
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<td>• Funding</td>
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<td>Technology</td>
<td>• HIE services and capabilities</td>
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<td>• Service model</td>
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<td></td>
<td>• Technical platform</td>
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<td>• Vendor selection process</td>
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Updates on Related Initiatives
Innovation Examples:

Advanced Reporting and Predictive Analytics in the Fee-for-Service Context
Increased Reimbursement from Enhanced HCC Reporting

NW EHR Demonstration Project - 2014

**Combined analysis of clinical & claims data** from a Medicare Advantage payor and a Community Hospital

For 10 randomly selected patients, identified Hierarchical Condition Categories (HCC) increased by 44.6%

<table>
<thead>
<tr>
<th>Patient</th>
<th>All ICD-9 diagnoses in EHR</th>
<th>HCC-relevant diagnoses</th>
<th>HCCs from diagnosis codes</th>
<th>HCCs from 2013 EHR data not included in 2013 claims data</th>
<th>Persisting HCCs from prior EHR data not included in 2013 claims data</th>
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<td><strong>Total</strong></td>
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<td><strong>65</strong></td>
<td><strong>5</strong></td>
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Uncompensated Care: Cost Bands & Patient Cohort Identification
(from a Mid-Size Community Hospital, 2014 data)

Predictive Analytics to Target Efficient Intervention in the High-Cost Cohort
Next Steps
## Proposed Agendas for 2016 Gov. Council Meetings – For Discussion

<table>
<thead>
<tr>
<th>Meeting 2: Delivery System Transformation</th>
<th>Meeting 3: Transformation Plan</th>
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<td>• Continue discussion and obtain consensus on delivery system transformation approach</td>
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<td>• Launch planning &amp; implementation teams on: HIE, delivery system, and payment reform</td>
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<td>• Discuss measurement</td>
<td>• Financing and payment mechanisms to support reforms</td>
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<td>• HIT/HIE update</td>
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### Spring Webinar:
Medicare Value-Based Payment Approach

### Fall Planning & Implementation Team Meetings

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**Note:** Confidential Working Draft Not for Distribution
Appendix
Vermont Blueprint for Health

Enhanced PMPM payments vary by NCQA recognition year and score

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

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

Medicaid Members  Medicare Members  Commercial Members  State & Other Employees

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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

<table>
<thead>
<tr>
<th>Results for Calendar Year 2013</th>
<th>Medicaid</th>
<th>Commercial</th>
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<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>
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<tr>
<td>Total CHT Payments</td>
<td>$2,343,603</td>
<td>$5,182,633</td>
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<tr>
<td>Total Investment Annual</td>
<td>$4,428,638</td>
<td>$8,758,635</td>
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<tr>
<td>Total Expenditures per Capita (participants)</td>
<td>$7,775</td>
<td>$4,854</td>
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<tr>
<td>Total Expenditures per Capita (comparison)</td>
<td>$7,877</td>
<td>$5,519</td>
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<tr>
<td>Differential per Capita (participant vs. comparison)</td>
<td>$101</td>
<td>$565</td>
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<tr>
<td>Total Differential (participants vs. comparison)</td>
<td>$8,477,839*</td>
<td>$81,337,965</td>
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*Includes expenditures for special Medicaid services (SMS)