Our challenge

To anyone who cares for patients, it’s clear that the U.S health care system is not living up to its potential.

Research tells us that the U.S. health care system is costly and fragmented, and care isn’t always delivered according to the best-available clinical evidence.

For primary care physicians and other providers, our system has created an untenable situation: not enough time to provide the care they want to deliver, and not enough income to get off the treadmill created by fee-for-service payment arrangements.

The status quo is also ill-equipped to support true collaborative care, where providers work with each other and with patients to maintain and improve patients’ health.

*The Institute of Medicine in its recent report* **Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, said it best:**

“If home building were like health care, carpenters, electricians and plumbers would work from different blueprints and hardly talk to each other.

If airline travel were like health care, individual pilots would be free to design their own preflight safety checks — or not perform one at all.”

A key driver of this current state is how we pay for care – we create incentives for volume and not value. To address this challenge we are changing the way we pay providers, starting with primary care. We’re beginning our work there because we know that primary care providers equipped with the right tools can make a dramatic, positive difference in health care quality and costs.
Our Solution

We will launch our Patient-Centered Primary Care program across all markets in late 2012 and throughout 2013 and 2014. In many ways, this program is an extension of the medical home and ACO pilots we implemented across our markets over the last four years. The measurable improvements in quality and cost that we saw in these pilots gave us the confidence to build a program around the most successful components of each and expand our efforts.

Our Patient-Centered Primary Care program provides funding and tools to help practices adopt the principles of patient centered care, including:

- Care management focused on high risk patients
- Coordination of care across the delivery system
- Promotion of wellness and prevention
- Shared decision-making between physicians and patients
- Ensured access to care
- Measurement of outcomes and compliance with evidence-based guidelines

How it will work for you

We designed our Patient-Centered Primary Care program to provide an inclusive and flexible framework:

Inclusive, because we have not established barriers to participation. Any practice willing to adhere to the program terms can participate, whether they are small independent practices or part of large integrated delivery systems, whether they are just beginning the journey towards patient centered care or are already confident in managing population health.

Flexible, because it is not a one-size-fits-all approach. We’re moving past acronyms like PCMHs or ACO and creating a set of solutions that allow us to support and collaborate with physicians based on their readiness to accept accountability for cost and quality of care. This is the case regardless of how they are organized.

We’re committed to making patient-centered care the “new normal,” supported by new payment arrangements that reward this type of care. These programs will apply to nearly all product types including, but not limited to PPO and HMO products.

The Patient-Centered Primary Care Program contains the following important elements:

- Practice-Level Participants
  We will administer this program at a primary care practice level, rather than at an individual physician level. All primary care physicians in a practice will work together to meet the program’s objectives and will share the financial benefits. The program applies to participating primary care physicians in the following specialties: general practice, family practice, internal medicine, pediatrics and geriatrics.

- Attributed Members
  A practice’s patient panel will be defined depending on the type of plan in which the patient is enrolled. For all products that require the patient to select a PCP, that provider is used. For open-access products, we use a visit-based attribution methodology which assigns members to the PCP with whom they appear to have the most established relationship based on claims data from the previous two-years.
○ **Care Coordination Payments**

Care coordination PMPM payments reimburse providers for work they do outside of a traditional patient visit. That work could include care planning, maintaining health registries, or following up with patients via phone or email. These activities improve health and reduce costs. Upfront PMPM payments enable PCPs to invest in the outreach staff and technology they need to transform their practices and manage the health of their patients.

Each market will have a PMPM base rate. This base rate may be thought of as a payment for a patient of average risk.

The base rate paid will be adjusted based on the risk score of each patient in the population, subject to an upper and lower limit. For example, the risk score for a healthy 25 year old would be <1, whereas the risk score for a 55-year-old with diabetes and hypertension would be >1. For each of the providers’ patients, we will calculate a PMPM payment by multiplying the [base rate] X [patient’s risk score subject to the upper and lower limit].

○ **Shared Savings Opportunity**

Shared savings payments reward primary care physician for successfully managing the quality and overall healthcare costs for their population of Anthem patients. Shared savings works like this:

We will project expected costs, known as Medical Cost Targets, by reviewing historical medical costs for the practices’, or a group of practices, population of patients, trended forward to reflect certain projected cost increases. (We sometimes group practices together to ensure that the Medical Cost Targets are calculated on the basis of a statistically valid pool of Anthem patients.)

We then compare member costs incurred for the population of Anthem patients during a one-year measurement period with the Medical Cost Targets.

If the actual costs are less than the Medical Cost Targets AND the provider meets a quality threshold, then the provider group becomes eligible to receive a portion of any savings. This payment is known as a shared savings bonus. If a provider does not meet the quality threshold, the provider is NOT entitled to any shared savings bonus, regardless of the savings generated.

If the provider meets the quality threshold and therefore is eligible to earn a shared savings bonus, the amount of the bonus varies based on the provider’s performance on the quality and utilization measures. The better their scores, the higher the percentage of the shared savings providers earn, subject to a maximum payment amount.
Your role

We designed our patient-centered care approach with plenty of support for providers, but also with some expectations in mind:

- Ensure care is available to patients 24 hours a day, 7 days a week, through extended hours, after-hours call, e-mail or virtual visits.
- Participate in our care management and disease management models
- Establish dedicated practice staff positions to support this program
- Use the tools made available to support the program
- Use a registry to effectively manage the patient population
- Choose treatments wisely, including the use of appropriate generic Rx substitutes when available
- Meet appropriate performance on nationally-endorsed quality measures

A leap forward

Our Patient-Centered Primary Care program offers a much more comprehensive approach to cost and quality improvement than pay-for-performance or value-based programs of the past. With its financial rewards, practice support, and sharing of meaningful information, our approach provides practices strong tools and opportunity to improve the health of our members while also improving the affordability of care.