PRIMARY CARE MONTANA (PCMT) TIER 1 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
"Basic" Ensuring preventive services	"Plus" Managing transitions of care	"Advanced" Fully managing complex populations

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 1 Overview

Tier 1 is Montana Medicaid's foundational primary care program which 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 for Tier 1 PCMT Program

- 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 (July 2027 – June 2028).
- Providers may attest to meeting Tier 1 Provider Requirements (below) 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 Payment Model

Participating providers receive a PMPM care coordination fee.

- In **Year 1**, participating providers receive a $6.00 PMPM payment based on meeting Tier 1 Provider Requirements.
- Starting in **Year 2**, participating providers must continue to meet Tier 1 Provider Requirements *and must also meet* performance targets on selected quality measures

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 claims based clinical quality measures from the list below

Quality Measures

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

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

Measure Name	
Cervical Cancer Screening (CCS-AD)	Controlling High Blood Pressure (CBP-AD)
Colorectal Cancer Screening (COL-AD)	Glycemic Status Assessment for Patients with Diabetes (GSD-AD) **inverse*
Breast Cancer Screening (BCS-AD)	Lead Screening in Children (LSC-CH)
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+)	Screening for Depression and Follow-Up Plan: • Ages 12 to 17 (CDF-CH) • Age 18 and Older (CDF-AD)
Child and Adolescent Well-Care Visits (WCV-CH)	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)