Patient-Centered Medical Home Program Update

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(BlueCross BlueShield of Tennessee Inc., an Independent Licensee of the BlueCross BlueShield Association)
Becoming Agents of Change

**The CMS Innovation Center:**
- $10 Billion Investment:
  - Accountable Care
  - Bundled Payments
  - Primary Care Transformation
- Announced renewed commitment to value-based care
- Revised ACO Program
- Introduced Care Management Reimbursement

**Health Care Finance Administration:**
- State Innovation Models Project
- Bundled Payments
- PCMH
- 3 bundles launched
- 70 in design over 5 years
- PCMH project underway
- Unified platforms for Medicaid with ADT & care management

**BlueCross & BlueShield:**
- PCMH
- Bundled Payments
- Pay for Performance
- Shared Savings
- Strategic Partners
- PCMH re-investment of $65M over 5 years (2014-2018)
- MA Stars program
- QCPI – Commercial
- P4G BlueCare
- Multiple shared-savings models launched
PCMH Expansion Update & 2015 Program Evaluation

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Strategic Partnership Landscape

CURRENT LANDSCAPE

- New Narrow network product design
- Dual Network
- Transition of Care
- LifeScan

= Patient-Centered Medical Home locations

• TBD

PCMH Annual Conference 2016 – Becoming Agents of Change
## PCMH Expansion Update

### 2015 Practices

<table>
<thead>
<tr>
<th>Practice</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heritage Medical Associates</td>
<td>Nashville</td>
</tr>
<tr>
<td>Saint Thomas Medical Partners</td>
<td>Nashville</td>
</tr>
<tr>
<td>Heritage Medical Associates</td>
<td>Nashville</td>
</tr>
<tr>
<td>Premier Medical Group</td>
<td>Clarksville</td>
</tr>
<tr>
<td>Memorial Health Partners</td>
<td>Chattanooga</td>
</tr>
<tr>
<td>Consolidated Medical Group</td>
<td>Memphis</td>
</tr>
<tr>
<td>Rural Health Services Consortium</td>
<td>Rogersville</td>
</tr>
<tr>
<td>Summit Medical Group – expanded to all locations</td>
<td>Knoxville</td>
</tr>
<tr>
<td>Jackson Clinic – expanded to all locations.</td>
<td>Jackson</td>
</tr>
</tbody>
</table>

### 2016 Practices

<table>
<thead>
<tr>
<th>Practice</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellmont Memorial Associates</td>
<td>Kingsport</td>
</tr>
<tr>
<td>Christ Community Health Services</td>
<td>Memphis</td>
</tr>
<tr>
<td>Dickson Medical Associates</td>
<td>Dickson</td>
</tr>
<tr>
<td>Erlanger Health Systems</td>
<td>Chattanooga</td>
</tr>
</tbody>
</table>

*currently in negotiations with 4 additional practices.*
2015 PCMH Program Evaluation: Study Design

• In lieu of measuring impact using a randomized trial method, an alternative method to minimize selection bias is propensity matching. A case-control propensity matching was used to measure the effectiveness of PCMH program for this initiative.

• Propensity Matching Algorithm was used to select PCMH members and compare them over time to non-PCMH members (i.e. 3 to 1 matching population).

• Variables that affect PCMH cost and utilization are put into a logistic regression model to compute a probability of selection:
  1) Age
  2) Sex
  3) LOB
  4) Rx Benefit (i.e. ASO accounts that carve Rx out)
  5) Region (of member)
  6) Chronic diseases
  7) Prior year normalized risk score
  8) Prior year allowed pmpm
## PCMH 2015 Evaluation Results: Quality Improvement

Significantly higher quality compliance scores on 9 out of 12 measures in the PCMH practices.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Eligible</th>
<th>Compliant</th>
<th>Compliance Rate</th>
<th>Difference from Non PCMH</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment</td>
<td>42,650</td>
<td>29,613</td>
<td>69.4%</td>
<td>39.0%</td>
<td>*&lt;0.001</td>
</tr>
<tr>
<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</td>
<td>1,007</td>
<td>252</td>
<td>25.0%</td>
<td>1.8%</td>
<td>0.2456</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>10,455</td>
<td>8,765</td>
<td>83.8%</td>
<td>8.7%</td>
<td>*&lt;0.001</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>17,919</td>
<td>14,119</td>
<td>78.8%</td>
<td>5.2%</td>
<td>*&lt;0.001</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>21,780</td>
<td>16,201</td>
<td>74.4%</td>
<td>11.8%</td>
<td>*&lt;0.001</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Eye Exams</td>
<td>6,052</td>
<td>3,219</td>
<td>53.2%</td>
<td>11.3%</td>
<td>*&lt;0.001</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c Control (&lt;8%)</td>
<td>6,052</td>
<td>2,434</td>
<td>40.2%</td>
<td>20.8%</td>
<td>*&lt;0.001</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c Testing</td>
<td>6,052</td>
<td>5,641</td>
<td>93.2%</td>
<td>3.3%</td>
<td>*&lt;0.001</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Medical Attention for Nephropathy</td>
<td>6,052</td>
<td>5,065</td>
<td>83.7%</td>
<td>9.0%</td>
<td>*&lt;0.001</td>
</tr>
<tr>
<td>Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis</td>
<td>277</td>
<td>232</td>
<td>83.8%</td>
<td>7.7%</td>
<td>0.0076</td>
</tr>
<tr>
<td>Osteoporosis Management in Women Who Had a Fracture</td>
<td>26</td>
<td>7</td>
<td>26.9%</td>
<td>-14.0%</td>
<td>0.1869</td>
</tr>
<tr>
<td>Use of Spirometry Testing in the Assessment and Diagnosis of COPD</td>
<td>417</td>
<td>169</td>
<td>40.5%</td>
<td>3.9%</td>
<td>0.1578</td>
</tr>
</tbody>
</table>
2015 PCMH Program Evaluation: Cost Savings Model

PCMH population breakdown into 3 to 1 propensity matching model

- 38% of PCMH population is included in the propensity model
- PCMH population has to 12 months continuous attribution in a PCMH group for all of 2015
- Non PCMH Attributed to a Non PCMH practice at end of 2015
- High cost claimants (claim >= $100k for 2015) are excluded

<table>
<thead>
<tr>
<th>Categories</th>
<th>PCMH</th>
<th>Non PCMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Pull (Members attributed to a provider)</td>
<td>198,990</td>
<td>1,000,335</td>
</tr>
<tr>
<td>BCBST Continuous Enrollment in 2015</td>
<td>29,914</td>
<td>99,024</td>
</tr>
<tr>
<td>PCMH Continuous Attribution in 2015</td>
<td>72,546</td>
<td>-</td>
</tr>
<tr>
<td>Exclude members with allowed claims &gt;= $100,000 in 2015</td>
<td>420</td>
<td>4,046</td>
</tr>
<tr>
<td>Previous Year Continuous Enrollment in 2014</td>
<td>17,980</td>
<td>265,007</td>
</tr>
<tr>
<td>Failed to match in propensity model</td>
<td>2,965</td>
<td>549,639</td>
</tr>
<tr>
<td><strong>Post-Matching population</strong></td>
<td>75,165</td>
<td>75,165</td>
</tr>
<tr>
<td><strong>Post-Matching population (Chronic only)</strong></td>
<td>37,583</td>
<td>37,583</td>
</tr>
</tbody>
</table>
Comparing PCMH vs. Non-PCMH Population:

3 to 1 propensity matching:

- PCMH population is “bending the trend” on cost at a .47% vs 1.52% (non-PCMH) pmpm improvement
- a 2.87 ROI is achieved with this population
- PCMH admits per 1k lowered by -3.4% vs. – 0.5% Non PCMH population
- Scripts/1000 and pharmacy cost are higher in the PCMH population vs non-PCMH
PCMH Program: Long-Term Strategy
PCMH: Our Mission and Scope

**Mission:** Transforming lives of Tennesseans through coordinated, patient-centered care, resulting in improved quality, health outcomes, and patient/member satisfaction.

**Scope:** All LOBs; selected subset of BlueCross contracted Primary Care Providers; currently includes adult primary care practices but in future would include pediatric practices. Enterprise PCMH five-year (2014 – 18), $65M expansion with a goal of 500K BlueCross members and/or 50 PCMH practices.
PCMH: What We Do

Promote, support and enable PCMH providers to redesign primary care to achieve better value, better care and better outcomes.

Work closely with PCMH providers, patients and BlueCross population health programs to connect, share and coordinate among all of the participants concerned with a patient's care to achieve better and more effective care.

*Promote, Support, Enable… Connect, Share, Coordinate*
PCMH Program Goals

• Support Enterprise Strategic Goals:
  Deliver Best Medical Value – Partner with providers to improve cost and quality
  Drive Positive Change – Drive health care system improvement

• Support the primary care strategy and population health goals of each of the lines of business to drive improvements in quality, utilization, health care costs and outcomes.

• Promote and enable the transformation of selected primary care practices across the state of Tennessee through new payment models, focused staff resources, and IT / analytics / reporting resources.
PCMH Program Goals

• Promote and enable high performance for PCMH practices participating in BlueCross value-based programs for all lines of business.

• Leverage the PCMH model of care to improve quality, cost and outcomes at the individual member level. With a focus on care coordination, chronic care, transitions of care, and preventive services.

• Through the BlueCross strategic partnerships and PCMH practices, build a network of high performing practices and providers.
PCMH Program: Promote, Support, Enable

- Value
- Triple Aim
- Chronic Care
- Medical Home
- Payment Reform
- Population Health
- Individual Care

BlueCare
Medicare Advantage
Commercial

PCMH Program
PCMH Practice

- Embedded Care Coordinators
- Clinical Managers
- Medical Directors
- NCQA Consultants & Resources
- IT Tools/ Registry / Analytics
- Payment Model
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**Patient-Centered Medical Home Program**
(Alternative payment to support embedded care coordination)

### Medicare Advantage
- **MA STARS**
  (Alternative payment based on Quality performance)
- **MA Gain Share**
  (Alternative payment based on Quality performance)

### BlueCare
- **Tennessee Health Care Innovation Initiative (THCII)**
  (Alternative payment based on Quality & Efficiency performance)

### Commercial
- **Quality Care Partnership Initiative (QCPI)**
  (Alternative payment based on Quality performance)

#### Primary Care
- **MA Specialty Share**
  (Alternative payment based on Quality & Efficiency performance)

#### Specialty Care
- **THCII Specialist Bundles**
  (Alternative payment based on Quality & Efficiency performance)

#### Facility Care
- **MA Facility Share**
  (Alternative payment based on Quality & Efficiency performance)
- **Fixed Rate Corridors for TN Hospitals**
  (Alternative payment based on Quality & Efficiency performance)

- **Commercial Specialty Share**
  (Alternative payment based on Quality & Efficiency performance)
- **Commercial Facility Share**
  (Alternative payment based on Quality & Efficiency performance)
Key Takeaways

1. The BlueCross collaboration with PCMH practices continues to demonstrate the ability to produce better quality and a lower cost trend.

2. The PCMH model of care is foundational structure whereby BlueCross will continue to roll out new partnership and payment models.

3. The embedded care coordinator is *connector* between the PCMH practice, providers and BlueCross’ population health programs.
Thank you