Montana PCCM Redesign

Key Partner Meeting

May 5, 2025 – 9 a.m.

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

Project Recap To Date

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Key Partner Feedback Sessions To Date

Key Partners	Meeting Date
Large Key Partner Kick Off	10/2/24
Montana Primary Care Association	10/24/24
Montana Hospital Association	10/30/24
Blue Cross Blue Shield Montana	10/30/24
Tribal Health Directors/Tribal Consultation	11/6/24
Montana Pediatrics	11/7/24
Montana Medical Association	11/18/24
Large Key Partner Meeting	11/18/24
Montana Primary Care Collaborative	11/21/24
Large Key Partner Meeting	12/18/24
Montana Healthcare Foundation	12/29/24
Rural Health Clinics	2/13/25
Montana Chapter of American Academy of Pediatrics	3/12/25

Key Partner Feedback Sessions To Date

- Current PMPM model is not enough to engage providers in primary care case management
- Regional variation and population density create challenges
- Data sharing, integration, access to real time data are necessary to support care coordination and improve health outcomes
- A less complex model with reduced Tiers
- Look to provide support to many providers; including Tribal Providers, RHCs, and small independent practices
- Improve patient attribution approach to reflect more accurate provider accountability and member engagement
- Provide flexibility and transparency in performance measures

Initial Data Analysis Findings: Current Programs

Population Characteristics	PCP Utilization*	Emergency Department/Inpatient Utilization Analysis	Overall Costs
• PCMH has older, more male population than the other programs • The Passport Program is the only program with <50% people 18-64 • CPC+ Tier 1 and Tier 2 programs have very similar populations demographically	• Overall, cost shifting out of ED and IP and into PCP for all four care management programs • CPC+ Programs and Passport all consistently (approx. 24%) of members with a PCP Preventive Visit. PCMH is closer to 15%	• PCMH has the highest rates of utilization and ED/IP costs. They also have the sickest population • Passport, PCMH, CPC+ Tier 1 and Tier 2 programs all have contributed to lowering ED/IP rates since 2018 with similar success	• The Passport and CPC + T1 and T2 programs have cost growth at or below overall Medicaid growth. • The PCMH program is growing faster than the rate of inflation for the overall Medicaid program, but that may be due to a comparatively higher pop. with BH diagnosis. PCMH also has lower cost share of ED and IP.

*Post-PHE data may not fully reflect long-term trends due to COVID-related anomalies.

Tiered Model Option

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Design Reflects Both State Priorities & Key Partner Feedback

Intended to **meet providers where they are** with incentives and supports that allow providers to move toward more advanced management of their member populations

Keeps **barriers to entry low for small/less resourced providers** but adds accountability measures to ensure value achieved

Allows **flexibility to define targeted performance measures** working with Key Partners but intended to align with established accreditation frameworks and CMS core measure sets

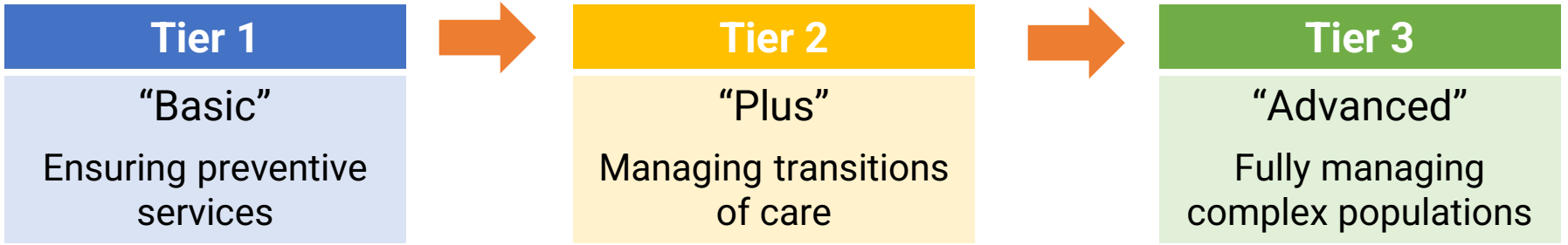
Dependent on data interoperability and care management platforms that share information, but acknowledges likely state role to support providers with timely data to support performance improvement

Note:

- **The model framework presented today is intended as a starting point for additional development and refinement**
- **DPHHS has not selected a model**
- **We want your feedback to ensure we are heading in the right direction!**

Proposed Three Tier Model

- Accommodates different provider sizes/resources by providing a glidepath toward higher levels of population health management, with increasing expectations for structure and performance as you move along the glidepath.
- From basic management of ensuring strong preventive services for your member population, to managing transitions of care, to fully managing complex populations.
- Cost of enhanced PMPM payments in higher tiers will be offset by reductions in potentially avoidable ED and IP hospital utilization



Tier 1 – "Basic"

Proposed High-level Framework Description for Discussion

Proposed Performance/Quality Goals	Proposed State/Provider Expectations	Decision Points	Other Design Comments
Improving preventative care and/or chronic conditions such as: • Closing preventative care gaps (e.g., well child visits) • Improvement in condition-related measures • State pre-defines list of targeted performance measures, each provider chooses from list	• Beginning Year 1, State pays PMPM fee if provider meets reporting requirements • Beginning Year 2, provider performance evaluated annually on selected measures • PMPM fees can be paused in future years if no demonstration of improvement or attainment of performance targets • Could have PMPM fees resumed by demonstrating improvement • State provides monthly care gap reports to participating providers	• **Targeted performance measures** • **Improvement and attainment targets** • **Number of performance measures provider needs to select** • **Other tier-specific participation requirements** • **PMPM amounts**	• Providers receive PMPM payments for a period of time, without demonstrating improvement or attainment, to allow providers time to meet performance expectations

Tier 2 – “Plus”

Proposed High-level Framework Description for Discussion

Proposed Performance/Quality Goals	Proposed State/Provider Expectations	Decision Points	Other Design Comments
Meet Tier 1 goals, plus: • Manage transitions of care post hospitalizations and ED visits • Eligibility dependent on having minimum # of attributed Medicaid members	• Enhanced PMPM • Annual measurement • Continuing eligibility for enhanced PMPM could be made contingent on meeting target on HEDIS follow-up after ED visits for individuals with multiple high-risk conditions • Continue Tier 1 PMPM eligibility as above	• **Minimum number of attributed members** • **Targeted performance on ED follow-up measure** • **Other tier-specific participation requirements** • **PMPM amounts**	• State must operationalize HEDIS metric • Tier 1 and Tier 2 are stackable -- e.g., it is possible for provider to earn Tier 2 PMPM but not the Tier 1 PMPM

Tier 3 – "Advanced"

Proposed High-level Framework Description for Discussion

Proposed Performance/Quality Goals	Proposed State/Provider Expectations	Decision Points	Other Design Comments
Meet Tier 1 and Tier 2 goals, plus: • Care manage high cost, high need populations to increase engagement in primary care and reduce potentially avoidable ED visits and hospitalizations • Reduce low-value care	• Builds on continued Tier 1 and Tier 2 PMPM funding and expectations • State offers a CM PMPM fee plus a shared savings payment based on reducing risk adjusted (for example, using CDPS Rx) total cost of care and meeting a quality gate using Tier 1 and Tier 2 metrics and performance targets • Continuing eligibility for CM PMPM fee could be made contingent on meeting performance of required CM tasks	• **CM tasks (risk assessment, care plans, TOC) and performance targets** • **CM PMPM amounts for high-risk care management** • **Shared savings program parameters including benchmark cost target and minimum attribution** • **Other tier-specific participation requirements**	• State will risk stratify members to determine which qualify for high-risk care management, establish expectations for CM tasks & pay a CM PMPM for those individuals

Detailed Tier-Specific Participation Requirements TBD

Proposed new Approach to Provider Participation Requirements for the Value-Based Program:

- Acknowledges that many providers meet some but not all NCQA PCMH requirements, and that full certification can be a barrier
- Would define participation based on attainable PCMH qualities
- Requirements grouped into six medical home domains per tier, directly aligned with NCQA's PCMH concept areas[1]

Team-Base Care:
Structure of practice's leadership, care team responsibilities and how the practice partners with members, families, and caregivers

Knowing and Managing Your Patients:
Requirements for data collection, medication reconciliation, evidence-based clinical decision support and other activities

Access and Continuity:
How practices provide members with convenient access to clinical advice and help ensure continuity of care

Care Management and Support:
Care management protocols to identify members who need more closely-managed care

Care Coordination and Care Transitions:
Primary and specialty care clinicians effectively share information and manage member referrals

Performance Measurement and Quality Improvement:
Practices develop ways to measure performance, set goals, and develop performance improvement activities

[1] NCQA PCMH Recognition Concepts web page. NOTE: NCQA PCMH Recognition Concepts are general and align with the standards within other PCMH models including, for example, AAAHC, Joint Commission, and URAC.

Illustrative Example: Possible Team Based Care Participation Requirements

Glidepath to more advanced performance level

Tier 1 Requirements	Tier 2 Requirements	Tier 3 Requirements
1. Designated medical home clinician lead and a staff person who manages the medical home	1. Meets all Tier 1 standards 2. Defined organizational structure and staff responsibilities/skills to support PCMH 3. Patients/families involved in practice governance or on stakeholder committees 4. Has regular patient care team meetings or a structured communication process focused on individual patient care 5. Care team staff involved in performance evaluation and quality improvement activities	1. Meets all Tier 1 and Tier 2 standards 2. Has at least one care manager qualified to identify and coordinate behavioral health needs

Additional Discussion Questions

- **Status Quo.** Which tier do you believe your provider organization would currently fall within?
- **Feasibility.** Do you believe the provider organization(s) that you represent would be able to, over the next five years:
  - Progress beyond Tier 1?
  - Progress beyond Tier 2?
- **Provider Supports.** Besides PMPM and incentive payments, what other supports will providers need to be successful within their current tier, and progress through the tiers?
- **Clinically Integrated Network (CIN) Supports.** How might the state support the continued development or enhancement of Montana CINs?

Future Project Timeline/Meeting Dates

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Future Key Partner Meeting Dates

Monthly Key Partner Meetings Tentative Schedule:

- June 5 – 11 a.m. to 12 p.m.
- July 1 – 11 a.m. to 12 p.m.
- Aug. 1 – 10 a.m. to 11 a.m.
- Sept. 8 – 11 a.m. to 12 p.m.
- Oct. 1 – 11 a.m. to 12 p.m.