Montana Patient-Centered Medical Home Program

2015 Public Report

A report on the first year results of the Montana program implementation.
Message from the Commissioner

Thank you for your interest in the Montana Patient-Centered Medical Home Program, a major health policy initiative of my administration.

This report summarizes data submitted by healthcare providers and private health insurers and Medicaid (payors). Applications, reports and narrative sections document how the PCMH model is changing the healthcare experience for Montanans.

I thank the CSI staff, our partners at the Department of Public Health and Human Services and all the stakeholders who have served and worked hard to get this exciting program up and running. We are off to a great start and I look forward to future progress and a healthier Montana.

Sincerely,

Monica J. Lindeen
Office of the Montana State Auditor
Commissioner of Securities and Insurance
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Montana Patient-Centered Medical Home Program

2015 Public Report

SECTION I: INTRODUCTION

The Montana Patient-Centered Medical Home Program (PCMH) is in its infancy with one year of data to report since the program launched. However, the baseline data is encouraging and supports the proposition that the PCMH program advances comprehensive primary care and will keep Montanans healthier. PCMHs in Montana promote high-quality, cost-effective care by providing primary care providers with better opportunities and resources to enhance care coordination. In order to qualify for the Montana PCMH program, healthcare providers must submit a Comprehensive Application, obtain accreditation from an approved accreditation agency and report on 3 out of 4 quality-of-care “metrics” identified by the Commissioner in administrative rule. A qualified clinic in the Montana PCMH program can promote and market itself as a PCMH and can engage in PCMH enhanced compensation contracts with Montana insurers and Medicaid.

This report summarizes data from the Comprehensive Application, the Quality Metrics Report and an additional narrative report on patient experiences submitted by the PCMH healthcare providers. The report also summarizes data from private health insurers and Medicaid (payors) on their utilization reports (rates of healthcare use - ER visits and hospitalizations) and their narrative reports document how they partner with providers to improve Montanan’s healthcare experience. The PCMH healthcare providers and payors report on quality and utilization measures, which allows the program to gauge its success against documented national health outcomes and utilization benchmarks and the federal Healthy People 2020 targets.

What is a PCMH?

A patient-centered medical home is not a building, house, or hospital. It is a team of healthcare professionals that transform their focus from just treating illness after the fact to keeping patients healthy and avoiding expensive complications. A PCMH utilizes a “team” of people in various positions, such as physicians, physician assistants, nurse practitioners, nurses, care coordinators, dieticians, behavioral health consultants, and pharmacists to coordinate all aspects of a patient’s health. The care team engages the patient as an active participant in their healthcare through better communication regarding the individual’s responsibility for their own health. PCMHs provide a comprehensive approach to healthcare, addressing every aspect of a patient’s health, at all stages of life. PCMHs coordinate care with other parts of the healthcare system such as specialty healthcare providers, hospitals, and nursing homes. Some PCMHs also connect patients to community resources such as affordable housing or affordable health insurance. PCMHs prevent and manage disease better by following up with patients to ensure that preventive care and necessary treatment for chronic disease is delivered in a timely and appropriate manner.
History of the Montana PCMH Law

The Montana Patient-Centered Medical Home Act became law on April 30, 2013 and its provisions are contained in Mont. Code Ann. Title 33, Chapter 40. The provisions of this Act were proposed by the Montana Office of the Commissioner of Securities and Insurance (CSI) in close consultation with the Commissioner’s PCMH Advisory Council. Council members included healthcare providers, health insurers, representatives from the state Medicaid division, and consumer advocates. The bill codified the definition of a patient-centered medical home in Montana state law and established a governance structure for the state-wide program. The Act gives the Commissioner rule-making authority to govern the program and requires the Commissioner to set standards for PCMHs, in consultation with stakeholders, including healthcare quality and performance measures that include prevention and uniform standards for measuring cost and medical usage. The Act requires PCMH providers and payors to report to the Commissioner on their compliance with those measures. The Act allows the Commissioner to qualify patient-centered medical homes that have obtained accreditation from an approved accrediting agency and that meet the standards set in rule.

The Montana PCMH Act sets clear expectations for the Montana PCMH program to help payors, providers, and patients achieve better health outcomes and lower costs. It also establishes anti-trust protection through ongoing state involvement in the oversight of the program. The law’s anti-trust protection allows multiple payors and providers to share the cost of transforming a medical practice into a PCMH.

The law further provides for government agency oversight, but requires input from interested parties through the creation of a stakeholder council. The stakeholder council has met monthly since November 2013 and also has several subcommittee meetings each month.

Program Governance and Administrative Rules

In September 2013, the CSI worked with stakeholders and adopted the program’s first set of administrative rules. According to the rules, a PCMH healthcare provider must apply for qualification and receive approval from the Commissioner before promoting itself as a medical home. Payors may only use healthcare providers qualified by the Commissioner as PCMHs when offering “medical home” services to covered individuals. The rule allows the Commissioner to “provisionally qualify” a patient-centered medical home for one year if the practice needs additional time to obtain accreditation. Furthermore, the Commissioner may extend the provisional status one time only, for an additional six months. A list of PCMHs can be found on the CSI website at these links: Qualified PCMHs and Provisionally Qualified PCMHs. In 2014, there were 70 PCMHs in Montana.

National Accreditation

The September 2013 rules established the program requirements for Montana PCMHs regarding national accreditation. A primary care practice must obtain accreditation from a nationally recognized accrediting organization approved by the Commissioner as meeting the standards of the Montana PCMH Program. The rule requires the Commissioner to approve and maintain a current list of national accrediting organizations that have demonstrated their standards meet or exceed those required by the Montana PCMH Act.
Four accrediting agencies prepared side-by-side-comparisons of the standards in their PCMH accreditation program to the standards outlined in the Montana PCMH law. They submitted a description of their recognition/accreditation process for medical practices seeking to gain a PCMH designation. All of the comparisons and processes were closely examined to determine which entities were the best fit with the Montana law and stakeholder priorities for PCMHs in Montana. Three entities were approved: The National Committee for Quality Assurance [NCQA], The Joint Commission [JCo], and The Accreditation Association for Ambulatory Health Care [AAAHC].

**Stakeholder Council Duties**

The September 2013 rules also established the PCMH Stakeholder Council duties and the timelines for required reporting. The stakeholder council consists of 15 members who represent some of the interested parties identified in Mont. Code Ann. 33-40-104: the Department of Public Health and Human Services, public health agencies, health plans, government health plans, primary care providers, and healthcare consumers. The Commissioner selects stakeholders from those who submit a letter of interest. Council members serve a 12-month term. The first council convened in November 2013. The stakeholder council is consulted on all consequential decisions regarding the PCMH program.

**Quality Metrics**

Specific quality metrics were adopted in rule in December 2014, fulfilling the requirement to set standards on a uniform set of healthcare quality and performance measures that include prevention services. The four adopted quality measures are: blood pressure control, diabetes control, tobacco cessation and childhood immunizations. These rules also require qualified and provisionally qualified PCMHs to report annually to the Commissioner on their performance related to the healthcare quality metrics, pursuant to Mont. Code Ann. 33-40-105 (5). The reports enable the Montana PCMH Program to measure quality improvement over time for the program as a whole. Summary data from the PCMH 2014 quality metric reports is in Section V of this report.

**Payment Methods and Utilization Measures**

The CSI also adopted rules on standards for payment methods and measures relating to cost and medical usage (utilization measures). In the first year, PCMH payors were required to report on two measures: emergency room visits and hospitalizations. (Summary data on PCMH payors’ first year of utilization measure reports is in section VI.) Montana payors that wish to establish a patient-centered medical home program for their members must submit a letter of intent to the Commissioner, describing how their proposed method of compensating providers meets the requirements of the statute and the rule. Payment models must support enhanced primary care and promote the development of patient-centered medical homes. Payment methods may include payment for patient-centered medical home recognition status; reimbursement for patient-centered medical home services such as care coordination, disease management, population management, behavior health specialist services, and clinical pharmacist services; payment for improvement in quality metrics; shared savings incentives; block grants to enhance patient-centered medical home capabilities of practices; and other types of payment that the Commissioner approves as supporting the goals of the Montana PCMH Program. The Commissioner reviews and approves or disapproves the letters of intent. Copies of the approved payor letters are available to the public and posted on the CSI website [here](#). Currently, there are four approved payors, including Medicaid.
SECTION II: QUALIFYING AND PROVISIONALLY QUALIFYING PRACTICES

The Commissioner qualified the first group of PCMH practices in early 2014, based on a Preliminary Application. The PCMH had to indicate if it had received, or was seeking, accreditation from a national accrediting organization and which one. The recognition documentation was required to be attached. Later in 2014, the CSI followed up with a Comprehensive Application that provides more detail about the practice’s PCMH transformation process. Summary data on key points from the application is below. The questions asked in 2014 were about the practice’s current status at that time. Healthcare practices seeking PCMH qualification in 2015 and beyond must submit the Comprehensive Application as part of their initial application.

Comprehensive Application (Year 1 - 2014)

The application was developed to help practices identify their PCMH focus, strengths, and weaknesses. The information contained in this document also allows program administrators to connect participants with appropriate resources, if the practice is interested. The program also uses this information to highlight the strengths of the Montana PCMH program and to identify areas where improvement could occur and assistance could be provided. The data helps program administrators make informed decisions regarding program development, such as reporting requirements. PCMH providers can use the information as an advocacy tool in their organizations and payors can use the information to plan their PCMH contracts. The application’s comparative data shows the progress of the practices’ PCMH transformation year-to-year.

Types of Program Participants

Figure 1. Practice Site Ownership

* 73 total responses, 99% of submissions
Figure 2. Practice Type

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo (one provider)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Single site, single specialty</td>
<td>31% (22)</td>
</tr>
<tr>
<td>Multi-site, single specialty</td>
<td>4% (3)</td>
</tr>
<tr>
<td>Single site, multi-specialty</td>
<td>23% (16)</td>
</tr>
<tr>
<td>Multi-site, multi-specialty</td>
<td>19% (13)</td>
</tr>
<tr>
<td>Residency, academic</td>
<td>11% (8)</td>
</tr>
<tr>
<td>Community health center</td>
<td>29% (20)</td>
</tr>
</tbody>
</table>

* 70 total responses, 100% of submissions

Figure 3. Primary Care Specialties

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family medicine</td>
<td>81% (56)</td>
</tr>
<tr>
<td>General practice</td>
<td>22% (15)</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>39% (27)</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>13% (9)</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>29% (20)</td>
</tr>
<tr>
<td>Other</td>
<td>6% (4)</td>
</tr>
</tbody>
</table>

* 69 total responses, 99% of submissions
Comparison between Qualified and Provisionally Qualified PCMHs

Figure 4. Compares qualified to provisionally qualified PCMH practices that have incorporated care coordination and/or disease management into care delivery.

2014 Progress in Practice Transformation Efforts

Figure 5. Methods used to enhance access to care or encourage patient self-management, 2014.

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic communication</td>
<td>79% (56)</td>
</tr>
<tr>
<td>Expanded office hours</td>
<td>72% (51)</td>
</tr>
<tr>
<td>Same day appointments</td>
<td>99% (70)</td>
</tr>
<tr>
<td>Clinical advice system available when office is not open</td>
<td>77% (55)</td>
</tr>
<tr>
<td>Patient portal</td>
<td>82% (58)</td>
</tr>
<tr>
<td>Other</td>
<td>3% (2)</td>
</tr>
</tbody>
</table>

* 71 total responses, 95% of submissions
Figure 6. Elements of care coordination in PCMH care delivery, 2014

<table>
<thead>
<tr>
<th>Element of Care Coordination</th>
<th>Percentage (Number of Responses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborate and assist patients in personal goals for their improved health (self-management goal setting)</td>
<td>70% (47)</td>
</tr>
<tr>
<td>Patients receive paper or electronic copy of their Care Plan specific to their chronic disease</td>
<td>81% (54)</td>
</tr>
<tr>
<td>Your clinic electronically generates lists of patients needing care and contacts these patients</td>
<td>75% (50)</td>
</tr>
<tr>
<td>Your clinic has some system for the team to do pre-visit planning or huddles</td>
<td>97% (65)</td>
</tr>
<tr>
<td>Your clinic does additional coordination of care for complex, high use patients (referrals, labs, tests)</td>
<td>76% (51)</td>
</tr>
<tr>
<td>System in place to follow-up pro-actively with patients having recent ER visit and or hospitalization</td>
<td>79% (53)</td>
</tr>
<tr>
<td>Other</td>
<td>4% (3)</td>
</tr>
</tbody>
</table>

* 67 total responses, 91% of submissions
Qualified and provisionally qualified PCMH practices and PCMH payors submit annual data reports on the required quality and utilization measures. However, data alone does not provide enough information to effectively evaluate the Montana PCMH Program. Therefore, the CSI also developed the PCMH Healthcare Provider Annual Report for providers to describe successes, and perhaps ongoing challenges, in a more narrative, detailed, clinic specific format. Some questions followed-up on the data collected from the 2014 Comprehensive Application while other questions related to the data contained in the 2014 Quality Metrics Report. And finally, other questions asked about the broader story of PCMH transformation, beyond the data, and its effects on staff and patients.

The following sections are excerpts and summaries from the March 2015 reports.

Practice Transformation - Effects on Staff and Patients

Clinics were asked to share the most beneficial aspect of PCMH practice transformation:

1. For Primary Care Physician and other providers:
   - Standard training program
   - More recognition for hard work and feeling of accomplishment
   - Helpful for identifying where improvement is needed
   - Better able to track “high-need” patients and over-utilizers
   - Better able to track where patient care gaps may exist
   - Expands the role and types of care team members
   - Pre-visit planning and the daily huddle

2. For Patients:
   - Patient receives a written treatment plan
   - Team-based care where patient sees the same provider and other team members
   - Patient gets comprehensive care, for all stages of life
   - Provides better sense of care and concern for patient as an individual
   - Better monitoring and care for high-risk patients
   - Better tracking of referrals to reduce number of patients who fall through the cracks
   - Improved patient access to providers, with early morning and same-day appointments, and their own medical record
Patient Success Stories related to 2014 Quality Metrics

Clinics were asked to share a patient success story, for each quality metric, if possible, that resulted from the clinic’s PCMH implementation. Here are a few examples:

METRIC 1: A1C control in diabetes patients

The first two stories show how PCMHs successfully educate and engage patients to be proactive in their healthcare. The last story is a great example of comprehensive care coordination by a PCMH that oversaw a patient through their continuum of care from the hospital to home health.

- Dietary education with the “Calorie King” book, a quick reference for counting carbohydrates and calories, leads to better Hemoglobin A1c control.

- A clinic began to identify patients as "high-risk" and created a diagnosis code in the EMR. A patient was seen shortly after this process began. She was seen again in 3 months and her A1C had dropped to 7.4. The "high-risk" diagnosis motivated her to change her diet and exercise program.

- A new diabetic patient in her mid-50s was discharged from the hospital on new antidiabetic medication and given a blood glucose machine. When questioned about how she was doing, the patient indicated confusion with the new meds, the use of the machine and mentioned feeling weak. The patient was assessed as having difficulty leaving her home without assistance and had a knowledge deficit in management of her diabetes. Home Health was set up to assist in diabetes education and a physical therapy referral provided instruction in safety and use of a walker. PCMH follow-up reduced the probability of re-hospitalization.

METRIC 2: Blood pressure control in patients with hypertension

Patients in a PCMH that provides education on their condition and encouragement toward self-care experience real health improvements.

- Preplanning improves identification of the patients not monitoring their own blood pressures or blood sugars. Education helps patients understand the importance of regular monitoring and bringing logs to appointments. Without the logs, needed changes in treatment might be delayed or may not happen since the clinic would otherwise rely solely on in-office readings.
METRIC 3: Tobacco Screening and Cessation Intervention

A shift toward better patient tracking and team-based care approaches prevents tobacco users from being overlooked.

- Since PCMH implementation, patients are queried at each office visit whether they are interested in stopping tobacco use. Educational information and resources are given to all patients and they are encouraged to stop smoking. Once a patient decides to quit, the health coach RN follows-up with the patient on a regular basis to support them and provide encouragement. Patients are given logs to record when they smoke and identify triggers. The log is reviewed with the health coach and physician. Goals are set and the health coach follows-up to mark their progress.

- A patient tried the Montana Quit Line and medications to stop tobacco use but was unsuccessful. Now, with regular phone call follow-up from the clinic’s care coordination nurse, the patient was able to quit smoking. Before PCMH, the practice did not screen every patient...since PCMH, the practice screens every patient thirteen years and older and utilizes standardized education materials.

METRIC 4: Childhood Immunizations

Enhanced access and communication are pillars of the PCMH model that help increase childhood immunization rates.

Other General Successful Practices

- Improved outcomes due to follow-up calls, mail and phone outreach to chronic disease patients.

Practice Transformation related to 2014 Quality Metrics

Clinics were asked to share the best aspects of PCMH practice transformation for patients:

METRIC 1: A1C control in diabetes patients

Better patient education, tracking disease management, and medication management all contribute to better controlled diabetes.

- Registered nurses (RNs) in the patient care teams develop a quality management project for diabetic patients. RNs contact each newly diagnosed diabetic (or patients with HgbA1c of >9%) 1-2 weeks after the patient has been in the clinic; learn how the patient is either adapting to the new diagnosis or dealing with diabetes that is not well controlled; assists the patient with their glucometer, meal plans, exercise plans and helps the patient identify and overcome barriers to improvement; helps the patient improve their self-management.

- Diabetics are monitored for A1C, and given foot exams.

- Expanded use of clinical pharmacists for chronic disease management visits.
METRIC 2: Blood pressure control in patients with hypertension

Again, patient education and increased disease monitoring results in better controlled hypertension.

- Many clinics report significant reduction in patients who have uncontrolled (by definition) hypertension due to better monitoring and better follow-up after medication changes.
- Uniformed education across the spectrum of healthcare practitioners; providers collaborate with patients to formulate specific BP goals and document in electronic record; patients are encouraged to take home a BP monitor.

METRIC 3: Tobacco Screening and Cessation Intervention

A team-based approach to improve patient tracking incorporating behavioral health prevents tobacco users from being overlooked because it is a comprehensive approach.

- Many clinics report that all patients are screened for tobacco use prior to seeing providers and providers are then informed about a patient’s need for tobacco cessation intervention. Clinics can concentrate on patients who are serious about quitting and initiate referrals to the Quit Line. A care coordination nurse does follow-up calls.
- Medical and dental teams meet daily and the staff discusses the needs of the patients they see that day, including behavioral health specialists.
- Behavioral health referrals have increased.

METRIC 4: Childhood Immunizations

- Improved use of data for outreach to those due or overdue for immunizations
- Child immunizations are checked in the state immunization registry prior to visit.

Depression Screening Practices

Clinics that currently do depression screening were asked to answer how they target patients:

- Target adolescents and geriatrics, as these are extremely high risk groups...also, all patients twelve and over receive screening at their annual wellness exam.
- Medicare patients at annual wellness visit.
- All mothers at their baby’s two and six-month visits for post-partum depression.
- When concerns arise from social history discussions with medical assistants, nurses and providers.
Clinics were also asked to describe any barriers to depression screening:

- The greatest barrier is the stigma ... many patients do not want to be screened because they have no intention of doing anything about it.
- Patients aren't ready to address these issues.
- Lack of referral resources.
- In eastern Montana, the biggest barrier is access to higher levels of care or treatment and no inpatient psychiatric services for people who are suffering with progressive mental health challenges. Many private counselors in the area require a payor source to see and treat people and many patients have no insurance or income.
- The biggest barriers are the EMR (electronic medical record) and time. The EMR does not allow for a seamless approach to document the screening and the results of that screening.
- Patient denial. If a patient is not honest, appropriate intervention cannot be implemented.
- Patients often resent being asked the same questions each time ... but providers know their situation may have changed ... must work to be mindful of the patient’s perspective.
SECTION IV: PCMH PAYOR ANNUAL REPORT

PCMH payors also submitted annual reports that include other information necessary to evaluate the Montana Patient-Centered Medical Home Program. The payor’s raw data on ER visits and hospitalizations does not provide enough information to effectively evaluate the Montana PCMH Program. Therefore, the CSI developed the PCMH Payor Annual Report to fill in the gaps for proper evaluation and to give the payors a chance to describe how their partnerships with providers aim to improve quality and lower costs.

The PCMH payors incentivize health care providers to improve health and lower costs in the following ways:

- Payor A provides per member, per month payments to PCMHs. The payment is based on participation in the Montana PCMH program with the implied quality standard of qualification and accreditation. There are also payments (bonuses) that result from meeting the payor’s benchmarks for health outcomes established in the payor contract. The health outcomes are verified through data sharing between the provider and the payor.

- Payor B supports PCMHs through a Complex Care Coordination Program where patients are assigned to a PCMH provider based on their choice and utilization. Patients are screened for chronic diseases. The health risks and likelihood of hospitalization for that patient is analyzed. The PCMH practice is provided information about patients who need care coordination. A physician-driven care plan is developed with the participation of the physician, patient, patient's family, and the care coordination team clearly identified. Ongoing coordination is provided by the care coordination team to encourage compliance and achieve the highest level of health and wellness for the patient. Payment support is provided through billing codes for services provided outside of traditional provider and patient face-to-face visits.

- Payor C provides payments to PCMHs based on the “Triple-Aim” (Improving the patient experience of care [including quality and satisfaction]; Improving the health of populations; and Reducing the per capita cost of healthcare. According to the Institute for Healthcare Improvement.) They provide information on gaps-in-care for the PCMH to identify improvement opportunities. The payor and the PCMH meet regularly to consider patients, conditions, and improvement opportunities. The payor also offers grant opportunities for delivery system innovation.

- Payor D requires contracted providers to conduct outreach to patients to address gaps-in-care and engage them in their healthcare decisions and treatment plans. They compensate PCMHs through one of three per member, per month fees: Participation/Prevention fee (no chronic diseases); a single chronic condition; or more than one chronic condition. The payor and the PCMH share information on patient health outcomes and quality measurement data. The PCMH uses the information to identify patients in need of additional care and contacts them within the calendar year for preventive and chronic disease care. The payor also requires the PCMH to refer patients, as necessary, to community-based programs such as the cardiovascular disease and diabetes prevention program, the arthritis exercise and self-management programs, the fall prevention program, the home visiting programs, the Montana Quit Line, and other programs as available.
The payors report information back to clinics about patient health outcomes and performance in the following ways:

- Three of four PCMH payors currently report information back to clinics on patient health outcomes and performance. The fourth plans to begin reports in 2016.
- Payor A creates provider reports based on clinical and claims data to guide practices in quality improvement efforts. The payor conducts educational sessions based on year-end outcomes with all PCMH providers, and meets with PCMHs for individual education and collaboration based on needs identified by the data.
- Payor C meets with PCMHs monthly to review cost, utilization, quality reports, and gaps-in-care reports so the PCMHs can reach out to patients to offer chronic care management.
- Payor D sends PCMH providers quarterly reports to identify gaps-in-care, using recent claims data. PCMH providers address the gaps with patients and submit data to the payor on metrics such as weight, BMI, and blood pressure.

Expectations for use of enhanced reimbursement:

- Three of the four payors have specific recommendations regarding how PCMHs can use their enhanced reimbursement. Expectations include hiring a Care Coordinator, support for technology systems, staffing, team-based care education, and population management education.
- Two of those three payors enforce their expectations through payments. One payor uses billing codes; the other payor, with their PCMHs, mutually tracks spending throughout the program year.

Other points of interest:

- No PCMH payors currently work with practices on quality improvement activities for population management. Population health management is the collective health outcomes of a group of individuals, such as a pre-determined list of a payor’s members who are PCMH patients.
- No PCMH payors currently educate their members about what it means to be in a patient-centered medical home, although one payor has plans for educational outreach in 2015. (Please note: The Montana PCMH Program is implementing a patient education program in 2015-2016.)
- One payor has seen differences in outcomes between patients in PCMHs and patients in non-PCMHs, including decreased ER visits, hospitalizations, and length-of-stays in their PCMH population. The other payors’ programs are too new to produce data on outcomes.
- Three of the four payors plan to expand their programs in 2016. One indicated they will expand to fifteen additional clinics and another indicated plans to expand the enrolled member population and increase the contracted clinics.
SECTION V: QUALITY METRIC DATA ANALYSIS

PCMHs are required by administrative rule to report data annually on three of the four following quality metrics:

1. Blood pressure control among adults with diagnosed hypertension
2. Control of A1C levels in adults diagnosed with diabetes
3. Screening for tobacco use and tobacco cessation counseling for adults
4. Age-appropriate immunization for children

These measures were selected because they create a narrow focus for the first year of the program. They are common health indicators that represent major health issues in Montana and are already tracked by providers. Each of these metrics has considerable potential to improve health outcomes for PCMH patients. These metrics also align with public health goals.

The Commissioner provides data reporting instructions for PCMHs in the form of guidance, which is published on the agency website here. For the initial report, data was submitted to the Commissioner for the period January 1-December 31, 2014, by March 31, 2015.

Practices had two reporting options for 2015: patient-level data or attested aggregate data. Patient-level data includes specific information for each patient in the practice or a sample of patients. For example, blood pressure control patient-level data includes the following: sex, date-of-birth, date blood pressure was measured, systolic blood pressure, and diastolic blood pressure for either all PCMH patients or a sample of their patients. Patient-level not only provides much greater accuracy in data for feedback to clinics and program evaluation, but also provides more opportunities for PCMHs to do specific, targeted quality improvement projects based on the sex or age range of their patients.

By comparison, attested aggregate data for blood pressure control only includes the number of adults (aged ≥18 through 85 years) in the PCMH patient population, the number of adults (aged ≥18 through 85 years) with diagnosed hypertension in the PCMH patient population, and the number of adults with diagnosed hypertension for whom documented blood pressure at the most recent outpatient visit during reporting period was less than 140 systolic mmHg and less than 90 diastolic mmHg. The CSI conducted extensive research and consulted with experts on the benefits of patient-level data compared to attested aggregate. Key points of the research can be found here.

Commissioner Lindeen approved the 2013-2014 PCMH Stakeholder Council recommendation on types of reporting:

All practices will submit aggregate clinical quality data in March 2015 for the measures in the Administrative Rules of Montana (ARM). Practices can volunteer to submit patient-level data as a pilot in March 2015. The ultimate goal is for all practices participating in the Montana PCMH Program to submit patient-level data starting March 2017. A work group will convene to oversee the development of required systems to collect, analyze, and report on patient-level data by March 2017. The work group will also recommend privacy and security infrastructure and data governance.

The following charts provide data for the above four listed measures, divided by attested aggregate vs. patient-level reporting. Note that Montana PCMHs have a slightly lower rate of hypertension and a higher blood pressure control rate than both the national estimate and the Healthy People 2020 target.
Figure 7. Documented Hypertension Rate and Blood Pressure Control Rate among Montana PCMH clinics compared to the national estimate and Healthy People 2020 target (2014) – Attested Aggregate

| Documented Hypertension Rate and Blood Pressure Control Rate among Montana PCMH Clinics Compared to the National Estimate and Healthy People 2020 Target, 2014 |
|----------------|----------------|----------------|
| **MT PCMH**    | **National Est†** | **HP 2020 Target** |
| Documented hypertension* | 26.9 | 27.5 | 29.0 |
| Blood pressure control** | 61.2 | 66.6 | 48.9 |

*Percentage of adults aged ≥18 through 85 years in the PCMH patient population who (a) have the diagnosis of hypertension, including ICD-9 code groups 362.11 and 401.00-404.99, and (b) had one or more outpatient visits during the reporting period: calendar year 2014.

**Percentage of the patients described above who had documented systolic and diastolic blood pressure <140mmHg and <90mmHg respectively, at most recent outpatient visit, during the reporting period.

† Data Source: National Health and Nutrition Examination Survey 2009-2012

# Healthy People: Provides science-based, 10-year national objectives for improving the health of all Americans. Each Healthy People 2020 objective has a: reliable data source; a baseline measure; and, a target for specific improvements to be achieved by the year 2020.

**Limitations**

- Patients with missing blood pressure values were considered "Not Controlled."
- Analysis excluded patients aged >85 years during the calendar year, blood pressure dates outside of reporting calendar year, and systolic (SBP) or diastolic blood pressure (DBP) values outside of acceptable range (SBP <60 mmHg or SBP >240 mmHg and DBP <40 mmHg or DBP >150 mmHg).
Figure 8. Documented Hypertension Rate and Blood Control Rate among Montana PCMH clinics compared to the national estimate and Healthy People 2020* target (2014) – **Patient-level**

<table>
<thead>
<tr>
<th>Documented Hypertension Rate and Blood Pressure Control Rate among Montana PCMH Clinics Compared to the National Estimate and Healthy People 2020 Target, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage</strong></td>
</tr>
<tr>
<td>Documented hypertension*</td>
</tr>
<tr>
<td>Blood pressure control**</td>
</tr>
</tbody>
</table>

*Percentage of adults aged ≥18 through 85 years in the PCMH patient population who (a) have the diagnosis of hypertension, including ICD-9 code groups 362.11 and 401.00-404.99, and (b) had one or more outpatient visits during the reporting period: calendar year 2014.

**Percentage of the patients described above who had documented systolic and diastolic blood pressure <140mmHg and <90mmHG respectively, at most recent outpatient visit, during the reporting period.

† Data Source: National Health and Nutrition Examination Survey 2009-2012

# Healthy People: Provides science-based, 10-year national objectives for improving the health of all Americans. Each Healthy People 2020 objective has a: reliable data source; a baseline measure; and, a target for specific improvements to be achieved by the year 2020.

**Limitations**

- Patients with missing blood pressure values were considered “Not Controlled.”
- Analysis excluded patients aged >85 years during the calendar year, blood pressure dates outside of reporting calendar year, and systolic (SBP) or diastolic blood pressure (DBP) values outside of acceptable range (SBP <60 mmHg or SBP >240 mmHg and DBP <40 mmHg or DBP >150 mmHg).
Figure 9. Documented tobacco use rate and cessation intervention rate among Montana PCMH clinics compared to the national estimate and Healthy People 2020* target (2014) – **Attested Aggregate

Limitations

- Patients with missing tobacco use values were considered non-tobacco users.
- Please consider the rates of tobacco use with caution. A clinic survey found that 23% of clinics used different specifications other than the Montana guidance to pull their tobacco use and intervention data. Attested aggregate data does not allow for detection of data outliers. The Montana PCMH Program is moving toward patient-level data collection in 2017 to avoid the bias in interpretation of aggregate data.

^ The Montana tobacco cessation intervention measure and the HP2020 measure are incompatible and cannot be compared to each other. The HP2020 tobacco cessation counseling target is to increase the percentage of visits among tobacco users where tobacco cessation counseling was ordered or provided. The MT PCMH measure is the percentage of tobacco users who received cessation intervention at any time during the reporting period.
Figure 10. Documented tobacco use rate and cessation intervention rate among Montana PCMH clinics compared to the national estimate and Healthy People 2020* target (2014) – Patient-level

Limitations

- Patients with missing tobacco use values were considered non-tobacco users.

^ The Montana tobacco cessation intervention measure and the HP2020 measure are incompatible and cannot be compared to each other. The HP2020 tobacco cessation counseling target is to increase the percentage of visits among tobacco users where tobacco cessation counseling was ordered or provided. The MT PCMH measure is the percentage of tobacco users who received cessation intervention at any time during the reporting period.

*Percentage of adults aged ≥18 in the PCMH patient population who (a) have tobacco use documented, and (b) had two or more outpatient visits for any reason, or had one preventive care visit during the reporting period: calendar year 2014.

**Percentage of the patients described above who received tobacco cessation intervention during the reporting period.

† Data Source: National Health Interview Survey 2013

# Healthy People: Provides science-based, 10-year national objectives for improving the health of all Americans. Each Healthy People 2020 objective has a: reliable data source; a baseline measure; and a target for specific improvements to be achieved by the year 2020.
Montana Patient-Centered Medical Home Program

Figure 11. Documented diabetes rate and rate of uncontrolled diabetes among Montana PCMH Clinics compared to the national estimate and Healthy People 2020* target (2014) – Attested Aggregate

Limitations
- Excluded patients aged >75 years, A1C reported dates <1/1/2014 or >12/31/2014, and unreliable A1C values <4.0 or >20.0.
- Missing A1C values were coded as uncontrolled 9.1% and missing A1C reported dates were coded as 1/1/2014.

*Percentage of adults aged ≥18 through 75 years in the PCMH patient population who (a) have the diagnosis of diabetes type 1 or 2, including ICD-9 code groups 249.00-249.99 and 250.00-250.99, and (b) had one or more outpatient visits during the reporting period: calendar year 2014.

**Percentage of the adults described above, for whom the most recent documented A1C during the reporting period was >9.0% or there was no measured A1C.


# Healthy People: Provides science-based, 10-year national objectives for improving the health of all Americans. Each Healthy People 2020 objective has a: reliable data source; a baseline measure; and a target for specific improvements to be achieved by the year 2020.
Figure 12. Documented diabetes rate and rate of uncontrolled diabetes among Montana PCMH Clinics compared to the national estimate and Healthy People 2020* target (2014) – Patient-level

Limitations

- Excluded patients aged >75 years, A1C reported dates <1/1/2014 or >12/31/2014, and unreliable A1C values <4.0 or >20.0.
- Missing A1C values were coded as uncontrolled 9.1% and missing A1C reported dates were coded as 1/1/2014.

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*Percentage of adults aged ≥18 through 75 years in the PCMH patient population who (a) have the diagnosis of diabetes type 1 or 2, including ICD-9 code groups 249.00-249.99 and 250.00-250.99, and (b) had one or more outpatient visits during the reporting period: calendar year 2014.

**Percentage of the adults described above, for whom the most recent documented A1C during the reporting period was >9.0% or there was no measured A1C.

† Data Source: National Health Interview Survey 2011 for estimate of prevalence of diabetes among adults and National Health and Nutrition Examination Survey 2009-2012 for estimate of proportion of diabetic patients with A1C > 9.0%

# Healthy People: Provides science-based, 10-year national objectives for improving the health of all Americans. Each Healthy People 2020 objective has a: reliable data source; a baseline measure; and a target for specific improvements to be achieved by the year 2020.
Figure 13. Percentage of children aged 36 months* who received all age appropriate doses of selected vaccines recommended by the Advisory Committee on Immunization practices (2014) – **Attested aggregate**

Limitations

- Receipt of vaccine doses was not confirmed through medical chart review.
- Vaccination refusals and medical contraindications were reported by some clinics, while other clinics reported them as “No” or “Not immunized.”

*All children in the PCMH population who had a 3rd birthday during January 1, 2014 through January 1, 2015 and who had one or more outpatient visit during 2014.

DTaP = diphtheria and tetanus toxoids and a cellular pertussis vaccine; HepB = hepatitis B vaccine; Hib = Haemophilus influenzae type B conjugate vaccine; IPV = inactivated poliovirus vaccine; MMR = measles, mumps, and rubella vaccine; PCV = pneumococcal vaccine; VAR = varicella vaccine.

§Combined series (received all vaccinations) (4:3:1:3:1:4) includes ≥4 doses of DTaP, ≥3 doses of IPV, ≥1 dose of MMR, full series of Hib (≥3 doses for PCMH data, 3 or 4 doses for NIS depending on product type), ≥3 doses of HepB, ≥1 dose of VAR, and ≥4 doses of PCV.

†Data Source: National Immunization Survey (NIS); estimated immunization coverage for children aged 19–35 months during 2013.
Figure 14. Percentage of children aged 36 months* who received all age appropriate doses of selected vaccines recommended by the Advisory Committee on Immunization practices (2014) – **Patient-level**

*All children in the PCMH population who had a 3rd birthday during January 1, 2014 through January 1, 2015 and who had one or more outpatient visit during 2014.

DTaP = diphtheria and tetanus toxoids and a cellular pertussis vaccine; HepB = hepatitis B vaccine; Hib = Haemophilus influenzae type B conjugate vaccine; IPV = inactivated poliovirus vaccine; MMR = measles, mumps, and rubella vaccine; PCV = pneumococcal vaccine; VAR = varicella vaccine.

§Combined series (received all vaccinations) (4:3:1:3:3:1:4) includes ≥4 doses of DTaP, ≥3 doses of IPV, ≥1 dose of MMR, full series of Hib (≥3 doses for PCMH data, 3 or 4 doses for NIS depending on product type), ≥3 doses of HepB, ≥1 dose of VAR, and ≥4 doses of PCV.

†Data Source: National Immunization Survey (NIS); estimated immunization coverage for children aged 19–35 months during 2013.

Please note: Patient-level immunization data from five PCMHs was excluded from this chart due to an error found in their data. Their reported data inadvertently included children too young for the immunizations and therefore significantly lowered the overall immunization rates.

**Limitations**

- Receipt of vaccine doses was not confirmed through medical chart review.
- Vaccination refusals and medical contraindications were reported by some clinics, while other clinics reported them as “No” or “Not immunized.”
Figure 15. Raw Data from the PCMH Quality Metric Reports - 2014

<table>
<thead>
<tr>
<th>METRIC 1: Blood Pressure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Documented hypertension</td>
<td>78,428</td>
</tr>
<tr>
<td>Blood pressure control</td>
<td>51,616</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>METRIC 2: Diabetes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Documented diabetes</td>
<td>24,600</td>
</tr>
<tr>
<td>Documented A1C&gt;9.0% (not controlled)</td>
<td>5,219</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>METRIC 3: Tobacco</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Documented tobacco user</td>
<td>10,950</td>
</tr>
<tr>
<td>Tobacco cessation intervention</td>
<td>4,679</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>METRIC 4: Immunization</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator (All children age 36 months*)</td>
<td>629</td>
</tr>
<tr>
<td>Combined series (received all vaccinations)</td>
<td>423</td>
</tr>
<tr>
<td>4+DtaP</td>
<td>539</td>
</tr>
<tr>
<td>3+Hep B</td>
<td>548</td>
</tr>
<tr>
<td>3+Hib</td>
<td>563</td>
</tr>
<tr>
<td>3+IPV</td>
<td>564</td>
</tr>
<tr>
<td>1+MMR</td>
<td>572</td>
</tr>
<tr>
<td>4+PCV</td>
<td>470</td>
</tr>
<tr>
<td>1+Var</td>
<td>549</td>
</tr>
</tbody>
</table>

*All children in the PCMH population who had a 3rd birthday during January 1, 2014 through January 1, 2015 and who had one or more outpatient visit during 2014.

**Please note: Patient-level immunization data from five PCMHs was excluded from this table due to an error found in their data. Their reported data inadvertently included children too young for the immunizations and therefore significantly lowered the overall immunization rates.
SECTION VI: UTILIZATION MEASURE DATA ANALYSIS

The PCMH Act requires the Commissioner to adopt rules establishing a “uniform set of measures related to cost and medical usage.” The rule adopted on utilization measures requires all PCMH payors to report to the Commissioner on emergency room (ER) visits and hospitalization rates. The Commissioner provided reporting instructions regarding the required data on the agency website here. The first payor reports were submitted by March 31, 2015, and will be submitted annually thereafter.

For ER visits and hospitalizations, if attributed population data were available, the payor provided the utilization rates for both the entire population of the payor’s fully-insured book of business and also the rates for the population consisting of members with 7 or more months of contiguous attribution to a PCMH within a single calendar year during the reporting period. For the 2014 reporting period, only one payor provided utilization data for an attributed population.

With assistance from the Robert Wood Johnson Foundation’s State Health and Value Strategies Program, Mathematica, a policy research consulting firm, assessed the usability of the ER visits and hospitalization data submitted by Montana PCMH payors. Mathematica provided a detailed description of measure definitions for each payor, rates for each measure, and benchmarks for comparing the rates.

The data and analysis below is from Mathematica’s July 2015 report to the CSI, “Usability of Data and Recommendations for Future Data Collection.”

(CSI Note: How each payor calculated their rates is very important information to keep in mind when reviewing the rates.)
Table 1: How payors calculate ER visits and hospitalizations:

- For ER visits, indicates whether ER visits are reported separately by disposition (lead to hospitalization vs. did not lead to hospitalization) and whether multiple ER visits on the same day are reported as a single visit.
- For hospitalizations, indicates whether hospitalizations outside of Montana are included; which facility types are included; and how transfers between acute care facilities or units within a hospital are handled when calculating the rates.
- And whether observation bed stays are reported separately.

As observed, there is considerable variation across the four payors in the construction and reporting of their utilization measures. The variation is likely to be reflected in differences in the 2014 rates of acute care utilization across payors.

Table 1. Payor rate definitions for acute care utilization measures

<table>
<thead>
<tr>
<th>Numerator components definitions</th>
<th>Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Payer A</td>
</tr>
<tr>
<td><strong>Emergency Room Visits</strong></td>
<td></td>
</tr>
<tr>
<td>ER visit reporting by disposition</td>
<td></td>
</tr>
<tr>
<td>All ER visits reported as a single rate</td>
<td>-</td>
</tr>
<tr>
<td>ER visits reported separately by disposition (lead to hospitalization vs. did not lead to hospitalization)</td>
<td>x</td>
</tr>
<tr>
<td>Only reported ER visits that did not lead to a hospitalization</td>
<td>-</td>
</tr>
<tr>
<td><strong>Multiple ER visits on the same day</strong></td>
<td></td>
</tr>
<tr>
<td>Reported as a single ER visit</td>
<td>x</td>
</tr>
<tr>
<td>Reported as multiple ER visits</td>
<td>-</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
</tr>
<tr>
<td>Included hospitalizations that occurred outside of Montana</td>
<td>x</td>
</tr>
<tr>
<td><strong>Rates reported included the following facilities:</strong></td>
<td></td>
</tr>
<tr>
<td>Short-term general and specialty hospitals</td>
<td>x</td>
</tr>
<tr>
<td>Critical access hospitals</td>
<td>x</td>
</tr>
<tr>
<td>Psychiatric hospitals and units</td>
<td>x</td>
</tr>
<tr>
<td>Birthing centers</td>
<td>x</td>
</tr>
<tr>
<td>Rehabilitation hospitals and units</td>
<td>-</td>
</tr>
<tr>
<td>Long-term care hospitals</td>
<td>-</td>
</tr>
<tr>
<td>Swing beds</td>
<td>-</td>
</tr>
<tr>
<td>Skilled nursing facilities</td>
<td>-</td>
</tr>
<tr>
<td><strong>Hospitalizations reported as:</strong></td>
<td></td>
</tr>
<tr>
<td>Separate admissions if change in facility or transfer</td>
<td>x</td>
</tr>
<tr>
<td>A single admission for a continuous inpatient episode</td>
<td>-</td>
</tr>
</tbody>
</table>
Table 2: 2014 rates of acute care utilization by the four payors

- Payor A reported rates for their fully-insured book of business as well as their PCMH-attributed population.
- Payors B, C, and D reported rates only for their fully-insured book of business.

It is notable that for payor A, all rates of ER visits and hospitalizations were lower for the PCMH-attributed population than for the fully-insured book of business.

Table 2. Utilization Rates

<table>
<thead>
<tr>
<th></th>
<th>Payer A</th>
<th>Payer B</th>
<th>Payer C</th>
<th>Payer D</th>
<th>Benchmark range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ER Visits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ER visits that do not lead to a hospitalization</td>
<td>All</td>
<td>184</td>
<td>-</td>
<td>-</td>
<td>641</td>
</tr>
<tr>
<td></td>
<td>Attributed</td>
<td>165</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>ER visits that lead to a hospitalization</td>
<td>All</td>
<td>29</td>
<td>-</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Attributed</td>
<td>21</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total ER visits</td>
<td>All</td>
<td>-</td>
<td>175</td>
<td>131</td>
<td>371-445¹</td>
</tr>
<tr>
<td></td>
<td>Attributed</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>All</td>
<td>67</td>
<td>65</td>
<td>57</td>
<td>129</td>
</tr>
<tr>
<td></td>
<td>Attributed</td>
<td>63</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Notes: All rates are per 1,000 members. "–" indicates rate was not reported by payer or available as a benchmark rate.

¹ 371 per 1,000 is specific to Montana and comes from: The Henry J. Kaiser Family Foundation. 2013 Hospital Emergency Room Visits per 1,000 Population by Ownership Type. 1999 - 2013 AHA Annual Survey, Copyright 2015 by Health Forum, LLC, an affiliate of the American Hospital Association. Available at: [http://kff.org/other/state-indicator/emergency-room-visits-by-ownership/]. Accessed on May 14, 2015.


² 94 per 1,000 is specific to Montana and comes from: The Henry J. Kaiser Family Foundation. 2013 Hospital Emergency Room Visits per 1,000 Population by Ownership Type. 1999 - 2013 AHA Annual Survey, Copyright 2015 by Health Forum, LLC, an affiliate of the American Hospital Association. Available at: [http://kff.org/other/state-indicator/admissions-by-ownership/]. Accessed on May 14, 2015.

Mathematica places the payors’ rates into context by comparing them to state or national benchmark rates for the two utilization measures. The last column of Table 2 provides ranges of publicly available rates for total ER visits and hospitalizations. Mathematica presents ranges of national rates, as well as those specific to Montana, using several data sources. In addition to the rates presented in Table 2, data that describe rates by payor type indicate that ER visit rates per 1,000 members vary from 210 for private insurance to 820 for Medicaid.¹ The benchmark rate ranges indicate that the payors’ rates are generally below the range of these comparison rates for ER visits. Payors A, B, and C are well below these benchmarks, while Payor D is above the range for ER visits. All payors are below the range for Medicaid as a whole when we examine rates by payor. For hospitalizations, payors A, B, and C are below the benchmark rate.

SECTION VII: CONCLUSION AND PLANS FOR 2016 REPORTING YEAR

In the first year of the Montana PCMH Program implementation, PCMH providers, payors and the CSI have experienced many learning opportunities. Discrepancies between the Montana PCMH provider reporting instructions and national standards, such as the Physician Quality Reporting System (PQRS), are being addressed now before the 2016 reporting cycle to further reduce provider burden and improve data accuracy and analysis. PCMH payors are reviewing how to align their utilization measure definitions and reporting methods with each other for better validity and to achieve uniformity. After considering requests from legislators and other interested parties, the PCMH Stakeholder Council has recommended to the Commissioner one additional quality metric, depression screening, for the 2016 reporting year. Depression is a critical health issue in Montana. For the past forty years, Montana has ranked in the top five states for suicide rates in the nation. Forty-five percent of individuals who die by suicide visit their primary care provider within a month of their death. Seventy-six percent of PCMH practices indicated they are able to electronically report on the percentage of patients who are screened for depression.

In July, all PCMH practices received clinic-specific Feedback Reports. The reports help clinics use their first year of data to identify gaps-in-care, explore new and innovative processes, and investigate the functionality and operability of their IT data systems. The PCMH practices can then use this information to reach out to patients before chronic diseases develop or worsen. The CSI will continue to work closely with stakeholders, PCMH providers and payors to develop a program that supports the goals of simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per capita cost-of-care for the benefit of communities across Montana.
