HMA

# Montana PCCM Redesign

## Key Partner Meetings

November 18, 2024

# MEETING OBJECTIVES

*Share data analysis and key partner feedback on desired features of a redesigned PCCM program*

- **Provider Requirements**
- **Strategies to Support Established Requirements**
- **Care Coordination Supports and Quality Measures**
- **Value Based Purchasing**

# KEY PARTNER FEEDBACK RECEIVED FROM THE FOLLOWING ORGS

Montana Primary Care Association
Montana Hospital Association
Montana Health Care Foundation
Montana Pediatrics
Blue Cross Blue Shield
Montana Department of Public Health and Human Services
Montana Medical Association
Indian Health Services
Tribal Health Chairs
Tribal Health Departments
Urban Indian Organizations
Montana Consortium for Urban Indian Health

# KEY THEMES: PROVIDER REQUIREMENTS & PAYMENT STRATEGIES

**Align with other payors**

- Addresses volume
- Incentivizes providers in a standardized way
- Streamlines quality goals and reduces provider burden

**Support Integrated Behavioral Health**

**Current PMPM model is not enough to engage providers in primary care case management**

- Reimbursement needs to be enough to support the additional time and resources required to meet care management goals

**Regional variation and population density create challenges** for one statewide type of reimbursement arrangement

# KEY THEMES: STRATEGIES TO SUPPORT PERFORMANCE AND CARE COORDINATION REQUIREMENTS

**Data sharing, integration, access to real time data are necessary**

- Availability of data that is broadly trusted and easy to use
- Participation in HIE, shared care plans
- Data needs to be available to adequately inform risk stratification
- Help providers develop a medical picture of patients that is sharable for care coordination purposes and track patient improvements

**80% of practices in Montana are using team-based care** – essential to supporting non-physician team members, ensuring each team member is practicing at the top of their licensure, support screening practices - and the challenges inherent in that are small volume and revenue.

Across payor type, execution of VBP strategies for primary care in Montana has been difficult to prioritize since COVID

# KEY THEMES: STRATEGIES TO SUPPORT PERFORMANCE AND CARE COORDINATION REQUIREMENTS

- **Support for Tribal Health Providers** in care coordination activities and generally meet providers where they are
- **Patient attribution** is a concern that needs to be addressed for providers to be able to serve their assigned panel
- Risk scores in Montana can be artificially low because of **coding issues**
- **Providers welcome TA and support to adopt VBP** which could be provided by state, PCCM Entity, and/or Network
- Potentially **reduce number of tiers** from four to three

# KEY THEMES: CARE COORDINATION SUPPORTS AND QUALITY MEASURES

Telehealth and ECHO cannot be the only provider support available

- Provide primary care practices with **real time access to pediatric or subspecialty support** in cases where patient is considering going to the ER

Consider developing a **specialist directory** – where they are and how to access them (for providers and patients alike to use)

**Leverage HIE** to provide access to **shared plans of care** and other patient summaries to enable more efficient care

Consider requiring **standardized health risk screenings**

Support providers in **patient education and engagement**

# KEY THEMES: VALUE BASED PURCHASING

- Models need to **meet providers where they are** and provide options for level of VBP readiness and potentially regional variation
- **Hold providers accountable** for patients who are really their patients
- Provide **transparency in measures** and allow providers to compare to their peers as well as state benchmarks
- **Look into vendors who can provide care coordination and actuarial support** to the state in administering VBP (e.g., Main Street, Imagine Pediatrics)
- Most key partners are open to various approaches to incentives/bonus arrangements

# DID NOT FIND CONSENSUS ON POPULATION FOCUS

No consensus on:

- If/who should be a target population in any VBP arrangement
- How to hold providers accountable while still ensuring provider participation/access
- How to appropriately risk adjust (reliance solely on retro claims analysis will not produce appropriate incentive)
- Specifics of a preferred VBP model (although no apparent interest in downside risk)

# DATA ANALYSIS

# METHODOLOGY

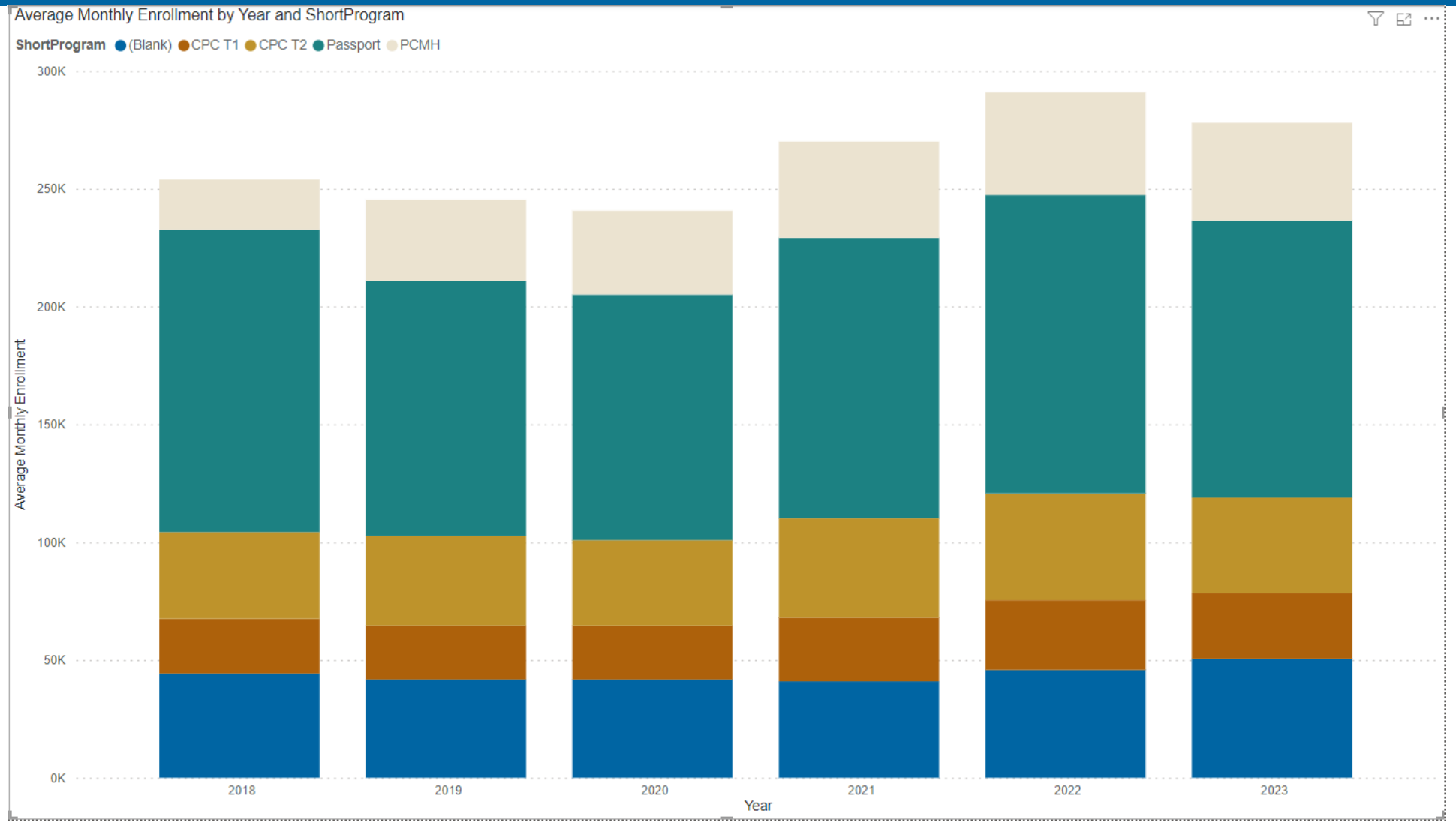
- Received Claims and Eligibility Data from DPHHS from 2018 – 2023; data included inpatient and outpatient. Did not include HCBS, Duals, Pharmacy
- Included (Age, Race, Gender, County, Program) demographic data
- Specifically analyzed Inpatient, ED, and PCP data, as well as overall cost.
- Creates a strong foundation for analysis of efficacy for Beneficiary Access as well as Cost Control

# HOW TO USE THIS ANALYSIS

- Observe Trends With Curiosity
- Acknowledge Limitations with Caution
- Embrace the Complexity

# ENROLLMENT ANALYSIS

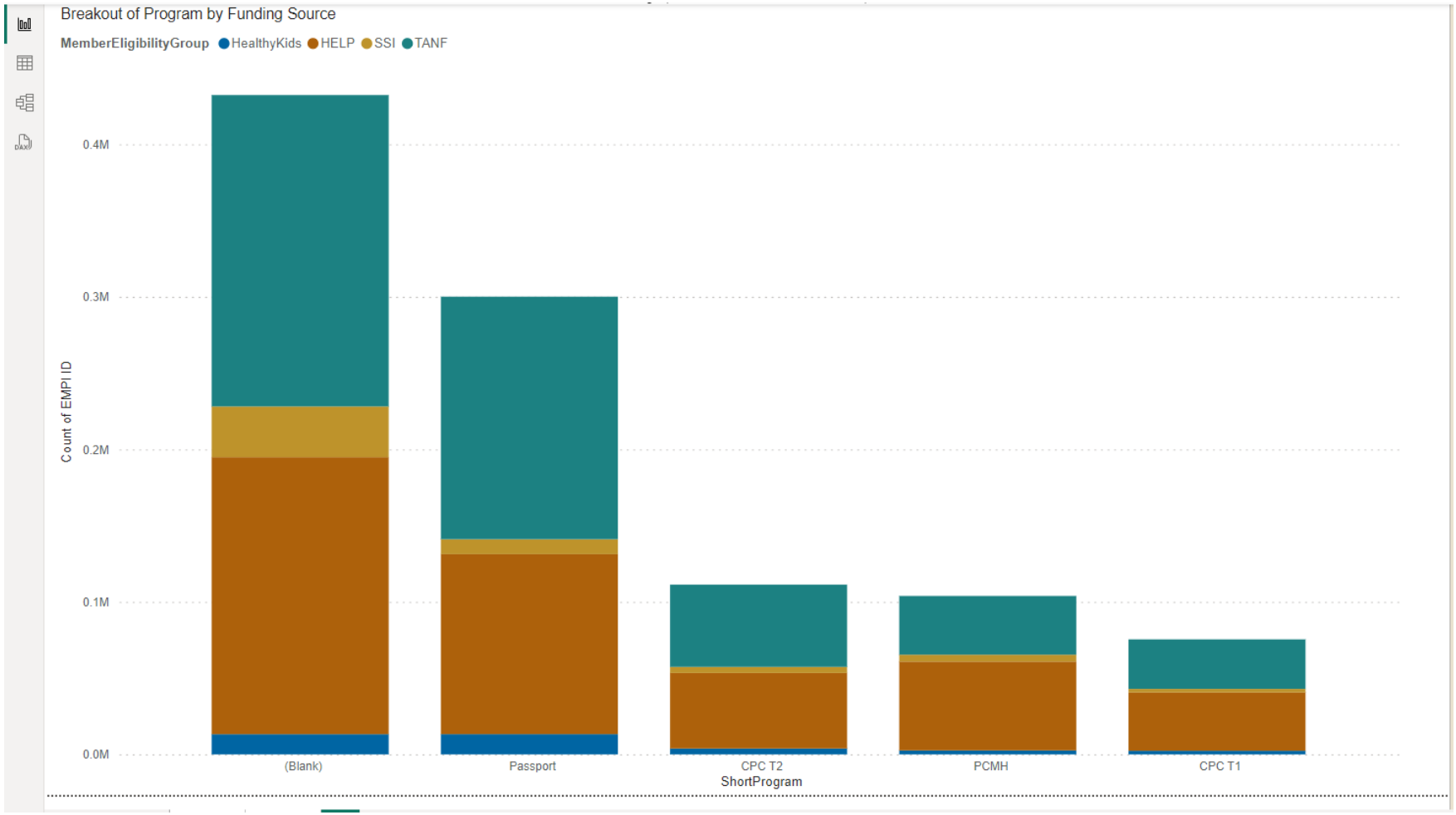
# AVERAGE MONTHLY ENROLLMENT ACROSS MEDICAID




Notes

- The number of members in PCMH has grown relative to the Medicaid Population
- The other populations held steady.
- Blank means not enrolled in any PCCM program

# BREAKOUT OF PROGRAM BY FUNDING SOURCE




Notes

- The PCMH program has a higher proportion of HELP members than other programs. CPC+ T1 and PCMH are the only programs funded over 50% by HELP.
- Blank, Passport, and CPC+ T2 hold similar proportions of members by funding source to each other.
- Blank means not enrolled in any PCCM program

# UTILIZATION ANALYSIS

# PROGRAM BREAKOUT OF MEMBERS WITH A PCP PREVENTIVE VISIT

| Year | CPC T1 | CPC T2 | NO PROGRAM | Passport | PCMH |
|---|---|---|---|---|---|
| 2018 | 23% | 24% | 12% | 23% | 15% |
| 2019 | 23% | 23% | 12% | 25% | 15% |
| 2020 | 23% | 21% | 11% | 24% | 14% |
| 2021 | 26% | 24% | 11% | 26% | 16% |
| 2022 | 25% | 23% | 9% | 25% | 16% |
| 2023 | 23% | 21% | 11% | 23% | 15% |

Notes

- CPC+ Programs and Passport all have similar rates of PCP Preventative visits
- PCMH is closer to the traditional Medicaid population

# PROGRAM BREAKOUT OF MEMBERS WITH A BH ED VISIT

| | A | B | C | D | E | F |
|---|---|---|---|---|---|---|
| 1 | Year | No Program | CPC T1 | CPC T2 | Passport | PCMH |
| 2 | 2018 | 1.6% | 2.6% | 3.1% | 2.4% | 4.4% |
| 3 | 2019 | 1.7% | 2.5% | 3.1% | 2.3% | 4.3% |
| 4 | 2020 | 1.5% | 2.2% | 3.0% | 2.1% | 4.1% |
| 5 | 2021 | 1.3% | 2.5% | 3.2% | 2.4% | 4.3% |
| 6 | 2022 | 1.1% | 2.1% | 2.8% | 2.3% | 4.1% |
| 7 | 2023 | 1.3% | 1.9% | 2.5% | 2.0% | 3.6% |

Notes

- Behavioral Health ED Visits are *not* solely an indicator of how well cared for someone is
- PCMH has the highest rate of BH ED Visits. CPC+ T2 is next followed by CPC+ T1/Passport
- National average numbers are not easily found

# COST ANALYSIS

# TOTAL PMPM COST ANALYSIS

| Program Type | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | Average Rate of Inflation |
|---|---|---|---|---|---|---|---|
| CPC T1 | $271 | $300 | $300 | $314 | $308 | $316 | 3.32% |
| CPC T2 | $280 | $312 | $313 | $325 | $310 | $340 | 4.29% |
| Passport | $298 | $323 | $304 | $325 | $324 | $347 | 3.29% |
| PCMH | $335 | $377 | $401 | $423 | $403 | $431 | 5.73% |

Observations

- The rate of inflation for the PCMH program is outpacing the overall Medicaid Program
- The rate of inflation for the CPC+ T1 and Passport is underpacing the rate of Medicaid's inflation
- The rate of inflation for CPC+ T2 is negligible in relationship to the rate of Medicaid Inflation (~4.33%)

# ARE EXPENSES MOVING INTO PRIMARY CARE?

| | PCP Proportion | | | ED Proportion | | | IP Proportion | | |
|---|---|---|---|---|---|---|---|---|---|
| Program | 2018 | 2023 | Difference | 2018 | 2023 | Difference | 2018 | 2023 | Difference |
| CPC T1 | 15.0% | 17.7% | 2.7% | 14.3% | 11.2% | -3.1% | 7.3% | 6.3% | -1.0% |
| CPC T2 | 12.4% | 13.8% | 1.4% | 15.1% | 15.8% | 0.7% | 8.5% | 7.3% | -1.3% |
| Passport | 15.4% | 18.1% | 2.7% | 14.9% | 13.0% | -2.0% | 9.3% | 9.1% | -0.2% |
| PCMH | 15.4% | 17.9% | 2.4% | 17.4% | 13.8% | -3.6% | 10.6% | 8.4% | -2.2% |
| Statewide | 14.9% | 17.3% | 2.4% | 15.2% | 13.4% | -1.8% | 9.1% | 8.3% | -0.8% |

Observations

- CPC+ T1 and PCMH are the two programs which are meeting or outperforming statewide trends in all three categories
- Passport is outperforming statewide trends in 2 of 3 categories
- Yes, overall expenses are moving into primary care and away from ED and Inpatient in all categories.

# PROGRAM DESIGN OPTIONS

# PROGRAM DESIGN COMPONENTS TO ADDRESS PARTNER INPUT

**Regardless of the model chosen, several components provide opportunities to address stakeholder feedback**

| | | |
|---|---|---|
| Remove PCMH accreditation as a requirement for participation | Emphasize behavioral health integration | Leverage cross-payor alignment where feasible (Medicare and BCBS measures and incentives) |
| Improve performance transparency through provider dashboarding and benchmarking | Explore opportunities for risk adjustment to account for population density and geography | Provide several options for provider participation to account for provider variance and readiness |
| Focus on improved and timely data sharing | Remove $3 PMPM Passport model which provides insufficient incentives for practice transformation | Shift away from delayed incentive payments and reduce the number of incentivized measures/outcomes |

# PROGRAM DESIGN OPTIONS TO ADDRESS KEY PRIORITIES

## Merge Features of CPC+ and PCMH

- Expand provider eligibility for bonus payments tied to quality outcomes
- Develop aligned tiered PMPM methodology with maximum of three tiers
- Potential future option for providers to participate in shared savings once operational improvements have been implemented

## Develop PCCM Entity Model with Provider-Led Entities

- Leverage ability of entities to assist with care coordination efforts
- Provides opportunity for Medicaid to support networks operating under other payor structures
- Provides opportunity for Medicaid to support already existing networks under other payor models (e.g., Medicare Shared Savings ACOs)

# NEXT STEPS

Individual Stakeholder Sessions

October-November

Reconvene Stakeholder Group

*December 16th*

Preliminary Model Components

*December 2024 (prior to legislative session)*

Additional Stakeholder Sessions to further discuss specific program details (e.g., attribution, data, provider requirements)

Member Stakeholder Session(s)

*Early 2025*