MT PCCM Redesign

Data Analysis Review

September 8, 2025 11:00 am

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Care Management Model Overview

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Tier 2 and Tier 3 Design Principles

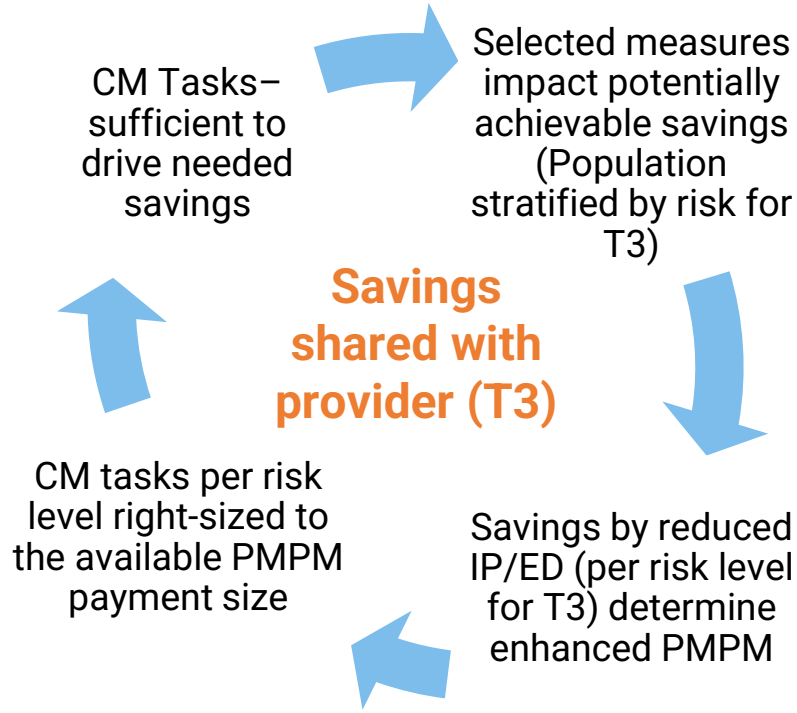
Goal of care management (CM) activities: **reduce ED and IP hospital utilization**

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



Potential Tier 2 and 3 Tasks

Tier 2 Transitions of Care Tasks
Contact patient in hospital to educate on TOC process/obtain contact info
Contact w/in 2 business days of discharge to: verify discharge instruction compliance, confirm/arrange PCP or specialist appointment as needed, and address barriers to treatment plan compliance
Medication reconciliation
Verify follow-up ambulatory visit completed; if not, contact patient to reschedule

Tier 3 Care Coordination (CC) Tasks	Low Risk	Med/ High Risk
Onboarding new members within 30 days of enrollment	x	x
Outreach to members who have not been seen in the health center in the previous 12 months	x	x
Initial or annual health risk screen (includes PHQ)	x	x
Community-based organization referrals	x	x
Closing gaps in care and wellness messaging	x	x
Post-ED visit contact	x	x

Tier 3 Care Management (CM) Tasks	Low Risk	Med/ High Risk
Comprehensive risk assessment and initial/major revision of care plan		x
Telephonic care plan review		x
Face-to-face care plan update in office		x
Post-hospitalization transition of care (low risk)	x	
Post-hospitalization transition of care (medium and high risk)		x
Disease management/health coaching		x

Related Decision Points:

- **Required tasks**
- **CC tasks versus CM tasks**
- **Required Health risk assessment tool (single tool or at discretion of the provider)**
- **Care plan component requirements**
- **Frequency of care plan updates**
- **Task completion reporting requirements**

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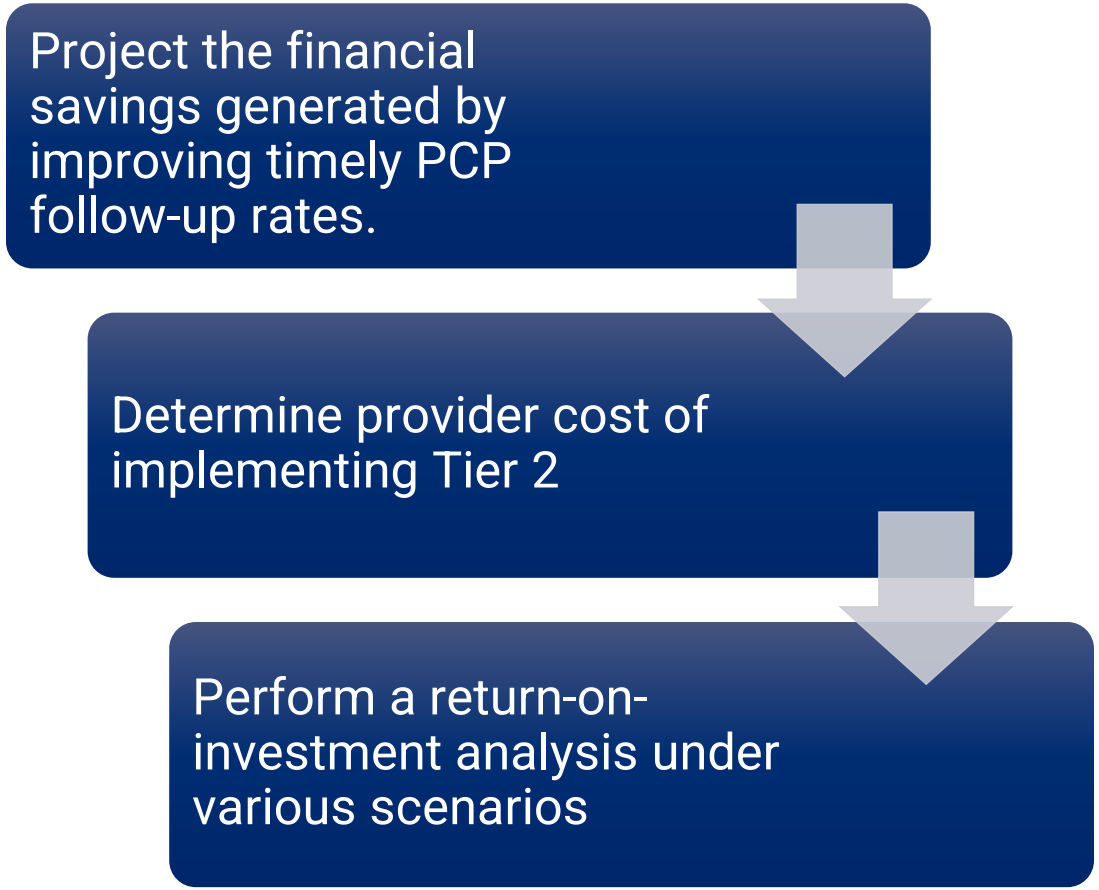
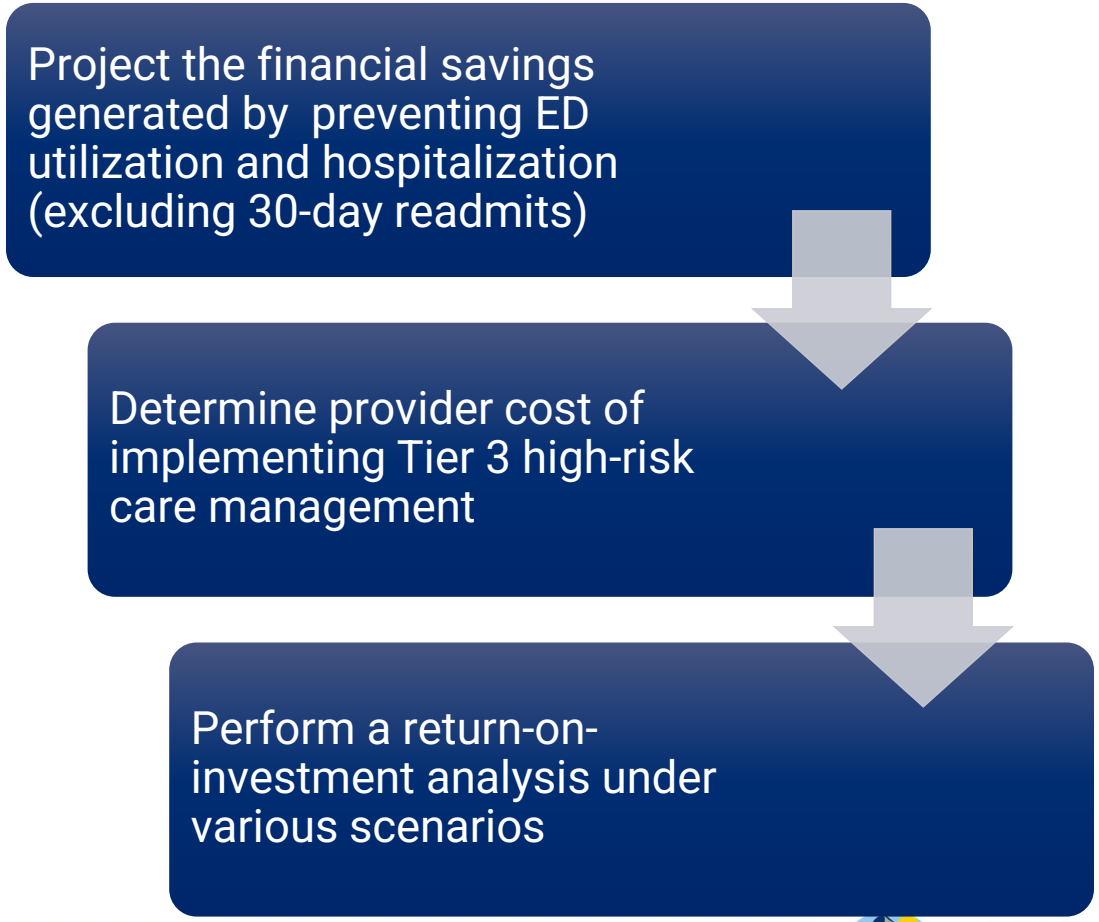
Tier 2: Improving the Transitions of Care Process Post-Hospitalization

- Calculate the current impact of a timely primary care provider follow-up visit on hospital readmissions
- Develop a tool to estimate the potential savings from improving the timely PCP follow-up rate
- Develop a Tier 2 PMPM rate that reflects service cost but also returns a positive return-on-investment
- Develop a framework to evaluate the effectiveness of the proposed Tier 2 program



Tier 3: High-Risk Care Management

- Identify which ambulatory-sensitive conditions are both common and have the greatest impact on ED and inpatient utilization
- Of those conditions, identify those that are most amenable to improved adherence by provider and patient to evidence-based care
- Develop a Tier 3 PMPM care management fee that reflects service cost but also returns a positive return-on-investment
- Develop a framework to evaluate the effectiveness of the proposed Tier 3 program



Data Analysis

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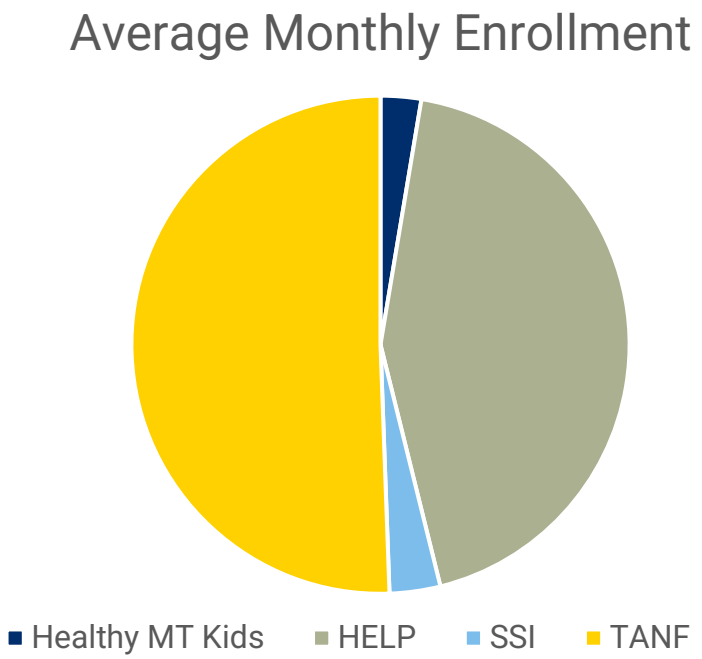
Data Review Outline For Tier 2 and Tier 3

- **Review Key PCCM Enrollment Characteristics for 2023**
- **Review Inpatient and Emergency Department Utilization**
- **Forecasting Case Management (CM) Needs**
- **Questions**

PCCM Enrollment Characteristics

Enrollment by Eligibility Group

Member Eligibility Group	Average Monthly Enrollment	Unique Yearly Count
Healthy MT Kids	6,027	10,376
HELP	99,500	131,207
SSI	7,535	9,103
TANF	115,701	153,346
Total	228,763	304,032



PCCM Enrollment Characteristics Review: What Did We Learn?

TANF + HELP = 90%+ of total PCCM population

228,783 = 2023 average monthly PCCM enrollment

These numbers used to forecast need for the CM Model

Forecasting Case Management Need

Population Percentages by CM Level

	Population Percentage	Low	Mid	High
TANF/CHIP	53.2%	99.0%	0.0%	1.0%
HELP	43.5%	95.0%	3.0%	2.0%
SSI	3.3%	80.0%	15.0%	5.0%

Applied CM Level Percentages By Average Monthly Enrollment

	Population Percentage	Low	Mid	High
TANF/CHIP	53.2%	120,484	0	1,217
HELP	43.5%	94,536	2,985	1,990
SSI	3.3%	6,039	1,132	377

In this slide we establish the base of how many members will need which “levels of care” by using Medicaid eligibility categories to drive determination.

PCCM ED and Inpatient Review

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Emergency Department (ED) and Inpatient (IP) Utilization for 2023

	Average Member Months	ED Visits	ED Visits Per 1000 MM	IP Visits	IP Visits Per 1000 MM	30-Day Readmit Rate
TANF/CHIP	121,728	107,102	73.3	4,689	3.2	35.4%
HELP	99,500	132,866	111.3	8,233	6.9	27.6%
SSI	7,535	19,500	215.7	1,616	17.9	32.7%
Total	228,763	259,468	94.5	14,538	5.3	30.7%

Inpatient Odds Ratios – Chronic Conditions

Chronic Condition	# of Members	% of Members with Condition	% of Pts with Condition with Admission	% of Admissions for All Population	Avg # of Admits for Pts with Condition	Odds Ratio
Alzheimer's	72	0.0%	4	6%	0.08%	3.50
Atrial Fibrillation	2,398	1.0%	399	17%	5.18%	2.21
CHF	1,981	0.9%	454	23%	6.40%	2.40
CKD	2,137	0.9%	305	14%	4.17%	2.32
COPD	6,284	2.7%	782	12%	8.33%	1.81
Depression	37,764	16.5%	2,926	8%	41.82%	2.43
Diabetes	17,284	7.6%	1,676	10%	18.28%	1.86
Pediatric Asthma	22,869	10.0%	1,163	5%	12.33%	1.80
Stroke	1,823	0.8%	350	19%	4.06%	1.97

ED Visits Odds Ratios – Chronic Conditions

Chronic Condition	# of Members	% of Members with Condition	% of Pts with Condition with ED Visit	% of ED Visits for All Population	Avg # of ED Visits for Pts with Condition	Odds Ratio
Alzheimer's	72	0.0%	20.7%	0.0%	8.06	1.3
Atrial Fibrillation	2,391	0.7%	11.1%	2.0%	8.14	1.6
CHF	1,978	0.6%	19.5%	1.8%	7.92	1.7
CKD	2,137	0.6%	26.9%	1.3%	6.72	1.4
COPD	6,281	1.9%	29.4%	4.9%	7.22	1.6
Depression	37,685	11.2%	23.1%	24.8%	5.92	1.7
Diabetes	17,268	5.2%	18.2%	9.8%	6.09	1.4
Pediatric Asthma	22,867	6.8%	26.3%	13.7%	5.40	1.7
Stroke	1,802	0.5%	26.3%	1.7%	8.08	1.7

Financial Analysis

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Financial Impact of Timely PCP Follow-up Post Hospitalization

	Overall 30-day Readmit Rate	7-day Post-D/C PCP F/U	8 to 30-day Post-D/C PCP F/U	No Post-D/C PCP F/U in 30 days	Cost of Readmits	Savings
PCP follow-up visit post hospital discharge (baseline)	--	15.9%	23.2%	60.9%	--	--
30-day rehospitalization rate (baseline)	30.7%	12.5%	16.7%	40.8%	**$27,177,007**	--
Projected Impact by Follow-up (f/u) Assumption:						
Improving 7-day f/u without impacting 30-day follow-up rate	30.1%	30.0%	9.1%	60.9%	**$26,644,291**	**$532,716**
Improving 30-day f/u 50%	27.9%	20.2%	29.8%	50.0%	**$24,700,349**	**$2,476,658**
Improving 7 and 30-day f/u	27.5%	30.0%	20.0%	50.0%	**$24,330,190**	**$2,846,817**
Improving 7 and 30-day f/u	21.1%	37.5%	37.5%	25.0%	**$18,723,740**	**$8,453,267**
Improving 7 and 30-day f/u even further to achieve a 14% readmit rate.	14.6%	50.0%	50.0%	0.0%	**$12,928,434**	**$14,248,573**

Note: This analysis projects a potential overall follow-up rate for modeling purposes but does not account for confounding factors that may influence follow-up rates, including baseline risk.

Hospital Financial Analysis – PCCM Only

Financial Impact of Timely PCP Visits Post-Hospital Discharge

2023 Hospitalizations	Total number of non-maternity hospitalizations in 2023	14,538
	Average cost per admission	$8,730
	Overall 30-day readmission rate	30.7%
30-day readmission rate:	With ambulatory PCP visit within 7 days of discharge	12.5%
	Without ambulatory PCP visit within 7 days of discharge	34.1%
	With ambulatory PCP visit within 30 days of discharge	16.7%
	Without ambulatory PCP visit within 30 days of discharge	40.8%
Potential Annual Savings:	From a 7-day PCP follow-up visit	$35,918,456
	From a 30-day PCP follow-up visit	$30,506,819

Hospital Financial Analysis – Scenario Modeling

Scenario	Overall 30-day Readmission Rate	Savings
Baseline:		
PCP follow-up visit post hospital discharge	15.0%	--
30-day rehospitalization rate	30.7%	--
Projected Impact by Follow-up (f/u) Assumption:		
Improving 7-day f/u without impacting 30-day f/u rate	30.1%	$532,716
Improving 30-day f/u 50%	27.9%	$2,476,658
Improving 7 and 30-day f/u	27.5%	$2,846,817
Improving 7 and 30-day f/u further	21.1%	$8,453,267l
Improving 7 and 30-day f/u further to get to achieve 14% readmit rate	14.6%	$14,248,573

Forecasting Case Management Needs

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Case Management Tasks and Costs – Scenario Modeling

Potential Tasks	Time (hrs)	Frequency per year			CC time/yr (hrs)			CM time/yr (hrs)		
		Low	Mid	High	Low	Mid	High	Low	Mid	High
Onboarding new members within 30 days of enrollment	0.5	0.25	0.25	0.25	0.125	0.125	0.125	0	0	0
Outreach to members not seen in previous 12 months	0.25	0.2	0.2	0.2	0.05	0.05	0.05	0	0	0
Initial or annual health risk screen (includes PHQ, assumes multiple attempts sometimes required)	0.5	1	1	1	0.5	0.5	0.5	0	0	0
Community -based organization referrals	0.25	0.5	1	2	0.125	0.25	0.5	0	0	0
Closing gaps in care and wellness messaging	0.5	1	2	2	0.5	1	1	0	0	0
Post-ED visit contact	0.25	0.5	2	4	0.125	0.5	1	0	0	0
Comprehensive risk assessment and initial/major revision of care plan	1.5	0	1	2	0	0	0	0	1.5	3
Telephonic care plan review	0.5	0	2	8	0	0	0	0	1	4
Face-to-face care plan update in office	0.5	0	1	2	0	0	0	0	0.5	1
Disease management/health coaching	0.5	0	3	6	0	0	0	0	1.5	3
Hours PMPY					**1.43**	**2.43**	**3.18**	**0**	**4.5**	**11**

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Note: Values in red font are estimates that can be modified

Case Management Tasks and Costs – Scenario Modeling

Population Percentages by CM Level	Pop. Percentage	Low CM	Mid CM	High CM
Percentage of TANF/CHIP members	53.2%	99.0%	0.0%	1.0%
Percentage Medicaid Expansion members	43.5%	95.0%	3.0%	2.0%
Percentage of ABD members	3.3%	80.0%	15.0%	5.0%
MCO Blend	100.0%	96.63%	1.80%	1.57%

Hours/100 plan members	Total	Low Risk	Mod Risk	High Risk
Care coordinator	147.0	137.7	4.4	5.0
Care manager	25.3	0.0	8.1	17.2
Non-Contact Time (Downtime/Inefficiencies/other tasks)	15%			
Total Working hours per year	1840			

CM Staff Expense	Total Plan Membership per FTE	Salary and benefits/yr	PMPM
Care coordinator	1064	$50,000	$3.92
Care manager	6175	$85,000	$1.15
Team Total PMPM			$5.06
Incremental overhead expense as % of staffing expense		20%	
Incremental overhead expense PMPM			$1.01
Total CM staff expense PMPM			**$6.08**

Case Management Tasks and Costs – Scenario Modeling

Shared Caseload Composition

	Total	Low Risk	Mod Risk	High Risk
Care Coordinator Caseload	1064	1028	19	17
Care Coordinator hours spent	1564	1465	46	53
Care Manager Caseload	6175	5967	111	97
Care Manager hours spent	1564	0	500	1064

Caseload/Staffing Assuming Panel Size of 6,000

Percent of moderate and high-risk members who agree to care management	Participation Scenarios			
	100%	75%	50%	25%
# licensed care managers	0.97	0.97	0.97	0.97
# high risk members	94	71	47	24
high risk case load per FTE CM	97	73	48	24
# moderate risk members	107.9	81	54	27
moderate risk case load per FTE CM	111	83	56	28
# in care management	201.9	151	101	50
Case load per FTE CM	208	156	104	52

Premium by Population

Population	Amount
TANF/CHIP PMPM*	$300
Medicaid Expansion*	$600
ABD PMPM*	$1,000
Blended Premium PMPM*	$454
CM expense as % of premium	**1.3%**

** Estimated*

Staff Cost Assuming Panel Size of 6,000

Staffing	FTE	Salary and Benefits
Care Coordinators	5.64	$282,047
Care Managers	0.97	$82,594
Total	**6.61**	**$364,641**

Future Project Timeline/Meeting Dates

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Future Key Partner Meeting Dates

Key Partner Meetings Schedule:

Date: October 7th 1:00 – 3:00 pm, in-person,

Location: DoubleTree by Hilton, Billings, MT

We welcome your input anytime!

Please send any additional feedback to mtprimarycareprograms@mt.gov