MT PCCM Redesign – Primary Care Montana (PCMT)

Key Partner Meeting: Tier 3 Design Feedback

October 16, 2026 - 9:00 am MT

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Agenda

Welcome and Meeting Objectives

PCMT Provider Technical Assistance (TA) Update

Tier 3 Model Refresher

What We Heard: May 28 Meeting and Tier 3 Design Survey

Tier 3 Design Decisions: Key Partner Input

Risk levels • Staffing approach • Time and frequency • Care management scope • Participation and review

Next Steps

Questions and Close

Meeting Objectives

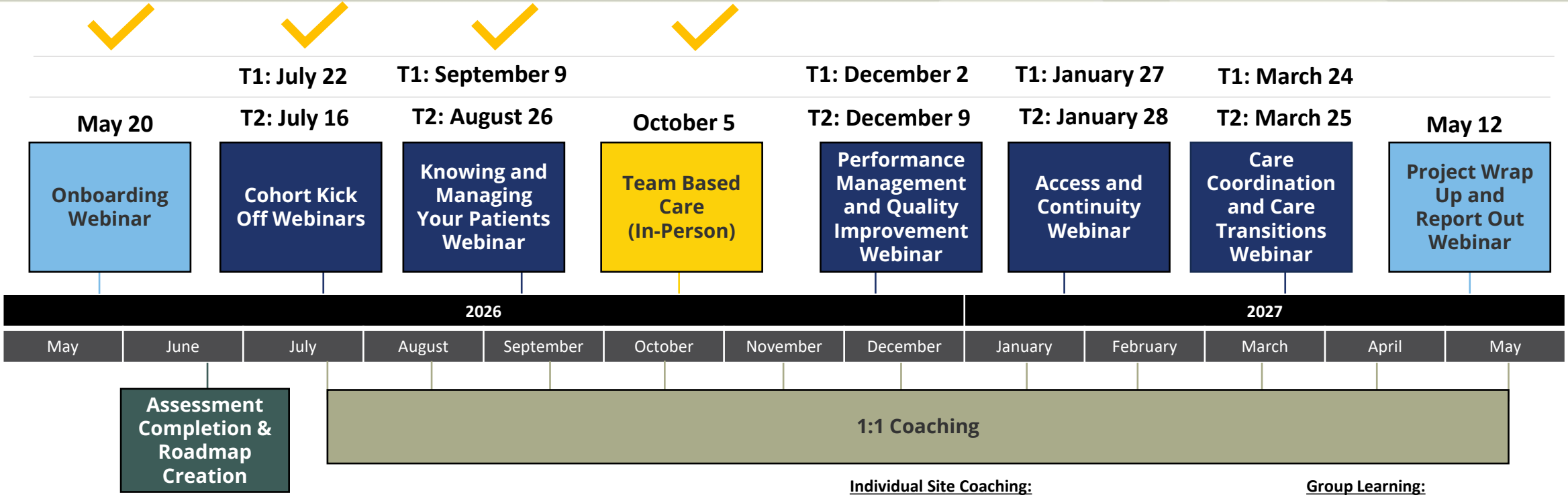
- **Refresh** Key Partners on the proposed Tier 3 care management model
- **Share** what we heard from the May 28 meeting and the Tier 3 Design Survey
- **Gather input** on design options to help DPHHS make Tier 3 decisions

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PCMT Provider TA Update

99 Clinic sites have registered for TA

248 Unique TA sessions held to date



Individual Site Coaching:

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

Group Learning:

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

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Tier 3 Model Refresher

Health Management Associates

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Tier 3 at a Glance

Who It Serves

Care management of members with complex physical and/or behavioral health conditions, often with health-related social needs, with frequent ED use and hospitalization

Goal

Reduce barriers to following the treatment plan and build self-management skills to lower the risk of hospitalization and frequent ED visits

Payment Model

PMPM care management fee plus a portion of risk-adjusted total cost of care savings for total assigned members

Qualifying Entity

PCP practice, RHC, FQHC, health system, or CIN that meets Tier 1 and 2 criteria; qualifying minimum attribution still to be determined

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PCMT Step Ladder of Care

Tier 1

PRIMARY CARE SERVICES

All patients receive this level of service, including PCP appointments, referral management, population health activities

Tier 2

TRANSITIONS OF CARE

Patients who have been treated in a hospital or other institutional setting and are returning to the community.

Tier 3

COMPLEX CARE MANAGEMENT

High-risk, multiple chronic conditions, sub optimally managed as manifested by frequent ED visits and hospitalization, often with health-related social needs.; shared savings incentive opportunity

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Evidence-Based Elements of Complex Care Management

- Risk stratification to identify those most likely to benefit
- Integration with the Primary Care Team
- Face to face interactions with care managers and their patients on a regular basis
- HIT support to inform care planning, support communication, and monitor effectiveness
- Strong linkages between behavioral health and physical health
- Strong emphasis on medication management
- Transitions of care support
- Addressing health related social needs
- Efficient use of the “right staff” at the top of their license and having a team approach to getting the work done

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Care Coordinators/Care Managers High Level Responsibilities

Care Coordinator (Unlicensed)	Care Manager (LCSW/LPN/RN)
• Outreach and ongoing patient engagement • Patient education and awareness; promote self-management • Coordinate referrals, other needed community resources • Closing care gaps and social determinants • Other tasks as requested by the Care Manager	• Outreach and ongoing patient engagement • Patient education and awareness; promote self-management • Medication review and support for treatment adherence • Brief interventions, motivational interview and behavior change • Create and update patient goal setting and care plans • Communicate appropriately with PCP and other team members about concerns and patient progress

Assumption: Transitions of care for those in high-risk care management paid for by Tier 2 fees.

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PCMT Strawman

PCMT Care Management (strawman for discussion purposes only based on 3% moderate and 3% high-risk of assigned population)							
Tasks	Time allocated (hours)	Frequency Per Year		Care Coordinator time/yr (hrs)		Care Manager time/yr (hrs)	
		Mod Risk	High Risk	Mod Risk	High Risk	Mod Risk	High Risk
Initial or annual comprehensive health risk assessment (assumes multiple attempts are sometimes required)	1	1	1	0.00	0.00	0.03	0.03
Initial/annual major revision of care plan	1	1	1	0.00	0.00	0.03	0.03
Community -based organization referrals and follow-up	0.5	0.375	0.375	0.006	0.006	0.00	0.00
Specialty, diagnostic and other external referrals	0.5	1	1.5	0.02	0.023	0.00	0.00
Closing gaps in care and wellness messaging	0.5	1	1	0.02	0.02	0.00	0.00
Post-ED visit contact	0.5	0.5	1.5	0.01	0.023	0.00	0.00
Telephonic care plan review	0.75	2.25	8.25	0.00	0.00	0.05	0.19
Post-hospitalization transition of care	1.5	0.00	0.00	0.00	0.00	0.00	0.00
Disease management/health coaching	0.5	2	2	0.00	0.00	0.03	0.03
Hours PMPY				0.04	0.07	0.14	0.28

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Potential Roles of Clinically Integrated Networks

- Aggregating providers to meeting minimum number of assigned members to qualify for Tier 3
- Developing standard care management and clinical models of care
- Deciding which care management tasks are best centralized and which are best delivered in the practices
- Joint investing in a population health platform, analytics and other infrastructure
- Sharing experience and best practices

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What We Heard

May 28 Key Partner Meeting and Tier 3 Design Survey

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What We Heard: Key Partner Feedback

Sources: May 28 key partner meeting discussion and polling; Tier 3 Design Survey (10 provider and partner responses)

Where Key Partners Generally Agree

- **Task list:** the proposed care management tasks are largely the right ones
- **Team-based delivery:** clinicians order and oversee; trained non-licensed staff can carry out many tasks
- **Patient movement:** members move between risk levels as their health changes
- **Flexibility:** requirements should not become a prescriptive "check-off" list

Where Views Differ or Concerns Remain

- **Risk levels:** clarification needed on how moderate-risk and high-risk are addressed differently in CM activities
- **Staffing:** role-based assignments vs. activity-based requirements; licensed staff for post-ED contact
- **Time and frequency:** seen as underestimated for onboarding, care planning, referrals, and outreach; frequency questioned in both directions
- **Feasibility:** payment adequacy, credit for outreach attempts, rural capacity, and network participation

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From Feedback to Design Decisions

Risk levels	Moderate tier may confuse care teams; patients move between levels; risk scores could reflect complexity	**1. How many risk levels?**
Activities vs. roles	Define what must be done, not who does it; specify licensure only where required	**2. How prescriptive should staffing be?**
Time and frequency	Assumptions may be too low for complex patients; fixed counts don't fit every patient	**3. Minimums or planning assumptions?**
Scope gaps	Add patient navigation and referral tracking; consider remote monitoring and social needs support; stand-alone assessment may duplicate visit-based care planning	**4. What belongs in Tier 3 care management?**
Participation and review	Network-level contracting, attribution minimum, outreach credit, and periodic review of assumptions	**5. How do providers participate, and how will the model be reviewed?**

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Tier 3 Design Decisions

Key Partner Input

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Decision 1: Risk Levels

Design question: Should Tier 3 recognize separate moderate- and high-risk care management levels?

Options for discussion

A **Two levels (current proposed model)**
Moderate and high risk, with quarterly vs. monthly care plan updates

B **High risk only**
Tier 3 care management focuses on the highest-risk members

C **One standard, adjusted by risk**
Same core expectations; risk scores or incentives reflect complexity

What We Heard

- **May 28:** split on a moderate tier; concern it could confuse care teams
- **Survey:** most supported two levels; one suggested dropping moderate risk unless payment increases
- **Both:** members move between levels as health changes

Discussion Questions

1. Should care teams be given the flexibility to decide if monthly or quarterly care plans are updated if it changed a member from high to moderate risk?
2. If two levels remain, what if anything should differ between them besides care plan updates?
3. What should trigger moving a member between levels?

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Decision 2: Staffing Approach

Design question: How prescriptive should Tier 3 be about who performs each care management task?

Options for discussion

A — Role-based (current proposal)
Each task assigned to a care coordinator (unlicensed) or care manager (licensed)

B — Activity-based
DPHHS defines required activities; practices decide who performs them

C — Hybrid
Activity-based, with licensed staff or clinical oversight required only for specific tasks

What We Heard

- **May 28:** focus on activities, not job titles; specify licensure only when regulation requires it
- **Survey:** blended teams work with clinical oversight; requiring licensed staff adds cost
- **Both:** post-ED contacts may need licensed staff for education and urgent needs

Discussion Questions

1. Which tasks, if any, should require licensed staff or clinical oversight?
2. How should practices show they have the right team in place?
3. Would different role labels (e.g., lead vs. support) be clearer?

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Decision 3: Time and Frequency Standards

Design question: Should task frequencies be required minimums, or assumptions used to set the PMPM?

Options for discussion

A **Required minimums**
Contracts specify a minimum number of contacts per member per year

B **Planning assumptions only**
Time and frequency set the PMPM; practices deliver care based on need

C **Core minimums plus need-based care**
A few required elements (e.g., annual assessment and care plan); other tasks based on need

What We Heard

- **May 28:** time underestimated for onboarding, care planning (up to ~5 hours for some), and referral tracking
- **Survey:** outreach often takes many attempts; some frequencies too high, others too low
- **Both:** assumptions should align with other state programs

Discussion Questions

1. Which option would be most workable for your organization?
2. How should unsuccessful outreach attempts or patient refusals be counted?
3. Which time or frequency assumptions most need to change?
4. How should ability of complex care management to at least pay for itself be taken into consideration when choosing tasks and allocating task frequency?

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Decision 4: Care Management Scope

Design question: Which activities should be part of Tier 3 care management?

Options for discussion

A **Keep the current task list**
Proposed tasks with minor clarifications

B **Add activities**
E.g., patient navigation and referral tracking, remote monitoring, social needs support

C **Streamline**
Combine the stand-alone risk assessment with visit-based care planning and risk reports

What We Heard

- **May 28:** add patient navigation alongside referral management
- **Survey:** suggested remote patient monitoring and social work support for food, housing, financial, and addiction-related needs
- **Survey:** stand-alone assessment may duplicate work already done at visits

Discussion Questions

1. Which additions would most reduce ED visits and hospital stays?
2. Should any task be removed or combined?

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Decision 5: Participation and Ongoing Review

Design question: How should providers participate in Tier 3, and how should the model be reviewed over time?

Options for discussion

A — Contracting level
Individual practices, networks (e.g., CINs), or both

B — Attribution minimum
Set the minimum number of attributed members to participate

C — Review cycle
Revisit time, workload, and payment assumptions after the first year

What We Heard

- **May 28:** interest in network-level contracting; a lower minimum may reduce barriers
- **Survey:** several smaller practices plan to join through a CIN; concerns about payment adequacy and rural capacity
- **May 28:** asked whether assumptions will be revisited after launch

Discussion Questions

1. What minimum attribution level makes Tier 3 feasible, optimizing provider participation while maintaining statistically sound determination that savings were not due to statistical variation?
2. What would make network-level participation work for you?
3. How often, and how, should DPHHS revisit assumptions with key partners?

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Next Steps

1

Synthesize feedback

Combine today's input with May 28 and survey feedback

2

DPHHS design decisions

Refine Tier 3 care management expectations and assumptions

3

Risk stratification

Actuarial work and key partner discussion on identifying members for Tier 3

4

Shared savings model

Benchmark and performance period cost, PMPM, and savings earned

Additional feedback is welcome

Send written comments on Tier 3 design options to **MTPrimaryCarePrograms@mt.gov**

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Key Partner Questions and Discussion



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Contact Information

- Questions and/or concerns?
  - MTPrimaryCarePrograms@mt.gov
- Next Key Partner Meeting:
  - Date and time TBD – Next Tier 3 topic: Risk Stratification

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