Part II: PCMH: The Core Economic And Accountability Model

Preface

The core PCMH Program, which is supported by the TCCI Program, is based on a number of beliefs, assumptions and theories about what must be done to transform the health care system in the CareFirst region – and, by extension, the American health care system.

These beliefs, theories and assumptions are rooted in common every day experience and common sense. They are based on essentially simple and straightforward ideas that have been around a long time. They find expression at the intersection of financing, structure and accountability in the health care system. They build on the old fashioned idea of the central and inescapable role of the PCP and NP. But, they weave this idea and a number of others together in a way that has not been tried before in an attempt to create a model on a region wide scale that could become a model on a national scale.

As important as they are, the PCP or NP, alone, cannot credibly be a PCMH. A team is needed that is composed of these PCPs together with other allied professionals. The Program takes the view that small performance teams of PCPs – called Medical Care Panels – are the essential building blocks.

While the days of the solo PCP are ending, the centrality of their role endures and even ascends in value. The PCMH Program sees a path forward that represents an alternative to the employment of PCPs by large health systems (a direction taking place in the CareFirst region just as it is all over the U.S.). Their continued independence as part of viable small teams is seen as central to cost control and increased value.

A powerful outcome oriented incentive tied to the actual results achieved by a Panel (which is a performance unit) for the whole cohort of Members it collectively treats is seen as central to transformation. This incentive is not tied to process measures or to primary care alone, but, rather, to global improved quality and cost outcomes for the whole cohort of Members cared for by the Panel. All design considerations and financing features flow from this – including how accountability is fixed, how information is gathered and displayed, how supports are arranged (through TCCI) and how the role of the network administrator (CareFirst) is defined and carried out.

Recognition of the importance of the micro local nature of health care is seen as central as well. High touch for those Members with multiple chronic diseases – through high Engagement with the PCP/NP and team leveraging the best local health care assets – is among the greatest areas of emphasis.

So, on the belief that any system of health financing can be beaten, the PCMH Program design takes the view that the "secret" is to design a system that when beaten, is beaten in a socially productive way. The beliefs, assumptions and theories behind the PCMH Program shape a system that is meant to be beaten – but, one that can only be beaten by improved quality and cost restraint over time – and, by actual achievement of strong outcomes, not simply well intentioned process oriented attempts to do so.

In effect, the core to the whole PCMH design is to build a market driven model in which the pursuit of informed self-interest by PCPs drives the whole system to better outcomes. This fosters focus on the Members at the top of the Illness Burden Pyramid and on other "at risk" Members who might otherwise move up in the Illness Burden Pyramid were it not for more attentiveness to them and their risks.

In effect, the model reinforces and adds impetus to the very reason why most PCPs went into their chosen field to begin with – to take care of these kinds of Members. The difference is that it gives them a tangible, substantial reward to do so.

Incentives are the key to change. There are no penalties, no risk shifts, and no complicated mazes of rules that are the active ingredients in this new model.

The primary care team with the PCP/NP at the center, becomes not only the essential provider, but the essential "buyer and arranger" of specialty services for Members. This causes specialists to become responsive to a marketplace of informed PCP/NP "buyers" or lose ground in the struggle for referrals. These buyers are incented to seek cost effective results. No Member can perform this "buying" function better for themselves.

Indeed, the Program takes the view that a collective market composed of informed and motivated PCPs is in the best position to productively influence specialist behavior – and with it, hospital behavior. The independence of primaries to do so is seen as central.

Therefore, the hospital in this marketplace is not seen as the central player around which to organize. Indeed, it is the shrinkage of the hospital as the central player that is the consequence of this model. Stabilization of Members at home and in their community – through avoidance of unnecessary or preventable admission, re-admission and ER use as well as avoidance of the miscues of over medication, is seen as central to long term savings. In short, the savings derived from avoided hospital use pays for the incentives and redirection that must occur.

The rules of financing in the PCMH Program fulfill the beliefs, theories and assumptions as outlined in this **Part II**. These ideas are universal, apply to all payers and are scalable without limit. There is not a single brick and no mortar. There is, however, extensive online integration of Program elements, extensive use of online data transparency and a blended capitation and FFS financing model in which it is essential that global capitation be fused with FFS payments.

The execution of the underlying beliefs and theories, therefore, requires an online infrastructure that is the essential scaffold upon which the beliefs find expression and come to life. A network administrator who is also an information supplier and connector – with the breadth to reach all settings, all providers, all services anywhere as well as the broader purchasing marketplace – is seen as the essential scaffold builder and maintainer as well as the strategic partner to the PCP, NP and Medical Care Panel. This is the role CareFirst plays.

This **Part II**, therefore, sets the stage for all that follows in **s**ubsequent **Parts** and establishes the core goals of the PCMH Program that the larger TCCI Program seeks to support and enable.

Basic Principles And Core Ideas For Providers And Members

The aspirations that guide CareFirst's approach to improving cost and quality outcomes are rooted in five core ideas. Before setting forth the specifics of the PCMH Program which is the heart of the larger TCCI Program, it is worth noting these core ideas – all of which are aligned with CMS' Triple Aim of improving the Member experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.

Five Core Ideas Relating to Providers – Especially PCPs and NPs

There are five key ideas that shape the PCMH Program. They are:

First, the best approach is to build on incentives that foster partnership and greater accountability as well as reward changes in behavior. Nothing in the PCMH Program is predicated on penalties or the shift of insurance risk to providers. Therefore, there is nothing in payment methodology that could negatively disrupt or influence provider judgment in caring for Members;

Second, quality of care measures must be built in from the beginning to assure that any drive toward cost control does not result in suboptimal quality. The single most critical component of quality is the degree of Engagement among the Member, the PCP or NP, the specialist, and other health care professionals involved in the Member's treatment, all of whom comprise the Care Coordination Team. This is never more necessary than for the chronic care Member with multiple conditions/diseases that persist over time and that are treated in multiple settings through multiple providers;

Third, PCPs and NPs must be better rewarded for seeking and actively pursuing the best outcome for their Members over time and across all care settings – not just in their own offices. Further, the PCP and NP must be better compensated for taking more time with certain chronic care Members at the point of care to reach a considered judgment about their needs and to more fully follow-up on their care over time;

Fourth, the FFS System is useful in some essential ways that simply cannot be pushed aside or discarded. Among these are documentation of services actually rendered and the accurate "capturing" of the enormous variation in services often required to treat Members with different circumstances, conditions and diagnoses. These benefits of FFS payment should not be tossed aside in the dash to a new "bundled" approach to financing health services.

However, the virtues of capitation – such as stronger focus on outcome and results – must be brought to bear. The best path is not to rely wholly on one approach or the other. That is, the key to a new payment approach lies in a blend of the two methods that rewards both cost control and high quality outcomes over time while harnessing the benefits of FFS. This also eases implementation for all parties; and

Fifth, the power of real-time, web-based online connectivity must be brought to bear on the problem of sharing information about Members with and among their care givers more completely and easily – especially in creating and maintaining a longitudinal Member record. This alone improves the chances for attaining better outcomes and is less about Electronic Medical Record (EMR) Systems within provider offices and more about the connectivity between and among providers and payers who will always be on disparate systems.

Five Core Ideas Relating to CareFirst Members

There are five core ideas that relate to Members. These ideas relate to how Members can play a constructive role in curtailing health care cost growth. It is, after all, their health status that is the principal and sustaining driver of health care service use.

First, a baseline health assessment at the yearly enrollment of each Member is a starting point in focusing Member attention on lifestyle consequences and emerging health risks. Such an assessment is designed to engage the Member in working with his/her PCP or NP for better health outcomes. The assessment itself is composed of two parts: A questionnaire and Biometric Screening. If conducted in the workplace, apart from the PCP, the results of both parts should be shared with the PCP (with the Member's consent);

Second, there should be no cost barrier in the form of deductibles and/or copayments that prevent Member access to primary care services (for sick care), preventive screenings and prescription drugs necessary for the management of chronic disease;

Third, there should be meaningful incentives for Members to form a strong, lasting relationship with the PCP or NP of their choice – regardless of their health status. But, this should come with the freedom to access care around the PCP or NP if the Member feels this is appropriate so that no "lock in" occurs. At present, nearly one-sixth of CareFirst Members do not have a PCP or NP – particularly young, healthy people who do not think they need health care services or those whose conditions/illnesses cause them to be already in the care of specialists. Moreover, the right of Members to switch PCPs or NPs at any time should be preserved. The Program imposes no limit on the ability of Members to choose their PCP or NP or to change their PCP or NP at any time;

Fourth, there should be meaningful financial incentives for Members with chronic disease – especially those with multiple chronic diseases – to comply with Care Plans developed by their PCP or NP and to take steps to reduce their health risks. This is probably best done by taking a page from the high deductible health plan playbook in the form of subjecting higher cost specialty and hospital based services to deductibles and copayments, but then waiving these in whole or part when Members comply with their Care Plans thereby reducing their risks for future health care expenditures;

Fifth, Members should be covered by a complete benefit plan, including coordinated/integrated prescription drug and mental health coverage as part of a purposeful design. No "savings" should be achieved by curtailing or creating holes in coverage that become traps for the Member or inhibitors to Care Plan implementation. No "carve outs" of services should occur causing a difficulty in coordinating services or obtaining complete data on a Member. In particular, no design should foster hidden rules, gaps, cost-sharing or conditions that create surprises when access to service is sought by the Member or when a Member tries to comply with Care Plan directives.

However, here again, the ACA establishes rules for benefit plans that cause them to include considerable cost-sharing. These rules may inhibit the achievement of this objective in the individual and small group market segments, in particular, where ACA rules and benefit plan requirements are most felt.

The Combination of the Provider and Member Ideas – in Full Alignment – is the Foundation of the CareFirst Strategy

The two sets of five core ideas for Providers and Members described above shape the design of the PCMH Program and the Blue Rewards product portfolio which is presented more fully in **Part V**. Blue Rewards is an amalgam of HMO, PPO and high deductible design ideas – itself, a new "weave" – with a purposeful point of view: To induce more health risk awareness in the Member, reward health risk reduction, and foster guided, coordinated care when the Member needs it. The five ideas behind the provider model are also an amalgam of proven techniques in a "new weave". Put together, they are intended to induce better overall outcomes in cost and quality for Members.

Thus, the core concepts underlying these Guidelines are diffused through the entire CareFirst product portfolio and provider network design.

Key Beliefs Underlying The PCMH And TCCI Programs

PCMH is More Than a PCP or NP

PCPs and NPs, by themselves, are not set up in the current environment to provide appropriate Care Coordination for Members with multiple chronic conditions. A typical comprehensive Care Plan involves multiple services in multiple settings over an extended period of time, with labs, prescriptions and imaging services associated with each. Multiple follow-ups are often required. Specialists are extensively used.

The complete picture of the Member's health status that emerges from all of the interactions involved must be monitored, continually interpreted through ongoing interaction with the Member and the Member's various care givers, and then acted upon effectively. This is difficult to do and is not done well or at all in many cases. The lack of financing for these coordinating services inhibits their doing.

To have a hope of realizing better coordination over time, the most immediate challenge facing most PCPs or NPs is the lack of a care support team. This must be overcome. Therefore, key to the Program is a care support team – which is referred to in these Program Description and Guidelines as a Care Coordination Team that includes the PCP, the PCP's Group, all participants on the PCP's Medical Care Panel, other treating providers and health care professionals who provide PCMH services to the Medical Care Panel and/or CareFirst's Members.

The Care Coordination Team is led by a RCD who is supported by a number of LCCs, RCDs and LCCs are all RNs. These nurses are in the best position to provide ongoing Care Coordination – especially for Members with multiple chronic diseases – under the direction of the PCP or NP.

It is this fulcrum between PCP and NP and the support team that improves the chances for stronger Member outcomes. It is precisely this fulcrum that is lacking in so many primary care practices, especially the small ones that predominate since they do not have the resources.

A support team, in turn, goes beyond the RCD and LCC. It often includes other health professionals, such as nutritionists, health educators, physical therapists, pharmacists and mental health professionals, among others. It is critical that these support services be locally based and well-woven into the community where the PCP or NP is located and the Member lives. And, the home may be the best setting for the provision of these services – a place where few services are provided today. Home care services account for less than three percent of CareFirst's current spending.

Accessible primary care services – including extended service hours and telemedicine – are also critical to high quality outcomes. This is necessary for the avoidance or reduction in ER visits and preventable hospital readmissions. But, the availability of many PCPs or NPs is limited to regular office hours with little or no back-up and coverage. After-hours coverage is often provided by the local hospital ER.

It is apparent that the elements listed above – while generally seen as desirable – are often missing, given the way in which PCPs practice. PCPs and NPs in solo practice or in small practices are simply not in a position to offer extended access or to provide continuity of services through Care Coordinators and other allied health professionals within their practices. Without overcoming this, no real change can occur.

The Goals Of The PCMH Program

There are three goals of the PCMH Program:

First, the Program seeks to encourage all CareFirst Members to select and use a PCP or NP regardless of benefit coverage plan (e.g., PPO or HMO). Adoption of Blue Rewards features is, of course, strongly encouraged.

Second, with the PCP or NP in the role of quarterback, the Program seeks to have the PCP or NP differentially and persistently focus on resource intensive Members. These include those Members in Band 2 with multiple chronic diseases who need a Care Plan, as well as on those in Band 3 at high risk of further breakdown in health status.

Care Plans are generally developed for Members whose Illness Burden Score is at least two times the average in the PCMH Program. The PCP and NP are the key to intelligent, informed guidance and assistance to the Member who needs to make changes in lifestyle or comply with the requirements of a treatment regimen/plan.

In support of this, the Program seeks to provide PCPs or NPs with additional dedicated Care Coordination Team Members, including allied health professionals who are charged with active Care Plan follow-up over time to minimize care gaps or breakdowns and to promote healthier lifestyles.

In other words, the PCMH Program seeks to enable PCPs or NPs to disproportionately focus on the health outcomes, treatment patterns, and plans of their Members most in need of enhanced support – across all settings – and not just the small portion of services that relate to primary care. To do this, PCPs and NPs must have connection to and Engagement with the other participants on the Care Coordination Team in a way that does not cost the PCP or NP – or a "Panel" – up-front dollars to create and maintain. This is exactly what the TCCI Program provides through its HTC, CCM, CCC and EMP Programs. Over 300 nurses are involved in these Programs in the CareFirst area as part of the PCMH and TCCI Programs.

Third, the Program seeks to enable the PCP and NP to better see and understand the downstream costs and quality implications of his/her referrals and to take a continuous interest in this through informed specialist selection and collaboration. That is, the Program seeks to encourage the PCP and NP to wisely select providers of specialty services with a considered eye toward both the cost and quality of outcome which the Member may be unable to effectively do on his/her own.

Simply stated, the Program seeks to foster a greater connection and Engagement between the PCP and NP and the specialists that serve his/her Members by focusing his/her attention on **both cost and quality outcomes** achieved for his/her Members over time across all settings. This is accomplished through a combination of technical support, the development of networks of local Care Coordination Teams and direct, substantial financial incentives to the PCPs and NPs to become concerned with the downstream consequences for their Members resulting from their Care Plans and referral decisions.

In the PCMH Program, high quality, coordinated and anticipatory service across PCP and specialist is seen as the key to cost-effective results. That is, high quality works for cost control – not against it.

An Important Key Is PCP/NP And Member Engagement

To achieve these goals, a high level of Engagement by PCPs with their Members in the top three illness bands is essential. This means that the PCP or NP must be deeply involved in the Care Plan and implementation process for their eligible Members. Each Care Plan must, in effect, constitute a "contract" between PCP or NP and Member if it is to be effective. Care Plan development and maintenance in the PCMH Program cannot be relegated by a PCP or NP to someone else.

Since Engagement between the PCP or NP and the various specialists involved in a Member's Care Plan is also essential, the Program design seeks to foster strong communication between the PCP or NP and specialists in weighing the options and various courses of treatment for a Member. It does not seek to have PCPs or NPs second guess the judgments of specialists or attempt to do the job of the specialist. Rather, it seeks to focus PCP or NP attention on the "when" and "where" decisions regarding specialty care and to truly engage the specialist in shared, ongoing decision making – that is, true consultation around the need of each Member in a Care Plan.

This means obtaining the considered judgment of both the PCP or NP and the specialist about a Member's course of action – with the Member involved as much as possible. This "considered judgment" then guides the Care Plan and all modifications of it over time. It is in this environment that the RCD, LCC and support team carry out their role, monitor Member progress and provide feedback on results to the PCP or NP.

Incentives For Members To Select PCPs And NPs In The Most Effective Panels

CareFirst believes it is important to encourage Members to choose PCPs or NPs in cost-effective, high quality Panels through reductions in their cost-sharing. CareFirst has built an incentive to do this into its entire product portfolio based on

the track record that has emerged from Panel performance. This new Program – called PCMH+ – identifies high performing Panels with at least three full years of experience in the Program.

As of January1, 2016, a new version of Blue Rewards became available that encourages access to these high performing PCMH+ Panels. By choosing PCPs or NPs in these high performing Panels, CareFirst Members are able to gain access to more affordable, high quality health care while the PCPs and NPs in Panels have an opportunity to gain Members as a direct result of their strong performance. This new Program is described more fully at the end of Part III of the Guidelines.

Summary Of The Key Beliefs Underlying The CareFirst PCMH Program

With all that has been said above, it now becomes evident that the CareFirst PCMH Program is predicated on a number of underlying core beliefs and theories. These beliefs and theories find expression throughout the 10 Design Elements of the PCMH Program and 18 Program Elements of the TCCI Program. They are summarized below.

1. PCP And NP Accountability For Global Target Budgets Is Essential

The Program assumes that the PCP or NP should be the central player/quarterback and "arranger" of care across all settings and is in the best position to influence global health care spending for his/her Members, not just the small portion of spending provided in the PCP's or NP's office.

Therefore, the accountability of the PCP and/or NP in the PCMH Program is global – for all costs in all settings and for the aggregate cost and quality outcomes for Members attributed to the PCP.

The Program design assumes that the organization of PCPs and NPs into small teams is essential for backup and coverage and that the pooling of experience across the multiple PCPs and NPs on a team is needed to establish actuarially stable target budgets and to provide statistically meaningful reports designed to identify significant differences in cost and utilization patterns.

This is intended to promote effective, self-interested, highly focused peer review. Thus, in order to be eligible to join the PCMH Program, the PCPs and NPs are required by CareFirst to form "Medical Care Panels" even though this is unnatural for many in active practice today.

The right of Members to change PCPs or NPs and refer themselves for specialty care is viewed as a key counterbalance to any ability or inclination that the PCPs and NPs might otherwise have to under-provide care or stint on appropriate referrals to specialists.

Although Members are attributed to PCPs or NPs in Medical Panels, they retain the same "freedom of choice" rights to change PCPs or NPs and to refer themselves for specialty care that are embedded in their underlying benefit packages.

The main challenge in achieving sustained and focused care management is not limited to setting up of the PCP or NP in his/her office to be a PCMH, but rather, enabling of PCPs and NPs to coordinate care and see patterns of care and cost beyond their office across all settings and over time for their Members.

As noted earlier, the Program causes PCPs and NPs to take accountability for the overall cost and quality of services provided to their Members in any and all settings.

This requires additional capabilities that PCPs and NPs do not typically have – and, cannot reasonably be expected to obtain in many cases. These include Care Coordination capabilities that are well outside the PCP's or NP's office, including nurses who serve as LCCs; and a common Member record across all settings, with highly accurate information on services actually rendered to the PCP's or NP's Members in all settings (hence, the importance of FFS). These capabilities are, therefore, supplied by CareFirst as the administrator of the PCMH and TCCI Programs.

Simply paying PCPs more through a PMPM mechanism will not – by itself – produce results. Rather, the Program assumes that it takes two parties to achieve meaningful, sustained results toward better outcome and cost control over time: The PCP and the PCMH Program administrator/payer who spans the entire network and healthcare system – well beyond the reach of the PCP.

Administrative capabilities provided by this central administrator/payer – a role played by CareFirst – must include ubiquitous web connectivity, information feedback on Member care patterns over time across all settings, and the ability to offer support capabilities such as dedicated LCCs, HBS, and EMP of high risk Members. Member rosters stratified by Illness Burden and episode profiling (to better see patterns of care) are critical capabilities well beyond the reach of most PCPs and NPs to develop on their own. All of these capabilities are provided to PCPs and NPs by CareFirst.

Large hospital-based integrated care systems such as those fostered by risk-based ACO models should not be made the central players in global budget target models. Rather, global budget target models should be built around the PCP or NP as the central player.

Systems built on hospital-centric cores will likely create conflicting goals and may not the best chassis for long term cost control. Indeed, they may very well be antithetical to it. Specifically, hospital-centric systems have business models that are volume-driven. Specialists and hospitals – whose volumes are most vulnerable to a Program designed to root out inappropriate use – are financially, organizationally and philosophically not well-positioned to be early and aggressive adopters of the kinds of changes in medical practice that are sought by the Program.

2. Financial Incentives To PCPs And NPs Must Be Substantial

Offering strong financial incentives to PCPs and NPs to reward them for differentially focusing on the needs of Members with chronic disease or those at high risk for chronic disease is critical to bending the cost curve and improving overall quality for defined populations of Members.

The most powerful incentive offered in the Program is a very substantial upside-only "gain share" opportunity in which Medical Panels that perform well on quality metrics and beat overall budget targets receive additional large increases in their compensation levels. These additional/supplemental fee payments can be in the 20 to 50 percent range. The "target budgets" given to Panels are set by trending the historical, risk adjusted experience of each Panel's attributed Member population from a base year (generally 2010). The Program uses a shared savings approach to reward and offer incentives to PCPs and NPs to work together towards better overall quality and cost outcomes for the cohort of Members in their Panel.

The shared savings method used in the PCMH Program – which pays incentives in the form of FFS supplements to PCPs and NPs – enables these incentives to be applicable to all lines of commercial business, including insured and ASO accounts.

This broad inclusivity of all types of coverage is essential to broad market adoption – which, in turn, is essential to assuring the Program is significant enough in size to induce PCP and NP attention to the Program's objectives.

FFS as a payment method should not – and cannot – be wholly replaced in the foreseeable future, but its volume-inducing effect can be mitigated by global health care budget targets for Medical Care Panel Member populations.

The essential benefit of FFS payment – the tie between specific services actually rendered and payment – must be maintained. This is critical to data completeness, transparency, and accuracy which enable the Program's quality measurements and information analyses and reports to be generated. This will be further enhanced with the adoption of HIPAA 5010 and ICD-10 standards.

The FFS basis of payment to PCPs and NPs is conducive to motivating the PCPs and NPs to continue (or increase) their rendering of primary and preventive services to Members.

There is little concern for overuse by the PCPs and NPs because these services are currently underprovided in many instances and account for so little of overall health care costs.

Shared savings incentives to PCPs and NPs can be relied upon to drive much more judicious use of specialty and hospital services.

The Program assumes these incentives will change behavior and that PCPs and NPs will become more attentive to when and where they refer and to the cost and quality outcomes resulting from these referrals. In effect, the Program gives PCPs and NPs a direct stake in Member outcome over time for services they did not render themselves but, in fact, are essential for their Members.

No individual PCP or NP or group of PCPs and NPs is in a position to take on risk for the total costs of their population of Members.

As previously noted, PCP and NP incomes account for only five to six percent of total health care spend. PCPs and NPs cannot feasibly underwrite even small overruns in total medical cost budgets.

Therefore, the PCMH Program's system of global accountability and rewards is based solely on incentives. These incentives are tied to total population outcomes regarding total cost savings and are conditioned on achievement of quality standards. The key assumption is that the Program's incentives are powerful enough to work even when they operate without risk – and that these incentives are powerful enough to change behavior in the directions desired.

Once formed, a Panel's base experience for all the health costs of its Members is adjusted for changes in the illness burden of its Members over time. Once these costs are further adjusted for Overall Medical Trend they are re-based only under certain specific circumstances relating to large changes in the physician composition of a Panel.

In effect, the incentive is to beat trend in cost growth year after year after changes in the illness level among Members in a Panel is normalized – and to do so by improving overall performance for the cohort of Members in each Panel. The Panel that beats trend attains a reward in shared savings that becomes greater when done consistently year over year. Multiple Panels beating trend, bends trend. This leads to systemic cost control and improvement in care quality.

3. Improving Quality Outcomes Is Essential To Cost Control

Quality improvement and cost control are seen as inextricable – they go hand in hand and are mutually reinforcing.

The most important cost control and quality improvement action is to actively coordinate care for the multi-chronic Member across time and multiple settings/providers and to closely monitor high risk Members before they break down – that is, to fill in gaps in care effectively. This requires capabilities beyond the reach of the PCP alone.

OIAs to Panels are based on degree of savings achieved against budget targets, but they are adjusted up or down based on Panel performance against a substantial list of industry proven quality measures. This makes quality performance an integral part of outcome performance assessment.

Engagement between PCP or NP, Member and LCC is the single most essential element in obtaining quality outcomes and is the driving force of the Program toward quality improvement.

Engagement means paying attention to the needs of certain Members more closely over time due to their conditions or illnesses and working actively with them as well as with a nurse-led care team in coordinating their care across time and care settings.

Engagement and aligned incentives induce coordinated, focused action around the dual purposes of cost control and quality improvement over time with the Member at the center.

4. Reporting/Informatics On Demand Is Critical

Information feedback to PCPs and NPs on their Panel's total cost and care patterns – including PCP/NP knowledge of the cost of specialty referrals by episode – is critical to causing productive behavioral change.

This information enables the PCP or NP to make prospective decisions on when and where he/she refers Members for specialty care and to make informed decisions about Member "slotting" into different Programmatic or clinical tracks outside the PCP's or NP's office.

It is a core premise of the Program that judicious decisions about when to refer, and to whom to refer, are more important keys to cost control and outcome than anything the PCP or NP does in his/her office.

Exposing and highlighting differences in quality and cost outcomes within and across Medical Care Panels will encourage individual PCPs/NPs and Medical Panels to examine their own performance and their opportunities

to improve care and their own incomes. This information is essential to motivating and sustaining behavioral change.

Cost and quality data gathered and reported in a disciplined, common way across the PCMH network for all care in all settings by all providers is essential to behavioral change since it creates a fair and uniform yardstick of performance.

To do this, detailed claim data is needed. Only the administrator/payer is capable of providing this information and CareFirst provides it to the PCMHs through a sophisticated package of online, regularly updated SearchLight Reports and other information**.** Much of this data is derived from claims – a key and essential byproduct of the FFS system that must be maintained.

The Program attempts to create a viable health care market by providing Medical Panels with information and financial incentives that make them informed "buyers" of specialty based services who are able effectively to represent the interests of their attributed Members.

The interests of the Medical Panels and their attributed Members are aligned because the Members want timely, high quality, cost-effective medical care and the Medical Panels are most likely to retain Members and earn incentive awards by providing this kind of medical care. Equally important, the PCPs and NPs become the "buyers" and arrangers of specialty care services for their CareFirst Members and make key decisions about when and where to refer Members. The outcomes achieved by Members rest heavily on these decisions.

5. Care Management Supports Are Essential To PCP Success

Locally based nursing support in the development and maintenance of Care Plans is essential to the coordination of care for Members who have multiple chronic diseases. This support must be made available in a manner which does not place the entire expense of nursing support on the PCP or NP.

Hospital transition of care nursing support and case management services for critically ill Members of PCPs and NPs is essential to overall cost control and improved outcomes that are typically beyond the reach of most PCPs or NPs. Most cost in the health care system starts with a hospitalization.

Pharmacy consultation for Members with multiple medication/prescriptions is essential to stabilization of the multi-chronic Member and should be performed in cooperation with local pharmacists.

Behavioral health services are essential to a high percentage of Care Plan Members and must be made available to PCPs and NPs and local nurses as a continuing part of any overall Program of Care Coordination.

HBS and home assessments are essential to stabilizing Members with multiple chronic diseases and must be readily available as a resource for PCPs and NPs in Care Plan development and maintenance.

The CareFirst PCMH Program Can Be Seen As A Market Driven Model

In sum, the CareFirst PCMH Program seeks behavioral change on the part of PCPs and NPs that is driven by their pursuit of enlightened self-interest through incentives to improve quality and cost in the aggregate for their defined population of attributed Members. These incentives are intended to fuel the desire on the part of PCPs and NPs to work as a part of a small team-driven approach in which performance and reward are tightly linked. Team performance and cooperation is assumed to be atypical for many PCPs/NPs and must be induced to occur by the Program's rules, structure and incentives.

The role of the Program Administrator (CareFirst) is seen as essential as the role of the PCP and NP, but this role is supportive and enabling, not controlling. Rather, the incentives, accountability model, and information feedback loops in the Program are deliberately intended to create an etiology of productive change in behavior centered on the PCP/NP and his or her decision-making on behalf of Members that cuts across all settings and aspects of care.

Thus, in a deliberate way, the PCMH Program design is intended to be self-fulfilling, self-policing, and uses the pursuit of self-interest to achieve a larger public policy purpose. In this sense, it is a market-driven model. Little intrusion through traditional means of cost control (preauthorization, medical necessity reviews, etc.) is present. The dual goals of higher quality outcomes and more moderate cost trends are the intended result. Stated alternatively, the Program uses incentives and accountability to create a market driven dynamic in which PCPs and NPs "shop" for specialty and other services on behalf of their Members and focus on the Members that need them the most across time and settings of care. This is something the Member cannot do as well for himself or herself.

Indeed, the "OIA", explained in **Part III**, **Design Element #9** that follows, is the method used by CareFirst to calculate the level of financial reward that is distributed to the Medical Panels. Medical Panels that achieve at least a minimum level of Member Engagement and beat their target budgets earn an OIA. That is, the Panels that achieve savings for their whole cohort of Members receive incentive payments which are paid in the form of increases to their fees in subsequent periods. These awards, in turn, are tied to the percentage level of savings the Panels generate in their target budgets and their relative performance on a set of defined quality measures. The level of OIA is ratcheted up and down to reflect the relative quality and consistency of performance of each Medical Panel.

This gives the Medical Panels strong motivation to both save on costs and improve quality. Medical Panels that improve quality without saving costs do not receive incentive payments on the grounds that total healthcare costs (at nearly 18 percent of GDP) are already at the breaking point of affordability and funding payment for higher quality alone without also improving efficiency is no longer feasible.

Quality improvement and cost control are seen as inextricable. Cost control without quality improvement is impossible over the long term. PCPs and NPs cannot achieve improvements in quality and cost control by themselves. Indeed, they must catalyze these improvements by effective, informed relationships with specialists. The Program gives them the tools to do so and incentive to use them in this regard.

In short, the PCMH and TCCI Programs assume that any system can be beaten. The PCMH and TCCI Programs set up a system that is designed to be beaten but, when beaten, is beaten in a socially productive way.