

# Montana State Innovation Model Design

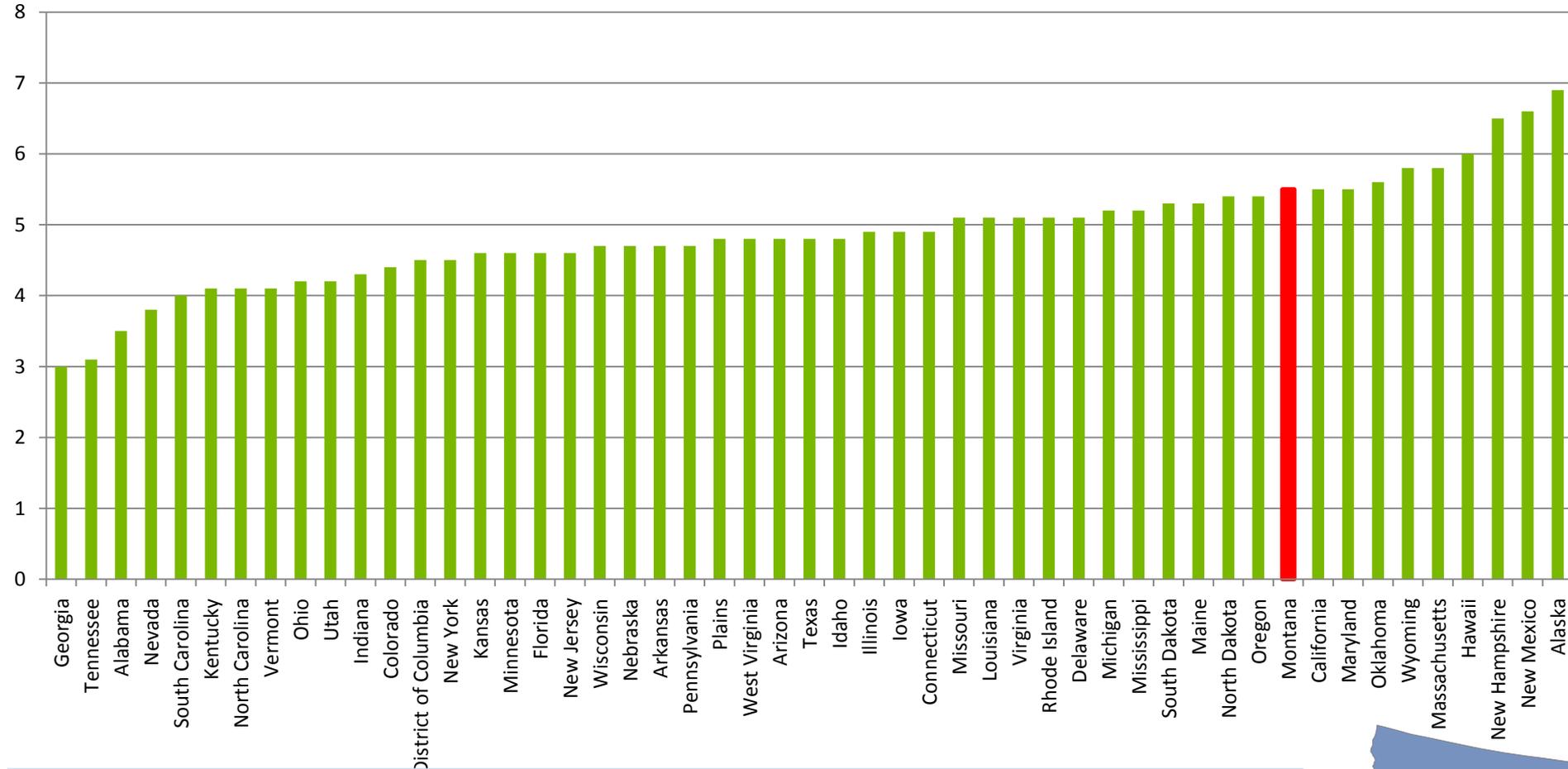
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December 3, 2015



# Percent Increase in Per Capita Health Spending by State

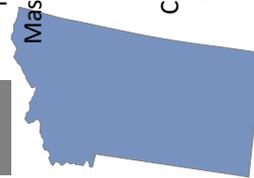
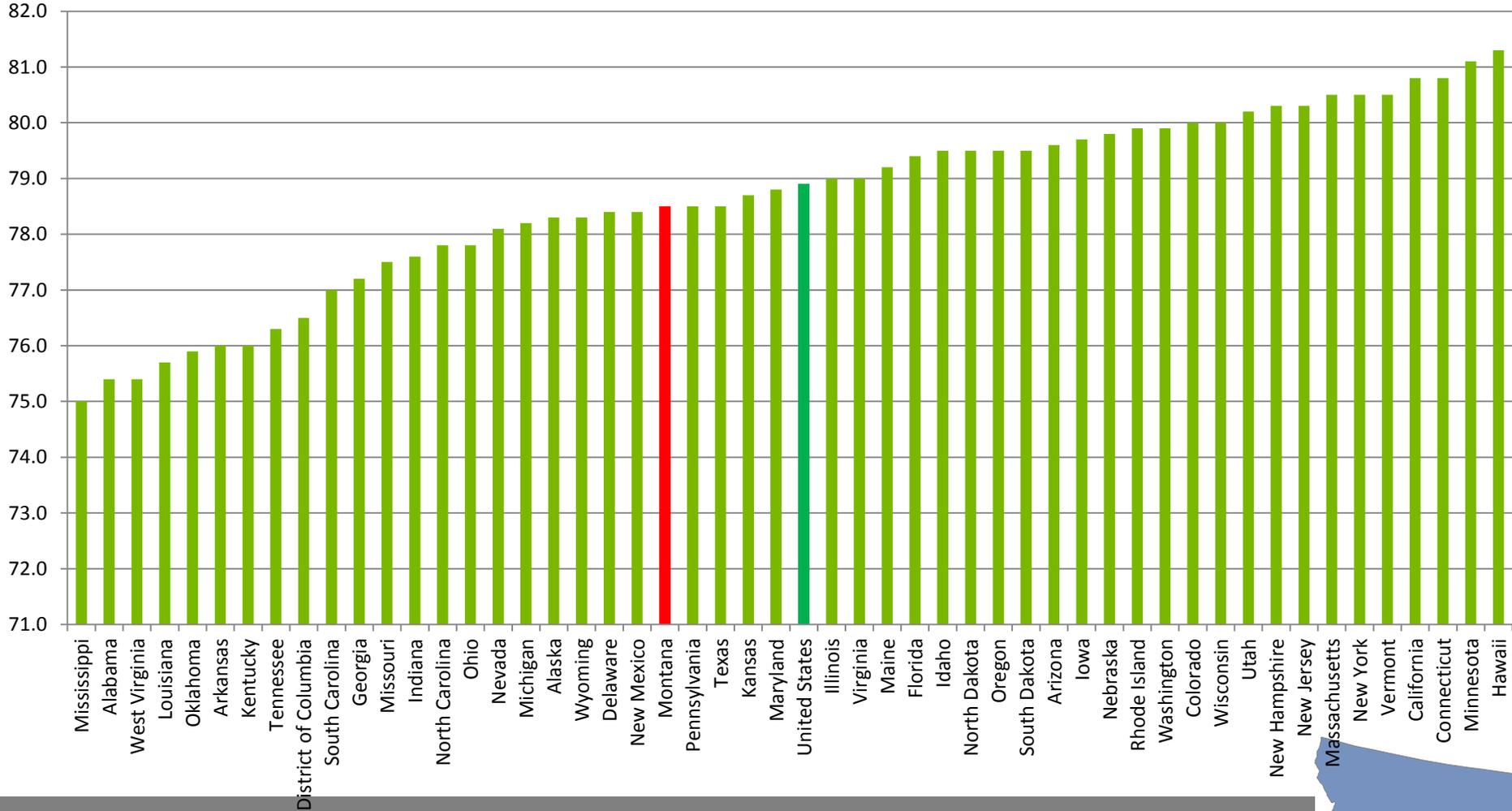
Across all payers 2004-2009



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

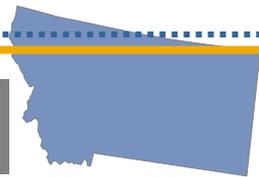


# Life Expectancy at Birth, 2009



# Montana SIM Award Overview

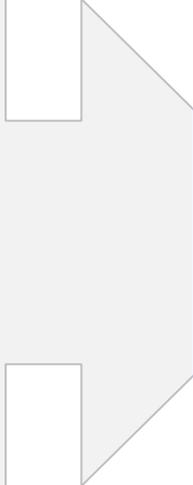
- Center for Medicare & Medicaid Innovation initiative
- SIM application submitted on July 21, 2014 to design a State Health Care Innovation Plan to support multi-payer delivery and payment system transformation
  - Received letters of support for the application from state's major payers, providers 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





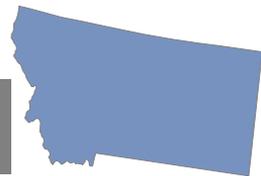
# Montana SIM Goals

- 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



# How This Initiative Matters to Everyone



## Patient Perspective

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



## Employer Perspective

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



## Health Plan/Payer Perspective

- 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



## Provider Perspective

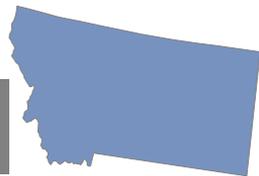
- Better care for patients
- Increased satisfaction
- Financial support for previously uncompensated services
- Compensation based on value of care and quality rather than volume
- Team-based care

# 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:

- Key stakeholders
- State needs, opportunities and flexibility to implement value-based payment transition
- Existing value-based payment models in Montana
- Medicare value-based transition plan
- Multipayer alignment

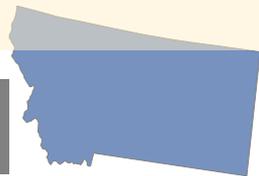


# Governor's Council Charge

*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
- ✓ 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

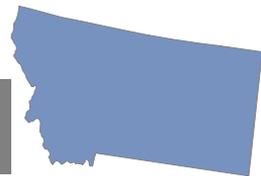


# Governor's Council

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## Providers

- ✓ **Lenette Kosovich**, CEO, Rimrock Substance Use Disorder Treatment Center
- ✓ **Maria Clemons**, Executive Director of Northwest Community Health Center
- ✓ **Eric Arzubi**, Chair of the Dept. of Psychiatry at the Billings Clinic
- ✓ **John Felton**, President and CEO of Riverstone Health in Billings
- ✓ **Jeffrey Fee**, CEO of St. Patrick Hospital in Missoula.
- ✓ **Bill Gallea**, Owner of Lewis and Clark Emergency Physicians
- ✓ **John Goodnow**, CEO of Benefis Health System in Great Falls.
- ✓ **Michael Vlases**, Chief of Staff at Bozeman Deaconess Hospital
- ✓ **Bob Marsalli**, Executive Director of the Montana Primary Care Association
- ✓ **Steve McNeese**, CEO, Community Hospital of Anaconda
- ✓ **Jon Goodnow**, CEO, Benefis Health System



# Governor's Council (continued)

## Private Payers

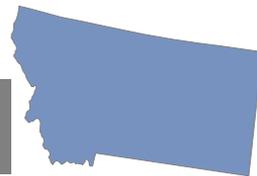
- ✓ **Michael Frank**, CEO, Montana BCBS
- ✓ **Todd Lovshin**, VP and Montana Regional Director, PacificSource
- ✓ **Dr. Jonathan Weisul**, Clinical Advisor for Population Health Allegiance Benefit Plan

## Public Payers and Leaders

- ✓ **Tara Veazey**, Governor Bullock's healthcare policy advisor
- ✓ **Monica Lindeen**, Montana Commissioner of Securities and Insurance
- ✓ **Sheila Hogan**, Director of the Montana Department of Administration (State Employee Health Plan)
- ✓ **Richard Opper**, Director of the Montana DPHHS (Medicaid, Healthy Montana Kids)

## Tribal Health Leaders and Health Care Experts

- ✓ **Keith Bailey**, Executive Director, Health Indian Alliance (FQHC)
- ✓ **Aaron Wernham**, CEO, Montana Health Care Foundation
- ✓ **Anna Whiting Sorrell**, Patient/Citizen Advocate
- ✓ **Janelle Nelson**, Executive Director of Montana Independent Health Alliance
- ✓ **Dr. Bill Reiter**, Reiter Foundation



# Leadership Committee

- **Tara Veazey** - Project Sponsor and Governor Bullock's Health Policy Advisor
- **Lesia Evers** – DPHHS Tribal Relations Manager
- **Christina Goe** – Office of Insurance Commissioner
- **Todd Harwell** – Public Health and Safety Division Administrator
- **Mary Dalton** – Medicaid Director
- **Sarah Medley** – Mountain Pacific Quality Health Foundation CEO
- **Connie Welsh** – Montana University System Health Plan
- **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
- **Kelley Gobbs** -- DPHHS PCMH Program
- **Jessica Rhoades** – SIM Project Director and DPHHS Intergovernmental Relations



# Snapshot of Montana Coverage



## 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.<sup>+</sup>

## 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).

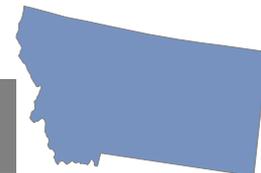
- The State Employee Plan administers six state-run primary care clinics.

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

## Uninsured

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

<sup>+</sup> 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.



# Montana's PCMH Program

## 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

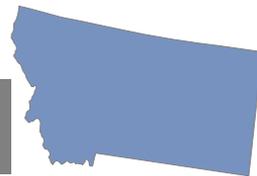
## Quality

- 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

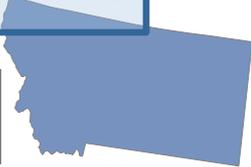
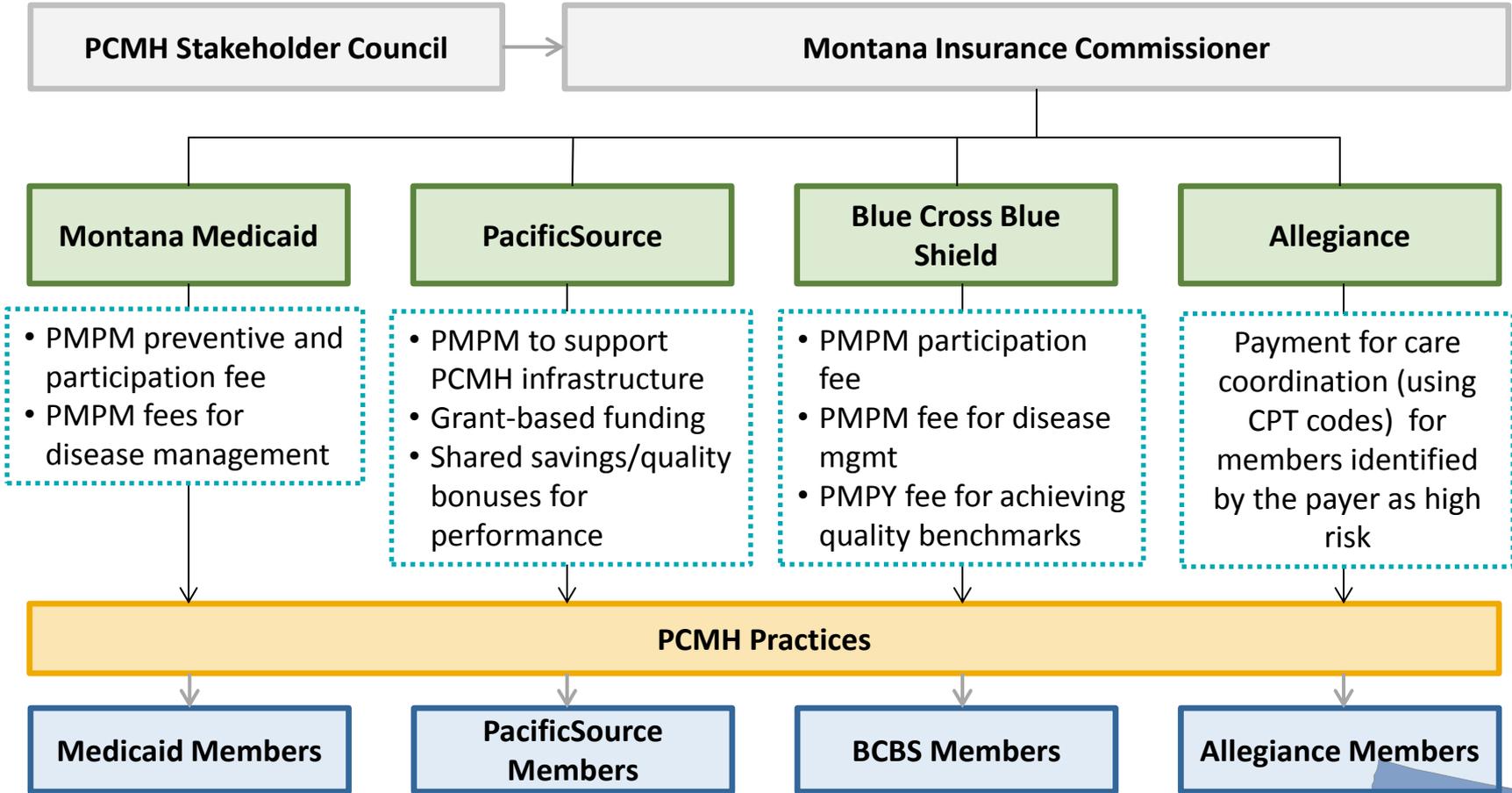


- 70 PCMHs participated
- Popular elements of practice transformation included:
  - Same day appointments
  - Patient portals
  - Clinical advice outside of office hours
- Initial quality results are promising
  - Rates of hypertension, diabetes, and tobacco use were close to or lower than national and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



# Montana's Foundation for Delivery System Reform and Payment Transformation

## Montana's existing PCMH program is a good foundation



# Medicaid Expansion Reforms



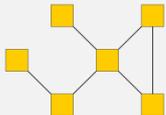
- ✓ **Health Risk Assessments (HRAs)** will provide screenings for patients and match them to preventive care and other service needs.



- ✓ **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

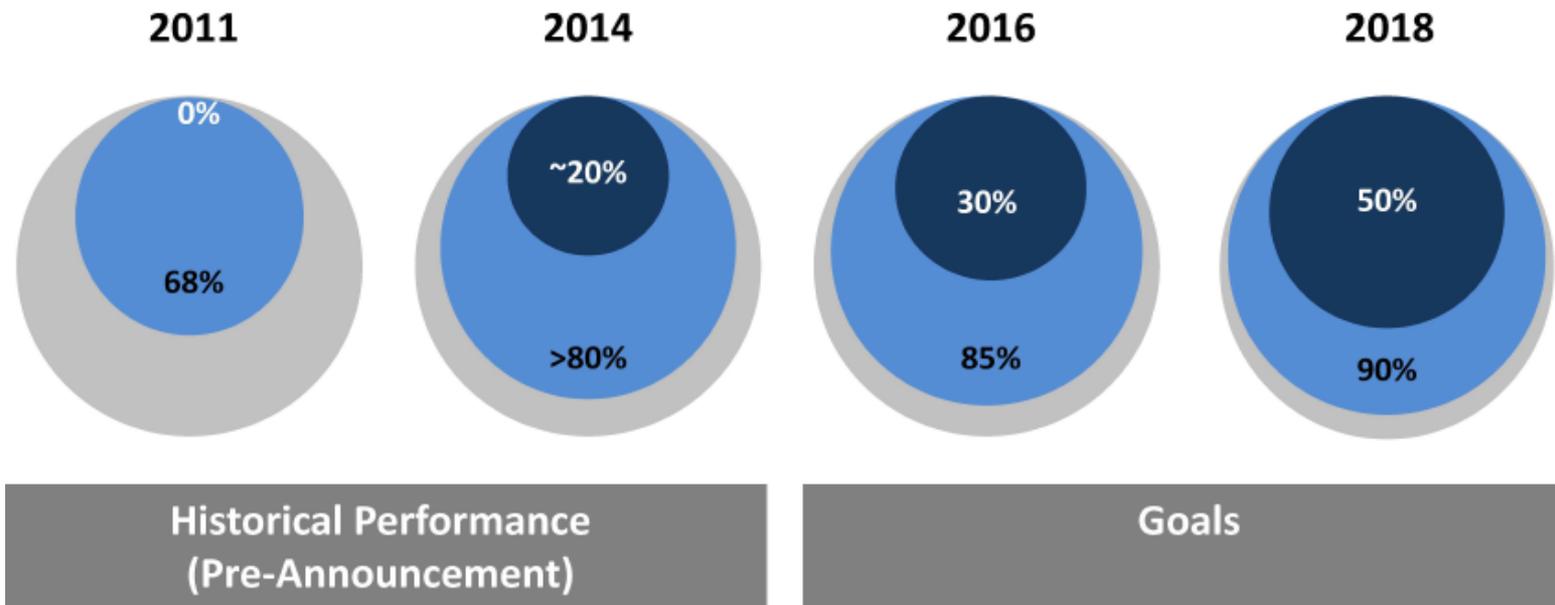


# Medicare is Transitioning to Value-Based Payment

*“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



# Started with Key Interviews

## 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 Olfeld, 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

# Delivery and payment models

Considerations guiding 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
- Coordinated or accountable care models
- Telehealth pilot
- Public health system
- Others

## Can the model address identified gaps?

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

## Identify existing efforts in integration

- Where are their opportunities for alignment with existing behavioral health integration efforts and work to address health disparities.

*How can the State use its Flexibility and Opportunities to advance multi-payer delivery system reform?*



# Governor's Council Themes

*Takeaway: Stakeholders want to be part of the change and need a common agenda*

## Key Issues

1. Behavioral and physical health integration, including substance use/chemical dependency and mental health
2. Disparities and social determinants of health
3. Health information exchange (HIE) and telehealth

### Challenges

- Workforce
- Rural nature of the state/access to care
- Lack of data/HIE infrastructure
- Funding/financing for new initiatives

### Opportunities & Solutions

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



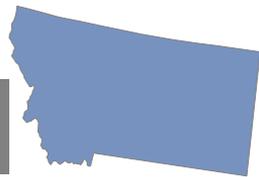
# Components that could help integrate behavioral and physical health

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PCMH/Medicaid  
health homes

Community  
health teams

Telehealth

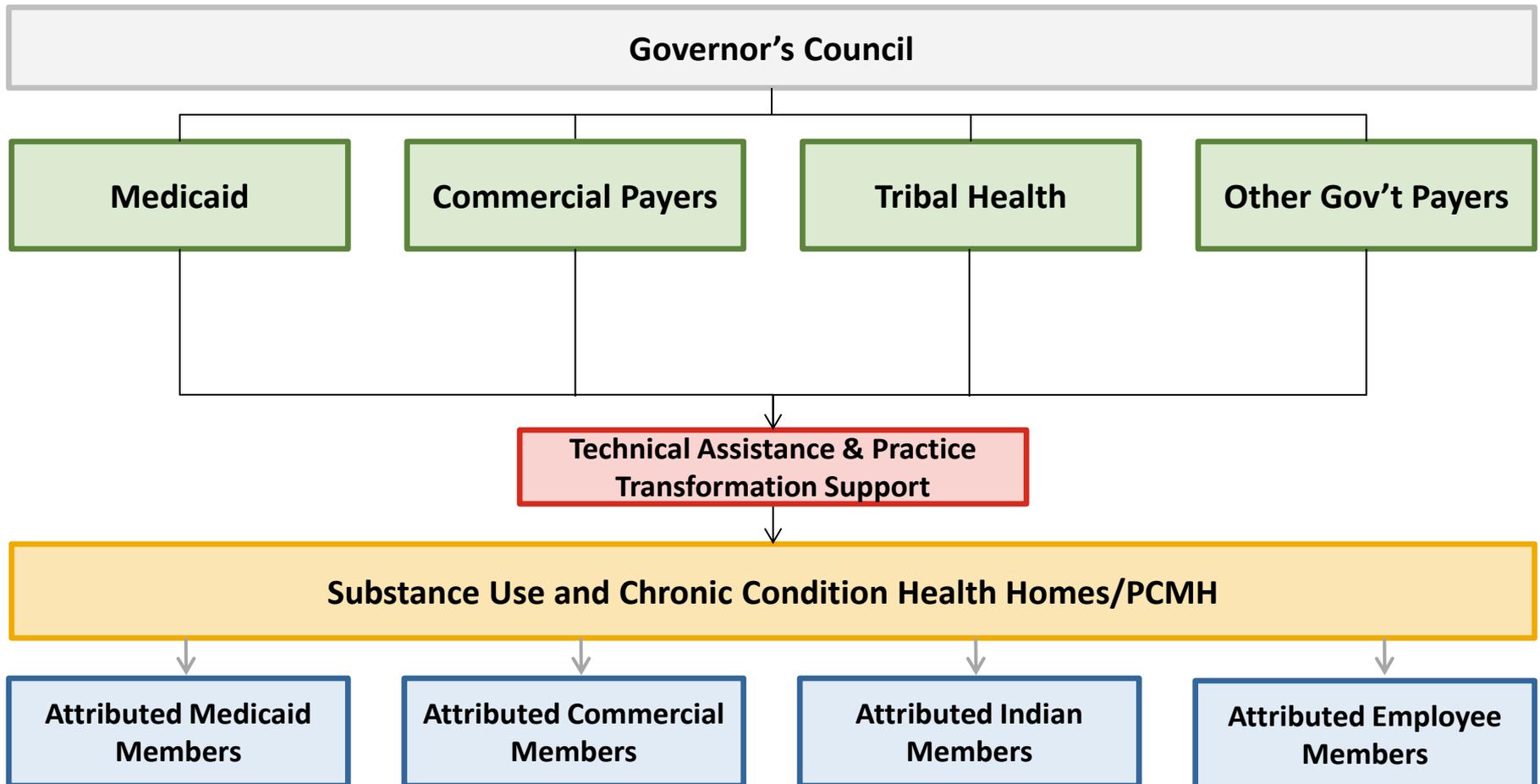


# Integrated Physical & Behavioral Health: PCMH Compared to Medicaid Health Homes

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

# Integrated Physical and Behavioral Health EXAMPLE:

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



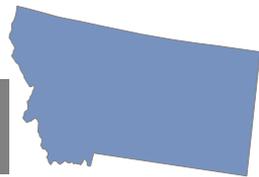
# Delivery Model Components Overview

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PCMH/Medicaid  
health homes

Community  
health teams

Telehealth



# Community Health Teams

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

## CHT Program Characteristics

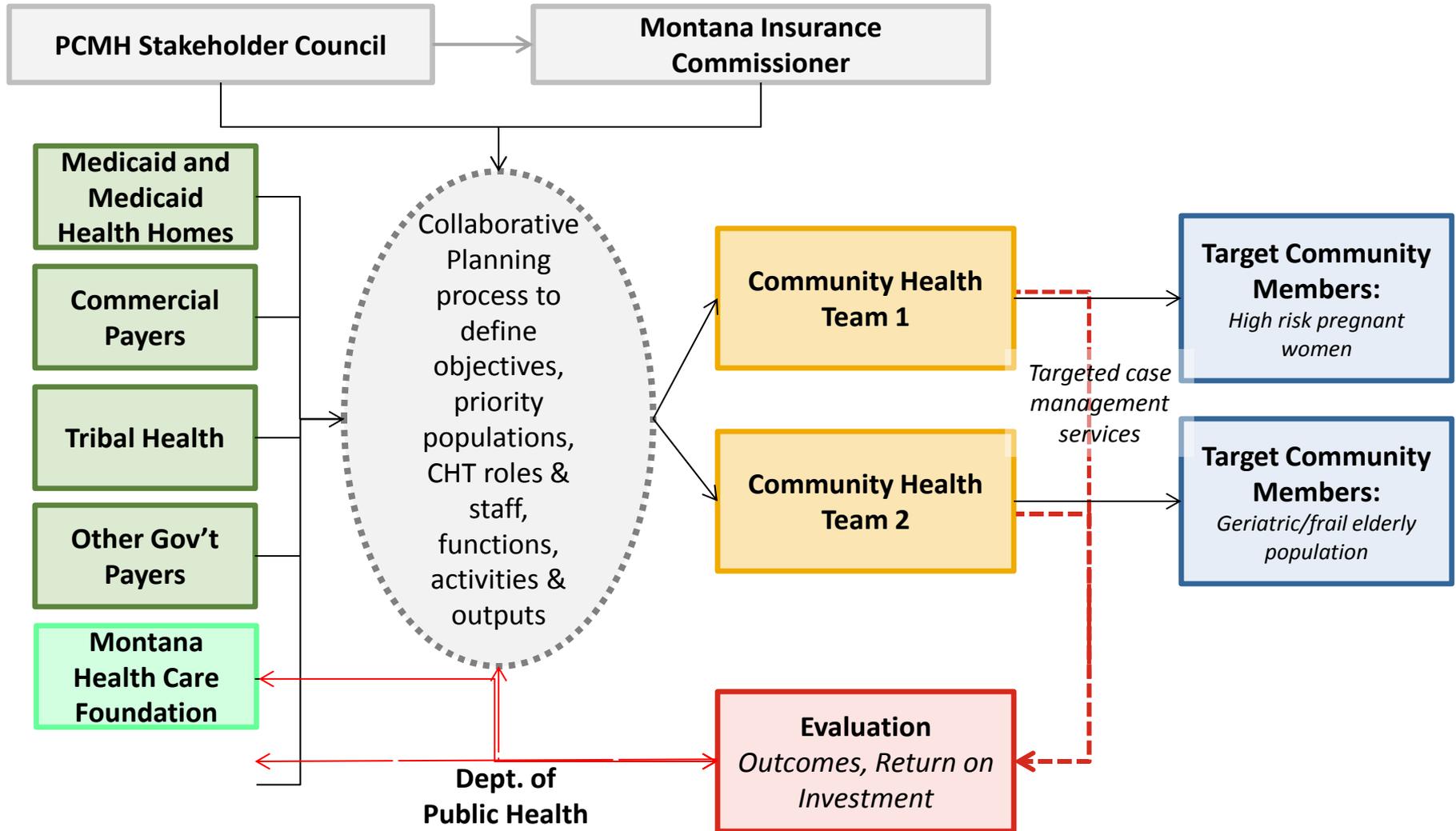
- Multidisciplinary care teams that coordinate services, promote self-management and help manage medications
- Sustained continuous relationships between patients and team staff established and cultivated through regular face-to-face contact
- Mechanisms to routinely send and receive information about 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.



# Community Health Teams OPTION

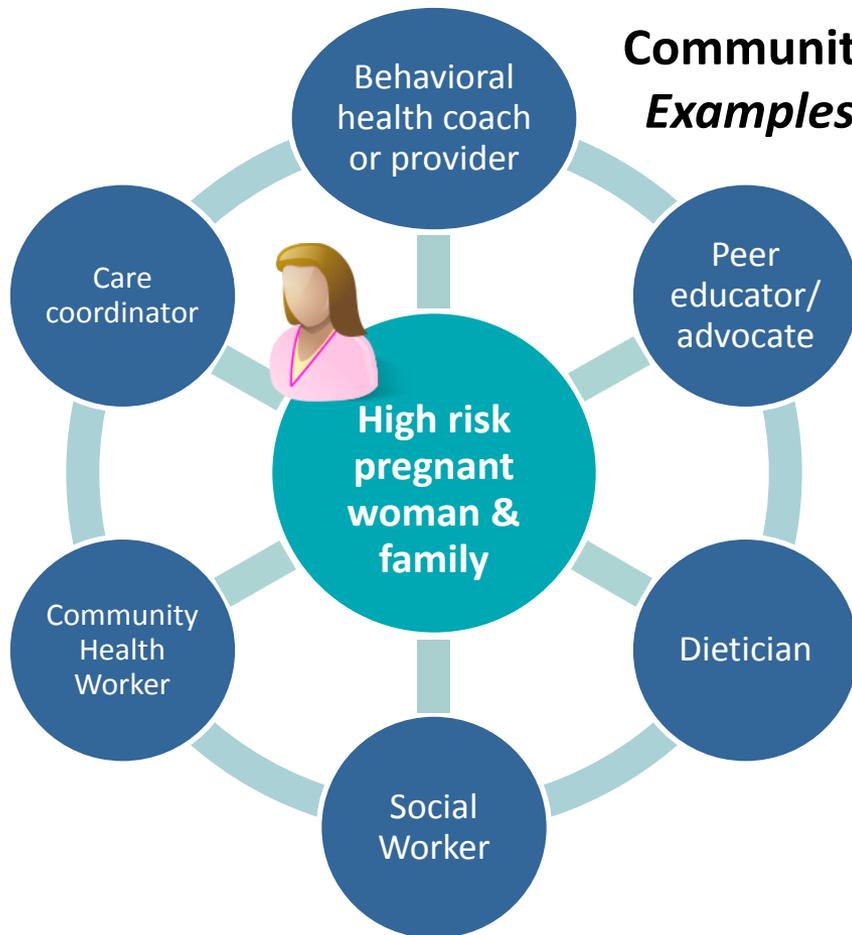
Payer and grant funding supports development of two CHTs to serve all community members regardless of insurance status



# 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*



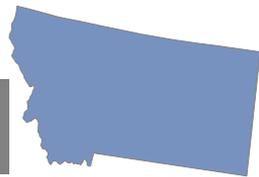
# Delivery Model Components Overview

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Medicaid health  
homes

Community  
health teams

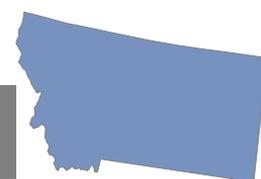
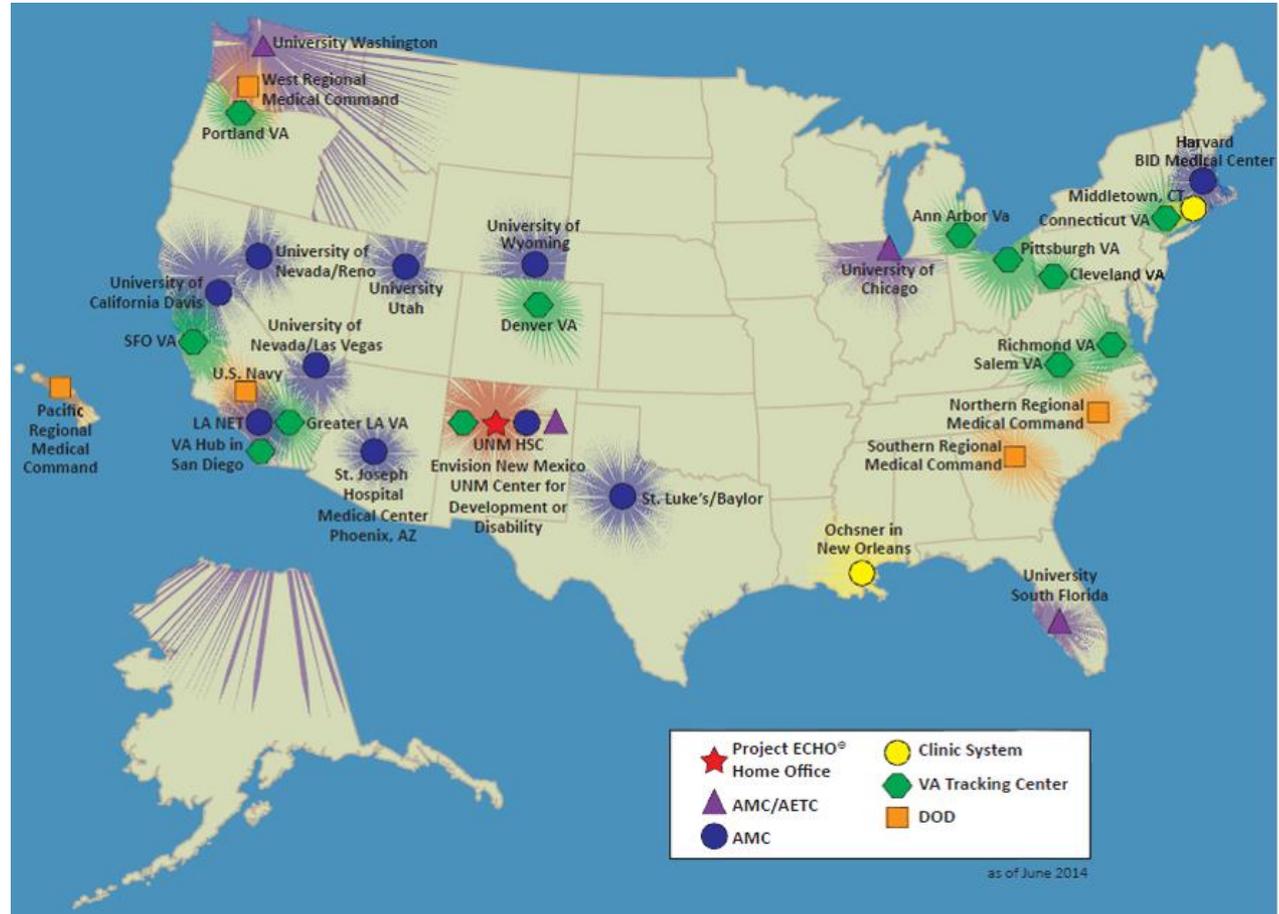
Telehealth



# EXAMPLE: 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



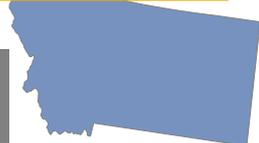
# To coordinate care and measure value we need information

## Clinical Data

- Hospital and clinic electronic health records
- Lab and radiology
- Pharmacy
- Health departments
- Indian Health Services

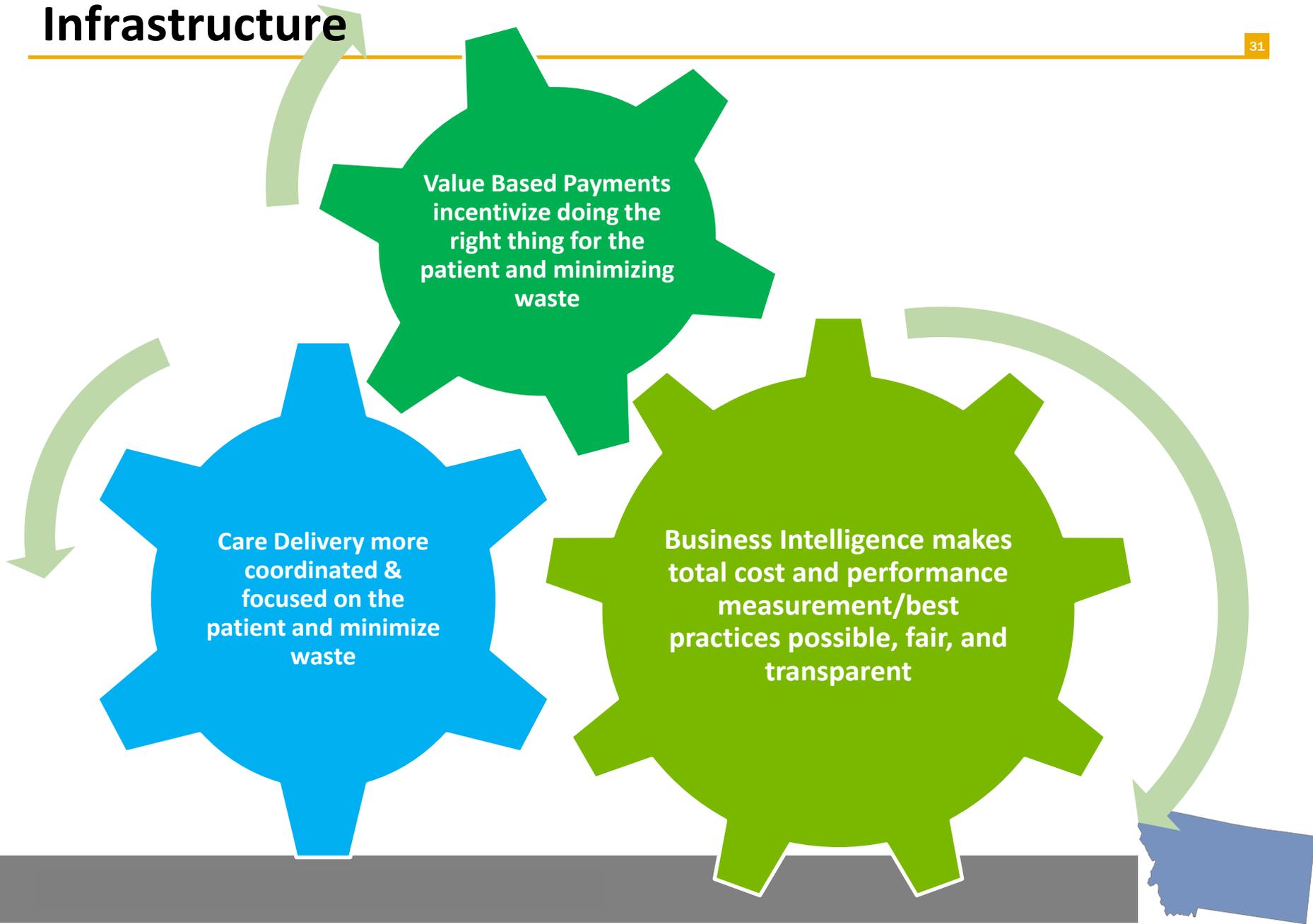
## Claims Data

- Medicaid & Medicare
- Employee health plans
- Commercial health plans
- Pharmacy benefits management organizations



# Infrastructure

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# Data Infrastructure

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

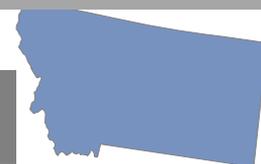
## **Create or enhance state data sharing capabilities**

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



## **Improve adoption and use of HIT and information exchange**

- Stakeholder collaboration
- Focus on supporting value
- Build on existing infrastructure

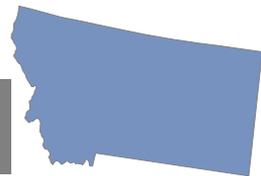


# Potential of HIE in Montana – Stakeholder Feedback

**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 Priorities

- 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



# Get Involved

## Upcoming Meetings and Stakeholder Webinars

**[Dphhs.mt.gov/SIM](https://dphhs.mt.gov/SIM)**

**Jessica Rhoades**

**[jrhoades@mt.gov](mailto:jrhoades@mt.gov)**

**406-444-3666**

