HMA

# Montana PCCM Redesign: Key Partner Kick Off

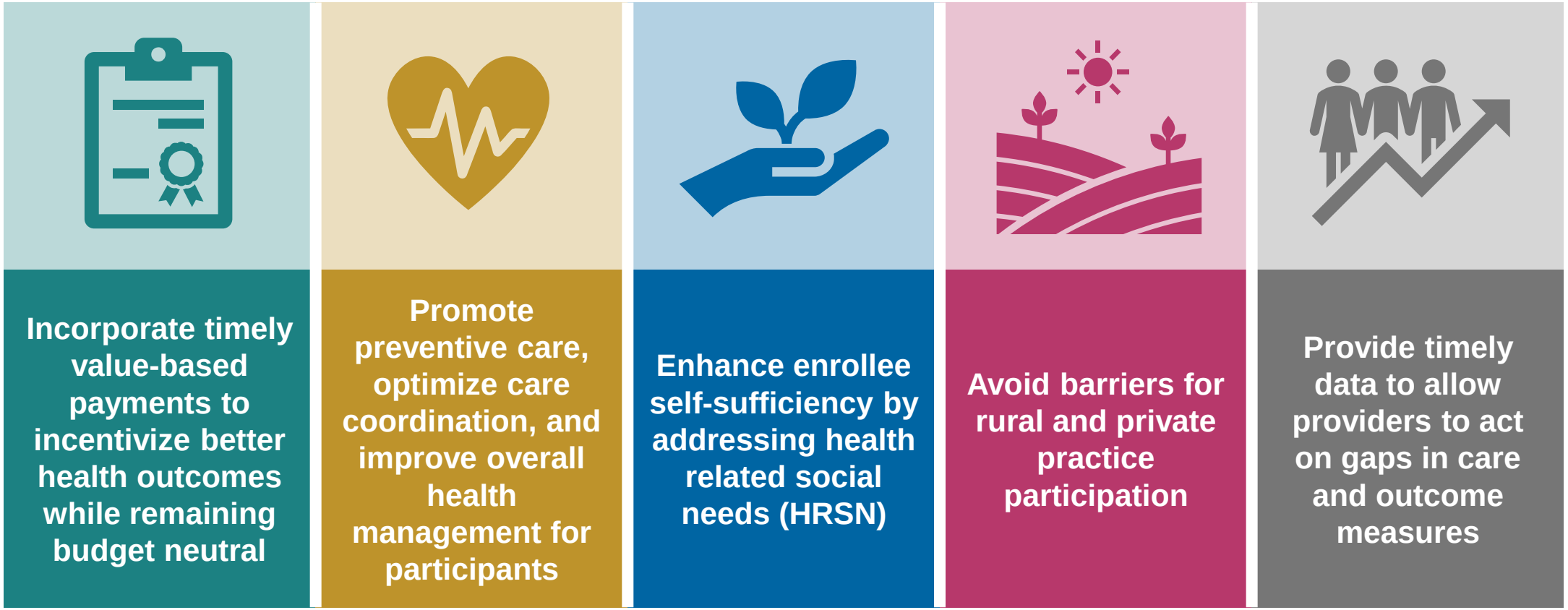
October 2, 2024

# MEETING OBJECTIVES

- Introduce PCCM Redesign Project and HMA Role
- Introduce Key Partners
- Project Scope and Timeline
- Themes from Key Partner Survey
- Overview of National Landscape
- Key Partner Feedback on Design Components

# DPHHS PCCM REDESIGN GOALS

DPHHS seeks to transition from its four disparate PCCM models to a unified, comprehensive, and value-based program that incorporates the following key elements and can be leveraged for additional Medicaid programs and services.



# PROJECT SCOPE & TIMELINE

# OVERVIEW OF HMA SCOPE OF WORK

- Research & Program Selection
- Regulatory & Compliance Review
- Waiver or State Plan Amendment Preparation
- Public Notice & Partner Input
- Support DPHHS Led Actuarial Analysis
- Support DPHHS Led Provider Education/Outreach

# OVERVIEW OF TASK ONE DECISION POINTS

| | | |
|---|---|---|
| Delivery System Model | Value-Based Payment Strategy(s) | Provider Eligibility & Qualifications - Including FQHC Regulatory Considerations & Specialist, Behavioral Health, and HCBS Coordination |
| Outcomes to Incentivize | Infrastructure to Support Providers - Including Data Sharing Strategies | Enrollee Eligibility, Assignment, or Attribution |
| Opportunities to Address HRSN | Governance Model | State Operations and Infrastructure to Support Model |

# PROJECT STATUS

## Conducted Project Kick Off Meetings with DPHHS

- Confirmed agreement on objectives and pain points with DPHHS key partners
- Identified data needed to assess current state and inform redesign
- Determined required partner feedback
- Presented national landscape and high-level program design options to address Montana needs

## Initiated Key Partner Engagement Activities

- Key Partner Survey closed late last week
- Today is the Initial Key Partner listening and feedback session

## Planned Ongoing Partner Input

- Focused engagement and targeted discussion on key design elements
- Present and seek feedback on initial model concept

# CURRENT MONTANA PCCM PROGRAMS

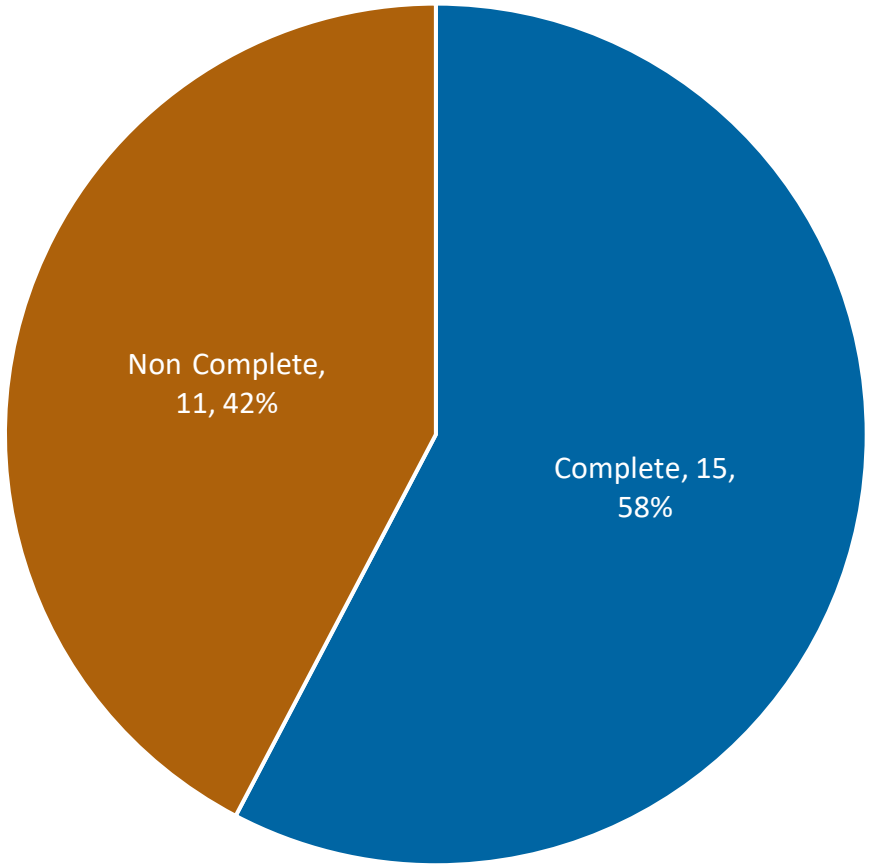
| Program | Provider Requirements | Service Requirements | Reimbursement | Unique Features |
|---|---|---|---|---|
| **Passport to Health** | • Any Medicaid enrolled primary care provider (PCP).<br>• Program includes various types of providers and facilities. | • Care coordination through referrals.<br>• 24/7/365 emergency care guidance. | • $3.00 PMPM for ABD and Medically Frail.<br>• $1.00 PMPM for others. | • Operated in all counties except 4 as of 2024.<br>• Mandatory enrollment for eligible members. |
| **Team Care** | • Providers enrolled in Passport | • Educate members on proper use of healthcare services and prescriptions. | • Extra $3.00 PMPM for each Team Care Member. | • Add-on program to Passport.<br>• TC members are also in PCMH and CPC+. These programs have enhanced payment from Passport, and do not receive additional payment.<br>• Focused on prescription education. |
| **Patient Centered Medical Home (PCMH)** | • Meet Passport Provider criteria.<br>• Maintain NCQA PCMH recognitions.<br>• Report clinical quality measures annually. | • Educate members on PCMH services.<br>• Address care gaps.<br>• Engage patients and families.<br>• Assist in goal setting.<br>• Screen for behavioral health. | • Tier One: $3.33 PMPM<br>• Tier Two: $9.33 PMPM<br>• Tier Three: $15.33 PMPM | • Complex Care option available: $471.10 PMPM. |
| **Comprehensive Primary Care Plus (CPC+)** | • Providers participate in either Track 1 or Track 2.<br>• Meet Passport Provider criteria.<br>• Maintain PCMH recognition.<br>• Report Clinical Quality Measures. | • Outreach to attributed members.<br>• Review claims data.<br>• Engage patients and families.<br>• Use decision aids. | Track 1:<br>• Tier One: $3.33 PMPM<br>• Tier Two: $9.33 PMPM<br>• Tier Three: $15.33 PMPM<br>• Tier Four: $21.33 PMPM<br><br>Track 2:<br>• Tier One: $6.33 PMPM<br>• Tier Two: $12.33 PMPM<br>• Tier Three: $18.33 PMPM<br>• Tier Four $24.33 PMPM<br>• Tier Five: $34.33 PMPM | • Potential for annual incentive bonus. |

# FINDINGS FROM KEY PARTNER SURVEY

# FEEDBACK GATHERED TO DATE ON CURRENT MODELS

| STRENGTHS | OPPORTUNITIES |
| --- | --- |
| • Strong participation among PCPs | • Attribution model<br>• Specialist referral process<br>• Lack of incentives in all programs except CPC+<br>• Delayed incentive payments in CPC+<br>• Data timeliness and availability for providers to impact outcomes |

# 26 SURVEY RESPONDENTS REPRESENTING 4 CATEGORIES OF KEY PARTNERS



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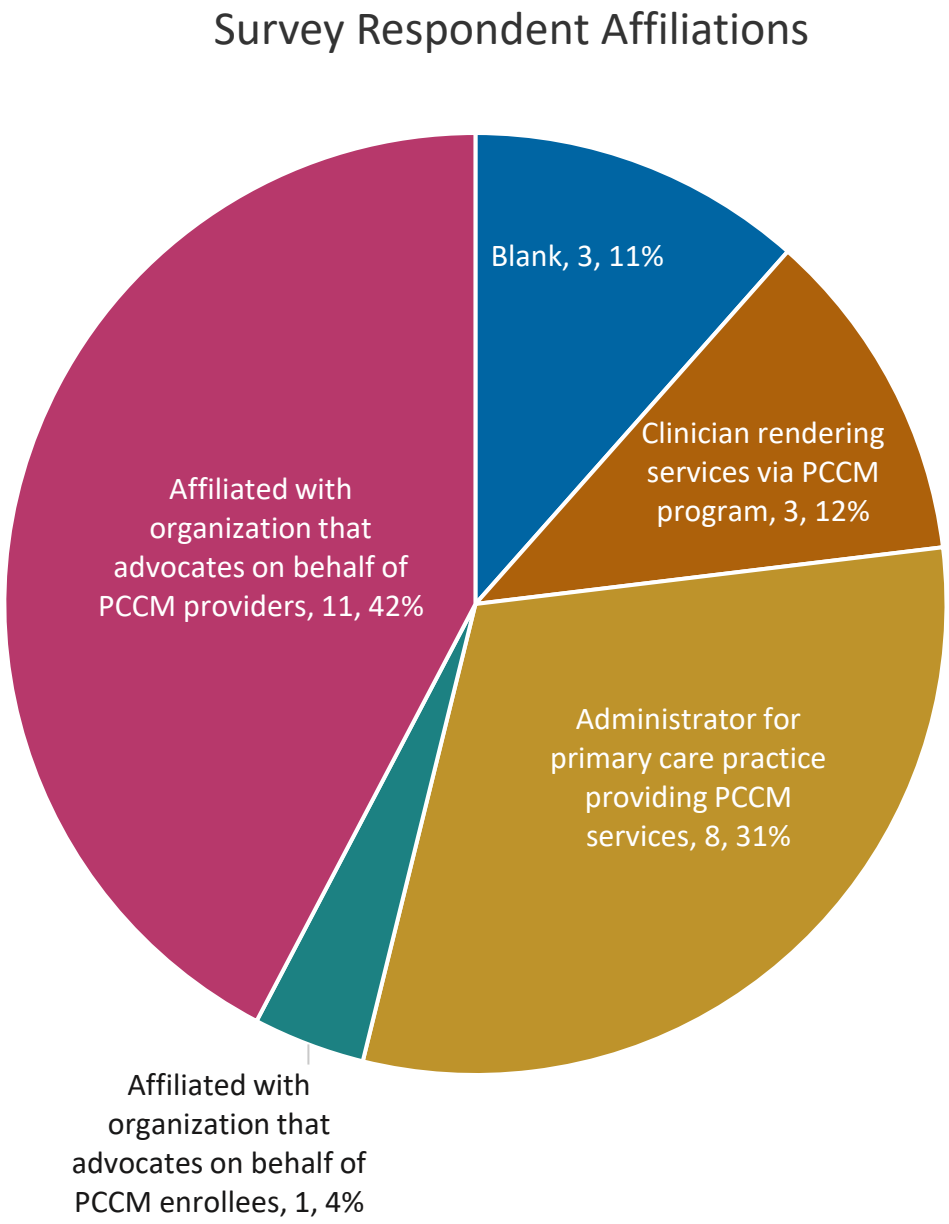
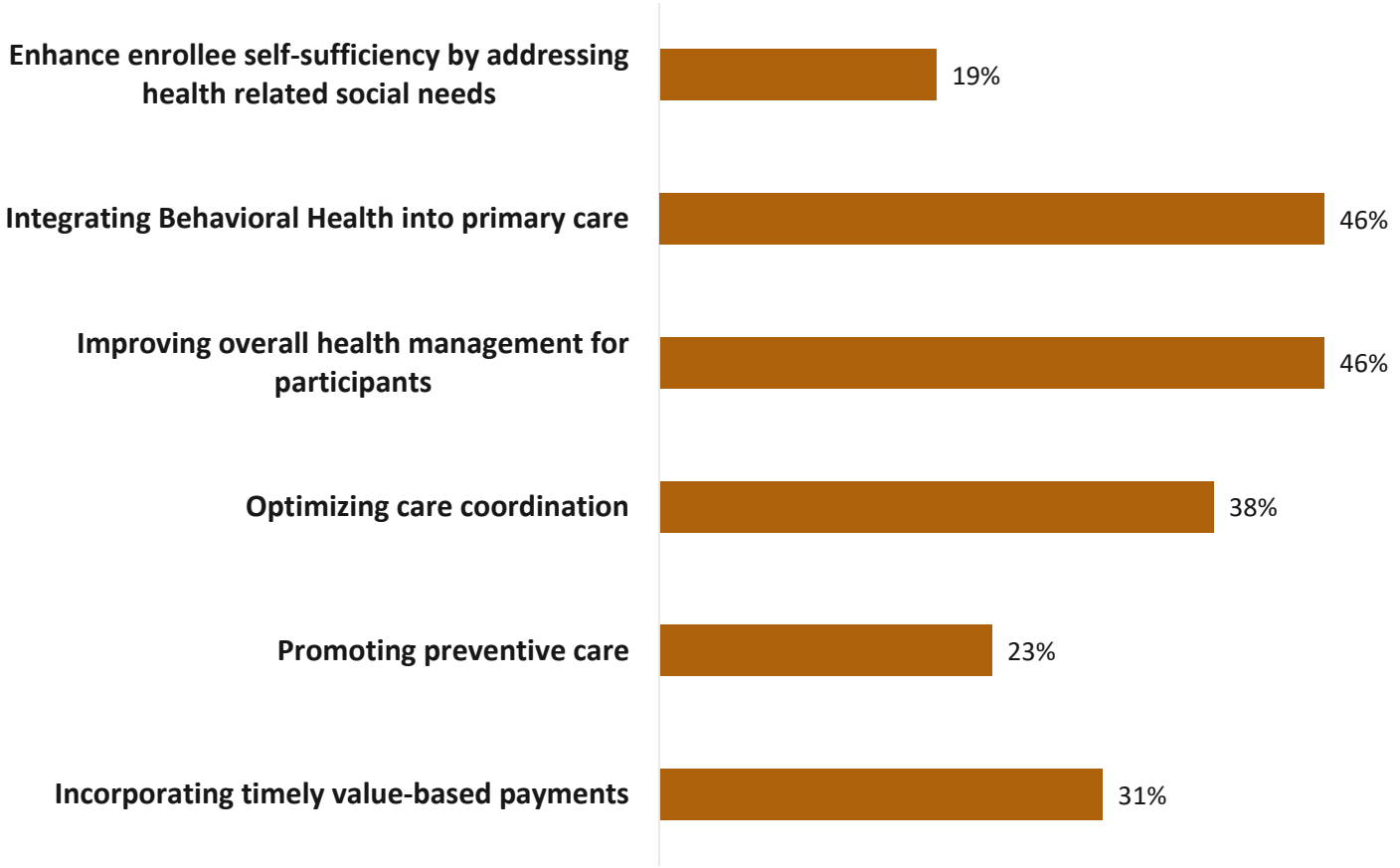


# KEY PRIORITIES FOR REDESIGN

## What do you believe are the key priorities for redesign of the PCCM Program?

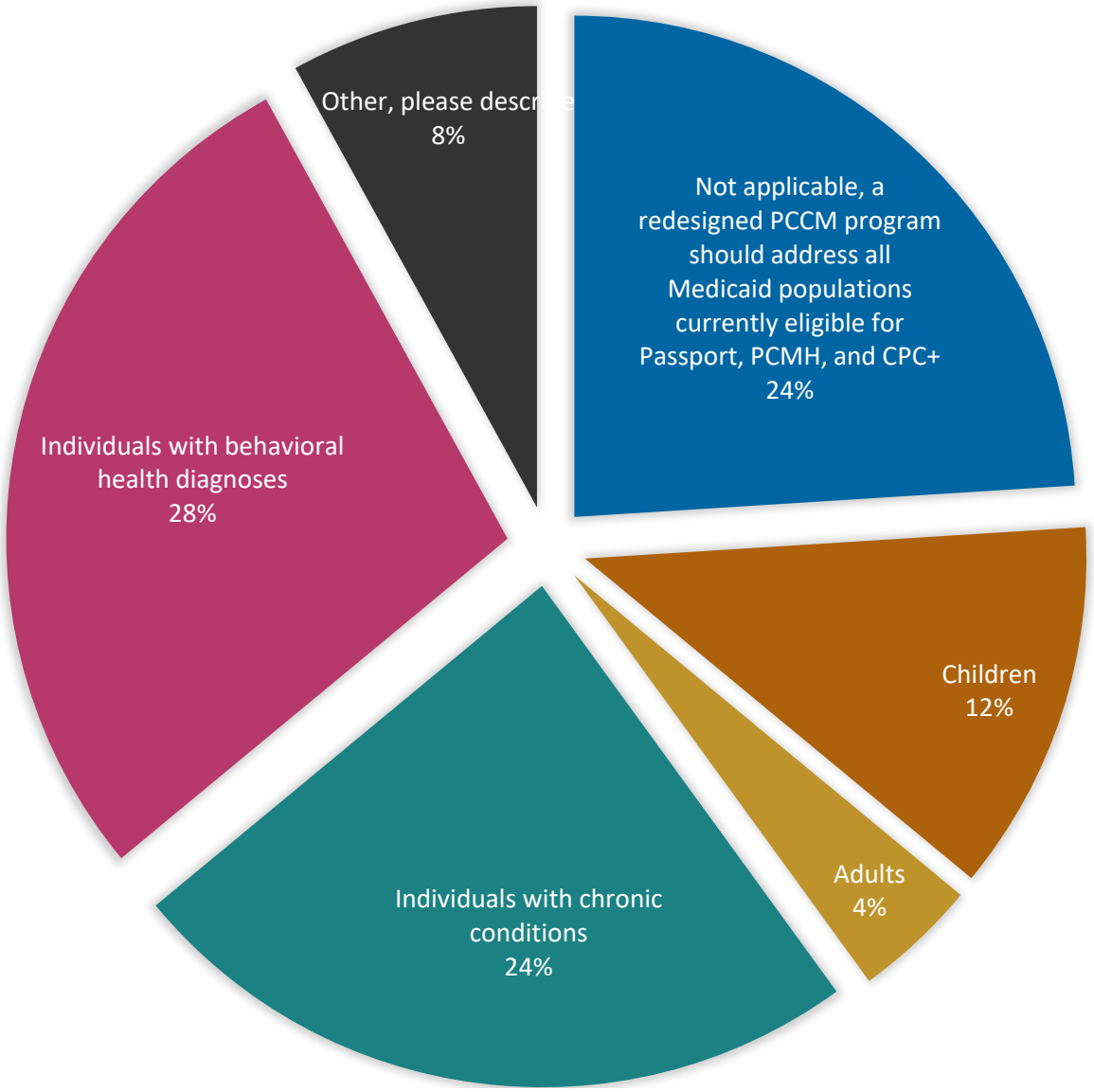
*(n = 15, Multiple selections allowed)*



# VIRTUAL 3-WAY TIE BETWEEN ALL POPS, BH, AND INDIVIDUALS WITH CHRONIC CONDITIONS

## WHAT POPULATIONS SHOULD BE PRIORITIZED IN A REDESIGNED PCCM PROGRAM?

***(N = 15)***



# PATIENT OUTCOMES OR METRICS TO BE PRIORITIZED

# PREFERENCES ON PAYMENT MODELS TO BE CONSIDERED

**What specific patient outcomes or metrics do you believe should be prioritized in the redesigned PCCM program?** *(Multiple selections allowed)*

| | Count | Percent |
|---|---|---|
| Preventive care visits | 8 | 31% |
| Immunizations | 4 | 15% |
| Behavioral health measures | 10 | 38% |
| Age or gender specific screenings (e.g., breast cancer, cervical cancer, colorectal cancer) | 8 | 31% |
| Chronic condition measures (e.g., hemoglobin A1c for people with diabetes, controlling high blood pressure, use of imaging studies for low back pain) | 10 | 38% |
| Cost savings in addition to quality outcomes | 7 | 27% |
| Utilization measures (e.g., emergency department visits and inpatient readmissions) | 10 | 38% |
| Other, please describe | 3 | 12% |

**Which of the following payment model(s) should DPHHS consider in redesigning its PCCM programs?** *(Multiple selections allowed)*

| | Count | Percent |
|---|---|---|
| Per member per month payment (PMPM) to support provider infrastructure, such as care coordination fees or investments in health information technology (in addition to fee for services claims reimbursement) | 10 | 38% |
| Bonuses for reporting quality metrics (in addition to fee for service claims reimbursement) | 10 | 38% |
| Penalties for not reporting quality metrics (in addition to fee for service claims reimbursement) | 2 | 8% |
| Bonuses for performance on quality metrics (in addition to fee for service claims reimbursement) | 12 | 46% |
| Shared savings program through which providers receive additional payment when they meet cost and quality metrics that results in more efficient spending within the Medicaid program (in addition to fee for service claims reimbursement) | 9 | 35% |
| Replace fee for service claims reimbursement with PMPM payment for assigned Medicaid enrollees | 3 | 12% |
| Other, please describe | 3 | 12% |

# KEY FEEDBACK ON SPECIFIC DESIGN COMPONENTS: SUMMARY

## Care Coordination

- Tools/resources (CHAs, Integrated Behavioral Health)
- PCMH Level 4 challenges with patient engagement and home-visits
- Consider inclusion of after hours on-demand pediatric care as a support to care coordination
- Specific care coordination supports for Tribal health providers and Urban Indian Organizations

## Technology and Data Sharing

- Need for additional access to timely data on health outcomes
- Metrics that evaluate impact of intervention and impact on total cost of care
- Provider-level information
- Recommend use of state HIE and potentially data interfaces into provider EMRs

## Provider Reimbursement

- Recommend linking incentives to quality
- Increase reimbursement, if possible; PMPM too low

## Populations to Prioritize

- Reconsider Tier 4 qualifications (Many patients need care coordination who have not had a recent ER/Inpatient encounter)
- Prioritize highest cost members and dual eligibles
- Potentially include Meadowlark Initiative in redesigned reimbursement model to support BH staffing in perinatal setting

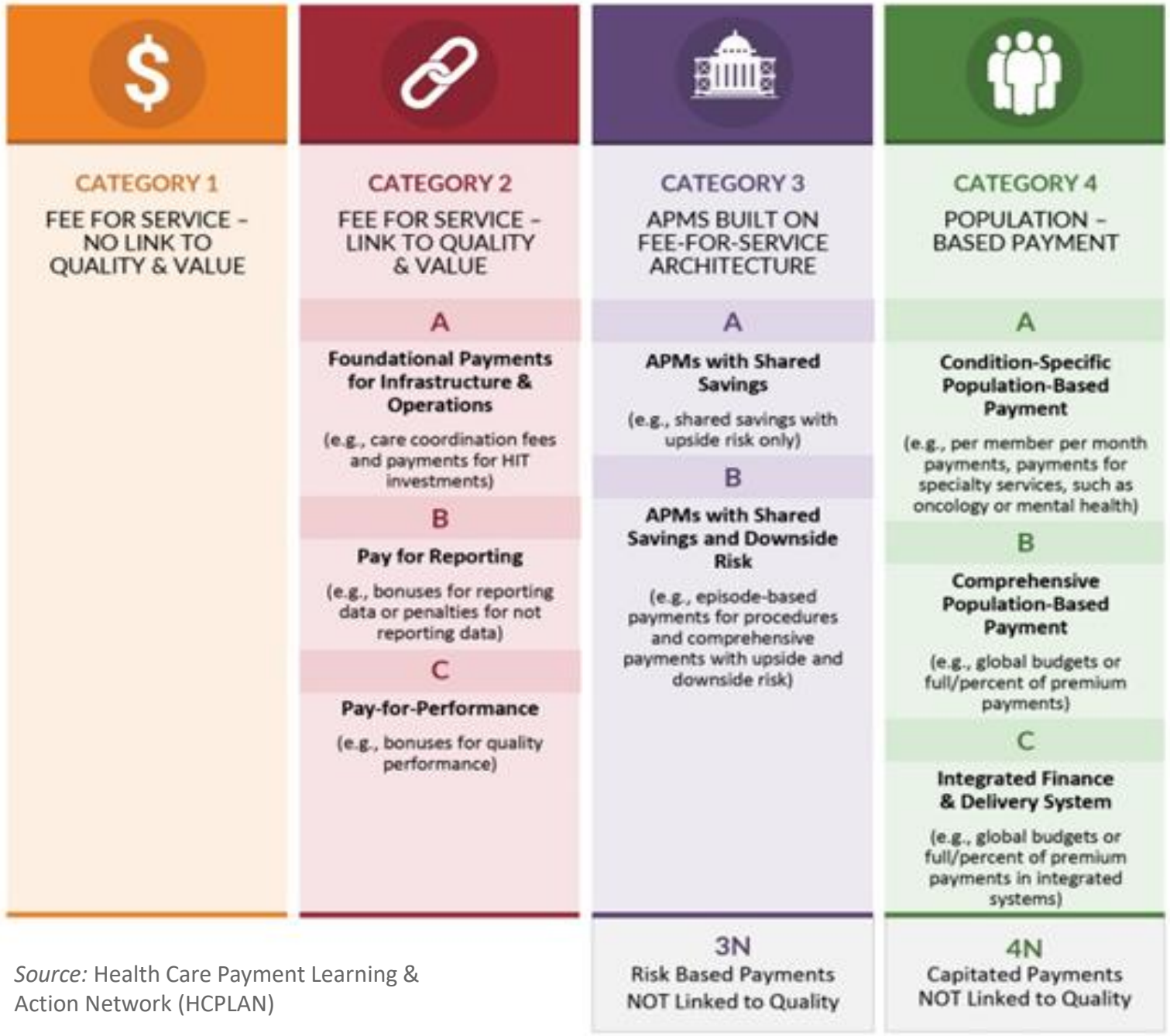
# OVERVIEW OF NATIONAL LANDSCAPE

# ALTERNATIVE PAYMENT MODEL (APM) FRAMEWORK

Category 1: Passport to Health

Category 2A: PCMH

Category 2C: CPC+



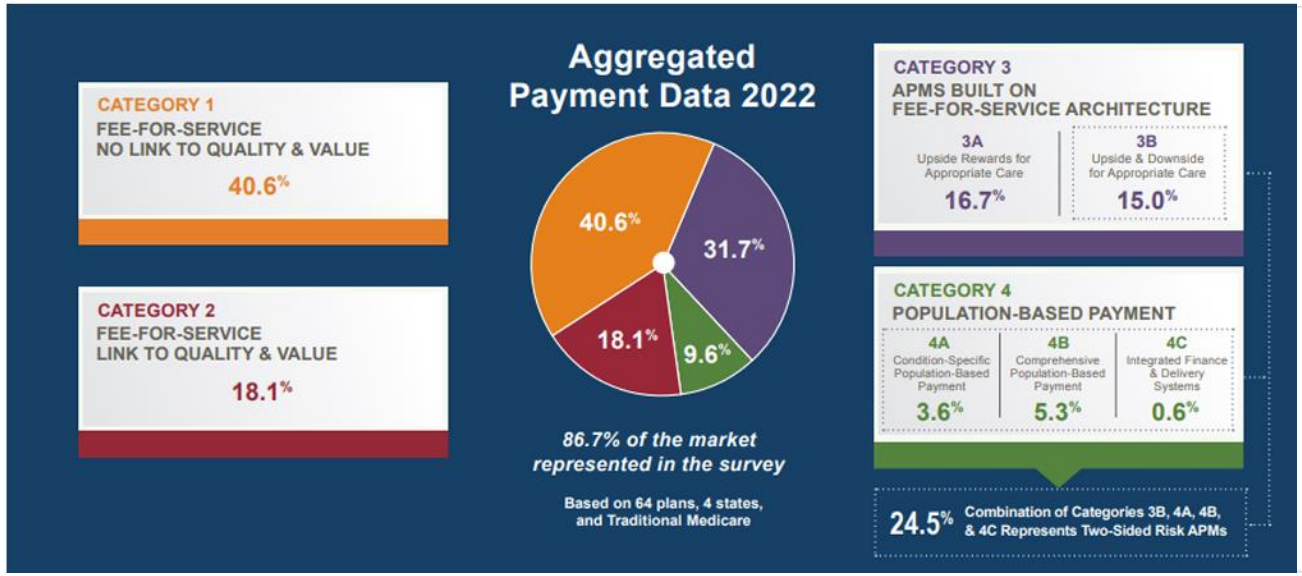

*Source:* Health Care Payment Learning & Action Network (HCPLAN)

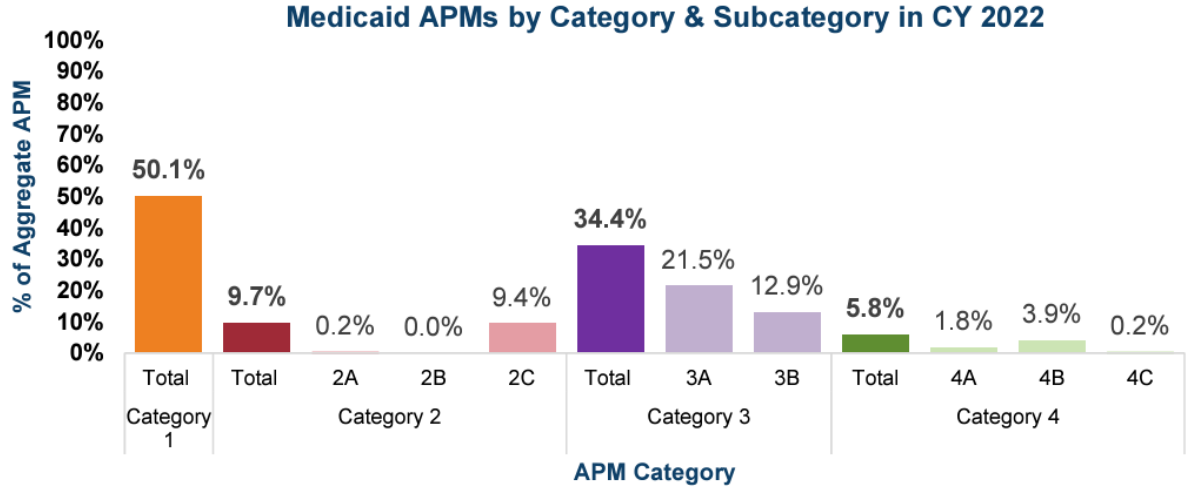
# NATIONAL PROGRESS ON ADVANCING ALTERNATIVE PAYMENT MODELS

## GOAL STATEMENT

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk alternative payment models (Categories 3B and 4 of the LAN APM Framework)

| | Medicaid | Commercial | Medicare Advantage | Traditional Medicare |
|---|---|---|---|---|
| 2024 | 25% | 25% | 55% | 50% |
| 2025 | 30% | 30% | 65% | 60% |
| 2030 | 50% | 50% | 100% | 100% |






*Source:* Health Care Payment Learning & Action Network (HCPLAN)

# DELIVERY SYSTEM MODELS

## States are advancing value-based payments (VBP) in their Medicaid programs through a variety of delivery system models.

Arrangements vary by entity or provider type(s) with which the Medicaid agency contracts and the underlying payment mechanism. Each model offers an opportunity to incorporate and customize VBP structure and policy.

### Primary Care Case Management (PCCM)

State contracts directly with a physician, physician group practice, physician assistant, nurse practitioner, or certified nurse-midwife to furnish case managements services, including the location, coordination, and monitoring of primary health care services.

### PCCM Entity

State contracts with entity(s) that provide a defined set of functions in addition to primary care case management. Functions may include intensive case management, care plan development, provider contracting or oversight, FFS payment (including VBP) on behalf of state, enrollee outreach and education, call center operation, provider profiling and/or improvement, quality improvement activities, coordination with behavioral health and/or LTSS providers.

### Accountable Care Organizations (ACO)

Groups of doctors, hospitals, and other health care professionals that work together to give patients high-quality, coordinated service and health care, improve health outcomes, and manage costs. ACOs may be in a specific geographic area and/or focused on patients who have a specific condition.

### Managed Care Organizations (MCO)

State contracts with health plans that assume financial risk for their enrolled population. MCOs reimburse a contracted network of providers which can incorporate VBP. States can either define VBP arrangement MCOs are mandated to follow or permit MCO flexibility in design.



*Sources:* CMS, 42 CFR 438.2

# PCCM STATE EXAMPLE:
# OKLAHOMA PATIENT-CENTERED MEDICAL HOME

## Oklahoma contracts with patient centered medical homes (PCMHs).*

Bonus payment eligibility and amounts are paid based on PCMH performance against peers. Providers in the bottom third or relative to the median (depending on the measure) receive no payment and top performers receive higher payment. There is also an “improver bonus” for performance increases.

### Care Coordination Payment
PCMHs receive PMPM care coordination payment that is tiered based on practice characteristics (hours availability, use of evidence-based care, etc.). Payments also vary based on population served (adult only, child and adult, or child only).

### Primary Care Reimbursement
Claims are paid fee-for-service.

### Provider Transparency
Provider scorecards are provided to view individual performance and comparison to peers.

### Bonus Payments
Quarterly bonus payments are made for ED utilization, BH screenings, and obesity measures.

*The state implemented Medicaid managed care in 2024; however, a portion of the population remains in PCMH.



*Source:* Oklahoma Health Care Authority

# PCCM ENTITY STATE EXAMPLE:
# ALABAMA COORDINATED HEALTH NETWORK (ACHN)

| Overview | Governance | Quality Improvement | ACHN Reimbursement | Provider Reimbursement |
|---|---|---|---|---|
| » State contracts with seven regional entities responsible for care coordination within the region.<br><br>» Led by an executive director, quality care manager, care coordination supervisor, pharmacist, and medical director. | » ACHN governing boards must include PCPs (50%), two in-region hospitals, and representative(s) from a community mental health center, SUD treatment facility, FQHC, and a consumer.<br><br>» Each ACHN also has a Consumer Advisory Committee that presents to governing board. | » Quality improvement projects focused on population priorities such as substance abuse, infant mortality, and obesity.<br><br>» Metrics and benchmarks focus on items under control of ACHN and PCPs such as well child visits, immunization rates, BMI, case management. | » PMPM for quality improvement activities<br><br>» Care coordination payment based on recipient complexity and level of activity<br><br>» Bonus payments for performance on ten measures (tied to annual improvement and performance against regional benchmark) | FFS payment plus PCP bonus payment based on:<br>» Performance on quality measures aligned with ACHN measures (50%)<br>» Cost-effectiveness (45%)<br>» PCMH recognition (5%) |



*Source:* Alabama Medicaid

# PCCM ENTITY STATE EXAMPLE:
# COLORADO REGIONAL ACCOUNTABLE ENTITIES (RAE)

## Overview

- State contracts with seven RAEs responsible for care coordination within the region. Phase III will reduce contracts to four RAEs.
- RAEs are responsible for coordinating physical and behavioral health and administering Colorado's capitated behavioral health benefit.

## Quality Improvement

- Exploring permanent supportive housing benefits through an 1115 waiver.
- Strengthening collaboration with SNAP and WIC enrollment to support food security. ·
- Integrating RAE systems with the Social Health Information Exchange (SHIE) and supporting providers in effectively use
- Using CMS core metrics/NCQA metrics to align with other payers

## RAE Reimbursement

- Aligning the ACC with other value-based payment programs to create a comprehensive payment reform system for Health First Colorado providers
- Capitated payment for behavioral health
- PMPM administrative fee for care coordination and management of whole-person care, including HRSN

## Provider Reimbursement

- RAEs pay PCPs alternative payment models with incentive payments tied to outcome targets.
- Aligned with other value-based payment programs to create a comprehensive payment reform system for Health First Colorado providers



*Source:* Colorado HCPF

# HYBRID MODEL STATE EXAMPLE

**Idaho's model includes medical homes and value care organizations (VCOs)**

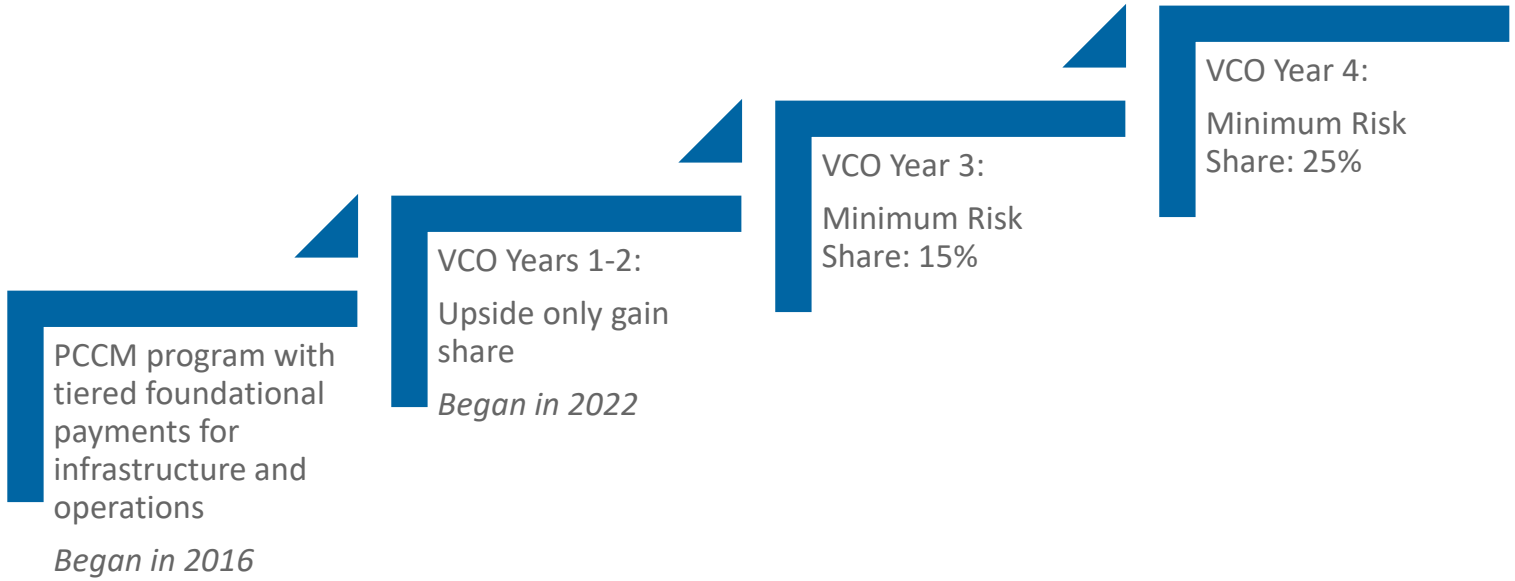
- Healthy Connections is a PCCM program that utilizes a network of providers to serve as the "medical home"
  - Providers are paid a PMPM tiered fee based on the level of care coordination they render and PCMH accreditation status.
- Under Healthy Connections Value Care, the state contracts with VCOs, which include hospital networks and primary care providers that are held accountable for outcomes and costs, in exchange for an ability to share in savings
  - VCOs contract with PCCM providers and must develop clinical and operational processes to enhance performance of the network in achieving quality, cost, and outcomes goals. This includes process for rewarding clinical improvement and holding providers accountable.



*Source:* Idaho Department of Health & Welfare

Idaho has taken a staged approach to progress along the APM framework.

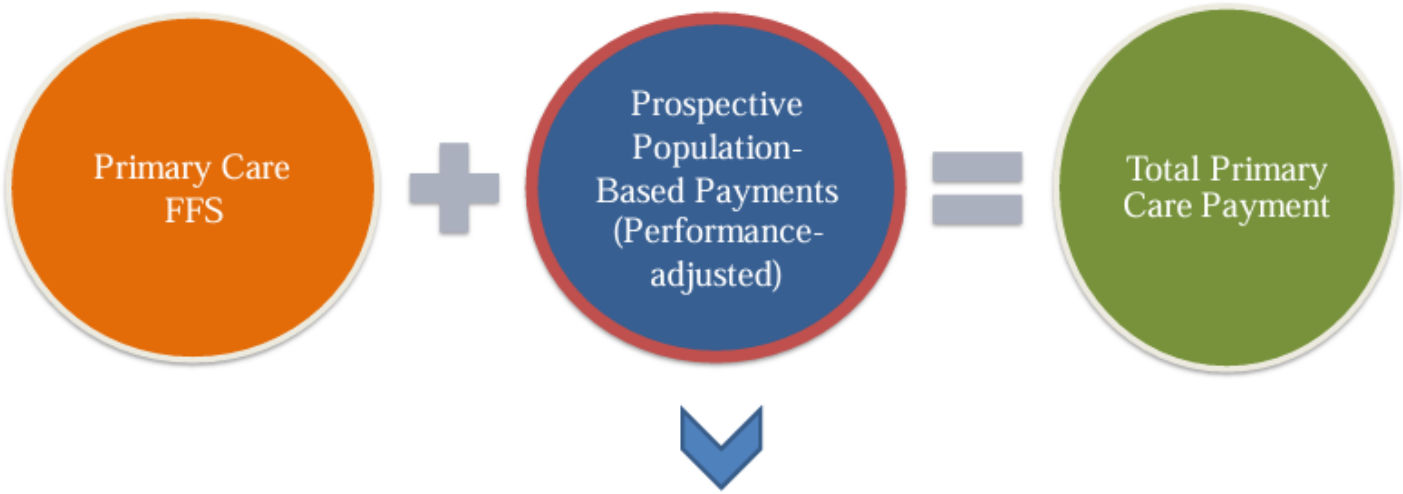
The state accounts for variance in provider readiness through maintenance of a PCCM model and incorporation of Value Care Organizations (VCO) that take on escalating risk and expand participation beyond primary care.






*Source:* Idaho Department of Health & Welfare

Maine has aligned its performance measures with other payers, including Medicare's Primary Care First and other state initiatives. The state also provides tiered PMPM payments based on practice characteristics and is seeking to increase the volume of payments tied to value.




- ✓ *Population- and risk-adjusted*
- ✓ *Adjusted for performance on <10 measures*
- ✓ *Rate increases available based on practice characteristics and alignment with Accountable Communities program*



*Source:* Maine Department of Human Services

# KEY PARTNER FEEDBACK ON DESIGN COMPONENTS

# EXAMPLES OF OPTIONS AND PROGRAM FEATURES AVAILABLE TO ADDRESS PRIORITIES

**A multitude of options are available to meet State goals while addressing stakeholder feedback. Design of a Montana-specific model could consider elements from several models, such as:**

| | | |
|---|---|---|
| Merge features of PCMH and CPC+ to expand eligibility for bonus payments | Develop one tiered per member per month payment methodology (e.g., based on practice characteristics and/or enrollee risk stratification) | Leverage features of CMS Innovation Center models to advance multi-payer alignment (e.g., Primary Care First and/or Making Care Primary) |
| Implement additional resources to support provider practices (e.g., PCCM entity model) | Incorporate operational improvements (e.g., data accessibility, timeliness of incentive payments, and PCCM provider referral requirements) | Transition current PCCM models to payment model targeted to enrollees with chronic conditions (e.g, health homes) |

# KEY FEEDBACK THEMES DISCUSSION

- Based on the program characteristics we have discussed:
  - What sounds promising and worth further research?
  - What concerns do you have?
  - What specific features do you want to learn more about?
- Are there other program design components you would like to see considered when evaluating potential program features?

# NEXT STEPS

Individual Stakeholder Sessions

*10/14/24 – 11/8/24*

Reconvene Stakeholder Group

*Two more times prior to finalizing the outline model in December*

Preliminary Model Components

*December 2024 (prior to legislative session)*

# APPENDIX

# 3 SURVEY RESPONDENTS REPRESENTING PASSPORT AND PCMH EACH

| 8. How satisfied are you with the program functions and processes? | | | | | | | |
|---|---|---|---|---|---|---|---|
| Passport to Health | (blank) | Very Satisfied (5) | Satisfied (4) | Neutral (3) | Dissatisfied (2) | Very Dissatisfied (1) | N/A |
| a. Attribution/Member Assignment | 67% | 0% | 0% | 22% | 0% | 11% | 0% |
| b. Specialist referrals process | 67% | 0% | 0% | 33% | 0% | 0% | 0% |
| c. Referrals to social services process | 67% | 0% | 0% | 33% | 0% | 0% | 0% |
| d. Care coordination and management processes at your organization | 67% | 11% | 11% | 11% | 0% | 0% | 0% |
| e. Care coordination and management tools and resources | 67% | 0% | 11% | 11% | 11% | 0% | 0% |
| f. State-defined quality measures and incentives | 67% | 0% | 11% | 11% | 11% | 0% | 0% |
| g. Access to timely data and information from the state | 67% | 0% | 11% | 0% | 11% | 11% | 0% |
| h. Reimbursement | 67% | 0% | 0% | 0% | 33% | 0% | 0% |
| i. PCCM PMPM payment processes | 67% | 0% | 0% | 11% | 22% | 0% | 0% |
| j. Reporting requirements | 67% | 0% | 11% | 11% | 11% | 0% | 0% |

| 8. How satisfied are you with the program functions and processes? | | | | | | | |
|---|---|---|---|---|---|---|---|
| PCMH | (blank) | Very Satisfied (5) | Satisfied (4) | Neutral (3) | Dissatisfied (2) | Very Dissatisfied (1) | N/A |
| a. Attribution/Member Assignment | 25% | 0% | 0% | 25% | 50% | 0% | 0% |
| b. Specialist referrals process | 25% | 0% | 0% | 50% | 0% | 25% | 0% |
| c. Referrals to social services process | 25% | 0% | 0% | 50% | 25% | 0% | 0% |
| d. Care coordination and management processes at your organization | 25% | 25% | 25% | 25% | 0% | 0% | 0% |
| e. Care coordination and management tools and resources | 25% | 0% | 25% | 50% | 0% | 0% | 0% |
| f. State-defined quality measures and incentives | 25% | 0% | 0% | 75% | 0% | 0% | 0% |
| g. Access to timely data and information from the state | 25% | 0% | 25% | 0% | 50% | 0% | 0% |
| h. Reimbursement | 25% | 0% | 0% | 25% | 50% | 0% | 0% |
| i. PCCM PMPM payment processes | 25% | 0% | 25% | 50% | 0% | 0% | 0% |
| j. Reporting requirements | 25% | 0% | 0% | 75% | 0% | 0% | 0% |

# 1 SURVEY RESPONDENT REPRESENTING CPC+

| 8. How satisfied are you with the program functions and processes? | | | | | | | |
|---|---|---|---|---|---|---|---|
| Comprehensive Primary Care Plus (CPC+) | (blank) | Very Satisfied (5) | Satisfied (4) | Neutral (3) | Dissatisfied (2) | Very Dissatisfied (1) | N/A |
| a. Attribution/Member Assignment | 67% | 0% | 0% | 33% | 0% | 0% | 0% |
| b. Specialist referrals process | 67% | 0% | 0% | 33% | 0% | 0% | 0% |
| c. Referrals to social services process | 67% | 0% | 0% | 33% | 0% | 0% | 0% |
| d. Care coordination and management processes at your organization | 67% | 0% | 0% | 33% | 0% | 0% | 0% |
| e. Care coordination and management tools and resources | 67% | 0% | 0% | 33% | 0% | 0% | 0% |
| f. State-defined quality measures and incentives | 67% | 0% | 0% | 33% | 0% | 0% | 0% |
| g. Access to timely data and information from the state | 67% | 0% | 0% | 33% | 0% | 0% | 0% |
| h. Reimbursement | 67% | 0% | 0% | 33% | 0% | 0% | 0% |
| i. PCCM PMPM payment processes | 67% | 0% | 0% | 33% | 0% | 0% | 0% |
| j. Reporting requirements | 67% | 0% | 0% | 33% | 0% | 0% | 0% |
| k. CPC+ Incentive process | 67% | 0% | 0% | 33% | 0% | 0% | 0% |