MT PCCM Redesign – Primary Care Montana (PCMT)

Key Partner Meeting

March 19, 2026 10:00 am

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DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Agenda

- Upcoming Implementation Milestones

- Review of Primary Care Montana Tiers and Key Features

  o Attribution

  o Performance goals by Tier

  o Reimbursement

- Provider TA Overview

- PCMT System Preparations

- Tier 3 Design Next Steps

- Key Partner Q&A

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Upcoming Implementation Milestones

Key Partner Engagement

- State Plan Amendment Public Notice Posting: Posted on 02/27/26
- 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 & Preliminary 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.

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Review of Primary Care Montana Tiers and Key Features

Health Management Associates

Review of Patient Attribution Approach

Initial Attribution:	Prospective and claims based, enabling providers to clearly identify the patients for whom they are accountable at the beginning of each performance period
Eligible PCPs:	Family Medicaid Primary Care Providers, including Family Practice, General Practice, Pediatrics or Internal Medicine MDs, APRNs, Physician Assistants
Ongoing Attribution:	DPHHS is proposing to periodically perform passive PCP reassignment to better reflect where the beneficiary is receiving primary care. Details on this are forthcoming.

Resources: 10/7/25 Key Partner deck, slides 17-21

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Review of Performance Goals by Tier

Primary Care Montana accommodates different provider sizes/resources by providing a glidepath toward higher levels of population health management.

Tier 1	Tier 2	Tier 3
"Basic" Ensuring preventive services	"Plus" Managing transitions of care	"Advanced" Fully managing complex populations

Tier 1 **quality measures** are aligned with CMS Medicaid Core Sets and benchmarks, with focus on feasibility and reducing provider burden

Tier 1 quality measures must be met and Tier 2 **performance targets** will be set for follow up after hospitalization within 14 days and readmission rates.

Tier 3 **shared savings** for total cost of care for all assigned Medicaid members. Includes complex care management for individuals with complex physical and BH conditions
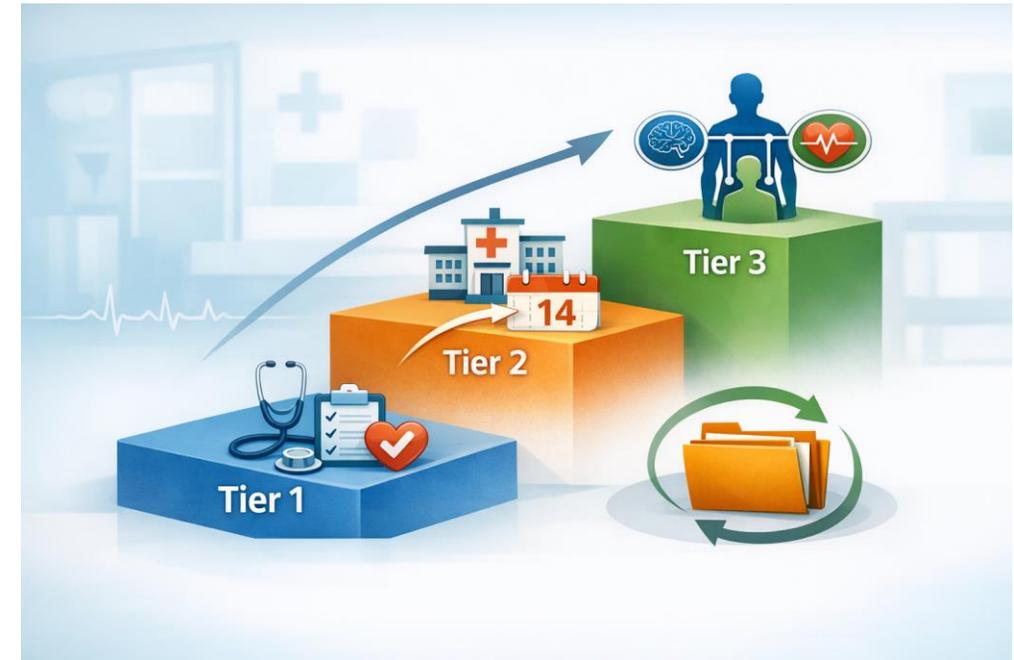
Review of Reimbursement Framework

Tier 1 and Tier 2 Reimbursement:

PMPM payments are designed to offset the administrative and staffing investments required for participation

Tier 3 Reimbursement:

In addition to PMPM payments, incentives include upside shared savings

Resources: (6/5/25 Key Partner Mtg, slides 8–15; 7/1/25 Key Partner Mtg, slides 12–14, 2/11/26 Key Partner mtg, slides 9-19).

Provider Readiness for Participation

The Department is committed to providing dedicated technical assistance (TA) to providers to support their ability to participate and progress along the three-tier glide-path.

The TA model will include:

- Department assistance to navigate the enrollment process and data systems as they become available

- Comprehensive, practice-centered technical assistance to support primary care providers and their interdisciplinary care teams in successfully implementing and advancing through the three-tier PCCM model

PCMT System Preparations

Phase 1:

Between April 11- May 1, 2026, existing providers that are active in the PASSPORT, PCMH and CPC+ programs who are eligible for the PCMT program will have a PCMT EU created on their enrollment record.

Adding the PCMT EU enables DPHHS to begin preparation activities to transition existing members currently assigned to their care program IDs to their new PCMT ID in the Care Management solution.

This phased approach is designed to reduce disruption for providers as they move from the current care management programs to the new PCMT program.

No action is required from providers during Phase 1.

PCMT System Preparations

Phase 2:

Beginning June 22, 2026, providers will be able to update their PCMT enrollment records, complete required attestations, and sign agreements.

Once the agreement has been signed and update submitted, DPHHS will be closely tracking the records and processing.

We encourage providers to complete and submit their required updates to their PCMT record by July 17, 2026, to ensure DPHHS can complete the review and approval process and finalize the records to avoid a disruption in PCMT Per Member Per Month (PMPM) payments.

Training materials and dates will be posted in advance of Phase 2.

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Practice-Centered Technical Assistance

Readiness and current-state assessment to identify gaps in meeting requirements and determine TA needs

Individualized practice support tailored toward specific needs

Learning collaborative and peer exchange forum for shared learning, peer problem-solving, and dissemination of best practices among similar practices

Data literacy and performance improvement support to support actionable use of data to meet performance targets

Quality improvement and sustainment support to improve care, achieve goals, and advance to higher tiers

LEARN MORE

Save the Date: April 13, 2026, 11:00 am – 12:30 pm

What: Town Hall session to learn more and enroll in technical assistance

Who: All interested PCCM providers

Next steps: Register - PCMT Town Hall - Provider TA Kickoff

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Tier 3 Next Steps

Health Management Associates

Tier 3: Focus on High-Risk Care Management

Overview
Care management of individuals with complex physical health and/or behavioral health conditions, often with complicating health-related social needs

Goals
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

Payment Model
PMPM care management fee and a portion of risk-adjusted total cost of care savings

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Montana's Long-Term Value-Based Care Strategy

Category 1:
No link to quality. Not considered value-based payment methods

Category 2:
FFS link to quality and value

Category 3:
APM built on FFS

Upside Shared Savings

Pay for Performance

Pay for Reporting

Fee-for-Service

Foundational Payments

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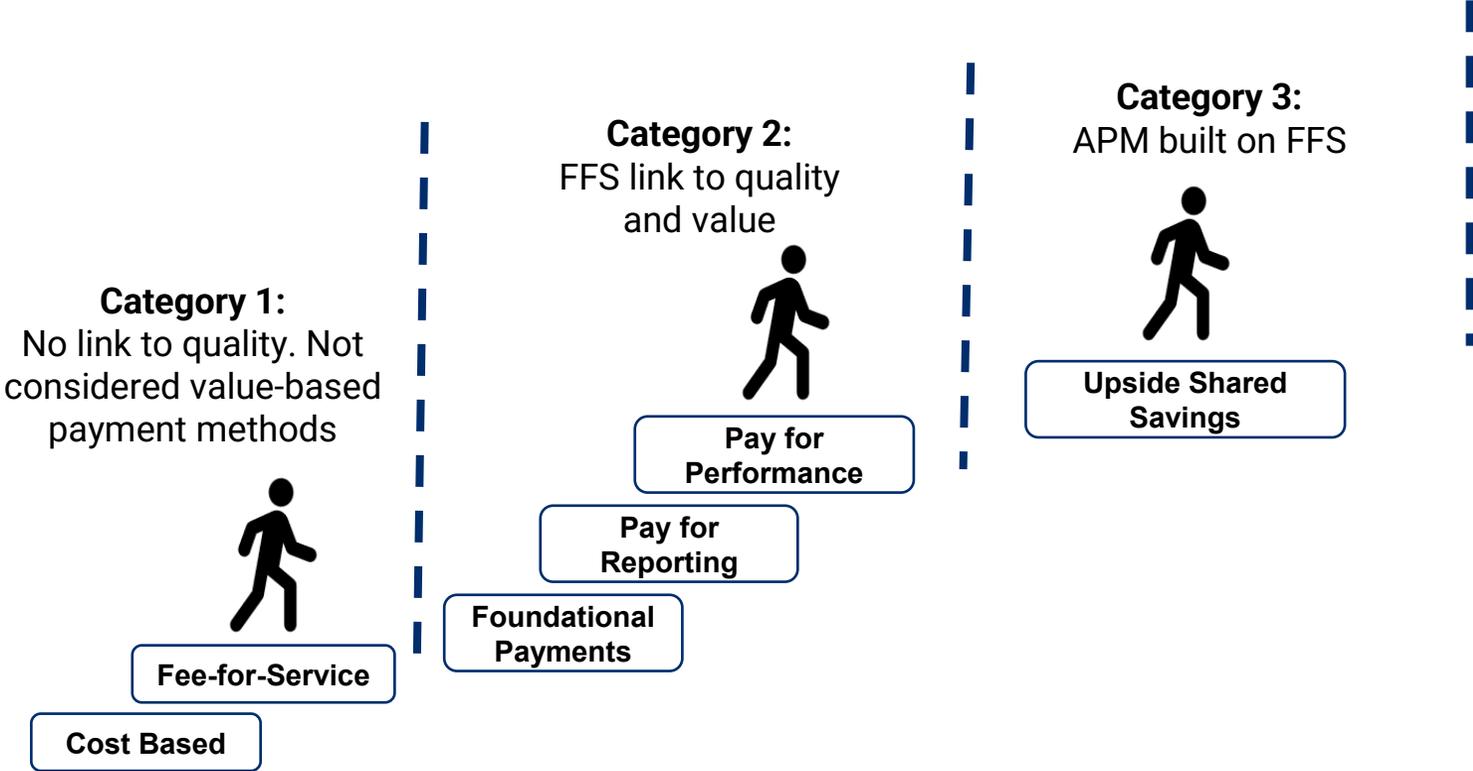
DPHHS will begin by implementing shared savings with a long-term goal of moving toward provider risk sharing.

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Shared Savings Overview

Objective: Reduce low-value utilization of the health care system as demonstrated by reducing risk-adjusted and trended 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.

Population Cost Target

Performance/ Actual Cost

Delta = Shared Savings

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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

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Proposed Value-Based Care (VBC) 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

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Next Steps: Future Tier 3 Discussions

Care management expectations → **Risk stratification** →

Shared savings model
- Benchmark period cost
- Performance period cost
- Establish PMPM
- Determination of savings earned by provider

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Key Partner Questions and Discussion

Contact Information

- Questions and/or concerns?
  - MTPrimaryCarePrograms@mt.gov
- Next Key Partner Meeting:
  - Week of April 13, 2026
- Montana Medicaid Provider PCMT Program Town Hall – TA Kickoff
  - April 13, 2026, 11:00 am – 12:30 pm
  - Register Here: https://mt-gov.zoom.us/webinar/register/WN_4dxnn3KYRBKFpOYGwRqXLQ?ampDeviceId=c2617c90-516a-454a-b58e-db6aa42bdcf2&ampSessionId=1773845956533
- Coming Soon!
  - PCMT Website