MT PCCM Redesign

Tribal Consultation

December 10, 2025 10:15 am

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

Agenda

- Review, Development, and Design
- Tier 1: Focus, Provider Requirements, and Performance Measures
- Tier 2: Focus, Provider Requirements, and Performance Measures
- Tier 3: Focus and Phase-in Timeline
- Member Enrollment Policies
- I/T/U Impact Summary
- Next Steps

Review, Development, and Design

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Timeline: From Start to Now

2022

- HRD Tasked to Redesign Montana PCCMs
- Aug. 2022: Key Partner Meetings Begin.
- Dec. 2022: Tribal Consultation Discussion on PCCMs

2023

- Fall 2023: Key Partner Meetings Paused
- Oct. 2023: Tribal Consultation Discussion

2024

- Aug. 2024 Consultant HMA Onboarded for PCCM Redesign Project.
- Sep. 2024: DPHHS/ HMA/ Key Partner Kick Off Meeting
- Oct. 2024: Monthly Key Partner Meetings Resume

2025

- Oct. 2025: Key Partner Meetings Paused (Will Resume in 2026 for Tier 3 Discussions)
- Oct.- Dec. 2025: Tier 1 and Tier 2 Proposed Requirements Finalized.
- Dec. 2025: Tribal Consultation

Department's Goal: Transition from four distinct Primary Care Case Management (PCCM) Models to a unified, value-based program that meets provider where they are and incorporates the following key elements.

Incorporate timely value-based payments to incentivize better health outcomes while remaining budget neutral	**Promote preventive care, optimize care coordination, and improve overall health management for participants**	**Avoid barriers for rural and private practice participation**	**Provide timely data to allow providers to act on gaps in care and outcome measures**

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A Design Reflects Both State Priorities & Key Partner Feedback

Intended to **meet providers where they are** with incentives and supports that allow providers to move toward more advanced management of their member populations

Keeps **barriers to entry low for small/less resourced providers** but adds accountability measures to ensure value achieved

Allows **flexibility to define targeted performance measures** working with Key Partners but intended to align with established accreditation frameworks and CMS core measure sets

Dependent on data interoperability and care management platforms that share information, but acknowledges likely state role to support providers with timely data to support performance improvement

Reducing Barriers for Provider Participation

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The Approach to Detailed Tier-Specific Participation

Proposed new Approach to 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.

Provider Capabilities Verification

Verification that Requirements are Met by:

1. Providers would either:
   a) attest to meeting the requirements, or
   b) demonstrate they had a commensurate recognition/ certification (e.g., NCQA PCMH, URAC, AAAHC, TJC)
2. State would reserve the right to request documentation, if needed.

Review Three Tier Model

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Tier 1: Preventive Care

Tier 1: Focus on Preventive Care

Tier 1 Model Overview: July 2026 Implementation

Description:	Care coordination fee paid to participating primary care provider practices
Goal:	Improve outcomes on select HEDIS quality metrics and align with CMS Core measures
Provider Eligibility:	Initially any willing primary care provider serving Montana Medicaid beneficiary; continued participation contingent on meeting performance targets
Payment Model:	Per-member-per-month (PMPM); amount to be determined

Tier 1 : Provider Participation Requirements

Team-Based Care:	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 routine 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** 4. Helps patients unattributed to the provider **change** patient's attributed PCP

Tier 1:Provider Participation Requirements (cont.)

Care Management and Support:	**N/A** (T3 focus)
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:	Meets **performance targets** for three selected clinical quality measures

Tier 1: Reporting Measurements

Measure Name	CMS Core Set Median (2024)
Cervical Cancer Screening (CCS-AD)	50%
Colorectal Cancer Screening (COL-AD)	37.7%
Breast Cancer Screening (BCS-AD)	50.3%
Well-Child Visits in the First 30 Months of Life (W30-CH) - First 15 months of life (6+) - 15 to 30 months of life (2+)	-59.0% -65.3%
Child and Adolescent Well-Care Visits (WCV-CH)	49.2%

Measure Name	CMS Core Set Median (2024)
Controlling High Blood Pressure (CBP-AD)	60.5%
Glycemic Status Assessment for Patients with Diabetes (GSD-AD) *inverse	38.8%
Lead Screening in Children (LSC-CH)	58.1%
Screening for Depression and Follow-Up Plan: - Ages 12 to 17 (CDF-CH) - Age 18 and Older (CDF-AD)	-2.0% -2.0%
Timeliness of Prenatal Care: - Under Age 21 (PPC2-CH) - Age 21 and Older (PPC2-AD)	-64.0% -71.8%
Postpartum Care: - Under Age 21 (PPC2-CH) - Age 21 and Older (PPC2-AD)	-61.0% -64.5%

Providers must meet benchmarks of at least three (3) out of twelve (12) measures.

Discussion and Comments on Tier 1 Requirements

Tier 2: Transitions of Care

Tier 2: Focus on Transitions of Care

Tier 2 Model Overview: July 2026 Implementation

Description:	Care coordination fee to help hospitalized patients transition back to ambulatory care in the community
Goal:	Increase the percentage of discharged patients with follow-up PCP visits within 7 days and reduce unplanned repeat hospitalizations within 30 days of discharge
Provider Eligibility:	Tier 1-participating primary care providers who are actively managing transitions of care post-hospitalization; continued participation contingent on meeting performance targets
Payment Model:	PMPM care coordination fee; amount and tasks to be determined; funded by savings generated from reducing readmissions

Tier 2: Provider Participation Requirements
(in addition to Tier 1 requirements)

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 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
Care Management and Support:	**N/A** (T3 focus)

Tier 2: Provider Participation Requirements
(in addition to Tier 1 requirements, cont.)

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 7 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** for follow up after hospitalization within seven days 2. Meets **performance targets** for readmission rates

Tier 2: Reporting Measurement

Quality Measure Reporting	Manage Transitions of Care
• Must meet benchmark of 3 out of 12 quality measure defined on slide 19.	• Must manage transitions of care for all in-patient hospital stays.

Tier 2: Transitions of Care Process (TOC)

Evidence-Based Practices Include:

Contacting the patient during hospitalization to educate on the TOC process and verify preferred method of communication and contact information

Follow-up contact within 2 business days of hospital discharge to verify compliance with discharge instructions, verify and if necessary, arrange a timely follow-appointment with a PCP or specialist as clinically appropriate, and address any barriers to compliance with the treatment plan

Medication reconciliation (either during the post-discharge contact above or at the follow-up visit) and to remind the member to bring medicine bottles to that appointment

Verifying the follow-up ambulatory visit was completed and if not, contact the patient to reschedule the visit

Discussion and Comments on Tier 2 Requirements

Tier 3: High-Risk Care Management

Tier 3: Focus on High-Risk Care Management (to be phased in 2027)

Tier 3 Model Overview

Description:	Care management of individuals with complex physical health and/or behavioral health conditions, often with complicating health-related social needs
Goal:	Reduce patient barriers to compliance with their treatment plan and improve self-management skills to reduce the risk for hospitalization and frequent emergency room visits
Provider Eligibility:	Participating in Tier 1 & 2; presents an acceptable description of their care management model; has at least XX number of attributed beneficiaries alone or as part of a clinically integrated network
Payment Model:	PMPM care management fee; amount and tasks to be determined; a portion of risk-adjusted total cost of care savings

Decision Still Needed for Tier 3

- Provider/Network Participation Requirements-Certifications
- Incentives
- Reporting and Performance Requirements
- Risk Stratification Tool
- Upside Risk/ Phased in Downside Risk
- Minimum Number of Attributed Members
- Period of Participation
- Review Periods

Discussion and Comments on Tier 3 Focus

Decisions Made with Key Partners

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Decisions Made with Stakeholder Feedback

1. Providers will choose 3 measures from the menu
2. MT will use CMS Core Set Medians as the benchmark as the starting point (except for the depression screening measure)
3. Providers will a) meet or exceed the benchmark, and/or b) demonstrate a 10% or more improvement in their rate(s) for each selected measure
4. Beginning Year 1, State pays PMPM fee if provider meets reporting requirements
5. Beginning Year 2, provider performance evaluated annually on selected measures
6. PMPM fees will be paused in future years if no demonstration of improvement or attainment of performance targets
7. PMPM fees could be resumed by demonstrating improvement

Member Enrollment Policies

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Proposed Eligible Populations

Populations Eligible to Voluntarily Enroll*	Populations NOT Eligible to Participate
• Children (Medicaid & HMK+) • Parent & Caretaker Relatives • Aged, Blind & Disabled • Foster Care Children • Expansion Adults • Pregnant Women • Breast & Cervical Cancer Program	• 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

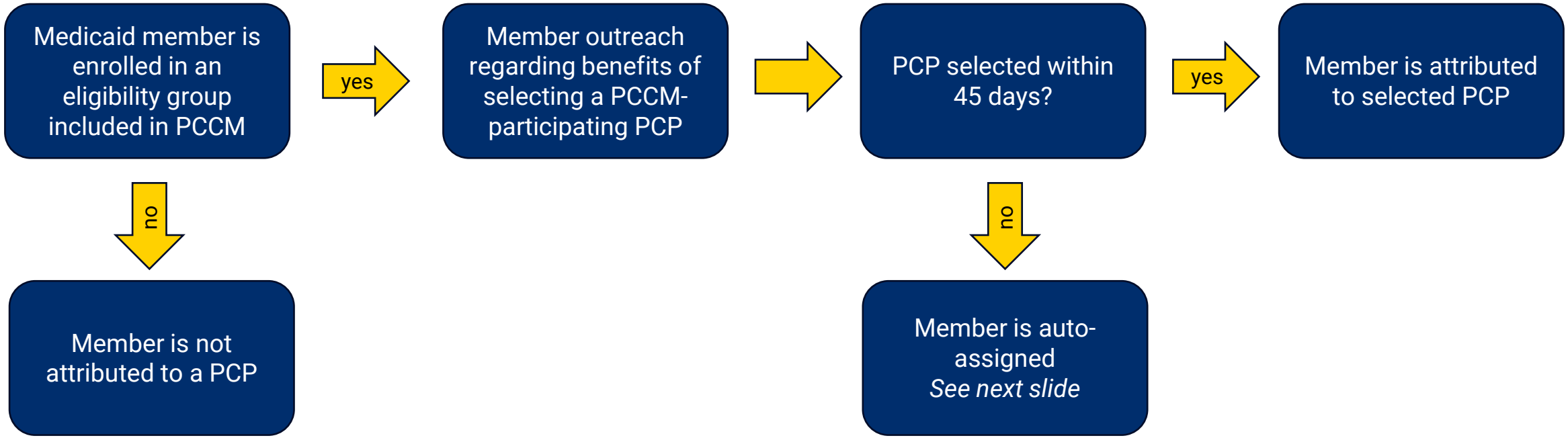
Rationale for Proposed Population Exclusions

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

*Proposed included populations aligned with Passport, with the addition of Breast & Cervical Cancer Program & Pregnant Women.

Member Enrollment Process

During initial program launch, members will remain attributed to their existing Passport, PCMH, or CPC+ provider if they participate in the new program. The following process is proposed to address current members with a non-participating PCP and ongoing enrollment process for new members.



Proposed Member Assignment/Attribution Methodology

If member does not select a participating PCP within 45 days and has not received care from a Medicaid provider outside of the PCCM program (determined by claims), the system will use a programmed algorithm to auto assign a PCP. The system will look at:

I/T/U Impact Summary

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Impact Summary

Who	What Happens after June 30, 2026
IHS, Tribal 638 Clinics, and UIOs	Can continue providing primary care services for AI/AN members. May enroll in the new program and select a Tier that fits their resources.
Members (AI/AN)	Not required to enroll in the new program. Must choose a Primary Care Provider (PCP), but can continue care at IHS, Tribal, or UIO clinics.
Passport to Health Providers	Will no longer receive Passport PMPM payments after June 30, 2026.
Tribal 638 Programs	Can be enrolled in both T-HIP and the new program (Tier 1 or Tier 2).
AI/AN T-HIP Members	Can receive services from both T-HIP and new program Tier 1 or Tier 2 providers, if eligible.

Impact Summary Discussion and Comments

What perspectives or concerns do the Tribes, Indian Health Services, or Urban Indian Organizations have regarding the potential impact of this redesign that the Department may not have considered?

Next Steps

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Future Activities/Timeline

- October – December 2025: Finalize program design for T1/T2 and draft SPA
- November 2025: Continued key partner feedback on Tier 3
- January – February 2026: Conduct public and tribal comment periods
- March 2026: Submission of SPA to CMS
- March – June 2026: CMS review and discussions; provider education and outreach
- June 2026: CMS approval
- July 2026: Implementation of Tier 1 and Tier 2
- July 2027: Proposed Phased in date of Tier 3