CareFirst BlueCross BlueShield's Patient-Centered Medical Home Program: An Overview

CareFirst BlueCross BlueShield's Patient-Centered Medical Home (PCMH) program is designed to provide primary care providers (PCPs) with financial incentives, data, tools and support to provide high quality, lower cost care to CareFirst members. Understanding that 12 percent of CareFirst members accounted for almost 63 percent of the costs that CareFirst pays for health care services (for its under age 65 commercial population), and that nearly 80 percent of these patients suffer from multiple chronic conditions, the PCMH program is designed to enable physicians to closely coordinate care for the chronically ill, as well as help these patients better manage their diseases and improve their overall health.

Launched in January 2011, CareFirst's PCMH is among the nation's first network-wide programs with robust physician participation and patient reach within Maryland, Washington, D.C. and Virginia. A voluntary program, nearly 4,000 PCPs – both physicians and nurse practitioners – representing 80 percent of CareFirst's network participate. Approximately 1.1 million CareFirst members are covered by the program.

How the PCMH Program Works

One of the central components of the PCMH Program is PCPs and nurse practitioners (NPs) being at the center of a team of health professionals focused on providing coordinated care for those patients who need it most. Incentives to PCPs reinforce the central role of primary care in helping members manage their health risks, as well as guide their care when they experience major illness, especially involving chronic disease such as diabetes, COPD, asthma and high blood pressure.

Participating providers receive a 12 percentage point increase in their fee schedule, agreeing to higher compensation in exchange for increased effort and time devoted to improved coordination of care. They also receive additional new fees for developing care plans for select patients with certain chronic or multiple conditions and additional fees for keeping the care plans up-to-date. Further, incentives (paid as fee increases) can be earned tied to better outcomes for the patients under the care of each panel of PCPs in the program.

CareFirst's PCMH program enables collaboration between physicians, local nurses, and other health professionals to manage care. PCPs collaborate with specialists of their choice and other medical professionals to initiate, more closely coordinate, and track care for the sickest of patients, or those at highest risk for future illness. To that end, the program facilitates implementation of Care Plans directed by primary care providers with the support of local community-based care teams (Care Coordination Teams) headed by RN Local Care

Coordinators, who arrange for and track the care of those members who are at highest risk or who would benefit most from a comprehensive Care Plan. As a result of collaboration and coordinated care, health care providers can take steps to keep patients healthier, and prevent chronic conditions from developing into even more serious health issues.

An integral tool in this process is the CareFirst online portal, which provides PCPs with access to an array of information. Physicians can see information on specialist costs to inform referrals; complete claims based on member health records to manage and closely monitor care; view SearchLight reports that can help identify gaps in care for their patient population; and review complete care plans with notes from all providers engaged in a patient's care. This depth of information is unavailable to most PCPs in typical practice settings today.

Through its Total Care and Cost Improvement (TCCI) program, CareFirst provides access to an array of targeted health programs – including home care, enhanced monitoring for chronic conditions and a specialty consult program, to name just a few – that provide additional supports for complete coordination of care across the full continuum of health needs.

The CareFirst PCMH is designed to improve health care quality while, over time, bending the cost curve. By providing incentives to primary care providers based on patient outcomes, promoting collaboration and integration between health care providers, and emphasizing coordinated care for the chronically ill, the PCMH program is truly patient-centered.

First-Year Results

In the first complete year of the program (ending December 31, 2011) nearly 60 percent of eligible primary care Panels (the small groupings/teams of primary care physicians and nurse practitioners that form the basis of the program) earned increased reimbursements for their performance in the PCMH program. Increased reimbursements - or Outcome Incentive Awards (OIAs) - are based on a combination of savings achieved by a particular Panel for its CareFirst members against projected annual total care costs for these members, as well as performance on quality measures related to the provision of care to Panel patients. OIAs for the program's first year are paid to PCMH participants in the form of increased fee reimbursements for certain primary care services beginning July 1, 2012 and continuing through June 30, 2013. These incentives are earned and recalculated each year depending on Panel performance the previous year.

Highlights of the first-year of the PCMH program include:

- Program participants (Panels) earning OIAs achieved an average 4.2 percent savings against expected 2011 care costs.
- Panels that did not earn OIAs registered costs that averaged 4 percent higher than expected for 2011.

- On average, Panels earning OIAs saw an increase in their reimbursement level of 20 percentage points. This increase is in addition to a 12 percentage point increase paid to all participants that continue to remain in good standing in the PCMH program.
- The cost of care for all CareFirst members attributed to PCMH participants was 1.5 percent lower than had been projected for 2011.
- Quality scores for panels receiving an OIA and those not receiving an OIA were comparable.

The PCMH program measures quality performance in a number of ways. These include nationally recognized measures for appropriate use of health care services and effectiveness of care. In addition, Panels can also earn quality points related to their engagement in the PCMH program and based on measures related to patient access (such as the use of e-scheduling and extended office hours) and structural capabilities (including the use of e-prescribing and electronic medical records). PCMH Panels can maximize their OIAs by increasing their quality scores while realizing savings against projected health care costs for their population of patients.

Second-Year Results

In the PCMH program's second year (ending December 31, 2012), the overall savings against projected cost of care for the more than 1 million members covered by the program rose to 2.7 percent – or $98 million. In addition, the number of eligible panels earning OIAs for their program performance rose to 66 percent (196 of 297 panels).

Other key facts about 2012 PCMH results:

- Panels earning OIAs achieved an average 4.7 percent savings against expected 2012 care costs.
- Panels that did not earn OIAs registered costs that averaged 3.6 percent higher than expected in 2012; an improvement over 2011 performance.
- 74 percent of panels that earned OIAs in 2011 earned them again in 2012, meaning their patients registered lower than expected total health care costs for two consecutive years.
- On average, Panels earning OIAs will see an increase in their reimbursement level of 29 percentage points. This increase is in addition to a 12 percentage point increase paid to all participants that continue to remain in good standing in the PCMH program.
- Quality scores for panels that earned OIAs were 3.7 percent higher than for panels that did not earn OIAs in 2012. Overall, quality scores for PCMH panels rose by 9.3 percent from 2011 to 2012.

Program Evaluation

In March, 2013, CareFirst announced the selection of three organizations representing some of the nation's leading health researchers to conduct independent, comprehensive evaluations of the PCMH program. A joint team from Harvard University, Brandeis University and the Massachusetts Institute of Technology was selected, along with teams from George Mason University and Westat. These groups will conduct both qualitative and quantitative analysis of the PCMH program. All three selected groups have begun work on their evaluations, work that will continue through 2016.

Extending the PCMH Program to the Medicare Population

In June 2012, CareFirst was awarded a $24 million Health Care Innovation Award from CMS. The grant will fund a three-year program designed to serve 25,000 Medicare beneficiaries in Maryland. CareFirst's grant was the third largest nationwide and the largest single grant for a PCMH program awarded through the CMS Innovations grant program. CareFirst is the only pure payer leading a program funded through the program.

Under the auspices of the grant, CareFirst will extend the tenets of its commercial PCMH program to the Medicare population. A limited number of existing PCMH Panels will be recruited into the program to demonstrate the impact of the PCMH when combining the two largest payers in Maryland – Medicare and CareFirst.