

# Montana State Innovation Model Design

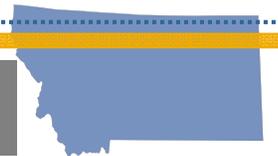
---

**Governor's Council Meeting**

**January 19, 2016**

# Agenda

- 10:00 – 10:10** ■ Welcome and Meeting Objectives
- 10:10 – 10:50** ■ Montana Health Care Needs Assessment
- 10:50 – 11:20** ■ Governor’s Council Approach and Common Agenda
- 11:20 – 12:20** ■ Montana Case Studies on Physical and Behavioral Health Integration
- 12:20 – 12:40** ■ *Lunch Break*
- 12:40 – 1:40** ■ Montana Case Studies (continued)
- 1:40 – 2:40** ■ Discussion of Potential Physical and Behavioral Health Integration Reforms in Montana
- 2:40 – 2:55** ■ *Afternoon Break*
- 2:55 – 3:20** ■ Proposed HIE Planning Approach
- 3:20 – 3:45** ■ Updates on Related Initiatives
- 3:45 – 3:50** ■ Next Steps
- 3:50 – 4:00** ■ Public Comment



---

## 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



# Medicare: Care Management Codes

---

- 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



# Chronic Care Management – CCM

---

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:
  - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>
- CMS – Chronic Care Management FAQs:
  - [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment for CCM Services FAQ.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment%20for%20CCM%20Services_FAQ.pdf)
- Pershing Yoakey & Associates (PYA) TCM white paper:
  - <http://www.pyapc.com/resources/collateral/white-papers/TCM-whitepaper-PYA.pdf>
- CMS – Transitional Care Management FAQs:
  - <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-tcms.pdf>



- Contact Information

- Patty Kosednar

- Health Technology Services/Mountain-Pacific Quality Health

- 406-461-4410

- [pkosednar@mpqhf.org](mailto:pkosednar@mpqhf.org)

- Thank You



## **Governor's Council Approach and Common Agenda**



# ***For Reference – Governor’s Council Themes***

***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

### **Challenges**

- Workforce
- Rural nature of the state → access to care
- Lack of comprehensive patient data
- Funding & financing for new initiatives

### **Opportunities & Solutions**

- PCMH expansion
- Medicaid Health Homes
- Community health teams
- Telehealth
- Health information exchange
- Coordination and alignment between public and private sectors

# For Reference – Hypotheses: Common Agenda & Approach

20

## 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:<br>Common Agenda<br>and Next Steps   | Meeting 2:<br>Delivery System<br>Transformation  | Meeting 3:<br>Transformation<br>Plan   | Meeting 4:<br>Launch Planning &<br>Implementation<br>Teams   | Meeting 5:<br>Presentations on<br>Recommended<br>Reforms  | Meeting 6:<br>Develop<br>Recommendations<br>to Governor  |
|---|--|--|--|---|--|
| January, 2016   | March, 2016  | May, 2016  | July, 2016   | October, 2016   | December, 2016   |
| <ul style="list-style-type: none"> <li>Review needs assessment</li> <li>Develop consensus on Gov. Council common agenda and approach</li> <li>Discuss potential models for physical, behavioral health integration</li> <li>HIT/HIE approach</li> </ul> | <ul style="list-style-type: none"> <li>Continue discussion and obtain consensus on delivery system transformation approach</li> <li>Discuss measurement</li> <li>HIT/HIE update</li> </ul> | <ul style="list-style-type: none"> <li>Obtain consensus on key elements of transformation plan</li> <li>Financing and payment mechanisms to support reforms</li> <li>HIT/HIE update</li> </ul> | <ul style="list-style-type: none"> <li>Launch planning &amp; implementation teams on: HIE, delivery system, and payment reform</li> <li>Teams to develop implementation recommendations on specific reforms</li> </ul> | <ul style="list-style-type: none"> <li>Planning and implementation team report outs to full Gov. Council</li> <li>Expert panels/ speakers on recommended reforms</li> </ul> | <ul style="list-style-type: none"> <li>Agree on recommended reform proposals for Montana</li> <li>Begin developing report to Governor</li> </ul> |
| <p><b>Spring Webinar:</b><br/>Medicare Value-Based Payment Approach</p>   |  | <p><b>Fall Planning &amp; Implementation Team Meetings</b></p>   |  |   |  |



---

**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

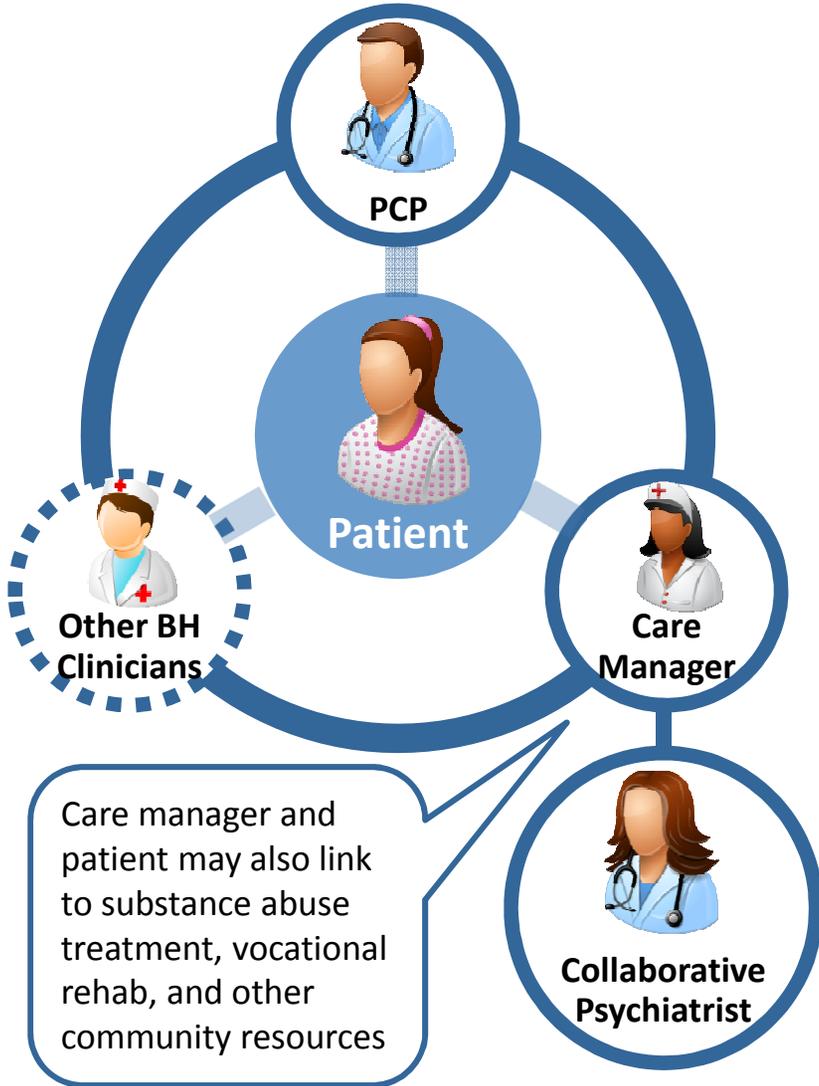
Financing

Timing

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



# Collaborative Care Model

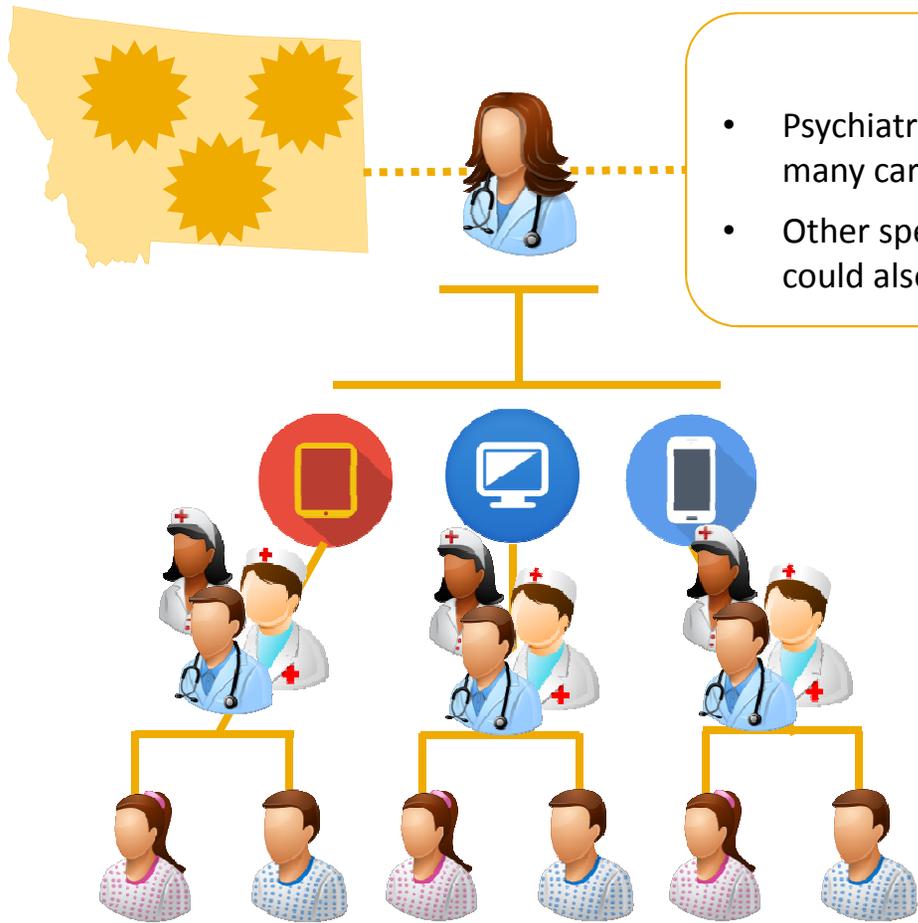


## Care Team Roles

- **Primary care physician** is directly involved in developing and implementing a treatment plan
  - **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
  - **Psychiatrist** serves as a consultant to provide diagnostic consultation on difficult cases and is accessible to care manager and PCP
- Team uses validated clinical tool - PHQ 2 and PHQ 9 - to identify and monitor at-risk patients.
- 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

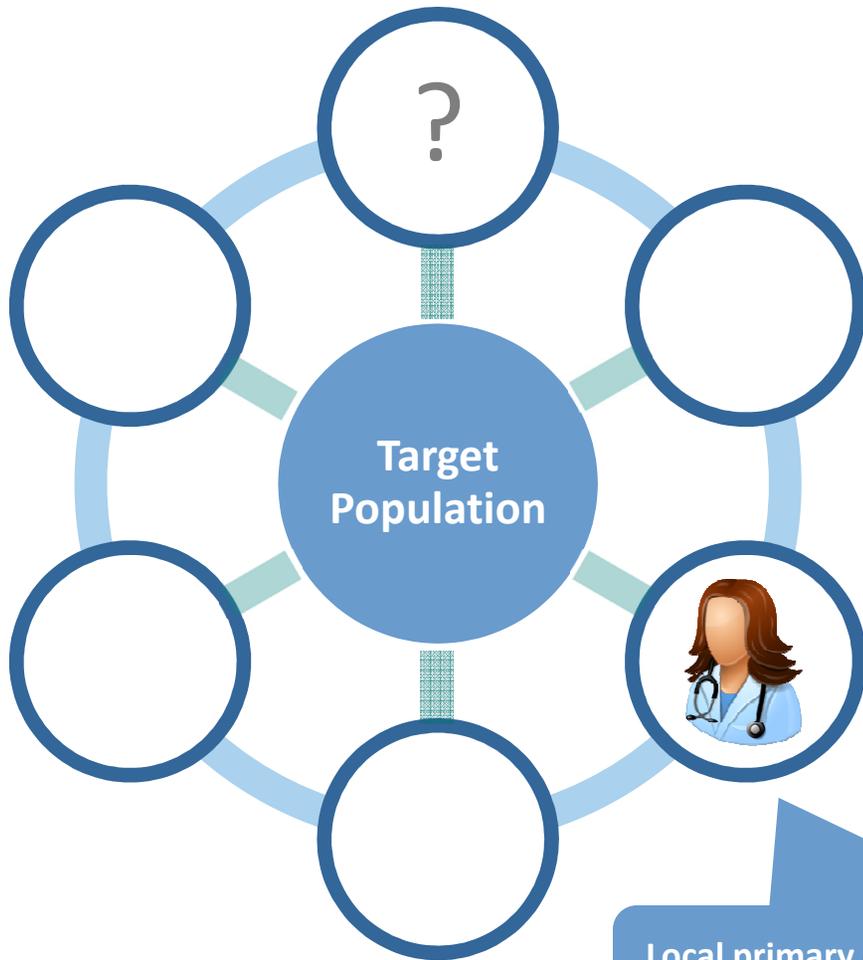
## Vermont CHT Roles

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



# Potential for HIE in Montana – Stakeholder Feedback

31

## 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

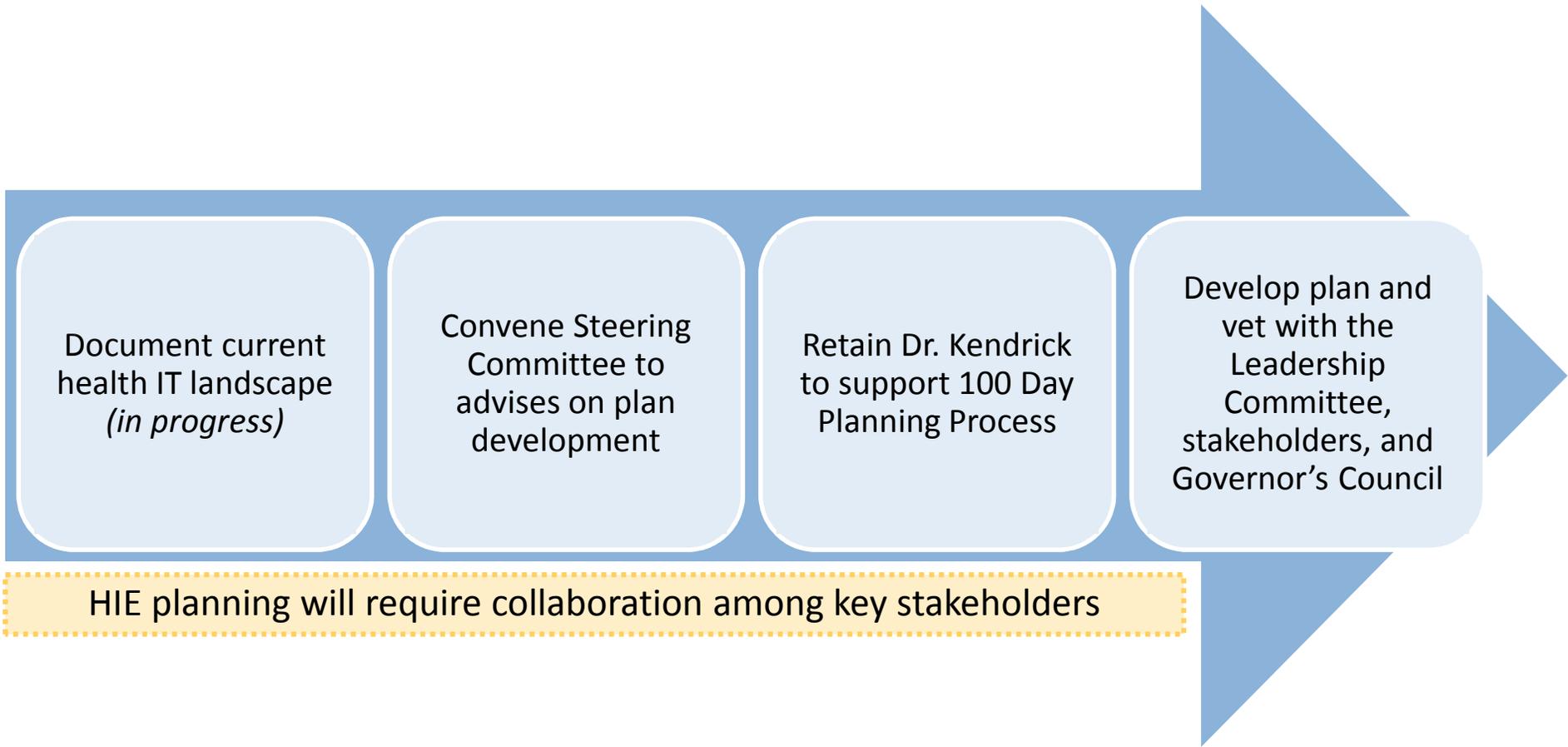
**At the Montana Medical Association (MMA) meeting in September, stakeholders discussed and prioritized challenges that may be addressed through access to and exchange of health information.**

## Top Challenges

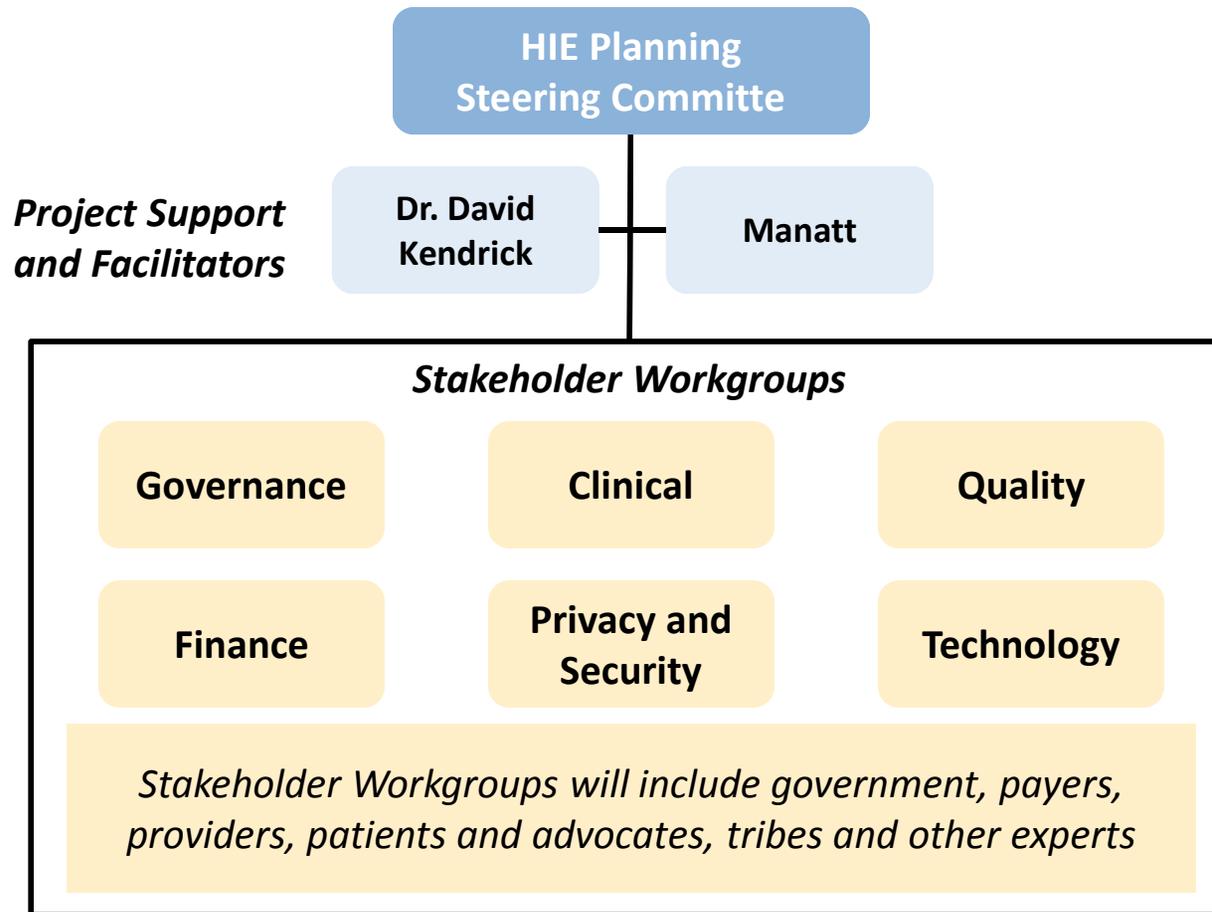
- Interoperability:
  - Bidirectional, timely exchange of structured data
  - Access to and exchange of summary care records
  - Workflow → getting data into health information systems
- Population health data & management
- Measuring and reporting value and quality
- Patient engagement & access to information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



# Proposed SIM HIE Work Plan



# 100 Day Planning Process – Proposed Structure



# 100 Day Planning Process – Proposed Workgroups

| Workgroup                                | Key Issues   |
|--|--|
| <b>Governance</b>                        | <ul style="list-style-type: none"> <li>• Vision and mission</li> <li>• Organizational principles</li> <li>• Governance models</li> <li>• Leadership/Board of Directors</li> <li>• Bylaws</li> <li>• Forming a legal entity (if appropriate)</li> <li>• Participant representation</li> <li>• Decision-making processes</li> <li>• Participation agreements</li> </ul>  |
| <b>Clinical drivers of HIE/use cases</b> | <ul style="list-style-type: none"> <li>• Need identification</li> <li>• Use case definition (inpatient, outpatient, emergency settings, care management, institutional settings, etc.)</li> </ul>  |
| <b>Quality</b>                           | <ul style="list-style-type: none"> <li>• Quality use cases and measurement priorities               <ul style="list-style-type: none"> <li>• Support for value-based payment models</li> <li>• Public health reporting</li> </ul> </li> <li>• Data standards and collection</li> </ul>   |
| <b>Privacy and security</b>              | <ul style="list-style-type: none"> <li>• Privacy and security requirements</li> <li>• HIPAA privacy, security, and breach notification rules</li> <li>• Uses of patient health information (PHI)</li> <li>• Consent model</li> <li>• Data sharing agreements</li> <li>• Patient and provider education and engagement</li> <li>• Participation agreement, especially Business Associate Agreement (BAA) framework</li> </ul> |
| <b>Finance/Business model</b>            | <ul style="list-style-type: none"> <li>• Revenue models and sustainability</li> <li>• Funding</li> </ul>   |
| <b>Technology</b>                        | <ul style="list-style-type: none"> <li>• HIE services and capabilities</li> <li>• Service model</li> <li>• Technical platform</li> <li>• Vendor selection process</li> </ul>   |

---

## 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

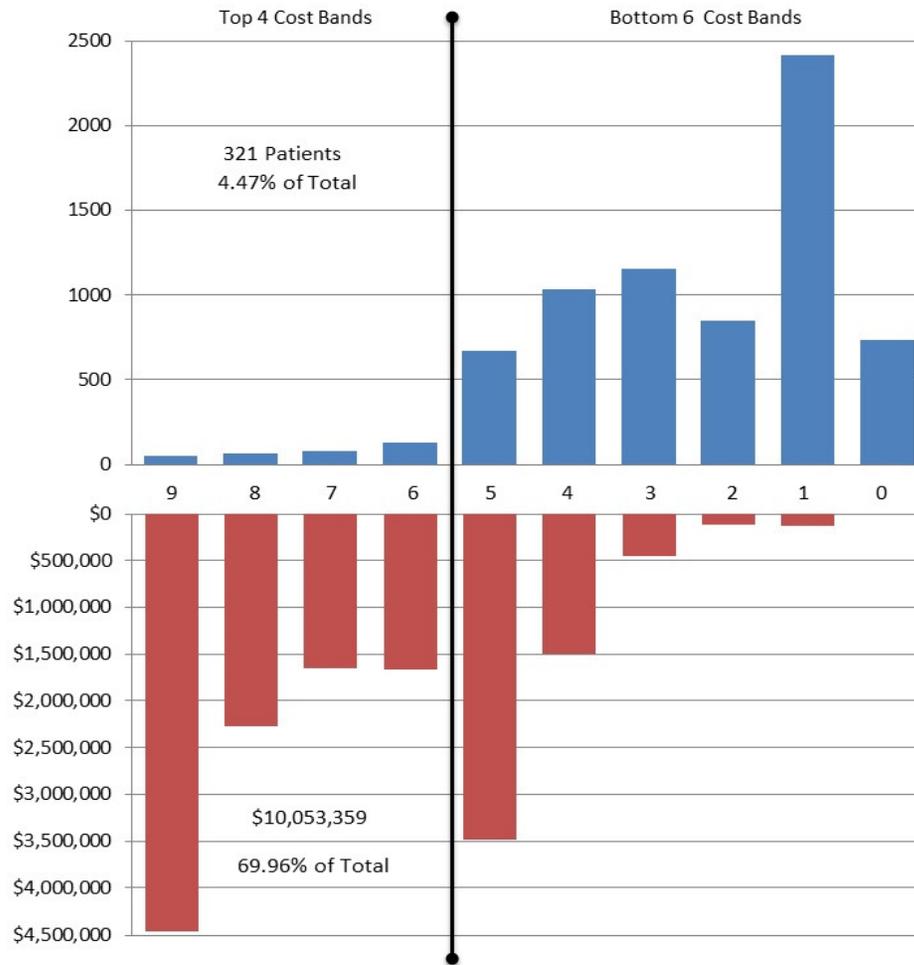
**Combined analysis of clinical & claims data** from a Medicare Advantage payor and a Community Hospital  
For 10 randomly selected patients, identified Hierarchical Condition Categories (HCC) increased by 44.6%

| Patient      | All ICD-9<br>diagnoses in<br>EHR | HCC-relevant<br>diagnoses | HCCs from<br>diagnosis<br>codes | HCCs from 2013<br>EHR data not<br>included in 2013<br>claims data | Persisting HCCs<br>from from EHR<br>data prior to 2013<br>not included in<br>2013 claims data |
|--------------|----------------------------------|---------------------------|---------------------------------|---|---|
| 1            | 14                               | 4                         | 2                               | 0   | 0   |
| 2            | 81                               | 11                        | 6                               | 1   | 1   |
| 3            | 69                               | 7                         | 5                               | 0   | 2   |
| 4            | 130                              | 14                        | 7                               | 0   | 6   |
| 5            | 100                              | 23                        | 10                              | 1   | 4   |
| 6            | 151                              | 14                        | 10                              | 1   | 3   |
| 7            | 23                               | 7                         | 5                               | 0   | 2   |
| 8            | 89                               | 19                        | 13                              | 2   | 4   |
| 9            | 73                               | 9                         | 7                               | 0   | 2   |
| 10           | 70                               | 0                         | 0                               | 0   | 0   |
| <b>Total</b> | <b>800</b>                       | <b>108</b>                | <b>65</b>                       | <b>5</b>  | <b>24</b>   |

# 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

| Meeting 2:<br>Delivery System Transformation | Meeting 3:<br>Transformation Plan | Meeting 4:<br>Launch Planning & Implementation Teams | Meeting 5:<br>Presentations on Recommended Reforms | Meeting 6:<br>Develop Recommendations to Governor |
|--|-----------------------------------|--|--|---|
| March, 2016                                  | May, 2016                         | July, 2016   | October, 2016                                      | December, 2016                                    |

- Continue discussion and obtain consensus on delivery system transformation approach
- Discuss measurement
- HIT/HIE update

- Obtain consensus on key elements of transformation plan
- Financing and payment mechanisms to support reforms
- HIT/HIE update

- Launch planning & implementation teams on: HIE, delivery system, and payment reform
- Teams to develop implementation recommendations on specific reforms

- Planning and implementation team report outs to full Gov. Council
- Expert panels/speakers on recommended reforms

- Agree on recommended reform proposals for Montana
- Begin developing report to Governor

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

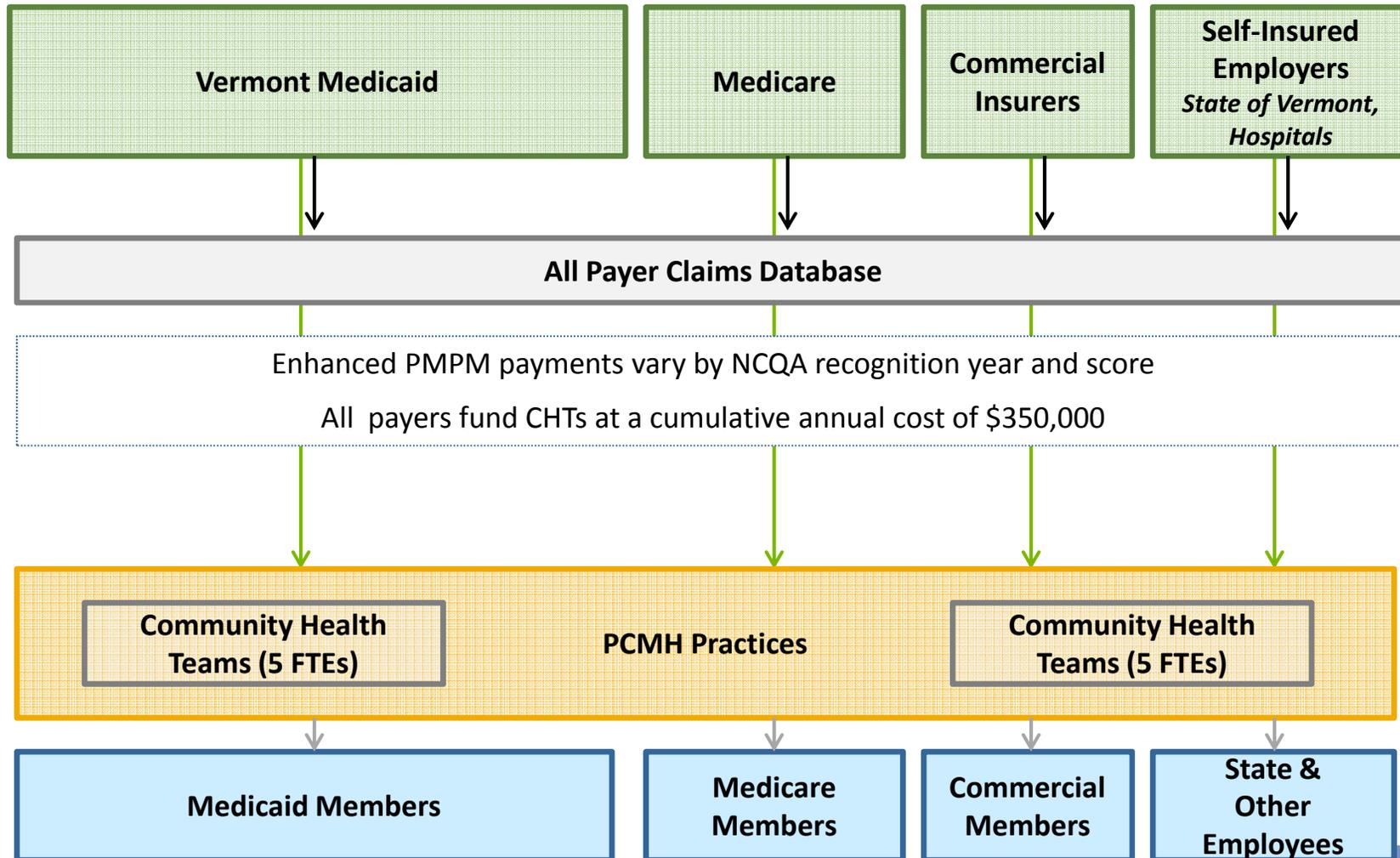
**Fall Planning & Implementation Team Meetings**



# Appendix



# Vermont Blueprint for Health



# 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         |
| <b>Total CHT Payments</b>                                   | <b>\$2,343,603</b>  | <b>\$5,182,633</b>  |
| 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             |
| <b>Differential per Capita (participant vs. comparison)</b> | <b>\$101</b>        | <b>\$565</b>        |
| <b>Total Differential (participants vs. comparison)</b>     | <b>\$8,477,839*</b> | <b>\$81,337,965</b> |

\*Includes expenditures for special Medicaid services (SMS)

