



Complex Care Management Fee Proposal

Rationale:

Medicare beneficiaries with multiple, complex chronic conditions account for the majority of program spending. In fact, people with five or more conditions accounted for 20 percent of the Medicare population in 1999 and two-thirds of program spending. Beneficiaries with five or more conditions see an average of 14 different doctors in a year, have almost 40 physician visits and fill almost 50 prescriptions in a year. The NCCC believes there is a need for a relatively simple mechanism that would provide the proper incentives for complex chronic care coordination at the physician level (where utilization decisions are made) and would provide a mechanism to raise the level of physician quality over time.

Definitions:

Chronic Condition: A condition expected to last a year or more requiring ongoing medical management.

Eligible Physician Provider: A Medicare-participating physician provider who is approved by the Secretary to be a Complex Care Management Provider and has at least 50 eligible beneficiaries in her practice.

Eligible Beneficiary: A beneficiary enrolled in both Medicare Parts A and B who has at least five chronic conditions, one of which is major as determined by the Secretary, who has seen at least four unique Medicare clinical care providers in the past three months, and is currently taking at least three unique medications.

Participating Beneficiary: An eligible beneficiary who has elected to participate in the Complex Care Management program, has specified a complex clinical care management provider and who agrees to consult with the designated complex clinical care management provider when arranging consultations with providers not referred by the Complex Clinical Care Management Provider.

Complex Care Management Provider: An eligible physician provider who

- Agrees to coordinate complex care for participating beneficiaries, consult with other treating providers (including but not limited to other treating physicians, other medical professionals involved in patient care, residential and inpatient facilities, and pharmacies), community services, and
- Agrees to recognize patient treatment preferences, and
- Is certified by the Secretary as meeting standards defined by the Secretary and being capable of coordinating clinical care for eligible beneficiaries.

A CCMP shall meet standards established by the Secretary that shall include:

- √ Appropriate office staffing, operating under the direction of the complex clinical care management provider, which is sufficient in size and expertise to address the complex clinical care coordination needs of participating beneficiaries in the practice;
- √ An ability and process to identify eligible beneficiaries
- √ An ability to coordinate care for participating beneficiaries
- √ An ability to maintain and update patient records to ensure that care provided by other treating providers (including the instructions of other treating providers and any related lab results, prescription orders, and ancillary treatment services) is included in the record
- √ An ability to periodically review the medical record of participating beneficiaries to identify problems related to transitions, poly-pharmacy, and care continuity and to respond to resolve identified problems
- √ Capability for electronic recordkeeping and communication systems as the Secretary may specify, that may include such things as patient notice and reminder systems, and adverse drug interaction notice systems

- √ Capability for coordinating with community-based supportive services
- √ An ability to communicate with participating beneficiaries or family caregivers as needed and appropriate, using telephonic and/or electronic communications; and
- √ Other appropriate standards as may be determined by the Secretary.

The Secretary shall determine if there are physician specialties that are, as a class, not appropriate for the role of Complex Care Management Providers.

The Program:

Payments: The Secretary shall make monthly administrative payments, outside the physician fee schedule, to the Complex Care Management Provider for each participating beneficiary enrolled with the Provider.

Beneficiary Enrollment Period: A participating beneficiary shall remain enrolled with a designated Complex Care Management Provider for a period of at least five months. A participating beneficiary’s request to change to another Complex Care Management Provider shall become effective in the month following the month in which such a request is made [follow M+C enrollment rules in this regard]. The Secretary shall issue a special enrollment card to each participating beneficiary that identifies the beneficiary as a participating beneficiary and identifies the contact information for the elected Complex Care Management Provider.

Profiling: The Secretary shall send quarterly reports to each Complex Care Management Provider that inform, in aggregate, on the Provider’s participating beneficiary caseload, using measures determined by the Secretary that are derived from existing Medicare data sources. Measures the Secretary may consider are not limited to, but may include:

- Caseload rate of ambulatory care sensitive condition hospitalizations relative to geographic area norms for all eligible beneficiaries ¹
- Average number of unique providers relative to geographic area norms for all eligible beneficiaries
- Average number of unique prescriptions and average number of unique prescribers relative to geographic norms for all eligible beneficiaries (*if there is a Medicare drug benefit*)
- Average number of ER visits relative to geographic norms for all eligible beneficiaries
- Average number of physician visits relative to geographic norms for all eligible beneficiaries

To the extent that the caseload data of a Complex Care Management Provider exceeds geographic norms, the CCMP can request patient level detail from the Medicare contractor to help identify treating providers, medical events, and follow up as appropriate.²

In the first three years of the program, all report measures developed and designated by the Secretary will be for information purposes only. At the end of three years, the Secretary shall determine which standards/measures are to be information-only, and which will become standards that Complex Care Management Providers must meet in order to continue program participation.

Effective Dates: Effective upon enactment for participating beneficiary enrollment beginning 24 months after enactment.

¹ The geographic norm comparison would include only the comparable group of ‘eligible beneficiaries’ if there is a Medicare Rx benefit. If there is no Medicare Rx benefit, the ‘control group’ would have to be beneficiaries with five or more chronic conditions, one of which is major, who saw four unique clinical providers in prior three months.

² CCMPs might like to receive individualized participating beneficiary reports on a quarterly basis that include the names of other treating providers to allow them to better monitor and manage care in this non-gatekeeper system. However, this may not be technically feasible at this time for CMS.