



Montana Health Care Innovation Plan

GOVERNOR STEVE BULLOCK'S
COUNCIL ON HEALTH CARE
INNOVATION AND REFORM

Governor Bullock appointed a council of private and public payers, providers, regulators, and patient advocates to guide the development of a statewide health transformation plan for Montana. The governor charged this group of health care sector leaders with identifying opportunities to improve care delivery and control costs in Montana's health care system, and exploring opportunities to coordinate between public and private sectors to improve health system performance and population health. This plan describes the Council's efforts to incentivize health care value over volume and improve individual and community health, while making health care more affordable for patients and preserving taxpayer resources.

June 2016

Montana State Innovation Model Design Project



Contents

- Acknowledgements..... 4
- Executive Summary..... 5
 - Montana’s Vision 5
 - Health Care Landscape and Foundation 5
 - Public-Private Partnership 6
 - Governor’s Council Prioritized Issues 6
 - Challenges and Opportunities 7
 - Target Populations 8
 - Delivery Models 8
 - Data Infrastructure 9
 - Value-Based Payment Reform 10
- Stakeholder Engagement and Planning Process..... 11
 - Approach..... 11
 - Governor’s Council on Health Care Innovation and Reform 12
 - Charge 12
 - Leadership Committee..... 13
 - Other Stakeholder Engagement 14
 - Website..... 14
 - Coordination with Other Advisory Groups 14
- Montana Health Care Landscape..... 14
 - Introduction: Access to Care..... 14
 - Health Care Providers 16
 - Health Professional Shortage Areas 16
 - Behavioral Health Provider Shortages..... 16
- Montana’s Health Insurance Market..... 17
 - Individual Market..... 17
 - Small Employer Market..... 17
 - Coverage and Payers..... 18
 - Market Participation 19
 - Uninsured in Montana 19
 - Medicaid Expansion 20



Silos and Fragmentation 20

Health Information Technology Landscape 21

 Meaningful Use and EHR Adoption 22

Population Health 24

 Behavioral Health and Chronic disease 24

 Impact of Mental Health on Chronic Disease Risk Factors Among Adults 24

 Substance Use and Mental Treatment in Montana 25

 American Indian Health Status and Disparities 26

 Target Populations for Delivery System Reform 28

 Payer Data Provided Foundation for Governor’s Council Approach 28

Models for Delivery System Transformation 28

 Range of Opportunities and Flexibility for Reform 28

 Foundation for Innovation 34

Delivery System Transformation Design Objectives 39

 Driver Diagram 39

 Aims 39

 Primary Drivers 39

 Secondary Drivers 39

 Measures 39

 Governor’s Council Principles and Approach 41

Models for Delivery System Transformation 42

 ECHO-Enhanced Collaborative Care 43

 Community Resource Teams 51

 Medicaid Health Homes 55

Transitioning to Value-Based Payment 59

 Path to Value-Based Payment 59

Delivery System Innovation Operational Plan 61

 Financial Analysis 61

 Overview 61

 Funding Sources 62

 Approach 65

 Collaborative Care Model 65

 Community Resource Team Model 70



Montana Health Care Innovation Plan

Conclusion.....	74
Workforce	74
HealthCARE Montana	75
Montana Health Care Workforce Advisory Committee	76
Rural Health IT Network Grant	76
Behavioral Health Workforce Training Implementation Plan	77
Behavioral Health Coaches	78
Community Health Workers	79
Rural Behavioral Health Primary Care Collaborative.....	79
Project ECHO.....	80
Monitoring and Evaluation	80
Measurement and Reporting Alignment.....	80
Existing Measure Inventory	80
Montana PCMH Program Provider Metrics.....	81
Community Resource Teams and ECHO-Enhanced Collaborative Care Measures	82
Timeline and Approach to Continued Planning and Implementation.....	84
Proposed Pilot Timeline and Next Steps.....	84
ECHO-Enhanced Collaborative Care	85
Community Resource Teams	85
Health IT Plan.....	85
Health IT Transformation.....	86
Introduction	86
Administrative Claims Data.....	86
Project ECHO.....	89
Health Information Exchange	91



Acknowledgements

Many thanks go to the hundreds of Montanans from across the state who contributed to the development of the State Health System Innovation Plan. Without their ideas, expertise, engagement and commitment, this plan would not exist.

While gratitude is due to the members of the council and to the following individuals who invested critical time and energy into this plan, participation in the planning process does not imply endorsement of every element contained therein.

Eric Arzubi, Keith Bailey, Carol Ballew, Ron Baldwin, Zoe Barnard, Marilyn Bartlett, Beckie Beckert-Graham, Monica Berner, Jean Branscum, Anna Buckner, Maria Clemons, Jessica Cotton, Mary Dalton, Ron Dewsnap, Dorothy Dupree, Lesa Evers, Jeffrey Fee, John Felton, Michael Frank, Jonah Frohlich, John Flink, Stuart Fuller, Ginny Furshong, Bill Gallea, Dori Glanz Reyneri, Kelley Gobbs, Christina Goe, John Goodnow, Jon Griffin, Amanda Harrow, Todd Harwell, Eric Higginbotham, Sheila Hogan, Greg Holzman, Kevin Howlett, Patricia Kosednar, Lenette Kosovich, Sarah Jordt, Kris Julliard, Monica Lindeen, Bill Lombardi, Steve Loveless, Todd Lovshin, Cary Lund, Mary Lynne Billy-Old Coyote, Bob Marsalli, Kelly McCarthy, Shannon McDonald, Steve McNeece, Sara Medley, Barbara Mettler, Janelle Nelson, Albert Olszewski, Glenda Oldenberg, Ron Olfield, Richard Opper, Duane Preshinger, Kim Pullman, Michelle Quinn, William Reiter, Jessica Rhoades, Robert Runkel, Diane Sands, Lara Shadwick, Cindra Stahl, John Thomas, Vicki Turner, Tara Veazey, Michael Vlases, Mark Wakai, Kier Wallis, M'Liss Weisner, Jonathan Weisul, Connie Welsh, Aaron Wernham, Anna Whiting Sorrell, John Williams, Todd Wilson, and Nicholas Wolter.



Executive Summary

Montana's Vision



In 2013, Governor Bullock shared his vision that, “To have a healthy economy, we need healthy citizens.” At the core of the governor’s vision was a desire for greater value in health care. “For those of us with health insurance, we’re paying too much and getting too little. And for the tens of thousands of Montanans who don’t have insurance, the emergency room has become a primary care facility, pushing costs for all of us even higher.”

Patients need increased access to the right care, at the right time, in the right place, better coordination of care, and care that is less costly and avoids unnecessary or duplicative services.

Providers need financial support for previously uncompensated services, compensation based on value of care and quality rather than volume, and an increased ability to coordinate care across providers, systems, and payment sources.

Health plans need healthier, happier plan members, help addressing factors outside of plan control, decreased cost of care, lower utilization management needs, and value-based health plan design.

Employers need a healthier workforce and improved productivity, reduced absenteeism, and less costly care.

Health Care Landscape and Foundation

By nearly all measures, the health care industry is one of the fastest growing industries in the state and is projected to maintain that status during the next decade. More than 67,000 Montanans are employed in this sector, making it one of the largest employers in the state. The health care industry has a direct impact of \$4.9 billion dollars and an estimated total gross economic output of \$6.8 billion in Montana.

While Montana has seen many innovative and promising pilot programs, efforts have historically been funded with small amounts of one-time grant funding, are not always well coordinated, and when funding is exhausted, many of the efforts have folded. Aligned approaches that drive sustained and large-scale delivery system change are a challenge given the state’s geography and limited resources.

We know that healthier Montanans make for healthier businesses, families, and a stable state economy. Individual health can have an enormous impact on individuals, their families, and the



overall economy. Behavioral health disorders in particular have a profound social impact. People with behavioral health conditions are more likely to live in poverty, have lower socioeconomic status, and lower educational attainment.¹ In 2007, those diagnosed with serious mental illness had annual earnings averaging \$16,000 less than the general population.² A *Journal of Occupational and Environmental Medicine* study found that employers in the U.S. spend on average \$33 billion per year in lost work and productivity due to depression alone.³ Each year, approximately 217 million days of work⁴ are lost or partially lost due to productivity decline related to mental disorders, costing United States employers \$193 billion annually.⁵ Better access to treatment will reduce these costs and improve productivity.

Public-Private Partnership

In October of 2015, after securing passage and approval for a private alternative to Medicaid expansion that has already brought low-cost health care coverage for more than 45,000 Montanans, Governor Bullock appointed a council of private and public payers, providers, regulators, and patient advocates to guide the development of Montana's statewide health transformation plan.

The governor charged this group of health care sector leaders with:

- Identifying opportunities to improve care delivery and control costs in Montana's health care system, and
- Exploring opportunities to coordinate between public and private sectors to improve health system performance and population health.

Governor's Council Prioritized Issues

The Governor's Council reviewed the health care landscape in Montana and prioritized three issues for its initial focus:

- Physical and behavioral health integration, including substance use, chemical dependency and mental health integration,

¹ Russell, L. (October 2010). *Mental Health Care Services in Primary Care Tackling the Issues in the Context of Health Care Reform*. Washington, DC: Center for American Progress.

² Hogg Foundation for Mental Health/Methodist Healthcare Ministries. (March 2011). *Crisis Point: Mental Health Workforce Shortages in Texas*. http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf

³ Langlieb, A.M. and Kahn, J.P. How Much Does Quality Mental Health Care Profit Employers? *Journal of Occupational and Environmental Medicine*, 47(11).

⁴ Hertz, R.P., and Baker, C.L. (2002). The Impact of Mental Disorders on Work. *Pfizer Outcomes Research*. http://www.theihcc.com/en/communities/health_care_consumerism/mental-health-parity---implementation-best-practic_g684w5lr.html

⁵ Hogg Foundation for Mental Health/Methodist Healthcare Ministries. (March 2011). *Crisis Point: Mental Health Workforce Shortages in Texas*. http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf



- Social determinants of health and disparities among American Indians and other populations, and
- Health information technology (IT) infrastructure, including health information exchange (HIE) and telehealth.

Challenges and Opportunities

The Governor’s Council identified the following challenges and opportunities related to the set of prioritized issues.

Challenges	Opportunities & Solutions
<ul style="list-style-type: none"> •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 	<ul style="list-style-type: none"> •Health IT services and workforce initiatives: <ul style="list-style-type: none"> •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

To guide its work addressing these challenges, the Council adopted the following principles.

Delivery Model Principles

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





Target Populations

In March of 2016, public and private payers presented data to the Governor’s Council on their respective high cost/high need populations. Across payers, several health care conditions emerged as potential targets for delivery model reform. These target conditions are aligned with those prioritized in Montana’s State Health Improvement Plan, developed in 2013 to advance population health in Montana.

- Patients with behavioral health conditions, especially depression and substance use, and
- Patients with chronic disease or other serious health conditions, especially:
 - Diabetes
 - Heart disease
 - Kidney disease
 - Low birth weight babies
 - Cancer
 - Musculoskeletal conditions

Delivery Models

Montana’s payment and delivery system reform efforts have focused recently on patient-centered medical homes (PCMHs). State legislation defines a PCMH as a model of health care that is directed by a primary care provider offering family-centered, culturally effective care that is coordinated, comprehensive, continuous, and, whenever possible, located in the patient’s community and integrated across systems. PCMHs promote a team approach to care under which health care professionals are able to work at the “top” of the license. This means increasing the use of staff members with lower-level credentials, who are often under-utilized compared to what their clinical licensure and personal potential may permit them to do, thereby reserving resources of high-level providers to address more acute or complex needs. Most teams include, in addition to primary care providers, a care coordinator, patient educators, and sometimes a mental health provider and clinical pharmacist.

Four payers, including Medicaid, Blue Cross Blue Sheild of Montana, Allegiance, and PacificSource currently participate in the PCMH Program. Initial results are promising and provide an ideal foundation upon which other delivery and payment reform efforts can be built. Other delivery models, including Collaborative Care, Community Resource Teams, and Medicaid Health Home pilots will build on the PCMH foundation to more effectively serve target populations with access barriers and disparities. These models are described below:

- ECHO-Enhanced Collaborative Care: Project ECHO is a technology-enhanced model that provides collaboration from specialists at a “hub” to remote primary care physicians and providers seeking to increase specialized knowledge in treating complicated conditions. Collaborative care is an evidence-based integrated physical and behavioral health care model that that has proven to be effective at treating mental health conditions such as depression and anxiety. Increasing collaborative care can be challenging in a large, rural



state like Montana with significant behavioral health workforce shortages. In an effort to overcome these challenges, Montana's pilot proposes to use simple Project ECHO technology and protocols to provide psychiatric expertise and consult to remote collaborative care teams.

- **Community Resource Teams:** Community Resource Teams bring interdisciplinary providers and staff together to help “super utilizer” patients by addressing patient needs outside of the traditional care setting (e.g., in the community or home). Montana will pilot Community Resource Teams in three communities over the next two years, using a “hotspotting” approach to support super-utilizer patients with the goal of reducing patient utilization, preventing readmissions, and improving patient and provider satisfaction.
- **Medicaid Health Homes:** Patients with multiple or severe chronic conditions could potentially benefit from better coordination and management of the health and long-term services they receive. Health homes are designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and long-term community-based services and supports. The health home model of service delivery is specific to Medicaid, and expands on the traditional medical home model by building additional linkages and enhancing coordination and integration of medical and behavioral health care to better meet the needs of people with multiple chronic illnesses. The model aims to improve health care quality and clinical outcomes as well as the patient care experience, while also reducing per capita costs through more cost-effective care. Medicaid Health Homes will be piloted by four sites (two mental health centers and two federally qualified health centers) to provide integrated primary, mental health and substance use services for 16 to 25 year olds. The results of these pilots will help the Montana Department of Health and Human Services evaluate how Health Homes may be able to address behavioral health and chronic conditions for other populations.

Data Infrastructure

In order for Montana to engage in payment reform models that pay and reward for outcomes and not just volume, payers and providers need the ability to collect and analyze data in a meaningful way. As new care and payment models evolve, establishing such a platform could open doors to more innovative ways of delivering and coordinating care and paying for services. A collaboratively developed health information exchange (HIE) has the potential to create pathways to improvements within our systems of care and assist in targeting limited resources to those most in need. An alliance of providers in Billings is currently implementing an HIE pilot project. Concurrently, the Montana Medical Association, in collaboration with the Montana Hospital Association, is leading a statewide group of stakeholders to receive updates and learn from the pilot and use those learnings to begin planning a statewide effort.



Value-Based Payment Reform

As Montana looks to implement and fund integrative care, it will need to evaluate and pursue payment models that support the effective delivery models. This will represent a significant shift from the current fee-for-service payment structure under which most health care is paid in Montana. The transition to from fee-for-service to value-based payments will need to evolve over time, as payers and providers build the requisite systems, capacity, and agreements.

The Montana DPHHS, Governor's Office, and Governor's Council on Health Care Innovation are committed to continuing the multi-stakeholder engagement and planning process initiated through the SIM Design Grant and to advancing multi-payer delivery system and payment reform. Work groups will facilitate the continued planning, stakeholder engagement, and implementation of regional multi-payer pilots that can evolve towards larger scale, multi-payer statewide initiatives.

The pilots projects envisioned in this plan would allow Montana to test promising models at a regional level and across payers before considering larger scale and statewide reforms. Recognizing this opportunity, the state is actively convening payers, state and federal agencies, providers and foundations with the goal of supporting and evaluating the pilots, while continuing active and meaningful stakeholder engagement to advance delivery system and payment reform.

Montana's innovation plan outlines an approach and initial estimates of costs and savings for the proposed delivery models.



Stakeholder Engagement and Planning Process

Approach

Montana's goal is to improve health and health care delivery and lower costs. In order to achieve these aims, Governor Bullock appointed a group of key stakeholders and decision-makers to serve on the Governor's Council on Health Care Innovation and Reform. The Council provides a forum for ongoing public-private collaboration between multiple payers, purchasers, providers, communities, work groups, and public agencies to identify opportunities to act in complementary ways.

The Council's 2016 calendar is below. The Council meets bi-monthly and will continue to discuss and refine the proposed pilots in the coming months. The Council will also spend significant time in future meetings discussing American Indian health, which has been identified as an important area of focus.

The implementation of any one strategy by any one sector in isolation will not achieve transformative change, and ongoing collaboration is integral to transformation. Intensive engagement of a broad range of stakeholders is a centerpiece of the Montana Health Care Innovation initiative. The Governor asked DPHHS to lead the effort on behalf of the state, so that Medicaid could serve as a catalyst for reform and create an inclusive process. Through this process, DPHHS has sought meaningful input from a wide array of stakeholders through interviews, one-on-one meetings, webinars, conferences, public forums and industry association meetings. DPHHS oversaw the process of collecting ideas, aligning efforts, and identifying areas of potential common ground across stakeholders that could suggest preliminary mechanisms for transforming health care in Montana.

DPHHS also became the first state agency to become a national "committed partner" in the Health Care Payment Reform Learning Action Network, the national table that mirrors the work of the Governor's Council. The Learning and Action Network is a partnership of private payers, employers, consumers, providers, states, state Medicaid programs, and other partners working to expand alternative payment models.

Montana's innovation planning structure includes representatives from the following organizations:

- Governor's Council on Health Care Innovation and Reform
- State Innovation Leadership Committee
- Representatives from other work groups and related efforts:
 - Healthier Montana Task Force
 - Patient Centered Medical Home Advisory Council
 - HIE/HIT Work Group



Montana Health Care Innovation Plan

- Pilot work groups for community resource teams, ECHO-enhanced collaborative care, and Medicaid health homes
- Government agencies
 - Montana Department of Public Health and Human Services
 - Public Health and Safety Division
 - Montana Medicaid
 - Montana Commissioner of Securities and Insurance
 - Montana Department of Administration
 - State Employee Health Plan
- Montana’s Quality Improvement Network-Quality Improvement Organization, Mountain Pacific Quality Health Foundation

Governor’s Council on Health Care Innovation and Reform

Charge

The governor charged the Governor’s Council on Health Care Innovation and Reform with:

- Identifying opportunities to improve care delivery and control costs in Montana’s health care system, and
- Exploring opportunities to coordinate between public and private sectors to improve health system performance and population health.

The Council aims to reach consensus while implementing new delivery system models and accompanying value-based payment methodologies. Ultimately, the Council hopes to improve patient experience and health and reduce costs.

In pursuit of these goals, the Council’s meeting schedule has and will include the following topics:

Council Launch	Common Agenda and Next Steps	Delivery System	Innovation Plan	Launch Planning & Implementation Teams	Presentations on Recommended Reforms	Pilot Details
Nov 3	Jan 19	March 8	May 10	July 12	Sept 13	Nov 15



Montana Health Care Innovation Plan

Overview of SIM and progress to date. Present health care reform options as developed and refined by background research and stakeholder input	Review needs assessment Develop consensus on common agenda, 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 HIT/HIE update	MACRA briefing Update on State Innovation Plan Integrated behavioral health lexicon Pilot/Implementation working sessions HIT/HIE update	American Indian health presentation and discussion Implementation working sessions by model HIT/HIE update	Planning and implementation reports to full Gov. Council Continue implementation on planning HIT/HIE update	Obtain consensus on pilot details HIT/HIE update
--	---	--	--	--	---	---

Leadership Committee

A Leadership Committee works to oversee the planning process. Staff leadership from the Montana Commissioner of Securities and Insurance, the Montana Department of Administration, the Montana Department of Health and Human Services, the MT Quality Innovation Network Quality Improvement Organization, and the Governor’s Office meet bi-weekly or as needed to:

- Oversee the SIM Project design process across all work streams and deliverables,
- Provide background information and data, as available, to inform research and analysis of health system reforms,
- Assess and provide information on policy flexibility and opportunities within the state (e.g. regulations, legislation, waivers, etc.) to advance health system reforms,
- Provide direction on innovation models selected for further research and analysis, and
- Review and provide input on deliverables and drafts developed.

Members of the Leadership Committee also participate in presentations to and meetings of the Governor’s Council.



Other Stakeholder Engagement

Website

Montana DPHHS' website provides information to stakeholders and the public including information about Governor's Council meetings and meeting materials. An email listserv is used to distribute email announcements, presentations, and other program-related information to interested stakeholders.

The Montana SIM website can be found at <http://dphhs.mt.gov/healthcare/innovation>.

Coordination with Other Advisory Groups

In addition to the Governor's Council and its accompanying stakeholder engagement activities, there are several advisory bodies and stakeholder groups that meet regularly to address health care programs and issues in Montana. There was natural crossover between many members of the Governor's Council and members of other stakeholder bodies, allowing for aligning efforts and sharing among these groups. Department staff coordinated with these groups where appropriate and invited them to attend and provide updates at the Governor's Council meetings.

Healthier Montana Task Force

Governor Bullock appointed a diverse Task Force to assist the Department of Public Health and Human Services in implementing the State's health improvement plan and monitoring progress in creating a healthier Montana. A member of the task force serves on the Governor's Council. The Task Force has also provided general input to Montana's innovation plan.

Patient Centered Medical Home Stakeholder Council

The PCMH Act was passed by the 2013 Montana Legislature and signed into law by Governor Bullock. The law set up a council of stakeholders to create standards for the program, outline the qualifications for health care providers and insurers to participate, and promote the program. The volunteer council includes primary care providers, health plan representatives, Medicaid staff, public health officials, and consumer advocates. A member of the PCMH Stakeholder Council serves on the Governor's Council.

Montana Health Care Landscape

Introduction: Access to Care

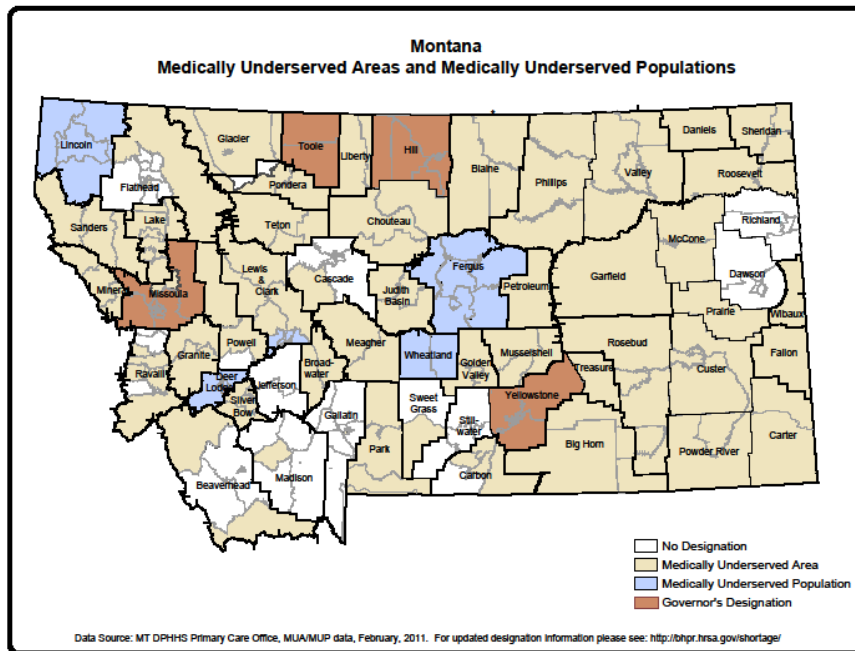
While the number of uninsured in Montana continues to drop, many Montanans still experience limited access to health care for financial or geographic reasons or both. More than



half of the state’s population lives in rural or frontier areas,⁶ characterized by limited access to health care. Many face long distances and travel times to reach essential services.⁷ In fact, most Montana counties are designated as medically underserved.⁸

Geographic isolation and the long distances between towns and health care organizations are often barriers to health care access in Montana. Fifty-four percent of Montanans travel more than five miles (one way) to get to a doctor’s office; 13% travel more than 30 miles; 7% travel more than 50 miles.⁹ With little or no public transportation available in many of Montana’s isolated, rural communities, access to local primary care and out-of-town specialty medical services can be a problem. One Montana Critical Access Hospital CEO always began medical provider recruiting conversations with, “Our town is 70 miles from the nearest McDonald’s, 90 miles from the nearest Wal-Mart and 200 miles from the nearest shopping center. Can you handle that?”¹⁰

Financial and geographic barriers to health in Montana are unequally distributed by race: half of non-Indian residents but nearly two-thirds of American Indian residents live in medically underserved counties.



⁶ <http://www.raonline.org/states/Montana.php>

⁷ Larson EH et al. *State of the Health Workforce in Rural America*. Rural Health Research Center, University of Washington, Seattle, 2003.

⁸ <http://bhpr.hrsa.gov/shortage/muaps/index.html>

⁹ Centers for Disease Control, Behavioral Risk Factor Surveillance System Data (BRFSS) State Added Question, “Travel Access To Health Provider,” 2005.

¹⁰ *Montana Health Care Association (MHCA)*, <http://www.mthealthcare.org/>



Health Care Providers

Health Professional Shortage Areas

There are 65 hospitals in Montana and of those, 48 are critical access hospitals. Fifty-nine hospitals in Montana are in rural or frontier counties, and seven counties don't have a hospital at all. According to the Montana Rural Health Plan, published in 2011 by DPHHS, 46 of the rural/frontier counties in Montana are completely or partially designated as Primary Care Health Professional Shortage Areas (HPSAs). This means 51% of Montanans live in primary care health professional shortage areas. Rural communities also have proportionately fewer primary care doctors than urban areas.

Montana has 2,419 practicing physicians, of which 78 percent are located in just six counties. There are approximately 1,922 primary care providers (including PAs and APRNs) currently in Montana. Montana ranks 35th in terms of the U.S. Census Bureau's analysis¹¹ of doctors per 100,000 resident population. In 2020 Montana is projected to face a shortage of more than 2,000 registered nurses (RNs).

Demand for physical therapists, pharmacists, and dentists is expected to grow at the national level as well as in Montana.

Behavioral Health Provider Shortages

According to the Health Resources Services Administration, all of Montana's 56 counties have been designated health care provider shortage areas (HPSAs) for mental health services. For a full report of all health care shortage areas, see Montana Primary Care Needs Assessment - 2016.¹²

Providers and facilities are especially scarce on the eastern side of the state. In fact, eastern Montana is the largest and most severe mental health shortage area in the entire United States, creating a significant disparity in access to mental health care among those who live there. The eastern Montana Mental Health Professional Shortage Area includes 78,607 Montana residents and is spread over 17 counties and 47,945 square miles.

Of all medical professions, psychiatrists are in shortest supply, according to the Kaiser Family Foundation. Except for Yellowstone County, the entire state of Montana is designated as a mental health professional shortage area. There are no practicing psychiatrists in eastern Montana outside of Yellowstone County, with the exception of on half-time psychiatrist, based in Livingston and employed by Billings Clinic, who provides telemedicine services to Glendive.

¹¹ <http://www.census.gov/statab/ranks/rank18.html>

¹² Montana Primary Care Needs Assessment, 2016

<https://dphhs.mt.gov/Portals/85/publichealth/documents/PrimaryCare/March2016PCNeedsAssessment.pdf>



Even in Yellowstone County, the wait time for a new outpatient office visit with a Billings Clinic psychiatrist exceeds 37 days. Efforts to recruit additional psychiatrists for practice in Montana have been difficult, and Billings Clinic has found that it takes at least two years to recruit a new provider.

Montana's Health Insurance Market

Individual Market

At the end of 2011, the individual health insurance market had 53,739 covered lives and only two insurers with a market share of more than four percent. In 2016, there are 80,619 lives covered in the individual market and three health insurers with a market share of 10 percent or more.

Sixty-five percent of individual market policies (52,358) were issued through the Health Insurance Marketplace and 86 percent of those individuals qualified for a federal premium tax credit. Forty-eight percent of the individuals covered through the Marketplace qualified for cost sharing reductions. Looking at the individual market as a whole, on and off the Marketplace, 59 percent of the total individual market qualified for a tax credit (an increase from 50 percent last year) and 33 percent of the total individual market qualified for cost sharing reductions.

Small Employer Market

The small employer group market at the end of 2011 had approximately 54,500 covered lives. In 2016 there were 48,333 covered lives, an 8 percent increase over 2015. The small group market declined when the individual market became "guaranteed" available after 2014 and when health status discrimination and pre-existing condition exclusions were eliminated. For many people, individual coverage became more affordable because of premium tax credits. Consequently, many small, family owned businesses moved to the individual market exchange.

In 2011, there were four health insurers with a market share over 4 percent. In 2016, there are two health insurers with a market share over 10 percent and three other insurers with a smaller market share that are actively marketing small group health plans in Montana.

The most selected plan types across the individual and small group markets were the silver and bronze plans. In the individual market, silver was the most popular plan type on the Marketplace and bronze was the most popular plan type outside the Marketplace. In the small group market, silver was the most popular plan type, followed by gold.



Coverage and Payers

2015 Baseline Snapshot of Montana Coverage

Individual Market (Incl. Marketplace)

- 80,619 individuals receive coverage in the individual market.
- 52,358 are enrolled in Marketplace plans

Employer-Sponsored Insurance

- 478,200 individuals (47% of the population) are covered through employer-sponsored plans.¹³

Medicare

- As of 2015, 201,359 individuals were enrolled in Medicare (20% of the population)

Medicaid/Healthy Montana Kids (CHIP)

- As of May 2016, Montana Medicaid and CHIP covered over 193,231 people, including 44,114 newly eligible through Montana's Medicaid expansion.¹⁴
- Approximately 115,006 of these enrollees are children.

Tribal Health/IHS

- 65,000 Montanans identify as American Indian or Native American.
- More than 40% of these individuals are uninsured.

Other Public Plans

- The Montana State employee plan covers 33,000 employees, dependents, and retirees, (3% of the population). In addition, the University Health Plan has roughly 18,000 covered lives.

Uninsured

- As of June 2016, the percentage of Montanans lacking health insurance has fallen to 7.4%, down from about 20% three years ago. In total numbers, approximately 195,000 Montanans lacked health insurance in 2013, before the final elements of the Affordable Care Act took effect. In 2015, an estimated 151,000 Montanans lacked health insurance (15% of the population).¹⁵

¹³ Kaiser Family Foundation estimates based on the Census Bureau's March 2015 Current Population Survey (CPS: Annual Social and Economic Supplements). Accessed at Kaiser Family Foundation kff.org/other/state-indicator/total-population/ 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.

¹⁴ DPHHS Enrollment Reports

¹⁵ <http://csimt.gov/news/montana-uninsured-population-decreases/>



Market Participation

At the state level, Montana is leveraging health care purchasing power to advance health care innovation through the joint efforts of Medicaid (which operates Medicaid, the HELP Plan, and Healthy Montana Kids), the Department of Administration's Health Care and Benefits Division and a coalition of commercial insurance carriers including BlueCross BlueShield of Montana, Allegiance, and PacificSource. The initiative includes payers who cover 90 percent of the fully insured commercial market.

Montana's public plans have also leveraged their contractual relationships to advance health care transformation. Medicaid partners with its administrative services organization (ASO), BlueCross BlueShield of Montana (BCBSMT), to participate in payment and delivery system reform. Montana's Health Care Benefits Division State Employee Health Plan, the largest self-insured employer plan in Montana, partners with its ASO, Allegiance, to participate in payment and delivery system reform for its 31,500 members including employees, dependents, and retirees of the state. The health benefits division of Montana's institutions of higher education has also been participating in the planning process. The State Employee Plan is also laying the groundwork for the future participation of interested local education agencies and local governments.

Montana providers are also actively engaged in health care delivery system transformation. The leaders of the Montana Medical Association and Montana Academy of Family Physicians serve on the Governor's Council and have been vital partners in the Montana's intensive stakeholder engagement process.

Uninsured in Montana

In 2012, the Office of the Commissioner of Securities and Insurance (CSI) retained the University of Montana Bureau of Business and Economic Research (BBER) to conduct a comprehensive study of the uninsured population. BBER conducted household surveys and consulted with other expert resources. In 2012, BBER found that there were approximately 195,000 uninsured people in Montana, about 20 percent of the population.

In the spring of 2014 and 2015, the CSI surveyed health insurers and Medicaid, and determined that the uninsured population had decreased to 16.9 percent in 2014 and 15 percent in 2015. This reduction was mainly due to growth in the individual health insurance market (primarily the Health Insurance Marketplace) and an increase in children covered by Medicaid and Healthy Montana Kids (HMK), which is Montana's Children's Health Insurance Program.

Montana has consistently seen strong Marketplace enrollment. For both 2014 and 2015, Montana was among the ten states with the highest percentage of those eligible for



Marketplace plans who enrolled.¹⁶ Although a five percent decrease in the uninsured rate after only two years was significant, a large number of individuals were falling into the “coverage gap” because Montana had not expanded Medicaid. Many of the remaining uninsured, an estimated 80,000, were unable to afford to purchase individual coverage, no matter how badly they needed it, because individuals below 100 % of FPL are barred from accessing premium tax credits and cost sharing reductions in the exchange.

Medicaid Expansion

On January 1, 2016, the Montana expanded state Medicaid eligibility to include all adults up to 138 percent of the Federal Poverty Level, which is about \$16,000 for an individual or \$33,000 for a family of four. Expansion has been a tremendous success, with more than 46,000 newly eligible individuals enrolled as of June 1, 2016. The new program, which is administered through a contract with Blue Cross Blue Shield of Montana, has already saved the state more than \$3 million in general fund dollars.

Upon implementation of Medicaid expansion, the uninsured rate plummeted dramatically. In June 2016, CSI recalculated insurance coverage and determined that the current uninsured rate is approximately 7.4 percent. Approximately 957,000 Montanans have health coverage, while about 76,000 remain uninsured.

Silos and Fragmentation

Like other states, Montana’s current health system runs along multiple fault lines. The system remains largely siloed, which can cause significant gaps in coordination between and among primary care and specialty practices; between and among ambulatory and hospital settings; and between and among primary care and behavioral health. Seamlessness of care for individuals with physical health, mental health, and/or substance use issues is widely recognized as desirable, but administrative and financing challenges have stood in the way of a more coordinated effort. Despite a host of innovative initiatives and programs, many providers and programs manage a distinct element of a person’s or community’s health, and are paid separately or not paid at all.

In a fee-for-service environment, savings in one silo or funding stream caused by intervention by another cannot easily be moved or shared to provide incentives to produce the outcomes desired. This challenge is further exacerbated by restrictions the state legislature has placed on funding for health care and social programs. As such, there are few incentives for actors within the system to work collaboratively to meet complex needs. This unnecessarily frustrates individuals and families as they try to navigate in and across systems of care and social

¹⁶ Kaiser Family Foundation <http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/>



supports—and, more critically, can result in missed opportunities to prevent complications and unnecessary deaths.

This is despite mounting evidence that the greatest expenditures and most preventable adverse health outcomes are associated with a lack of care coordination for individuals and families who have complex needs across multiple systems.

The silos and gaps between physical and behavioral health have been glaring. Studies consistently find that integrated behavioral health improves overall patient outcomes and reduces hospital utilization, and yet the Montana Health Care Foundation's 2016 report, *Integrated Behavioral Health in Montana: A baseline assessment of benefits, challenges and opportunities*, found that the majority of Montana health care providers are not delivering fully integrated care. Only one-third described their practices as fully integrated.

The report identifies integrated behavioral health as a potential solution for some of Montana's most challenging health issues. However, current funding structures, private and public, are often fragmented and not conducive to the kind of integrated recommended. Additionally, serious behavioral health workforce shortages limit Montana's ability to address the need.

This challenge is exacerbated by the lack of Health Information Technology systems that can aggregate and analyze claims and encounter data across payers, and the lack of interoperable systems that can communicate with each other.

While Montana has seen many innovative and promising pilot programs attempting to address the lack of an information infrastructure, these efforts have largely been uncoordinated and have not achieved statewide scale. Many promising efforts are in early stages, not yet fully systematized, and do not yet have a clear path to sustainability or expansion. The state's geography and lack of resources have posed challenges to aligning approaches that drive sustained and large-scale delivery system change.

Health Information Technology Landscape

Health data, the ability to share that data among a patient's providers, and the collective capacity to aggregate the data at a population level for analysis are all critical for systemwide health care innovation.

Meaningful Use (MU) is a CMS Medicare program that aims to promote the use of data in the provision of health care. It provides incentives for providers to use electronic health records with the goal of improving patient care. Meaningful use in a health information technology (HIT) context, defines minimum U.S. government standards for using electronic health records (EHR) and for exchanging patient clinical data between health care providers, and patients.

The use of health information technology is growing in Montana. This section of Montana's plan describes HIT usage, with a focus on publicly available data on electronic health record



(EHR) adoption and meaningful use attainment among Montana’s hospitals and providers. Also included is information on EHR adoption among IHS, Tribal, and Urban Indian Health providers, and EHR-focused initiatives among community health centers and State-owned and operated health care facilities.

Meaningful Use and EHR Adoption

Montana Provider Meaningful Use and EHR Adoption Highlights¹⁷

Hospitals

- 91% of all Montana Critical Access Hospitals and small rural hospitals have demonstrated meaningful use.
- 92% of all Montana hospitals have demonstrated meaningful use through Medicare.
- 89% of Montana Medicaid enrolled hospitals (64 hospitals) have demonstrated meaningful use.

Professionals

- 43% of all Montana qualified professionals (in both Medicare and Medicaid) have adopted, implemented, or upgraded EHRs or demonstrated meaningful use.
- 53% of physicians, 23% of NPs, and 5.5% of Physicians Assistants have demonstrated meaningful use.
- Only 12% of all Montana Medicaid professionals have demonstrated meaningful use.*
 - 14% of Medicaid dentists
 - 15% of Medicaid mid-level practitioners
 - 9% of Medicaid physicians and psychiatrists

All IHS and tribal-operated facilities in Montana use the IHS Resource and Patient Management System (RPMS), which captures and stores administrative and claims data. The RPMS EHR system is certified for meaningful use under 2014 Office of the National Coordinator for Health Information Technology (ONC) Standards (as of October 2014).

Montana tribal and IHS leaders have identified the following issues related to HIT that need to be addressed looking forward¹⁸:

- RPMS upgrades to support participation in PCMH and other delivery models; RPMS is not currently able to support required reporting
- RPMS is not currently able to meet Medicare (PQRS) reporting requirements

¹⁷ Source: ONC Health IT State Summary, February 2015.

*EMAIL FROM DARCI J. WIEBE, FISCAL BUSINESS ANALYST

¹⁸ Source: Interviews with IHS and tribal health leaders and

[HTTPS://WWW.HEALTHIT.GOV/SITES/DEFAULT/FILES/RTC_ADOPTION_AND_EXCHANGE9302014.PDF](https://www.healthit.gov/sites/default/files/rtc_adoption_and_exchange9302014.pdf)



Some tribal health centers and urban programs in Montana are “on track” to meet meaningful use requirements, and are focused on Medicaid incentives – Urban Indian programs report delays in rolling out EHR enhancements (e.g. Direct Messaging and Patient Health Portal) that could facilitate participation in meaningful use.)

Other EHR Adoption Initiatives

Montana Primary Care Association Initiative

- 14 community health centers have adopted, implemented, and are meaningfully using eClinicalWorks (eCW) practice management system and EHR
- MPCA is leading a grant-funded initiative with 16 community health centers to build a data aggregation and population health analytics network
- 4 beta sites have implemented the eCW aggregation/analytics tool as of Q1 2016
- Implementation with remaining sites will continue through Fall 2016
- Health information exchange (HIE) is a top priority for a future phase of work¹⁹



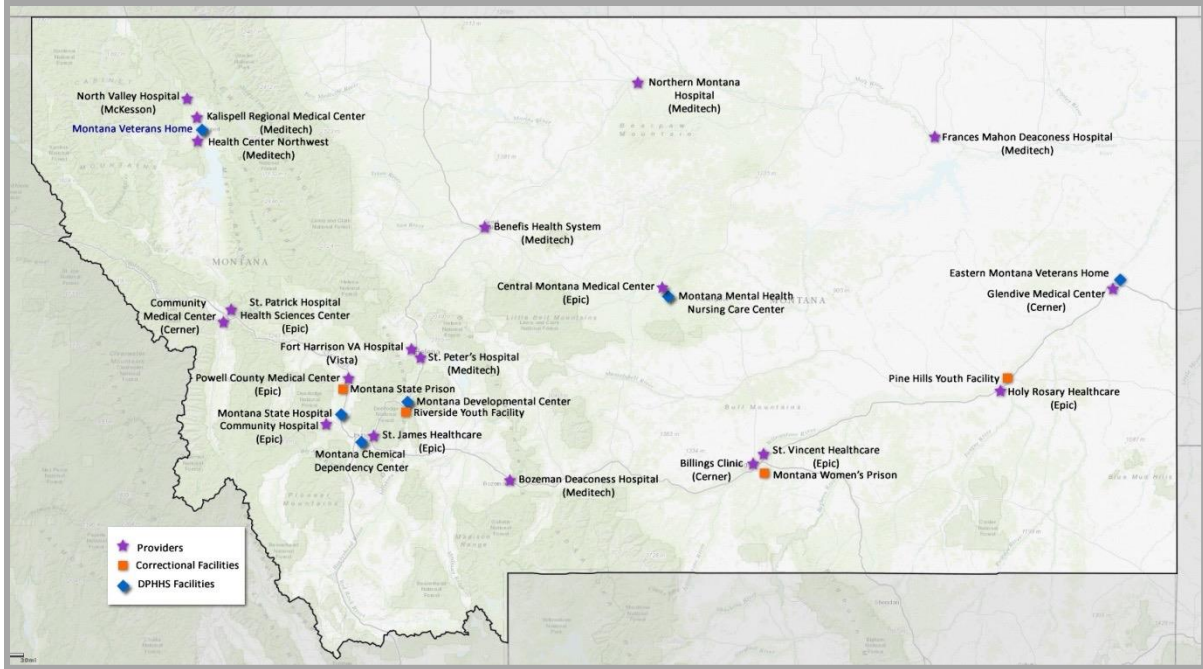
State owned and operated health care facilities

Disparate EHRs are currently used across state facilities, including the Montana State Hospital, Department of Corrections facilities, and the Montana Chemical Dependency Center, making

¹⁹ Source: Bob Marsali, Executive Director, Montana Primary Care Association.



information to support care transitions and population health management difficult. Montana is evaluating requirements and considering opportunities to transition to a single EHR platform



Note: State employee clinics are not pictured.

for state facilities.

Population Health

The Governor’s Council used the Montana State Health Improvement Plan as a resource to inform the Governor’s Council’s selection of target population health priorities. The State Health Improvement Plan was completed in June 2013. Specific concerns identified by the Governor’s Council are outlined below.

Behavioral Health and Chronic disease

Impact of Mental Health on Chronic Disease Risk Factors Among Adults²⁰

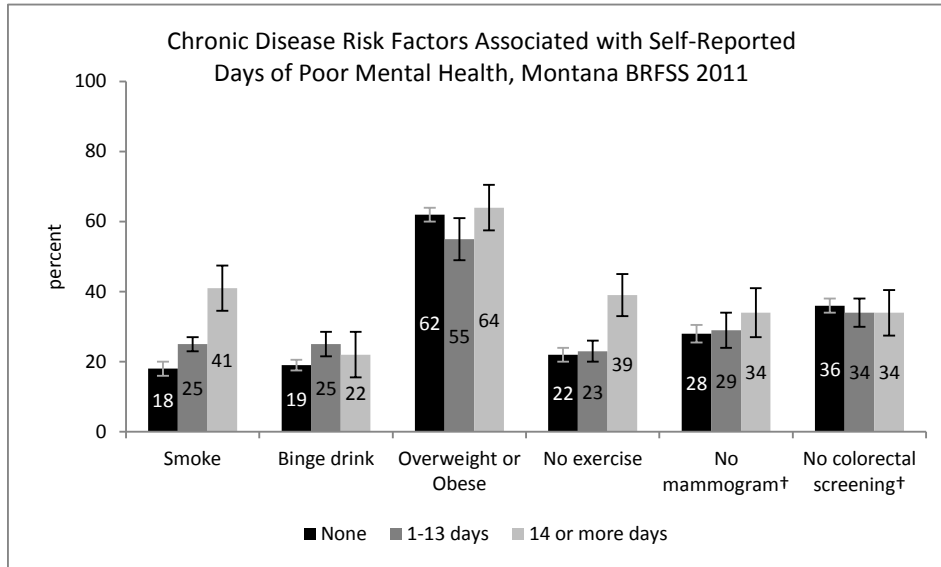
The Council identified specific concerns surrounding the connection between mental or behavioral health and chronic conditions or chronic disease risk factors. This concern is demonstrated in the data. For example, one fifth of respondents to the 2011 Montana Behavioral Risk Factor Surveillance System (BRFSS) survey reported experiencing between one and 13 days of poor mental or emotional health in the month prior to the survey; 11% reported

²⁰ Montana Behavioral Risk Factor Surveillance System, 2011, <http://74.205.72.25/html/brfss-index.shtml>



experiencing 14 or more days. The remaining two thirds did not report experiencing poor mental or emotional health.

Respondents who reported experiencing 14 or more poor mental health days per month also reported significantly higher rates of smoking and failure to engage in any leisure time exercise. Both are risk factors for most chronic diseases. Days of poor mental health were not associated with significant differences in other risk factors, such as binge drinking, being overweight or obese, or failing to participate in breast or colorectal cancer screening.



The risks of cardiovascular disease are also significant. It is the leading cause of death among adults in Montana. Twelve percent of non-Indian residents and 15% of American Indian residents reported a history of heart attack, stroke, or coronary artery disease. Approximately one third reported being diagnosed with high blood pressure or high serum cholesterol. Nearly two thirds of non-Indian respondents and almost three quarters of American Indians were overweight or obese. Smoking was substantially higher among American Indian than among non-Indian residents. All are risk factors for cardiovascular disease. These conditions are not mutually exclusive; respondents may have had a history of more than one critical health event or more than one high-risk condition.

Substance Use and Mental Treatment in Montana

Substance use is also an identified problem in the state. Alcohol is the most commonly used substance among Montana adults. One in five Montanans reported binge drinking and 8% reported heavy drinking.

More than a third of high school students reported drinking in the past month, and a quarter reported having five or more drinks on one occasion. A quarter also reported riding with a driver who had been drinking and 10% reported drinking and driving. Marijuana use and the



use of prescription drugs without a prescription were also common. Students reported using other drugs (cocaine, heroin, methamphetamine, ecstasy, and steroids) infrequently, although 12% reported trying inhalants at least once.

Substance use is a major contributing factor to death by unintentional injury, which has been the leading cause of death for Montanans between the ages of 1 and 49 years. The age-adjusted mortality rate in Montana was 54.1/100,000 (95% CI 49.6 – 58.9) in 2011, higher than the U.S. rate, which averaged between 38 and 40 per 100,000 between 2000 and 2009.²¹ Most unintentional injury deaths among Montana residents were caused by motor vehicle crashes (34%), falls (21%), and poisoning (17%). Among poisoning deaths, most were from use or misuse of prescription or illicit drugs.

More than two thirds of patients with depression receive treatment in the primary care setting²². This is occurring in a context characterized by inadequate training opportunities, geographic isolation, and severe time constraints facing rural clinicians. A recent study reported that two-thirds of primary care physicians could not get outpatient mental health services for their patients.²³ Patients whose chronic medical care needs are not treated in the ambulatory care setting often surface in acute care settings where treatment costs may easily exceed the costs of ambulatory care by up to 20 times.

American Indian Health Status and Disparities

The Council also identified concerns regarding the significant disparities between American Indian and non-Indian health access, status and outcomes. Improving health equity and reducing such disparities must be a priority for Montana. Unfortunately, many Native Americans go without adequate health care for a variety of reasons. Although access to care is a concern for all rural residents, it is even more dire for American Indians. Nearly two-thirds of American Indian residents in Montana live in medically underserved counties, and more frequently report barriers to care access than non-Indian residents, including lack of access to primary care and preventative services like screening, testing, and check-ups. Lack of access, in combination with other social determinants, ultimately contributes to Indians dying a generation younger than non-Indians.

In the 2011 Behavioral Risk Factor Surveillance System (BRFSS) survey, American Indian residents reported that they did not have a person they regarded as their usual health care provider more frequently than non-Indian residents.

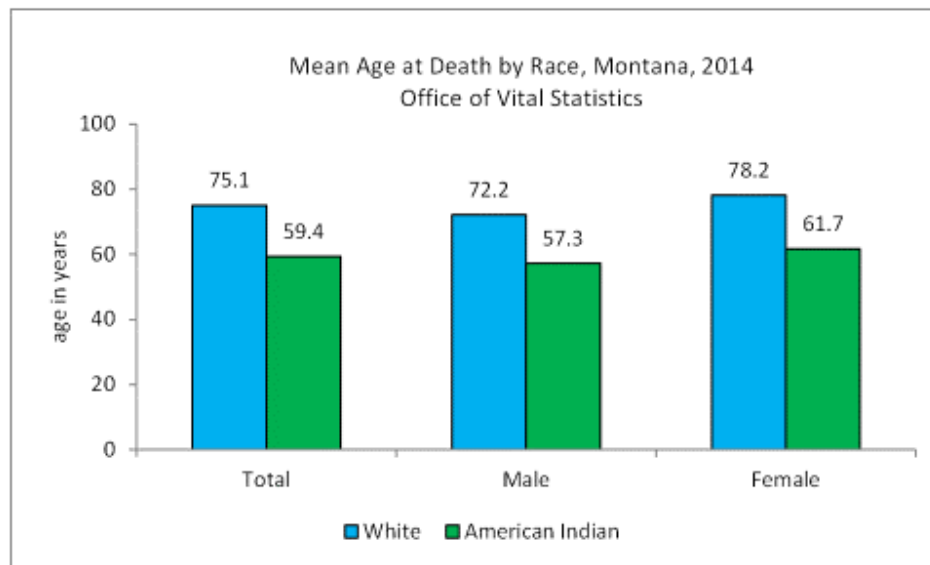
²¹ <http://www.cdc.gov/nchs/fastats/acc-inj.htm>

²² Mental illness surveillance among adults in the United States. Reeves WC1, Strine TW, Pratt LA, Thompson W, Ahluwalia I, Dhingra SS, McKnight-Eily LR, Harrison L, D'Angelo DV, Williams L, Morrow B, Gould D, Safran MA; Centers for Disease Control and Prevention (CDC). <http://www.ncbi.nlm.nih.gov/pubmed/21881550>

²³ A three-component model for reengineering systems for the treatment of depression in primary care. Psychosomatics. 2002 Nov-Dec;43(6):441-50. Oxman TE1, Dietrich AJ, Williams JW Jr, Kroenke K. <http://www.ncbi.nlm.nih.gov/pubmed/12444226>



The age-adjusted mortality rate for non-Indian residents of Montana was substantially lower than for American Indian residents: 742.6 per 100,000 compared to 1184.6 per 100,000. In addition, the mortality rates for many individual causes of death were lower for non-Indian residents than for American Indian residents.



American Indian residents of Montana have substantially higher incidence rates of lung cancer, as well as colorectal, kidney, and liver cancers.

The federal government has a trust obligation to provide health care to Native Americans. This is delivered through a system of providers that include the Indian Health Service, tribal health programs, and Urban Indian Health Centers. There are three hospitals in the state that are classified as Indian Health Services (IHS), located in the communities of Browning, Crow Agency and Harlem. The Fort Belknap Health Center in Harlem was the first Indian Health Service critical access hospital in the nation. Two tribes in MT, the Confederated Salish & Kootenai and Chippewa Cree, operate their own health programs.

There are five Urban Indian Health Programs in Montana, with services ranging from outreach and enrollment support to full FQHC medical services. Urban programs operate partially as IHS facilities (through contracts or grant terms) but also in part as Medicaid providers, and do not fit cleanly in either regulatory scheme. Some urban programs may have the same ability to support and participate in reforms as Medicaid providers.



Target Populations for Delivery System Reform

Payer Data Provided Foundation for Governor’s Council Approach

The Governor’s Council convened a multi-payer data working group to identify target populations, conditions, and opportunities for improvement. Specifically, the group identified significant and high correlations between populations with co-occurring physical acute or chronic conditions and behavioral health conditions.

In March of 2016, payers presented data to the Governor’s Council on high cost/high need populations. Across payers, several groups emerged as potential areas of focus. The priorities are consistent with those identified by Montana’s State Health Improvement Plan.

- Behavioral health, especially depression and substance use
- Chronic diseases and other high-cost conditions:
 - Diabetes
 - Heart disease
 - Kidney disease
 - Low birth weight babies
 - Cancer
 - Musculoskeletal conditions

These target populations then informed and helped to target the Council’s discussions about delivery system transformation, as described in the following section.

Models for Delivery System Transformation

Montana law has many of the building blocks in place to improve health care and reduce costs. Montana has a long history of innovation and finding creative solutions to its rural health care challenges. This experience, when combined with the regulatory framework outlined below, provide Montana with flexibility and opportunity to discover solutions to the state’s health care challenges.

Range of Opportunities and Flexibility for Reform

Commissioner of Securities and Insurance Authority

The Commissioner of Securities and Insurance (“CSI” or “Commissioner”) has broad authority over fully insured health plans sold in Montana. The Commissioner’s authority allows her to perform plan management for the federal Health Insurance Exchange. State Law requires rate review for small employers and the individual insurance market.



Under existing state law, the Commissioner has the authority enforce all state laws pertaining to insurance. This authority includes the ability to:

- review all rates
- approve policy forms and benefit templates
- review and approve network adequacy
- license and regulate the solvency of insurers,
- license insurance agents, consultants and third party administrators
- handle consumer complaints and appeals
- investigate fraud and abuse in the insurance market
- examine insurers for compliance issues
- investigate and prosecute insurance code violations
- certify Patient Centered Medical Homes

The Commissioner may issue state-specific guidance for health plans issued in Montana, both inside and outside the Exchange, as long as it does not interfere with the application of federal law. The authority has been used by the Commissioner to regulate plans consistently market wide.

The Commissioner is also responsible for administering the Montana Patient Centered Medical Home (PCMH) program under the 2013 Montana Patient-Centered Medical Homes Act. To assist in this effort, the Commissioner has established in rule an Advisory Council that meets monthly to provide input on the administration of the program. As part of this effort, a set of PCMH certification standards has been established. Furthermore, quality and utilization measures have also been established in administrative rule. PCMH participation is voluntary, but the PCMH designation can only be claimed by payers and providers that are in compliance with program rules, including data reporting on the identified quality measures and utilization measures.

Several PCMHs have also implemented integrated behavioral health, including but not limited to: Riverstone Health in Billings, Northwest Community Health Center in Libby, and Southwest Montana Community Health in Butte.

Benefits & Parity for Behavioral Health

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and accompanying CMS regulations, is the law that governs the payment of mental health claims in Montana. MHPAEA prohibits self-funded employer group health plans and all health insurance issuers from imposing more restrictive limitations on mental health and substance use treatment benefits than on physical health benefits. This parity is also required under the Affordable Care Act (ACA) "Essential Health Benefits" law and regulations, which applies to individual and small employer group insurance.



The Insurance Commissioner uses her authority to approve policy forms/benefit templates and investigate and resolve consumer complaints to prevent discrimination against people with mental illness and ensure compliance with the minimum legal requirements of MHPAEA. To date, Montana's Insurance Commissioner has taken action to correct non-compliant plan designs, and to ensure that payers re-processed claims and paid back consumers.

Medicaid Authority

Medicaid in Montana operates under the authority of Title XIX of the Social Security Act and §§ 50-4-104 and 53-6-101, MCA. The State Plan lays out state Medicaid rules and design consistent with federal requirements, amendments to the State Plan (SPAs) need CMS approval.

Medicaid Section 1115 Waivers operate under the authority of Section 1115 of Title XIX of the Social Security Act, as well as § 53-2-215, MCA. Under Section 1115, the Secretary of Health and Human Services may waive a broad range of Medicaid rules for states to pursue "demonstration" projects to expand eligibility, impose premiums or other requirements, receive funding for services otherwise not covered, or use new delivery or payment mechanisms. These waivers must:

- be approved by the secretary,
- further objectives of the Medicaid program, and
- be budget neutral.

Montana code gives the state broad authority to pursue, implement, and terminate 1115 Waivers, adopt rules as necessary to do so, and establish coverage, eligibility, financial, and other requirements for administration and delivery of services. DPHHS also has similar broad authority to pursue 1915(c) home and community based services waivers, and to expand the range of services provided to specific populations (often those with disabilities) under Medicaid.

Medicaid Expansion

With the passage of the HELP Act during the 2015 legislative session and subsequent approval of a Waiver from CMS, Montana's Medicaid program was authorized to expand eligibility to include non-disabled childless adults with incomes below 138% of the Federal Poverty Level (FPL) and parents with incomes between 50-138% FPL. The state will receive 100% federal funding for all Medicaid services provided to these newly eligible individuals through 2016, with the funding phasing down to 90% in 2020 and beyond. Montana has contracted with a Third Party Administrator (TPA) to administer the coverage for these adults. While 23 states have expanded their traditional Medicaid programs, and 7, including Montana, are using an alternative, Montana is the first state in the nation to use a third-party administrator (TPA) model for Medicaid expansion. Montana's goal in using the TPA model is to leverage an existing commercial insurer with established, statewide provider networks, turnkey



administrative infrastructure and expertise to administer efficient and cost-effective coverage for new Medicaid adults.

This approach has allowed for rapid implementation with broad network capacity. An additional benefit of the third-party administrator approach is that it supports continuity and integration of Montana's Medicaid program and the commercial insurance marketplace in the state.

Nearly one-third of low-income families experience frequent income fluctuations that cause "churning" or changes in premium tax credit program eligibility that shift these families from the Medicaid program to eligibility for subsidies to purchase private coverage (and vice versa). Churning leads to coverage gaps and discontinuities in health plan coverage and provider networks available to consumers. These gaps are detrimental to improving efficiency and quality of health care for low and modest income Montanans. By using a TPA anchored in the commercial insurance market, Montana will provide Medicaid coverage through a provider network that is more likely to be available to lower-income residents even as they gain economic independence and transition to private market coverage.

The same legislation authorized the Montana Medicaid program to pursue innovation and reform, such as:

- Strengthening and evaluating existing Primary Care Case Management (PCCM) programs
- Expanding case management programs for high risk enrollees
- Establishing pilot programs for pain management, decrease emergency room use, and substance use treatment and prevention
- Engaging members with chronic and behavioral health conditions in care models to reduce costs or improve outcomes such as:
 - Patient centered medical homes
 - Accountable care organizations
 - Managed care organizations
 - Health improvement programs
 - Health homes for chronic conditions or behavioral health
- Strengthening data sharing with providers

Medicaid's ability to influence reform efforts will increase significantly with the addition of the expansion population. Enhanced federal funding can be leveraged to support care coordination and care management services for the expansion group under any delivery model.



Telehealth and Teleconsultation Payment

A new Montana state law passed in 2015²⁴ requires private payers to cover certain telehealth services from physicians and other qualified providers in a manner equivalent to in-person coverage. Providers receive reimbursement for telehealth at the same level as in-person services. The law mandates coverage under private health insurance plans and defines telemedicine as the use of real-time interactive audio, video, or other telecommunications technology, including store-and-forward-technology, used by a health care provider or health care facility to deliver health care services at a site other than the site where the patient is located. Under the new statute, telemedicine would be reimbursable for the following facilities and services from licensed health care providers: critical access hospitals, hospices, hospitals, long-term care facilities, mental health centers, outpatient centers for primary care, outpatient centers for surgical services, physicians (MD and DO), podiatrists, pharmacists, optometrists, physical therapists, speech language pathologists and audiologists, psychologists, physician's assistants, social workers, professional counselors, occupational therapists, nutritionists, addiction counselors, registered nurses, and advance practice registered nurses.

Medicaid has reimbursed the following provider types for being the distance provider (the site at which the health care provider is located) for telehealth since 2013:

- Physicians
- Mid-Level providers
- Psychiatrists
- Psychologists
- Licensed Professional Counselors
- Schools
- Social Workers
- Rural Health Clinics
- Community Medical Centers
- Indian Health Service
- Speech Pathologists
- Outpatient Hospitals
- Case Management-Mental Health

Medicaid has also reimbursed for the following provider types for originating site (the site at which the patient is located) since 2013:

- Outpatient Hospitals
- Physicians
- Critical Access Hospitals
- Rural Health Clinics

²⁴

[http://laws.leg.mt.gov/legprd/LAW0210W\\$BSIV.ActionQuery?P_BILL_NO1=270&P_BLTP_BILL_TYP_CD=SB&Z_ACTION=Find&P_SESS=20131](http://laws.leg.mt.gov/legprd/LAW0210W$BSIV.ActionQuery?P_BILL_NO1=270&P_BLTP_BILL_TYP_CD=SB&Z_ACTION=Find&P_SESS=20131)



- Federally Qualified Health Centers

Medicaid's telehealth (as opposed to teleconsultation) coverage requires interactive audio-video, and that audio-video systems are secure and HIPAA compliant to meet federal requirements.

In the future, Montana Medicaid will also examine options for reimbursing Medicaid provider consultation with appropriate criteria via live video services and is open to looking at additional reimbursement models.

Health Homes State Plan Option

The new state plan option under Section 2703 of the ACA allows states to provide coordinated care to enrollees with multiple chronic conditions and serious mental illness. This option must enhance linkages to community, social supports and/or improve coordination between physical & behavioral health. It expands upon traditional medical home and PCMH models to provide intensive services for highest need patients. Services defined by Section 2703 include:

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

There is a 90% enhanced federal match for the first two years of health home services, so the state would want to ensure that the health homes are thoroughly and thoughtfully planned before launch, to fully leverage available funds. There is flexibility for payment methodology. Many states use capitated PMPM fees, similar to Montana's PCMH payment model.

Licensing and Behavioral Health

DPHHS Certificate of Need (CON) and Licensing Authority

Under §§ 50-5-304, 53-6-106, MCA and 37.106.1, ARM, DPHHS may issue certificates of need (CON) and/or licenses for certain types of health care facilities and service lines before they may be established, expanded, or renovated. These facilities and service lines include, long term care, and home health for CON and hospitals, outpatient physician, and mental health for licensing.

CON review standards may include, but are not limited to, the need of the population in the service area, the impact of the proposal on health care costs and availability of a less costly or more effective alternative, and consistency with regional joint planning efforts.

Licensing standards may include, but are not limited to, staffing, administration, training, health services, social services and care planning.



To date, MT has set basic standards for CON and licensing through rules and has developed a State Health Care Facilities Plan to focus the CON process on priority areas. Licensing for mental health facilities is currently restricted by county – potentially impeding telehealth and other cross-county mental health services. Standards for licensing and CON could be used to drive or enable reforms, address quality and supply, and address disparities.

Innovation in Indian Country

Tribal Health Authorities include the Indian Self-Determination & Education Assistance Act (ISDEAA) and the Indian Health Care Improvement Act. Tribes may “contract” with IHS (under Title I of ISDEAA) to provide one or more IHS Programs, Functions, Services, or Activities (PFSAs) that the IHS would otherwise provide. Tribes may “compact” with IHS (under Title V of ISDEAA) to assume full funding and control over one or more of these PFSAs. Alternatively, Tribes may allow IHS to operate all PFSAs.

IHS/Tribal 638 Facilities, including those operated by tribes, are funded by appropriations and reimbursement from other payers. Medicare and Medicaid pay an all-inclusive rate, negotiated between IHS and CMS each year. The state receives 100% Federal Medical Assistance Percentages (FMAP) for Medicaid payments made to IHS facilities for IHS eligible individuals. IHS has an “Improving Patient Care” program at some sites, which emphasizes patient-centered care, primary care access, care teams, and measuring improvements in care.

The Purchased and Referred Care (PRC) program funds primary and specialty health care services not available at IHS or tribal health care facilities and purchased from private health care providers – including private health insurance coverage and plans through the Health Care Marketplace. Such purchases can leverage savings that tribes can use to invest in innovation and transformation programs.

Montana’s recent Medicaid expansion is also important in Indian Country. Twelve percent of the newly-enrolled population are Native Americans. New revenue from Montana’s Medicaid expansion will be critical for building health infrastructure, expanding the workforce, and keeping health care providers in tribal communities. Medicaid revenues will bring new funds to the programs and further investment in the American-Indian health system infrastructure and workforce. Expansion is an opportunity to provide more health care services, create more jobs, and employ more Native Americans in tribal communities.

Foundation for Innovation

PCMH Program

Montana’s efforts around payment and delivery system reform have initially focused around PCMHs. State law defines a PCMH as a model of health care that is:



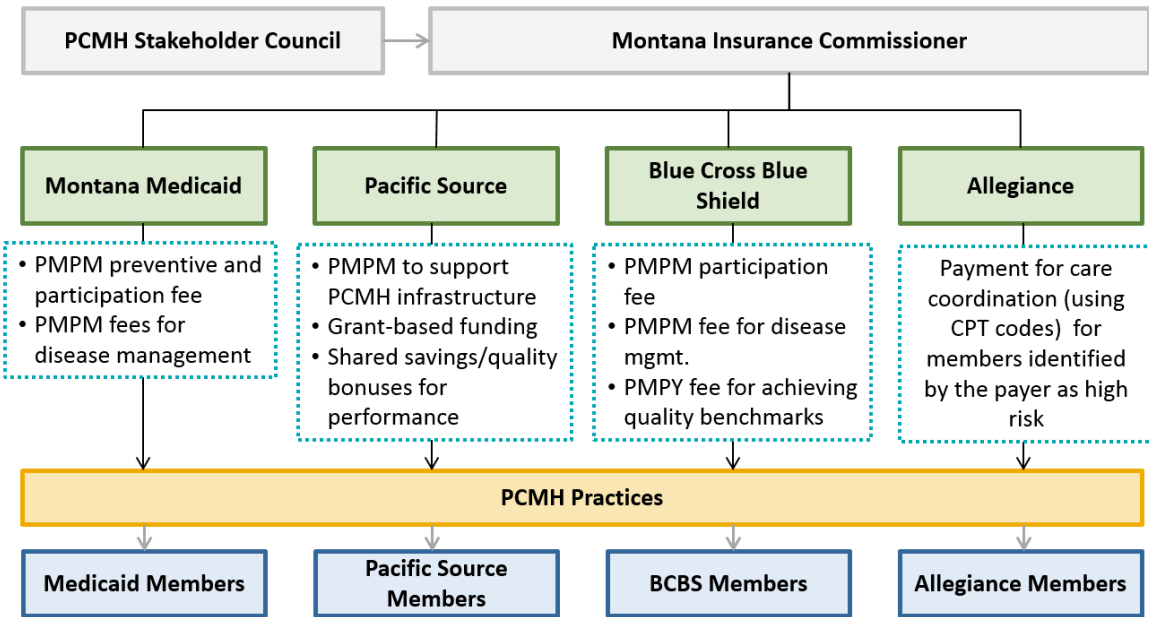
- Directed by a primary care provider offering family-centered, culturally effective care that is coordinated, comprehensive, continuous, and, whenever possible, located in the patient's community and integrated across systems;
- Characterized by enhanced access, with an emphasis on prevention, improved health outcomes, and satisfaction;
- PCMH promotes a team approach to care where health care professionals are able to work at the “top” of the license. Most teams include, in addition to primary care providers, a care coordinator, patient educators, and sometimes a mental health provider and clinical pharmacist.
- Qualified by the commissioner under § 33-40-104, MCA as meeting the standards of a patient-centered medical home, including accreditation from a recognized accrediting organization; and
- Reimbursed under a payment system that recognizes the value of services that meet the standards of the patient-centered medical home program.

In September 2013, the CSI worked with an appointed PCMH Stakeholder Council to adopt the program’s first set of administrative rules. A list of PCMHs can be found on the CSI website, including Qualified PCMHs²⁵ and Provisionally Qualified PCMHs.²⁶ There are 61 PCMHs in Montana, including the largest health care provider systems in all of the major cities. These practices reported that they saw 354,043 unique patients in 2014.

Four payers, including Medicaid, currently participate in the PCMH Program, and initial results are promising. BCBSMT has the largest number of members attributed to a PCMH practice, 29,260 members with 7 contiguous months. BCBSMT pays a monthly care coordination fee, plus additional monthly fees for monitoring patients with one or more chronic illnesses. In addition, BCBSMT pays quality bonuses to the PCMH clinics with which they have contracts. Montana Medicaid has a pilot PCMH program that covers 8,586 members as of April 30, 2016. Medicaid uses a similar payment structure to BCBSMT, however does not include quality bonuses. BCBSMT administers a portion of the Medicaid expansion population for DPHHS, and BCBSMT will begin offering PCMH services to Medicaid expansion plan participants in July 2016. The payers report on two utilization measures: ER visits and hospitalizations.

²⁵ <http://csimt.gov/wp-content/uploads/070815QualifiedPractices.pdf>

²⁶ <http://csimt.gov/wp-content/uploads/070815ProvisionallyQualifiedPractices-1.pdf>



Montana PCMH clinics use a team approach to care that includes a care coordinator and other mid-level practitioners including registered nurses. A significant number of PCMH clinics also have a behavioral health provider and have integrated behavioral health with primary care. The patient is part of the care team and the focus is on chronic disease management and prevention services for the whole patient population. In addition, the clinics usually offer expanded clinic hours, electronic communication, same day appointments, a clinical advice system outside of office hours, a patient portal, and active follow up for patients that have a recent ER or hospital visit.

All PCMH practices report quality metric data on three of four quality measures: A1C control, blood pressure control, child immunizations up to age three, and tobacco cessation counselling. In 2016/17, the program added depression screening as an additional quality measure. The Commissioner’s 2015 report shows that in general, the PCMH clinics are meeting or exceeding the Montana Healthy People 2020 targets for these measures. Initial PCMH reports have already shown improvements in diabetes control, child immunization, blood pressure control, and tobacco cessation.

The PCMH Stakeholder Council meets monthly and has several subcommittees as well. The Stakeholder Council advises the Commissioner on decisions that affect the program. The Commissioner collects data, and experts from DPHHS analyze the data. The Commissioner issues a public report annually that reports on data collected as well as narrative reports on progress received from the practices.



SAMHSA Funding

Montana mental health and substance use services funded in part by approximately \$10 million in block grants from the Substance Abuse and Mental Health Services Administration (SAMHSA). Montana develops block grant proposals every 2 years. This funding must be spent on services not covered by Medicaid. Grant stipulations require some funds to be used for substance use prevention and early serious mental illness. Additional grant opportunities allow the state to develop and test innovative models for behavioral health, such as a Certified Community Behavioral Health Clinics Grant, a Co-Occurring Capacity Building Grant, or Montana State Youth Treatment Implementation.

General fund appropriations also support mental health and substance use services, but are narrowly targeted towards specific uses, including: 72 hour crisis stabilization, drop in center services, short term voluntary inpatient stays in lieu of involuntary commitment to the state hospital.

Community Level Population Health Efforts

The following programs and efforts are currently in place in the state and could be leveraged to advance to goals of the Council.

Living Life Well

The Montana: Living Life Well Program (Stanford's Chronic Disease Self-Management Program) is an effective self-management education program for adults with chronic health problems. It is not specific to any particular disease or condition, but empowers participants experiencing a range of health conditions to take an active role in managing their health by giving them the key skills needed to manage any chronic health condition. Participants who have completed the program have gone on to demonstrate increased exercise, increased ability to complete social and household activities, less depression, increased confidence in their ability to manage their condition, and decreased emergency department visits and hospitalizations.

Cardiovascular Disease and Diabetes Prevention Program

Cardiovascular disease and diabetes are significant cost drivers for Medicaid and all health care payers in Montana. The cost of diabetes care in Montana exceeds \$580 million a year. The Cardiovascular Disease and Diabetes Prevention Program (CDDPP) is an intensive lifestyle intervention to reduce the risk of developing cardiovascular disease and to prevent Type 2 diabetes. There are currently 18 sites statewide providing the CDDPP. Since inception, more than 6,000 adult Montanans have enrolled in the program. From 2008-2012, 64 percent of participants achieved the physical activity goal (>150 minutes of physical activity per week), 34 percent achieved the seven percent weight loss goal, and 50 percent achieved five percent weight loss.



Tobacco QuitLine

The Montana Department of Health and Human Services, Public Health and Safety Division operates three tobacco cessation programs. The Montana Tobacco Quitline supports Montanans to help them quit commercial tobacco and other nicotine delivery products. The American Indians Commercial Tobacco Program has dedicated American Indian coaches, additional counseling sessions, and culturally appropriate coaching for those who have a relationship with sacred tobacco. A pregnancy program provides tailored services for pregnant women, including additional coaching with a dedicated female coach, an additional six weeks of nicotine replacement therapies following the birth of the baby, and a monetary reward for each coaching call completed, up to nine calls.

Telestroke Project

Many Montana residents living in rural areas lack access to stroke neurologists that can provide advanced care in the early hours of a stroke. The Cardiovascular Health Program, in collaboration with the Montana Stroke Initiative and the Montana Health Research and Education Foundation, has developed telestroke capabilities in Montana. The Cardiovascular Health Program has partnered with neurologists from Montana, Washington, Colorado and Oregon to provide 24/7 coverage for Montana's hospitals that use the telestroke system.

Office of American Indian Health

In 2015, Governor Bullock issued an executive order establishing a state Office of American Indian Health within the Director's Office of DPHHS. This office is responsible for overseeing the development and implementation of an action plan that identifies specific factors contributing to health disparities and strategies DPHHS will pursue for addressing those factors. Although this program is in its early stages, there is great potential for improving and lengthening the lives of American Indians.

In July of 2016, at its scheduled meeting, the Governor's Council plans to present information about the structure of the health system in Indian country and introduce the office and its goals.

Other Pilot and Planning Projects in Behavioral Health Integration

The following projects are being closely watched by the Governor's Council. Results from these pilots will provide important data that will help inform Montana's innovation work:

- The Montana Health Care Foundation, which is represented on the Governor's Council, has funded a number of pilot projects across the state that seek to plan and integrate behavioral health care (mental health and substance use treatment) into conventional physical health care, a goal that aligns with the priorities of the Governor's Council.



- Grantee pilot projects seek to develop and implement integrated behavioral health care models, to be delivered at primary care sites, mental health care sites, schools, and other intervention points in the community. Grantees are interested in improving health outcomes, reducing crisis situations, and reducing health care costs, among others. Several will receive training and technical assistance from the National Council for Behavioral Health.

Delivery System Transformation Design Objectives

Montana’s plan includes a driver diagram which links key objectives to tactics and desired outcomes.

Driver Diagram

The driver diagram describes the central goals of the Governor’s Council, the primary drivers expected to create progress towards those goals, the interventions proposed to implement each of the primary drivers, and the key metrics that will be used to evaluate progress. The Driver Diagram informs Montana’s core planning process.

Aims	Primary Drivers	Secondary Drivers	Measures
<p>Improved health of Montanans by:</p> <p>Preventing, identifying and managing chronic physical and behavioral health conditions, especially when they are co-occurring</p> <p>Supporting high-risk, vulnerable patient population and reducing health disparities (e.g.</p>	<p>Consider, test and expand delivery models including: Collaborative Care, Project ECHO, Community Resource Teams, PCMHs, and Medicaid Health Homes that improve patient engagement and support physical and behavioral health integration and disease management</p>	<p>Identify target populations for delivery models; focus on high utilizers with co-occurring physical and behavioral health conditions</p> <hr/> <p>Consider and obtain consensus on multi-payer delivery model reforms, with a focus on the use of interdisciplinary care teams and extending workforce</p>	<p>Launch multi-payer pilots</p> <p>Explore federal, state, and philanthropy-based funding opportunities to test and expand models</p> <p>Continue convening Governor’s Council</p> <p>PCMH clinical quality and outcome metrics*</p> <p>Inpatient and ED utilization and cost</p>



Montana Health Care Innovation Plan

<p>American Indians)</p>		<p>Leverage existing capabilities and infrastructure including: PCMH program, Mountain-Pacific CMMI project, Billings Project ECHO, and expand to other populations and payers</p>	<p>measures</p>
<p>Improved Montana Health care System by:</p> <p>Improving physical and behavioral health integration</p> <p>Improving access to primary, specialty and behavioral health services</p>	<p>Examine infrastructure to support and align outcomes measurement across payers and delivery models</p>	<p>Evaluate ways to create and enhance data initiatives to support population health and analytics</p> <p>Explore use of telehealth ECHO capabilities to extend reach of delivery models and improve access</p> <p>Support stakeholder collaboration around health information exchange</p>	<p>Telehealth/ECHO component for 1+ multi-payer pilot</p> <p>Launch of 1+ data infrastructure alignment initiative</p> <p>Continued HIE stakeholder planning</p>
<p>Control Health care Costs in Montana by:</p> <p>Reducing preventable use of ED and inpatient</p>	<p>Consider ways to leverage policy and payment authority to implement and spread value-based payment models</p>	<p>Leverage Medicaid purchasing power, including through Health Home program, to advance alternate payment models</p>	<p>Inclusion of I/T/U providers in multi-payer pilots</p> <p>Medicaid participation in multi-payer pilots, health homes, CPC+</p>



services Paying for value		Explore leveraging State Employee Plan, University Plan, and other Government plan purchasing power to advance alternate payment models	Other public and private plan participation in pilots
		Explore collaborative models with commercial and tribal /IHS/urban payers to advance alternate payment models	

*PCMH clinical quality/outcome measures:

- Blood pressure control
- Tobacco use and intervention
- A1c control
- Age-appropriate immunization for children
- Depression screening

Governor’s Council Principles and Approach

Montana’s stakeholders have identified a set of core principles to guide the development of Montana’s plan. The Council uses these principles to evaluate potential health care delivery models to pursue. The principles include the following:

- **Patient centered:** Any model pursued must put the needs and the experience of the patient (and his/her family) first. Its systems and processes must deliver care that is respectful of and responsive to individual patient preferences, needs, and values. This includes respecting and valuing the patient’s culture.
- **Data-driven and measurable:** The model should be driven by the needs identified from population data, and the results must be able to be measured.
- **Empowering and supportive of providers, and simple and flexible to rollout:** Providers are overwhelmed with the myriad of programs and requirements they must adhere to in order to receive payment. They want to improve care and outcomes for their patients, and need tools and models that support and empower them to do that.



- **Replicable for different conditions:** Recognizing that conditions vary significantly across Montana, any model chosen must be adaptable and able to succeed in a range of conditions with varying levels of resources.
- **Scalable:** The option must be able to be scaled up from a pilot to a statewide program.
- **Sustainable and tied to payment reform:** There must be a means to pay for the model that is sustainable over the long term, and the model should be paid for in a way that advances value-based payment.
- **Multipayer and collaborative:** The model must be supported by multiple payers, and should promote collaboration across payers and providers.

Council members representing a range of perspectives across the health care system agreed on the importance of focusing on these areas of shared concern in a way that would lay the foundation for success. Because members recognized that developing and implementing a plan for Montana was a broader project than the State Innovation Model Design process, the Council committed to continuing to work together after this plan was developed.

The planning process began with an assessment of the needs of the state's health care system. The Council began by considering the valuable insight provided by the key informant stakeholder interviews and the Council members' own expertise and knowledge about the needs for delivery system and payment reform. To better understand the population health needs, the Council reviewed the State Health Improvement Plan and data provided by health care payers in the state about their high-cost, high-needs patient populations.

The group evaluated the data from payers and the available information about the state's population health, as well as feedback from stakeholders and key informants about gaps in the current health care delivery system, to select its strategic areas of focus. The Council seeks to prioritize addressing the following needs in selecting delivery models to implement:

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

Models for Delivery System Transformation

To develop Montana's plan, the Governor's Council considered relevant case studies from other states, reviewed and discussed draft models, evaluated the models using the Council's core principles, and considered key questions/issues for further design of each model.



The Council recognized that Montana's PCMH program provides a logical foundation upon which future reforms can be built. The Council reviewed a range of delivery and payment models across the continuum of value based payment reforms to assess what might be the best fit for Montana and the existing PCMH foundation. These included Health Homes, Accountable Care Organizations, Project ECHO, Integrated Behavioral Health, pay-for-performance models, and bundled payments.

The models that gained the most support from the Council for further exploration at this time are the following:

- Collaborative Care model to integrate behavioral and physical health care delivery, which could be coupled with Project ECHO to extend the model in rural and underserved areas
- A "hotspotting" model to target the highest need populations, and facilitate community/social supports to address the social determinants of health
- Medicaid Health Homes
- Patient Centered Medical Homes

These models are not exclusive – one practice could engage in all of them. The models have the potential to build on one another; practices that have successfully adopted and implemented the patient centered medical home model may be better able to adopt the Collaborative Care or Community Resource Team models.

The transformation of clinical practices to achieve full integration of health care typically advances over a continuum, often beginning with improved coordination and eventually achieving system-level integration. Recognizing that full integration brings the best outcomes in terms of cost, quality and experience, Montana has emphasized models of integration, such as the Collaborative Care model, that achieve full systemic integration.

These models all reflect promising evidence and have a higher likelihood of success in Montana because they could each build on existing projects and work already underway. The Council is now moving to fully define and pursue these models. Implementation of these models could vary based on community needs and target populations. The Governor's Council will focus on key high level components of the models, with the recognition that local provider, population and workforce needs will drive variations in implementation.

ECHO-Enhanced Collaborative Care

Overview and Evidence

Collaborative Care

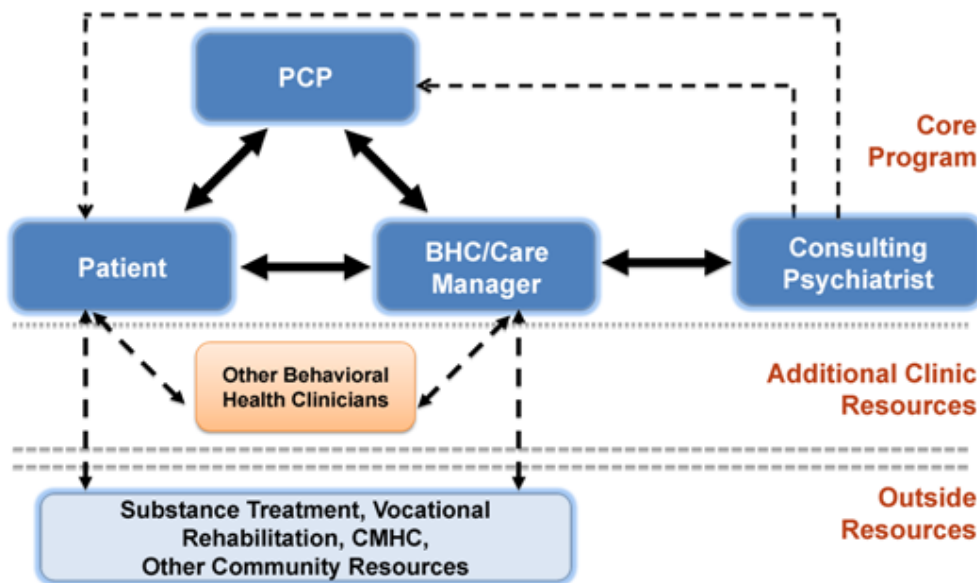
The Collaborative Care model integrates treatment for depression into the primary care setting. It seeks to address the barriers that prevent many from getting the depression treatment they need, particularly the shortage of mental health providers, lack of follow through in the



provision of care, and stigma. Integrated care programs try to address these challenges by providing both medical and mental health care in primary care and other clinical settings. Offering mental health treatment in primary care reflects an understanding of the connection between mental and physical health, recognizing that they are interrelated and should be addressed jointly.

The Collaborative Care model is a specific model of integrated care that comes from the AIMS Center at the University of Washington. It treats common mental health conditions such as depression and anxiety that require systematic follow-up. Trained primary care providers and embedded behavioral health professionals provide evidence-based treatment, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected. It requires the transformation of the primary care practices who adopt it.

A Collaborative Care Team consists of the patient, primary care provider (PCP), care manager, consulting psychiatrist and interdisciplinary team, and other behavioral health clinicians. The role of the PCP is to identify and refer to the care manager patients who could benefit from behavioral health care. The PCP works in consultation with the care manager and oversees all aspects of a patient’s care. The care manager is a behavioral health professional embedded in the PCP’s office who coordinates the Collaborative Care Team and performs all care management tasks. The consulting psychiatrist and interdisciplinary team supports and collaborates with the PCP and care manager by consulting with them about patients who are clinically challenging or need specialty behavioral health services. The team may also include other behavioral health clinicians, either embedded in the PCP’s office or in the community, who see patients for in-person treatment.





The Collaborative Care Model is recognized as strongly evidence-based. It has been tested in more than 70 randomized controlled trials in diverse settings, with different provider types and patient populations. This research has found Collaborative Care to be more effective than usual care across diverse populations for range of mental health conditions, and it produced demonstrated improvement in health disparities in low-income, ethnic minority populations. The model has received strong endorsement from patients, primary care providers, and psychiatrists.

Collaborative Care improves care while also reducing costs. The largest study to date found the model produced a return on investment of \$6.50 for each dollar spent. There were net savings in every category of health care costs examined, including pharmacy, inpatient and outpatient medical, mental health, and specialty care.²⁷ In leading to better patient outcomes, better patient and provider satisfaction, and reductions in health care costs, the Collaborative care model has demonstrated the potential to achieve the triple aim of health care reform. The Collaborative Care model requires support from a consulting psychiatrist, which has proven challenging for some of the Montana practices that have adopted the model because of the dearth of psychiatrists in the state. Recognizing this challenge, the Governor's Council is interested in enhancing the Collaborative Care model by connecting it with Project ECHO.

ECHO

Project ECHO[®] is an innovation that dramatically improves both capacity and access to specialty care for rural and underserved population. This low-cost, high-impact intervention is accomplished by linking expert multidisciplinary care teams with primary care clinicians through teleECHO[®] clinics. In these distance-based clinics, experts co-manage patient cases and share their expertise via mentoring, guidance, feedback and didactic education. This enables primary care clinicians to develop the skills and knowledge to treat patients with common, complex diseases in their own communities, reducing travel costs, wait times and avoidable complications. This results in a higher percentage of patients being managed by the primary care clinician and referrals to specialists reserved for complex, high-risk patients. The ECHO model[™] is not “telemedicine” where the specialist team assumes the care of the patient, rather, it is a collaborative practice model where the primary care clinician retains responsibility for patient care, operating with increasing independence as their skills and confidence grow.

Project ECHO leverages technology to connect primary care teams with consulting specialists who can help them address the specialty needs of their patients. It shares knowledge and expands treatment capacity, resulting in improved care for more people. A Health Affairs Study reported, “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.”²⁸

²⁷ <https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf>

²⁸ <http://content.healthaffairs.org/content/30/6/1176.full>



Project ECHO works by linking expert specialist teams at an academic ‘hub’ with primary care clinicians in local communities – the ‘spokes’ of the model. Together, they participate in weekly tele-clinics, which are virtual grand rounds, combined with mentoring and patient case presentations. The clinics are supported by basic, widely available teleconferencing technology. During teleECHO clinics, primary care clinicians from multiple sites present patient cases to the specialist teams and to each other, discuss new developments relating to their patients, and determine treatment.

Specialists serve as mentors and colleagues, sharing their medical knowledge and expertise with primary care clinicians. ECHO creates ongoing learning communities where primary care clinicians receive support and develop the skills they need to treat a particular condition, such as mental health concerns or chronic pain. As a result, they can provide comprehensive, best-practice care to patients with complex health conditions. Project ECHO operates across diseases and specialties, across urban and rural locales, and across different types of delivery services.

Research has found that Project ECHO improves physician-reported measures of knowledge, skills, professional satisfaction, practice recognition, and promotes provider retention in rural and underserved communities.²⁹ It increases access to specialist treatment for patients in rural areas.³⁰ A 2011 study published in the *New England Journal of Medicine* showed that the quality of hepatitis C care provided by Project ECHO-trained primary care clinicians was equal to that of care provided by university-based specialists.³¹

Project ECHO has the potential to expand the reach and return on investment of other proven models, such as Collaborative Care.

The technology itself is free and works on laptops, tablets, on smart phones. The first hub in Montana was launched in Billings in 2016. This Billings Clinic ECHO project is grant funded, and participating providers have given in-kind support.

²⁹ Innovative telementoring for pain management: project ECHO pain.
<http://www.ncbi.nlm.nih.gov/pubmed/24648365>

³⁰ Case Study: Project ECHO Expands Access to Specialty Care for Rural Patient.
<http://www.commonwealthfund.org/publications/newsletters/quality-matters/2009/november-december-2009/case-study>

³¹ Expanding access to hepatitis C virus treatment—Extension for Community Health Care Outcomes (ECHO) project: Disruptive innovation in specialty care. <http://onlinelibrary.wiley.com/doi/10.1002/hep.23802/abstract>



Montana Landscape

ECHO-Enhanced Collaborative Care

Residents of rural communities face tremendous challenges in accessing mental health and substance use treatment services in Montana. In many rural communities across our state, low population, geographic isolation, and few community health resources in general exist simultaneously, confounding attempts to improve access to behavioral health care in the ambulatory setting. And, as outlined previously, behavioral health professionals are few and far between.

American Indian communities face additional language and cultural barriers to effective treatment. Nearly every rural county Community Health Needs Assessment (CHNA) in Montana cites access as one of the top three community health priorities. This problem is well-acknowledged, resulting in a specific strategy in the Montana State Health Improvement Plan calling for “early identification, intervention and referral to treatment as key to improving mental health access.”

Three FQHCs currently practice the Collaborative Care model: Southwest Montana Community Health Center, Bighorn Valley Health Center, and Partnership Health Center. All of these clinics are also qualified PCMH practices. These practices have reported that the Collaborative Care model has helped strengthen integration and better meet the mental health needs of patients. However, they have faced challenges finding consulting psychiatrists to complete the model.

The ECHO-enhanced Collaborative Care model offers promising opportunities to address Montana’s goal to integrate primary care, mental health and addiction services using a virtual community health team. It also allows for efficient dissemination of best practices, expanding clinical toolbox of existing workforce through collaboration with UNM, UW, and OHSU and offers a way to support and encourage a workforce in isolated, rural areas of Montana.

Leveraging grant funding and in kind provider contributions, Billings Clinic became the first Montana Hub operating on the Project ECHO® model, commencing a program of mental and behavioral health support in collaboration with the Montana Department of Corrections (DOC) in early 2016. The Billings Clinic care team traveled to New Mexico, headquarters of Project ECHO®, for immersion training in December, 2015. Meetings were held with project stakeholders (Montana Department of Corrections, Rimrock Foundation, University of New Mexico and Billings Clinic staff) to complete a needs assessment, identify multi-disciplinary team that include psychiatrists, social workers, pharmacists, addictions staff, and representatives from the DOC to review some of the more complicated cases, and establish a date and location for the Project ECHO kick-off meeting. The project includes weekly educational support and up to 40 case presentations and consultations, as well as formal program evaluation.



Dr. Eric Arzubi, who chairs the Psychiatric Department at Billings Clinic and serves on Montana's Governor's Council, leads the team and the project. Other team members currently include a psychiatrist and pharmacist from Billings Clinic, a licensed addictions counselor from Rimrock Foundation, and the Department of Corrections. Other members of the interdisciplinary team may include nurses, social workers, other behavioral health specialists, and care coordinators. That team will collaborate with the patient's provider to help with addressing addiction and mental health care, regardless of location.

The Project ECHO kick-off meeting was held in Billings on January 20, 2016. This meeting allowed us to introduce all partners to the tools and methodologies that will be used, develop professional rapport to begin the network of knowledge transfer, distribute documents and establish a timeline of events. The meeting was attended by 26 team members. During the month of January, Billings Clinic worked closely with the Department of Corrections to determine their spoke sites, while key members of the Project ECHO team trained with UNM staff on best practices for successful ECHO Clinics.

In February 2016, curriculum, case presentation and patient recommendation forms were developed and shared by all partners. Working with the identified receiving (spoke) sites, two mock sessions were held with officials from UNM participating, allowing for feedback on ECHO Clinic effectiveness. The HUB and Spoke Sites participated in Project ECHO Partner Learning sessions developed by the University of New Mexico.

The first Project ECHO Clinic was held on March 8, 2016 at the Department of Health and Human Services offices in Helena, and clinics are now held weekly. There are two components to each ECHO Clinic. The first portion of the meeting is curriculum-based learning. Participants are able to develop a larger understanding of a wide variety of mental health, medical and addiction issues during these learning sessions. The second component of the consultation is the case presentation. The case presentation is a dialogue-driven portion featuring de-identified cases from the spoke sites and results in collaboration among multidisciplinary professionals to develop recommendations for next steps in the patient's care. The ultimate goal is to improve patient care and increase provider access to other professionals who might be able to offer an advanced perspective. This model of care has proven beneficial by providing a creative and cost-effective system of delivering education and peer-to-peer support.

Planning and Implementation

The Governor's Council is exploring how to support a model of Collaborative Care that is enhanced by Project ECHO under a multi-payer pilot program for primary care practices across Montana. The Project ECHO Hub at Billings Clinic would become the consulting specialist team for practices using the Collaborative Care model, and could thereby serve many primary care practices at once—up to ten in the pilot—dramatically increasing capacity.

This telehealth-enabled interdisciplinary care team model for complex patients would improve the quality of life and care for patients and better integrate behavioral and physical health care



to boost the ability of primary care physicians to address mental health treatment needs in the long term.

The Governor’s Council will participate in pilot work groups as appropriate, and evaluate the pilot as it considers ways to develop pilot funding and transition to value-based payment models to sustain the model. The planning and evaluation effort will consider the following criteria:

Component	ECHO Enhanced Collaborative Care
Target Population	<ul style="list-style-type: none"> • Individuals seeking primary care with mental health and/or substance use disorders • Target subset – 5% - 10% – of payer populations with these conditions • Identify via (1) analysis of claims data and/or (2) PCP or specialist assessments
Delivery Model	<ul style="list-style-type: none"> • Collaborative care model with behavioral health consultant/specialists onsite part time • ECHO enhanced collaborative care model (BH consultant/specialists accessible through ECHO Hub) • ECHO Hub can also educate participating providers and disseminate best practices • ECHO Hub can also support providers not implementing Collaborative Care (a “control” cohort)
Providers	<ul style="list-style-type: none"> • Primary care practice sites that self-identify or are identified by payers: <ul style="list-style-type: none"> • Certified PCMHs • Practices that will implement collaborative care using ECHO • Practices that will implement collaborative care with onsite BH consultant • Indian Health Service, Tribal, and Urban Indian Health (ITU) providers
Geography	<ul style="list-style-type: none"> • Statewide, ensuring participation in areas with disparity/access challenges • Interested providers identified to date are located in Butte, Hardin, and Missoula
Funding and Payment Model	<ul style="list-style-type: none"> • Requires up front funding to hire staff to implement collaborative care model locally; training resources are free/made available by the University of Washington AIMS Center • Project ECHO Hub costs approximately \$300,000



	<ul style="list-style-type: none">• Pay for reporting, with transition to pay for performance or other value-based models after pilot
Evaluation	<ul style="list-style-type: none">• Compare metrics among PCMHs implementing collaborative care vs. those who are not• Compare metrics among practices using ECHO consults vs. those that rely on onsite specialists• Provider-reported metrics could include behavioral health screenings, care coordination metrics• Payers report on utilization, cost, and other outcome-based metrics

Billings Clinic, also a qualified PCMH clinic, will be able to launch the initiative as soon as funds are secured. Payers are working together with participating providers and the foundation to identify resources and funding to support the pilot. Under this program:

- A Collaborative Care multidisciplinary team will be established at the Billings Hub, including a psychiatrist, a pharmacist specializing in psychiatric/behavioral health medications, a clinical social worker/licensed addictions counselor and any other clinicians or staff resources necessary to address the clinician support and patient treatment questions to be addressed.
- Up to 10 ‘spoke sites’ could participate in the weekly Collaborative Care ECHO teleECHO®, representing primary care clinicians and care managers with an estimated total patient panel of up to 750. Additional clinicians could sign on to view the teleECHO and benefit from the session, but actual presentation of cases for review would be limited to ten sites.
- Each weekly session would feature a didactic session focused on expanding primary care clinician knowledge of evidence-based care and strengthening peer-to-peer relationships across the state for mutual support and improved clinical outcomes. All participants in the didactic session are eligible for continuing education credit specific to their professional licensing requirements.
- Following the didactic session, de-identified case presentations originating from the primary care spoke sites will be discussed. This improves the ability of primary care clinical teams to evaluate and treat patients more effectively in the local area, improving clinical outcomes, sharing knowledge and reducing the referral rate to specialists for non-complex care.
- Follow-up summaries are sent to all participants at the conclusion of each weekly teleECHO® clinic. Session evaluations are collected and periodic formative reports are written and disseminated to all stakeholders.



Community Resource Teams

Overview and Evidence

The current health care delivery system does not meet the needs of a portion of patients with complex, hard-to-manage needs and chronic conditions. Their chronic conditions worsen over time, which leads to more expensive, invasive, and risky treatment. They usually have multiple emergency department visits, hospital admissions, mental health concerns, substance use concerns and/or complex social barriers to receiving care. These patients, known as “super utilizers” of health care, comprise much of the one percent of patients that account for more than 20 percent of total health care expenditures.³²

The Camden Coalition of Healthcare Providers launched an initiative to better serve these patients, which is now known as “hotspotting.” Hotspotting is a data driven approach that identifies and strategically allocates resources to better support high-cost, high needs super utilizer patients. It moves toward a multi-disciplinary, coordinated system of care that treats the whole patient, including the non-medical needs that affect health, such as housing, mental health, substance use, and emotional support.³³

The intervention work of the Camden Coalition is based on genuine caring, healing relationships that are rooted in acceptance. From there, four key principles guide the interventions: motivational interviewing, trauma-informed care, accompaniment, and harm reduction. These principles come from the behavioral health field reflects the integration of physical and behavioral health that occurs through the hotspotting interventions.

The support for these super utilizer patients comes in the form of community resource teams, locally-based care coordination teams that help manage patients across the continuum. These multidisciplinary care teams coordinate services, promote self-management and help manage medications. Regular face-to-face contact establishes and cultivates sustained continuous relationships between patients and team staff. In addition to helping coordinate health care services, team members routinely connect patients with relevant community-based resources. The community resource teams are targeted to high-risk, high-need, or high-cost patients, and they focus on transitions in care, when extra support is especially needed. The teams implement mechanisms to routinely send and receive information about patients between practices and care teams.

These teams often use community health workers (CHW), defined by the American Public Health Association as “frontline public health workers who are trusted members of and/or has an unusually close understanding of the community served. This relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

³² <http://kff.org/health-costs/slide/national-health-expenditures-per-capita/>.

³³ <http://hotspotting.camdenhealth.org/>



The key defining characteristics of CHWs are that they possess an intimate knowledge of community needs and resources and carry the trust and respect of community members in ways that the traditional health care workforce may not. These attributes often enable CHWs to address the social determinants of health where the health care system may face limits resulting from lack of time, skills, cultural affinity and community linkages.

A growing body of research demonstrates CHWs' positive impact on patient and community health, particularly among low-income and minority populations: CHW programs have shown success in improving chronic disease management,^{34,35,36,37} enhancing disease prevention and screening,^{38,39,40,41,42,43} promoting positive lifestyle behavior changes,^{44,45} facilitating insurance enrollment,⁴⁶ and reducing unnecessary health service utilization.^{47,48}

Federal-level efforts – including HHS's *Action Plan to Reduce Racial and Ethnic Health Disparities*⁴⁹ and their *Promotores de Salud Initiative*⁵⁰ – also recognize the important contribution CHWs make in reaching vulnerable, low income, and underserved Americans and call for the use of CHWs to provide multiple services to help reduce health disparities.

³⁴ Brownstein, JN, Chowdhury, FM, Norris, SL, Horsley, T, Jack, L, Jr., Zhang, X, et al. Effectiveness of community health workers in the care of people with hypertension. *Am J Prev Med.* 2007; 32(5): 435–447.

³⁵ Norris SL, Chowdhury FM, Van Le K, Horsley T, Brownstein JN, Zhang X, et al. Effectiveness of community health workers in the care of persons with diabetes. *Diabetes Care.* 2006;23(5): 544–556.

³⁶ Islam NS, Wyatt LC, Patel SD, et al. Evaluation of a community health worker pilot intervention to improve diabetes management in Bangladeshi immigrants with type 2 diabetes in New York City. *Diabetes Education.* 2013;39:478-493.

³⁷ Baig AA, Wilkes AE, Davis AM, et al. The use of quality improvement and health information technology approaches to improve diabetes outcomes in African American and Hispanic patients. *Med Care Res Rev.* 2010;67:163S-197S.

³⁸ Ingram M, Torres E, Redondo F, Bradford G, Wang C, O'Toole M. The impact of promotores on social support and glycemic control. *The Diabetes Educator.* 2007; 33(Suppl. 6):172S–178S.

³⁹ Hansen LK, Feigl P, Modiano MR, Lopez JA, Sluder E, Moinpour CM. An educational program to increase cervical and breast cancer screening in Hispanic women: A southwest oncology group study. *Cancer Nurs.* 2005;28:47–53.

⁴⁰ Navarro A, Senn K, McNicholas L, Kaplan R, Roppe B, Campo M. Por la vida model intervention enhances use of cancer screening tests among Latinas. *Am J Prev Med.* 1998;15:32–41.

⁴¹ Martinez J, Ro M, Villa NW, Powell W, Knickman JR. Transforming the delivery of care in the post-health reform era: what role will community health workers play? *Am J Public Health.* 2011;101:e1-15.

⁴² Islam NS, Zanowiak JM, Wyatt LC, et al. A randomized controlled, pilot intervention on diabetes prevention and healthy lifestyles in the New York City Korean community. *J Commun Health.* 2013;38:1030-1041.

⁴³ Hunter J, Guernsey de Zapien J, Papenfuss M, Fernandez M, Meister J, Giuliano A. The impact of a promotora on increasing routine chronic disease prevention among women aged 40 and older at the U.S.-Mexico border. *Health Educ Behav.* 2004;31(Suppl 4):18S–28S.

⁴⁴ Elder JP, Ayala GX, Campbell NR, Slymen D, Lopez-Madurga ET, Engelberg M. Interpersonal and print nutrition communication for a Spanish-dominant Latino population: Secretos de la buena vida. *Health Psychology.* 2005;24:49–57.

⁴⁵ Corkery E, Palmer C, Foley ME, Schechter CB, Frisher L, Roman SH. Effect of a bicultural community health worker on completion of diabetes education in a Hispanic population. *Diabetes Care.* 2005;20: 254–257.

⁴⁶ Perez M, Findley SE, Mejia M, Martinez J. The impact of community health worker training and programs in NYC. *J Health Care Poor Underserved.* 2006;17:26-43.

⁴⁷ Fedder DO, Chang RJ, Curry S, Nichols G. The effectiveness of a community health worker outreach program on health care utilization of west Baltimore City Medicaid patients with diabetes, with or without hypertension. *Ethn Dis.* 2003;13:22-27.

⁴⁸ Enard KR, Ganelin DM. Reducing preventable emergency department utilization and costs by using community health workers as patient navigators. *J Healthc Manag.* 2013;58:412-427; discussion 28.

⁴⁹ U.S. Department of Health & Human Services. *HHS Action Plan to Reduce Racial and Ethnic Health Disparities* [Internet]. Washington, DC: U.S. Department of Health & Human Services; 2011. Available at: http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

⁵⁰ U.S. Department of Health & Human Services. *HHS Promotores de Salud Initiative* [Internet]. Washington, DC: U.S. Department of Health & Human Services; 2015 Jun. Available at: <http://minorityhealth.hhs.gov/omh/content.aspx?ID=8929>.



Vermont implemented a program similar to Community Resource Teams under the umbrella of the broader Vermont Blueprint for Health, a statewide public-private initiative to transform care delivery, improve health outcomes, and enable everyone in the state to receive seamless, well-coordinated care, while also controlling costs. The Vermont Blueprint builds on a foundation of patient-centered medical homes, with which the community health teams collaborate and coordinate. The multidisciplinary teams partner with primary care offices, hospitals, and health and social service organizations and coordinate community-based support services. The teams offer individual care coordination, health and wellness coaching, and behavioral health counseling, and they connect patients to social and economic support services. The services are open to all Vermont residents – there are no cost-sharing, referral, prior authorization, or eligibility requirements.⁵¹

Each Community Resource Team has flexible staffing, design, scheduling, and sites of operation, with decisions driven by local leadership. The teams are designed to address regional health improvement authorities and fill gaps in care, and are developed through an inclusive process that includes the input of medical and community-based service organizations.

The Community Resource Team model is promising, and early results from the Camden Coalition model and the Community Health Team model in Vermont indicate significant potential for improving outcomes and reducing costs. The Camden Coalition model reduced admissions and ED visits by 40% on its first 36 patients, and saw corresponding decreases in hospital costs of 60% on this population. The Camden model is currently being evaluated through its first randomized control trial, but results are not yet available on net impacts.⁵²

In Vermont, objective assessments of pilot sites suggested early improvements in clinical quality and use, such as better control of hypertension. In addition, qualitative assessment suggested that providers and patients value the role of community health teams in connecting patients with behavioral health, chronic care management, and social services support.⁵³

Montana Landscape

In Montana, pilot projects in three communities over the next two years will use “hotspotting” philosophies to bring together new and existing resources and technologies to develop intervention teams—called Community Resource Teams—to support Montana’s super-utilizer patients and integrate behavioral and physical health care.

ReSource outreach teams will consist of a nurse (RN) embedded in PCMHs working with community health workers and coaches. These teams will integrate across community health care systems to wrap services around patients. Teams will go out to the patients and meet them where they are. Volunteers will be used as care extenders. Tablet technology will be used to enhance and sustain relationships.

⁵¹ <http://content.healthaffairs.org/content/30/3/383.full>

⁵² Robert Wood Johnson Foundation, *A Revolutionary Approach to Improving Health Care Delivery*, February 2014.

⁵³ <http://content.healthaffairs.org/content/30/3/383.full>



There is a high expectation that there will be many positive returns from this project, including shared regional resources, new technology in rural settings, more community collaboration, increased medication safety, increased patient satisfaction, and addressing of social determinants of health.

Additionally, other promising efforts that will help guide the development of CHWs in Montana are currently underway: the Montana Health Care Foundation has funded projects that are testing models of CHW or CHW-like roles in various settings, and the Montana Geriatric Education Center has a CHW project focused on the aging population.

Planning and Implementation

These pilots are led by Mountain-Pacific Quality Health, which applied for and received nearly one million dollars in funding from the Centers for Medicare & Medicaid Services (CMS) to implement and scale the Special Innovation Project. The hotspotting efforts will be focused in Billings, Helena, and Kalispell, but strategies and interventions will be spread across the state. Mountain-Pacific will partner with the renowned Camden Coalition of Health Care Providers to carry out these pilots. Their work in Montana health care systems will test, fund and deploy Resource Teams to reduce unnecessary hospital readmissions; spread best practices through the development, coordination and scaling of these Resource Teams; work with payers to develop sustainable payment mechanisms for community health teams; and save money through improved coordination of care across health care settings.

The Governor’s Council will monitor the MPQH pilot and participate in pilot work groups as appropriate to evaluate the effort and, if successful, consider ways to develop value-based payment models to sustain the resource teams.

The planning and evaluation effort will consider the following criteria:

	Community Resource Teams
Target Population	<ul style="list-style-type: none"> • Individuals with two or more hospital inpatient admissions in six months with multiple chronic conditions • Target subset – 2% - 5% – of payer populations who meet pilot criteria • Identify via analysis of claims data or provider referral
Delivery Model	<ul style="list-style-type: none"> • Interdisciplinary teams address complex patient needs outside of the primary care setting • Expand capacity of existing CRTs to serve other patients; Current CRTs are Medicare only



	<ul style="list-style-type: none"> • Central convening/education/training resource (hosted by Mountain Pacific) to support scale and replication
Providers	<ul style="list-style-type: none"> • PCMH certified practices, PCPs, FQHCs, Indian/Tribal/Urban providers, and others in target areas • Teams will be anchored with specific providers, but will serve the community at large
Geography	<ul style="list-style-type: none"> • Statewide, ensuring participation in areas with disparity/access challenges • Mountain Pacific Community Resource Team locations: Billings, Helena, and Kalispell • Montana Health Care Foundation is funding super utilizer projects in Livingston, Missoula, Sydney • Other geographies TBD as interested payers and providers emerge
Funding and Payment Model	<ul style="list-style-type: none"> • Requires up front funding to hire or repurpose staff to create Community Resource Teams • Ongoing payment for services provided by health professionals (e.g., CHWs, coaches, etc.) • Funding to support centralized resource center • Pay for reporting, with transition to pay for performance or other value-based models after pilot
Evaluation	<ul style="list-style-type: none"> • Measure reductions in total cost of care/total claims of patients (payer-reported) • Compare pre- and post-pilot hospital admissions and ED visits (payer-reported) • Provider-reported metrics could include care coordination metrics, community resource connections

Medicaid Health Homes

Overview and Evidence

As outlined above, Montana has the option to pursue the establishment of Medicaid Health Homes, a new state plan option created by the Affordable Care Act which allows states to provide coordinated care to enrollees with multiple chronic conditions and serious mental illness. Health homes expand upon traditional medical home/PCMH models to provide intensive services for highest need patients. The homes must enhance linkages to the community, social supports and/or improve coordination between physical and behavioral health.

Medicaid Health Homes are staffed by a designated provider or team of health care professionals. The team may be based in primary care or behavioral health providers' offices, coordinated virtually, or located in other settings that suit beneficiaries' needs. To be eligible



for Health Home services, individuals must have one of the following: at least two chronic conditions (e.g., mental health, substance use, asthma, diabetes, heart disease), one chronic condition and risk for a second, or one serious and persistent mental health condition.

In Missouri, which was the first state to implement Medicaid Health Homes, evidence has demonstrated notable cost savings. Missouri developed a robust program for enrollee with chronic conditions and serious mental illnesses. Community Mental Health Center (CMHC) health homes serve members with serious mental illnesses or emotional disorders, and Primary Care health homes serve members with multiple chronic physical conditions. Each health home model has established care team model and staffing ratios, and nurse care managers are seen as key to both models. The state annually reviews and adjusts each Health Home's PMPM (CMHCs receive more than PC Health Homes), and shared savings may be available based on performance.

After 18 months, PC health homes had decreased PMPM cost by \$30.79 with a total cost reduction of \$7.4 million, and CMHC health homes had decreased PMPM costs by \$76.33 with a total cost reduction of \$15.7 million.

There is a 90 percent enhanced federal match for the first two years of health home services. Enhanced funding for Health Homes is applicable to adults who are not eligible for the newly eligible FMAP.

Montana Landscape

Through a planning effort funded by a grant from SAMSHA for State Youth Treatment-Implementation (SYT-I) Transitioning Youth at a Healthy Age Grant, Montana will plan the state's first Medicaid Health Homes. The health homes will be piloted by four sites (two mental health centers and two federally qualified health centers) to provide integrated primary, mental health and substance use services for transition-aged youth age 16 to 25 year old, including both American Indian and non-Indian youth. The goal of the pilot is to fill a critical need by providing evidence-based care to transitional aged youth with substance use and co-occurring disorders.

Montana has an Interagency Planning Council that will facilitate linkage and coordination between all systems serving adolescents and transitional aged youth in order to increase access to care.

The new health homes being created will serve individuals eligible under the Medicaid State Plan or a waiver who meet certain criteria. The focus of care for Medicaid health homes will be behavioral health integration and comprehensive care management. The health homes provide care coordination and health promotion, comprehensive transitional care from inpatient to other settings and follow up, individual and family support, and referrals to community and social support services. The homes use health IT to link services.



Planning and Implementation

During the planning phase, Montana's Medicaid Health Home pilot sites will receive technical assistance from the National Council for Behavioral Health to build capacity, infrastructure and policies appropriate for a Health Home Model. The pilot sites will receive hands-on training and consultation on how to implement a Behavioral Health Home model. The sites will be trained in implementing the CARF-Behavioral Health Standards, and their experience will be used to inform the development of standards for programs providing integrated Behavioral Health Home services.

Montana will submit a State Plan Amendment to pursue enhanced funding for this option through a care model that layers upon, but does not duplicate, its PCMH program. Many of the planned grant activities will build on the foundation laid by Montana's State Adolescent Treatment Enhancement & Dissemination Program (SAT-ED) grant. This will support care coordination and integration efforts in the four sites, by the end of Year 2 of the grant, with the hope of having approval before the grant concludes.

As part of this process, Montana's state-wide multi-year Workforce Training Implementation Plan will be updated to include:

- Education for key stakeholders on the workforce shortage and treatment needs of transitional aged youth;
- Expanded access to training webinars that build capacity of the behavioral health care and recovery workforce, especially for those in those in rural and frontier areas; and
- Training treatment providers in the evidence-based program Interactive Journaling, and promoting the use of the evidence based assessments.

The state will collect expenditure and utilization data for treatment, recovery and support services for 16 to 25 year olds. The participating practices will annually update the data, and the results will be used to recommend policy and system changes to build infrastructure and capacity to better serve this population.

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

While Montana's Medicaid program is also implementing PCMHs, the Medicaid Health Home model is an opportunity to address a more targeted population with behavioral and/or chronic care needs.



	PCMHs	Medicaid Health Homes
Populations served	All populations	<p>Individuals eligible under the Medicaid State Plan or a waiver who have:</p> <ul style="list-style-type: none"> • At least two chronic conditions* • One chronic condition and are at risk for another • One serious and persistent mental health condition <p><i>*Chronic conditions include: mental health, substance use, asthma, diabetes, heart disease, overweight</i></p>
Staffing	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"> • 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	<p>Focused on delivery of traditional primary care services, enhanced use of health IT/HIE, patient-provider communication, etc.</p>	<ul style="list-style-type: none"> • 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
-------------------	--	---

Transitioning to Value-Based Payment

Path to Value-Based Payment

As Montana looks to implement and fund integrated care, it will need payment models that support the added value in the delivery models it wishes to pursue. One-time, grant-funded projects are not adequate to address health care transformation. It is critical that Montana develops value-based payment methodologies to provide adequate, ongoing resources for these models in order to sustain them. Building the staff and infrastructure necessary to deliver better practices and achieve the desired transformation in health care delivery requires long term, sustainable funding. This will represent a significant shift from the current fee-for-service payment structure that pays for most health care delivered in Montana. The transition from fee-for-service health care payment to value-based payments will transpire in stages, as payers and providers build the systems and capacity to move to value-based payments.

This process is comprised of three phases: securing payment for enhanced services, payment for reporting, and payment for performance and shared savings. Planning for the move to payment for performance and bundled payments can occur simultaneously in parallel; these stages do not need to occur sequentially. Planning for both will begin in 2016, with implementation of pilots beginning in 2017 and expanding over time.



Value-Based Payment Models: Payment for Enhanced Services

The first step will be to identify a means of funding the enhanced services connected to the delivery models that Montana will pursue. These initial funding models will likely draw on existing payment sources and models.

Existing care coordination and telehealth/teleconsultation are paid for in a variety of ways by a variety of payers. This includes fee for service reimbursement (FFS), per member per month payments (PMPM), and grant funding from private and public payers.

Potential initial funding models for new delivery models include:

- “Lump sum” grant or payer funding for pilots;
- Enhanced FFS PMPM payments: Payers could also agree to provide other enhanced PMPM FFS payments to support these models, for example to support rural or tribal providers using Medicaid Integrated Care authority or private payer arrangements;
- PCMH payments: Under the PCMH program, payers could agree to provide enhanced PMPM FFS payments or develop shared savings arrangements to support many of the enhanced team-based care coordination services provided under the models;
- FFS care coordination, disease management, and telehealth/teleconsultation codes; and
- Medicare care coordination codes, particularly the transition care management code, can be used to pay for telehealth consultations and support care coordination upon discharge.

Value-Based Payment Models: Pay-for-Reporting

Once practice transformation resources are in place to advance new delivery models, the next step will be to incentivize quality measurement reporting, wherein payers develop agreements to pay providers for reporting agreed-upon metrics. The opportunity also exists for Montana to continue and expand existing pay-for-reporting efforts within Montana PCMH and other programs. Fee-for-service reimbursements can continue alongside the new payment structures.

Value-Based Payment Models: Pay-for-Performance

In this stage, Montana will encourage payers participating in new delivery models to incorporate or bolster pay-for-performance, or true value-based payment, into their payment models. For example, Montana’s PCMH providers are already incorporating pay-for-performance and shared savings components into their PCMH payment models.

Value-Based Payment Models: Shared Savings

Fee-for-service reimbursement could continue during this stage, but payers will be encouraged to enhance or add value-based payment models that incorporate shared savings for defined population. It is recommended that this process begin with shared savings models and graduate to shared risk models over time.



Comprehensive Primary Care Plus

Montana Medicaid and commercial payers representing 90 percent of the fully insured market in Montana worked together to apply to participate in the CMS Comprehensive Primary Care Plus program in June of 2016. The Comprehensive Primary Care Plus (CPC+) model is a new, innovative, value-based five-year payment and delivery reform model that takes this aim to the next level in partnership with primary care practices, starting January 1, 2017. CPC+ gives practices the flexibility to deliver primary health care in more innovative ways, in the manner that best meets patients' needs—without being tethered to the 20-minute office visit. It allows practices to pool this “non-visit based funding” from multiple public and private payers and apply it to a whole-population proactive primary care management strategies and agree to take on upside and downside risk.

Delivery System Innovation Operational Plan

Montana's health care innovation plan will be operationalized through the planning, evaluation, and growth of the state's ECHO-enhanced collaborative care, community resource team, and Medicaid health home pilots that are described in other sections. Described below are the operational details related to financing the models, workforce, monitoring and evaluation.

Financial Analysis

Overview

The Department of Public Health and Human Services, Governor's Office, and Governor's Council on Health Care Innovation are committed to continuing the multi-stakeholder engagement and planning process initiated through the SIM Design Grant and to advancing multi-payer delivery system and payment reform. The state and stakeholders understand that funds are no longer available through the CMS Innovation Center's State Innovation Model (SIM) Initiative to test delivery and payment models. As such, the state, in collaboration with the Governor's Council, will seek alternative funding from the federal government, state, private payers, foundations, and other public and private sources to support continued planning, stakeholder engagement, and implementation of regional multi-payer pilots that can evolve towards larger scale, multi-payer statewide initiatives.

The following financial analysis describes the state's plan to pursue alternative funding sources and outlines an approach and initial estimates of costs and savings for the proposed delivery models. We note that the approach and estimates will continue to be refined as the models and their core components evolve through further planning and a subsequent implementation phase.



Funding Sources

Public

Federal Grant Funding. The state, in consultation with the Governor’s Council and key stakeholders, will monitor and evaluate potential federal funding opportunities to support continued planning and implementation efforts across payers. Potential funding sources include the CMS Innovation Center, CMS Special Innovation Projects (SIPs), and the Substance Abuse and Mental Health Services Administration (SAMHSA). For example, should the CMS Innovation Center make additional SIM design or testing funds available, the state will apply for a second round of funding. The state will also consider applying under other Innovation Center models such as the Health Care Innovation Awards and will continue to support stakeholders as they pursue and participate in other Innovation Center models. Today, Montana providers are participating in various Innovation Center models, including bundled payments, the Advanced Primary Care Practice demonstration, Medicare Care Choices model, Community-based Care Transitions program, Transforming Clinical Practices initiative, and the Strong Start for Mothers and Newborns initiative.

CMS also recently announced an opportunity for Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) to apply for SIP awards to pursue innovations “that advance local efforts for better quality and smarter spending.”⁵⁴ Montana’s QIO Mountain-Pacific Quality Health has been an active partner in SIM planning, serving on the Leadership Committee and providing the foundation for the proposed community resource team model through their existing SIP award. The state, in partnership with Mountain-Pacific, will evaluate the new opportunity to determine whether one or both of the proposed pilots would be eligible for SIP support.

SAMHSA is third potential source of federal funding the state will actively consider. The state currently receives SAMHSA block grants totaling approximately \$10 million annually to pay for services not covered by Medicaid. The state will look for opportunities within existing SAMHSA-supported programs and pursue future grants to support the proposed multi-payer delivery models and the transition to value-based payment. For example, the state received a \$2.3 million, “Transitioning Youth at a Healthy Age Grant,” to develop four behavioral health homes for transitional aged youth with substance use and co-occurring disorders. The work under the grant will take place through 2018 and promote integrated primary and behavioral health care which aligns with the proposed collaborative care model under the SIM initiative. The state will actively work to align the health home delivery model for transitional aged youth with the proposed collaborative care model and consider how increasing value-based payment models can support the program once grant funding has been exhausted.

Medicaid Health Homes. The state will evaluate the extent to which enhanced Medicaid matching funds can support the implementation of proposed multi-payer delivery models

⁵⁴ The CMS Blog, *CMS Invites Quality Innovation Network – Quality Improvement Organizations to Submit Special Innovation Projects to Expand Their Reach in Improving Care Delivery*, March 30, 2016.



through existing funding streams, such as Health Homes. Health Homes, created under Section 2703 for the Affordable Care Act, are an optional Medicaid State Plan benefit to coordinate care for Medicaid beneficiaries with chronic conditions and/or a serious and persistent mental health condition. Health Home providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. States receive a 90 percent enhanced Federal Medical Assistance Percentage (FMAP) for Health Home services for the first eight quarters the program is effective.⁵⁵ Montana is in the initial stages of developing a Health Home program and will seek CMS technical assistance as it proceeds toward implementation. The state will build upon its experiences developing behavioral health homes for transitional aged youth with substance use and co-occurring disorders (described above) to inform its development of a larger Health Home program to serve Medicaid beneficiaries with chronic conditions and serious and persistent mental health conditions. The state anticipates beginning development of the required State Plan Amendment (SPA) in 2017 and launching the program in 2018. During the planning phase, the state will identify public and private sources of the required 10 percent state match for the first eight quarters of the program.

State Funding. The state will also work to identify funding that may be used as the state match for the Medicaid Health Home program or other federally-supported programs requiring a state match.

Private

Together with the Governor's Council, the state plans to pursue various private funding sources through Montana-based and national foundations.

Montana-based Foundations. The Montana Health Care Foundation is an active participant on the Governor's Council and in its 2016 Call for Proposals focuses on three areas that are aligned with the proposed multi-payer delivery models: integrated behavioral health, American Indian health, and partnerships for better health. Under its new integrated behavioral health initiative, the Foundation is interested in supporting "collaborative, systems-based solutions to behavioral health challenges in Montana," and "creating new partnerships between organizations that strengthen the services in a region through using existing resources more efficiently and effectively."⁵⁶ The Foundation will provide one-year planning grants up to \$35,000 for organizations committed to implementing integrated behavioral health, but that require training and technical assistance to plan for implementation, and two-year grants up to \$150,000 to support implementation of integrated behavioral health initiatives.

Under the categories of American Indian health and partnerships for better health, the Foundation will fund projects with a 12–24 month time period with a maximum award of \$50,000 for a one-year project and \$150,000 for a two-year project. Projects the Foundation will consider again demonstrate alignment with the proposed multi-payer deliver models

⁵⁵ Medicaid.gov. *Health Homes*.

⁵⁶ Montana Health Care Foundation. *Montana Health Care Foundation 2016 Call for Proposals*.



developed under the SIM Design Grant. Specifically, the Foundation will consider funding projects that:

- Utilize community health teams and other approaches to care coordination, case management, and community outreach;
- Identify and improve outcomes among “super utilizers;” and
- Address the health and health service needs of urban Indians.

The state is considering how continued planning or implementation may be supported by the Foundation in the second half of 2016 and beyond and will apply for viable opportunities under the 2016 Call for Proposals.

While the state anticipates the Montana Health Care Foundation will continue to be an important potential funding partner as Montana proceeds with multi-payer delivery system and payment reform, the state will need to rely on additional private and public sources of support. As such, the state will also pursue funding from the foundations of private payers with a presence in Montana including Blue Cross Blue Shield of Montana and PacificSource.

National Foundations. The state will pursue funding from national foundations that have historically supported and funded the proposed delivery models and are focused on addressing key disparities among the target populations, especially the American Indian population. One national funder that Montana plans to engage is the Robert Wood Johnson Foundation (RWJF) due to their track record of providing technical assistance to states on delivery system and payment reform as well as their focus on identifying and expanding interventions that have a meaningful impact on health. The state is currently evaluating whether it may be eligible for technical assistance through RWJF’s State Health and Value Strategies program. In the past, RWJF has funded projects aimed at testing and advancing collaborative care, integrated behavioral health, and team-based interdisciplinary care. RWJF is also among the foundations that supports Project ECHO which may be an important enhancement to the proposed delivery models, allowing the models to serve a greater number of Montanans than they could otherwise achieve on their own.

In-Kind Support

The state recognizes the importance of continuing the collaborative stakeholder process initiated under the SIM Design Grant and will allocate in-kind resources to support continued staffing of the Governor’s Council. To date, the state has provided approximately 2.5 FTEs to staff the SIM Design Grant and will continue to allocate in-kind staffing to support ongoing planning efforts and support of the Governor’s Council. Mountain-Pacific Quality Health has also generously offered staffing support as an in-kind resource. These in-kind resources will be critical to maintaining the momentum of the Governor’s Council and planning efforts, as well as development of grant applications for financial and technical assistance, but ultimately additional staffing resources will be required to advance pilot implementation.



Approach

To assess the potential for costs and savings related to the state's proposed multi-payer delivery models, the state requested data on key target populations from each payer participating in the Governor's Council, and conducted research on literature evaluating the each of the proposed delivery models. Below, this data and research have been incorporated in an assessment of the potential implementation costs and savings opportunities related to the models across payers. All figures detailed below are preliminary. The state greatly appreciates the payers' contributions of time and resources throughout the planning process, and especially appreciates the efforts made to gather and share data to inform this financial analysis.

There are several important variables that are critical when estimating the potential costs and impact of the proposed delivery models. These include:

- Size of the target population
- Acuity of the target population
- Average cost of the target population
- Key model characteristics (e.g., scope, duration)
- Cost of model implementation and evaluation (pilot and scaled)
- Evidence of model's impact with similar populations

These variables were incorporated in the analysis below, and are described in more detail in the following sections.

Collaborative Care Model

Literature and Assumptions

The Collaborative Care model has been well-documented to reduce the health care costs of targeted individuals, and to result in a positive return on investment when implemented in an evidence-based manner. More than 70 randomized control trials have been performed on the model to date. The results from the largest of these studies – the IMPACT program study, a four year study run by the University of Washington and published in 2002 – showed reduced costs and net savings in every category of health care costs examined by the researchers, including pharmacy, inpatient and outpatient care, mental health and specialty care. The study documented a return on investment of \$6.50 on every dollar spent over the four year study period.⁵⁷

More recently, an issue brief developed for the CMS Health Home Resource Center provided an updated analysis of the costs and benefits of the Collaborative Care model, and projected the model would result in a return on investment of \$5.78 for every dollar spent, assuming a four

⁵⁷ Health Home Information Resource Center, *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes*, May 2013.



year program implementation period.⁵⁸ These findings are not payer specific, and the issue brief notes that its findings are consistent with studies of the Collaborative Care model’s impact on patients with depression, anxiety, and severe mental illness, as well as with results of analyses conducted by large integrated health systems such as Kaiser and Intermountain Health.

To assess the potential impact of the Collaborative Care model in Montana, this financial analysis relies on the CMS issue brief estimates for costs and savings of the model, as shown in the table below.

Collaborative Care Model: Impact Assumptions⁵⁹		
	Average Per Year (4 Year Window)	Total (4 Year Window)
Implementation Cost/Patient	\$225	\$900
Savings/Patient	\$1,300	\$5,200
Net Impact	\$1,075	\$4,300
ROI	5.78	5.78

This financial analysis does not consider other potential indirect economic benefits of the Collaborative Care model. However, other studies have shown that improved depression care resulted in positive outcomes on employment and workforce participation.⁶⁰

Potential Opportunity

Adoption and implementation of the Collaborative Care model across payers holds significant potential for Montana. With the recognition that the state is still in the planning phase and will iterate estimates as the model is refined, this financial analysis aims to size the potential opportunity of the Collaborative Care Model in terms of both costs and savings across public and private payers.

The target population for this model is individuals with mental health diagnoses, with a focus on individuals with depression, anxiety, and substance use. Payers self-reported data on the target population to inform the financial analysis, using various methodologies to arrive at the estimated target population. These methodologies will need to be refined and standardized as planning moves forward.

On average across payers, this population is estimated to make up approximately 8% of all health plan enrollees. As described earlier, the analysis utilizes data provided by various payers. Implementation costs and savings are calculated based on the assumptions found in literature

⁵⁸ Id.

⁵⁹ Id.

⁶⁰ Id.



and detailed above. As a result of the Collaborative Care ECHO project, system savings would be realized by:

- increased throughput of patients in the primary care clinic setting;
- reduced acute admission for mental and behavioral health issues;
- reduced patient referral to mental and behavioral health specialists for non-complex matters that are manageable in the primary care setting;
- reduced cost of polypharmacy as primary care clinicians have access to specialty pharmacy assistance for prescribing; and
- reduction in chronic diseases known to be correlated to untreated mental and behavioral health issues.

Collaborative Care Model: Potential Opportunity								
Payer	Targeted Members*		Implementation Cost		Savings		Net Savings	
	Average per Year	Total (4 Years)	Average per Year	Total (4 Years)	Average per Year	Total (4 Years)	Average per Year	Total (4 Years)
Medicaid (Traditional) ⁶¹	7,770	31,080	\$1.75 M	\$6.99 M	\$10.10 M	\$40.40 M	\$8.35 M	\$33.4 M
Healthy Montana Kids ⁶²	1,342	5,368	\$0.30 M	\$1.21 M	\$1.74 M	\$6.98 M	\$1.44 M	\$5.77 M
State Employee Plan <i>Estimated Impact</i> ⁶³	2,308	9,233	\$0.52 M	\$2.08 M	\$3.00 M	\$12.00 M	\$2.48 M	\$9.93 M
Commercial Payers ⁶⁴	21,747	86,988	\$4.89 M	\$19.57 M	\$28.27 M	\$113.08 M	\$23.38 M	\$93.51 M
Medicare ⁶⁵	16,925	67,700	\$3.81 M	\$15.23 M	\$22.00 M	\$88.01 M	\$18.19 M	\$72.78 M

⁶¹ Medicaid data is only for the Passport population (about 75% of Medicaid members). Mental health data is only for the top 5% of the Passport population and reflects those with mental health as a primary risk category, including psychotic/schizophrenic disorders, mood disorder, bipolar, and depression.

⁶² Healthy Montana Kids data was provided by BCBSMT, which serves as the third party administrator for the State’s CHIP program. Mental health diagnoses reflected in the analysis include depression, serious mental illness (e.g. bipolar, schizophrenia, borderline personality disorder), as well as substance use disorders.

⁶³ No data on mental health diagnosis was available from the State Employee Plan. To estimate the potential impact for the employee health plan, we used the average percent of members across other payers with a mental health diagnosis and applied this to the plan’s total membership.

⁶⁴ Data includes BCBSMT commercial, PacificSource individual and small group, and Allegiance members (not including State Employee Plan members). Methodologies to identify the targeted members varied. PacificSource included members with depression or serious mental illness, Allegiance included members with primary diagnoses of affective disorders, alcohol use and dependence, attention deficit disorders, dementias, depression, drug use and dependence or tobacco use disorders, and BCBSMT included all members with depression, serious mental illness, or substance use disorders.

⁶⁵ Data provided by Mountain Pacific Quality Health, the State QIO. Data reflects individuals with a principle diagnosis of serious mental illness, anxiety, depression, prolonged posttraumatic stress disorder, or substance use disorders. Spending figures include Part A and B claims, and include an estimate of the annual Part D payment per beneficiary.



Collaborative Care Model: Potential Opportunity

Payer	Targeted Members*		Implementation Cost		Savings		Net Savings	
	Average per Year	Total (4 Years)	Average per Year	Total (4 Years)	Average per Year	Total (4 Years)	Average per Year	Total (4 Years)
TOTAL	50,092	200,369	\$11.27 M	\$45.08 M	\$65.12 M	\$260.5 M	\$53.85 M	\$215.4 M

*All members included in this analysis have a mental health diagnosis.

As shown in the table above, if the Collaborative Care model were implemented across all payers in Montana for these targeted members with a mental health diagnosis, the model has the potential to result in approximately \$215.4 million in net savings over a four year implementation period. This reflects a significant opportunity for the state of Montana, and makes the case for ongoing funding to support continued planning, implementation and evaluation of this model.

Pilot

Given the significant opportunity of this model, Montana is considering proceeding with one or more multi-payer pilots to test the Collaborative Care model with the target population and to refine the assessment of the model’s costs and savings potential. Should the state proceed with and obtain grant funding to support a pilot, it would aim to test the model in both urban and rural settings and across public and private payers. The pilot would also be designed to build on and align with other public and private delivery reform initiatives in the state, by focusing on testing the model with providers that are participating in the planned Medicaid Health Home program and providers and payers participating in the existing PCMH program. The pilot could also be tested with providers who receive funding through the Montana Health Care Foundation’s integrated behavioral health initiative.

The financial analysis below provides an example of the potential scope of such a pilot, if all payers participated in the pilot and had 5 percent of their members with mental health diagnoses (as shown in the chart above) enrolled in the pilot.



Collaborative Care Pilot: Potential Opportunity

Payer	Targeted Members*		Implementation Cost		Savings		Net Savings	
	Average per Year	Total (4 Years)	Average per Year	Total (4 Years)	Average per Year	Total (4 Years)	Average per Year	Total (4 Years)
Medicaid (Traditional)	389	1,554	\$87.4 K	\$349.7 K	\$505.1 K	\$2.0 M	\$417.6 K	\$1.7 M
Healthy Montana Kids	67	268	\$15.1 K	\$60.4 K	\$87.2 K	\$348.9 K	\$72.1 K	\$288.5 K
State Employee Plan <i>Estimated Impact</i>	115	462	\$26.0 K	\$103.9 K	\$150.0 K	\$600.1 K	\$124.1 K	\$496.3 K
Commercial Payers	1,087	4,349	\$244.6 K	\$978.6 K	\$1.4 M	\$5.6 M	\$1.2 M	\$4.7 M
Medicare	846	3,385	\$190.4 K	\$761.6 K	\$1.1 M	\$4.4 M	\$909.7 K	\$3.6 M
TOTAL	2,505	10,018	\$563.5 K	\$2.2 M	\$3.3 M	\$13.0 M	\$2.7 M	\$10.8 M

*All members included in this analysis have a mental health diagnosis.

As shown above, even with a limited multi-payer pilot intervention, and recognizing that these are initial figures, Montana could see savings of approximately \$10.8 million across payers in four years.

ECHO Enhancement

Pairing the Collaborative Care model with Project ECHO can increase the model’s ability to serve patients and by enhancing the clinical capabilities and reach of the existing workforce. As described in the Delivery Models section of this Plan, Project ECHO enables providers and care managers to access interdisciplinary teams and specialists via video and teleconference technology to improve care for patients who are clinically challenging or need specialty services. In the case of the Collaborative Care model, access to a Project ECHO Hub could provide the team on the ground with access to psychiatrists and behavioral health professionals that are in short supply locally, but critical to effectively managing patient care and improving health outcomes.

For example, if ECHO enabled the state to double the size of just the pilot population from 5 percent of the total target population to 10 percent, it could result in \$10.8 million in additional savings from the model. The pilot would test the potential for ECHO to expand access to the Collaborative Care model and expand the return on investment of this model in Montana.

Billings Clinic will incur costs for administrative support and management of the teleECHO® sessions, costs for staffing the interdisciplinary panel, transcription of teleECHO sessions, transmission equipment and broadcast fees, program evaluation and miscellaneous costs.



Based on our actual costs, funding for these fixed and variable Hub expenses is required as follows:

Year 1	Year 2	Year 3	Year 4	Year 5
\$ 273,917	\$ 276,214	\$ 278,556	280,946	\$ 283,383

Community Resource Team Model

Literature and Assumptions

The Community Resource Team model is promising, and early results – for example from the Camden Coalition model on which Montana’s Community Resource Team approach is based, and from a similar Community Health Team model in Vermont – indicate significant potential to reduce costs of enrolled individuals. However, there is not yet significant literature on the potential cost or return on investment of this model.

The Camden Coalition model reduced admissions and ED visits by 40 percent on its first 36 patients, and saw corresponding decreases in hospital costs of 60 percent on this population. The Camden model is currently being evaluated through its first randomized control trial, but results are not yet available on net impacts.⁶⁶

In Vermont, the state has implemented Community Health Teams, a similar model, across payers. A recent evaluation of the model showed annual costs were outweighed by savings in both the commercial and Medicaid markets.⁶⁷ Medicaid saw a return on investment of approximately \$1.20 for every dollar spent, compared to approximately \$9.60 per dollar in the commercial market. These savings are attributable both to the implementation of Community Health Teams, but also practice transformation and other primary care focused reforms.⁶⁸

In Montana, Mountain-Pacific Quality Health is pursuing a Community Resource Team model for Medicare patients in Billings, Helena, and Kalispell. The program received a CMS SIP award of approximately \$1 million over two years to support 150 patients; Mountain-Pacific estimates the model will lead to a return on investment of approximately \$13.60 for every dollar spent.⁶⁹

To assess the potential impact of the Community Resource Team model in Montana, this financial analysis relies on the documented potential costs from the Mountain-Pacific Quality Health project. The analysis uses a conservative assumption of a return on investment of \$1.20 per dollar spent. These assumptions are detailed in the table below.

⁶⁶Robert Wood Johnson Foundation, *A Revolutionary Approach to Improving Health Care Delivery*, February 2014.

⁶⁷Department of Vermont Health Access, *Vermont Blueprint for Health, 2014 Annual Report*, July 2015.

⁶⁸Id.

⁶⁹Mountain Pacific Quality Health, Technical Proposal for the CMS Special Innovation Project 2 (IRSS-2) Award



Community Resource Team Model: Impact Assumptions		
	Average Per Year (2 Year Window)	Total (2 Year Window)
Implementation Cost/Patient⁷⁰	\$3,333	\$6,667
Savings/Patient	\$4,000	\$8,000
Net Impact	\$667	\$1,333
ROI	1.20	1.20

This assumption for return on investment is very conservative, given the range of outcomes under different models as described above. As Montana moves forward with this model, the state will refine and test these assumptions. In practice, the implementation cost and return on investment is likely to vary by payer (as it did in Vermont), and by community. The implementation cost will depend on the availability of local resources, the level of support from participating providers, and the geographically varied salaries of Resource Team members.

In addition, the state expects to see other less easily quantifiable returns on investment such as the potential for reduced adverse drug events, increased beneficiary tenure in the home setting, and acceleration of community collaboration and the use of shared regional resources.

Potential Opportunity

As described above, this financial analysis takes a conservative approach to estimating the potential opportunity of the Community Resource Team model in Montana. This analysis, like the analysis of the Collaborative Care model, utilizes data self-reported by payers through their participation in the Governor’s Council. Implementation costs and savings are calculated based on the assumptions found in literature and detailed above.

The target population for this model was defined as individuals with elevated risk scores. Payers self-reported data on the target population to inform the financial analysis, using various methodologies to arrive at the estimated target population. These methodologies will need to be refined and standardized as planning moves forward.

On average across payers, this population was about 5 percent of all health plan enrollees. Typically risk scores are first calculated for each enrollee in a health plan and take into account age, sex, and diagnoses; diagnoses are associated with a numeric value according to their respective Hierarchical Condition Category (HCC) which represents the relative expenditures a plan is likely to incur for an enrollee with the diagnosis.⁷¹

⁷⁰ Id.

⁷¹ Kaiser Family Foundation. *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors*. January 22, 2014.



Community Resource Team Model: Potential Opportunity								
Payer	Targeted Members*		Implementation Cost		Savings		Net Savings	
	Average per Year	Total (2 Years)	Average per Year	Total (2 Years)	Average per Year	Total (2 Years)	Average per Year	Total (2 Years)
Medicaid (Traditional)⁷²	5,018	10,036	\$16.7 M	\$33.45 M	\$20.07 M	\$40.14 M	\$3.35 M	\$6.69 M
Healthy Montana Kids⁷³	98	196	\$0.33 M	\$0.65 M	\$0.39 M	\$0.78 M	\$0.07 M	\$0.14 M
State Employee Plan⁷⁴	1,576	3,152	\$5.25 M	\$10.51 M	\$6.30 M	\$12.61 M	\$1.10 M	\$2.10 M
Commercial Payers⁷⁵	19,395	38,790	\$64.65 M	\$129.30 M	\$77.58 M	\$155.16 M	\$12.93 M	\$25.86 M
Medicare⁷⁶	8,050	16,100	\$26.83 M	\$53.67 M	\$32.20 M	\$64.40 M	\$5.37 M	\$10.73 M
TOTAL	34,137	68,274	\$113.8 M	\$227.6 M	\$136.5 M	\$273.1 M	\$22.76 M	\$45.52 M

*All members included in this analysis have elevated risk scores.

As shown in the chart, if the Community Resource Team model were implemented across all payers in Montana for these targeted members with elevated risk scores, the model has the potential to result in approximately \$45.5 million in net savings over a two year implementation period. This initial opportunity assessment reflects a promising opportunity for the state of Montana, and makes the case for ongoing funding to support continued planning, implementation and evaluation of this model.

⁷² Medicaid data is only for the Passport population (about 75% of Medicaid members). Data reflects Passport members with the risk scores in the top 5%.

⁷³ Healthy Montana Kids data was provided by BCBSMT, which serves as the third party administrator for the State’s CHIP program. High risk members are designated as "in crisis" based on their risk scores under the Verisk DxCG Risk Model.

⁷⁴ Employee Health Plan risk data reflects the top 5% of all enrollees by risk score.

⁷⁵ Data includes BCBSMT commercial, PacificSource individual and small group, and Allegiance members (not including State Employee Plan members). All payers used the Verisk model to identify high risk members, but methodologies varied. BCBSMT identified members "in crisis" based on their risk scores, PacificSource included members with risk scores in the highest prospective risk category (score of 7 or higher), and Allegiance included members with relative risk scores above 2.5 (i.e., are 2.5 times as likely to have a predicated event, such as a hospitalization, as the average).

⁷⁶ Data provided by Mountain Pacific Quality Health, the State QIO. Data reflects beneficiaries in the top 5% of all beneficiaries when ranked by combined total Part A and Part B claim payments. Spending figures include Part A and B claims, and include an estimate of the annual Part D payment per beneficiary.



Pilot

As with the Collaborative Care model, Montana may proceed with one or more multi-payer pilots to test the Community Resource team model with the target population. A pilot phase will allow the state and participants to assess the model’s costs and savings potential, and also test whether the conservative return on investment assumption should be increased to reflect actual outcomes. Should the state proceed with and obtain grant funding to support a pilot, it would aim to test the model in both urban and rural settings and across public and private payers. The pilot would also be designed to build on and align with other delivery reform initiatives in the state, including by testing the model with providers participating in the planned Medicaid Health Home program and providers and payers participating in the existing PCMH program.

The financial analysis below provides an example of the potential scope of such a pilot, if all payers participated in the pilot with 5 percent of their members with elevated risk scores enrolled in the pilot.

Community Resource Team Pilot: Potential Opportunity								
Payer	Targeted Members*		Implementation Cost		Savings		Net Savings	
	Average per Year	Total (2 Years)	Average per Year	Total (2 Years)	Average per Year	Total (2 Years)	Average per Year	Total (2 Years)
Medicaid (Traditional)	251	502	\$836.3 K	\$1.67 M	\$1 M	\$2 M	\$167 K	\$334.5 K
Healthy Montana Kids	5	10	\$16.3 K	\$32.7 K	\$19.6 K	\$39.2 K	\$3.3 K	\$6.5 K
State Employee Plan	79	158	\$262.7 K	\$525.4 K	\$315.2 K	\$630.5 K	\$52.5 K	\$105.1 K
Commercial Payers	970	1,940	\$3.2 M	\$6.5 M	\$3.9 M	\$7.8 M	\$646.5 K	\$1.3 M
Medicare	403	805	\$1.3 M	\$2.7 M	\$1.6 M	\$3.2 M	\$268.3 K	\$536.7 K
TOTAL	1,707	3,414	\$5.7 M	\$11.4 M	\$6.8 M	\$13.6 M	\$1.1 M	\$2.3 M

*All members included in this analysis have elevated risk scores.

As shown above, even with a limited multi-payer pilot intervention, and recognizing that these are initial figures, Montana could see savings of approximately \$2.3 million across payers in two years.

ECHO Enhancement

As discussed with respect to the Collaborative Care model, pairing the Community Resource Team model with Project ECHO can increase the model’s ability to serve patients and enhance the clinical capabilities and reach of the existing workforce. As described in the Delivery Models



section of this Plan, Project ECHO bolsters a Community Resource Team by giving the team access to specialists, such as a psychiatrist or behavioral health consultant, to improve care for patients who are clinically challenging or need specialty services. Project ECHO may be particularly helpful for Community Resource Teams that rely on peers or other trusted community members to interface with patients, but who do not have formal medical training and have limited access to providers and specialists in their communities.

For example, if ECHO enabled the state to double the size of just the pilot population from 5 percent of the total target population to 10 percent, it could result in \$2.3 million in additional savings from the model. The pilot would test the potential for ECHO to expand access to the Community Resource Team model and expand the return on investment of this model in Montana.

Conclusion

This analysis concludes that Montana's proposed multi-payer delivery models hold significant promise. Independently, these models have the potential (over time, once fully implemented) to improve care for as many as 80,000 Montanans each year, resulting in as much as \$77 million in net savings annually, if they were applied across payers and to all target populations identified in this analysis.

The pilot projects envisioned in this Plan would allow Montana to test these models at a regional level and across payers, and to refine this analysis before considering larger scale statewide reforms. Recognizing this opportunity, the state will actively seek to convene payers, state and federal agencies, foundations, and other potential funders with the goal of securing funding to support and evaluate these pilots, as well as continue active and meaningful stakeholder engagement to advance delivery system and payment reform.

Workforce

The readiness and availability of the right workforce is essential to achieving the Governor's Council's vision for transformation. As such, the Council has identified workforce development as a key area of concern. As noted above, serious workforce shortages exist, particularly among behavioral health providers. Most areas of rural Montana also face problems of workforce maldistribution, with some of the biggest challenges in the areas of primary care and behavioral health. The delivery models the Council is considering piloting will require health care workers with specific skill sets, some of which may not currently exist.

Montana's delivery models are designed to address workforce shortages by leveraging the existing workforce and creating new types of positions. Project ECHO will enhance primary care providers' ability to address the behavioral health needs of Montana patients and mitigate the state's behavioral health shortages, and community resource teams will create new mechanisms to support patients. These models and can be used in areas both rural and urban where workforce shortages exist.



In addition, Montana has several major workforce development initiatives underway that can be leveraged to prepare the workforce necessary for the delivery transformation models outlined in this plan.

HealthCARE Montana

The Montana University System's Area Health Education Center and Office of Rural Health and the Montana Department of Labor and Industry and launched the HealthCARE Montana project to meet the current and future need for health care workers in Montana. HealthCARE Montana strives to facilitate high-quality, locally accessible, and industry-relevant training opportunities in the high-demand, high-skill area of health care. An innovative statewide, industry-driven partnership, the HealthCARE Montana project is comprised of a 15-college consortium, the Montana Department of Labor & Industry, the Office of the Commissioner of Higher Education, and the Montana Area Health Education Center (a U.S. Department of Health and Human Services funded program).

The project is funded by a \$15 million Trade Adjustment Assistance Community College and Career Training (TAACCCT) grant from the U.S. Department of Labor's Employment and Training Administration. HealthCARE Montana is a collaborative project that helps train, recruit, and retain health care professionals in rural and frontier Montana by:

- Helping prospective students identify and access pathways toward a health care certificate or 2-year degree, as well as supporting them throughout their health care education to ensure academic success;
- Developing an accelerated nursing curriculum to guide health care providers toward higher levels of practice and to ease the nursing shortage in Montana;
- Increasing opportunities for on-the-job training by developing health care apprenticeships; and
- Building and sustaining a rural, "home-grown" health care workforce that serves the smallest communities in the farthest regions of Montana.

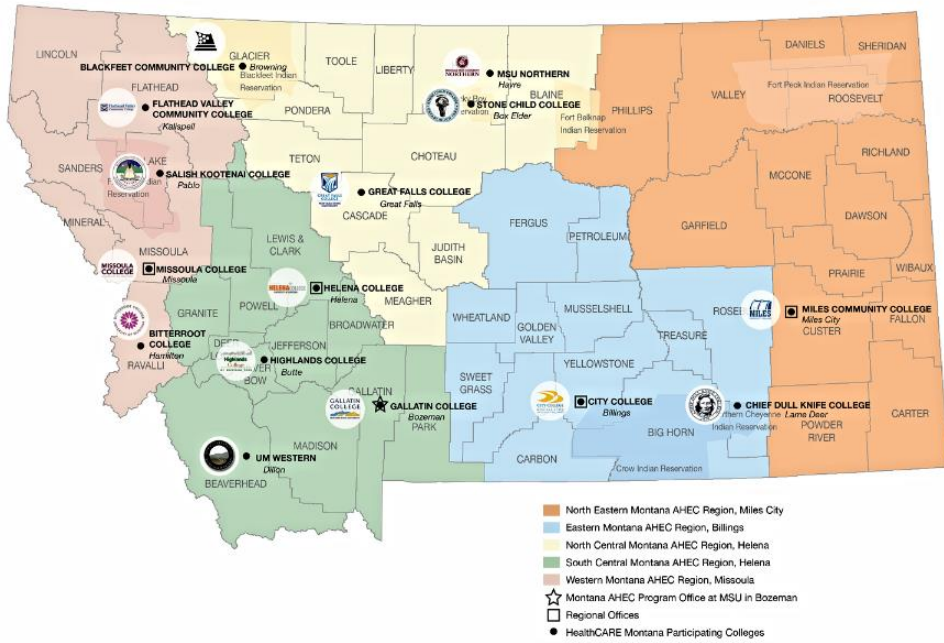
This collaboration continues to provide opportunities to systematically streamline career pathways into health occupations, so Montanans can get the quality health care they need, resulting in successful employment outcomes for all students, with attention to adult learners and veterans.

Fifteen Montana community colleges are engaged to provide health education to HealthCARE Montana participants, including several on or near reservations: Bitterroot College UM; Blackfeet Community College; Chief Dull Knife College; City College MSUB; Flathead Valley Community College; Gallatin Community College MSU; Great Falls College MSU; Helena College UM; Highlands College MT Tech UM; Miles Community College; Missoula College UM; MSU Northern; Salish Kootenai College; Stone Child College; and UM Western.



Montana Health Care Innovation Plan

PARTICIPATING COLLEGES



Montana Health Care Workforce Advisory Committee

Montana’s Health Care Workforce Advisory Committee was created in 2006 to provide guidance to the state on how to assure that there is a well-trained workforce sufficient in number, breadth and quality to meet the need of all regions of the state.

In September 2010, the Committee, in partnership with the State Workforce Investment Board (SWIB), was awarded a State Health Care Workforce Development Grant from the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services. The outcome of the grant has been the development of a Health Care Workforce Strategic Plan for Montana.

Membership in the MHWAC has expanded to over 100 participants representing the many facets of the health care industry in Montana, including State Innovation Model project staff. The committee is now in the process of updating its strategic plan and will continue to provide a forum for public and private sector workforce data analysis. The Committee has also been working to develop standards and a curriculum for community health workers.

Rural Health IT Network Grant

The Montana Rural Health IT Network was formed in September 2013 as a result of a Network Workforce Grant through the Office of Rural Health Policy (HRSA). The mission of the Network is “to accelerate and sustain optimal use of health information technology to improve care in Montana.” Grant funding is used to support student participants to obtain certificates in Health



IT through Montana universities and colleges. The students are reimbursed for tuition/fees and books. Student participants have largely been incumbent workers who are already working in small, rural facilities. The grant will conclude in 2017.

The goal for the grant program is to train incumbent health care workers to use new health information technologies in a variety of settings, including team-based care environments, long-term care facilities, patient-centered medical homes, accountable care organizations, hospitals, and clinics. This workforce program will focus on the four key topic areas of population health, care coordination, new care delivery and payments models, and value-based and patient-centered care.

Behavioral Health Workforce Training Implementation Plan

Montana has a state-wide multi-year Workforce Training Implementation Plan which was developed to increase the number of behavioral health care and other child-serving professionals trained in substance use and co-occurring treatment needs of Montana youth. Negotiations are underway with the University of Montana to house and sustain the delivery of the online training webinars beyond the grant period.

In 2013, the Children's Mental Health Bureau (CMHB) applied for and was awarded a SAMHSA State Adolescent Treatment Enhancement Dissemination (SAT-ED) grant in order to launch the Montana Co-occurring Capacity Building Project (MCCB). The overarching goal of the project is to meet the needs of the growing population of youth with co-occurring disorders who are underserved or are not receiving treatment across the state. For these youth, there is a serious limitation of access to treatment that addresses both serious emotional disturbance and their substance use disorder concurrently.

Meeting the social service needs of Montana's youth with co-occurring and substance use disorders requires a well-organized and prepared network of properly trained providers. Training and development of the workforce is one part of a comprehensive strategy toward statewide quality improvement in this area. Fundamental to this work is identifying gaps in provider's knowledge, skills, and abilities through the assessment of both organizational and individual needs, and addressing those gaps through targeted training and development opportunities.

At the time of grant application, the state of Montana did not have a coordinated, formalized state-wide, multi-year training plan for behavioral health care and child-serving agency professionals. At the state level, the resources needed to support a comprehensive cross-agency, workforce development effort are limited, including human capital and funding. No single entity was tracking the availability of the workforce available to treat youth with co-occurring disorders. As work began on the grant and the magnitude of the workforce shortage became clear, workforce development was added as an additional goal.



A statewide multi-year Workforce Training Implementation Plan was developed to increase the number of behavioral health care and other child-serving professionals trained in substance use and co-occurring treatment needs of Montana youth. The plan focuses on providing targeted training efforts to those licensees primarily responsible for delivering substance use and co-occurring disorders treatment services. The four categories of service providers targeted are: Licensed Addiction Counselor (LAC), Licensed Clinical Social Worker (LCSW), Licensed Clinical Professional Counselor (LCPC), and Licensed Marriage and Family Therapist (LMFT). These are the primary service providers for \$36 million of the state's \$55 million spent on children's mental health, substance use and co-occurring disorders treatment services and are directly involved in the delivery of an additional \$10-12 million of services.

Western Montana Addiction Services (WMAS) has the primary responsibility to develop the plan and provide the trainings. It receives grant funding through the Children's Mental Health Bureau (CMHB) at the Montana Department of Health and Human Services. An important legacy of the plan is that WMAS will be established as a training center that has the capacity to provide online and in-person trainings for the behavioral health care workforce serving adolescents with substance use and co-occurring disorders. The partnership with CMHB and the other state-level, child serving agencies on the Planning Council will continue in order to meet the growing needs of Montana's licensed professionals and the communities they serve.

WMAS established a Workforce Development Committee in 2013. This committee served as a focus group of key stakeholders and leading treatment experts who generated an initial list of workforce training needs. Subsequently, a survey was conducted on a sample of clinical leaders to further assess needs.

Based on the survey's assessments, WMAS has arranged for training opportunities to increase providers' capacity to provide high quality substance use and co-occurring treatment to Montana youth. The trainings include expanding access to webinars that focus especially on the needs of those in rural and frontier areas. Montana is training treatment providers in two evidence based programs, Integrated Co-Occurring Treatment and Motivational Enhancement Treatment/Cognitive Behavioral Treatment. The state, through DPHHS, is also promoting the use of the evidence-based assessments, such as the Teen Addiction Severity Index.

Behavioral Health Coaches

Through the state innovation planning process, providers and the Montana Medical Association identified the need for behavioral health coaches as a key new role to supplement the needs of team based care. A behavioral health coach is a non-licensed health professional with an AA or BA plus an internship, who is trained to identify adverse health behaviors and risks and guide patients to more optimal health behaviors and lifestyle.

Behavioral health coaches will be able to screen for mental health issues and barriers to improving care beyond the clinical setting, but are not mental health counselors. These professionals empower, educate, motivate, and guide patients with health care needs. They



work as part of a health care team, usually in a clinic setting. Their role would have some crossover to care coordination and patient education but would be distinct from current nursing and medical assistant roles.

Community Health Workers

A growing number of states across the country are using community health workers to improve health outcomes. In Montana, a 2015 survey by the Montana Area Health Education Center found that nineteen organizations in Montana reported having a staff position that delivered community health worker or similar services, and many more reported an interest in using community health workers in the future. Currently, these workers are employed by non-profits, health care organizations including FQHCs and hospitals, tribal health organizations and state agencies. They may be called by other titles including Community Health Representatives (Tribal Health and IHS), Snap-Ed Nutrition Educators, Outreach Workers, Navigators, Resource Advocates, Peer Support Workers and Community Paramedics. Their roles include assisting patients with navigating the health care system, including setting up health screenings, assisting patients with health insurance, and other patient education; working to overcome non-medical barriers to achieving health by connecting patients with community resources and services, such as food or energy assistance, transportation to medical appointments, housing assistance. Community Health workers would also be tasked with providing health care organizations with input from the communities they serve.

As national interest in community health workers has grown, the number of states establishing standards and curricula has soared. Montana is joining this movement, and Montana AHEC is leading the creation and development of a Montana community health worker curriculum. The workgroup has begun to identify the core competencies that stakeholders believe Montana community health workers must have. Once the group has finalized the core competencies, it will begin to develop the curriculum to support the competencies. The group has also identified the need for payment models that will support the work of community health workers in order to facilitate widespread adoption.

Rural Behavioral Health Primary Care Collaborative

Four primary clinic sites across the state received a Health Resources and Services Administration HRSA grant to support integrated behavioral health: Glasgow, Plains, Libby and Kalispell. This grant, led by Western Montana Area Health Education Center (AHEC), permanently placed pre-licensed clinical social worker and psychology post-doctoral graduates in primary care settings while providing salary support until the providers were licensed. It also provided remote pre-licensure supervision.

A high percentage of clinicians work where they train, and this grant has helped overcome barriers to bringing new masters or doctorate level clinicians to rural practices who otherwise could not have provided the necessary supervision.



Project ECHO

Project ECHO has the potential to assist Montana in meeting its workforce needs in multiple ways. The consulting team of experts would add to the existing workforce and extend the limits of primary care providers' care, increasing patients' access to specialty knowledge. In addition, and perhaps more importantly, the project has the potential to improve recruitment and retention of providers in rural areas, as well as improve the quality of the care they deliver. Primary care providers in remote areas of the state can feel isolated and unsupported. Project ECHO connects these providers with experts who can support them so they feel better equipped to meet the needs of their patients, and connects them with a network of peers. It efficiently disseminates knowledge, research, and current best practices, thereby expanding the clinical toolbox and feelings of success of the existing workforce.

Monitoring and Evaluation

Multipayer collaboration and alignment is valuable to providers who contract with multiple payers such as Medicaid, commercial payers, and Medicare. Using shared and aligned measures where possible reduces the reporting and administrative burden on providers – thus reducing cost pressures. It also helps Montana move beyond fragmented and disconnected efforts by creating a new degree of coordination and learning that can magnify impact. As with aligned delivery and payment models, aligned, incentivized quality measures also help ensure adequate financial support for practices to make fundamental changes to their care delivery. Further, when payers share cost, utilization, and quality data¹ with practices at regular intervals, it facilitates practices' ability to manage their patient population's health, leading to smarter spending, better care, and healthier people.

Measurement and Reporting Alignment

Montana underwent a robust process for consolidating and aligning measures through its PCMH process. There is significant alignment among quality measures among Montana's existing programs. It is important that ongoing measures not increase the burden on providers by aligning with the PCMH measurement process and federal measurement programs like Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the Comprehensive Primary Care Plus program (CPC+).

Existing Measure Inventory

The PCMH program requires five metrics to be measured and reported.



Montana Health Care Innovation Plan

	Montana PCMH Program	Medicaid Core Measures	Physician Quality Reporting System	Medicare Shared Savings Program	Public Health and Safety Division Strategic Plan	State Health Improvement Plan
Hypertension	✓	✓	✓	✓	✓	✓
Tobacco use and intervention	✓	✓	✓	✓	✓	✓
A1C control	✓	✓	✓	✓	✓	✓
Childhood immunizations	✓	✓	✓		✓	✓
Depression screening	✓ *	✓	✓	✓		✓

*Measure is forthcoming in 2016.

Montana PCMH Program Provider Metrics

Measure	Denominator	Numerator
Blood pressure control in adult population with diagnosed hypertension	All adults aged ≥18 through 85 years in the PCMH patient population who: a) have the diagnosis of hypertension, AND b) had one or more outpatient visits during the reporting period	Number of these adults for whom documented blood pressure at time of most recent outpatient visit during the reporting period was systolic
Tobacco use and intervention for cessation in adults	All adults aged ≥18 years in the PCMH patient population who: a) had two or more outpatient visits for any reason, or who had one preventive care visit during the reporting period, AND b) were documented to be tobacco users	Number of tobacco users who received a tobacco cessation intervention during the measurement period
HbA1C results for adults with diagnosed diabetes mellitus	All adults aged ≥18 through 75 years in the PCMH patient population who a) have the diagnosis of diabetes mellitus* (type 1 or type 2), AND b) had one or more outpatient visits during the reporting period	All adults aged ≥18 through 75 years in the PCMH patient population who (a) have the diagnosis of diabetes mellitus* (type 1 or type 2), and (b) had one or more outpatient visits during the reporting period
Age-appropriate immunization for children who were age 3 during the reporting period.	All children in the PCMH population whose 3rd birthday occurred from January 1, 2014 through January 1, 2015 and who had one or more outpatient visits during calendar year 2014	Number of these children who had received all age-appropriate immunizations before their third birthday

* Diabetes mellitus (or diabetes) is a chronic, lifelong condition that affects your body's ability to use the energy found in food. There are three major types of diabetes: type 1 diabetes, type 2 diabetes, and gestational diabetes.

The PCMH Stakeholder Council has recommended to the Insurance Commissioner one additional quality metric – depression screening – for the 2016 reporting year. Seventy-six percent of PCMH practices indicated they are able to electronically report on the percentage of patients who are screened for depression.



Community Resource Teams and ECHO-Enhanced Collaborative Care Measures

Pilot evaluation is critical, and payers and practices participating in each pilot are best placed to develop and build on existing alignment of access, outcome, process, and structural measures for the pilots in the state. The Governor’s Council will regularly revisit these measures to review progress on the pilots, delivery and payment reform in the state.

Goals	Strategies	Measures of Success
<p>Improved health of Montanans by:</p> <p>Preventing, identifying and managing chronic physical and behavioral health conditions, especially when they are co-occurring</p> <p>Supporting high-risk, vulnerable patient population and reducing health disparities (e.g. American Indians)</p>	<p>Consider, test and expand delivery models including: Collaborative Care, Project ECHO, Community Resource Teams, PCMHs, and Medicaid Health Homes that improve patient engagement and support physical and behavioral health integration and disease management</p>	<ul style="list-style-type: none"> • Multi-payer pilots launched • Explore federal, state, and philanthropy-based funding opportunities to test and expand models • Continue convening Governor’s Council • PCMH clinical quality and outcome metrics* • Inpatient and ED utilization and cost measures
<p>Improved Montana Health care System by:</p> <p>Improving physical and behavioral health integration</p> <p>Improving access to</p>	<p>Examine infrastructure to support and align outcomes measurement across payers and delivery models</p>	<ul style="list-style-type: none"> • Telehealth/ECHO component for 1+ multi-payer pilot • Launch of 1+ data infrastructure alignment initiative • Continued HIE stakeholder planning



Montana Health Care Innovation Plan

<p>primary, specialty and behavioral health services</p>		
<p>Control Health care Costs in Montana by:</p> <p>Reducing preventable use of ED and inpatient services</p> <p>Paying for value</p>	<p>Consider ways to leverage policy and payment authority to implement and spread value-based payment models</p>	<ul style="list-style-type: none"> • Inclusion of I/T/U providers in multi-payer pilots • Medicaid participation in multi-payer pilots, health homes, CPC+ • Other public and private plan participation in pilots

The pilot project work groups will also consider the following measures as pilots are developed:

	Care Coordination Process Measures	Clinical/Utilization/Outcome Measures
<p>Both Models</p>	<p>Enrolled patients Graduated patients Relapsed patients Transition of care measures (e.g. referrals and follow ups) Patient satisfaction Provider satisfaction</p>	<p>Required PCMH measures (when applicable) Inpatient admissions/cost Hospital readmissions/cost Emergency department visits/cost Outpatient utilization/cost Pharmacy utilization/cost Total cost of care</p>
<p>Community Resource Team</p>	<p>Volunteer participation Duration of team-patient relationship Social issues addressed</p>	<p>Inpatient admissions/cost Emergency department visits/cost Patient satisfaction</p>



Timeline and Approach to Continued Planning and Implementation

Montana’s goal is to improve health and health care and lower costs. In order to achieve these aims, the Governor’s Council will provide a forum for ongoing public-private collaboration between multiple payers, purchasers, providers, communities, work groups, and public agencies to identify opportunities to act in complementary ways. The ongoing collaboration between decision-makers will help advance, monitor, and evaluate progress on Montana’s goals.

Montana has or will convene work groups to facilitate further development of each delivery model pilot. Each workgroup will be composed of the pilot leader or leading organization and individuals representing public and private organizations with expertise and interest in supporting the identified model and target population. Workgroups will convene by conference calls and in-person meeting and be lead either by the state innovation planning team or by private partners involved in the Governor’s Council planning process including teams for the: Health Information Exchange, ECHO, Community Resource Teams, and Medicaid Health Homes.

In addition to work groups, Montana will continue to engage the relevant advisory panel members and other stakeholder groups to keep these stakeholders abreast of workgroup progress throughout the entire transformation planning process. These groups serve as a sounding board and guiding hand for the Governor’s council as specific questions, ideas or proposals are generated.

Proposed Pilot Timeline and Next Steps

Pilot Planning	Pilot Launch & Implementation	Pilot Evaluation	Expansion
6 – 9 Months	12-36 Months	Pre/Post/During Pilot	End of Pilot/Post-Pilot
<ul style="list-style-type: none"> Obtain funding Define and refine target populations for each model Finalize core components of delivery models Identify provider participants 	<ul style="list-style-type: none"> Launch pilots Continue training as needed Provide technical assistance to providers Report to Governor’s Council on pilot progress 	<ul style="list-style-type: none"> Determine measures and sources Collect baseline data (pre-pilot) Review and analyze data on regular basis (to extent possible) to inform pilot approach 	<ul style="list-style-type: none"> Review evaluation findings Develop report on pilots and outcomes Decide whether pilots will be expanded If pilots will be expanded, refine models and address key components for new target populations, providers, and geographies



<ul style="list-style-type: none"> • Recruit additional staff as needed • Begin training • Determine provider payment model 	<ul style="list-style-type: none"> • Refine pilots in light of evaluation findings 		<ul style="list-style-type: none"> • Refine evaluation approach as needed
--	---	--	--

ECHO-Enhanced Collaborative Care

Montana’s ECHO-enhanced collaborative care pilot was launched in May with two participating community health centers. Evaluation of Montana’s hub at Billings Clinic will begin after six weeks and a formal evaluation will begin in November.

While it is clear that there is a need to support rural clinicians in the treatment of patients with behavioral and mental health issues, Billings Clinic has emphasized that the scope of the problem and potential return on investment should be better understood by payers, policy makers and other stakeholders. Billings Clinic has secured a study and evaluation proposal from Health Management Associates which could facilitate the development of broad support for the ECHO model. This evaluation would also indicate other areas that could be effectively served through the ECHO model.

Community Resource Teams

In November of 2015, Montana Pacific Quality Health Foundation was awarded one of 16 two-year Special Innovation Projects (SIPs) secured by regional Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs). Planned outcomes that will be measured include: improvement in inpatient admissions and emergency department visits within six months post-intervention, and patient satisfaction.

Health IT Plan

If Montana is to engage in payment reform models that pay and reward providers for outcomes and not just volume, we need the ability to collect and analyze data in a meaningful way. As new care and payment models evolve, Montana’s lack of a comprehensive platform for the exchange of health information and analytics becomes an item of discussion. Establishing such a platform could open doors to more innovative ways of delivering care and paying for the



services. This has the potential to create pathways to improvements within our systems of care and assist in targeting limited resources to those most in need.

Health IT Transformation

Introduction

Montana's Health Information Technology transformation must build on where Montana is today, and with the state's unique environment and market in mind. The appropriate technology and data infrastructure will be key to implementing Montana's health care transformation. The Montana HIT Transformation plan includes three components:

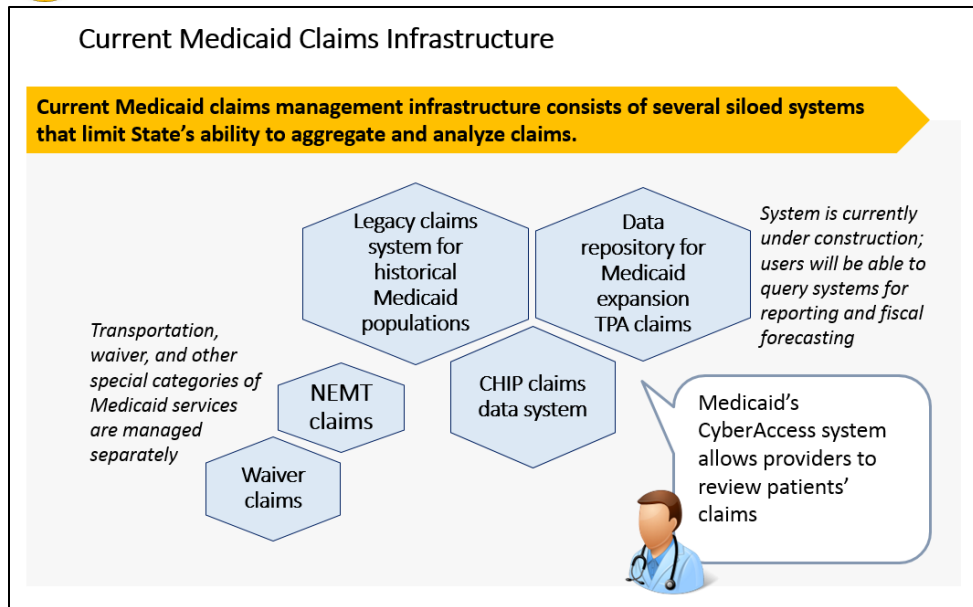
- A collaboration between Montana Medicaid and the State Employee Health Plan to enhance Montana's claims data analysis capabilities.
- Minimal IT infrastructure and free software for the ECHO-enhanced collaborative care model. Billings Clinic, Montana's hub site, already had the necessary teleconferencing equipment in place, and spoke sites need only a web cam and an internet connection.
- A Health Information Exchange (HIE) pilot project, which will begin by identifying the high-cost, high-needs patients for Montana's hotspotting project, as well as facilitate automatic data quality reporting for Montana's PCMH program.

Administrative Claims Data

Current State

Current Medicaid claims management infrastructure consists of several siloed systems that limit Montana's ability to aggregate and analyze claims. There are separate systems for:

- Waiver claims
- Non-emergency medical transportation
- Legacy claims systems for historical Medicaid populations
- CHIP claims
- Data repository for Medicaid expansion TPA claims (system is currently under construction)
- Current BCBS claims system
- BCBS CHIP claims system



Expanding the Project

In 2016, the State Employee Health Plan ended a previous external data management contract and will build a data warehouse to store its own data. The warehouse may eventually house other state medical data such as Medicaid data, State Hospital and other facility data, and data from the Department of Corrections. The State Employee Health Plan aims to include data analytics and predictive modeling to support population health management.

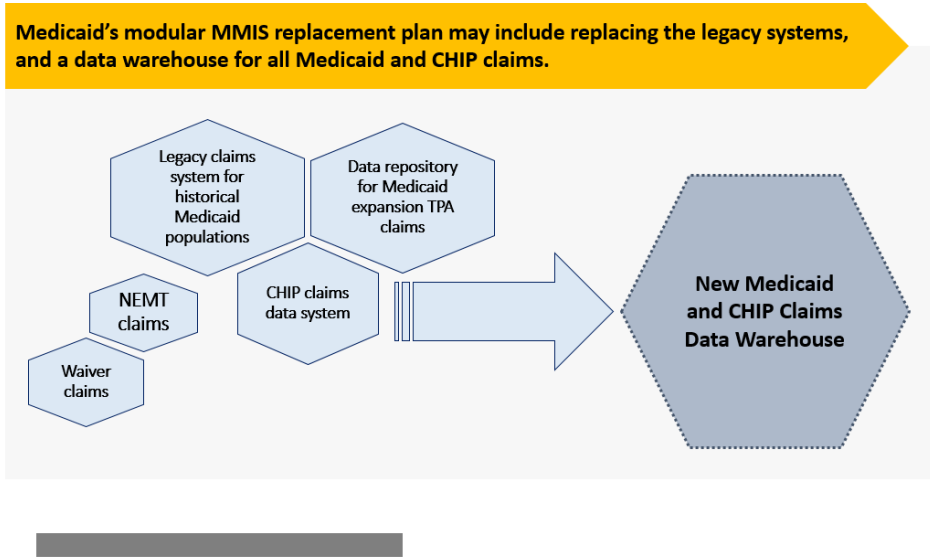
The project may also be an opportunity for Medicaid to consolidate multiple siloed administrative data systems in use currently. Montana's Medicaid program is building a data warehouse for Medicaid expansion claims from its third party administrator (BCBS MT), and may consider compiling all Medicaid and CHIP claims in single Medicaid warehouse as part of an MMIS replacement plan.

This data warehouse could be an opportunity for the state to streamline the collection and storage of claims data. Over 240,000 covered lives could be represented in the contemplated data warehouse, including approximately 30,000 state employees, 205,000 Medicaid and CHIP clients, and 4,000 inmates from Department of Corrections. The development of an additional, enhanced analytics could be developed and connected to the data warehouse to enhance the state's ability to effectively engage in population health management and improve health outcomes through targeted care management and interventions. Montana could consider allowing the addition of other public or private-sector employers to the data warehouse.



Approach to planning and implementation

Streamlining Medicaid Claims Management



Medicaid may consider whether it would be appropriate to request federal funding to support further development of the data warehouse to support Medicaid’s needs, including the development of population health management tools. which may be available to finance 90% of the cost this project, with 10% of the cost coming from state Medicaid funds An exception to the Office of Management and Budget Circular A87 cost allocation rule A87 allows Medicaid to purchase tools and allow for appropriate re-use for other parties.

States may receive 90/10 matching funds, on an ongoing basis, for modernization of Medicaid eligibility and enrollment systems and MMIS claims systems.⁷⁷ Ongoing maintenance and operation of systems receive 75% match, provided that the systems meet certain criteria, including using a modular approach to development, enhanced funding may support integration of Medicaid systems with other state programs. Through Dec. 31, 2018 states are not required to allocate the costs of developing certain core system components to other federally-funded humans service programs, and can instead use Medicaid 90/10 funding to develop these system components. This exception does not apply to maintenance and operations costs.

Planning and implementation efforts will be conducted in partnership with the Montana Department of Administration and are dependent upon state budgeting and resource considerations.

⁷⁷ CMS final rules 2346-F (April 2011) and 2392-F (December 2015)
Tri-Agency SMD Letters on OMB A-87 guidance exception (April 2011 and July 2015)



Project ECHO

Current state

As described earlier, a new project recently launched in Billings and will connect local providers with specialists through teleECHO clinics. Leveraging grant funding and in kind provider contributions, Billings Clinic launched the first Montana-based Project ECHO hub in January 2016 as an addictions and behavioral health collaborative to support clinicians within Department of Corrections (DOC).

The project uses the same kind of technology as tele-medicine. But using the technology so that a provider can see a patient, ECHO is a tool for a team of providers to collaborate with each other, regardless of where they're based. Dr. Eric Arzubi, who chairs the Psychiatric Department at Billings Clinic and serves on Montana's Governor's Council, will lead the team and the project. Other team members currently include a psychiatrist and pharmacist from Billings Clinic, a licensed addictions counselor from Rimrock Foundation, and the Department of Corrections. Other members of the interdisciplinary team may include nurses, social workers, other behavioral health specialists, and care coordinators.

Providers can access ECHO Hubs to support care for the target populations. Project ECHO operates 39 hubs for nearly 30 diseases and conditions in 22 states and five countries outside the U.S., including sites within the Department of Defense health care systems.

The current Billings Clinic ECHO project is grant funded, and has been provided in kind support from participating providers. State law requires private payers to cover certain telehealth services; providers receive reimbursement for telehealth at the same level as in-person services, however, reimbursement for teleconsultation services varies across payers. Montana Medicaid will currently reimburse a provider enrolled in Medicaid who delivers services via live video services; Medicaid is open to considering additional reimbursement models, including reimbursement for teleconsultation services if relevant criteria are in place.

Expanding the Initiative

Designated Professionals Work with Patients in Community

Montana has 17 community-based treatment and corrections facilities and as noted earlier, there aren't enough psychiatric services to go around. ECHO technology and software could be expanded in Montana to address workforce challenges and support delivery reform efforts and to help Montana mitigate these shortages.

Designated health care professionals in the community (e.g. care managers, physicians, tribal health facilities, community health workers) could consult independently or as a team through the ECHO Hub when delivering care. The multidisciplinary team will collectively share strategies, best-practices, and appropriate testing or pharmacy recommendations to best serve the patient. The technology could be used ideally with a specific care model (e.g. Collaborative Care) or to generally integrate services across behavioral/physical health.



The needs for expanding this project are minimal. Montana's hub site, already has the necessary teleconferencing equipment in place, and the IT infrastructure and capital expenditure needed are manageable. iHealth and iECHO are offered by Project ECHO for free, including the creation of a data archive on their server. They also offer training for hub and spoke staff.

Hub site needs are as follows:

- Videoconferencing bridge
- Videoconferencing recording device
- Webcam interfacing capacity/software
- Webcam
- Microphone
- iHealth software (confidential, HIPAA-compliant tools used to facilitate patient case presentations, management and outcomes evaluation)
- iECHO software (confidential, HIPAA-compliant tools used to manage and report outcomes)

Spoke site needs are as follows:

- Fast and reliable internet connection
- Microphone/headset
- Small video or webcam or PC camera
- iHealth software (confidential, HIPAA-compliant tools used to facilitate patient case presentations, management and outcomes evaluation)
- iECHO software (confidential, HIPAA-compliant tools used to manage and report outcomes)

Approach to planning and implementation

Project ECHO may help Montana address persistent workforce issues due to the rural nature and size of the state, including the lack of psychiatrists and other specialists and the difficulty of retaining primary care providers/family docs who feel unsupported without access to specialists. Traditional telehealth may also ease the burden on patients with complex or chronic conditions who today must travel long distances to see a specialist or may even forego care. The Project ECHO model has been met with considerable enthusiasm and is grounded in a tested innovation; a work group of the Governor's Council is in the process of planning the expansion effort.

The Governor's Council will set up a work group led by Dr. Arzubi to plan and implement the ECHO expansion.



Health Information Exchange

Current state

Health information exchange (HIE) enables health care professionals and patients to securely access and share health information electronically. It is widely accepted that HIE among delivery settings – inpatient, outpatient, emergency – is critical to improving the quality and efficiency of the health care system, yet HIE in Montana is limited between organizations, and many providers operate in information silos. Appropriate and timely sharing of patient information can better inform decision making at the point of care and supports providers to avoid readmissions and medication errors, improve diagnoses, and decrease duplicate testing.⁷⁸

In the past, efforts to catalyze HIE under the Health Information Technology for Economic and Clinical Health (HITECH) Act led to the development of HealthShare Montana. HealthShare Montana, a non-profit organization, was charged with developing and implementing a statewide HIE network, but the effort failed in 2014 due to lack of funding and stakeholder disagreements over governance and technology.

Recently, a new alliance of providers and payers in Billings began working to pilot a Health Information Exchange in the Billings area. The Governor’s Council is actively observing the pilot, and the Montana Medical Association and Montana Hospital Association have established a statewide group of stakeholders to monitor the pilot and build toward expansion to a statewide HIE.

Billings HIE pilot

An community alliance of providers and payers in Billings, Montana’s largest community, is working together to expand the exchange of health information statewide to serve Montanans achieving four primary aims:

- Improved health of Montanans through demonstrated health outcomes;
- Improved health care system in Montana with greater impact and better experience;
- Controlling health care costs in Montana through the right care at the right time and in the right place; and
- Informing health care decisions for patients, providers, payers, employers and policy makers.

This pilot will include core health information exchange (HIE) services such as electronic Master Patient Indexing (MPI), a comprehensive Provider Directory, data quality processes, protected health information (PHI) access auditing, and a provider health information portal. In addition, secure communications will be supported through Direct Messaging and care transitions and coordination will be facilitated by HIE incorporated software systems. A statewide patient portal will be developed and clinical decision support tools will be provided within the HIE

⁷⁸ HealthIT.gov, Health Information Exchange.



environment. Finally, a robust health analytics platform will be expanded to facilitate public health reporting, risk stratification, and calculation of electronic clinical quality measures (eCQMs) and other reportable performance measures. BCBSBMT has engaged the two largest hospital systems and the largest federally qualified health center in the state in an HIE pilot project as a demonstration of success. This pilot is expected to create a pathway for the establishment of a neutral, not-for-profit organization designated to house the Montana Health Information Exchange.

The Billings HIE Alliance provided the state with the following description of the pilot, needs, and objectives for inclusion in this plan.

Pilot Program Objectives

Objective 1: Broad Adoption of Health Information Exchange among eligible providers.

The project will identify and target those eligible providers (EPs), which have not yet completed meaningful use or connected with health information exchange. The project will provide user accounts and training to enable the EP to become a meaningful user of the HIE, which involves:

- Recruiting and educating EPs about Meaningful Use (MU) and HIE,
- Contracting with EPs,
- Configuration of accounts (provider portal and Direct Messaging),
- User training and certification prior to credentialing,
- Provision of access and ongoing management of accounts and audit logs,
- Establish clinical data feeds from practices to the HIE, including;
- Construction and implementation of data feeds from EP's electronic health records (EHR) to the HIE,
- Validation and mapping of data from EHR feeds to support analytics; and
- Integration of practice level data into payer and other sourced data.

Anticipated benefit: The benefits of broad adoption of HIE will increase the achievement of Meaningful Use, but more importantly will enable providers to practice patient-centric (rather than practice-centric) medicine and establish a learning health care system through the provision of data and performance analytics as well as clinical decision support to guide iterative improvement.

Objective 2: Establishment of a centralized Provider Directory.

The project will design, develop and implement a centralized electronic Provider Directory enabling resolution of each provider across the state to a single, unique identifier. In addition, providers will be organized and associated to clinics, health systems and other organizations where they deliver care to allow providers to understand their performance as a practice, health system and at a community level. The Provider Directory will empower patient attribution models for primary care, specialty care, readmissions reduction programs, and many



other uses. Attribution models allow patients to be linked with providers for specific purposes. For example, the clinical analytics tools can be used to identify gaps in care for specific patients. Patient attribution enables that report to be routed automatically to each patient's primary care provider (PCP) who is best positioned to take action on the care gap. The project will also make available an Application Programming interface and authorize certified information exchanges, providers, and appropriate state agencies to place service calls to resolve provider identities across the state.

Anticipated benefit: Correctly identifying providers is critical for implementing security as well as feedback mechanisms to enhance care. Patient attribution capabilities allow HIE data to translate into knowledge that can be delivered directly to each patient's doctor for definitive action. The represents an entirely new level of clinical decision support for practices and physicians to use in improving patient care.

Objective 3: Establishment of a uniform Direct Messaging platform.

Secure Direct Messaging and Health Information Service Provider (HISP) services are required by all providers to meet Meaningful Use standards. The HIE can provide these services to all providers and eligible hospitals (EHs) and further leverage these capabilities to include other critical layers in the health care delivery system such as long term care, home health, hospice, payer activities and many others. The Direct Messaging platform will be interfaced with the Provider Directory to enable accurate selection of receiving parties for the secure messages. Functionality will be extended to leverage direct messaging as a standardized message transport system as well.

Anticipated benefit: Secure messaging will be widely distributed and the care of patients will benefit from improved communications between providers and other health care services and agencies. In addition, patients will benefit from having a secure Direct account of their own to communication directly with their providers. The processes for individuals requesting Direct accounts will be standardized across the state. The methods will reduce administrative costs in attainment and management of Direct accounts and in turn increase the overall adoption and utilization of the Direct platform. A standard and centralized credentialing process ensures all have uniformly met the same burden of proof of identity while reducing the long term cost of the system to the state and stakeholders by spreading costs across many more participants.

Objective 4: Establishment of reportable lab, immunization, condition and syndromic reporting to the Montana Department of Public Health and Human Services.

Meaningful Use requires that EPs implement feeds to health departments for reporting labs, conditions and immunizations. An extension of the interfaces with DPHHS will provide capabilities for reporting monitored lab results, submitting targeted conditions to a registry, and reformatting the immunization messages as necessary to meet the required specification. In addition, the interface can be made bidirectional to move data from the state immunization registry and other registries to the point of care. Meaningful Use certification will be pursued



for the public health reporting systems.

Anticipated benefit: Public health reporting is one of the most difficult, yet most important requirements in Meaningful Use. By enabling the automated reporting of labs, conditions and vaccines, EPs will be contributing significantly to the ability of the public health system to detect and respond to outbreaks and other acute and chronic public health issues.

Objective 5: Implementation of advanced privacy and security systems.

The project will provide for design, development and implementation of systems and tools required to inform centralized auditing and active monitoring of the privacy and security electronic health data contained in the HIE and respective supporting systems. Auditing tools will allow for the delegation of auditing services to appropriate health care and state agencies. Active monitoring tools will use intelligent algorithms to identify potential breaches of privacy across the enterprise.

Anticipated benefit: Effective monitoring and reporting of privacy and security considerations establishes and reinforces trust among participating providers, organizations and individual patients. Applications and systems developed will comply with federal legislation for auditing and compliance in regards to the access to and breach of protected health information. The applications will streamline the auditing process to identify potential security concerns and facilitate the joint investigation and resolution of concerns between the HIE and its constituents.

Objective 6: Enable systems to improve care transitions and care coordination.

The existing software system for care transition management will be further integrated with the Provider Directory and core health information exchange services. EHR interfaces will be standardized and offered to all users. Further, the entire system will be Meaningful Use certified to the benefit of all participating EPs and EHRs. Finally, analytics and reporting systems for care transitions will be enhanced to provide monitoring required for continuous quality improvement and centralized reporting for overall statewide care transition activity.

Anticipated benefit: Transitions of care are critical events in the course of care for patients. Meaningful Use Stage 2 requirements for care transitions are challenging to providers. Use of the HIE's electronic care transition system will generate reduced wait times for access to specialty care, reductions in overall need for specialty care services and significant reductions in the total cost of care for patients being referred for other services. This expansion will further integrate these tools into the workflow of busy providers enabling them to better use these tools to improve care coordination and reduce costs.



Objective 7: Expand the availability of community-wide decision support and patient risk stratification.

The HIE will offer advanced clinical decision support capability that takes into account many clinical data elements on each patient and generates a tailored risk profile for common chronic conditions (i.e. heart attack, stroke, diabetes, diabetic complications, breast cancer, lung cancer, and colon cancer). In addition, this system will provide tools for alerting providers to these risks at the point of care along with educational tools for use with patients. The HIE will provide a way for this action oriented system to be used for large populations of patients and enable the resulting risk analysis data to be used by treating providers in risk stratifying their patients.

Anticipated benefit: The risk stratification system will provide several services that are important to improving the quality of patient and reducing health care costs. The system will be available at the point of care for participating patients no matter where they present for care. This ensures that even if the patient is being seen for a cold or flu, risk for stroke or heart attack can be discussed and appropriate referrals and testing be performed. The tool itself can also be used to engage and educate patients, generating significant increases in understanding and patient adherence to their medications. Finally, the results of the risk analyses are stored and aggregated to assist providers with managing risk in their patient populations.

Objective 8: Enhance and deploy systems to support the viewing, downloading and transmission (VDT) of health records to patients.

The project will enhance existing patient port and personal health record services with improved interfaces to the core HIE system and tailored interfaces to EHR platforms. The system will allow providers to identify and credential their patients to the HIE. Once credentialed, patients will have the ability to view, download and transmit their personal health records. In addition, the reporting required for Meaningful Use and other analytics will be integrated into the community health analytics platform.

Anticipated benefit: The free patient portal system will achieve higher adoption among patients because it provides access to data from and communications with all connected HIE providers. In addition, it will greatly enhance each EP's ability to meet the current Meaningful Use requirements for patient engagement in VDT.

Objective 9: Expand community health analytics services to include electronic clinical quality measures and other critical reporting capabilities.

The project will expand existing data quality, data warehousing and advanced analytics services to support electronic Clinical Quality Measures, the Physician Quality Reporting System (PQRS) and other required reporting for EPs and EHS. In addition, care gaps and utilization alerting will be provided to subscribed providers, leveraging previously described patient attribution logic to permit secure communications directly with each patient's PCP. The system will allow for



discrete monitoring of individual provider progress toward goals as well as in aggregate at the institutional, community and state level.

Anticipated benefit: The implementation of community health analytics leveraging clinical data together with claims data will provide clinicians with much needed reporting and other tools for managing population health as well as optimizing individual care. EPs and EAs will be able to attest for Meaningful Use based on eCQM reporting from the HIE and community health analytics platform. Public health organizations will have the capability to actively monitor utilization of the health care system and relevant population health indicators in near real time. Analyses generated from this system will also support policy and planning activities such as workforce development, payment program evaluation and effectiveness of specific interventions.

Objective 10: Establish connectivity with federal agencies.

The project will design, develop, and implement the capability to connect with federal agencies when appropriate for the purposes of improving patient care, controlling costs, monitoring quality, auditing, and public health reporting. Blue Button technology is available for this purpose and will support the creation of a federated interface. The HIE will also be capable of providing IHE XCA standard interfaces as well as traditional HL-7 data feeds. Pending the appropriate approvals of all parties and the availability of capacity with the VA, Indian Health Services and Department of Defense, interfaces will be built to connect to those organizations for unidirectional and (if possible) bi-directional data exchange.

Anticipated benefit: Many Montanans receive most or part of their care in DOC, VA, and IHS facilities, which currently do not exchange data with the most HIEs. This creates, at best, an inconvenience for the patient and added cost; and at worst, a potential patient safety issue. Having these interfaces in place will be helpful in mitigating these concerns and improving the quality of patient care.

Expanding the initiative

The Montana Medical Association, in conjunction with the Montana Hospital Association will facilitate a stakeholder monitoring and evaluation process with key public-private stakeholders share information about the pilot's development and consider how the pilot could be supported and expanded including whether and how the pilot might become a statewide HIE. Although in its early stages of development, the Montana health information exchange effort currently is establishing a foundation of trust with rapidly expanding private-public partnerships. In order to maintain trust and engagement, the health information exchange organization will be setup as a neutral, not-for profit corporation organized and operated for sole purpose of serving information needs of participants jointly working together under a clearly designed governance structure. Fair representation and decision making authority will be granted to all key stakeholder groups including state agencies such as DPHHS and Montana Medicaid in addition to patient advocacy groups, critical access and prospective payment system (PPS) hospitals, physician groups, commercial payers, medical associations and



societies, tribal and urban Indian providers, Indian Health Services, the university system and policy makers. The health information exchange organization will:

- Guide the development for mutually agreed upon data use cases for clinical and quality improvement;
- Create a business and financial model aligned with current regulatory and market demands;
- Formulate privacy and security policies and procedures that adhere to current industry standards;
- Acquire a technological platform vendor with proven capacity and capability to achieve the use cases and objectives established by the governing body; and
- Establish the necessary contracting processes, participation agreements, terms and conditions and other organizational policies and procedures necessary for usual business operations.

The Montana HIE organization will be designed similar to a public utility in that it be a stand-alone entity housing and maintaining the infrastructure for a public service – managing shared, statewide health information – subject to public control and regulation ranging from community-based groups to state agencies. It will not be owned by any one entity and will be governed by those with the greatest interest in realizing success.

Approach to planning and implementation

In conjunction with Governor Bullock's Council on Health care Innovation, health care leaders across the state have designated HIT and HIE development as a high priority initiative. Following this executive level commitment and the stemming from the high degree of engagement currently held among Montana physicians to make HIE a reality, the Montana Medical Association (MMA) has created a committee on health information exchange with the intent of serving in a lead role coordinating and facilitating ongoing HIE planning discussions in collaboration with the Department of Health and Human Services, the Commissioner of Securities and Insurance, and the Governor's Council on Health Care Innovation.

The MMA and MHA are currently working to establish a statewide steering committee of key stakeholders who will oversee statewide discussion of how the pilot can be supported, monitored, and expanded in a thoughtful and beneficial way.

Goals

- Facilitate access to and retrieval of clinical data to provide safer, timelier, efficient, effective, equitable, patient-centered care through health information exchange (HIE).
- Explore the feasibility of establishing a Montana health information exchange organization (HIO) to provide the capability to electronically move clinical information between disparate health care information systems while maintaining the meaning of the information being exchanged.



- Explore the HIO infrastructure's capacity to provide clinical data for purposes such as public health as well as organization and provider quality assessment and improvement.

Action Plan

April 2016

April 4, 2016: Meeting of HIE Planning Work Group to evaluate a proposed plan of action, related costs, and discuss funding of plan.

April 15, 2016: Submit grant proposal

May 2016

May 2016 to June 2017: Monitoring of the Billings HIE Pilot Project by benchmark reports from Pilot Project partners.

Planning Work Group to hold conference call with key members of HealthShare Montana to understand lessons learned; pilot project update; work on one day meeting: identify stakeholder attendees (and Governing Board), potential sponsors, define desired outcome, set date and location, and draft Steering Committee agenda for a September/October meeting.

Work on environmental scan of HIE related projects.

September/October 2016

1 1/2 day meeting of stakeholders (HIE Steering Committee) on state HIE Project led by Dr. David Kendrick (in-person). Report on pilot and the technical infrastructure. Facilitated session to affirm core principles and organize into a Governance Board. Breakout sessions on privacy/security, sustainability and clinician use cases.

November/December 2016

Organizational Governance Board meeting to review of Sept/Oct work on governance models, privacy/security, sustainability and clinician use cases. Define workgroups needed, charge and membership.

January/February 2017

Initial meetings for workgroups, led by Dr. Kendrick via teleconference.

February 2017 Second meeting of Governing Board. Present reports from workgroups and gain additional guidance. Report on pilot.

March/April 2017

Workgroup meetings, with connectors to pilot project work as applicable.

May/June 2017

Third meeting of Governing Board to hear final reports and recommendations from workgroups. Report on pilot (projected to complete in early summer). Guidance given to staff



on actions needed based on workgroup reports.

Determine additional information and action needed to make final decision on moving forward with HIO. Reach general consensus on direction to proceed with business plan development. Review deliverables from Dr. Kendrick.

If the pilot is going well, the group will consider the process for informing how other clinics, hospitals, insurers can “tee up” to be ready to grow pilot and consider transition discussion points.

August 2017

Fourth meeting of Governing Board to hear report on pilot (projected to complete in early summer). Make related decisions for HIO. Review start of business plan from Dr. Kendrick.

Conclusion

Building on Montana’s progress to improve coverage and its vision for a healthier Montana, the Governor’s Council on Health Care Innovation is well-positioned to act on the initiatives proposed in this plan. These payment and service delivery reforms and the tremendous work done over the course of the Model Design period are intended to build on current success by aligning economic incentives with improvements in care coordination, efficiency, and the health of Montanans. With this goal in mind, we submit this plan to CMMI on behalf of the citizens of the state of Montana, and look forward to continued collaboration, partnership, and success.