

COMPLEX CARE MANAGEMENT (CCM) PROGRAM

What is Complex Care Management?

The Complex Care Management (CCM) program (Tier Four of PCMH) focuses on a small group of high-need Medicaid members who account for a significant portion of healthcare costs. Specifically, five percent of patients contribute to more than 50 percent of healthcare spending. The goal of CCM is to reduce unnecessary emergency room visits and inpatient hospital stays by providing targeted, proactive care to members who might otherwise rely on more costly healthcare services.

How does the CCM program work?

CCM is designed to work in collaboration with providers participating in the Patient-Centered Medical Home (PCMH) program. The CCM team helps Medicaid members who frequently use emergency or hospital services by addressing both their medical and social needs, often through in-home visits. The program's approach is modeled after a successful initiative led by Partnership Health in Missoula, which has reduced unnecessary emergency room visits and hospital admissions.

How are providers reimbursed?

Providers in the CCM program receive \$470.10 per member per month for each enrolled member.

What is the composition of the CCM care team?

Each CCM care team consists of at least two professionals:

- A **nurse**, who addresses the medical needs of the patient.
- A **Licensed Behavioral Health Professional** or a paraprofessional with a minimum of 40 hours of behavioral health training, who helps address the member's mental and social health needs.

How are members enrolled and managed?

The CCM care team meets with members face-to-face, typically in their homes or another non-clinical location of the member's choice, to assess their healthcare needs. After the initial visit, members are formally enrolled in the program. In the first three months, home visits are conducted at least weekly. For the next three months, visits occur biweekly. Members can stay enrolled for up to six months, with a maximum of 30 members under the care of a single CCM team at any given time. Extensions beyond six months require approval from the Department.

Who qualifies for the CCM program?

Members must meet specific criteria to qualify for enrollment, including:

- Being attributed to a provider's PCMH clinic.
- Having two or more chronic medical conditions.
- Having had at least two emergency room visits in the last 60 days, or two or more inpatient stays for the same condition in the last six months.
- Being open to intensive case management.
- Not being transiently homeless, as the program is focused on members with stable housing.

Program data

In State Fiscal Year 2024 and through September 2024, the program served 22 participants at a cost of \$26,325.60.