Montana PCCM Redesign

Key Partner Meeting

July 1, 2025 – 11:00am

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

Project Recap to Date

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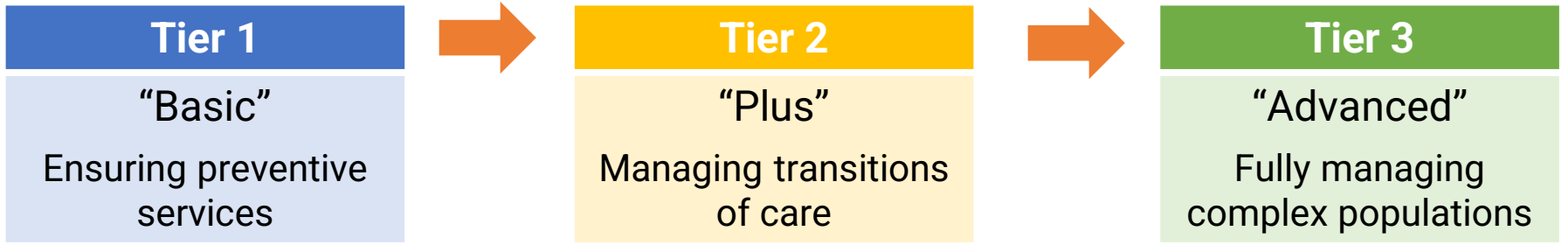
Proposed Three Tier Model

- 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



Refresh on June 5 Key Partner Meeting

Topics and information covered:

- Review proposed Tier 1 framework
- Discuss feedback on potential performance measures for Tier 1
- Discuss feedback on feasibility of provider participation in tracking performance measures
- Discussion of next steps

Tier 2 Design Proposal

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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 targets. • Continue Tier 1 PMPM eligibility as above	• Minimum number of attributed members • Targeted performance on 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 2 Design Principles

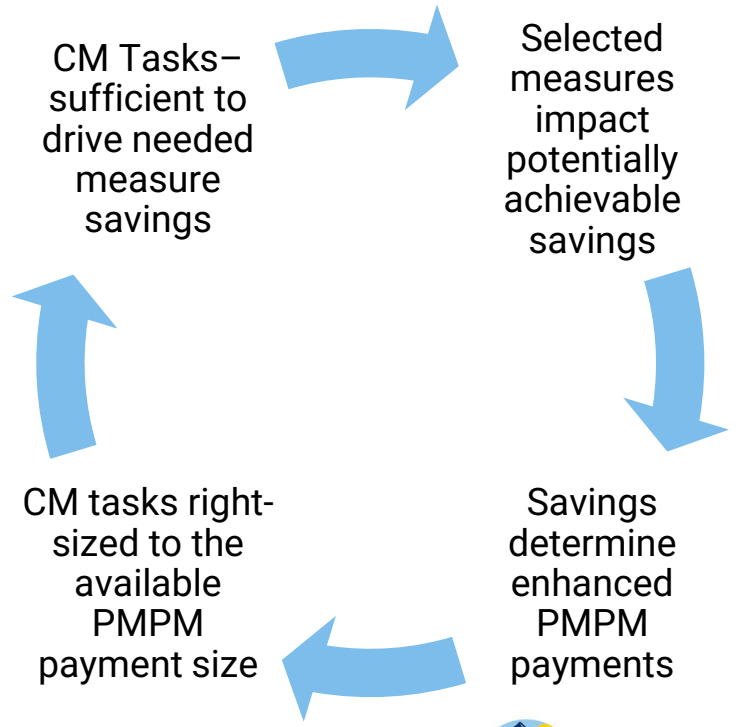
Goal of care management (CM) activities: **reduce ED and IP hospital utilization**

Reductions in potentially preventable ED/IP hospital utilization **(savings) offsets PMPM CM payments**

Cost modeling using Montana-specific data to design measures, payment, and CM activities

Iterative design cycle used – adjustments in one component requires commensurate adjustments in other components

Goal: **Find sweet spot** where CM activities sufficient to generate needed improvement that generates sufficient savings to fund PMPM payments



Initial Selected Measure to Impact Potentially Achievable Savings

CY 2024 Non-Maternity Hospitalizations by Condition	
Why start with hospitalizations?	Highest unit cost and can be impacted by a better transitions of care process
Why focus on non-maternity IP readmissions?	BH and med-surg readmissions are much higher than readmissions following deliveries
Why assess readmission rates by presence of prevalent ambulatory-sensitive conditions?	To help providers identify which conditions may be amenable to improvement in clinical care as well as improvement in care coordination post-hospitalization
Other proposed design considerations	• Separate adult and child rates • Consider different models for different provider types
Why use CY 2024 data?	• To accommodate claims lag • Includes an Incurred but Not Reported (IBNR) factor

Discussion Points:

Is this the right measure to start with?

Should other criteria be included?

Projecting Savings to Fund Enhanced PMPM

	Analysis Question:	Montana Data To Be Used:

Step 1: Analyze MT-specific data	Are readmission rates reduced by timelier ambulatory visit follow-up (f/u) and how does PCP f/u compare to specialist f/u? How does this look across prevalent ambulatory-sensitive conditions?	• Hospitalizations (initial and re-hospitalizations w/in 30 days)
		• 30-day readmission rates overall and:
		  ○ With PCP f/u w/in 7 days, 7-14 days, 15-30 days, or >30/none
		  ○ With specialist f/u w/in 7 days, 7-14 days, 15-30 days, or >30/none

Step 2: Estimate savings if improvement achieved	Use the analysis above and MT's average cost of hospitalization to estimate the potential reduction in 30-day rehospitalization rates and associated costs if improvement in timely ambulatory visit f/u post-hospitalization achieved (recognizing that not a randomized study and there may be some selection bias with this approach)	

Discussion Point:

Is this a reasonable approach to estimating potential reductions in rehospitalization costs?

Determine and Price a Standardized Transition of Care (TOC) Process

Examples of Potential Evidence-Based Practices Include:

Contacting the patient during hospitalization to educate on the TOC process and verify preferred method of communication and contact information

Follow-up contact within 2 business days of hospital discharge to verify compliance with discharge instructions, verify and if necessary, arrange a timely follow-appointment with a PCP or specialist as clinically appropriate, and address any barriers to compliance with the treatment plan

Medication reconciliation (either during the post-discharge contact above or at the follow-up visit) and to remind the member to bring medicine bottles to that appointment

Verifying the follow-up ambulatory visit was completed and if not, contact the patient to reschedule the visit

Use Financial Modeling Tool to:

- Project the average cost to perform the agreed upon TOC process
- Compare provider cost to implement the TOC process to projected savings from reduced 30-day readmissions to set a fee
- Decide if a pay-for-performance program can be added with task completion metric(s), assuming a statistically sufficient number of events

Follow up on Tier 1 Design Feedback

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Performance Summary

Claims-Based Measures Recommended for Inclusion

Measure Name	CPC+/PCMH Benchmark	NCQA/ CMS Core Set Median (2023)
Cervical Cancer Screening (CCS-AD)	45%	NA
Colorectal Cancer Screening (COL-AD)	56%	38.6%
Breast Cancer Screening (BCS-AD)	55%	53.3%
Well-Child Visits in the First 30 Months of Life (W30-CH)	NA	59.2%
Child and Adolescent Well-Care Visits (WCV-CH)	NA	45.3%

Additional Measures for Feasibility Discussion

Measure Name	CPC+/PCMH Benchmark	NCQA/ CMS Core Set Median (2023)
Controlling High Blood Pressure (CBP-AD)	71%	63.9%
Glycemic Status Assessment for Patients with Diabetes (GSD-AD) **inverse*	9%	35.8%
Lead Screening in Children (LSC-CH)	NA	57%
Screening for Depression and Follow-Up Plan: - Ages 12 to 17 (CDF-CH) - Age 18 and Older (CDF-AD)	84%	NA
Timeliness of Prenatal Care: - Under Age 21 (PPC2-CH) - Age 21 and Older (PPC2-AD)	NA	83.1%
Postpartum Care: - Under Age 21 (PPC2-CH) - Age 21 and Older (PPC2-AD)	NA	78.6%

Summary of Tier 1 Discussion - Key Partner Survey

Written Survey Results and Concerns Related to Quality Measures:

- "Means of reporting on measures – if it requires manual reporting or using supplemental HCPCs codes (CPT II/G-codes), that is a problem for RHCs. We could do it through an interface using QRDA files or something similar."
    - Other respondents said they already collect these measures by directly feeding from EPIC to the ACO and can do the same for Medicaid
- "Suggest TA for practices to determine how to participate in VBP and understand what the 'lift' is."
- "Many women have our PCPs do care coordination with an OB doc out of town. In these cases, we would not want to be measured on something outside of our control."

Summary of Tier 1 Key Partner Survey Cont.

- Reasonable attainment and improvement targets?
  - Core Set medians - 6 respondents
  - NCQA benchmarks - 3 respondents
  - CPC+/PCMH benchmarks - 4 respondents

- How many performance measures are reasonable?
  - 1-2 measures – 6 respondents
  - 3-4 measures – 4 respondents

- Providers chose from a menu or all report same measures?
  - Pick from a menu – 7 respondents
  - Same measures – 3 respondents

Future Project Timeline/Meeting Dates

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Future Key Partner Meeting Dates

Monthly Key Partner Meetings Tentative Schedule:

**Note 90-minute meetings*

- August 1st 10:00 – 11:30 pm
- September 8th 11:00 – 12:30 pm
- October 1st 11:00 – 12:30 pm