PRIMARY CARE MONTANA (PCMT) PROGRAM AND PROVIDER TECHNICAL ASSISTANCE (TA) FREQUENTLY ASKED QUESTIONS

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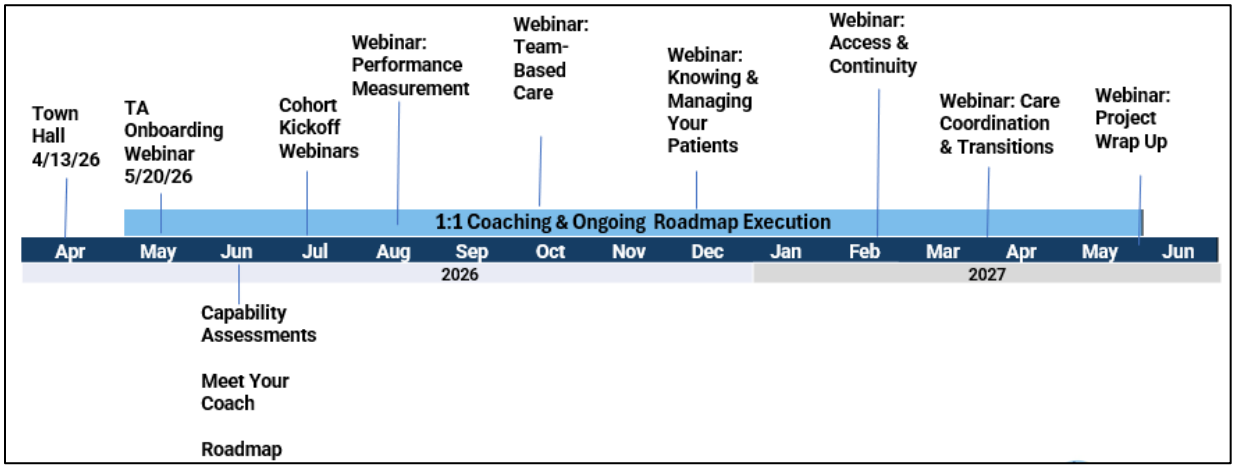
TA EXPECTATIONS AND TIMELINE

What is the TA timeline?

Technical Assistance (TA) will begin with the May 20, 2026, enrollment webinar and continue through at least the first six months of PCMT implantation. Practices can join later, but early participation is encouraged so they can benefit from the support during the initial roll out.



If we can't attend the 5/20/26 enrollment webinar, will there be another one scheduled?
A recording of the May 20, 2026, webinar will be available. A Health Management Associates (HMA) coach will also reach out to connect 1:1 with enrolled practices, and additional webinars may be scheduled based on provider interest and need.

What is the estimated time commitment for practices electing to enroll in TA for the first six months (capability assessment, 1:1 coaching, webinars)?
Practices should plan about 2-3 hours per month for TA, including 1:1 coaching and webinars. Actual time may vary by practice based on identified needs (capability assessment and roadmap), and TA can be ramped up as needed. 1:1 coaching is estimated to occur monthly but could be more frequent.

What is the cost for Technical Assistance?
For providers participating, or wanting to participate, the PCMT program, Technical Assistance is a free resource. Funding for PCMT Technical Assistance is provided by the Rural Health Transformation Program (RHTP).

PROGRAM DESIGN

PCMT ELIGIBILITY

How will the Per Member Per Month (PMPM) payment apply to the Rural Health Clinic (RHC) payment model?
RHCs can participate in PCMT and receive the PMPM reimbursement in addition to the RHC prospective payment system (PPS) rate. PCMT was designed to ensure that RHCs could fully participate in PCMT.

For larger organizations, do we enroll at the Taxpayer Identification Number (TIN) level or each individual clinic level?
Each practice location enrolls as a PCMT provider. Enrollment and attribution occur at the location level (TIN/service location), not at the individual rendering provider level.

How does this affect us, as we are part of an Accountable Care Organization (ACO)? What are the age groups we are including in this?
The PCMT program is for Montana Medicaid and Healthy Montana Kids *Plus* members and does not affect any ACO arrangements a practice may have with commercial or Medicare payers. All Medicaid age groups are included in the PCMT as long as the member is enrolled in Medicaid coverage and not in a population excluded from the program. Populations excluded from PCMT are:

- Dual Eligibles (Members who have Medicaid and Medicare)

- Reside in a Nursing Facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities, or Psychiatric Residential Treatment Facility
- Members with Medicaid eligibility less than three (3) months
- Members enrolled in a 1915(c) Waiver
- Spend-down members
- Presumptively eligible members
- Members enrolled in the Family Planning Waiver

Regarding the ACO Medicare members, if they have Medicaid as secondary will it include these members?
Similar to Montana's (MT) current Passport to Health (Passport), Patient Centered Medical Home (PCMH) and Comprehensive Primary Care Plus (CPC+) programs, dual eligibles are not included in this program. You would not get a PMPM for dual eligible members.

PCCM Program Changes

Will the Patient Centered Medical Home (PCMH) certification requirement still be a part of this new program or will that no longer be required?
The PCMT program was designed to align with National Committee for Quality Assurance (NCQA) PCMH requirements but does not require full recognition/certification. Practices will need to meet the PCMH-aligned requirements identified for each Tier. There is not an explicit requirement to get or maintain PCMH recognition. If you do have PCMH recognition, it will count as meeting the PCMH-aligned Tier requirements.

What does this change mean for specialist physicians who currently are retrieving Passport referral numbers from primary care providers (PCPs) to see Medicaid members?
Passport referral numbers will no longer be required on claims for services provided on or after July 1, 2026. Some services will still require a medical order or prior authorization, and individual providers or systems may still choose to require referrals internally. Providers should consult their provider-specific fee schedules, manuals, and the Administrative Rules of Montana to determine when a medical order or prior authorization is required.

Since this program kicks off July 1, 2026, can we stop calling PCPs 7/1/26 for Passport referral numbers?
For services provided after 7/1/26, Passport referrals will no longer be required.

Will there be a program specific manual to reference?
Yes. The Department of Public Health and Human Services (DPHHS) will post a PCMT program specific provider manual to the provider website (Medicaidprovider.mt.gov), replacing the current Passport manual. Once posted, DPHHS will send a notification to all providers.

Does this mean that there will be no prior authorization needed for Medicaid from PCP or referrals?
No. Prior authorization and medical orders for services will still be required when applicable. Under PCMT, PCPs will manage referrals within their practice or system rather than adding referral numbers to claims.

Quality Measures

What quality metrics are part of this program?
Quality metrics are listed in the Tier 1 and Tier 2 Fact Sheets on our PCMT website here: https://dphhs.mt.gov/MontanaHealthcarePrograms/pcmt

How often will we receive performance data and in what format?
Performance data will be shared as monthly reports – pushed out through the Provider Services ICAP Portal (ICAP Portal).

The Healthcare Effectiveness Data and Information Set (HEDIS) core set has some measures around Mental health, ADHD, Depression screening, etc. Do you anticipate these being rolled in at some point?
The 2026-2027 quality metrics selected are part of the HEDIS core set, but do not represent the complete core set. The selected measures were chosen in consultation with Key Partners and include measures for primary care-impacted conditions and services, measures that impact a large percentage of members, measures that are reasonable to calculate with available data, and measures that many providers are familiar with from CPC+ and PCMH reporting requirements, HEDIS, Uniform Data System (UDS), and Blue Cross Blue Shield's value-based care program.

The Department will analyze quality measures continually. Measures can and will be updated in future years to ensure continued alignment with HEDIS and CMS core measures.

What are the pregnancy measures for participation and during the postpartum period?
Prenatal and post-partum care measures align with HEDIS measures – timeliness of prenatal care and receipt of postpartum care.

Can we review and give input on the measures?
The measures have been selected and vetted with key partners.

Data Reporting

How does Montana Medicaid get the quality measures data?
Most of the selected measures are claims-based, and others are clinical data obtained through the state's Health Information Exchange (HIE), Big Sky Care Connect.

- The requirement for Tier 1 is to meet 3 out of 12 quality metrics. Providers can meet requirements with just claims-based measures.

Are you accepting CPT II codes?
Yes

When CPT II codes are not placed on a claim, can they be entered on the provider portal to close those measures?
No - CPT II codes can only be collected through clean claims submitted to Medicaid or through the HIE (Big Sky Care Connect). The Department will define a process for a provider to report if there is a discrepancy is found by a provider, but providers will not be able to manually close a measure.

Is gap closure only based upon claims submitted or will there actually be a gap report that can be completed and submitted to Medicaid?
Information to close a gap will be primarily pulled from claims and through the HIE (Big Sky Care Connect). At this time, there will **not** be a manual gap closure report providers can manually fill out and return to the Department.

How can we review our measures in semi-real time in order to adapt and utilize our Electronic Medical Records system (EMRs)?
DPHHS will provide monthly reports to providers. Measures are claims-based with optional Electronic Health Records (EHR) Measures. DPHHS utilizes Big Sky Care Connect to connect to clinical information from provider EHRs.

If reports are inaccurate due to erroneous claims and clinical data in Big Sky Care Connect, technical assistance can help improve cleanliness of data, rather than rely on manual entry and ongoing fixes of the data that place burden on the providers.

PAYMENT

What amount are the incentive payments?

- Tier 1 provides a $6 PMPM payment.
- Tier 2 provides an $11 PMPM payment.
- Tier 3 payment, including PMPM and shared savings, is still being determined.

If there are no incentive payments for Tier 1 and Tier 2, are there repercussions if you don't meet the measures?

- The incentive payment for Tier 1 and Tier 2 is the PMPM. To maintain status in the PCMT program, you must meet performance measures.
- In year 1 of program launch, participating is enough to get a PMPM payment for providers. In year 2, if provider performance does not meet benchmarks or improvement targets in future years, a practice will not maintain their PMPMs and may possibly be

removed from participation in the program. If a provider does get removed from participation, they can re-apply again in the future. The reporting year is calendar year (January 1 – December 31).

What is the payment cycle for PMPM payments?
Per member per month – monthly payment for attributed members. Ex: July attribution will be paid the first of August.

ATTRIBUTION AND PCPS

As Medicaid eligibility is being reassessed frequently, what will the reliability of attributed member lists be? How will Medicaid determine member attribution?

- Members are first attributed based on their choice of primary care provider (PCP). Their chosen provider does not have to be a PCMT PCP. They can select or change their PCP at any time by calling the Member Help Line or using the Member Portal.
- If a member does not choose a PCP, attribution is then determined prospectively using claims-based information, enabling providers to clearly identify the member for whom they are accountable at the beginning of each performance period.
- Attribution is determined on the second day of each new month, and attribution lists will be available monthly for providers.
- If a Medicaid member is determined to be eligible as of a date within a month, their coverage is effective either on that date or the first day of that month, and coverage generally continues through the end of the month in which they no longer meet eligibility requirements.
- DPHHS will periodically perform passive PCP reassignment to better reflect where the beneficiary is receiving primary care.

How often will gap reports be provided to clinics?
Gap reports will be provided through the provider portal monthly.

What will the process for changing PCP look like?
The PCP assignment and re-assignment process will not change. There will still be a delay in the system of about 30 days for assignments to be reflected in the attribution reports. However, passive PCP reassignment will also provide an opportunity to adjust PCP assignment based on which PCP members are seeing. Since the gatekeeping referral requirement will be removed as of July 1, 2026, members can go to their new provider before that change takes place in the system.

Will members who are attributed but not seen by their PCP be included in the quality metric calculations?
Members part of a provider's attribution are included in their quality measure whether the provider sees the member or not. The focus of a population health program is to have

accountability and oversight over the population of members, not just the members that come to the clinic. PCPs should still focus on outreach to members attributed to providers to get them into the clinic for needed services.

If an attributed member is receiving care elsewhere, that Medicaid member can actively switch their PCP. Additionally, DPHHS will conduct periodic passive reattribution. There is limited pathways for providers to offload members not seeking care.

Can the member be seen by any specialty clinics if their PCP is not with the specialty clinic?
Yes – they can and should. Members should be encouraged to go to a provider of their choice.

Does the PCP change only affect those who are signed up for this program?

- All eligible Medicaid members can choose a PCP, or one will be assigned—this process is not changing.
- Providers choose whether to participate in the program. Medicaid members of participating providers will be included in the program. A Medicaid member can choose not to participate in the program by selecting a PCP that is not participating. As such, the program is voluntary for both providers and members.

If a member goes to a clinic as their majority provider/PCP, will they be passively attributed to the clinic even if the member does not make the change themself?
Yes. Members will be sent a notification about a change in their attributed PCP, with the opportunity to make changes.

When we start utilizing quality measures based on a claims feed, will the attributed lists be accurate by the following month?
Monthly attribution may change based on Medicaid enrollment, disenrollment, and requested PCP changes. Passive reattribution will occur periodically but will not occur monthly.

- Attribution lists will be sent through the provider portal. The list will identify new members, current members, and disenrolled members.

Will there be a way to stabilize member attribution to minimize impact on measure performance of members potentially being either disenrolled/ re-enrolled from Medicaid changes?
Because PCMT attribution is tied to Medicaid eligibility and PCP selection, some movement in and out of attributed panels is unavoidable and will be reflected in the monthly lists and any claims-based quality reporting. Monthly attribution files will show which members are newly attributed, continuing, or have disenrolled so practices can track who is in their panel for the relevant measurement month. Passive re-attribution will occur periodically rather than every

month, which will help reduce frequent PCP changes due solely to minor claims variation. In addition, quality measures will be calculated using a defined measurement period and anchor dates (for example, looking at whether a member was attributed and eligible on a specific date or over a minimum continuous enrollment period), which is a standard approach used in Medicaid and other value-based programs to stabilize attribution for performance measurement.

Will you provide us a list of attributed members for each provider we enroll?
Under PCMT, members are attributed to the practice location at the TIN level, not to individual rendering providers. Because attribution occurs at the location/TIN, the Department will supply attributed member lists by enrolled PCMT location, rather than separate lists for each individual provider. Individual providers will be associated to that practice location.

Will our quality metrics be retroactively updated for the member who took some time to be passively attributed accurately?
Quality metrics for performance assessment and benchmarking purposes will be calculated in alignment with passive attribution. DPHHS will not need to retroactively change quality reports to assess performance.

How does attribution work during perinatal period if a member sees a different OB provider than PCP?
Attribution is based on PCP. The prenatal metrics are timeliness of prenatal care (received in the first trimester or within 42 days of enrollment) and postpartum care—both of which can be and are often provided by the PCP, even if a member sees a different Obstetric (OB) provider for further pregnancy visits and delivery. A member may see an OB for postpartum care, but the PCP should still ensure that care was provided, and if not, provide postpartum services. As such, the PCP still works to ensure the provision of adequate prenatal and postpartum care. Since providers need to meet benchmarks or improvement targets for 3 of 12 measures, providers are not dependent on perinatal measures if they are not providing this care.

Member Communication

Will members receive education about this new program and how important it is for them to have annual well visits with their primary provider?
Yes. All members will be informed about the PCMT program, the transition from Passport to Health, and what that means for them. Communication will be distributed through standard channels, such as member letters, the member newsletter, or other Department approved outreach methods. Messaging will highlight the purpose of the program and what members can expect. DPHHS already sends out communication to members about the importance of Well Child Visits, this goes out yearly and bi-yearly and will continue to do so.

- A new member guide will be made available July 1, 2026 on the Medicaid.mt.gov website: 2026 Medicaid Member Guide. Member notifications of PCMT will go out the beginning of May.

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