

Montana State Innovation Model Design Initiative

Stakeholder Webinar

October 6, 2015
10 – 11:30 am



Agenda

- | | |
|------------------|--|
| 10:00 – 10:25 am | Montana SIM Overview and Healthcare Landscape |
| 10:25 – 11:10 am | Montana Authority & Levers |
| 11:10 – 11:15 am | Stakeholder Engagement & Next Steps |
| 11:15 – 11:30 am | Question & Answer Session |

Objectives

- Provide an overview of Montana's State Innovation Model (SIM) initiative
- Describe important characteristics of Montana's health care landscape – status, providers, and payers – that inform SIM priorities
- Review State authority and levers that may be used to advance SIM goals
- Discuss opportunities for stakeholder engagement & respond to questions from webinar participants

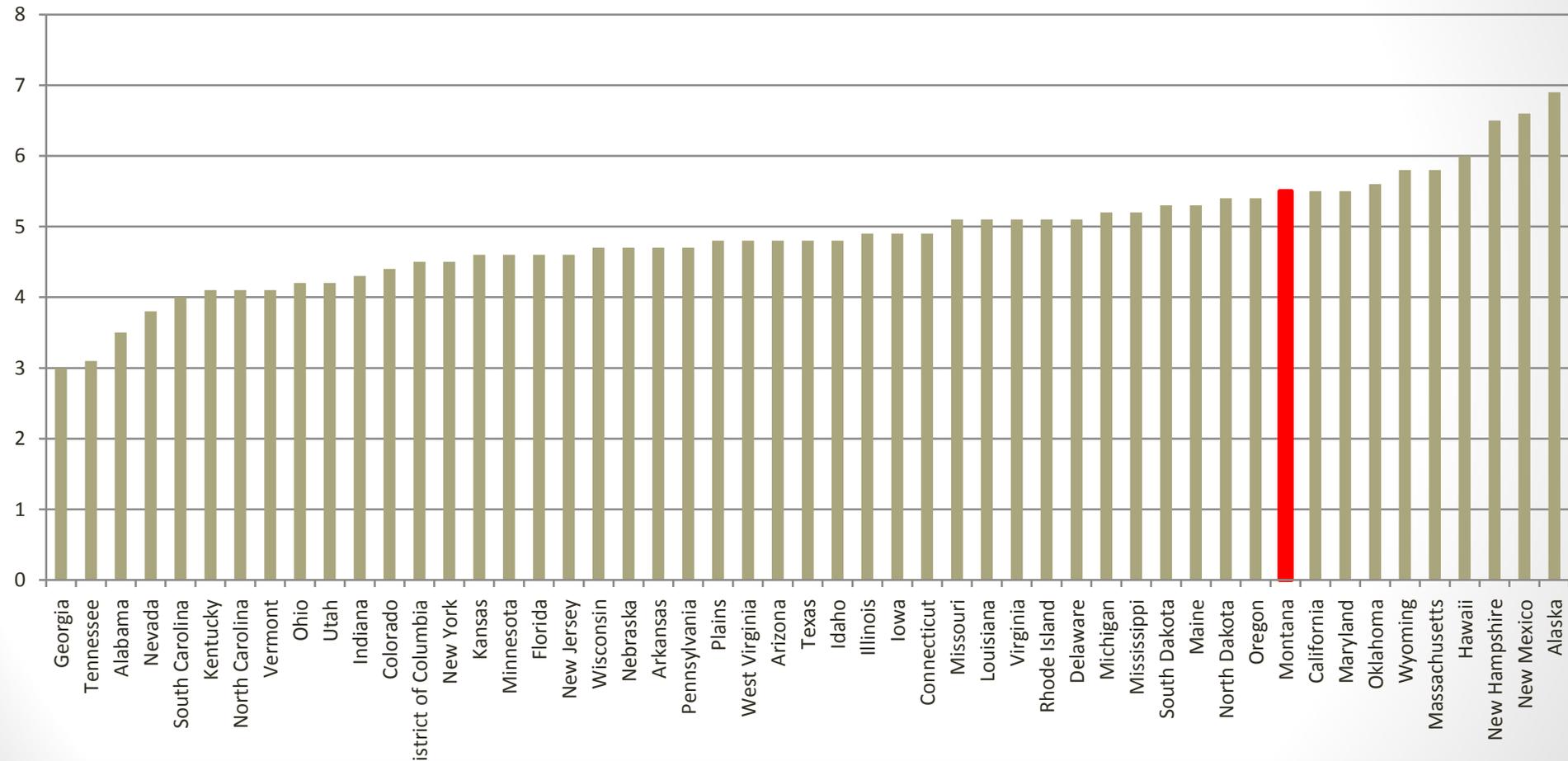
Montana SIM Context





Percent Increase in Per Capita Health Spending by State

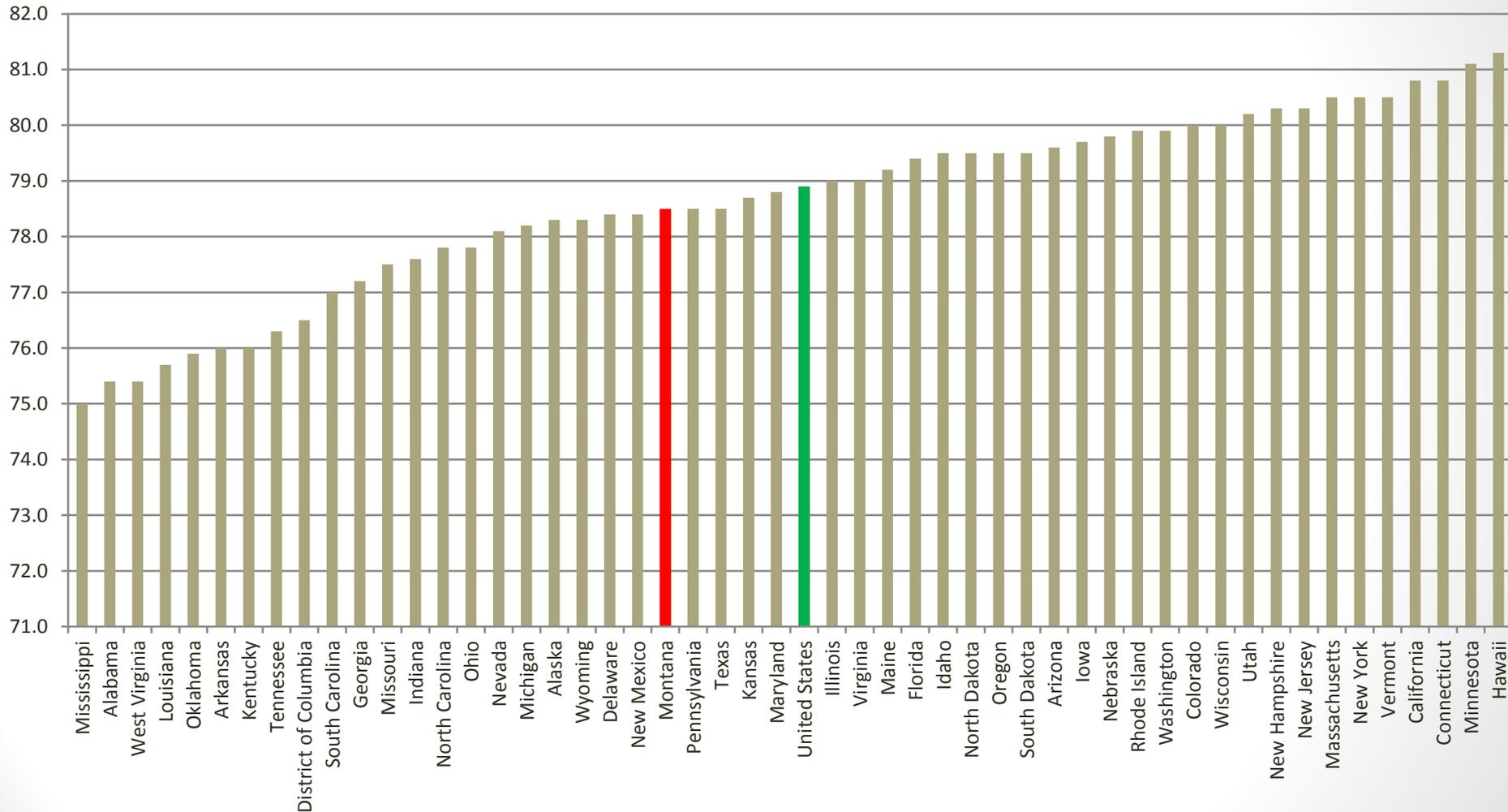
Across all payers 2004-2009



Montana has seen average health care costs rise at greater rate than 41 other states



Life Expectancy at Birth, 2009



Montana's life expectancy is lower than the national average



Prevention

Immunizations

Only 2 states ranked worse than Montana for percentage of children ages 19-35 months who received recommended vaccines. (2011)

Mammograms

Only four states have worst rates of women over 50 who reported having a mammogram in the last 2 years. (2010)



Health Disparities

Lifespan

On average the lifespan of American Indians in Montana is twenty years less than their non-Indian neighbors, friends and coworkers.

Healthcare Needs

American Indians are significantly more likely to suffer from cardiovascular disease, cancer, and respiratory illness.



There is also good news

- ✓ Montana has lower prevalence rates of obesity among adults than the U.S. and is one of the few states where the obesity rate is not increasing.
- ✓ MT has higher rates of physical activity levels among adults compared to the U.S.
- ✓ While childhood immunizations rates in MT were very low in 2008, MT has made significant progress to increase these rates through 2014. We anticipate that the childhood immunization rates will continue to increase in 2016 due to the policy changes supported by Governor Bullock and adopted by the 2015 legislative session.

Montana SIM Design Award Overview





Montana 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 multipayer 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
- The Governor's Council on Healthcare Innovation and Reform will serve as the lead convener for the purchasers, payers, providers, and systems.

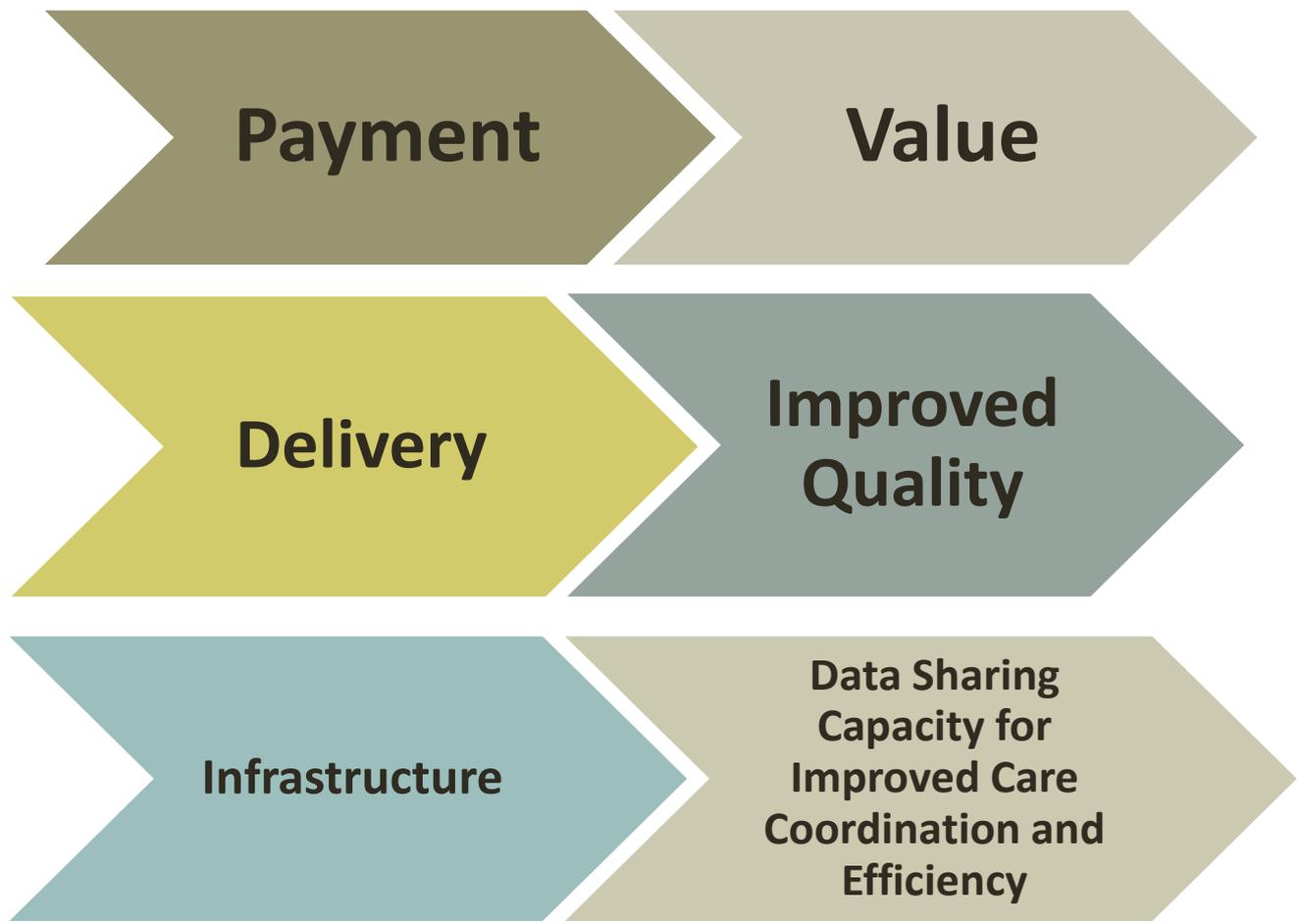
Montana's SIM Design Award Goals

- 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's Vision for Multi-Payer Innovation



This Initiative Matters to Everyone



Patients

- Right care, right time, right place: Access
- Better coordination of care
- Decreased need for unnecessary services – services match needs
- Less costly



Providers

- Better care for patients
- Financial support for previously uncompensated services
- Compensation based on value of care and quality rather than volume
- Team-based care



Health Plans/Payers

- Healthier, happier plan members
- Helps address factors outside of plan control, moves care upstream
- Decreased cost of care and lower utilization management needs
- Value-based health plan design



Employers

- Healthier workforce and improved productivity
- Decreased absenteeism costs
- Less costly care



Montana will use the State Health Improvement Plan to inform SIM priorities and options.

	State Health Improvement Plan	State Innovation Model (SIM)
Stakeholders	Public Health and Safety Division of the Montana Department of Public Health and Human Services with key stakeholder groups and the public	Multi-payer, providers, consumers and the public
Timeline	Completed in June 2013	May 2015 – June 2016
Objectives	<ul style="list-style-type: none"> Information on the health status and health needs of Montanans. Focus on using evidence-based strategies and practices to address documented health needs. 	<ul style="list-style-type: none"> 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.
Oversight	Healthier Montana Task Force appointed as oversight body to direct and monitor the implementation of State Health Improvement plan.	Governor's Council on Healthcare Innovation and Reform will be appointed to contribute input and expertise from private and public sector payers, providers, and patient advocates



Montana's Healthcare Landscape



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.

State Employee Plan

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.

Uninsured

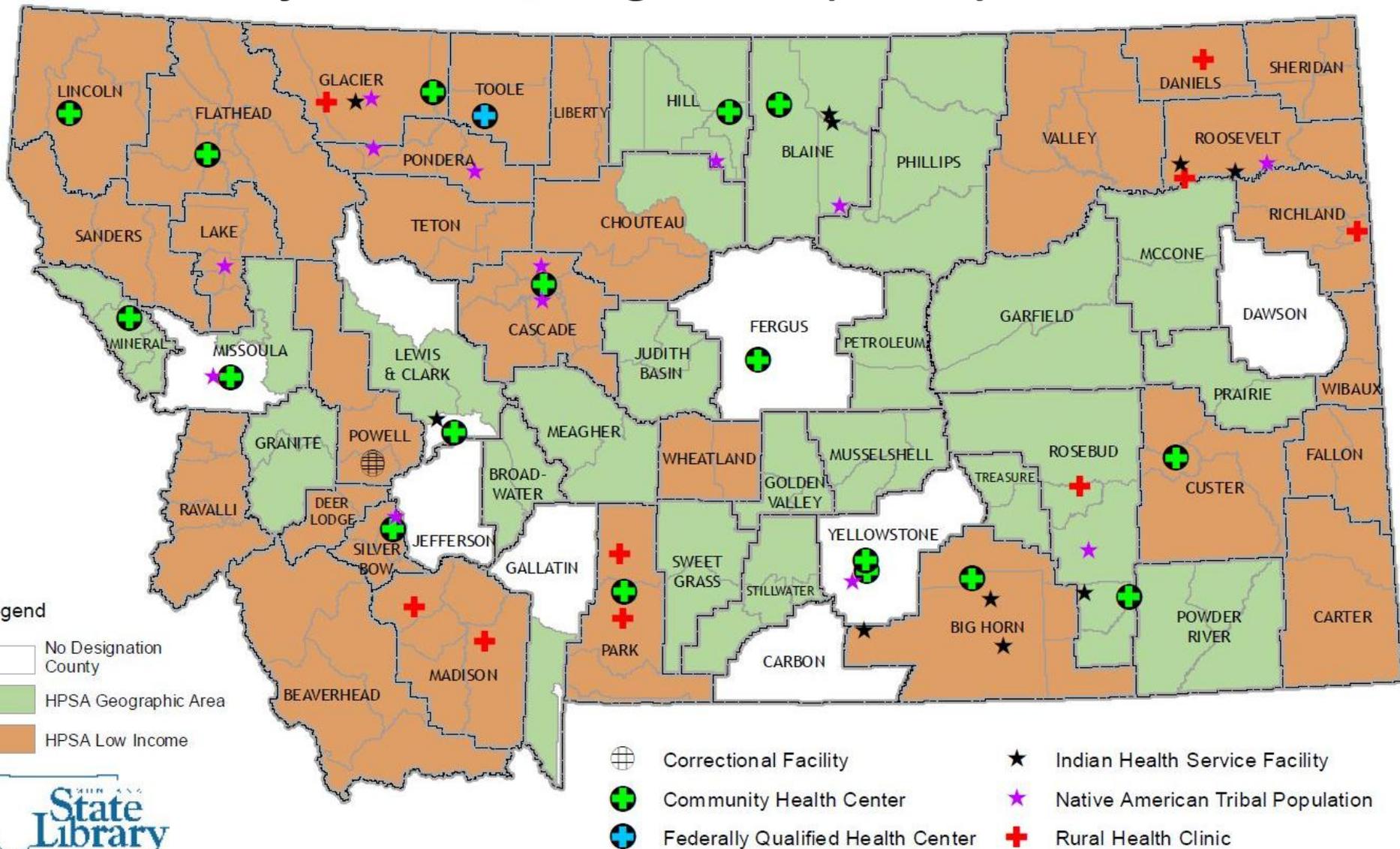
As of August 2015, 151,000 individuals (15%) were uninsured.

⁺ 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 and notes section

Health Professional Shortage Areas (HPSAs)





Patient Centered Medical Homes

- Montana's efforts around payment and delivery system reform have initially focused around patient centered medical homes (PCMHs)
- State legislation defines 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.
- Four payers, including Medicaid, currently participate in the PCMH Program
- Initial results are promising

Montana Authority & Levers



Introduction and Key Terms

This presentation provides an overview of statutory and regulatory authority and other levers that the State of Montana is using, or could use, to advance and support multi-payer health system reforms. In a future webinar, we will explore how other states have used their authority and other levers to advance reforms.

- **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.

Overview: State Authority on New Care Models



Commercial Plans. The Insurance Commissioner in Montana has authority to regulate patient centered medical home (PCMH) models, but 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.

COMMERCIAL PLANS

Insurance Commissioner Authority & Levers: PCMHs

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

Insurance Commissioner Authority & Levers: Private Coverage

Source of Authority

- Commissioner's authority* allows her to perform plan management for the Exchange
- State Law allows rate reviews for small employer, indiv. market (see next slide)

Scope of Authority

- Under existing State law, Commissioner has the authority to:
 - Review all rates (see next slide)
 - Approve policy forms and benefit templates
 - Review and approve network adequacy
 - Handle consumer complaints and appeals
 - Certify PCMHs (see previous slide)
- The Commissioner may issue State-specific guidance for health plans issued in Montana, both inside and outside the Exchange
- Per Montana's PCMH legislation (see previous slide), Commissioner may regulate PCMHs in all types of commercial plans

Use of Authority to Date

- Commissioner regulates plans consistently market wide (inside and outside Exchange)
- Commissioner has not issued State-specific guidance for FFM applicant plans related to payment/delivery reforms**

Key Takeaways for Montana SIM

- Commissioner has broad authority over health plans sold in Montana
- State legislation may be needed to allow Commissioner to issue rules/incentives to require health care delivery reforms in fully insured health plans

• CMS and CCIIO Final 2016 Letter to Issuers, in the Federally-facilitated Marketplaces, February 20, 2015
<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf>

** The Commissioner has regulated plan designs for prescription drugs, related to specialty tier drugs, inside and outside the Exchange

Insurance Commissioner Authority & Levers: Rate Review

Source of Authority

- State law* allows Commissioner to conduct rate reviews for small employer, individual market health insurance

Scope of Authority

- Commissioner has authority to review all rates for issuers in the individual or small employer group market.
- Commissioner may consider factors including:
 - Medical loss ratio
 - Costs and expenses, and trends related to utilization and unit cost
 - Changes in the issuer's health care cost containment and quality improvement efforts
- If the Commissioner finds a rate excessive or unjustified, the insurer may still implement the proposed rate (unless it is determined to be discriminatory), but the Commissioner will publish her finding on the State website and elsewhere.

Use of Authority to Date

- To date, authority has been used successfully in negotiations with insurers to reduce rates, and to better understand the costs of healthcare in Montana
- Rates are published in Montana for the first time

Key Takeaways for Montana SIM

- Rate review process could be used to incentivize reform (e.g. by directing attention to areas where plans could leverage delivery reforms to lower claims costs)
- Rate review could also be used to further increase transparency in individual and small group employer markets

Insurance Commissioner Authority & Levers: ACOs

Source of Authority

- Montana Code Section 33-31 – 102, 201, 202 and 207

Scope of Authority

- ACOs assuming certain levels of risk could fall within the definition of “health maintenance organizations” in State law (“provides for or arranges basic health care services to enrollees on a prepaid basis...”).
- In this case, an ACO must be authorized by the Commissioner to operate; unauthorized insurers are subject to criminal penalties.
- In reviewing a risk-bearing ACO’s application, the Commissioner may consider the ability of the ACO to effectively bear risk for services and meet its financial obligations to enrollees.
- PACE programs are exempted from the definition of HMO, and the Commissioner may waive HMO requirements for ACOs under the Medicare Shared Savings Program.

Use of Authority to Date

- The Commissioner views this authority as an important consumer protection measure, but has not to date used the authority to regulate Commercial ACOs in Montana

Key Takeaways for Montana SIM

- Some ACOs in Montana may need to pursue Commissioner authorization before operating
- The level of risk borne by ACOs will determine the level of authority the Commissioner has to require such authorization

MEDICAID

Medicaid Landscape: Snapshot of Delivery Models

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: Expansion

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

- The expansion may add up to 45,000 Medicaid enrollees by the end of FY 2019.
- Coverage is expected to begin January 1, 2016.
- 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 (TPA) to administer the coverage for these adults.
- Certain individuals including those with special health care needs and American Indians will not be enrolled under the TPA, but will receive Medicaid State Plan services.

Medicaid Authority: State Plan & General

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
 - Option for Health Homes enhanced funding (see slide 17)
- MT Code establishes principles for Medicaid policy, notably:
 - Effective and efficient care, market-based approaches
 - Strengthening ties between patients and providers
 - Patient education and engagement
 - Gradual reforms to minimize impacts on State economy

Use of Authority to Date

- MT has approved SPA for its PCMH limited demonstration project- state pays capitated PMPM fee + standard FFS payments for PCMH services to voluntarily selected providers

Key Takeaways for Montana 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
- MT Code “principles” imply legislative support for payment and delivery reforms to cut costs while improving patient-centeredness, quality

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

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!

Medicaid Authority: TPA Contracting for Expansion

Source of Authority

- MT SB 405 (see subsequent slide for details)
- Pending 1115 & 1915(b) waivers for Expansion Group

Scope of Authority

- SB 405 authorizes State to contract w/Third Party Administrator (TPA) to administer services for the expansion group
- State requesting CMS approval in 1115, 1915(b) waivers for Expansion
- TPA contract will cover care for Expansion population, excluding those with “exceptional health needs”
- Expansion may add up to 45,000 additional Medicaid enrollees by the end of FY 2019
- TPA to perform variety of functions, including:
 - Provider network development and management
 - Claims processing for most benefits
 - Quality assurance
 - Case management and care coordination services
- SB 405 allows DPHHS to ask TPA to assist in its reform efforts

Use of Authority to Date

- TPA bids have been scored, contract negotiation process begins this month
- State has not dictated a particular payment model for the TPA to administer for expansion population – RFP is silent on PCMHs, includes reforms like care coordination and health risk assessments to emphasize preventive care

Key Takeaways for Montana SIM

- TPA contract is opportunity to advance reforms for large number of adult Medicaid enrollees

Medicaid Authority: SB 405

Source of Authority

- MT SB 405

Scope of Authority

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

- Strengthening and evaluating existing PCCM programs
- Expanding case management programs for high risk enrollees
- Establishing pilot programs (e.g. pain management, decrease ED overuse, and prevent drug or alcohol addiction or abuse)
- Engaging members with chronic/BH conditions in care models to reduce costs or improve outcomes:
 - Patient-centered medical homes
 - Accountable care organizations
 - Managed care organizations
 - Health improvement programs
 - Health homes for chronic conditions, or behavioral health
 - Other innovative delivery models
- Strengthening data sharing with providers

Use of Authority to Date

- State has PCMH program (see previous slides)
- State has not dictated a particular model or reforms for the expansion TPA to administer

Key Takeaways for Montana SIM

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

Medicaid Authority: Health Homes State Plan Option

Source of Authority

- New State Plan Option under Section 2703 of the ACA

Scope of Authority

- Allows States to provide coordinated care to enrollees w/multiple chronic conditions, serious mental illness
- Must enhance linkages to community, social supports and/or improve coordination between physical & behavioral health
- Expands upon traditional medical home/PCMH models to provide intensive services for highest need patients
- Services defined by S. 2703, include:
 - Care management and coordination
 - Individual/family support
 - Referral to community support services
 - Use of health information technology to link services across settings
- 90% enhanced federal match for first 2 years of HH services
- Flexibility for payment methodology - many states use capitated PMPM fees, similar to MT's PCMH payment model

Use of Authority to Date

- Montana has not yet taken up this option, but is considering the option for those with behavioral health and chronic conditions

Key Takeaways for Montana SIM

- Montana would have to submit a SPA to pursue, requires CMS approval
- MT would need to develop care model that layers upon, but does not duplicate, its PCMH program
- Enhanced funding for Health Homes applicable to adults who are not eligible for the newly eligible FMAP.

TRIBAL HEALTH

Tribal Health Authority: Delivery/Payment Reform

Source of Authority

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

Scope of Authority

- Tribes may “contract” with IHS (under Title I of ISDEAA) to provide one or more IHS services, programs, functions, or activities (PFSAs) that the IHS would otherwise provide
- Tribes may “compact” with IHS (under Title V of ISDEAA) to assume full funding and control over one or more of these PFSAs
- Or, tribes may allow IHS to operate all PFSAs
- HIS/Tribal 638 facilities (including tribally run) are funded by appropriations and reimbursement from other payers.
 - Medicare and Medicaid pay an all-inclusive rate, negotiated between IHS and CMS each year.
- 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; emphasizes patient-centered care, primary care access, care teams, measuring improvements in care.

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

Tribal Health Authority: Urban Indian Health Programs

Source of Authority

- Indian Health Care Improvement Act
- Indian Self-Determination & Education Assistance Act

Scope of Authority

- IHS contracts with, and/or makes grants to, 34 nonprofit Indian health programs in urban areas nationwide
- Contract and grant terms dictate level of oversight IHS has over operation of these programs
- Programs provide services for American Indians who are not able to access IHS services due to eligibility, or because they reside outside of IHS and tribal service areas
- Some programs provide comprehensive health services and operate clinics, other run more limited health programs
- Supported by line item in IHS budget and may bill Medicaid and other payers – but:
 - They do not receive the all-inclusive IHS rate
 - State receives regular FMAP (not 100%) for payments

Use of Authority to Date

- There are 5 Urban Indian Health Programs in Montana, with services ranging from outreach and enrollment support to full FQHC medical services

Key Takeaways for Montana SIM

- Urban programs operate partially as IHS facilities (through contracts or grant terms) but also in part as Medicaid providers, and do not fit cleanly in either regulatory scheme
- Some urban programs may have ability to support and participate in reforms as Medicaid providers

LICENSING & BEHAVIORAL HEALTH

DPHHS Certificate of Need (CON) & Licensing Authority

Source of Authority

- Montana Code 50-5-304, 53-6-106
- Montana Rules, Chapter 37.106

Scope of Authority

- DPHHS may issue certificates of need and/or licenses (for 1-3 years) for certain types of health care facilities and services lines (including long term care, home health for CON; hospitals, outpatient physician, mental health for licensing) before they may be established, expanded, or renovated
- CON review standards may include, but are not limited to:
 - ✓ The need of the population in the service area
 - ✓ The impact of the proposal on health care costs and availability of a less costly/more effective alternative
 - ✓ Consistency with regional joint planning efforts
- Licensing standards may include, but are not limited to:
 - ✓ Staffing, administration, and training
 - ✓ Health services, social services and care planning

Use of Authority to Date

- MT has set basic standards for CON and licensing through rules and has developed a State Health Care Facilities Plan to focus the CON process on priority areas
- Licensing for mental health facilities is currently restricted by county – potentially impeding telehealth and other cross-county mental health services*

Key Takeaways for Montana SIM

- Standards for licensing and CON could be used to drive or enable reforms, address quality and supply, and address disparities
- CON and licensing are imposed only at certain “touch points” (e.g. renewals, new facilities, expansions, etc.)

*Perspective from interview with Mental Health provider

Behavioral Health Authority & Levers

Source of Authority

- SB 418

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 (see following slide)

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

Behavioral Health Lever: SAMHSA Funding

SAMHSA Funding Lever

- Montana mental health and substance abuse services funded in part by ~\$10 million in block grants from the Substance Abuse and Mental Health Services Administration (SAMHSA)
 - Montana develops block grant proposals every 2 years (proposal for FFY 2016-17 is under development)
 - Must be spent on services not covered by Medicaid
 - Grant stipulations require some funds to be used for substance abuse prevention, early serious mental illness
- Additional grant opportunities allow State to develop and test innovative models for behavioral health:
 - Certified Community Behavioral Health Clinics Grant
 - Co-Occurring Capacity Building Grant
 - Montana State Youth Treatment Implementation

Use of Lever to Date

- Montana recently applied for a Certified Community Behavioral Health Clinics planning grant, to assess readiness for mental health centers to become certified clinics – as specified by CMS and SAMSHA - and develop a prospective payment methodology for these services

Key Takeaways for Montana SIM

- SAMHSA funding is relatively flexible, and could be used to support capacity building and other behavioral health reform efforts in Montana, especially for services not covered by Medicaid

Behavioral Health Authority: Benefits & Parity

Source of Authority

- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), CMS regulation 78 FR 68240, SHO Letter #13-001
- ACA Section 1302, CMS Essential Health Benefits regulations 78 FR 42159, 78 FR 12834

Scope of Authority

- MHPAEA prohibits self-funded large group employer plans and issuers from imposing more restrictive limitations on MH/SUD benefits than on medical/surgical benefits
- Mental health and substance use benefits must be covered in parity with physical health benefits under ACA “Essential Health Benefits” law and regulations
 - Applies to individual market plans, small employer group plans, Medicaid expansion group and other Medicaid “Alternative Benefit Plan” recipients
- Insurance Commissioner uses authority to approve policy forms/benefit templates and consumer complaints (see slide 8) to prevent discrimination against people with mental illness and ensure compliance with minimum legal requirements

Use of Authority to Date

- Montana’s Insurance Commissioner has taken action to correct non-compliant plan designs, and to ensure payers re-processed claims and paid back consumers

Key Takeaways for Montana SIM

- Insurance Commissioner, working with CMS, can take action under existing authority to enforce parity and ensure non-discriminatory benefit design

Stakeholder Engagement & Next Steps



Stakeholder Engagement Update



Date	Meeting and Tentative Topics
October 6th 10 – 11:30 am	Stakeholder Webinar <ul style="list-style-type: none"> • SIM overview • Health care landscape • Levers and authority
October 23rd 9 – 10:30 am	Stakeholder Webinar <ul style="list-style-type: none"> • Case studies • Care delivery and payment transformation options
November 3rd 10 am – 2 pm	Governor's Council on Innovation and Reform Meeting <ul style="list-style-type: none"> • SIM overview and progress to date • Care delivery and payment transformation straw model
November 18th 1 – 3 pm	Healthier Montana Task Force <i>Great Northern Hotel, Helena</i>
December 3rd	Montana HealthCare Forum Conference <i>Hilton Garden Inn, Great Falls</i>



Get Involved

dphhs.mt.gov/sim

Jessica Rhoades

406.444.3666

jrhoades@mt.gov

Questions?

