FEHB Program Carrier Letter
All FEHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2013-01 **Date: January 24, 2013**

Fee-for-Service [1] Experience-rated HMO [1] Community-rated [1]

SUBJECT: Patient Centered Medical Homes (PCMH) within the Federal Employees Health Benefits (FEHB) Program

This carrier letter provides additional guidance on PCMH as a delivery model within the FEHB Program. OPM encourages carriers to pursue the Triple Aim of improved patient care, improved population health, and reduced health care costs.[1] This letter outlines the recognition, payment, accountability, and reporting requirements for carriers seeking to achieve these goals through implementation of PCMH. OPM emphasizes the PCMH initiative is considered a delivery model that can be implemented throughout the plan year.

Definition

The Agency for Healthcare Research and Quality (AHRQ) defines PCMH as "a model of the organization of primary care that delivers the core functions of primary health care…" and that care is delivered by providing comprehensive, patient-centered care that is coordinated across service providers and emphasizes quality and patient safety.[2]

Background

A growing body of evidence supports investment in PCMH to improve care coordination and reduce overall system costs, particularly the high costs associated with avoidable hospital admissions and overutilization of emergency services.[3] PCMH augments ongoing efforts such as precertification, discharge planning, disease management, and case management to improve care coordination and management for chronic conditions. As systems of care transform across the nation, PCMHs are becoming the nucleus for accountable care organizations (ACO) and state based innovation initiatives that strive to achieve better health outcomes through integration of primary care, specialty care, inpatient services, behavioral health, and community supports.

To manage health care costs and utilization, OPM initially encouraged support for integrated health care delivery systems in the 2011 Call Letter.[4] The agency reinforced PCMH as a means of strengthening the relationship between primary care physicians and patients in the 2012 Call Letter.[5] Carriers responded to the 2012 Technical Guidance by reporting the criteria used to define PCMH, the percentage of practices so recognized, the number of covered lives in PCMH, the type of payment incentives used, and the metrics used to analyze outcomes.[6] Carriers were also encouraged to facilitate the participation of FEHB members in the Centers for Medicare and Medicaid Services' (CMS) Comprehensive Primary Care (CPC) initiative. Even with these efforts, preliminary readmission data for FEHB carriers suggest that readmission rates are not yet declining, underscoring the need for continued emphasis on effective primary care.

Implementation
As of December 2012 over 500,000 FEHB lives were already enrolled in PCMH practices. To ensure consistency for members and payment auditability going forward, this letter specifies criteria that will be applied to PCMH within the FEHB Program.

Recognition
OPM requires FEHB plans that offer PCMH to utilize criteria that document enhanced access, management of patient populations, care management and planning, provision of self-care support, care coordination, and performance measurement.[7] The following national certification or recognition programs contain these criteria:

- NCQA Patient Centered Medical Home Recognition—Levels 2 and 3[8]
- The Joint Commission Primary Care Medical Home Certification[9]
- URAC Patient Centered Health Care Home Certification[10]
- AAAHC Medical Home Certification[11]

Carriers utilizing any other means of PCMH certification should submit details of their externally validated standards and methodology to OPM for consideration.

Covered Lives
OPM strongly prefers that all FEHB patients enrolled in a practice that has achieved PCMH status receive comprehensive PCMH services. In response to the 2012 Technical Guidance, some carriers reported providing PCMH services to only the diabetic patients in a practice. Carriers may prioritize specific populations for inclusion if a stepped approach is necessary. However, there must be a plan for all FEHB lives enrolled in the practice to be included in a reasonable timeframe.

Patient Engagement
To achieve improved health outcomes, patients must be engaged as partners in their care and aware of the benefits of integrated primary care. OPM strongly urges FEHB plans to communicate the availability and advantages of PCMH to members. Carriers should anticipate that OPM will request identification of PCMH practices in future provider directories.

Accountability
HEDIS measures required of all plans are outlined in Carrier Letter 2012-25. We expect high levels of performance for plans implementing PCMH. We will analyze year over year HEDIS trends for plans offering PCMH and compare results across the FEHB portfolio. To assess the results of PCMH, OPM will focus on a subset of the required list including:

- Breast Cancer Screening (BCS)
- Follow-up After Hospitalization for Mental Illness – 7 Day Follow-up after Discharge (FUH)
- Comprehensive Diabetes Care (CDC) – Hemoglobin-A1c Testing
- Comprehensive Diabetes Care (CDC) – LCL-C Screening
- Cholesterol Management for Patients with Cardiovascular Conditions – LCL-C Screening (CMC)
- Plan All-Cause Readmissions (PCR)
- Ambulatory Care — Emergency Department Visits (AMB-B)
- Medication Management for People With Asthma (MMA)
- Well-Child Visits in the First 15 Months of Life (W15)

Payment
For experience-rated contracts, investments to support PCMH transformation may be submitted for consideration outside your administrative expense limit if needed. These expenses will be revised outside your limit if the plan cannot cover the added expenses within your proposed limit. Justification for these expenses should be included in your expense limitation proposal.

Comprehensive Primary Care (CPC) Initiative and Other Models
OPM considers practices participating in CMS's CPC initiative to be equivalent to recognized/certified PCMH practices. Carriers contracting with CPC practices should include appropriate FEHB members in this initiative. A complete list of participating practices by geographic region can be found by visiting www.innovations.cms.gov. Please communicate with eligible FEHB enrollees regarding the opportunity to participate.

If your plan has PCMH for other lines of business or is participating in other PCMH demonstrations, please include FEHB members to the greatest extent possible. To coordinate arrangements between FEHB and CPC or other demonstration projects, you may contact Mary Scheuermann at mary.scheuermann@opm.gov.

Reporting
While OPM is reinforcing that PCMH may be implemented throughout the benefit year, OPM will request the following information annually: the number of PCMH practices, number of FEHB covered lives in those practices, and any updates to the status of their PCMH certification/recognition. Carriers introducing PCMH for the first time should include documentation of practice certification/recognition.

We appreciate the commitment of FEHB plans to improve health outcomes and care coordination for federal employees and their families.

Sincerely,

John O'Brien
Director
Healthcare and Insurance

[1] Berwick, D.M., Nolan, T.W., & Whittington, J. 2008. The triple aim: care, health, and cost. *Health Affairs 27*(3), pp. 759-769.
[2] AHRQ. 2012. Defining the PCMH. Retrieved from: http://www.pcmh.ahrq.gov/.
[3] Nielsen, M. et al. 2012. Benefits of implementing the PCMH: A review of cost and quality results. Patient Centered Primary Care Collaborative.
[4] OPM Call Letter 2011-05.
[5] OPM Call Letter 2012-09.
[6] OPM Carrier Letter 2012-12 (Technical Guidance).
[7] Adapted from Standards and Guidelines for NCQA's PCMH, 2011.
[8] http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx
[9] http://www.jointcommission.org/accreditation/pchi.aspx
[10] https://www.urac.org/pchch/what-is-pchch/
[11] https://www.aaahc.org/accreditation/primary-care-medical-home/