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Horizon BCBSNJ/NJAFP Patient Centered Medical Home Collaboration Pilot

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Agenda

- Pilot Design
- Lessons Learned
- Importance of Relationship Building
- Achievements and Next Steps

Background and case for change

- Horizon BCBSNJ did not have ongoing relationships with many physician societies in New Jersey
- Primary care physicians were facing increasing administrative costs without the ability to easily generate additional revenue from traditional primary care practice.
- Horizon BCBSNJ's relationships with network primary care physicians where less then optimal
- The state of primary care in New Jersey at near crisis. Few residents were staying in pure primary care fields and even fewer were planning to practice in New Jersey.
- Primary care manpower issues were magnified by expected increases in demand brought about by an aging population and the reduction of new primary care providers
- Strong foundations of primary care tend to characterized all well perfuming and efficient care delivery systems.

PCMH BACKGROUND

- PCMH developed and promoted by all major primary care specialty societies as idealistic representation of primary care delivery
- Primary care office envisioned as initial source for access into delivery system for holistic patient care needs.
- Primary care's value in well managed system lies in ability to care manage/coordinate services to populations of patients over and above the mere provision of basic services
- Health care is local and care management is best provided by personal physician within local delivery system

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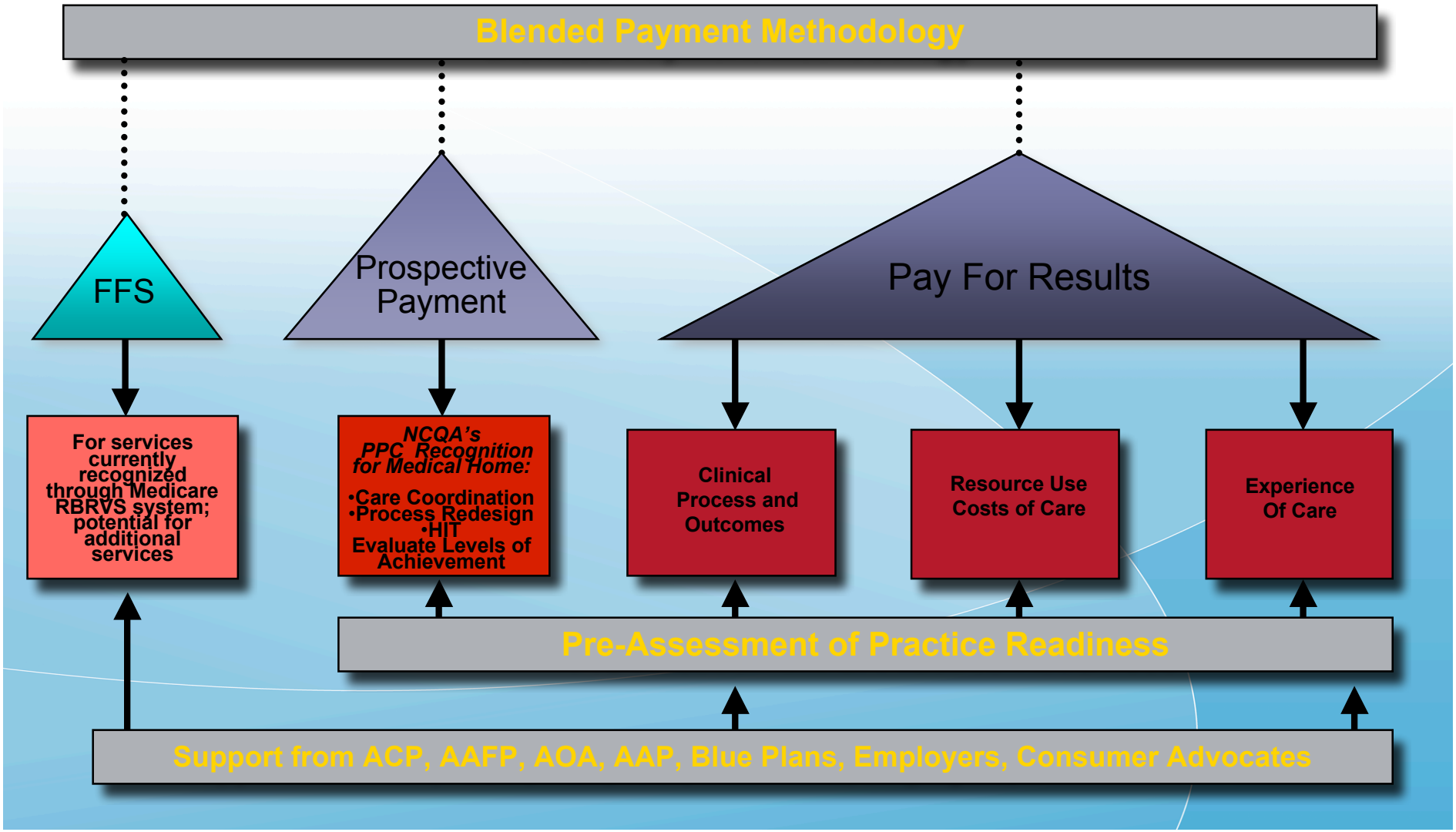
Joint Principles -Patient Centered Medical Home – (PCMH)

- Every patient should have an identifiable Personal Physician
- Care should be team based within a medical practice and led by a primary care physician
- There should be a Whole Person Orientation – holistic view of medical practice
- Care should feature Care Coordination and/or integration with all facets of the health care system.
- Quality and safety should be prominently emphasized
- Enhanced access to care should be provided
- Payment / reimbursement to support this broader variety of services including care coordination is necessary and needs to be provided

Reimbursement model supports practice transformation, care coordination, and value



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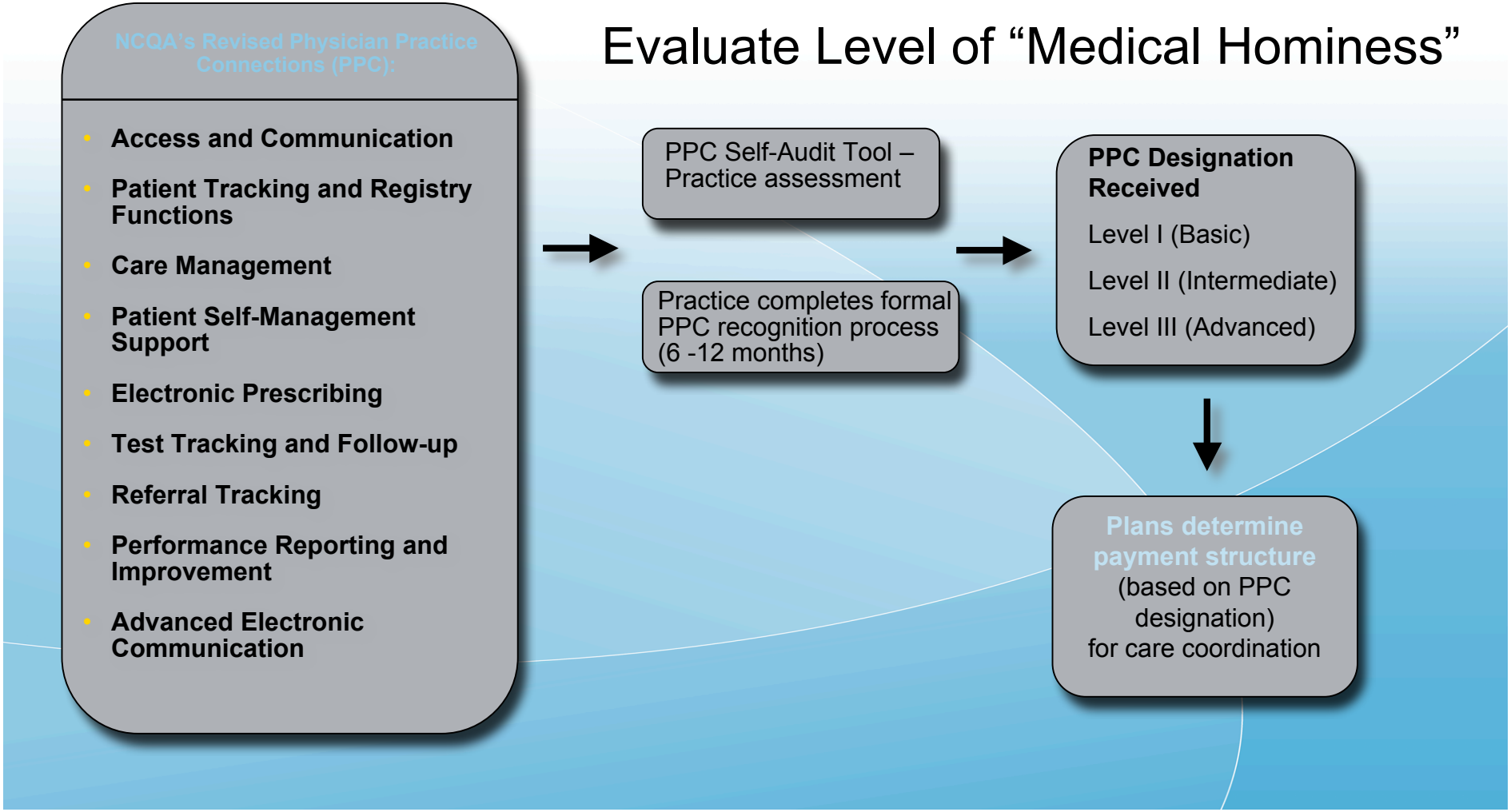
Care Coordination and Health Information Technology

Payment: Prospective Payment and FFS



Horizon BCBSNJ/NJAFP PCMH Collaboration

- **Timeline**
  - 2008 – Began collaboration and reached basic agreement around nature and structure of pilot basic
  - Feb 2009 - Letter of Intent signed and Press Announcement released by both organizations
  - Feb 25th - DOBI approves contract amendment for PCMH pilot
  - March 1st – recruitment process began
  - March 25th – Formal NJAFP Kickoff Meeting scheduled - New Brunswick, NJ. Educational program underway.
  - **Current status – 33 practices, 189 physicians, 77 locations in 14 Counties**
  - **~5000 diabetic patients**
  - April through Sept - Practice education and process design, accreditation preparedness, NCQA submission, validation and scoring.
  - Oct 2009 – Pilot launch
  - Oct 2010 – measurement period ends
  - 1st quarter 2011 – Data accumulation and result determination.

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Horizon BCBSNJ/NJAFP PCMH Collaboration

Letter of intent signed by Horizon BCBSNJ and the New Jersey Academy of Family Physicians (NJAFP) to move forward collaboratively with PCMH Pilot

- **Pilot Goals**
  - Evaluate the potential of transforming primary care practices in NJ into a model consistent with the Patient Centered Medical Home
  - Determine if such a PCMH model can deliver lower cost, high quality care, while improving patient experience and physician satisfaction
  - Provide operational experience and outcome data that could support expanded model in future years.
  - Support Horizon's willingness to collaborate with responsible physician organizations around improving delivery system capabilities and supporting primary care practice.

Horizon BCBSNJ/NJAFP PCMH Collaboration

- **Pilot Design**
  - ~ 5,000 adult diabetic lives
  - 25-50 adult primary care practices
  - Measurement period – 12 months
  - NCQA PCMH accreditation prerequisite for entry
  - EMR, electronic registry, or MD/Click provided

- **Success Metrics**
  - Reduced overall costs of care (pmpm) amongst selected population of diabetic members seeking care in Medical Homes
  - Improved quality outcomes (13 specific quality measures)
  - Improved member experience with care process
  - Improved physician satisfaction
  - External recognition of Horizon BCBSNJ as collaborative partner interested in the viability of primary care and improving care to members through delivery system reform.

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Clinical Quality Measures

- Diabetic Women Screened for Breast Cancer
- Diabetic Women Screened for Cervical Cancer
- Diabetics Receiving Colon Cancer Screening
- Medical Assistance of Diabetics with Smoking Cessation
- Influenza Immunization of Diabetics
- ACE Inhibitor or ARB Treatment Diabetic patients with hypertension
- Retinal eye examination performed
- Medical attention for nephropathy
- Low density lipoprotein cholesterol (LDL-C) screening performed
- Hemoglobin A1c (HgbA1c) tested
- Blood Pressure Control <130/80 mm Hg
- Diabetic Control LDL-C controlled (LDL <100 mg/dl)
- HgbA1c controlled (HgbA1c <7%)
- ACE Inhibitor or ARB Treatment Diabetic patients with hypertension

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Horizon BCBSNJ/NJAFP PCMH Collaboration

- **Role of NJAFP**
  - Physician representation in program development
  - Practice recruitment *(in conjunction with Horizon BCBSNJ)*
  - Education/ NCQA accreditation
  - Medical Home practice transformation and monitoring *(in conjunction with Horizon BCBSNJ)*
  - Result assessment and validation *(in conjunction with Horizon BCBSNJ)*
  - Measurement of patient experience and physician satisfaction

- **Reimbursement**
  - PMPM payment for care coordination
  - Fee for service per usual
  - Potential outcome reward based on level of documented aggregate cost savings, accessed by practice meeting specific quality of care determinations. All funding to come from documented savings (after expenses), relative to control in gain-sharing model.

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Horizon BCBSNJ/NJAFP PCMH Collaboration

Associated Stakeholder Interest

- Caremark – e prescribing (i-scribe linkage) and “Minute Clinic” integration
- Connectivity Vendor – Relay Health
- LabCorp – Lab support, care coordination, MDClick integration
- Pharma interest in clinical support – Merck, Pfizer, Sanofi Aventis, AstraZeneca
- Employer interest – IBM, Merck, Pfizer
- N.J. Hospital Quality Cooperative (HUMC, St Barnabas, Atlantic Health System) – “Aligning Forces for Quality”

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Lessons Learned

- **Plan Thoroughly** - Planning for ongoing transformation training beyond NCQA recognition important to maintain momentum for change.

- **Resource Appropriately** - Resources for ongoing monitoring and support need to planned and provided to ensure support.
  - Make sure both partners are on the same page, be explicit regarding expectations on both sides.
  - Provider Partner Organization must have sufficient governance strength and support to continually monitor practice performance in a strong yet unthreatening manner.
  - If not, assume that health plan personnel will need to play a much more involved role.

- **Operations Count** - Do not underestimate the complexity of the allocation process nor assume that every participant will highly prioritize the need to provide support
  - Assume physician participants will not universally perform required processes to support collaborative allocation.
  - Close enough is never close enough for physicians.

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Lessons Learned -2

- **Support –** Practices require continued and constant support for transformation
  - Don't assume that practices will know how to coordinate care or manage care of populations.
  - Provide Data on patient utilization, costs, and quality gaps in care to target care coordination activities
  - Provide information to target high risk populations to focus opportunities for savings
- **Communication** - You can never communicate too much
- **Exit Strategy** - Have predetermined exit strategy in place for those practices that don't meet their obligations without putting the entire pilot at risk

The Value of Relationships

- The entire PCMH model is based on creating a strong relationship between patient and primary care team.
- The ability for the NJAFP to be so successful in recruiting and preparing practices for NCQA recognition was based on building strong relationships between NJAFP staff and primary care office champions'
- The ability of a physician professional society and the States largest commercial health plan to collaborate in an initiative to support primary care was in large part due to strong personal trust and relationships between NJAFP leadership and Horizon clinical staff.
- Engagement of NJAFP leadership in monitoring the ongoing performance of the practices in the pilot has lead to the development of an ongoing workgroup that is committed to building an expanded PCMH model that we hope will transform the future of primary care in NJ.
- Expansion of the PCMH model will depend on the development of a relationship of mutual trust and mutual dependence between the primary care provider community and the payer community.
  - Payers will have to provide some incentive for investment for transformation.
  - Providers will also have to invest in themselves with the expectation that the value they create will be understood and appreciated by payers and the efficiencies realized will be shared.

Achievements

- Program helped develop 32 practices in New Jersey as recognized PCMHs. Prior to program there was but a single NCQA recognized program in New Jersey.
- Physicians of many primary care disciplines could be brought together and engaged in a pilot program designed to promote patient centered care.
- Practices in New Jersey are interested in transformation into PCMHs and some have made significant strides without significant reimbursement support.
- The NJAFP has developed a highly successful training program with tools that have been shown to greatly assist practices looking for NCQA recognition.
- A great deal of mutual respect and trust has been generated between a regional commercial insurer, a significant primary care professional society and a small collection of primary care practices and physician leaders that can help catalyze the next great leap forward for the improvement of the primary care delivery system in NJ.

Next Steps – Expanded PCMH Pilot Project Design and Creation of New Subsidiary

This pilot was in part responsible for initiating a review of the status of healthcare iin NJ following the passage of healthcare reform and in part led to a significant decision by Horizon Blue Cross Blue Shield of New Jersey to announce last week a decision to create a subsidiary company, Horizon Healthcare Innovations.

The new company's role will be to develop, implement and test new and iinnovative pilots aimed at promoting redesign of the health care delivery system into one that provides improved patient experience, higher quality care, and greater efficiency.

It will accomplish these goals through stimulating change in the current fragmented and flawed health care delivery system, through changing reimbursement models from that which reward volume to those which pay for quality outcomes and will be supported by innovative benefit structures.

One of the first pilot projects of Horizon Healthcare Innovations, a division of Horizon Blue Cross Blue Shield of New Jersey, will be to rollout a **new and significantly expanded primary care PCMH pilot** that we hope will become a linchpin for a significant change in the position of primary care in a redesigned healthcare system for New Jersey. Representatives of the NJAFP have been extremely enthusiastic about these developments and have been working closely with us on designing this new pilot program for many weeks.