Patient-Centered Medical Home 2017 Program Performance Report

Contents

Program Headlines 2011 - 2017

The PCMH Program Has Directly Saved Over $1 Billion in Healthcare Spending, and Contributed to an Even Larger Savings of $5.5 Billion Against Historical Trends

Over $440 Million Has Been Paid Out as Additional Performance Based Payments to PCPs

Nearly 1 Million Members Have Engaged in Targeted Program Services, with over 250,000 in Clinically Directed Care Plans

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OVERVIEW AND SCOPE OF THE MODEL

Overview of the Commercial PCMH/TCCI Program

The CareFirst PCMH/TCCI Program is in its eight year of commercial region-wide operation

- Includes over 4,300 participating Primary Care Providers managing care for over 1 million CareFirst Members
- Provides financial incentives, clinical supports, and data analytics to PCPs to achieve high levels of quality care and lower total cost of care
- Manages $5.5 billion a year in total hospital, non-hospital and drug spending for Members
- Generates tens of thousands of nurse-prepared care plans per year for high risk/high cost Members.
- Has curbed CareFirst's overall medical trend to historic lows over the life of the Program
- Has decreased costly hospital admissions substantially over the life of the Program
- Has led to high levels of sustained member satisfaction that continue to rise as the Program matures

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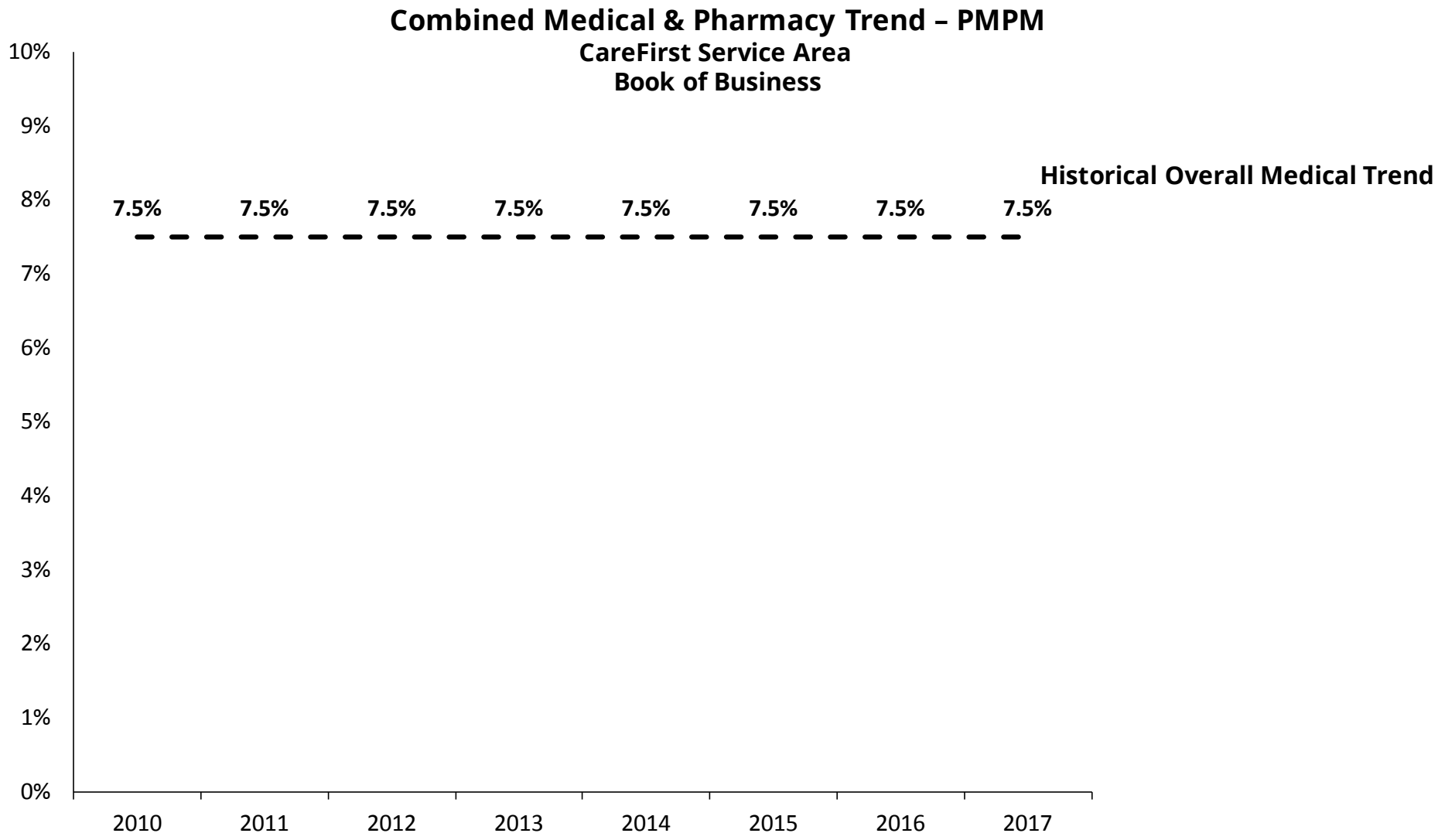
SUSTAINED FAVORABLE RESULTS (2011 – 2017)

Longest Period of Low Trend & Costs Avoided by "Bending the Curve"



Source: Medical and Cost Measures that Matter; CareFirst In-Service Area; January 2012-April 2018, Paid Through April 2018

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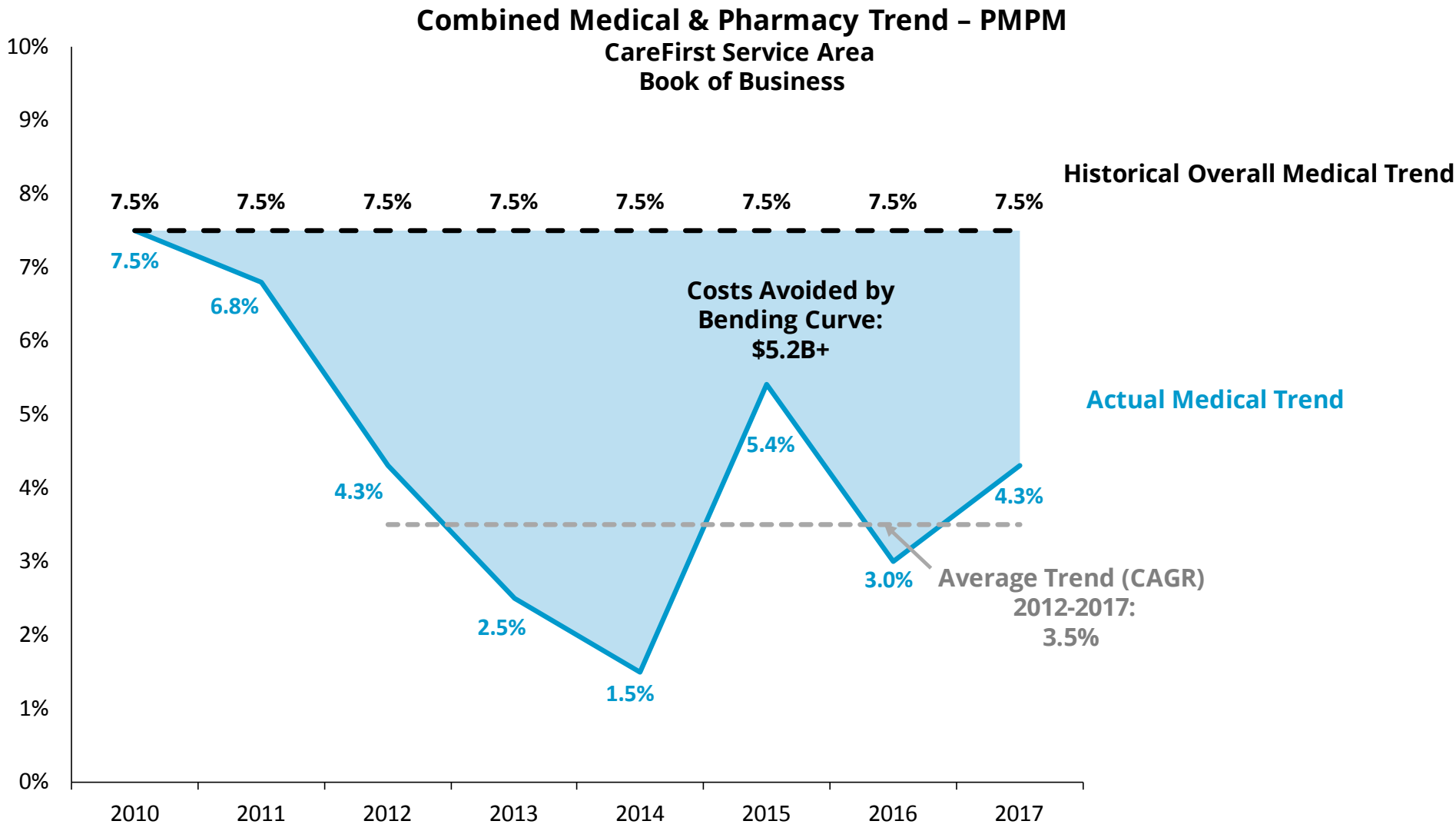

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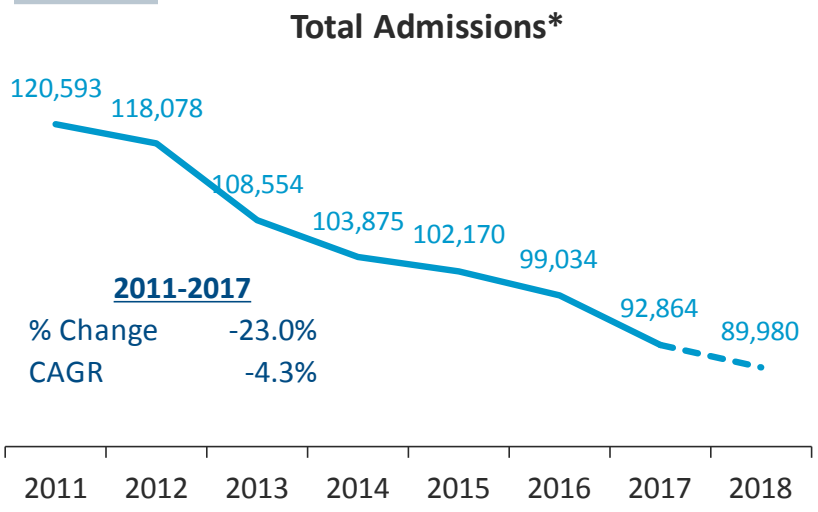
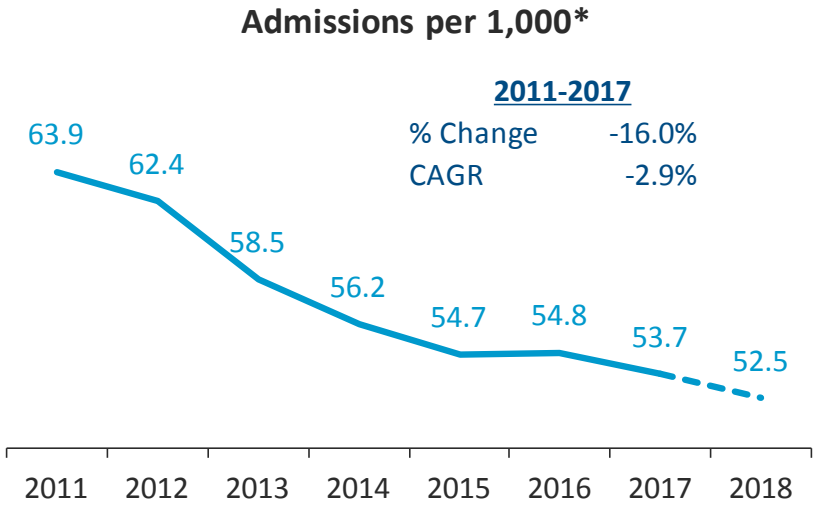
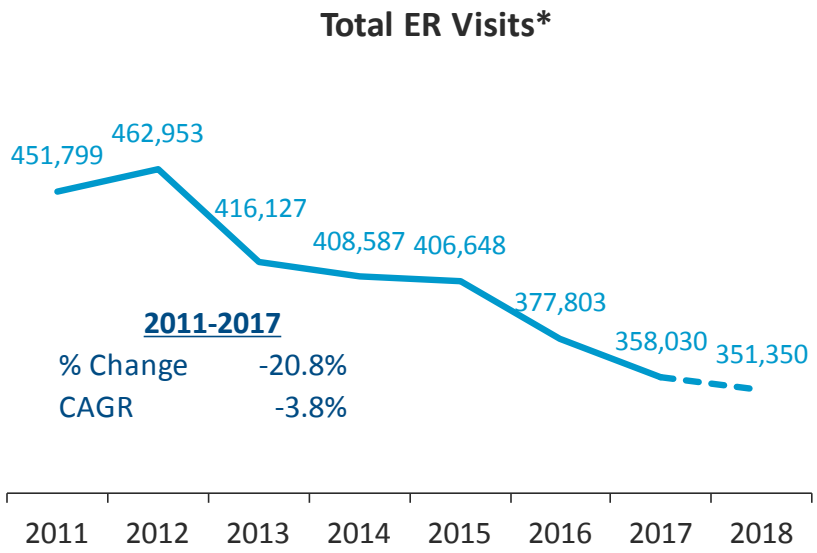
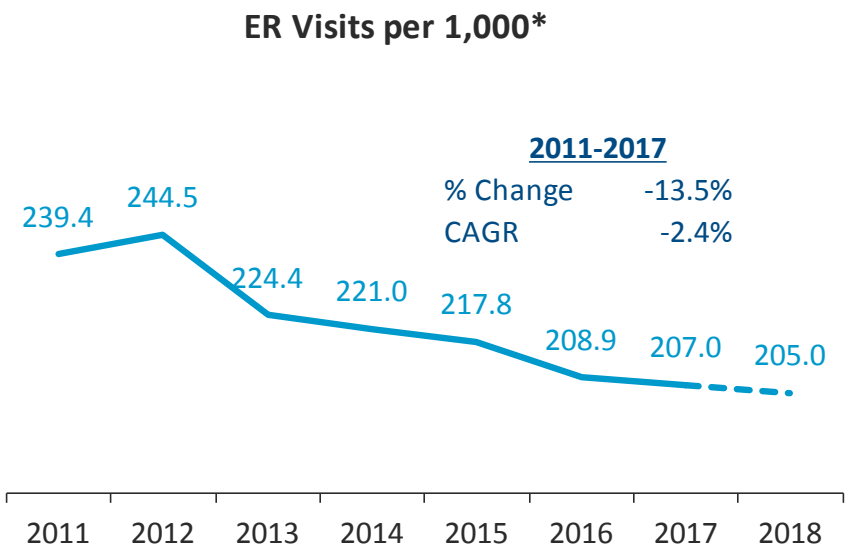
Improvements in Care Delivery and Care Cost Control: 2011-2018







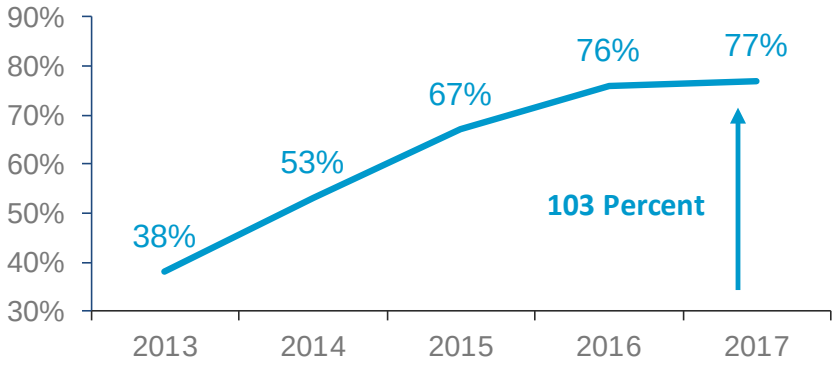


* CareFirst In-Service Area Book of Business, excluding Medicare Primary

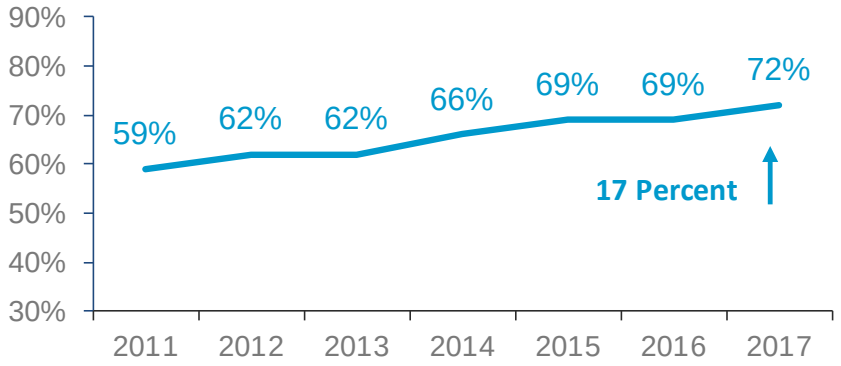
PCMH Quality Scores Steadily Improved

- The Overall Quality Score is an equally weighted average based on the value of the Engagement and Clinical Quality scores. Overall Quality has increase by 35% over 4 years.
- Beginning in 2013, Engagement Score rates across all panels have continued to improve by 19.3% each year.

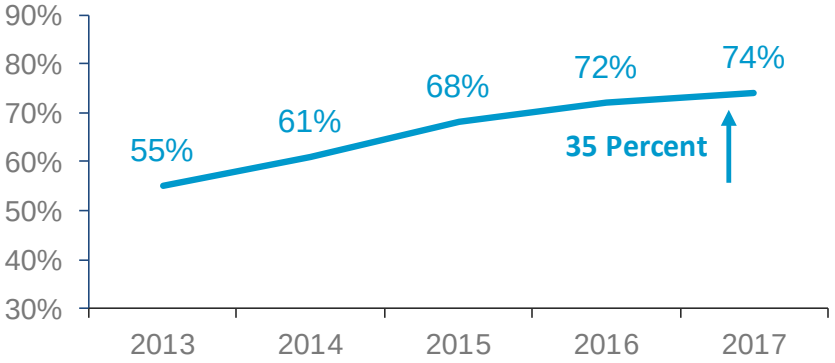
Overall Engagement Rate



Overall Clinical Measures Performance

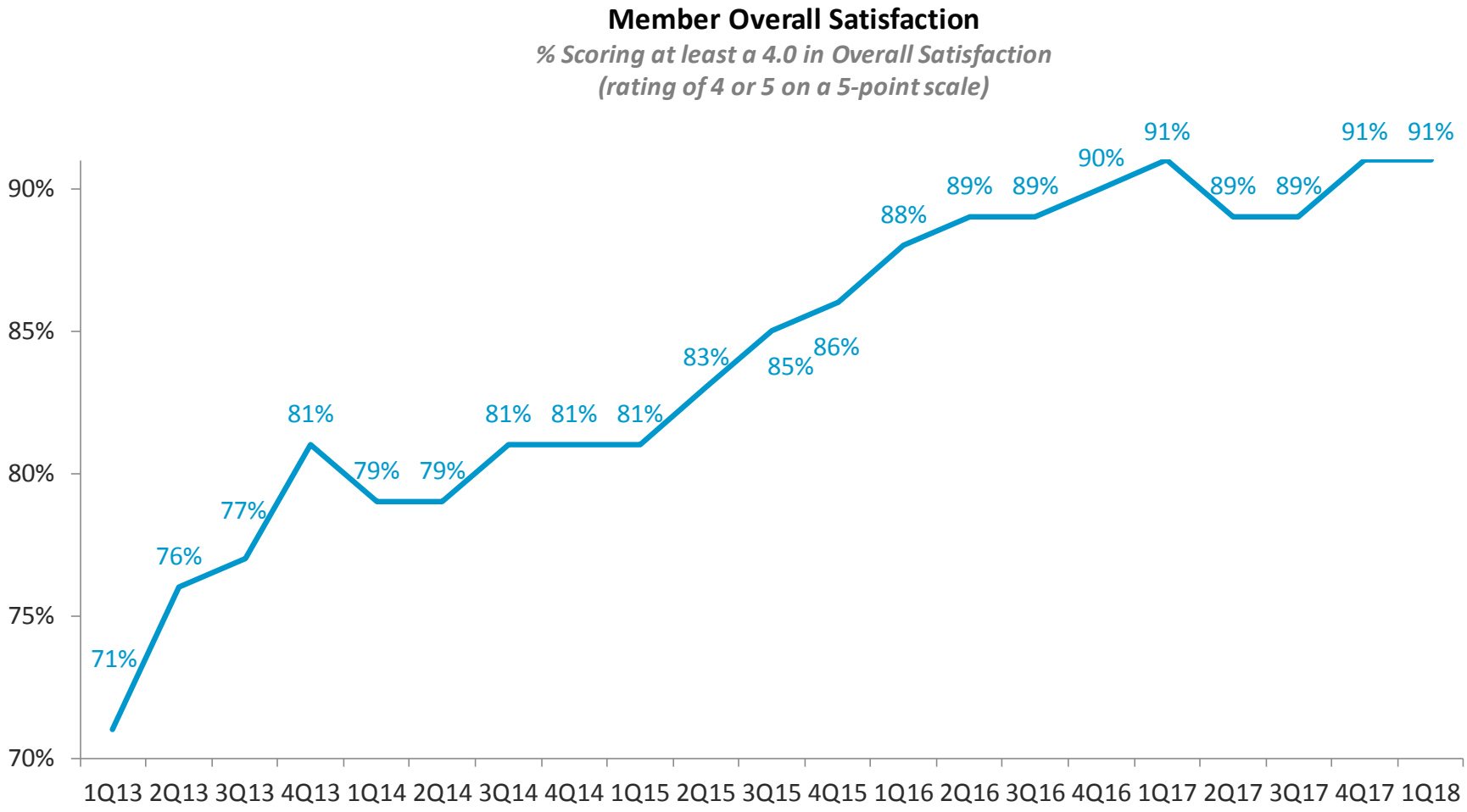


Overall Quality Score



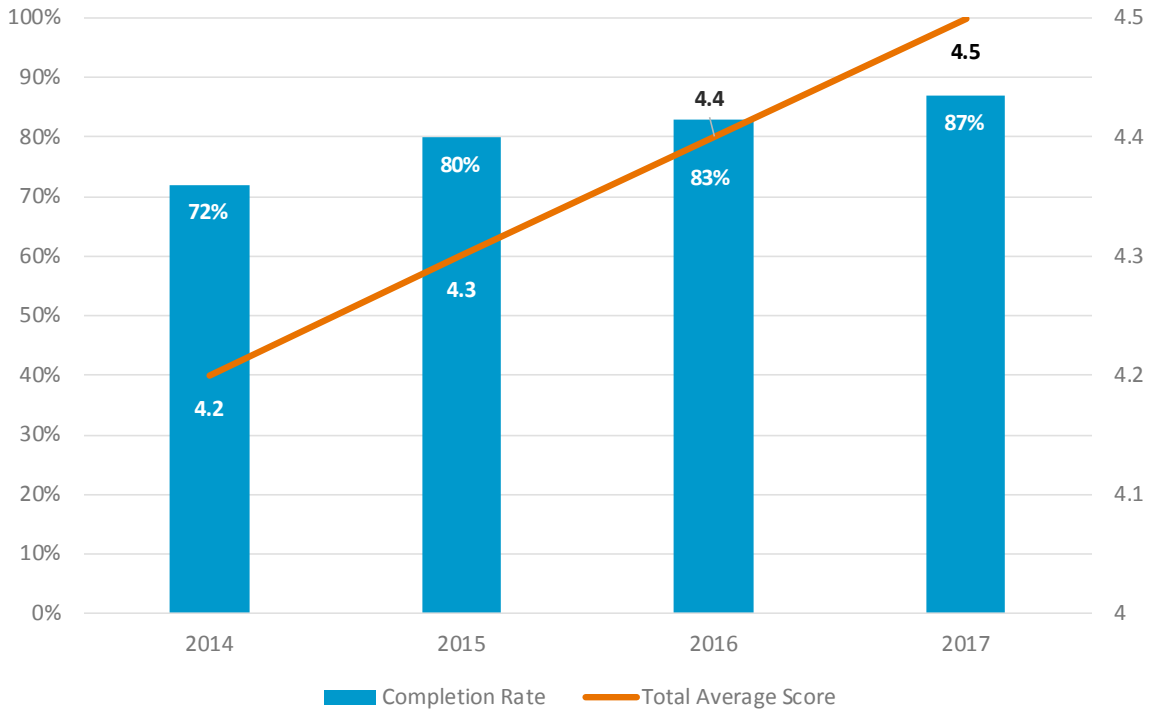
High Overall Satisfaction for Patients in Care Plans

- Ratings from Members in care plans have been very high and have risen as the Program has matured.



Member Survey Results

- Greater percentages of members are responding year-over-year with a higher level of satisfaction with over 77,000 members surveyed between 2014 and 2017
- Over 4,800 members (87%) completed the survey in the first quarter of 2018, with an average overall score of 4.5



2013 results includes an incomplete year's worth of data

Member Survey Questions

1. You understand the Care Coordination Plan, including the actions you are supposed to take

2. Your Care Coordination nurse and Care Coordination team are helpful in coordinating your care

3. Your doctor or nurse practitioner spends enough time with you

4. After starting your Care Coordination Plan, you have access to information that you need to understand and manage your health better

5. Finally, Overall, your health is more stable and better managed as a result of the Care Coordination Plan

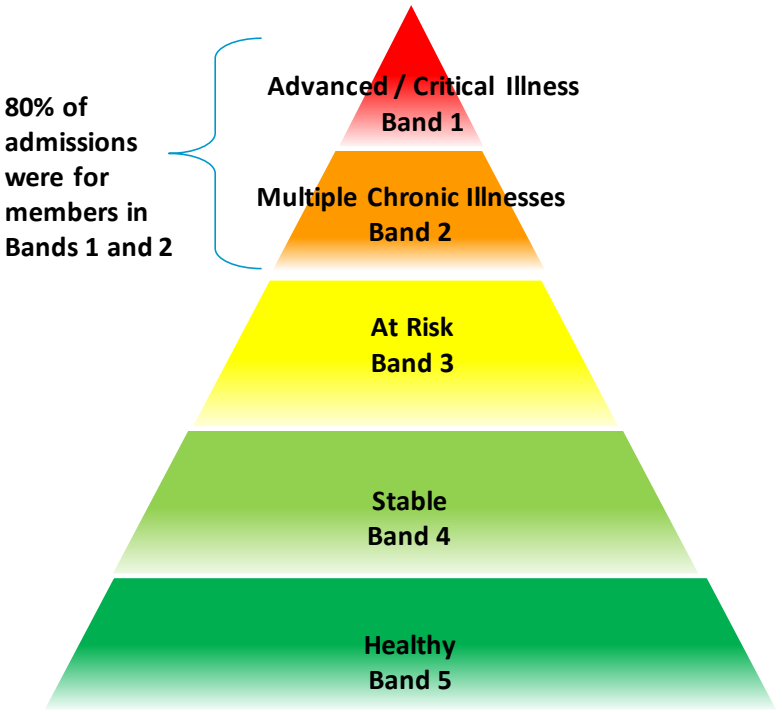
THE FACTS THAT SHAPE THE LANDSCAPE

The Experience in the CareFirst Region

- CareFirst Members account for 41% of the non-government commercially covered population in CareFirst's service area
- The region has had some of the highest hospital admission and readmission rates in the nation – that are now declining
- CareFirst customer accounts (often in the services sector) generally have generous benefit designs in the Large Group and FEP (Federal Employee Program) segments and far less generous benefits in the Individual and Small Group segments
- Prior to the start of the PCMH program in 2011, CareFirst's Overall Medical Trend (i.e. rise per Member per month) was regularly between 6% and 9% annually, averaging 7.5% in the 5 – 10 year period preceding the launch of the Program on January 1, 2011

Illness Pyramid – The Rosetta Stone
2017 CareFirst, non-Medicare Primary Population – "Population Health"

- Health care costs are concentrated at the top of the illness burden pyramid – the top two bands account for less than 13% of the population but over 60% of total costs
- PMPM cost for the sickest members (Band 1 – Advanced/Critical Illness) is more than 100 times that of the healthiest members (Band 5)

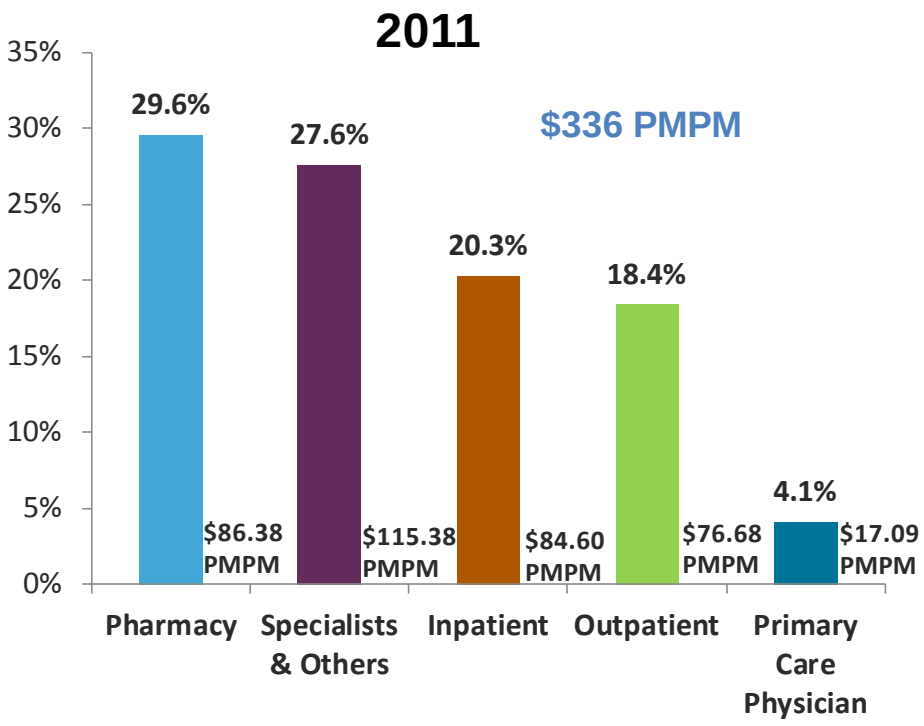


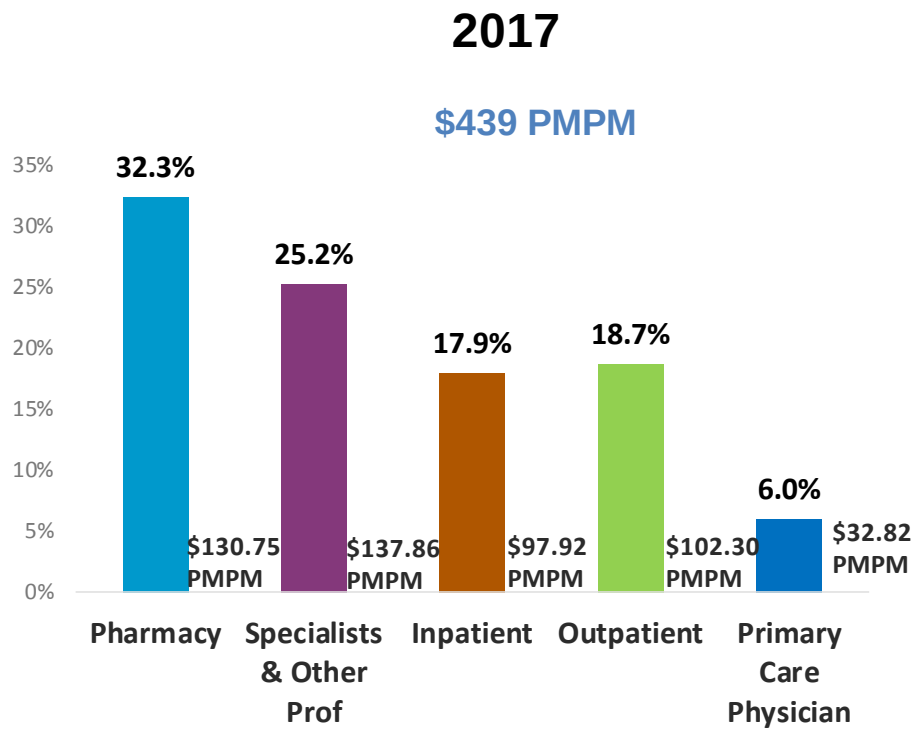
Percent of Population	Percent Of Cost	Cost PMPM	Admits Per 1,000	Readmits Per 1,000	ER Visits Per 1,000
3.0%	35.2%	$4,908	880	166	1,150
9.2%	27.2%	$1,216	218	16	585
13.0%	16.4%	$522	34	3	325
35.0%	16.9%	$199	4	0	165
39.8%	4.3%	$44	1	0	37

Data from YE 2017

Total Distribution of CareFirst Medical Payments

- Spending on prescription drugs is the largest share of the CareFirst medical dollar (including spending in both the Pharmacy and Medical portions of CareFirst benefit plans)
- This places increased focus on pharmacy care coordination and utilization





Medical spending is based on 2011 and 2017 CareFirst Book of Business. Pharmacy % is adjusted to represent typical spend for members with CareFirst's pharmacy benefit.

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THE FRAMEWORK OF THE PATIENT-CENTERED MEDICAL HOME MODEL

Without Healthcare Cost Control, Not Much Else Matters — CareFirst's PCMH Program

PCMH Five Key Characteristics

- Accountability for total cost of care
- Incentive only
- Information rich
- Behavior change based
- Uniform model

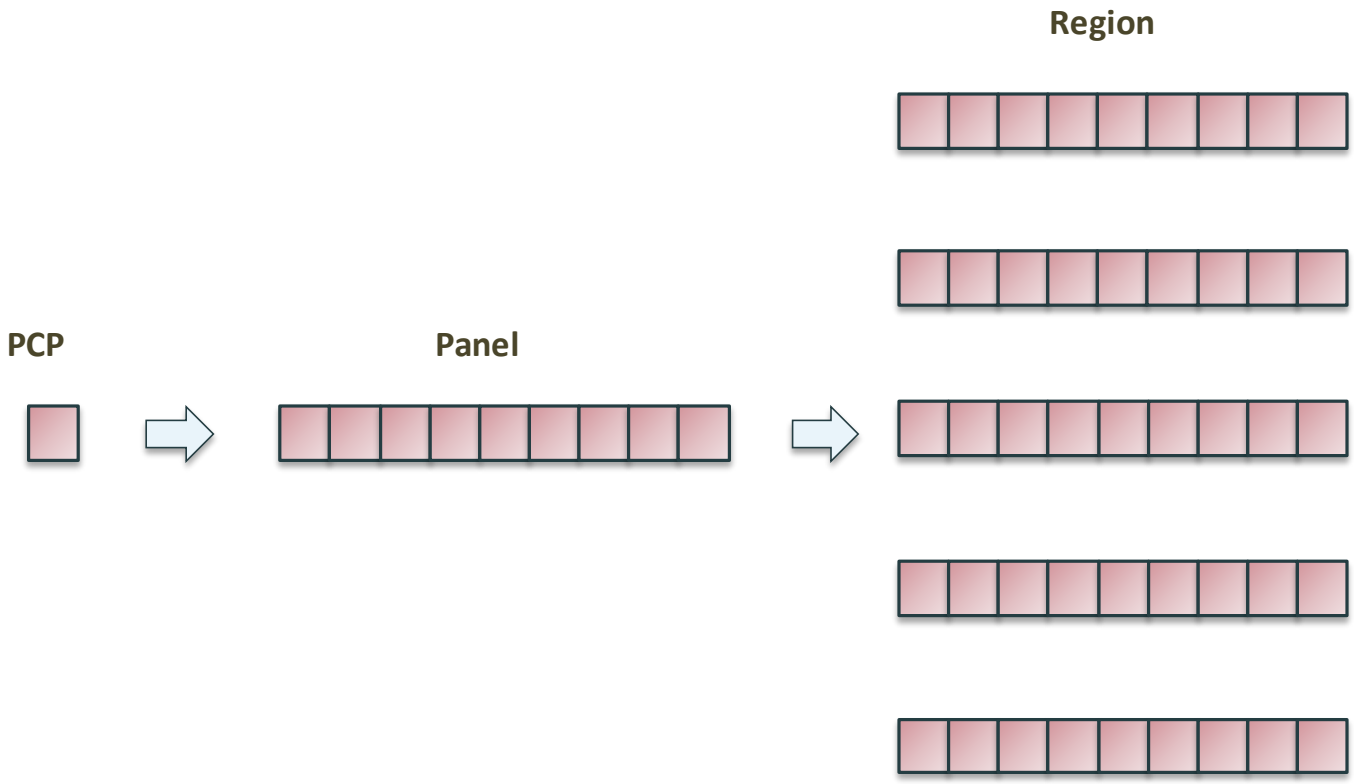
PCP Panels – Small Teams – Performance Units

Characteristics of Panels

- Average Panel Size: 10 PCPs
- The more independent the better
- The "buyers" and arrangers of all services

Roles of Panels

- Backup and coverage
- Peer review – shared data
- Pooled experience



Patient Care Account – Illustration of A Scorekeeping System for Panels

- A Patient Care Account for each Panel is set up
- All expected costs (Credits) and all actual costs (Debits) are recorded in this account

Patient Care Account

Debits (PMPM)	Credits (PMPM)
All services paid (Allowed Amount) for every line in every claim	Global projected care costs expressed as a PMPM

Credits are Calculated as Follows:

$9.0M	Base Year Costs (2010); 1.26 IB Score for 3,000 members
x 1.29	Overall Medical Trend over 6 years at 6.5%, 5.5%, 3.5%, 3.5%, 3.5, 3.5%
x 1.079	Illness Burden Adjustment 2017 vs. 2010 (1.36/1.26)
$12.5M	Performance Year Target (2017)
÷ 36,000	Member months for 3,000 members
$347	Target PMPM care costs

Patient Care Account – Illustration of One Patient for One Year

- Debits are based on actual claims paid at CareFirst's allowed amounts – shows every service ever rendered to any attributed Member by any provider at any time in any setting

Mary Smith – One Member

Debits			Credits	
1/4/2016	Primary Care Visit	$50		
1/4/2016	Vaccination	$10		
1/7/2016	Pharmacy Fill	$120	January	$347
2/4/2016	ER Visit	$700	February	$347
2/4/2016	ER Treatment	$300	March	$347
3/6/2016	Ophthalmologist Visit	$127	April	$347
4/22/2016	Orthopedic Visit	$257	May	$347
4/25/2016	Pharmacy Fill	$120	June	$347
4/25/2016	Physical Therapy	$22	July	$347
5/5/2016	Physical Therapy	$22	August	$347
7/10/2016	Pharmacy Fill	$120	September	$347
8/22/2016	Dermatologist Visit	$300	October	$347
8/23/2016	Pathology Test	$50	November	$347
10/15/2016	Outpatient Hospital Visit	$1,448	December	$347

$12,500,000 per year in global cost, divided by 36,000 member months = $347 PMPM

Total Debits: $3,646

Total Credits: $4,164

Patient Care Account – Illustration of One Panel for One Year

- All Debits and Credits are compared monthly and at the end of each Performance Year after 3 months claims run-out
- Savings are converted to bonuses/incentives that are paid as fee increases
- Panels are partially protected from catastrophic cases by a $85,000 "stop loss" point

XYZ Family Practice Group (10 PCPs)

Debits		Credits	
Primary Care	$774,060	Mary Smith	$4,164
Inpatient Care	$2,967,230	John Doe	$4,164
Outpatient Care	$3,354,260	Jane Richards	$4,164
Specialist Care	$2,451,190	Bob Jones	$4,164
Ancillary Care	$1,290,100	Steve Patel	$4,164
Prescription Drugs	$2,064,160		

List of Members continues to a total of 3,000 attributed to this panel.

Savings From Expected Cost: $503,000

Total Debits: $12,101,000 **Total Credits: $12,492,000**

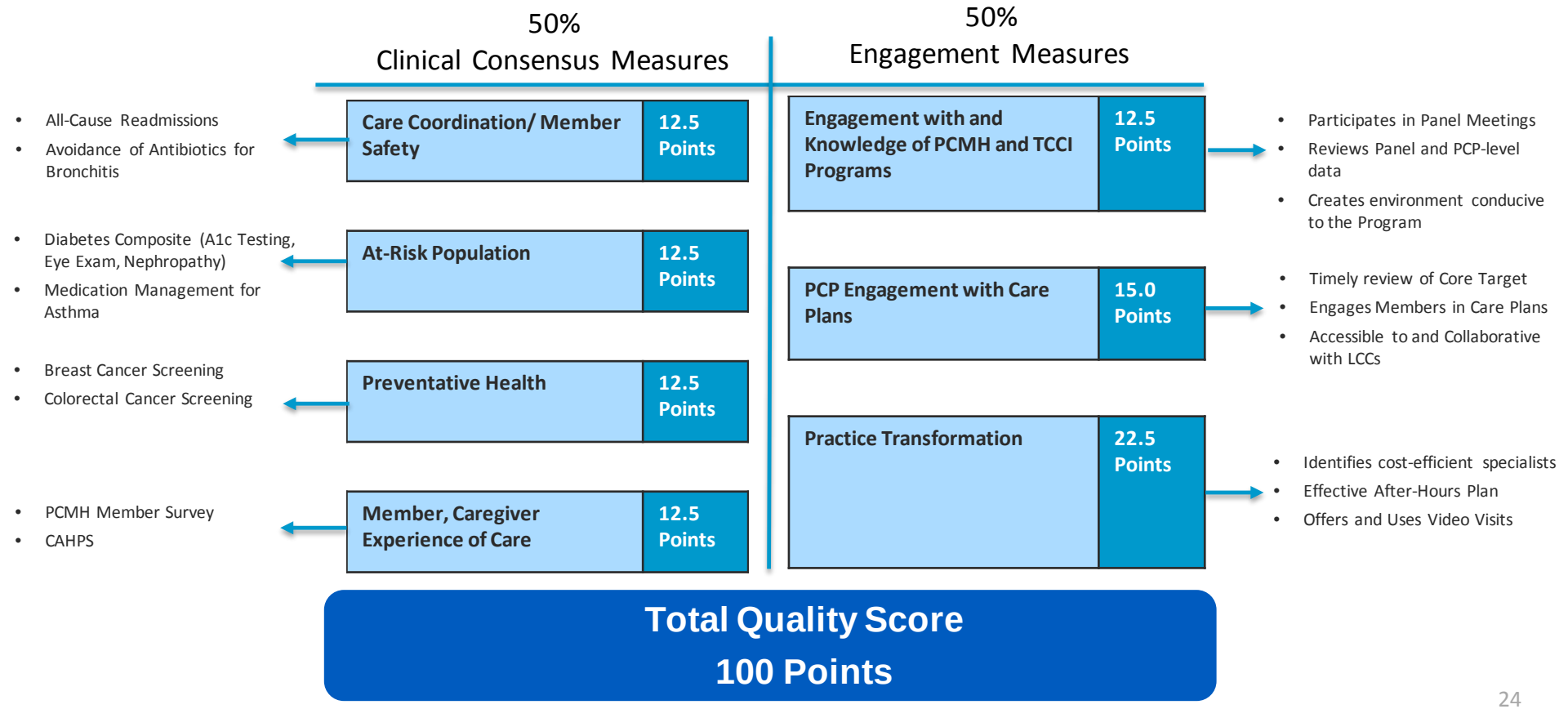
* 80% of Claims in excess of $85,000: ($112,000)

Net Debits: $11,989,000

Note: In any panel, month to month fluctuations in Membership occur - Member month counts above reflect this.

Quality Scorecard - 2017

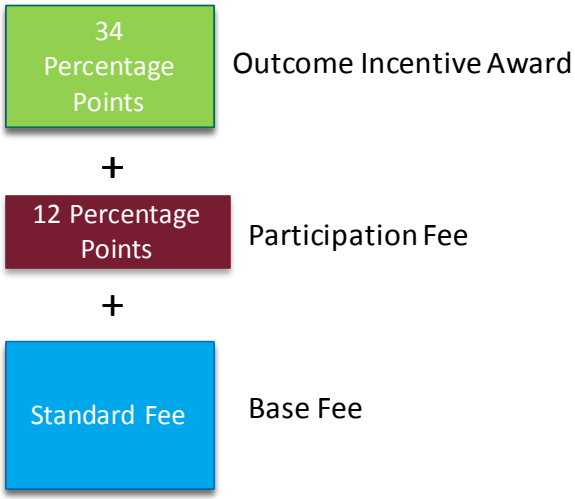
- Quality is measured in two components: Clinical Measures and Engagement – Both have equal weight on an 100 point scale
- An equal weight is placed on Panel Engagement/Practice Transformation as on Clinical Measures
- Panels must score a minimum 35 of 50 Engagement points to earn an OIA
- Clinical Measures are those established by CMS as "consensus measures" with commercial payers



OIA Awards are at the Intersection of Savings and Quality

OIA Awards: Degree of Savings

EXAMPLE: PCP PERCENTAGE POINT FEE INCREASE: YEAR 1					
QUALITY SCORE	SAVINGS LEVELS				
	10%	8%	6%	4%	2%
80	67	53	40	27	13
60	56	45	34	23	11
40	46	37	28	18	9



Persistency Increases In OIAs

Program rewards *consistent* strong performance

Panels who earn an OIA for

- 2 Consecutive Years = OIA increased by 10%
- 3 Consecutive Years = OIA increased by 20%

Persistency Awards recognize sustained results and incents Panels not to under serve their patients in seeking results

Continuing Growth of the Program

- The number of PCPs and Panels has grown steadily along with the global cost of care they coordinate and manage
- Nearly 90% of eligible PCPs in the region now participate

Year	Panels*	Global Cost of Care
2011	180	$1.7B
2012	283	$2.5B
2013	402	$3.6B
2014	424	$4.0B
2015	408	$4.5B
2016	432	$5.0B
2017	430	$5.5B

*Panel totals are averaged throughout the year

Current State of Panels, Providers & Members

- CareFirst categorizes Panels into four types as shown below
- Approximately 75% of PCPs practice outside of a large health system

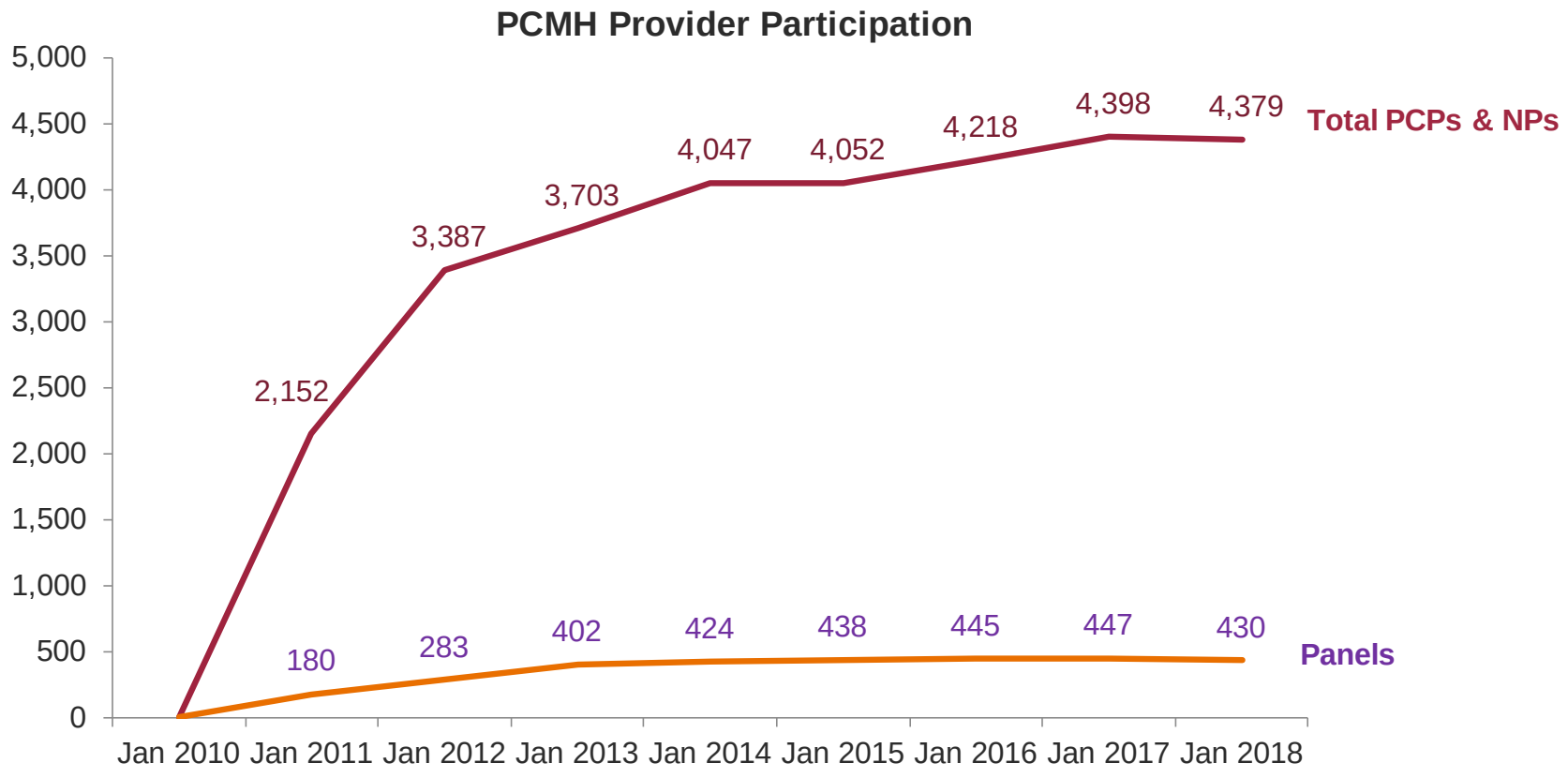
Panel Types

Panel Type	Panels	Providers	Providers/ Panel	Members	Members/ Panel
Single Panel Virtual	145	1,306	9.0	331,186	2,284
Single Panel Independent	62	636	10.3	174,356	2,780
Multi Panel Independent	98	1,021	10.4	233,939	2,387
Multi Panel Health System	125	1,276	10.2	324,876	2,599
Year End 2017	**430**	**4,239**	**9.9**	**1,062,356**	**2,471**

PCPs in non-viable panels excluded

Provider Growth in the Program

- Provider's participation in CareFirst's TCCI/PCMH program continued to grow in 2017
  - 4,379 providers in 430 Panels participate as of January 2018
  - Likely reached saturation point
  - Largest network and member enrollment in a single uniform program model in the United States



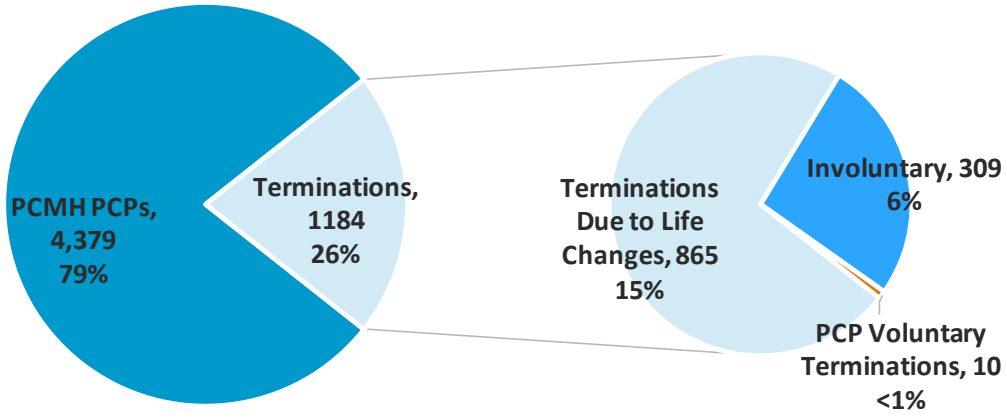
PCMH Program Has Been Remarkably Stable – Despite "Swirl" of Activity from Hospitals, Government

Program Stability

- PCMH program has been remarkably stable
- Less than 1% of PCPs have left the Program due to dissatisfaction
- The vast majority of terminations (80%) reflect life changes: retirement, stopped practicing as a PCP, moved out of area
  - Remainder were initiated by CareFirst due to a lack of engagement by the PCP/Panel
  - Of PCP terminations for lack of engagement, 5% later returned to the Program.

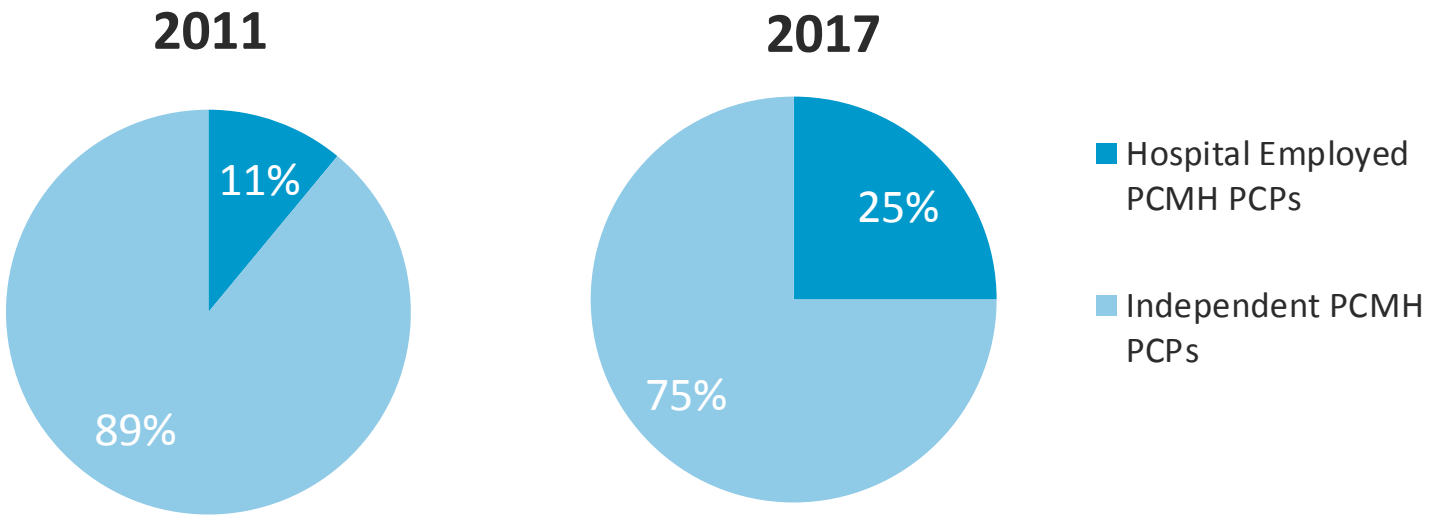
Panel Stability

- Panels have also remained remarkably stable over seven years with few undergoing a "substantial change" [defined as 50% change in PCPs and 5% change in base PMPM].
  - Only 52 Panels (12%) have met the threshold for substantial change since inception:



Employed vs. Independent PCPs – Goal: Maintain Independence

- Within the CareFirst service area, PCPs (as well as Specialists) are joining larger group practices or hospital-owned practices (i.e., MedStar, Johns Hopkins, LifeBridge, Inova, etc)
- Recent national reports suggest 53% of physicians are employed by a health system
- Consolidation is often due to the lack of attractive economics in operating smaller practices and the promise of better security and a better financial position in a large system
- Hospital-owned PCP practices typically require referral within the hospital's system
- Since the launch of the CareFirst PCMH Program, hospital employed PCMH PCPs have increased from 11% in 2011 to 25% in 2017 – still well below national average



Source: PCMH Practice Consulting Group, 2018

Stability in Program Structure

Consistency in Program Design is Key to Behavior Change

- PCMH Program model has been consistent since program inception – this has mattered greatly and this stability fosters physician behavior change
- Model, data, and incentive infrastructure is uniform across all Panel types – permits valid comparisons on performance
- Stability in Panel participation and performance has been remarkable
  - 70% of all viable Panels (244 out of 348) have been in the program for 7 years:
    - Only 6 (3%) have never had savings after 7 years

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FIVE STRATEGIES FOR PCMH SUCCESS

5 Focus Areas for Panels

- We have found 5 focal points for action – things a Panel can do as a practical matter – to positively impact cost and quality outcomes
- The higher weight of the Referral Pattern focal point reflects the importance of the most value laden decisions made by a PCP: when and where to refer for specialty care

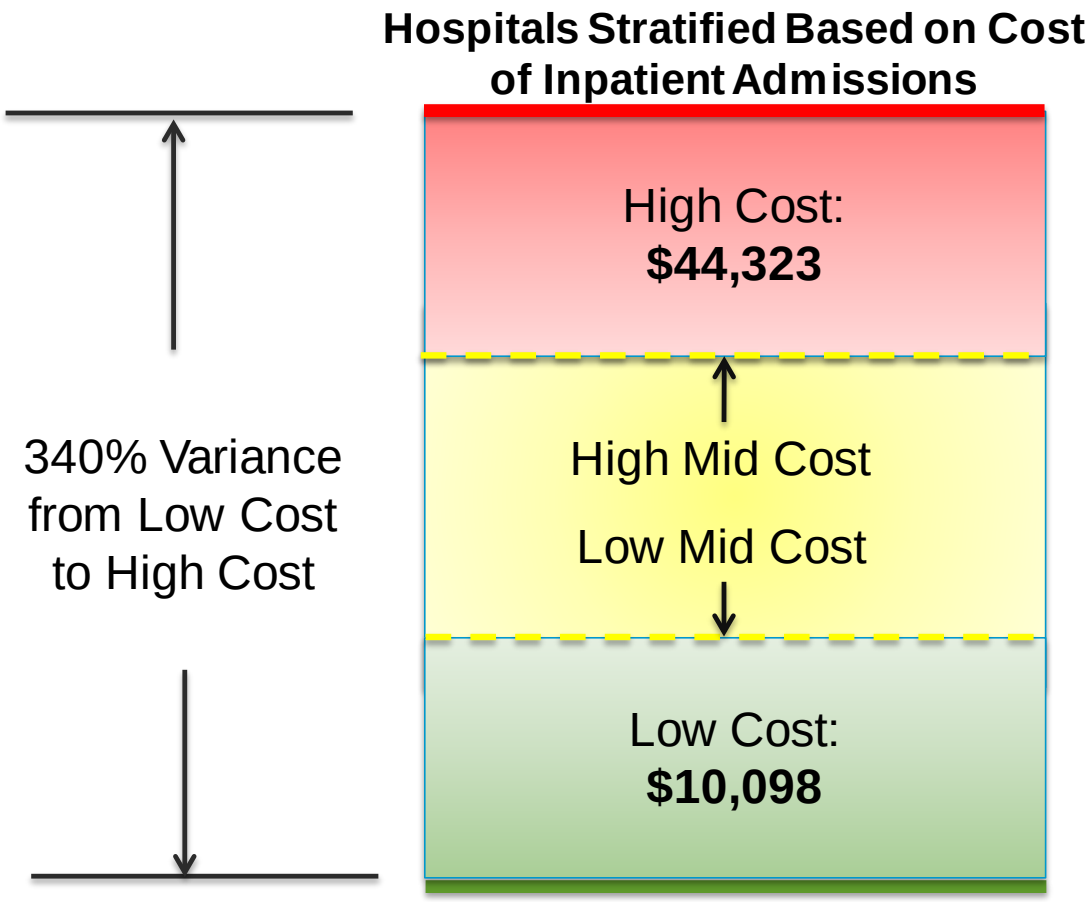
PCMH HealthCheck
Five Focus Areas for Panels that Most Influence Cost and Quality

Five Focus Areas	Weight
1. Effectiveness of Referral Patterns	35%
2. Extent of Engagement in Care Coordination	20%
3. Effectiveness of Medication Management	20%
4. Consistency of Performance within the Panel	15%
5. Gaps in Care and Quality Deficits	10%

A Complete Specialist Profile

1. Cost
(2015) – *Shared only with PCPs*
2. Quality
(Q3 2018) – *Shared only with PCPs*
3. Patient Satisfaction
(Q4 2018)
4. Practice Accessibility
(Q4 2018)
5. Responsiveness & Information Sharing
(Q4 2018) – *Shared only with PCPs*

Huge Variability in Costs Among Hospitals



Source: CareFirst Health Informatics – 2014 thru 2016 Data

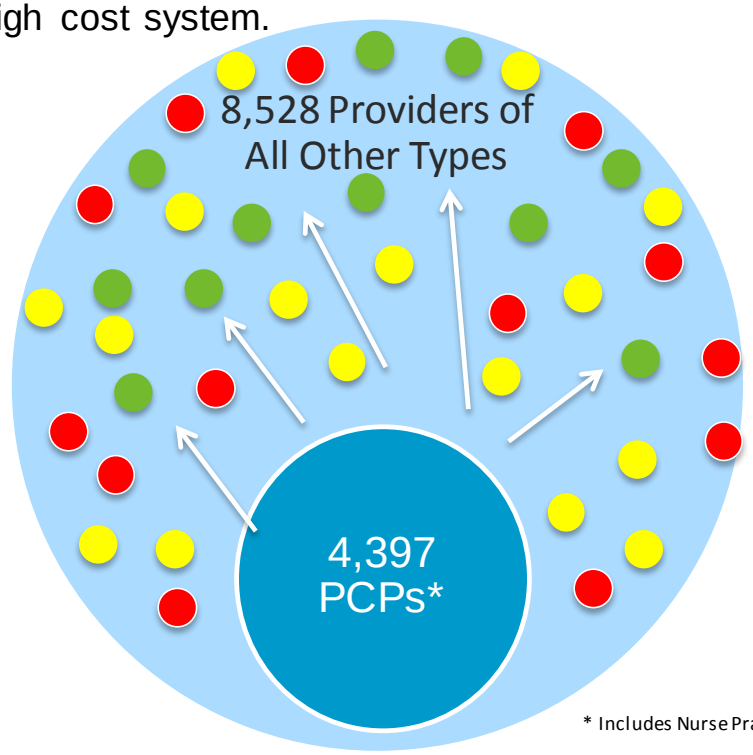
Top 20 Cause of Admissions — Academic vs. Community Hospitals

CareFirst

Admission Type		Book of Business			Academic Medical Center			Community Hospital		
	Top 20 Episodes	Admits	% of Total #	Actual Avg $	Admits	% of Total #	Actual Avg $	Admits	% of Total #	Actual Avg $
1	Pregnancy w Vaginal Delivery	13,369	19.1%	$12,036	198	4.3%	$16,603	1,274	26.3%	$9,839
2	Pregnancy w Cesarean Section	7,826	11.2%	$15,665	164	3.5%	$23,050	696	14.3%	$11,746
3	Osteoarthritis	5,455	7.7%	$28,835	87	1.8%	$38,930	519	10.7%	$22,926
4	Condition Related to Treatment - Medical/Surgical	2,511	3.2%	$27,526	240	5.1%	$32,467	128	2.6%	$14,176
5	Coronary Artery Disease	2,345	3.1%	$29,750	138	3.0%	$39,718	82	1.7%	$16,552
6	Pneumonia, Bacterial	2,252	3.1%	$19,786	95	1.9%	$23,166	123	2.3%	$12,757
7	Newborns w/wo Complication	1,903	2.0%	$34,604	72	0.8%	$69,230	148	2.2%	$25,059
8	Cerebrovascular Disease	1,821	2.4%	$23,875	135	2.8%	$39,529	68	1.3%	$11,528
9	Diabetes	1,709	2.2%	$16,181	59	1.3%	$16,025	66	1.4%	$10,398
10	Overweight and Obesity	1,708	2.4%	$19,753	2	0.0%	$0	261	5.4%	$16,779
	Total for Top 20	**52,827**	**72.0%**	**$18,054**	**1,747**	**36.0%**	**$27,755**	**3,911**	**79.2%**	**$13,203**

Panels Make Core Care Arranging Decisions – Increasingly Directing Referrals to Cost Effective Providers

- High, Mid-High, Mid-Low, and Low Cost Specialist rankings are shared with PCMH PCPs.
  - Quality judgment is left to PCPs – PCPs refer where they believe they will get the best result.
  - PCPs develop a list of **preferred specialists**; free to make exceptions.
  - Since providing this cost information, CareFirst has seen evidence of changes in referral patterns from independent PCPs – many have become convinced of the efficacy of referring to lower cost Specialists and Hospitals for common, routine illnesses.
  - In contrast, PCPs employed by large health systems have lost freedom to refer where they want – only referring to specialists within their high cost system.



* Includes Nurse Practitioners

Variation in Cost Among PCMH Panels

- The difference in total PMPM cost between the top quartile and the bottom quartile of adult Panels is 20.6% and 25.1% for pediatric Panels
- The greatest reasons for variation in cost are Panel specialty referral patterns
- CareFirst offers incentives to Members to select PCPs in higher performing Panels (PCMH Plus)

Adult Panels

Cost Quartile	Risk Adjusted PMPM
Low	$371.29
Mid-Low	$398.38
Mid-High	$417.65
High	$447.75
Total	$407.02

20.6%

Pediatric Panels

Cost Quartile	Risk Adjusted PMPM
Low	$167.33
Mid-Low	$180.45
Mid-High	$191.99
High	$209.28
Total	$185.56

25.1%

Variation in Cost Among PCMH Panels in 2017

- Two thirds of large Health System Panels are high or high-mid cost, while three quarters of all Virtual Panels are low or low-mid cost.
- Large Health System Panels typically cause PCPs to refer only to specialists in their own system, usually at high cost

Cost Tercile	Health System Panels	Virtual Panels	Single Panel Independent	Multi-Panel Independent
Low	12%	42%	36%	16%
Mid-Low	21%	31%	21%	22%
Mid-High	29%	20%	21%	27%
High	38%	6%	21%	35%
Total	100%	100%	100%	100%

Cost Variation Among Specialists can be 150%

- The difference in cost between High and Low cost Specialists varies from 20-150% across each episode type/category and across all episodes and specialties
  - Average Episode Range in dollars and percent:
    - » Orthopedic Surgery, $1,050/35%
    - » General Surgery: $1,550/37%
    - » Cardiovascular Disease: $510/45%
    - » Gastroenterology: $900/60%

Specialists Stratified Relative to Regional Episode Cost

- Drivers of variation in cost include:
  - Facility cost
  - Professional fees
  - Visit frequency
  - Style of practice (testing, procedures, etc.)
  - Pharmacy utilization

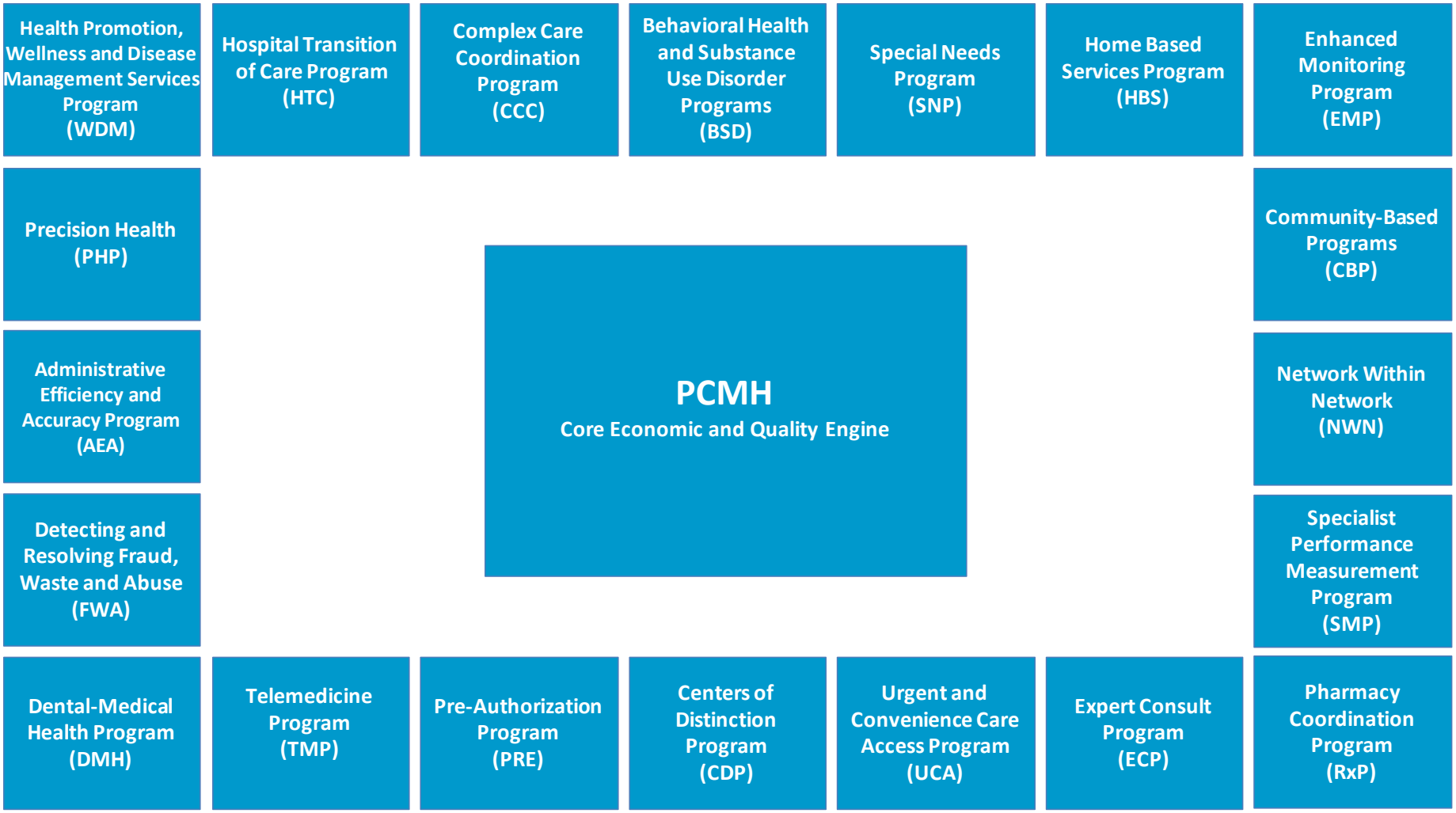
TOTAL CARE AND COST IMPROVEMENT PROGRAM (TCCI)— KEY SUPPORTS

Total Care and Cost Improvement Program (TCCI)

The Total Care and Cost Improvement (TCCI) Program Provides a Full Range of Supports

- Experience has shown that financial incentives alone are not enough to result in a long term bend in the care cost trend curve
- Extensive additional supports are needed that address the entire continuum of care
- These essential capabilities and supports are well beyond the means of Panels – especially independent ones in the community
- All are aimed at coordinating care, the “efficiency” of referrals to specialty care, or providing key ancillary services
- Supports must span settings, provider types and multiple geographic areas
- It is not any one thing that is needed – it is a cluster of things all aimed at the same results: higher quality + lower costs

TCCI Elements: 2011-2018



PROVIDING PCPS WITH ACTIONABLE DATA

Substantial Data & Analytic Capability Underlie Program

- CareFirst processes 36 million Medical claims annually – every line of every claim is stored
- CareFirst Business Intelligence database houses information equivalent to multiple Libraries of Congress
- The system includes all clinical notes for those in care plans as well as collected data from all care coordination partners
- All data is totally secure / encrypted
- Multiple years of data, all online and available 24 x 7 with a few clicks – organized, summarized and drillable
- SearchLight is the reporting system responsible for organizing and presenting the data
- Panels are provided with Key Indices and Top 50 Lists
- Information is disseminated by a field team of over 35 masters degree Practice Consultants

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PCMH SearchLight

CareFirst

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PCMH SearchLight Report for Panel ABC

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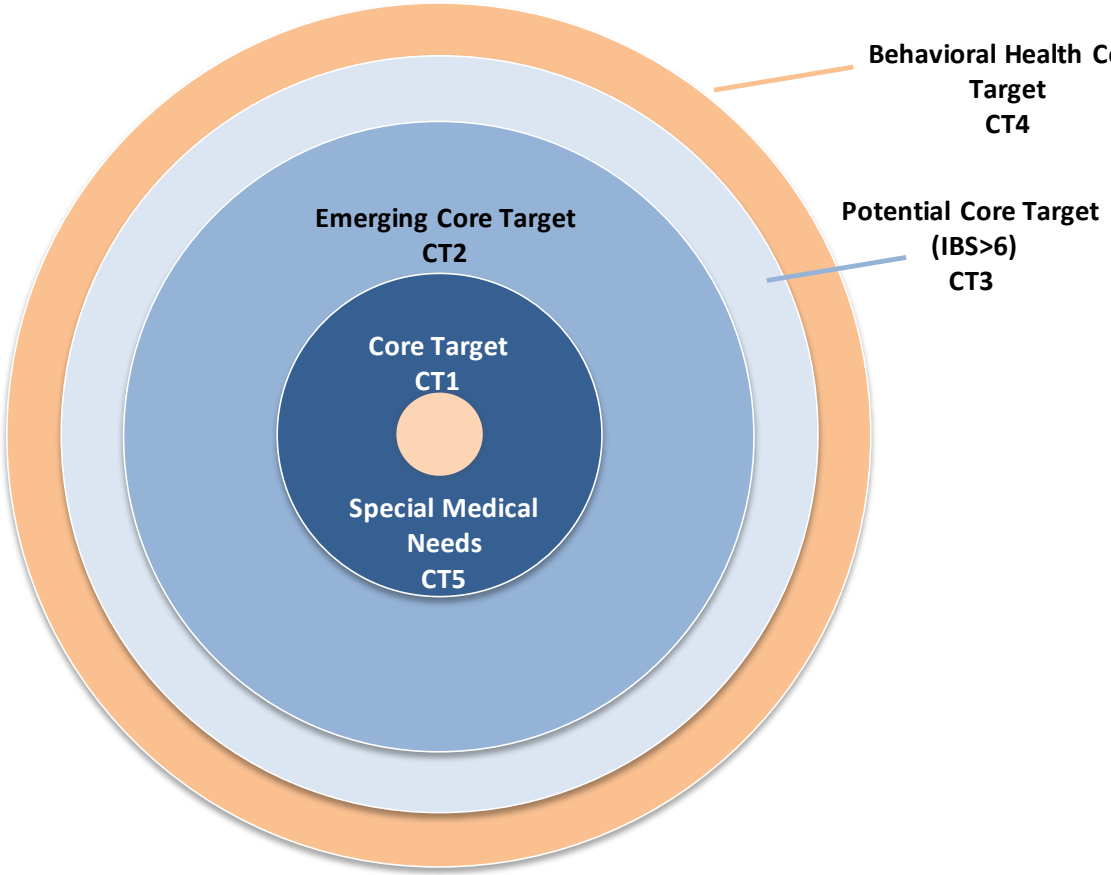
PCMH SearchLight Report for Panel ABC

Core Target Concentric Circles



The Core Target (CT) Populations - Trailing Twelve Months Ending April 2018							
	Members	% Total Population	Avg IB Score	Avg Overall PMPM	Admits per 1,000	Readmits per 1,000	ER Visits per 1,000
Unique CT 1 - 4 Members	90,566	4.3%	7.53	$3,684.28	714	242	789
Remaining Book-of-Business	2,020,542	95.7%	0.68	$229.57	20	0	147

CareFirst

PCMH
Patient-Centered Medical Home

OUTCOME INCENTIVE AWARD PATTERNS

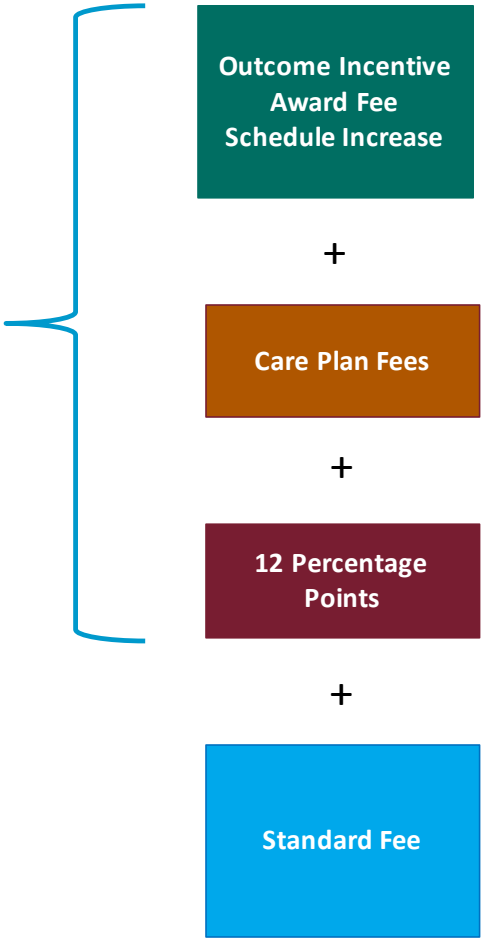
Outcome Incentive Award

- PCMH Program rewards Panels, as strongly as possible, for the results they achieve on cost savings and quality improvements on their entire attributed population
- Net overall (Total Cost of Care) savings at a Panel level is a requirement to receive any OIA
- Minimum quality and engagement thresholds are gates to an OIA, even if savings are produced
- OIAs are based on “shared savings” and are adjusted upward or downward for quality performance
- OIAs are also adjusted depending on the population size of the Panel – due to the enhanced credibility that accompanies a larger size Member population
- To reward consistent performance, OIAs are adjusted upward for Panels that earn incentives for consecutive years

The Average PCP in the Program Who Achieves a Savings Earns $37,650 in Additional Annual Income

- CareFirst's fee schedule (including provider specific arrangements or PSPs) for primary care is 92% of the Medicare fee schedule
- PCPs have a material incentive to produce a cost savings and to maintain that level of savings over time

In 2017, Pay for Value has averaged 63%



Outcome Incentive Award (Average: **$30,000** Per PCP)

Care Plan Fees (Average: $**450** Per PCP)

Participation Fee (Average: **$7,200** Per PCP)

Base Fee (Average: **$59,800** Per PCP)

PCMH – 2017 Outcome Incentive Award Results

- Approximately 67 percent of participating Panels in 2017 achieved savings for their members against the expected cost of care
- 62 percent of the PCMH program's Panels met both the cost and engagement criteria
- Average 53 percentage point increase on primary care fees paid by CareFirst to "winning" Panels
- For a PCMH PCP earning an average award in 2017, this translates into approximately $32,000 in increased income
- The estimate for OIAs to be paid out for the 2017 performance year is $78 million, contributing to $363 million in payouts for performance years form 2011 to 2017

Performance Year	Panels Achieving Savings	Panels Receiving an OIA	Average Award As a % of Increased Fee Schedules	Net Savings % (all Panels)*	Panels Missing OIA Due to Low Quality
2011	60%	60%	25%	1.5%	n/a
2012	66%	66%	33%	2.7%	n/a
2013	68%	68%	37%	3.1%	n/a
2014	84%	48%	59%	7.6%	16.0%
2015	74%	57%	42%	3.9%	12.1%
2016	67%	59%	49%	3.0%	12.6%
2017	67%	72%	53%	4.0%	4.9%

Note: 2014 was the first year Panels had to meet quality standards to earn an OIA. Quality standard criteria were raised in 2015 and 2016 Not all Panels achieving savings received an OIA.
*Net Savings is the amount Panels were over budget subtracted from the amount other panels were under their targets.

Note: 2017 - Panels without savings can earn OIA by being cost efficient (OIA Alternative) or participate in PCMH Plus

KEY INSIGHTS

Summary of Key Insights

1. **PCP Scope of PCP Accountability Needs to be Global, As do Supports**

   It is essential for the PCPs in the Panel to be accountable for all care outcomes and all costs for all Members in their Panel. The TCCI Program Array of supporting capabilities is essential.

2. **Nature of Incentives Have to be Tied to Population Health Outcomes at a Panel Level**

   Reward under the Program comes when the sum of individual results contributes to improved outcomes for the whole membership of a Panel in a way that can be seen, measured, and compared. This is the essential goal of "Population Health".

3. **Consistency in Incentive Design is Essential**

   Consistency builds trust with skeptical PCPs that the income based on value-based payments tied to outcomes is fairly measured and rewarded. In addition – Incentives and the risk of losing them are sufficient motivator for change, not large risk shifts that the PCP cannot bear or penalties.

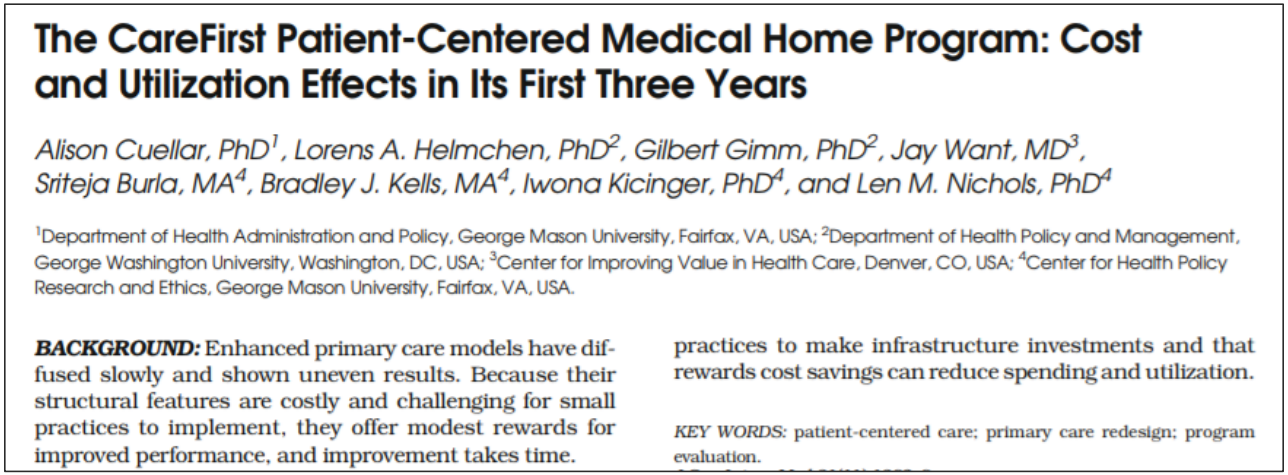
4. **Self-Chosen Teams with Wide Specialty Physician Choices are Critical to PCP Acceptance of Accountability**

   It is critical for PCPs to pick their own Panel teams and change membership as needed. Equally important is the focus on preferred specialists and forming efficient referral patterns.

5. **Data Must Be a Click Away**

   Without comprehensive views of patterns matched with the ability to drill down into detail at the Member level, the result is inattentiveness on the part of primaries to feedback. The more available, complete, and drillable the data, the more it is used in decision making by PCPs.

Independent Evaluations Confirm Positive Results



The CareFirst Patient-Centered Medical Home Program: Cost and Utilization Effects in Its First Three Years

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BACKGROUND: Enhanced primary care models have diffused slowly and shown uneven results. Because their structural features are costly and challenging for small practices to implement, they offer modest rewards for improved performance, and improvement takes time. practices to make infrastructure investments and that rewards cost savings can reduce spending and utilization.

KEY WORDS: patient-centered care; primary care redesign; program evaluation.

George Mason University

- Independent Evaluators from George Mason University found that the CareFirst PCMH program reduced total spending 2.8% per year by year 2 and 3 of the program (2012-13).
- In recent work currently under peer-review, GMU found that a similar cost growth reducing effect persisted through 2014-16. This would be the longest sustained effect in the PCMH literature.
- Contrast these results with CMS' Comprehensive Primary Care Initiative, which generated no net savings in any of it's 4 years, and has been modified to exclude total cost of care as a metric.

Westat

- Since 2013, Westat's evaluation has examined the implementation of CareFirst's PCMH program over time and drivers of program success.
- Case studies from 2017-18 indicate that the program's key elements are increasingly embraced by participating primary care practices.
- Analysis indicates that providers on winning panels were more likely to value the financial incentives from the program, and have more widespread use of care plans through the program for high risk individuals.