COMMISSIONER OF SECURITIES & INSURANCE

MONICA J. LINDEEN
COMMISSIONER

OFFICE OF THE MONTANA
STATE AUDITOR

November 2016

Dear Montana Patient-Centered Medical Home Payor:

As a requirement of my approval of your participation in the Montana Patient-Centered Medical Home (PCMH) Program, your company or program must submit a report on the cost and utilization measures identified in administrative rule. The deadline for PCMH payors to submit their report on Emergency Room visits and Hospitalizations to the Montana Office of the Commissioner of Securities and Insurance is on or before **April 30, 2017**. Reports must be created using the attached measure definitions and reporting instructions.

Thank you for your participation in the Montana PCMH program. The program is making a difference in patient care in Montana and your support is critical to the ongoing transformation process.

Sincerely,

Monica J. Lindeen
Commissioner of Securities and Insurance
Montana State Auditor

Attach: 2017 Payor Guidance

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PCMH Payor Cost and Utilization Measures Guidance

Report Deadline: April 30, 2017

Introduction

Montana private insurers and public payors with PCMH contracts are required by The Patient-Centered Medical Home Act (Act) to report annually on compliance with a uniform set of cost and utilization measures. According to Administrative Rule of Montana 6.6.4909, the annual deadline for reports from PCMH payors on utilization review measures to the Montana Office of the Commissioner of Securities and Insurance (CSI) is April 30. Submit reports to Ramona Bidon at rbidon@mt.gov.

Payors must submit data from calendar year 2016 on two utilization measures: Emergency Room visits and Hospitalizations. The prescribed method for defining the measures and reporting is outlined below. Flexibility is allowed for attribution methods, if approved by the Commissioner. However, a recommended attribution method is below. Payors that did not have an attributed PCMH population in 2016 will report these measures for their entire population.

Measure Definitions

Emergency Room (ER) Visits

- Report separately, ER visits that lead to a hospitalization.
- Report separately, ER visits that do not lead to a hospitalization.
- Collapse multiple ER visits on the same day into the same episode of care. ("Same day" is defined as one calendar day from 12:00 am to 11:59 pm.)
- Exclude observation bed stays.

Hospitalizations

- Include all acute facilities.
- EXCLUDE the following facilities: skilled nursing facilities (SNF) or swing bed designations, long-term care hospitals, medical and surgical rehabilitation hospitals, non-acute mental health, such as residential mental health treatment facilities, and birthing centers.
- Include hospitalizations that occur outside of Montana.
- Combine multiple components of care during a continuous episode into a single admission count as long as they are all inpatient care, (for example, transfers across acute care settings).
- REMOVE newborn and delivery hospitalizations from the hospitalization rate.

METHOD FOR MEASURING THE REQUIRED UTILIZATION MEASURES

- **Method for measuring and reporting of Emergency Room Visits (ER Visits per 1,000*)**
  ER Visits per 1,000 is the average number of emergency room facility visits provided under medical coverage, per 1,000 members per year. The number of visits is based on the count of unique patient and service date combinations (ER Visits/ (Member Months/1000))*12.
- **Method for measuring and reporting of Hospitalization Rates (Admits per 1,000*)**
  Admits per 1,000 is the average number of acute admissions per 1,000 members with medical coverage per year (Admits/ (Members Months/1000))*12.
- **Report the underlying numerator and denominators of the rates:** validation of the correct calculation cannot be done without the underlying numerator and denominator counts.

REPORTING INSTRUCTIONS

- **Report two sets of calculated rates for both measures:**
  1. For the population consisting of the entire fully insured book of business.
  2. For the PCMH population consisting of members with 7 or more months of contiguous attribution to a PCMH within the reporting period of calendar year 2016.
- **Report Final Action Claims:** final action claims avoid double counting hospitalizations and ensure all clinical and payment information is for the combined stay.
- **Indicate if observation bed stays are included or excluded in the Emergency Room visit rate.**
- **Indicate if you are unable to exclude any of the hospital facilities in the measure definition or defined either measure differently in any way.**
- **Submit a detailed description of the attribution method used to create the rates.**

RECOMMENDED ATTRIBUTION METHOD

1) PCMH is established when an approved entity notifies payor of their intent to participate and signs an agreed upon contract.
2) PCMH sends payor a list of participating healthcare providers **practicing** Primary Care within the following specialty categories:
   a. Family Practice
   b. Internal Medicine
   c. Internal Medicine w/ subspecialty of Endocrinology (for diabetic patients)
   d. Pediatrics
   e. OB/GYNs
   f. General Practice
   g. Nurse Practitioners and Physician Assistants practicing in one of the above specialties
3) Member eligibility is established based on active payor membership for the specified time period & exclusion of certain lines of business.
4) Member qualification for participation in PCMH:
   a. Member-Provider relationship established using 2-year retrospective payor claims utilization (provider type, volume, and frequency of visits).
5) PCMH and payor repeat the above process on a monthly basis to an agreed upon provider and patient panel for reporting and compensation purposes.

Please Note: This is one proposed attribution method. Payors may develop other attribution methods, ***as approved by the Commissioner.***