MT PCCM Redesign – Primary Care Montana (PCMT)

Key Partner Meeting

May 28, 2026 - 11:30 am

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Agenda

Quick Provider TA Update

Tier 3 Discussion:

- Care Management Overview
- Evidence Based Framework
- Staffing Model and Roles
- Discussion and Polling
- Next Steps

PCMT Provider TA Update

65 Clinics have registered for TA

TA Onboarding Webinar May 20

HMA Coaches are reaching out and scheduling the capabilities assessment

What is Care Management?

Activities that assist patients and their support systems to manage medical and psychosocial problems with the aim of improving health and reducing the need for expensive medical services

The goals are to:

- Improve patients' functional health status
- Enhance coordination of care
- Eliminate duplication of services
- Reduce the need for expensive medical services

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

PCMT Step Ladder of Care

Tier 1

PRIMARY CARE SERVICES

All patients receive this level of service, including PCP appointments, referral management, population health activities

Tier 2

TRANSITIONS OF CARE

Patients who have been treated in a hospital or other institutional setting and are returning to the community.

Tier 3

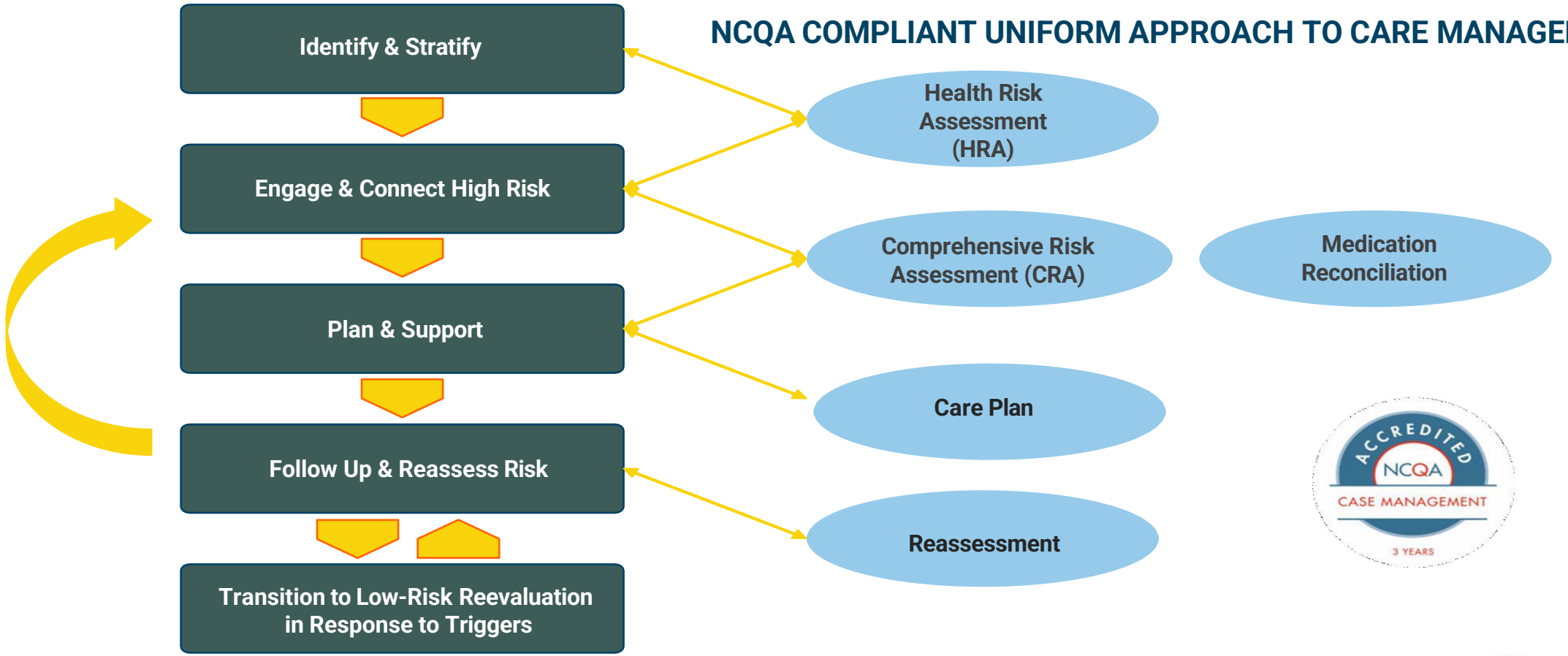
COMPLEX CARE MANAGEMENT

High-risk, multiple chronic conditions, sub optimally managed as manifested by frequent ED visits and hospitalization, often with health-related social needs.

Evidence-Based Elements of Complex Care Management

- Risk stratification to identify those most likely to benefit
- Integration with the Primary Care Team
- Face to face interactions with care managers and their patients on a regular basis
- HIT support to inform care planning, support communication, and monitor effectiveness
- Strong linkages between behavioral health and physical health
- Strong emphasis on medication management
- Transitions of care support
- Addressing health-related social needs
- Efficient use of the “right staff” - at the top of their license and having a team approach to getting the work done

Evidence-based Best Practice as Determined by NCQA



Care Coordinators/Care Managers High Level Responsibilities

Care Coordinator (Unlicensed)	Care Manager (LCSW/LPN/RN)
• Outreach and ongoing patient engagement • Patient education and awareness; promote self-management • Coordinate referrals, other needed community resources • Closing care gaps and social determinants • Other tasks as requested by the Care Manager	• Outreach and ongoing patient engagement • Patient education and awareness; promote self-management • Medication review and support for treatment adherence • Brief interventions, motivational interview and behavior change • Create and update patient goal setting and care plans • Communicate appropriately with PCP and other team members about concerns and patient progress

Assumption: Transitions of care for those in high-risk care management paid for by Tier 2 fees.

Determining High-Risk Care Management Staffing and Cost

- Choose care management tasks
- Assign task to Care Coordinator or Care Manager
- Allocate tasks by risk stratification
- Estimate time per task
- Estimate frequency of task
- Estimate ED visit rates
- Estimate salary and benefit expense
- Modify assumptions based on cost

PCMT Strawman

PCMT Care Management (strawman for discussion purposes only)							
Tasks	Time allocated (hours)	Frequency Per Year		Care Coordinator time/yr (hrs)		Care Manager time/yr (hrs)	
		Mod Risk	High Risk	Mod Risk	High Risk	Mod Risk	High Risk
Initial or annual comprehensive health risk assessment (assumes multiple attempts are sometimes required)	1	1	1	0.00	0.00	0.03	0.03
Initial/annual major revision of care plan	1	1	1	0.00	0.00	0.03	0.03
Community -based organization referrals and follow-up	0.5	0.375	0.375	0.006	0.006	0.00	0.00
Specialty, diagnostic and other external referrals	0.5	1	1.5	0.02	0.023	0.00	0.00
Closing gaps in care and wellness messaging	0.5	1	1	0.02	0.02	0.00	0.00
Post-ED visit contact	0.5	0.5	1.5	0.01	0.023	0.00	0.00
Telephonic care plan review	0.75	2.25	8.25	0.00	0.00	0.05	0.19
Post-hospitalization transition of care	1.5	0.00	0.00	0.00	0.00	0.00	0.00
Disease management/health coaching	0.5	2	2	0.00	0.00	0.03	0.03
Hours PMPY				0.04	0.07	0.14	0.28

Discussion and Polling Questions

Are these the right care management tasks? (Y/N)

If not, how should they be modified?

Tasks
1. Initial or annual comprehensive health risk assessment (assumes multiple attempts are sometimes required)
2. Initial/annual major revision of care plan
3. Community-based organization referrals and follow-up
4. Specialty, diagnostic and other external referrals
5. Closing gaps in care and wellness messaging
6. Post-ED visit contact
7. Telephonic care plan review
8. Post-hospitalization transition of care
9. Disease management/health coaching

Discussion and Polling Questions

Are the tasks appropriately assigned to care coordinators vs. care managers? (Y/N)

PCMT Care Management (strawman for discussion purposes only)							
Tasks	Time allocated (hours)	Frequency Per Year		Care Coordinator time/yr (hrs)		Care Manager time/yr (hrs)	
		Mod Risk	High Risk	Mod Risk	High Risk	Mod Risk	High Risk
Initial or annual comprehensive health risk assessment (assumes multiple attempts are sometimes required)	1	1	1	0.00	0.00	0.03	0.03
Initial/annual major revision of care plan	1	1	1	0.00	0.00	0.03	0.03
Community -based organization referrals and follow-up	0.5	0.375	0.375	0.006	0.006	0.00	0.00
Specialty, diagnostic and other external referrals	0.5	1	1.5	0.02	0.023	0.00	0.00
Closing gaps in care and wellness messaging	0.5	1	1	0.02	0.02	0.00	0.00
Post-ED visit contact	0.5	0.5	1.5	0.01	0.023	0.00	0.00
Telephonic care plan review	0.75	2.25	8.25	0.00	0.00	0.05	0.19
Post-hospitalization transition of care	1.5	0.00	0.00	0.00	0.00	0.00	0.00
Disease management/health coaching	0.5	2	2	0.00	0.00	0.03	0.03
Hours PMPY				0.04	0.07	0.14	0.28

Discussion and Polling Questions

Is the estimated time allocated for each task appropriate? (Y/N)

Tasks	Time allocated (hours)
1. Initial or annual comprehensive health risk assessment (assumes multiple attempts are sometimes required)	1
2. Initial/annual major revision of care plan	1
3. Community -based organization referrals and follow-up	0.5
4. Specialty, diagnostic and other external referrals	0.5
5. Closing gaps in care and wellness messaging	0.5
6. Post-ED visit contact	0.5
7. Telephonic care plan review	0.75
8. Post-hospitalization transition of care	1.5
9. Disease management/health coaching	0.5

Discussion and Polling Questions

Should we have both moderate and high-risk categories, the difference between the frequency of care plan updates? (Y/N)

PCMT Care Management (strawman for discussion purposes only)

Tasks	Time allocated (hours)	Frequency Per Year		Care Coordinator time/yr (hrs)		Care Manager time/yr (hrs)	
		Mod Risk	High Risk	Mod Risk	High Risk	Mod Risk	High Risk
Initial or annual comprehensive health risk assessment (assumes multiple attempts are sometimes required)	1	1	1	0.00	0.00	0.03	0.03
Initial/annual major revision of care plan	1	1	1	0.00	0.00	0.03	0.03
Community -based organization referrals and follow-up	0.5	0.375	0.375	0.006	0.006	0.00	0.00
Specialty, diagnostic and other external referrals	0.5	1	1.5	0.02	0.023	0.00	0.00
Closing gaps in care and wellness messaging	0.5	1	1	0.02	0.02	0.00	0.00
Post-ED visit contact	0.5	0.5	1.5	0.01	0.023	0.00	0.00
Telephonic care plan review	0.75	2.25	8.25	0.00	0.00	0.05	0.19
Post-hospitalization transition of care	1.5	0.00	0.00	0.00	0.00	0.00	0.00
Disease management/health coaching	0.5	2	2	0.00	0.00	0.03	0.03
Hours PMPY				0.04	0.07	0.14	0.28

Discussion and Polling Questions

Is the expected frequency of tasks appropriate? (Y/N)

	Tasks	Time allocated (hours)	Frequency Per Year	
			Mod Risk	High Risk
1.	Initial or annual comprehensive health risk assessment (assumes multiple attempts are sometimes required)	1	1	1
2.	Initial/annual major revision of care plan	1	1	1
3.	Community -based organization referrals and follow-up	0.5	0.375	0.375
4.	Specialty, diagnostic and other external referrals	0.5	1	1.5
5.	Closing gaps in care and wellness messaging	0.5	1	1
6.	Post-ED visit contact	0.5	0.5	1.5
7.	Telephonic care plan review	0.75	2.25	8.25
8.	Post-hospitalization transition of care	1.5	0.00	0.00
9.	Disease management/health coaching	0.5	2	2

Key Partner Questions and Discussion

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Next Steps: Future Tier 3 Discussions

Risk Stratification

Shared Savings

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

Contact Information

- Questions and/or concerns?
  - MTPrimaryCarePrograms@mt.gov
- Next Key Partner Meeting:
  - DPHHS will pause Key Partner meetings while working on risk stratification. We will plan to reconvene in August or September.