Montana State Innovation Model Design

Preparatory Webinar for Governor’s Council

October 27, 2015
Agenda

11:00 – 11:05  Welcome and Introductions
11:05 – 11:10  SIM Overview
11:10 – 11:55  Examples of Value-Based Delivery and Payment Reforms
  • PCMH Expansion & Improvement
  • Behavioral & Physical Health Integration
  • Payment Reform
11:55 – Noon  Next Steps
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
PAYMENT & DELIVERY SYSTEM REFORM MODELS
## 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

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

**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
Vermont Blueprint for Health

Enhanced PMPM payments vary by NCQA recognition year and score
All payers fund CHTs at a cumulative annual cost of $350,000

Community Health Teams (5 FTEs)

Medicaid Members

Medicare

Medicare Members

Commercial Insurers

Commercial Members

Self-Insured Employers

State of Vermont, Hospitals

State & Other Employees

Community Health Teams (5 FTEs)

All Payer Claims Database

Commercial Insurers
In Vermont, community health teams provide support to citizens to ensure access to coordinated preventive health and social support services.

**CHT Design**

- Multidisciplinary team 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 Manager & Coordinator
- Certified Diabetes and Health Educators
- Community Health Worker
- Mental Health & 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

<table>
<thead>
<tr>
<th>Results for Calendar Year 2013</th>
<th>Medicaid</th>
<th>Commercial</th>
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</thead>
<tbody>
<tr>
<td>Number of Participating Beneficiaries</td>
<td>83,939</td>
<td>143,961</td>
</tr>
<tr>
<td>Total Medical Home Payments</td>
<td>$2,085,035</td>
<td>$3,576,002</td>
</tr>
<tr>
<td>Total CHT Payments</td>
<td>$2,343,603</td>
<td>$5,182,633</td>
</tr>
<tr>
<td>Total Investment Annual</td>
<td>$4,428,638</td>
<td>$8,758,635</td>
</tr>
<tr>
<td>Total Expenditures per Capita (participants)</td>
<td>$7,776</td>
<td>$4,954</td>
</tr>
<tr>
<td>Total Expenditures per Capita (comparison)</td>
<td>$7,877</td>
<td>$5,519</td>
</tr>
<tr>
<td>Differential per Capita (participant vs. comparison)</td>
<td>$101</td>
<td>$565</td>
</tr>
<tr>
<td>Total Differential (participants vs. comparison)</td>
<td>$8,477,839*</td>
<td>$81,337,965</td>
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</tbody>
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*Includes expenditures for special Medicaid services (SMS)
Payer and grant funding supports development of two CHTs to serve all community members regardless of insurance status.

Collaborative Planning process to define objectives, priority populations, CHT roles & staff, functions, activities & outputs.

Target Community Members:
- High risk pregnant women
- Geriatric/frail elderly population

Evaluation Outcomes, Return on Investment
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.
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
PCMHs may address access and workforce issues and engage otherwise hard to reach patients through telehealth.
Note: Pay-for-performance will be discussed in the value-based payment model section of the presentation.
Minnesota SIM Practice Transformation

- **Learning communities** led by experts, teaching and professional organizations offer intensive training opportunities for providers

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

- **Practice transformation grants** of up to $20,000 available to small and rural providers 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
Payer and grant funding supports practice transformation to (1) optimize existing PCMH practices and (2) support readiness of aspiring PCMH practices.
### 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
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**Pursue Value-based Payment Models**
- Migrate to pay-for-value and models that share risk and reward
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*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

<table>
<thead>
<tr>
<th></th>
<th>PCMHs</th>
<th>Medicaid Health Homes</th>
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<tbody>
<tr>
<td><strong>Populations served</strong></td>
<td>All populations</td>
<td>Individuals eligible under the Medicaid State Plan or a waiver who have:</td>
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<tr>
<td></td>
<td></td>
<td>- At least two chronic conditions*</td>
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<td></td>
<td></td>
<td>- One chronic condition and are at risk for another</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- One serious and persistent mental health condition</td>
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<tr>
<td></td>
<td></td>
<td>*Chronic conditions include: mental health, substance use, asthma, diabetes, heart disease, overweight</td>
</tr>
<tr>
<td><strong>Staffing</strong></td>
<td>Typically defined as physician-led primary care practices, but often include mid-level practitioners and other health care professionals</td>
<td>Designated provider or team of health care professionals; professionals may be:</td>
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<tr>
<td></td>
<td></td>
<td>- Based in primary care or behavioral health providers’ offices</td>
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<tr>
<td></td>
<td></td>
<td>- Coordinated virtually</td>
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<tr>
<td></td>
<td></td>
<td>- Located in other settings that suit beneficiaries’ needs</td>
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<tr>
<td><strong>Payers</strong></td>
<td>Multi-payer (Medicaid, Commercial, Medicare)</td>
<td>Medicaid</td>
</tr>
<tr>
<td><strong>Care focus</strong></td>
<td>Focused on delivery of traditional primary care services, enhanced use of health IT/HIE, patient-provider communication, etc.</td>
<td>• Strong focus on behavioral health integration</td>
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<tr>
<td></td>
<td></td>
<td>• Comprehensive care management</td>
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<tr>
<td></td>
<td></td>
<td>• Care coordination and health promotion</td>
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<tr>
<td></td>
<td></td>
<td>• Comprehensive transitional care from inpatient to other settings and follow up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Individual and family support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Referral to community and social support services</td>
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<td></td>
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<td>• The use of health IT to link services</td>
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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.

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<thead>
<tr>
<th>Community Mental Health Center (CMHC) and Primary Care (PC) Health Homes</th>
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<tbody>
<tr>
<td>• CMHC Health Homes serve members with serious mental illnesses or emotional disorders</td>
</tr>
<tr>
<td>• PC Health Homes serve members with multiple chronic physical conditions</td>
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<tr>
<th>Care Team Framework</th>
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<tbody>
<tr>
<td>• Established care team model and staffing ratios for each Health Home model</td>
</tr>
<tr>
<td>• Nurse care managers are seen as key to both models</td>
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<tr>
<th>Enhanced PMPM + Potential Shared Savings</th>
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<tr>
<td>• State annually reviews and adjusts each Health Home’s PMPM (CMHCs receive more than PC Health Homes)</td>
</tr>
<tr>
<td>• Shared savings may be available based on performance</td>
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</tbody>
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<thead>
<tr>
<th>18 Month Outcomes</th>
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<tbody>
<tr>
<td>• PC: PMPM cost decreased by $30.79 with a total cost reduction of $7.4M</td>
</tr>
<tr>
<td>• CMHC: PMPM cost decreased by $76.33 with a total cost reduction of $15.7M</td>
</tr>
</tbody>
</table>
Missouri Medicaid Health Homes

Missouri Department of Mental Health
- Provides quarterly lists of CMHC clients with care gaps as identified by HEDIS indicators
- Daily data transfer of new hospital admits/discharges
- PMPM to support health home services and activities
- Potential shared savings
- Attributes beneficiaries
- Providers may proactively enroll patients in Health Homes

CMHC Health Homes
Accredited by Council on Accreditation of Rehabilitation Facilities

Missouri Medicaid
- PMPM to support health home services and activities
- Attributes beneficiaries
- Providers may proactively enroll patients in Health Homes
- Potential shared savings

PC Health Homes
Accredited by National Committee for Quality Assurance

Missouri Primary Care Association
Provides administrative support

Sends/receives clinical data/reports

Medicaid Beneficiaries
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

- Health Home Director: 1:2,500
- Nurse Care Manager (RN): 1:250
- Care Coordinator: 1:500
- Behavioral Health Consultant: 1:750
- Physician Champion: 1:500

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

- Health Home Director: 1:500
- Nurse Care Manager (RN): 1:500
- Care Coordinator: 1:250
- Primary Care Physician Consultant: 1 hour/enrollee
- Patient: 1:250

CASE STUDY

CASE STUDY

CASE STUDY

CASE STUDY
Substance use and chronic condition Health Homes provide coordinated services to high need, high cost populations across payers.
Value-Based Payment Models

Expand Montana’s PCMH Program
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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

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

**Diagram**

- **PCMH**
- **Comprehensive Primary Care Initiative (CMMI)**
- **Health Homes** (Medicaid)
- **Episodes of Care** (multi-payer)
- **Other Care Models**
- **CPCi**
- **Episode-based care delivery**
- **Population-based care delivery**
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

Arkansas Medicaid
- Attributes beneficiaries to PCMHs (300 min.)
- Enhanced PMPM to support practice transformation and care coordination
- Shared savings
- Medicaid Information Interchange
- Practice progress reports, historical views of costs and quality
- Shared savings

QHPs Participating in the Private Option
- Enhanced PMPM to support practice transformation and care coordination
- Potential shared savings/risk arrangements

Commercial Insurers
- State & Wal-Mart Employees
- Employees

Self-Insured Employers
- State of Arkansas, Wal-Mart

Medicaid Beneficiaries
- Marketplace Members
- Commercial Members
- Medicaid Information Interchange
- Practice progress reports, historical views of costs and quality

PCMH Practices

Arkansas Medicaid

QHPs Participating in the Private Option

Commercial Insurers

Self-Insured Employers
- State of Arkansas, Wal-Mart

Medicaid Beneficiaries
- Marketplace Members
- Commercial Members
- State & Wal-Mart Employees
Arkansas Payment Improvement Initiative

Arkansas Medicaid & Commercial Insurers
- Continues to pay providers according to established fee schedule
- Determines shared savings/risk for PAPs
- Reviews claims to determine Principal Accountable Provider for each episode

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)

Providers
- Providers submit information not available through billing system and access quality and cost data

Medicaid & Commercial Members
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
NEXT STEPS
Delivery and Payment Reform Model Next Steps

- Convene Governor’s Council and obtain feedback
- 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