

Primary Care Montana (PCMT) Provider Enrollment Agreement – Tier 1 and Tier 2

Provider (Facility) Name		
Mailing Address		
City	State	ZIP
Physical Address		
City	State	ZIP
Phone Number	Fax Number	
NPI	PCMT ID	
Email address		
Tier Level of Enrollment (Tier 1 or Tier 2)		

Section 1. Legal Authority

Enrollment in Primary Care Montana (PCMT) (the program) under this addendum shall be part of the provider's Montana Healthcare Programs enrollment for purposes of governing the provider's participation in the PCMT program. This addendum shall not in any way reduce or modify the provider's Montana Healthcare Program enrollment with respect to participation or provision of services under Montana Healthcare Programs.

The provider(s) hereby agrees to comply with all applicable laws, rules and written policies including but not limited to Title XIX of the Social Security Act, the Code of Federal Regulations (CFR), Montana Codes Annotated (MCA), Administrative Rules of Montana (ARM), written Department of Public Health

and Human Services (Department) policies, policies contained in provider manuals, and the terms of this document.

The Department may update PCMT program requirements, including tier definitions, performance standards, and operational procedures, through changes to administrative rule, the PCMT Provider Manual, and other written guidance. Such updates become binding of PCMT providers as the effective date specified in the Department's issuance.

Section 2. Purpose and Program Goals

The purpose of this addendum is to obtain Primary Care Case Management (PCCM) services for designated Montana Healthcare Programs and Healthy Montana Kids *Plus* (HMK *Plus*) members from the contracting provider under the Primary Care Montana (PCMT) program. PCMT is intended to support a primary care value-based delivery model, that emphasizes comprehensive, coordinated, and person-focus care for attributed members.

Program Goals include, at minimum:

- Ensuring timely access to primary care and establishing or strengthening a “medical home” relationship.
- Improving continuity of care across physical health, behavioral health, and social support services.
- Encouraging preventative care and effective chronic disease management.
- Promoting appropriate use of emergency departments and urgent care clinics and reducing avoidable utilization.
- Supporting care coordination and transitions between levels and settings of care.

The Department may access and revise PCMT goals and performance expectations in administrative rules, program manuals, or other written guidance, which will be incorporated by reference into this agreement.

Section 3. Term

This agreement becomes effective on the signature date of the provider or facility, and approved by the Department, but not prior to July 1, 2026. The agreement shall remain in effect until otherwise amended or terminated under Section 14 of this agreement. The Department may periodically revise PCMT policy or operation requirements through rule making or written guidance; such changes will apply to providers upon the effective date specified in said documents.

Section 4. Provider Eligibility and Program Participation

1. Provider Participation Eligibility

- a. The Provider must be enrolled, and remain in good standing, as a Montana Medicaid provider, under Montana Healthcare Programs.
- b. A Primary Care Montana Provider (PCMT Provider) may be:

- i. An individual physician or mid-level practitioner (e.g. General Practice, Family Medicine, Internal Medicine, Pediatrics, Clinical Nurse Specialist, Nurse Practitioner, Physician Assistant).
 - ii. A Federally Qualified Health Center, Rural Health Clinic, Indian Health Service provider, a Tribal Healthcare Clinic, or other primary care clinic or organization approved by the Department.
 - c. The provider must execute this PCMT Provider Enrollment Agreement (solo or group, as applicable) and comply with all PCMT participation requirements in the Department manuals and guidance.
2. PCMT Participation Tier
- a. At the time of enrollment, the provider must elect to participate as either a Tier 1 PCMT provider or a Tier 2 PCMT provider, as those tiers are defined in the PCMT Provider Manual.
 - b. Tier 1 and Tier 2 participation is contingent upon completion of the applicable PCMT Tier attestation and Department approval of attestation. Providers can either attest they meet the requirements of Tier 1 or Tier 2 or provide PCMH recognition (NCQA, AAAHC, TJC, URAC).
 - c. The elected tier (Tier 1 or Tier 2) and effective date of tier participation will be recorded by the Department and will determine the care delivery expectations and payment methodologies applicable to the provider.

Section 5. General Provider Responsibilities

PCMT providers must carry out the responsibilities described in this section for all PCMT-attributed members, in addition to meeting all standard Montana Healthcare Programs Requirements.

- 1. Enrollment and acceptance of members
 - a. Accept PCMT-attributed members, including voluntary and auto-assignments in the order they are enrolled, up to any Department-approved panel limit.
 - b. Not discriminate on the basis of health status, need for services, disability, or anticipated utilization.
- 2. Relationship and continuity of care
 - a. Develop and maintain an ongoing relationship with PCMT members to support continuity of care and a stable medical home.
 - b. Identify and actively engage members with complex or high-risk needs for enhanced care management, consistent with Department guidance.
- 3. Core primary care and care coordination
 - a. Provide and arrange for primary and preventive care, health maintenance, treatment of illness and injury, and medically necessary referrals and follow-up.
 - b. Coordinate care across settings (e.g. specialty care, behavioral health, hospitals, post-acute care, community-based services) to reduce fragmentation and avoid duplication.
- 4. Preventive and screening services
 - a. Provide age-appropriate services, including well-child visits, EPSDT services, lead screening, adult preventive visits, and immunizations, in accordance with program.
- 5. Member education and navigation
 - a. Educate members about appropriate use of office visits, telehealth when available, urgent care clinics, and emergency departments.
 - b. Provide information on how to obtain after-hours and urgent care guidance 24 hours per day, 7 days per week, as specified in Department policy.

6. Non-discrimination
 - a. Not engage in discrimination prohibited under 42 CFR 438.3(d)(4)
7. Referral network and timely access
 - a. Internally maintain arrangements with, or referrals to, physicians, practitioners, and facilities sufficient to furnish timely services without compromising quality of care.
 - b. Make appointments based on members' routine, preventive, urgent, and emergent needs, consistent with access standards established by the Department.
8. Medical records and information exchange
 - a. Maintain an up-to-date medical record for each PCMT member and support HIPAA-compliant information exchange with other providers and care managers.
 - b. Upon a member's written request, transfer medical records to the member's new primary care provider within timelines specified by Department policy.
9. Care coordination documentation
 - a. Maintain a written or electronic record of care coordination activities, including referrals, care plans (where required), and follow-up arrangements for PCMT members.
10. After hours and coverage arrangements
 - a. Provide or arrange for coverage for needed services, consultation, and emergency referral approval during normal business hours and ensure 24-hour availability of information, referral, and direction for emergency medical conditions.
 - b. Ensure coverage for vacations, illness, and other absences.
11. Marketing and member communications
 - a. Not distribute marketing materials intended to influence member enrollment or choice of provider without prior Department approval.
 - b. Not engage in door-to-door, telephone, email, text message, or similar "cold call" activities with the purpose of soliciting enrollment or disenrollment.
12. Interpreter and language access
 - a. Offer interpreter services to members with limited English proficiency and provide oral interpretation for any language at no cost to the member; interpreter services are covered by Medicaid.
 - b. Provide written information in easily understood language and, where applicable, in prevalent non-English languages in the service area.
13. Reporting and program communication
 - a. Respond to Department requests to verify services paid were authorized or coordinated by the PCMT provider, as applicable to the PCMT design.
 - b. Notify the Department and/or its fiscal agent in writing or electronically of practice changes (e.g., change of address, closure, change in participation in PCMT) within required timelines.
14. Ongoing review of PCMT requirements
 - a. The PCMT provider is responsible for remaining current with PCMT requirements and agrees to review the PCMT Provider Manual, provider notices, and related guidance on an annual basis at minimum, and more frequently as needed, to ensure continued compliance with program standards and requirements.
15. Provider notification to members of new address or name change
 - a. Providers are responsible for notifying members attributed to their clinic if they have a new address or business name change. Providers are also required to notify the Department's fiscal agent of changes to their address or business name.
16. Written Materials and Oral Interpretation

- a. The PCMT provider will make available written information regarding the practice and PCMT, in easily understood language and format for members, including members with limited literacy.
- b. Written materials will be made available in prevalent non-English languages in the service area.
- c. The provider will provide oral interpretation services for any language at no cost to the member; Interpreter services are covered by Montana Healthcare Programs and may be accessed through methods specified on the provider website.

Section 6. Member Attribution, Enrollment, and Changes:

1. Attribution and Enrollment in the PCMT program
 - a. The Department will define PCMT-eligible populations and attribution methods in the PCMT Provider Manual and other written guidance (e.g. member selection, claims-based attribution, or other methodology).
 - b. Members eligible for the PCMT program will receive information about the PCMT program and a letter which includes a list of possible PCMT providers within the member's geographical area. The list is generated to suggest the best possible provider for the member.
 - c. If the member fails to choose a provider, or let the Department know who their PCP is (even if the PCP is not a PCMT provider), the Department may assign a provider using factors such as prior primary care use (claims history), claims history, provider relationship with other family members, AI/AN designation, and geographic proximity, subject to provider capacity.
2. Member-initiated changes
 - a. Members may request a change in PCP or PCMT provider without cause using processes established by the Department (e.g., Member Help Line, web portal, or written request).
 - b. Unless otherwise specified, changes will generally not appear effective until the first day of the following month.
3. Provider-initiated disenrollment
 - a. The PCMT provider may request to disenroll a member from their panel by providing 30 days written notice to the member and to the Department. The PCMT provider should provide services during the notice period, or until the member has established with a new PCP (whichever comes first) to ensure continuity of care.
 - b. A PCP may not disenroll a member from their panel based on a change in health status, high utilization, disability, diminished mental capacity or uncooperative behavior resulting from special needs, except if behavior seriously impairs the ability to furnish services to the member or others, or for failure to pay co-payments or other member-responsibility amounts when allowed by law.
4. Reasons for provider-initiated disenrollment may include
 - a. Physically or verbally abusive or threatening behavior.

Section 7. Primary Care Montana (PCMT) Panel Management and Enrollee Lists

The Department or its designee will provide PCMT providers with regular (e.g. monthly) panel lists of attributed members, including key identifying and contact information through secure electronic method (e.g. Provider MPATH portal). A Team Care list will accompany the PCMT list if

applicable. The Team Care list will include the name of the members' pharmacy to which all prescriptions must be written.

PCMT providers must review panel lists, reconcile discrepancies, and notify the Department of needed corrections according to Department instructions outline in the PCMT provider manual.

Section 8. Clinic-Level Requirements (Group or System Participation)

Providers of health care services either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the ownership and administrative and financial control of the main provider are required to participate in the PCMT and Team Care programs. Further, they must:

1. Accept auto-assignment.
2. Not limit or restrict Montana Healthcare Programs members unless the same limits or restrictions apply to non-members.
3. Accept new Montana Healthcare Programs members at the same rates as non-members are accepted.
4. Only disenroll members from his or her caseload per this agreement and subject to approval by the Department.

Section 9. Provider Fees and Payments

1. PCMT Reimbursement:
 - a. In addition to standard fee-for-service reimbursement, PCMT providers receive per member, per month (PMPM) capitated payment to provide a medical home for the PCMT members assigned to their caseload. The PMPM is paid whether the provider sees the member that month. The PMPM is paid with the expectation that the items listed in this agreement are completed as needed for the members' coordination of care.
 - b. The PMPM payment is generated by the Department and is paid to the providers under their PCMT Provider ID number. The PCMT provider does not need to bill the Department for these services.
2. Changes in PCMT Tier Status
 - a. A provider initially enrolled as Tier 1 may request advancement to a higher Tier by submitting an updated PCMT Tier Attestation and any required supporting documentation, in the form and manner specified in the PCMT provider manual.
 - b. Tier advancement is not effective until approved by the Department or Department's contractor and assigned an effective date. The Department will provide a written notice of the effective date of any tier advancement and any associated payment changes.
 - c. A provider's tier status and effective dates (initial enrollment, advancement, or demotion) will be maintained by the Department and may be reflected in Department systems and member materials.
 - d. If the Department determines that a provider is not meeting applicable performance standards for its current tier, the Department may, consistent with PCMT policy and applicable law, take one or more of the following actions:
 - i. Send notification of non-compliance of program policy and corrective action timeline.

- ii. Suspend some or all tier-related payments (including PMPMs or incentive payments) while the provider is under corrective action.
 - iii. Demote the provider from current tier status to a lower status if the provider is meeting lower status requirements and attestations.
 - iv. Remove the provider from PCMT participation if the provider does not meet minimum Tier 1 requirements or fails to comply with corrective action.
- e. The Department will notify the provider, in writing of any suspension of payment, demotion in tier, or removal from PCMT participation, including the effective date of the action and, where applicable, the provider's right to request review or appeal.

Section 10. Inspection and Audit of Records and Access to Facilities

The Department, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the PCP, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the agreement period or from the date of completion of any audit, whichever is later. Programmatic oversight audits will happen as outlined in the provider manual.

Section 11. Prohibitions: Excluded and Debarred Individuals

PCMT providers are prohibited from knowingly having a certain relationship with individuals or entities who are debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement programs under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or an individual or entity who is an affiliate of a person described above. Prohibited relationships include, at minimum:

1. A director, officer, or partner of a PCMT provider;
2. A subcontractor of the PCMT provider where subcontracted activities are material to PCMT obligations.
3. Any person with beneficial ownership of five percent or more of the PCMT provider's equity.
4. Any network provider or person with employment, consulting or other arrangement with the PCP for the provision of items and services which are significant and material to the PCP's obligations under its contract with the Department.

If the Department finds a PCMT provider is not in compliance with these prohibitions, it must notify appropriate federal authorities and may determine whether to continue, renew, or extend the agreement consistent with federal requirements.

Section 12. Sanctions

Pursuant to 42 CFR 438.700, 438.702 and other authority, the Department may impose sanctions if it determines a PCMT provider acts or fails to act as follows:

1. Fails substantially to provide medically necessary services required by law or under this agreement with the Department.
2. Discriminates among members on the basis of their health status or need for health services, including practices that discourage enrollment or retention of members with high needs.
3. Misrepresents or falsifies information furnished to CMS, the Department, members, or other providers.
4. Distributes or causes to be distributed marketing materials that have not been approved by the Department or contain false or materially misleading information.
5. Violates other applicable requirements of sections 1903(m), 1932 or 1905(t)(3) of the Act, or any implementing regulations.
6. Fails to comply with applicable laws, rules, Department policies, provider manuals, or terms of this agreement, including, but not limited to: Title XIX of the Social Security Act, the Code of Federal Regulations, Montana Code Annotated, Administrative Rules of Montana, written Department of Public Health and Human Services policies, including policies contained in provider manuals, and the terms of this contract.

Pursuant to 42 CFR 438.702, for any violations of this section, the Department may impose the following sanctions:

1. Civil monetary penalties up to the amounts specified in federal regulations.
2. Grant members the right to terminate enrollment without cause and notify the affected members of their right to disenroll.
3. Suspend all new enrollment, including auto-assignments, after the date the Secretary or the Department notifies the PCMT provider of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.
4. Suspension of payment for members enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

Before imposing any of the sanctions above, the Department must give the PCMT provider timely written notice that explains the basis and nature of the sanction, and any appeal rights. Nothing in this section precludes the Department from imposing additional sanctions under state law.

Section 13. Penalties: Decrease in Tier

1. Department-initiated decrease in tier
 - a. Failure to meet PCMT tier-specific performance standards, including required reporting, quality measures, or care management expectations, may result in tier-specific remedies such as payment suspension, demotion to a lower tier, or removal from PCMT, in addition to or instead of other sanctions available under this section.
 - b. If a provider's level of participation is decreased from Tier 2 to Tier 1, the provider will receive written notification of Tier level change. The provider can re-apply to be a Tier 2 provider when they can demonstrate they can meet the Tier 2 benchmarks. The provider will need to complete a new "Primary Care Montana (PCMT) Provider Enrollment Agreement" form and attest to Tier 2 requirements.

- c. If a provider's level of participation is decreased from Tier 1, the provider will be removed from the PCMT program and will be able to re-apply to the program when they can demonstrate they can meet the benchmarks. The provider will need to complete a new "Primary Care Montana (PCMT) Provider Enrollment Agreement" form when re-applying to be part of the program.

Section 14. Termination

1. Department-initiated termination
 - a. The Department has the authority to terminate a PCMT agreement, decrease the providers Tier level participation, and/or enroll the PCP's members with another participating provider if the Department determines the PCP has failed to carry out substantive terms of this agreement or meet applicable statutory regulation requirements.
 - b. Before terminating the PCMT agreement, the Department must give the PCP written notice of its intent to terminate the agreement and the reason for termination. The PCP provider has the right to appeal the termination.
2. Provider-initiated termination
 - a. A PCMT provider may voluntarily terminate participation in PCMT by providing written notification to the Department 30 days prior to the termination date.
 - b. In group practices, termination of one participating practitioner requires timely notification and unlinking the provider from the group's PCMT Provider ID number as instructed by the Department.
3. Continuity of Care
 - a. Following termination (by either party), the provider must cooperate with the Department and receiving providers to ensure continuity of care for PCMT members, including transfer of record, and transitional care communications as required by policy.

Section 15. Attachments

The following attachments must be completed and submitted with this agreement to indicate the enrolling provider understands the terms and conditions that regulate the Primary Care Montana program:

1. Attachment A: Primary Care Montana (PCMT) Tier 1 Provider Attestation Requirements
2. Attachment B: Primary Care Montana (PCMT) Tier 2 Provider Attestation Requirements

By signing below, the provider acknowledges that PCMT requirements may change over time and agrees to monitor the PCMT Provider Manual, the Department guidance, and recertify as required.

I agree to comply with the participation requirements of the Primary Care Montana program, as cited in this agreement. I certify that all information provided in this agreement is true, accurate, and complete.

Authorized Provider/Facility Signer:

Date:

Printed Name and Title:

Agreement Completed by:

Date:

Printed Name and Title:

Attachment A: Primary Care Montana (PCMT) Tier 1 Provider Attestation Requirements

Providers will attest to meeting Tier 1 Requirements on the PCMT Provider Portal.

Tier 1 Provider Requirements

PCMH Concept	Requirement
Team-Based Care:	1. 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 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:	1. Meets performance targets for three clinical quality measures

Quality Measures

Performance targets will be based on CMS Core Set medians (except depression screening). In at least three measures from the DPHHS-defined list, providers must:

- **Meet or exceed** benchmark performance, or
- Demonstrate **≥10% improvement**:

A list of current Quality Measures can be found on the PCMT Provider Website.

Attachment B: Primary Care Montana (PCMT) Tier 2 Provider Attestation Requirements

Providers will attest to meeting Tier 1 AND Tier 2 Requirements on the PCMT Provider Portal.

Tier 2 Provider Requirements

PCMH Concept	Requirement
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 medications¹ 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
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 14 days of discharge

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.

	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 on attributed members for follow up after hospitalization within 14 days 2. Meets performance targets on attributed members for readmission rates