Montana Department of Public Health and Human Services (DPHHS)

Status of Montana Medicaid Primary Care Case Management Programs

December 6, 2022

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Agenda

1. **Background of Medicaid Primary Care Programs**
2. Future of Montana Medicaid Primary Care
3. Medicaid Primary Care Model Discussion

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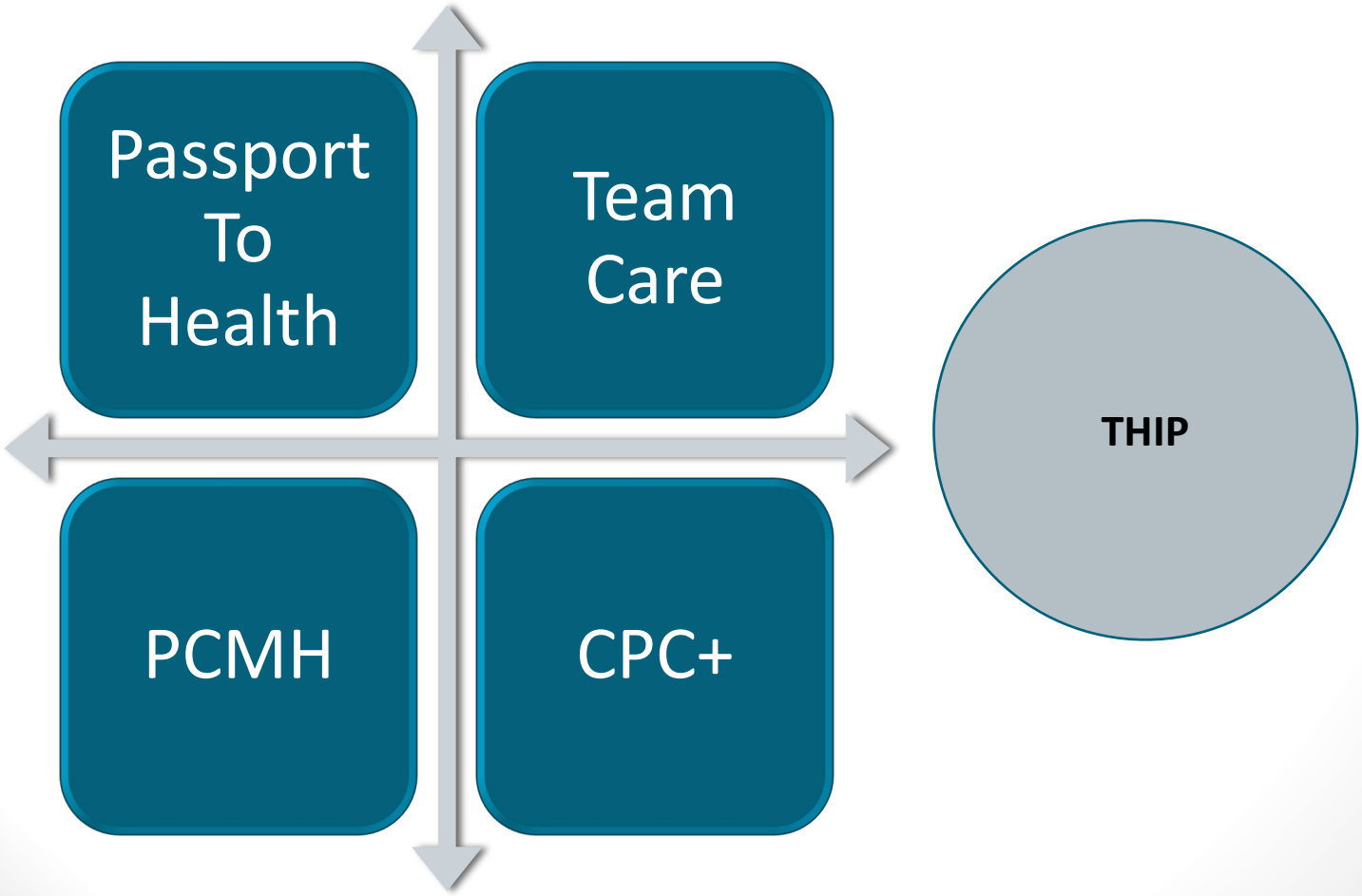
Primary Care Case Management

What is Primary Care Case Management?

- In a PCCM model, states contract directly with primary care providers to provide care management services to Medicaid enrollees.
- Primary Care Case Management Programs (PCCM) help ensure that Medicaid members have a regular health care provider who helps coordinate their care.
- Medicaid members voluntarily choose their primary care provider. If they do not select a provider within 45 days of becoming eligible, then the member is assigned to a primary care provider.
- The primary care provider receives a monthly case management fee per enrollee for coordinating care in addition to a fee-for-service payment for the medical services provided.
- Most services must be provided or approved by the member's primary care provider.

Current Medicaid Primary Care Case Management Programs



Passport to Health

Passport to Health (Passport) Facts

- **Provider Requirements:**
  - Any Medicaid enrolled physician or a mid-level practitioner, Clinic, FQHC, RHC, IHS, Tribal Health Center, or Urban that provides primary care within their scope of practice.

- **Services:**
  - Care coordination by providing referrals for medically necessary care.
  - Passport providers must provide direction to members in need of emergency care 24/7/365.

- **Reimbursement:**
  - Providers receive a per member per month (PMPM) case management fee of $3 for members determined categorically eligible for Aged, Blind, Disabled and Medically Frail Medicaid and $1 for all other Medicaid eligible members enrolled in Passport.

Team Care

Team Care Facts

- Member enrollment in Team Care is based on utilization that is found to be excessive, inappropriate, or fraudulent with respect to need.
- Team Care members are enrolled with a Primary Care Provider (PCP) to manage their care and receive all Medicaid prescriptions from one pharmacy.
- Members are identified for Team Care by the following methods:
  - DUR (Drug Utilization Review) Board Referrals – The DUR board performs pharmacy reviews of Medicaid's pharmacy claims. Members determined to be misusing or abusing pharmacy services are automatically enrolled in the program.
  - Provider Referrals - Montana providers can make direct referrals into the program by contacting the department.

Team Care

Team Care Facts

- **Provider Requirements:**
  - Be enrolled in Passport.
- **Services:**
  - Educate members about appropriate use of health care services and prescriptions.
- **Reimbursement:**
  - Passport providers receive an additional $3 PMPM for each Team Care member on their caseload.

Patient Centered Medical Home

Patient Centered Medical Home (PCMH) Facts

- **Provider Requirements:**
  - Meet the requirements of a Passport Provider.
  - Maintain PCMH recognition by the National Committee for Quality Assurance (NCQA).
  - Report clinical quality measures annually to DPHHS.

- **Services:**
  - Outreach all Medicaid members to provide education on PCMH services available.
  - Review Medicaid claims data and address gaps in care with the patient.
  - Engage patients and families in their treatment plan and improvement of care.
  - Engage patients in goal setting and shared decision-making, using decision aids and specific techniques (e.g., motivational interviewing).
  - Screen patients for behavioral health concerns and coordinate behavioral health services.

Patient Centered Medical Home

Patient Centered Medical Home (PCMH) Facts

- **Reimbursement:**
  - Members are assigned a health risk score and assigned to one of three tiers based on their medical risk using diagnoses and claims history. Providers are reimbursed PMPM care management fees based on the tier the member is assigned.
    - Tier One: $3.33
    - Tier Two: $9.33
    - Tier Three: $15.33

Patient Centered Medical Home - Continued

Patient Centered Medical Home (PCMH) Complex Care Management Option

- Participating PCMH providers have the option to participate in Tier Four Complex Care Management (CCM).

- **Provider Requirements;**
  - Provide for a CCM care team that must include a nurse and a Licensed Behavioral Health Professional or a paraprofessional with at least 40 hours of behavior health training.
  - Meet face to face in a high-risk member's home for 6 months, weekly for the first three months and every other week for the last three months.

- **Services:**
  - Provide necessary assessment and referrals to care for both medical and non-medical factors that impact the member's health.

- **Reimbursement:**
  - Providers are reimbursed $470.10 PMPM for members enrolled in this tier of PCMH.

Comprehensive Primary Care Plus

Comprehensive Primary Care Plus (CPC+) Facts

- **Provider Requirements:**
  - Providers can participate in Track 1 or Track 2 based on the following provider requirements:

  - **Track 1:**
    - Be enrolled in Passport.
    - Report clinical quality measures to DPHHS annually.
    - Previous selection of practice into CPC+ by CMS; **or**
    - Maintain PCMH Certification as a Patient Centered Medical Home through the following PCMH accrediting organizations: The National Committee for Quality Assurance (NCQA); the Joint Commission; the Accreditation Association for Ambulatory Health Care; or URAC.
    - Report clinical quality measures annually to DPHHS.

Comprehensive Primary Care Plus Continued

Comprehensive Primary Care Plus (CPC+) Facts

- **Track 2:**
  - In addition to the criteria for Track 1, practices selected for Track 2, must meet the following qualification criteria:
    - Provide integrated behavioral health services to include assessments of a member's psychosocial needs and provide referrals to resources and supports.
    - Conduct care team meetings weekly to review patient-level data and internal monitoring.
    - Provide at least two types of alternative access to healthcare including e-visits, phone visits, and group visits.
    - Provide at least one alternative contact modality, such as, emails, text reminders, or letters.

Comprehensive Primary Care Plus Continued

Comprehensive Primary Care Plus (CPC+) Facts

- **Services:**
  - Outreach all members attributed to the provider practice to provide education on CPC+ services available.
  - Review Medicaid claims data and address gaps in care with the patient.
  - Engage patients and families in their treatment plan and improvement of care.
  - Engage patients in goal setting and shared decision-making, using decision aids and specific techniques (e.g., motivational interviewing).

Comprehensive Primary Care Plus - Continued

Comprehensive Primary Care Plus (CPC+) Facts

- **Reimbursement:**
  - Members are assigned a health risk score based on their score of potential risk and are divided into tiers. Providers are reimbursed based on the member risk-stratified, PMPM care management fees.

Track 1	Track 2
Tier One: $3.33 Tier Two: $9.33 Tier Three: $15.33 Tier Four: $21.33	Tier One: $6.33 Tier Two: $12.33 Tier Three: $18.33 Tier Four: $24.33 Tier Five: $34.33

  - Providers also may receive an annual incentive bonus payment based on prevention and utilization quality measures.

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Medicaid Primary Care Redesign

Why does the state want to redesign Medicaid Primary Care Case Management programs?

- Challenges with current Medicaid PCCM programs:
  - Multiple variations of similar but differently managed programs.

Passport and Team Care:

- Provides little incentive for either physicians or patients to change their behavior to ensure better health outcomes.
- Providers see no benefit to taking on patients with complex health problems that require additional care.

PCMH and CPC+

- Limits the type of providers who qualify to participate.
- Program provider incentives are not consistent.
- Opportunities are not equitable between programs.
- Program measures are not shared timely.

Medicaid Primary Care Redesign - Continued

Goals of Medicaid Primary Care Redesign

- Encourage practice transformation to enhance primary care practices.
- Provide claim-based quality information to providers for improved care.
- Improve member health outcomes.
- Develop a measurement and evaluation strategy to demonstrate program value through value-based payment.

Medicaid Primary Care Redesign - Continued

Medicaid Primary Care Design Collaboration

- DPHHS seeks input from stakeholders to:
  - Redesign the current primary care service delivery models to reduce variations in Montana Medicaid primary care services;
  - Address inequities in PCCM programs allowing more providers to participate in enhanced care delivery incentives; and
  - Consolidate Passport, PCMH, and CPC+ to create one comprehensive primary care case management program designed to fit the needs of Montana.

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Primary Care Questions for Discussion

- Of the current Primary Care Case Management programs your facilities participate in, how does it impact the services you provide?

Primary Care Questions for Discussion

- What are the challenges and/or gaps in providing primary care services under the current Medicaid primary care models?

Primary Care Questions for Discussion

- How do your health care facilities currently measure patient outcomes?

Primary Care Questions for Discussion

- What components do you believe are important to include in the Montana Medicaid Primary Care program?

Contact Information

Darci Wiebe, Administrator **Health Resources Division**	DWiebe@mt.gov (406) 444-4458
Mary LeMieux, Bureau Chief **Member Health Services**	MLeMieux2@mt.gov (406)444-4146