Patient Centered Medical Home and Comprehensive Primary Care Programs

Program Overview

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Eligibility

The Florida Blue Patient Centered Medical Home (PCMH) program and Comprehensive Primary Care program (CP2) are invitation only programs offered to primary care physicians (family medicine, internal medicine, pediatrics and general practice), ARNPs and PAs, who meet a defined set of clinical quality metrics, along with attribution and cost parameters.

Patient Centered Medical Home (PCMH) Program

PCMH is an integrated health care delivery model that provides patients comprehensive, continuous and coordinated medical care, including wellness and preventive services, with a goal of improving health care outcomes. All groups enrolling in the PCMH program must be recognized as a PCMH through a national organization that provides accreditation and/or designation as a Patient Centered Medical Home. Fifty percent (50%) of participating physicians in the group must receive recognition. Organizations include National Committee for Quality Assurance (NCQA), URAC, The Joint Commission or Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). Application for recognition or documentation of completion is required as part of the enrollment process. You have 24 months to complete the recognition process.

Comprehensive Primary Care Program (CP2)

CP2 is available for practices that are not able to take on the administrative activities associated with obtaining PCMH recognition at this time. Clinical quality metrics and outcome performance metrics are the same as PCMH, but the CP2 award percentage is less than the PCMH program award and you do not have to obtain designation from a national accrediting agency.

To be eligible for these programs, a physician or physician group must:

- Participate in our NetworkBlue provider network
- To be eligible, all providers in the group must participate
- Meet attributed membership requirements of 300 commercial members under the age of 65
- ***Meet or exceed expectations*** as compared to peers in a core set of Healthcare Effectiveness Data and Information Set (HEDIS®) clinical quality metrics
- Attest to providing members access to the practice a minimum of 6 hours weekly before 9 a.m., after 5 p.m. and/or weekends
- Attest to using an e-prescribing tool with decision support application
- Attest to the using the Quality and Efficiency Reporting Portal no less than quarterly
- 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 the participation of any physician or physician group in the Patient Centered Medical Home or CP2 programs. Additional information on Patient Centered Medical Home recognition can be found on the following websites:

Joint Commission - https://www.jointcommission.org/certification/priamry_care_medical_home_certification.aspx

URAC - https://www.urac.org/accreditation-and-measurement/accreditation-programs/all-programs/patient-centered-medical-home/

NCQA - http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh

Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) - http://www.aaahc.org/en/accreditation/primary-care-medical-home/

Membership Attribution

Members are attributed to the PCP who 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. HMO members are attributed to the PCP they have selected.

Clinical Quality

Clinical quality metrics in the Patient Centered Medical Home and CP2 programs are derived from evidence-based guidelines, are clinically actionable, impact a large patient population and align with Florida Blue quality initiatives. You must ***meet*** or ***exceed expecations*** as compared to 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 ***below expectations*** as compared to peers in the clinical quality metrics will have the opportunity to close outstanding care gaps through Availity.

Preventive Health Screenings and Management

- Cervical cancer screening
- Mammography screening
- BMI – measure only
- Use of imaging studies for low back pain
- Annual monitoring for patients on persistent medication
- Proportion of days covered with statins
- Colorectal screening

Diabetes Management

- HbA1C lipid panel
- Diabetic retinal exam
- Screening for diabetic nephropathy
- Proportion of days covered - diabetes all class

Pulmonary Management

- Long-term control Rx use
- Avoidance of antibiotic treatment of adults with acute bronchitis
- Medication management for people with asthma

Cardiovascular Care

- Post MI: Beta blocker persistence

Immunizations and Vaccinations

- MMR
- VZV
- Rotavirus
- DPT
- HEP A
- HEP B
- HiB
- Influenza
- IPV
- 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 - 21 for a well visit

Measurement and Design

The health care industry is rapidly moving from paying for volume of services to paying for outcomes of services by aligning appropriate payment for the right performance.

Our PCMH and CP2 programs support this by measuring where your health care dollars are spent.

We offer 2 tracks for physicians/physician groups to participate in:

Track 1 is for groups with more than 5,000 attributed members. We use total cost of care that's risk adjusted, and weighted per member per month costs to compare your cost trends with those of your peers. At the end of a 12-month measurement period, groups will share any earned savings if they performed better than their peers in managing the total cost of care growth rate. Track 1 PCMH groups receive 50 percent of any shared savings. Track 1 CP2 groups receive 40 percent of any shared savings. The shared savings are distributed through a one time lump sum payment at the end of the program year.

Track 2 is for groups with attribution of 300 to 4,999 members. We measure PCMH efficacy through cost reduction as it relates to avoidable hospital admissions and emergency room visits for Ambulatory Care Sensitive Conditions (ACSCs).

ACSCs are health conditions for which adequate primary care reduces the need for emergency room visits and/or hospital admission. Savings are calculated by evaluating the shift in location where members seek treatment for these conditions. Physician groups receive a portion of the savings by redirecting visits from hospital inpatient and emergency room settings to lower cost PCP and specialty office settings. Track 2 PCMH participants will receive 50 percent of any shared savings. Track 2 CP2 participants will receive 40 percent of any shared savings.

We use the ACSC conditions identified and developed by the Agency for Healthcare Research and Quality:

Vaccine preventable

1. Influenza and pneumonia
2. Other vaccine preventable conditions

Chronic

3. Asthma
4. Congestive heart failure
5. Diabetes complications
6. Chronic obstructive pulmonary disease (COPD)
7. Angina
8. Iron-deficiency anemia
9. Hypertension
10. Nutritional deficiencies

Acute

11. Dehydration and gastroenteritis
12. Pyelonephritis
13. Perforated bleeding ulcer
14. Cellulitis
15. Pelvic inflammatory disease
16. Ear nose and throat infections
17. Dental conditions
18. Convulsions and epilepsy
19. Gangrene

Scorecards

The PCMH and CP2 programs focus 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 at the group and individual physician level.

Scorecards and reports are shared with you on a monthly basis through the QERP tool so you can see your trends and implement steps for improvement. Your practice transformation specialist can help you interpret the results and will work with you to develop action plans to address any opportunities.

Additional Benefits

Participating PCMH and CP2 physicians are clearly identified in the Florida Blue online provider directory. Members can view a summary of the PCMH or CP2 program, identify whether a physician participates in the program and search for a physician by their PCMH or CP2 program participation status.

Many of our self-insured groups are designing benefits that tier copayments and coinsurance to encourage their employees to use physicians who participate in one of our patient-centered programs.

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 our Patient Centered Medical Home and/or Comprehensive Primary Care programs. If you have questions, please contact our Professional Program support, **Chambrica Morgan** at **chambrica.morgan@bcbsfl.com** or call **(904) 905-7575**.

[1] Availity, LLC is a multi-payer joint venture company. For more information or to register, visit Availity's website at availity.com.