

Montana PCCM Redesign

Key Partner Meeting

June 5, 2025 – 11:00am



DEPARTMENT OF
**PUBLIC HEALTH &
HUMAN SERVICES**

Project Recap to Date

Health Management Associates



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HUMAN SERVICES**

Refresh on May 5 Key Partner Meeting

Topics and
information
covered:

Walk through of proposed 3 Tier Model

Summary of poll results

Major areas of agreement

Discussion of next steps



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

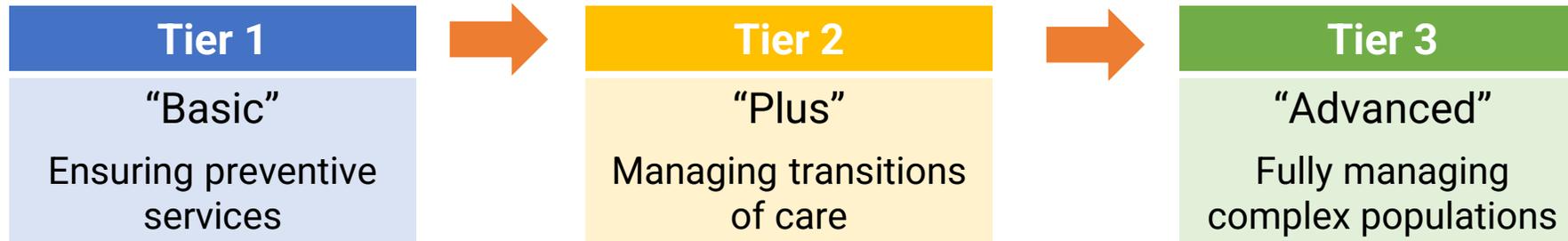
Note:

- 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
<p>Improving preventative care and/or chronic conditions such as:</p> <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Targeted performance measures • Improvement and attainment targets • Number of performance measures provider needs to select • Other tier-specific participation requirements • PMPM amounts 	<ul style="list-style-type: none"> • Providers receive PMPM payments for a period of time, without demonstrating improvement or attainment, to allow providers time to meet performance expectations



Tier 1: Identifying potential performance measures

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Process for Identifying Potential Performance Measures

CMS Medicaid and CHIP Core Set measures, and **aligned** with CPC+/PCMH, UDS and BCBSMT measures

Focus on **primary care-provided services**, both pediatric and adult
(Note: Providers accountable only for measures applicable to population served)

Preference for measures impacting a **significant portion of the population**

Measures with **opportunities for improvement** (based on NCQA/CMS Core Set 2023 median or CPC+/PCMH benchmarks)

Feasibility of reporting: **data availability** for accurate measure calculation

Consideration for **areas of care**: preventive, chronic condition, BH, perinatal (to be discussed)

Result: 11 measures selected for further discussion

- 5 claims-based measures DPHHS recommends for inclusion (subject to discussion)
- 6 additional measures DPHHS would like to discuss further before determining feasibility of inclusion



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) <i>*inverse</i>	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%



Adult Primary Care Access and Preventive Care Measures **Recommended for Inclusion**

Measure	Cervical Cancer Screening (CCS-AD)	Colorectal Cancer Screening (COL-AD)	Breast Cancer Screening (BCS-AD)
Description	<p>Percentage of women screened:</p> <ol style="list-style-type: none"> 1) Ages 21 to 64 who had cervical cytology performed within the last 3 years 2) Ages 30 to 64 who had cervical high-risk human papillomavirus (hrHPV) testing, or cervical cytology/high-risk human papillomavirus (hrHPV) co-testing, within the last 5 years 	<p>Percentage of adults ages 46 to 75 who had appropriate screening for colorectal cancer.</p>	<p>Percentage of women ages 52 to 74 who received a mammogram to screen for breast cancer.</p>
Data Collection Method	Administrative, hybrid, ECDS, or EHR	ECDS, or EHR	ECDS, or EHR
Measure Alignment	Core Set, CPC+/PCMH, UDS, BCBSMT C	Core Set, CPC+/PCMH, UDS, BCBSMT C, MA	Core Set, CPC+/PCMH, UDS, BCBSMT C, MA
CPC+/PCMH Benchmark	45%	56%	55%



Child Primary Care Access and Preventive Care Measures **Recommended for Inclusion**

Measure	Well-Child Visits in the First 30 Months of Life (W30-CH)	Child and Adolescent Well-Care Visits (WCV-CH)
Description	<p>Percentage of children who had well-child visits with a primary care practitioner during the last 15 months:</p> <p>1) children who turned age 15 months and who had six or more well-child visits from birth to age 15 months;</p> <p>2) children who turned age 30 months and who had two or more well-child visits from age 15 months to 30 months.</p>	<p>Percentage of children and adolescents ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner or an obstetrician/gynecologist.</p>
Data Collection Method	Administrative	Administrative
Measure Alignment	Core Set, BCBSMT C	Core Set, BCBSMT C
CMS Core Set Median (2023)	59.2%	45.3%



Adult Chronic Conditions Measures:

Feasibility Discussion

Measure	Controlling High Blood Pressure (CBP-AD)	Glycemic Status Assessment for Patients with Diabetes (GSD-AD)
Description	Percentage of adults ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	Percentage of adults ages 18 to 75 with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) at the following level: HbA1c Poor Control (>9.0%) <i>*Note: Inverse measure. Higher rate is poorer performance</i>
Data Collection Method	Administrative, hybrid, or EHR	Administrative, hybrid, or EHR
Measure Alignment	Core Set, CPC+/PCMH, UDS, BCBSMT C, MA	Core Set, CPC+/PCMH, UDS, BCBSMT C, MA
CPC+/PCMH Benchmark	71%	9%



Additional Primary Care and Behavioral Health Screening Measures: **Feasibility Discussion**

Measure	Lead Screening in Children (LSC-CH)	Screening for Depression and Follow-Up Plan
Description	Percentage of children who turned age 2 and who had one or more capillary or venous lead blood test for lead poisoning from birth through their second birthday.	Percentage of patients screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying visit: 1) Ages 12 to 17 (CDF-CH) 2) Age 18 and Older (CDF-AD)
Data Collection Method	Administrative or hybrid	Administrative or EHR
Measure Alignment	Core Set (Mandatory)	Core Set (Mandatory), CPC+/PCMH, UDS, BCBSMT C
CMS Core Set Median (2023)	57%	NA

Maternal and Perinatal Health Measures: Feasibility Discussion

Measure	Timeliness of Prenatal Care	Postpartum Care
Description	<p>Percentage of deliveries of live births that had a prenatal care visit in the first trimester (176 to 208 days before the delivery date), on or before the enrollment start date, or within 42 days of enrollment in Medicaid or CHIP.</p> <ol style="list-style-type: none"> 1) Under Age 21 (PPC2-CH) 2) Age 21 and Older (PPC2-AD) 	<p>Percentage of deliveries of live births with a postpartum visit on or between 7 and 84 days after delivery.</p> <ol style="list-style-type: none"> 1) Under Age 21 (PPC2-CH) 2) Age 21 and Older (PPC2-AD)
Data Collection Method	Administrative or hybrid	Administrative or hybrid
Measure Alignment	Core Set, BCBSMT C	Core Set, BCBSMT C
NCQA Median (2023)	83.1%	73.6%



Discussion: Tier 1 Design Decisions

Targeted performance measures:

Claims-based:

1. Cervical Cancer Screening
2. Colorectal Cancer Screening
3. Breast Cancer Screening
4. Well-Child Visits in the First 30 Months of Life
5. Child and Adolescent Well-Care Visits

Measures for Feasibility Discussion:

1. Controlling High Blood Pressure
2. Glycemic Status Assessment for Patients with Diabetes
3. Lead Screening in Children
4. Screening for Depression and Follow-Up Plan
5. Timeliness of Prenatal Care
6. Postpartum Care

1. What are reasonable attainment and improvement targets for these measures?
 - a. Attainment: Core Set (ie national state-level) medians, MT CPC+/PCMH benchmarks
 - b. Improvement: 10% over prior year
2. How many performance measures (per adult, child populations) is reasonable?
 - a. 1-2
 - b. 3-4
 - c. 5 or More
3. Should providers be able to choose which measures to report from a menu, or should all providers report the same measure(s) in Tier 1?
 - a. Yes
 - b. No
 - c. Neutral/not sure



Future Project Timeline/Meeting Dates

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Future Key Partner Meeting Dates

Monthly Key Partner Meetings Tentative Schedule:

**Note 90-minute meetings*

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

