Beyond Medicaid: Critical Roles for Public Health, Insurance, and State Employees Departments in Fostering Multi-Payer Payment Reform

Wednesday, September 23, 2015
1:00-2:30 pm ET

Supported by Kaiser Permanente
Project Overview

- Funder: Kaiser Permanente Community Benefit
- Project: *Achieving Payment Reform to Improve Quality and Integration of Care*
- Purpose: Assist states ready to improve delivery system integration via multi-payer payment and delivery system reforms
## Agenda

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National Academy for State Health Policy

- 28-year-old non-profit, non-partisan organization
- Offices in Portland, Maine and Washington, D.C.
- Working together across states, branches and agencies to advance, accelerate and implement workable policy solutions that address major health issues
- Convening state leaders, focusing spotlight on policy innovations, providing assistance to states to make policy changes, disseminating best practices
Multi-payer Medical Home Initiatives Launched Between 2008-2014

Circles denote the 7 Comprehensive Primary Care Initiative (CPCi) regions. The federal government counts the combined 7 regions as a single initiative.

## Multi-Payer Medical Home Conveners during 2008-2014

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<td>Executive Health Department</td>
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<td>Federal Government</td>
<td>Comprehensive Primary Care Initiative (CPCi) 7 Regions: AR, CO, NJ, NY, OH &amp; KY, OK, OR</td>
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State/Public Employee Departments as Purchasers in Multi-payer Medical Home Initiatives, 2008-2014
State Public Health Role as a Provider

- State public health departments have important resources to support multi-payer payment reform by leveraging public health providers and other resources.
Introducing Today’s Panel

Amanda Eby, Project Administrator, Montana Office of the Commissioner of Securities and Insurance

Frank Johnson, Director of System and Payment Reform for the Maine Health Management Coalition (former Executive Director, Maine Office of Employee Health & Benefits)

Dr. Harry Chen, Commissioner, Vermont Department of Health
The Montana Patient-Centered Medical Home Program

Amanda Roccabruna Eby, Project Administrator
Office of the Commissioner of Securities and Insurance
Montana State Auditor
The Montana PCMH Act

Became Law on April 30, 2013:

- Codified the definition of PCMH in Montana state law
- Gave the insurance commissioner rule making authority to govern the program, such as
  - Set standards for qualification of PCMHs
  - Set standards for healthcare quality and performance measures including prevention
  - Set uniform standards for measuring cost and medical usage
- Allows the commissioner to recognize patient-centered medical homes that meet standards decided by the commissioner
- An independent study of the Montana PCMH Program’s effectiveness was assigned to a legislative interim committee
Implementing the Montana PCMH Act

- September 2013 - Adopted first administrative rules
- November 2013 - Appointed the first stakeholder council
- January 2014 - Approved which accrediting organizations meet Montana’s standards
- February 2014 - Qualified the initial medical practices
- December 2014 - Adopted rules on Montana specific standards to measure quality improvement
- December 2014 - Adopted rules on standards for participating payers to provide consistency and transparency
MT PCMH Program

Stakeholder Council Mission

- Advise the insurance commissioner and direct program development
- Establish and monitor performance standards that are specific and focused
- Establish and monitor payment standards that innovatively support enhanced primary care
- Ensure program efforts support the Triple Aim goals

The Montana PCMH Program serves

- To orchestrate consistent, standardized PCMH implementation
- To advance an efficient and effective healthcare system based on primary care
Implementing the Montana PCMH Act

- Commissioner Lindeen approved three national accrediting agencies for the Montana PCMH Program:
  - The National Committee for Quality Assurance (NCQA)
  - The Accreditation Agency for Ambulatory Health Care (AAAHC)
  - The Joint Commission
- There are currently 60 Qualified PCMHs in Montana that have already received accreditation from an approved entity and 1 Provisionally Qualified PCMH that is working toward accreditation and must receive it within 12 months of applying to the program
- Blue Cross Blue Shield of Montana, PacificSource Health Plans, Allegiance Life and Health, and Medicaid are approved payors contracting with PCMHs
Since early in her term, the Commissioner has valued the PCMH concept and recognized the potential impact to improve care and lower costs over time.

- Stakeholders requested the Commissioner convene them as a neutral entity that is neither a payor, nor provider.
- CSI has leverage in bringing payors to the table for discussions as the insurance department.
- When legislation was needed, PCMH was a more feasible route politically, than other ACA-related type reforms.
Clinical Quality Reporting Standards

- The Chronic Disease Prevention/Health Promotion Bureau at the Montana Department of Public Health partners with CSI on quality metric data reporting guidance, data analysis, and data feedback to clinics
  - Agency and organization partnerships such as this are critical.
- The stakeholder council unanimously agreed on four measures in the first year for a narrow, specific focus on quality improvement:
  - Hypertension control
  - Tobacco cessation
  - Childhood immunizations
  - A1C control
  - (Depression screening was just added for 2016)
Insurers wishing to participate in the Montana PCMH Program must submit a letter of intent describing their proposed method of compensation for approval.

Letters are available to the public, excepting trade secrets.

PCMH payors report ER visits and hospitalization rates in aggregate for their entire population and separately for PCMH patients, annually.
Goals for Program Standards

- Under the PCMH law, the commissioner must make rules on healthcare quality and utilization measures and payment standards.
- The Quality Metrics Subcommittee and Payer Subcommittee worked with CSI staff to develop the measures and payment standards.
- Quality reporting standards need to glean meaningful data, but not be an administrative burden.
- Utilization measures need to provide a meaningful way to measure progress in the future.

- Overall – Are PCMHs in Montana improving the quality of care and health of their patients and are they reducing their utilization?
Lessons Learned in 1st Year of Implementation

• Health care providers being regulated by the insurance commissioner is a new relationship requiring patience and understanding from both sides

• Even when you think everyone understands and is on board, they usually don’t, expect to have to pause and reverse several times to explain options in order to get buy in from as many stakeholders as possible and move forward
Data reporting requirements should be flexible – for payors and providers
  - Payors are allowed to use their own attribution methods
  - Providers are allowed a step wise approach toward all patient-level data in 2017

Aligning with national standards such as PQRS was more difficult than anticipated, cannot underestimate the need for attention to detail

Payor reporting standards need to be refined specific enough with provider input to provide uniform data and show specific PCMH impact
Questions?

Call 1-800-332-6148
Or visit www.csimt.gov
www.MontanaHealthAnswers.com
@CSILindeen
commissioner Monica J. Lindeen
Maine State Employee Health Commission (SEHC)

September 23, 2015
State Employee Health Commission (SEHC)

- 24-member labor/management organization serving as health plan trustee
- Plan participants—forest ranger, highway supervisor, corrections officer, classroom instructors, retirees
- Plan covers 40,000 lives statewide
- SEHC has authority over benefit design, member out-of-pocket expenses, vendor agreements
- Committed to value-based benefits with incentives to select high-quality, safe, effective care
Value-Based Purchasing Strategy

• SEHC convinced of gaps in care – poor quality drives avoidable utilization and costs

• In 2005 adopted strategy to:
  – Encourage consumers to make informed decisions about their care
  – Provide incentives for plan members to seek higher value care
  – Reward providers who can demonstrate better value
Tiering Benefits Based on Value

• Tiered networks for hospitals and primary care practices introduced
• Provider performance determined by publicly reported measures of clinical quality, patient safety and patient experience
• Primary objectives:
  – Encourage public disclosure of performance
  – Drive performance improvement
  – Provide incentives to shape decision-making
What Were The Results of These Initiatives?

• Significant increase in public reporting by providers

• Sustained high performance by selected providers

• Plan members shifted utilization to higher-value providers, particularly for outpatient hospital services

• Challenge of rewarding high-value providers – no reliable cost measures
Payment Reform to Support System Transformation

- Primary Care viewed as cornerstone to integrated care
- SEHC organized other large self-insured plan sponsors to support PCMH pilot
- Plan sponsors pledged to pay a per member per month (PMPM) fee to practices in the PCMH pilot
- PMPM support continued as pilot expanded
Current Status of Primary Care Payment

• PCMH payments have helped practices but meaningful payment reform still lacking
• All fee-for-service (FFS) based, no capitation
• Most payers provide modest PMPM for PCMH support
• Limited use of payments for care management, quality incentives and shared savings
• Both payers and providers are focusing on ACO contracts
Current Challenges

• Payers would prefer to let the health systems figure out how to support primary care practices

• Health systems would prefer that the payers simply provide a PMPM payment and get out of the way

• Plan sponsors hold the key to advancing payment reform
Plan Sponsors’ Role

• Define/adopt expectations and accountability for practices to achieve advanced primary care status across payers

• Require contractual standards in ACO agreements to link compensation with performance and transformation goals

• Demand greater transparency
Lessons

• Both public and private purchasers have considerable leverage to alter delivery and payment – use it

• Delicate balance between demanding accountability for new models and supporting innovations with patience

• Meaningful primary care payment form is complicated in markets where ACOs and system consolidation dominate
Questions?

Frank Johnson, Director of System and Payment Reform, Maine Health Management Coalition

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www.mehmc.org
Beyond Medicaid: Critical Role for Public Health in Fostering Multi-payer Payment Reform

Learnings from Vermont

Harry Chen, MD
Commissioner

September 23, 2015
The Health Department’s priorities:

**GOAL 1:** Reduce prevalence of smoking & obesity

**GOAL 2:** Reduce the prevalence of substance abuse and mental illness

**GOAL 3:** Improve childhood immunization rates
All-Insurer Payment Reforms

Local leadership, Practice Facilitators, Workgroups

Local, Regional, Statewide Learning Forums

Health IT Infrastructure

Evaluation & Comparative Reporting
Financing

All Payers

Medicare

Medicaid

Payment Reform

Fee for Service (Volume)

$ PPPM - NCQA - PCMH Score

Shared Capacity

$ Staff Capacity

$ Staff Capacity

$ PPM Capacity

$ Quality NCQA – PCSP score (in design)

$ Shared Interest (proposed)

Delivery System Reform

Patient-Centered Medical Homes

Community Health Teams

SASH Nurse & Case Mgr.

Chronic Care Initiative

HUBS 5 Regional Programs

SPOKE Teams 20+
In December 2013, tobacco CPT codes were turned on, allowing reimbursement of tobacco counseling among all Medicaid smokers and resulting in improved outcomes and reimbursement of needed services including NRT.

- BCBS has covered NRT for its customers receiving counseling through the state’s Quitline.
Vermont Vaccine Purchasing Program
Vermont is a “universal vaccine state”

- Immunization Program purchased all pediatric vaccines
- In 2007, state Vaccines for Adults program introduced; modeled after VFC
- Vaccines purchased from CDC contract by the state are 15% - 50% less than private purchase
- No separation of public/private vaccine stocks
- Excellent vaccine access at medical homes

Vermont Department of Health
Cost to Vaccinate One Child with Vaccines Universally Recommended from Birth Through 18 Years of Age: 1990, 2000, and 2013

2013 represents minimum cost to vaccinate a child (birth through 18); exceptions are 1) no preservative influenza vaccine, and 2) HPV for males and females.

Federal contract prices as of February 1, 1990, September 27, 2000, and November 18, 2013.
Current system wasn’t sustainable

- Some federal funding for vaccines was reduced, making it impossible to offer all recommended pediatric vaccines
- Low adult immunization rates due in part to poor access to vaccines at PCP’s
- Providers like the universal vaccine plan as it saved money and time

Vermont Department of Health
Initial Steps in Development of the Vermont Vaccine Purchasing Pool

- Legislation (2009)- 3 year “Pilot”
- Pilot Advisory Committee included Medicaid and insurers
- Challenges
  - How to fairly assess vaccine costs without adding administrative work for PCP’s
  - Medicare – Part B
  - Medicaid – limited data on adult enrollment
  - Ensuring high enrollment of PCP’s

Vermont Department of Health
Initial Vaccine Purchasing Plan

Pilot: Vaccines For Vermonters

VDH

- Purchase and Distribute Vaccine
- Pay for vaccines
- Report Vaccine Use
- Submit Claims: (1) administration; (2) 1st for Vaccine
- Reimburse Administration claim

Insurer

- Bill for vaccine costs

Provider

Vermont Department of Health
Welcome to the Vermont Vaccine Purchasing Program

VVPP facilitates the universal purchase of vaccines in Vermont. It provides funding for all vaccines federally recommended for children and for certain adult vaccines selected by the Vermont Department of Health. By collecting payments from health plans, insurers, and other payers and remitting the funds to the state, we make it possible for:

- Health care providers to receive state-supplied vaccines at no charge.
- All children to have easy access to critical vaccines.
- Adults can receive covered vaccines at no charge.
- All payers to participate in one of the most efficient, cost-effective systems in the country for purchasing and distributing childhood vaccines.

News & Notices

Assessment System Training Events
New Website Launched
Notice of Assessment Dates
Successes of the VVPP

- Collaboration with insurers (including Medicaid) and providers
- Insurer agreement to pay a quarterly assessment on covered lives, not vaccine administered
- Moving collection of funds outside of the Health Department (contract with KidsVax)
- Zoster vaccination rates increased
Challenges of the VVPP

• Medicare doesn’t contribute and reimburses for some (flu, pneumococcal) vaccines through Part B

• Medicaid adult numbers are increasing

• Adult providers aren’t familiar with vaccine management, leading to waste and increased staff time

• Due to low vaccine usage, some adult providers don’t want to participate
Care Alliance for Opiate Addiction
Historical Context of MAT in Vermont

- Skyrocketing demand
- Unstable provider network
- High transportation costs
- High cost population- triple average cost
- Increasing levels of low level property crimes
- Clear relationship to crisis in Child Welfare system
- Clear relationship to crisis in Corrections
“Hub and Spoke Model”

Results for Patients

➲ An established physician-led medical home
➲ A single MAT prescriber
➲ A pharmacy home
➲ Access to existing Community Health Teams
➲ Access to Hub or Spoke nurses and clinicians
➲ Linkages between Hubs and primary care Spoke providers in their areas
“Hub & Spoke” Health Home for Opioid Addiction

**Care As Usual**
- 5 Regional Centers
  - Addictions Treatment
  - Methadone OTP
- 125 Physicians Prescribing Buprenorphine OBOT

**Health Home**
- ~ 6 FTE RN, MA / 400 Pts
  - OTP & OBOT
  - Methadone & Buprenorphine
- 2 FTE RN, MA / 100 Pts
  - OBOT
  - Buprenorphine

Comprehensive Care Management - Care Coordination - Health Promotion - Transitions of Care - Individual and Family Support - Referral to Community & Social Supports

**Advanced Primary Care Practices and Community Health Teams**

**HUB**

**SPOKES**
What is Working Well?

- MAT “System”
  - Statewide Coverage Model
  - Integration of Primary Care with Specialty Treatment
  - Comprehensive Care for Addiction
  - Integrated & Coordinated -three systems
  - Improved physician acceptance with support systems

- Bundled Payment Model
Gaps, Barriers and Disincentives

- New Approach – Start Up Issues
- Messaging to Legislature and Policy Makers
- Private Insurance Coverage-Now in
- Lack of Physicians Willing to Treat Population
- Challenge with Integration of Social Services
- Link with Criminal Justice System Poses Unique Challenges
Challenges

- Network Capacity – recruiting providers
- Joint DVHA-ADAP Programmatic Framework
- Practice Improvement & Standardization of Care
  - Need for better “basic training”
- Financing & State Plan Amendment
- Multi-Payer Participation
- Federal Regulatory Framework (OTP/OBOT) not “rural friendly”
  - Lack of addiction specialists
  - High transportation costs
Thank you

Questions and Answers

Questions for the presenters?

Please type them into the chat box now!
Thank You for Participating!

Achieving Payment Reform Project Team:
- Neva Kaye, Managing Director
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- Mary Takach, Senior Program Director
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- Ledia Tabor, Project Director
  - Email: ltabor@nashp.org

Additional Resources:
- www.nashp.org
- NASHP’s Achieving Payment Reform Toolkit: www.statereform.org/multi-payer-payment-reform-toolkit

Please fill out your evaluation form!