| **Principles of Care Coordination** | **Current PCCM** | **Proposed change to PCCM** | **Operational changes proposed** | |
|---|---|---|---|---|
| **Comprehensive services linked by an "integrator." Payments reflect patient complexity** | PCP office serves as care coordinator | Diminution ~~**or elimination**~~ of the care coordination fee for patients who do not receive comprehensive care | VFC participation; 24 hour coverage; extended hours, **dual eligibles** | Enhanced cc payment for medically complex patients and/or medical home certification, **phase in augmentation of P4P** |
| **Initial intake assessment** | No formal policy | Encourage providers to perform comprehensive intake assessment | Modifier on new code for enhanced reimbursement | MN example, AAP Bright Futures |
| **Provide care across multiple settings and providers** | No formal policy | Enhance communication between PCP and other providers of health care | Utilization of the **MEDI** portal to facilitate communication between the PCP and specialist, **e-consult payments (IRIS at Cook Cty)** | ICARE; "Who's my PCP" function to enhance communication between ER and PCP; centralize reminder function at IHC |
| **Electronic Health records & quality assessment** | Periodic physician reports with statewide comparisons | Encourage utilization of electronic health records | Utilize "meaningful use" criteria, consider augmenting federal incentives | |
| **Risk-based payment systems** | P4P and well care bonuses based on HEDIS metrics | Regional or systemwide risk pool linked to improved nonurgent ER and hospital utilization | | |

# MAC Care Coordination Subcommittee

## Recommendation for a Blended Care Coordination Payment
## Across-the-Board care coordination payments plus
## Care Coordination Payments for High risk, High Vulnerability Patients

**Jerry Kruse, MD, MSPH**

Researchers at the Johns Hopkins Bloomberg School of Public Health have shown that care coordination in Patient Centered Medical Homes reduces healthcare costs and improves healthcare outcomes[1,2] . More recently researchers from the Center for Excellence in Primary Care Institute at the University of California San Francisco, the IBM Global Healthcare Transformation Initiative, and the Patient-Centered Primary Care Collaborative have corroborated this information by studying care coordination systems and Patient Centered Medical Homes in the United States.[3]

Medicaid systems in the United States, including those in North Carolina, Illinois, and Wisconsin, have shown improved healthcare outcomes and lower costs when there are Across-the-Board payments for care coordination that are combined with care coordination payments for high cost, high vulnerability patients. The provincial universal healthcare systems in Canada, particularly in Ontario, demonstrate that Across-the-Board payments that are stratified by five year age intervals and by gender are most effective in improving outcomes and lower costs.[4] As representative of the Association of Departments of Family Medicine (the organization of all the chairs of Family Medicines in medical schools in the United States) to the Departments of Family Medicine in the medical schools in Canada, I have been able to observe this system firsthand..

For the past four years, I have been a member of COGME, a federal advisory committee to the Secretary of Health and Human Services, to the Senate Health, Education, Labor, and Pension Committee, and to the House Energy and Commerce Subcommittee on Health. COGME recently produced its 20th Report, which reviewed all of the above literature, and found the two types of care coordination payments to be effective in improving the healthcare system and improving health for the population.[5]

Over the past few years, Illinois Medicaid has provided across the board care coordination payments through the Illinois Health Connect Program, and has arranged for a private enterprise, McKesson, to perform care coordination of high risk, high vulnerability patients. It is my belief, based on all of this data, that a system which blends the two types of

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[1] Starfield B, Shi L, Macinko D: Contributions of Primary Care to Health and Health Systems, *Milbank Quarterly*. 83(3), 2005

[2] Starfield B, Shi L: The Medical Home, Access to Care, and Insurance: A Review of Evidence. *Pediatrics*, 2004;113:1493-99

[3] Grumbach K, Grundy P: Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States, November 16, 2010. http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf

[4] Family Health Teams, Advancing Family Healthcare, Guide to Physician Compensation, September 2009, version 3.0.

[5] COGME 20th Report. http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf

payments for care coordination will be the most effective in improving the health of the citizens of Illinois and lowering healthcare costs. Following is a short explanation of the two types of payments.

### 1. Across-the-Board Care Coordination Payments to Primary Care Practices in Patient Centered Medical Homes

Patient Centered Medical Homes (PCMHs) are primary care practices that are usual sources of comprehensive, longitudinal care and exhibit the four central functions of primary care: 1) first contact access, 2) patient focused care over time, 3) comprehensive care, and 4) coordinated, integrated care. Recently high functioning data management systems have been shown to assist these practices in achieving the four essential functions of primary care. PCMHs may be identified either by NCQA certification, or achieving a proper range of evaluation and management codes set by CMS standards.

Per-member per-month care coordination payments that are paid for all patients in the practice (across-the-board) are most effective when stratified by five year age intervals and gender. An example is shown below in Table 1. In the Canadian experience, 12 to 14 year old males are the least costly group to the healthcare system. Actuarial analysis has been utilized, particularly in the province of Ontario, to determine the relative cost of other age groups. In Table 1, a base payment of $4 per member per month for 12 to 14 year old males has been used as an example, and the per-member per-month payments for other age groups has been computed using multipliers based on the actuarial analysis in Ontario. $4 per-member pe- month for 12 to 14 year old males was chosen because experience in other states, such as Wisconsin, has shown that average payments of $6 per member per month is an adequate incentive to develop sophisticated care coordination systems.

Across the board care coordination payments are utilized to perform many of the functions that are defined in NCQA certification. A function of major importance is the registry function, in which all patients eligible for various types of healthcare screening are listed, and in which patients with various diseases are monitored to determine the effectiveness of the practice in achieving practice benchmarks and improving healthcare indicators. Across-the-Board care coordination payments are also effective in providing pre-visit preparation, meaningful use of electronic health records, visit summaries, medication reconciliations, tracking the laboratory tests and consultations, and assurance of coordination of between the care in the primary care office and outside agencies, such as consulting specialists physicians, hospitals, nursing homes, mental health organizations, and community service agencies. Each care coordination payment can also be used to help directly provide mental health services under the roof of the Patient Centered Medical Home. This has been done for some time in Hamilton, Ontario and has now been implemented at the SIU Quincy Family Practice Center in Quincy, Illinois. Thus, the main function of Across-the-Board care coordination payments is the provision of a financial incentive for members of the practice to organize data and reach all patients who are assigned to the practice. It is understood that there will be variable success in this endeavor, but the data clearly shows the effectiveness of Across-the-Board care coordination payments in improving health outcomes and lowering costs for the system.

# Table 1

## *Example:*

## Across-the-Board Care Coordination Payments for Primary Care Practices in Patient Centered Medical Homes

| | Payment ($ per month) | |
|---|---|---|
| **Age (years)** | **Male** | **Female** |
| 0-4 | 9.47 | 8.94 |
| 5-11 | 4.91 | 4.85 |
| 12-14 | 4.00 | 4.12 |
| 15-19 | 4.29 | 6.78 |
| 20-24 | 4.30 | 8.83 |
| 25-29 | 4.67 | 10.01 |
| 30-34 | 5.31 | 10.16 |
| 35-39 | 5.75 | 9.41 |
| 40-44 | 5.79 | 8.91 |
| 45-49 | 6.61 | 9.70 |
| 50-54 | 7.06 | 9.87 |
| 55-59 | 7.80 | 9.72 |
| 60-64 | 8.94 | 9.86 |
| 65-69 | 10.44 | 10.91 |
| 70-74 | 12.58 | 12.72 |
| 75-79 | 14.79 | 14.71 |
| 80-84 | 18.13 | 18.05 |
| 85+ | 23.49 | 24.05 |

*Explanation: This table begins with a $4.00 per member per month payment for 12 to 14 year old males, the least costly group to the health care system. Payments for other age groups are derived from multipliers determined by actuarial analysis by age and gender in Ontario. (Guide to Physician Compensation, September, 2009, Version 3.0)*

## 2. Care Coordination for High Risk, High Vulnerability Patients

Several states and nations have shown the importance of making an effort to identify high risk, high vulnerability patients from a population to receive intensely coordinated community-based care. There is evidence, best described by the community care of North Carolina program[6], but also demonstrated by states such as Illinois, that a population-based assessment of

[6] Community Care of North Carolina http://www.communitycarenc.org/

high risk, high vulnerability patients is the method most likely to effectively improve outcomes and lower healthcare costs. In North Carolina, community steering committees receive a per-person per-month payment for every Medicaid patient in the area served by the steering committee. Most often, the steering committees are the county public health departments. The total payment to the health department is used to identify high risk, high vulnerability patients and to hire care coordinators to provide intensive community-based services to improve access to care, quality of care and to be a patient advocate. In North Carolina, the care coordinators hired by the public health departments have offices in the primary care practices, to better increase integration between various community agencies and the primary care practice. Care coordinators facilitate transitions of care for the patient such as hospital to home, hospital to nursing home, home to nursing home, primary care physician to consulting specialty physician, etc. The care coordinators also have a direct link to pharmacy management services, which has been highly effective. In North Carolina, the per-person per-month payments for the Medicaid population in the area of the steering committee approximately equals the per-member per-month care coordination payments to the primary care practices for Across-the-Board care coordination.

### 3. Summary

I believe that the MAC Care Coordination Subcommittee should recommend a system of care coordination payments for both Across-the-Board care coordination at the practice level, and for care coordination for high risk, high vulnerability patients at the population level. Study must be done to determine the absolute amount of payments, but the payments should be of sufficient magnitude to incent the primary care practices and the public health departments to develop services that will optimally improve healthcare outcomes and lower costs. I have no doubt that closer collaboration between public health departments and primary care practice Patient Centered Medical Homes is an absolute necessity for the most effective, efficient and equitable healthcare system for the state of Illinois.

# PCMH-PPC Proposed Content and Scoring

| Standard 1: Access and Communication | Pts |
|---|---|
| **A. Has written standards for patient access and patient communication**** | **4** |
| **B. Uses data to show it meets its standards for patient access and communication**** | **5** |
| | **9** |

| Standard 2: Patient Tracking and Registry Functions | Pts |
|---|---|
| A. Uses data system for basic patient information (mostly non-clinical data) | 2 |
| B. Has clinical data system with clinical data in searchable data fields | 3 |
| C. Uses the clinical data system | 3 |
| **D. Uses paper or electronic-based charting tools to organize clinical information**** | **6** |
| **E. Uses data to identify important diagnoses and conditions in practice**** | **4** |
| F. Generates lists of patients and reminds patients and clinicians of services needed (population management) | 3 |
| | **21** |

| Standard 3: Care Management | Pts |
|---|---|
| **A. Adopts and implements evidence-based guidelines for three conditions **** | **3** |
| B. Generates reminders about preventive services for clinicians | 4 |
| C. Uses non-physician staff to manage patient care | 3 |
| D. Conducts care management, including care plans, assessing progress, addressing barriers | 5 |
| E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities | 5 |
| | **20** |

| Standard 4: Patient Self-Management Support | Pts |
|---|---|
| **A. Assesses language preference and other communication barriers** | **2** |
| **B. Actively supports patient self-management**** | **4** |
| | **6** |

| Standard 5: Electronic Prescribing | Pts |
|---|---|
| A. Uses electronic system to write prescriptions | 3 |
| B. Has electronic prescription writer with safety checks | 3 |
| C. Has electronic prescription writer with cost checks | 2 |
| | **8** |

| Standard 6: Test Tracking | Pts |
|---|---|
| **A. Tracks tests and identifies abnormal results systematically**** | **7** |
| B. Uses electronic systems to order and retrieve tests and flag duplicate tests | 6 |
| | **13** |

| Standard 7: Referral Tracking | PT |
|---|---|
| **A. Tracks referrals using paper-based or electronic system**** | **4** |
| | **4** |

| Standard 8: Performance Reporting and Improvement | Pts |
|---|---|
| A. Measures clinical and/or service performance by physician or across the practice** | 3 |
| B. Survey of patients' care experience | 3 |
| **C. Reports performance across the practice or by physician **** | **3** |
| D. Sets goals and takes action to improve performance | 3 |
| E. Produces reports using standardized measures | 2 |
| F. Transmits reports with standardized measures electronically to external entities | 1 |
| | **15** |

| Standard 9: Advanced Electronic Communications | Pts |
|---|---|
| A. Availability of Interactive Website | 1 |
| B. Electronic Patient Identification | 2 |
| C. Electronic Care Management Support | 1 |
| | **4** |

**** Priority Elements**