Blended Payment Models and Associated Care Management Fees

Robert Graham Center
Presentation to the
American Academy of Family Physicians
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Background

- Triple Aim Initiative: improve quality of care, increase access, and decrease cost of healthcare
- Primary care: important component in achieving Triple Aim, challenged to radically transform care delivery while still facing archaic traditional fee-for-service reimbursement
- Avenues to achieve care delivery changes include Blended Payment Models and Care Management Fees

Objectives

- American Academy of Family Physicians would like to provide guidance to their members over care management fees (CMFs)
- Robert Graham Center proposed to first produce a systematic literature review to begin addressing the issue:

Estimating/reconfirming the value of a care management fee within the context of the patient-centered medical home

- **What is the "right" value?**
- **What should be included?**
- **What's the return on investment of a care management fee to a payer?**

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Systematic Literature Review Methodology

- Total 631 identified publications, 63 included in review
- Systematic:
  - Peer reviewed sources: PubMed, EconLit, JSTOR, etc.
  - Grey literature sources: CMS, SSRN, etc.
- Snowballing:
  - Historical: Reference lists of identified articles
  - Recent: Articles citing identified articles
- Criteria:
  - Publications since 2009
  - Language: English

Findings Overview

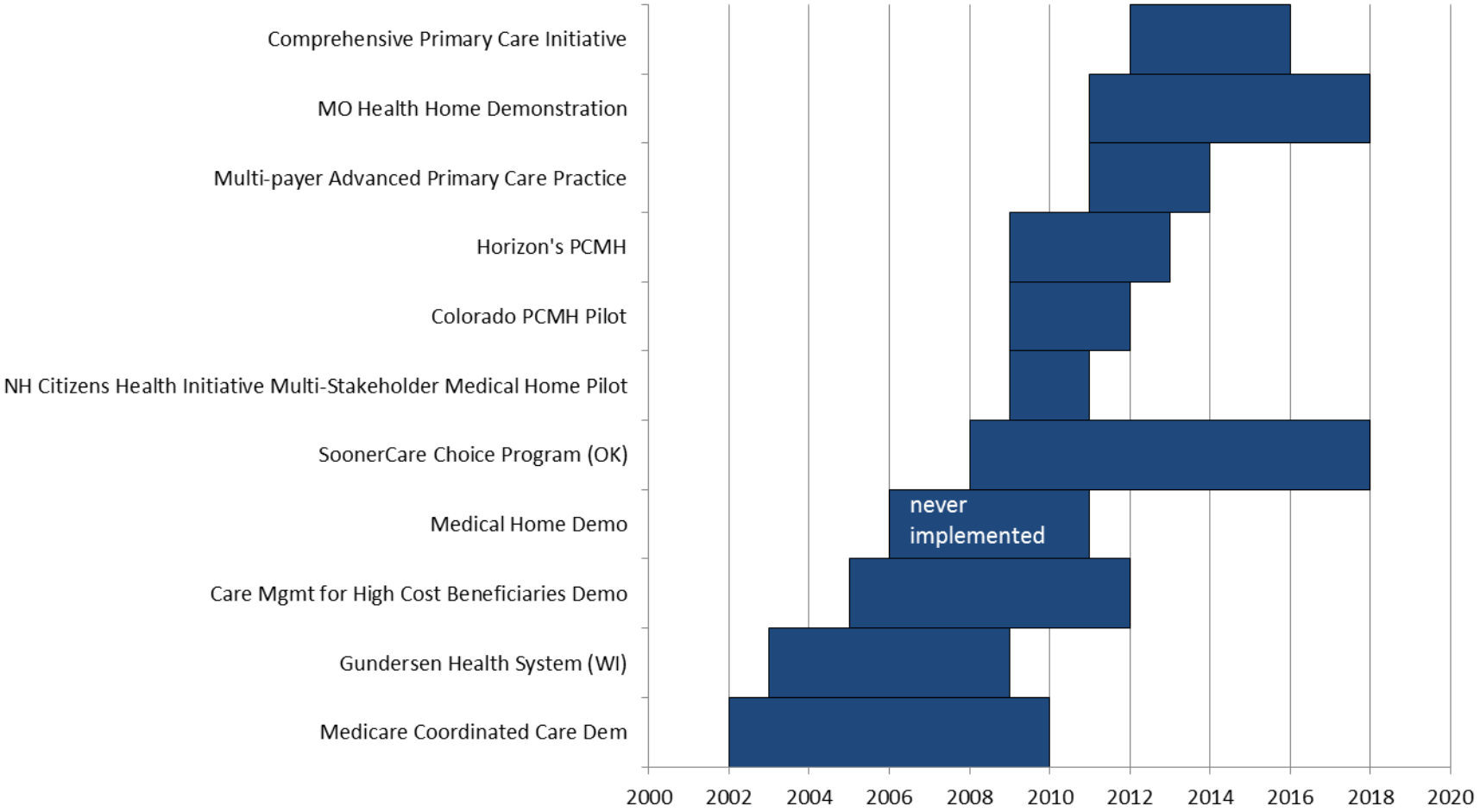
- CMFs are fluid and are set based on a matrix of three component matrices:
  - Patient Matrix (age/health)
  - Covered Services Matrix
  - Service Intensity Matrix
- PCMH Level determines the practices location in the Services and Intensity Matrices
- Variability is considerable:
  - Fees documented in the covered literature ranged from $0.60 PMPM to $444 PMPM

Definitions

Care coordination (CC)	• Organization of patient care between two or more participants to facilitate appropriate healthcare delivery services • Managed by exchange of info among participants responsible for care
Care management (CM)	• Can be used interchangeably with care coordination • Often involves assigning patients to a single staff member who monitors clinical care/support services in the hopes of reducing the need for expensive medical services
Disease management (DM)	• Shares some features with care management/coordination • Includes services that teach patients about their disease and how to adhere to diet, meds, exercise • Often targeted towards patients w/ specific chronic diseases
Case management	• Enhancing factor of care coordination through designation of care manager

Source: McDonald et al. (2007), Peikes, Brown, Chen, & Schore (2008)

Timeline: Programs with Care Management Fees



Source: Robert Graham Center

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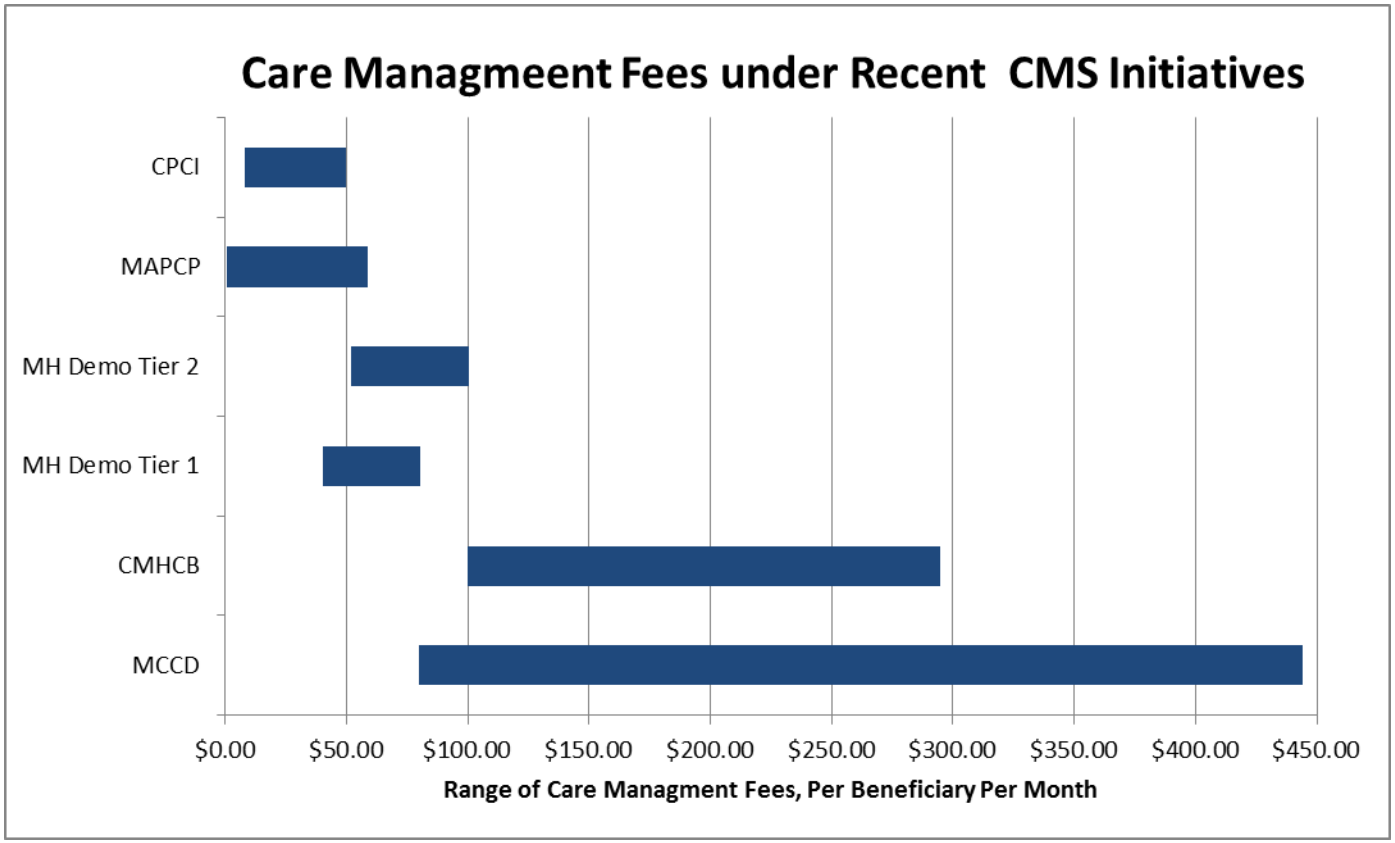
CMS Initiatives

- 2002; CMS Medicare Coordinated Care Demonstration; 15 sites; CMFs $80–$444 PMPM
- 2005; CMS Care Management for High-Cost Beneficiaries Program; six organizations; CMFs $100–$295 PMPM
- 2006; CMS Medical Home Demonstration; CMFs $17.12–$100.35 PMPM; canceled in 2011in lieu of Multi-payer Advanced Primary Care Practice Demo

CMS Initiatives Cont.

- 2011–2014; CMS Multi-Payer Advanced Primary Care Practice Demo (MPAPCP); eight states; CMFs from $0.60–$58.50 PMPM, most states had a CMF of approximately $10 PMPM; Fees determined based on medical home tier level/patient disease burden complexity
- 2012–2016; CMS Comprehensive Primary Care Initiative (CPCI); seven localities; CMFs average $20 PMPM, risk adjusted to $8–$40 PMPM for first 2 years, reduced to $15 PMPM for years 3 and 4



CMS Initiative Average Care Management Fee Range Comparison

CMS Initiative	Care Management Fee (PMPM)
CPCI	$8-$50
MAPCP	$0.60-$58.50
MH Demo Tier 2	$51.70-$100.35
MH Demo Tier 1	$40.4-$80.25
CMHCB	$100-$295
MCCD	$80- $444

Source: Robert Graham Center compilation

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Other Patient-Centered Medical Home Pilots

- List of programs:
  - Colorado Patient-Centered Medical Home Pilot
  - New Hampshire Citizens Health Initiative Multi-Stakeholder Medical Home Pilot
  - Horizon's Patient-Centered Medical Home
  - Gundersen Health System
  - SoonerCare Choice Program
  - Missouri Health Home Demonstration
- Most determined the CMF by stratifying payments based on medical home tier
- CMFs ranged from $1-$144 PMPM depending on the program

Care Mangement Fees Vary by Patient Matrix

Program	Patient Matrix (Age/Health)	Per Member Per Month CMF
Pennsylvania MAPCP	Level 1 (Beneficiary 18 years or younger)	$0.60
	Level 2 (19-64 years)	$1.50
	Level 3 (65-74 years)	$5.00
	Level 4 (>=75 years)	$7.00
Minnesota MAPCP	1-3 Chronic Conditions	$10.14
	4-6 Chronic Conditions	$20.27
	7-9 Chronic Conditions	$40.54
	10 or more Chronic Conditions	$60.81
Medical Home Demonstration	Tier 1	$40.40
	HCC Score < 1.6	$27.12
	HCC Score > 1.6	$80.25
	Tier 2	$51.70
	HCC Score < 1.6	$35.48
	HCC Score > 1.6	$100.35

Source: Robert Graham Center

Note: HCC = hierarchical condition categories

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Care Mangement Fees Vary by Covered Services Matrix

Program	Services Covered	Per Member Per Month CMF
MCCD: CenVaNet	In-home monitoring device to monitor patients RNs and social workers as care managers Monitor patients over telephone or in-person	$80.00
MCCD: CorSolutions	Program disease manager and Medicare-certified home health nurse Teaching plan w/ eight educational modules Routine monitoring every other week for first few months Covers cardiac/non-cardiac prescription drugs for low-income patients	$444.00
MAPCP: Maine	Care Coordination Fee	$7.00
	Community Health Team Fee	$2.90
MAPCP: Michigan	Care Coordination Fee	$2.00
	Community Health Team Fee	$4.50

Source: Robert Graham Center

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Care Mangement Fees Vary by Service Intensity Matrix

Program	Intensity	PMPM CMF
CMHCB: Care Level Management	Home based care, 24/7 access to physician, each beneficiary has two physicians Uses nurses and care managers for follow-up visits 16-item tool to assess patient acuity, such as ER visits in last 6 months, presence of unmet social/emotional needs	$295
CMHCB: Texas Tech University Health	Remote nurse call-centers to contact beneficiaries	$117

Source: Robert Graham Center

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Conclusions

- RGC's objective: describe known programs and their relevant care management fees
- Limitations:
  - No information on negotiation process
  - Limited details on breakdown of CMFs for most programs
  - Without more information cannot determine 'common' services
- Technological changes may trump many of the current systems in the near future(e.g. tele-health)

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Next Steps

- Researchers:
  - additional research on breakdown of care management fees and the effect of care management fees on health care costs – to the practice, payers, and the 'system' as a whole
- AAFP: prescriptive description of either
  - the 'ideal' care management fees covered under various population/services/intensity bundle or
  - given a population, the 'ideal' services/intensity bundle covered by care management fees

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Recommendations

- For AAFP to offer effective advice to members:
  - Attempt to obtain more details on the breakdown of the care management fees for the CMS programs reviewed
  - Investigate primary care practices experience with negotiating with private payers for care management fees
  - Investigate how private payers approach the negotiation process

CMS Program Follow-up

Task	Deadline (tentative)
1. Create Program Contact List	11/1/2013
2. Ask Programs for final approved CMS request for funding/proposal	(initial contact) 11/8/2013
3. Review Proposals	11/8/2013-11/29/2013
4. Create table breaking down products/services and patient population covered by CMF	12/6/2013
5. Create one summary table that aggregates over individual tables	1/10/2014
6. Write up Report	2/7/2014

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THE END

Systematic Literature Review PubMed Search Terms

(("care coordination"[Title/Abstract]) OR ("coordinated care"[Title/Abstract]) OR ("care management"[Title/Abstract]) OR ("patient management"[Title/Abstract])) AND (fee[Title/Abstract] OR fees[Title/Abstract] OR reimbursement[Title/Abstract] OR payment[Title/Abstract]) AND (English[Language]) AND ("2009/01/01"[Date - Publication] : "3000"[Date - Publication])

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History

Care Management Through the Decades	
1960s	Deinstitutionalization movement for mental health
1970s	National Institute of Mental Health promotes 'case management' for mentally ill
1980s	State Medicaid programs begin operating primary care 'case management' programs
1990s	CMS launches national 'case management' payment methodology Shift toward care coordination
2000s	CMS launches first demonstrations with care management fees
2010s	CMS Innovation Center established, expands payment delivery change
Source: Robert Graham Center	

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