Medicaid Primary Care Case Management in Montana

IHS/Tribal Monthly Medicaid Training

November 19th, 2024 – 9:00 a.m.

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

The Five PCCM/PCCMe Programs in Montana

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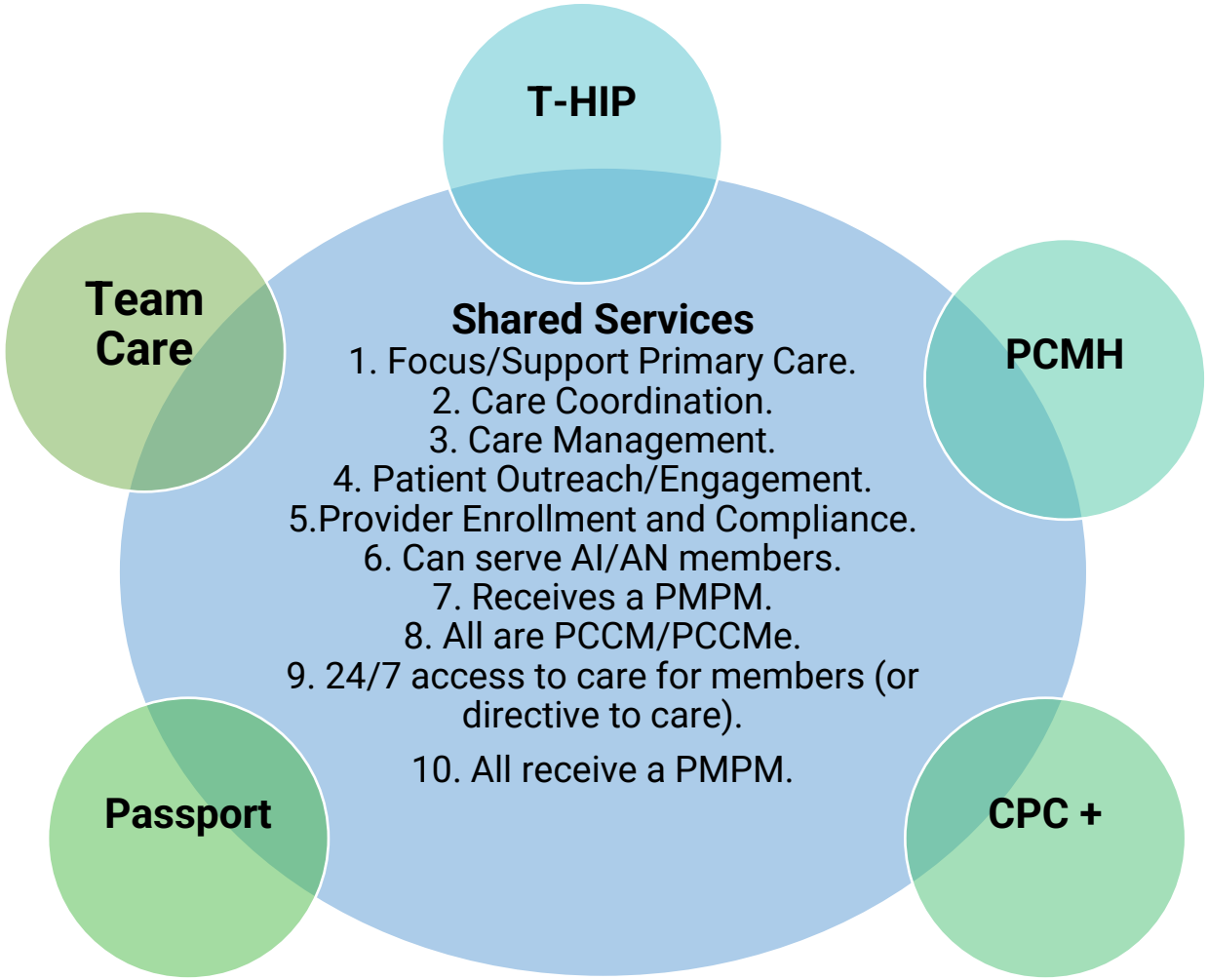
Primary Care Case Management Definition:

42 CFR 438 Primary Care Case Management (PCCM) is defined as:
A system under which a PCCM/PCCMe contracts with the State **to furnish case management services (which include the location, coordination and monitoring of primary health care services)** to Medicaid beneficiaries.
The regulations also define a Primary Care Case Manager (PCCM) as: ▪ A physician assistant, ▪ A nurse practitioner, ▪ A certified-midwife
These definitions establish PCCM as a model where providers contract directly with the state Medicaid agency to **provide case management and coordinate primary care services for Medicaid enrollees**.

PCCM/PCCMe in Montana

Passport to Health	Comprehensive Primary Care Plus (CPC+)	Patient Centered Medical Home (PCMH)	Tribal Health Improvement Program (T-HIP)
Team Care			

Current Program/Service Overlaps



Passport to Health

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Passport to Health

- **Provider Requirements:**
  - Any Medicaid enrolled primary care provider; including physicians, mid-level practitioners, clinics, FQHC's, RHCs, **Tribal Health Centers, or Urban Indian Organizations**, **IHS,** within their scope of practice.
  - Must sign a Passport provider agreement.
- **Services:**
  - Provide care coordination through referrals for medically necessary care.
  - Offer 24/7/365 emergency care guidance to Passport members.
- **Reimbursement:**
  - Providers receive a monthly case management fee per member (PMPM):
    - $3.00 for members determined categorically eligible for Aged, Blind, Disabled, and Medically Frail Medicaid.
    - $1.00 for all other Medicaid-eligible members enrolled in Passport.

Patient Centered Medical Home

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Patient Centered Medical Home (PCMH)

- **Provider Requirements:**
  - Meet Passport Provider criteria.
  - Maintain PCMH recognition by National Committee for Quality Assurance (NCQA).
  - **Report clinical quality measures annually. However, these are imported weekly.**
- **Services:**
  - Educate Medicaid members on available PCMH services.
  - Address care gaps by analyzing Medicaid claims data.
  - Engage patients and families in their treatment and care improvement.
  - Assist patients in setting goals and making shared decisions using specific techniques.
  - Screen and coordinate behavioral health concerns.

PCMH Continued:

- **Reimbursement:**
  - Members are grouped by medical risk into three tiers.
    - Tier One: $3.33
    - Tier Two: $9.33
    - Tier Three: $15.33

PCMH Complex Care (Tier 4) Option:

- **Provider Requirements:**
  - Maintain a CCM care team including a nurse and a Licensed Behavioral Health Professional or trained paraprofessional.
  - Conduct face-to-face meetings in a high-risk member's home for 6 months: weekly for the first three months, and every other week for the last three months.
- **Services:**
  - Conduct assessments and make referrals for both medical and non-medical factors affecting the member's health.
- **Reimbursement:**
  - Providers receive $470.10 per member per month (PMPM) for members enrolled in this PCMH tier.

Comprehensive Primary Care Plus (CPC+)

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Comprehensive Primary Care Plus (CPC+)

- **Provider Requirements for Track 1:**
  - Enroll in Passport.
  - Previously CMS selected practices or maintain **PCMH Certification** (e.g. JCAHO) through recognized accrediting organizations.
  - **Report clinical quality measures annually to DPHHS. However, these are imported weekly.**
- **Additional Requirements for Track 2:**
  - Meet Track 1 criteria.
  - Provide integrated behavioral health services.
  - Conduct weekly care team meetings.
  - Offer various types of alternative access to healthcare (e.g., e-visits, phone visits, and group visits)
  - Provide alternative contact methods (e.g., emails, text reminders, or letters).

CPC + Continued:

Services:

- Reach out to member for CPC+ education.
- Analyze Medicaid claims data and address care gaps with patients.
- Involve patients and families in members treatment plan and care improvement.
- Assist patients in setting goals and making shared decisions using specific techniques.

Reimbursement:

- Members are assessed a health risk scored and placed into a reimbursement tier.
- Providers may receive an annual incentive bonus payment based on prevention and utilization quality measures.

Track 1

Tier One:	$3.33
Tier Two:	$9.33
Tier Three:	$15.33
Tier Four:	$21.33

Track 2

Tier One:	$6.33
Tier Two:	$12.33
Tier Three:	$18.33
Tier Four:	$24.33
Tier Five:	$34.33

Team Care

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Team Care

- **Background:**
  - The Team Care program was established in August 2004 to replace the restricted card program. Team Care is for members who use more medical services than the average members indicating they need assistance in learning how to use their Medicaid benefits the right way. Members enrolled in the program receive education about how to get the right care at the right time at the right place.
- **Provider Requirements:**
  - Providers enrolled in Passport are required to participate.
- **Services:**
  - Educate members on proper use of healthcare services and prescriptions.
- **Reimbursement:**
  - Passport providers receive an extra $3 per member per month (PMPM) for each Team Care member they manage.
- **CPC+ and PCMH Providers:**
  - Are required to participate, but do not get the additional $3.00 PMPM.

What is a value-based program in a Fee-for-Service State?

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Value-Based Care Program in a Fee-for-Services State:

- **Definition:**
  - A hybrid model that introduces quality and outcome-based incentives within the existing fee-for-service framework.
- **Key Components:**
  - Maintains fee-for-service reimbursement structure
  - Adds performance-based incentives or penalties
  - Focuses on quality metrics and patient outcomes
- **Implementation:**
  - Identify quality measures (e.g., readmission rates, patient satisfaction)
  - Set performance targets
  - Establish incentive/penalty structure
  - Implement data collection and reporting systems
- **Benefits:**
  - Gradual transition from volume to value
  - Improved care quality and patient outcomes
  - Potential cost savings for payers and patients

Future of a value-based model in Montana

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Value-based in Montana:

- Montana is moving away from Passport, CPC+, PCMH, and Team Care to a single value-based model.
- This new model will be developed no later than March of 2026.
- Key Objectives:
  - Ensure primary care access,
  - Establish member partnerships,
  - Provide continuous coordinated care,
  - Improve care continuity,
  - Encourages preventive health care,
  - Promote EPSDT services,
  - Reduce inappropriate medical services use,
  - Decrease non-emergent ED visits, and
  - Control health care costs.

Possible Impact to I/T/U Communities (1/2)

Current Situation:

- Most Medicaid members (about 70%) are in the Passport program.
- Members must choose a Passport provider unless they qualify for an exemption.
- This rule will likely continue in the new program.

Member Options:

- Medicaid members can choose their provider, but it must be a Passport provider.
- If an Indian Health Service, Tribal, or Urban Indian (I/T/U) clinic doesn't join the new program, Native American members will need to pick a different primary care provider who is in the program.

Access to Care:

- Native American members can still get care at I/T/U clinics without a referral.
- For non-I/T/U providers, members will still need a referral from their members primary care provider.

Possible Impact to I/T/U Communities (2/2)

Special Considerations for Tribal Providers:

- There might be confusion if the new program and T-HIP offer similar services.
- Tribes might have to choose between being a T-HIP provider or joining the new program.
- Members can still choose a non-Tribal provider as their main care provider.

Department's Commitment:

- The Department is taking proactive steps to prevent potential conflicts between the Tribal Health Improvement Program (T-HIP) and the new value-based program. We are:
  - Collaborating with HMA to identify and address any overlaps in services.
  - Actively reaching out to engage with I/T/Us to ensure their perspectives are incorporated.
  - Developing clear distinctions between care coordination and care management services in T-HIP and PCCMs to avoid duplication and enhance efficiency.

Contact Information and Resources

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Additional Resources

	Website	Staff
Passport to Health Provider Manual - Includes information for CPC+, PCMH, and Team Care.	https://medicaidprovider.mt.gov/manuals/passporttohealthmanual	• Joshua Turner • Jacqui Roberts
Tribal Health Improvement Program (T-HIP) Provider Manual	https://medicaidprovider.mt.gov/manuals/THIP	• Elizabeth Wisner-Kinsey • Casey Peck

Acronyms

- **CCM** – Complex Care Management
- **CPC+** – Comprehensive Primary Care Plus
- **DPHHS** – Montana Department of Public Health & Human Services
- **ED** – Emergency Department
- **HRD** – Health Resource Division
- **HMA** – Health Management Associates
- **I/T/U** – Indian Health Service/ Tribal 638/ Urban Indian Organizations.
- **NCQA** – National Committee for Quality Assurance
- **PCCM** – Primary Care Case Management
- **PCMH** – Patient Centered Medical Home
- **PMPM** – Per Member Per Month
- **PCP** – Primary Care Provider
- **T-HIP** – Tribal Health Improvement Program
- **URB** – Utilization Review Board