JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

Paying Primary Care Providers for Care Coordination: *Considerations and Evidence from Other States*

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Overview

- **What is the evidence on the effectiveness of care coordination PMPM payments?**
  - Care coordination PMPM payments have been shown to reduce costs and improve quality when partnered with a model for care delivery
- **Do accountability mechanisms exist to track the effectiveness of care coordination?**
  - Yes, there are more than 100 published measures
  - Mechanisms include CPT codes, EHR documentation, and process, cost, and quality measures
- **We conclude: A clinical model plus a payment approach to enable the model can lead to improved outcomes**

What are approaches to pay primary care providers for care coordination?[1,2]

- **Per member per month (PMPM):** Payment to providers, in this case intended to cover care coordination services not covered under traditional reimbursement for clinical services
- **Pay for performance (P4P)**: bonus payment given to providers if they meet agreed-upon quality performance measures or improve performance (on top of FFS to incentivize quality)
- **Traditional capitation**: Prospective payments that are independent of visit volume and can support paying for all care both inside and outside of a traditional visit, often using risk adjustment and quality measures to mitigate the risk of inappropriate underutilization of services

1. Gold, S. B., & Park, B. J. (2016). *Effective payment for primary care an annotated bibliography.* (). Washington, DC: Starfield Summit. Retrieved from https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/StarfieldSummit%20Annotated%20Bibliography_Payment-FIN.pdf
2. Park, B., Gold, S. B., Bazemore, A., & Liaw, W. (2018). How evolving united states payment models influence primary care and its impact on the quadruple aim. *Journal of the American Board of Family Medicine : JABFM, 31*(4), 588-604. doi:10.3122/jabfm.2018.04.170388 [doi]

What are approaches to pay primary care providers for care coordination?[1,2]

- **Shared Savings**: Providers held accountable for the quality, cost, and experience of care of an assigned population. If costs are below set financial targets, the providers get to keep some of the savings
- **Total Cost of Care (TCOC)**: Provides a risk-adjusted payment to an entity that is responsible for the full range of medical services (hospital and outpatient) for their patient panel. In some models the responsible party is the hospital, in other models a provider group or ACO may be assigned responsibility. Reductions to TCOC occur through using patient-centered care teams and primary care enhancements

1. Gold, S. B., & Park, B. J. (2016). *Effective payment for primary care an annotated bibliography.* (). Washington, DC: Starfield Summit. Retrieved from https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/StarfieldSummit%20Annotated%20Bibliography_Payment-FIN.pdf
2. Park, B., Gold, S. B., Bazemore, A., & Liaw, W. (2018). How evolving united states payment models influence primary care and its impact on the quadruple aim. *Journal of the American Board of Family Medicine : JABFM, 31*(4), 588-604. doi:10.3122/jabfm.2018.04.170388 [doi]

Payment reform can leverage these payment tools in combination with a model for care delivery[1,2]

- Examples of payment models include:
  1. Patient centered medical home (PCMH)
  2. Comprehensive Primary Care Plus (CPC+)
  3. Health Home
  4. Accountable Care Organizations (ACOs)
- Common elements of successful models include:
  - Clear goals for outcomes with a vision for how care will be delivered
  - Timely and accurate data sharing
  - Risk adjustment to account for differences in patient panels
  - Prospective payments to allow practices to make upfront investments
  - Payments connected to a focused set of metrics and performance on the 4 C's (contact, continuity, comprehensiveness, and coordination)
  - Use of multidisciplinary care teams

1. Gold, S. B., & Park, B. J. (2016). *Effective payment for primary care an annotated bibliography.* (). Washington, DC: Starfield Summit. Retrieved from https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/StarfieldSummit%20Annotated%20Bibliography_Payment-FIN.pdf
2. Park, B., Gold, S. B., Bazemore, A., & Liaw, W. (2018). How evolving united states payment models influence primary care and its impact on the quadruple aim. *Journal of the American Board of Family Medicine : JABFM, 31*(4), 588-604. doi:10.3122/jabfm.2018.04.170388 [doi]

What is the evidence on the effectiveness of care coordination PMPM payments in Patient Centered Medical Homes?

Outcome	Evidence by State Program
Costs	• **North Carolina ($3 PMPM for care management and $2.50 for medical home activities)[1]:** $184 million in savings and 7.87% relative PMPM savings • **Illinois (PMPM management fees and bonus payments)[2]**: annual savings of 6.5-8.6% with $1.46 billion Medicaid savings; inpatient costs declined by 30.3% but outpatient costs rose • **New Jersey ($3-$5 PMPM care coordination fee with optional performance bonus)[3]**: patient costs decreased but not enough to cover PCMH program • **New York (payments use 63% as a risk-adjusted base, 27% as bonus, and 10% FFS)[4]**: one model finds a 6-8% reduction in health care spending growth
Quality & Utilization	• **North Carolina ($3 PMPM for care management and $2.50 for medical home activities)[1]:** the rate of inpatient admissions declined from 420 per thousand per year to 384 per thousand per year from 2007 to 2011 • **Illinois (PMPM management fees and bonus payments) [2]**: quality improved across all metrics but one (metrics included cervical cancer screening, colonoscopy, and diabetes) • **New Jersey ($3-$5 PMPM care coordination fee with optional performance bonus)[3]:** mixed results on quality measures and no change in utilization

1. Fillmore, H., DuBard, C. A., Ritter, G. A., & Jackson, C. T. (2014). Health care savings with the patient-centered medical home: Community care of north carolina's experience. Population Health Management, 17(3), 141-148. doi:10.1089/pop.2013.0055 [doi]
2. Phillips, R. L.,Jr, Han, M., Petterson, S. M., Makaroff, L. A., & Liaw, W. R. (2014). Cost, utilization, and quality of care: An evaluation of illinois' medicaid primary care case management program. Annals of Family Medicine, 12(5), 408-417. doi:10.1370/afm.1690 [doi
3. Patel, U. B., Rathjen, C., & Rubin, E. (2012). Horizon's patient-centered medical home program shows practices need much more than payment changes to transform. Health Affairs, 31(9), 2018-2027. doi:10.1377/hlthaff.2012.0392
4. Vats, S., Ash, A. S., & Ellis, R. P. (2013). Bending the cost curve? results from a comprehensive primary care payment pilot. Medical Care, 51(11), 964-969. doi:10.1097/MLR.0b013e3182a97bdc [doi]

What is the evidence on the effectiveness of care coordination PMPM payments in Health Homes & ACOs?

Outcome	Evidence by State Program: Health Homes[1]
Costs	• **Missouri (care coordination for complex patients)**: $5.7 million saved from reduce hospitalizations, $2 million saved in Medicaid, and $148 PMPM saved on average
Quality & Utilization	• **Missouri (care coordination for complex patients)**: hospital admissions reduced by 5.9% and ED use by 9.7% per 1,000 enrollees as well as improvements in blood sugar, cholesterol, and blood pressure levels

Outcome	Evidence by State Program: ACOs[2]
Costs	• **Medicare Shared Savings Program (risk-adjusted PMPM and bonus payments)**: ACOs earning shared savings is increasing (24% in 2013 to 30% in 2015), with $429 million in total program savings in 2015 • **Pioneer ACO (higher shared savings and risk with prospective PMPM option)**: Six of the 12 ACOs qualified for shared savings and one repaid losses in 2014
Quality & Utilization	• **Medicare Shared Savings Program (risk-adjusted PMPM and bonus payments)**: 84% of quality measures were improved in both 2014 and 2015 • **Pioneer ACO (higher shared savings and risk with prospective PMPM option)**: quality scores increased on average, from 87% in 2014 to 92% in 2015

1. MO HealthNet. (2014). Missouri primary care health homes: interim evaluation review summary. Jefferson City, MO: MO HealthNet. Retrieved from https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/mo_healthnet_primary_care_hh_interim_evaluation_report_summary.pdf
2. Kocot, S. L., & White, R. (2016). Medicare ACOs: Incremental progress, but performance varies. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20160921.056715/full/

What is the evidence on the effectiveness of care coordination PMPM payments in other models?

Outcome	Evidence by State Program
Costs	• **Iora Health (receives fixed, risk-adjusted PMPM from payers and incorporates additional payments for meeting quality or use targets)[1]**: One Iora case study reports a 12.3% decrease in expenditures • **Michigan (fee-for-value (P4P program) incentivizing coordination, quality, and low costs)[2]:** 1.1% lower spending for adult participations and 5.1% lower for children
Quality & Utilization	• **Iora Health (receives fixed, risk-adjusted PMPM from payers and incorporates additional payments for meeting quality or use targets)[1]**: Iora reports ER visits reduced by 48% and by 41% for inpatient admissions; also improvements in blood pressure • **Michigan (fee-for-value (P4P program) incentivizing coordination, quality, and low costs)[2]:** quality maintained or improved for 11 of 14 measures

1. Fernandopulle, R. (2013). Learning to fly: Building de novo medical home practices to improve experience, outcomes, and affordability. The Journal of Ambulatory Care Management, 36(2), 121-125. doi:10.1097/JAC.0b013e3182871fac [doi]
2. Lemak, C. H., Nahra, T. A., Cohen, G. R., Erb, N. D., Paustian, M. L., Share, D., & Hirth, R. A. (2015). Michigan's fee-for-value physician incentive program reduces spending and improves quality in primary care. Health Affairs (Project Hope), 34(4), 645-652. doi:10.1377/hlthaff.2014.0426 [doi]

What accountability mechanisms exist to track the effectiveness of care coordination?

- In 2014, AHRQ published a Care Coordination Measure Atlas (https://www.ahrq.gov/sites/default/files/publications/files/ccm_atlas.pdf)
- In 2013, Schultz et al identified care coordination 96 measures, many of which focus on communication and information transfer (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3651252/pdf/1472-6963-13-119.pdf)
- The National Quality Forum maintains an online repository of endorsed quality measures

What accountability mechanisms exist to track the effectiveness of care coordination?

Mechanism	Implementation	Challenges
CPT codes	Billing codes exist for care coordination activities	• Do not provide information about how care coordination is achieving model of care (value)
EHR documentation	Allows more flexible tracking of care coordination activities	• Independent practices may not have sufficient EHR capabilities[1]
Process measures	May be calculated using claims, EHR, or survey data	• May increase provider documentation time With numerous measures available, may be difficult to gather consensus on best process measures
Quality measures	Select quality measures in alignment with model of care	• Measures may need to vary by practice and patient population • Measures outcome rather than care coordination actions
Cost Measures	Select utilization measures in alignment with model of care	• Measures may need to vary by practice and patient population • Measures outcome rather than care coordination actions

1. Townsend, B., Bentz, D., & Fan, N. (2019). *Primary care collaborative report 2019.* (). Dover, DE: Delaware General Assembly. Retrieved from https://www.pcpcc.org/sites/default/files/resources/Collaborative%20Report%20-%20January%202019.pdf

What are the key takeaways from the evidence?

- Care coordination per member per month (PMPM) payments in combination with a model of delivery reform can reduce spending and improve patient outcomes

- Adoption of care coordination PMPM payments is not sufficient to improve care delivery
  - Clinical model + payment approach to enable the model ⇒ improved outcomes