MT PCCM Redesign

Key Partner Meeting

February 11, 2026 1:00 pm

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

Agenda

- July 2026 Implementation Updates
  - Program Name
  - Updates to Provider Participation Requirements in Response to 10/7/25 Key Partner Feedback Meeting
  - Key Implementation Milestones
  - Rates Overview
  - Provider Advantages in New PCMT Model
- Tier 3 Design
- Next Steps

July 2026 Implementation Updates

Health Management Associates

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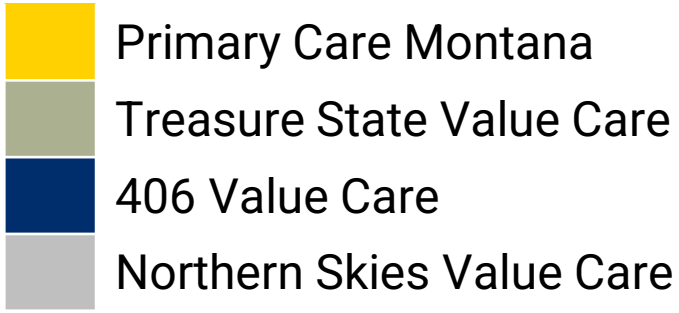
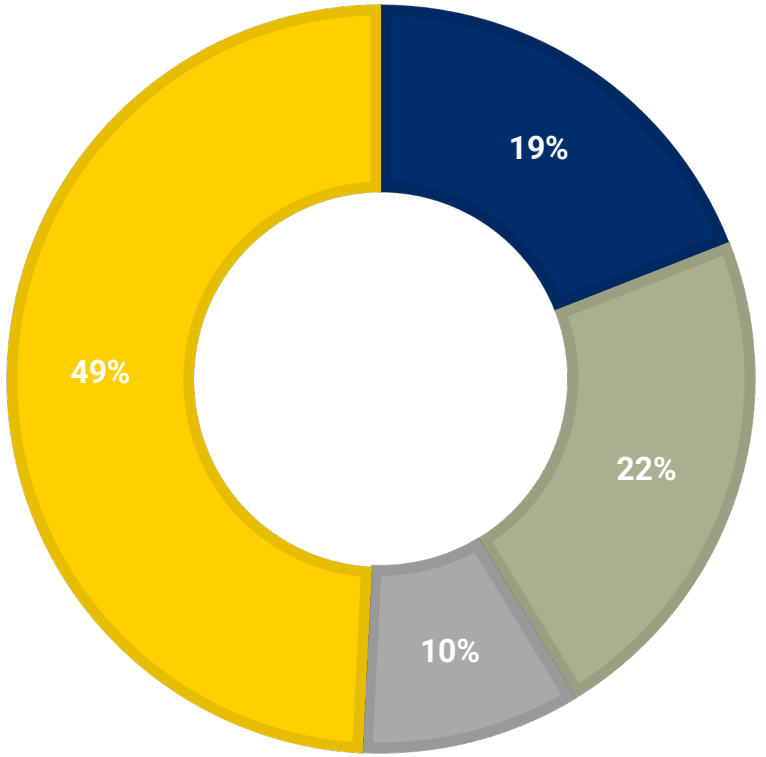
Introducing Primary Care Montana (PCMT)

The program name was selected based on key partner survey results





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Tier 1: Provider Participation Requirements

Providers must attest to meeting requirements during enrollment.

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~~ acute 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 or electronic means 4. Helps patients unattributed to the provider **change** patient's attributed PCP
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

Tier 2: Provider Participation Requirements

(in addition to Tier 1 requirements)

Providers must attest to meeting requirements during enrollment.

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 Quality Improvement (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

*Medication reconciliation, as defined by NCQA PCMH standards, is the process of obtaining and maintaining an accurate list of all medications a patient is taking and addressing potential conflicts, including name, dosage, frequency, and drug-drug interactions.

Tier 2: Provider Participation Requirements

(in addition to Tier 1 requirements)

Providers must attest to meeting requirements during enrollment.

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~~ 14 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 ~~7~~ 14 days 2. Meets **performance targets** for readmission rates

Upcoming Implementation Milestones

Key Partner Engagement

- State Plan Amendment Public Notice Posting: No later than 02/28/26
- State Plan Amendment Submission to CMS: No later than 03/31/26
- Bi-Monthly Key Partner Meetings

PCMT Provider Enrollment

- Phase 1 Automated Onboarding: Provider Enrollment & Enrollee Assignment: May 2026
- Phase 2 Provider Enrollment / Phase 1 Revalidation & Enrollee Assignment: July 2026
- Provider Technical Assistance: Beginning April 2026 and Ongoing

PCMT Enrollee Engagement

- Enrollee Notices: April 2026 – May 2026
- Enrollee Assignment: Aligned with Phase 1 and 2 of the PCMT Provider Enrollment Above.

Rates Overview – Tier 1 Modeling Assumptions

Assumed Tasks and Level of Effort	Time (hrs)	Frequency per year			CC time/yr (hrs)		
		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
Outreach to members not seen in previous 12 months	0.25	0.2	0.2	0.2	0.05	0.05	0.05
Initial or annual health risk screen (includes PHQ, assumes multiple attempts sometimes required)	0.5	1	1	1	0.5	0.5	0.5
Community -based organization referrals	0.25	0.5	1	2	0.125	0.25	0.5
Closing gaps in care and wellness messaging	0.5	1	2	2	0.5	1	1
Post-ED visit contact	0.25	0.5	2	4	0.125	0.5	1
Hours PMPY					**1.43**	**2.43**	**3.18**

Rate Overview – Tier 2 Scenario Modeling

	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.

Rates Overview – Calculations

- Calculations
  - Legislative Appropriation
  - Savings
  - Assumptions
- PMPMs:
  - Tier 1 - $6.00
  - Tier 2 - $11.00

Provider Advantages in New PCMT Model

Feature	Passport	PCMH	CPC+	PCMT (Today)
No Referral Hassles	✗	✗	✗	✓ No more referrals (Passport ID) required on claims
Quality Measure Tracking	Not required	Partial	Partial (manual)	✓ Fully automated — no manual reporting
Enhanced PMPM Payments	$1.11 avg	$5.57 avg	$8.03 avg	✓ Tier 1 $6.00 / Tier 2 $11.00
Technical Assistance & Support	✗	Partial	Partial	✓ Dedicated TA from the Department + Consultant
PCMH Certification Requirement	Not required	Required	Required	✓ No certification needed to participate
Data-Driven Insight Tools	✗	Partial	Partial	✓ PCMT Roster and Performance Measure Report
Glidepath to Value-Based Care	✗	✗	✗	✓ Designed glidepath to future VBP opportunities
Member Accessibility & Engagement	✗	✗	✗	✓ Stronger connection and choice for member

Tier 3

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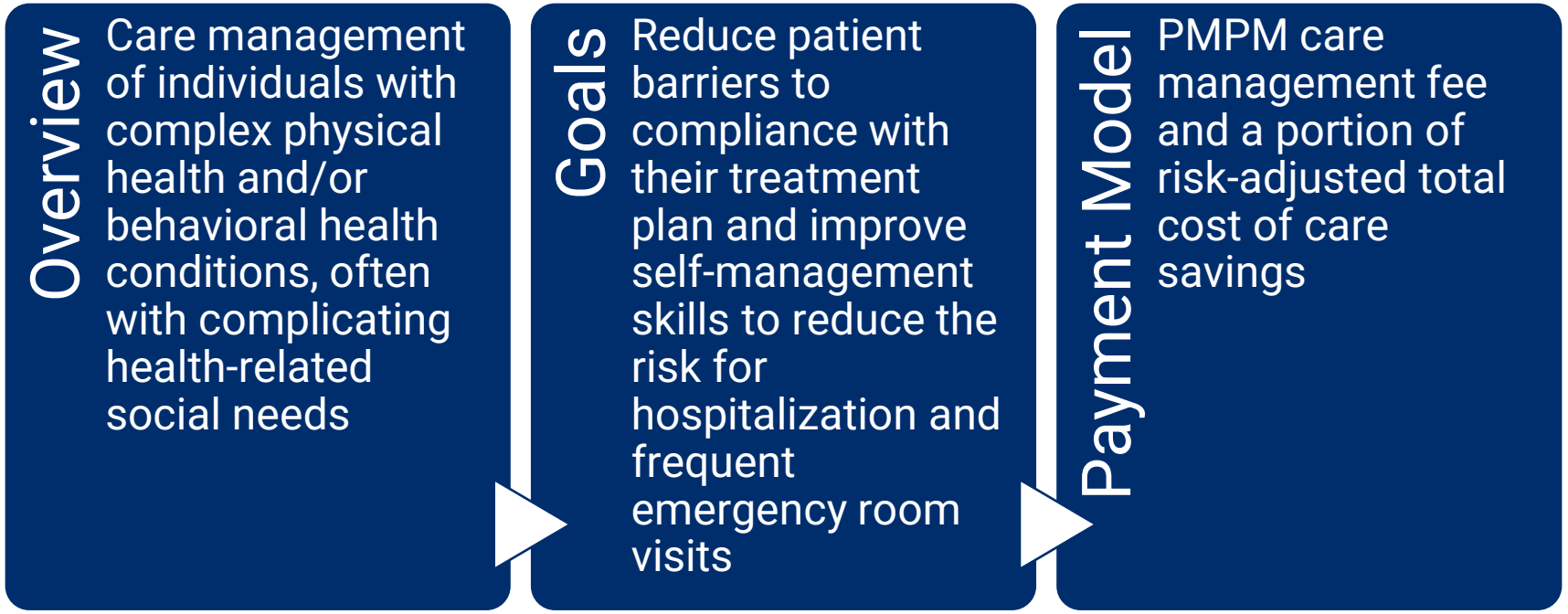
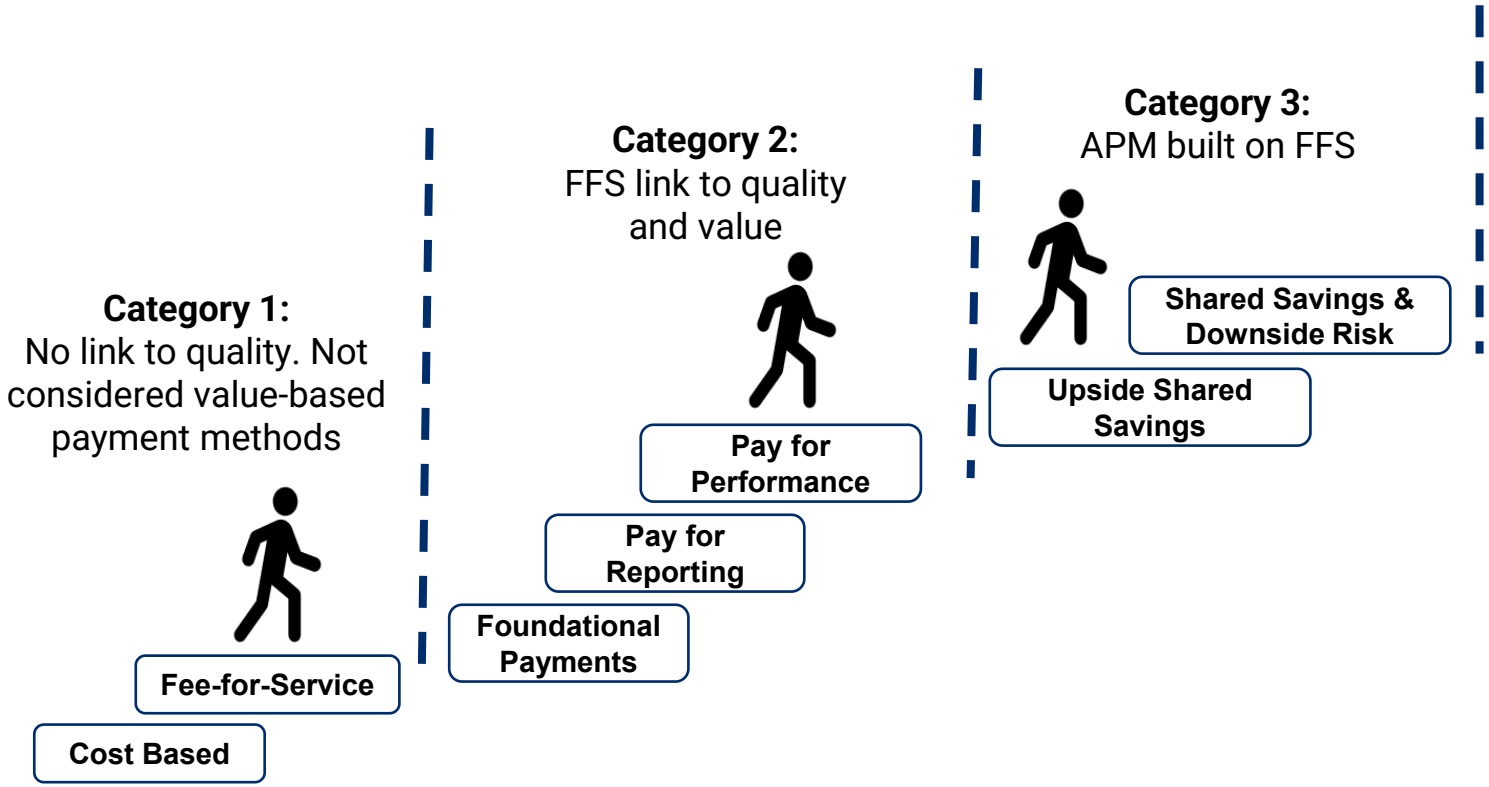
Tier 3: Focus on High-Risk Care Management



Montana's Long-Term Value-Based Care Strategy



DPHHS will begin by implementing shared savings with a long-term goal of moving toward provider risk sharing.

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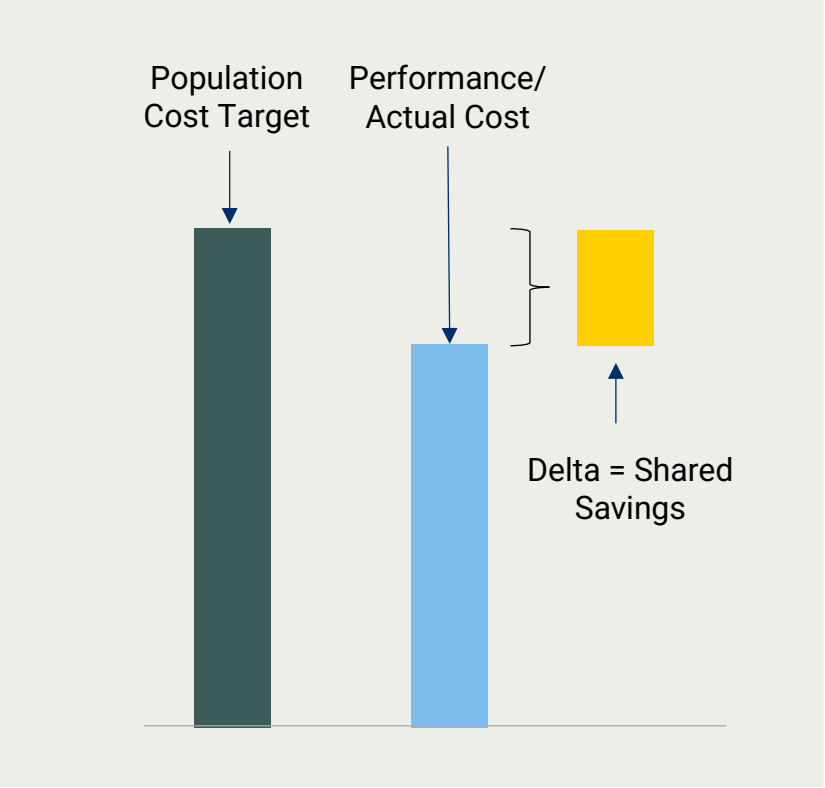
Shared Savings Overview

Objective: Reduce low-value utilization of the health care system as demonstrated by reducing risk-adjusted total cost of care below a benchmark determined by historical experience while improving quality metric outcomes.

Method: Offer a shared savings program to qualified primary care provider entities.



Definition of a Tier 3 Qualifying Entity

Discussion: What minimum beneficiary attribution level do providers need to consider participation in Tier 3? For example, Medicare Shared Savings Program (MSSP) utilizes 5,000 while Medicaid managed care programs typically require 2,000 to encourage participation. Are there other questions or concerns on proposed requirements?

Primary Care Provider

Family Practice, General Practice, Pediatrics or Internal Medicine MDs, APRNs, PAs

Tier 1 & 2 Participant

All Provider Entity PCPs must meet Tier 1 & 2 participation criteria.

Provider Entity Possibilities

PCP practice, RHC, CHC, health system employed PCPs, or CIN

Minimum Tier 3 Beneficiary Attribution

TBD

Value-Based Care Agreement Terms

Discussion: Do any of these proposed general terms of participation cause concern or introduce barriers to participation?

1. **Term:** One-year terms with automatic renewal if not terminated by either party
2. **Termination for Cause:** Termination with at least 90-day notice for failure to meet Tier 1, 2, or 3 expectations
3. **Annual Updates:** Evaluate and, if necessary, revise the VBC agreement annually at least 90 days prior to beginning of new performance year
4. **Mid-Year Changes:** Amend the contract mid-performance year only to comply with regulatory requirements or by mutual consent
5. **Mid-Year Terminations:** Reserve the ability to terminate a shared savings/risk arrangement mid-performance year but avoid doing so

Next Steps: Future Tier 3 Discussions

Care management expectations → Risk stratification → Shared savings model

- Benchmark period cost
- Performance period cost
- Determination of savings earned by provider

Contact Information

- Questions and/or concerns?
  - MTPrimaryCarePrograms@mt.gov
- Next Key Partner Meetings:
  - Week of March 16, 2026
  - Week of April 13, 2026
- Coming Soon!
  - PCMT Website