MT PCCM Redesign

On-Site Key Partner Meeting, Billings MT

October 7, 2025 1:00 pm

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

Agenda

- Review Three Tier Model
- Tier 1: Performance Measures
- Tier 1 and Tier 2: PCMH Provider Participation Requirements
- Enrollment Policies
- Next Steps

Review Three Tier Model

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Tier 1: Focus on Preventive Care

Tier 1 Model Overview: July 2026 Implementation

Description:	Care coordination fee paid to participating primary care provider practices
Goal:	Improve outcomes on select HEDIS quality metrics and align with CMS Core measures
Provider Eligibility:	Initially any willing primary care provider serving Montana Medicaid beneficiary; continued participation contingent on meeting performance targets
Payment Model:	Per-member-per-month (PMPM); amount to be determined

Tier 2: Focus on Transitions of Care

Tier 2 Model Overview: July 2026 Implementation

Description:	Care coordination fee to help hospitalized patients transition back to ambulatory care in the community
Goal:	Increase the percentage of discharged patients with follow-up PCP visits within 7 days and reduce unplanned repeat hospitalizations within 30 days of discharge
Provider Eligibility:	Tier 1-participating primary care providers who are actively managing transitions of care post-hospitalization; continued participation contingent on meeting performance targets
Payment Model:	PMPM care coordination fee; amount and tasks to be determined; funded by savings generated from reducing readmissions

Tier 3: Focus on High-Risk Care Management

Tier 3 Model Overview (To be Phased in at a Later Date)

Description:	Care management of individuals with complex physical health and/or behavioral health conditions, often with complicating health-related social needs
Goal:	Reduce patient barriers to compliance with their treatment plan and improve self-management skills to reduce the risk for hospitalization and frequent emergency room visits
Provider Eligibility:	Participating in Tier 1 & 2; presents an acceptable description of their care management model; has at least XX number of attributed beneficiaries alone or as part of a clinically integrated network
Payment Model:	PMPM care management fee; amount and tasks to be determined; a portion of risk-adjusted total cost of care savings

Tier 1: Performance Measures

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Proposed Tier 1 Measurement

Measure Name	CMS Core Set Median (2024)
Cervical Cancer Screening (CCS-AD)	50%
Colorectal Cancer Screening (COL-AD)	37.7%
Breast Cancer Screening (BCS-AD)	50.3%
Well-Child Visits in the First 30 Months of Life (W30-CH) - First 15 months of life (6+) - 15 to 30 months of life (2+)	-59.0% -65.3%
Child and Adolescent Well-Care Visits (WCV-CH)	49.2%

Measure Name	CMS Core Set Median (2024)
Controlling High Blood Pressure (CBP-AD)	60.5%
Glycemic Status Assessment for Patients with Diabetes (GSD-AD) *inverse	38.8%
Lead Screening in Children (LSC-CH)	58.1%
Screening for Depression and Follow-Up Plan: - Ages 12 to 17 (CDF-CH) - Age 18 and Older (CDF-AD)	-2.0% -2.0%
Timeliness of Prenatal Care: - Under Age 21 (PPC2-CH) - Age 21 and Older (PPC2-AD)	-64.0% -71.8%
Postpartum Care: - Under Age 21 (PPC2-CH) - Age 21 and Older (PPC2-AD)	-61.0% -64.5%

Decisions Made with Stakeholder Feedback

1. Providers will choose 3 measures from the menu
2. MT will use CMS Core Set Medians as the benchmark as the starting point (except for the depression screening measure)
3. Providers will a) meet or exceed the benchmark, and/or b) demonstrate a 10% or more improvement in their rate(s) for each selected measure
4. Beginning Year 1, State pays PMPM fee if provider meets reporting requirements
5. Beginning Year 2, provider performance evaluated annually on selected measures
6. PMPM fees will be paused in future years if no demonstration of improvement or attainment of performance targets
7. PMPM fees could be resumed by demonstrating improvement

Tier 1 and Tier 2: PCMH Provider Participation Requirement

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Proposed Approach to Detailed Tier-Specific Participation

Proposed new Approach to Provider Participation Requirements for the Value-Based Program:

- Acknowledges that many providers meet some but not all NCQA PCMH requirements, and that full certification can be a barrier
- Would define participation based on attainable PCMH qualities
- Requirements grouped into six medical home domains per tier, directly aligned with NCQA's PCMH concept areas[1]

Team-Based Care:
Structure of practice's leadership, care team responsibilities and how the practice partners with members, families, and caregivers

Knowing and Managing Your Patients:
Requirements for data collection, medication reconciliation, evidence-based clinical decision support and other activities

Access and Continuity:
How practices provide members with convenient access to clinical advice and help ensure continuity of care

Care Management and Support:
Care management protocols to identify members who need more closely-managed care

Care Coordination and Care Transitions:
Primary and specialty care clinicians effectively share information and manage member referrals

Performance Measurement and Quality Improvement:
Practices develop ways to measure performance, set goals, and develop performance improvement activities

[1] NCQA PCMH Recognition Concepts web page. NOTE: NCQA PCMH Recognition Concepts are general and align with the standards within other PCMH models including, for example, AAAHC, Joint Commission, and URAC.

Detailed Participation Requirements: Design Considerations

Decision Made: Verification that Requirements are Met

1. Providers would either:
   a) attest to meeting the requirements, or
   b) demonstrate they had a commensurate recognition/ certification (e.g., NCQA PCMH, URAC, AAAHC, TJC)
2. State would reserve the right to request documentation, if needed

Discussion Questions for Consideration for Upcoming Slides

1. Are these the right requirements for each Tier?
   a) If not, does it need to be modified, moved to a different Tier, or excluded from the program?
   b) Are there other requirements we should consider?
2. What would be the difficulty level in achieving these requirements?
   a) None/we already meet them
   b) Could meet them, but would need state support [describe]
   c) It is unlikely my organization (or the providers I represent) could meet these requirements

Proposed Detailed Participation Requirements

Tier 1

Team-Based Care:	Designated **clinician lead** of the medical home and a **staff person to manage** the medical home
Knowing and Managing Your Patients:	1. Documents an up-to-date **problem list** for each patient with current and active diagnoses 2. Conducts **depression screenings** for adults and adolescents using a standardized tool 3. Proactively and routinely identifies populations of patients and **reminds them**, or their families/caregivers about at least **one Tier 1 measure**
Access and Continuity:	1. Provides **same-day appointments** for routine and urgent care to meet identified patient needs 2. Provides routine and urgent **appointments outside regular business hours** to meet identified patient needs 3. Provides timely clinical advice **by telephone** 4. Helps patients unattributed to the provider **change** patient's attributed PCP

Proposed Detailed Participation Requirements

Tier 1 *(cont.)*

Care Management and Support:	**N/A** (T3 focus)
Care Coordination and Care Transitions:	1. Systematically **manages lab and imaging tests** by flagging abnormal results and bringing them to the attention of the clinician and notifying patients/ families/ caregivers of abnormal lab and imaging tests 2. Systematically **manages referrals** by giving the consultant or specialist the clinical question, the required timing and the type of referral
Performance Measurement and Quality Improvement:	Meets **performance targets** for three selected clinical quality measures

Proposed Detailed Participation Requirements *(in addition to Tier 1 requirements)*

Tier 2

Team-Based Care:	1. Regular patient care **team meetings or structured communication** process focused on individual patient care 2. Involves care team in **performance evaluation and QI activities**
Knowing and Managing Your Patients:	1. Assesses the **language needs** of its population 2. Conducts comprehensive (social, behavioral, physical) **health assessments** 3. Implements **clinical decision support** following evidence-based guidelines for care of (at least two: a) Mental health condition, b) Substance use disorder, c) Chronic medical condition, d) Acute condition, e) Condition related to unhealthy behaviors, f) Well child or adult care, g) Overuse/appropriateness issues 4. Reviews and **reconciles medications** for more than 80 percent of patients received for care transitions 5. Maintains an **up-to-date list** of medications for more than 80 percent of patients.
Access and Continuity:	**1. Outreach** within 60 days to new patients to establish care
Care Management and Support:	**N/A** (T3 focus)

Proposed Detailed Participation Requirements *(in addition to Tier 1 requirements)*

Tier 2 *(cont.)*

Care Coordination and Care Transitions:	1. Systematically **manages lab and imaging tests** by tracking tests until results are available 2. Systematically **manages referrals**, providing pertinent demographic and clinical data, including test results and current care plan **3. Tracking referrals** until the consultation or diagnostic test report is available, flagging and following up if overdue 4. Systematically **identifies patients** with hospital admissions and emergency department visits **5. Shares clinical information** with admitting hospitals and emergency departments 6. Within 2-3 business days following a hospital admission or emergency department visit , **contacts patients** for follow-up care 7. Offers a primary care **follow-up visit** within 7 days of discharge **8. Follows up with patient** if the scheduled post-hospitalization discharge appointment is missed **9. Facilitate patient's timely follow up** with specialist(s) after hospital discharge, as indicated on the patient discharge instructions
Performance Measurement and Quality Improvement:	1. Meets **performance targets** for follow up after hospitalization within seven days 2. Meets **performance targets** for readmission rates

Beneficiary Enrollment Policies

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Beneficiary Enrollment Policy Framework

OBJECTIVE

Develop enrollment policies that comply with federal PCCM program requirements and support these goals:

- Prioritize Enrollee Choice
- Maintain Continuity with Current PCP Assignments
- Encourage Provider Participation While Recognizing Variation in Readiness
- Ensure Sufficient Attribution

Proposed Eligible Populations

Populations Eligible to Voluntarily Enroll*	Populations NOT Eligible to Participate
• Children (Medicaid & HMK+)	• Dual Eligibles
• Parent & Caretaker Relatives	• Reside in a Nursing Facility, ICF/IID, or PRTF
• Aged, Blind & Disabled	• Eligibility < 3 Months
• Foster Care Children	• 1915(c) Waiver Enrollees
• Expansion Adults	• Spend-Down
• Pregnant Women	• Presumptively Eligible
• Breast & Cervical Cancer Program	• Family Planning Waiver

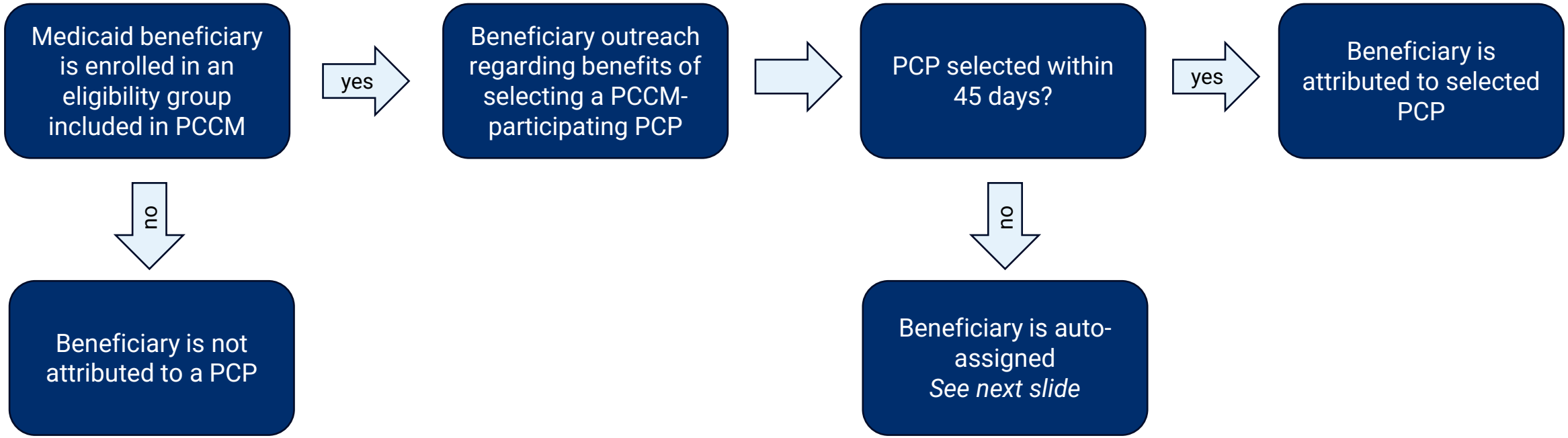
Rationale for Proposed Population Exclusions

- Prevents duplication with other Medicaid case management programs
- Excludes beneficiaries with Medicaid eligibility periods insufficient to impact outcomes

*Proposed included populations aligned with Passport, with the addition of Breast & Cervical Cancer Program & Pregnant Women.

Proposed Beneficiary Enrollment Process

During initial program launch, enrollees will remain attributed to their existing Passport, PCMH, or CPC+ provider if they participate in the new program. The following process is proposed to address current enrollees with a non-participating PCP and ongoing enrollment of new beneficiaries.



Proposed Assignment/Attribution Methodology

If beneficiary does not select a participating PCP within 45 days AND there are no claims from a Medicaid provider not participating in PCCM, system identifies if participating PCP is available for assignment.

Next Steps

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Future Activities/Timeline

- October – December 2025: Finalize program design and draft waiver or SPA
- November 2025: Continued key partner feedback on Tier 3
- January – February 2026: Conduct public and tribal comment periods
- March 2026: Submission of waiver or SPA to CMS
- March – June 2026: CMS review and discussions; provider education and outreach
- June 2026: CMS approval
- July 2026: Implementation of Tier 1 and Tier 2