Valuation of Care Management Performed by Primary Care Physicians

An Issue Brief

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Introduction

The U.S. health care system is undergoing a transformation as health insurers shift from paying based on volume to paying based on the value of services health providers deliver. As part of the shift from volume to value, health insurers have begun increasing payments to primary care physicians because of the important role they play. As managers of patients' overall care, primary care physicians are key to keeping patients healthy and out of the hospital. This brief explores the value primary care physicians create through care management and how this value might be included in payments.

Applying Value-based Payment Models in the Public and Private Sectors

Both public and private health insurers are making the transition to paying providers based on the value of care. In the public sector, the U.S. Department of Health and Human Services (HHS) released aggressive goals in January 2015 describing its plans as the largest payer—through the Centers for Medicare and Medicaid Services' (CMS) Medicare program—to move toward value-based payment. Under CMS' plan, 30% of traditional fee-for-service Medicare payments will shift to alternative payment models by 2016, increasing to 50% by 2018.[1]

Reacting to the announcement that CMS plans to shift its approach to payment, Douglas Henley, MD, FAAFP, executive vice president and chief executive officer of the American Academy of Family Physicians (AAFP) stated, "We're all partners in this effort focused on a shared goal. Ultimately, this is about improving the health of each person by making the best use of our resources for patient good. We're on board, and we're committed to changing how we pay for and deliver care to achieve better health."[2]

The private sector has aligned in support of the same goals as the public sector. According to the nonprofit, Catalyst for Payment Reform, health insurance plans have dramatically shifted how they pay physicians and hospitals. Forty percent of health plan payments are now designed to encourage health care providers to deliver higher quality care, compared to just 11% in 2013.[3]

Value-based payments often take the form of care management fees for primary care physicians. These are typically up-front payments for proactively engaging with patients to manage their health. Care management is especially important for patients with complex health care needs, such as the chronically ill. Medicare, Medicaid, private health insurers, and physicians are currently debating and testing a range of alternative approaches to paying physicians for care management. The approaches differ in the structure and size of the payments that are offered.

Standardized Terms

For the purpose of this brief, the following definitions will be used:

Care Management: The set of services offered through a primary care practice intended to improve the health of patients, especially those with complex health care needs is referred to as care management. These services include those provided by office staff that, under the supervision of a primary care physician, reach out to patients and work with them to understand their health needs and to coordinate care across the medical neighborhood. For this issue brief, we have used the National Committee for Quality Assurance's (NCQA) patient-centered medical home (PCMH) definition for care management, as that model has been the most widely studied.

Six Key Elements of an NCQA PCMH

1. Patient-Centered Access
2. Team-Based Care*
3. Population Health Management*
4. Care Management and Support*
5. Care Coordination and Care Transitions*
6. Performance Measurement and Quality Improvement

**PCMH element also included in AAFP's definition of care management*.

Benefits: The positive contributions to the health care system created by care management are called benefits. There are many potential benefits associated with care management, including improved clinical outcomes for patients, better experience of care, and lower total health care costs. This brief is focused on the financial benefits of care management (lowering total costs). The financial benefit will determine whether care management is economically viable and sustainable in the long term.

Value: The extent to which the benefits of a health care intervention exceed an intervention's costs for a particular health care stakeholder is called value. We note that value is a subjective term that might vary based on the stakeholder's priorities. In general, improving quality or decreasing costs (or both) leads to greater value. Expressed mathematically, value equals quality divided by cost.

Benefits of Care Management

Numerous studies published in peer-reviewed journals have demonstrated the value of care management organized by primary care physicians.

Reduction in Total Cost of Care

An important benefit of care management is a reduction in total costs to deliver care to patients. Numerous studies[4,5,6,7,8] have identified reductions in total cost of care associated with patients who have received care management services organized by primary care physicians in a PCMH model. Research has found reductions, ranging from 4.4%[4] to 11.2%[6] for a particularly high-cost, frail, and elderly population. Associated reductions in per patient per month (PPPM) spending ranged from $16.73[4] to $107.[6] Inpatient costs have been cited as the primary driver of savings, accounting for between 19%[9] and 62%[10] of savings. The Alexander

et al.[4] and van Hasselt et al.[10] studies are particularly valuable, because they looked at the impact of care management in a large number of diverse practices.

Interestingly, the reduction in total cost of care found by van Hasselt et al. was not due to a reduction in the use of expensive inpatient services. Instead, the reduction was due to patients who received care management tending to receive inpatient services from lower cost hospitals.[10] This suggests that care management can create value for payers through primary care physicians consciously directing patients who need hospital-level care to high quality, lower cost hospitals and physicians.

Reductions in Utilization of High-Cost Services

Another way care management leads to reductions in total health care costs is by reducing utilization of high-cost, acute care services. When people receive high-quality care from their primary care physician, particularly for their chronic conditions, they are less likely to experience rapid declines in their health that require costly treatment in a hospital or a visit to a hospital emergency department (ED).

The following studies found care management contributed to a reduction in hospitalizations for chronically ill or other high-risk patients. Neal et al. found a range of 0.2-0.3 fewer hospital admissions per patient during a three-year period.[7] Higgins et al. found statistically significant decreases in annual reductions between 48-91 hospitalizations per 1,000 patients.[6] In his evaluation of a care management intervention implemented by the Veterans Affairs (VA), Nelson et al. found the VA's Patient Aligned Care Teams (PACT) were associated with a 13.4% reduction in hospitalizations for chronic conditions that can be managed effectively by primary care physicians.[11]

David et al.[12] and van Hasselt et al.[10] found care management is associated with reductions in the use of hospital EDs. David et al. found a physician practice that was recognized as a PCMH was associated with 5.24-7.78% reductions in all-cause ED visits among chronically ill patients.[12] Looking specifically at the impact of care management on the use of EDs for conditions that can be effectively managed by primary care physicians, Pines et al. found 7-8 fewer visits per 100 patients annually.[5] Van Hasselt et al. found 13 fewer visits per 1,000 patients annually for a Medicare population.[10] Neal et al. found care management is associated with significant reductions in the need for specialist care (10-12 fewer visits per 1,000 patients annually).[7]

Enhanced Quality of Care

A third benefit of care management is an increase in the proportion of patients receiving high-quality, appropriate care. One study looked at the quality of care patients received in three key areas—diabetes, cardiovascular (blood pressure and cholesterol), and general prevention.[11] Diabetes patients who received care management services through a PCMH received higher quality care at a lower cost. The care they received was higher quality, both

from a process and an outcome perspective. Patients were more likely to receive appropriate care and it was more likely that their diabetes remained under control. They also were more likely to have their cholesterol tested and under control, and they were more likely to have their kidney function appropriately monitored.[11]

Patients with high blood pressure in the VA's PACT practices were more likely to have controlled their blood pressure. Likewise, patients with ischemic heart disease were more likely to be tested for cholesterol, to have their cholesterol controlled, and to have documentation of a prescription for aspirin during their most recent visit.[11]

Patients receiving care management had higher rates of preventive services. Patients were more likely to have received an influenza vaccination, to be screened for cervical cancer, and to be offered medications for tobacco cessation.[11]

Improved Experiences for Patients and Practice Staff
One final area where care management demonstrated a benefit was for patient and staff experience of care. In studying the impact of PACT adoption on VA practices' patient experience of care, researchers found significantly higher results on the Consumer Assessment of Health Providers and Systems (CAHPS) survey. The survey examined patients served by PCMH sites where PACT was effectively implemented, compared with sites where PACT was less effectively implemented (9.33 vs. 7.53). Similarly, practice staff in well-implemented PACT sites reported lower emotional exhaustion scores (2.29 vs. 2.80 by the Maslach Burnout Inventory scale).[11]

Payment for Care Management (Cost to Health Insurers)
Payments for care management vary widely, and are subject to regional variation and negotiation between health insurers and provider groups. The most common method of payment is a fixed amount per member per month (PPPM). A study looking at the prices public and private health insurers are offering for care management services performed by primary care physicians found the median payment amount to be $4.90 PPPM.[13]

The Value of Care Management for Health Insurers
Based on the literature, there is a significant difference between the typical cost of care management for health insurers and the benefits health insurers can expect from care management, which lowers the total cost of care.

In order for care management delivered by primary care physicians to be sustained, the benefit to all stakeholders (patients, physicians, health insurers, etc.) must be clear. The literature has shown numerous benefits of care management for patients

Benefits of care management provided by primary care practices exceeds current payments by insurers:

- Value of care management to payers: $16.73 PPPM[4]
- Payment to physicians (cost to insurers): $4.90 PPPM[13]

and health insurers. Patients receive higher quality care and health insurers benefit from lower total costs of care that exceed the average cost of purchasing care management services from physicians. The questions that remain are, given the significant gap between the benefits health insurers are receiving and what they are paying physicians to offer care management, should physicians receive additional payment for the care management services they are providing? If so, how can physicians and health insurers work together to set appropriate payment rates and enhance the value of the overall system?

Conclusion: Implementing Equitable Physician Payment is Possible

Studies have shown primary care physicians who invest in care management are creating significant value for the health care system through higher quality care at a lower total cost. On the whole, care management payments do not fully compensate physicians for the value they create. One of the best studies of the reduction in total costs of care (a benefit to health insurers) created by effective care management in a commercial population found a $16.73 PPPM reduction.[4] This is considerably more than what insurers are paying for care management, which is $4.90 PPPM.[13]

As patients, physicians, and health insurers work together to create value in the health care system, care management will play an important role. Care management payments should align with value and sustain the commitment of physicians to better quality care over time.

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