CAREFIRST
COMMON MODEL PILOT

SUMMARY OF RESULTS
(2012 – 2016)

Q2 2017

Background and Overview

In 2012, CareFirst, Inc. ("CareFirst") was awarded a three-year, $20 million Health Care Innovation Award ("Innovation Award" or "Award") by the Center for Medicare and Medicaid Innovation. The Award was to pilot the application of CareFirst's Total Care and Cost Improvement ("TCCI") and Patient-Centered Medical Home ("PCMH") Program (the "Program") to Medicare Fee-For-Service ("FFS") beneficiaries in Maryland. This "Common Model", as it became referred to, offered identical incentives, data/analytic supports, rules, and quality standards for both Medicare beneficiaries and CareFirst Members.

The Common Model Pilot (the "Pilot") involved 140 PCPs in 14 teams ("Panels") of PCPs with 60,000 attributed CareFirst Members, and over 40,000 attributed Medicare Primary FFS beneficiaries. These Panels were selected to be representative (in structure and geography) of the larger PCMH Program CareFirst operates in its service area involving over 4,300 PCPs in over 440 PCP Panels. The Pilot began to serve Medicare beneficiaries in July 2013 and concluded on December 31, 2016 – a time span of three and a half years. For the entire period of the Pilot, Panels assumed responsibility for total cost and quality outcomes for their attributed Medicare FFS and CareFirst patient populations.

At the outset of the Common Model, CareFirst and the Centers for Medicare and Medicaid Services ("CMS") agreed on two goals for the Pilot and documented these goals in a written plan:

> **The first goal** was to control the rising total cost of care for Medicare beneficiaries and CareFirst Members attributed to Panels in the Pilot, principally by reducing hospital utilization. Specifically, the goals set were to achieve a 7.5 percent reduction in hospital admissions over the period (from 2012 baseline levels) and slow the rise in PMPM total beneficiary costs to produce a rate of increase at least one percent lower than the State of Maryland's 3.5 percent per capita target for Part A spending, under the State's All-Payer Hospital Model, for total care costs in Parts A & B combined (including the cost of care coordination activities).
>
> **The second goal** was to improve the quality of care delivered to the beneficiary population, measured by a set of industry-standard "consensus" measures agreed to by CMS that CareFirst and other programs use in commercial adult populations.

In addition to these two goals, CareFirst set out with CMS to test whether:

- A common set of rules, incentives, and infrastructure supports for the region's largest public and private payers would increase engagement among primary care providers and accelerate and deepen behavioral change toward value-based care;
- A common care coordination infrastructure to support high-risk and high-cost beneficiaries would result in effective/deeper adoption and substantial declines in hospital-based services; and
- Sharing Medicare claims and enrollment data on a beneficiary specific basis could be implemented for care coordination and population health management purposes.

The Common Model incorporated the basic structure and features of the PCMH Program that CareFirst operates for its commercial members:

> (a) it is organized around small, self-selected groups of PCPs ("Panels") who are given Target Budgets based on the trended historical costs of their attributed beneficiaries with ongoing risk adjustments;
>
> (b) the Panels are given financial awards ("Outcome Incentive Awards") if they beat their target budgets and meet quality and patient engagement standards;
>
> (c) the Panels are supported by CareFirst-supplied nurses ("Local Care Coordinators") who help the PCPs identify and manage frail and complex patients by coordinating their care and establishing and updating care plans for them; and
>
> (d) the Panels also receive assistance in the form of regular online data feeds, analytic reports, and other ancillary services.

Initial Challenges

After receiving the Innovation Award and outlining the goals and theories to be tested in the Pilot, CareFirst set out to apply its TCCI and PCMH technical and operational infrastructure used for its commercial Members to Medicare FFS beneficiaries in order to operate the Common Model. However, the data received from CMS was in such sub-optimal condition that the launch of the Pilot was delayed by over a year while data deficiencies were resolved.

To assure that the data on the Medicare beneficiaries was usable, CareFirst engaged in significant collaborative discussions with CMS to improve and refine the data delivery process necessary to support the Pilot. The result of this collaboration was the creation of a high-quality, electronic process that allowed CareFirst to receive and maintain beneficiary specific enrollment and claims data on a monthly basis. The data was segregated from CareFirst's commercial business, and was made secure to support the application of the TCCI/PCMH Program for Medicare beneficiaries.

The creation of this data framework allowed for a beneficiary attribution process to be conducted by CareFirst that proved to be more reliable than the process originally performed by CMS. This enabled PCPs to quickly identify those Medicare beneficiaries who were most in need of intervention as well as to gain a view of the status of all their attributed beneficiaries and CareFirst Members in the same manner. It also enabled CareFirst to provide data views online to PCP Panels, through a large array of drill-down reports structured in a common way for both populations. Finally, it allowed CareFirst to compile and use beneficiary data in a single, comprehensive database that stored detailed claims information and reported patterns of care and outcomes for each PCP's beneficiary population.

Launch in Mid-2013

Once the data framework was in place, CareFirst launched the Pilot in July 2013 and used the last six months of 2013 to rapidly build the supporting care coordination workforce of RNs who would conduct care coordination activities, establish workflows in PCP practices, and ramp up the Program for Medicare beneficiaries. In 2014, as the Pilot matured, promising results began to emerge. The results prompted CMS to extend Award funding for an additional one-year period, allowing for Pilot activities to continue until the end of 2015 in order to obtain two full calendar years of experience.

Due to CMS funding limits, however, CareFirst's Award funding was reduced by approximately $3 million in 2015, resulting in Panel incentive payments for 2014 and 2015 being capped at roughly one-third of what was actually earned by the Panels. Nevertheless, even with reduced incentives, PCP engagement continued to deepen while cost and quality outcomes continued to trend positively as the Program matured.

Indeed, 2015 results were so encouraging that CareFirst voluntarily agreed to financially support care coordination efforts at its own expense for the 40,000 Medicare FFS beneficiaries in 2016, after the end of the Innovation Award, as a bridge to a more extended pilot of the Common Model thereafter. Even after being told that there would be no incentive payments distributed for the 2016 performance year, 13 of the 14 Panels participating in the Pilot agreed to continue to participate through 2016, in hopes that their efforts would enhance the likelihood of continuing the Common Model on a larger scale. This was not to be the case since CMS chose to pursue its own CPC+ design instead of the Common Model thereafter.

Final results through 2016 show marked evidence that the Common Model caused substantially improved quality in beneficiary care, a decline in costly hospital utilization, and an overall moderation in Part A & B costs were accounted for.

The results of the Common Model Pilot include the following:

- Overall Part A & B costs Per Beneficiary Per Month ("PBPM") remained essentially flat, rising 1.7% even after the costs of care coordination and incentives are included;
- Sharp reductions in beneficiary use of hospital-based services occurred;
- The Quality and Engagement Scores of PCPs improved more dramatically throughout the three-year period, when compared to Panels not in the Pilot;

- Beneficiaries served by Care Plans were highly satisfied with their care and health outcomes, growing more satisfied as the model progressed; and
- Virtually all providers involved expressed a strong desire to continue the model.

These results are explained more fully below.

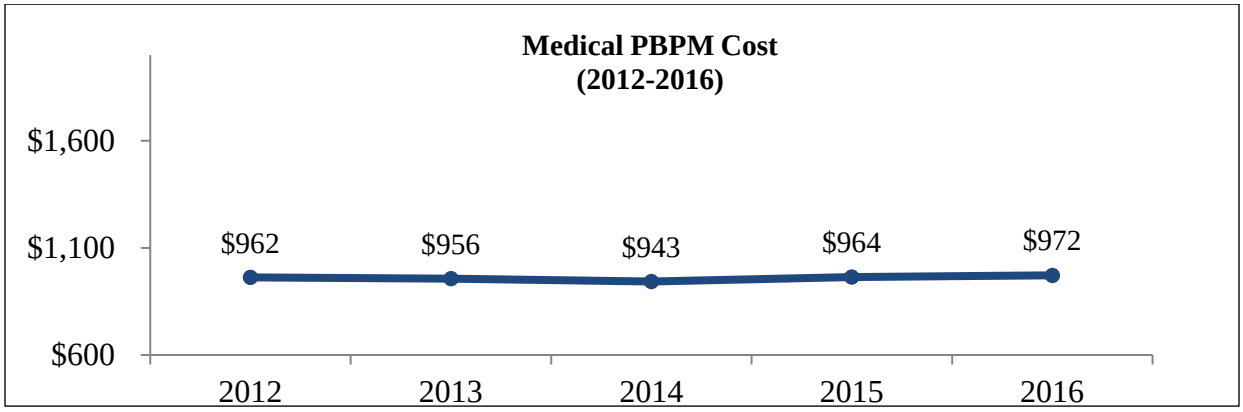
Strong Cost-Savings Results

While CareFirst is the largest healthcare payer in the Mid-Atlantic region in terms of the number of people it serves, Medicare is the largest when measured by the size of total outlays paid to health care providers. When combined, Medicare and CareFirst comprise approximately half of all individuals living in the region as well as approximately half of all payments to providers.

The Common Model Pilot was representative of this larger picture. The 100,000 patients that were attributed to the participating panels generated over $3.1 billion in claims ($1.5B CareFirst and $1.6B Medicare) during the Pilot – more than enough to see patterns and produce meaningful results.

The Common Model showed credible evidence of cost savings. When analyzing the Medicare claims data received from CMS during the entire length of the Award (with three months claims run out), the data show Overall Medical PBPM costs remained essentially flat from the Program's 2012 base-year through the end of 2016. This can be seen in **Figure 1**.

Figure 1: Part A & B Costs Per Beneficiary Remained Flat Over The Course Of The Award



Over the course of the Award, total Medicare Part A & B base-year (2012) costs per beneficiary were trended 2.5 percent in each of the four years of the Pilot. Then, actual costs – as they emerged each year in paid claims data – were compared to these trended cost targets. In CareFirst's commercial program the targeted overall medical cost trend declined from 7.5 percent in 2011 to 3.5 percent in 2014 and has remained there for the last three years. The commercial trend target is applied to both medical and pharmacy costs combined, whereas in the Pilot only Part A and B costs were included, since Part D costs were unavailable.

Actual results for the attributed Medicare population were compared to their trended targets from the 2012 base-year – after accounting for the cost to operate the Program and services not covered by Medicare such as care coordination and certain home-based services. Savings equated to a total of 5.3 percent from target levels over the course of the Pilot. This materially exceeded the estimate CareFirst made in its 2012 HCIA application.

From 2013, when the Common Model was launched, through 2016, the cumulative actual increase in Medicare's Total Part A and Part B expenses per beneficiary in the U.S. was a remarkably low 3.3%. During the same period, the actual total Part A and Part B expenses per beneficiary in Maryland increased by only 1.4%. These trends were at historic lows for reasons that are not entirely clear. The Common Model achieved a similar increase to the State of

Maryland (i.e., 1.7%) in Part A and Part B expenses per beneficiary. However, this was after all the Common Model's additional costs for care coordination fees, ancillary services, and incentives were included.[*]

Health care cost increases in general, and Medicare cost growth in particular, have fallen over the last few years from their historical levels but experts have been puzzled by this decline given that the chief factors that produce hyperinflation in health costs have not been countered by any effective, broadly deployed changes in FFS incentives or the delivery system—for example, ACOs have generally failed to save costs, other innovation models have produced minor successes in isolated experiments, etc. In contrast, the Common Model established a strong incentive system designed to save costs, improve quality and provide needed care management services to high-risk, high-cost patients. This structure is believed by CareFirst to be capable of resisting future excess health cost increases.

Figure 2 displays the accounting, against targeted budgets, for all care coordination and program operating expenses, as well as the pay out of a portion of savings generated by winning Panels through Outcome Incentive Awards ("OIAs").

Figure 2: Common Model HCIA Total Savings (July 1, 2013 – December 31, 2016) (Rounded)

	2013 (Half Year)	2014	2015	2016[†]	Total
Targeted Costs vs. Actual Costs					
Base-Year Costs Trended 2.5% per year[‡]	$228M	$484M	$519M	$486M	**$1.72B**
Actual Medicare Part A &B Claims	($210M)	($453M)	($486M)	($459M)	**($1.61B)**
Care Coordination Fees	($0.3M)	($4.7M)	($5.4M)	($3.7M)	**($14.1M)**
Ancillary Services	($0.0M)	($0.3M)	($0.6M)	($0.5M)	**($1.4M)**
Outcome Incentive Awards to Panels	($0.3M)	($1M)	($2M)	($0M)	**($3.3M)**
Total Claims / Program Costs	($211M)	($459M)	($494M)	($463M)	**($1.63B)**
Total Savings from Target	**$17M**	**$25M**	**$25M**	**$23M**	**$90M**

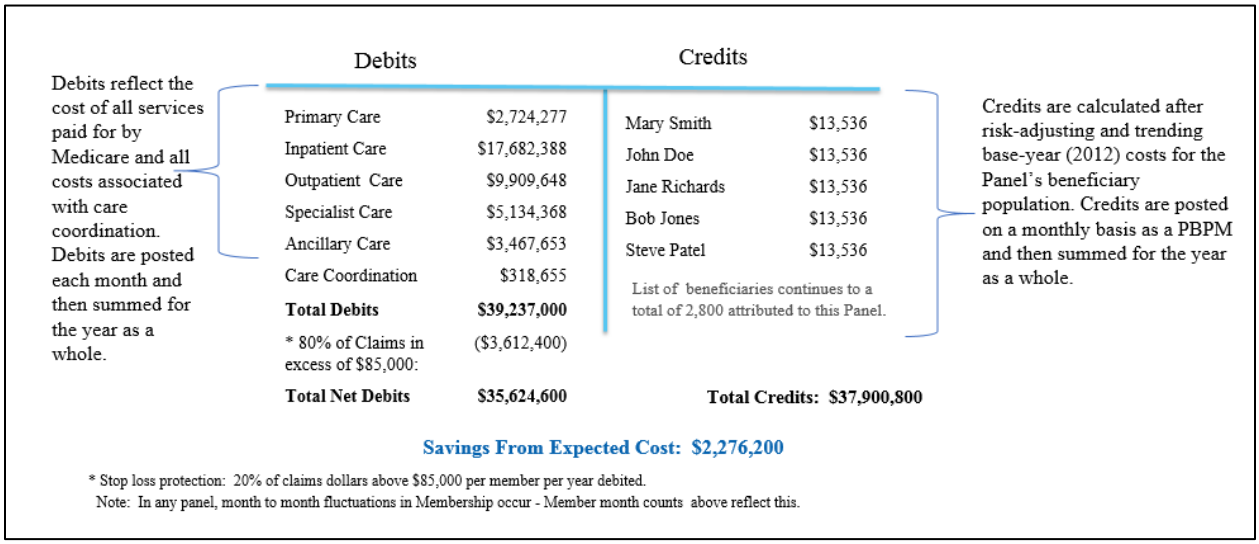
Hence, the ultimate measure of global cost performance for all 14 Panels, in the aggregate, was determined by comparing the Medicare global cost target ("Credits") for each Panel, against actual Medicare FFS Part A & B claims ("Debits") inclusive of all incentives and costs associated with care coordination for the Panels that were accumulated during the performance period. **Figure 3**, below, illustrates both sides of the ledger used to determine if a savings was achieved for the Medicare population in a particular Panel.

[*] Common Model total costs from 2013-2016 are used when making comparisons to the State of Maryland or national costs because State data for 2012 is not available

[†] In 2016 only 13 Panels participated in the Program during the CareFirst-funded extension.

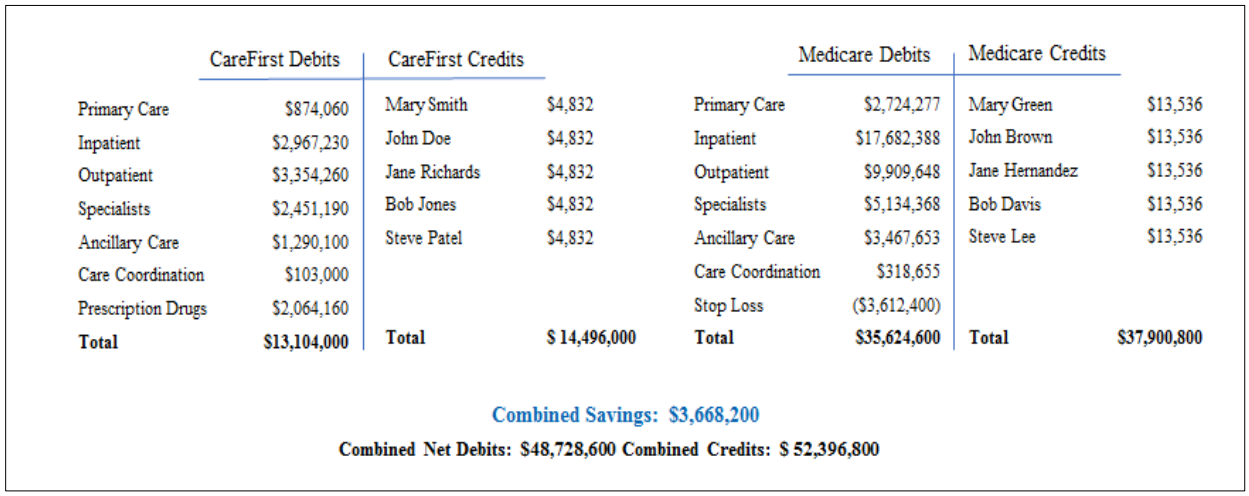
[‡] At the Panel-level, base-year actual costs are adjusted for risk and total number of members due to the varying mix of members across Panels by year, and then trended.

Figure 3: Medicare Beneficiary Global Cost Measure – Panel Specific Illustration For 2016 Model Patient Care Account



The Medicare global savings methodology used in the Common Model was identical to the methodology used for the commercial CareFirst Members of each Panel. As with CareFirst's commercial program, a Panel's global cost savings, along with its quality results, determined if – and how much – a Panel received as an OIA. **Figure 4** shows an illustration of the aggregate Debits, Credits, and Savings of a typical Common Model Panel for both its CareFirst Members and Medicare beneficiaries. The illustration below shows a Panel that hypothetically saved over $3.6 million.

Figure 4: Illustration Of Patient Care Account Of A Common Model Panel (10 PCPs), 2016 Model Patient Care Account



Over the course of the Pilot, all participating Panels earned Medicare OIAs in at least one year. Thirteen of the Panels (93 percent) achieved Medicare OIAs in two years and 12 of the 14 Panels earned a Medicare OIA in at least two of the three payout years.[§] These same Panels had similar results in the commercial program that exceeded the results of all other peer Panels not in the Common Model, (**Figure 5**). Over 85 percent of Common Model Panels achieved a commercial OIA in all four years for their CareFirst Members, compared to only 30 percent of all other Panels in the CareFirst only PCMH Program.

[§] *In the last year of the Pilot (2016) only 13 Panels participated in the Pilot and OIAs were not distributed.*

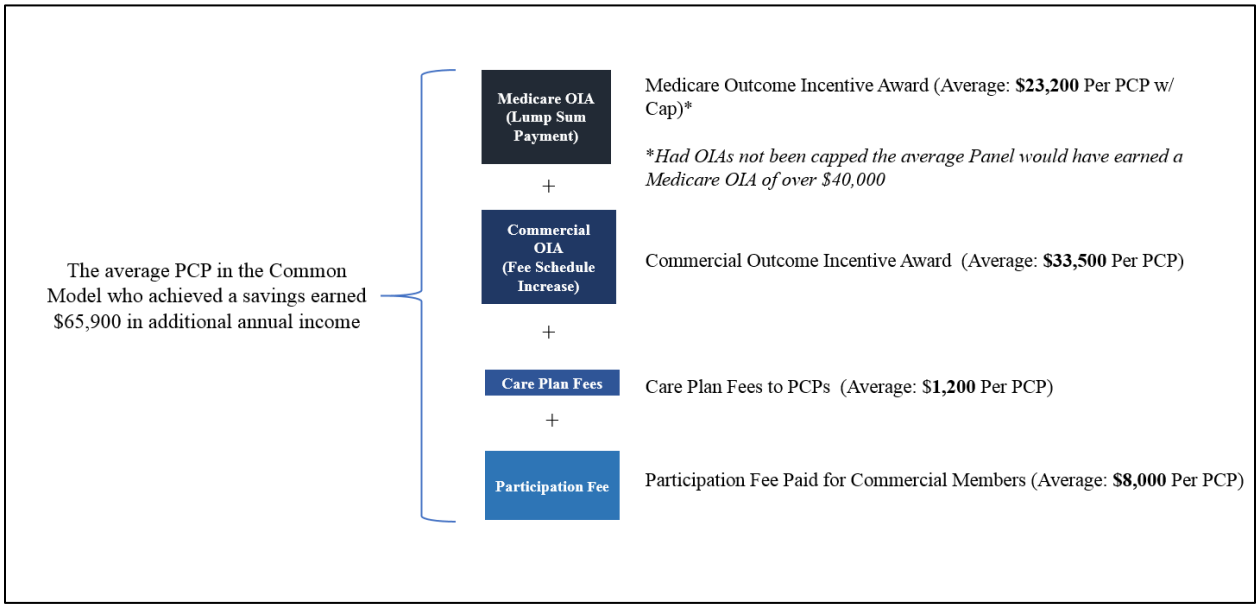
Figure 5: Comparison Of Panels' Commercial OIA Results

Year	Panels Earning Commercial OIAs		Size of Average Commercial OIA	
	Common Model Panels	All Other Adult Panels	Common Model Panels	All Other Adult Panels
2013	85.7%	72.1%	55%	35%
2014	100%	50.6%	77%	59%
2015	100%	55.7%	41%	41%
2016	92.3%	56.5%	43%	50%

In the final Performance Year of the Pilot (2016) 11 of 13 Panels had positive savings for attributed Medicare beneficiaries and would have been entitled to OIAs had funding been available. Nearly all (13 out of 14) of the participating Panels agreed to continue in the Pilot for 2016 with the understanding that OIAs would not be distributed, in the hope that another year of success would lead to a more permanent expansion of the Program.

As shown in **Figure 6**, in the years when OIAs were distributed, the average PCP achieved a savings for both their Commercial and Medicare populations and they earned substantial additional income.

Figure 6: Total Additional Income To PCPs Under The Common Model



According to Panel participants, their superior performance was largely driven by the fact that the financial incentives and expanded supports provided were substantially more powerful because they applied to approximately 50 percent or more of the patients seen by the Panels rather than just to CareFirst Members. This is further supported when comparing the Common Model Panels' commercial overall medical trend, during the years of the Pilot, to all other adult Panels in the commercial PCMH Program.

Substantial Improvement in Health Outcomes

CareFirst measured 10 key metrics during the Award, called "Measures that Matter," which were tracked regularly for both Medicare beneficiaries and CareFirst Members in the commercial program. The Program sought a material

change in these measures, particularly those measures that relate to costly hospital utilization. The measures are listed in **Figure 7**.

Figure 7: Measures that Matter – Key Program Metrics[**]
(Common Model Panels' Medicare FFS Results)

Measures that Matter	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	Program Trend (2013-2016)
Medical Per-Beneficiary Per-Month Cost	**$962**	**$956**	**$943**	**$964**	**$972**	**1.0%**
ER Visits per 1,000 Beneficiaries	**369.6**	**357.4**	**368.5**	**361.8**	**360.1**	**-2.57%**
Cost Per Emergency Room Visit	**$1,219**	**$1,292**	**$1,300**	**$1,443**	**$1,384**	**13.54%**
Admissions Per 1,000 Beneficiaries	**306.0**	**293.6**	**276.1**	**249.0**	**251.6**	**-17.78%**
Admitted Days Per 1,000 Beneficiaries	**4766.8**	**4,407.4**	**4,190.5**	**3,686.5**	**3,181.1**	**-33.27%**
Cost Per Admission	**$22,906**	**$23,426**	**$23,981**	**$26,394**	**$24,424**	**6.63%**
All Cause Readmissions Per 1,000 Beneficiaries	**48.2**	**44.2**	**42.0**	**39.7**	**40.3**	**-16.39%**
Cost Per Readmission	**$24,749**	**$25,144**	**$25,113**	**$28,917**	**$24,316**	**-1.75%**
Outpatient Facility Visits Per 1,000 Beneficiaries	**2,246.5**	**2,186.9**	**2,117.9**	**2,081.6**	**2,165.0**	**-3.63%**
ASC Visits Per 1,000 Beneficiaries	**342.2**	**333.8**	**320.5**	**331.3**	**325.9**	**-4.76%**

The admission rate was regarded as an essential measure in determining the impact of improved population health. A key sign of care breakdown in the health status of any population is the volume of admissions, readmissions, and ER visits. A central purpose of the Common Model was to minimize the cycle of breakdown that usually occurs among individuals with multiple chronic diseases – particularly for those whose disease is advanced and whose health status makes them very vulnerable to breakdown.

As shown in **Figures 9** and **10**, the Panels in the Common Model achieved significant decreases in hospital utilization. At the launch of the Award, CareFirst's goal was to reduce total hospital admissions by 7.5 percent by the end of 2015 from base year (2012) levels. This goal was far exceeded as the rate of hospital admissions declined 18 percent by the end of 2016 from base year levels as is shown in **Figure 8**. Similarly, readmissions were reduced by 16 percent by the end of 2016 (**Figure 8**). The total rate of inpatient days per 1,000 beneficiaries decreased even further - by a stunning 33.3 percent during the Pilot period **(Figure 9);** while ER visits per 1,000 beneficiaries showed a slight decline **(Figure 8**). These results were achieved on a population of beneficiaries whose average age was 74.7.

These results are even more remarkable because they occurred in a population with a high presence of chronic conditions that maintained an Illness Burden Score ("IBS") greater than 5.0. This reflects the fact that the average Medicare beneficiary attributed to the Common Model was more than five times sicker than the average commercial Member. For some context, in CareFirst's commercial program an individual with a 5.0 IBS would fall within the sickest 3 percent of the population. For Medicare, 27 percent of beneficiaries have an IBS of 5.0 or greater.

[**] Per-Beneficiary-Per-Month totals are based on the total dollars paid by Medicare. All "Cost Per" totals include the full cost of the service including any beneficiary cost-sharing.

Figure 8: Common Model Medicare Beneficiary Hospital Utilization

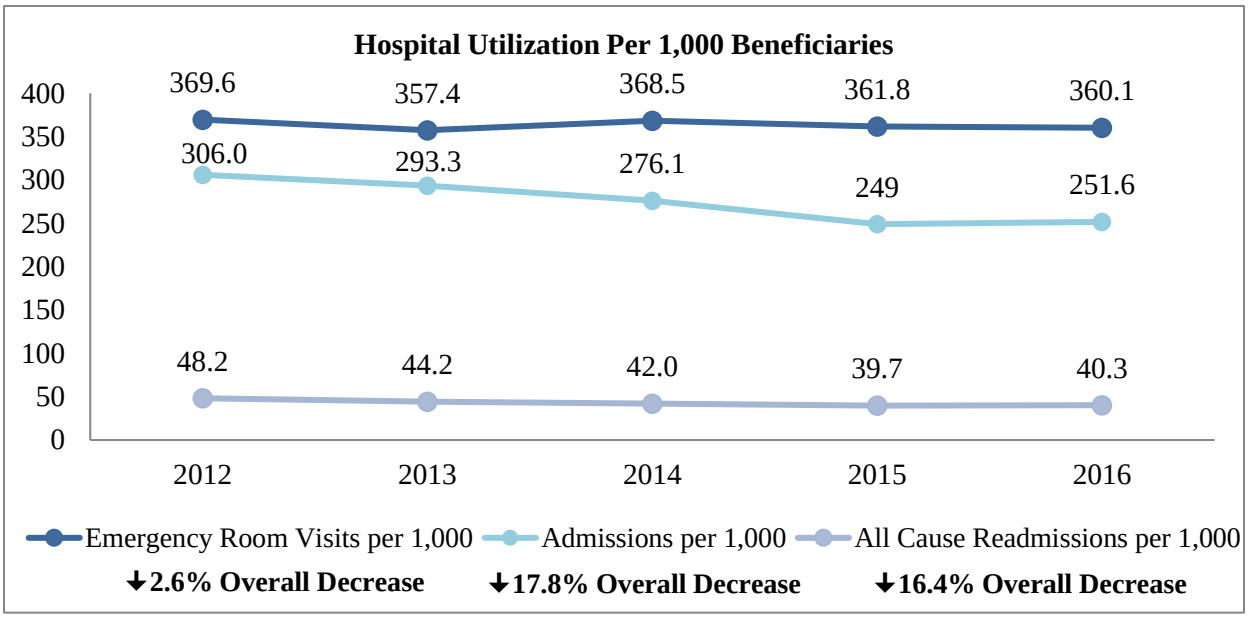
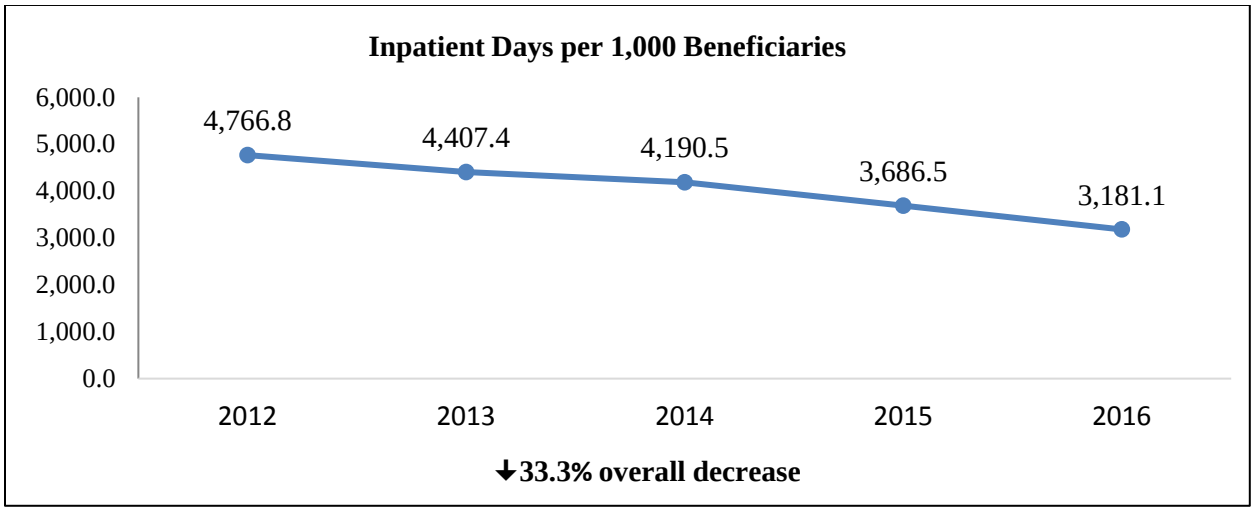


Figure 9: Common Model Medicare Beneficiary Inpatient Days



For Medicare beneficiaries who were sufficiently ill to be placed in formal Care Plans, the results were remarkable. **Figure 10** displays data for beneficiaries, at regular intervals up to one year after Care Plan activation that shows metrics for Admissions, ER visits (per one thousand beneficiaries), and Medical PBPM costs for the various time frames shown compared to the 12 months prior to the Care Plan's activation.

Beneficiaries, whose care had been coordinated under the Pilot, were on average, 76 years old at the time they were placed in a Care Plan. This is one year older than the average for the entire population of attributed Medicare beneficiaries. These beneficiaries had an average IBS of 10.6, which is more than double that of the beneficiary population as a whole and over 10 times the average illness level of the CareFirst membership. Care Plan beneficiaries had multiple, uncontrolled, chronic-conditions that were typically being treated by multiple specialists and ancillary service providers.

Figure 10: Medicare Beneficiary Patterns Before and After Care Plan Activation

Continuously Enrolled 12 Months After Care Plan Members 2,034 Avg. Age 75.9	Utilization Measure	12 Months Prior to Care Plan Start Date	6 Months After		9 Months After		12 Months After	
			Metric	% Diff to Pre-CP	Metric	% Diff to Pre-CP	Metric	% Diff to Pre-CP
	Admits/ 1,000	718.8	319.7	-55.5%	479.4	-33.3%	636.2	-11.5%
	ER/1,000	954	427.1	-55.2%	632.2	-33.8%	822.0	-13.9%
	Total PBPM Care Costs	$2,289	$2,151	-6.0%	$2,203	-3.7%	$2,214	-3.3%

During the four years of the Award, over 4,000 beneficiaries were placed in Care Plans - representing approximately 10 percent of the attributed population. Of these, more than 2,000 Care Plans were completed early enough to see results over a full year after completion of the Care Plan. These beneficiaries typically experienced sharp reductions in hospital utilization subsequent to the activation of their Care Plan. Six months after activation, the admit rate dropped by over half.

After a full 12 months, the level of hospitalizations, remained markedly lower than pre-activation. These results are even more significant when considering that these beneficiaries were a full year older, more fragile and had a significant increase in IBS to over 12.0 during the subsequent year following Care Plan activation.

Quality Care Measures Showed Marked Improvement

Improving the quality of care delivered to patients was a key objective of the Pilot. There is material evidence that the Common Model had a powerfully positive effect on the behavior of PCPs in caring for their patients. In addition to the 10 Measures that Matter, CareFirst tracked several additional measures that are components of the PCMH Quality Scorecard which was calculated for every CareFirst Member as well as for Medicare beneficiaries in the 14 Panels.

The measures that comprise the Quality Scorecard are industry standard clinical quality measures, Member satisfaction surveys, and PCP Engagement Scores. The 14 Panels in the Award showed consistent improvement in Quality Scores throughout the Award **(Figure 11)** and outperformed Panels not in the Common Model on quality outcomes in each of the three years of the Pilot.

The Program's core clinical measures align with the CMS core clinical measures, so as to eliminate any inconsistency in what PCPs must accomplish regarding quality for Medicare beneficiaries and CareFirst members. These are sometimes referred to as the "Consensus Measures." The CareFirst clinical quality score aligns with these CMS measures, and the detailed technical specifications for the measures are defined by NCQA.

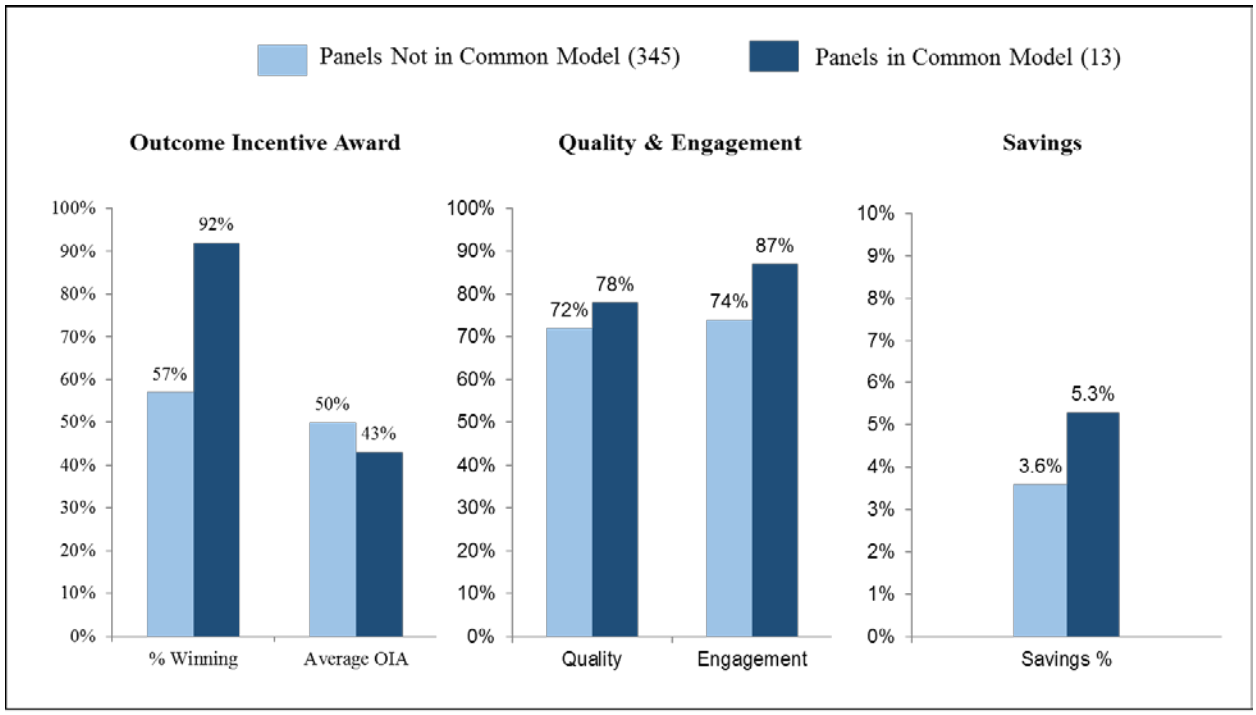
Figure 11: Common Model Panel Average Quality Scores (100 Point Scale)

(100 Point Maximum)	2013	2014	2015	2016
Common Model Panel Medicare Quality Score	**60.2**	**70.4**	**73.8**	**n/a**
Common Model Panel Commercial Quality Score	**64.2**	**71.5**	**73.3**	**77.6**
All Other Panels Commercial Quality Score	**53.8**	**61.3**	**68.2**	**72.3**

This increase in quality, we believe, was largely due to the Common Model Panels' increased engagement with the Program. PCPs in Common Model Panels were 22 percent more engaged with the Program than those solely in the commercial program as shown in **Figure 12**. This supports the core theory of the Award. That is, Common Model PCPs became more involved in and committed to care management activities because half or more of their patients were under the same rules, data model, incentives, and supports.

This increase in engagement led to more coordinated and attentive care for the most vulnerable patients, which ultimately impacted the degree of savings achieved by the Panels. As shown in **Figure 12,** not only did the Common Model Panels have higher engagement and quality scores for Medicare, they had better results for CareFirst Members as well. And, they achieved this for their commercial Members while achieving a commercial savings rate that was nearly 50 percent greater than the savings rate produced by all other Panels that were not in the Common Model.

Figure 12: 2016 Commercial Outcomes Comparison



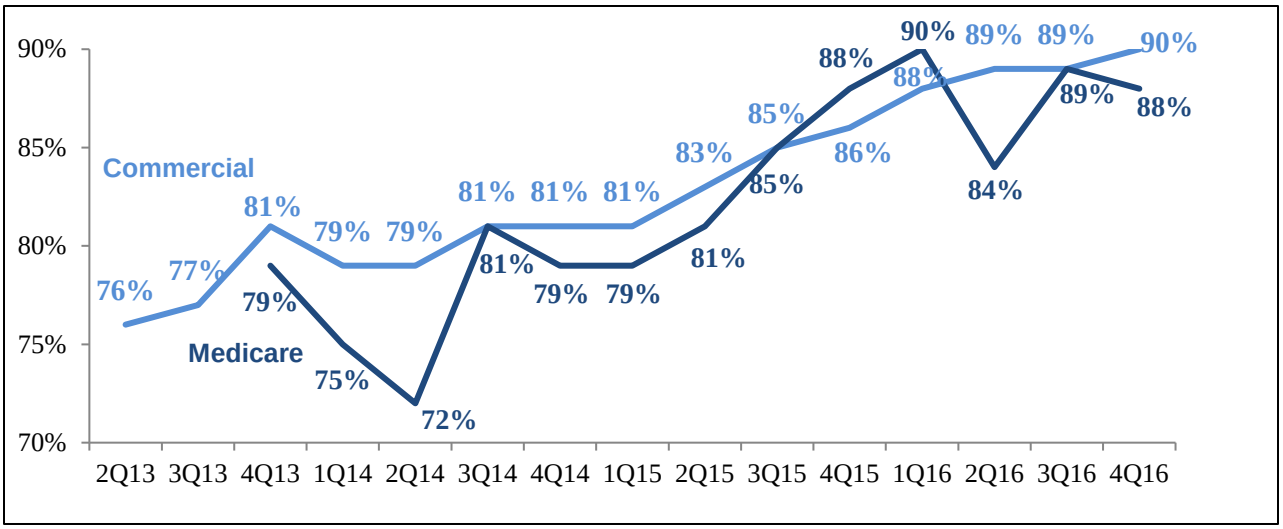
Source: CareFirst HealthCare Analytics – 2015 Performance Year

Patient Satisfaction Was High and Continued to Improve During the Pilot

Based on the results of continuous independently conducted surveys of Medicare beneficiaries and CareFirst Members in Care Plans, high satisfaction rates were achieved throughout the Pilot Panels **(Figure 13)**. The response rate to surveys among CareFirst Members and beneficiaries consistently remained over 80 percent – an extremely high level. As the Pilot ended, the Overall Satisfaction Score reached its highest level at 4.4 on a five-point scale (**Figure 14)** with nearly 90 percent of beneficiaries scoring a 4.0 or higher on Overall Satisfaction with the Common Model.

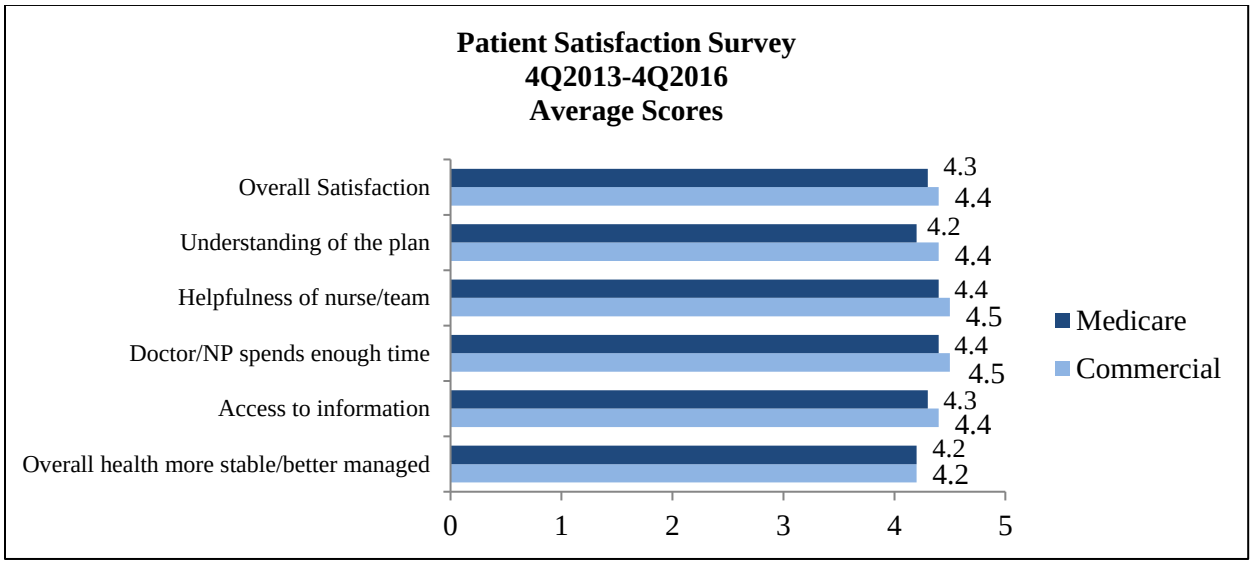
Figure 13: Patient Satisfaction Rates

(Percent Scoring at least a 4.0 in Overall Satisfaction)



These statistics show that those Medicare beneficiaries and CareFirst Members who experienced the health care system most frequently – and participated in the Common Model most fully - strongly believed that their overall health was more stable and better managed than it was before they were in the Program. This result was consistent with the satisfaction of CareFirst Members in the Program and underscores the impact the Program had on the most vulnerable patients.

Figure 14: High Levels Of Satisfaction And Better Managed Health



Participating Physicians Advocated for Continuation of the Pilot

At the conclusion of the Award, all PCPs who participated in the Award were asked if they would wish to continue their participation and whether they thought it helped them in providing high value care to their attributed Medicare beneficiaries and CareFirst Members. Virtually all PCPs in the 14 Panels responded strongly in the affirmative to both questions, emphasizing that the Pilot was a "valued addition" to an extremely "challenging" population that requires great attention.

One practitioner stated that the Pilot was "the first serious effort [they've] seen to improve health and reduce costs for Medicare patients." Several physicians gave accounts of outcomes they achieved as a direct result of the Pilot including the avoidance of "numerous admissions and ER visits." There was great disappointment among participating physicians when the Award ended. Indeed, nearly all of the participating PCPs signed a petition to CMS that called for a more permanent implementation of the Common Model.

Evaluation of the Common Model

Four independent evaluations of CareFirst's TCCI/PCMH Program and the Common Model have been performed to date and several peer-reviewed articles resulting from the work of the evaluation teams have appeared in health trade publications. The groups included: a joint team from Harvard University, Brandeis University, and the Massachusetts Institute of Technology; a team led by the George Mason University Center for Health Policy Research and Ethics; a team from Westat, an independent research organization; and a team from Mathematica Policy Research, who were engaged by CMMI to focus specifically on the Common Model Pilot.

Results from two of the evaluators found that CareFirst's Program created a cost savings after accounting for the costs to run the Program. Additionally, they concluded that the quality of care for patients and the engagement levels of providers rose during the Pilot. Results from the other two evaluators reached equivocal/neutral conclusions. One of these neutral conclusions, published by the Harvard/Brandeis Team, was based on data from the very early years of the Program - a period during which PCPs were still learning and becoming familiar with the Program.

The other neutral conclusion came from Mathematica Policy Research in an evaluation of the Common Model that did not review the full three and a half years of the Pilot and used a methodology and measures that did not actually correspond to the core goals of the model. Instead, the authors created "comparison" Panels that collectively did not represent a credible control group since the comparison Panels did not represent the geographic diversity present in the Common Model Panels and averaged far fewer beneficiaries per Panel as well as fewer high-risk beneficiaries per Panel. The comparison Panels also consisted of far fewer health system-operated Panels, which are typically much higher-cost Panels compared to independent Panels.

Mathematica also restricted their evaluation to only 25 percent of patients in the Pilot, analyzing the results of Members who had been continuously attributed to the Panel for the entire length of the Innovation Award, rather than all attributed Members. In addition, they did not evaluate the last full year of the Pilot (2016), which was the most mature year.

From CareFirst's perspective, the results actually achieved by the Pilot's Panels speak for themselves. The Pilot constitutes one of the only true public-private partnerships to use common rules, incentives, and data on a substantial population for a substantial period of time. The results hold real promise for further longer-term, large-scale success.

Conclusion

In sum, while the Common Model Pilot was in operation for just three and a half years, meaningful behavior change occurred among PCPs, toward value-based care and improved cost and quality outcomes. These changes were more pronounced in the Common Model Panels than in the rest of the PCMH Program where CareFirst was the only payer. This conclusion is consistent with the theory CareFirst put forth at the onset of the Award and demonstrates the potential power of the Common Model in bringing about behavior change among PCPs toward value-based care.

The participating practices began to reform the way they practiced by changing when and to whom they referred their patients for specialty care, how they assessed patient need for care coordination, how they used data, and how they made themselves more accessible to patients in greatest need. They also worked ever more effectively with the nursing and ancillary provider support they received in activating and maintaining Care Plans for their most vulnerable patients. These changes were deepening and accelerating as the Pilot ended.

The PCMH/TCCI Program itself, on which the Common Model is built, is inherently sustainable and has been in operation for nearly seven years on a region-wide scale involving 4,300 PCPs. As such, the Program is one of the largest and most mature patient-centered medical homes in the country. Each year, over the past six years, the Program has grown, with nearly 1.2 Million CareFirst Members now covered through nearly 450 Panels. These Panels are supported by more than 400 dedicated care coordination nurses and other ancillary services professionals. Most of these professionals are locally based in order to increase "hands on" engagement and face-to-face support to PCPs and Panels. Their work generates 50,000– 60,000 Care Plans per year for high-risk/high-cost CareFirst Members across the CareFirst service area.

In particular, it is worth noting that this field-based workforce is supported by a common fully web-based infrastructure with a universal patient health record and well-functioning data feeds for both Medicare beneficiaries and CareFirst Members. This extensive set of capabilities help PCPs better understand and manage the health of their population of attributed patients. The infrastructure in place for CareFirst Members can be easily extended should Medicare beneficiaries ever return to the Program.

The Common Model Pilot represented only a very small portion of the far larger PCMH Program. When one considers that only 14 Panels participated in the Award, the full scope of the potential for the Common Model comes into view if one considers that it could be extended to many more Panels in the larger Program. One of the most attractive aspects of the Common Model is that Medicare FFS beneficiaries in the region, and potentially other groups, such as dual eligible beneficiaries, could leverage the substantial PCMH/TCCI Program infrastructure that already exists to support PCPs in their efforts to improve quality and reduce costs.

While no model can be definitively proven in just over three years, we believe the results described in this document are highly encouraging and we continue to believe that the Common Model demonstrated that health care costs can be curbed, quality can be improved and unstable, complex patients can be cared for in a timely, effective way through well-designed collaborations between Medicare and large private payers.