2023 PCF and PCMH | Benefits of participation

The Patient-Centered Medical Home (PCMH) is a practice **model** for the organization and delivery of healthcare that helps to improve the patient's experience of care, improve the health of populations, and reduce or control the costs of healthcare. The **PCMH care delivery model** allows the primary care provider and the patient to be the center of the healthcare system, to know what is going on and help the patient be in control of their health.

For 2023, Arkansas Blue Cross is offering two programs that follow the **PCMH care delivery model**, **Patient-Centered Medical Home (PCMH)** and **Primary Care First (PCF)**. Participating practices will receive per-member, per-month (PMPM) payments to support practice redesign and care coordination efforts. Practices that qualify will also receive a performance-based adjustment (PBA).

Patient benefits

The **PCMH care delivery model** combines the expertise of medical staff with the efficiency of electronic health records (EHR) to manage and coordinate the patient experience through the entirety of the continuum of care. This integrated approach makes navigating the complicated healthcare system easier for individual patients. In addition to saving time and frustration, patients enjoy:

- Enhanced access to care
- A greatly improved patient experience
- Improved quality of care
- Better outcomes
- Care inclusion/accountability
- Coordinated care

Provider benefits

While integrating new responsibilities and technology can be challenging, it can also be very rewarding. The team approach allows physicians to shift many of their patients' preventive and maintenance needs to support team members. In turn, physicians can focus their attention on the patients who truly need medical attention, resulting in:

- Greater job satisfaction
- Improved population management techniques
- Improved patient and staff satisfaction
- Improved office efficiency
- Improved clinical quality performance

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Better quality outcomes and cost savings

Practices participating in PCMH and PCF will receive per-member, per-month (PMPM) care management fees to support practice redesign and care coordination efforts. These fees are monthly payments (not based on the volume of office visits) to support staffing and training demands of transforming a practice. Care management fees are risk-adjusted, with higher PMPM for patients with more severe illnesses and lower PMPM for patients with lower risk

Professional population-based payments

Practices participating in PCF will receive a monthly, risk-adjusted professional population-based payment to allow flexibility in caring for patients, in exchange for a reduced fee-for-service payment per visit.

Performance-based adjustments (PBA)

We will pay a performance-based adjustment (PBA) to encourage and reward accountability. The performance-based adjustment will be based on a combination of utilization measures and clinical quality metrics.

- Utilization includes three measures: emergency department utilization, hospital admissions and generic prescribing rates.
  - Performance on utilization measures will be calculated quarterly, and adjustments will be applied to monthly care management fees. Practices that meet at least one target will receive a positive adjustment. PCF and PCMH practices are at risk for a negative adjustment if they do not meet at least one target.
- Clinical Quality performance will be calculated and paid annually. Clinical Quality metrics and targets will be the same for both PCF and PCMH.
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  - Physicians and Advanced Practice Providers in Family Practice, General Practice, Internal Medicine, and Geriatric specialties will have eight clinical quality metrics.
  - Pediatricians will have eight clinical quality metrics specific to children. Providers eligible for the pediatrician measures include pediatricians and advance practice providers working in collaboration with a pediatrician.

Quality outcomes are achieved through a team-based, comprehensive, coordinated approach to care, following evidence-based guidelines.

Care coordination

Care coordination facilitates communication, coordinates services, addresses barriers and promotes resources, while balancing clinical quality and cost management. Each clinic may handle care coordination differently, and the role may include medical assistants, registered nurses and even nontraditional multidisciplinary team members, including social workers and registered dietitians.

Key activities of care coordination include connecting patients with community resources, transitions of care from the hospital/emergency department setting, identifying care opportunities/gaps and patient outreach and education.

Members of a PCMH or PCF care team may include:

- Patient
- Provider
- Clinical staff
- Office staff
- Community resources
- Hospitals
- Specialists
- Family members
- Social workers
- Pharmacists
- Dietitians
- Other healthcare professionals