



**BlueCross BlueShield  
of Montana**

December 23, 2014

Monica J. Lindeen, Commissioner  
Office of the Commissioner of Securities and Insurance  
840 Helena Avenue  
Helena, Montana 59601

Dear Commissioner Lindeen,

Below is a second version of the Blue Cross and Blue Shield PMCH 2015 payment notification, with additional details regarding our reporting and member attribution methodology.

In 2015, BCBSMT intends to maintain the current reimbursement structure for our Patient Centered Medical Home initiative.

Specifically, we will pay each contracted entity a PMPM participation fee for each attributed member, and a PMPM fee for chronic disease management. The diagnoses recognized for chronic disease management include: diabetes, ischemic vascular disease, hypertension, asthma, and depression. Members with more than one identified chronic disease condition will be reimbursed at a higher rate than those with a single chronic condition.

Additionally, each contracted entity will be eligible to receive a PMPY fee for achievement of quality benchmarks based on the following measures: Adult preventive services, Adult ischemic vascular disease care, Adult asthma care, Adult diabetes management, Adult Hypertension, Adult depression, Child preventative, Child asthma, and Child diabetes.

The following describes how BCBSMT will calculate and report the required utilization metrics:

**1. Method for measuring and reporting of Emergency Room Visits (ER Visits per 1,000\*)**

ER Visits per 1,000 is the average number of emergency room facility visits provided under medical coverage, per 1,000 members with medical coverage per year. The number of visits is based on the count of unique patient and service date combinations  $(ER\ Visits / (Member\ Months / 1000)) * 12$ . This calculated rate will be applied for comparison to the population consisting of the entire BCBSMT fully insured book of business, and to the population consisting of members with 7 or more months of contiguous attribution to a PCMH within a single calendar year for the reporting period.

**2. Method for measuring and reporting of Hospitalization Rates (Admits per 1,000\*)**

Admits per 1,000 is the average number of acute admissions per 1,000 members with medical coverage per year  $(Admits / (Members\ Months / 1000)) * 12$ . This calculated rate will be applied for comparison to the population consisting of the entire BCBSMT fully insured book of business, and to the population

consisting of members with 7 or more months of contiguous attribution to a PCMH within a single calendar year for the reporting period.

The following describes how BCBSMT attributes members to a PCMH entity:

- 1) PCMH is established when an approved entity notifies BCBSMT of their intent to participate, and signs an agreed upon contract.
- 2) PCMH sends BCBSMT list of participating providers **practicing** as Primary Care within the following specialty categories.
  - a. Family Practice
  - b. Internal Medicine
  - c. Internal Medicine w/ subspecialty of Endocrinology (for diabetic patients)
  - d. Pediatrics
  - e. OB/GYNs
  - f. General Practice
  - g. Nurse Practitioners and Physician Assistants practicing in one of the above specialties
- 3) Member eligibility is established based on active BCBSMT membership for the specified time period & exclusion of certain lines of business
- 4) Member qualification for participation in PCMH
  - a. Member – Provider relationship established using 2-year retrospective BCBSMT E&M claims utilization (provider type, volume, and frequency of visits)
- 5) PCMH and BCBSMT repeats the above process on a monthly basis to set agreed upon provider and patient panel for reporting and compensation purposes.

It is our intent to grow the number of BCBSMT members engaged with a contracted PCMH clinic. However, there are a large number of variables which impact the volume of members attributed to the BCBSMT PCMH program, including absolute numbers of fully insured members, potential for addition of members within self-funded programs, number of providers who choose to participate in program, and geographic dispersion of members compared to geographic location of contracted PCMH entities. Given these variables, it is not possible to provide an accurate estimate of PCMH growth in 2015.

Sincerely,



Monica E. Berner, MD  
Vice President and Chief Medical Officer