



Payment to Promote Sustainability of Care Management Models for High-Need, High-Cost Patients

**INSIGHTS FROM THE
HEALTH CARE TRANSFORMATION TASK FORCE**



Who We Are

The **Health Care Transformation Task Force** is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. We are committed to rapid, measurable change, both for ourselves and our country. We aspire to have 75% of our respective businesses operating under value-based payment arrangements by 2020.

Our High Cost Patient Work

The **Improving Care for High-Cost Patient Work Group** identifies and evaluates key areas that drive costs for patients in health care systems. We address risk stratification of high-need, high-cost patients and describe best practice initiatives that perfect handoffs and improve care coordination, assuring person/family-centered care, better outcomes, and lower costs. This includes patients near the end of life, patients who undergo high-cost events, and patients with multiple chronic illnesses including behavioral health issues that challenge traditional disease and case management. The High-Cost Patient Work Group’s guiding principles are as follows:

1	Health care costs are highly concentrated in a very small patient subpopulation. Identifying and managing care for this group of patients is an important step towards improving health outcomes and reducing total costs for the entire population.
2	Effective care management programs will utilize both qualitative (physician- or patient-reported information) and quantitative (claims, electronic data) resources to identify high-need, high-cost patients. These patients may include those nearing the end of life, patients with multiple chronic illnesses, and patients with behavioral health issues or complex social needs.
3	Best practice models of care management will take a holistic, person-focused and family-centered approach to health including its behavioral, social, and physical aspects.
4	Best practice models of care management will emphasize care coordination across providers and have robust primary care capabilities at their center.
5	Common accountability targets, metrics, and incentives across systems will allow for meaningful comparability of care coordination models and true best practice identification. Transparency of these metrics will foster provider accountability.
6	Reimbursement across all payers should encourage value in delivery models and should be both scalable and sustainable across diverse provider settings and patient populations.

To further these principles, the Work Group is authoring three papers: Proactively Identifying the High Cost Population (available [here](#)); Developing Care Management Programs to Serve High-Need, High-Cost Populations (available [here](#)); and Payment to Promote Sustainability of Care Models for High-Need, High-Cost Patients (the subject of this paper).

1 “Proactively Identifying the High Cost Population,” Insights from the Health Care Transformation Task Force, Accessed at: <https://static1.squarespace.com/static/548b623fe4b0991231a05ff0/t/55ca2d24e4b0d196f157ebf4/1439313188533/Proactively+Identifying+the+Hi+gh+Cost+Population+White+Paper+-+Updated+August+5th.pdf>



Introduction

Improving quality and lowering costs for the most complex patients in our health care system has long been a priority for numerous public and private sector stakeholders. A robust body of literature demonstrates that a significant proportion of health expenditures are concentrated among medically complex individuals. High-need, high-cost patients are concentrated principally in the Medicare and Medicaid populations and to a lesser extent in commercial populations. Task Force members' general experience is no different; a typical member allocates a disproportionate amount of resources towards caring for a very sick, but small group of patients. Quality outcomes, particularly those related to care coordination and patient experience, are often substandard for this population.

This is the third of three papers the Task Force's Improving Care for High-Cost Patients Work Group is developing to inform the work of health systems and payers seeking to improve care and reduce costs for high-need, high-cost populations. The first paper combined evidence to guide the selection of individual patients who might benefit most from targeted care management. It identified patients near the end of life and those with persistent, high spending patterns. The second paper described the foundational elements of successful care management programs to address the needs of these high-need, high-cost populations, including patient and family engagement, team-based care, and transitional support, and provided examples of Task Force member programs, as well as lessons learned from their experiences.

This final paper outlines emerging payer and provider partnerships that incentivize sustainable delivery system re-engineering to improve care for the high-need, high-cost population through innovative value-based payment models. Its findings reinforce the overarching themes that are exhaustively documented elsewhere and remain salient for Task Force members: (1) the fee-for-service payment system has and continues to impede broad adoption of effective interventions for high-need, high-cost patients; and (2) conflicting requirements and methodologies from multiple payers threaten to hinder progress in the future, even in supportive environments.

This paper illustrates Task Force members' important investments in care management infrastructure and their success with improving outcomes for high-need patients under a patchwork of payment arrangements. The Work Group firmly believes that high-need, high-cost patient interventions operate most effectively in population-based payment contexts aligned across public and private payers. Population-based payment is defined as a payment based on the number of individuals meeting criteria, rather than linked to a specific service, or specific individual. In support of common understanding and further progress in this area, the Work Group offers several examples and recommendations in the following sections:

1. The continuum of payment models in use for high-need, high-cost patient interventions among Task Force members and throughout the broader U.S. health system;
2. Key considerations and recommendations regarding the design of payment models for complex care management, disease management, and palliative care initiatives; and,
3. Recommendations to ensure all high-need, high-cost patients are offered needed services, regardless of insurer.

The Work Group believes that the examples and recommendations provided in this paper will help accelerate adoption of population-based payment and provide a starting point for greater alignment of payment methods across the U.S. health system. Well-designed population-based payment models have the potential to reorient care delivery to provide better outcomes to those patients who need it most, and thereby increase value.

I. The Continuum of Payment Models in Use for High-Need, High-Cost Patient Interventions among Task Force Members and Throughout the Broader U.S. Health System



As discussed in the first white paper, although the high-cost patient population can include those with episodic high spending (i.e., individuals that have increased costs due to a sudden event, but that decrease as the condition resolves), the outcomes for these patients are not as modifiable by care management and support. In contrast, those with chronic medical issues, often with complicating social or behavioral factors, can benefit most from care management. These patients with complex chronic needs are described as “high-need, high-cost” patients. Previous work by the Task Force shows that no common definition exists across Task Force membership, or even within organizational business lines, for this population. Many members use a proprietary mix of predictive risk modeling, retrospective utilization review, and individual referrals to identify those patients most likely to benefit from targeted interventions. In the elderly Medicare population, the high-need, high-cost patient profile often includes those beneficiaries with multiple chronic conditions, or those who are nearing the end of life. Among Medicaid populations, mental illness or social determinants, such as homelessness, are drivers of persistently high spending patterns. Among working-age adults, receiving on-going care from multiple specialists can drive persistent high spending patterns.

Diversity of “high-need, high-cost” patient definitions at the outset makes alignment around payment methods challenging. In addition, although Task Force members have previously detailed several common care model elements across programs for high-need, high-cost populations, there is not a common definition about the most effective services for this population. In an attempt to classify the range of payment models currently supporting this multitude of focused activity, the Work Group began with the current Centers for Medicare and Medicaid Services (CMS) four-category framework for alternative payment models (APMs), which includes the following:

1. Fee-for-Service – No Link to Quality or Value
2. Fee-for-Service – Linked to Quality and Value
3. Alternate Payment Models (APMs) Built on Fee-for-Service Architecture
4. Population-Based Payment

Moving from Category 1 toward Category 4 in the framework involves increasing provider accountability for both quality and total cost of care, with a greater focus on population health management, as opposed to payment, for specific services. In addition, each category has several subdivisions that further detail the complexity and degree of risk underpinning each model. For instance, Category 3 APMs built on fee-for-service architecture move from providing only upside gainsharing under subgroup 3A to including both upside and downside risk in subgroup 3B.¹

¹ For further clarification on the categories and subgroups, see: Health Care Payment Learning and Action Network, Alternative Payment Model (APM) Framework, white paper, Jan. 2016. <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>



While focusing solely on payment structures rather than patient outcomes is misguided, Task Force members steadfastly believe that moving toward shared risk within categories (e.g., Category 3A to 3B) and population-based payment across categories (e.g., Category 3 to 4) is an important foundational goal for both their organizations and the U.S. health system as a whole. In short, Task Force members have found that population-based payment is conducive to experimentation with—and expansion of—covered services, coordination across delivery settings, and foundational investments in the infrastructure necessary to improve quality and lower costs for various high-risk populations.

In Table 1, we classify examples of payment arrangements for high-need, high-cost patients among payers, both Task Force and non-Task Force members. While there is evidence of supportive payment models across all business lines, inconsistent application of supportive payment models across a provider network complicates the analysis. For instance, Anthem only contracts to pay an upfront care management fee to delivery systems already offering care coordination services. The fee is not paid to all providers across the network. Similarly, Aetna reimburses hospice facilities for delivering care, in non-Medicare business under its compassionate care program according to the sophistication of the specific vendor. Therefore, although supportive payment models exist across all business lines, they may not be available to all providers in the network.

Table 1. Sample of Representative Payment Models Offered by Payers for High-Need, High-Cost Populations

	Category 1 Fee-for-Service – No link to Quality or Value	Category 2 Fee-for-Service – Linked to Quality and Value	Category 3 APMs Built on Fee-for-Service Architecture	Category 4 Population-Based Payment
Description		At least a portion of payments vary based on the quality or efficiency of health care delivery	Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services with opportunities for shared savings	Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and systems are paid and responsible for the care of a beneficiary for a long period (>1 year)
Medicare		2A. Medicare FFS: CPT 99490	3A. MSSP Track 1 ACO 3B. MSSP Track 2ACO	4A. NextGen ACO, PACE 4B. BCBS-MI Medicare Advantage High-Intensity Care Model, single, monthly global code
Commercial		2C. BCBS-MI Provider Delivery Care Management: trained care managers, FFS+5% 2D. Anthem--case mgmt. fee paid on top of FFS payment with small withhold based on value.		4A. OptumCare 4B. BCBS MN and ND; BCBS-MA AQC
Medicaid		2B. Vermont PCMH Medicaid Health Homes: care management payment for serving members with chronic illnesses and serious and persistent mental illnesses	3B. Oregon CCOs	4A. Arkansas Health Homes 4B. Minnesota Accountable Care Communities



From the provider view, delivery systems are patching together payment models to support their programs. Table 2 demonstrates how some Task Force members and other delivery systems are leveraging value-based models to invest in care management and social services that are not reimbursable under traditional fee-for-service insurance programs. Despite the existence of supportive payment models across business lines, they are not broadly available. For example, many providers build programs for Medicare Advantage patients. While programs like the Medicare Shared Savings Program offer promising approaches and resources for Medicare Fee-for-Service (FFS) populations, Task Force members acknowledge that it is often challenging to extend these expanded services to FFS patients. Similar dynamics exist on the Medicaid side. As a result, patients with similar clinical profiles in the very same practice may not be able to access the same level of care management services.

Task Force members have found that despite the financial challenges noted above, high-need, high-cost patient interventions operate most efficiently when all the patients with complex conditions in a particular practice are eligible to participate in the program, regardless of payer. This leads not only to better population health outcomes, but ultimately lower cost of care—successful multi-payer alignment significantly reduces administrative burdens by harmonizing quality measurement and reporting requirements. Moreover, multi-payer collaborations can amplify incentives to undertake certain performance improvement activities and invest in the infrastructure needed for complex care management.

Case Study: Public Payer Implementation

Section 2703 of the Affordable Care Act established a new Medicaid State Plan Amendment (SPA) Option that enables states to implement health home programs, designed to support targeted care coordination services for Medicaid members with chronic conditions.² As of late 2015, 19 states and the District of Columbia had implemented a health home program, reaching over 1.2 million beneficiaries nationally.³ In many cases, states have opted to target their health home programs to serve Medicaid members with serious mental illnesses and chronic conditions such as asthma, heart disease, diabetes, and more. Typically states pay a per-member-per-month (PMPM) care coordination fee to a provider or network of providers to provide care management, coordination services, health promotion, transitional care follow-up, connections to social services, and the like. In some cases, states have offered tiered PMPM care coordination fees to providers, taking into account the acuity of members served. A large scale study of the program's impacts is being conducted by the Urban Institute and will be complete in October 2016.⁴ Though the program is still relatively new nationally and its full impact is still being considered, some states have begun to establish financial and clinical linkages between the health home program, which by definition serves some of the highest-need, highest-cost beneficiaries, and more sweeping value-based payment models. For example, New York State has recently launched specialized managed care plans called Health and Recovery Plans (HARPs) that focus on Medicaid beneficiaries with serious mental illnesses and substance use disorders.⁵ In late 2016, the state will start enabling some providers to enter into ACO type arrangements targeting HARP enrollees. All enrollees are offered health home care coordination services, recognizing that health home care coordination services are a useful tool for impacting total cost of care. As New York launches a more comprehensive effort to spur on delivery transformation, requiring 80-90% of Medicaid managed care payments to flow through value-based payments by 2020, health homes will be a critical building block underneath such arrangements.⁶

2 <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>

3 <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-information-resource-center.html>

4 <https://aspe.hhs.gov/basic-report/evaluation-medicaid-health-home-option-beneficiaries-chronic-conditions-annual-report-year-three#conclude>

5 https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/harp_hiv_snp.htm

6 Roadmap link is here: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm



Table 2. Sample of Representative Payment Models Received by Providers to Support High-Need, High-Cost Patient Models

	Category 1	Category 2	Category 3	Category 4
	Fee-for-Service – No link to Quality or Value	Fee-for-Service Linked to Quality and Value	Alternative Payments Based on a Fee-For-Service Architecture	Population-Based Payment
Medicare		St. Joseph: CPT 99490	Providence: Shared Savings ACO (upside—3a) Atrius Health: Pioneer ACO Montefiore: Pioneer ACO	Advocate: Full risk for Medicare Advantage Providence: Full risk for Medicare Advantage St. Joseph: Full risk for Medicare Advantage Atrius Health: Full risk for Medicare Advantage Montefiore: Full risk for Medicare Advantage
Commercial		Advocate: Humana PPO, BCBS PPO (self-insured pop w/o shared savings) St Joseph: Anthem--case mgmt. fee paid on top of FFS payment with small withhold based on value.	Advocate: United, Cigna PPOs BCBS-IL PPO Providence: Direct-to-employer ACO contracts St. Joseph: CareConnect Montefiore: shared savings arrangements	Advocate: Blue Care Direct, Advocate Associates EPO/HMO BCBS-IL HMO, BCBS-IL BlueAdvantage HMO, BCBS-IL Blue Precision HMO Humana HMO (partial risk for ambulatory services) Montefiore: full delegated risk
Medicaid	Advocate: Illinois Medicaid	Advocate: Illinois Medicaid	Montefiore: shared savings arrangements	Montefiore: full delegated risk

Case Study: Delivery System Receiving Payments in Multi-Payer Environment

Virtually all health care delivery systems reiterate both the importance and challenge of multi-payer alignment. A salient example comes from St. Joseph Health, an integrated health care delivery system providing a full range of care from facilities including 14 acute care hospitals, home health agencies, hospice care, outpatient services, skilled nursing facilities, community clinics, and physician organizations. St. Joseph’s delivers care across a variety of urban centers, smaller cities, and rural communities in California, Texas, and New Mexico.

St. Joseph offers the CareConnect program, an intensive outpatient care management for both Medicare and commercial high-need, high-cost patients. St. Joseph is reimbursed for its high-cost patient interventions under a variety of payment methods spanning Categories 2-4 in the LAN APM framework (see Table 2). The organization has found full capitated payment arrangements (currently covering about 30 percent of its patient population) are the most conducive to both the foundational and operational requirements of its care coordination work. Examples of the former include investments of the data sharing infrastructure necessary for performance monitoring and improvement. Expansion and coordination of ancillary services like mental health and social support also work best in a full-risk ACO environment.

II. Key Considerations and Recommendations Regarding the Design of Payment Models for Complex Care Management, Disease Management, and Palliative Care Initiatives



Several unique features of complex care management initiatives for high-need, high-cost patients should be considered when designing payment models to support their sustainability.

1. *The highest-need, highest-cost population is ever-changing.*

Payment models for care management programs should be population-based and account for a population that changes from month-to-month and year-to-year, no matter how this population is defined. Payment systems should focus not on identifying the highest-cost patients at any given moment and providing care for this cohort over time, but on identifying and providing care for the population of high-need, high-cost patients who will most benefit from care management services. To achieve this, models must periodically re-evaluate this population and adjust the provision of care management services accordingly.

2. *Providers must be incentivized to identify patients for whom they can have the most impact.*

In order to ensure that the patients who would most benefit from care management services are included in care management programs, providers must be incentivized to seek out the patients for whom they can have the most impact, without inadvertently encouraging “cherry picking,” or creating other problematic incentives. Fee-for-service care management payments incentivize provision of care management services regardless of medical necessity. In fact, roughly 30 percent of each dollar paid for care goes to low/no-value care—care of a higher intensity, expense, and risk where lower intensity treatments yield the same outcomes at lower costs.⁷

With proper risk adjustment, population-based payment incentivizes providers to find savings by managing care for those most in need, and re-allocating that savings to improve care in other areas. Low-value care is the single largest driver of unnecessary costs, roughly three percent of Gross Domestic Product (GDP), so mitigating low-value care creates an immediate, demonstrable financial impact. While provider incentive payments based on outcomes also incentivize care management for those patients most in need, providers are not at risk for the total cost of care, which reduces the incentive to control volume. A provider may improve outcomes for a patient, but if a disproportionate amount of low-value care is generated in the process, there will be no savings.

3. *Provider incentives must be based on Triple Aim outcomes.*

To the degree that provider incentive payments for care management are used, these payments must be based on Triple Aim outcomes. Per-member-per-month (PMPM) incentive payments not based on outcomes incentivize care without sufficiently incentivizing health, and may drive-up costs rather than contain them. Therefore, if such payments are used, there should be metrics that are evaluated to ensure that the Triple Aim is met.

⁷ <http://www.nationalacademies.org/hmd/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx>



Alignment around measures for complex care management provides an area for further progress. Many Task Force members report patient-centered goal setting as a key element driving their care models, therefore alignment around a core set of indicators quantifying patient-reported outcomes for complex patients can simultaneously improve quality and lower the administrative burden on providers. Measuring quality of life, and developing appropriate Patient Reported Outcomes Measures (PROMs), is especially important for those with comorbidities and for whom condition-specific measures cannot provide an adequate picture of the total quality of care received, such as individuals with Alzheimer’s, dementia, and other cognitive impairments. One way to do this is through the measurement of “Healthy Days,” a Centers for Disease Control and Prevention (CDC) metric designed to measure quality of life over time.⁸ Ultimately, if the quality proposition of a model of care is premised on quality measurement, then the model can only serve consumers well if there are sufficient quality measures to account for the needs and diversity of the population. Significant work should continue to be conducted to develop measures that can adequately evaluate the complex high-need, high-cost population.

4. Apply and align risk-adjustment payment methodologies.

Risk adjustment and methods to protect providers from insurance risk are more important when focusing on high-need, high-cost populations than general populations. Many Task Force members note the plurality and complexity of methods for—and desirability of alignment around—risk adjustment. Modifying current risk adjustment methodology has the potential to provide a starting point for more consistent standards, provided any changes to the current CMS-Hierarchical Condition Category (HCC) risk adjustment model properly account for changes in predicted costs associated with the interaction between behavioral health conditions and physical health outcomes. Important areas that merit attention and inclusion in risk scores are functional status (similar to the Program for All-Inclusive Care for the Elderly (PACE) programs) and socioeconomic status. The application of risk corridors or re-insurance can also mitigate risk in population-based payments, including for unforeseeable costs not directly tied to the provision of care. This is especially important for high-need, high-cost patients who stand to lose the most if the system is caught under-resourced.

5. Providers face financial “barriers to entry” to make initial programmatic and infrastructure investments.

Task Force members find that most savings are primarily driven by reductions in acute hospital care, post-acute care, and emergency department use. Preventing inappropriate and/or avoidable use of these settings requires upfront investments in initiatives and infrastructure to transition utilization, when appropriate, to ambulatory settings through increased patient access, compliance, and engagement in primary and preventative care. Upfront investments include information technology that enables better information exchange and identification of high-need, high-cost patients, developing wrap-around social supports related to housing and other services, and actual expansion of primary care services in underserved settings. These challenges are addressed by population-based payment arrangements and can also be overcome with other sources of seed funding. For example, in New York Delivery System Reform Incentive Payment (DSRIP) funds are intended to provide up-front funding to lay the ground work for high-need, high-cost population programs.

8 <http://www.cdc.gov/hrqol/pdfs/mhd.pdf>



Some believe that unless a delivery system has already built infrastructure for population management (i.e., utilization management, population-level analytic capability, IT connectivity), accepting responsibility for management of high-need, high-cost patients is not financially viable. In any case, payers should recognize the initial investment and ongoing operational costs of such infrastructure and reflect those in payments to systems implementing Category 3 and Category 4 systems.

6. Program are most effective when they engage and partner with patients in their own care management.

Incorporating expansion of covered services and benefit changes to enhance patient engagement opportunities can increase effectiveness of programs. Task Force members find that collaboration and engagement with patients, and those that are impacted by the patient’s disease burden, are critical to improving health outcomes and experience of care—particularly among the highest-need patients—which in turn allows for program savings to be fully realized. Meaningfully engaging patients, families, caregivers, and others as partners in care is the best way to encourage patients to consistently seek care. Financial incentives should be designed to remove barriers to establishing strong relationships with providers, rather than as financial inducements. One relevant example is waiving copayments for face-to-face visits with care coordinators for patients enrolled in a care management program, and waiving or reducing co-payments for maintenance and medication.

Case Study: Private Payer Implementation

The Blue Cross Blue Shield of Michigan (BCBSM) High Intensity Care Model (HICM) uses a comprehensive list of chronic conditions in conjunction with indicators of high utilization or poor care management to identify the high-need, high-cost population that will benefit the most from care management services. The number of chronic conditions each member has is determined from a list of 35 chronic diseases. BCBSM considers members to have a disease if they had two or more occurrences of its diagnosis codes in claims during a two-year period. Health and utilization indicators are also assessed for each member.

The majority of the services provided through the HICM program are home-based and delivered by specially trained, dedicated teams including Nurse Practitioner (NP)/Registered Nurse (RN), Master of Social Work (MSW), pharmacist, nutritionist, Licensed Practical Nurse (LPN), and a medical director. The program included annual comprehensive health and care management assessments, 24/7 phone access, individualized care plans, care coordination, and care transitions management. Payment is provided through a combination of fee-for-service encounter payments as well as a global monthly code for care coordination, phone encounters, and team conferencing.

The intensive care management provided to these patients since October 2014 has improved quality of life, reduced Medicare Advantage medical spend by one—two percent. A quality impact assessment is slated for 3Q2016.

III. Recommendations to Ensure all High-Need, High-Cost Patients are Offered Needed Services, Regardless of Insurer



Both insurers and providers are experimenting with care models tailored to the needs of high-need, high-cost patients and discovering that only some forms of an alternative payment model will sustain these care models over time. The core of the care models require upfront investments in outpatient services and care across the continuum, such as face-to-face care coordination, mental health and social services, and home visits, to prevent expensive hospitalizations and emergency department visits. Interviews with Task Force members and other successful programs around the country point to a set of conclusions about the types of supportive payment models.

Findings regarding sustainable payment models:

1. A form of sustainable payment is a per-member-per-month care management fee based on Triple Aim outcomes for high-risk patients, plus shared savings.

In this case, a per-member-per-month (PMPM) care management fee is paid based on the distribution of risk scores for a population of patients attributed to a provider organization or network of providers. Examples include Oregon's Coordinated Care Organizations and Anthem's Enhanced Primary Health Care Program, which provide an enhanced PMPM fee to medical groups based on attributed members with two or more chronic conditions. Payers are naturally cautious about offering upfront payment alone, without at least some shared risk if savings are not realized. These programs are distinct from Patient-Centered Medical Home (PCMH) payments, which are made to individual physicians who cannot provide the range or depth of services required by many high-need, high-cost patients. Oregon combines both approaches in its statewide multi-payer approach.

2. Providers with existing care management program for high-need, high-cost patients prefer full-risk capitation payments.

Capitation provides an important cash flow advantage for operational costs such as care coordinators and systems to more closely manage high-need, high-cost patients across care settings, as well as the flexibility to cover services not normally reimbursed, such as home visits from credentialed but unlicensed staff. Additionally, capitation allows organizations to fund care coordination services.

3. Traditional fee-for-service payment systems do not reimburse providers for care management services when furnished.

Provider systems face painful choices between providing needed services to patients based on their clinical needs, regardless of their plan or benefit design, and the financial sustainability of their organization when they provide care that is not paid for. In cases where care management programs exist for some patients covered under supportive payment models, systems often accept patients covered under fee-for-service plans if referred from a contracted physician, but do not actively recruit patients. Other systems seek the "tipping point" where enough patients are in alternative payment models to offset the cost of providing the services to all patients.

4. Using CPT-based codes to represent fee-for-service for care management services is insufficient to advance adoption of programs for high-need, high-cost patients.

Although providers with existing programs may use this form of payment to augment revenue for existing care management programs, none sustain their programs based on this payment model alone.



The Work Group supports the Chronic Care Management (CCM) CPT codes to offset some of the expenses for coordinating care for sick beneficiaries; however, any strategy that simply adds more fee-for-service codes is misguided. Fee-for-service payments for care management services provide some revenue to support a program, but are always insufficient over time. Also, as these new CPT codes are “priced” by Medicare they are calculated on the old FFS methodology rather than their true value, which includes the ability to help offset upfront program implementation costs. The adaptable and sometimes unpredictable nature of care provided to complex patients is incompatible with a payment system predicated on the delivery of a discrete set services.

Based on the findings above, Task Force members endorse the following actions to make value-driven, sustainable models more broadly available for high-need, high-cost patients:

Public Purchasers and Policy Makers

Principal among the Task Force’s recommendations to public policymakers is the need to continue the movement toward population-based payment models.

- Task Force members endorse the movement toward Advanced Alternative Payment Models (APMs) under the Medicare Access and CHIP Reauthorization Act (MACRA) and increasing incentives to move away from the Merit-Based Incentive Payment System (MIPS) and toward the Advanced APM track. It appears unlikely that a MIPS system could adequately support effective programs for high-need, high-cost patients.
- Capitation should allow for initial investment and ongoing operations and maintenance of population management systems.
- Allow value-based insurance design in Medicare Advantage products and other Medicare APMs. Elimination of copayments has proved effective to increase patient access to care and overcome other common implementation barriers for patients.
- Align with commercial APMs around quality measurement, risk adjustment, and budget setting methodologies to reduce unnecessary administrative burden, create a single set of reporting standards, and allow more dollars to be spent on patient services.
- Task Force members report the importance of linking mental health and social services for high-need, high-cost patients. Behavioral health carve-outs in many states that originally were designed to assure parity for mental health services have had the unintended consequence of creating many difficulties accessing and coordinating services. Additionally, many states are experimenting with changing Medicaid payment to increase access to social, nutritional, and housing services for high-need, high-cost patients. Provider, practices, and/or plans partner with patients to identify high-value, trusted community and social supports as part of these efforts.
- In parallel, privacy laws related to sharing of behavioral health information should be updated to allow more ready access to such data, due to their importance as noted above.



Private Payers and Providers

We are in a period of innovation and experimentation with payment and care models for high-need, high-cost patients. Eventually, common definitions for the target patient population as well as common service agreements will help to make effective programs more broadly available across the health care markets. Task Force members are in the position to take steps to simplify contracting between plans and providers:

- Develop a definition of the high-need, high-cost patient population. A useful definition would differentiate between patients with chronic conditions that can be addressed in a PCMH from complex patients with medical, social, mental health needs that require intensive care management.
- Develop a common understanding, with patients and consumers as key collaborators, on the key services plans and providers should expect to offer to patients in order to fully meet their health care needs. The Task Force has the opportunity to build on previous work to describe care model elements to create definitions specific enough for a blueprint delegation agreement or request for information.

Improve Accountability for Value-Based Outcomes

Our interviews found a wide variability in quality and cost accountability measures used for high-need, high-cost programs. The Task Force has the opportunity to align around core measures that are applicable to the high-need, high-cost population. Traditional chronic care Healthcare Effectiveness Data and Information Set (HEDIS) measures are inadequate for this population. In addition to broadly recognizing the importance of patient feedback, it is especially important to promote development of Patient Reported Outcomes Measures (PROMS). Patient-centered care—care that matches the goals, preferences, and values of the patient—is critical to effective care management for high-need, high-cost patients and current measures do not adequately assess effectiveness of this critical domain.



Conclusion

The high-need, high cost patient population, a small percentage of the overall patient population, accounts for a large majority of national health care expenditures. Much progress has been made in addressing both how to identify that patient population, as well as the appropriate care management services they should receive to help manage their health care needs. However, there has not yet been broad scale adoption of payment models for care management services that create incentives for accountability for the total cost of care furnished to those patients. Task Force payer and provider members report that broad adoption of effective care management programs across payers and setting is hindered by a fee-for-service payment architecture and the presence of multiple funding streams within a single program. Task Force members believe that a transition to population-based payment is imperative to ensure that patients with the highest need and highest costs are offered necessary services, regardless of insurer, and that the programs in which they are enrolled are sustainable over time. The recommendations presented in this paper are offered as ways to move payment for care management services away from fee-for-service and toward full-risk capitation payments, with the ultimate goal of improving outcomes and reducing costs for high-need, high-cost patients.