Primary Care Montana (PCMT)

PCMT 101 Training

May 8, 2026

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

Agenda

Primary Care Montana (PCMT): The Redesign Process
Who Can Participate
Attribution Process
Review of PCMT Tiers and Key Features
What Your Practice Must Be Ready To Do
PCMT Provider Technical Assistance (TA)
Team Care Program
Next Steps
Discussion/Questions

Primary Care Montana (PCMT): The Redesign Process

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PCMT: What Providers Need to Know

Preparing for the July 2026 Launch of Tiers 1 and 2

Primary Care Montana (PCMT) is the Montana Medicaid and Healthy Montana Kids *Plus* (HMK *Plus*) new primary care case management (PCCM) value-based program (VBP) model.

Today's discussion will focus on upcoming changes, their implications for your practice, and the steps needed to prepare.

Key Partners Helped Shape Tiers 1 and 2

DPHHS, with it's contractor Health Management Associates, worked with Key Partners through virtual and in-person feedback sessions during the development of PCMT Tiers 1 and 2.

- Partners included organizations representing primary care, hospitals, Tribes and Tribal Health Clinics, Urban Indian Organizations, pediatrics, rural providers, and other statewide stakeholders.
- That feedback helped inform a model designed to reduce barriers to participation, support rural and private practices, and prove more usable data and practice support.

Key Partner Feedback in the redesign process:

- Design a model to engage PCPs in case management
- Consider regional variation and population density
- Ensure data sharing, integration, access to real time data are included to support care coordination and improve health outcomes
- A less complex model with reduced tiers
- Provide support to many providers; including Tribal providers, RHCs, and small independent practices
- Improve patient attribution approach to reflect accurate provider accountability and member engagement
- Provide flexibility and transparency in performance measures

Transition to PCMT

NEW PCMT PROGRAM

Integrates and replaces the prior Medicaid Primary Care Case Management (PCCM) programs, including Passport to Health (Passport), Comprehensive Primary Care Plus (CPC+), and Patient-Centered Medical Home (PCMH), into a single, multi-tiered voluntary model.

CARE COORDINATION PMPM

At the launch of PCMT, providers will no longer receive the monthly per member per month (PMPM) payments they currently receive for the Passport, CPC+, and PCMH programs.

You must enroll in PCMT to continue receiving a care coordination payment.

TIMELINE

June 30, 2026: Passport, PCMH, and CPC+ end
July 1, 2026: PCMT Tiers 1 and 2 Launch
July 1, 2027: Projected Tier 3 Phase-In

NO REFERRAL REQUIREMENT

Unlike the previous Passport program, PCMT removed the referral requirement (Passport ID) on claims, reducing administrative burden for your practice, starting on day one.

Provider Advantages in New PCMT Model

Feature	Passport	PCMH	CPC+	PCMT (Today)
No Referral Hassles	X	X	X	✓ **No more referrals (Passport ID) required on claims**
Quality Measure Tracking	Not required	Partial	Partial (manual)	✓ **Fully automated — no manual reporting**
Enhanced PMPM Payments	$1.11 avg	$5.57 avg	$8.03 avg	✓ **Tier 1 $6.00 / Tier 2 $11.00**
Technical Assistance & Support	X	Partial	Partial	✓ **Dedicated TA from the Department + Consultant**
PCMH Certification Requirement	Not required	Required	Required	✓ **No certification needed to participate**
Data-Driven Insight Tools	X	Partial	Partial	✓ **PCMT Roster and Performance Measure Report**
Glidepath to Value-Based Care	X	X	X	✓ **Designed glidepath to future VBP opportunities**
Member Accessibility & Engagement	X	X	X	✓ **Stronger connection and choice for member**

Who Can Participate

Who Can Participate - Providers

☑ **Eligible Provider Types**

- Family Practice MDs
- General Practice MDs
- Internal Medicine MDs
- APRNs (Advanced Practice RNs)
- Physician Assistants (PAs)
- IHS, Tribal 638 Clinics, UIOs
- FQHCs, RHCs
- Clinics (Pediatric, Family Medicine, etc.)

Tier Selection

Any willing medical primary care provider/facility serving Montana Medicaid members can start in the tier that best meets their capabilities.

No PCMH Certification Needed!

Unlike previous programs, full PCMH certification is not required for Tier 1 or Tier 2 participation. Providers must attest to meeting PCMT requirements **or** demonstrate an equivalent recognition.

How to Show You're Ready

Providers **attest** to meeting practice requirements ***or*** show an equivalent recognition (e.g., NCQA, URAC, AAAHC, TJC).

Who Can Participate - Members

Populations Eligible to Voluntarily Enroll*
• Children (Medicaid & HMK+) • Parent & Caretaker Relatives • Aged, Blind & Disabled • Foster Care Children • Expansion Adults • Pregnant Women • Breast & Cervical Cancer Program

Populations NOT Eligible to Participate
• Dual Eligibles • Reside in a Nursing Facility, ICF/IID, or PRTF • Eligibility < 3 Months • 1915(c) Waiver Enrollees • Spend-Down • Presumptively Eligible • Family Planning Waiver

Rationale for Population Exclusions

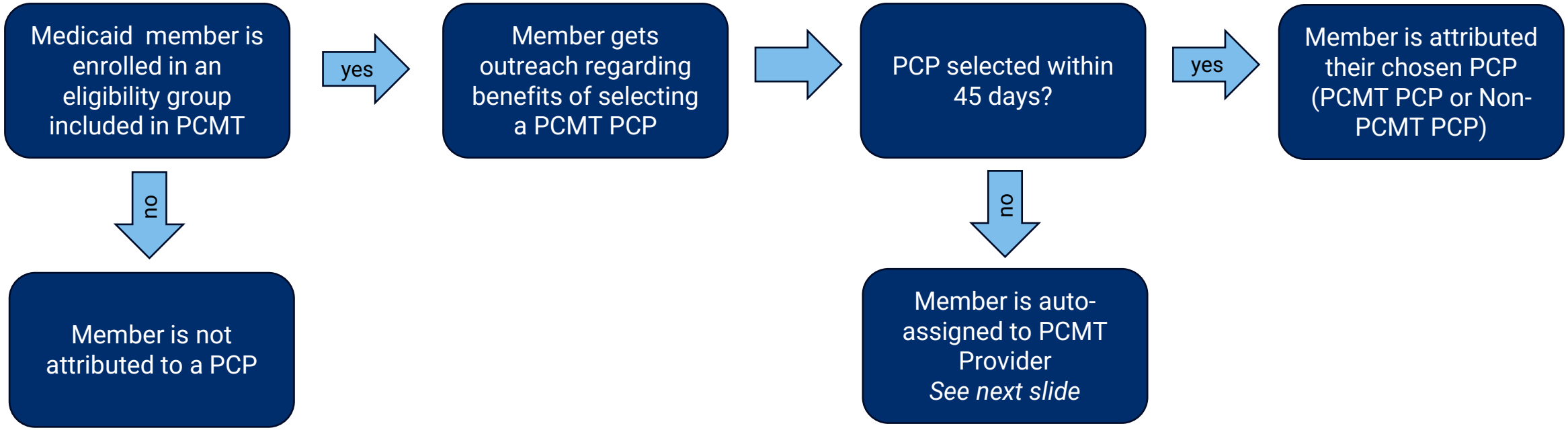
- Prevents duplication with other Medicaid case management programs
- Excludes beneficiaries with Medicaid eligibility periods insufficient to impact outcomes

*Included populations align with Passport, with the addition of Breast & Cervical Cancer Program & Pregnant Women.

Attribution Process

Member Enrollment Process

During initial program launch, enrollees will remain attributed to their existing Passport, PCMH, or CPC+ provider. Members (enrollees) do not have to join the new program. They only need to tell us who their primary care provider (PCP) is or choose an opt-out reason. If a member does not respond, we will automatically assign them to a Primary Care Montana (PCMT) provider.



Auto-Assignment/Attribution Methodology

If member does not select a PCP within 45 days AND there are no claims from a Medicaid provider (non-PCMT PCP or PCMT PCP), system identifies if participating PCMT PCP is available for assignment.

Review of PCMT Tiers and Key Features

Health Management Associates

PCMT Program Overview

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

July 2026 Implementation

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Approach to Detailed Tier-Specific Participation

The Approach for PCMT Provider Participation Requirements for the Value-Based Program:

- Acknowledges that many providers meet some but not all NCQA PCMH requirements, and that full certification can be a barrier
- Would define participation based on attainable PCMH qualities
- Requirements grouped into six medical home domains per tier, directly aligned with NCQA's PCMH concept areas[1]

Team-Based Care:
Structure of practice's leadership, care team responsibilities and how the practice partners with members, families, and caregivers

Knowing and Managing Your Patients:
Requirements for data collection, medication reconciliation, evidence-based clinical decision support and other activities

Access and Continuity:
How practices provide members with convenient access to clinical advice and help ensure continuity of care

Care Management and Support:
Care management protocols to identify members who need more closely-managed care

Care Coordination and Care Transitions:
Primary and specialty care clinicians effectively share information and manage member referrals

Performance Measurement and Quality Improvement:
Practices develop ways to measure performance, set goals, and develop performance improvement activities

[1] NCQA PCMH Recognition Concepts web page. NOTE: NCQA PCMH Recognition Concepts are general and align with the standards within other PCMH models including, for example, AAAHC, Joint Commission, and URAC.

Tier 1: “Basic”

Ensuring Preventive Services

Tier 1 Overview

Tier 1 is Montana Medicaid and HMK *Plus*'s **foundational primary care program** focuses on strengthening preventive care, improving quality outcomes, and supporting patient-centered primary care practices.

Participating providers receive a per-member per-month (PMPM) care coordination fee in exchange for **meeting benchmarks and performance expectations.**

Objectives

- Improve performance on select HEDIS preventive or chronic condition quality measures
- Align with Centers for Medicare & Medicaid Services (CMS) Adult and Child Core Set measures
- Promote preventive care, early detection, and proactive management of patient needs
- Support primary care practices in delivering accessible, coordinated care

Tier 1 Provider Eligibility

- Open to any willing medical primary care provider (PCP) serving Montana Medicaid members
- Ability to meet annual performance targets on preventive or chronic condition measures, beginning in Year 2 of program implementation (Jan 1, 2028 – Dec 31, 2028).
- Providers must attest to meeting Tier 1 Provider Requirements **or** demonstrate attainment of PCMH recognition
- Ability to demonstrate compliance with Tier 1 Provider Requirements as requested by the Department of Public Health and Human Services (DPHHS) through periodic review process

Tier 1 Provider Requirements (Slide 1/2)

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

Tier 1 Provider Requirements (Slide 2/2)

PCMH Concept	Requirement
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 from the list below

Quality Measures

Performance targets will be based on CMS Core Set medians (except depression screening).

For at least three measures from the DPHHS-defined menu, providers must:

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

2026-2027 DPHHS Measure List

- Cervical Cancer Screening (CCS-AD)
- Colorectal Cancer Screening (COL-AD)
- Breast Cancer Screening (BCS-AD)
- Well-Child Visit in the First 30 Monts of Life (W30-CH)
  - First 15 months of life (6+)
  - 15-30 months of life (2+)
- Child and Adolescent Well-Care Visits (WCV-CH)
- Controlling High Blood Pressure (CBP-AD)
- Glycemic Stat Assessment for Patients with Diabetes (GSD-AD)*inverse
- Lead Screening in Children (LSC-CH)
- Screening for Depression and Follow-Up Plan:
  - Ages 12 to 17 (CDF-CH)
  - Age 18 and Older (CDF-AD)
- Timeliness of Prenatal Care:
  - Under Age 21 (PPC2-CH)
  - Age 21 and Older (PPC2-AD)
- Postpartum Care:
  - Under Age 21 (PPC2-CH)
  - Age 21 and Older (PPC2-AD

Tier 2: “Plus”

Managing Transitions of Care

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Tier 2 Overview

Tier 2 of Montana Medicaid and HMK *Plus*'s PCCM program provides a per-member per-month (PMPM) care coordination fee to support 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

- **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 Provider Requirements (Slide 1/2)

In addition to Tier 1 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 medications** 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

[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.

Tier 2 Provider Requirements (Slide 2/2)

PCMH Concept	Requirement
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 **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 - achieve a rate that is the lower of 21% or a relative 10% improvement over the baseline rate. Individual provider goals in Y2 based on Y1 baseline, using gap closure methodology.

Tier 3: “Advanced”

Fully Managing Complex Populations

Tier 3: Design Status

Tier 3 is being designed with an anticipated go live date of July 2027. Tier 3 will have a focus on managing complex populations.

What Your Practice Must Be Ready to Do

What Your Practice Must Be Ready to Do

Tier 1 Practices	Tier 2 Practices
Practices need foundational medical home capabilities, including: • Preventive care workflows, • Access, • Tracking, and • Quality improvement.	Building on Tier 1 by adding: • Transitions of care workflows.
Year 1: No Performance Gates In Year 1of program launch, PMPM is paid for meeting Quality Measure Reporting Requirements. After Year 2, Payment will only be paused if no improvement on benchmarks.	

PCMT Provider Technical Assistance (TA)

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

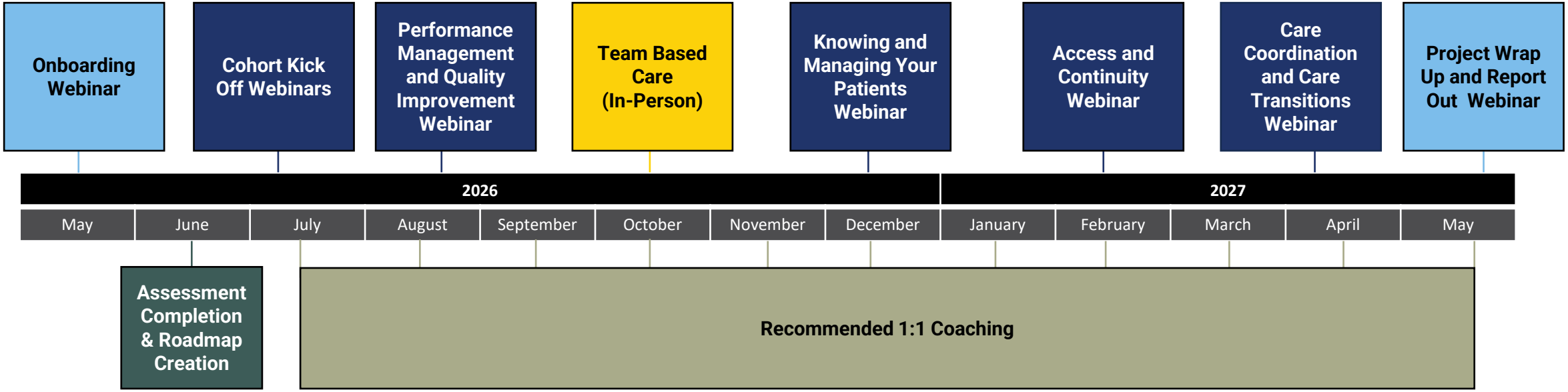
Quality improvement and sustainment support to improve care, achieve goals, and advance to higher tiers

LEARN MORE

Kick Off Town Hall Recording Available by emailing
PCMTProviderTA@healthmanagement.com

What: Town Hall session to learn more and enroll in technical assistance
Who: All interested PCMT providers

TA Timeline



Individual Site Coaching:

- Required 1:1 TA Onboarding
- Recommended Monthly 1:1 Coaching

Group Learning:

- All Cohort Webinars
- Cohort Specific Webinars
- In-Person Group Learning

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Provider TA Next Steps: Getting Started

1. Sign up to participate in Provider TA using the link or QR code below by May 15th.
2. Attend the Onboarding Webinar: **May 20, 12-1 p.m. MT**
3. Get connected to your coach

Sign-up to Participate

https://bit.ly/PCMTTA-Register

Team Care Program

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Team Care Program

Team Care Program will continue as a stand-alone program after the end of Passport

- As needed, members will continue to be locked-in to a pharmacy and a PCP
- PCPs will no longer receive an additional PMPM payment for Team Care members attributed to them

Team Care Manual: https://medicaidprovider.mt.gov/teamcare

- New Team Care Manual coming soon

Next Steps

Milestones

Key Partner Engagement

- State Plan Amendment Public Notice Posting: Posted on February 27, 2026
- State Plan Amendment Submission to CMS: April 2, 2026
- Bi-Monthly Key Partner Meetings

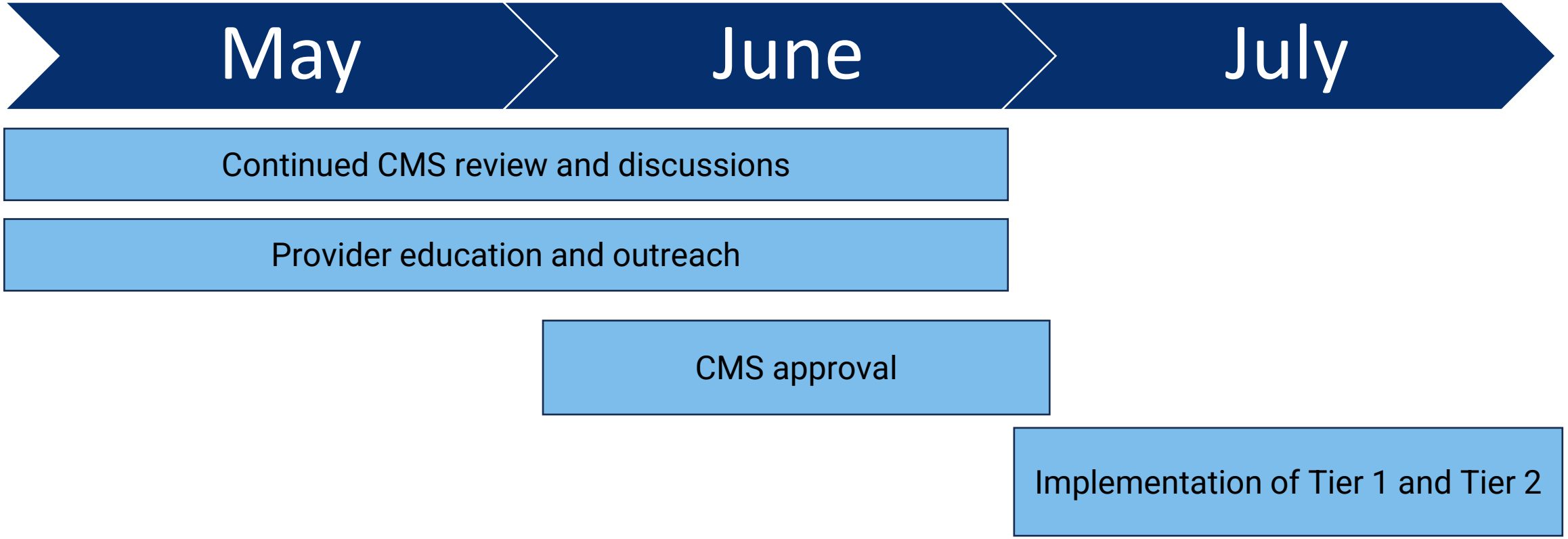
PCMT Provider Enrollment

- 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: April 2026 and Ongoing

PCMT Enrollee Engagement

- Enrollee Notices: May 2026
- Enrollee Assignment: Aligned with Phase 1 and 2 of the PCMT Provider Enrollment Above.

Timeline of Upcoming Milestones



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Contact Information

- Questions and/or concerns?
  - MTPrimaryCarePrograms@mt.gov

- PCMT Website:
  - https://dphhs.mt.gov/MontanaHealthcarePrograms/pcmt
    - PCMT Tier 1 Fact Sheet
    - PCMT Tier 2 Fact Sheet
    - PCMT TA Town Hall Q&A

Discussion/Questions