



Florida Association of Community Health Centers, Inc  
Florida Academy of Family Physicians  
Florida Osteopathic Medical Association

## Critical Concepts for a Successful Florida Medical Home Program

Many agree that Florida's health care system is far too costly and promotes fragmented and episodic care. It clogs the hospital emergency rooms and is significantly challenged by efforts to produce improved health outcomes. This is clearly evident in medically underserved and uninsured populations; and it is especially amplified in minority populations. Florida does not currently have a strategy to control health care costs, ensure greater access, and move the state towards more positive and lasting outcomes and it is widely known that primary care is the least expensive and most effective way to accomplish these goals. Primary care is key in addressing:

- Disparities in health status and access to health care experienced by low income and/or underserved communities;
- The epidemic of chronic diseases (all preventable) in underserved communities; and
- The requirement that any restructuring in the health care system be designed to address rising healthcare costs by preventing expensive and avoidable emergency room visits and hospitalizations.

Florida does not currently recognize primary care as the anchor of the health care system. If meaningful change is to occur – and it must – the state must commit to investing in primary and preventive care. Clear accountability for what is being done, as well as a focus on achieving results and cost savings, must be principle parts of the focus of this campaign. Safety net providers should not be the recipients of the crumbs of the system.

The “health care home” or “medical home” has been proven to be an effective model to provide quality care. A growing body of evidence shows that a robust primary care system reduces costs, improves health outcomes, and reduces the disparities on health care that are based on race, ethnicity, and income. We must make primary care a priority if Florida is to have highest quality, most effective health care at the most efficient cost.

In 2009, Florida decided to look closely at the medical home concept through legislation as one way to produce better outcomes and reduce costs. The Florida Association of Community Health Centers (FACHC), The Florida Academy of Family Physicians (FAFP), and the Florida Osteopathic Medical Association (FOMA) have formed the Florida Primary Care Coalition (FPCC) to advance this concept in the development of a Patient-Centered Medical Home (PCMH) Model for Florida. The FPCC has taken pieces of effective systems from other states and added them to existing, working infrastructure in Florida's current health care system, so as to not re-invent what already works.

In order for the Florida health care system to realize positive change, a solid commitment from the Legislature is imperative. A significant difference in the way Florida does business will need to be considered to insure a successful outcome in the pilot projects being recommended by the FPCC. Florida and her people can no longer afford to ignore new and innovative approaches to our health care dilemma.

Patient-Centered Primary Care Medical Home models are not replacements for HMOs. The PCMH model is a delivery system and the other a payor system first. If Florida is to consider cost savings, then there is a place for both to assist our efforts in controlling costs. The recommendations set forth herein are for establishing pilot programs for PCMH projects in Florida to address the need for focus on primary care.

As Floridians, we can no longer afford to accept what we have been doing as the only way to do business.

**Andy Behrman**  
**President/CEO FACHC**

**Tad Fisher**  
**Executive Director FAFP**

**Steve Winn**  
**President/CEO FOMA**

## Executive Summary

The budget and belt-tightening that is sweeping across virtually all sectors of the U.S. economy is nothing new for state agencies – especially those charged with administering health care. State agencies have been coping for years with swelling health care expenses and prescription drug costs, rising far faster than the general rate of inflation. They also have seen the effects of soaring health insurance premiums that have caused some employers to drop or drastically scale back those benefits for their employees. This is in the face of the widely reported statistic that 14,000 Americans lose their coverage every day – which is often accompanied by a loss of employment and income.

A serious reevaluation of the current medical landscape that is inclusive of all stakeholders is needed to allow for greater health services, treatments, and outcomes for patients, while enhancing payments to providers. These incentives would assist patients in achieving improved long-term and short-term health and assist Primary Care Providers in remaining open, while encouraging an increase in number and/or retention of family and other local practitioners (a lack of which has become a serious issue, and will only grow with time).

Therefore, it is imperative that states find a way to improve health service delivery through efficiencies, while retaining – and expanding upon – their effectiveness. One such proposed method is through the **Patient-Centered Medical Home (PCMH)** model. An important point to remember when considering the implementation of a PCMH pilot program is that dollars can be saved from the total budget if there is a stronger financial investment in supporting primary care. This requires a new perspective that measures global budgets rather than keeping budget neutral “silos” such as hospital care versus physician office care versus nursing home care. States’ Medicaid expenditure dollars that are matched by the federal government are still spent (though fewer may be necessary); however these funds will better serve the people for whom they are meant to benefit. **Primary Care Providers (PCPs)** that choose to operate within this system will receive enhanced reimbursements – either through direct increases to reimbursement rates on a per patient per month (PPPM) basis or combined with an improved procedure/visit incentive basis. Additional financial “bonuses” should be provided when the physician practice shows it has achieved better benchmarks and outcomes.

Part of the PCMH’s strong appeal...is that it potentially unites 4 compelling areas of health care reform activity...research on primary care’s value, improved approaches to chronic care, consumerism, and new health care–related information and communication technology. There is mounting evidence showing primary medical care’s value in assuring a health care system of higher quality at lower cost and with more equity.

Paul A. Nutting, MD

*Initial Lessons From the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home*

According to the Patient-Centered Primary Care Collaborative (an organization that assists in focusing efforts locally and nationally towards meaningful and accurate PCMH implementation) there are currently 44 states in addition to the District of Columbia that are either piloting or planning a Medical Home (MH) pilot program to some degree. In fact, there have been over 330 laws passed amongst those states.

If states could save just one percent of all Medicaid expenditures each year due to diversion and preventative care, then millions of dollars could be saved and reinvested into better health outcomes for their citizens. In fact, as demonstrated in this report, **a conservative estimate would place annual Medicaid savings in Florida between \$200 and \$900 million by FY 2012-13**, were the PCMH program instituted statewide.

## What is a Patient-Centered Medical Home?

A **Patient-Centered Medical Home (PCMH)** provides accessible, continuous, coordinated and comprehensive patient-centered care. A Medical Home (MH) is managed centrally by a primary care physician (PCP) with the active involvement of non-physician practice staff. In order to be deemed a MH, most typical physician practices will need to improve practice infrastructure and meet certain new qualifications and performance measures. The operation of a PCMH requires more work and more services than physicians have been paid historically to perform. Thus, physicians feel as though there is an absolute requirement to reform primary care reimbursement levels if they are expected to undertake practice transformation to the level expected and needed to accomplish MH status.

The American Academy of Pediatrics (AAP) introduced the MH concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the MH concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. The AAP has been joined by the American Academy of Family Physicians, the American Osteopathic Association and the American College of Physicians to collectively advocate in favor of the MH concept. In March 2007, these organizations, which represented about 333,000 physicians at the time, developed seven joint principles to serve as the underpinnings of a workable PCMH.<sup>1</sup> These principles, which can be found at the link provided in the footnote below, are:

1. **Personal Physician:** Each patient has an ongoing relationship with a **Personal Physician (PP)** trained to provide first contact, continuous and comprehensive care.
2. **Physician Directed Medical Practice:** The PP leads a team of individuals who collectively take responsibility for the ongoing care of patients.
3. **Whole Person Orientation:** The PP is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
4. **Care is Coordinated and/or Integrated:** Develop a network of registries, information technology, health information exchange, and other means in a culturally and linguistically appropriate manner to assure that patients get the necessary and correct care.
5. **Quality and Safety:**
  - Practices should advocate for their patients to be a part of achieving the healthiest outcomes for themselves;
  - Evidence-based medicine and clinical decision-support tools should guide decision-making;
  - Physicians in the practice should be held accountable for continuous quality improvement by way of voluntary reporting of performance measurement and improvements;
  - Patients should be allowed to actively participate in decision-making and feedback is sought to ensure patients' expectations are being met;
  - Information technology should be utilized appropriately to support patient care, performance measurement, patient education, and enhanced communication;
  - Practices should go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they can provide patient centered services as prescribed by the MH model;
  - Patients and families should participate in quality improvement activities;
  - The Florida MH Model should rely on the National Committee for Quality Assurance (NCQA) guidelines defining criteria for a MH.
6. **Enhanced Access:** Care is available through systems (e.g. open scheduling, expanded hours, and new options for communication) between patients, their PP, and practice staff.
7. **Payment:** Appropriately recognize the added value provided to patients who have a PCMH. The MH model may provide additional payments to encourage enhancements to existing infrastructure and services. The payment structure should:

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<sup>1</sup> Joint Principles of the Patient-Centered Medical Home, March 2007. <http://www.medicalhomeinfo.org/joint%20Statement.pdf> Last accessed on 9-26-2009.

- Reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit;
- Reimbursement should start at a 95% Medicare fee-for-service rate for Tier 3 PCMH, 80% for Tier 2 PCMH, and 70% for Tier 1 PCMH (please see Appendix A for corresponding Tier requirements); Pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources;
- Support adoption and use of health information technology for quality improvement;
- Support provision of enhanced communication access such as secure e-mail and telephone consultation;
- Recognize the value of physician work associated with remote monitoring of clinical data using technology;
- Allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits);
- Recognize case mix differences in the patient population being treated within the practice;
- Allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting;
- Allow for additional payments for achieving measurable and continuous quality improvements.

**Intended Effects:** Medical Homes encourage a population-based, proactive, and planned approach to health care delivery. MHs coordinate care across various providers to facilitate the provision of recommended services, eliminate redundancies or unnecessary care, and engage patients and their families in their care regimen.

**Incentives for Providers:** PCPs are encouraged to improve practice infrastructure to qualify as a MH. A physician whose practice qualifies as a MH is required by terms of the agreement to provide specific standards of care and coordination and will receive supplementary payments for additional work and value provided.

**Potential Problems:** Standards for providers to qualify as MHs most often are linked to a complex designation process offered by the National Committee for Quality Assurance (NCQA) for a moderate fee. Some PCMH pilot projects have chosen other criteria. Physicians serving as MHs may have limited ability to coordinate care in some settings. Without aligned incentives, hospitals and specialists may resist cooperating with MHs, impeding the model's success – despite appropriate effort by the primary care team.

Current national leadership has also warmed to the idea of a MH, announcing recently<sup>2</sup> that Medicare dollars will now be utilized to assist states in funding these operations and/or pilot programs<sup>3</sup>. The United States Health and Human Services Secretary, Kathleen Sebelius, cited widespread endorsement for this model when announcing the Medicare inclusion of the MH. The article also cited a bill coming out of the U.S. Senate, presented by the Senate Finance Committee Chairman, Max Baucus, which – in part – would allow for the enhancement of payments to physicians that choose to participate in the MH model. The Vermont program, which will soon serve 60,000 people and pays doctors an extra \$1.20 - \$2.39 PPPM, was cited as a success story that added to the momentum pushing the concept forward in Washington and across the country.

## Lessons Learned and Evidence Discovered Thus Far

Although the concept of the MH model has been around for four decades, it is the current movement towards this option for medical provision that has spurred an influx in academic and independent studies.

<sup>2</sup> Zhang, Jane. *The Wall Street Journal*, “Medicare to Fund ‘Medical Home’ Model.” September 16, 2009. <http://online.wsj.com/article/SB125313645498617439.html> Last accessed on 9-26-2009.

<sup>3</sup> The federal government and the Center for Medicare and Medicaid Services (CMS) were initiating the beginnings and developing the designs for the MH model as a result of legislation passed during the Bush Administration, such as the Tax Relief and Health Care Act of 2006. [http://www.cms.hhs.gov/demoprojectsevalrpts/downloads/medhome\\_factsheet.pdf](http://www.cms.hhs.gov/demoprojectsevalrpts/downloads/medhome_factsheet.pdf) Last accessed on 9-26-2009.

These examinations have attempted to provide a variety of data elements and conclusions that range from financial to health outcomes. The findings of the literature review conducted for the purposes of this study revealed that the overwhelming majority of studies have reported results that will accomplish the goals set out by the creators of the model – save the states money (while providing for more funds to practitioners) and, more importantly, increase access and quality of care while improving the long-term and short-term health of patients.

A report<sup>4</sup>, published in the *Annals of Family Medicine* in May of this year, which discussed the attempt to expand the MH model demonstration projects into more states nationally, provides many useful insights as to the advantages and disadvantages of implementing this model in a more expansive area. Some of these observations were:

1. Practices often have to adjust their time and activity allocations to accommodate the changes required by increased reporting and accountability – this includes the organizational culture;
2. Levels of technological advancements are scattered. In other words, not all offices/practices/etc. have the same technological resources for record-keeping/information transmittal/etc. To achieve this standardized integration, time and financial resources may be required;
3. It may be necessary for the National Committee for Quality Assurance (NCQA, the body that oversees a majority of recognition programs previously noted) to adjust its processes and standards to accommodate for the incremental and taxing changes that must be undertaken to fully participate in the PCMH system;
4. “Learn to be a learning organization”: Rather than closing the book on the rules and regulations of the program once it is decided and initiated, those overseeing the program, its progress, and its success should continuously take into account recommendations, experiences, and results to modify and/or adjust the model as they arise, as each locality – or even each practice or physician – comes with it unique and particular situations and successes/failures.

Dr. Andrew Bindman published an editorial<sup>5</sup> that examined a study conducted by Grant Atlas and colleagues that makes a compelling case that a personal physician is one of the key elements of the MH that increases quality provided. “By using an innovative measure, the study reported that patients who were more connected to a personal physician were more likely to receive recommended primary and secondary prevention services in primary care settings<sup>6</sup>. The effect size was clinically meaningful, and patient–physician connectedness was a stronger determinant of delivered preventive services than proven predictors, such as patients’ age, sex, and race or ethnicity.” The findings were said to be consistent across a variety of activities designed to prevent more serious conditions, as well as amongst subgroups of patients defined by their disease or type of medical insurance.

A recently released study<sup>7</sup> conducted by the Group Health Cooperative, now named Group Health Research Institute (a Seattle-based consumer-governed, nonprofit health care system founded in 1947 that coordinates care and coverage), concluded that the PCMH model could reduce the cost of care for patients and help solve the nation’s primary care physician shortage. In comparing a sample of 9,200 patients from Group Health’s MH to a control group after one year, patient visits to the emergency room decreased by 29 percent, while the rate of hospitalization dropped by 11 percent and the MH had 6 percent fewer in-person visits. Also, patients at the MH reported a 94 percent increase in e-mail use, 12 percent more phone consultations, and more group visits and self-management support workshops. All of these activities resulted in a patient assessment that they received better health care, including needed screening tests, management of their chronic illnesses, and monitoring of their medications.

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<sup>4</sup> Paul A. Nutting, MD, MSPH; William L. Miller, MD, MA; Benjamin F. Crabtree, PhD; Carlos Roberto Jaen, MD, PhD; Elizabeth E. Stewart, PhD; and Kurt C. Stange, MD, PhD. *Initial Lessons From the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home*,

<sup>5</sup> Bindman, Andrew B., MD. *Annals of Internal Medicine*. “Is there a Personal Doctor in the House?”, Volume 150, Number 5, (2009), 351-352. <http://www.annals.org/cgi/reprint/150/5/351.pdf> Last accessed on 9-26-2009.

<sup>6</sup> “The report also showed that patient–physician connectedness varies among practice organizations. The percentage of patients with a personal physician varied by more than 25% (45.6% to 71.2%) across 13 primary care practices. The rate was higher in the 9 private practices than the 4clinics, but the statistically significant difference of 3.6% between the types of sites was relatively minor.”

<sup>7</sup> “Medical Home Produces Better Care at No Added Cost”, September 1, 2009. <http://www.ghc.org/news/news.jhtml?repositid=common/news/news/20090901-medicalhome.html> Last accessed on 9-25-2009

## Experience with Implementation

Various payers and insurers have piloted MH programs. In Massachusetts, the Massachusetts Coalition for Primary Care Reform has established a framework for MHs, with payment methods including risk-adjusted PPSM payments as well as bonus payments for achieving desired outcomes in quality, patient experience, and cost-effectiveness (MACPR 2008).

In other states, and nationally, a number of payers – including Aetna, Blue Cross and Blue Shield Association, CIGNA, Geisinger, United HealthCare, and the Centers for Medicare and Medicaid Services (CMS) – are developing, or have implemented, MH pilots. Specific current or planned examples include the following<sup>8</sup>:

- CIGNA and Dartmouth-Hitchcock launched a MH pilot program in New Hampshire in June 2008. The program covers patients on the CIGNA plan receiving care from Dartmouth-Hitchcock PCPs practicing in family medicine, internal medicine, and pediatrics. The pilot currently covers approximately 17,000 patients. An evaluation is intended for the program once it has been operational for 12 months.
- A UnitedHealth Group MH pilot in Arizona involving 6,000 patients and 7 medical groups began in 2009 and is scheduled to end in 2011.
- The state of Maine provided \$500,000 in 2009 for a pilot project in 10 - 20 practices that is aimed at covering between 30,000 and 50,000 residents of Maine.
- Geisinger Health Care has piloted a MH program in Pennsylvania. Components of the Geisinger model include round-the-clock primary and specialty care access, a nurse care coordinator in each practice site, virtual care management support, and a “personal care navigator” to respond to patients’ inquiries (Paulus 2008). The Geisinger model focuses on proactive care to minimize hospitalizations and manage chronic diseases. A referral network is linked with the primary care practice. Electronic health records support internet-based reporting of lab results, clinical reminders, self-scheduling, prescription refills and other capabilities. Geisinger makes practice-based payments to participating physicians, as well as monthly “transformation stipends” to strengthen and expand infrastructure. Each MH receives monthly performance reports of its quality and efficiency results.
- In January 2010, the Centers for Medicare and Medicaid Services (CMS) had planned to initiate a MH demonstration to improve quality of care, reduce costs, and improve health care coordination for Medicare beneficiaries with qualifying chronic conditions (Maxfield et al. 2008).<sup>9</sup> CMS uses a two-tier MH model. Tier 1 MHs must have 17 basic capabilities (including capacity to track referrals, tests, and provider follow-up). Tier 2 MHs must satisfy all Tier 1 MH qualifications and also have electronic medical record keeping, coordinate services following inpatient and outpatient care, and have three of nine optional capabilities. CMS recently announced that the pilot is being discontinued, as CMS intends to more broadly encourage PCMH adoption for Medicare beneficiaries.

Included among the numerous states that are embarking on the journey of implementing pilot programs for PCMHs are Oklahoma and North Carolina, which represent programs that have existed for varying lengths in somewhat differing forms. Whereas Oklahoma’s PCMH pilot began in January of 2009 (though many facets of it have been in place for some time), North Carolina’s has been in place for over a decade (1998). Therefore, it is useful to note where North Carolina’s program has experienced success and continuity as a way of providing suggestions to Oklahoma’s OHCA (Oklahoma Health Care Authority), as well as other states, to ensure achieving optimal results.

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<sup>8</sup> These examples and more can be found in the Patient-Centered Primary Care Collaborative publication: “Patient-Centered Medical Home: Building Evidence and Momentum”. [pcpcc.net/content/pcpcc\\_pilot\\_report.pdf](http://pcpcc.net/content/pcpcc_pilot_report.pdf) Last accessed on 11-25-09, or in the studies cited.

<sup>9</sup> A list of qualifying chronic conditions is available at: [http://www.acponline.org/running\\_practice/pcmh/demonstrations/conditions.pdf](http://www.acponline.org/running_practice/pcmh/demonstrations/conditions.pdf)

## Oklahoma Pilot

Families that receive SoonerCare (SC) – Oklahoma’s Medicaid program – benefits may choose one PCP for the entire family, or each member can have a different one. SC members are encouraged to first visit their PCP, one of more than 1,400 PCPs serving 600,000-plus members across the state.

Some individuals on SC have complex or unusual health care needs and utilize SC’s Health Management Program (which began in February 2008 to benefit those with exceptionally complex chronic conditions). The program is offered to certain members who are at high risk for complications of their disease or who have multiple serious illnesses (for example, diabetes and high blood pressure). Depending on how severe their problems are, they work with a nurse care manager in person or over the phone. The nurse directs them in ways to improve how they manage their health and communicates information on their status with the members’ PCP. Medical practices that treat members with such chronic conditions receive regular mailings on treating diseases, invitations to continuing medical education events, and can enlist the assistance of a practice facilitator for a month or two. The practice facilitator can help the providers and their staffs develop quality improvement techniques, improve their efficiency, and create a clinical disease registry tool to track certain diseases across their entire patient population.

One of OHCA’s newest pilot programs is "Special Delivery," a project that encourages early prenatal care, which is aimed at ensuring pregnant women know what benefits they have while identifying high-risk cases for early care management. Since SC pays for about half of all Oklahoman deliveries each year, it is imperative that OHCA help pregnant women get the care they need to have healthy babies.

In an attempt to make the system more streamlined and less burdensome for all parties involved, SC has made an attempt to reduce paperwork for network providers through a secure Internet billing site, which provides real-time claim information to plans for a new online provider contracting process. Another SC attempt to take advantage of technological savings and simplicities is a recent project that allows pregnant mothers to electronically enroll their infants at the hospital as soon as they deliver. OHCA also has received a grant that will eventually allow Oklahomans to apply over the Internet rather than fill out paper applications at county offices. This program, called "No Wrong Door," is expected to roll out in October 2009 and expand the integration and utilization of technology, while saving costs for both paper and staff time.

The most recent change involving SC’s MH involves restructuring the way health care providers are paid for services. Some providers felt that the previous rate structure, in which providers were paid a capitated monthly fee<sup>10</sup> for their entire panel of SC members, was inequitable. Recent data suggest the United States is facing a pending shortage of PCPs across the nation. Reasons noted by providers include inadequate reimbursement from health programs (such as Medicaid and Medicare). With approval of the agency’s official health care provider body, the Medical Advisory Committee, and candid input from physicians who volunteered to take part in a Medical Advisory Task Force, SC developed a new rate structure.

Payments under the new structure were to begin as of Jan. 1, 2009, upon approval of the CMS. Providers will now receive a monthly “case management fee” for coordinating care that is smaller than the previous amount, but they will be paid for the services they provide<sup>11</sup>. The monthly per-member payments also vary (depending on whether the provider sees children, adults, or both). The payment structure also includes SoonerExcel, in which providers receive quarterly "payments for excellence" for performing child health exams, prescribing generic drugs, screening for breast and cervical cancer, providing inpatient care, and participating in a project to diminish the unnecessary use of the ER. Providers also receive bonus payments for meeting child immunization goals and child health checkup measures.

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<sup>10</sup> "Capitation" refers to a fixed payment for treating an entire panel of patients regardless of whether they were ill and required care.

<sup>11</sup> Often referred to as “fee for service”

## North Carolina: What Was and Is CCNC

North Carolina began implementing its **Community Care of North Carolina (CCNC)** program (NC Medicaid) in 1998. With the ultimate goal of enhancing quality while controlling cost, the state adopted an enhanced MH model of care that connects patients with a PCP to serve as a MH (accompanied by an enhanced reimbursement to that provider for managing care) and includes a heavy emphasis on care coordination, disease and care management, and quality improvement. The CCNC program is focused on local networks of community providers that are comprised of physicians, case managers, hospitals, social service agencies, and county health departments. CCNC pays each network \$2.50 a month for each Medicaid recipient and an additional fee of \$2.50 to each physician for each Medicaid patient in the physician's practice, a total investment of \$5 for each patient. One of the keys to the program is managing patients with chronic diseases and making sure they transition seamlessly between primary care physicians, subspecialists and hospitals.

In 1991, North Carolina transitioned its Medicaid program from a traditional fee-for-service model to a PCCM program, called Carolina Access (CA). Carolina Access focused on linking enrollees to a MH where PCPs served as a MH and gatekeeper to specialty services. In return for these services, the PCPs received a modest care coordination fee. In 1998, nine networks (in nine counties) began piloting the CCNC program with a focal point on incorporating care management and quality improvement efforts into the program. These networks included some of the larger CA practices, which took the lead in developing the community partnerships and creating the non-profit networks that administer the pilot program. The networks receive an enhanced payment (or fee) of \$3 per member per month (or \$5 per member per month for elderly or disabled enrollees). Networks hire local case managers and elects a physician to serve as a clinical director, whose duty it is to work with a statewide board of directors to organize and direct initiatives across the networks. As of May 2009, the CCNC was comprised of 14 networks that included more than 3,200 physicians and covered over 913,000 Medicaid enrollees, accounting for over 67% of the state's Medicaid population.<sup>12</sup> The networks, designed in close connection with the state's provider groups, developed into teams of community providers that provided a more expansive reach of resources and infrastructure to support providers' ability to manage patient care. Over time, new networks formed to take the program statewide.

Statewide, network physicians and case managers implement disease management programs for asthma, diabetes, chronic care, and congestive heart failure in addition to case management for high-cost, high-risk patients. These PCPs also manage the use of high cost services, including pharmacy and emergency room utilization initiatives. Implementing these initiatives includes providing targeted patient education and care coordination, utilizing best practice guidelines, and monitoring results. Beyond these initiatives, other programs are being implemented on a pilot basis in some CCNC networks, which include mental health integration, chronic obstructive pulmonary disease, stroke prevention, childhood obesity, and special needs children.

The **Quality Measurement and Feedback Initiative (QMFI)** allows the board of clinical directors to identify performance measures and benchmarks for program-wide quality improvement initiatives through which they can evaluate the performance of individual practices and the networks as a whole. Performance data are collected through claims databases and chart reviews, and then compared with national and regional benchmarks and shared back with participating practices. This facilitates data and information sharing, as well as communication between practices concerning successful strategies and practices, which has been indicated as one of the most significant benefits of belonging to a network.

The Cecil G. Sheps Center at The University of North Carolina at Chapel Hill conducted a study of the two longest-operating disease management initiatives in the CCNC (the asthma and diabetes initiatives).<sup>13</sup>

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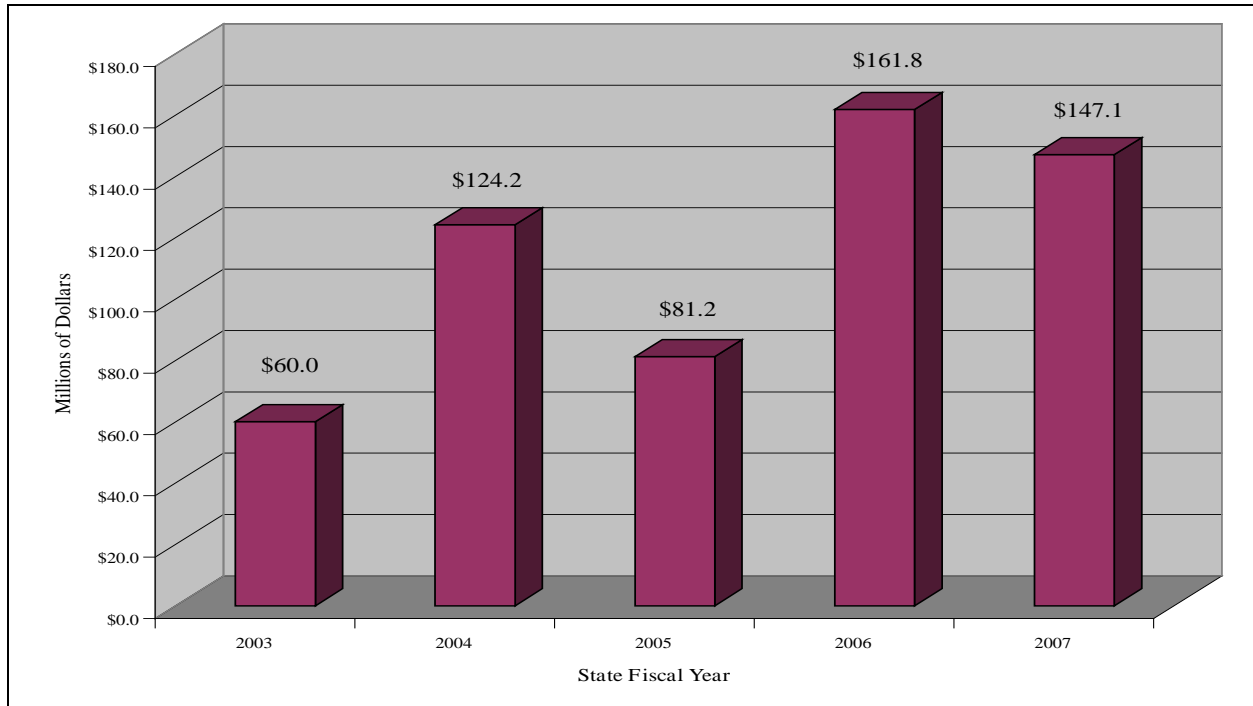
<sup>12</sup> Artiga, Samantha, Kaiser Commission on Medicaid and the Uninsured. Policy Brief: *Community Care of North Carolina: Putting Health Reform Ideas into Practice in Medicaid*. May 2009. <http://www.kff.org/medicaid/upload/7899.pdf> Last accessed on 9-25-2009.

<sup>13</sup> Ricketts T.C., et al, "Evaluation of Community Care of North Carolina Asthma and Diabetes Management Initiatives: January 2000-December 2002," The Cecil G. Sheps Center for Health Services Research, Chapel Hill, NC. April 15, 2004. <http://www.communitycarenc.com/PDFDocs/Sheps%20Eval.pdf> Last accessed on 9-25-2009.

The state achieved an estimated \$3.3 million in savings for people with asthma between 2000-2002 (spending \$79.4 million vs. \$82.7 million). It was hypothesized that much of the savings for asthma patients was driven by lower rates and a greater reduction in hospital use for CCNC enrollees. It was also found that the state grossed an estimated \$2.1 million in savings for diabetes patients between 2000-2002 (spending \$75.4 million vs. \$77.5 million).

Using the data provided by a Mercer Consulting study in the following chart and Medicaid patient data, the average per-patient per year (PPPY) savings for 2007 is estimated at about \$169.85, down from 2006's estimated PPPY savings of \$198.80, but double 2003's estimated average of \$80.38.

### Estimated Annual State Savings from Community Care of North Carolina



Source: Mercer Consulting, CCNC/ACCESS Cost Savings, Analysis for State Fiscal Years 2003, 2004, 2005 and 2006.

**NOTE:** Mercer analysis also compared CCNC savings relative to a benchmark of projections of what costs would have been including both fee-for-service Medicaid spending and spending under the Access program in the state. Estimated savings based on this benchmark are larger than the levels presented in the brief.

As such, CCNC not only provides important lessons for broad reform efforts, but also demonstrates the Medicaid program's ability to incorporate quality improvement strategies that enhance its ability to provide coordinated, cost effective care to low-income individuals with significant health needs via the MH and CHC models. Several states, including Iowa, Massachusetts, Minnesota, Washington, and West Virginia, are developing MH models in Medicaid as a first step to adopting a multi-payer MH system for all state residents. The following Table presents some and other states' programs.

## A Selection of State PCMH Programs

State	Program Name	Activation Date	Program Length	Size	Recognition Program	Data Element to be Gathered				
						Clinical Quality	Cost	Patient Experience/Satisfaction	Provider Experience/Satisfaction	Other
Colorado	CO Multi-Stakeholder Multi-State PCMH Pilot	April-09	2 Years	3 Metro Areas	Yes	Yes	Yes	Yes	Yes	No
Illinois	Quality Quest MH	February-09	1 Year	3 Counties	Undecided	Yes	Yes	Yes	Yes	No
Louisiana	LA Health Care Quality Forum MH Initiative	September-07	3 Years	4 Cities	Yes	Unknown	Unknown	Unknown	Unknown	No
Maine	ME Multi-Payer PCMH Pilot	Early 2009	3 Years	Statewide	Yes	Undecided	Undecided	Undecided	Undecided	No
Michigan	Aligning PCMH Stakeholders in Michigan	Under Develop.	Unknown	Statewide	Yes	Undecided	Undecided	Undecided	Undecided	No
New Hampshire	NH Multi-Stakeholder MH Pilot	January-09	2 Years, Following Payment Start (April 2009)	Statewide	Yes	Yes	Yes	Yes	Yes	No
New York (A)	NY Hudson Valley p4p/MH Project	2008	5 Years	10 Counties	Yes	Yes	Yes	Yes	Yes	No
New York (B)	EmblemHealth MH High Value Network Project	2008	2 Years	NY City & Surrounding Counties	Yes	Yes	Yes	Yes	No	No
Ohio/Kentucky	Greater Cincinnati Aligning Forces for Quality MH Project	Spring 2009 (Expected)	Unknown	Greater Cincinnati	Yes	Yes	Yes	Yes	Yes	No
Pennsylvania	Southeastern PA Rollout of the Chronic Care Initiative	May-08	3 Years	SE PA	Yes	Yes	Yes	Yes	Yes	Yes
Rhode Island	RI Chronic Care Sustainability Initiative (CSI-RI)	October-08	2 Years	Statewide	Yes	Yes	Yes	Yes	Yes	No
Tennessee	Memphis Multi-Payer PCMH	January 2009 (Planned)	Unknown	Memphis	Yes	Yes	Yes	No	No	No
Texas	TX PCMH Demonstration Project	Unknown	Unknown	Unknown	Undecided	Undecided	Undecided	Undecided	Undecided	Undecided

Source: American College of Physicians, State-by-State Demonstration List

[http://www.acponline.org/running\\_practice/pcmh/demonstrations/locations.htm](http://www.acponline.org/running_practice/pcmh/demonstrations/locations.htm)

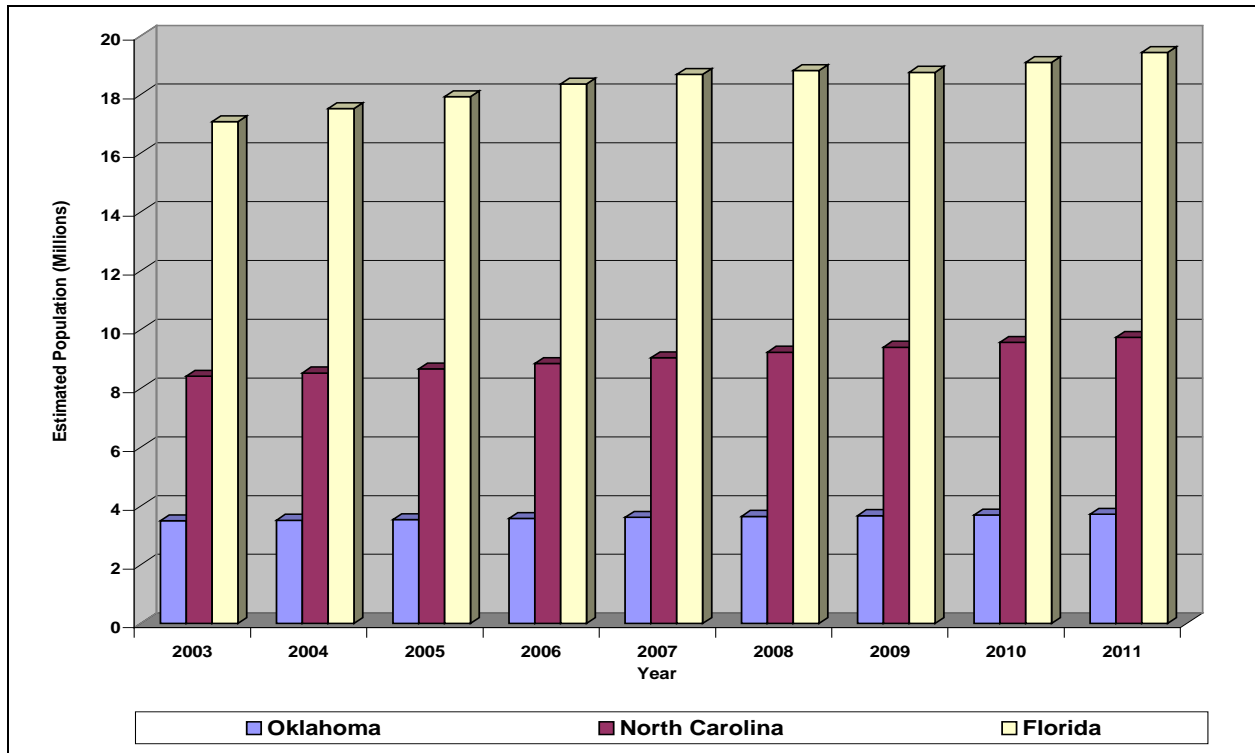
**NOTE:** New York (A) is government-based; New York (B) is insurer-based (EmblemHealth)

### How Does Florida Compare?

In terms of size, Florida's population is fourth largest in the nation (only California, New York and Texas are larger) and provides more care via Medicaid than almost all other states – and many states combined. For the purposes of this study, North Carolina and Oklahoma's PCMH models have been cited as comparisons. What is apparent from this comparison – based solely on population and Medicaid caseloads – is that Florida has a much larger mountain to climb for a total statewide PCMH program.

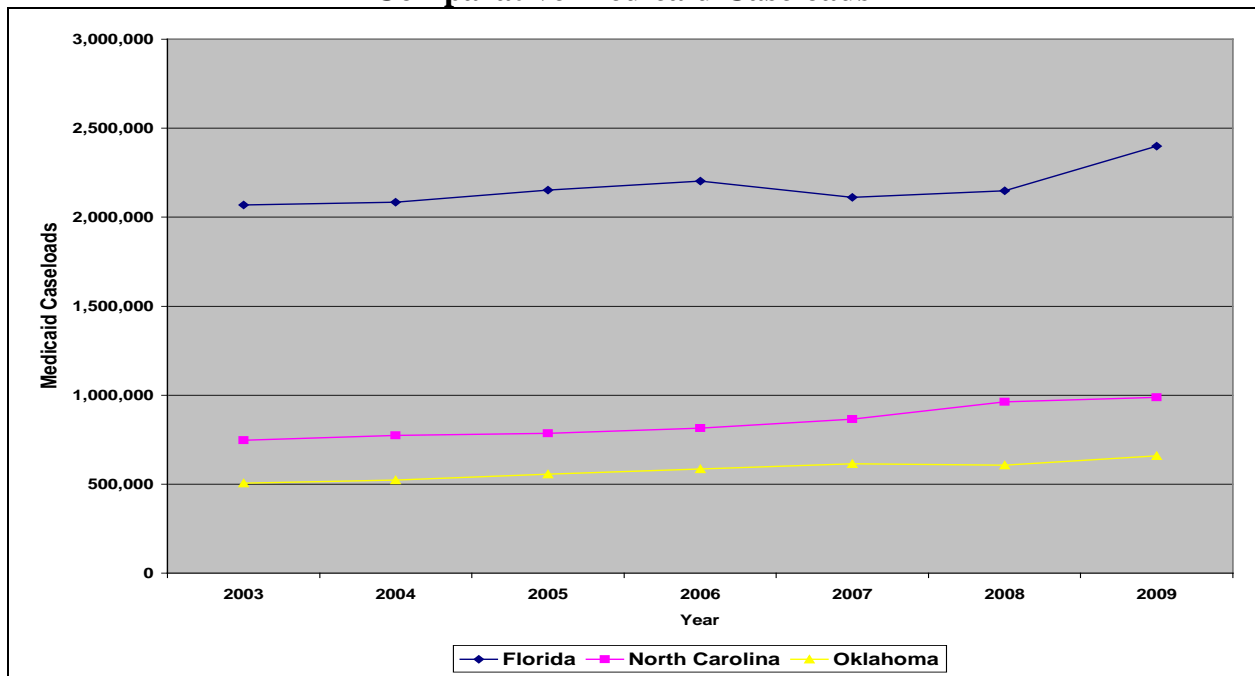
Specifically, Florida’s population is four times larger than that of Oklahoma and twice as large as North Carolina and the number of Medicaid recipients does not waver very much from these ratios.

### Comparative Population Estimates



Source: US Census Bureau (2000); Oklahoma Department of Commerce (2001-2008); North Carolina Office of Budget and Management (2001-2009); University of Florida Bureau of Economic and Business Research (2001-2009); All others generated by applying each state’s average annual percentage change as determined by available years data

### Comparative Medicaid Caseloads\*

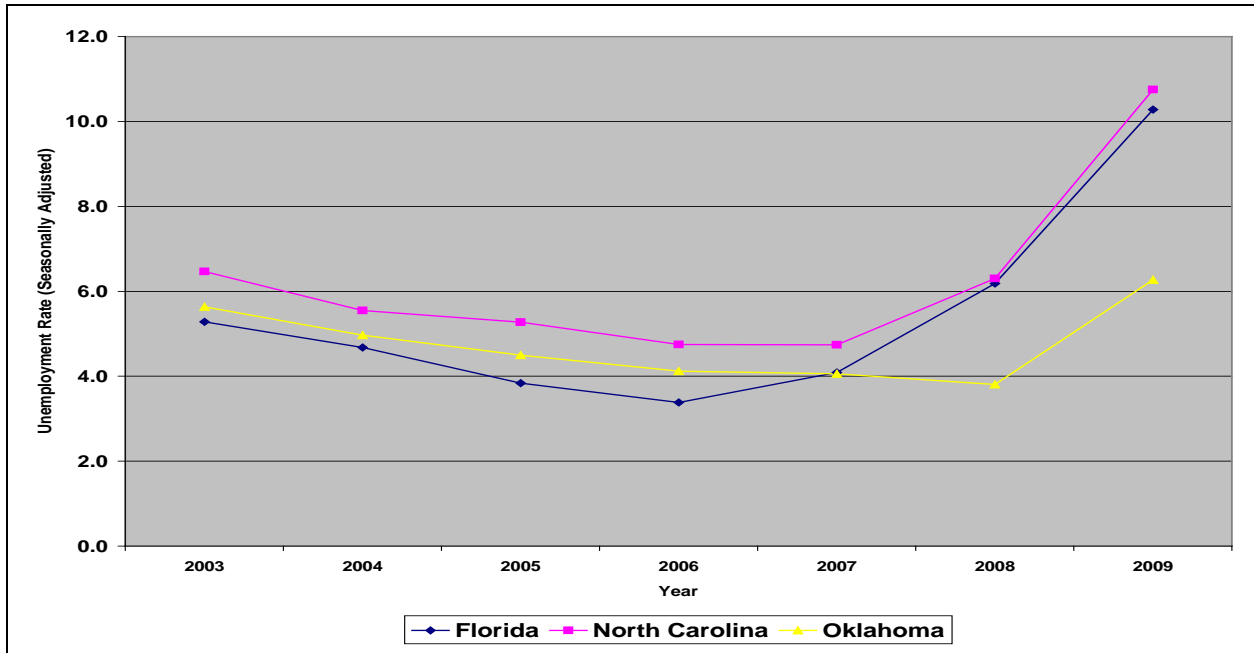


Source: Florida Office of Economic and Demographic Research (EDR), Social Services Estimating Conference (2009); Oklahoma Health Care Administration; CCNC/CA Medicaid Monthly Enrollment Reports

\*NOTE: Florida and North Carolina data were based on monthly case average, while Oklahoma data are annual August reported data.

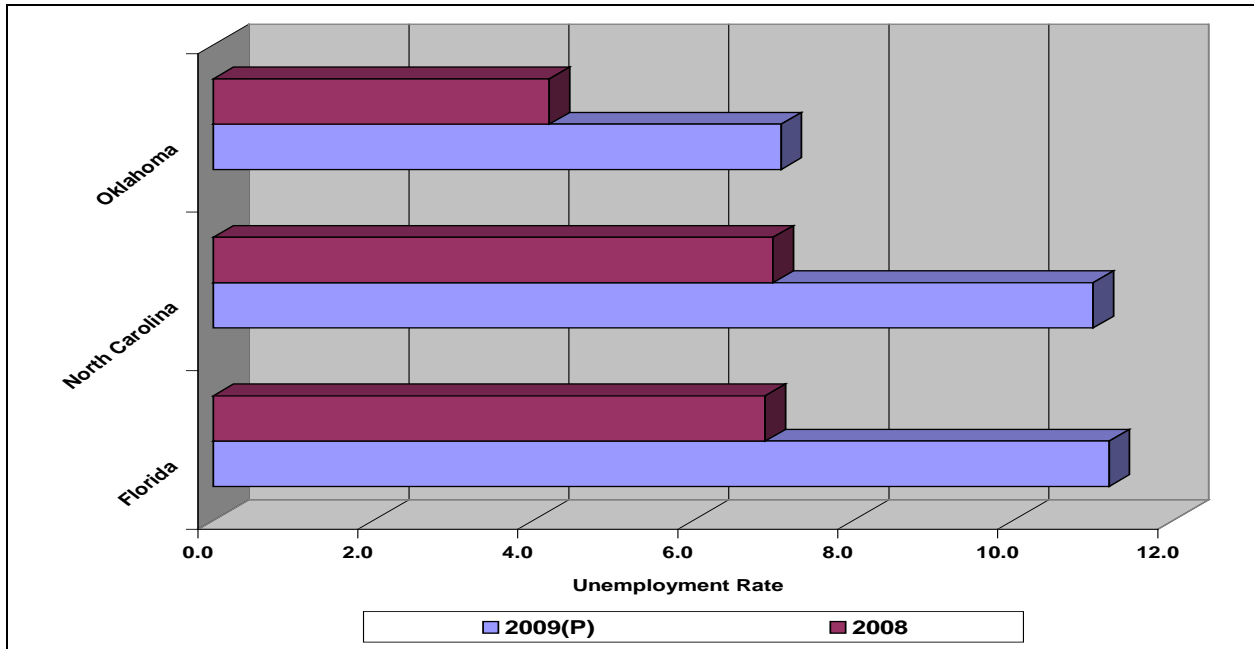
All economic indicators are pointing towards a continuation of the economic troubles into the future. Therefore, it has become more imperative than ever to implement the best practices and efficiencies wherever and whenever possible. Medicaid expenditures have been increasing exponentially over the past several years – and are expected to nearly double in Florida by fiscal year (FY) 2013 from expenses in FY 2003 that were \$11.44 billion. As presented in the following charts, after years of continual growth and improvement, the financial and employment statistics do not bode well for future Medicaid expenses.

### Comparable Unemployment Rate



Source: US Bureau of Labor Statistics (BLS)

### Comparative October Unemployment Rates (October 2008 & 2009)



Source: US Bureau of Labor Statistics (BLS)

\*Note: October 2009 unemployment data are preliminary

## What Does this Mean for Florida's Future?

The Patient-Centered Primary Care Collaborative (PCPCC)<sup>14</sup> is “a coalition of major employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, physicians and many others who have joined together to develop and advance the [PCMH].” The group includes member numbers in excess of 500 organizations. This collaborative is a national entity which assists governments, insurers, and all stakeholders involved in transitioning towards a PCMH model, providing suggestions, proposals, guidance, and information on a number of issues related to the difficult adjustments.

This group reaches across nearly all states to lend a hand in beginning programs, from legislation to best practices. The PCPCC also provides models of implementation related to a number of stumbling blocks (or potential avenues, depending upon one's perspective) at the state level. For instance, there is information on their website that provides results from a number of studies, such as the examination of running a part of the PCMH program through the Children's Health Insurance Program (CHIP)<sup>15</sup> or Public-Payer MH initiatives<sup>16</sup>.

Florida does not have any active PCMH pilot projects in place at this time. The Florida Academy of Family Physicians (FAFP) has been working with Blue Cross Blue Shield (BSBS) of Florida in the development of a PCMH demonstration project, which is aimed at lasting for 3 years. BSBS states that a handful of pilot practices are expected to begin in early 2010.<sup>17</sup> Another project being spearheaded by the FAFP in Florida is currently underway with the partnership including UnitedHealth Group, the American Academy of Pediatrics, the American Osteopathic Association, and the American College of Physicians.<sup>18</sup>

It is important to note that although federally qualified health centers generally do not meet all the criteria established by NCQA, their efforts and the methodologies associated with quality improvement, coordinated care, health information technology, and evaluation criteria closely mirror NCQA's standards. NCQA has laid out 9 standards containing 30 elements (note Appendix C). In a review of FQHCs in Florida, nearly 75% of the centers have or are close to achieving 70% of these assessment goals. While it would take some effort on the part of the centers to become fully NCQA accredited, it would take less time than starting completely from zero. FQHCs will provide a medical home to nearly one million patients this year. Establishing a tiered system to become accredited might move the process along quickly.

With the momentum moving in what could be the most positive direction possible, Florida is answering the call to enhance its fiscal efficiencies and patient-centered treatment regimen. The Florida Legislature and AHCA should be applauded for taking the initiative and deciding to move forward with PCMH pilot project efforts.

The following chart is presented that illustrates the percentage of total Florida state government funds that are consumed by Medicaid. These expenditures currently exceed 27% of total funds, while the hospital-related Medicaid costs have also grown to represent six percent of all funds (or approximately 30% of all Medicaid expenditures). As the figures shown in the following charts indicate, Florida's annual expenditures are increasing rapidly – over \$1 billion (or 65%) for hospital-related visits between FY 2003 and FY 2009 alone.

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<sup>14</sup> <http://pcpcc.net> Last accessed on 9-25-2009.

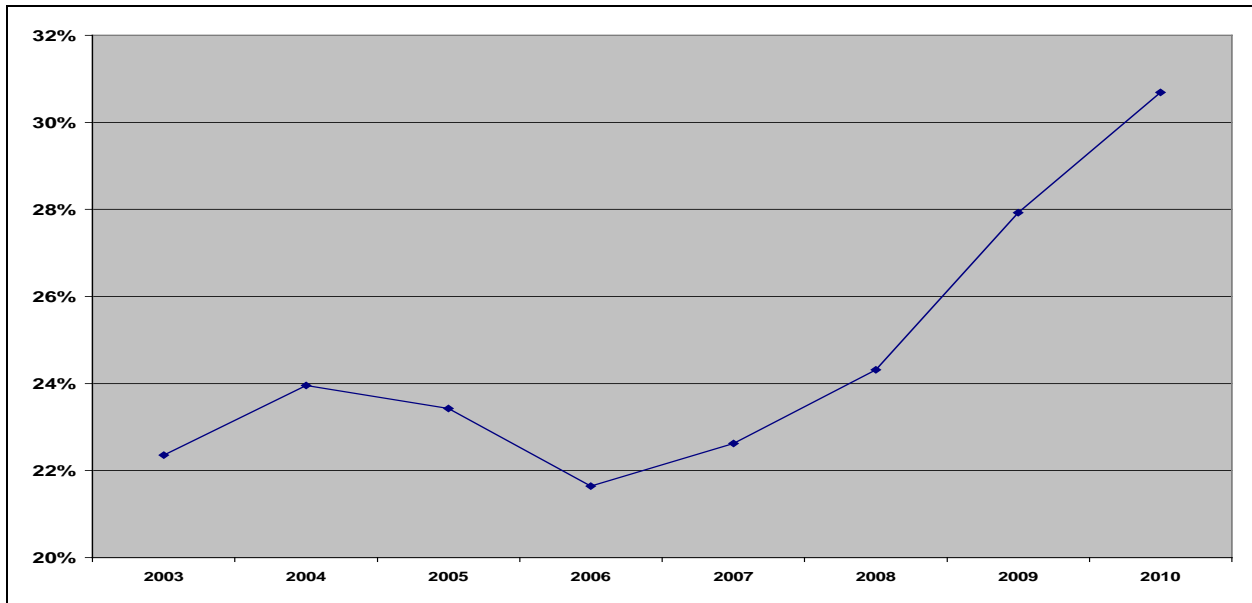
<sup>15</sup> Group Health Cooperative. “Primary Care “Medical Home” Pilot Shows That Investing in Care Pays for Itself”. June 18, 2009. <http://www.ghc.org/news/news.jhtml?repositid=/common/news/news/20090618-medicalhome.html> Last accessed on 9-25-2009.

<sup>16</sup> National Academy for State Health Policy. “Public Payer Medical Home Initiatives, State Health Policy Briefing, April 2009”. <http://pcpcc.net/content/public-payer-medical-home-initiatives> Last Accessed on 9-25-2009.

<sup>17</sup> <http://www.aafp.org/online/en/home/membership/initiatives/pcmh/aafpleads/chapterpcmh.html#Parsys1211> Last accessed on 9-25-2009.

<sup>18</sup> Healthcare Financial Management Association. “The Medical Home Model”. [http://www.hfma.org/publications/business\\_caring\\_newsletter/archives/The+Medical+Home+Model.htm](http://www.hfma.org/publications/business_caring_newsletter/archives/The+Medical+Home+Model.htm) Last accessed on 9-26-2009.

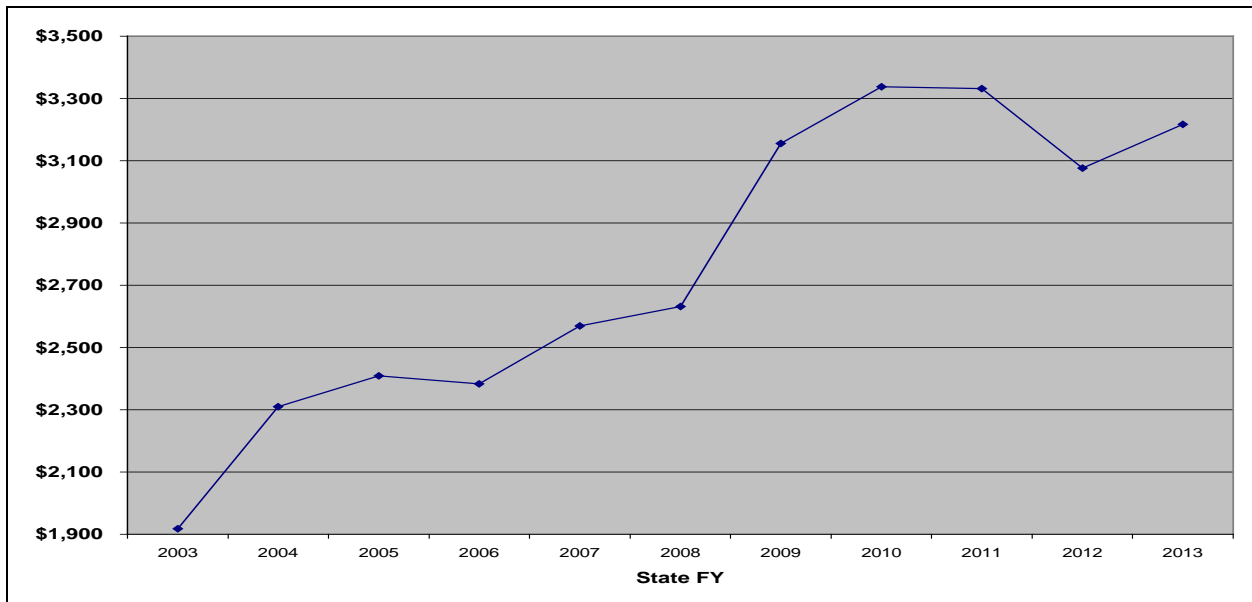
## Percentage of Total Florida State Revenues Consumed by Medicaid Expenditures



Source: Florida Office of Economic and Demographic Research, Revenue Estimating and Social Services Conference(s) and FACHC  
 \*NOTE: FY 2010 figures are estimated.

By implementing a PCMH program, Florida will be presented with the opportunity to slow the growth rate of the cost per Medicaid enrollee, while enhancing access to the state's most vulnerable populations – those that are either uninsured, underinsured, or individuals in the federal and state health insurance plans (Medicare/Medicaid). An AHCA study published in 2005 reported that FQHCs play a major role in reducing unnecessary emergency room costs. This study found health centers reduce unnecessary ER visits by 32 percent.<sup>19</sup>

## Florida Medicaid Hospital Inpatient/Outpatient Expenditures (Millions of Dollars)



Source: Florida Office of Economic and Demographic Research, Social Services Conference(s)  
 NOTE: FYs 2010-2013 are estimates

<sup>19</sup> Agency for Health Care Administration, 2005 Florida Emergency Department Use.  
<http://ahca.myflorida.com/Publications/forms/EmergencyDepartment.pdf>

Currently, fiscal savings for the state of Florida are not concrete. The actual results will require extensive data gathering and reporting. AHCA has been undertaking an elaborate and exhaustive effort to obtain and analyze a massive amount of health data, to be subsequently published online. This is a vital aspect to the reporting and verification of success and financial benefits for decision-makers, researchers, and citizens alike that should be integrated into a part of the implementation planning for the state’s pilot programs.

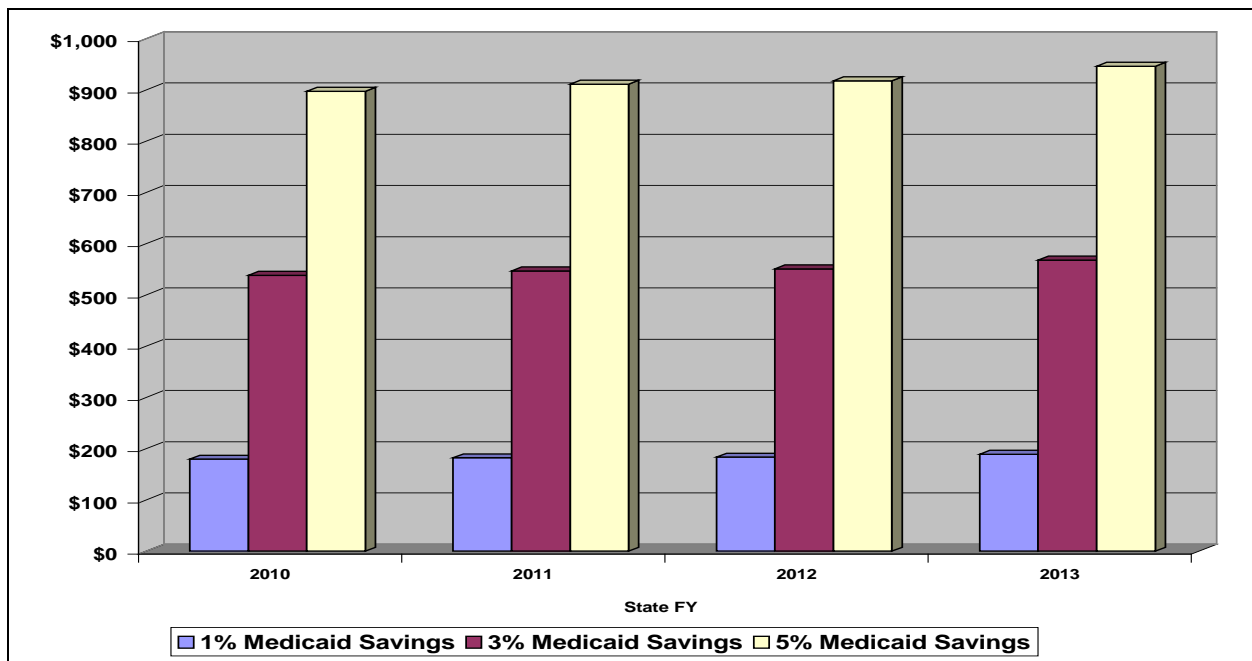
Similarly, AHCA should also be commended for the recent implementation and activation of the Florida Medicaid Health Information Network (MHIN), as it will enhance the ability of practitioners to coordinate care and accurately provide the best service(s) for individuals that opt to participate. This network will play a key role in the success of the Medical Home program and should be offered to anyone in the state that wishes to take advantage of this beneficial health technology system.

An estimate of the amount of savings that may be realized from a PCMH pilot has been drawn from various pieces of data from the Florida Office of Economic and Demographic Research (EDR) for the Florida Legislature.

Presented in the following charts are the potential savings to the state Medicaid program under the statewide implementation of a PCMH. The data used were extracted from the EDR Social Services Conference Report(s) and represent the potential savings of 1%, 3%, and 5% to both the Medicaid program in its entirety and the hospital-related Medicaid expenditures.<sup>20</sup> **As depicted in the following charts, the savings (in millions of dollars) for FY 2013 are as follows:**

	1% Savings	3% Savings	5% Savings
<b>Medicaid Total</b>	\$189.27	\$567.81	\$946.35
<b>Hospital-Related Total</b>	\$32.17	\$96.52	\$160.86

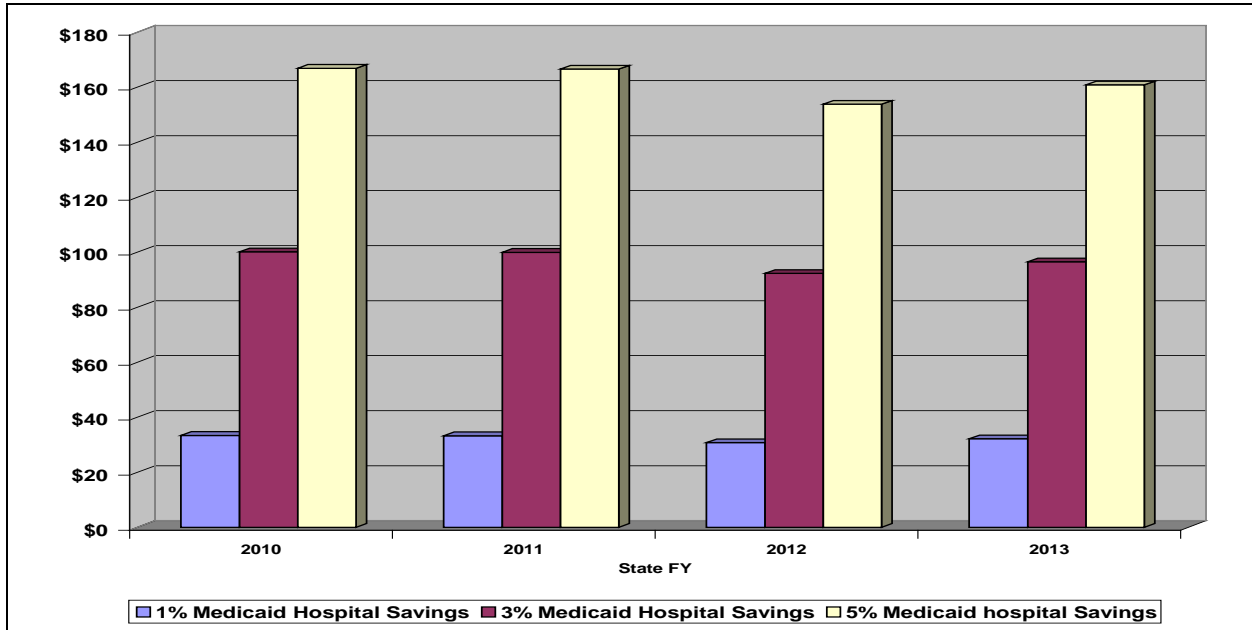
**Potential Savings in Florida Medicaid as a Result of a PCMH**  
(Millions of Dollars)



Source: Florida Office of Economic and Demographic Research (EDR), Social Services Estimating Conference; and FACHC<sup>21</sup>

<sup>20</sup> It is assumed that, upon full implementation of the PCMH model, that Medicaid patients will receive care coordination and the proper preventative and diagnostic treatments and, thus, avoid greater expenses which would otherwise be incurred in high cost settings (ER and inpatient)

## Potential Savings in Florida from PCMH Hospital Diversion Programs (Millions of Dollars)



Source: Florida Office of Economic and Demographic Research (EDR), Social Services Estimating Conference; and FACHC

### Concluding Thoughts: Will Florida Overcome its Medicaid Complications?

The question remains as to whether Florida will utilize the innovative tools – such as the PCMH model – in an effort to improve health care outcomes and ensure the success of Florida’s move into the 21<sup>st</sup> century. Recent improvements and decisions made by the State Legislature and AHCA are showing positive signs for Florida’s most needy residents. Data from throughout the nation and in this report provide hope for those working towards the ultimate goal of providing the highest quality care for the best price.

A critical issue not addressed in this report is the serious shortage of primary care workforce in Florida. The number of family medicine residency graduates each year is less than the number of retiring family physicians in Florida – and completely inadequate for projected population growth and aging. Internal medicine residency graduates now enter primary care at a rate of less than 10 percent and similar low rates are occurring in pediatric residency graduates. Florida has provided funding for three new medical schools in recent years, but has not opened more residency training positions (and, in particular, primary care residency training positions). As a result, many graduating medical students will be forced to move out of state upon graduation – few of which will return. Legislative action will be required to correct this imbalance.

The budgetary success of a PCMH is predicated upon the great majority of Medicaid patients being able to have definitive treatment of their problems at the time of their visit, without extensive testing and referral to other providers. This requires a knowledge and skill level of a residency-trained PCP as a leader of the PCMH team. Mid level providers without close physician coordination will not be able to realize this efficiency.

However, since primary care specialties – as a group – have professional salaries less than 50 percent of other medical specialties, the number of medical students choosing training in primary care has been decreasing for more than 5 years. Providing better primary care incomes in a PCMH setting (better pay for better value) has the hope of reversing this trend, but requires political will to accomplish. Florida Statutes have loan repayment programs for primary care physicians, but are in need of funding.

It will be vital to invest adequate payment into PCMH projects to incent PCPs to participate. The North Carolina model has been successful in recruiting most PCPs in each locale because Medicaid fees are close to Medicare fees. In Florida, Medicaid fees are 57 percent of Medicare reimbursement (not withstanding stimulus funds) and a marked inhibition to physician participation. It is strongly recommended that PCMH pilot projects in Florida Medicaid begin on a small scale with market-level physician fees, as well as enhanced revenue for added services and value.

The pilot projects should determine whether efficiency and cost avoidance overall are equal to the extra funding of the PMCH, as described above. Assuming a positive or neutral fiscal result, progressive Medical PCMH rollout could then be implemented throughout the state. This would be a win for the patient (better care), a win for the PCP (better pay), and a win for Florida's budget (less cost). Only time will tell if Florida will excel where others have succeeded, but – regardless of the ultimate outcome – it can be assured that those patients receiving care via this program will be better off and healthier, thereby saving countless dollars for Florida and her taxpayers.

### **Important 2008-2009 developments concerning MHs included:**

- The National Committee for Quality Assurance released Physician Practice Connections®–Patient-Centered MH (PPC-PCMH™), a set of voluntary standards for the recognition of physician practices as MHs.
- The New England Journal of Medicine published recommendations for the success of MHs that included increased sharing of information across health care providers, the broadening of performance measures, and the establishment of payment systems that share savings with the physicians involved.
- Guidance for patients and providers on operationalizing the Joint Principles was made available.
- The American Medical Association expressed support for the Joint Principles.
- A coalition of "consumer, labor and health care advocacy groups" released nine principles that "allow for evaluation of the MH concept from a patient perspective."
- Initial findings of a MH national demonstration project of the American Academy of Family Physicians were made available in 2009. A final report on the project, which began in 2006 at 36 sites, will be published in 2010.
- By 2009, 44 states and the District of Columbia have passed over 330 laws and/or have PCMH activity.

Florida might consider different approaches to its medical home projects. The FPCC suggests that pilots could be drawn up in three different ways:

- (1) ***Chronic Care Model Pilots*** – This model shall focus on smaller physician practices. Primary care providers shall work with payers and providers to identify various disease states. Through the collaborative effort of the primary care provider and the payers and providers, programs shall be developed to improve management of agreed upon conditions of the patient. Through this model, the primary care provider may utilize current practices of multi-payer workgroups. These groups shall be comprised of the medical directors of the major health care payers and the state payers along with medical providers and others.
- (2) ***Individual Medical Homes Pilots*** – These pilots shall focus on larger physician practices. They shall seek certification from the National Committee on Quality Assurance. That initial certification will be Level I certification. This would be granted by virtue of certifying the provider is in the process of attaining certification and currently have met provisional standards as set by the National Committee on Quality Assurance. This provisional certification lasts only one year with no renewal option.

**(3) Community-Centered Medical Home Pilots** – This approach shall link primary care practices with community health teams, which would grow out of the current structure in place for federally qualified health centers. The community health teams shall include social and mental health workers, nurse practitioners, care coordinators and community health workers, a majority of whom currently operate in community hospitals, home health agencies and other settings. These pilots shall identify these resources as a separate team to collaborate with the primary care practices. The teams would focus on primary prevention –such as smoking cessation programs and wellness interventions, as well as working with the primary care practices to manage patients with multiple chronic conditions.

Within this pilot all health care organizations are connected and share resources. Citizens can enter the system of care from any point and receive the most appropriate level of care or be directed to the most appropriate care. Any financial incentives in this model would involve all health care payers and could be used to encourage collaboration between primary care practices and the community health teams.

## **Florida Medical Home Pilots**

There are still a significant number of counties that do not have managed care. In fact, only 37 counties have Medicaid HMOs. The Agency for Health Care Administration (AHCA) reports that of the nearly 2.7 million patients currently covered by Medicaid, over 530,000 are in MediPass and nearly 860,000 are fee-for-service (FFS). It would be impractical to commit to covering all MediPass patients through a medical home model while also providing for infrastructure and capital growth to take on the additional patients.

Federally Qualified Health Centers (FQHCs) and County Health Departments (CHDs) currently serve a large portion of the MediPass patients, as they operate in many of the counties where there are no managed care organization. It is the intent of this recommended pilot to show that a strong primary care based system, anchored with a medical home for all patients, has the ability to significantly reduce the growth in health care spending in the state – which is essential to strengthening our system of care.

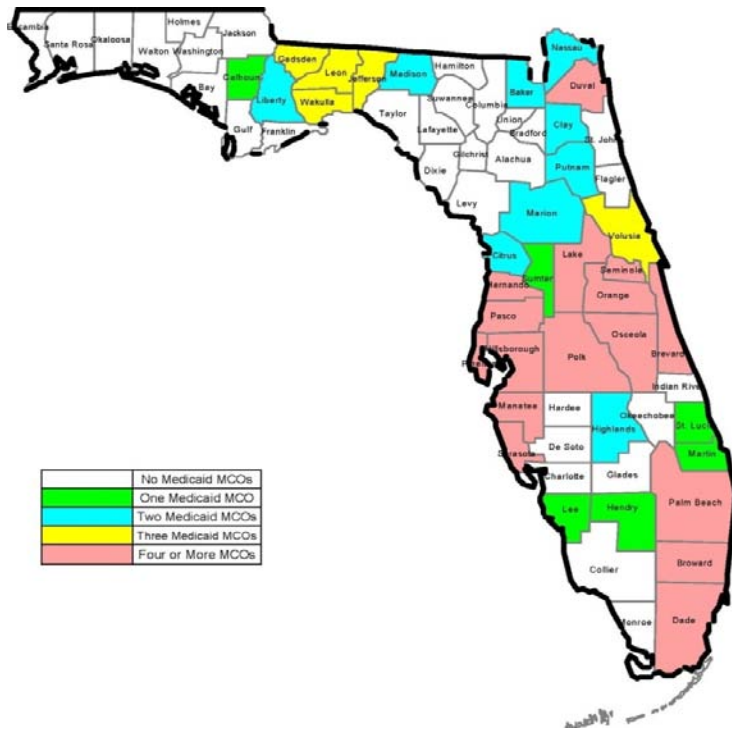
The Florida Primary Care Coalition (established by FACHC, FAFP, and FOMA) proposes three medical home pilot programs be adopted under the criteria addressed in this document:

- 1) A Northern pilot (which will include Alachua, Citrus, Clay, Marion, Putnam, and Sumter) would provide primary care for over 53,000 Floridians;
- 2) A Southern pilot (which will include Charlotte, Desoto, Glades, Hardee, Hendry, Highlands, Lee, Martin, Okeechobee, and St. Lucie) would provide primary care for nearly 74,000 Floridians; and
- 3) A Western pilot (which will include Escambia and Santa Rosa) would provide primary care for close to 34,000 Floridians.

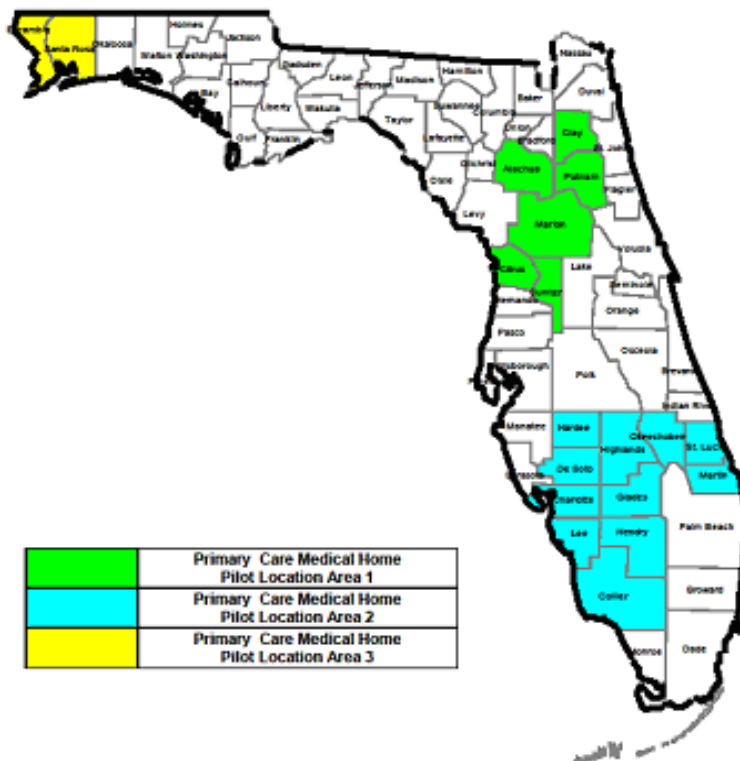
A potential fourth, or Central, pilot that may be considered would include Hillsborough, Hernando, Pasco, Pinellas, Manatee, and Sarasota. The two areas recommended have minimal or (in most of these counties) no managed care penetration with which to compete. A number of state resources are already in place in these two areas to assist in building a strong primary care system.

All MediPass patients in the pilot counties will be transitioned towards medical homes with primary care providers that meet minimum criteria for Tier 1, Tier 2, or Tier 3 providers in that county (please see Appendix A for Tier details). Providers will apply to AHCA for Medical Home Tier 1, 2, or 3 status and be approved for the appropriate incentivized reimbursement rates upon approval. Patients that are not currently with a provider who meets the criteria will be redirected to a medical home provider –such as the FQHC in that area. Patients already served in a medical home will not be affected.

### Florida Medicaid Penetration Chart



### Medical Home Pilot Project Areas



NCQA criteria will be the standard to which care delivery shall be measured. Measuring and reporting health care quality requires a complex combination of scientific rigor and technical competence in identifying suitable performance metrics, data collection processes, and statistical analysis. It is recommended that a group of professionals be assembled that will work towards the determination of the performance measurement system's intricacies in relation to Florida's current medical system, in direct correlation to NCQA standards and guidelines for PCMH certification.

There are five steps detailed by the NCQA that must be undertaken by the proposed oversight group in order to successfully implement the NCQA standards in Florida's PCMH pilots. These steps include:

**Choice of Measures:** A team of performance measurement specialists should be convened to determine which of the measurements proposed by the NCQA would be best for Florida and how, if at all, these measures must be adapted to the current environment. It is imperative that several factors be considered when choosing measures. These factors include determining the ultimate goal of each measurement, how the measurement(s) will be used, and how many are needed.

**Consensus-Building Processes:** Potentially the most vital step other than the choice in measurements is the necessity of developing a consensus of the selected performance measures. Building support for a measurement program begins with choosing measures that have been developed and/or vetted via a transparent, consensus-based process that allows for public comment.

**Data Collection and Verification:** There must be a location to which applicants for PCMH certification can submit their data and an entity that is responsible for reviewing and verifying these data. It is essential that these data be uniform and have the ability to be compared across PCMHs. Based on its experience and processes, NCQA may serve as an illustration of a system Florida will wish to replicate. However, should the Legislature choose to entrust the measurement oversight to the NCQA, it should be required that an entity, such as AHCA be included as a key player and included in data and information sharing, as Florida's taxpayers should have a significant level of accountability included in the measurement program that will result in a significant amount of funds being distributed to Primary Care Providers via incentives and increased reimbursements.

1. **Pilot testing of measures**
2. **Sample size determination**
3. **Data transmission**
4. **Verification**

**Data Analysis and Reporting:** It is helpful to initially create mock tables that array sample data in the desired format. Following completion of descriptive analysis, additional analyses to better understand performance variation, trends and associations should be conducted. Such analysis can assist in identifying underlying performance trends and explanations (e.g., performance differences by region, patient age or socio-economic status, correlation of targeted clinical processes or outcomes with organizational or other variables) and might subsequently inform quality improvement activities tailored to the issues uncovered through exploratory data analysis.

**Measure Maintenance:** After performance measurements have been developed, tested, vetted via consensus approval, and have been deployed, it is essential that they be maintained, updated, and improved on an annual basis. Critical elements of this activity include updating and refining data element specifications and collection rules, as well as the periodic, in-depth, and ad-hoc evaluation of the merits of the performance measure.

## APPENDIX A: Proposed Tiered System

- **Tier 1: Basic Practice** (Traditional provider)
  - Must supply all medically necessary primary and preventive services for patients
  - Maintains system to track: Patient meds, test results, referrals
  - NCQA certification is not mandatory
  - Collection and submission of Encounter Data required
  - E-Prescribing required
  - Individual/family support and education materials (e.g. pamphlets, website links, etc.) provided to enhance Behavioral Medicinal Outcomes (e.g. smoking cessation and health eating habits)
  
- **Tier 2: Mid-Level or Beginner Medical Home**
  - Must supply all medically necessary primary and preventive services for patients
  - Maintains system to track: Patient meds, test results, referrals
  - 24/7 response line not mandatory
  - NCQA certification is not mandatory
  - Collection and submission of Encounter Data required
  - E-Prescribing required
  - Individual/family support and education materials (e.g. pamphlets, website links, etc.) provided to enhance Behavioral Medicinal Outcomes (e.g. smoking cessation and health eating habits)
  - Designs and provides written copies of plan to implement and maintain Primary Care Provider Medical Home to oversight agency
  - Keeps open slots available in daily schedule (morning **and** afternoon) to allow for emergency/urgent care visitations by patients as an Emergency Room diversion
  - Makes an honest effort to maintain up to date information on individual patients' procedures, tests, medications, etc. that may not fall within their coordinated care network, but may be retrieved from a proposed data warehouse housed within the agency
  - Multiple interaction points between Primary Care Provider and patient (email, scheduled and unscheduled mailings, phone calls)
  
- **Tier 3: Full Scale Medical Home**
  - Must supply all medically necessary primary and preventive services for patients
  - Maintains a full time practice of no less than 30 scheduled hours per week
  - Maintains system to track: Patient meds, test results, referrals
  - 24/7 response line is mandatory

- Acceptable to have a messaging system that has a guaranteed response time below 30 minutes.
- Must have NCQA certification
  - Also, regularly self-assesses, based upon national benchmarks, standards, and guidelines to ensure a continuous improvement in the quality or services/processes provided to patients
- Required after hours care availability
- Required team coordination; includes documentation of contact with specialist and other health disciplines that provide care for the patient other than that provided by Primary Care Provider
- Collection and submission of encounter Data required
- E-Prescribing required; including the follow-up and background investigation into current meds being taken by the patient to avoid interactions and duplications
- Individual/family support and education materials (e.g. pamphlets, website links, etc.) provided to enhance Behavioral Medicinal Outcomes (e.g. smoking cessation and health eating habits)
- Designs and provides written copies of plan to implement and maintain Primary Care Provider Medical Home to oversight agency
- Keeps open slots available in daily schedule (morning **and** afternoon) to allow for emergency/urgent care visitations by patients as an Emergency Room diversion
- Must maintain up to date information on individual patients' procedures, tests, medications, etc. that may not fall within their coordinated care network, but may be retrieved from a proposed data warehouse housed within the agency
- Multiple interaction points between Primary Care Provider and patient (email, scheduled and unscheduled mailings, phone calls)
- Post-visit follow-up
- Implements specific evidence-based clinical practice guidelines for preventative and chronic care as defined by the appropriate specialty category: e.g. AAP, AAFP, etc.
- Must provide a minimum of four hours of “after-care” per day or a sum of twenty per week
  - These hours are above and beyond the normally scheduled office hours [generally between 9 am and 5 pm].
  - Hour limitations to be set at a later date [e.g. not before 7 am or not after 9 pm]
  - Case by case analysis will be required to satisfy this requirement

## APPENDIX B: Proposed Medical Home Incentives

1. **Tiered Medicaid Reimbursement Rate Increases:** Based on the tiers provided in Appendix A, PCPs should be reimbursed at an increased rate, as determined by their PCMH status. If a PCP is qualified at the highest level and meets all standards set forth for Tier 3, then said PCP should be reimbursed at a 95% rate. The Tier 2 PCPs should be reimbursed at a rate of 80% and the Tier 1 PCPs should be reimbursed at a rate of 75%.
  - a. Tier 1 providers must move from Tier 1 to Tier 2 within 12 months in order to maintain the enhanced rate. If provider is not a Tier 2 provider by the end of that period, they will revert back to the state's base rate for Medicaid reimbursement.
  - b. Tier 2 providers will have 24 months to move from Tier 2 to Tier 3. If provider does not meet the criteria for Tier 3 at the end of the 24 month period, they will revert back to the Tier 1 Reimbursement rate.
2. **Participation in Collection, Sharing, and Coordination of EHS (Electronic Health System(s)):** As Florida is entering the next phase of the 21<sup>st</sup> century, it is imperative that medical records be kept electronically. This effort allows for a more coordinated, rapid, and – most importantly – safe health outcome for Medicaid patients. The incentives to participate in this system will be made available at the federal level, beginning in October of 2010, and should be provided at the state level as well. Each PCP should be responsible for initiating and developing an EHS, which can be tied to AHCA's FMHIN.
  - a. EHR (Electronic Health Records system): Federal guidelines for incentives are detailed on the Center for Medicare and Medicaid Services (CMS) website. This is a part of the American Recovery and Reinvestment Act of 2009 and focuses on the “meaningful use” criteria being developed by the Health IT Policy Committee in conjunction with the National Coordinator for Health Information Technology. The Recovery Act establishes a 100 percent Federal Financial Participation (FFP) for States to provide incentive payments to eligible Medicaid providers to purchase, implement, and operate (including support services and training for staff) certified EHR technology. It also provides a 90 percent FFP for State administrative expenses related to carrying out this provision.<sup>22</sup>
  - b. FMHIN (Florida Medicaid Health Information Network): The Florida Agency for Health Care Administration (AHCA) recently unveiled a Medicaid patient health information technology (HIT) network. AHCA will now be able to share amongst participating PCPs the medical history of all Florida Medicaid patients.

A collaboration of the two systems is imperative, as the EHR would collect current, real-time data and information on Medicaid patients and the AHCA FMHIN will be able to both catalogue both these data and provide a historical record.
3. **Base Coordinated Care Case Management Fee:** Each Medicaid patient for whom care is coordinated (and documented as such) will result in a fee being provided to the PCP at a flat rate per case of \$3 PMPM.
4. **Age Group Tier System:** The amount to be provided to the PCP under this tiered system should be either in addition to based fee amount or as an adjustment to the base fee amount. The tiers are determined based on patient load demographics. This aspect of the primary care preventative strategy would be more focused on younger patients and, therefore, those PCPs that see exclusively patients

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<sup>22</sup> Further information can be found at: <http://www.hhs.gov/recovery/programs/index.html#Health> and <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3466&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&> Last accessed on 12-9-09.

under the age of 18 would be provided with the greatest benefit, with descending amounts based on if the PCP sees primarily adults or a diverse age range that includes both adults and children.

5. **Emergency Room Diversion:** One of the best results of improved primary care in a MH setting is that patients remain at the PCP level and do not end up – as often – in the emergency room (ER). Upon establishment of an individual with a PCP, the PCP is then held accountable for the individual through a reduction of visitations to the ER and increases in contact with the PCP. The John Hopkins University Adjusted Clinical Group (ACG) Case-Mix System (if utilized) would add a risk factor to the calculation, enhancing fairness and equity to the system; as patient choices cannot ultimately be controlled, rather, they can be redirected. Therefore, for each encounter that can be proven to result in an ER diversion, an incentive should be provided to the PCP of an undetermined amount.

Incentivized requirements, based on the individual encounter, should include, but not be limited to:

- a. Patient Contact: If the patient sees the PCP as their first solution – not the ER – then the patient should be able to contact the PCP or the PCP’s staff to determine ER need. This can be done through a variety of methods, each of which should be accompanied by an incentive: For example:
  - i. 24/7 Availability: This option may range from providing the patient with the personal contact information of the PCP (or a member of the staff), a 24 hour hotline operated by the PCP, or an answering service that has a maximum response time of 30 minutes.
  - b. Extended Hours: A PCP can exercise an option to provide extended hours of operation to patients beyond their current daily schedule. However, there are limitations and exceptions to this option. For example, the initial hours of operation must be a minimum of eight consecutive hours between the hours of 7:00 am and 6:00 pm. Hence, any hours of operation that are “extended hours” cannot qualify as such if they fall during those hours, unless the “extended hours” are no more than 2 hours prior and/or 2 hours after that predetermined timeframe. However, to qualify as “extended hours”, the PCP must offer no less than 3 consecutive, “extra” hours in one business day, no less than 3 days per week. Weekend hours are also acceptable – and should be provided with an incentive greater than that for regular “extended hours”.
6. **Physician Inpatient Admitting & Visits:** The current landscape makes it difficult for Medicaid patients to locate and be seen by PCPs. This incentive would encourage PCPs to take in more of these individuals. PCPs will be compared to peer PCPs in a predetermined geographical or statistical area and ranked based on the percentage of patients they see that are Medicaid patients. The incentive per encounter will be based on this ranking. For example, if a PCP saw more of these patients than anyone else in the established area, this PCP may be awarded with a 15 percent addition to the proposed increased rate already provided. On the other hand, the person at the lowest end of the ranking may only receive an extra 5 percent.
7. **Generic Drug Prescribing:** Amount of incentive to be provided is based on which “quartile” of peers the PCP ranks and the number of Generic Drug Prescripts (GDPrs). Based on the number of total prescriptions written, the percentage of GDPrs is compared amongst PCPs to rank into quartiles, based on this utilization ratio (number of GDPrs compared to non-GDPrs). The predetermined fiscal incentive amount is then applied, based on the PCP’s quartile tier to the actual number of GDPrs. Specifications as to quartiles are to be determined later (e.g. 95%, 85%, 75%, 65% and below), but should reflect a significant variation of percentiles to encourage competition and compliance.

*EXAMPLE:* A PCP prescribed 100 GDPrs, which resulted in quartile ranking of Tier 2. Therefore, based on the Tiers below, this PCP would receive \$75.00 in GDPr incentive funds.

Tier 1: \$1.00/GDPr

Tier 2: \$0.75/GDPr

Tier 3: \$0.50/GDPr

Tier 4: \$0.25/GDPr

8. **E-Prescribing:** PCPs are encouraged to utilize an electronic database, monitored by the state, to enhance patient safety, coordinate efforts, collect data, and streamline process. A flat rate per prescription of \$0.50 is recommended. Therefore, if all prescriptions were electronic prescripts the PCP in the previous example would receive a total of \$125.00 (\$50 e-prescribe & \$75 GDPr).
9. **Cancer Screenings:** A variety of cancer screenings are a key in disease management and long-term cost avoidance. Examples of screenings include, but may not be limited to, cervical cancer, breast cancer, and prostate cancer. PCPs should be provided with a standard rate per screening, to be determined later, but should be no less than \$1.00.
10. **Diabetic Screenings/Preventative Measures:** Another key disease management technique is the education of both potential and current diabetic patients on the risks and successful avoidance/management methods for the disease. A flat rate per screening and/or education session between PCP and patient should be provided to the PCP. This rate, to be determined later, should be no less than \$1.00 per documented and approved meeting.
11. **EPSDT Screening (Early Periodic Screening, Diagnosis, and Treatment):** A tiered payment system per screening, based on age group would need to be developed in a fashion comparable to that found in Oklahoma's SoonerCare incentives program. The incentive amount would be based on evidence and intervention data and corresponding age groups.
12. **DTAP Screenings (Diphtheria, Tetanus, and Pertussis Immunizations):** If a PCP provides a child's 4th DTAP immunization by age 2, then they become eligible for a \$3.00 per child incentive payment.

**APPENDIX C: Outline of National Committee for Quality Assurance  
General Guidelines:  
Physician Practice Connections Patient-Centered Medical Home  
(PPC-PCMH)**

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

\*\* Minimally required to pass as a PCMH