Eligibility

The Florida Blue Patient Centered Medical Home (PCMH) is an invitation only program offered to family medicine physicians, internal medicine physicians and pediatricians who meet a defined set of clinical quality metrics. To be eligible for the Patient Centered Medical Home program, a physician or physician group must:

• Practice primary care medicine in the field of internal medicine, family practice or pediatrics
• Participate in NetworkBlue
  • To be eligible, all physicians within the group must be participating
• Meet attributed membership requirements of 300 commercial members under the age of 65
• Perform Same or Better than their peers in a core set of Healthcare Effectiveness Data and Information Set (HEDIS®) clinical quality metrics
• Achieve PCMH recognition from a third party national organization such as the National Committee for Quality Assurance (NCOA), Bridges to Excellence®, The Joint Commission or URAC or demonstrate that they are actively engaged in the recognition process
  • 50 percent or more of a physician’s group must achieve recognition
• Groups will have 12 to 24 months from initial date of enrollment to receive recognition. Applications for PCMH recognition must be provided as part of your enrollment package.
• Attest to providing members access to the practice a minimum of 6 hours weekly before 8 a.m., after 6 p.m. and/or weekends
• Attest to utilization of an e-prescribing tool with decision support application
• Attest to a willingness to implement the core standards of a PCMH:
  • Enhanced Access
  • Whole Person Orientation
  • Coordination of Care
  • Personal Physician
  • Safety and Quality
  • Physician Directed Practice Team

Florida Blue must approve any physician or physician group participating in the Patient Centered Medical Home.

Additional information on Patient Centered Medical Home recognition can be found on the following websites:

Bridges To Excellence - http://www.bridgestoexcellence.org/node/38/#/13
Principles of a Patient Centered Medical Home

PCMH is a model of health care based on an ongoing, personal relationship between a patient, doctor and the patient’s care team.

**Personal physician** - Each patient has an ongoing relationship with a personal physician, nurse practitioner, or physician assistant trained to provide first contact, and continuous and comprehensive care. The emphasis is on a strong patient-physician relationship.

**Physician directed medical practice** - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

**Whole person orientation** - The personal physician is responsible for providing for all the patient’s health care needs or takes responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life such as acute care, chronic care, preventive services and end of life care.

**Care is coordinated and/or integrated** - All elements of the complex health care system (e.g., sub-specialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services) are coordinated and/or integrated. Care is facilitated by registries, information technology, health information exchanges and other means to ensure that patients receive care when and where they need it in a culturally and linguistically appropriate manner.

**Enhanced Access** - Access to health care is improved by increasing same day/sick appointments and having access to a physician 24/7 in the office or by phone after hours.

**Safety and Quality** - The focus is on evidence-based medical practice, improved chronic disease management, and better communication through technology applications.

Additional information about Patient Centered Medical Home can be found at:

- **American Academy of Family Physicians**: www.futurefamilymed.org
- **American Academy of Pediatrics**: http://aappolicy.aappublications.org/policy_statement1_index.dtl#M
- **American College of Physicians**: www.acponline.org/advocacy/?hp
- **American Osteopathic Association**: www.osteopathic.org

Florida Blue has prepared a 2013-2014 PCMH Transformation Guide to help your practice through the transformation to a PCMH model of care. Available to all practices enrolled in the program, your practice can obtain a copy by sending an email to the Professional Programs support team at PPST@bcbsfl.com or call (800) 727-2227; say “More Choices,” then say “PPST.” Welcome books containing the Transformation Guide are hand delivered by your PCMH Team to all newly enrolled practices.
**Membership Attribution**

Members are attributed to a primary care physician (PCP) based on their previous year’s utilization on a monthly basis. Members are attributed to the PCP that has the greatest number of evaluation and management (E&M) visits during the 12 month period prior to the end of the reporting period as determined by administrative claims data.

All Florida Blue members receiving care in a PCMH practice regardless of their Florida Blue product, are eligible to receive the benefits of this enhanced delivery of care system even if they are not attributed.

**Clinical Quality**

Clinical quality metrics in the Patient Centered Medical Home program are derived from evidence-based guidelines, are clinically actionable, impact a large patient population and align with Florida Blue quality initiatives. **You must score Same or Better than your peers in the clinical quality measures to be eligible for any financial rewards.**

The program uses a core set of primary care clinical quality metrics that are endorsed by the National Quality Forum (NQF) and HEDIS®. They include adult and pediatric measures for both preventative screenings and chronic disease management. Metrics may change over time based on the latest nationally approved evidence.

Physicians scoring **Worse** than their peers in the clinical quality metrics will have the opportunity to request an inquiry annually. Your PPST Support team will guide you through the process.

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**Preventive Health Screenings and Management**

- Cervical Cancer Screening (report only)
- Mammography Screening
- Colorectal Cancer
- Use of Imaging Studies for Low Back Pain

**Diabetes Management**

- HbA1C Lipid Panel
- Diabetic Retinal Exam
- Screening for Diabetic Nephropathy

**Pulmonary Management**

- Long-term Control Rx Use
- Avoidance of Antibiotic Treatment of Adults with Acute Bronchitis

**Cardiovascular Care**

- Post MI: Beta Blocker Persistence
- Treatment of Cholesterol Management

**Immunizations and Vaccinations**

- MMR
- VZV
- Rotavirus
- DPT
- HEP A
- HEP B
- HiB
- Influenza
- OPV
- Pneumococcal
- Meningococcal
- TDAP

**Pediatric Management**

- Appropriate Testing of Children with Pharyngitis
- Treatment of Children with URI
- One annual visit for children aged 3 – 6 for a well visit
- One annual visit for children aged 12 to 21 for a well visit
Pharmacy Costs
Managing out-of-pocket expenses is a critical factor for member satisfaction and a key driver of ever increasing medical costs. This metric shows how you compare to your peers when ordering generic prescriptions. Your score is determined by the number of generic prescriptions written, divided by the total volume of prescriptions.

Clinical Cost and Efficiency
Health Care Reform is helping the health care industry to move rapidly from paying for volume of services to paying for outcomes of services by aligning the appropriate payment with the appropriate performance.
PCMH supports this by demonstrating where your patient’s health care dollars are spent. By providing you with risk adjusted per member per month costs for services generated by both the primary care physician and the specialists he or she refers to at a population level, our data allows you to have a more comprehensive view of all medical services your patients receive.

Medical Home Fee
The PCMH program includes a strong focus on health maintenance, preventive care and the management of members with chronic diseases. The program also acknowledges the additional time and attention these patients require. In recognition, the PCMH program may include a medical home fee for members with the following diagnoses:

- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Asthma
- Congestive Heart Failure (CH F)
- Pediatric Annual Well Visit Age 0-7

This medical home fee, if applicable, is paid once annually and begins after your first year of participation.

Practice Transformation
Florida Blue recognizes the PCMH model differs from most current medical practices. We are here to support you through the transition. Our PCMH team consists of a staff of subject matter experts called Practice Transformation Specialists (PTS). Each participating group is assigned a PTS. Your PTS will help you understand your financial data and support your transition to a PCMH model of care.

Florida Blue and the Florida Academy of Family Practice (FAFP) provide an annual seminar(s) on PCMH and practice transformation. Additional information on dates and locations for FAFP trainings will be provided throughout the year.

Scoring
Clinical Quality metric scoring is based on measurements using Florida Blue administrative claims and other sources of data. To arrive at the clinical quality metric score, the PCMH program includes the total number of patients who met the eligibility criteria for a metric (denominator) and the actual number of those patients who received the service for that metric (numerator). To be eligible, a physician must provide care to a minimum number of patients who satisfy the inclusion criteria. Each individual physician responsible for influencing patient care is given credit for claims data linking them to a service. The total eligible points are reduced for any metric for which the physician does not have the minimum number of patients.

Clinical quality metrics are your gateway to a financial award. You must score Same or Better than your peers for a threshold of eligible metrics to receive any financial award.

Scorecards
The PCMH program is focused on a practice’s ability to manage their patients at a population level. All financial results are reported at the practice level. Care gaps are available both at the group and the individual physician level.

Report cards are provided for you on a quarterly basis to determine your trends and allow you to implement steps for improvement. Report cards will be sent to you through a secure Florida Blue website. You will receive information on retrieving your report card each time it is published. These reports remain accessible for 30 days following notification.
Beginning third quarter 2013, physician groups will be able to access their scorecards through our web-based portal. Additional information on the portal is provided to practices enrolling in the program.

**Awards**

Upon completion of your first year of participation, awards are based on the outcomes of your physician group’s total cost of care trend to your attributed population. The awards are based on a shared savings model. Award calculations are based on your group’s prior year’s performance plus total Consumer Price Index (CPI) and your total cost of care per member per month as compared to your peers. Your award is expressed as a percentage amount referred to as the multiplier and is above and beyond your contract fee schedule rates. The multiplier is applied to applicable ambulatory primary care codes only.

*Any compensation provided under this program prior to PCMH recognition is subject to recovery at Florida Blue’s discretion if PCMH recognition is not achieved within the given timeframes.

**Patient Participation**

Engaging your patient in the concepts of a PCMH is critical to their success. Florida Blue strongly recommends obtaining a signed agreement from your patient to work towards the disease management goals you set forth. Once enrolled, we will provide an example of a patient engagement agreement form. You may use this form for your Florida Blue patients.

**Additional Benefits**

Participating PCMH physicians are clearly identified in the Florida Blue online provider directory. Members can view a summary of the PCMH program, identify whether a physician participates in the program and search for a physician by their PCMH program participation status.

Participating physicians are also identified in the Blue Cross and Blue Shield Association Physician Finder for out-of-state members coming to the state of Florida.

We look forward to your participation in the 2013-2014 Patient Centered Medical Home program. If you have questions, please contact our Professional Program team at (800) 727-2227; say “More Choices,” then say “Professional Programs.” Or contact us at PPST@bcbsfl.com.