



# Moving to Better Chronic Care in Medicare: NCCC Proposals for Change

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## **Creating Medical Homes for People with Multiple Chronic Conditions**

Rationale: These NCCC proposals represent a new focus for the Medicare program, targeting improved clinical management for the 30 percent of Medicare beneficiaries with multiple, complex medical conditions who currently account for nearly 80 percent of program spending. These proposals provide necessary and appropriate incentives to care for the most medically complex beneficiaries and create new levels of expected clinical coordination for beneficiaries who typically see at least eight different physicians and often have poor outcomes as a result. These proposals offer new payment and accountability standards that would begin to move the Medicare program to a chronic care delivery model. There are three different proposals below, two directed to the traditional Medicare program and one directed to health plan contracting.

*Complex Clinical Care Management Fee:* This would be a monthly, per head administrative fee paid to eligible providers serving eligible beneficiaries. Eligible beneficiaries are determined by physicians as having five or more chronic conditions, one of which is major, who have seen at least four unique clinical providers in the last three months and are taking at least three different prescribed medications. Eligible beneficiaries elect to participate and select an eligible complex clinical care manager for their treatment.

Eligible providers are physicians (including specialists) electing to participate and certified by the Secretary as eligible to participate. Eligible providers would agree to take on the role of principal physician in the care of a particular beneficiary and would have in place staffing and administrative systems sufficient to handle the role of clinical care coordination as determined by the Secretary, but would include a professional to remain apprised of treatment regimens imposed by other treating providers and identify areas of conflict, duplication or confusion (including pharmacy). The professional operates under the supervision of the participating physician. The participating physician would be responsible for keeping a robust medical record and initiating consultations with other treating professionals as necessary and assisting the beneficiary to sort through conflicting or contradictory clinical information. Other qualifying criteria would be access to and adoption of appropriate electronic information technology to support care coordination such as disease registries, systems that identify potential adverse drug interactions, notice and reminder systems.

Payment should be sufficient to support a medical professional to conduct the administrative tasks involved in a physician's practice who serves a large number of Medicare beneficiaries.

This proposal can be modified to include coordination with community-based supportive services—leveraging services not otherwise covered by Medicare in support of Medicare beneficiaries to produce better outcomes and improved quality of life.

Physicians would receive care profiles from contractors on key indicators such as number of unique physicians for enrolled beneficiaries, the number of ambulatory care sensitive condition hospitalizations relative to area norms, number of emergency room visits relative to area norms, or relative to standards specified by the Secretary. It is suggested that the profiling not include standards particular to specific treatment guidelines because the target beneficiary population have complex medical needs for which standard application of various treatment guidelines may not be appropriate.

*Outpatient Global Case Group Practice Payment:* This payment would be made to qualifying large group practices certified by the Secretary as eligible to participate and elected by target population beneficiaries. Beneficiaries eligible to elect a group practice to coordinate their clinical care are certified by physicians as having five conditions one of which is major, as determined by specifications put forward by the Secretary. This payment is a monthly prepayment to large group practices that encompasses direct physician services and ancillary services such as lab and other diagnostics. (The prepayment would not include home health, inpatient hospital, SNF, or DME).

The global case group practice would authorize all services (including inpatient and SNF) and pay directly for

ancillary services. Eligible group practices could be either general practice or multi-specialty electing to participate and certified by the Secretary as eligible to participate, although it is likely that multi-specialty practices will more readily elect to participate.

Eligible group practices would have to have staffing and administrative systems sufficient to handle the role of clinical care coordination and payment as determined by the Secretary. Required capabilities would include, at a minimum: (1) the ability to identify the target population; (2) the ability to refer and authorize services; (3) the ability to maintain a complete medical record in electronic form that encompasses diagnostic and treatment information (including pharmacy) from all treating providers and that is accessible to all treating providers. The group practice would have a system and protocol for review of multiple treatment regimens including identifying areas of conflict, duplication or confusion, and a process to initiate consultations to resolve conflicts and duplication. These large group practices would have to have information systems that facilitate chronic care management, such as disease registries and reminder systems as specified by the Secretary. The group practice would also have the ability to counsel and advise the beneficiary (and family caregivers) on all aspects of medical care (including disease self management) and initiate activity to do so.

Group practices would be responsible for coordinating all clinical care (and specifically finance most outpatient services from the case rate payment). Their performance would be measured against area norms of appropriate ambulatory care sensitive condition hospitalizations and SNF admissions.

*Specialty Health Plans:* With the Medicare health plan contracting program, there would be established a specific designation for contracting organizations that specialize in treating Medicare beneficiaries with multiple complex chronic conditions or frailty. General contracting rules and requirements that currently impede the continuation of current specialty programs and the development of new specialized programs would be modified. The designation would use capacity and programmatic criteria that ensure these programs are appropriate for care of frail and medically complex beneficiaries.

### **Defining Care Coordination as a Component Quality Care**

Rationale: Quality care for the Medicare population is, in part, how well the program addresses the needs of beneficiaries with multiple, complex chronic conditions. One important need of this specific population is care coordination. How well providers and health plans coordinate care for people with multiple and complex health care needs should become a defining element of quality standards and quality measurement in Medicare.

*Health Plan Care Coordination Quality Standard and Measurement:* The Medicare program would not contract with any health plan unless it had in place mechanisms to facilitate care coordination for people with multiple chronic conditions. Appropriate mechanisms to satisfy this requirement would be specified by the Secretary but could include mechanisms such as provider access to an electronic medical record for enrollees (or some other electronic format for key medical information such as pharmacy and lab results), or assignment of nurse case managers to beneficiaries with multiple complex conditions who have authority and access to treating providers. Health plans would have to demonstrate that internal incentives are sufficiently aligned to encourage care coordination among participating providers. Eventually, contracting plans could be measured on care coordination standards.

*Complex Care Manager Quality/Care Coordination Profiling:* Physicians receiving a complex clinical care management fee will receive performance reports for their patient population for whom they serve as the clinical care manager relative to normative Medicare population-based practice patterns in a geographic region as determined by the Secretary. The profile would include two sets of measures: one set as "information only" for which providers will not be held responsible and another set of measures for which they will be held accountable. Both sets of indicators would be developed by the Secretary. Among the indicators could be average number of unique physicians seen by patients, rate of hospitalizations for ambulatory care sensitive conditions and rate of emergency room use.

*Large Group Practice Quality/Care Coordination Profiling:* Group practices receiving outpatient global case payments would be required to provide key performance reports to the Secretary in such form and on such schedule as the Secretary will determine. The Secretary will develop two sets of measures: one set as ‘information only’ for which providers will not be held responsible for the results of the measurement and another set of measures for which they will be held accountable. Both sets of indicators would be developed by the Secretary but among the information-only indicators would be average number of unique physicians seen by patients. The measures for which group practices would be accountable would include measures of inpatient and other facility utilization (such as SNF) to ensure that costs are not inappropriately being directed from outpatient to inpatient services.

### **Improving Care, Coordination and Quality for Dual Eligibles**

Rationale: People who are concurrently eligible for both Medicare and Medicaid (dual eligibles) are among the most vulnerable, most frail, and most in need of both ongoing medical care and supportive services (long term care). Dual eligibles account for approximately 30 percent of Medicare spending and 30 percent of Medicaid spending and are among the highest cost groups in either program. In most states, there is little coordination between the programs to produce better outcomes and better resource utilization. Despite their high need and high resource use, creating coherent policy to better address the needs of the dually eligible population is difficult within the constraints of each of the programs that serve them. Current Medicare and Medicaid rules have not been effectively meshed to align program incentives to ensure the best care and the best outcomes for this population. Under the current system, States have little incentive to coordinate care across both programs since savings typically accrue to the Medicare program while costing Medicaid more to integrate and coordinate. The proposal below could align incentives, improve care coordination and integration for a vulnerable group of beneficiaries and allow States the opportunity to produce more efficiencies in the system and gain the rewards of that improvement.

*Encourage Effective Chronic Care for Dual Eligibles with Focused Medicare Financial Support:* Provide Medicare funding of dual eligibles to certain willing and eligible states. Eligible states are those that are approved by the Secretary as having the ability to provide integrated chronic care for the dual population through programs that link medical care to long term care and supportive services with such goals as reducing inappropriate hospitalizations for ambulatory care sensitive conditions, inappropriate and unsafe polypharmacy, and preventing or delaying a decline in health and functional status (along the lines of models like MSHO, PACE, Georgia Source program which are examples only). States would continue their commitment to Medicaid services not covered under Medicare (such as long term care and prescription drugs currently). The Medicare program would make prospective payments on behalf of the number of duals in the state. The Medicare payment would represent the state average Medicare fee for service costs of the dually eligible population or the M+C rate for the dual population (including risk/frailty adjustment), whichever is higher. State systems of care for this population would have to preserve beneficiary choice and guarantee access to all Medicare covered services. Medicare payments to a participating State would be indexed in future years, perhaps to the general rate of medical inflation or Medicare per capita spending growth.

*[Alternative Proposal:* Direct the Secretary and Director of the Office of Management and Budget to devise new approaches to calculating and evaluating Medicare and Medicaid budget neutrality for purposes of facilitating integrated care demonstrations for the dually eligible population and to solicit demonstration proposals that seek to re-align incentives for integrated and effective care for this population.]

### **Improving Healthcare Transitions**

Rationale: There are far too many barriers to coordinating care between sites of care for individuals moving through various sites of care. The barriers run the gamut from statutory, regulatory, policy issues to local interpretation of law, regulation or policy. There has been no comprehensive assessment of where the trouble spots are in the system in order to systematically address the problem in a cohesive, sensible way. Lack of seamlessness in transitions, particularly between hospital, nursing home, home health, and home, results in wasted resources as

similar and duplicative tasks are done repeatedly and often with contradictory outcomes while other important tasks are never undertaken because no one is truly responsible. These transitions often occur when the consumer and her representatives are least able to sort out the system and advocate on the consumer's behalf—these transitions typically occur at periods of acute illness and emotional stress.

*Report on Barriers to Continuity of Care in Health Care Transitions for Medicare Beneficiaries:* Request a Report to Congress by the IOM or similarly objective entity to help frame thinking about the Medicare barriers to effective health care transitions. Areas to be studied/reported on include: transitions between hospital, nursing home, home health, and home with a review of consumer and caregiver experiences in these transitions, and identification of the impediments to more appropriate care that arise from statute, regulation, policy, and local interpretations while charting a course of action for change and improvement. Such a study would focus both on barriers in managed care and the traditional program.

### **Benefits That Support Coordination of Care**

**Rationale:** The current Medicare program lacks coverage of a number of services important to people with chronic conditions and their family caregivers, such as case management. The program also, in some instances, lacks coverage policies that ensure provision of important services to maintain health and functional status of people with chronic conditions. What follows are suggestions for program benefit changes that improve the coverage of medically-oriented and coordination with supportive services.

*Skilled Home Visit Transitions Benefit:* The current Medicare home health benefit is expansive in terms of services offered under the benefit, but quite limited as to who may access the benefit. For people with serious chronic conditions, a more narrow, but more accessible benefit is needed to help maintain health and functioning prior to becoming sufficiently disabled by chronic conditions so as to be home bound. Beneficiaries who have five or more chronic conditions would be eligible for the benefit. This benefit would provide for a home visit by an RN, LPN, physician assistant in the employ of the billing physician; however, the visit could be undertaken without the direct supervision of the physician. A beneficiary would be eligible for the service during periods of transitions that are documented in the medical record (recent return home from the hospital, significant change in health status, change in medication regimen that requires monitoring). The benefit could be limited in any year (For example, a beneficiary could be limited to no more than three of these visits in a year and these visits could not occur/could not be billed while the beneficiary is receiving the traditional home health benefit nor a new case management benefit.)

*Case Management/Geriatric Assessment:* The current Medicare program is not oriented to providing ongoing geriatric care and management. There is a need for a new benefit that provides for annual geriatric assessments for frail, medically complex beneficiaries, and provides for ongoing case management that would, among other functions, link the beneficiary to community-based supportive services, whether or not those services are covered by the Medicare program.

*Clarifying that Medicare Coverage Does Not Require "Improvement":* Direct the Secretary to work with local contractors to revise incorrect local medical review policies that specify that beneficiaries must demonstrate a potential for improvement in order to access Medicare covered services, notably therapies. A standard of improvement is not required under law in order to access Medicare covered benefits for diagnosis and treatment of an illness or injury, yet local contractors sometimes deny coverage of important services such as home health or outpatient physical therapy when improvement in functioning is not likely. People with chronic conditions often need services to maintain current functioning and prevent decline into acute conditions (requiring more expensive care and treatment as a result).

### **Beneficiary Education Encouraging Medical Home**

**Rationale:** Medicare beneficiaries with multiple, complex chronic conditions see many different, unique providers in a year—beneficiaries with five or more conditions see almost 14 different doctors annually. Whether or not

there is a new administrative or benefit approach to coordinating care for beneficiaries with complex needs, the Medicare population as a whole could benefit from an education campaign designed to raise the level of awareness about the importance of having a medical home, and seeking out providers who are willing to communicate with other treating providers.

*Public Education Campaign:* Medicare should begin a public education campaign to increase beneficiary and family caregiver awareness of the benefits of finding a doctor who will help them navigate their different health conditions by working with them and their other treating providers to coordinate their medical care, consulting with other treating providers and reviewing all their medications. The program can use the Medicare handbook, tag lines on Explanation of Benefits forms, radio announcements etc.