Advising the Congress on Medicare issues

Care coordination in fee-for-service Medicare

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Outline

- Indicators of care coordination
- Care coordination models
- Evidence from Medicare demonstrations
- Challenges in applying care coordination models to FFS Medicare
- Possible next steps

Indicators of poor care coordination

- Beneficiaries must repeatedly communicate key information about their medical history
  - Medical records are unavailable at the time of their appointment or diagnostic tests are repeated (Schoen et al. 2009)
- Polypharmacy
  - Older patients have high rates of adverse drug events (Sarkar et al. 2011)
- Poor transitions between settings and providers
  - Communication between providers about a patient's care does not occur in a timely way (Were et al. 2009, Kripalani et al. 2007, Forrest and Glade 2000, Gandhi et al. 2000)
  - Adverse events can occur after hospital discharges (Forster et al. 2003)
- Unnecessary use of higher intensity settings
  - Ambulatory-care sensitive hospitalizations (Stranges and Stocks, 2010)
  - Ambulatory-care sensitive emergency department visits (Tang et al. 2010)
  - Potentially preventable readmissions (MedPAC 2007 and 2008, Jencks et al. 2009)

Care coordination policies can range from narrow to broad

Narrow

- **Fee schedule changes**
  - Expanded transition codes
  - Chronic care E&M codes

- **Dedicated care manager payment**
  - PMPM payments to medical practices or care managers
  - Payment for transitional care

- **Pay for outcomes**
  - Readmissions
  - Avoidable hospitalizations or ED visits

Broad

- **Broader payment reform**
  - ACOs, bundling
  - Capitation

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Care coordination models

- Practice transformation
  - Chronic care model, medical homes
- Embedded care manager
  - Aetna case manager model, Guided Care model
- Care transitions
  - Care transitions intervention, transitional care model
- External care manager
  - Community health teams, disease management

Care coordination over the life cycle

- Beneficiary-focused care
  - Elicit beneficiary's preferences and makes sure they are reflected in the treatment plan
  - Ensure beneficiaries are informed about their care options and are well situated to communicate effectively with their care team
- Palliative care
  - Focuses on managing the beneficiary's symptoms and setting achievable goals
  - Minimize pain and other side effects

Medicare demonstrations

Demonstration	Number of programs	Financial arrangement	Quality outcomes	Financial outcomes
Medicare Health Support	8	Monthly care management fee, at risk	Limited positive effect on clinical quality measures and very small effects on hospitalizations or ED visits	No programs saved net of fees
Care Management for High-Cost Beneficiaries	6	Monthly care management fee, must achieve at least 5% savings to retain fee	Little improvement in process measures, two programs reduced hospitalizations and improved mortality	Three programs saved net of fees, only one significant
Coordinated Care Demonstration	15	Monthly care management fee, not at risk	Limited improvement in quality, a few appeared to reduce hospitalizations	One program saved net of fees, but not significant

Challenges in applying care coordination models to FFS Medicare

- Applicability in different settings
  - Care coordination must occur in rural and urban settings and areas with and without strong provider consolidation
- Identifying beneficiaries in need of care coordination
  - Demonstrations were most financially successful targeting beneficiaries with Medicare spending twice the average
  - Care coordination need is most acute for patients with multiple chronic conditions and many hospitalizations
- Patient engagement and activation
  - Models that rely on significant patient engagement may need to be modified so that they work with beneficiaries with mental impairments or dementia
- Retaining beneficiaries and programs
  - Patients in Medicare can seek care from any willing provider
  - Some care coordination programs in the Medicare demonstrations dropped out midway

Key features from model evaluations and demonstrations

- Managing transitions
- IT and communication protocol
- Interface with direct medical team
  - Care coordination can be run by the medical practices themselves or by an external care manager that works closely with (or is physically located in) the medical practice

Center for Medicare and Medicaid Innovation projects

- Independence at Home demonstration
  - Medical professionals run primary care teams to treat Medicare beneficiaries in their homes
  - Scheduled to start summer 2012
- Community-based Care Transitions program
  - Hospitals in partnership with community-based organizations apply models of improving care transitions
  - Rolling application process, first programs selected fall 2011
- Medical homes
  - Three medical home models (one focused on FQHCs, two focused on medical practices)
  - Two projects are currently operational, one is in the application review stage
- Health care innovation challenge
  - Grants to support innovative ideas for delivering better health, improving care and reducing costs
  - Initial awards scheduled to be announced March 2012

Broader ways to approach care coordination in FFS Medicare

- Pursue broader payment reforms that have the potential to change the incentives for care coordination
- Reimbursement based on outcomes from coordinated care
  - For example, minimizing excess readmissions

Possible next steps

- Changing fee schedule codes
- PMPM payment
  - To medical practice
  - To external care manager
- Transitions payment
- Await interim results from CMMI demonstrations for further evidence on care coordination in FFS Medicare