

PRIMARY CARE MONTANA (PCMT) TIER 2 PROGRAM FACT SHEET

PCMT Program Overview

Montana’s redesigned Primary Care Case Management (PCCM) program, Primary Care Montana (PCMT), accommodates different provider sizes/resources by providing a glidepath toward higher levels of population health management, with increasing expectations for structure and performance as providers move along the glidepath. This approach allows providers to take on additional responsibilities at a pace matching their practice size and capabilities.

Tier 1	Tier 2	Tier 3
<p style="text-align: center;">“Basic” Ensuring preventive services</p>	<p style="text-align: center;">“Plus” Managing transitions of care</p>	<p style="text-align: center;">“Advanced” Fully managing complex populations</p>

The new tiered PCMT provider’s participation requirements build on the foundational concepts which Montana providers are familiar with through the current Passport to Health, Patient Centered Medical Home (PCMH) and Comprehensive Primary Care Plus (CPC+) provider agreement requirements.

Tier 2 Overview

Tier 2 of Montana Medicaid’s PCMT program provides a per-member per-month (PMPM) care coordination fee to support primary care providers (PCPs) in helping patients transition safely back to community-based care after inpatient hospitalization. Funding is tied to performance in improving post-discharge outcomes and reducing avoidable readmissions (unplanned hospital readmissions occurring shortly after a patient’s discharge from an initial admission).

Objectives for Tier 2 PCMT Program

- **Increase timely post-discharge follow-up:** Improve the percentage of patients who complete a primary care visit within 14 days of hospital discharge.
- **Reduce unplanned readmissions:** Lower the rate of 30-day hospital readmissions through proactive care management and coordination.

Tier 2 Provider Eligibility

Tier 2 builds upon Tier 1 by adding requirement for transitional care management.

- Must be meet the requirements of and participate in Tier 1
- Must be actively managing transitions of care after hospitalization
- Ongoing participation depends on meeting annual performance targets

Tier 2 Payment Model

Participating providers receive an enhanced \$11 PMPM care coordination fee.

- In **Year 1**, participating providers receive enhanced PMPM payment based on meeting Tier 1 and Tier 2 Provider Requirements.
- Starting in **Year 2**, participating providers must continue to meet Tier 1 and Tier 2 Provider Requirements *and must also meet* performance targets on follow up after hospitalization



within 14 days and readmission within 30 days. Providers must achieve a rate that is the lower of 21% or a relative 10% improvement over the baseline rate. DPHHS will set individual provider goals in Year 2 based on Year 1 baseline, using gap closure methodology.

Tier 2 Provider Requirements (in addition to Tier 1 Provider Requirements)

PCMH Concept	Requirement
Team-Based Care:	<ol style="list-style-type: none"> 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:	<ol style="list-style-type: none"> 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 medications¹ for more than 80 percent of patients who receive care for IP transitions 5. Maintains an up-to-date list of medications for more than 80 percent of patients.
Access and Continuity:	<ol style="list-style-type: none"> 1. Outreach within 60 days to new patients to establish care
Care Coordination and Care Transitions:	<ol style="list-style-type: none"> 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 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:	<ol style="list-style-type: none"> 1. Meets performance targets on attributed members for follow up after hospitalization within 14 days 2. Meets performance targets on attributed members for readmission rates - achieve a rate that is the lower of 21% or a relative 10% improvement over the baseline rate. DPHHS will set individual provider goals in Year 2 based on Year 1 baseline, using gap closure methodology.

¹ 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.