Health and Economic Livelihood Partnership Oversight Committee
July 13, 2016

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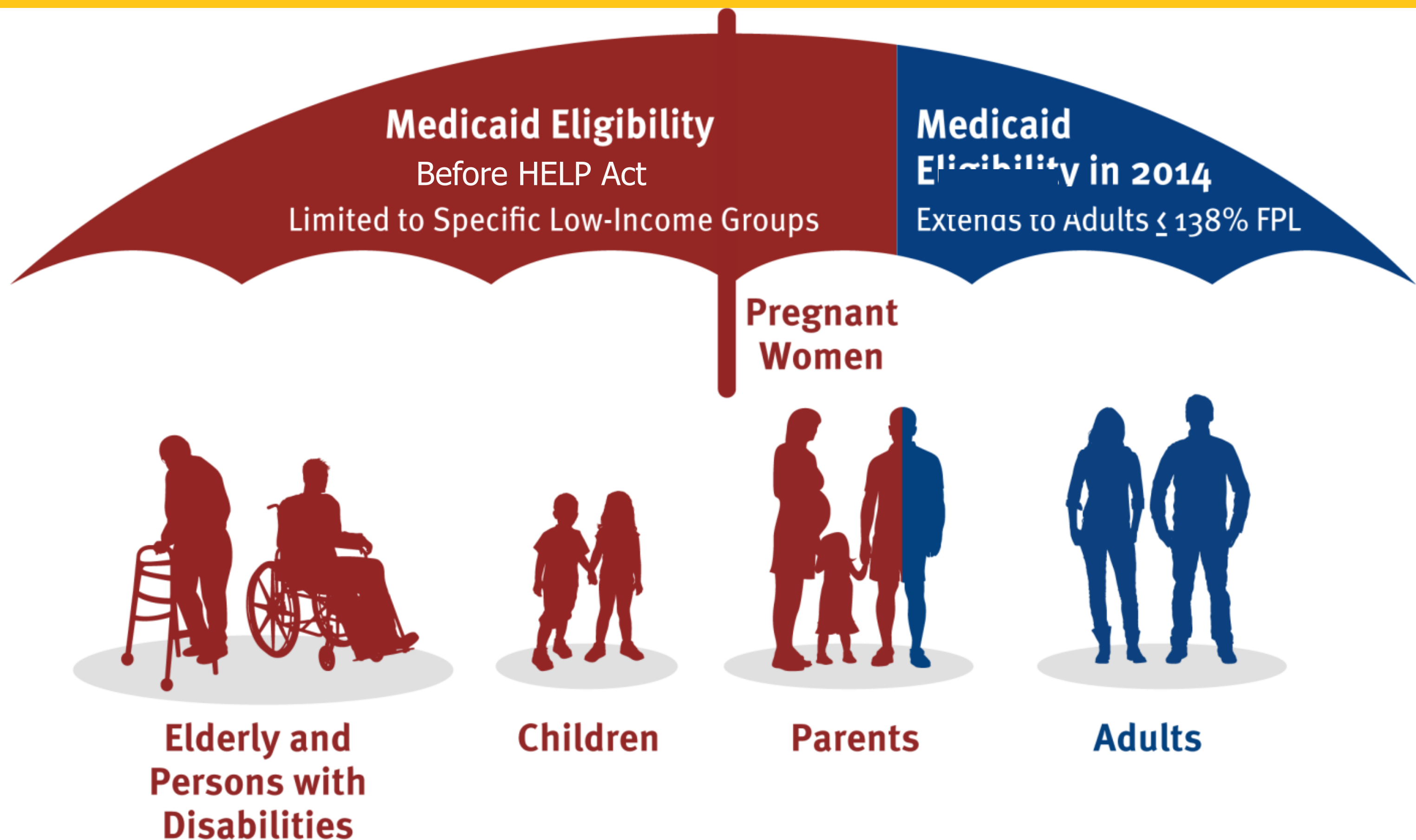
Eligibility



Now, parents and adults without kids living at home between the ages of 19-64 with an income at or below 138% of the Federal Poverty Level (FPL)

$1,350 a month for one person, and $2,300 a month for a family of three

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47,399

Montanans Enrolled

11,727

Preventive Dental Exams

1,350

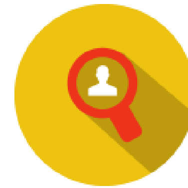
Vaccinations

2,645

Preventive/Wellness Exams

3,659

Cholesterol Screenings



1,449

Breast Cancer Screenings

3,047

Colorectal Cancer Screenings

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HELP Coverage by County

Lincoln 6.4% 1,232
Flathead 5.0% 4,718
Glacier 8.1% 1,113
Toole 3.3% 169
Liberty 8.0% 189
Hill 5.9% 977
Blaine 5.7% 375
Phillips 5.1% 214
Valley 4.0% 305
Daniels 2.0% 35
Sheridan 2.7% 101
Roosevelt 6.2% 702
Pondera 7.4% 463
Sanders 6.9% 784
Lake 6.3% 1,833
Teton 5.6% 339
Chouteau 3.4% 202
Richland 2.2% 257
McCone 6.6% 112
Mineral 5.1% 218
Missoula 5.3% 5,946
Powell 4.0% 278
Lewis and Clark 4.0% 2,632
Cascade 5.0% 4,107
Judith Basin 3.9% 78
Fergus 4.4% 500
Petroleum 3.5% 17
Garfield 2.2% 29
Dawson 2.9% 278
Wibaux 1.3% 15
Prairie 1.8% 21
Granite 3.0% 95
Ravalli 5.5% 2,257
Deer Lodge 4.8% 437
Silver Bow 5.8% 1,999
Jefferson 2.8% 321
Broadwater 3.0% 170
Meagher 9.3% 173
Wheatland 7.8% 164
Golden Valley 8.7% 74
Musselshell 7.5% 342
Rosebud 4.3% 400
Treasure 4.0% 28
Custer 3.4% 410
Fallon 2.9% 89
Gallatin 3.1% 3,034
Park 5.2% 821
Sweet Grass 2.4% 88
Stillwater 2.6% 241
Yellowstone 3.9% 6,138
Big Horn 6.0% 797
Carbon 3.7% 380
Powder River 2.1% 38
Carter 3.1% 36
Beaverhead 4.6% 434
Madison 2.1% 161

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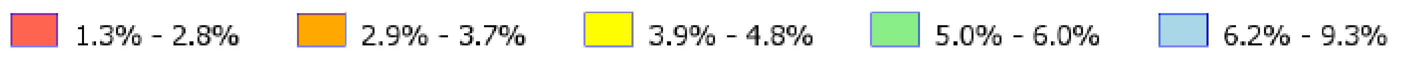
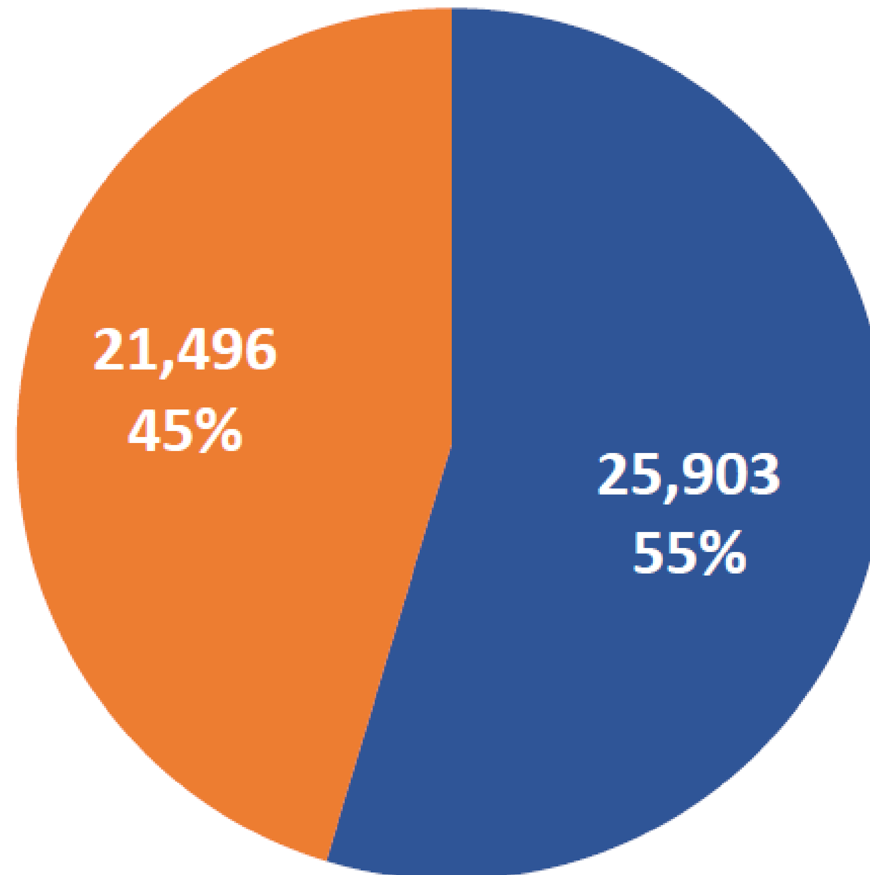


Demographics

HELP Newly Enrolled Gender



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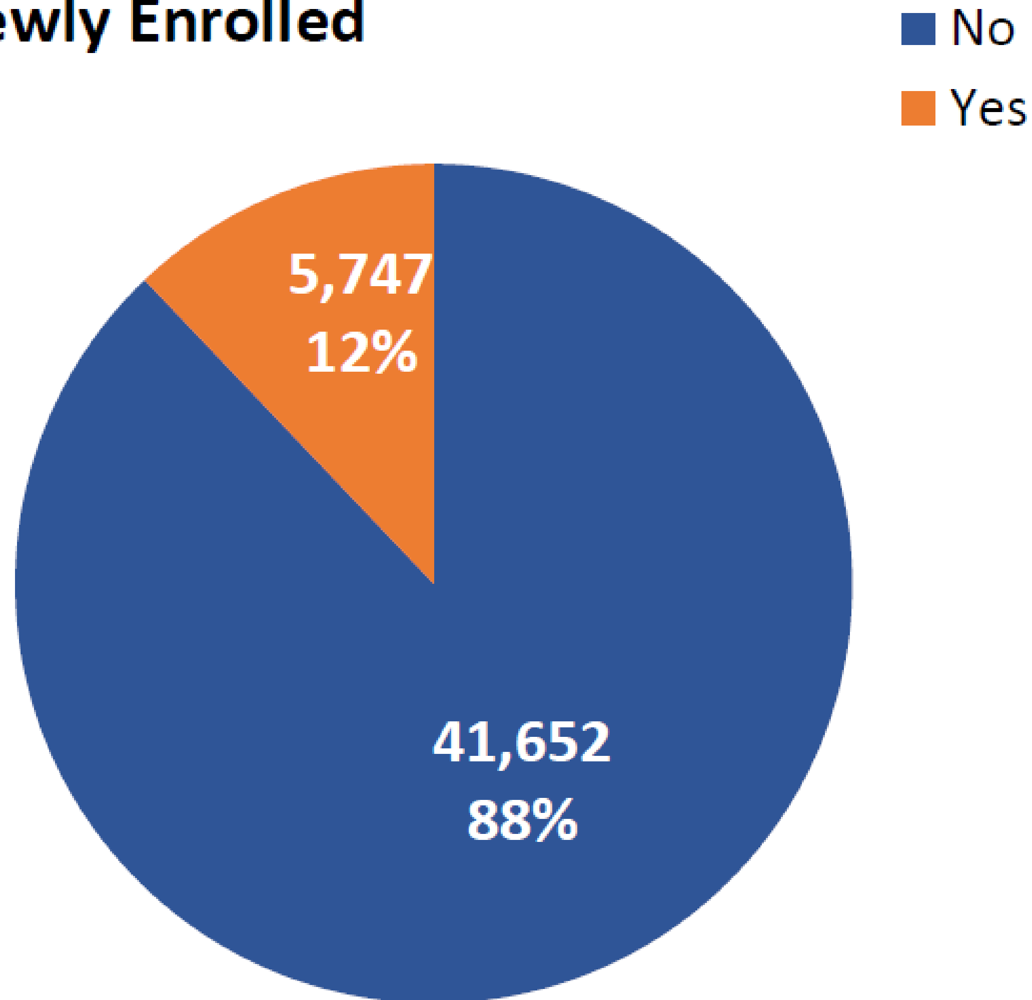
Demographics

HELP Newly Enrolled AI/AN



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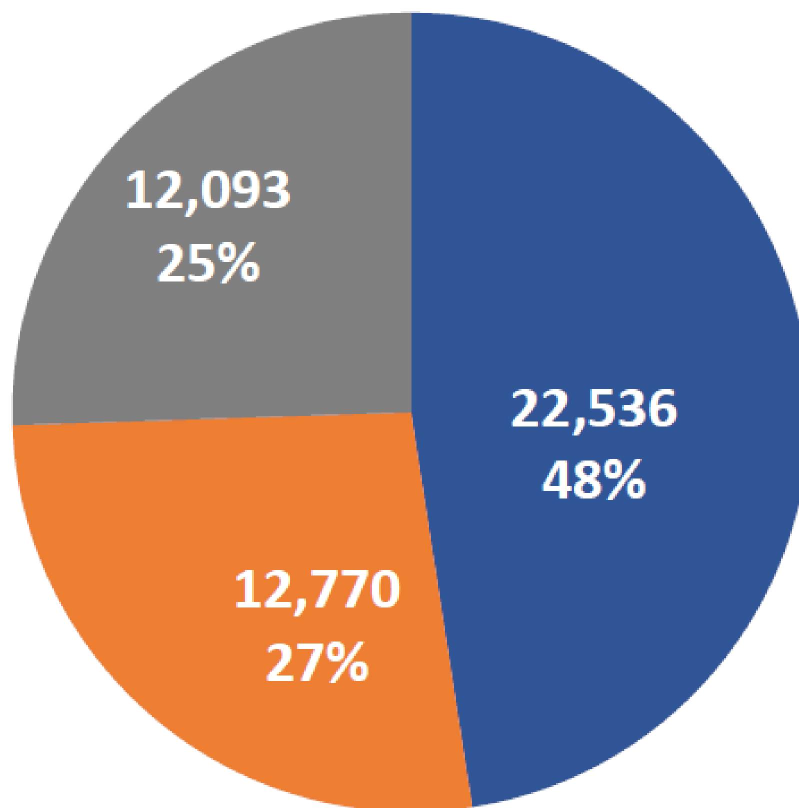
Demographics

HELP Newly Enrolled Age

■ 19-34 ■ 35-49 ■ 50-64



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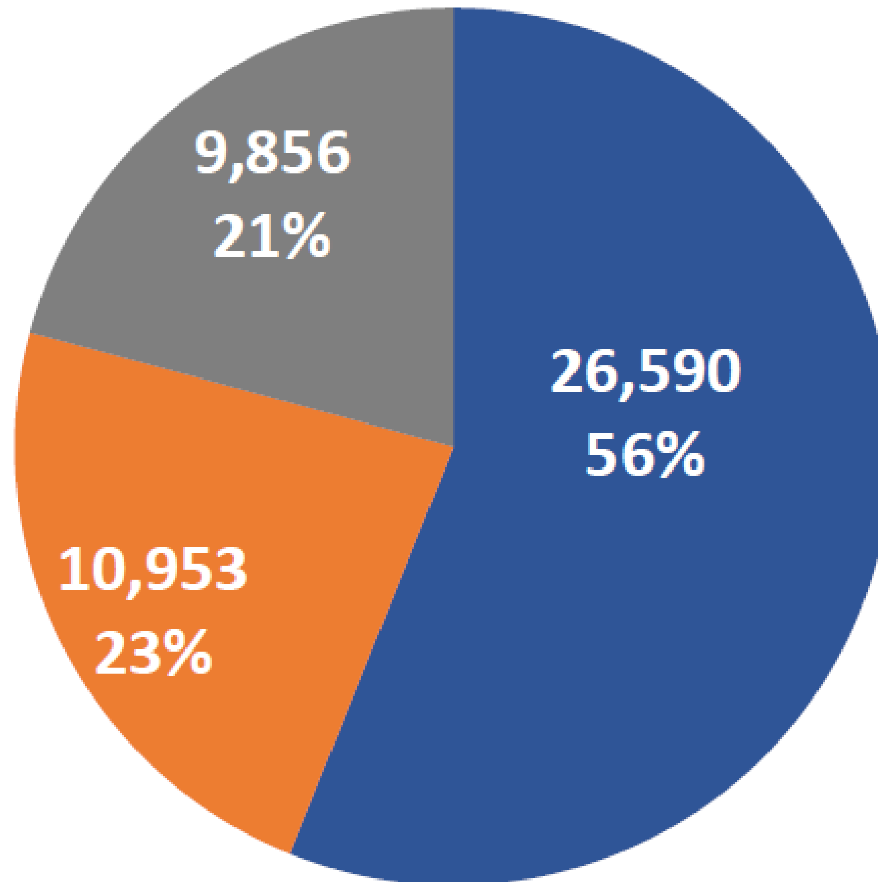
Enrollment by income

HELP Newly Enrolled
% FPL*

- 0-50
- 51-100
- 101-138



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Montana Report on the Uninsured

Jesse Laslovich, Office of the Commissioner of Securities and Insurance

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Financial Report

Marie Matthews, DPHHS Operations Branch Manger

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Good Deal for Montana

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Before HELP Act

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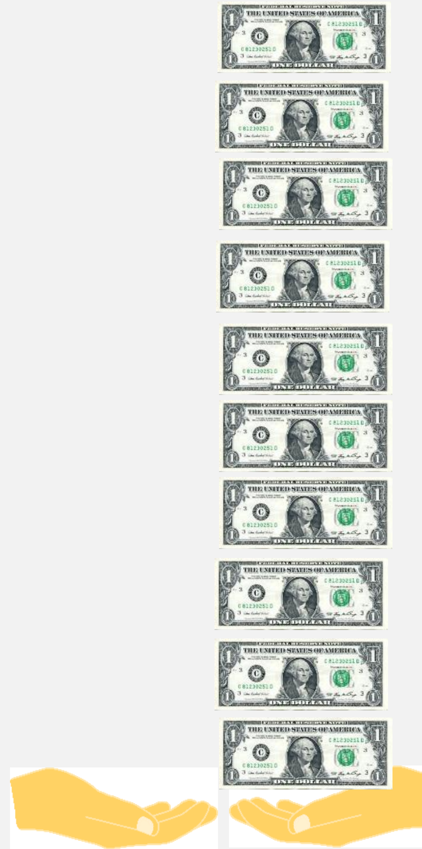
Montana Federal

2016-2017



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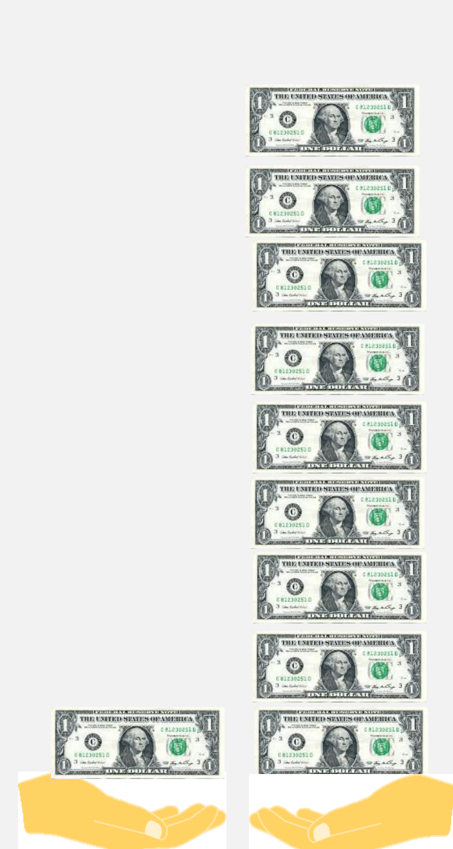
Montana Federal

2020 +



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Montana Federal

Enhanced FMAP Schedule

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YEAR	ENHANCED FEDERAL MATCHING RATE NEWLY ELIGIBLE ADULTS UP TO 138% FPL	
	State Share	***Federal Share***
2014	0%	100%
2015	0%	100%
2016	0%	100%
2017	5%	95%
2018	6%	94%
2019	7%	93%
2020+	10%	90%

Native American Enrollment and Outreach

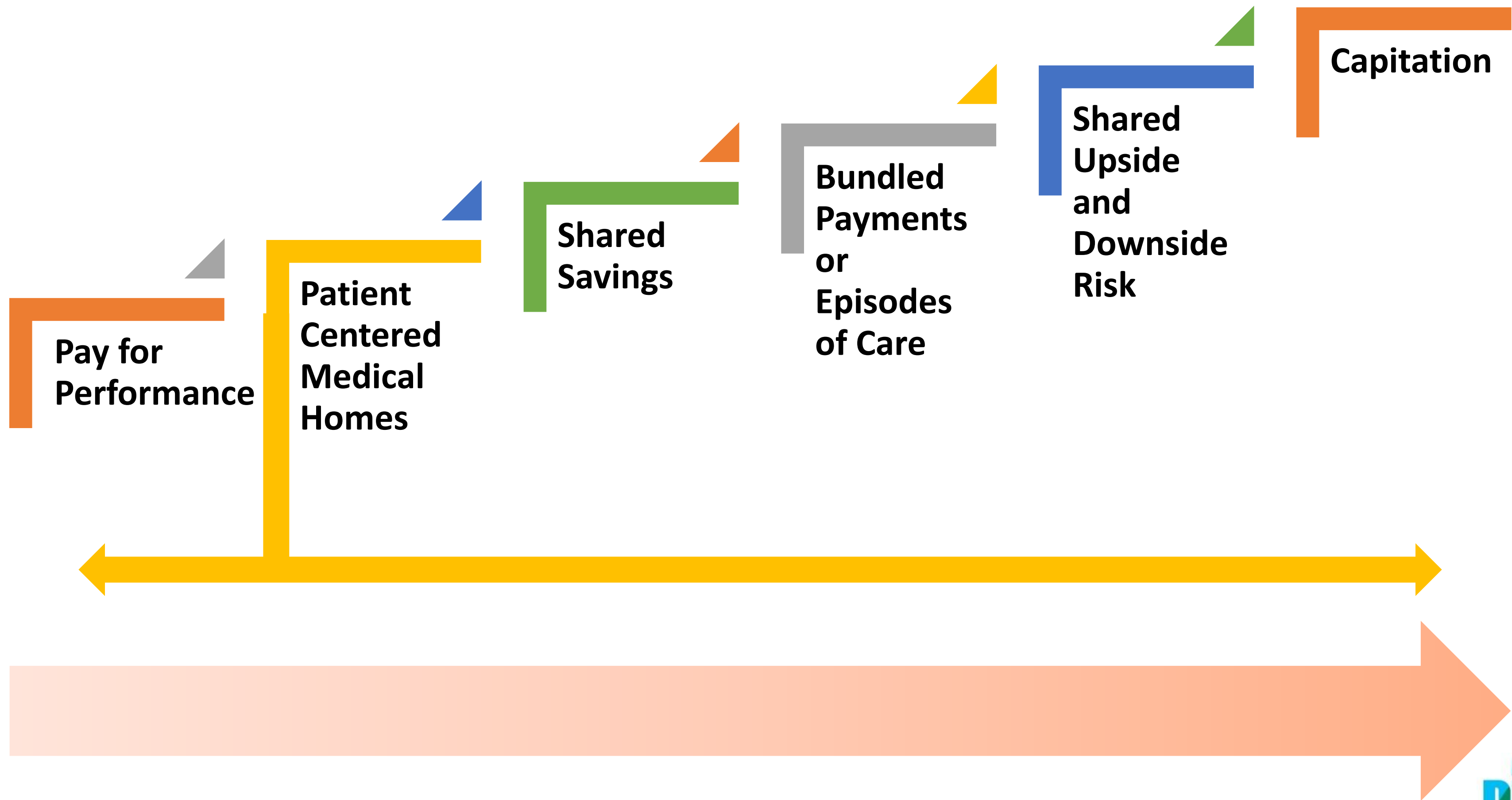
Montana DPHHS

Benefis

CSKT Tribal Health

Health Care Reforms & Innovations

Value-Based Payment Spectrum



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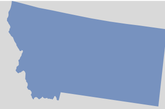
Governor’s Council on Health Care

Process for Transformation
- Governor’s Vision
- Public-Private Partnership
- Stakeholder Engagement



Montana Health Care Landscape
- Providers and Provider Need
- Coverage and Payers
- Challenges and Opportunities
- Foundation for Reform

Population Health
- Health Status and Equity
- Access to Care
- Target Populations for Delivery Reform

Delivery System Transformation
- ECHO-Enhanced Collaborative Care
- Community Resource Teams
- Medicaid Health Homes

Operational Plan
- Financial Analysis
- Workforce
- Metrics and Evaluation
- Continued Planning Timeline

Data Infrastructure
- Landscape
- Administrative Data Initiatives
- Project ECHO
- Billings HIE Pilot

Community ReSource Teams

Mountain Pacific Quality Health Foundation

Sara Medley, CEO

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Improving Coordination of Care

Sara Medley, CEO
Mountain-Pacific Quality Health

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Mountain-Pacific Quality Health

Mountain-Pacific Quality Health

WHO? WHAT? WHERE? AND WHY ?

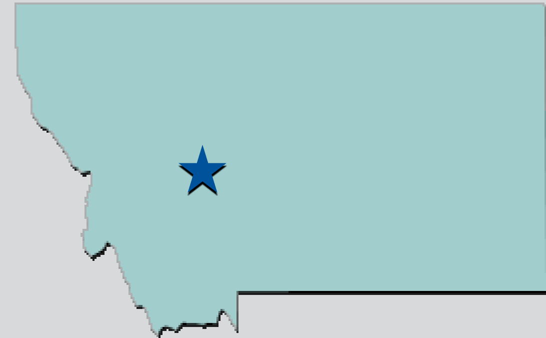
Mountain-Pacific Quality Health

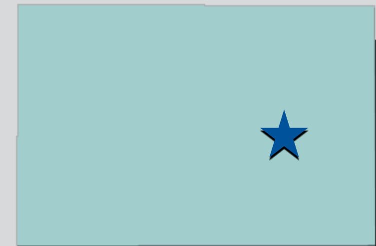
Who?

Mountain-Pacific Quality Health is…

- Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO)
  - Montana
  - Wyoming
  - Alaska
  - Hawaii
  - Guam
  - American Samoa
  - The Commonwealth of the Northern Mariana Islands
- Medicaid contracts
- Other contracts

Where?





What?

Mountain-Pacific supports quality improvement activities with…

Hospitals

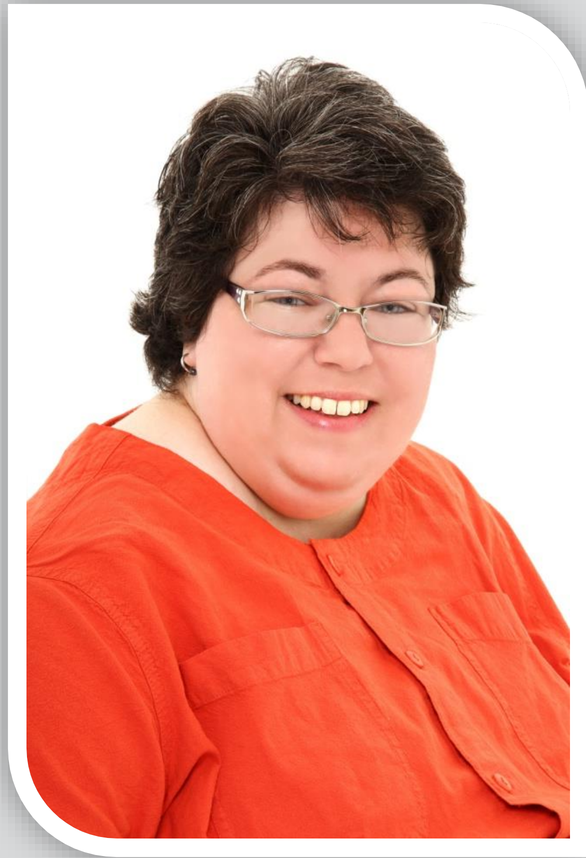
Nursing homes

Physician/practitioner offices

Patients and clients

Last but not least…

THE WHY



Meet Charlotte.

How Can We Help Charlotte?

“Hotspotting” Project

- First step: Analyze data
- Funded by CMS as special innovation project to target Medicare beneficiaries
- Expanded by Robert Wood Johnson Foundation to reach even farther

"Hotspotting"

1% of patients account for 22% of total health care expenditures

Data driven approach to identify and better **support high-cost, high needs patients** who are "super utilizers" of health care services

Meet Our Communities

Serving 16,406 beneficiaries

Northwest Montana Coalition

- 2 hospitals
- 2 nursing home/skilled nursing facilities
- 7 HHAs
- 3 physicians/practices
- 8 other providers and stakeholders

Meet Our Communities

Serving 16,406 beneficiaries

Serving 10,089 beneficiaries

Helena Area Coalition

- 1 hospital
- 1 nursing home/skilled nursing facility
- 1 HHA
- 2 physicians/practices
- 7 other providers and stakeholders

Meet Our Communities

Serving 16,406 beneficiaries

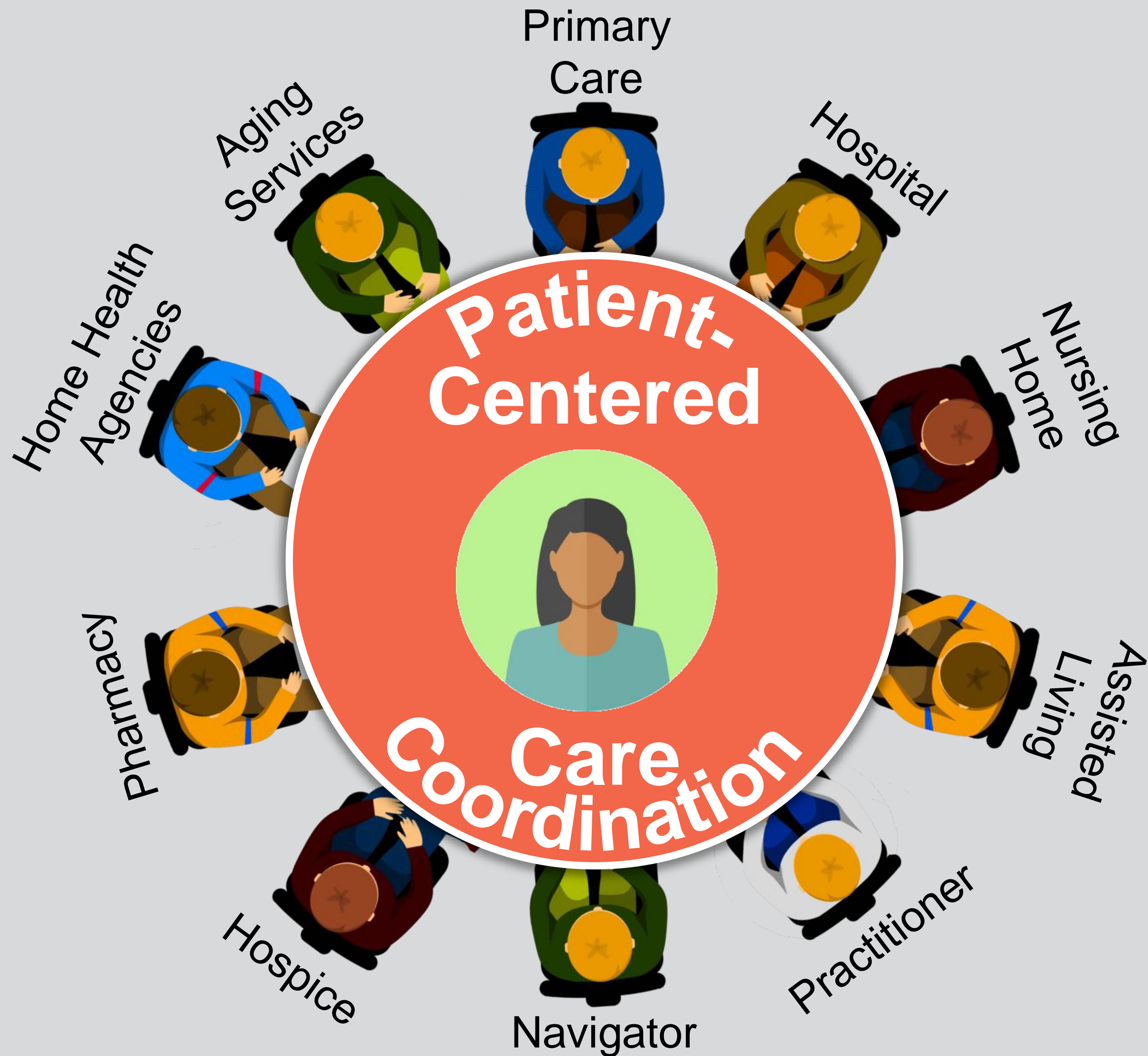
Serving 10,089 beneficiaries

Billings Area Coalition

- 2 hospitals
- 2 HHAs
- 1 physician/practice
- 3 other providers and stakeholders

Serving 25,515 beneficiaries

How Does It Work?



Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Mountain-Pacific Quality Health

Improving Care Coordination

IS IT WORKING?

Most Improved in the Nation

Hospital Admissions and Readmissions Rates in Montana, Wyoming, Hawaii and Alaska

Admissions per 1,000 Medicare Beneficiaries		
Baseline (CY2013)	Re-Measurement (CY2014)	Relative Improvement Rate (RIR)
208.42	**195.67**	**6.12%**

Readmissions per 1,000 Medicare Beneficiaries		
Baseline (CY2013)	Re-Measurement (CY2014)	Relative Improvement Rate (RIR)
30.10	**27.25**	**9.45%**

Montana Improvements

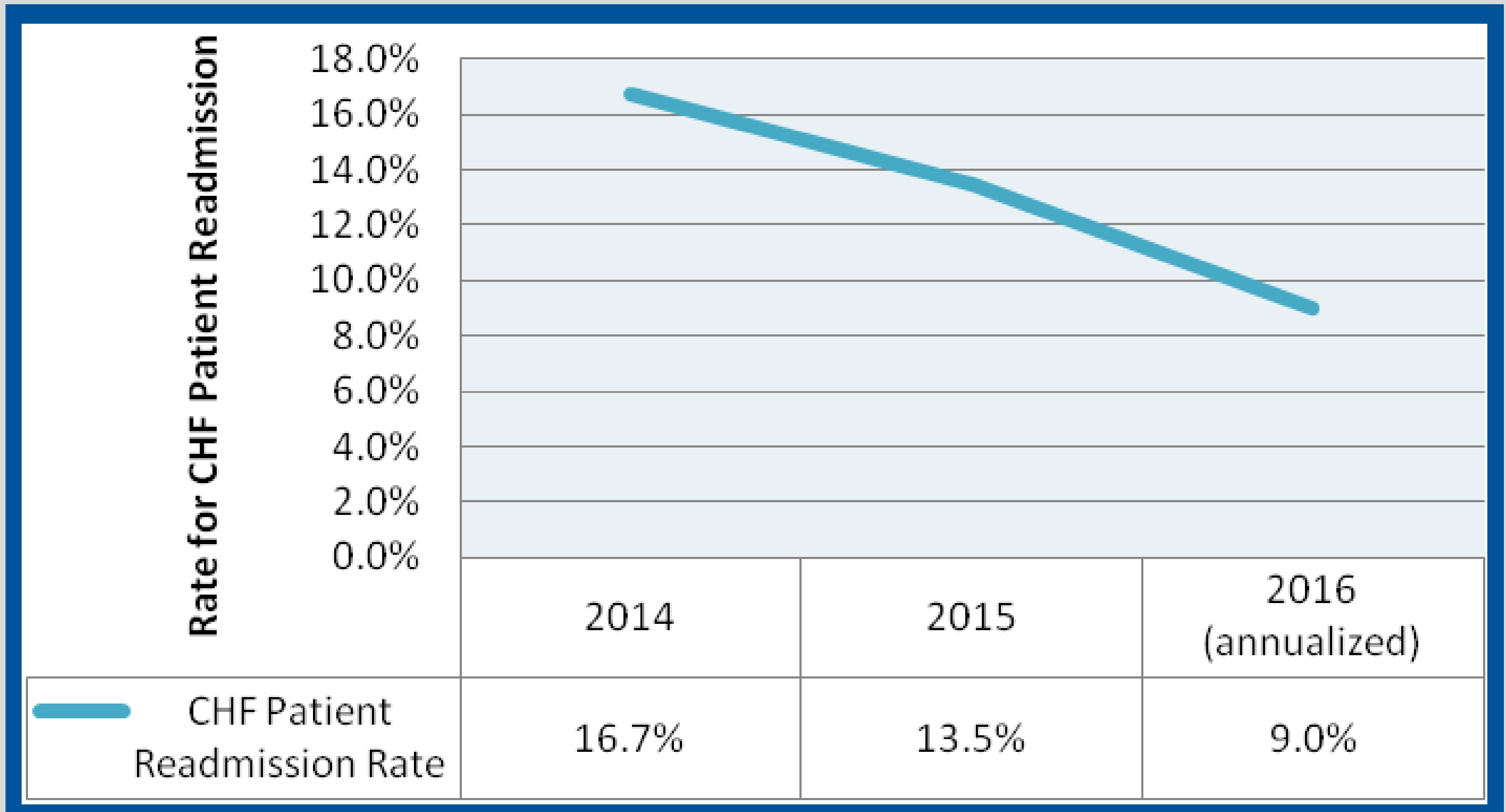
Reducing Unnecessary Hospital Admissions and Readmissions

Admissions per 1,000 Medicare beneficiaries		
Baseline (CY2013)	Re-Measurement (CY2014)	Relative Improvement Rate (RIR)
227.63	**212.19**	**6.78%**

Readmissions per 1,000 Medicare beneficiaries		
Baseline (CY2013)	Re-Measurement (CY2014)	Relative Improvement Rate (RIR)
31.47	**28.20**	**10.39%**

One Community's Results

Kalispell CHF Patient Readmission Rate



	2014	2015	2016 (annualized)
CHF Patient Readmission Rate	16.7%	13.5%	9.0%

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Mountain-Pacific Quality Health

Under Contracts with MT DPHHS

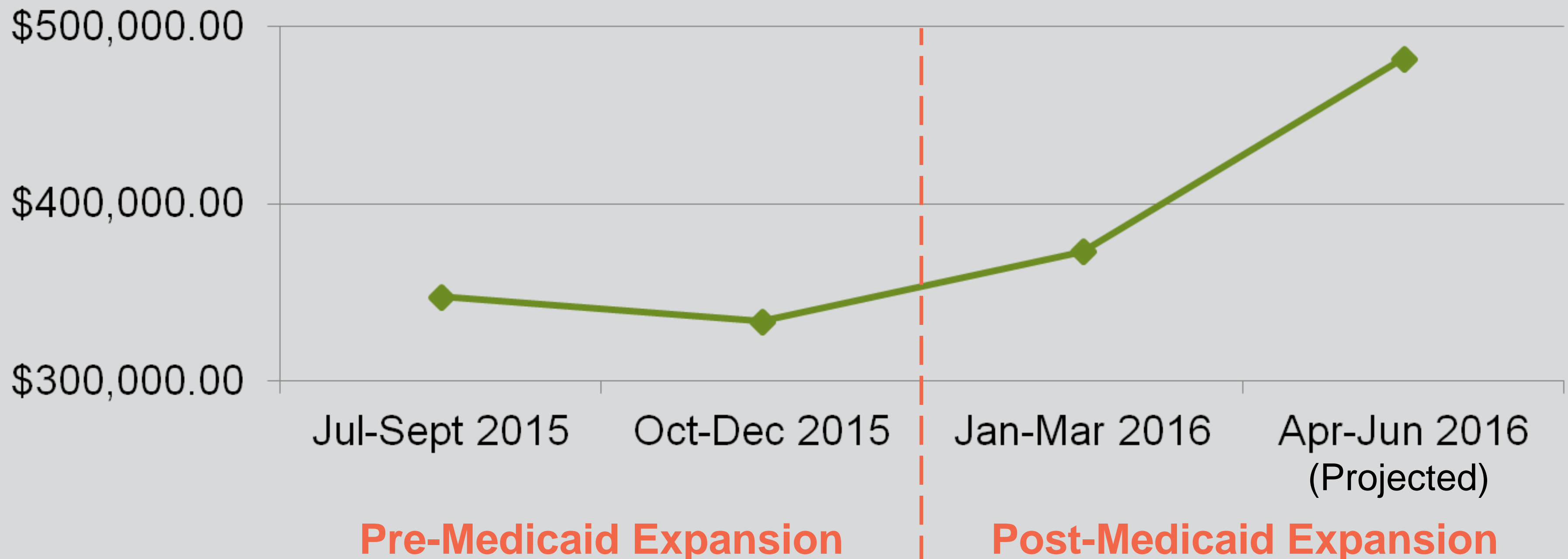
ROI RESULTS FROM EXPANSION WORK

Montana Medicaid

Transportation

Every $1 invested returned $1.66

FY2016 66% ROI

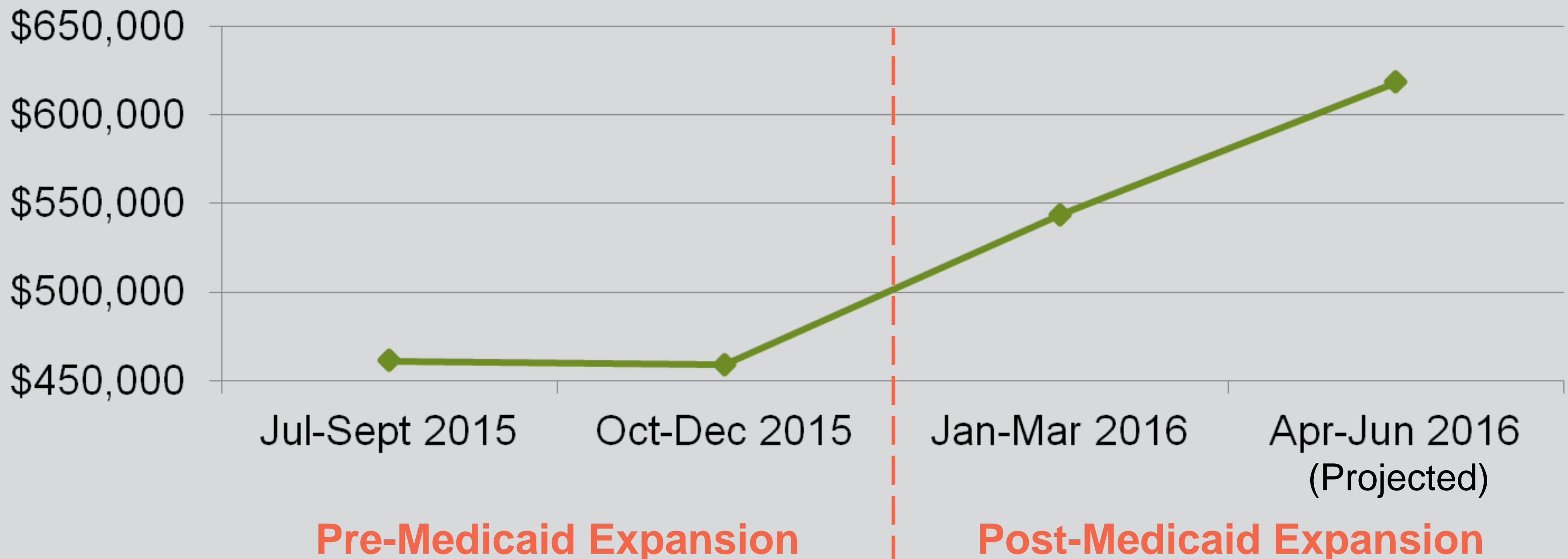


Montana Medicaid

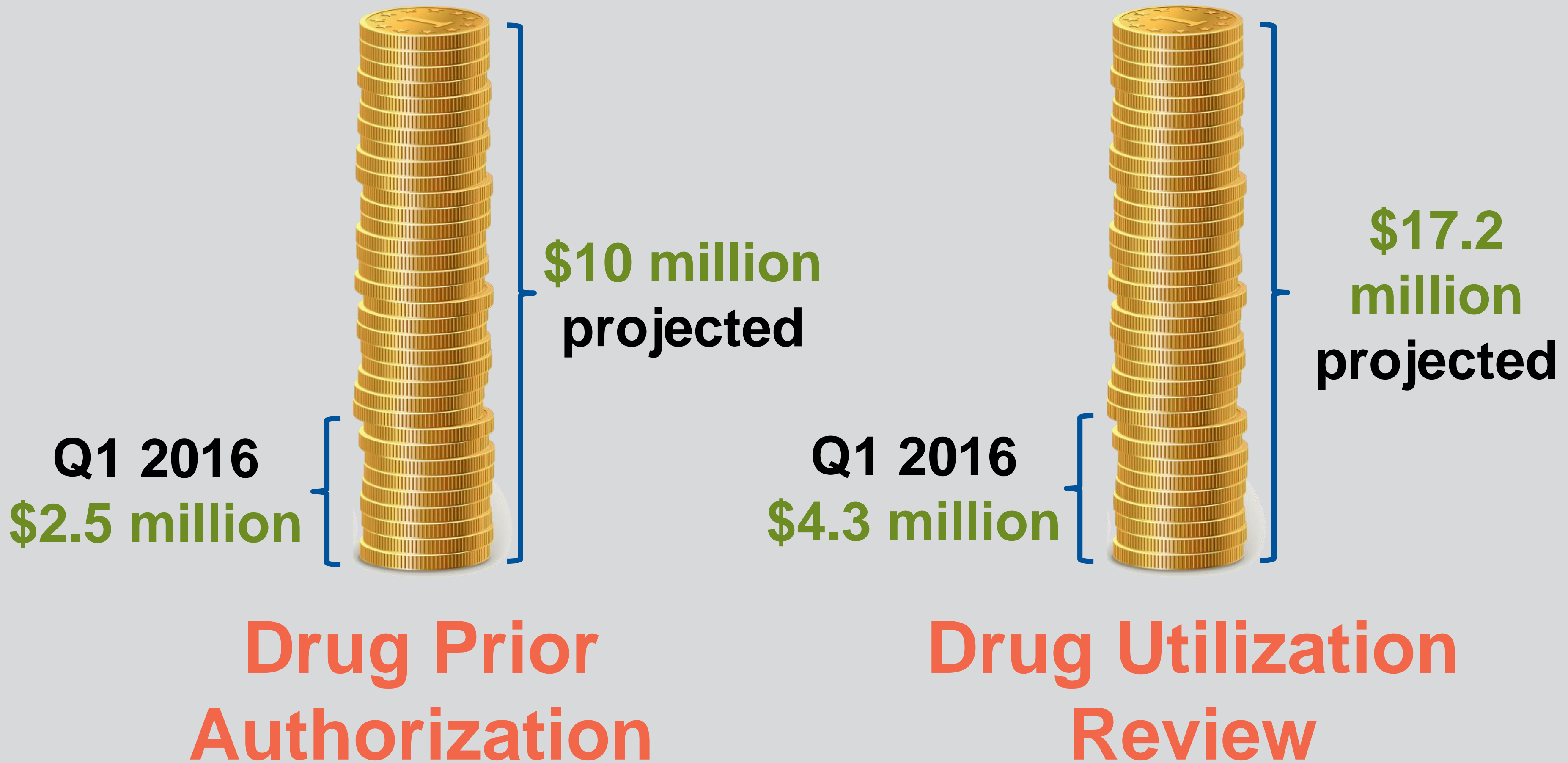
Utilization Review

Every $1 invested returned $5.93

FY2015: 455% ROI **FY2016: 530% ROI**



Drug PA and DUR Cost Savings (HELP Only)



Sara Medley, CEO
(406) 457-5820
smedley@mpqhf.org

Thank you!

QUESTIONS?

Comprehensive Primary Care Plus

Jess Rhoades and Jo Thompson, Montana DPHHS

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Comprehensive Primary Care + (CPC+) Overview

Under CPC+, Medicare will partner with other health care payers (both public and private) to invest in enhancements to primary care practices.

Application Timeline

Activity	Date
Payers apply first to participate in program	Applications submitted June 8th
CMS will select up to 20 regions, based on payer applications, where the program will launch	By July 15th
Providers in selected regions will apply to participate	July 15th – September 1st
Up to 5,000 practice sites will be selected to participate	October 2016
Program launches Program will run for five years	January 2017

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CPC+ Overview, Continued

Each payer proposed a payment model for primary care practices

Medicare's payment model features two tracks:

Track 1	Track 2
• Focused on building capabilities for comprehensive primary care • Practices provide care management, coordination, and similar services to all patients, agnostic of payer • PMPM payment of $15 on average, on top of usual FFS payment (excluding chronic care management code) • Quality bonus of $2.50 PMPM	• Focused on expanding care capabilities for more complex patients • Capitated, comprehensive fee for care management and portion of expected FFS revenue based on historical claims (average $235,000/year for site serving 700 Medicare beneficiaries) • PMPM payment of $100 for highest risk • Quality bonus of $4.00 PMPM • Decreases in FFS payments

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Montana CPC+

Four Montana payers applied:

- Medicaid
- BCBS
- PacificSource
- Allegiance

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Provider Engagement in CPC+

If Montana is selected as a CPC+ region, provider participation will be key.

- **Eligible applicants are primary care practices that:**
  1. Pass program integrity screening
  2. Provide health services to a minimum of 150 attributed Medicare beneficiaries
  3. Can meet the requirements of the CPC+ Participation Agreement
- **Practices will apply directly to the track for which they believe they are ready**
  - CMS reserves the right to offer a practice entrance into Track 1 if they apply to but do not meet the eligibility requirements for Track 2

- CMS defines a "**Primary Care Practice**" site as the single "bricks and mortar" physical location where patients are seen; includes all NPIs billing under a TIN at a practice site address
- CMS defines "**Primary Care Practitioner**" as a physician (MD or DO), nurse practitioner (NP), physician assistant (PA), or Clinical Nurse Specialist (CNS) with a primary specialty designation of family medicine, internal medicine, or geriatric medicine
- **FQHCs and RHCs are not eligible to participate**

Reminder: Participation in CPC+ "counts" as a MACRA Alternative Payment Model. This pathway could help smaller providers avoid likely Medicare payment cuts under the Incentive Payment System pathway.

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Medicaid: Proposed CPC+ Payment Model

Medicaid has proposed a two-part payment model:

PMPM Payments

"Care Management Fee"

- Track 1: Four tiers of PMPM payments, depending on patient risk and level of care management required
- Track 2: Five tiers of PMPM payments; top tier is for most complex patients:
  - Top 5% of the CPC+ pool
  - Members with persistent and severe mental illness, dementia

Specific payment amounts TBD, but will be adequate and will align with other payers

Performance-Based Incentives

- Annual bonus payment at end of year based on performance on specified measures relative to benchmarks/targets
- Utilization/Cost of Care measures: claims measures of inpatient admissions, ED visits for attributed members
- Quality/Outcomes measures: reported quality measures, CAHPS surveys, etc.

Payments will align, as possible, with other payers in the State

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Medicaid: Proposed CPC+ Payment Model

Providers will be expected to deliver value to payers and beneficiaries in return for enhanced payments.

<table>
<tr><th>CPC+ Driver</th><th>Provider Expectations</th></tr>
<tr><td>Comprehensive primary care functions, including: care management, access and continuity, planned care for population health, patient and family caregiver engagement</td><td rowspan="4">• Care management
• Increased access to care
• Increased continuity of care
• Better managed population health
• Better patient engagement
• Better family/support engagement
• Comprehensive coordinated care and services
• Reduced inpatient admissions
• Reduced ER visits
• Increased quality of care and patient experience based on CAHPS survey
• Quality measure reporting
• Enhanced and complex health IT systems*
• Further investment in health IT and EMRs*

*Enhanced expectations for Track 2 practices.</td></tr>
<tr><td>Use of enhanced, accountable payment</td></tr>
<tr><td>Continuous improvement driven by data</td></tr>
<tr><td>Optimal use of health IT</td></tr>
</table>

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Medicaid Payment Reform Pathway

These three Medicaid programs serve as the foundation for broader payment reforms

Limited scope program to date, could expand

Moving forward to develop new payment models

Primary Care Case Management Program for 70% of Medicaid enrollees ($3 PMPM)

Health Improvement Program for higher need patients, centered in community and tribal health centers ($3.75 PMPM)

Team Care is a restricted services program; patient care is managed by one PCP and one pharmacy ($6 PMPM)

Patient Centered Medical Homes

- More comprehensive program targeted to those with specific chronic diseases
- $9.33 PMPM for those with single chronic condition, $15.33 PMPM for two conditions, $3.33 for other patients
- Future plans: performance-based incentives
- Required quality reporting

Future Reform Models

- CPC+: Medicaid proposed PMPMs and performance -based incentives
- Health Homes: Considering health home program for high need enrollees (BH or multiple chronic conditions)
- Medicaid could provide enhanced PMPMs or other payment incentives under Health Home program

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Billings Health Information Exchange Pilot

Dr. Jon Griffin, BCBS-MT

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HELP-Link

Montana Department of Labor and Industry,
Scott Eychner

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Latest Research

Montana Budget and Policy Center
Heather O'Loughlin

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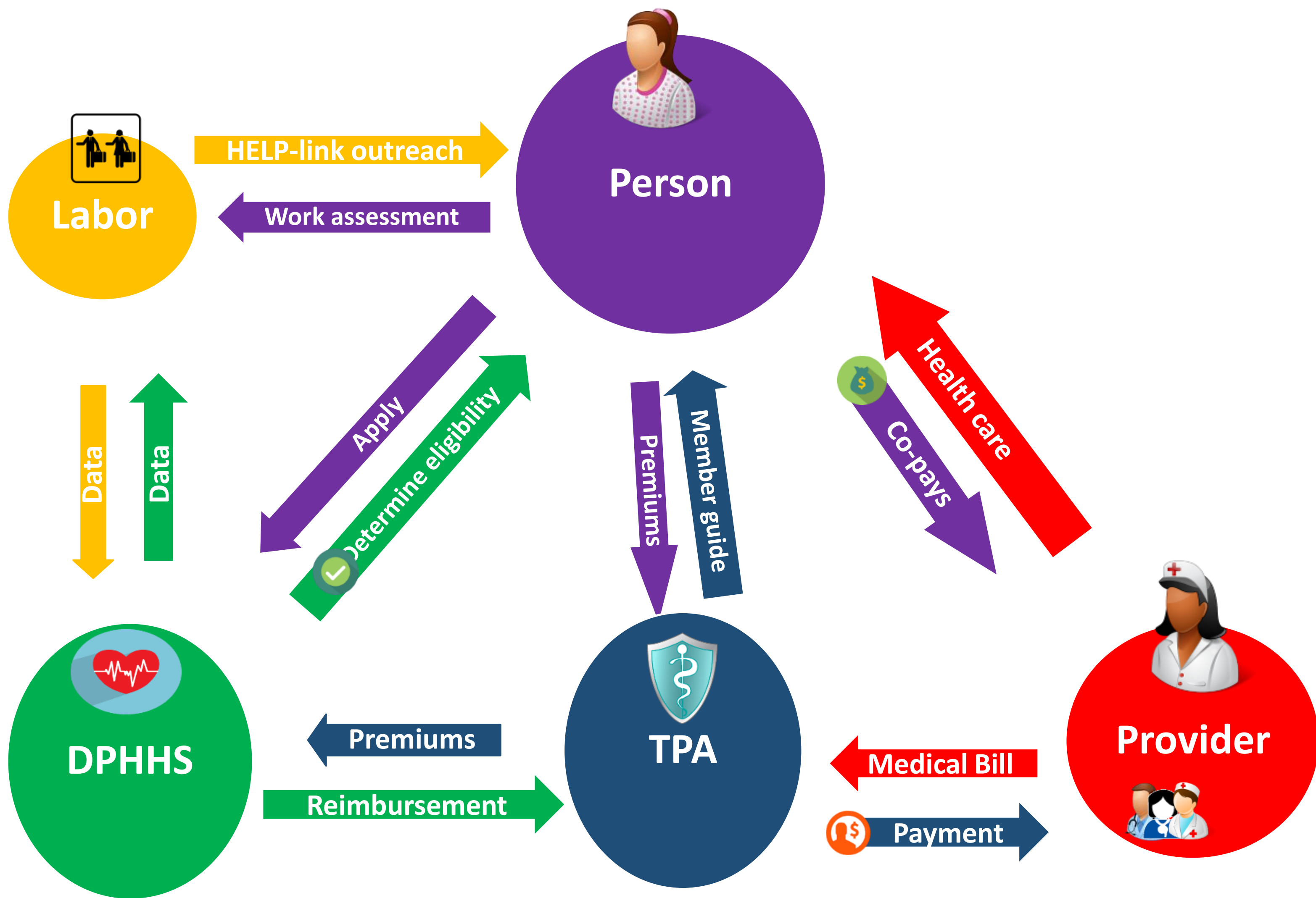
Summary Findings and Recommendations

Appendix



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HELP Act roles and responsibilities

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:

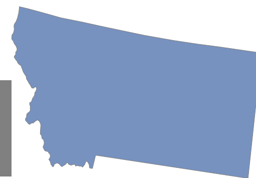
- Better quality of care for diabetes, vascular, asthma, depression, kidney disease, and hypertension
- Higher rates of cancer and substance abuse screening
- Improved measures of patient experience, including access to care, doctor rating, and continuity of care
- Physician support for program and augmented 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



Integrated Physical & Behavioral Health: PCMH Compared to 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