REVIEW OF MONTANA PCMH REVISED GUIDANCE

Please note: This document provides a crosswalk between our initial recommendations for suggested revisions to the payer guidance—copied and pasted below—and the revised draft payer guidance. We appreciate your willingness to incorporate our prior recommendations into the revised guidance, as we believe these will strengthen efforts to collect and report meaningful data that more accurately measures the success of the PCMH program to help practices further their practice transformation efforts. For each recommendation Mathematica previously made, we indicate below whether it was incorporated into the revised MT payer guidance ("DONE") and provide additional comments as needed where there are differences.

- **Consider further standardizing measure definitions in future guidance to payers.** Payers are currently defining their rates differently, making comparability across payers challenging. There are several technical considerations that, if standardized, will increase content validity and comparability across payers. While many of these issues were addressed in the March 2015 modifications, we recommend officially incorporating these clarifications into the next round of guidance. For example,
  - *Categorizing ER visits.*
    - DONE. In the event of multiple ER visits on the same day, collapse these visits into the same episode of care. As multiple ER visits in the same day often reflects continuing treatment for the same clinical reason and possible failure of the treating ER to stabilize the patient sufficiently before discharge.
    - DONE. Report separately ER visits that lead to a hospitalization from those that do not lead to a hospitalization.
  - *Categorizing hospitalizations.* It will be important that all payers submit data for similar hospitalizations, coming to a consensus on (a) which types of hospitalizations are included and (b) how these hospitalizations are defined. In the guidance clarifications, CSI recommended:
    - DONE. Payers include all acute facilities
    - DONE. Include hospitalizations outside of Montana.
    - Exclude all non-acute facilities such as: SNF (DONE), swing-bed designations (DONE), long-terms care hospitals, medical and surgical rehabilitation hospitals (DONE), non-acute mental health, such as residential mental health treatment facilities, and birthing centers. ~~and rehabilitation hospitals.~~
    - It could also be important for CSI and payers to standardize their definitions for these facility types based on the claims data being used to identify them.
    - DONE. It is also important to consistently handle multiple components of care during a continuous episode of care; we recommend reaching further consensus with payers as to how they handle the components of an episode (for example, transfers across acute care settings), which are

Commented [KG1]: We didn't include the following in our recommendations, but are added to the revised guidance and both make sense to include:
1. non-acute mental health, such as residential mental health treatment facilities
2. birthing centers

Commented [KG2]: This was not included in the guidance, which would be more work for the payers than some of the other recommendations. You might consider asking payers to explicitly report what differs in their rate definitions from the guidance, if they are not able to remove some of the facilities listed above. This will help you interpret rates across payers.

commonly combined into a single episode when they reflect continuation of acute care for the same clinical condition.

- *Categorizing observation stays.* Report observation stays as a separate category and exclude them from ER visits and hospitalizations.

- DONE. **Require submission of the underlying numerator and denominators of the rates**. In 2014, the payers submitted calculated rates per 1,000 members. Validation of the correct calculation could not be done without the underlying numerator and denominator counts. Further, it is highly desirable in health services research to estimate the precision of the calculated utilization rates.
- DONE. **Report final action claims.** Hospitals sometimes generate interim bills (for example, at the end of a fiscal year or during a long stay). Using these interim bills for the purposes of calculating performance measures or evaluations can generate noise in the data by appearing to be two hospitalizations and reducing the average payment per hospitalization. Researchers often use final action claims to avoid double counting hospitalizations and ensure all clinical and payment information is for the combined stay. We therefore recommend that CSI and payers develop consensus around using final action claims and incorporate this into future CSI guidance to payers.
- DONE. **Clarify guidance for delivery and newborn hospitalizations.** In performance measurement, it is typical to count delivery and newborn hospitalizations as a single hospitalization. This is often done to avoid what could be considered over counting hospitalizations. This issue may be of particular importance for Medicaid, which tends to cover many hospitalizations for routine deliveries and subsequent newborn care and reports, thus potentially skewing upwards their hospitalization rates. It is also highly unlikely that PCMHs will affect this type of hospitalization. CSI and payers may wish to consider this issue and offer future guidance to ensure consistency across payers.
- **Consider case mix adjustment.** Rates of ER visits and hospitalizations may vary based on a set of demographic characteristics of each payer's attributed population (or fully-insured book of business). As currently calculated, the rates do not account for these characteristics, such as age and sex, which could be drive differences in rates between payers' and across time if payers' insured population across time. A basic risk-adjustment approach, which accounts for age-sex differences by payer, could alleviate some of these differences to allow for more comparable rates.
- N/A. **Offer more specific guidance to payers.** In the current performance year, there was considerable flexibility in how payers interpreted the guidance and reported their ER and hospitalization rates. The March 2015 modifications helped clarify many of the technical considerations that can result in variations in claims-based utilization measures; but the timing of the clarifications did not translate into consistent reporting across the payers. It will be important moving forward to reach consensus on how the utilization measures will be constructed and reported balancing the potential increased costs to payers for modification of their standard reports with increased consistency across the payers and an increased linkage between primary care transformation and acute care utilization. This may help improve the face and content validity of the measures, increasing their usability for supporting the aims of the Montana PCMH initiative.

Commented [KG3]: This was not incorporated into the guidance based upon the consensus that no one wanted to add another measure, which would require changing the rule. In a request for additional information from the payers as to whether they can identify observation bed stays and if they are included/excluded from ER or hospitalization rates, this is the information that we have received:

- Medicaid provided very specific information that they can identify observation bed stays and that they do not include observation bed stays in either ER or hospitalization rates.
- Pacificsource provided the following information: Observation bed stays are "outpatient" per our reporting.
- BCBS provided the following information: our clinical reporting tool identifies observation stays as a facility claim with a revenue code of 760 or 762
- Allegiance provided the following information: We do not track Observation Stays as a separate measure. If we agree on the definition, I believe we can run a UDF report once a year.

We would recommend that you seek confirmation when the rates are reported that observation bed stays are excluded from the ER and hospitalization rates –similar to the statement that Medicaid provided. This will help you interpret rates across payers.

Commented [KG4]: This was not incorporated into the revised guidance.
We certainly understand the constraints around trying to incorporate case mix adjustment at this time. One downside to consider is that—without it—there is no way to control for changes over time in case mix when examining rates over time.