

**Part IV: Medicare Fee-For-Service (FFS) Beneficiaries In  
PCMH/TCCI: Expanding The Program’s Reach  
Via The “Common Model”**

## Preface

While CareFirst is the largest commercial health care payer in the Mid-Atlantic region when considering the number of people it serves, the single most significant payer in the region is Medicare when measured by the size of health care reimbursements it accounts for. Virtually all Medical Care Panels in the PCMH Program that offer adult medicine and all mixed Panels (pediatric and adult medicine combined) receive a substantial portion of their reimbursement from the Medicare Program.

The presence of chronic disease in the Medicare population is far higher than in the general under age 65 population, leading to a Medicare per capita spending level that is four times higher than that for CareFirst membership. Per capita Medicare expenditures in the CareFirst region are among the highest in the nation.

The CareFirst region also experiences a higher percentage of Medicare beneficiaries enrolled in Traditional Medicare (i.e., Medicare Fee-For-Service). This reflects the fact that Medicare Advantage Plans have not penetrated the CareFirst region to the same extent as in the rest of the nation, leaving the vast majority of the Medicare population in the region with little or no Care Coordination.

In total, there are just over one million Medicare Fee-For-Service (FFS) beneficiaries living in the CareFirst service area. CareFirst provides Medicare Supplementary products to a small portion of this population (serving approximately 65,000 beneficiaries), most of whom purchase Plan F – the most complete Medigap coverage plan available.

In fulfilling its mission to provide affordable health care coverage to as many people as possible in its service region, CareFirst has considered whether the capabilities now in place with the PCMH and TCCI Programs could be effectively applied to the large unmanaged Medicare FFS population. It is clear that indeed they can – and in so doing, contribute to more effective cost control and quality enhancement for CareFirst Members as well.

To this end, CareFirst has been operating since mid-2013, a pilot program – under an Innovation Award from CMS – called the “Common Model” that is the side-by-side application of the PCMH and TCCI Programs for both CareFirst and Medicare Fee-For-Service beneficiaries. The Innovation Award was completed on December 31, 2015 and its final results will be known and made available by July, 2016. This “Common Model” is described in the pages that follow.

Following the completion of the Award, CareFirst is providing a Mission related grant to support the carrying out of the Common Model through June, 2016 while efforts proceed with CMS to determine how best to continue to support the Model with Medicare Trust Fund monies on a larger scale.

## **Common Model**

The core idea behind the “Common Model” is to apply all the Program Elements present in the PCMH and TCCI Programs to both Medicare FFS beneficiaries and CareFirst Members.

Such a common approach, would provide “heft” for a more powerful transformation of the health care delivery system since a large portion of health care spending (50 percent) would be impacted and be subject to the incentives and accountability structure built into the PCMH/TCCI Programs. The inclusion of the Traditional Medicare population into the PCMH/TCCI Programs would provide a single model that is Member and primary care centric, as well as population based with a common underlying accountability and financial incentive system that is at the core of these Programs.

Indeed, a Common Model used by the region’s largest private and public payers – with common incentive rules, common infrastructure, common data sharing and transparency as well as common accountability – could create a powerful effect on the approach taken by PCPs and NPs in caring for their Members – to the potential benefit of the whole community. This, in turn, would likely influence the referral patterns to high value specialists used by these PCPs and could profoundly affect the level, nature and extent of hospital-based use (i.e., admissions, readmissions, ER visits) in the region, which, as noted, is among the highest in the nation and the central health care challenge the region faces.

The theory of action behind the Common Model is that when the shared savings concept is broadened to include both the Medicare and CareFirst populations, there will be a far more powerful financial reason for the PCPs to pay attention to total outcomes. As the PCPs become more involved in and committed to the care management activities that are encouraged and supported by the PCMH/TCCI Programs, their effects will grow, accelerate and spread throughout the health care system.

As noted, on a combined basis, Traditional Medicare (Parts A & B) and CareFirst reimbursements account for approximately half of all health care spending in the region. If placed under a single, common global incentive and accountability model focused on the chronic and multi-chronically ill sub-populations these payers serve (as well as those at greatest risk for chronic illness), a major impact could potentially be achieved in reducing hospital admissions, readmissions and over medication (and the complications that flow from this) – thereby better restraining the rise in health care spending while improving care outcomes for all.

The knowledge gained by Medical Care Panels over the past five years with the CareFirst membership and “tuning” of the model in this period of the operational supports and processes that make up the PCMH/TCCI Programs, has produced a network of PCPs armed with experience and knowledge of the tools that makes them more able to select and coordinate the care of the multi chronic Member – or those at high risk for chronic conditions. In short, their private sector experience with the PCMH and TCCI Programs enables PCPs and NPs to be well set up to deal with the greater challenges of Care Coordination required with the Traditional Medicare FFS population.

## **CMMI Innovation Award**

It was with these thoughts in mind that CareFirst applied to CMMI for a Health Care Innovation Award in early 2012. The purpose was to create a new model Pilot Program in which the Traditional Medicare FFS beneficiaries already being served by PCPs in the CareFirst PCMH network would be brought within the PCMH/TCCI Program framework.

CareFirst received one of the largest Innovation Awards in the nation and the only award of its kind to a payer to pilot the PCMH/TCCI Common Model for both Medicare FFS beneficiaries and CareFirst Members. CareFirst has operated the Pilot Program for approximately 40,000 Medicare FFS beneficiaries who are currently attributed to 14 Medical Care Panels selected because they are representative of all Panels in the PCMH and TCCI Programs.

These selected Panels coordinate care for both their Medicare FFS beneficiaries and CareFirst Members in a common way with intense focus on the chronic and multi-chronic Member. As much as possible, one set of rules, one common infrastructure, one set of data, one set of accountability rules and one incentive model applies to both payers.

In essence, the Innovation Award tests whether a common incentive-based system built around PCPs with strong Care Coordination features can create a new form of public-private partnership. This partnership model will ultimately help both CareFirst and CMS achieve the Triple Aim of better health, better health care (including quality and satisfaction), and lower costs through improvements.

This new model is inherently scalable and, if proven successful, could be extended virtually without limit to other geographic areas and other Member segments such as beneficiaries eligible for both Medicare and Medicaid. Unlike many Accountable Care Organizations under the Medicare Shared Savings Program (“ACOs”), CareFirst’s Innovation Award is truly PCP and Member centric and not tied to a specific hospital or health care delivery system.

**What Follows in this Part**

This **Part IV** describes the rules and methods that apply to the Innovation Award’s Common Model. Since providers and Panels cannot not be in multiple incentive or shared savings Programs which cover the same Medicare beneficiaries simultaneously, Providers and Panels voluntarily agreed to participate only in the Common Model Pilot Program and not in any other ACO or other Medicare Shared Savings Program.

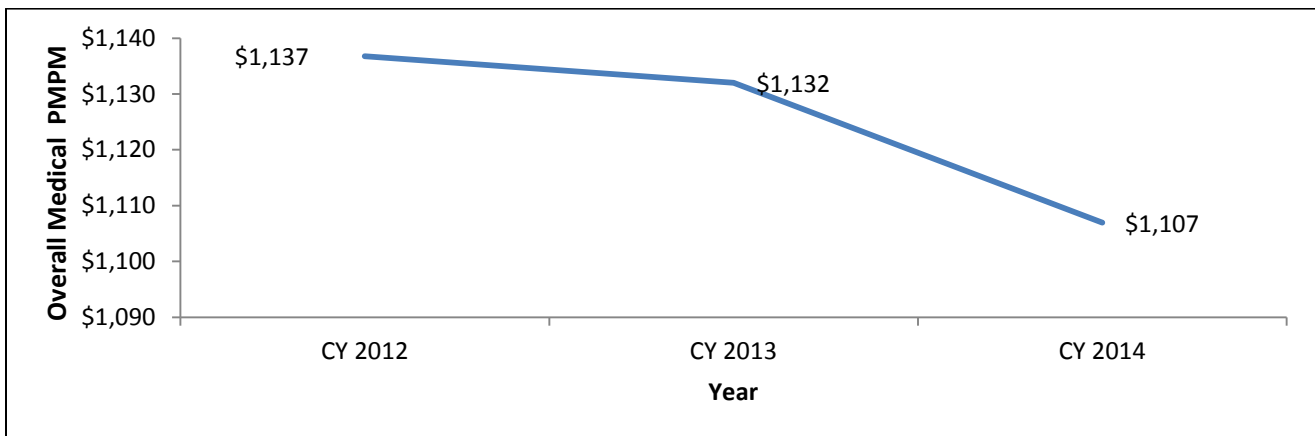
The CareFirst PCMH/TCCI Programs that are the subject of the CMMI Award contain highly detailed and specific rules which establish provider accountability, responsibility and incentives for cost and quality outcomes for CareFirst Members. The Innovation Award enables these very specific Elements, incentives and rules to be applied to the Medicare Fee-For-Service beneficiary population in carefully selected, pilot Panels of PCPs.

The driving assumption is that when the same rules, incentives, infrastructure and types of data are shared with experienced primary care Panels who treat both Medicare beneficiaries and CareFirst Members (which, on a combined basis, account for approximately 50 percent or more of the dollar flow in these Panels) that this will accelerate and deepen the impact on behavior change among the providers in these Panels. This, in turn, will motivate deeper change and accelerate progress towards the achievement of better cost and quality outcomes as well as improve the health of the Medicare and CareFirst populations in these Panels.

**Results Have Been Promising**

Given that CareFirst was three years into the PCMH/TCCI Programs at the start of the Innovation Award, there was high confidence that when the features and rules and incentives of these Programs were applied to the Traditional Medicare population, they would produce productive change. This has, indeed, proven to be the case. **Figure 1** shows results through December 31, 2014.

**Part IV, Figure 1: Overall Medicare PMPM For CMMI Panels (Part A & B)**

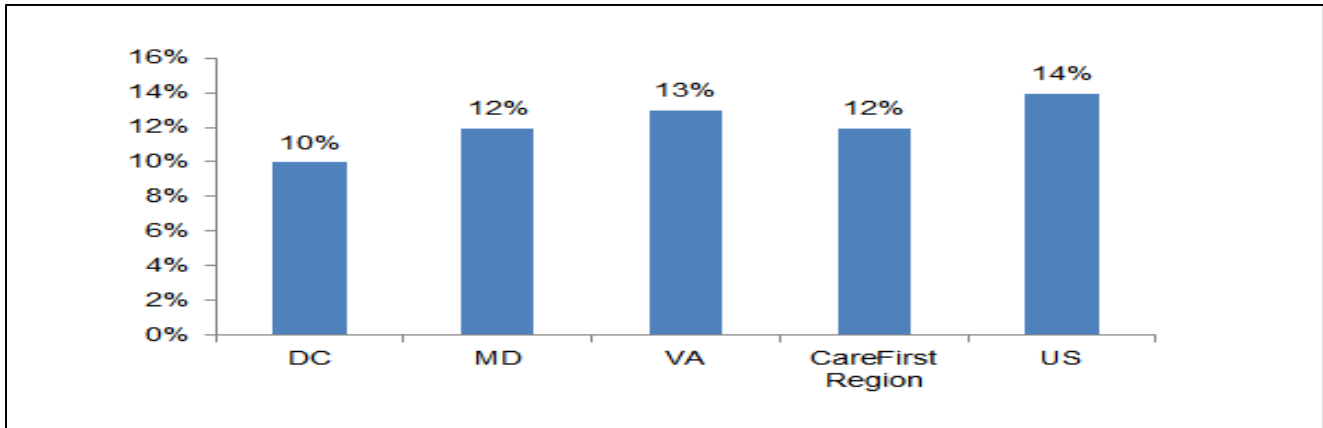


The Panels in the Common Model Pilot have all joined voluntarily. As of July, 2015 there were 14 Panels with more than 125 PCPs and approximately 40,000 Medicare beneficiaries. This membership has held steady through the Award period. The illness level in the Medicare population in the participating Panels has held steady or slightly increased during the period of the Award.

## The Key Facts That Shape The Challenge

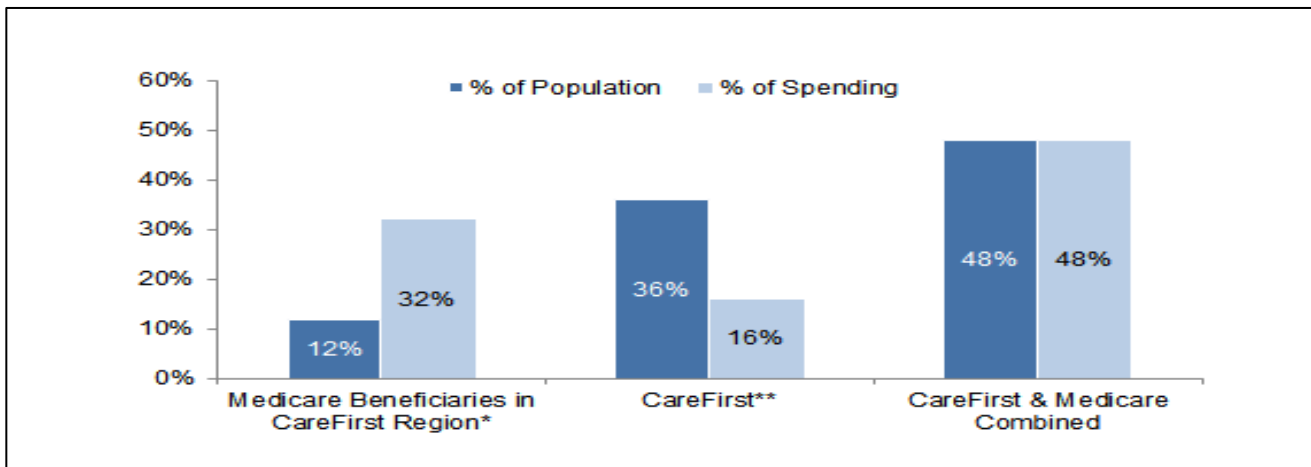
As is shown in **Figure 2** below, the CareFirst service region is generally representative of the nation as a whole in the proportion of the population that is over age 65 and Medicare eligible. There are an estimated 1.1 million Medicare eligible beneficiaries in the region accounting for approximately 12 percent of the total population. They account for approximately 32 percent of all health care spending in the region.

**Part IV, Figure 2: Percent Of Population Covered By Medicare, 2012<sup>1</sup>**



When looking at the combined picture of CareFirst and Medicare FFS enrollment and healthcare spending in the region, one can clearly see their large footprint in **Figure 3** below.

**Part IV, Figure 3: Percent Of Medicare Population And Spending, 2012<sup>2</sup>**



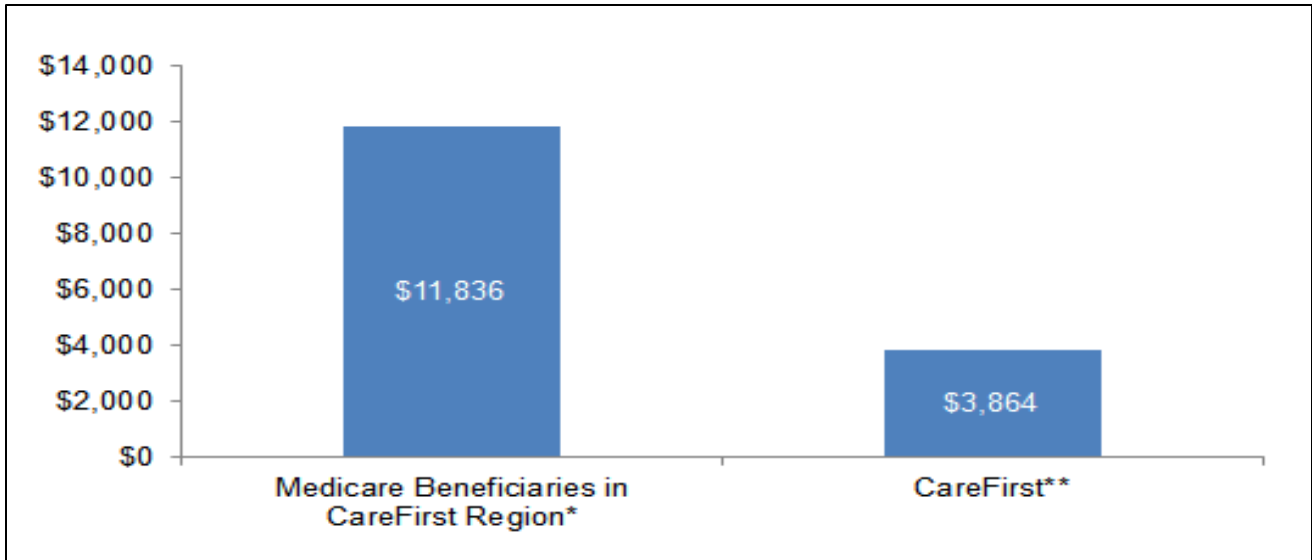
**Figure 4** on the next page shows that total spending per Medicare beneficiary is three to four times greater than that of the level of spending on the under age 65 population that makes up the vast majority of all CareFirst Members.

<sup>1</sup> Source: Kaiser Family Foundation State Health Facts (2011-2012). Medicare beneficiaries include managed care and Fee-For-Service (FFS) beneficiaries.

<sup>2</sup> Medicare beneficiaries include managed care and FFS beneficiaries CareFirst total population, excluding Members outside of CareFirst Service Area.

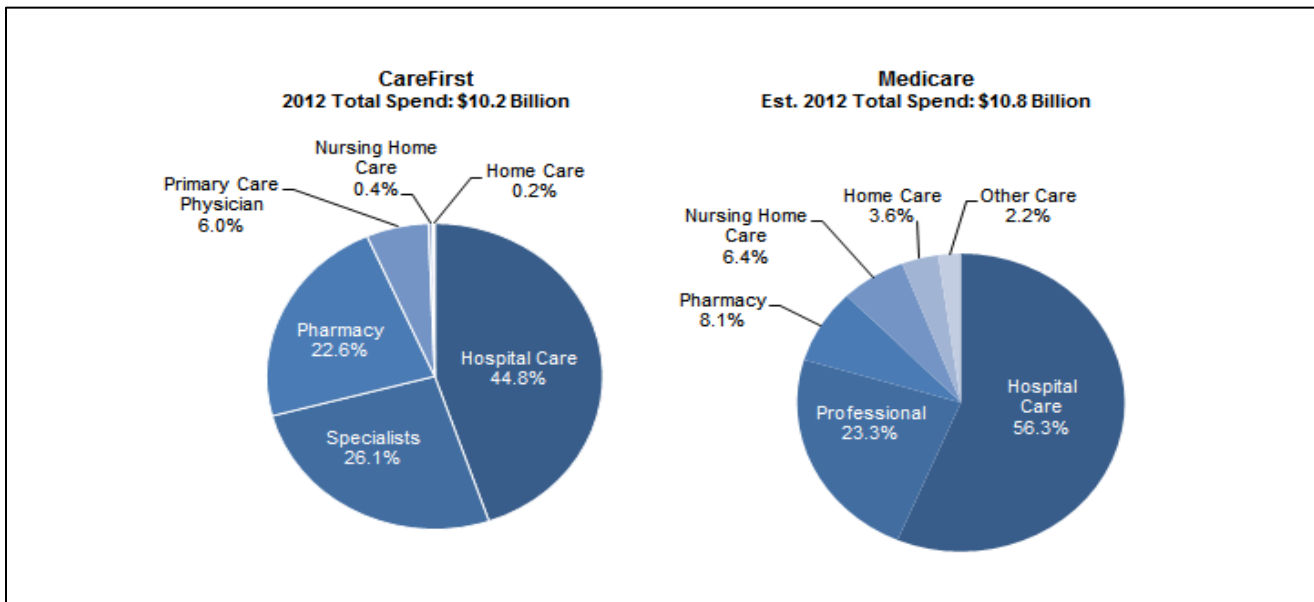
Source: Kaiser Family Foundation State Health Facts (2011-2012); CMS spend is 2012 estimated from CMS Health Expenditures by State of Residence, 2009, CareFirst December 2012 Unified Enrollment Report (UER) and 2012 Measures that Matter (MTM).

**Part IV, Figure 4: CareFirst Members' Per Capita Costs**



As can be seen in **Figure 5**, the portion of all Medicare spending on hospital and institutional services is significantly higher than in the CareFirst population reflecting the high dependency on hospital-based services in meeting the health care needs of the Medicare population.

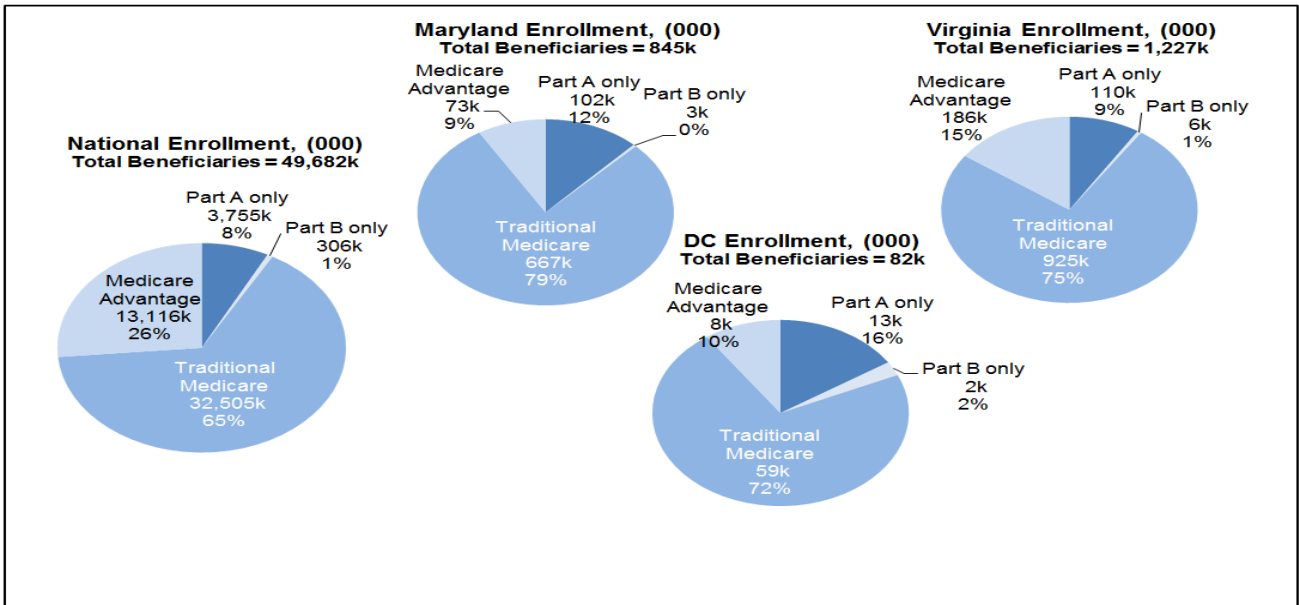
**Part IV, Figure 5: Comparison Of CareFirst And Medicare Spending – Total And Composition<sup>3</sup>**



Significantly, the portion of Medicare beneficiaries in the CareFirst service region that are covered by Parts A and B is greater than the national average as is shown in **Figure 6** on the next page.

<sup>3</sup> Source: CMS, National Health Expenditures (NHE), Health Spending by State of Residence, 2009. CareFirst 2012 allowed claims data.

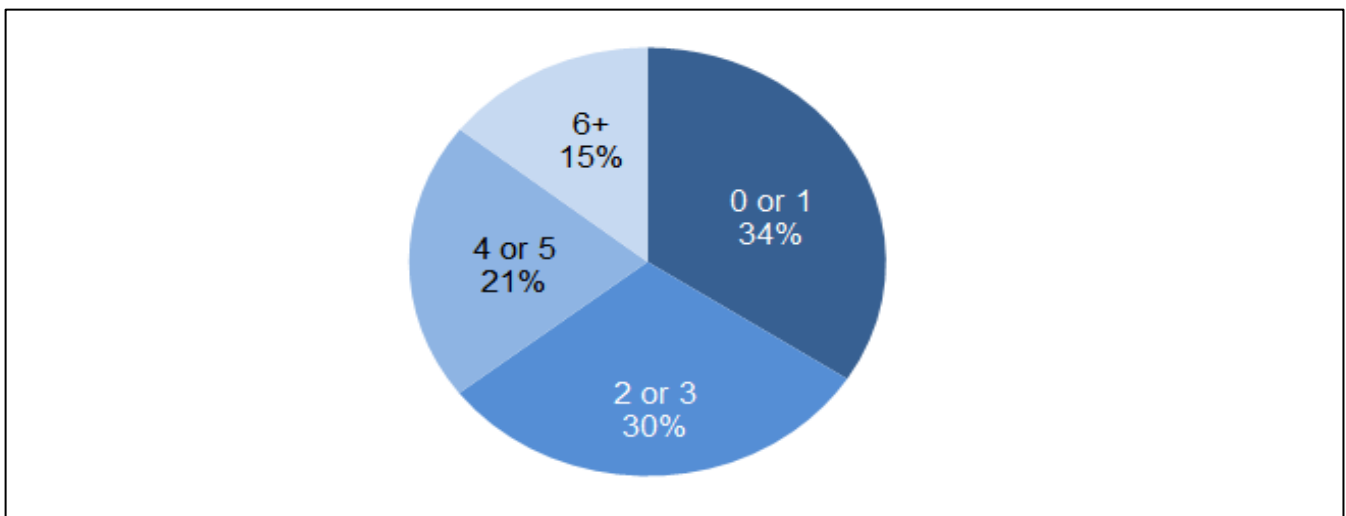
**Part IV, Figure 6: Medicare Enrollment By Type Of Coverage, 2012<sup>4</sup>**



This population receives virtually no Care Coordination and is particularly vulnerable to breakdowns that lead to hospital admissions, readmissions and greater use of hospital ERs.

This is highly significant because the prevalence of chronic disease among Medicare FFS beneficiaries is extensive as shown in **Figure 7** below.

**Part IV, Figure 7: Percent Of Medicare Fee-For-Service (FFS) Beneficiaries With Multiple Chronic Conditions, 2012 (Number Of Chronic Conditions Per Medicare Beneficiary)<sup>5</sup>**



<sup>4</sup> Source: CMS. Medicare & Medicaid Statistical Supplement. Chapter 2: Medicare Enrollment. Table 2.5. Medicare Enrollment: Hospital Insurance and/or Supplementary Medical Insurance for Total, Fee-For-Service (FFS), and Managed Care Enrollees by Area of Residence, as of July 1, 2012.

<sup>5</sup> Source: Centers for Medicaid and Medicare Services (CMS). Multiple Chronic Conditions Prevalence State/County Table: All Beneficiaries by Age, 2012.

The presence of chronic conditions has a substantial bearing on the costs of care for the Medicare population nationwide, but the CareFirst service region shows particularly poor results in the level of hospital admissions and readmissions as is shown in **Figure 8** below.

**Part IV, Figure 8: CareFirst Service Region: Medicare Fee-For Service (FFS) Beneficiaries Admission/Readmission Rates Versus U.S.<sup>6</sup>**

2011	Inpatient Costs Per Capita	Admissions Per 1,000	30-day Hospital Readmission Rate
National Average	\$2,684	312	17.5%
US Maximum	\$3,487	361	22.7%
US Minimum	\$1,727	167	12.9%
<b>MARYLAND</b>	<b>\$3,487*</b>	<b>331</b>	<b>19.9%</b>
<i>Maryland Rank</i>	53 <sup>rd</sup>	39 <sup>th</sup>	41 <sup>st</sup>
<b>DC</b>	<b>\$3,243</b>	<b>361</b>	<b>22.7%</b>
<i>DC Rank</i>	52 <sup>nd</sup>	53 <sup>rd</sup>	51 <sup>st</sup>
<b>VIRGINIA</b>	<b>\$2,495</b>	<b>294</b>	<b>17.3%</b>
<i>Virginia Rank</i>	22 <sup>nd</sup>	27 <sup>th</sup>	22 <sup>nd</sup>

As indicated earlier, the region has had the highest hospital admission and readmission rates in the country. This presents a major opportunity to improve. With this improvement could come enhanced quality of care – as measured by a reduction in the cycle of readmission. It is believed that lower overall use of hospital-based care can only occur through better coordination of care for the multi-chronic Member in the community and home. PCPs are in the best position to oversee and direct this care.

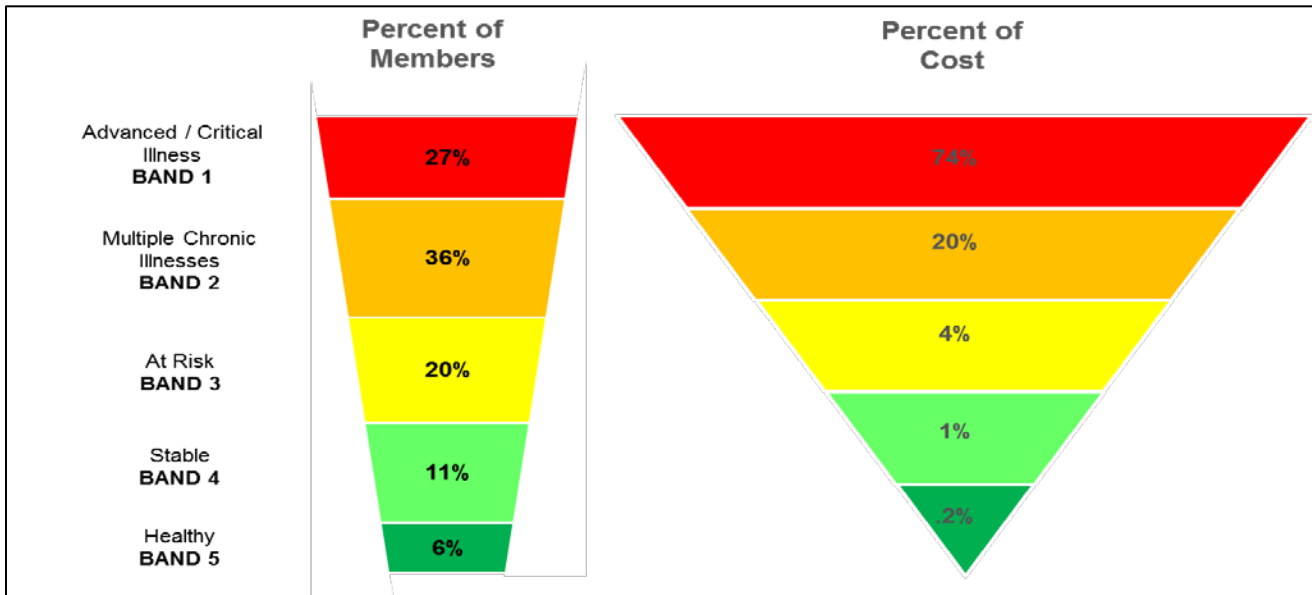
There is no more dramatic way to illustrate the impact of chronic disease on health care spending for the Traditional Medicare population than to examine the percent of all costs that are accounted for by the five Illness Bands used in the PCMH/TCCCI Programs. This is shown in **Figure 9** on the following page.

<sup>6</sup> Inpatient and Outpatient costs per capita in Maryland were adjusted down by 6.07% to adjust for indirect and direct medical education costs and down by 6.82% to adjust for uncompensated care costs. Without this adjustment, Maryland cost figures were overstated.

Source: CMS Medicare State Level Demographic, Cost, Utilization, and Quality Data, 2011. 30-day Readmission Rate data were reviewed from the Commonwealth Fund Maryland State Health System 2009 Scorecard.

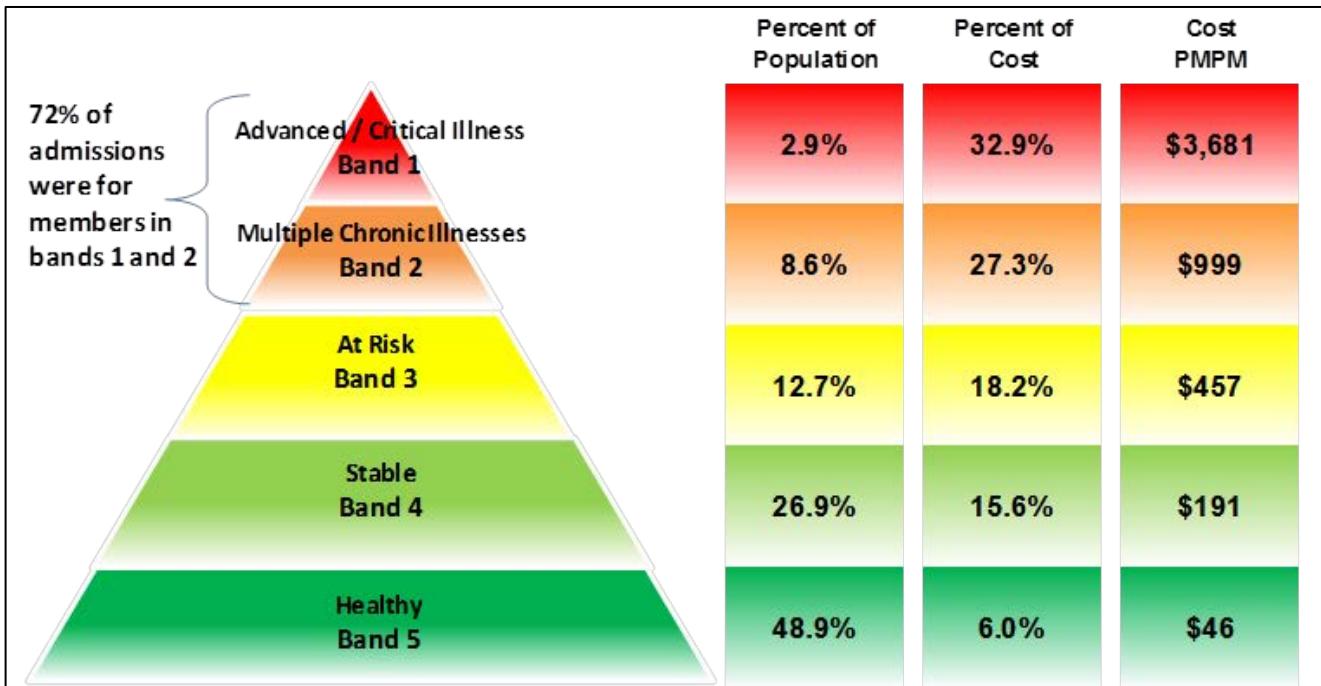


**Part IV, Figure 9: Illness Burden Pyramid: 2014 Spending Among Age 65+ CareFirst Members<sup>7</sup>**



This concentration of cost near the top of the Illness Burden Pyramid contrasts sharply with the pattern in the under age 65 population which, while also very concentrated in the top two bands, is nowhere near as dramatic as is shown in **Figure 10** below.

**Part IV, Figure 10: CareFirst Illness Burden Pyramid, 2014<sup>8</sup>**

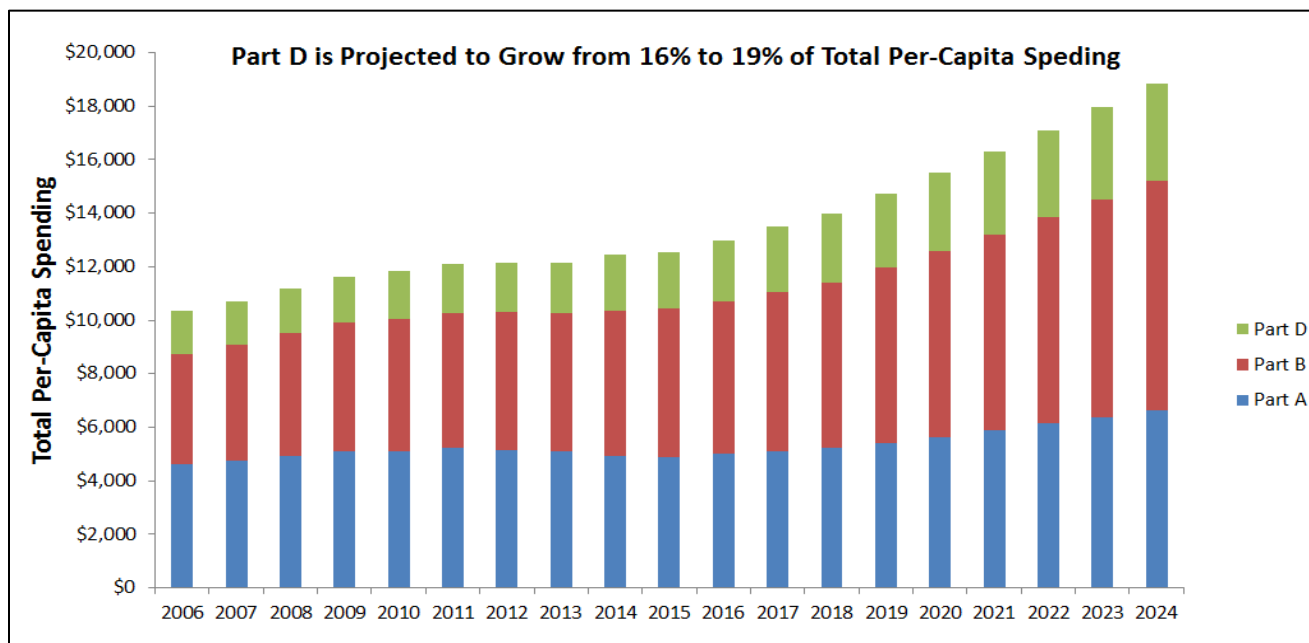


<sup>7</sup> Source: CareFirst HealthCare Analytics – incurred in 2014 and paid through March 2015 – CMMI Grant Data for Medicare Beneficiaries.

<sup>8</sup> Source: CareFirst HealthCare Analytics – Incurred in 2014 and paid through March 2015 – CareFirst Book of Business, excluding Medicare Primary Members.

Prescription medications are the primary means of treating beneficiaries with multiple chronic conditions. Yet, despite the fact that nearly 70 percent of Medicare beneficiaries have two or more chronic conditions, recent Medicare data suggests only about 11 percent of Part D enrollees have participated in any medication therapy management programs. This is likely because physicians and hospitals lack real-time data on a Member’s medication use and have little time to invest in adherence interventions, and have little financial incentive to allocate time or resources to improving medication use. This occurs as Part D drug costs continue to become a greater portion of overall spending for Medicare beneficiaries. This is shown in **Figure 11** below.

**Part IV, Figure 11: Medicare Fee-For-Service (FFS) Per-Capita Spending 2006-2024<sup>9</sup>**

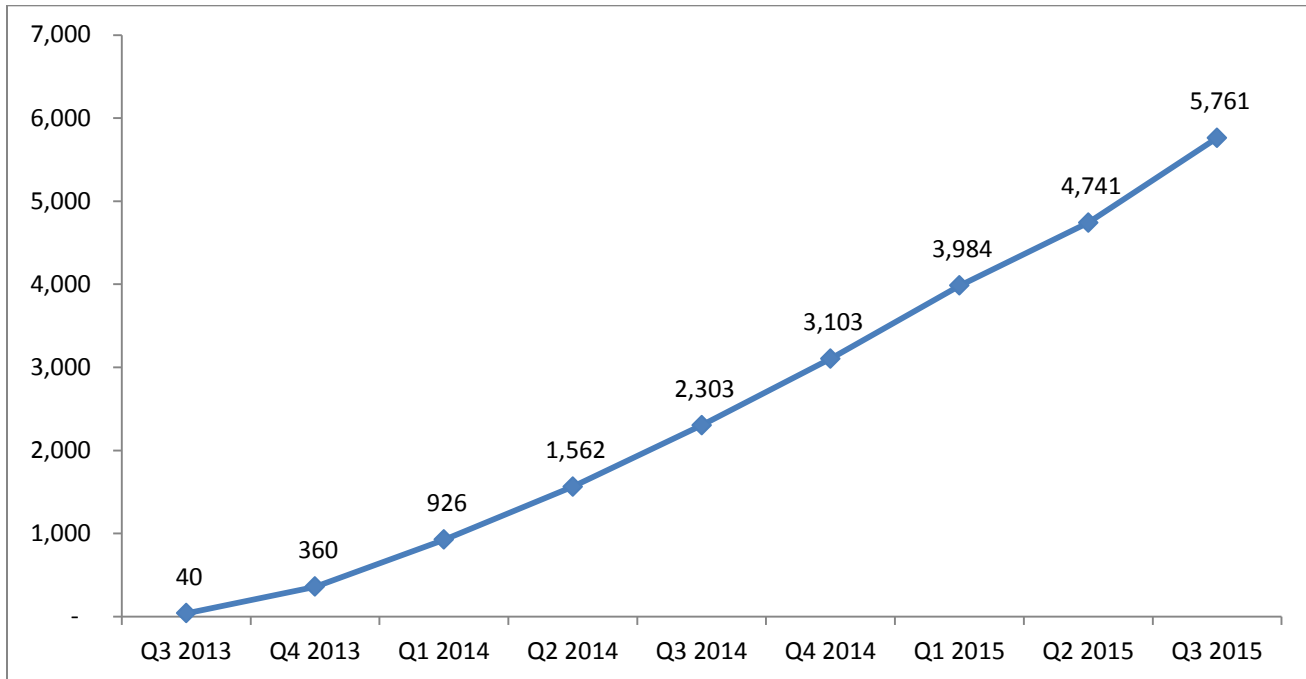


Pharmacy costs are a large percentage of all medical costs in the average Panel. Beneficiaries with multiple chronic conditions or acute illnesses can often be on 10 prescriptions or more. Under the TCCI CMR Program, a pharmacist conducts Comprehensive Medication Reviews for Members at high risk for drug interactions or adverse events, and works directly with all of the member’s prescribers to resolve or prevent drug-related problems. Similarly, a pharmacist works directly with beneficiaries who have chronic conditions or drug regimens that predict a risk of nonadherence, gaps in care, or other drug-related problems. Both CMR and MTM are provided to individuals who are likely to benefit, regardless of the pharmacy at which they fill their prescriptions.

In the Common Model Pilot, under the Innovation Award, Part D data is not available in a timely manner. Therefore, Care Coordinators conduct medication reconciliations for every beneficiary in a Care Plan by painstakingly reconstructing and documenting all medications each beneficiary is on. The medication information is derived from beneficiary interviews (based on medication lists or information developed after the beneficiary brings in pill bottles for review), provider records from all specialists involved in the beneficiary’s care, as well as information from the Member Health Record, if available. Over the course of the Innovation Award, CareFirst has performed thousands of medication reconciliations, as shown on the next page in **Figure 12**. Through this, PCPs have improved visibility of the variety of medications beneficiaries are taking – from narcotics to over-the-counter medications. This has led to dosage corrections and other changes in the prescriptions of beneficiaries as well as to more informed clinical decisions.

<sup>9</sup> Source: 2015 Medicare Trustees Report, July 2015

**Part IV, Figure 12: Total Medication Reconciliation Volume Under The Common Model Pilot**



**The Core Idea: Common Model Strengthens Behavioral Change Toward Triple Aim**

Given the facts above, there is a compelling opportunity to bring Traditional Medicare FFS beneficiaries into the PCMH/TCCI Programs in an attempt to achieve the purposes of the Triple Aim.

To start, it is useful to recognize that the average PCP in active practice in adult medicine has on average 250 Medicare beneficiaries in their practice. This means that the average Panel has between 2,500 and 3,000 total such beneficiaries for whom they are currently providing care. Of these, over 85 percent are enrolled in the Traditional Medicare Program. Indeed, the Traditional Medicare FFS population that is in the Panels selected for the Innovation Award Program exhibit this pattern and account for approximately 40,000 total Medicare FFS beneficiaries in addition to the 60,000 total CareFirst Members in these Panels.

If these Medicare FFS beneficiaries are supported in the same manner as CareFirst Members in the PCMH Program – through care plans and the array of TCCI Programs - under the guidance of PCPs and NPs who are experienced with Care Plans and incented in the same manner as for CareFirst Members, it seemed reasonable that there should be a noticeable improvement in the quality of their care and a lessening of breakdowns resulting in high cost hospital-based services.

From a Panel’s point of view, the development of a common model for Medicare FFS beneficiaries and CareFirst Members enables them to modify and adopt consistent processes for both populations in order to focus more fully on the Members who need them the most – regardless of which of the two payers is involved. And, they can make more informed decisions regarding the “buying” and “arranging” of specialty services for these two populations with far more purchasing power and complete information.

The power that comes from combining the two Programs through the Common Model is illustrated in **Figure 13** on the next page. The average Panel in the PCMH Program with about 3,000 CareFirst Members had a target budget of approximately \$12 million in 2013 (Performance Year #3). This target represented the sum of the “Credits” in its PCA.

The inclusion of Medicare FFS Beneficiaries added about \$40 million more in Medicare “Credits” to the Panel’s PCA for 3,000 Medicare FFS beneficiaries in the example below. This would bring the Panel’s overall target budget to over \$50 million per year.

Given this size, even a modest savings against these target amounts could produce substantial OIAs. As shown in **Figure 13**, a six percent savings on Medicare and an eight percent savings on CareFirst Members would significantly reward PCPs and NPs in Medical Care Panels that lower costs through improvement in cost and quality results.

**Part IV, Figure 13: Combined Medicare And CareFirst Patient Care Account (PCA) For Typical Panel<sup>10</sup>**

	Medicare	CareFirst Commercial	Total
Beneficiaries/Members	3,000	3,000	6,000
Global Budget Target	\$40M	\$12M	\$52M
Potential Savings (%/\$)	6% / \$2.00M	8% / \$1.00M	\$3.00M
OIA ( \$ )	\$0.5M*	\$0.4M	\$0.9M

These potentially large OIAs have a profound impact on encouraging participating Panels to change their practice patterns and approach to Care Coordination as well as their workflows and referral patterns in pursuit of a higher reward for achieving better results. It also spurs Panels to more fully use the Program capabilities of TCCI to increase support to both populations within the same framework of rules – leading to efficiency as well as enhanced effectiveness which produces improved care outcomes and costs results.

The resulting impacts are felt well beyond the Panel itself and manifest themselves in lower admissions, readmissions, ER use, better medical outcomes and more carefully decided referrals to more cost effective specialists who admit to more cost effective hospitals.

**The Goals Of The Common Medicare Fee-For-Service (FFS) And CareFirst Model**

In short, there are three goals that the Common Model being piloted in the Innovation Award seeks to achieve:

**First**, provide greater impetus to Panels to transform their day-to-day operations toward more effective Care Coordination of multi-chronic Members across care settings and time. The key to this is for PCPs to make more informed “buying” decisions for Members who need specialty services – which, in turn, influences the use of more cost effective specialists and hospitals. The ultimate goal of the Common Model is to reduce cumulative total care costs from what otherwise would have been the case. The combined model enables a substantial increase in the “buying power” of PCPs who account for only three percent of Medicare spending and six percent of CareFirst spending;

**Second**, address the region’s most critical health care cost issue - the high rate of hospital use (in Member admissions, readmissions and ER visits). Specifically, the goal is to reduce admission/re-admission rates for Medicare beneficiaries participating in the Pilot Program through better stabilization of these beneficiaries at home or in the community. This requires the creation of well-developed and executed Care Plans involving Medicare FFS beneficiaries that include many enabling TCCI support Elements. Indeed, since inception of the Pilot Program, over 3,500 Care Plans have been implemented for these beneficiaries and admissions and ER use rates have dropped.

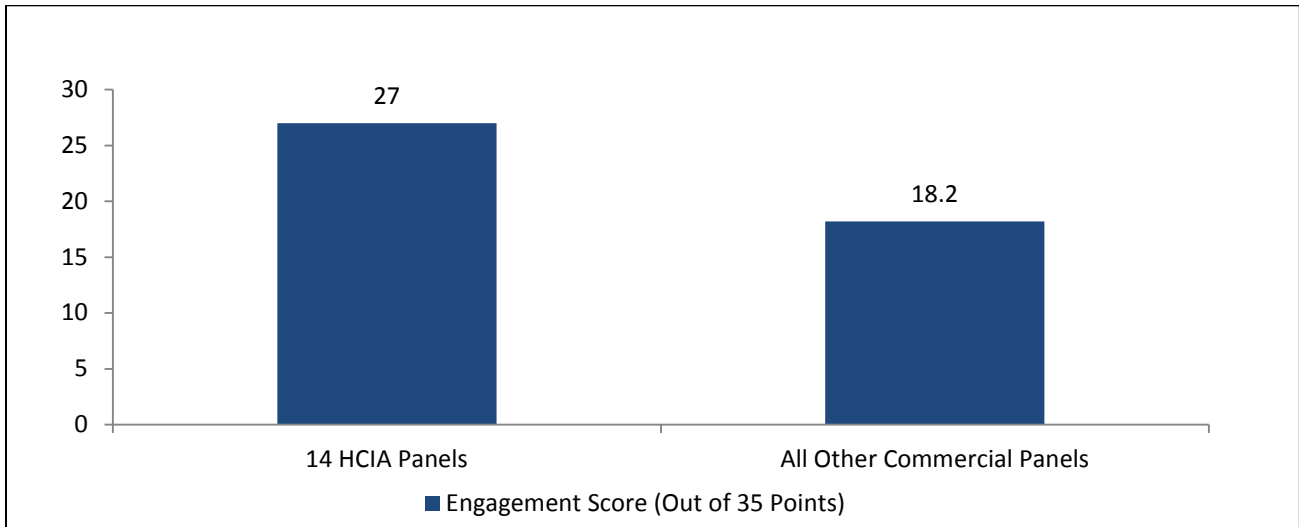
**Third**, improve quality through reductions in gaps in care and by overcoming the fragmented nature of health care services needed by the chronic Member/Beneficiary as well as fostering far greater attention to the causes of breakdowns in these Members. Indeed, the cohort of Panels that participated in the Pilot have considerably outperformed their peer Panels in the Commercial CareFirst PCMH Program on key quality measures.

<sup>10</sup> Medicare OIA payouts to Panel winners have been restricted due to CMMI Grant OIA fund limitations.

Taken together, these three goals help achieve the Triple Aim at the heart of CMS' interest: achieving better health, better health care and lower costs. The results to date against these three goals are shown in **Figures 14** through **18**.

As shown in **Figures 14 and 15**, Panels in the Pilot have become far more engaged in the Program, and achieve far better outcomes in all aspects of the PCMH/TCCI, than other Panels only in the commercial Program.

**Part IV, Figure 14: 2014 Average Primary Care Provider (PCP) Engagement Scores**



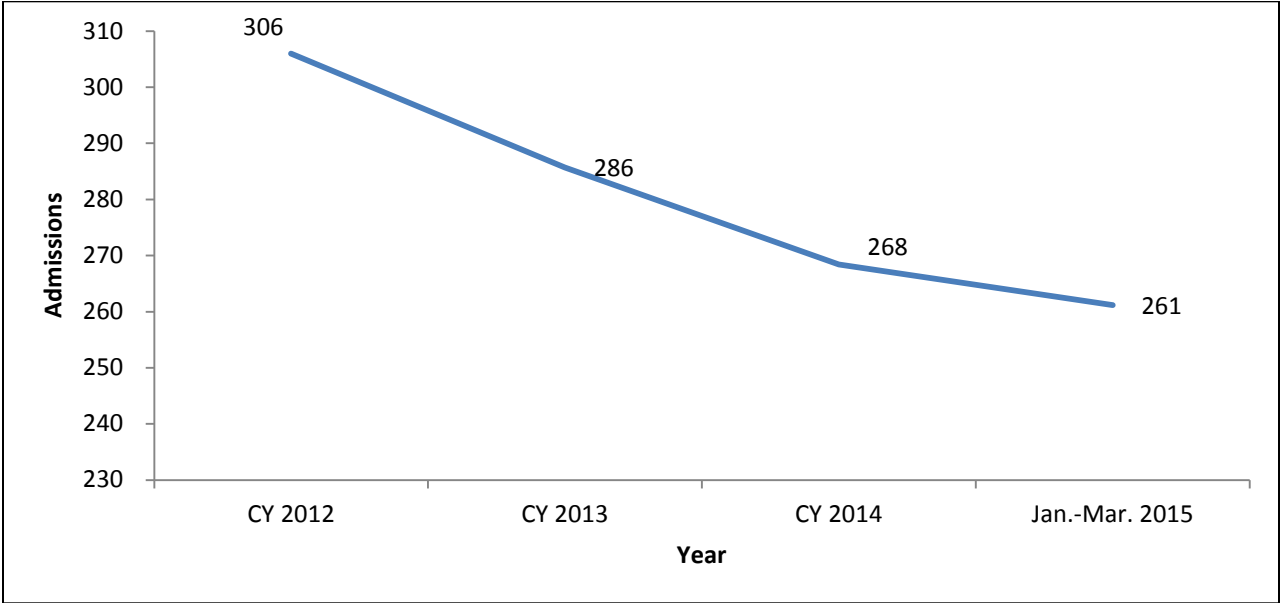
**Part IV, Figure 15: Panels Operating Under A Common Model Perform Better On Cost And Quality in 2014**

Measure	HCIA Participating Panels	Commercial Program (All Panels)	Difference
# of Panels	14 (100% winners)	417 (48 % winners)	N/A
Savings	10.1%	7.6%	2.5%
Average Quality Score	71.5	61.2	10.3
Average OIA	77	40	37

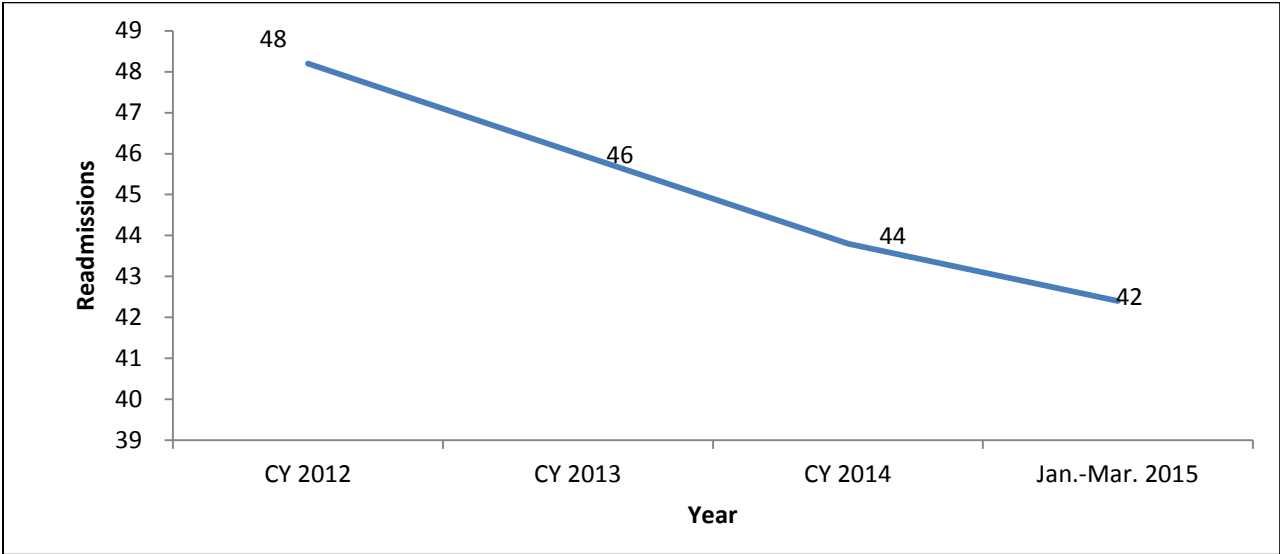
Under the Common Model Pilot, Panels have placed greater focus on their referral patterns to specialists and identified areas of opportunity to shift beneficiaries to more cost-efficient specialists. All 14 Panels created a list of preferred high value specialists and have begun to direct referrals to those specialists. Panels have incorporated these specialist lists into their daily operations by uploading their lists into their Electronic Health Record and/or distributing paper forms to other PCPs and office staff. By empowering PCPs with new cost referral data, the 14 Panels have provided beneficiaries with a wide array of choice, while sustaining a high percentage (86.6 percent) of referrals to high value specialists.

This level of engagement and focus has led to very encouraging results. As shown in **Figures 16** through **18** utilization metrics show promising signs of trending in the desired direction. The number of hospital admissions and readmissions per 1,000 beneficiaries, which had continuously increased prior to the launch of the Award, has had a steady decline since the Common Model was implemented. ER visits have seen an overall decrease and global medical cost has dropped significantly since 2012.

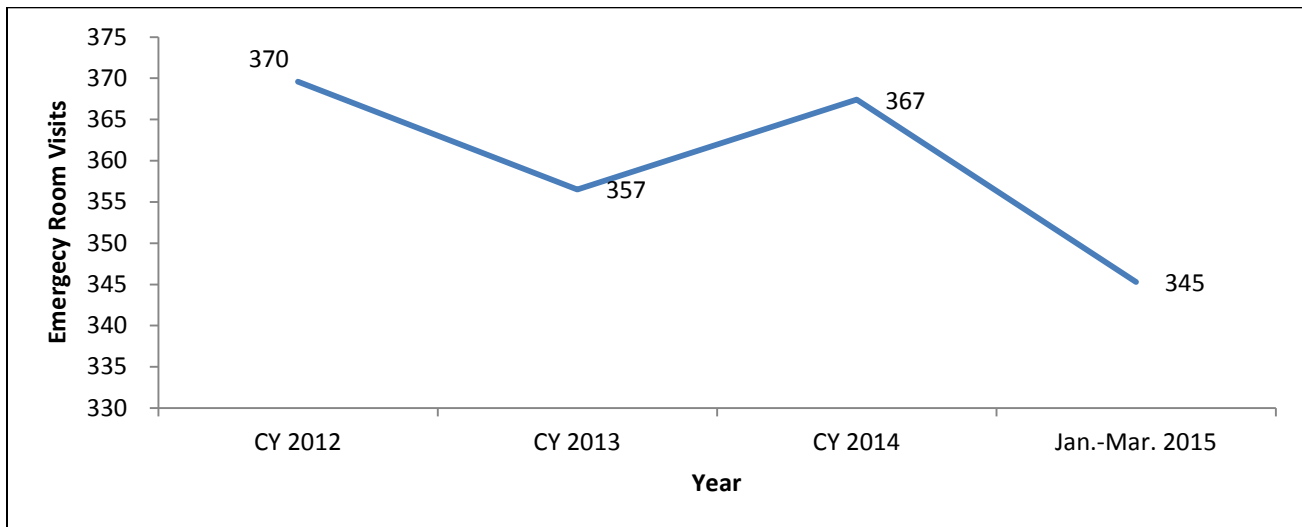
**Part IV, Figure 16: Total Admissions Per 1,000 Beneficiaries**



**Part IV, Figure 17: Total Readmissions Per 1,000 Beneficiaries**



**Part IV, Figure 18: Total Emergency Room Visits Per 1,000 Beneficiaries**



The Innovation Award enables a nearly complete uniformity in the way care for Medicare beneficiaries and CareFirst Members is coordinated through common, shared use of the PCMH/TCCI framework, data and incentives. This is outlined in the description below which describes how each PCMH and TCCI Design and Program Element is intended to work for Medicare FFS beneficiaries as part of the new integrated “Common Model” under the Innovation Award.

#### **Integrating Medicare Fee-For-Service (FFS) Into The PCMH And TCCI Programs: Common Rules And Incentives Under The Innovation Award**

##### **Data Comes First**

The first step in the implementation of the Innovation Award is the monthly receipt by CareFirst of data on Medicare FFS beneficiaries from CMS. This process has been developed jointly by CMS and CareFirst and was placed in routine operation in July, 2013. Medicare data is loaded into the CareFirst Business Intelligence (CBI) environment and data warehouse where it supports all aspects of the PCMH and TCCI Programs.

For the Panels that have been selected to participate in the pilot commencing on July 1, 2013, CMS provides complete and detailed enrollment and Part A and B claims data on each Medicare FFS beneficiary attributed to a PCP or NP in one of the selected pilot Panels.

The data supplied by CMS includes basic demographic information on each beneficiary as well as each beneficiary’s detailed medical claims history going back to calendar year 2010 (Part A and B claims). Unfortunately, Part D drug data is not readily available on a reasonably current basis (it is 18 months out of date). This requires that current drug data be obtained as part of a Care Plan for those selected beneficiaries whose care is to be coordinated. With the exception of the old or missing drug data, all information on Medicare beneficiaries and CareFirst Members is essentially the same and is derived from the same sources: 834 enrollment forms and 835 remittance forms.

Once Medicare data is obtained and held in the secure CareFirst data warehouse, all features of the iCentric System are enabled for Medicare FFS beneficiaries in the same manner as for CareFirst Members. This includes the monthly generation of SearchLight Reports that show emerging Panel experience for Medicare beneficiaries in the same way as for CareFirst Members (each is shown separately, but with the same views, drill downs and online features). This creates a parallel, side-by-side set of views: one for Medicare beneficiaries and one for CareFirst Members. The only exception is the lack of current drug data on Medicare FFS beneficiaries which CareFirst and CMS are working to overcome.

In essence, other than the fact that there are two different payers involved, the entire infrastructure and data supports to Panels are the same - enabling Panels who have learned to use the Elements of the TCCI Program for CareFirst Members - to apply these Elements to Medicare beneficiaries in the same manner.

## **Claims for Medicare Fee-For-Service (FFS) Beneficiaries Continue Through the Usual Intermediary Tracks**

It should be noted that primary care and other providers serving Medicare FFS beneficiaries continue to submit claims for their services to Medicare's administrative contractors in the standard way. These claims are processed and paid according to standard Medicare rules. This processing and payment by Medicare produces the data provided to CareFirst by CMS. Medicare fee payments to providers (Medicare "Allowed Amounts") are posted to PCAs of participating Panels before application of any beneficiary cost sharing and become "Debits" in the PCAs of Participating Panels in exactly the same way as are Debits for CareFirst Members (as CareFirst Allowed Amounts).

With this said, it is now possible to summarize how each of the 10 Design Elements of the PCMH Program are handled for Medicare FFS beneficiaries in the participating Innovation Award Panels.

### **Treatment of Participation Fee**

There is no Participation Fee paid to PCPs and NPs for Medicare FFS beneficiaries in the Common Model Pilot as there is for CareFirst Members. For CareFirst Members, the Participation Fee is paid as a fee schedule increase. Under the Innovation Award, all Medicare FFS payments are paid by Medicare and, since a Participation Fee is not included in Medicare coverage, the elimination of the Participation Fee is required.

### **No Risk to PCPs, NPs and Panels**

There is no risk taken by PCPs, NPs or Panels in the Common Model. The model extends the incentive-only feature of the CareFirst PCMH/TCCI Programs to the Panels participating in the Innovation Award for Medicare FFS beneficiaries.

### **Design Element #1: Medical Care Panels**

The Panels that are participating in the Innovation Award Pilot are already established and functioning with over four years of operating experience with the CareFirst PCMH/TCCI Programs. No changes in Panel composition or changes in the Program rules governing these Panels were needed to enable the integration of the Medicare FFS beneficiaries who have been attributed to these participating Panels. This, **Design Element #1**, as described in **Part III** continues to apply.

The only additional requirement placed on the participating Panels is that they voluntarily sign an addendum to their provider contract with CareFirst to apply all rules and features of the PCMH/TCCI Programs to their Medicare FFS beneficiaries and to cooperate with the Common Model Pilot Program and its evaluation/oversight.

### **Design Element #2: Member Attribution**

The attribution of Medicare FFS beneficiaries to PCPs and NPs within the Panels selected for the Common Model Pilot Program is performed by CareFirst using CMS data in the same manner as attribution is performed by CareFirst for its Members as outlined in **Part III, Design Element #2**. Throughout the award period (2013-2016), this has been performed by CareFirst on the same cycle and with the same frequency as occurs for CareFirst Members. CareFirst will use the monthly data files it receives from CMS to perform the attribution process for Medicare FFS beneficiaries.

### **Design Element #3: Calculation of Illness Burden Scores**

CareFirst calculates Illness Burden Scores for Medicare FFS beneficiaries in the Innovation Award in the same manner and on the same monthly cycle as it does for CareFirst Members as is described in **Part III, Design Element #3**. The results of these calculations are shown in SearchLight views in a manner that mirrors the views provided for CareFirst Members.

### **Design Element #4: Establishing Global Targeted Care Costs for Each Participating Panel and Debiting Care Costs against these Targets**

CareFirst establishes a Base Year Global Target Care Cost for each Medicare FFS beneficiary in a manner consistent with that for CareFirst Commercial Members as described in **Part III, Design Element #4**. However, instead of the 2010 base year generally used for CareFirst Members, CareFirst uses 2012 as the base year for Medicare FFS beneficiaries. This base year includes all claims information supplied by CMS for each attributed Medicare FFS beneficiary. The Global Target



Care Cost per beneficiary is updated with incremental new CMS data for periods beyond the Base Year in the same manner as for CareFirst Members.

To do so, CareFirst incorporates Illness Burden Scores in the Base Year for Medicare FFS beneficiaries and then reflects changes in these scores on a monthly basis in the same manner it does for CareFirst Members, including a final year end adjustment after three months run out of Medicare A and B claims experience following the Performance Year.

CareFirst applies a trend factor to the Illness Burden adjusted Base Year costs of Medicare FFS beneficiaries derived from a modified regional trend for Medicare Part A and B per capita expenditures. This is parallel to the OMT used to project the Illness Burden adjusted Base Year costs for CareFirst Members into each Performance Year. The Medicare OMT used for the 14 Panels was 2.5 percent and 2.5 percent for 2013 (six months) and 2014 respectively and was 2.5 percent for 2015.

The first performance period for Medicare FFS beneficiaries was July 1, 2013 to December 31, 2013. This short period reflects the mid-year start of Award supported operations. The full calendar year 2014 was used to measure performance of the participating Panels in Grant Year #2 – which was Performance Year #4 for CareFirst. A separate settlement for each of these periods was made after allowing three months of claims run out (as explained below).

CareFirst established and maintained a common PCA for each participating Panel that reflects Medicare “Credits” and “Debits” for each Panel’s Medicare FFS beneficiaries in the same manner as it does for each Panel’s CareFirst Members. The PCA will separately show Medicare and CareFirst Debits and Credits for each participating Panel as well as show the sum of all Credits and Debits for the two payers combined.

All Debits for Medicare in the PCA of each Panel include the Care Coordination fees for TCCI services such as HBS, CMR and EMP Services just as is done for CareFirst Members.

The same virtual Individual Stop Loss (ISL) protection (at \$75,000 per Member/beneficiary per year) is used for Medicare and CareFirst Members with the same Panel participation in the costs above this level (20 percent) debited to the PCA.

#### **Design Element #5: Deciding and Making Referrals**

CareFirst has integrated and includes data in SearchLight Reports on Medicare payments to specialists used by participating Panels in the same manner it does for specialists used by these Panels for CareFirst Members. Referrals for both populations are often to the same specialists. Hence, the additional Medicare A and B data augments the profile of the specialists used by the participating Panels and is made available to PCPs and NPs in deciding on referrals for both CareFirst Members and Medicare FFS beneficiaries.

In effect, the additional Medicare claims data is used to provide a more complete view of the cost patterns of the specialists that care for each participating Panel’s Members.

#### **Design Element #6: Enhanced Focus on the Chronic Member Through Care Plans**

The development and maintenance of Care Plans for Medicare FFS beneficiaries is carried out in the same manner as for CareFirst Members – as described in **Part III, Design Element #6**. Documentation of Care Plans in the iCentric System for Medicare FFS beneficiaries is performed in accordance with the same Standard Operating Procedures contained in **Appendix C** to these Guidelines.

This has been accomplished through the hiring of additional LCCs (supported by the Innovation Award) who are dedicated solely to Medicare beneficiaries in the participating Panels. These dedicated LCCs report in the same manner to RCDs as do their commercial counterparts and are subject to the same Care Plan quality review processes and standards. In total, approximately 40 new LCCs are assigned to the fourteen Medicare participating Panels for the purpose of Care Coordination for Medicare FFS beneficiaries.

The selection of Medicare FFS beneficiary candidates for Care Plans is carried out in the same manner that it is for CareFirst Members. Generally, the same selection criteria are used. However, disproportionately more Care Plan Eligible Medicare FFS Beneficiaries are targeted for Care Plans reflecting the far more extensive presence of chronic disease in the Medicare FFS population.

PCPs and NPs in participating Panels receive the same \$200 and \$100 Care Plan Development and Maintenance fees for Medicare FFS beneficiaries as paid for CareFirst Members in Care Plans. These fees are paid directly to the PCPs and NPs from CareFirst using Innovation Award funds and are not be billed to Medicare. The same monthly charge for LCC support for active Care Plans (\$380/month in 2015) is debited to the PCA of participating Panels for CareFirst Members and Medicare FFS beneficiaries as are the fees for other TCCI services such as HBS, CMR and EMP Services.

#### **Design Element #7: Maintenance of Online Member Health Record**

As with all CareFirst Members, CareFirst maintains an up to date Member Health Record for every Medicare FFS beneficiary in the same manner and to the same extent as for CareFirst Members. This record is composed of the same components as for CareFirst Members as presented in **Part III, Design Element #7**. The record can be accessed through iCentric in the same way as it is for CareFirst Members.

#### **Design Element #8: Measuring Quality – The Essential Ingredient**

All of the quality measures and the process by which these measures are determined is the same for Medicare FFS beneficiaries as for CareFirst Members, and are periodically updated to reflect the evolution of industry standards. This includes the calculation of Degree of Engagement in accordance with the Standard Operating Procedures that guide how Engagement is measured for CareFirst Members. All other quality measures are aligned the measures CMS currently uses for its Medicare Shared Savings Program. The weightings with regard to the various categories of quality measures also are the same for Medicare FFS beneficiaries and for CareFirst Members as is the 100 point scale on which quality is measured. There is no departure from the methodology described in **Part 3, Design Element #8** as further developed in **Appendix C**.

#### **Design Element #9: Reward for Strong Performance**

Within six months after the end of each Performance Year, CareFirst accumulates all Debits for services provided to CareFirst Members and Medicare FFS beneficiaries in each of the participating Panels during the Performance Year starting with 2013. As noted earlier, a short period (July 1, 2013 through December 31, 2013) was used for Medicare FFS beneficiaries due to the start of the pilot on July 1, 2013. A full Performance Year was used in 2014 and 2015 for Medicare beneficiaries in parallel with CareFirst Members.

In all respects, the methodology that is used to calculate an OIA is the same as presented in **Part III, Design Element #9**. This includes the use of the same matrices for the determination of the intersection between the quality score of the Panel and the degree of savings the Panel achieved.

Any participating Panel that is entitled to a Medicare OIA based on its Medicare performance will be paid this award in a lump sum during quarter three of the year following the performance year. This lump sum is calculated by multiplying the percentage OIA that is due the Panel times the Medicare allowed amounts for PCP services rendered to Medicare FFS beneficiaries in the Performance Year. For Virtual Medical Panels, this lump sum payment is divided up and paid to the constituent practices in the Panel based on each practice's portion of all primary care service claims that were generated by the Panel in the Performance Year.