

# Patient Centered Medical Home

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*An Overview of the Blue Cross and Blue Shield of Alabama Sponsored Pilot*

**2009**



**BlueCross BlueShield  
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association.

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## Medical Home Definition

Below is an excerpt from the Joint Principles of the Patient-Centered Medical Home:

American Academy of Family Physicians (AAFP)  
American Academy of Pediatrics (AAP)  
American College of Physicians (ACP)  
American Osteopathic Association (AOA)

Joint Principles of the Patient-Centered Medical Home  
March 2007

“The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient’s family.”

## Purpose Statement for the Blue Cross and Blue Shield of Alabama Medical Home Pilot

***PURPOSE:** To analyze the medical home concept and to trend both process of care and patient outcome data over an 18-24 month period. At the conclusion of the pilot we hope to better understand the time and monetary efforts required by a practice to attain and maintain a medical home environment as well as being able to produce tangible data in favor of the medical home approach to care.*

## Medical Home Advisory Panel

The Blue Cross Medical Home Pilot was developed through a collaborative effort with the following advisory panel participants:

- Boyd L. Bailey, Jr., MD
- John E. Brandon, MD
- Mary Margaret Crestani, MD
- William A. Curry, MD
- B. Jerry Harrison, MD
- A. Z. Holloway, Jr., MD
- Linda Lee
- Holly Midgley
- Michael J. Ramsey, MD
- C. Mike Soppet, MD
- Ross B. Vaughn, MD
- James C. Wiley, MD

## Blue Cross and Blue Shield of Alabama Physician Requirements for the Medical Home Pilot

The requirements below, in combination with the physician practice obtaining recognition through the National Committee for Quality Assurance (NCQA) Physician Practice Connections<sup>®</sup>- Patient-Centered Medical Home<sup>™</sup> (PPC-PCMH) program, will qualify participating physicians for a per member per month (PMPM) Care Management Payment during Phase II and III of the Pilot:

1. Physician must be a Preferred Medical Doctor (PMD) in good standing.
2. Physician must be board certified/eligible in family practice, internal medicine or pediatrics.
3. Practice has 24 hour/7 days a week on call coverage.
4. Practice accesses Blue Cross patient account information electronically (i.e., via *ProviderAccess*, practice management system, etc.).
5. Practice files 99 percent of claims electronically.
6. Practice agrees to use Electronic Funds Transfer (EFT).
7. Physician has admitting privileges or inpatient relationship with a hospitalist.
8. Physician recommends the use of our Personal Health Record (PHR) for their Blue Cross patients.
9. Physician agrees to use e-prescribing.
10. Physician agrees to pursue and obtain NCQA Physician Practice Connections<sup>®</sup>- Patient Centered Medical Home recognition within 12 months of the start of the pilot.
11. Single site location of the practice for more than 50 percent of the time.  
**Note:** Urgicare centers are not eligible for the pilot.
12. Medical records for all patients treated at the practice site, whether paper or electronic, are available to and shared by all clinicians, as allowed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.
13. The same systems (electronic and/or paper based systems) and procedures support clinical and administrative functions such as: scheduling time, treating patients, ordering services, prescribing, maintaining medical records and follow-up. It is recommended that the practice use an electronic practice management system.
14. The practice has written standards/procedures for scheduling, continuity of care, support of patient access, including policies for scheduling visits, responding to telephone calls and electronic communications. Non-physician staff follows the same procedures and protocols.

## Recommended Medical Home Pilot Practices

The pilot facilities below were selected by Blue Cross and Blue Shield of Alabama based on recommendations from leaders in the Alabama Chapters of the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP):

<b>Practice Name</b>	<b>City</b>
Anniston Pediatrics Inc.	Anniston
Auburn Pediatrics	Auburn
Dothan Pediatric Clinic PA	Dothan
Huntsville Pediatric Associates LLC	Huntsville
Internal Medicine Associates Dothan PA	Dothan
Providence Healthcare Services Inc.	Mobile
Niel C. Rasmussen, MD	Headland
Tamara A. McIntosh, MD	Ohatchee
Dorothy K. Nelder, MD	Piedmont
Tuscaloosa Internal Medicine LLC	Tuscaloosa
Subset of Kirklin Clinic	Birmingham
Southern Health Associates LLC	Troy
Carraway Internal Medicine Associates	Birmingham
Simon Williamson Clinic	Birmingham

# Pilot Program Structure

## Phase I (September 1, 2009 through September 30, 2010)

The focus of Phase I will be to encourage and support NCQA Physician Practice Connections<sup>®</sup>- Patient-Centered Medical Home<sup>™</sup> (PPC-PCMH) Recognition at the pilot facilities. During Phase I Blue Cross will work with the pilot facilities to develop meaningful outcome measures and an appropriate way to track patient/physician interaction (i.e., patient attribution).

### Physician Rewards for Phase I

- Practice Transformation Incentive – \$2,500 per practice
  - To be paid by September 30, 2009
  - To be used on any necessary resources such as Medical Home resources provided by specialty societies, e-prescribing tool, etc.
- Office Resource Incentive – \$500 per physician (up to \$3,000 per practice)  
This payment will assist in offsetting the NCQA cost and will be made after the practice has paid the application fee. (See out-of-pocket costs on page 6.)
- Recognition Reward – \$1,000 per eligible physician (up to \$5,000 per practice)  
The recognition reward will be paid to the practice once NCQA PPC-PCMH recognition has been attained.
- Once the NCQA PPC-PCMH application has been submitted, Blue Cross and Blue Shield of Alabama will work with the pilot facilities to identify 50 patients (with 25 alternate patients to account for unforeseen membership changes) to receive targeted intervention and to be tracked for outcomes purposes.

## Phase II (Focus on Process of Care)

*January 2010 (or once PPC-PCMH Recognition is achieved) through December 2010.*

- Practices will be eligible for payout upon receiving NCQA PPC-PCMH recognition. Phase II rewards will be based on the level of recognition attained by the practice, meeting patient experience thresholds, and meeting practice participation thresholds. Physicians can earn an incentive payment up to \$12,000 per physician.

## Phase III (Focus on Outcomes)

*January 2011 through December 2011.*

- Practices will be eligible for payout upon meeting outcome goals developed during Phases I and II. We will be working with pilot facilities during Phase I & II in order to identify outcomes measures, and data tracking methodology. Participating physicians will have the ability to earn an incentive payment of up to \$20,000 per physician.

Potential chronic conditions for outcomes tracking during the pilot include: diabetes, coronary artery disease (CAD), congestive heart failure (CHF), asthma, chronic obstructive pulmonary disease (COPD), hypertension and hyperlipidemia.

## National Committee for Quality Assurance (NCQA)



NCQA's Physician Practice Connections®- Patient-Centered Medical Home™ (PPC-PCMH) program reflects the input of the American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics and American Osteopathic Association and others in the revision of Physician Practice Connections® to assess whether physician practices are functioning as medical homes. Building on the joint principles developed by the primary care specialty societies, the PPC-PCMH standards emphasize the use of systematic, patient-centered, coordinated care management processes.

### Practice Out-of-Pocket Costs for NCQA PPC-PCMH Recognition

Number of Physicians in Practice	Initial Fee for Practice to Obtain a Survey Tool License	Discounted Application fee for NCQA Materials (Sponsors Discount)
1	\$80	\$360
2	\$80	\$720
3	\$80	\$1,080
4	\$80	\$1,440
5	\$80	\$1,800
6	\$80	\$2,160
7	\$80	\$2,520
8 or more	\$80	\$2,700

### Aspects of Care Measured by PPC-PCMH

- Access and Communication
- Care Management
- Electronic Prescribing
- Referral Tracking
- Advanced Electronic Communications
- Patient Tracking and Registry Functions
- Patient Self-Management Support
- Test Tracking
- Performance Reporting and Improvement



For more information about PPC-PCMH, visit [www.NCQA.org](http://www.NCQA.org) or contact NCQA Customer Support at 1 888 275-7585.

# PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts	Standard 5: Electronic Prescribing	Pts
A. <b>Has written standards for patient access and patient communication**</b>	4	A. Uses electronic system to write prescriptions	3
B. <b>Uses data to show it meets its standards for patient access and communication**</b>	5	B. Has electronic prescription writer with safety checks	3
	9	C. Has electronic prescription writer with cost checks	2
Standard 2: Patient Tracking and Registry Functions	Pts		8
A. Uses data system for basic patient information (mostly non-clinical data)	2	Standard 6: Test Tracking	Pts
B. Has clinical data system with clinical data in searchable data fields	3	A. <b>Tracks tests and identifies abnormal results systematically**</b>	7
C. Uses the clinical data system	3	B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
D. <b>Uses paper or electronic-based charting tools to organize clinical information**</b>	6		13
E. <b>Uses data to identify important diagnoses and conditions in practice**</b>	4	Standard 7: Referral Tracking	PT
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3	A. <b>Tracks referrals using paper-based or electronic system**</b>	4
	21		4
Standard 3: Care Management	Pts	Standard 8: Performance Reporting and Improvement	Pts
A. <b>Adopts and implements evidence-based guidelines for three conditions **</b>	3	A. <b>Measures clinical and/or service performance by physician or across the practice**</b>	3
B. Generates reminders about preventive services for clinicians	4	B. Survey of patients' care experience	3
C. Uses non-physician staff to manage patient care	3	C. <b>Reports performance across the practice or by physician **</b>	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5	D. Sets goals and takes action to improve performance	3
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5	E. Produces reports using standardized measures	2
	20	F. Transmits reports with standardized measures electronically to external entities	1
Standard 4: Patient Self-Management Support	Pts		15
A. Assesses language preference and other communication barriers	2	Standard 9: Advanced Electronic Communications	Pts
B. <b>Actively supports patient self-management**</b>	4	A. Availability of Interactive Website	1
	6	B. Electronic Patient Identification	2
		C. Electronic Care Management Support	1
			4

**\*\*Must Pass Elements**

## PPC-PCMH Scoring

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	75 - 100	10 of 10
Level 2	50 - 74	10 of 10
Level 1	25 - 49	5 of 10
Not Recognized	0 - 24	< 5

**Levels:** If there is a difference in Level achieved between the number of points and “Must Pass”, the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 “Must Pass” Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 “Must Pass” Elements do not Qualify.

## **NCQA Technical Requirements**

- 1) Computer with:
  - a. E-mail
  - b. Internet Access
  - c. Microsoft Word
  - d. Microsoft Excel
  - e. Adobe Acrobat Reader (available for free online)
- 2) Staff with ability to use the computer systems listed above
- 3) Access to the electronic systems used by the practice (e.g., billing system, practice management system electronic prescription writing, electronic health record)
- 4) Internet Explorer

## **Resources to Assist with Practice Transformation**

### **American Academy of Family Physicians**

- Joint Principles of the Patient-Centered Medical Home  
<http://practice.aap.org/content.aspx?aid=2063&nodeID=8002>
- TransforMed  
[www.transformed.com](http://www.transformed.com)

### **American Academy of Pediatrics**

- How to Become a Medical Home  
[www.medicalhomeinfo.org/tools/providerindex.html#Howto](http://www.medicalhomeinfo.org/tools/providerindex.html#Howto)
- Medical Home Toolkit  
[www.pediatricmedhome.org](http://www.pediatricmedhome.org)
- AAP and the Medical Home Model  
<http://practice.aap.org/content.aspx?aid=1597&nodeID=8002>

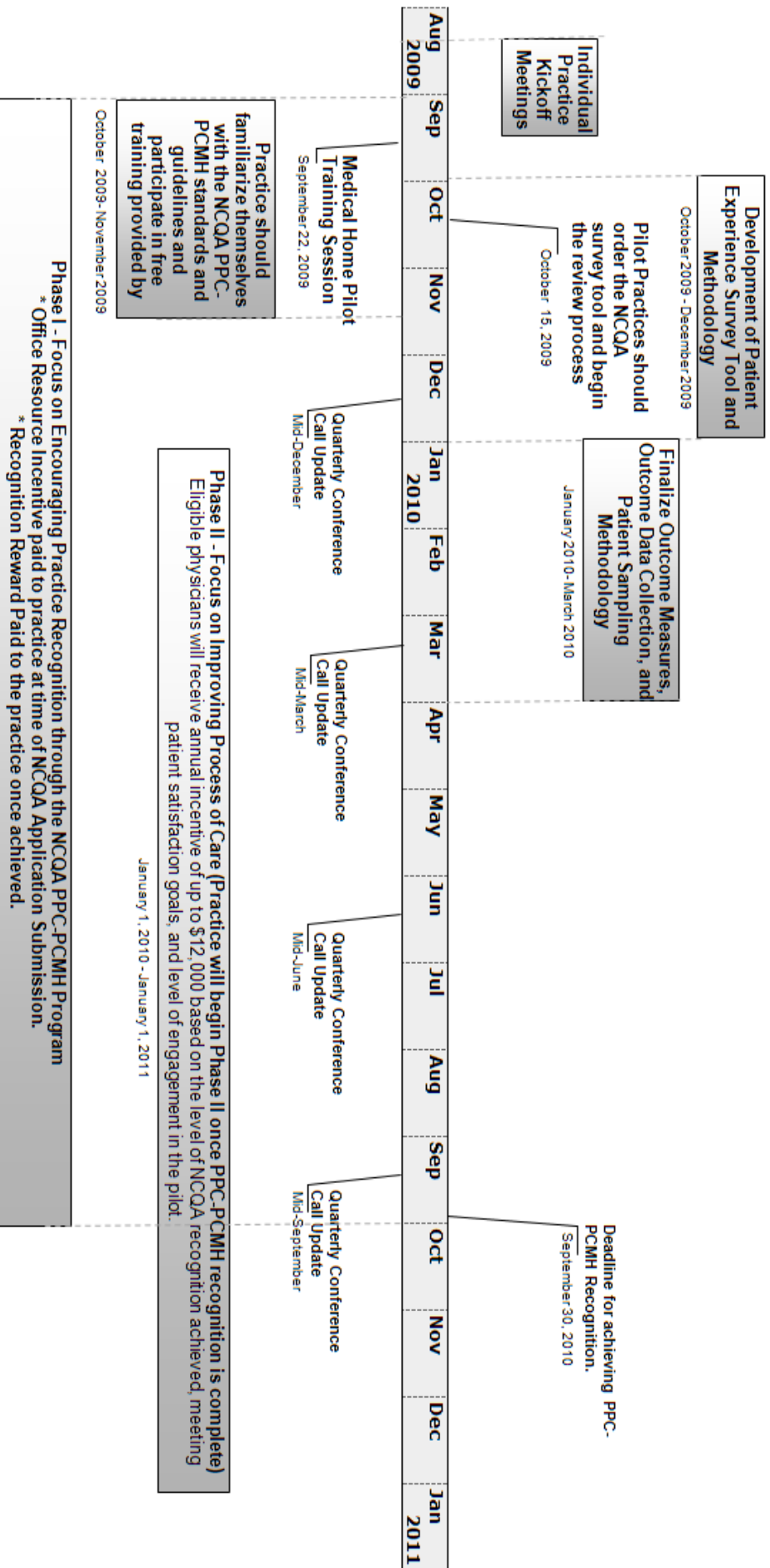
### **American College of Physicians**

- Understanding and Running a Patient-Centered Medical Home  
[www.acponline.org/running\\_practice/pcmh/](http://www.acponline.org/running_practice/pcmh/)

### **Additional Resources**

- The Commonwealth Fund: Patient Centered Care Research and Publications  
[www.commonwealthfund.org/Topics/Patient-Centered-Care.aspx](http://www.commonwealthfund.org/Topics/Patient-Centered-Care.aspx)
- National Center of Medical Home Initiatives  
[www.medicalhomeinfo.org](http://www.medicalhomeinfo.org)
- Patient-Centered Primary Care Collaborative  
[www.pcpcc.net/content/patient-centered-medical-home](http://www.pcpcc.net/content/patient-centered-medical-home)

# Blue Cross and Blue Shield of Alabama Medical Home Pilot (Phase I and Phase II Timeline)



Timeline is subject to change based on feedback from participating practices.