Governor's Council on Health Care Innovation Update for the Montana Medical Association

March 2016

Governor's Council on Health Care Innovation and Reform

Governor Bullock appointed an advisory council of private and public payers, providers, regulators, and patient advocates to guide the development of Montana's statewide health transformation plan.

Charge

1. Identify opportunities to improve care delivery and control costs in Montana's healthcare system

2. Explore opportunities to coordinate between public and private sectors to improve health system performance and population health

GOAL: Obtain **consensus** among public and private stakeholders – payers and providers – to **implement** one or more delivery system models and accompanying value-based payment methodologies to advance the triple aim in Montana of improved patient experience, improved population health, and reduced costs

Governor's Council Themes

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

Initial Issues to be Addressed

1. Physical and behavioral health integration, including substance use, chemical dependency and mental health integration
2. Social determinants of health and disparities among American Indians and other populations
3. Health information exchange (HIE) and telehealth

Challenges

- Workforce
- Rural nature of the state → limited access to care
- Lack of comprehensive patient data
- Integration of direct patient service environment and public health services
- Limited funding for new initiatives
- Fee-for-service payment environment
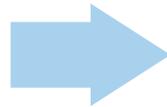
Opportunities & Solutions

- Health IT services and workforce initiatives:
  - Administrative claims data aggregation
  - Telehealth
  - Health information exchange
  - Project ECHO
- PCMH, Health Homes, ACOs and Collaborative Care Teams
- Greater alignment: public and private sectors
- Alternative, value-based payment models

Delivery Model Principles – *For Discussion*

As the Council considers and evaluates delivery models, it should assess the extent to which each model supports a set of core principles

Patient-centered

Data-driven and measurable

Simple and flexible for providers to rollout

Replicable for different conditions

Scalable

Sustainable and tied to payment reform

Collaborative

Multipayer

Delivery System Model Development Framework

Key Elements

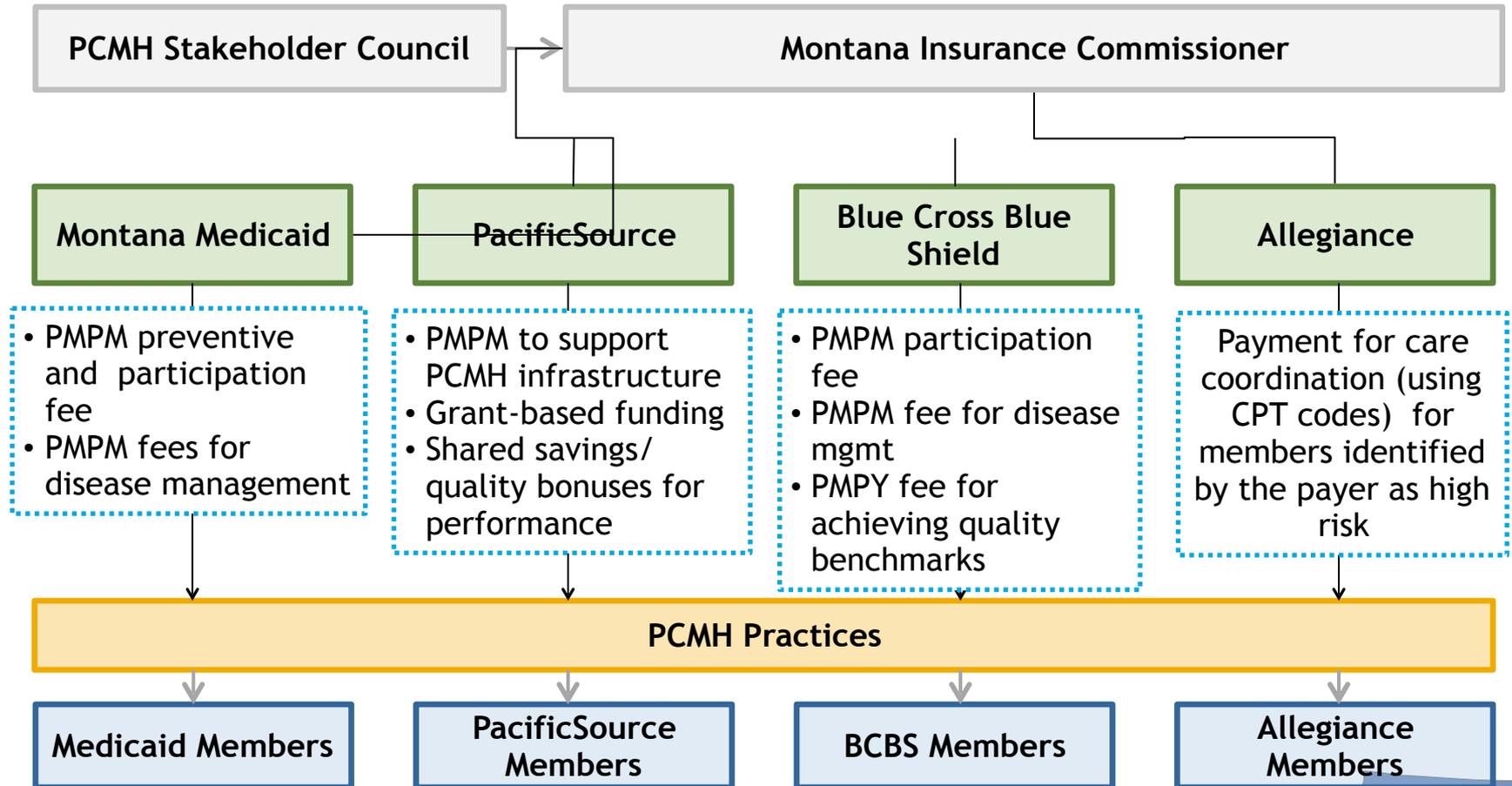| Process Step	Key Elements
Define objectives and target population(s)	• Data Working Group findings • Target populations and conditions
Consider potential impacts of delivery reform models	• Return on investment (ROI) • Scalability and sustainability • Measures
Define core elements of delivery models	• Care model definition • Existing resources
Develop supportive payment models	• Funding sources • Payer commitment • Value-based payment
Implement	• Stakeholder commitment • Work plan • Evaluation and refinement

PCMH as a Foundation for Reform

Montana's existing PCMH program should serve as the foundation for participating providers

PCMH Stakeholder Council	Montana Insurance Commissioner

Montana Medicaid	PacificSource	Blue Cross Blue Shield	Allegiance
• PMPM preventive and participation fee • PMPM fees for disease management	• PMPM to support PCMH infrastructure • Grant-based funding • Shared savings/ quality bonuses for performance	• PMPM participation fee • PMPM fee for disease mgmt • PMPY fee for achieving quality benchmarks	Payment for care coordination (using CPT codes) for members identified by the payer as high risk

PCMH Practices

Medicaid Members	PacificSource Members	BCBS Members	Allegiance Members

PCMH as a Foundation for Reform

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
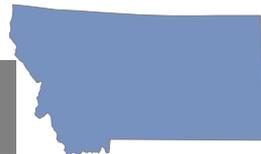
Quality

- 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

Evidence for PCMHs

The most recent evidence on PCMHs, including more than 30 published studies and evaluations, points to clear trends in reduced costs and utilization, and improved quality.

PCMHs are designed to provide a strong foundation for delivery system and payment reform.
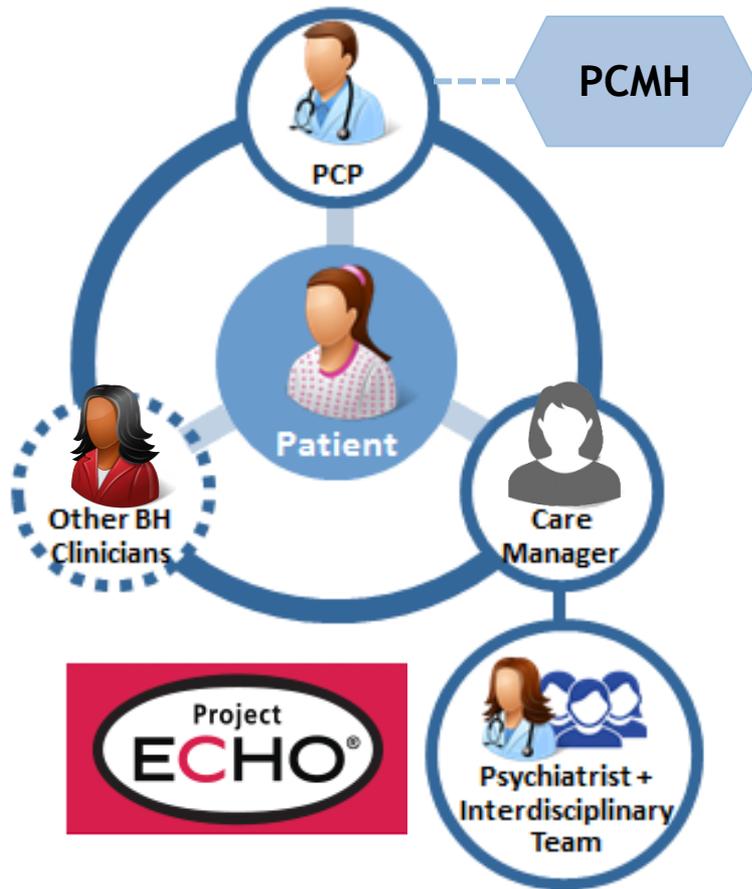
Improved Outcomes

✓ Recent studies have found:

- Better quality of care for diabetes, vascular, asthma, depression, kidney disease, and hypertension

- Higher rates of cancer and substance abuse screening

- Improved measures of patient experience, including access to care, doctor rating, and continuity of care

- Physician support for program and augmented services
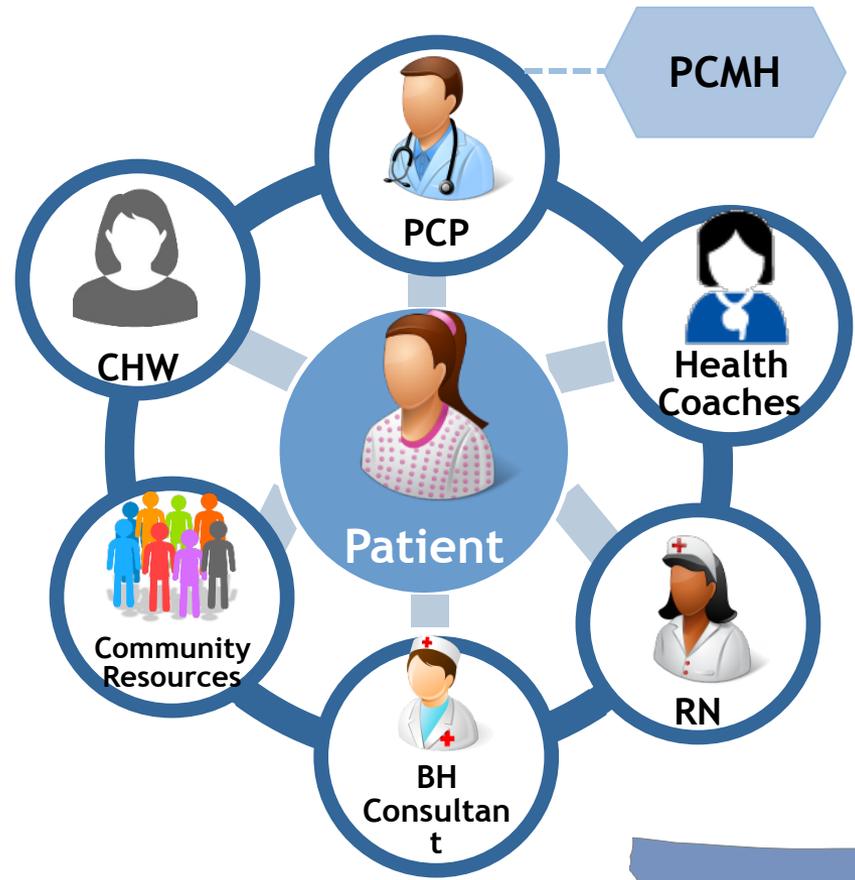
Reduced Utilization and Costs

✓ Recent studies have found reductions in ED visits, hospitalizations, specialty visits, prescription drug use and related costs

✓ By year 3, most programs see cost reductions:

- Geisinger Health System saved $53 PMPM (others cited PMPM savings of $9-40)

- BCBS Rhode Island PCMH program had ROI of 250%

- Minnesota multi-payer PCMH program saved an estimated $1 billion over 4 years
  - Nearly all Medicaid savings
  - Driven by reductions in hospital visits

Delivery System Models – Building on the PCMH Foundation

Collaborative Care Model (Could be Echo-Enhanced)

PCMH

PCP

Patient

Other BH Clinicians

Care Manager

Project ECHO®

Psychiatrist + Interdisciplinary Team

Hot-Spotting with Community Resource Teams

PCMH

PCP

CHW

Health Coaches

Patient

Community Resources

BH Consultant

RN

Spotlight on Evidence/ROI for Collaborative Care

The Collaborative Care Model has been tested in more than 70 randomized controlled trials in diverse settings, with different provider types and patient populations.

The model is recognized as strongly evidence-based.

Positive Health Impacts:

- ✓ More effective than usual care across diverse populations for range of mental health conditions
- ✓ Demonstrated improvement in health disparities in low-income, ethnic minority populations
- ✓ Strong endorsement from patients, primary care providers, and psychiatrists

Return on Investment:

- ✓ Largest study: ROI of $6.50 for each dollar spent
- ✓ Net savings in every category of health care costs examined:
    - Pharmacy
    - Inpatient and outpatient medical
    - Mental health
    - Specialty care

Spotlight on Evidence/ROI for Project ECHO

"Project ECHO expands access to best-practice care for underserved populations, builds communities of practice to enhance the professional development and satisfaction of primary care clinicians, and expands sustainable capacity for care by building local centers of excellence." – Health Affairs Study

Positive Impacts for Patients and Providers:

✓ As safe and effective as usual care

✓ Increases number of patients treated by specialists (expanding workforce)

✓ Increases access in rural areas

✓ Improves physician-reported measures of knowledge, skills, professional satisfaction, practice recognition

✓ Promotes provider retention in rural and underserved communities

Return on Investment:

✓ Hub costs estimated about $300,000 per year – first hub launched in Billings

✓ Free technology works with laptop, webcam, tablet, smart phone

✓ Expands ROI/reach of other proven models (e.g. Collaborative Care)

Spotlight on Evidence/ROI for Hotspotting

Camden Coalition model, on which the Mountain-Pacific model is based, is widely recognized as a promising model for a selection of the highest cost, highest need patients fitting into a patient typology.
The first randomized control trial evaluating the model is underway.

Positive Health Impacts:

✓ Increases security, genuineness, continuity of care

✓ Associated with improved patient motivation and active health management and improved patient perception of quality of life

✓ Improves care coordination by wrapping services around the patient

✓ Extends healthcare beyond the walls of the hospital and clinic to patient's home

✓ Addresses physical, situational, emotional and social barriers to health

✓ May help reduce hospital readmissions and improve coordination of fragmented care

✓ Integration of a behavioral health professional into the provider team treatment approaches

Return on Investment:

✓ Camden model reduced ED visits by 40% for the first 36 patients, and costs dropped by 60%

✓ Vermont Community Health Team model had net savings of nearly $90 million in 2013

✓ Vermont ROI was larger in commercial populations than in Medicaid

Pathway to Value-Based Payment Models

Secure Payment for Enhanced Services

Pay-for-Reporting

Pay-for-Performance (P4P) & Shared Savings

- Develop initial funding models for new delivery models:
  - "Lump sum" grant or payer funding for pilots
  - Enhanced FFS PMPM payments
  - PCMH payments
  - FFS care coordination, disease mgmt, telehealth codes
  - Health home payments
- Secure payer support of models and encourage tiered payment for providers in new delivery models
- Ensure payment for telehealth under parity law

- Initiate pay for reporting in new delivery models within one year of implementation
- Continue and expand pay-for-reporting efforts within Montana PCMH and other programs
- Continue FFS reimbursement
- Develop value-based payment transition plan

- Encourage payers participating in new delivery models to incorporate P4P in payment model
- Encourage payers participating in the PCMH program to incorporate P4P into PCMH payment model
- Continue fee-for-service reimbursement, but encourage payers to move to value-based payment models that incorporate shared savings for defined population
- Begin with shared savings models and graduate to shared risk over time
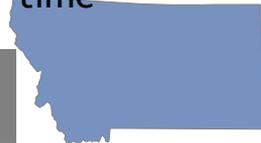
Example –Medicaid Health Home Funding Model

Community Resource Teams or Project ECHO Collaborative Care Providers (enrolled in Medicaid)

Target Medicaid Populations with SMI or Multiple Chronic Conditions

Funding Source

State eligible for 90% enhanced federal match for first two years of health home services:

✓ Care management and coordination
✓ Individual/family support
✓ Referral to community support services
✓ Use of health information technology to link services across settings

Funding Model

- State has flexibility to design payment methodology
- Range of payment methodologies available, from retaining current FFS model with PMPM care coordination to models with shared savings or upside risk.

Example – Commercial Shared Savings Funding Model

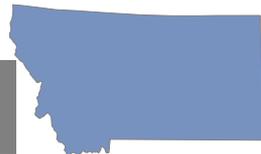Commercial payer attributes patient populations to CR or Collaborative Care Teams

Total Cost of Care < Baseline Cost

Payer makes retrospective shared savings payment to providers

Shared Savings Funding Model

✓ No downside risk

✓ Value-based model based on total cost of care

✓ Could also include quality incentives

✓ Successfully deployed in other States for ECHO and Collaborative Care

2016 Calendar

Common Agenda and Next Steps	Delivery System Transformation	Transformation Plan	Launch Planning & Implementation Teams	Presentations on Recommended Reforms	Develop Recommendations to Governor
January 2016	**March 8**	**May 10**	**July 12**	**September 13**	**November 15**
• Review needs assessment • Develop consensus on Gov. Council common agenda and approach • Discuss potential models for physical, behavioral health integration • HIT/HIE approach	• Continue delivery system discussions and obtain consensus on models • Begin to review payment models • Review driver diagram and discuss measurement • HIT/HIE update	• American Indian health leaders roundtable/ panel • Update on State Innovation Plan • Continued discussion of financing/ transition to value-based payment • Begin to discuss implementation • HIT/HIE update	• Launch planning & implementation teams on: HIE, delivery system, and payment reform • Teams to develop implementation recommendations on specific reforms	• Planning and implementation team report outs to full Gov. Council • Expert panels/ speakers on recommended reforms	• Agree on recommended reform proposals for Montana • Begin developing report to Governor

Spring Webinar:
Medicare Value-Based Payment Approach

Fall Planning & Implementation Team Meetings