

# Patient Centered Medical Home (PCMH)

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JENNIFER RIEDEN

MEMBER HEALTH MANAGEMENT BUREAU CHIEF



# Program Objective

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The medical home model of care offers a way to improve health care by transforming how primary care is standardized and delivered. The medical home model of care is based on the following core principles:

- Comprehensive Health Care directed by the patient's personal provider;
- Team-based, ongoing patient-centered care;
- Care Coordination across the health system using information technology;
- Enhanced Access through expanded hours, new communication methods, or alternative visits;
- Quality and Safety through evidence-based medicine, quality improvement, and performance measurement;



# Population Focus

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Currently 23 Federally Qualified Health Centers throughout the state are enrolled PCMH providers.

Members in the Passport to Health Program choose a primary care provider when enrolled in Medicaid

If they choose a provider who is a PCMH provider they are enrolled in the program.

Members are assigned a health risk score based on their score of potential risk across the entire population and are divided into three tiers.



# Program Description

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Practices must maintain PCMH recognition by the National Committee for Quality Assurance (NCQA).

Medicaid pays providers risk-stratified, per-member-per-month (PMPM) care management fees.

Medicaid members are assigned a health risk score based on their score of potential risk across the entire population and are divided into three tiers.

The care management fee amount corresponds to the risk-tier level.



# Required Care Management Staff

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The team is determined by the primary care practice. It must be team based and patient centered.

The teams usually consists of the primary care provider, a nurse, a social worker and in some cases a behavioral health specialist.



# Care Management Requirements

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Use a Medicaid distributed, monthly member registry to identify priorities for care management based on the indicated risk-tier level for each member and manage their patient population.

Required to outreach to all newly attributed members within 20 days of receiving their monthly member list.

Provide education to members on services available to them through the PCMH model.

Refer members to appropriate community-based programs as needed.

Engage with members and families in the design and improvement of care by using patient and family/caregiver advisory councils.



# Care Management Requirements cont.

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Assist members in navigating their medical neighborhood. Including both medical and social determinant needs.

Must include care management for behavioral health conditions. It is preferred this care management is done by a behavioral health professional.



# Program Demographics

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There are currently 23 practices enrolled in PCMH and approximately 39,000 Medicaid members including Medicaid expansion members.

Healthy Montana Kids members are also enrolled through BCBS.





# Program Measurement

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PCMH providers report quality measures annually to the Department. Medicaid merges claims data with the providers' clinical data for each measure to determine performance rates for each measure.

There are 21 measures for PCMH that are focused on preventive services.

Emergency room and inpatient hospital utilization are included as a quality measure. These reports are provided by the Department for providers.



# Tier 4-Complex Care Management (CCM)

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Started in October 2018

## Program Objectives:

Five percent of patients contribute to more than 50% of the healthcare costs; this proposal is aimed at those five percent. The purpose of this program is to reduce high/unnecessary use of the emergency room and inpatient services for a specific population. This proposal is based on the model currently being done by Partnership Health in Missoula. Partnership currently has 18 Medicaid members enrolled and has seen a reduction of unnecessary emergency room visits and inpatient stays for this population.



# Population Focus-CCM

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To be eligible for the CCM Program, the member must meet all of the following criteria:

- Be attributed to the contractor's Medicaid PCMH clinic;
- Have two or more chronic conditions;
- Be amenable to intensive care management; and
- Not be transient homeless.

In addition to the above criteria, the member must also meet one of the following:

- Have had two or more ER visits in the past 60 days; or
- Have had two or more inpatient stays in the past 6 months for the same reason.



# Program Description - CCM

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The purpose of CCM program is to partner with Patient Centered Medical Home (PCMH) providers to reduce costly services for Medicaid members with high utilization of emergency department visits and hospital admissions that might have been prevented by less costly interventions and primary care.

The CCM program is aimed at working with Medicaid members in their homes to improve the health of members with high utilization by focusing on both medical and non-medical factors that may be impacting the member's health.



# Required Care Management Staff - CCM

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Registered Nurse or Licensed Practical Nurse

Licensed Behavioral Health Professional or a Para Professional with at least 40 hours of behavior health training

- Behavioral health training must include crisis intervention, mental health first aid, cultural training, co-occurring disorders, and trauma informed care.

Social Worker – this provider type is optional



# Care Management Requirements- CCM

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The CCM care team must meet face-to-face with the member in their home or other location approved by the member that is not the PCMH clinic, to determine the member's health care needs. Members may not be enrolled until the initial home visit has occurred.

Ongoing in home visits should occur at least weekly for the first three months and at least every other week for the last three months.

Each CCM care team may not consist of more than 30 members at one time.

Members cannot be enrolled in the CCM program for more than 6 months without Department approval.



# Care Management Requirements - cont.

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Integrate behavioral health and social support program components to address non-medical factors that may be driving high utilization of Medicaid services.

Provide trauma informed care to address root causes of high utilization while addressing social determinants.

Assist with scheduling appointments and coordinating primary and specialty care.

Emphasize coordination around social services, behavioral health treatment, medical care, and disease management.

Provide timely follow up with CCM members after notification of an inpatient stay or ER visit.



# Program Measurement - CCM

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The following measures will be used for this program:

ER utilization

Inpatient Hospital Utilization

Primary Care Utilization

Member's Risk Score

Member Satisfaction Survey

Member's Social Determinant of Health Survey

