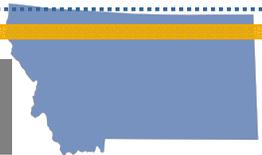


Montana State Innovation Model Design

Governor's Council Health Care Innovation and Reform Meeting
November 3, 2015

Meeting Agenda

- 10:00 – 10:15 ■ Welcome, Introductions and Governor’s Council Charge
- 10:15 – 10:25 ■ SIM Overview
- 10:25 – 10:50 ■ Montana Authority & Levers
- 10:50 – Noon ■ Examples of Value-Based Delivery and Payment Reforms
 - *PCMH Expansion & Improvement*
- Noon – 12:20 ■ Working Lunch
- 12:20 – 1:00 ■ Examples of Value-Based Delivery and Payment Reforms (continued)
 - *Behavioral & Physical Health Integration*
 - *Payment Reform*
- 1:00 – 1:30 ■ SIM Quality Metrics
- 1:30 – 1:45 ■ SIM HIT Planning
- 1:45 – 2:00 ■ Next Steps

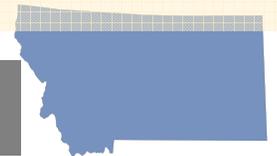


Governor's Council Charge

The Governor's Council on Healthcare Innovation and Reform will serve as the lead convener for the purchasers, payers, providers, and systems to inform Montana's SIM project design.

Governor's Council Responsibilities

- ✓ Review and provide input and expertise on transformation options developed by the Project Leadership Committee
- ✓ Consider a broad range of perspectives, from private and public sector payers, providers, tribal health representatives, and consumer/patient advocates
- ✓ Identify opportunities to improve coordination and collaboration between public and private payers
- ✓ Attend and participate actively in Governor's Council meetings
- ✓ **Recommend reforms to be included in Montana's SIM Transformation Plan**



Project Leadership Committee & Manatt Team

Project Leadership Committee Members

- **Tara Veazey** - Project Sponsor and Governor Bullock's Health Policy Advisor
- **Jessica Rhoades** – SIM Project Director and DPHHS Intergovernmental Relations
- **Lesa Evers** – DPHHS Tribal Relations Manager
- **Christina Goe** – Office of Insurance Commissioner
- **Todd Harwell** – Public Health and Safety Division Administrator
- **Mary Dalton** – Medicaid Director
- **Stuart Fuller** – DPHHS CIO
- **Marilyn Bartlett** – Director Administrator, Health Care and Benefits Division
- **Shannon McDonald** - Deputy Chief Legal Counsel, DPHHS Office of Legal Affairs
- **Robert Runkel** – DPHHS Economic Services Branch Manager
- **Amanda Harrow** – DPHHS SIM Policy Advisor

Manatt Team

- **Jonah Frohlich** – Managing Director
- **Kier Wallis**– Senior Manager
- **Dori Glanz Reyneri** – Manager

The Manatt team will support development of Montana's SIM Transformation Plan, including supporting meetings, conducting interviews and research, and helping to develop options and analysis related to value-based payment, delivery system and HIT reforms.

SIM OVERVIEW



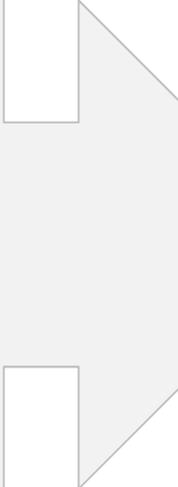
Montana SIM Award Overview

- Center for Medicare & Medicaid Innovation initiative
- SIM application submitted on July 21, 2014 to design a State Health Care Innovation Plan to support multi-payer delivery and payment system transformation
 - Received letters of support for the application from state’s major payers, providers across the state, and consumer advocacy groups
 - Awarded \$999,999 to support planning efforts from May 2015 – June 2016
- Supported by Governor Bullock’s office, the Montana Department of Health and Human Services, the Montana Commissioner of Securities and Insurance, and the Montana Department of Administration
- Governor’s Council is the lead stakeholder convener, but Montana will also conduct regular webinars, and launch stakeholder working groups as needed



Montana SIM Goals

- Identify opportunities to better coordinate care and build efficiencies into Montana's healthcare system
- Explore opportunities to coordinate between public and private sector to control cost and improve health system performance

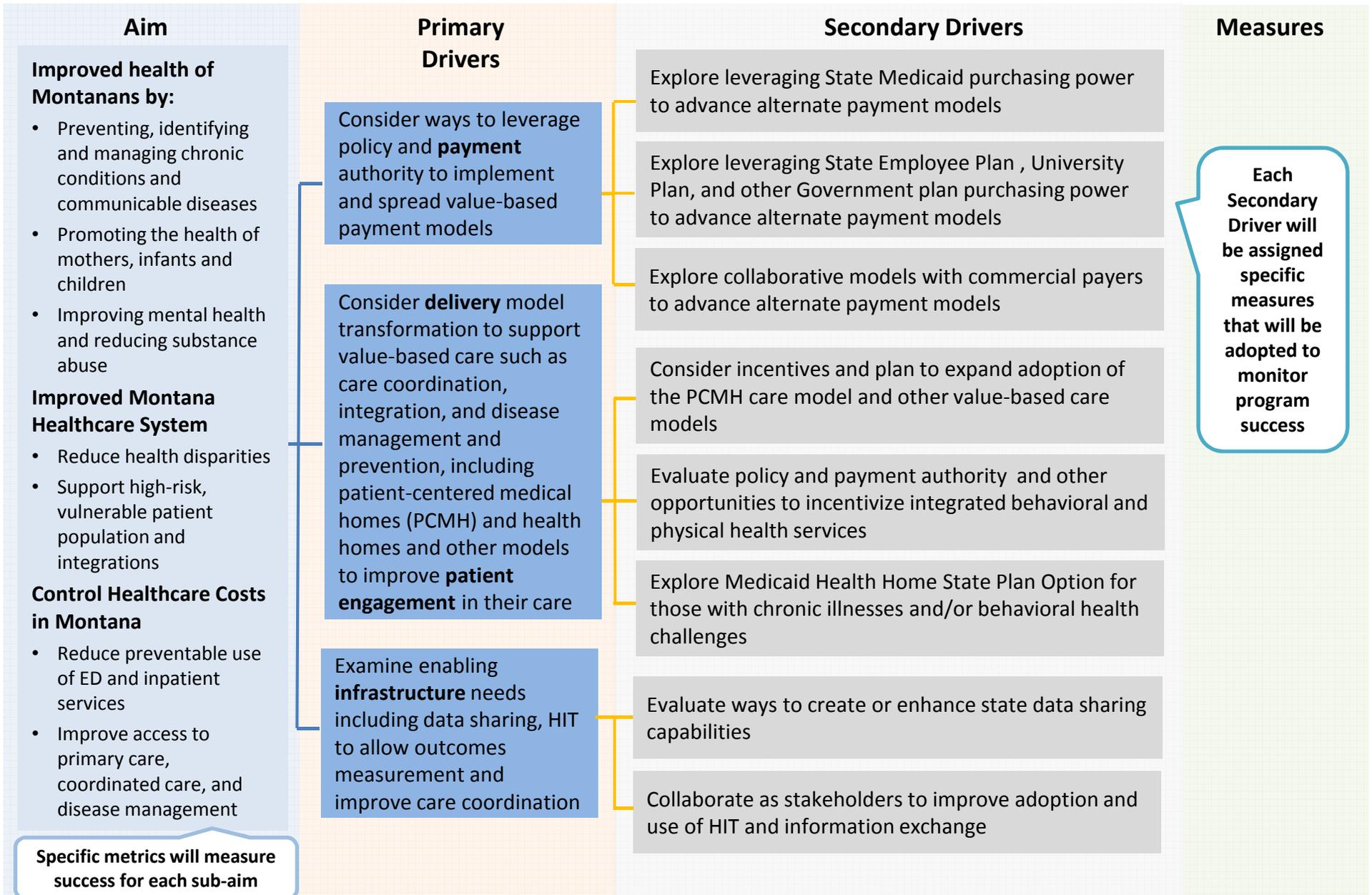


Core SIM Elements

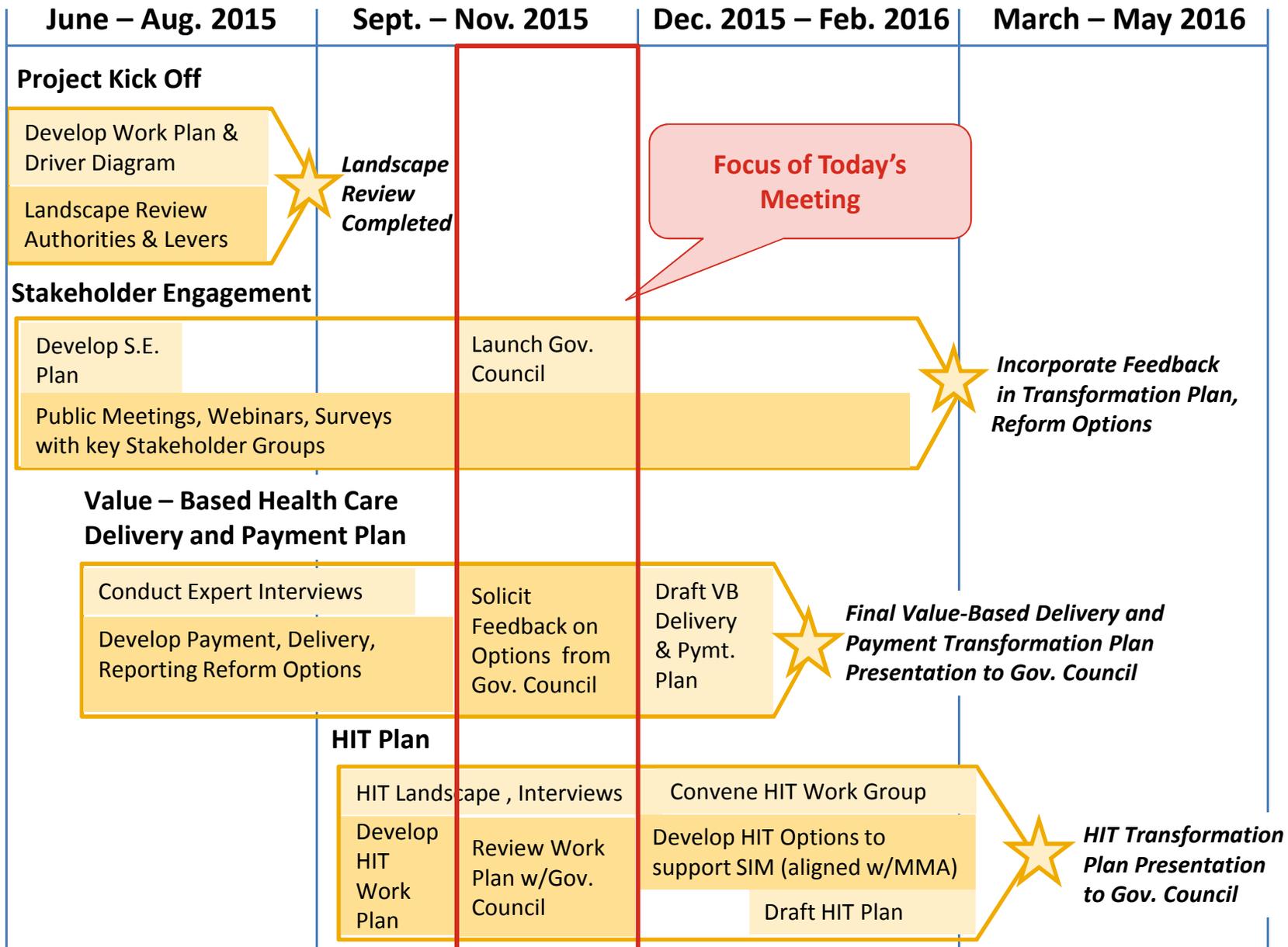
- ✓ Improving Health
- ✓ Baseline Healthcare Landscape
- ✓ Value-Based Payment and/or Service Delivery Models
- ✓ Leveraging Regulatory Options
- ✓ Health Information Technology and Infrastructure
- ✓ Stakeholder Engagement
- ✓ Quality Measure Alignment
- ✓ Alignment with State and Federal Initiatives



Montana SIM Approach: Draft Driver Diagram



SIM Work Plan & Progress to Date



SIM Work Plan: Other Key Project Outputs

- **Population Health Plan**

- Will build on the driver diagram to provide context on how SIM reforms target key population health issues in Montana

- **Monitoring and Evaluation Plan**

- Will outline how SIM implementation will be monitored and evaluated, also building upon driver diagram metrics

- **Financial and Operational Plan**

- Will serve as the roadmap for implementing SIM reforms, including identifying sources of funding and key milestones for implementation

- **Montana Transformation Plan**

- Montana's SIM Transformation Plan will be submitted to CMS in April, 2016



MONTANA AUTHORITY & LEVERS



Introduction & Key Terms

This section provides an overview of key statutory and regulatory authority and other levers that the State of Montana is using, or may consider using, under the models we will review today to advance and support multi-payer health system reforms.

A more detailed review of relevant Montana authority and levers can be found on the Montana SIM website*

- **Authority** include statutes and regulations giving State agencies the power to require or to authorize the use of alternative payment and/or delivery system reform activities.
- **Levers** include influence the State can use – through its purchasing power, in its role as a convener, and by other means – to influence and incentivize alternative payment and delivery system reform efforts.

*<http://dphhs.mt.gov/Portals/85/Documents/SIM/StakeholderEngagementWebinarOct62015.pdf>



Snapshot of Montana Covered Lives



Individual Market (Incl. Exchange)

87,000 individuals (8% of the State's population) receive coverage in the individual market.

- 48,500 are enrolled in Exchange plans

Employer-Sponsored Insurance

436,200 individuals (44% of the population) are covered through employer-sponsored plans.⁺

Medicare

As of 2013, 179,000 individuals were enrolled in Medicare (18% of the population) 35,000 were enrolled in Medicare Advantage plans.

Medicaid/CHIP

As of May 2015, Montana Medicaid and CHIP covered over 155,000 individuals (15% of the population.)

- About 75% of these enrollees are children, 20,000 are enrolled in CHIP.
- Expansion may add up to 45,000 Medicaid enrollees by the end of FY 2019.

Tribal Health/IHS

65,000 (6.5% of the population) identifies as American Indian.

- Over 40% of these individuals are uninsured.
- 68% (including those without insurance coverage) report access to IHS
- American Indians made up less than 2% of the total marketplace enrollment as of April 2014.

Other Government Plans

The State employee plan covers 33,000 employees, dependents, and retirees, (3% of the population).

- The State Employee Plan administers six state-run primary care clinics.

The University Health Plan has roughly 18,000 covered lives.

Uninsured

As of August 2015, 151,000 individuals (15%) were uninsured.

⁺ In 2011, 45% of those with employer sponsored insurance were in self-insured plans. Note that population percentages and other figures are approximate, and in some cases the base years vary. For sources, please see appendix.



Overview: State Authority on New Care Models



Commercial Plans. The Insurance Commissioner in Montana has authority to regulate patient centered medical home (PCMH) models, and some limited authority to advance or regulate other models of care and payment in commercial plans, including Exchange plans.



Medicaid. Medicaid has authority, under a range of waiver and state plan options, to advance a variety of alternative payment and delivery models for its enrollees, including adults newly eligible under the State's Medicaid expansion.



Tribal Health. Tribal health services and facilities are governed either by the rules and authority of the federal Indian Health Service, or by tribes that have elected, as allowed under federal law, to operate their own health centers. These "Title 5" tribes have significant authority to pursue alternative payment and delivery models.



Behavioral Health. Behavioral health (including mental health and substance abuse services) are funded by a variety of sources, and overseen in various ways by DPHHS and the Office of the Insurance Commissioner.

MT Definition of Patient-Centered Medical Home

15

Montana's efforts around payment and delivery system reform have initially focused around patient centered medical homes (PCMHs). Recent State legislation defined a PCMH as:

A model of health care that is:

- Directed by a primary care provider offering family-centered, culturally effective care that is coordinated, comprehensive, continuous, and, whenever possible, located in the patient's community and integrated across systems;
- Characterized by enhanced access, with an emphasis on prevention, improved health outcomes, and satisfaction;
- Qualified by the commissioner under 33-40-104 as meeting the standards of a patient-centered medical home; and
- Reimbursed under a payment system that recognizes the value of services that meet the standards of the patient-centered medical home program.



Insurance Commissioner Authority & Levers: PCMHs

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Source of Authority

- 2013 Montana Patient-Centered Medical Homes Act (reauthorization required in 2017)

Scope of Authority

- Insurance Commissioner has authority to regulate PCMHs and to set PCMH certification standards including:
 - Payment methods
 - Quality, performance, cost, utilization and access measures
 - Patient engagement
- Law applies to all commercial plans, including Exchange plans and “self-funded government plans.”
- Medicaid and CHIP excluded from standards related to payment, but all other standards and laws apply.

Levers

- PCMHs exempted from State and Federal antitrust laws
- Insurance Commissioner convener of private payers, stakeholders

Use of Authority/Levers to Date

- Convened PCMH stakeholder council
- Regulations on accreditation, quality and utilization metrics, stakeholder engagement

Key Takeaways for Montana:

- This authority limited to plans and providers IDing themselves as PCMHs, does not extend to other models (e.g. ACOs)
- Legislation required to extend authority to other models, and beyond 2017
- Commissioner has authority to regulate PCMHs established by the State Employee Plan, tribes, and some aspects of Medicaid PCMHs



Medicaid Landscape: Snapshot of Delivery Models

17

Montana's Medicaid population is currently participating in a variety of delivery models:

Passport to Health 1915(b) Waiver

- A primary care case management (PCCM) program in which the PCP delivers all care, or provides referrals. Enhanced care management services are also offered under the program.
- 75% of Montana Medicaid members enrolled in all 56 counties.
- Includes Team Care (restricted program), and the Health Improvement Program, which provides enhanced care management to high risk members.

Waivers for Special Populations

Montana operates several additional waivers targeting needed services to special populations:

- HCBS Developmental Disabilities Waiver
- HCBS Severe Disabling Mental Illness Waiver
- HCBS Montana Big Sky Waiver (Disabled or Seniors)
- 1115 Plan First Waiver (Family Planning Services)

PCMHs

- Medicaid currently has contracts with five PCMH providers, reaching about 5,200 members.
- Medicaid PCMHs receive an additional per member per month (PMPM) fee for PCMH services, ranging from \$3 to \$15 based on members' health status, as identified by claims.

Basic Medicaid Waiver

- 1115 waiver provides basic Medicaid services for certain low-income adults and expands eligibility to adults with serious disabling mental illness up to 150% FPL
- Over 18,000 adults are enrolled
- Provides physical health and enhanced mental health benefits for those with serious disabling mental illness
- Some adults are likely to transition to the new adult group with expansion (see next slide)



Medicaid Landscape & Authority: Expansion

18

With expansion, non-disabled childless adults with incomes below 138% FPL and parents with incomes between 50 – 138% FPL will gain Medicaid coverage.

- The State will receive 100% federal funding for all Medicaid services provided to these newly eligible individuals through 2016 (phasing down to 90% in 2020 and beyond).
- Montana will contract with a Third Party Administrator to administer expansion coverage.

Source of Authority

- MT SB 405

Scope of Authority

SB 405 expands Medicaid, requires use of TPA, and encourages Medicaid to consider reforms for the existing population as well, which could include some of the following:

- Strengthening and expanding case management programs
- Engaging members with chronic/BH conditions in care models to reduce costs or improve outcomes:
 - Patient-centered medical homes
 - Accountable care organizations
 - Health homes for chronic conditions, or behavioral health
 - Other innovative delivery models
- Strengthening data sharing with providers

Use of Authority to Date

- State PCMH program
- State has not dictated a particular model or reforms for the TPA to administer

Key Takeaways for Montana SIM

- SB 405 authority extends beyond expansion, allowing Medicaid to explore reforms for all enrollees
- TPA contract may be an opportunity to advance reforms for large number of adult enrollees

Medicaid Authority: State Plan & Health Homes

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Source of Authority

- Title XIX of the Social Security Act
- Montana Code Sections 50-4-104 and 53-6-101

Scope of Authority

- State Plan lays out State Medicaid rules/design in line with federal requirements; Amendments (SPAs) need CMS approval
- State Plan “options” provide flexibility in program design:
 - States can enroll most populations in PCMHs or other “primary care case mgmt.” models*
 - “Integrated Care Model” option allows various payment models for range of new delivery models (ACO, PCMH), e.g. enhanced FFS, PMPM capitation, shared savings
- Health Home option emphasizes coordinated care for highest need patients (multiple chronic conditions, serious mental illness). Health homes enhance linkages to community and social supports, and can integrate physical & behavioral health
 - 90% enhanced federal match for first 2 years
 - Flexibility for payment methodology - many states use capitated PMPM fees, like MT’s PCMH payment model

Use of Authority to Date

- MT has approved SPA for its PCMH limited demonstration project
- MT is considering pursuing health home option

Key Takeaways for MT SIM

- MT may use State Plan authority to expand its PCMH program, implement Health Homes, or pursue other payment and delivery reforms, without a waiver
- Enhanced funding for Health Homes applicable to adults who are not eligible for the newly eligible FMAP

*Federal law (1932(a)(1)(A))

Behavioral Health Authority & Levers

Source of Authority

- SB 418; Appropriations

Scope of Authority

- SB 418 includes a “policy statement” allowing DPHHS to make mental health investments that:
 - ✓ Support a community-based system of care
 - ✓ Improve data collection on outcomes, performance metrics
 - ✓ Improve collaboration between community mental health providers, nursing homes, state facilities

Levers

- Annual appropriations for DPHHS provides reimbursement for prevention, treatment for recovery in the community. General fund appropriations that support MH and SUD services, are narrowly targeted towards specific uses*, including:
 - 72 hour crisis stabilization
 - Drop in center services
 - Short term voluntary inpatient stays in lieu of involuntary commitment to the State hospital

Use of Authority to Date

- MT has in place, or has applied for, multiple SAMSHA-funded efforts to advance mental health capacity and reforms

Key Takeaways for Montana SIM

- Legislative intent seems to support efforts to reform the State mental health system, but appropriations leave little flexibility to support these types of innovative efforts
- Program leadership is supportive of integrating behavioral and physical health services



Medicaid Authority: 1115 Waivers

Source of Authority

- Section 1115 of Title XIX of the Social Security Act
- Montana Code Section 53-2-215

Scope of Authority

- HHS Sec. may waive broad range of Medicaid rules for States to pursue “demonstration” projects to:
 - Expand eligibility
 - Impose premiums or other requirements
 - Receive funding for services otherwise not covered
 - Use new delivery or payment mechanisms (PCMH, ACO)
- Must: be approved by the Secretary, further objectives of the Medicaid program, be budget neutral
- MT code gives State broad authority to:
 - Pursue, implement, and terminate 1115 waivers
 - Adopt rules as necessary to do so
 - Establish coverage, eligibility, financial, and other requirements for administration and delivery of services

Use of Authority to Date

- Montana is applying for an 1115 waiver for Expansion, and has an existing “Basic” waiver for certain adults (see slide 11)

Key Takeaways for Montana SIM

Montana could use 1115 waiver to:

- Receive Medicaid payment for PCMH or other care coordination services not otherwise covered
- Mandate enrollment in new delivery models (e.g. PCMH, ACO)
- Pilot new payment models for Medicaid providers related to delivery system reforms

However, many of these reforms could also be pursued under State Plan authority – waiver authority is not always required!

Tribal Health Authority: Delivery/Payment Reform

22

Source of Authority

- Indian Self-Determination & Education Assistance Act (ISDEAA)
- Indian Health Care Improvement Act

Scope of Authority

- Tribes may “contract” with IHS to provide one or more IHS services, programs, functions, or activities (PFSAs) that IHS would otherwise provide
- Tribes may “compact” with IHS to assume full funding and control over one or more of these PFSAs
- Or, tribes may allow IHS to operate all PFSAs
- IHS/Tribal 638 facilities are funded by appropriations and reimbursement from other payers.
 - Medicare and Medicaid pay an IHS all-inclusive rate
 - State receives 100% FMAP for Medicaid payments made to IHS facilities for IHS eligible individuals.**
- IHS has an “Improving Patient Care” program at some sites; emphasizing patient-centered primary care teams.
- 5 Urban Indian Health programs in Montana provide a range of services for Indians without IHS access. Urban programs do not receive IHS rate or 100% FMAP.

Use of Authority to Date

- MT IHS facilities have pursued only limited reforms, mostly in free-standing ambulatory centers (AAAHC certified); hospital sites are less advanced, are not truly engaged in IHS IPC program.*
- Two tribes in MT – the Confederated Salish & Kootenai and Chippewa Cree – operate their own health programs

Key Takeaways for Montana SIM

- The Salish & Kootenai and Chippewa Cree tribes have significant flexibility to align with and advance reforms under consideration for SIM.

*Perspective from interview with IHS Representative

** Generally comprised of members or descendants of federally recognized tribes, who live on or near federal reservations. See link for detailed definition: http://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p2c1#2-1.2

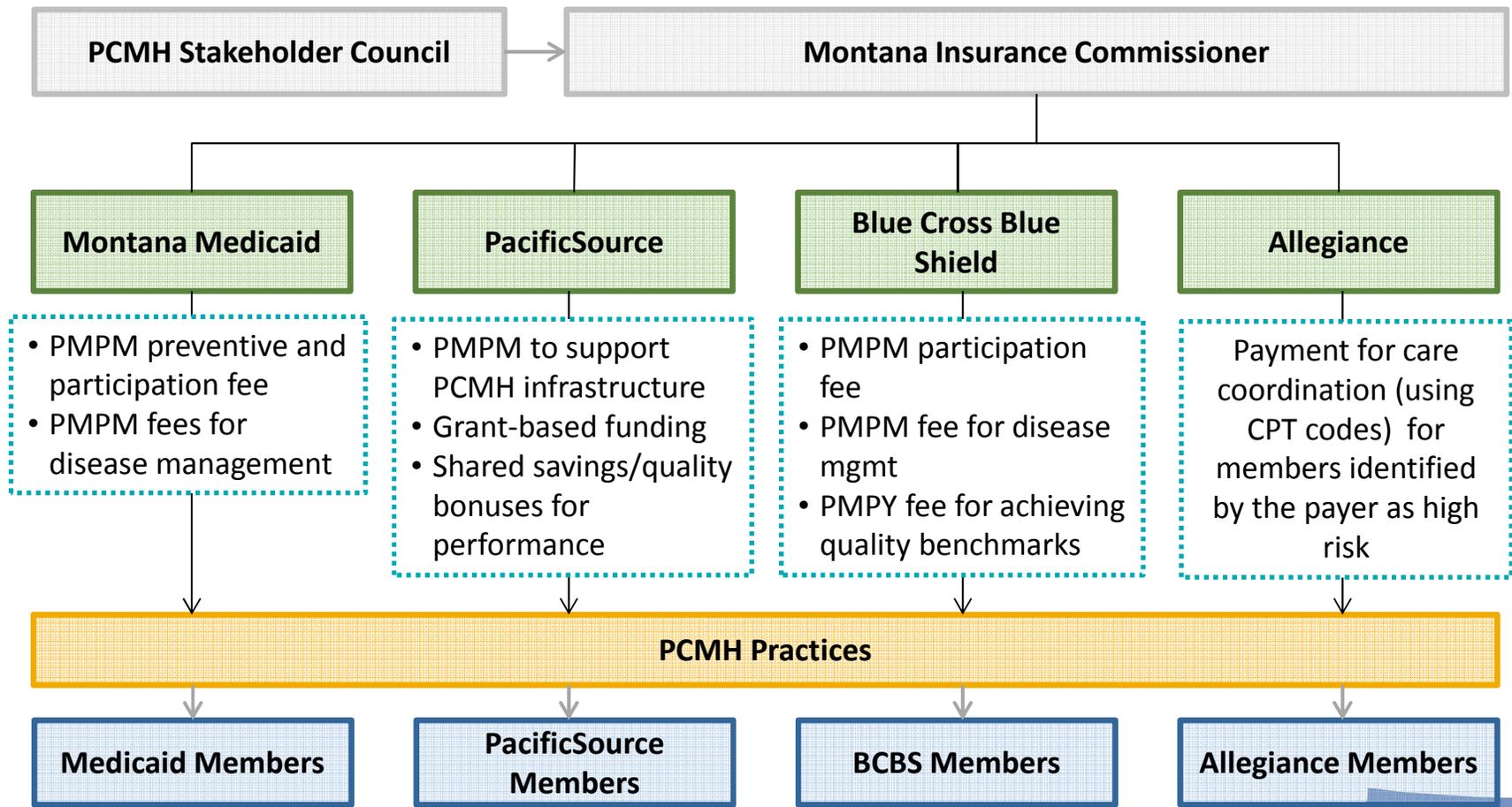


PAYMENT & DELIVERY SYSTEM REFORM MODELS



Montana's Foundation for Delivery System Reform and Payment Transformation

Montana's existing PCMH program should serve as the foundation



Montana's Foundation for Delivery System Reform and Payment Transformation

Participants

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

Governance

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

Quality

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

2014 At-a-Glance



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



Medicaid Expansion Reforms



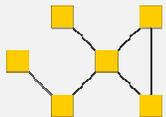
- ✓ **Health Risk Assessments (HRAs)** will provide screenings for patients and match them to preventive care and other service needs.



- ✓ **Innovative benefit and copayment design** will encourage patients to:
 - Understand the value of their insurance coverage
 - Be discerning health care purchasers
 - Take personal responsibility for their health care decisions
 - Develop cost-conscious behaviors as consumers of health care services
 - Engage in healthy behaviors



- ✓ **Efficient and cost effective coverage** will reduce uncompensated care costs and ensure health needs are met before complications arise



- ✓ **TPA model** will afford patients access to an established, statewide provider network with turnkey administrative infrastructure and expertise



Governor's Council Charge

Review Transformation models; for each the Governor's Council will:

1. Learn about relevant case studies from other states
2. Review and discuss draft models
3. Consider key questions/issues for further design of each model
4. Recommend models to fully define and pursue



Decision-Making Framework

Charge: Guide development of multi-payer care delivery system and payment transformation model for Montana

Does the model advance our aims?

- Improve the health of Montanans
- Improve Montana's healthcare system
- Control health care costs

Does the model build upon existing foundational programs?

- PCMH
- Primary care case management
- Coordinated care models
- Telehealth pilot
- Public health system

Can the model address identified gaps?

- Health integration
- Workforce shortages
- Rural access
- Health IT and HIE

Will the model advance multi-payer delivery system reform?

- Medicaid
- Commercial / Marketplace
- IHS/Tribal Health
- Medicare
- Other govt purchasers
- VA

How can the State use its authority and levers to advance multi-payer delivery system reform?



SIM Transformation Models

Expand Montana's PCMH Program

- Utilize existing Program oversight
- Implement community health teams
- Support practice transformation
- Utilize telehealth to address rural access issues and workforce shortages
- Transition from pay-for-reporting to pay-for-performance

Integrate Physical and Behavioral Health

- Target high-need populations with physical and behavioral health needs that drive majority of costs
- Enhance providers' care coordination and care management capacity, adopt co-located and integrated services
- Pursue Medicaid Health Home program

Pursue Value-based Payment Models

- Migrate to pay-for-value and models that share risk and reward
- Implement payment programs for effectively managing population health and outcomes while reducing costs to the State and payers

Options are not mutually exclusive and components of each may be combined in a comprehensive multi-payer initiative



PCMH Components

Community
Health Teams

Telehealth

Practice
Transformation

Pay-for-
Performance



PCMH Community Health Teams

Community Health Teams (CHTs) are locally-based care coordination teams that help manage patients across the continuum.

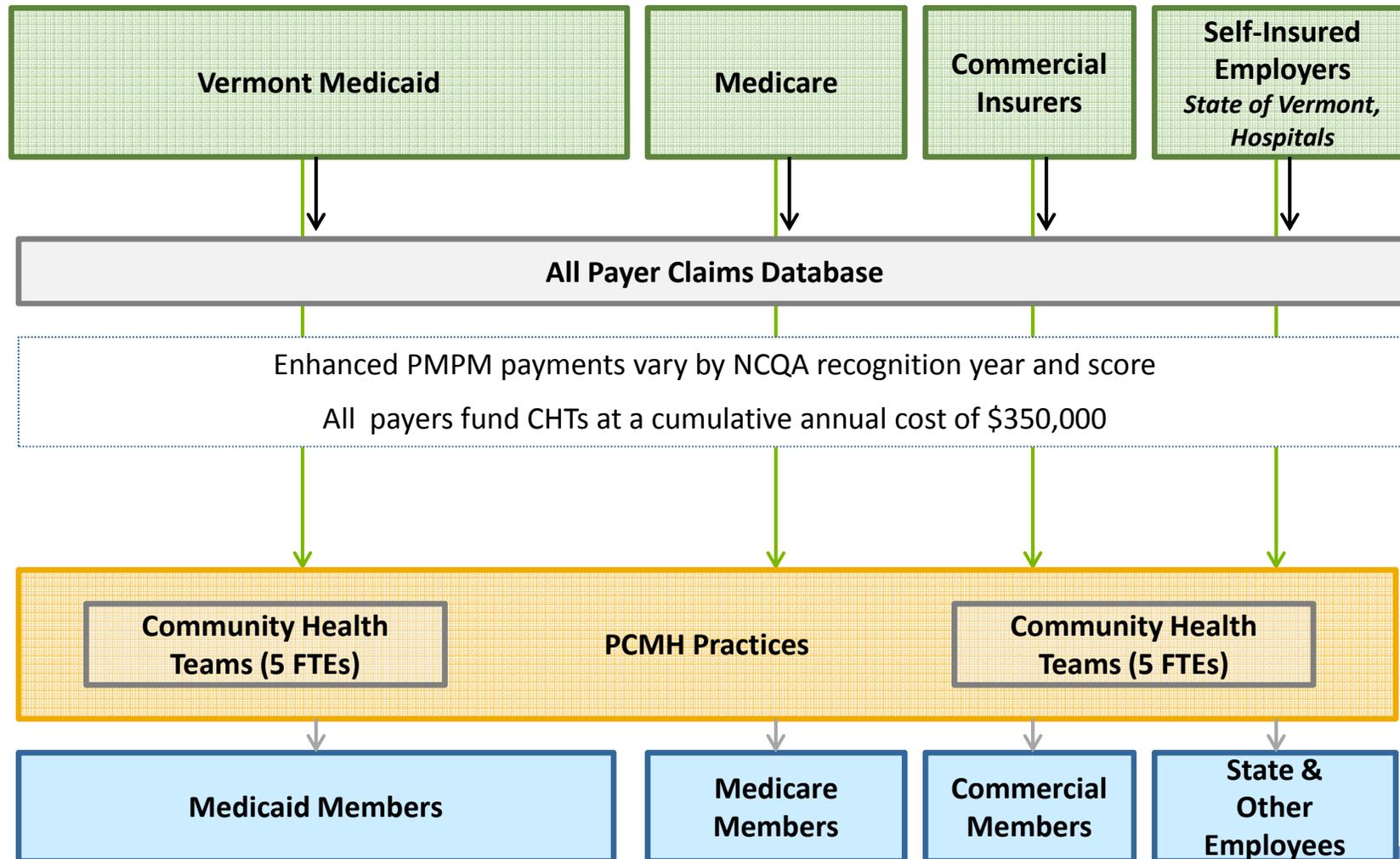
CHT Program Characteristics

- Multidisciplinary care teams that coordinate services, promote self-management and help manage medications
- Sustained continuous relationships between patients and team staff established and cultivated through regular face-to-face contact
- Mechanisms to routinely send and receive information about patients between practices and care teams
- Targeted to high-risk, high-need, or high-cost patients
- Focused on transitions in care
- Team members routinely connect patients with relevant community-based resources

Mountain Pacific Quality Health (MPQH) is developing an initiative with several of these characteristics. The MPQH model will use volunteers, primarily peers, who are deployed with “ReSource” care teams. The model also includes community health workers and health coaches.



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

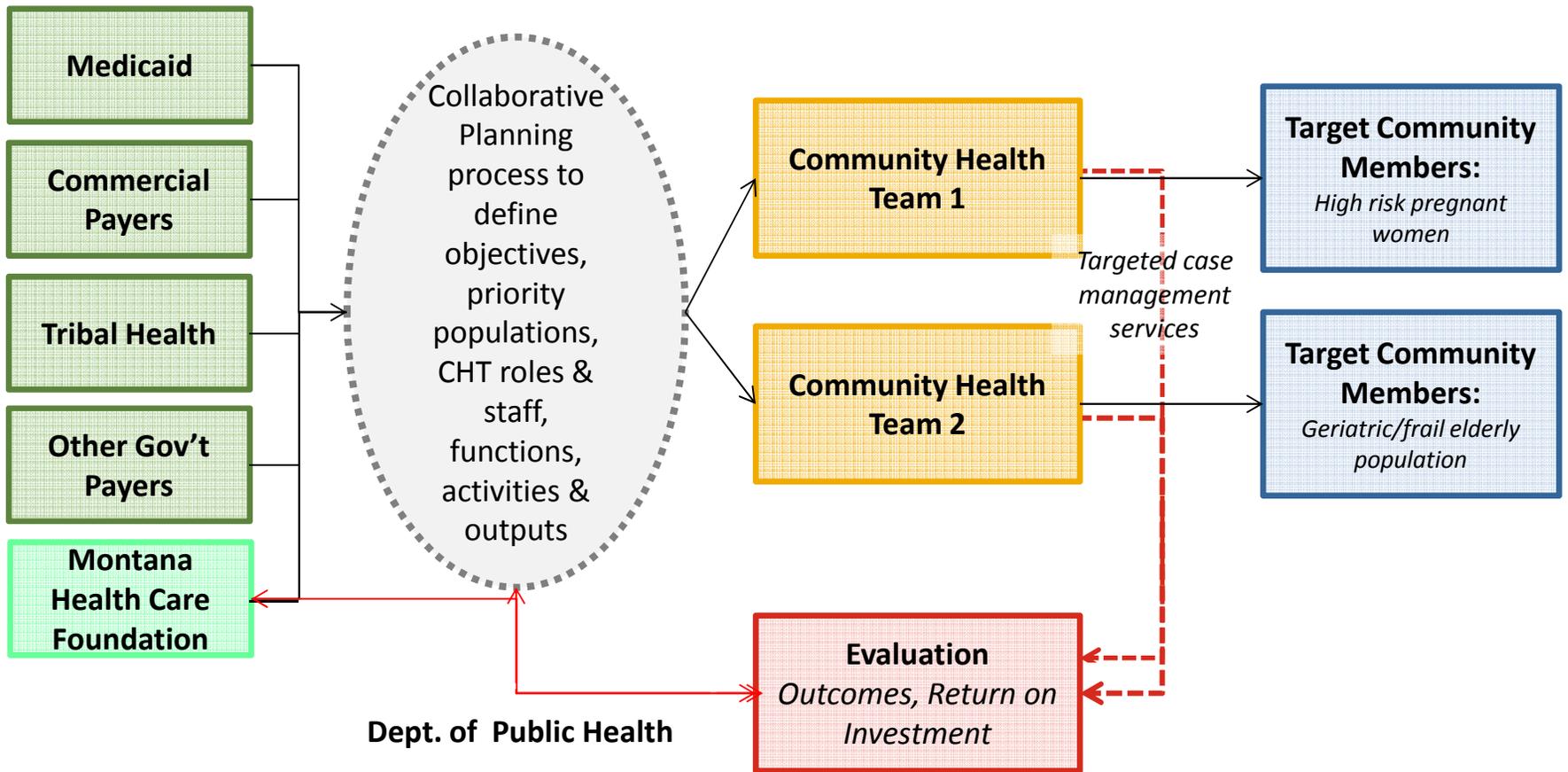
Results for Calendar Year 2013	Medicaid	Commercial
Number of Participating Beneficiaries	83,939	143,961
Total Medical Home Payments	\$2,085,035	\$3,576,002
Total CHT Payments	\$2,343,603	\$5,182,633
Total Investment Annual	\$4,428,638	\$8,758,635
Total Expenditures per Capita (participants)	\$7,776	\$4,954
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)



PCMH Community Health Teams Model – DRAFT

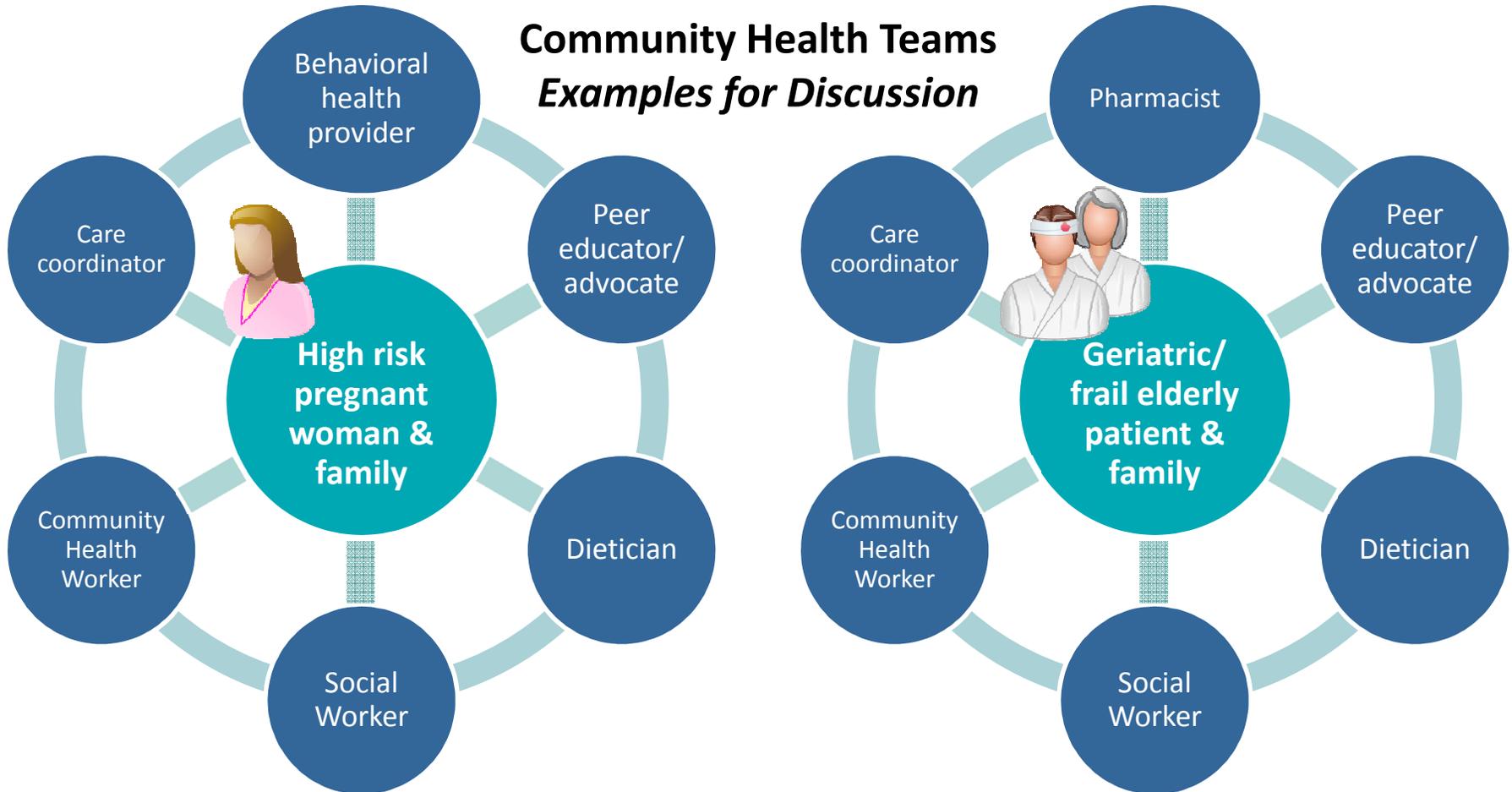
Payer and grant funding supports development of two CHTs to serve all community members regardless of insurance status



PCMH Community Health Teams & Targeted Case Management

- ✓ Targeted case management includes services that assist eligible individuals to gain access to needed medical, social, educational, and other services
- ✓ Services are targeted to specific classes of individuals, or to individuals who reside in specified areas of the state (or both)
- ✓ Patient and family engagement is central to Community Health Teams

Community Health Teams *Examples for Discussion*



PCMH Community Health Team Design Considerations 37

The design phase is critical to obtaining stakeholder buy-in and defining key model components, including:

- Target populations (conditions, demographics)
- CHT oversight
- CHT staffing model
- CHT financing
- Multipayer engagement
- Reimbursement for PCMHs that interface with CHTs
- Implementation plan
- Evaluation plan

On this slide, we are seeking only initial feedback from the Council.

We will discuss the processes to further vet and get stakeholder feedback and input on each of these considerations on a later slide.

PCMH Components

Community
Health Teams

Telehealth

Practice
Transformation

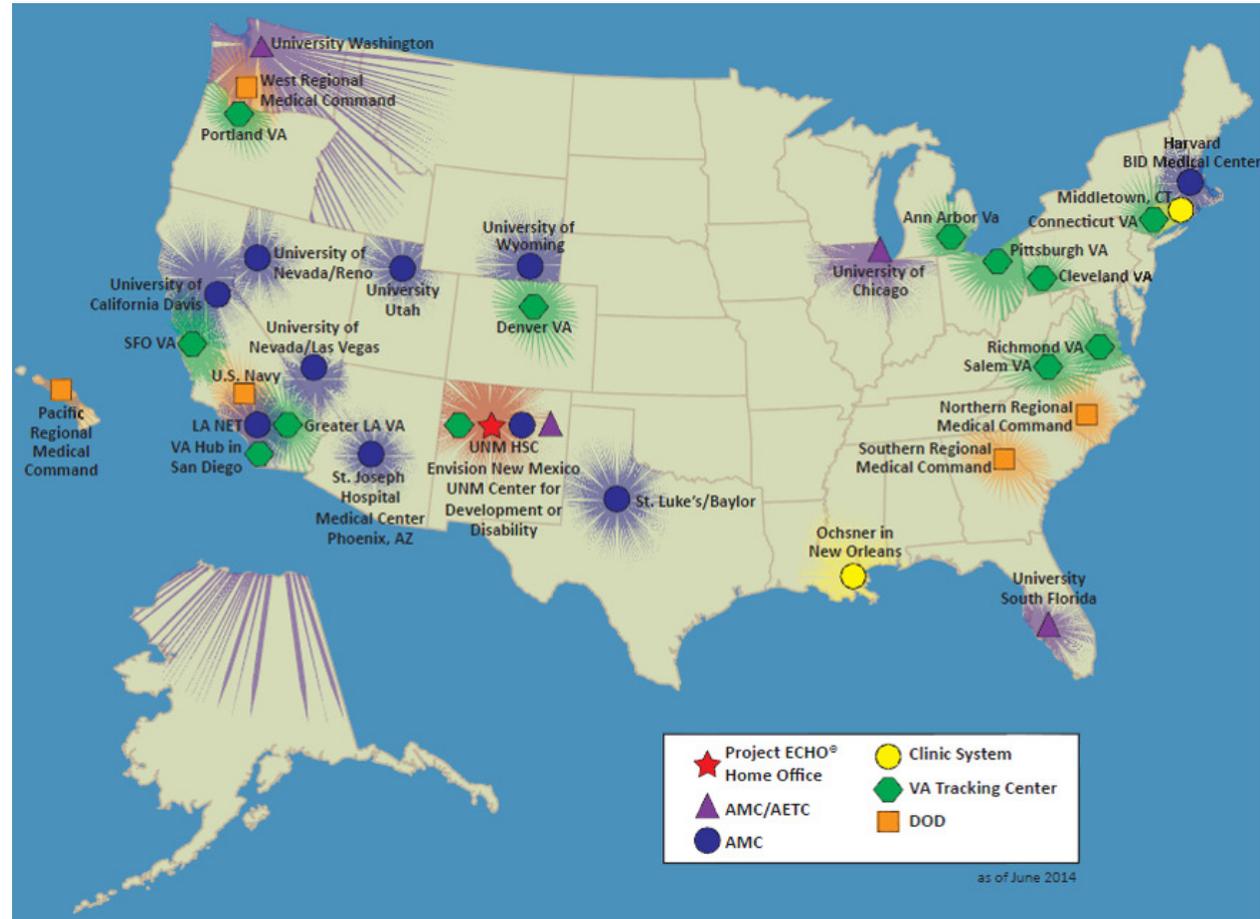
Pay-for-
Performance



Project ECHO

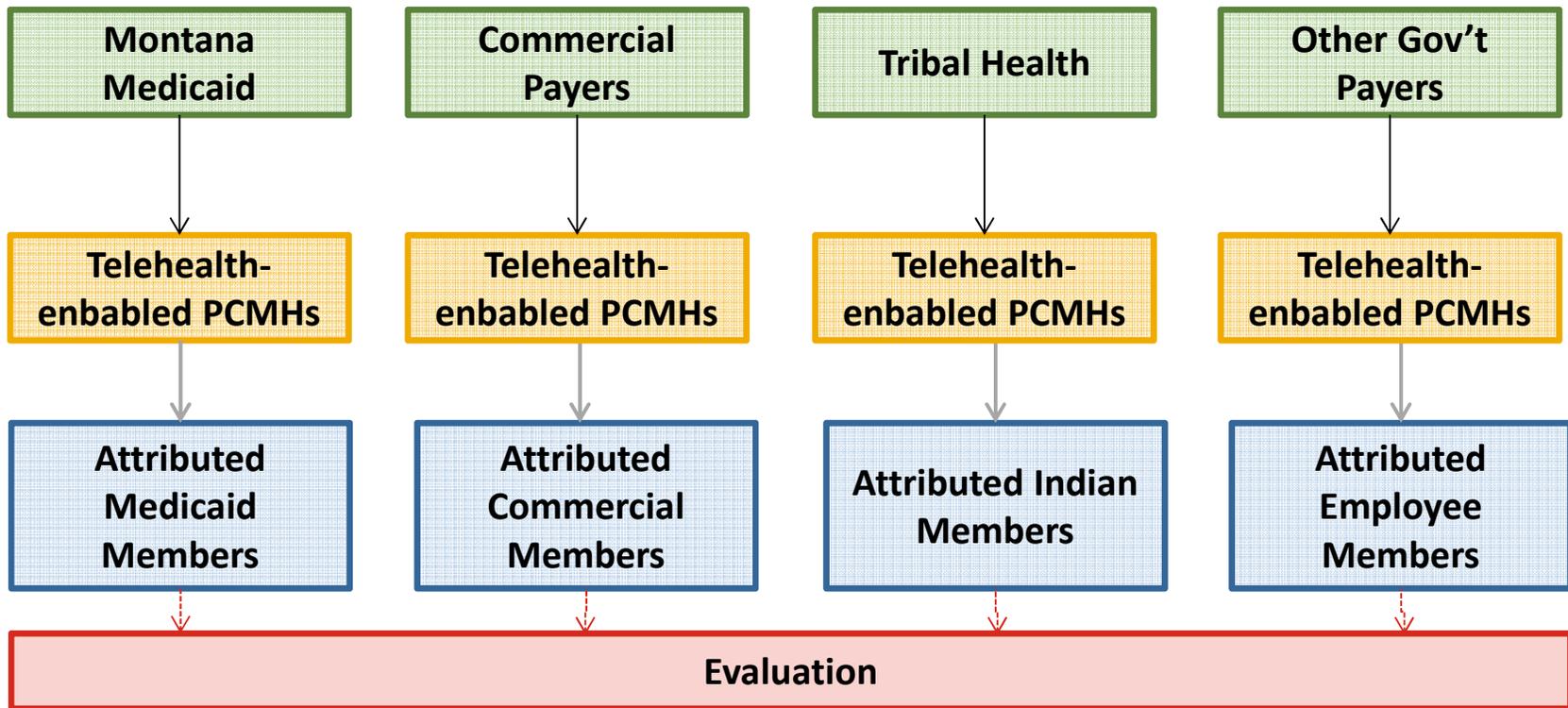


- Specialists at academic hubs are linked with primary care physicians (PCPS) in local communities
- Specialists mentor and discuss patient cases with PCPs in weekly teleECHO clinics
- Clinics are supported by basic teleconferencing technology
- Care provided by local PCPs has been proven as effective as care provided by specialists



Telehealth-Enabled PCMH Model – *DRAFT*

PCMHs may address access and workforce issues and engage otherwise hard to reach patients through telehealth.



Telehealth-Enabled PCMH Design Considerations

41

The design phase is critical to obtaining stakeholder buy-in and defining key model components, including:

- Definition of telehealth services to support PCMHs
- Identification of populations that may benefit from telehealth-enabled PCMHs
- Available telehealth infrastructure
- Multipayer engagement
- Reimbursement for PCMH telehealth services (parity law)
- Implementation plan
- Evaluation plan

On this slide, we are seeking only initial feedback from the Council.

We will discuss the processes to further vet and get stakeholder feedback and input on each of these considerations on a later slide.

PCMH Components

Community
Health Teams

Telehealth

Practice
Transformation

Pay-for-
Performance

Note: Pay-for-performance will be discussed in the value-based payment model section of the presentation.



Minnesota SIM Practice Transformation



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- ✓ **Learning communities** led by experts, teaching organizations, and professional organizations offer time-limited intense learning experiences for providers



- ✓ **Practice coaching** matches experts with practices to advise and provide resources as practices transform their work



- ✓ **Practice transformation grants** up to \$20,000 offer small and rural providers financial support for training, clinical systems redesign, implementation of new workflows, and coordination with learning collaborative work



- ✓ **Workforce grants** help providers hire and integrate new professionals into care delivery teams

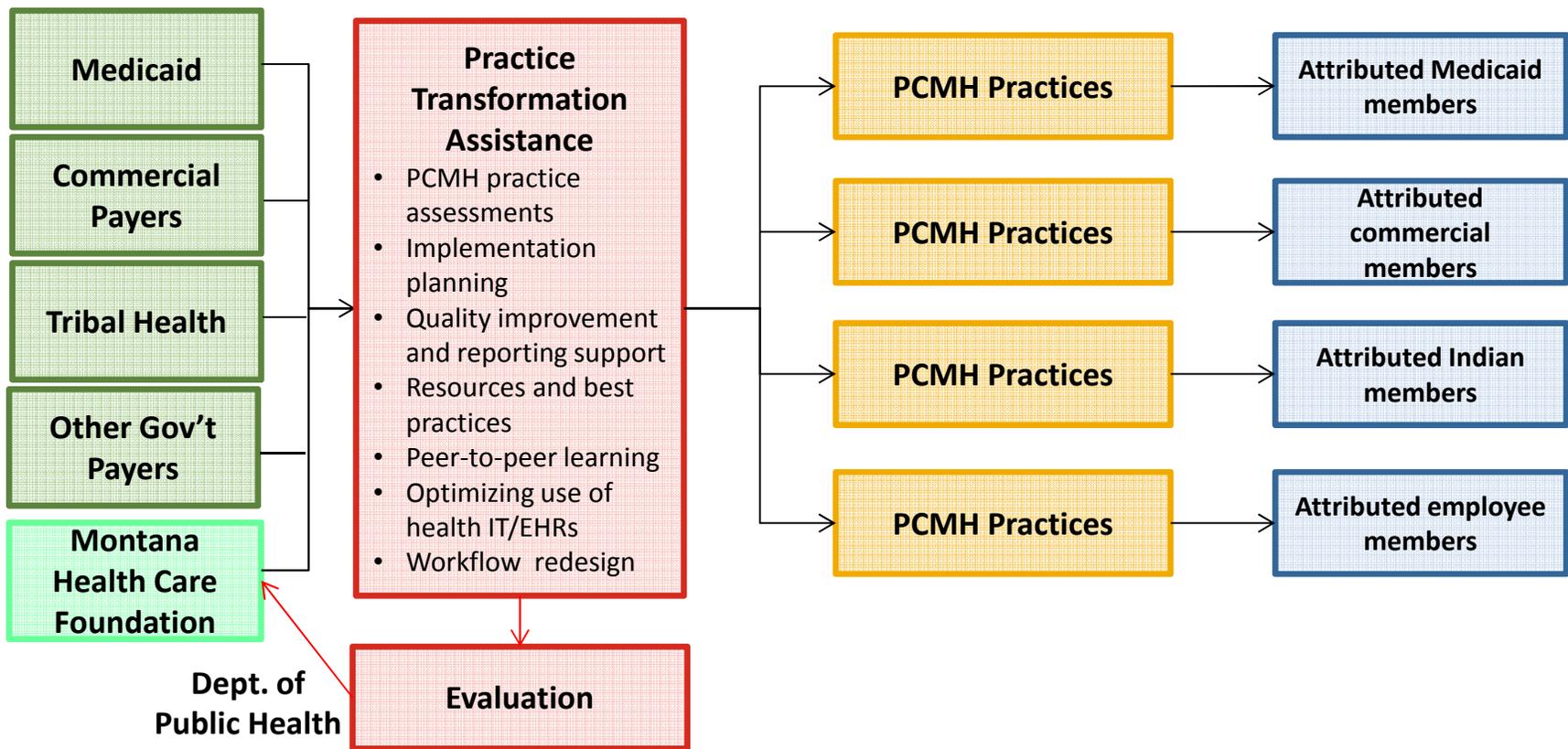


- ✓ **Statewide learning collaboratives** provide a forum for providers to share best practices, identify common issues, and develop solutions



PCMH Practice Transformation Model – DRAFT

Payer and grant funding supports practice transformation to (1) optimize existing PCMH practices and (2) support readiness of aspiring PCMH practices.



PCMH Practice Transformation Design Considerations

45

The design phase is critical to obtaining stakeholder buy-in and defining key model components, including:

- Definition of practice transformation “suite of services”
- Budget and funding sources
- Identification of potential service vendors/partners
- Practice service allocation methodology
- Multipayer engagement
- Implementation plan
- Evaluation plan

On this slide, we are seeking only initial feedback from the Council.

We will discuss the processes to further vet and get stakeholder feedback and input on each of these considerations on a later slide.

Integrated Physical & Behavioral Health

Expand Montana's PCMH Program

- Utilize existing Program oversight
- Support practice transformation
- Expand standardized quality reporting across public and private payers
- Utilize telehealth to address rural access issues and workforce shortages
- Transition from pay-for-reporting to pay-for-performance

Integrate Physical and Behavioral Health

- Target high-need populations with physical and behavioral health needs that drive majority of costs
- Enhance providers' care coordination and care management capacity, adopt co-located and integrated services
- Pursue Medicaid Health Home program

Pursue Value-based Payment Models

- Migrate to pay-for-value and models that share risk and reward
- Implement payment programs for effectively managing population health and outcomes while reducing costs to the State and payers

Options are not mutually exclusive and components of each may be combined in a comprehensive multi-payer initiative



Integrated Physical & Behavioral Health: PCMH and Medicaid Health Homes

	PCMHs	Medicaid Health Homes
Populations served	All populations	<p>Individuals eligible under the Medicaid State Plan or a waiver who have:</p> <ul style="list-style-type: none"> • At least two chronic conditions* • One chronic condition and are at risk for another • One serious and persistent mental health condition <p><i>*Chronic conditions include: mental health, substance use, asthma, diabetes, heart disease, overweight</i></p>
Staffing	Typically defined as physician-led primary care practices, but often include mid-level practitioners and other health care professionals	<p>Designated provider or team of health care professionals; professionals may be:</p> <ul style="list-style-type: none"> • Based in primary care or behavioral health providers' offices • Coordinated virtually • Located in other settings that suit beneficiaries' needs
Payers	Multi-payer (Medicaid, Commercial, Medicare)	Medicaid
Care focus	Focused on delivery of traditional primary care services, enhanced use of health IT/HIE, patient-provider communication, etc.	<ul style="list-style-type: none"> • Strong focus on behavioral health integration • Comprehensive care management • Care coordination and health promotion • Comprehensive transitional care from inpatient to other settings and follow up • Individual and family support • Referral to community and social support services • The use of health IT to link services

Missouri Medicaid Health Homes



Missouri was the first state to implement Medicaid health homes, and has a robust program for enrollees with chronic conditions and serious mental illnesses.

Community Mental Health Center (CMHC) and Primary Care (PC) Health Homes

- CMHC Health Homes serve members with serious mental illnesses or emotional disorders
- PC Health Homes serve members with multiple chronic physical conditions

Care Team Framework

- Established care team model and staffing ratios for each Health Home model
- Nurse care managers are seen as key to both models

Enhanced PMPM + Potential Shared Savings

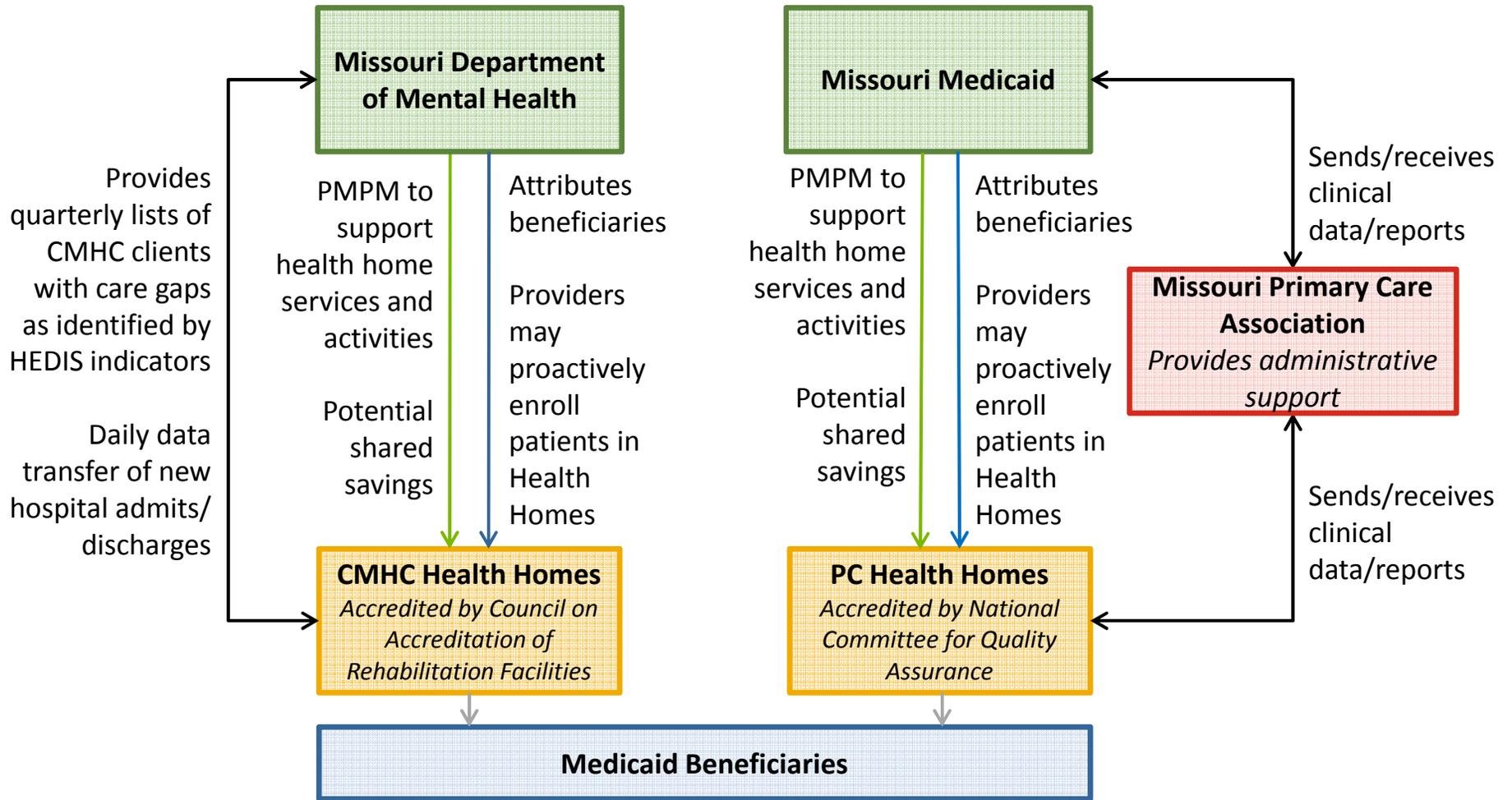
- State annually reviews and adjusts each Health Home's PMPM (CMHCs receive more than PC Health Homes)
- Shared savings may be available based on performance

18 Month Outcomes

- PC: PMPM cost decreased by \$30.79 with a total cost reduction of \$7.4M
- CMHC: PMPM cost decreased by \$76.33 with a total cost reduction of \$15.7M



Missouri Medicaid Health Homes

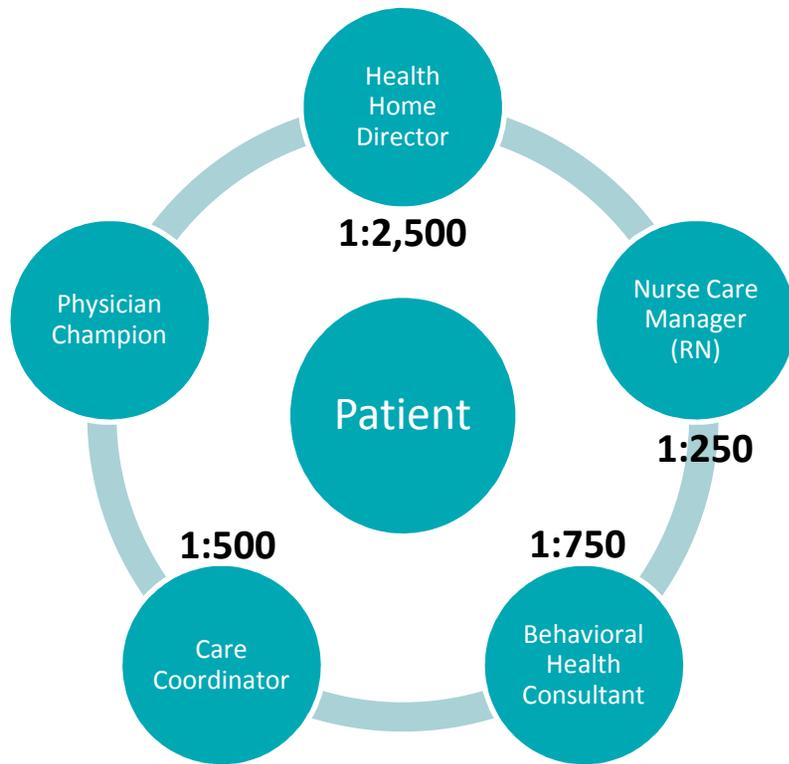


Missouri Medicaid Health Homes



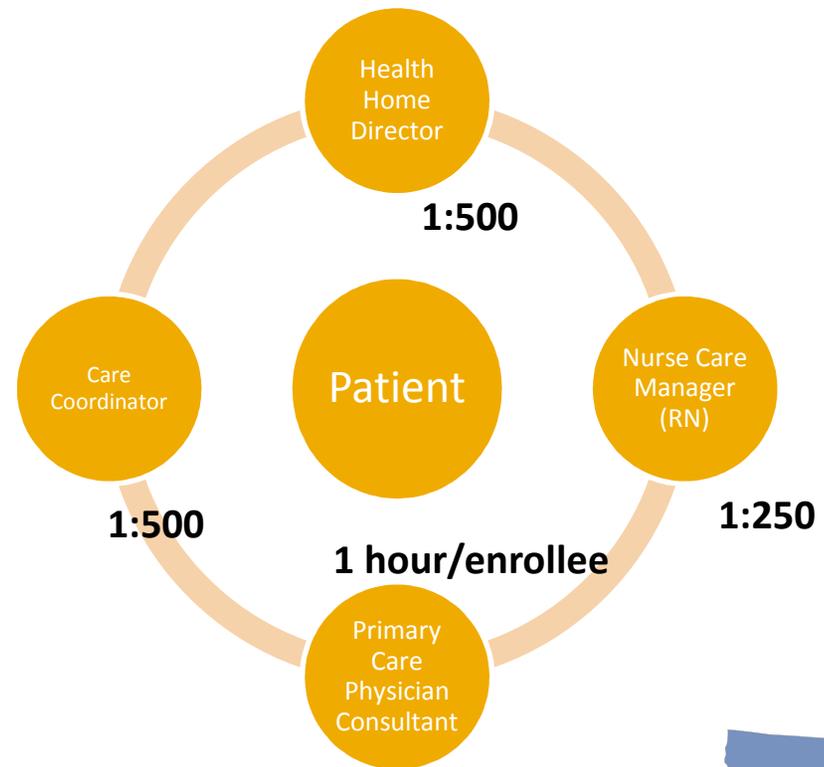
PC Health Homes Staffing Model/Ratios

Incorporates behavioral health care into the traditional primary care model through the addition of a behavioral health consultant



CMHC Health Homes Staffing Model/Ratios

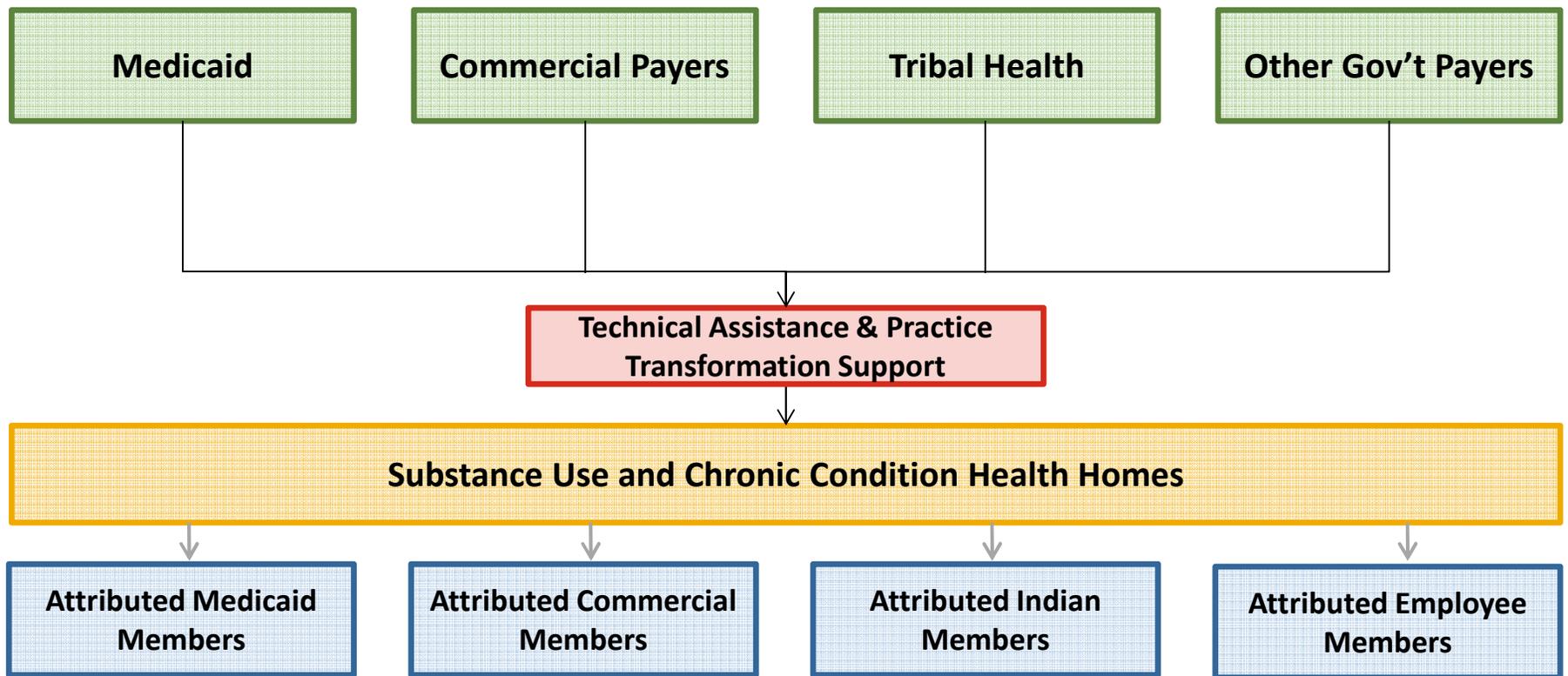
Incorporates primary care into the traditional behavioral health model through the addition of nurse care managers and primary care physician consultants



Integrated Physical and Behavioral Health: Health Homes

– **DRAFT**

Substance use and chronic condition Health Homes provide coordinated services to high need, high cost populations across payers



Integrated Physical and Behavioral Health: Health Home Design Considerations

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The design phase is critical to obtaining stakeholder buy-in and defining key model components, including:

- Medicaid Health Home design and implementation planning
 - Engage CMS technical assistance
 - Define target populations, considering increased reach of Health Home model with Medicaid Expansion
 - Develop Health Home provider/team staffing model
 - Develop attribution methodology and payment structure
- Identify components of Medicaid Health Home design that are relevant to Montana PCMHs operated by commercial and other insurers
 - Work with Governor’s Council to identify transferrable components
 - Integrate into MT PCMH Program

On this slide, we are seeking only initial feedback from the Council.

We will discuss the processes to further vet and get stakeholder feedback and input on each of these considerations on a later slide.

Value-Based Payment Models

Expand Montana's PCMH Program

- Utilize existing Program oversight
- Support practice transformation
- Expand standardized quality reporting across public and private payers
- Utilize telehealth to address rural access issues and workforce shortages
- Transition from pay-for-reporting to pay-for-performance

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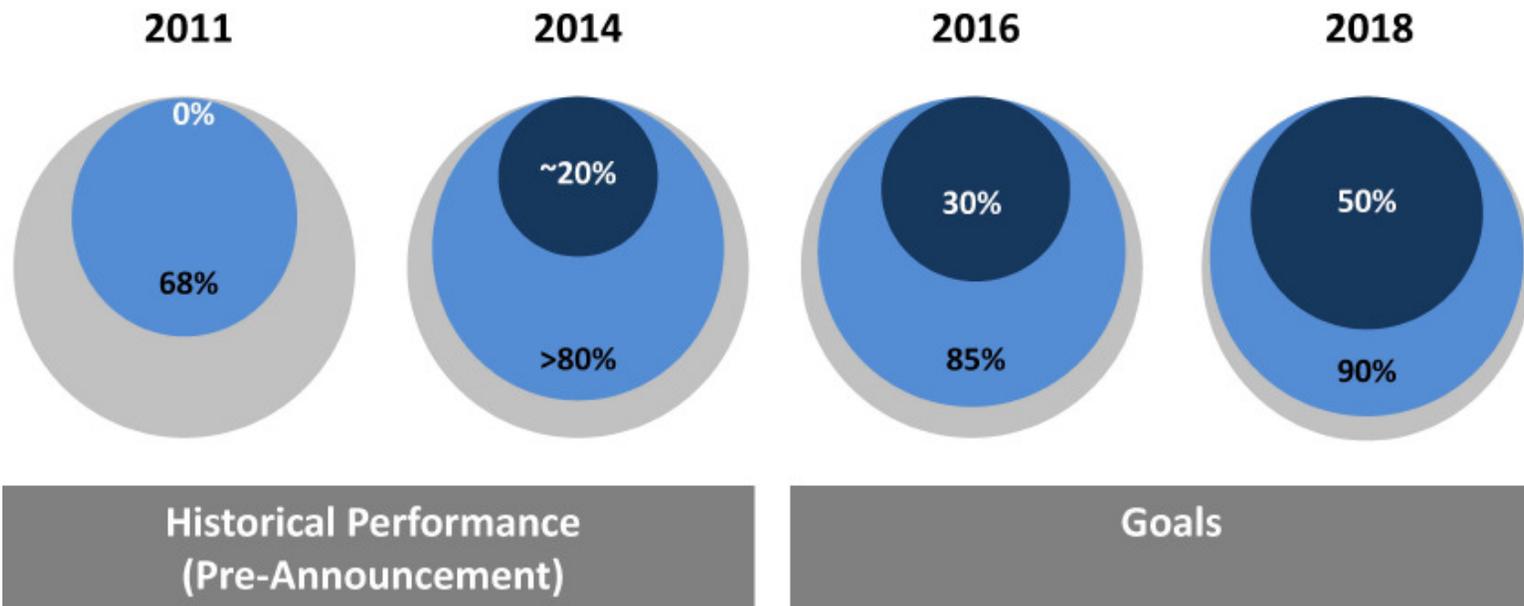


Medicare is Transitioning to Value-Based Payment

“As recently as 2011, Medicare made almost no payments to providers through alternative payment models, but today such payments represent approximately 20 percent of Medicare payments.”

- Sylvia Burwell, Secretary, U.S. Department of Health & Human Services

- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)



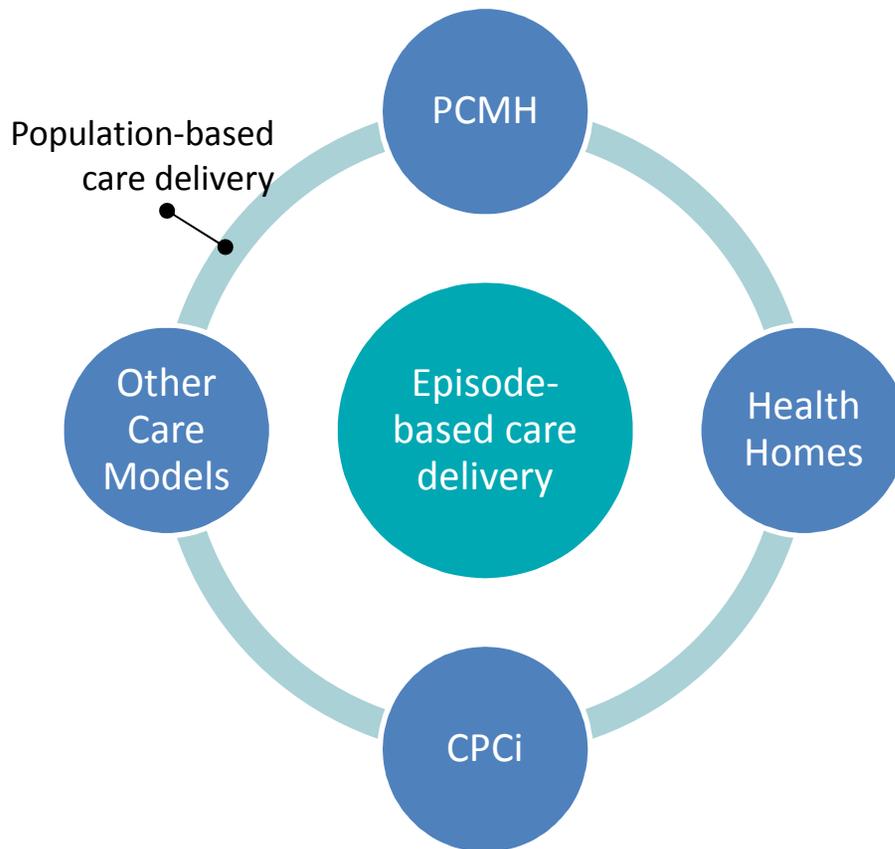
Source: HHS, October 2015



Arkansas Payment Improvement Initiative



Arkansas is simultaneously aligning levers and sources of authority to enact multi-payer delivery system reform.



Care Models

- **PCMH** (multi-payer) – Providers receive enhanced PMPM payments to support practice transformation
 - **Comprehensive Primary Care Initiative (CMMI)** – 69 primary care practices participate in multi-payer transformation initiatives
 - **Health Homes** (Medicaid)– Provide increased levels of care coordination for Medicaid members
- **Episodes of Care** (multi-payer) – Providers share in up and downside risk



Arkansas Payment Improvement Initiative



Arkansas's system transformation initiative brings together public and private payers around PCMHs, Health Homes, and episode-based payments.

Program Authority and Levers Facilitate multi-payer Delivery System Transformation

- PCMH: QHPs and Medicaid managed care plans must participate; Medicare participates through Comprehensive Primary Care Initiative
- Episode-based payments: Medicaid and commercial payers

Care Model Emphasizes Care Coordination and Practice Transformation

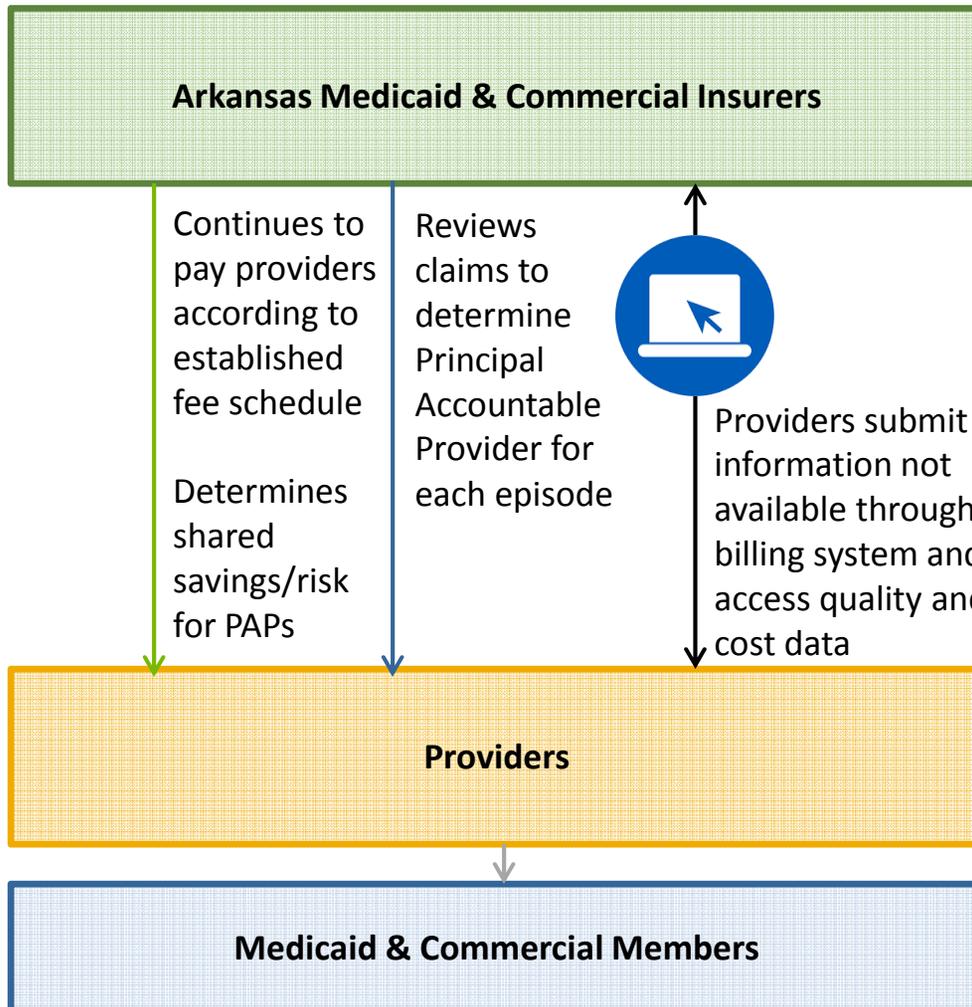
- Practices must demonstrate they are accomplishing transformation activities/enhancements
- Practices must have at least 300 attributed Medicaid beneficiaries upon PCMH enrollment

Payment Structure Provides Up-Front Support to Practices Before Graduating to Risk

- Payment structure offers up-front financial support through enhanced risk-adjusted PMPM payments
- Practices may share in upside risk (savings only) for PCMH and up/downside risk for episodes of care



Arkansas Payment Improvement Initiative



Multi-payer Targeted Episodes

- Perinatal
- Congestive Heart Failure
- Total Joint Replacement (Hip & Knee)
- Colonoscopy
- Gallbladder Removal
- Tonsillectomy
- Coronary Artery Bypass Grafting
- Asthma
- Percutaneous Coronary Intervention (PCI)
- Chronic Obstructive Pulmonary Disease (COPD)



Pursue Value-Based Payment Models – *DRAFT*

Pay-for-Reporting

- Continue pay-for-reporting efforts within Montana PCMH Program
- Continue fee-for-service reimbursement
- Develop value-based payment transition plan

Pay-for-Performance

- Encourage payers participating in the PCMH program to incorporate pay-for-performance into PCMH payment model
- Insurance Commissioner reviews and approves PCMH pay-for-performance programs
- Continue fee-for-service reimbursement, but encourage payers to move to value-based payment models that incorporate shared risk

Bundled Payments

- Identify and pilot approximately five bundled payment episodes with participating payers and providers
- Expand bundled payment pilot to include additional episodes and payers

Other Models

- Encourage overall transition to value-based payment through available models:
 - Shared savings
 - Shared risk
 - Accountable care organizations
 - Total cost of care



Value-Based Payment Model Design Considerations

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The design phase is critical to obtaining stakeholder buy-in and defining key model components, including:

- Existing value-based payment models in Montana
- Medicare value-based transition plan
- Key stakeholders
- State levers and authority to implement value-based payment transition among Medicaid and other State-purchased plans
- Multipayer alignment
- Implementation plan

On this slide, we are seeking only initial feedback from the Council.

We will discuss the processes to further vet and get stakeholder feedback and input on each of these considerations on a later slide.

Delivery and Payment Reform Model Next Steps

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- Review Governor's Council feedback – additional/ongoing feedback is welcome!
- Revise models to reflect feedback and additional research
- Test model concepts with key stakeholders
- Present models via stakeholder webinar
- Develop work plans
- Recommend models to Governor's Council at next meeting



SIM QUALITY METRICS



Current Quality Landscape

Many State and federal programs measure quality, but do so in silos which can be burdensome for providers and does not support multipayer reform

- Montana Patient Centered Medical Home (PCMH) Program
- Health Care Quality Measures for Medicaid and CHIP
- Medicare Shared Savings Program
- Physician Quality Reporting System (PQRS) – Medicare
- Public Health and Safety Division (PHSD) Strategic Plan: 2013 – 2018
- State Health Improvement Plan
- Other Programs?

Note: Payers also have unique quality reporting programs.



Montana PCMH Program

Participating PCMHs and insurers must report annually on a uniform set of quality and utilization measures

- In 2015, PCMHs were required to submit data from 2014 on at least three of four quality metrics:
 1. Hypertension
 2. Tobacco use and intervention
 3. A1C control
 4. Childhood immunizations*
- Reporting is aligned with Physician Quality Reporting System (PQRS) (for 1 – 3 above) and National Immunization Survey (CDC) (for childhood immunizations)
- In 2015, insurers were required to submit data from 2014 on two utilization measures
 1. ER visits
 2. Hospitalizations
- Insurers have flexibility in developing their attribution methods, but methods must be approved by the Commissioner

The Insurance Commissioner provided a suggested attribution method:

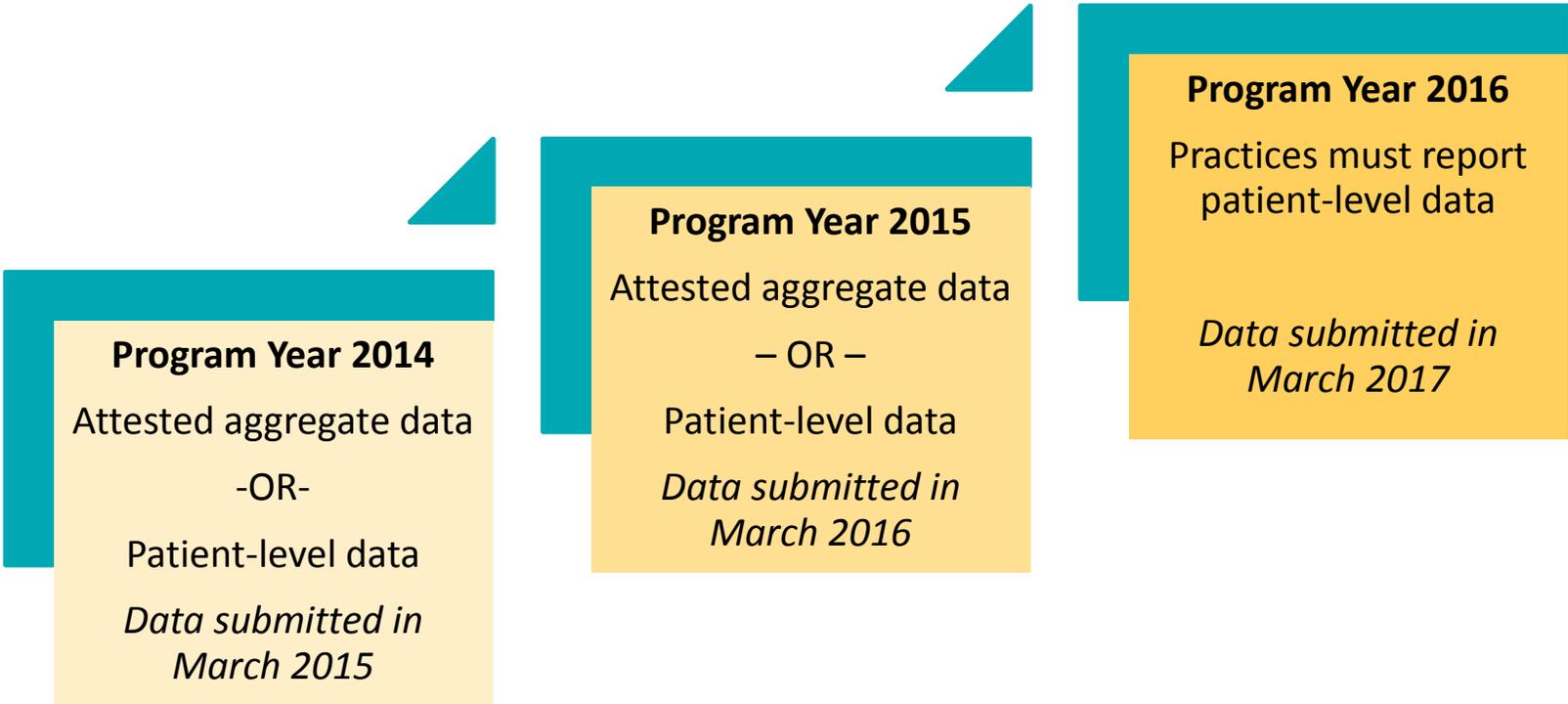
1. PCMH signs contract with insurer
2. PCMH sends insurer list of participating PCPs
3. Member eligibility established based on active insurer membership
4. Member-provider relationship established using 2-year retrospective review of claims data
5. Process is repeated monthly

*Pediatric practices are only required to report on childhood immunizations.



Montana PCMH Program

PCMHs must transition to reporting patient-level data by March 2017.



*PCMH practices opting to report patient-level data must use a random sample of at least 400 patients



PCMH Measures Crosswalk

There is significant overlap among quality measures in existing programs.

	Montana PCMH Program	Medicaid Core Measures	Physician Quality Reporting System	Medicare Shared Savings Program	Public Health and Safety Division Strategic Plan	State Health Improvement Plan
Hypertension	✓	✓	✓	✓	✓	✓
Tobacco use and intervention	✓	✓	✓	✓	✓	✓
A1C control	✓	✓	✓	✓	✓	✓
Childhood immunizations	✓	✓	✓		✓	✓
Depression screening	✓ *	✓	✓	✓		✓

*Measure is forthcoming in 2016.



Expand Quality Measurement and Reporting

	Option	Authority/Levers	Considerations/Discussion
1	Expand quality measures under Montana PCMH Program	Insurance Commissioner has authority to establish quality measures	<ul style="list-style-type: none"> • There is precedent for considering and introducing new measures • PCMH Stakeholder Advisory Council can vet and recommend new measures • Introduce cost measures • Develop measures to evaluate Community Health Teams, telehealth, and practice transformation efforts as they are implemented
2	Develop measures to evaluate SIM initiatives	State as convener	<ul style="list-style-type: none"> • Utilize stakeholder-based initiative to recommend subset of measures • Measures should support SIM goals and be aligned with the Driver Diagram • Utilize nationally recognized measures to minimize burden for payers and providers • Identify mechanisms to streamline data collection across participants (To be addressed in health IT/HIE workstream)



HIT PLANNING



Two Key Drivers for SIM HIT Plan

Value-based reforms will even further increase the need to access and analyze outcome data and enable improved care coordination

Create or enhance state data sharing capabilities

- All-payer claims database
- Statewide HIE
- Telehealth
- Strengthening other provider/payer data-sharing arrangements



Improve adoption and use of HIT and information exchange

- Stakeholder collaboration
- Technical assistance
- Focus on supporting PCMHs, other VB models



Potential of HIE in Montana – Stakeholder Feedback

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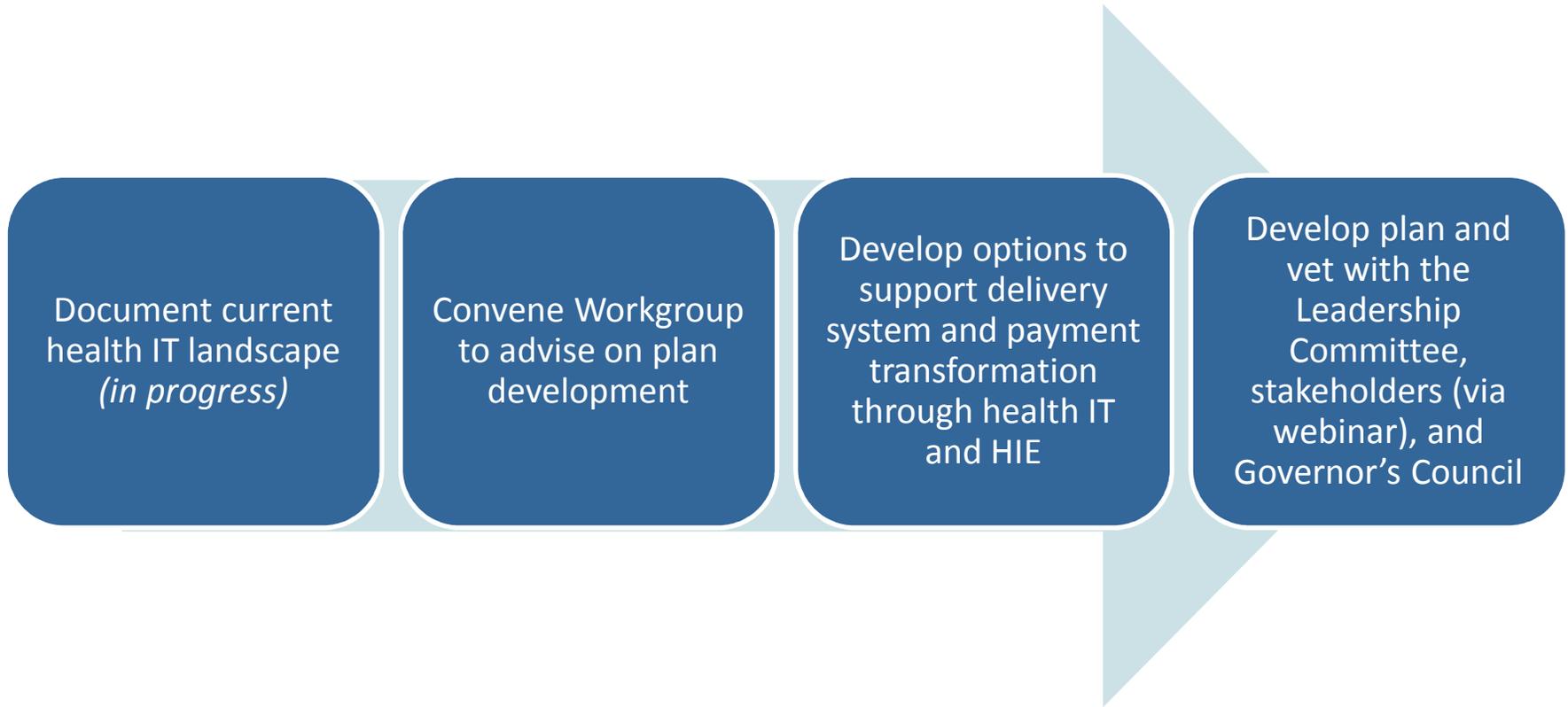
At the Montana Medical Association (MMA) meeting in September, stakeholders discussed and prioritized challenges that may be addressed through access to and exchange of health information.

Top Challenges

- Structured/unstructured data
- Referrals
- Interoperability/bidirectional and timely data exchange
- Population health data and management
- Access to and exchange of summary care records
- Quality reporting
- Patient access to information/patient engagement
- Workflow (getting data into health information systems)
- Measuring value



Next Steps: Proposed SIM HIT Work Plan



The SIM HIT planning timeline will be aligned with the MMA HIE work plan (under development) to ensure coordination between the two efforts.



NEXT STEPS



Next Steps and Key Dates

Upcoming Stakeholder Convening

- **November 18th** – Meeting of the Healthy Montana Taskforce
- **December 3rd** – SIM Presentation at the Montana Healthcare Forum

Next Governor's Council Meetings

- *Tentative* – **January 29, 2016**
 - Review and finalize recommendations on value and payment reform options
 - Review and finalize recommendations on quality metric alignment
 - Discuss HIT/HIE reform options/report out from HIE work group
 - Review other SIM work products, TBD
- *Tentative* – **March 9, 2016**
 - Review and finalize recommendations on HIT/HIE reform options
 - Review other SIM work products, TBD



APPENDIX



Key SIM Interviews to Date

Private Payers

- ✓ Jon Griffin, Medical Director, Montana BCBS
- ✓ Todd Lovshin, VP and Montana Regional Director, PacificSource
- ✓ Ron Dewsnup, President & General Manager, Allegiance Benefit Plan

Providers

- ✓ John Felton, President & CEO, Riverstone Health
- ✓ Steve McNeese, CEO, Community Hospital of Anaconda
- ✓ Jon Goodnow, CEO, Benefis Health System
- ✓ Barbara Mettler, Executive Director, South Central Montana Regional Mental Health Center
- ✓ Lenette Kosovich, CEO, Rimrock Substance Use Disorder Treatment Center
- ✓ Nicholas Wolter, CEO, Billings Clinic
- ✓ Steve Loveless and Ron Olfield, CEO, VP Finance/CFO, St. Vincent's Hospital
- ✓ Jeff Fee and Mark Wakai, CEO, St. Patrick Hospital (Providence) and Chair, MHA

Tribal Leaders/Health Experts

- ✓ Dorothy Dupree, Former Acting Area Director, Billings Indian Health Service
- ✓ Kevin Howlett, Tribal Health Director, Confederated Salish and Kootenai Tribes
- ✓ Keith Bailey, Executive Director, Health Indian Alliance (FQHC)
- ✓ Todd Wilson, Crow Tribal Health Department Director

Other

- ✓ Aaron Wernham, CEO, Montana Health Care Foundation
- ✓ Anna Whiting Sorrell, Patient/Citizen Advocate
- ✓ Dr. Bill Reiter, Northwest EHR Collaborative

Sources: Snapshot of Montana Health Coverage

Individual Market (Incl. Exchange)

- Data is from the most recent Health Enrollment Survey from the Montana Insurance Commissioner

Medicaid/CHIP

- Data provided by the Montana Department of Public Health and Human Services based on most recent enrollment reports

Employer-Sponsored Insurance

- Data is from Kaiser State Health Facts
- 2011 Self Insured Plan Data: http://www.ebri.org/pdf/notespdf/ebri_notes_11_nov-12.slf-insrd1.pdf

Tribal Health/IHS

- Breaking Barriers: Improving Health Insurance Enrollment and Access to Health Care in Montana, April 2014: http://allianceforajustsociety.org/wp-content/uploads/2015/04/BBReport_MT-4232015r.pdf
- 2012 Report: “Health Care Coverage & Income of American Indians & Alaska Natives” for CMS Tribal Affairs.

Medicare

- Kaiser State Health Facts: <http://kff.org/other/state-indicator/total-population/>

Uninsured

- Data provided by the Montana Insurance Commissioner

Public Employee Plans

- Data provided by the Montana Insurance Commissioner and the Montana State Human Resources Division



Other Integrated Behavioral Health Program Features

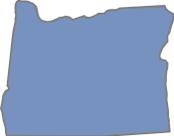


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South Dakota Medicaid stratifies eligible Health Home members into four tiers before they are assigned to a PCP or CMHC-led Health Home.

- South Dakota uses the Chronic Illness and Disability Payment System (CDPS) to stratify members' illness severity based on 15 months of claims data
 - Developed by UC San Diego and free to public agencies
 - Diagnostic classification system used by Medicaid programs to make health-based capitation payments for TANF and disabled Medicaid beneficiaries
- To receive payment, a Health Home provider must provide at least one service per quarter to an attributed member and document the service in their EHR



Oregon's Coordinated Care Organizations (CCOs) receive capitated payments to provide physical, mental health, and chemical dependency services.

- CCOs are community-based entities governed by partnerships of providers, community members, and risk-bearing entities
 - Governance structure must include a mental health or chemical dependency provider
- CCOs develop community health assessments and improvement plans in consultation with local stakeholders (e.g., hospitals, public health and social services agencies) to address community needs

