EXECUTIVE CHAMBERS
HONOLULU

DAVID Y. IGE
GOVERNOR

Hawai'i Health Care Innovation Models Project
Delivery and Payment Committee Meeting
October 14, 2015

Committee Members Present:
Judy Mohr Peterson (Co-chair)
Joy Soares (Co-chair)
Marya Grambs
Deb Goebert
Jennifer Diesman
Alan Johnson
Gary Okamoto
Rudy Marilla
Wendy Moriarty
Ron Fujimoto
Danny Cup Choy
John Pang
Paul Young
Dave Heywood
Karen Krahn
Anna Loengard
Kelley Withy (by phone)
Karen Pellegrin (by phone)
Sid Hermosura (by phone)
Sondra Leiggi (by phone)

Committee Members Excused:
Chad Koyanagi
Bill Watts
Kenneth Luke
Kristine McCoy
David Herndon
Mark Fridovich

Consultants:
Mike Lancaster
Laura Brogan
Andrea Pederson
Sally Adams
Steve Schramm
Stephanie Taylor
Alicia Oehmke (by phone)
Denise Levis (by phone)

Staff Present:
Trish La Chica
Beth Giesting
Abby Smith

Welcome and Introductions:
Co-chair Mohr Peterson welcomed Committee members and opened the meeting with introductions.

Hawaii Health Care Innovation Models Project
Delivery and Payment Committee Meeting
October 14, 2015

Meeting Objectives and Desire Outcomes: Beth Giesting

- Healthier families and communities
- Triple Aim +1
- Health care transformation is agenda and behavioral health integration provides pathway

Behavioral Health Integration Models that Support Children: Dr. Lancaster (see slides below)

Emphasized in the presentation were agreements on BHI models to-date, as follows:

- SIM Goals:
  - Identify behavioral integration delivery and payment models and agree to strategies and tactics to implement models that address improving early detection, diagnosis, and treatment of mild to moderate behavioral health conditions in primary care and prenatal settings.
  - Improve the capacity of primary care providers to address behavioral health issues on a primary care level and/or integrate behavioral health specialty services and community support services in primary care and prenatal practices.
  - Improve the care coordination of people with behavioral health conditions and linkage with treatment and community support services.
- SIM efforts will start with Medicaid and focus on children and adults (including pregnant women)
- Focus on three Evidence-Based Models:
  - SBIRT
  - Screening and Treatment of Depression (also focuses on anxiety)
  - Motivational Interviewing
- Participation is voluntary. PCP/OB will select a model that fits their population/interest
- The goals of these evidence-based practices include:
  - Increase comfort level of providers in identifying and treating substance abuse, depression, and anxiety in their practices
  - Provide support for practices through evidence-based practice models of care, education and training, and provider consults
  - Establish referral pathways for more complex patients that results in timely access to care
  - Support mild to moderate behavioral health patients to receive care in primary care/prenatal practice settings

Behavioral Health Integration Models that support value and BHI: Laura Brogan (see slides below)

Discussion addressed:

- Obtaining and analyzing data on behavioral health and severity of conditions is challenging. SIM used data produced by HHIC from 2012 hospital-related claims.
- Several good models were presented that can be analyzed to predict their effectiveness in Hawaii, including team models, workflow, payment or other incentives
- Specific elements of the models were discussed including the role and availability of CHWs, provider to provider consults, the availability of PCP training support through Project Echo and other means, and "pipeline" training in medical school and residencies to prepare PCPs to effectively address patient BH concerns.

- It was noted that acuity adjustments need to be considered to ensure that providers have incentives to care for sicker patients.

Return on Investment Analysis Presentation: Steve Schramm (see slides below)

Discussion addressed:

- Clarification of purpose of ROI analysis and next steps for SIM: It was noted that ROI analysis and expectations for clinical effectiveness will help garner policy and funding support among state agencies, Legislators and other stakeholders. There is not expected to be an opportunity to secure grant funds to demonstrate the value of the proposed innovations.

SHIP Update: Laura Brogan (see slides below)

Measures Discussion:

- *Please send any feedback, suggestions, comments to any SIM Team member (Beth, Joy, Abby, or Trish) and come prepared to discuss at next meeting*

Next meetings are November 6th from 10:30-12:30 (Capitol 329) and November 12th from 1-2:30 (SOT 1403).

Adjournment at 2:04 pm

State Innovation Model Design 2

DELIVERY AND PAYMENT COMMITTEE MEETING

OCTOBER 14, 2015

Meeting Objectives

To outline a transformation agenda to improve health of families and communities:

- Primary care and Behavioral Health (children and adults)
- Value-based payment reform
- Workforce changes
- Other system supports

THE TRANSFORMATION AGENDA:

HEALTHY FAMILIES AND COMMUNITIES IN HAWAI‘I

State's goals for health and care

Triple Aim

1. Better health
2. Better care
3. Better value/lower costs

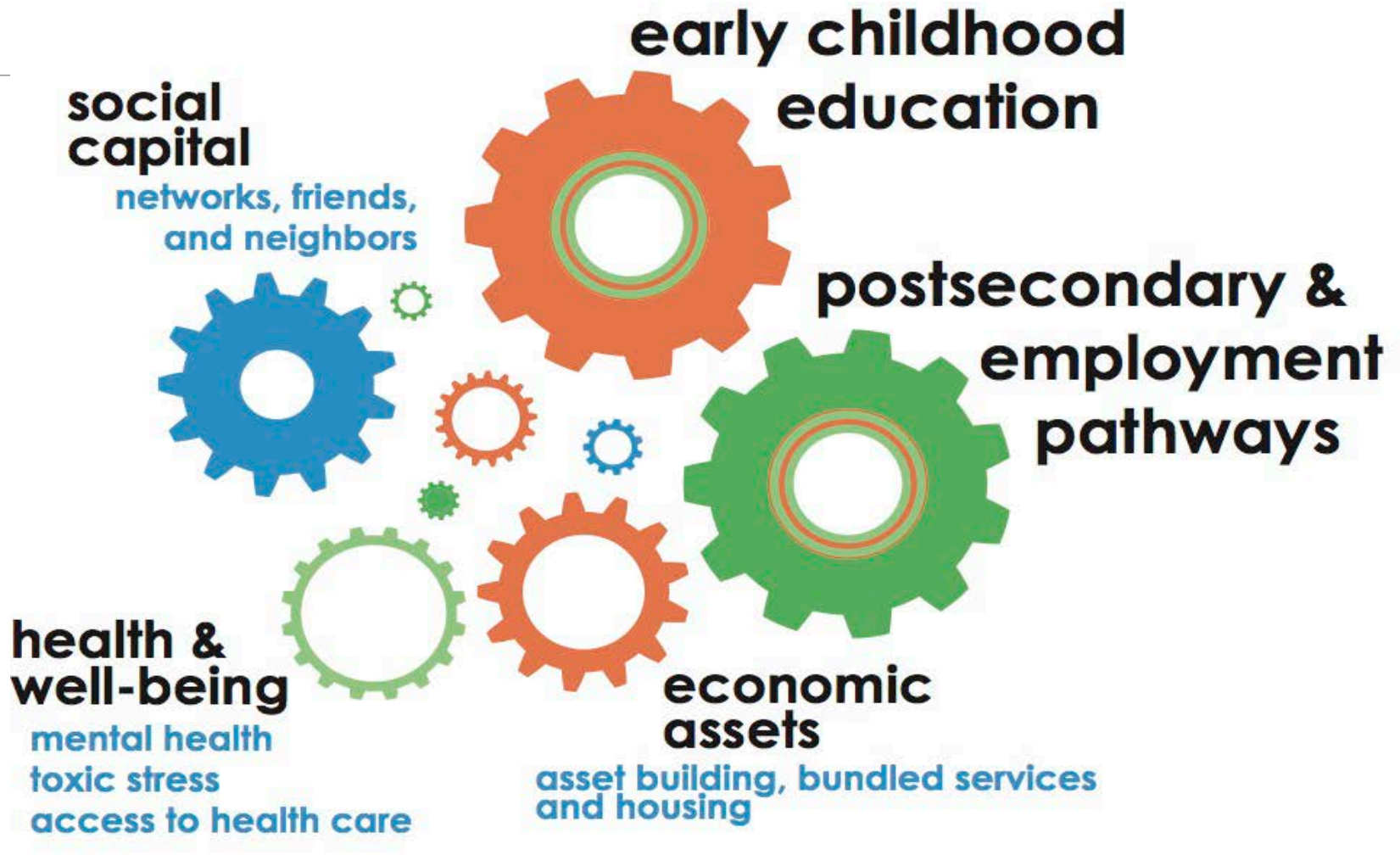
Beyond Clinical Care

1. Our house, our work, our education
2. Our families and community support
3. Our zip codes and our cultural codes

Matching Needs to Resources

1. Racial/ethnic identification
2. Geography
3. Economic resources

Transforming components into systems



SIM Focus

Health care transformation

Person/family focused and oriented to health

BH improvement advances broader agenda for primary care change

- New service models and sites
- Population health and care coordination
- New members of the work force, such as CHWs, and practicing in teams
- Use of health information exchange, patient portals, IT, telehealth
- Support for learning health care system, practice support
- System alignment – metrics, payment strategies
- Payment reform

Oral health improvement

Community Care
OF NORTH CAROLINA

Whole Person Care

Hawai'i SIM Managed Care Organization Meeting

October 13, 2015

Dr. Mike Lancaster

Goals for this Discussion:

- Review SIM agreements thus far
- Overview of the three BHI models being proposed
- Identify any alignment and/or synergy with current efforts around BHI in the MCOs
- Identify any alignment and/or incentives with PCMH
- Consensus on realistic expectations and buy-in from MCOs and PCPs
- Agreement on the core components of BHI

SIM Agreements for Hawai'i Integrated Care:

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SIM Agreements for Hawai'i Integrated Care:

- The goals of these evidence-based practices include:
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Proposed Evidence-Based Practice Models for BH Integration

1) **SBIRT**- Screening, Brief Intervention, Referral for Treatment; to help address the hidden issues with substance misuse in a PCP population
2) **Screening and Treatment of Depression** - based on IMPACT model to identify and treat depression in a PCP population
3) **Motivational Interviewing**- educate, engage, empower consumers we serve to be part of their health workforce

Evidence-Based Practices to Address Mild/Moderate BH Conditions in Primary Care:

- Focus is on Substance Use, Depression, Anxiety and Motivational Interviewing
- Goals:
  - Increase comfort level for PCPs in treating Substance Abuse (SA), Depression and Anxiety in their practice
  - Provide support for PCPs through Evidence-Based Practices (EBP) models of care, education and training, and provider consults
  - Establish referral pathways for more complex patients- timely access to BH care
  - Support mild to moderate BH patients to receive care in PCP setting

Reasons to Focus on the 12 – 18 years of age:

- Half of all lifetime behavioral health illnesses begin by age 14 and three quarters by age 24 (NIMH)
- Without intervention, child and adolescent BH conditions frequently continue and worsen in adulthood and are associated with disability and increased medical costs
- Adolescents who begin drinking before age 15 are 4 times more likely to develop alcohol dependency
- In Hawai'i the leading cause of death in young people aged 15 – 14 is suicide and it has doubled in the past 5 year

How to Train and Sustain all EBP Models

- Models of Training
  - Online/Face-to-Face/CME
  - Academic support: JABSOM? UH Hilo? Others?
  - AHEC, Project ECHO, Addiction Technology Transfer Center Network (ATTCN) Others?
- Sustain and Grow Knowledge Base
  - Technical Assistance: academic centers, MCOs
  - Learning Collaboratives: state, MCOs, academic
  - Tele-psych Consultation: JABSOM or private contracts

Workforce Issues and Opportunities:

- Community Health Workers (CHWs)
  - Path to certification
  - Community College – education / job builds
  - Define role of CHWs in the system
- Pharmacists
  - Inclusion in team based care
  - Pharm-2-Pharm
  - Medication reconciliation
- Psychologists
  - Inclusion in behavioral health planning
  - Consider prescribing privileges
- Tele-psychiatry
  - doc to doc consultation
- Role of SA Department

Health Information Technology Issues:

- Use of information technology has great potential for designing and facilitating integration efforts.
- Computerized exchange of BH information is complicated by the need to comply with specific confidentiality requirements (CFR 42 part 2).
- Privacy laws, regulations and policies hinder integration efforts as providers often apply the strictest interpretation of privacy laws to “protect” patients.
- Providers have stated the utmost importance of confidentiality in engaging adolescents in treatment.

Health Information Technology Issues, cont.:

- Conversations between physical and behavioral health providers must occur to ensure the necessary communication and information is available to optimize care and outcomes
  - Working on processing consent directives
  - Developing a referral and communication process and method to share meaningful information
  - Supporting the use of electronic prescribing
  - Agreeing on elements to include in a continuity-of-care (CCD) document

Models of Care Coordination – Define Expectations

Provided in a capitated system by the MCO

Covered as a billed service by providers in the community

Provided in a capitated system through MCO contract with community agency

Provided centrally through state control (North Carolina) Medicaid pays CCNC a PM/PM for care coordination through local networks)

Models of Care Coordination – Pros and Cons

Provided in a capitated system by the MCO

Pros

- PCPs have a know resource
- Standardized processes for care coordination (CC) – if defined by the State
- Remove access and support barriers to CC
- MCOs can align with other efforts

Cons

- Each MCO may have their own process and expectations for PCPs
- Potential limitation of funds to support BHI
- Availability of workforce

Models of Care Coordination – Pros and Cons

Covered as a billed service by providers in the community

Pros

- Practices can pay for CC and bill for their services
- Practices / PCPs can determine who needs CC
- Provide an incentive for PCP to integrate care

Cons

- No service definition
- Medicaid will need to build /define services and payments
- Potential for lack of standardization in the implementation of the CC models

Models of Care Coordination – Pros and Cons

Provided in a capitated system through MCO contract with community agency

Pros

- More local approach
- CC more knowledgeable on and linked with community resources
- Use local available workforce
- Build referrals and relationships locally

Cons

- Lack of available resources and workforce in remote and rural communities
- MCOs have to fund the service so funding may be an issue
- Potential for different approaches to CC across agencies – standardization issues

Models of Care Coordination – Pros and Cons

Provided centrally through state control (North Carolina) Medicaid pays CCNC a PM/PM for care coordination through local networks)

Pros

- Standardized approaches and definitions
- State determines focus of CC intervention (in concert with providers)
- Provides support for patient in practices

Cons

- Training
- Medicaid will need to build service and payment definitions and processes

Questions?

BEHAVIORAL HEALTH INTEGRATION DELIVERY AND PAYMENT MODELS

NAVIGANT
HEALTHCARE

PAYMENT TRANSFORMATION

» The goals of payment reform are to:

Move away from fee-for-service (FFS) toward paying for value

Align financial incentives to promote the delivery of high-value primary and preventive care

Reward improved health outcomes and reduced long-term patient expenditures

PRIMARY CARE PAYMENT TRANSFORMATION

» Primary Care Payment Models:

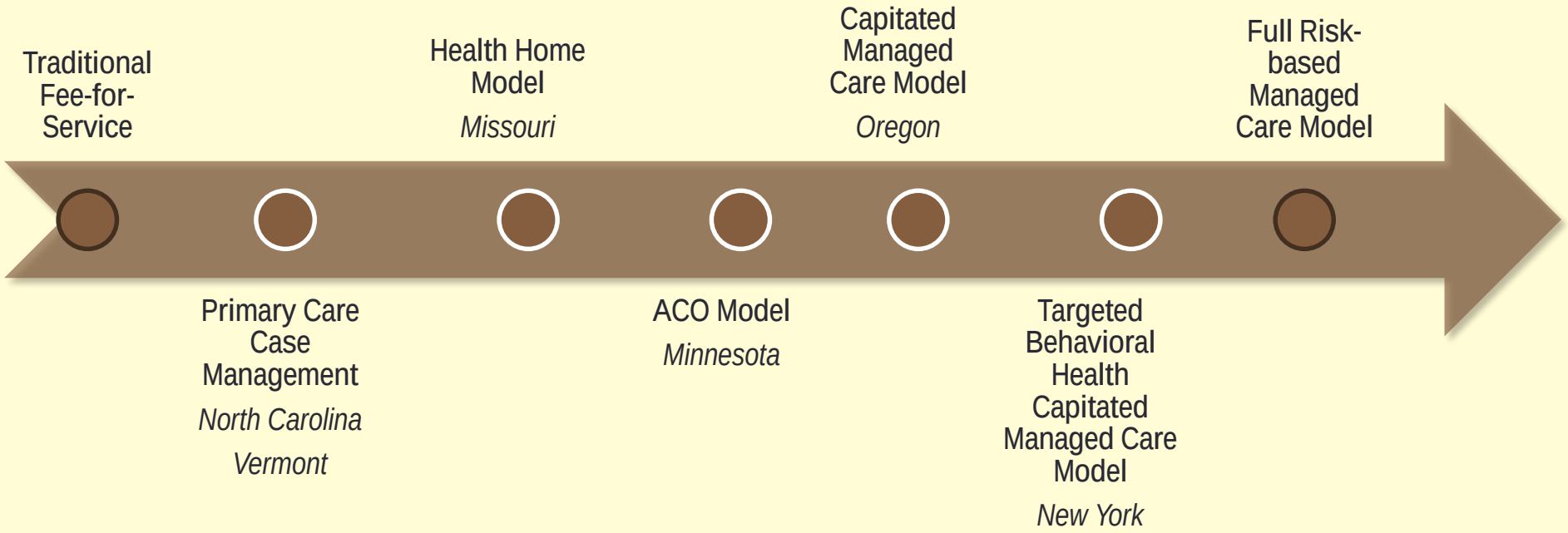
1. Traditional FFS
2. Fully capitated Per Member-Per Month (PMPM)
   - Can be targeted to certain populations or one-size fits all
   - Can be risk-adjusted
3. Enhanced PMPM
   - Primary Care Case Management (PCCM)
   - Extra money to cover costs of care management/coordination, extended office hours, HIT investments, pharmacy consultations, etc.
   - Often a feature of Patient Centered Medical Homes (PCMH) and Health Homes

PRIMARY CARE PAYMENT TRANSFORMATION

» Primary Care Payment Models, continued:

4. Pay for Performance Measures (P4P)
   - Bonus payments made based on provider performance on selected measures
   - Often risk-adjusted
5. “Shared Savings” Models
   - Based on an agreed-upon total cost of care analysis
   - Often a feature of Accountable Care Organization (ACO) models
6. Bundled Payments for episodes of care

PAYMENT MODELS ALONG INTEGRATION CONTINUUM



Traditional Fee-for-Service		
Low or no care management or care coordination	Potentially more unnecessary service utilization	Lower potential cost savings

Full Risk-Based Managed Care		
Higher level of care management and care coordination	Potential for improved quality of care	Reduced inappropriate utilization and cost savings

PRIMARY CARE CASE MANAGEMENT INTEGRATES PHYSICAL AND BEHAVIORAL HEALTH SERVICES

States contract directly with providers or procure services through a primary care case management subcontractor

Community Care of North Carolina (CCNC) Enhanced PMPM Payment

- Enhanced PMPM payments made to each of the 14 CCNC networks to support integration
- Funding supported hiring a psychiatrist and behavioral health coordinator for each network
- Implementation of behavioral health flags into an existing electronic care management tool

Vermont Blueprint for Health

- Integration is part of a statewide multi-payer initiative to transform primary care practices into patient-centered medical homes (PCMH)
- Participating PCPs are paid a PMPM fee by all payers on a sliding scale based on their NCQA score
- All payers share the costs of Community Health Teams

HEALTH HOMES: MISSOURI

1st
State to adopt Health Homes specifically for SMI populations

19,000
Medicaid beneficiaries enrolled in Health Homes

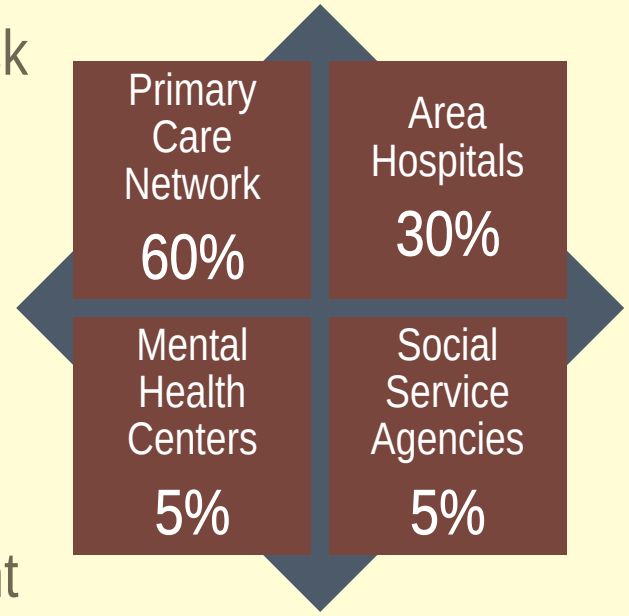
$60
Approximate PMPM payment to cover costs *(in addition to current FFS or managed care plan payments)*

- Missouri adopted the Medicaid Health Home option, made available by Section 2703 of the Affordable Care Act
- Statewide program led by CMHCs
- PMPM payment includes costs for a Nurse Care Manager, Behavioral Health Consultant, Health Home Director, Administrative Support Staff, and Care Coordination staff

ACO: MINNESOTA INTEGRATED HEALTH PARTNERSHIP (IHP)

- Delivery systems share in savings during the first year of participation
- After the first year, they also share the risk for losses
- ACO providers are accountable for:
  - Outpatient mental health
  - Chemical dependency services
  - Medical services
- Community health workers identify patient needs such as housing and transportation and to develop a plan; they also reach out to patients at homeless shelters, day centers and correctional facilities

Shared Savings Formula:



CAPITATED MANAGED CARE: OREGON'S APPROACH TO INTEGRATION

Coordinated Care Organizations (CCOs)	• Manage Medicaid physical and behavioral health benefits • Part of the State's effort to consolidate Medicaid and behavioral health purchasing • Have benchmark/improvements targets, including those related to screening of mental, physical and social issues
Primary Care Behavioral Health (PCBH) Model	• Option for CCOs and clinics to participate in Oregon's Patient-Centered Primary Care Home (PCPCH) model • Primary care teams include a behavioral health provider • Primary care clinics screen patients for mental, physical and social health concerns
Alternative Payment Methodology (APM) Pilot	• PMPM fee to Community Health Centers (CHC) • Experiments with embedding behavioral health professionals on physician teams • State is collecting data to analyze how payments could facilitate VBP and support CHC financial stability

TARGETED CAPITATED MODEL: NEW YORK'S HEALTH AND RECOVERY PLANS (HARPS)

Ongoing implementation; first phase of enrollment begins in New York City in Fall 2015

Integrated managed care product for individuals with SMI or SUD, plus high-risk utilization patterns or functional deficits

Subject to more extensive behavioral health staffing and experience requirements than those for MCOs enrolling individuals with less serious behavioral health needs

Required to include recovery-oriented home-and community-based services, such as employment and education supports

BUNDLED PAYMENTS FOR BEHAVIORAL HEALTH EPISODES

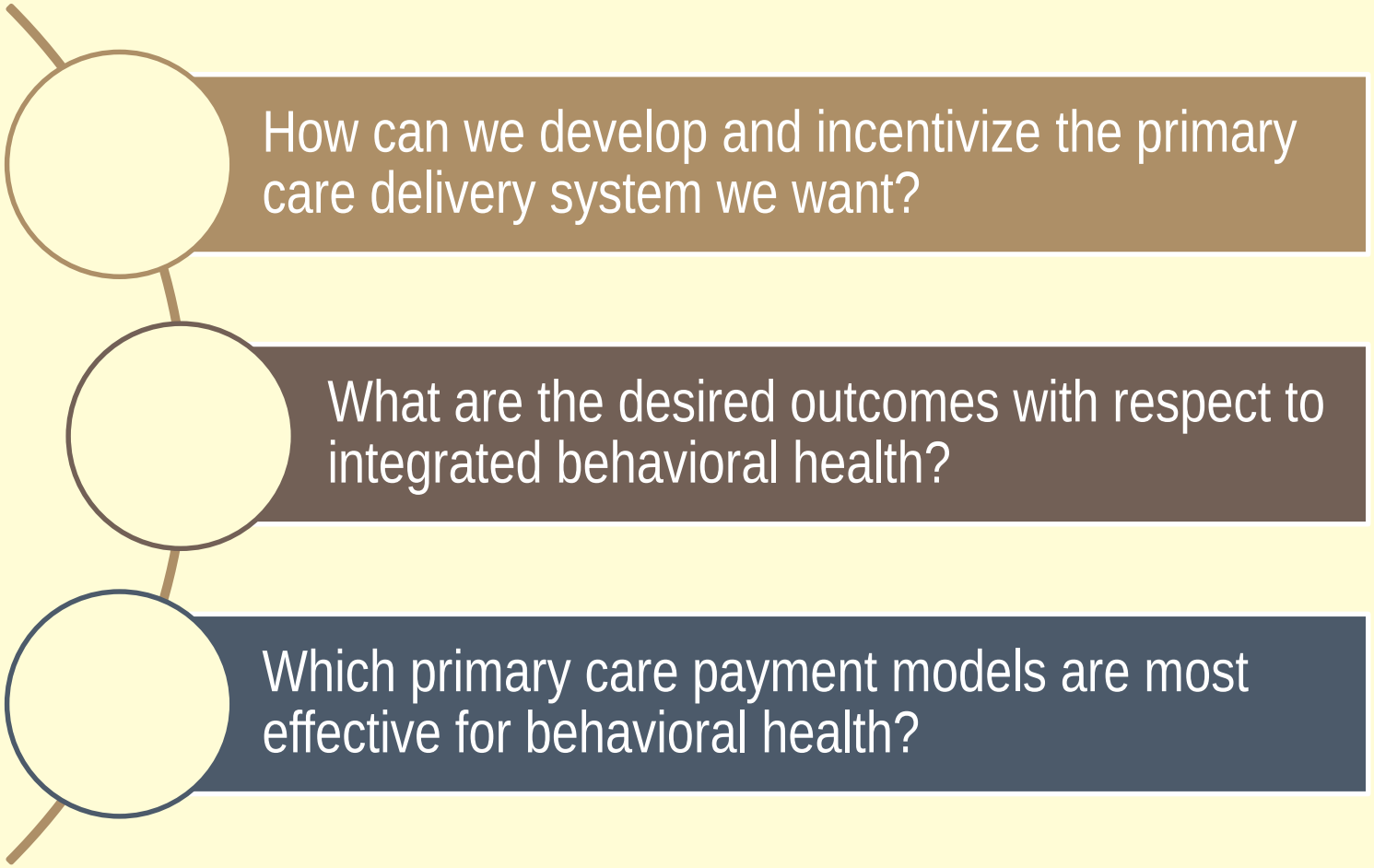
» Attention Deficit Hyperactivity Disorder (ADHD)
- Diagnosis of ADHD triggers the episode
- The Principle Accountable Provider is the provider (primary care or mental health provider) with the majority of visits
- Time period is 12 months
- Costs include all ADHD related charges
- Medicaid is the only participating payer

» Oppositional Defiant Disorder episode under development

» Developing episodes for behavioral health conditions including:
- ADHD
- Anxiety
- Post Traumatic Stress Disorder
- Schizophrenia
- Depression

» Implementation timeframe ranges from 2015 - 2019

DISCUSSION QUESTIONS



Hawaii SIM

Cost/Trend Analysis and Return on Investment Analysis

OCTOBER 14, 2015

Process of Projecting Future Expenditures

- Determinants of Risk
  1. Program Design (How?)
  2. Target Population (Who?)
  3. Benefits (What?)
  4. Service Delivery Network (Where?)

Cost/Trend Analysis

- Focus on Projecting Future Risk of Program(s)
- Normalize Data
  1. IBNR
  2. Program Changes
  3. Population Changes
- Separate Utilization and Unit Cost by Major Category of Service
- Identify Cost Drivers

Cost/Trend Analysis

- Isolate Historical and Concurrent Trends
- Project Prospective Trend Adjusting for Changes in:
  1. Mix
  2. Reimbursements
  3. Program Design

Dynamic Cost/Trend Model

- Potential Trend Ranges
  1. Low, Moderate, or Aggressive
  2. Externalities
- Target Areas
  1. Geography
  2. Population
  3. Setting

Return on Investment (ROI) Analysis

- Compare Projected Future Program Expenditures against Future Intervention Costs
- Base Data Projected Forward
- Two Projection Scenarios
  1. Absence of Interventions
  2. Presence of Interventions

ROI: Projection 1 – No Interventions

- Base Data Validation
- Normalization
- Program Changes
- Trend
- Non-Medical Loading

ROI:Projection 2 – Interventions Present

- Understand the SIM Interventions
- Project Impact on Total Costs and Utilization
- Focus on Change in ***Risk*** of Population
- Analyze by Major Category of Service

Dynamic ROI Model

- Care Management Impacts
  1. Low, Moderate, or Aggressive
  2. Downward Pressure on Acute Care
- Target Areas
  1. Geography
  2. Population
  3. Setting

State Health Innovation Plan (SHIP) Update

LAURA BROGAN, NAVIGANT CONSULTING

SHIP vs. Blueprint

Topic	SHIP	Blueprint
Target Audience	Public, Legislators, MED-QUEST, Payers, Providers, Centers for Medicare and Medicaid Innovation (CMMI)	Providers
Sections	• Description of Health Care Environment • Plan for Improving Population Health • Stakeholder Engagement and Process Deliberations • System Design and Performance Objectives • Service Delivery Model • Plan for Delivery System Transformation • Health Information Technology (HIT) Plan • Monitoring and Evaluation Plan • Financial Analysis • Operational Plan	• Rationale and Goals for Behavioral Health Integration (BHI) • Evidence-Based Practice Models • Team Approach • Infrastructure and Resource Needs

COMMITTEE MEETINGS

- Friday, November 6th from 10:30-12:30 in Capitol Room 329
- Thursday, November 12th from 1:00-2:30 in State Office Tower Room 1403