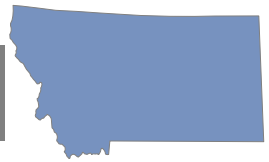
Montana State Innovation Model Design

Preparatory Webinar for Governor's Council

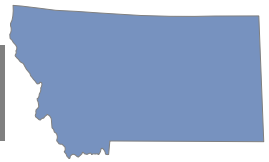
October 27, 2015

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

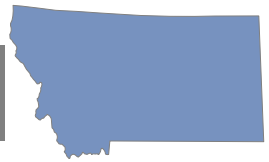


SIM OVERVIEW



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

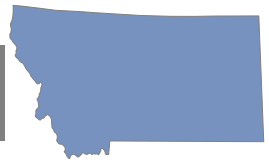


Montana SIM Goals

- 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



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

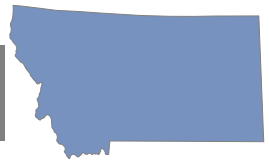
Integrate Physical and Behavioral Health

- 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

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



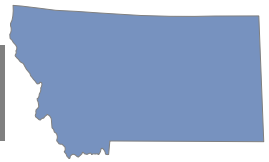
PCMH Components

Community Health Teams

Telehealth

Practice Transformation

Pay-for-Performance



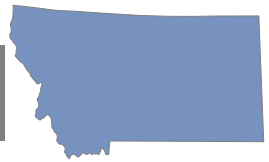
PCMH Community Health Teams

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

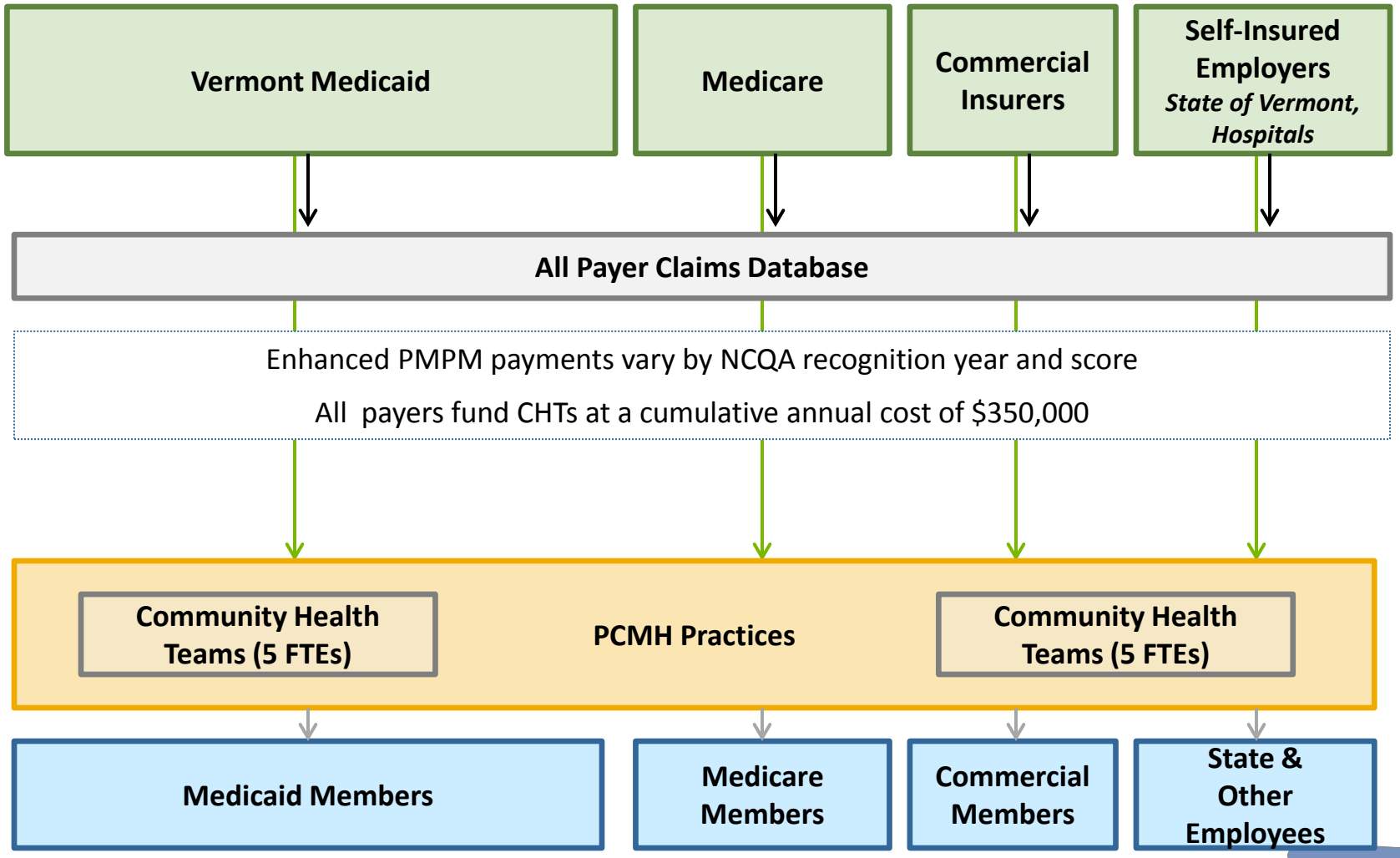
CHT Program Characteristics

- 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.

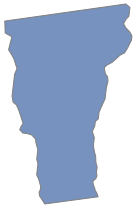


Vermont Blueprint for Health



Vermont Community Health Teams

CASE STUDY



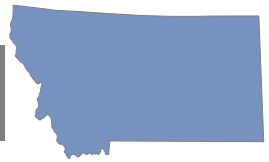
In Vermont, community health teams provide support to citizens to ensure access to coordinated preventive health and social support services

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



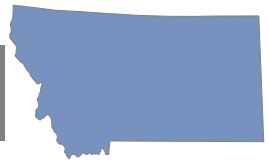
Vermont Community Health Teams

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

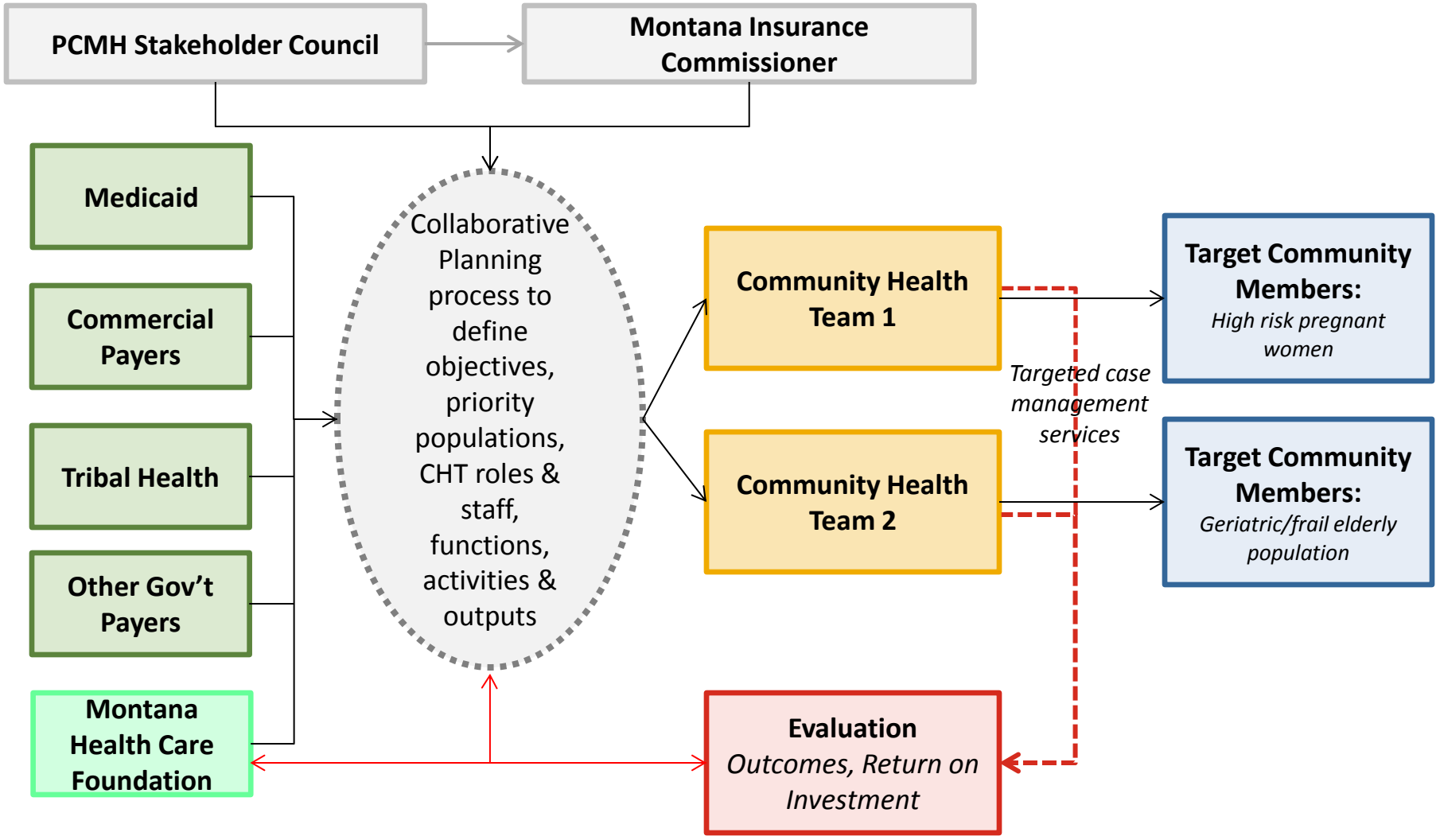
Results for Calendar Year 2013	Medicaid	Commercial
Number of Participating Beneficiaries	83,939	143,961
Total Medical Home Payments	$2,085,035	$3,576,002
Total CHT Payments	$2,343,603	$5,182,633
Total Investment Annual	$4,428,638	$8,758,635
Total Expenditures per Capita (participants)	$7,776	$4,954
Total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

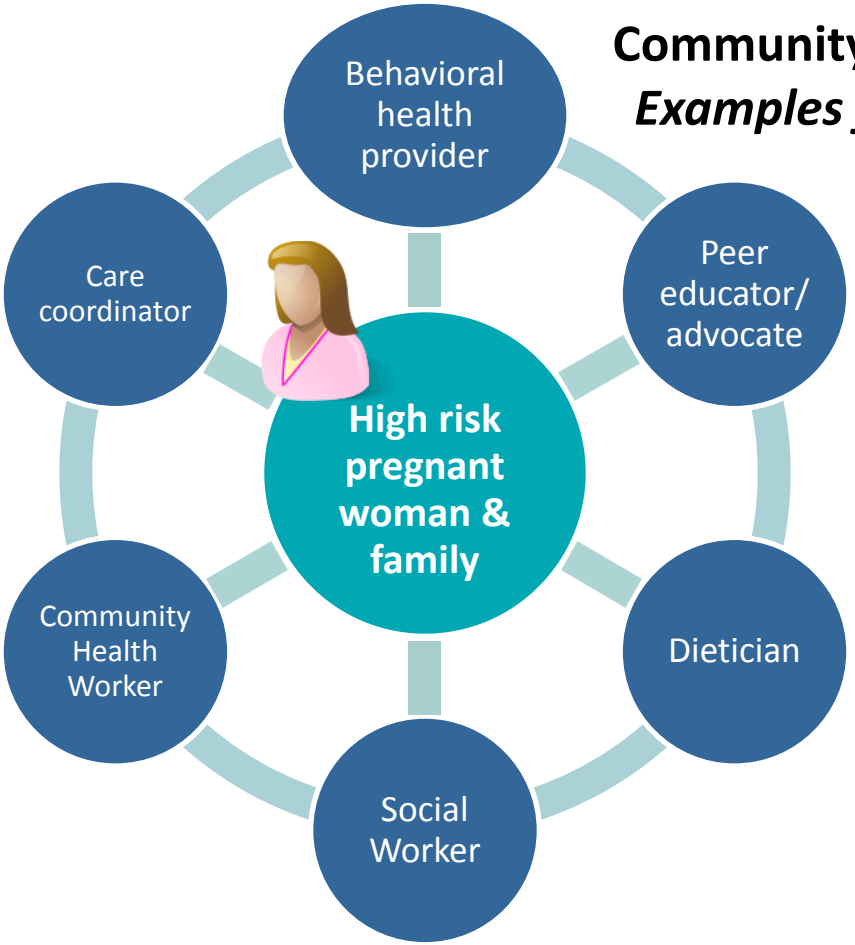
Payer and grant funding supports development of two CHTs to serve all community members regardless of insurance status



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



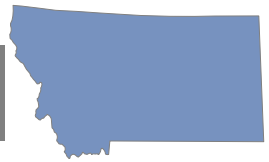
PCMH Components

Community Health Teams

Telehealth

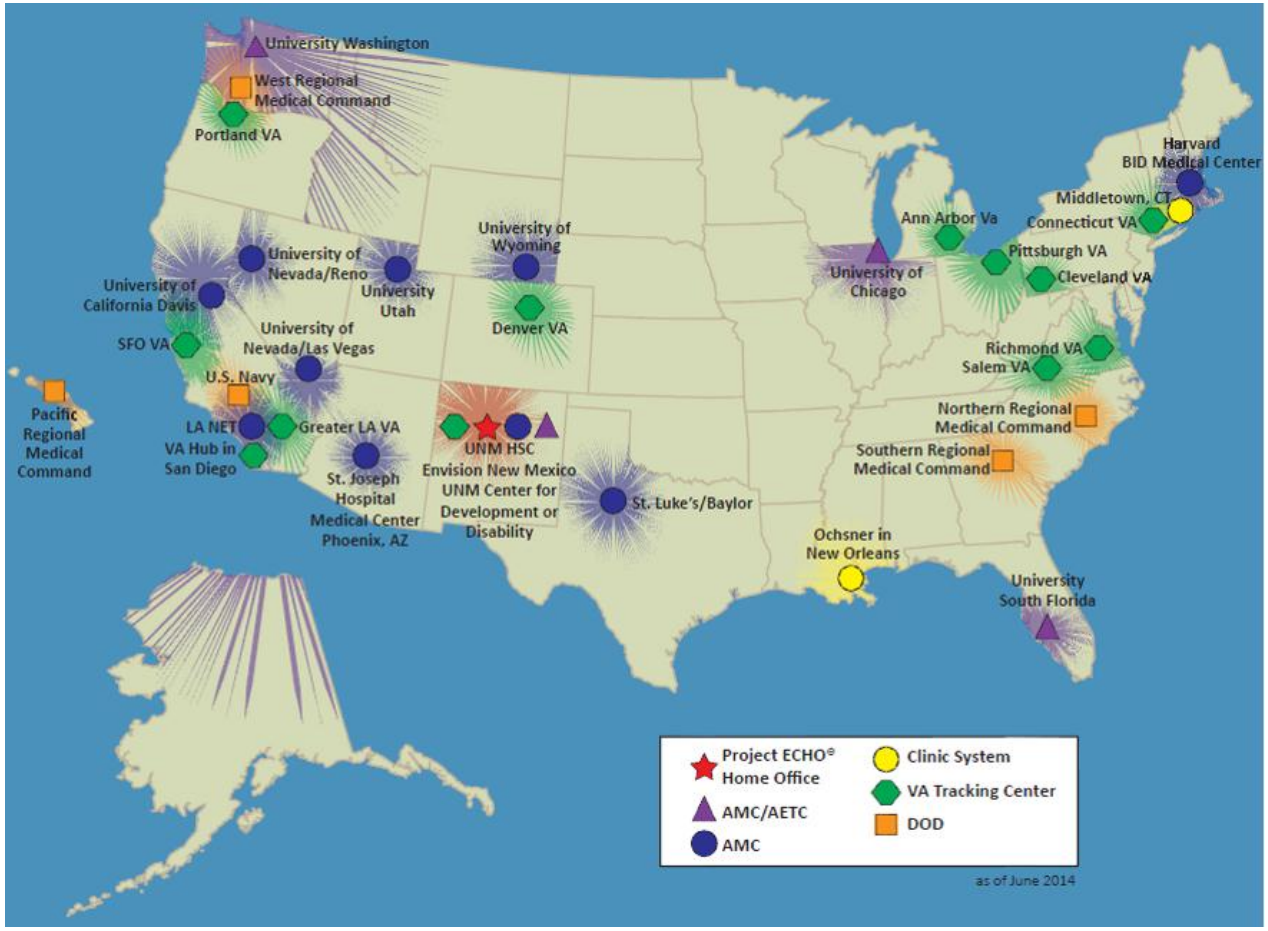
Practice Transformation

Pay-for-Performance



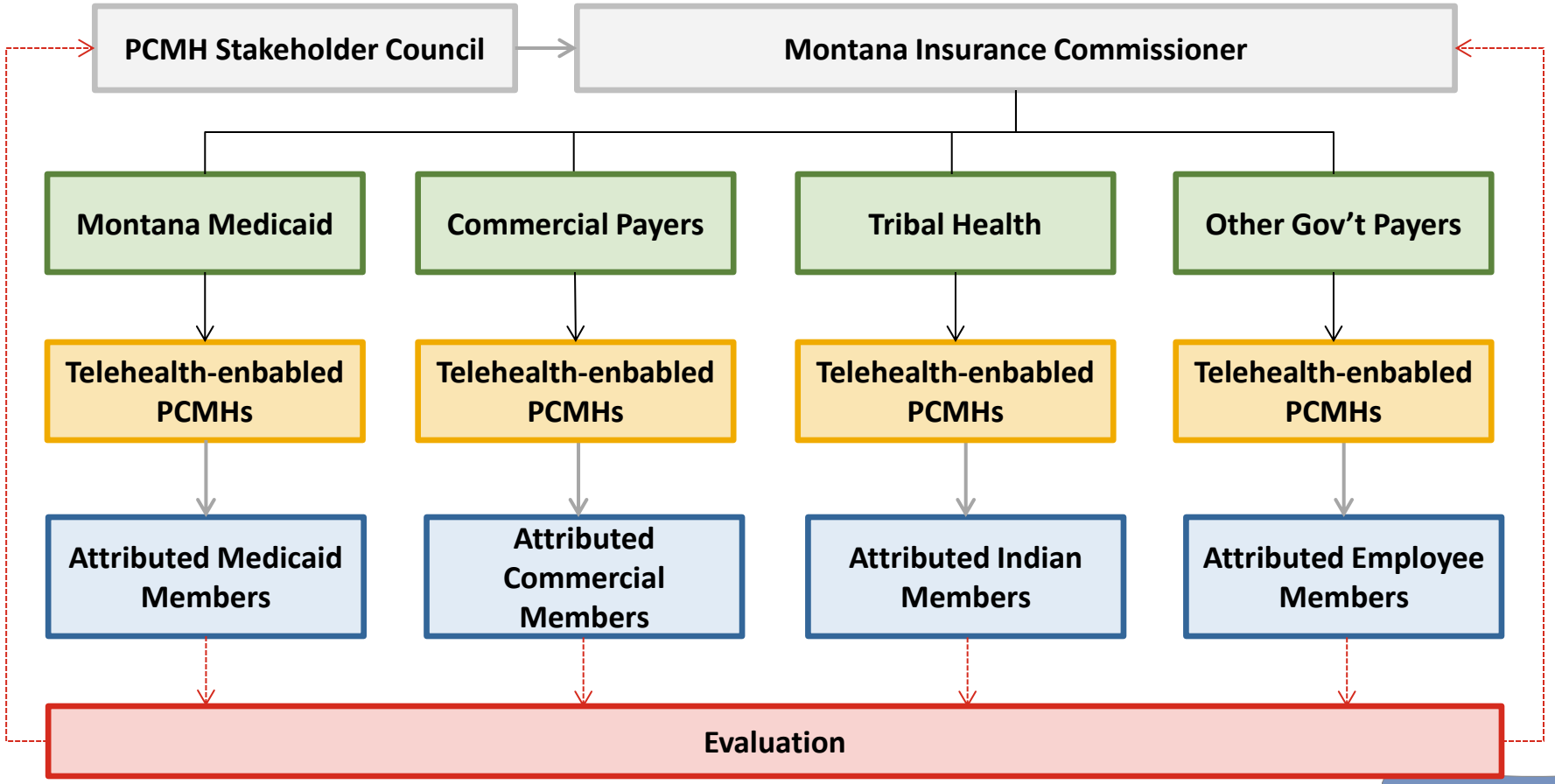
Project ECHO

- 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.



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

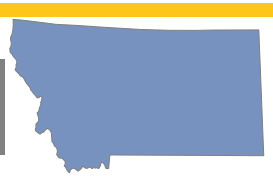
✓ **Learning communities** led by experts, teaching and professional organizations offer intensive training opportunities for providers

✓ **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

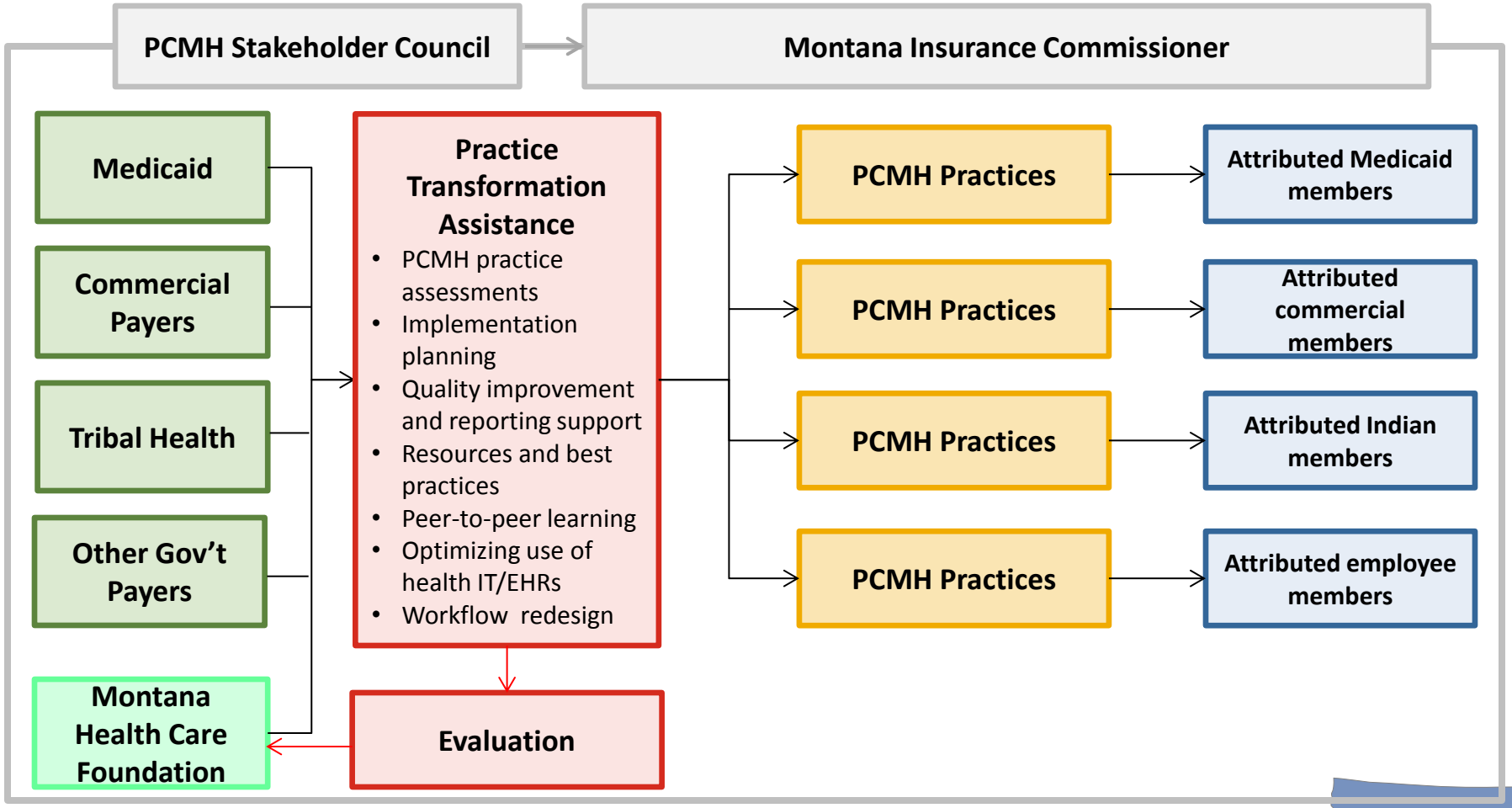
✓ **Workforce grants** help providers hire and integrate new professionals into care delivery teams

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



PCMH Practice Transformation Model – *DRAFT*

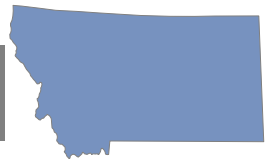
Payer and grant funding supports practice transformation to (1) optimize existing PCMH practices and (2) support readiness of aspiring PCMH practices.



Integrated Physical & Behavioral Health

Expand Montana's PCMH Program	Integrate Physical and Behavioral Health	Pursue Value-based Payment Models
▪ 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	▪ 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	▪ 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



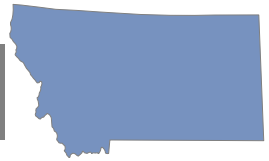
Integrated Physical & Behavioral Health: PCMH and Medicaid Health Homes

	PCMHs	Medicaid Health Homes
Populations served	All populations	Individuals eligible under the Medicaid State Plan or a waiver who have: • At least two chronic conditions* • One chronic condition and are at risk for another • One serious and persistent mental health condition **Chronic conditions include:* mental health, substance use, asthma, diabetes, heart disease, overweight
Staffing	Typically defined as physician-led primary care practices, but often include mid-level practitioners and other health care professionals	Designated provider or team of health care professionals; professionals may be: • 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.	• 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

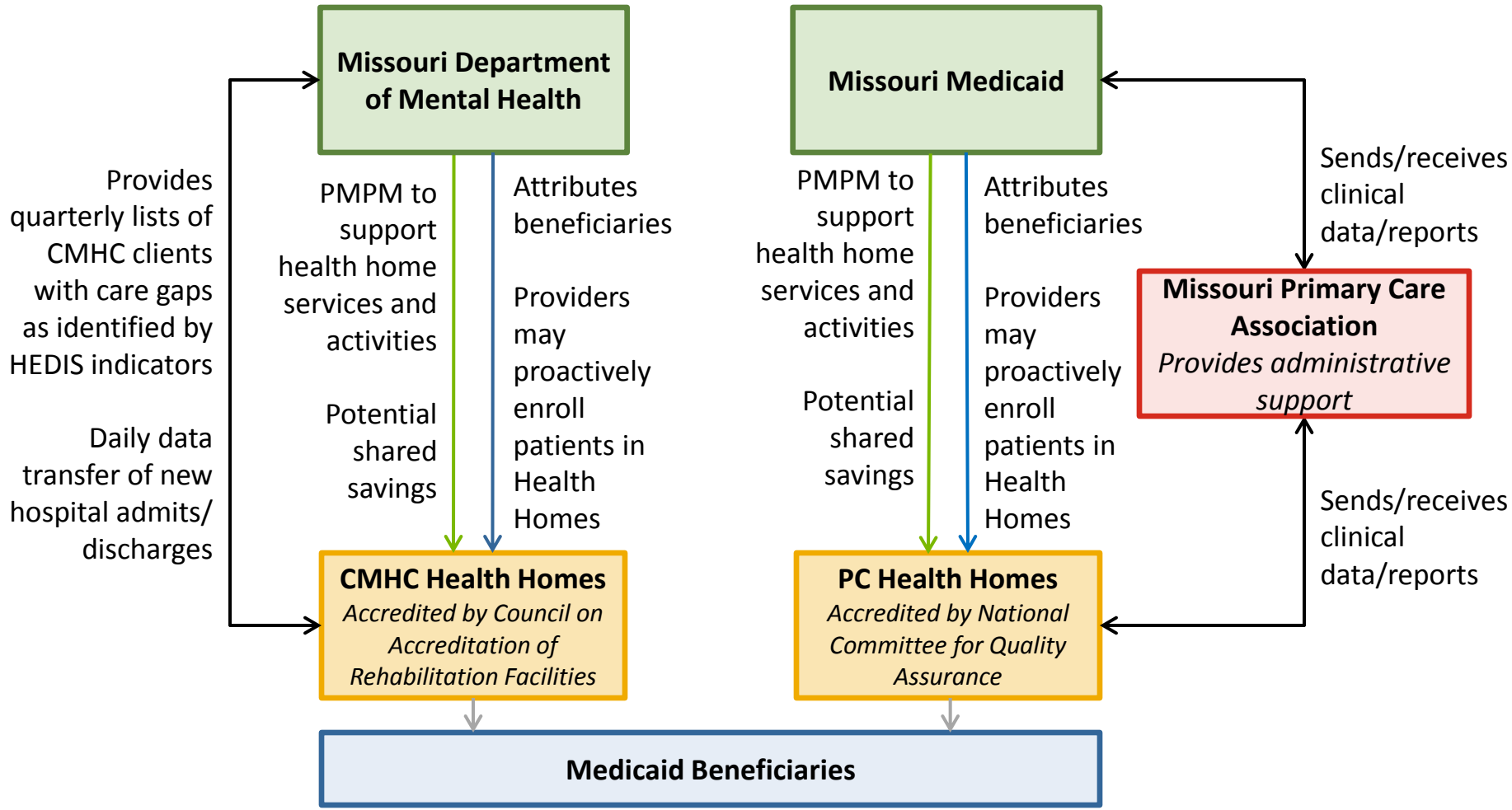
Missouri Medicaid Health Homes

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



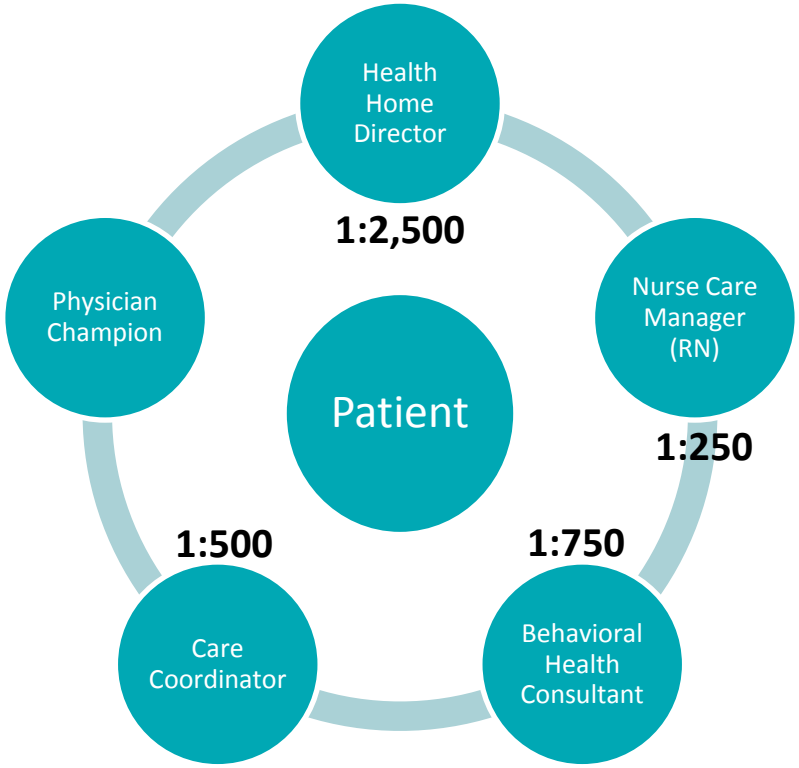
Missouri Medicaid Health Homes



Missouri Medicaid Health Homes

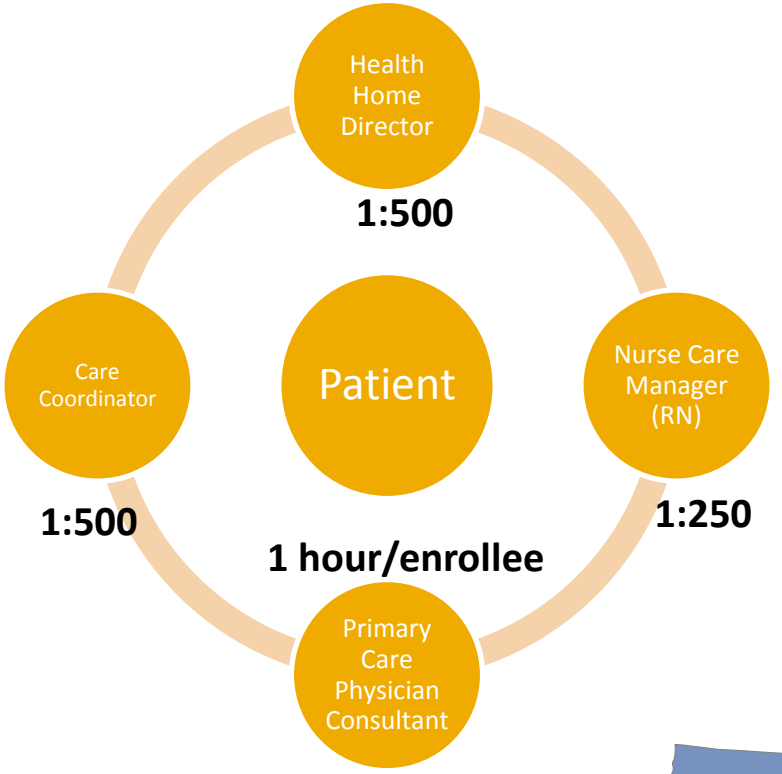
PC Health Homes Staffing Model/Ratios

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



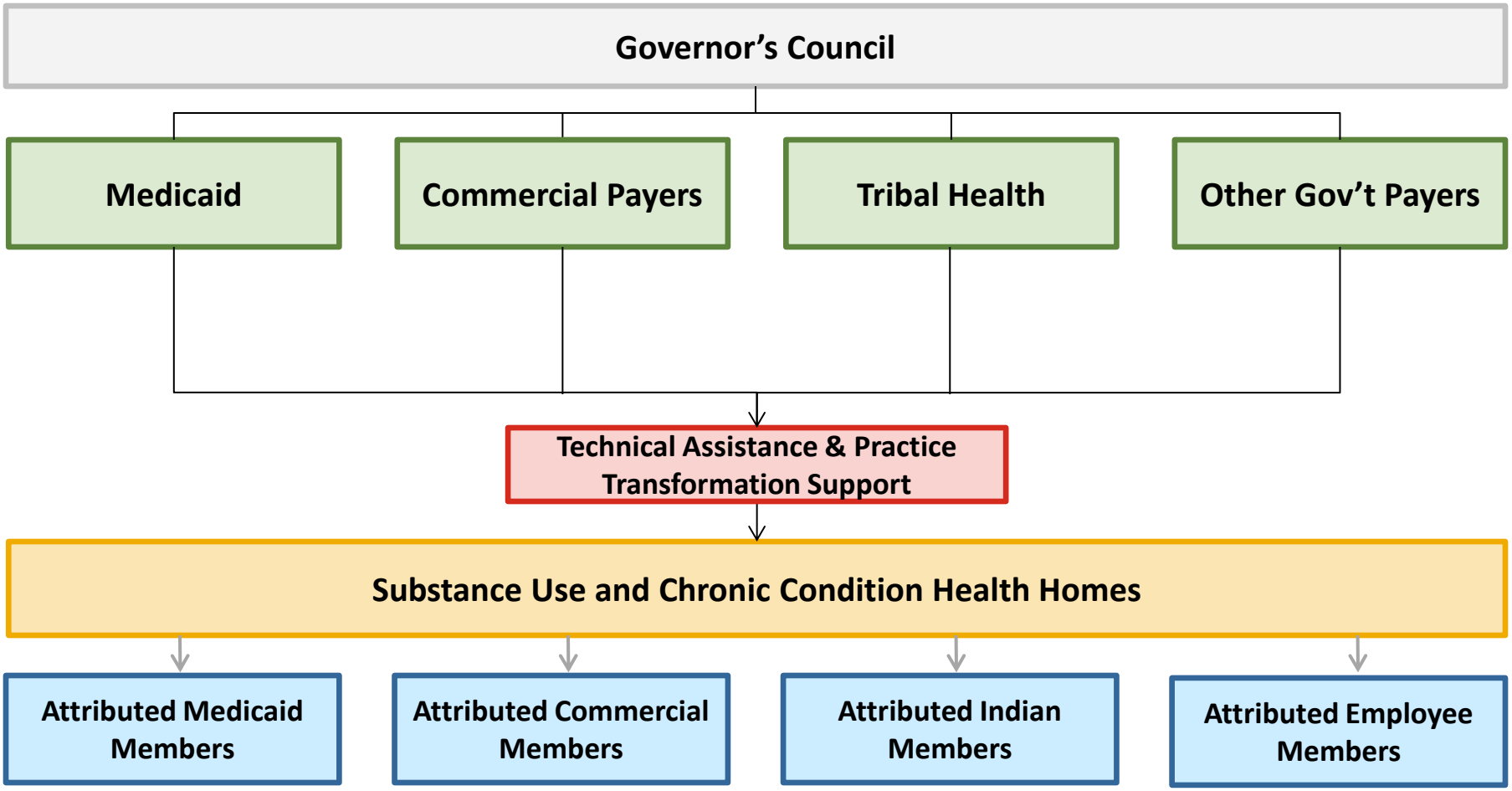
CMHC Health Homes Staffing Model/Ratios

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*

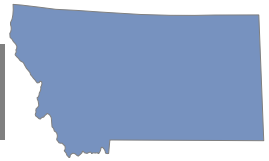
Substance use and chronic condition Health Homes provide coordinated services to high need, high cost populations across payers



Value-Based Payment Models

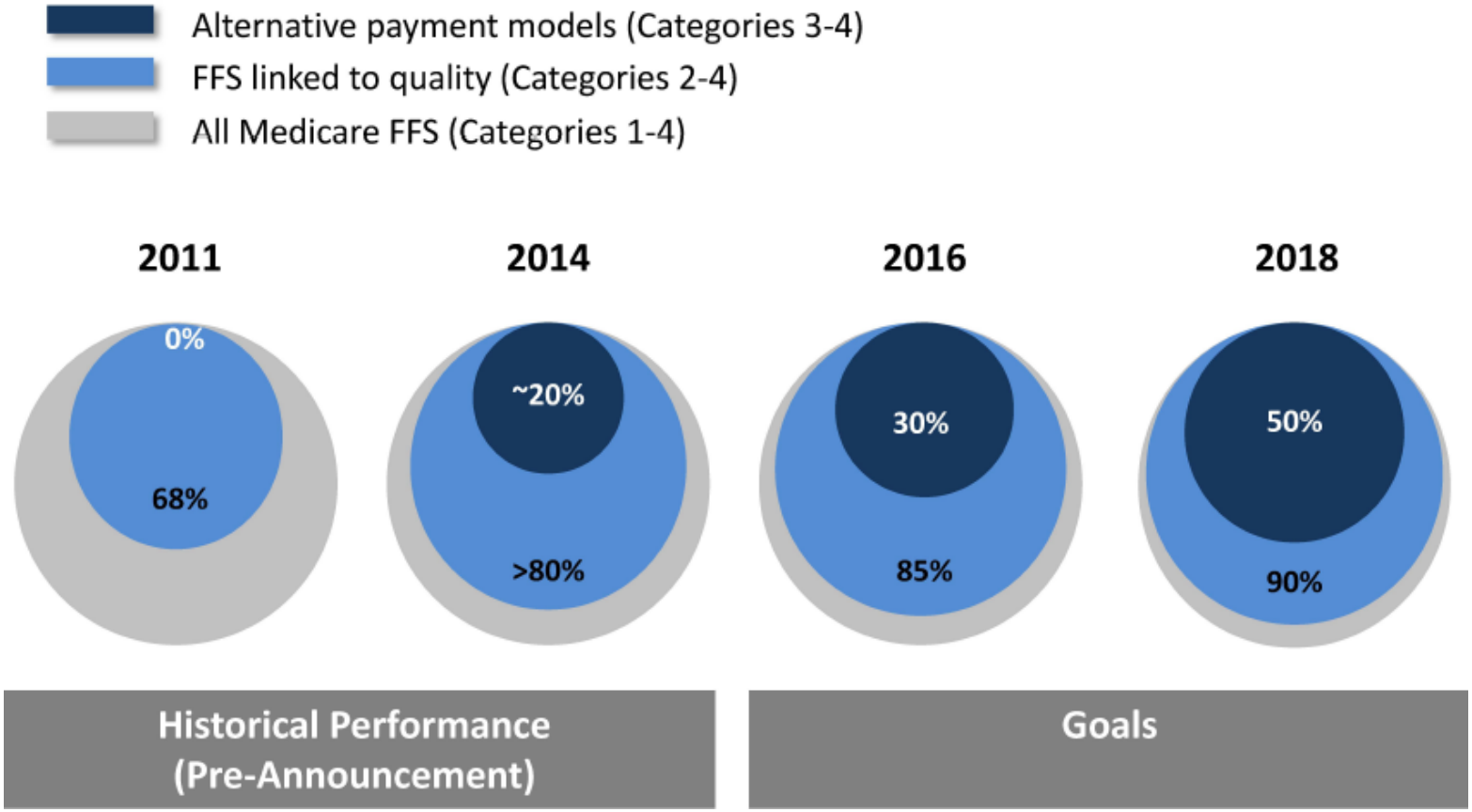
Expand Montana's PCMH Program	Integrate Physical and Behavioral Health	Pursue Value-based Payment Models
▪ Utilize existing Program oversight ▪ Support practice transformation ▪ Expand standardized quality reporting across public and private payers ▪ Utilize telehealth to address rural access issues and workforce shortages ▪ Transition from pay-for-reporting to pay-for-performance	▪ 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	▪ 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



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



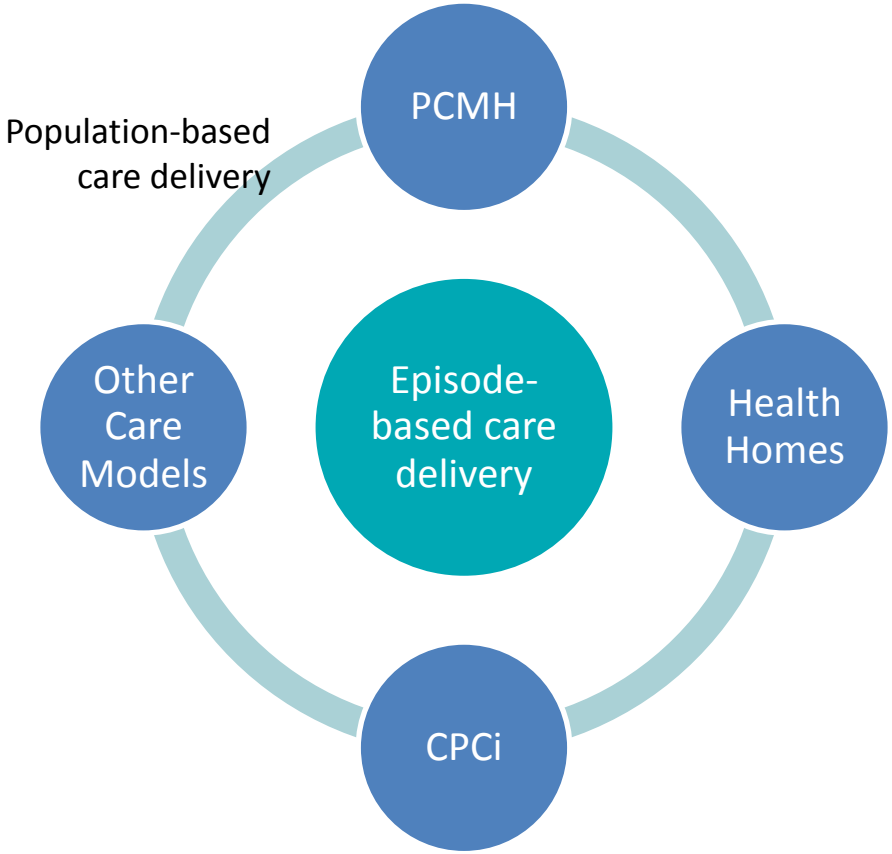
Source: HHS, October 2015

Arkansas Payment Improvement Initiative

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

Care Models

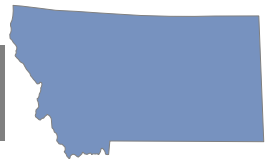
- **PCMH** (multi-payer) – Providers receive enhanced PMPM payments to support practice transformation
  - **Comprehensive Primary Care Initiative** (CMMI) – 69 primary care practices participate in multi-payer transformation initiatives
  - **Health Homes** (Medicaid)– Provide increased levels of care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



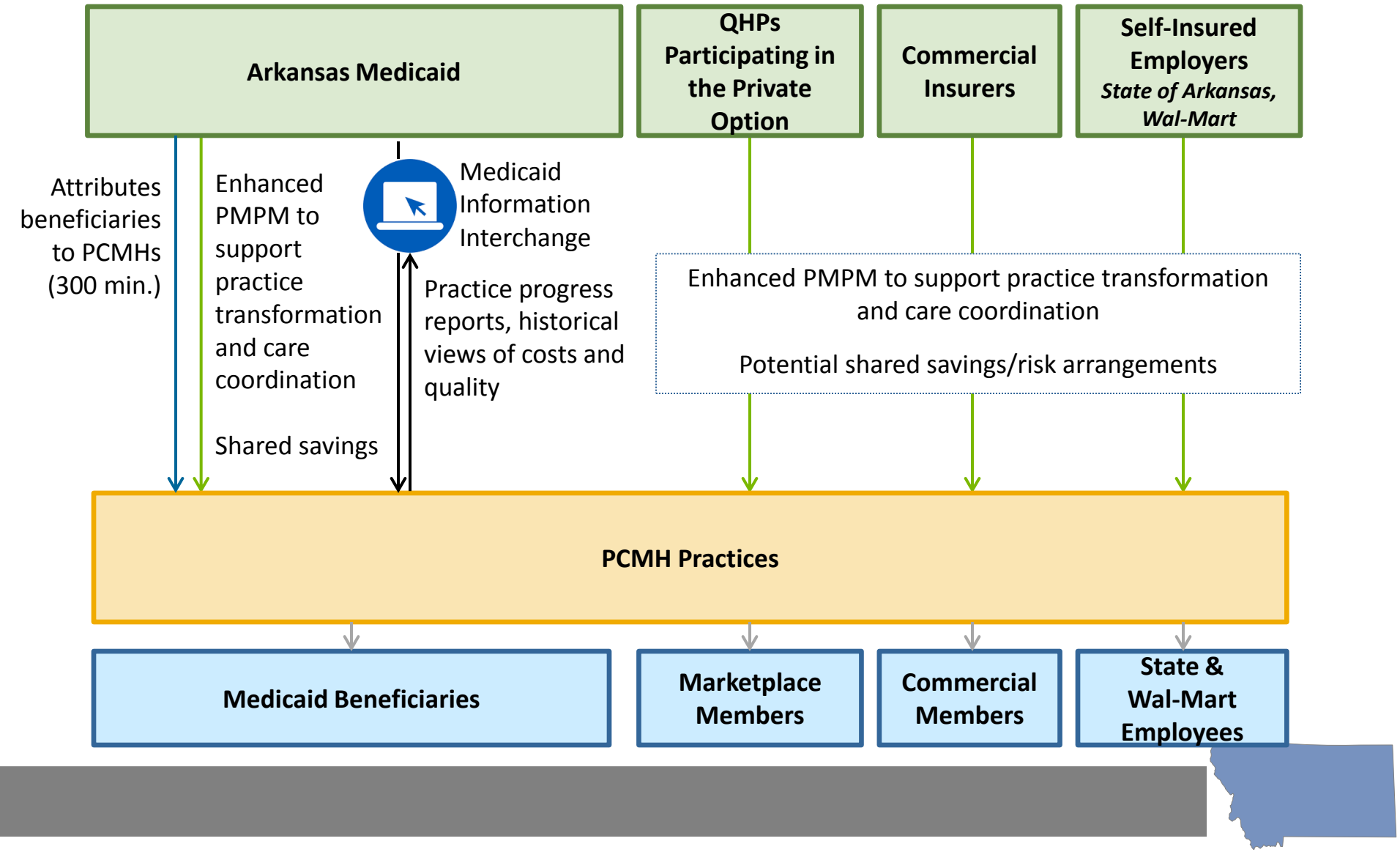
Arkansas Payment Improvement Initiative

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

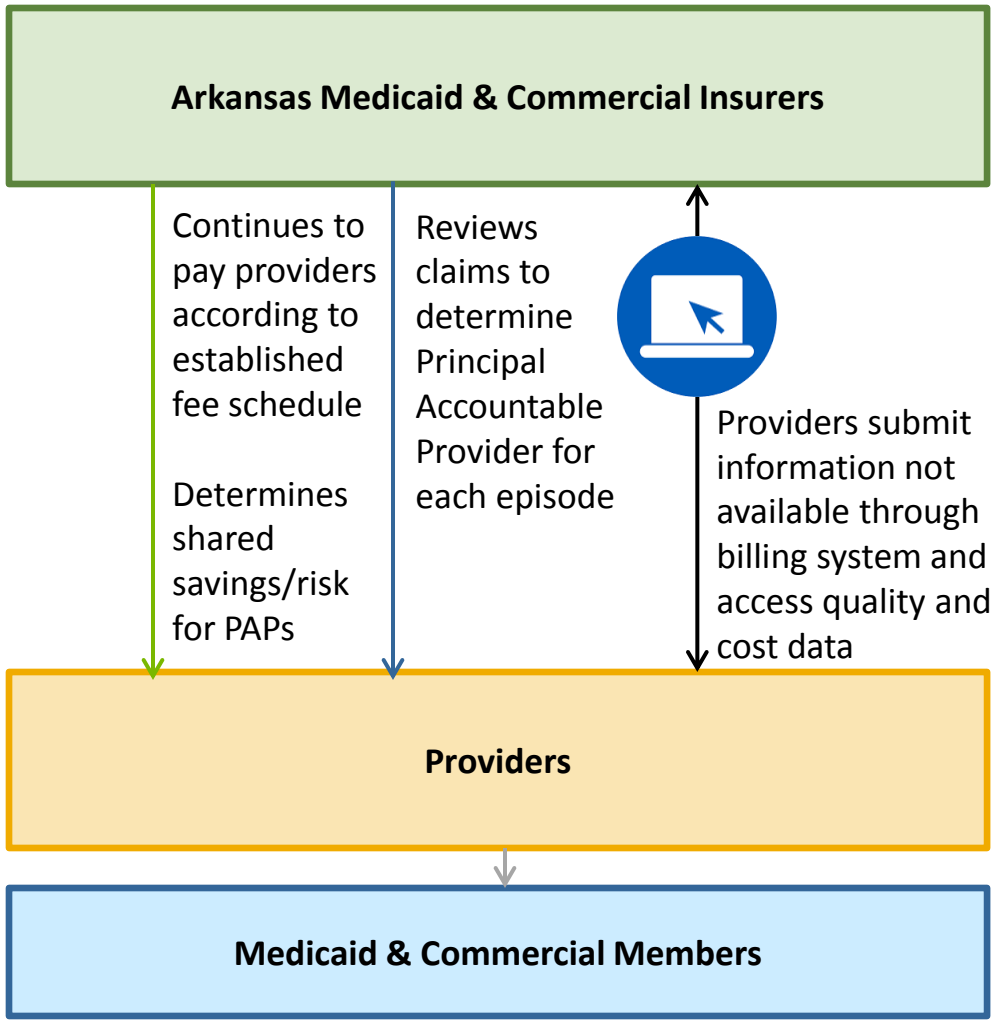
Program Authority and Levers Facilitate multi-payer Delivery System Transformation	• PCMH: QHPs and Medicaid managed care plans must participate; Medicare participates through Comprehensive Primary Care Initiative • Episode-based payments: Medicaid and commercial payers
Care Model Emphasizes Care Coordination 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



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

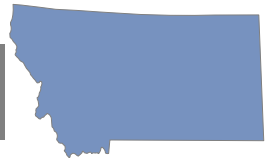
- Encourage payers participating in the PCMH program to incorporate pay-for-performance into PCMH payment model
- Insurance Commissioner reviews and approves PCMH pay-for-performance programs
- Continue fee-for-service reimbursement, but encourage payers to move to value-based payment models that incorporate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



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