



Montana Patient-Centered Medical Home Program

2016 Public Report

A report on the second year 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, Health Technology Services, and all the stakeholders who have served and worked hard to keep this program going strong into its second year. Most importantly, I thank the PCMH clinics that have invested the hard work into transforming to patient-centered care. I look forward to continued progress and a healthier Montana.

Sincerely,

A handwritten signature in black ink that reads "Monica J. Lindeen".

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



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Montana Patient-Centered Medical Home Program

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SECTION I: INTRODUCTION

The Montana Patient-Centered Medical Home Program (PCMH) has completed its second year, and this report contains data from 2015. The data is encouraging and continues to support the belief that the PCMH program advances comprehensive primary care and improves the health of Montanans. PCMHs in Montana deliver high-quality, efficient primary care with an increased focus on prevention and disease management. In order to qualify for the Montana PCMH program, healthcare providers must submit a Comprehensive Application, obtain recognition from an approved recognition agency and report on 3 out of 5 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 PCMH payors, including Medicaid.

This report summarizes data from the 2015 Progress Update, 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 ER visits and hospitalizations). The payors’ narrative reports document how they partner with providers to improve Montanans’ 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, dietitians, 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 recognition 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 recognition. Furthermore, the Commissioner may extend the provisional status one time only, for an additional six months. There are three accrediting agencies the Commissioner has approved for Montana PCMHs to seek recognition from: The National Committee for Quality Assurance [NCQA], The Joint Commission [JCo], and The Accreditation Association for Ambulatory Health Care [AAAHC]. A list of PCMHs can be found on the CSI website at these links: [Qualified PCMHs](#) and [Provisionally Qualified PCMHs](#). At the end of 2015, there were 63 PCMHs in Montana.

Stakeholder Council Duties

The September 2013 rules also established the PCMH Stakeholder Council duties and required reporting timelines. 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

The Montana PCMH Act requires the Commissioner to set standards on a uniform set of healthcare quality and performance measures that include prevention services (Mont. Code Ann. 33-40-105(2) (c)). In Year 1, the program adopted four quality measures and PCMHs reported 2014 data on blood pressure control, diabetes control, tobacco screening and cessation/intervention and childhood immunizations. In Year 2, the PCMH Stakeholder Council recommended adding a depression screening measure. The administrative rules were revised to add screening for clinical depression and follow-up plan for individuals age 12 and older. However, the rules maintained flexibility by allowing PCMHs to report three out of the five measures to the Commissioner in 2016. Beginning with the 2017 report (for the 2016 calendar year measurement period) a PCMH must choose and report on four out of five measures. 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 2015 quality metric reports submitted in 2016 is in Section V of this report.

Payment Methods and Utilization Measures

The Montana PCMH Program also established rules, pursuant to Mont. Code Ann. 33-40-105(2) (a) and (d), on standards for payment methods and measures relating to cost and medical usage (utilization measures). In Years 1 & 2, PCMH payors reported on two measures: emergency room visits and hospitalizations. (Summary data on PCMH payors' Year 2 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 achieving patient-centered medical home recognition status; reimbursement for patient-centered medical home services such as care coordination, disease management, population health management, the integration of behavioral health services into primary care, and clinical pharmacist services. Montana administrative rule allows for 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: PROGRAM GROWTH AND UPDATE

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, recognition from a national accrediting organization and which one. The recognition documentation was required to be attached. Also in 2014, PCMHs completed a [Comprehensive Application](#) that provides more detail about the practice's PCMH transformation process. There were three new Montana clinics provisionally-qualified as PCMHs in 2015; they submitted the Comprehensive Application as part of their initial application. Since then, one of those three became qualified when they received NCQA PCMH recognition in March 2016 and the other two expect to receive their NCQA recognition in October 2016.

2015 Progress Update

In 2015, CSI worked with the stakeholders to convert many of the questions from the original Comprehensive Application into a new Progress Update. Summary data (from October 2015) on key points from the Update is featured in the charts below. The Progress Update helps practices identify their PCMH focus, strengths, and weaknesses. The responses also allow program administrators to connect participants with appropriate resources, if the practice is interested. The administrators also use 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 comparative data shows the progress of practices' PCMH transformation year-to-year.



2015 Progress in Practice Transformation Efforts

Figure 1. Ways Montana PCMH practices have enhanced access to care and/or patient self-management.

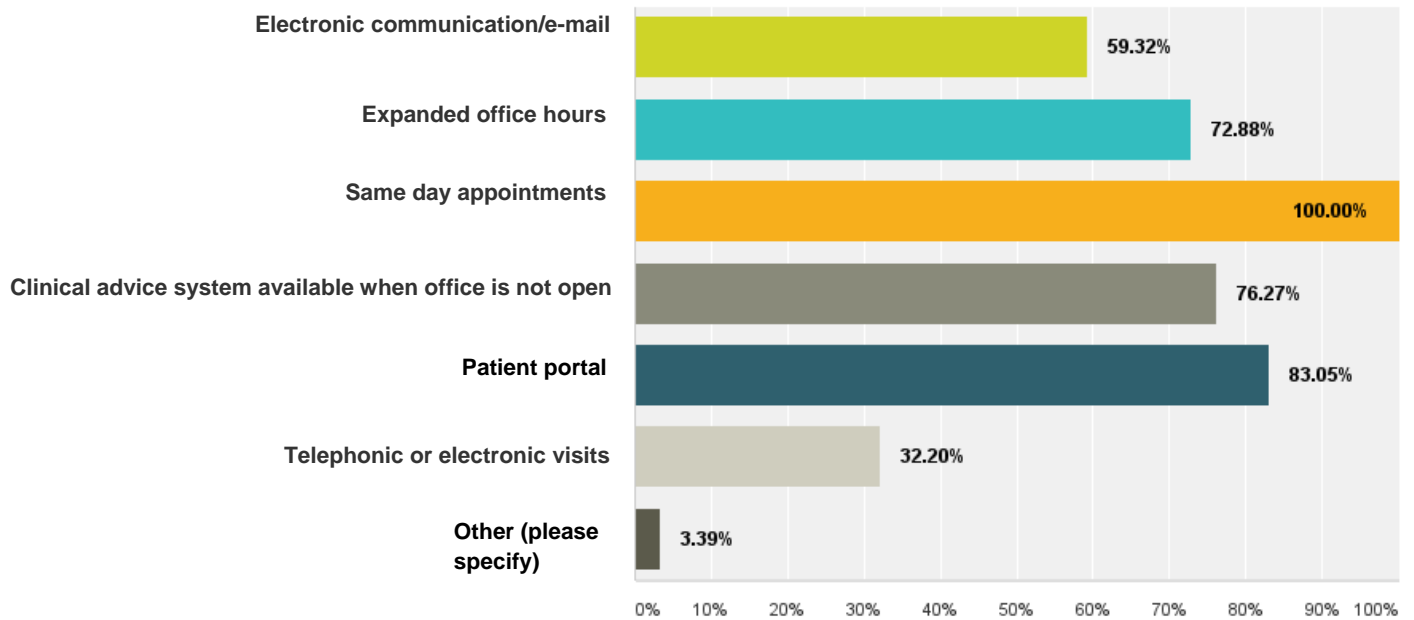
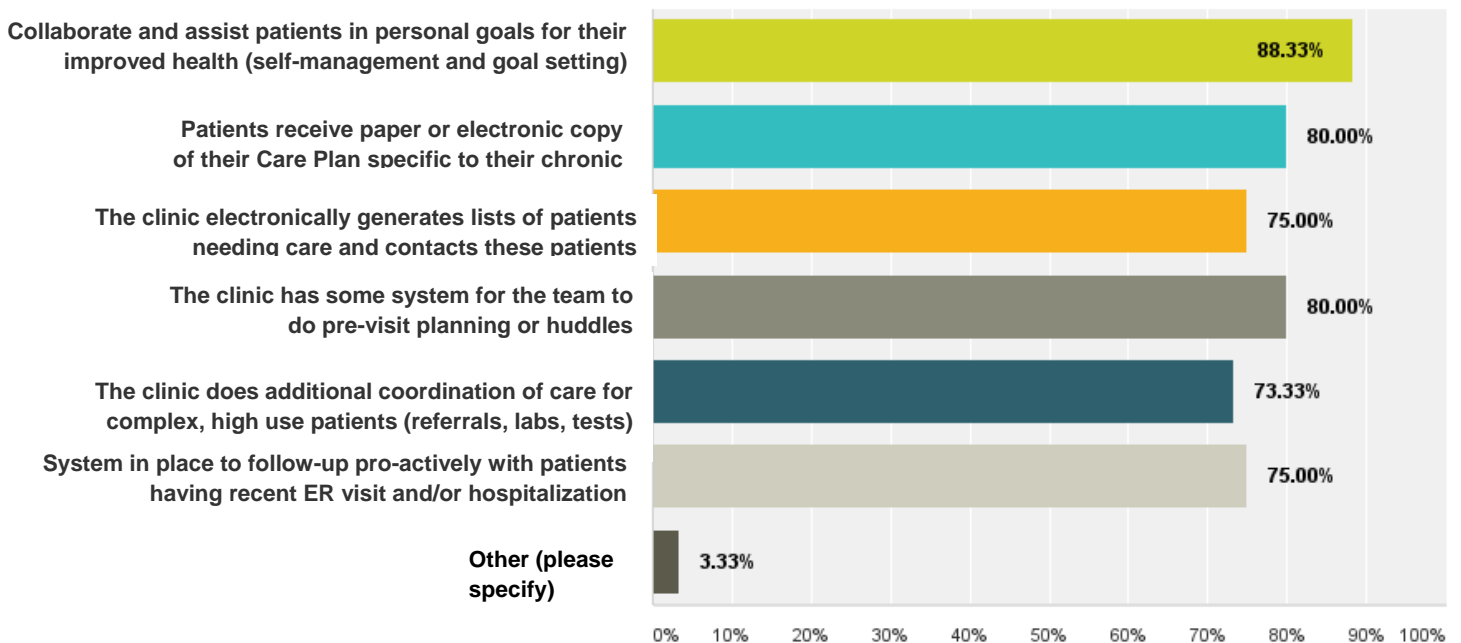


Figure 2. Elements of care coordination/disease management that are part of Montana’s PCMH care delivery.



Montana Patient-Centered Medical Home Program



Figure 3. Types of staff utilized on PCMH care teams.

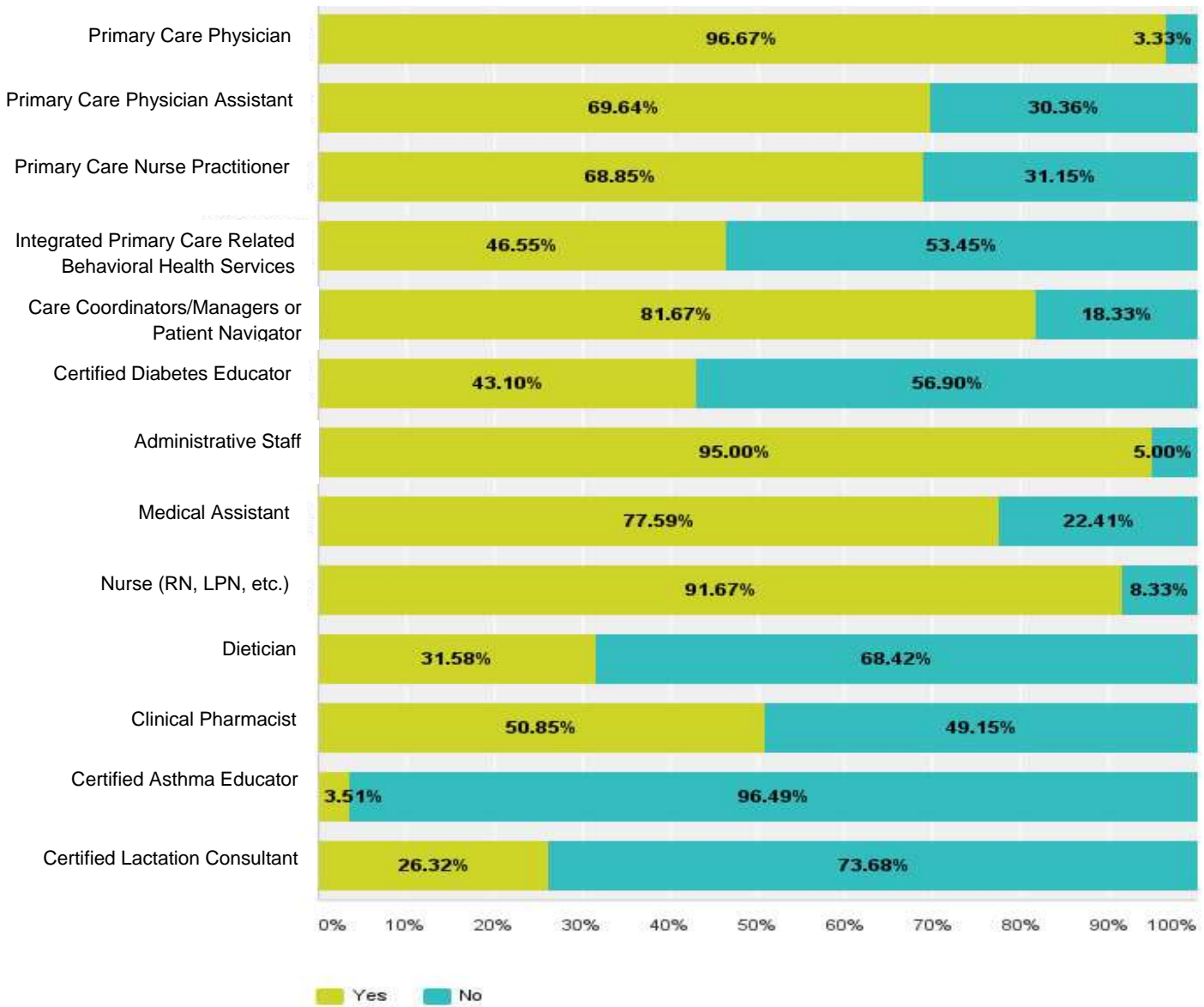


Figure 4. Percentage of PCMHs receiving enhanced reimbursement from commercial or public health plans for primary care related services.

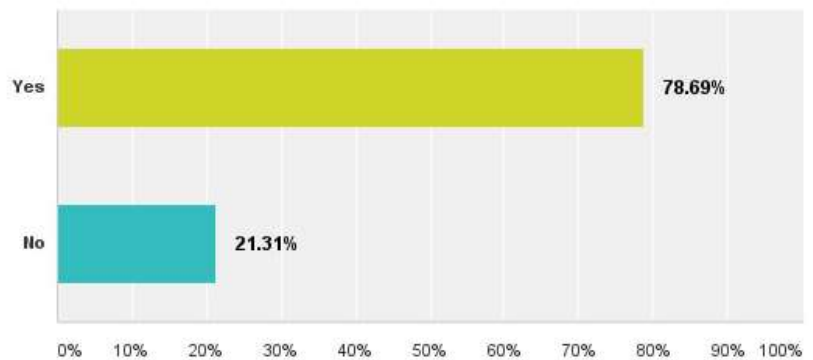




Figure 5. Percentage of total patient population for which clinics receive PCMH enhanced reimbursement.

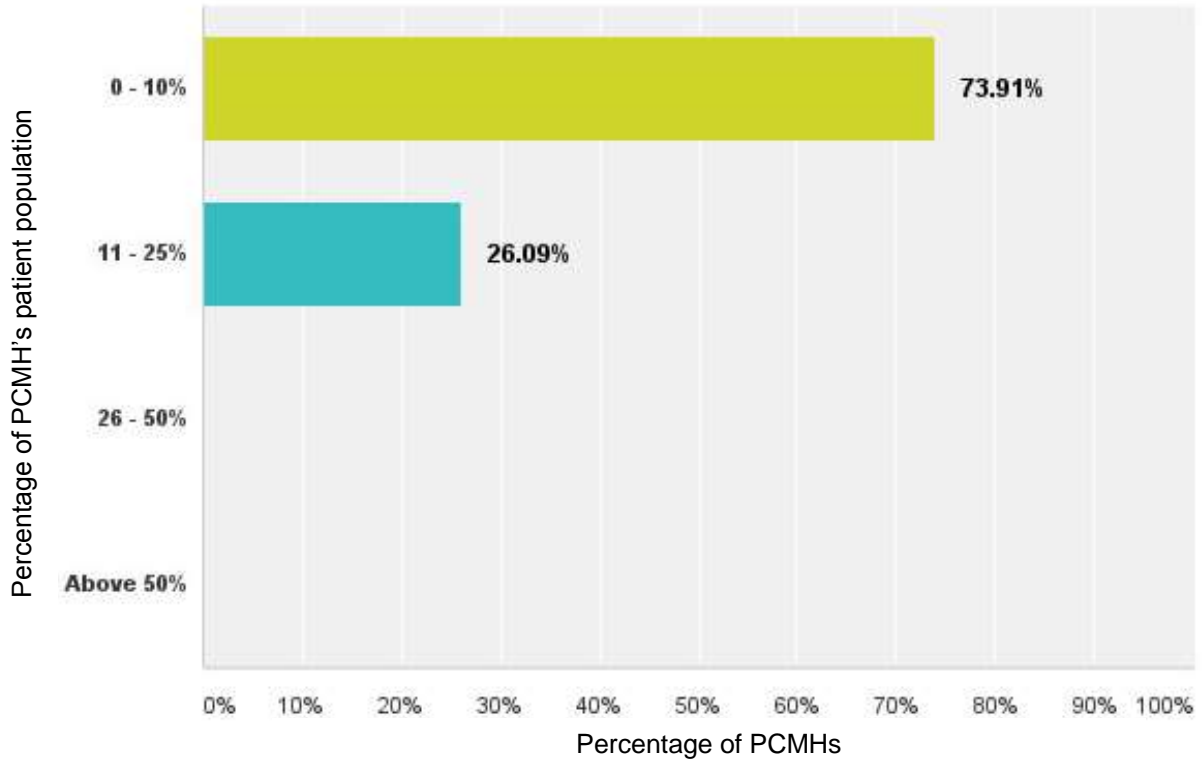
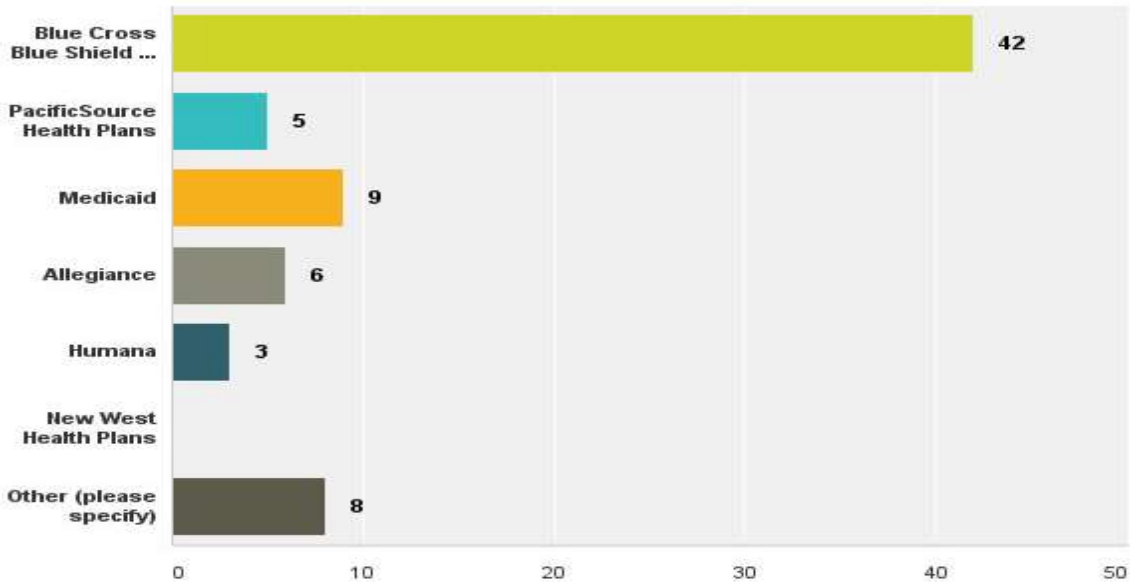


Figure 6. Number of PCMHs receiving enhanced reimbursement from each listed *payor.



*The numbers of PCMH clinics participating in the Blue Cross Blue Shield and Medicaid programs may be higher than numbers reported elsewhere because they include individual and satellite clinics within a health system.



PCMH Education to Patients

In early 2015, CSI and the PCMH Stakeholder Council convened an Education Subcommittee to work on educating consumers and providers on the PCMH concept and value. The subcommittee developed an education campaign divided into two phases: the Phase 1 in 2015 targeted consumers and then Phase 2 (currently underway) targets primary care providers. The consumer education involved creating an education toolkit for PCMHs to use to educate their patients on the model and its benefits.

Patient engagement is critical to successful PCMH implementation. The more patients understand how clinics are changing care delivery, the more they will understand the need to take control of their health. A key aspect of the PCMH model is empowering the patient and giving them tools to take charge of their health so it is important they understand the resources available to them. The patient becomes a member of the primary healthcare team. One PCMH patient made the following statement when asked if they knew they were part of a PCMH: “I may not quite know what PCMH is, but I always know who my people are.” This comment demonstrates the success of their PCMH clinic in establishing solid provider-patient relationships in an environment of team-based care.



The education tool kit sent to PCMH clinics included a poster and rack card for patients and talking points for PCMH staff. Patient advocates, primary care providers, care coordinators, and payors were consulted to develop these materials. The talking points were provided to PCMH staff as a guide for communicating with patients about the PCMH program. It was meant to be a general guide because the same services are not available at every PCMH. PCMHs had the ability to modify the document as necessary.

The poster was emailed to PCMHs and was intended to prompt questions from patients about PCMH. Clinics are able to print and hang the poster in exam rooms, hallways, or waiting rooms. The poster included white space for them to add specific clinic information either by editing the document electronically or attaching a logo sticker or address label.

Lastly, CSI mailed printed rack cards (pictured above) to all PCMHs qualified or provisionally-qualified in the program at the end of November 2015. They were encouraged to display the rack card along with their other clinic informational materials in exam rooms, waiting rooms, or reception areas.

Click the links below to review the education tool kit:

- [Staff Talking Points](#)
- [Poster](#)
- [Rack Card](#)

The CSI and stakeholders are working on Phase 2 of the education campaign in 2016. A survey was conducted to determine which primary care providers in the state are not in the program, their level of knowledge about PCMH, and their barriers to becoming a PCMH. The survey showed that technology and staffing limitations are common barriers. Several clinics want to learn more about the Montana PCMH Program. CSI will reach out to them to provide resources and guidance.



Technical Assistance to PCMHs for Quality Improvement Projects

In July 2015, PCMHs received individual feedback reports to help them 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. CSI hosted a webinar featuring experts from Mathematica¹, epidemiologists from Montana Department of Public Health and Human Services (DPHHS), and staff from Health Technology Services (HTS). The webinar explained analysis of Year 1 data and technical assistance opportunities for PCMHs. CSI staff followed up with the clinics explaining the next step of quality improvement to focus on improving the rates for each quality metric. CSI works with DPHHS and HTS, in a partnership that offers technical assistance (TA) related to quality improvement to PCMHs. This partnership produced a Health Information Technology/Health Quality Improvement Toolkit which includes clinical technical assistance for the PCMHs on the quality metrics (hypertension, diabetes, tobacco and immunization) from DPHHS and technical assistance on electronic health record (EHR) functionality from the HTS. Technical assistance began on the new depression screening measure in 2016.

DPHHS and HTS staff called PCMHs and offered them a free quality improvement opportunity related to one or more of the metrics. The goal was for PCMHs to improve the accuracy of their baseline data, receive guidance on leveraging their EHR functionality, and receive guidance from DPHHS on clinical best practices to support and improve their performance on quality measures. The goal of the project is to improve performance on quality measures each year, including the following stepwise approach:

- Goal 1 – Confirm existing or establish new baseline data for each clinic participating in TA
- Goal 2 - Improvement of one or more quality measures for each clinic participating in TA for 2015 reporting year
- Goal 3 – Provide data to support benefits of MT PCMH program to encourage continuation of MT PCMH law
- Goal 4 – Provide guidance and support to clinics in preparation for 2016 MT PCMH measures
- Goal 5 – Align MT PCMH quality reporting requirements with other quality reporting programs (Meaningful Use (MU), Physician Quality Reporting System (PQRS), Uniform Data System (UDS)) if possible, to help reduce administration for clinics).

As of June 13, 2016, HTS and DPHHS have recruited and worked with twenty-seven PCMHs on data technical assistance and clinical quality improvement. The recruited clinics work on tracking 2016 data and improving their workflows. Clinics have used micro funding from DPHHS to focus on improving diabetes outcomes using plan, do, study, and act (PDSA) cycles and saw immediate improvement in diabetic care. PCMHs also worked on patient-engagement and self-management of hypertension patients by developing protocols for patient education, developing a PDSA, and educating staff on the program. Other PCMHs also focused on improving the blood pressure control rate through patient education and workflows for providing patient education materials to hypertension patients. A common project by PCMHs for hypertension patients is a blood pressure cuff loaner program for self-monitoring of blood pressure. The project increases awareness and self-management.

¹ [Mathematica Policy Research](#) is a nonpartisan research organization dedicated to improving public well-being; they conduct policy research, data collection, and data analytics. CSI received consultation from Mathematica in 2015 as part of the Robert Wood Johnson Foundation's State Health and Value Strategies Program.



SECTION III: PCMH HEALTHCARE PROVIDER ANNUAL REPORT

Qualified and provisionally-qualified Montana PCMH clinics complete an annual report in addition to the data reports on the required quality measures. The CSI, with guidance from the stakeholder council, developed the PCMH Healthcare Provider Annual Report questions for providers to describe successes, and challenges, in a narrative, detailed, clinic-specific format. Some questions follow-up on data collected from the 2015 Progress Update while other questions relate to data contained in the 2015 Quality Metrics Report. And finally, a few questions ask about the broader story of PCMH transformation, beyond the data, and its effects on staff and patients.

The following excerpts and summaries are highlights from the March 2016 report responses:

A. Practice Transformation: Effects on Staff and Patients

Clinics were asked to share **the most beneficial aspect** of PCMH practice transformation for both providers and patients:

1. For primary care physicians and other providers:

- Improved communications, treatment plans, referrals, access to care, tests ordered and completed, and all other aspects of PCMH are being tracked with reports of **structured data in the electronic health record**...quality improvement staff can better evaluate work flow and compliance;
- The shift to the **team-care** model ... allows for distribution of work and support that was lacking in the old model of delivering patient care. Help build a strong support system for clinicians who deal with a very challenging patient population that requires detailed care and enormous amounts of time. Having a care manager, team assistant and nurse-provider teams have helped alleviate that burden;
- **Training** programs to support the development of each clinical team member's skills and **evaluating staff** to improve performance and compliance with standard workflows;
- Aligning clinical teams for **continuity of staffing** and patient care empanelment;
- **Clear roles** and responsibilities for each clinical team member;
- Tracking labs and referrals through to completion with success;
- Care **coordination**;
- Morning daily **huddles** ... entire team reviews the day's schedule as well as each individual patient's needs;
- Patient education and new patient protocol;
- Quality reporting;
- Mental health 24/7 resources;
- Beginning to see the transition from raw data to **actionable data**. The actionable data is being used to identify gaps in care, as a clinical decision support tool, and a process improvement tool;
- Team approach allows providers to work to the top of their license and ensure quality, consistent care and communication with patients;
- Utilizing Evidence Based guidelines;
- Identifying **at-risk patients** and reaching out individually;



- **Clinical pharmacists** running prescription drug registry reports to alert providers about patients who may be filling controlled substances at multiple pharmacies or receiving them from multiple providers.

2. For patients:

- Improved patient satisfaction by expanding online access to providers (for questions and medication refills) and their own **health information via online portal**;
- **Same-day access** improves clinic access for all patients;
- **Nurse care coordinator** follow-up of specific patients at regular intervals;
- A variety of services at an **affordable cost to all patients**... in one place;
- Continuous and team-based healing relationships... patients are familiar with their care team ... **develop trust**... this reduces barriers to information sharing and streamlines clinical care by reducing unnecessary clinical testing and referrals;
- **Written treatment (care) plans** for patients allow them to remember what was said, act on it appropriately, and return when indicated... care planning for patients helps the providers focus on patient needs;
- All team members focus on the patient as the “hub” of their care ... clinicians and outreach workers work in a “pod” where they can easily discuss and plan for patient’s individual needs;
- **Technology improvements** help patients to be more a part of the process;
- Emphasis on **preventive care**;
- Patient is the priority ... positive experience and getting excellent care.

B. Practice Transformation: Specific to 2015 Quality Metrics

An annual report question asked clinics to share **the best aspects of PCMH practice transformation for patients**. Below is a summary of some of the responses:

METRIC 1: A1C control in diabetes patients

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

- Diabetic educators help with medication education as well as educate on the disease process (pamphlets/handouts) in order for a patient to better understand its implications. Also many clinics work hard to get diabetic patients to return to the clinic for regular A1C checks;
- Use of the Diabetes Registry to contact diabetics who have not been seen within the last 6 months to get their A1C checked;
- Diabetes diagnosis is followed by a care plan and counseling on how to manage the disease, with specific information on how often labs should be drawn, when they need annual screenings/office visits, at home care, online resources, etc. With coordinated care, all of the other health issues affected by diabetes are also monitored on a regular basis and patients are reminded when they are due for particular testing; also provide prescriptions and order counseling.

METRIC 2: Blood pressure control in patients with hypertension

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

- Follow up with high risk patients to help them attain blood pressure (BP) control and medication compliance;



- Providers help patients to set optimal blood pressure goals and refer to nurse care coordinator, as needed. She calls these patients to see if they are following their plan, checking their BP at home and be sure they understand how to take their medications correctly.
- Use of the BP Cuff Loaner Program (DPHHS) to assist patients with their BP readings and determine undiagnosed hypertension in the general population;
- PCMH model helped clinic achieve a designation as a Million Hearts clinic².

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.

- Most clinics screen for tobacco use at all visits for patients over the age of 12. Education and referrals to community resources are provided to patients who are interested in quitting tobacco; they can request a support call via our care coordinator nurse as often as they need or want;
- Addressing tobacco use and cessation can be a challenge, but PCMH structure helps the healthcare team provide a comprehensive educational approach to assist patients in recognizing the disease burden related to tobacco use and the education and treatment options to facilitate healthy lifestyle behavior to quit smoking.

METRIC 4: Childhood Immunizations

- Improved use of data for outreach to those patients due or overdue for immunizations;
- Review pediatric patients' immunization records from the state registry to ensure that they are fully-immunized and educate on the importance of immunizations.

METRIC 5: Depression Screening

- Many clinics report that they screen annually for depression with all patients 12 and older. In some clinics, a score of 5 or higher (on the PHQ-9³), is considered a positive screen and the patient is offered counseling as well as follow up appointments. A patient with a high score is screened more regularly to check for improvement or decline in their depression status;
- Specific protocols for depression screening. Depending on what score the patient receives determines how quickly they receive behavioral health services. Sometimes includes protocol to guide staff to immediately perform a warm hand-off to a behavioral health provider if a patient answers yes to the suicide question in the PHQ-9;
- Patient referrals for positive depression screening to community resources, including counselors, psychiatrists, mental health resources, and hotline phone numbers;
- Expanding mental health staff helps clinics to approach depression management more efficiently and to increase interventions on positive depression screens. Adding case management also helps clinics to identify higher risk patients and gives them more resources in hopes of a positive outcome.

² [The Million Hearts®](#) Hypertension Control Challenge is a competition to identify practices, clinicians, and health systems that have worked with their patients to achieve hypertension control rates at or above 70% through innovations in health information technology and electronic health records, patient communication, and health care team approaches.

³ The PHQ-9 and PHQ-2, components of the longer Patient Health Questionnaire, offer psychologists concise, self-administered tools for assessing depression. They incorporate DSM-IV depression criteria with other leading major depressive symptoms into brief self-report instruments that are commonly used for screening and diagnosis, as well as selecting and monitoring treatment.



C. Patient Success Stories

An annual report question asked clinics to share a **patient success story** that resulted from the clinic's PCMH implementation. Here are a few examples that illustrate the real-life effectiveness of PCMH care coordination:

A patient with several health issues experienced improved quality of life and health outcomes due to team-based care and care coordination among multiple providers; and due to patient education and engagement.

- A 19 year-old newly diagnosed diabetic patient came to a clinic to establish care. Her primary care provider tested her A1C⁴, which was too high to register. The patient was also experiencing symptoms of depression, headaches, and fatigue. Patient was referred to diabetes pathway program, and for the next 3 months, patient had visits with clinical pharmacist for comprehensive medication management, where lab work was reviewed and medication recommendations were made to the primary care provider, in addition to nutrition and lifestyle counseling, as well as visits with her primary care provider (PCP) for co-management of diabetes. Patient established goals for her diabetes and learned self-management techniques during pharmacist visits. Patient had repeat A1C done in December, and was at 6.9⁵. The nursing staff ensured that the patient had the appropriate vaccinations in order to prevent disease that would be complicated due to the diabetes. The nurses contact the patient regarding follow up appointments and labs to ensure compliance; they educate the patient on the importance of regular blood sugar checks as well as keeping a journal of readings to better understand how her treatment plan is working. In addition, patient was referred to the Licensed Clinical Social Worker (LCSW) for counseling sessions; was also able to get insurance through expanded Medicaid with the assistance of a certified application counselor; and a pharmacist scheduled patient for a dental exam. Patient continues to follow-up per recommended intervals. Prior to PCMH implementation, clinic did not have these services available to patients, and prior to this model, each of the departments treated the patient within their specific scope of practice, then referred to other areas, without consistent follow up or communication between providers and departments.

Patient visit summaries have greatly improved patient engagement and knowledge of the importance of medication reconciliation.

- Shortly after implementing the patient visit summary process, a complex patient with multiple co-morbidities presented to the practice. This patient was appropriately screened through the intake process and medications were reconciled based on the patient report. Upon leaving his appointment, the patient received and reviewed his visit summary. He returned home and compared the medication list he received on his summary to his pill bottles. The patient then realized his cardiologist had made a significant change to the dosage of one of his medications. He promptly contacted the practice and advised nursing staff of the dosage change he had not reported to the staff at the time of his appointment. His medication list was updated. This small spark of interest and engagement from the patient in reviewing his visit summary and his medication list in comparison to his pill bottles highlighted the need for a correction in his

⁴ The A1C test is a blood test that provides information about a person's average levels of blood glucose, also called blood sugar, over the past 3 months. Someone who's had uncontrolled diabetes for a long time might have an A1C level above 8 percent.

⁵ For most people who have previously diagnosed diabetes, an A1C level of 7 percent or less is a common treatment target.



medication list at his PCP's office. Practice staff and patient realized the role this simple process played in ensuring patient medication safety. Had the patient contacted his PCP rather than his cardiologist to refill this medication in the future, the patient may have received the wrong dose.

Follow-up care and patient education prevents hospital readmission of high risk patients.

- Since implementing PCMH, a clinic completes follow-up calls on patients who have been in the hospital or emergency department. Follow-up calls help patients with questions regarding their illness, i.e. what to do for follow-up and reviewing their medications. Patients with heart failure diagnosis are seen within 7 days of discharge; also identify patients with LACE⁶ score 10 or higher who are at high risk for being readmitted and try to schedule follow-up appointments in one week.

A patient's health outcome would have been very different had a provider not taken extra time to ask the right questions and look at the whole picture of the patient's health.

- At a routine check-up, a patient complained about sinus pressure; patient thought she had a sinus infection. Provider took time to ask a few more questions, including if the patient had fallen recently. Patient stated that she had fallen twice in the past couple of weeks. Doctor ordered a CT scan of her head and discovered that she had a large subdural hematoma, and scheduled surgery.

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 payors' raw data on ER visits and hospitalizations does not tell the whole story on payment reform in 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 requires providers to do outreach to members within 20 days of attribution to establish the patient's care within the clinic and begin to address gaps-in-care. Outreach also includes care decisions or creating a care treatment plan. Gaps-in-care are created through combined clinical data from the provider's electronic health record system and the payor's claims data.
- Payor B provides a per member/per month incentive for participating in the Montana Patient-Centered Medical Home Program. With qualification in the program, there is an implied quality standard that inherently leads to improved health outcomes and decreased health costs. Therefore, the payor provides a direct incentive for the qualification work. Data sharing for improvements in care is incentivized at various levels based on quality outcomes and

⁶ The LACE index identifies patients that are at risk for readmission or death within thirty days of discharge. The LACE index scoring tool includes length of stay; acuity of admission; comorbidities; and emergency department visits.



benchmarks agreed on between the payor and providers. A per member per year incentive derives from shared data on quality outcomes relative to the agreed upon benchmarks.

- Payor C supports team-based enhanced primary care through reimbursement for non-physician time in developing plans of care and monitoring compliance for patients with high relative risk scores and chronic diseases.
- Payor D engages with providers on providing coordination for members who identify their provider. This is multi-beneficial for the members, the payor, and the provider because it allows them to understand each other's area of expertise in developing a system that allows for the best care at the best rate.

The payors report quality of care information back to PCMHs to measure patient health outcomes in the following ways:

- Payor A sends providers quality measures reports quarterly, using recent claims data for each measure. Payor A providers then address gaps-in-care with members and submit data with values for such measures as body mass index (BMI), blood pressure, outreach, etc.
- Clinical data from providers and claims data from Payor B is used to generate care gap reports that are shared with provider practices to guide quality improvement efforts. Additionally, Payor B fulfills State PCMH program annual reporting requirements. Payor B conducts educational sessions based on year end outcomes with all PCMH participants. Finally, Payor B representatives meet with contracted PCMHs on an individual basis at the practice site for more focused education and collaboration on results.
- Payor C reports gaps-in-care for patients with high relative risk scores and chronic diseases.
- Payor D shares a primary care provider (PCP) report on a monthly basis that shows all of their members attributed to the PCMH. The report shows the PCMH how many patients are in their care and the number of them with a chronic illness. It also has demographic information to allow the PCMH to reach out to the member to provide follow up and care. The PCMH also receives a quarterly gap report and a 5 star rating report. Then the provider returns an updated monthly PCP list for Payor D to go through and ensure the accuracy of the assigned members.

Expectations for use of enhanced reimbursement:

- Payor A and Payor B allow flexibility for PCMHs to use the enhanced reimbursement for PCMH infrastructure and staffing limitations based on their priorities, without enforcing specific expectations.
- Payor C expects PCMHs to use the enhanced reimbursement for a care coordinator, and the reimbursement is only paid when the care coordination services are provided.
- Payor D expects reimbursement to be used for EMR/EHR upgrades and care coordination. They expect to see gap scores decrease and the overall health of the population increase. This would be the overall expectation as they pay administrative fees to clinics in order to provide client support. They rely on having an accurate membership list month-to-month to manage the population to close the gap scores.

Payors reporting utilization and cost information back to PCMHs:

- Payor A produces a quarterly emergency room/emergency department use report. This report



lists all members assigned to that provider, who have four or more ER/ED visits in one quarter. The report lists diagnosis and utilization descriptions on each member meeting the criteria. This letter is mailed to each specific provider to promote discussion with their member. Providers should be using this information to follow-up with the member and address the reasons they are using the ER/ED.

- Payor C reports hospitalizations, ED visits, and imaging utilization for patients with high relative risk scores and chronic diseases. They report total plan payments, inpatient payments, and ED payments for patients with high relative risk scores and chronic diseases.
- Payor D reports utilization and cost data through their claims process data which then loads into their monthly PCP and Chronic Illness report. The monthly report also includes cost and claims data associated with each member. The PCMH staff reviews reports and provides care to enhance population health. The staff managing population health utilizes these reports frequently.

Other points of interest:

- No payor is currently educating their members on PCMH or collecting patient surveys or conducting focus groups to assess patient satisfaction.
- Payor D does monthly satisfaction surveys across all lines of business and when PCMH is fully implemented they are expecting to see an overall increase in satisfaction from those members.
- When asked if they saw differences in quality-of-care, utilization, or medical expenditures between patients in PCMHs and patients in non-PCMHs, Payor D noted quality-of-care and Payor B noted quality-of-care and utilization with decreased ER visits, hospitalizations, and length of stays in the PCMH population.
- Key focuses for 2017 include the following:
 - Enhanced primary care and care coordination through reimbursement for team-based care;
 - Accurate and timely reporting, relationship building with clinics on the same goals, and enhancing the process for implementing PCMH;
 - Gather a baseline for each measure and ensure providers are reporting quality measures accurately and uniformly, address barriers to gathering measures for each member, and work toward a solution to exchange and house the large amount of data gathered from and shared with providers;
 - Improving the exchange of data, aggregation and reporting.
- Plans for program expansion in 2017:
 - Payor A may expand to additional qualified PCMH clinics in the state and the members attributed to these providers. This will be possible when the current limits on reporting systems and limited resources become resolved and improved reporting methods are available.
 - At Payor B, outreach is ongoing to potential new clinical sites and member groups. Payor B will continue to expand and grow, but is unable to estimate when at this time.
 - Payor C will expand from approximately 10,000 to 75,000 members eligible for care coordination services.
 - Payor D will add anywhere from three to six PCMHs strategically in Montana.

(Please note: Additional population from Payor A may be added to the PCMH program in July 2016.)

SECTION V: QUALITY METRIC DATA ANALYSIS

PCMHs were required by administrative rule to report data on three of the five following quality metrics:

1. Blood pressure control among adults with diagnosed hypertension
2. Poor control of A1C levels in adults diagnosed with diabetes
3. Screening for tobacco use and tobacco cessation counseling/intervention for adults
4. Age-appropriate immunization for children who turned aged three during the measurement period
5. Screening for clinical depression and follow-up plan for individuals age 12 and older

The program maintained the first four measures from the first year of the program to track trends and look for improvement. They are common health indicators that represent major health issues in Montana. Each of these metrics has considerable potential to improve health outcomes for PCMH patients. These metrics also align with public health goals.

Addition of the Depression Screening and Follow-up Plan Measure

The additional fifth metric, depression screening and follow-up plan, was optional for clinics due to the continued flexibility in the rule to report on only three of the five possible measures in 2016. PCMHs shall choose four out of five measures to report data on in 2017, for the 2016 calendar year measurement period, and for all subsequent years. The program maintained the flexibility to allow 2016 to be a trial year for the depression metric. Stakeholders decided gradual implementation of the depression metric was the best approach to take for several reasons: it is a newer measure that many clinics do not have extended experience with reporting; many EMRs are not fully equipped to capture and report this data; and this two-part metric is difficult for establishing standardized workflows and processes in both care delivery and data entry and extraction. Please note: reporting on depression screening is optional for pediatric practices until the 2018 reporting year for the 2017 measurement period; then all pediatric clinics shall report on both the depression and immunization measures.

The Commissioner provides data reporting instructions for PCMHs in the form of *guidance*, which is published on the [agency website here](#). In Year 2, data was submitted to the Commissioner for the period January 1-December 31, 2015, by March 31, 2016.

Practices had two reporting options in 2016: patient-level data or attested aggregate data. Patient-level data includes specific information for each patient in the denominator of the measure. 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 all PCMH patients age 18 through 85 years who had a diagnosis of hypertension within the first six months of the measurement period or before the measurement period. Patient-level data 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) with diagnosed hypertension in the PCMH patient population, and the number of adults with diagnosed hypertension for whom most recent blood pressure was adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.



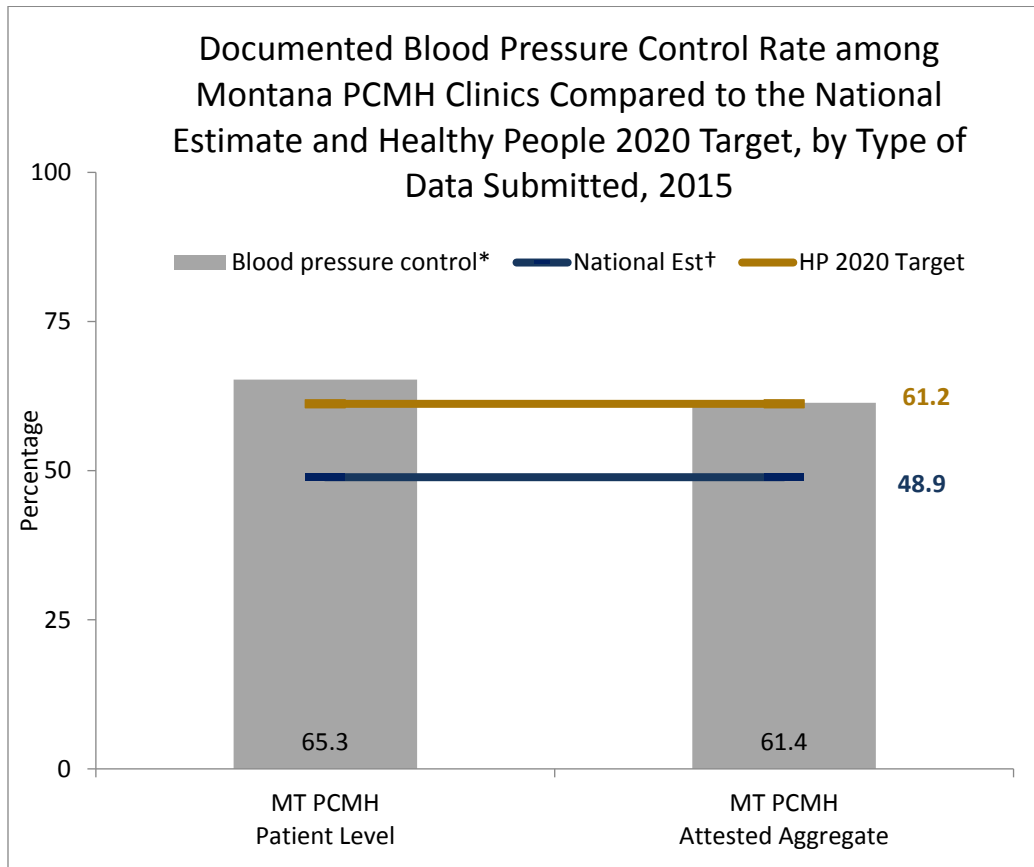
Data Excluded from Analysis

The Centers for Medicaid and Medicare Services (CMS) specification for the Diabetes A1C Poor Control measure, which the Montana PCMH Program used to create the data reporting guidance for 2015 reporting contained a logic error, which may have resulted in incorrect data for this measure being submitted for providers who chose to report aggregate data. In most cases these providers used existing clinical quality measure reports (EHR standard reports) to gather the aggregate data. Some of the EHR aggregate reports were incorrect due to the error on the CMS specification for this measure. There were two clinics in the Montana PCMH Program that submitted data on the Diabetes A1C Poor Control measure and encountered this problem with incorrect data, so their data was excluded from the total program's diabetes data analyzed for this report. There were also three clinics that found their aggregate data they submitted for the blood pressure control was inaccurate due to technical difficulty in aggregating data from two different EHRs after the health system changed EHRs part way through the measurement period.

The following charts provide data for the above five listed measures, comparing attested aggregate to patient-level reporting. *Note that Montana PCMHs have a higher blood pressure control rate than both the national estimate and the Healthy People 2020 Target and they have a higher depression screening rate than the national estimate.*



Figure 7. Documented blood pressure control rate among Montana PCMH clinics compared to the national estimate and the Healthy People 2020# target, by type of data submitted (2015)



*Percentage of adults aged ≥18 through 85 years in the PCMH patient population**, who had documented systolic and diastolic blood pressure <140mmHg and <90mmHg respectively, at most recent outpatient visit, during the reporting period: calendar year 2015.

**Who (a) have the diagnosis of hypertension, including ICD-9 code groups 401.0, 401.1, 4.1.9 or ICD-10 I10 and (b) had one or more outpatient visits during the reporting period: calendar year 2015

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

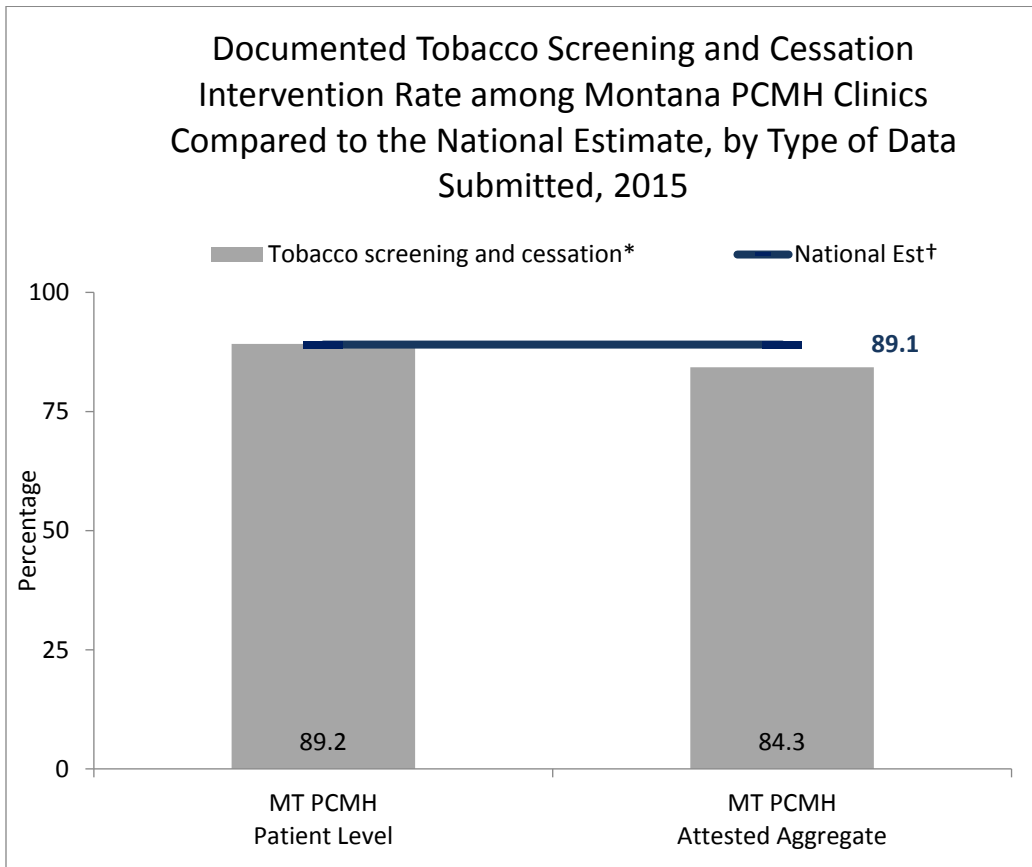
Healthy People: Provides science-based, 10-year national objectives for improving the health of all Americans. Each Healthy People 2020 objective has a: reliable data source; a baseline measure; and, a target for specific improvements to be achieved by the year 2020.

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 tobacco screening and cessation intervention rate among Montana PCMH clinics compared to the national estimate, by type of data submitted, (2015)



*Percentage of adults in the PCMH patient population** who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as tobacco users.

**Patients aged ≥18 who had a visit during the reporting period: calendar year 2015.

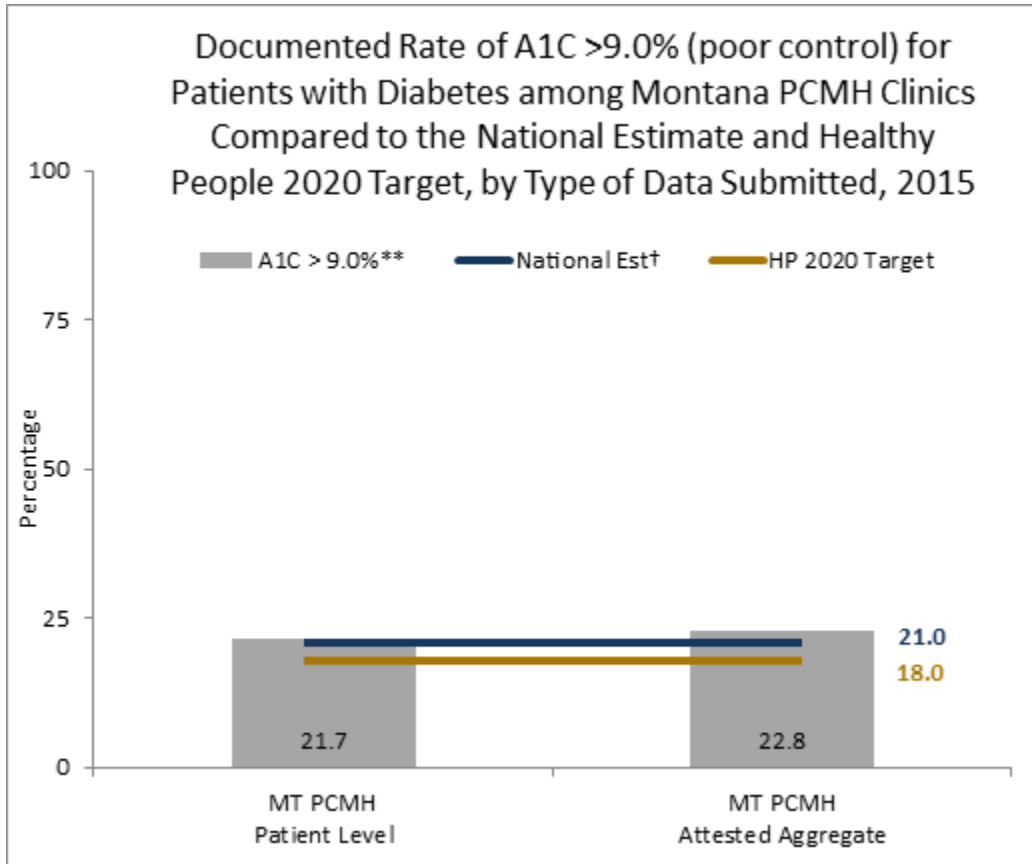
† Data Source: CMS Benchmarks for Measures Included in the Performance Year 2015 Quality and Resource Use Reports

Limitations

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



Figure 9. Documented rate of A1C >9.0% (poor control) for patients with diabetes among Montana PCMH clinics compared to the national estimate and the Healthy People 2020# target, by type of data submitted (2015)



*Percentage of adults aged ≥18 through 75 years in the PCMH patient population who (a) have the diagnosis of diabetes type 1 or 2. For diagnosis codes refer to [reporting guidance](#) and (b) had one or more outpatient visits during the reporting period: calendar year 2015.

**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.

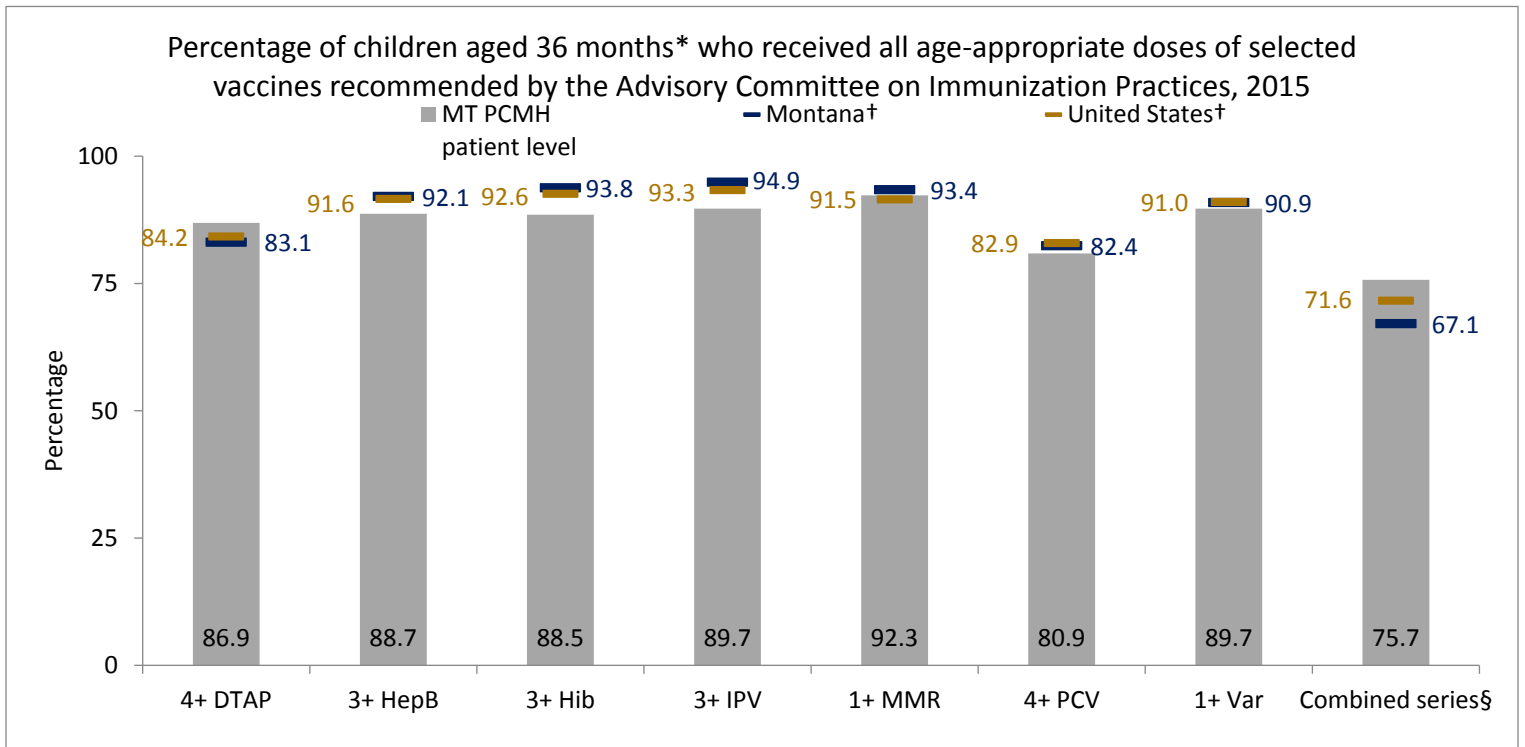
8/17/2016 REVISION: In 2015, the Healthy People 2020 Target was changed from 16.2 to 18.0.

Limitations

- Excluded patients aged >75 years, A1C reported dates <1/1/2015 or >12/31/2015, 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 1/1/2015.



Figure 10. Percentage of children aged 36 months* who received all age-appropriate doses of selected vaccines recommended by the Advisory Committee on Immunization Practices (2015) - **Patient-Level**



*All children in the PCMH population who had a 3rd birthday during January 1, 2015 through January 1, 2016 and who had one or more outpatient visit during 2015.

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.

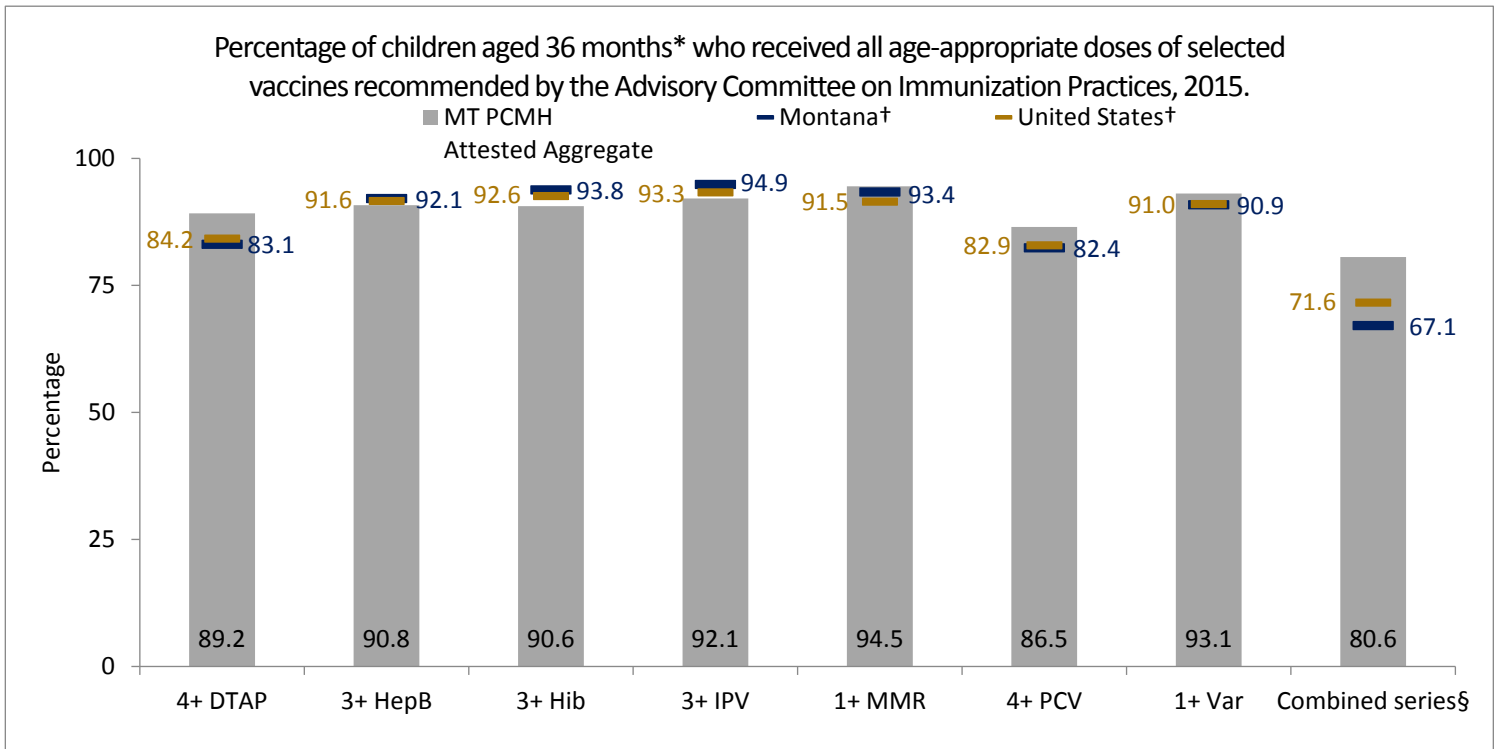
†Data Source: National Immunization Survey (NIS); estimated immunization coverage for children aged 19–35 months during 2013.

Limitations

- Receipt of vaccine doses was not confirmed through medical chart review.



Figure 11. Percentage of children aged 36 months* who received all age-appropriate doses of selected vaccines recommended by the Advisory Committee on Immunization Practices (2015) - **Attested aggregate**



*All children in the PCMH population who had a 3rd birthday during January 1, 2015 through January 1, 2016 and who had one or more outpatient visit during 2015.

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.

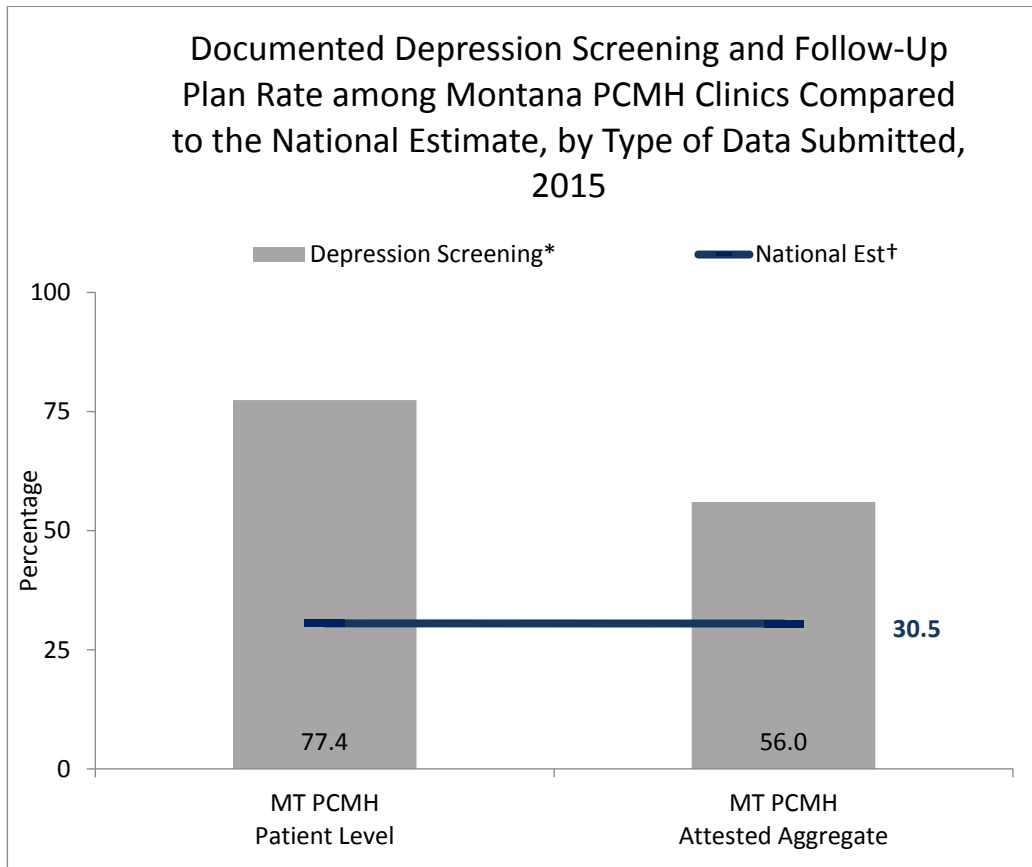
†Data Source: National Immunization Survey (NIS); estimated immunization coverage for children aged 19–35 months during 2013.

Limitations

- Receipt of vaccine doses was not confirmed through medical chart review.



Figure 12. Documented depression screening and follow-up plan rate among Montana PCMH clinics compared to the national estimate, by type of data submitted, 2015



*Percentage of patients aged 12 years or older in the PCMH patient population** who were screened for depression on the date of encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen.

**Patients aged ≥ 12 who had a visit during the reporting period: calendar year 2015.

† Data Source: CMS Benchmarks for Measures Included in the Performance Year 2015 Quality and Resource Use Reports

Limitations

- Analysis excluded patients who had not yet turned 12 years old by December 31, 2015



Figure 13. Raw Data from the PCMH Quality Metric Reports - 2015

	Patient-level [#]	Aggregate [#]
METRIC 1: Blood Pressure		
Documented hypertension among patients** aged 18 - 85 years	36,368	36,681
Blood pressure control	23,732	25,516
METRIC 2: Tobacco		
All patients** aged ≥18 years	49,400	82,464
Tobacco screening and cessation intervention	44,048	69,549
METRIC 3: Diabetes		
Documented diabetes among patients** aged 18 - 75 years	9,727	22,969
Documented A1C > 9.0% (not controlled)	2,108	5,241
METRIC 4: Immunization		
All children age 36 months*	1,001	2,458
Combined series	758	1,981
4 DTAP	870	2,192
3 Polio	898	2,265
1 MMR	924	2,322
3 Hib	886	2,228
1 HepB	888	2,233
1 Var	898	2,288
4 PCV	810	2,125
METRIC 5: Depression		
All patients** aged ≥12 years	10,798	45,238
Depression screening and follow up plan	8,354	25,342

*All children in the PCMH patient population who had a 3rd birthday between January 1, 2015 and January 1, 2016 and who had one or more outpatient visits during 2015.

** All patients within the designated age group who had one or more outpatient visits during 2015.

In 2016, 39 PCMHs submitted aggregate data, 18 PCMHs submitted patient-level data, and 4 submitted both types of data.



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 2015 payor reports were submitted by March 31, 2016, 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 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 the 2015 calendar year. For the 2016 reporting period, two payors provided utilization data for an attributed population. One of the two payors’s attributed population was for members with 7 months of attribution, although not necessarily contiguous.

Dr. Bryce Ward, health economist at the University of Montana Bureau of Business and Economic Research (BBER), conducted an analysis of the ER visits and hospitalization data submitted by Montana PCMH payors in 2016.

It is important to collect data separately on ER visits that do and do not lead to hospitalizations because CMS and PCMHs feel that they are more able to limit ER visits that do not lead to hospitalization. It is those types of visits that should and could be handled with enhanced or afterhours access to care by PCMHs. In 2015, for most of these metrics, three payors reported these data for people attributed to a PCMH and for their total book of business. For two payors we have data for an attributed PCMH population for only one year.

There are several limitations to this data that must be considered when reviewing it. Limitations are summarized below and explained in greater detail throughout the rest of this section:

- The data is not based on a randomized controlled trial, therefore the data are not statistically significant and the results do not provide any definitive answers. However, it may show trends that could serve as a basis for future data analysis or study design.
- The PCMH data is compared to all-patient data, which includes PCMH attributed patients rather than comparing PCMH to non-PCMH data. In addition, clinics which function as PCMHs *typically* provide these services to all patients in a clinic, not only to those patients who are attributed to a payor providing PCMH enhanced reimbursement.
- In addition, there may be some migration toward patient-centered, team-based care even if a practice has not been recognized as a PCMH by Montana’s PCMH program. Non-PCMH clinics may be offering similar benefits to patients which we know nothing about.
- There are many newly insured people as a result of increased access to insurance coverage. These patients may have been accustomed to getting treatment in the emergency department and may have had previously untreated conditions for which they sought treatment in the emergency department once they had insurance.



- Patient populations also differed. Some payors had a higher percentage of children and some had a higher percentage of FQHCs, groups that may have higher emergency department use or hospitalization rates.
- PCMH implementation is new in Montana with few patients and payors participating in PCMH models in 2014-2015. It is known from similar work in other states that changes in PCMH-related outcome measures may take several years to observe.



Table 1 presents the results for the rate of emergency department (ED) admissions and the rate of ED visits that do not result in an admission⁷ for all payors for 2015. For one payor, PCMH participants have a lower rate of ED admissions than non-PCMH participants. For two payors, PCMH participants have a higher rate of ED admissions. It is important to note that Payor A’s total population is approximately 60% children. According to Center for Disease Control and Prevention National Center for Health Statistics⁸, over one-third of ED visits made by children were injury related in 2009-2010. Injury related ED visits are not preventable by PCMH. Also, note that 75% of Payor A’s PCMH population is attributed to a Federally Qualified Health Center (FQHC) or Community Health Center (CHC). FQHCs and CHCs serve low-income, underserved and vulnerable populations that will often have higher utilization rates due to higher risk scores linked to their socioeconomic disadvantages. For one payor, we do not have data that allows us to compare this rate for the PCMH population to the payor’s total population.

Table 1: Emergency department visits per 1000 member months, 2015

	ED visits/1000		ED visits that do not lead to a hospitalization/1000	
	PCMH	All	PCMH	All
Payor A	867.22	646.41	783.72	587.79
Payor B	160	162.11	138.91	143.34
Payor C	275	170	225	150.6
Payor D	N/A	137.4	N/A	N/A



Table 2 presents emergency department (ED) utilization rates over time. The time trend also does not present a clear picture consistent with expectations. ED utilization increased in all populations. However, one possible explanation for this is that in 2014 and 2015, the uninsured

⁷ Payors report the number that result in an admission; however, PCMH research typically focuses on ED visits that do not result in an admission. Therefore, we compute the rate of ED visits that do not result in an admission by subtracting the number that result in an admission from the total number of ED visits and dividing by the number of member months.

⁸ Albert M, McCaig LF. Injury-related emergency department visits by children and adolescents: United States, 2009–2010. NCHS data brief, no 150. Hyattsville, MD: National Center for Health Statistics. 2014.



population shrank considerably because the individual market became guaranteed available and premium assistance and cost sharing reductions were implemented by the federal government. The newly insured had pent-up demand and also were unfamiliar with how to use their health plan. Many of the previously uninsured population were accustomed to seeking healthcare in emergency rooms because they could not be turned away there.

Table 2: Emergency department visits per 1000 member months, 2014-2015

	Payor B PCMH	Payor B All	Payor A All	Payor C All	Payor D All
2014	146.84	156.75	658.50	174.5	129.9
2015	159.99	162.11	646.41	170	137.4



Table 3 presents the results for the rate of hospitalizations. Two payors report lower rates in 2015 than they reported in 2014 in their overall populations. Two payors for whom we have inpatient admissions rate for an attributed population report higher inpatient admissions rates for their attributed populations than for their overall populations, and hospital admissions rates for the PCMH population increased over time (for the one payor from which we have trend data). However, the same mitigating factor concerning socio-economic status applies to Payor A as was stated above concerning ER rates. Also, the issues created by the pent-up demand of the previously uninsured may be affecting the numbers of Payor B.

Table 3: Hospitalizations per 1000 member months, 2014-2015

	Payor B		Payor A		Payor C	Payor D
	PCMH	All	PCMH	All	All	All
2014	35.14	28.87	N/A	59.3	65.1	27.4
2015	35.41	28.09	93.8	55.63	56.1	28.9

To draw conclusions from the comparison of the attributed population to the full population, one must assume that the full population provides a reasonable proxy for what would have happened to the attributed population in the absence of PCMH. The fact that the attributed population reports higher rates of utilization for some payors may reflect the fact that different providers serving different populations choose to become PCMHs. For instance, we received a limited set of demographics from one payor, and for this payor, the attributed population with employer provided insurance is much older than the non-attributed population. Similarly, the attributed population for this provider has slightly higher risk scores, which would cause the higher utilization rates. This may reflect the fact that sicker people are more likely to visit the doctor and thus more likely to be attributed to a PCMH than a healthy person who seldom (if ever) goes to the doctor.

To draw inference from a comparison of the attributed to the full population, one must make an assumption about what happens at non-PCMH practices. While we know that practices that qualify as



PCMHs meet certain thresholds, we do not know the extent to which non-PCMH practices have implemented PCMH-like attributes. Thus, we do not have a clear sense of how much PCMH practices differ from non-PCMH practices. In the absence of such information, interpreting observed differences is difficult.

It is unreasonable to expect that the effects of Montana’s PCMH program will show up in the data after only a few years. As discussed above, it takes several years for the effects of PCMH programs to make a population healthier, which decreases utilization, and then decreases cost. PCMH is still new in Montana, and relatively few patients are attributed to PCMH providers to be tracked regularly by a payor. Among payors whose data include both total member months and PCMH member months, between 3 and 11 percent of member months were attributed to a PCMH in 2015. One of the payors with an attributed PCMH population calculated just over 29,000 members in PCMH clinics as of April 2016. The other payor with an attributed population had 8,586 members enrolled in their PCMH program as of April 2016. The observed effects of PCMH may evolve as practices become more adept at PCMH and more patients participate.

At a minimum, to understand the effects of Montana’s PCMH program, we would like to observe data from all payors and providers for several years before and after PCMH implementation. With these data, we would understand how PCMH providers differed from non-PCMH providers prior to PCMH and to understand how PCMH patients differed from non-PCMH patients prior to PCMH. Then, we could compare how each group changed over time. With such comparisons, we can address important questions like, “Did implementing PCMH increase the differences between PCMH and non-PCMH practices or patients? If so, then it is plausible that observed differences stem from PCMH.”⁹ Unfortunately, the data required for such comparisons are not available (and in some cases do not exist) in Montana. Furthermore, Montana’s healthcare sector is simultaneously undergoing many other changes in addition to PCMH. Thus, separating changes due to PCMH from changes due to other factors may be difficult, if not impossible. Under these conditions, estimating the effects of Montana’s PCMH program at this time is difficult (and likely impossible).

⁹ However, one must also assume that nothing else changed over this period that could have also changed the outcomes examined and disproportionately affected PCMH practices or patients.



SECTION VII: CONCLUSION AND PLANS FOR 2017

In Year 2 of the Montana PCMH Program implementation, PCMH providers, payors and the program transitioned from establishing the initial groundwork for the program to focusing on consumer and provider education and quality improvement. The variation in the quality metric rates from Year 1 to Year 2 cannot necessarily be attributed to improved quality of care because it is too short of a time period for changes in the population's health to occur. However, the change in rates can be attributed to improvement in data extraction by PCMHs. Improvement in data tracking is still important progress, even if small, because data is a critical component to the complete practice transformation that occurs in PCMH implementation. While data extraction is improving generally, data reporting continues to be very challenging for many clinics. Therefore, CSI will continue to work with stakeholders to improve reporting specifications to be less burdensome on clinics.

The Montana PCMH Program is excited to have this first year of depression screening data with rates that fare so well compared to the national estimate. Many clinics are working to establish or improve workflows for depression screening to improve their data collection and tracking process and help more patients. Many geographic service areas may not have qualified mental health professionals or integrated behavioral health services available for assessment and treatment of depression. Recommendations include development of relationships with local or regional qualified mental health professionals, telehealth services, and/or other remote consultation mental health services.

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, reducing per capita cost-of-care for the benefit of communities across Montana and supporting PCMH clinics in their efforts to transform their practices.



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