

Structuring, Financing and Paying for Effective Chronic Care Coordination

A REPORT COMMISSIONED BY
THE NATIONAL COALITION ON CARE COORDINATION (N3C)

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EXECUTIVE SUMMARY

In the current health care reform debate, enhanced care coordination for people with serious chronic conditions is receiving attention as a key approach for improving both clinical quality and the experiences of patients and family caregivers, while helping to reduce health care spending. This paper explores options for structuring, financing and paying for care coordination that span the medical care and social support dimensions. It draws from research and demonstrations on the traditional fee-for-service Medicare population that focus on the medical dimension and also from research and demonstrations from Medicaid, Medicare Advantage, and programs of the Administration on Aging that have studied long-term services and supports not covered by traditional Medicare.

This final document, first prepared as a Working Paper that provided the basis for an invitational meeting on June 3, 2009 convened by the National Coalition on Care Coordination (N3C), incorporates observations and suggestions offered by three discussants and more than forty participants at the meeting.

This paper takes a broad view of care coordination, as characterized by the N3C definition: "Care coordination is a person-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which a care coordinator manages and monitors an individual's needs, goals, and preferences based on a comprehensive plan." The paper (1) considers the various populations in need of care coordination; (2) summarizes current evidence regarding the components of effective care coordination; (3) describes the various entities that are serving as the organizational focal point for plausible models and interventions, briefly presenting innovative examples of each type; (4) explores financing and payment options that can support these organizational approaches; and (5) presents conclusions and policy implications.

Target Population: The population segments most in need of care coordination are Medicare beneficiaries with multiple chronic conditions and, in particular, the frail elderly, individuals who in addition to chronic illnesses also often have functional and/or cognitive impairments. A significant number of these individuals are also low income and, therefore, dually eligible for Medicare and Medicaid.

"Effective" Care Coordination: For the purpose of defining "effective care coordination," both in the medical and the social support domains, and for identifying interventions and models that accomplish it, we have required that there be demonstrated improvement in (or at least maintenance of) the health and/or functional status of the chronically ill beneficiaries served by the program

and that there be demonstrated efficiencies in care as measured by reduction in institutionalization, including hospitalizations or nursing home admissions, reductions in emergency room use, and/or in total costs of care.

Evidence from the Medicare Population: For beneficiaries with multiple chronic conditions, three types of interventions have been demonstrated to be effective: (1) transitional care that uses nurses or coaches (depending on the model) to engage patients while in the hospital and then to follow them intensively for 4 – 6 weeks following discharge to ensure that patients and their caregivers understand and adhere to medications and other care and are successfully returned to the management of their primary care providers; (2) self-management education that engages patients for 4 – 7 weeks in community-based programs designed to "activate" them in the management of their chronic conditions; and (3) coordinated care that targets patients at high risk of hospitalization in the coming year, develops a plan of care, and then provides ongoing monitoring in conjunction with the patient, caregivers, and the primary care physician.

Based largely on the experience of the Medicare Coordinated Care Demonstration, in-depth analysis has further identified that the key attributes of successful interventions include: (1) targeting high-risk patients; (2) in-person contact between the patient and care coordinator; (3) close interaction between care coordinators and primary care physicians; (4) access to timely information on hospital and emergency room admissions; (5) focus on assessing, care planning, educating, monitoring, coaching patients on self-management, and teaching patients how to take medications properly; and (6) staffing that relies primarily on nurse coordinators but also involves social workers to provide and link to social support services for the subset of patients requiring this assistance.

Evidence from Medicaid to Address the Needs of Populations with Both Chronic Medical Conditions and Functional Limitations: Care coordination for this population requires both medical care and social supports to address limitations in performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs), services covered by Medicaid (for low-income beneficiaries) and some programs of the Administration on Aging not restricted by income. Since their introduction in 1981, Medicaid Home and Community-Based Services (HCBS) covered under Section 1915(c) waivers have been the source of innovative programs developed by states to serve nursing-home eligible beneficiaries who wish to remain in their own homes or other community settings. HCBS programs employ "care management" (also called "case management") personnel to use standardized assessment tools for determining an individual's eligibility for services, identify service needs,

develop a plan of care to meet these needs, and provide ongoing monitoring to assure that appropriate care is being provided. State experience with case management and care coordination in Medicaid is a source of important insights into effective models for the broader population with multiple chronic conditions requiring both medical and social support services.

Beginning in the mid-1990's, a number of states turned to managed care approaches for long-term services and supports, making a single contractor responsible for arranging services and accepting risk for paying for services provided. Contractors have been health plans, community services agencies, provider organizations, counties, or other entities. Three successful models have emerged: (1) an organization assumes risk for Medicaid long-term services only; (2) the organization is responsible for long-term support services and also for Medicaid-covered primary and acute care; and (3) an organization assumes responsibility for Medicare-covered services as well as the complete array of Medicaid-covered acute and long-term care services. PACE (Program of All-Inclusive Care for the Elderly) is a provider-based program in this model. Minnesota Senior Health Options (MSHO) was initially created under Medicaid Section 1115 demonstration authority and has evolved into a program that operates through capitation arrangements with nine Medicare Advantage Special Needs Plans (SNPs). This evolution has been followed by a number of other states, including Massachusetts and New Mexico, and has provided an evidence-based model of "care management" that the Medicare Improvements for Patients and Providers Act (MIPPA) and subsequent CMS regulation (4138 IFC and 4131 F) now specifies must be provided by all SNPs for each eligible beneficiary, effective as of 2010. Key components include: establishing an interdisciplinary care team, developing and implementing an individualized care plan, coordinating care across settings and providers for transitions of care, and delivering services to vulnerable individuals within the target population, specifically the frail/disabled, those with multiple chronic conditions, and those near the end-of-life.

Organizational Loci to Provide Effective Care

Coordination: Five basic types of organizations have demonstrated the ability to be the focal point for assembling and managing the components of effective chronic care coordination: medical practices, hospitals, integrated delivery systems, state/community organizations, and health plans. The models and interventions involve many of the same components, irrespective of the locus of organizational leadership. The key issues and examples of innovative models in each organizational type are as follows:

1. **Medical Primary/Principal Care Practices:**
As a possible solution to the challenges confronting primary care and as an approach to providing effective care coordination, the concept of the Patient-Centered Medical Home (PCMH)

has gained wide attention and support. A personal physician and care that is coordinated and/or integrated across all elements of the health care system and community resources are among the key principles that define the PCMH. An ongoing debate surrounds the issue of which patients should be the emphasis of the practice, with some advocates emphasizing the importance of targeting primarily patients with multiple chronic conditions (approximately 25 percent of the Medicare population) while the current design of the Medicare Medical Home Demonstration includes more than 80 percent of Medicare beneficiaries.

2. **Hospitals:** In many communities, hospitals are best positioned to be the convener of the various professionals needed to comprise a chronic care coordination team, possess the managerial know-how, and have the "deep pockets" to be able to capitalize the start up of a chronic care coordination enterprise. Patient case finding often occurs in the hospital, and hospitals have significant potential for improving transitions of care from an inpatient stay to either a post-acute care facility or to the patient's home, reducing hospital readmissions that are now a focus of considerable policy interest. Successful approaches to improving the transition from hospital to home and/or post-acute care facilities can provide a practical means for hospitals to continue appropriate post-hospital care to reduce the likelihood of preventable readmissions. Starting there, hospitals might be able to engage others in improving ambulatory care, thus reducing unnecessary hospitalizations for patients with ambulatory-care-sensitive conditions more generally, especially for patients with multiple chronic conditions.
3. **Integrated Delivery Systems (IDSs):** Multispecialty group practices, independent practice associations (IPAs), and physician-hospital organizations (PHOs) include specialists as well as primary care physicians, a range of other health professionals, such as nurses trained to care for patients with chronic conditions, and often a hospital or hospitals, as well. An IDS, therefore, has the capability to develop a range of care coordination interventions relevant to different segments of their patient populations. The Medicare Physician Group Practice (PGP) Demonstration has demonstrated the potential of integrated delivery to improve care coordination for patients with chronic conditions. Although still relying on fee-for-service payments, the bonus opportunities for performance to improve quality and reduce spending growth trends provides some support for a broad expansion of the concept of fostering IDSs, or, to use the

terminology in current policy discussions, “accountable care organizations”.

4. **State/Community Organizations:** A state’s Medicaid program is often the foundation for the lead organizational role that some state and community entities are playing in care coordination for older adults with multiple chronic conditions. North Carolina, for example, has used its Medicaid program as the basis for creating Community Care of North Carolina (CCNC), an enhanced medical home model of care linked with a community-based support system that is centered around local non-profit community networks comprised of physicians, hospitals, social service agencies, and county health departments. Within each network, a virtual team approach is used for chronic care coordination, with physicians in their medical home practices taking greater responsibility for the clinical component of care coordination and referring to a local agency for clinical and social support activities, such as teaching patients and family both generic and condition-specific self-management skills. Case managers are integral members of each network and work in concert with physicians to identify and manage high-risk, high-cost patients. Other examples and initiatives suggest the potential value of what has been called a “community health care extension service,” in which physicians in their offices interact with the state/community-based professionals to provide effective care coordination.
5. **Health Plans and Special Needs Plans (SNPs):** Paid a monthly capitation, health plans have the incentives and, in some cases, the organizational structure to establish effective care coordination programs for their enrollees. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 provided the Medicare Advantage program a unique model to address care coordination and other requirements of Medicare beneficiaries with chronic conditions and functional limitations by authorizing the creation of Special Needs Plans that could be marketed exclusively to enrollees dually eligible for Medicare and Medicaid, who have certain chronic or disabling conditions, or who are living in nursing homes. By mid-2009, more than 1.3 million Medicare beneficiaries were enrolled in SNPs. In the 2010 Call Letter for Medicare Advantage Organizations, CMS specified requirements for “care management” that must be met by all SNPs as of 2010 and provided a comprehensive set of attributes for chronic care coordination.

Payment and Financing Options: Payment options to support care coordination across these organizational loci within fee-for-service (FFS) Medicare involve a few basic options: modifying the Current Procedural Terminology (CPT) codes or levels of payment within the Medicare Physician Fee Schedule, creating a new risk-adjusted monthly fee per eligible beneficiary (a “per person per month”—PPPM fee), and developing a “shared savings” model to reward more efficient service delivery that also achieves specified quality objectives across a defined Medicare population. Within managed (capitated) Medicare and Medicaid models, options center on combining these financing sources to meet the needs of the dually eligible population. Encouraging effective transitions from the hospital could include modifications to the current Inpatient Prospective Payment System (IPPS). Considered by organizational locus, the options are as follows:

1. **Medical Primary/Principal Care Practices:** Payment options to support chronic care coordination in ambulatory practices have been discussed primarily in the context of the Patient-Centered Medical Home (PCMH). While raising the base payment level for “evaluation and management (E&M) services” – mostly office visits—or establishing new reimbursable codes to capture non-office based activities could be administratively simple, many of the activities required for effective care coordination do not lend themselves easily to FFS reimbursement.

Instead two other payment models have been proposed to support PCMHs: (1) continue to pay for all reimbursable services according to the established Medicare Physician Fee Schedule and then provide an additional PCMH monthly payment per beneficiary for performing medical home activities, with the payment based both on the level of capability of the Medical Home and on the complexity of the beneficiary as measured by the CMS HCC score, or (2) combine the additional PCMH activities with the current FFS payments into a capitation-like, comprehensive payment – a Per Person Per Month (PPPM) payment. Both of these approaches could include a pay-for-performance (P4P) element by placing a portion of the monthly fee at risk for performance on specified indicators of quality. These approaches have not yet been tested for the Medicare population.

2. **Hospitals:** Under current payment approaches other than capitation, hospital business models rely upon keeping beds full and therefore discourage transitional care interventions which would reduce readmissions. One option that has been proposed to change this business case would provide a lower payment for readmissions that occur within a specified period of time –

perhaps 15 days after discharge – for specific diagnoses amenable to transitional care. Part of the savings to Medicare from reduced readmissions would be put into the base diagnosis-related group (DRG) payment rates so that hospitals which do a good job on keeping readmissions down would get added payments in total. The expectations for care coordination that are part of the PCMH would align the incentives of community-based physicians with those of the hospital in encouraging good transitional care. Payment models that would actually encourage active hospital engagement in care coordination require movement away from the current payment methods Medicare and other payers use to reimburse hospitals because these methods promote the current hospital business imperative to keep beds occupied with insured patients.

- 3. Integrated Delivery Systems (IDSs):** The classic approach to payment has involved the use of capitation – population-based payment – that provides a fixed, prospectively-set amount to the organization for the population served, regardless of the actual use of services by the affected population. Wary of full risk-bearing because of bad experiences by many capitated provider entities, many physician and hospital organizations have preferred FFS payments. Although there are significant challenges in forming risk-bearing or risk-sharing IDSs, traditional Medicare could contract directly with these organizations without relying on a Medicare Advantage plan intermediary. With improved risk-adjustment techniques and the availability of performance measures, including measures of patient experience with care as well as clinical process and outcome measures, many flaws that plagued the use of capitation payments in the past might now be avoided.

The model from the Medicare Physician Group Practice (PGP) Demonstration lies between straight FFS and full-risk capitation, although the FFS incentives probably dominate. It combines usual FFS payments with a bonus payment that the participating delivery system can earn if, after meeting specified clinical performance measures centered around effective chronic care management, it achieves greater than 2 percent savings on projected Part A and B Medicare spending as calculated using a matched control group. Medicare shares in savings beyond 2 percent, and the group has no downside risk if their total spending comes in above projected – it keeps the FFS payments received, providing only limited incentives for efficiency. Going forward, CMS could add risk-sharing to the current shared savings approach and, as called for in draft House legislation, a modified capitation-like option that

would more decisively shift incentives consistent with the long-standing prepaid group practice payment model.

- 4. State/Community Organizations:** a number of payment models could support the chronic care coordination function. It is possible to reimburse the professionals involved on an FFS basis – with payment going either directly to the professionals or to an organization employing them. However, FFS reimbursement to individual professionals in a community would likely exacerbate already fragmented care, and FFS reimbursement to an organization providing a team orientation to care still contains perverse FFS incentives. Instead, payment can be provided on a PPPM basis as long as the patient receives services from the particular state/community-based organization providing chronic care coordination in conjunction with the physicians who are functioning in virtual teams. Payment for the actual medical services would be separate.

In the Integrated Pilot Program that has been implemented in the Vermont Blueprint for Health, the payment approach includes a quality-based PPPM payment to the practices and Federally Qualified Health Centers serving as medical homes and complementary and separate financial support for the Community Care Teams, which is shared by all participating payers. In this case, the professionals on the care teams are paid directly by salary. The Medicare Coordinated Care Demonstration provided a negotiated monthly fee for each beneficiary in the intervention group to participating organizations. At this point, it is not clear whether there is a “best” way to support the state/community organizations as the concept is relatively new and still being tested.

- 5. Health Plans/SNPs:** Much of the discussion related to paying integrated delivery systems applies as well to Medicare Advantage health plans. As of October 1, 2009, SNPs must also have a contract with the relevant state Medicaid program. From the beneficiary perspective, such contracts should help to achieve truly integrated care because one entity, the SNP, will now be programmatically and financially responsible for assuring that all Medicare and Medicaid services are provided, following the model of the Integrated Care Initiative launched in 2005 in Minnesota, Wisconsin, and Massachusetts. Medicaid capitation covers the costs of Medicare co-pays and deductibles, community care waiver benefits, personal care attendant benefits, and at least some risk for custodial nursing facilities, complementing the Medicare capitation the SNPs receive for each beneficiary to cover the costs of Medicare benefits. In the integrated care model,

SNPs are at full risk for costs, but the combination of risk-adjusted Medicare and Medicaid monthly payments have covered their high costs, and all plans have been financially viable. The current recession threatens the stability of State-based financial support and potentially the viability of this integrated approach.

Conclusions and Policy Implications: As health reform legislation is crafted and ongoing efforts to improve care coordination continue, the following conclusions are worth noting:

- **“One size does not fit all.”** The diversity in the population with multiple chronic conditions and/or functional limitations, the progression of needs over time for any given individual, and the considerable heterogeneity in market conditions and organizational capacity across the country require that multiple models be available.
- **Different models are more effective with different segments of the population.** Even while recognizing the heterogeneity in market structures and organizational capacities, it is nevertheless important to carefully target the care coordination model to the appropriate population segment.
- **Effective care coordination for people with multiple chronic conditions and/or functional limitations requires linkages between medical care and social support services.** The traditional medical dimension of care that may work reasonably well in responding to people with acute clinical problems is not sufficient to address the needs of many people with multiple chronic conditions and/or functional limitations. Linkages to social service and other state/community based resources are needed to improve or stabilize the medical condition of many patients. The availability of an interdisciplinary team of professionals, including nurses, social workers, pharmacists, and others, is therefore important to providing needed support. This team can be made available and supported in a number of different ways. The team may not have to be employed by the same organizational entity that provides medical care, as long as there is a close linkage between the medical and other components that comprise effective care coordination. Active engagement by the beneficiary and family (and other) caregivers is critical, but has often been an overlooked element in many current approaches.
- **Under current financing structures, both Medicare and Medicaid funding sources must be integrated to address the care coordination requirements of the dually eligible population with multiple chronic conditions and/or functional limitations.** The benefit structure of neither program alone covers the

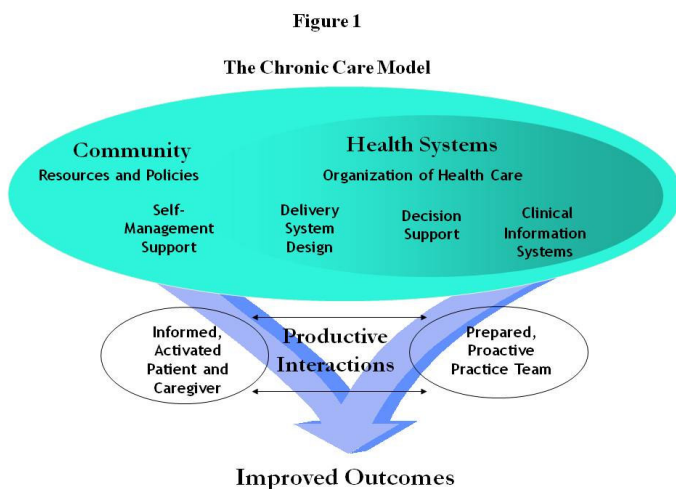
spectrum of medical and social support services needed by this population.

- **Fee-for-service payment is inherently limited for supporting care coordination activities and providing incentives for effective performance. Instead, payment approaches, such as a Per Person Per Month (PPPM) fee per eligible beneficiary, can be scaled to the care coordination model, risk-adjusted for patient complexity, and provide incentives based on the quality of care and care coordination, patient experience with care, and health spending for a defined population of patients.** Such approaches can be used in addition to or in place of fee-for-service payment.

Discussion at the June 3rd meeting highlighted one further conclusion – the need for much more robust testing of the various models and more rapid turnaround of findings than the current Medicare demonstration process can provide. The organizational resources and processes currently available to the Centers for Medicare & Medicaid must be significantly enhanced if the “promise of care coordination” is to be realized in a timeframe appropriate to the urgency of real health system reform.

I. INTRODUCTION

In the current health care reform debate, enhanced care coordination for patients with one or more serious chronic conditions is receiving attention as a key way of improving quality while controlling cost. “Care coordination” has traditionally been considered an essential component of home and community-based services focused on long-term services and supports. More recently, various medical models of care coordination have emerged focusing on the clinical issues relevant to care for patients with serious chronic conditions. The Wagner Chronic Care Model (Figure 1) has been one successful approach to integrating medical and social supports and in various forms is now being implemented in pilots and demonstrations.¹



This paper explores options for structuring, financing and paying for care coordination that span the medical and social support dimensions. It assumes that excellent chronic care coordination can concurrently improve quality of care, reduce health care spending, and improve patient and caregivers' experiences with the delivery system. The paper builds on two current efforts to synthesize the evidence base for care coordination that identify effective models and interventions demonstrated to improve patient outcomes while being at least “budget neutral” and preferably actually reducing the costs of caring for the population being served:

- Randall Brown's “The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Conditions,” which focused primarily on clinically oriented programs and was released in March 2009.²

¹ K. Coleman et al., “Evidence on the Chronic Care Model in the New Millennium,” *Health Affairs* 28(1): 75 – 85.

² R. Brown, “The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses,” Report Commissioned by the National Coalition on Care Coordination (N3C), March, 2009

- Carin Tinney of The Social Work Leadership Institute's forthcoming paper, “Coordinating Care Beyond the Medical Dimension: Models that Decrease Institutionalization and Improve Outcomes by Linking Social Support Services and Medical Interventions,” which focuses on the social support dimension of care coordination.³

This paper (1) considers the various populations in need of care coordination; (2) summarizes current evidence regarding the components of effective care coordination, including the special challenges and opportunities provided by care coordination for the frail elderly population dually eligible for Medicare and Medicaid; (3) describes the various entities that have served as the organizational focal point for plausible models and interventions, briefly presenting innovative examples of each type; (4) explores financing and payment options that can support these organizational approaches; and (5) presents conclusions and policy implications. First prepared as a Working Paper that provided the basis for an invitational meeting June 3, 2009 convened by the National Coalition on Care Coordination (N3C), this final document incorporates observations and suggestions offered by three discussants and more than forty participants (Appendix B presents the agenda and list of participants from the June 3rd meeting).

The realm of “care coordination” presents various definitional challenges. Some use the term “care coordination” literally to focus on the narrow aspects of care specifically related to the coordination function. For example, the National Quality Forum has defined care coordination as a “function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time.”⁴

Others use the care coordination concept more broadly to include the full range of integrated services for the target population. For example, recently, the National Coalition on Care Coordination, formed in 2008 by leading social, health care, family caregiver, and professional organizations, proposed that:

“Care coordination” is a person-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which a care coordinator manages and

³ C. Tinney, “Coordinating Care Beyond the Medical Dimension: Models that Decrease Institutionalization and Improve Outcomes by Linking Social Support Services and Medical Interventions,” Social Work Leadership Institute, New York Academy of Medicine, July 2009.

⁴ <http://www.qualityforum.org/pdf/ambulatory/txCareCoordination%20defa ndframe08-02-06.pdf>

monitors an individual's needs, goals, and preferences based on a comprehensive plan.”⁵

Whatever the particular merits of this latter definition, the point here is that it does not focus on a narrow notion of coordination but rather encompasses the range of services that would assist individuals with serious chronic conditions. Some might use a different term, such as “chronic care management,” which would subsume the narrower function of coordinating care across different people, functions and delivery sites. The purpose here is to indicate that the paper will use the term “chronic care coordination” to include a broad spectrum of activities, within both the medical and the social support dimensions that would benefit those with chronic conditions and functional and/or cognitive impairments.

Which Populations Benefit From Care Coordination?

Virtually all patients would benefit from activities in the Wagner Chronic Care Model. Indeed, combined with some of the traditional elements of primary care, such as ready access to care and longitudinal continuity of care, the Wagner model formed the basis for the patient-centered medical home (PCMH) standards that NCQA has promulgated, which in turn provide the basis for the proposed CMS Medicare Medical Home Demonstration (MMHD), loosely targeted to those Medicare beneficiaries with any chronic condition, i.e. more than 80 percent of Medicare beneficiaries. Indeed, an ongoing debate continues about whether the PCMH should apply to all patients in a practice, albeit with specific attention to patients with multiple chronic conditions who are more likely to benefit from greater attention to care coordination approaches, or whether from the outset it should focus only on subpopulations requiring coordination, leaving care for the majority of patients unchanged.

In recent years analyses, particularly from the Robert Wood Johnson Foundation (RWJF)-funded Partnership for Solutions,⁶ have emphasized the contribution to Medicare utilization and costs of chronic conditions, finding, for example, significant and dramatic increases in hospitalizations for ambulatory-care-sensitive conditions and overall health spending for beneficiaries with increasing numbers of co-existing, chronic conditions.⁷ However, while clearly useful for analytic purposes, counting the number of chronic conditions may not be particularly useful for operational policy purposes. For example, many people with multiple chronic conditions might not benefit as much from Wagner-model

interventions as others with even one disabling chronic condition, such as dementia.

To help sort out among potential chronic care coordination activities, we have identified the following somewhat distinct subpopulations, modifying the typology used by Dr. Joanne Lynn in her most recent book, *Sick to Death*⁸:

- Healthy people with acute, usually time-limited conditions, albeit occasionally life-threatening
- People with stable or early chronic illness that is consistent with their usual social role and long life
- People with one or more progressive chronic illnesses who are at risk for clinical deterioration that leads to shorter life span but generally maintain their usual social role
- People with serious, progressive, chronic illness, divided into two principal subcategories:
 - People with serious, progressive chronic illness who have functional limitations, including and especially cognitive impairment, that interfere significantly with their social role and ability to care for themselves
 - End-of-life care – triggered by a decision to focus on palliative rather than curative or ongoing sustaining care, both hospice care and, increasingly, “palliative” care

The closer to the top of the list, the more likely the purely medical models of care coordination would suffice, with social support services sought in specific situations. For people with serious, progressive chronic illness, the medical model alone rarely suffices. These people need integrated medical and social chronic care coordination. In the rest of the paper we will often discuss possible interventions for particular patient populations, with reference to this typology.

Within the group with serious progressive illness and functional limitations, the segment with the greatest requirements for care coordination is the frail elderly – individuals with multiple chronic conditions who also often have functional and/or cognitive impairments. A significant number of these individuals often are also low income and therefore dually eligible for Medicare and Medicaid. An estimated 7.5 million people qualify for both Medicare and Medicaid benefits, approximately 17% of the Medicare population and 18 percent of all Medicaid beneficiaries, accounting for approximately 24 percent of Medicare spending and 42 percent of Medicaid spending,

⁵ National Coalition for Care Coordination (N3C), “Overview of Current Initiatives,” March 2009.

⁶ Partnership for Solutions, *Medicare: Cost and Prevalence of Chronic Conditions*. Baltimore, MD: Johns Hopkins University, 2002.

⁷ Wolff, J.L., B Starfield, and G. Anderson 2002, “Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly.” *Archives of Internal Medicine* 162 (20): 2269-2276.

⁸ Lynn, J. *Sick to Death and Not Going to Take it Anymore: Reforming Health Care for the Last Years of Life*. Berkeley, CA: University of California, 2004.

totaling more than \$250 billion in FY2008⁹. Beyond medical chronic conditions, many of these individuals also have a number of limitations in their ability to perform basic personal care, measured as “activities of daily living (ADLs),” and ability to perform other functions that enable them to live independently in the community, evaluated as “instrumental activities of daily living (IADLs).”¹⁰

What is “Effective Chronic Care Coordination?”

For the purpose of defining “effective care coordination,” both in the medical and the social support realms, and for identifying interventions and models that accomplish it, we have required that there be demonstrated improvement in (or at least maintenance of) the health and/or functional status of the chronically ill beneficiaries served by the program and that there be demonstrated efficiencies in care as measured by reduction in institutionalization, including hospitalizations or nursing home admissions, reductions in emergency room use, and/or in total costs of care. These stringent criteria were applied by both Randall Brown and Carin Tinney in their papers, the key background resources for this paper.

Evidence from the Medicare Population

In evaluating the evidence for “effective” care coordination, Randall Brown in the “Promise of Care Coordination” required that total Medicare expenditures for beneficiaries receiving such services be reduced at least enough to cover intervention costs, while maintaining or improving beneficiary outcomes. Because the major contributor to Medicare expenditures is hospitalization, Brown further required that an “effective” intervention be one that reduced participants’ hospitalizations (including re-hospitalizations). Brown found evidence from randomized controlled trials that three types of interventions are effective in reducing hospitalizations for Medicare beneficiaries with multiple chronic conditions¹¹:

- **Transitional care interventions** in which patients were first engaged while in the hospital and then followed intensively over the 4 - 6 weeks after discharge to ensure they understood how to adhere to post-discharge instructions for medication and self-care, recognized symptoms that signified potential complications requiring immediate attention, and made and kept follow-up appointments with their primary care physicians. Naylor and colleagues, using

advanced practice nurses (APNs), and Coleman and colleagues, using a Care Transitions Intervention (CTI) guided by an APN “transition coach,” have demonstrated the effectiveness of this intervention using randomized control trials in a number of different hospitals.

- **Self-management education interventions** that engage patients for 4 -7 weeks in community-based programs designed to “activate” them in the management of their chronic conditions. Randomized controlled trials by Lorig and colleagues and by Wheeler have demonstrated that such interventions significantly reduced hospitalizations and costs over a period of 6 – 21 months. The interventions enable patients to self-manage symptoms/ problems, engage in activities that maintain function and reduce health declines, participate in diagnostic and treatment choices, and collaborate with their providers. The necessary education is provided by a mix of medical and non-medical professionals.
- **Coordinated care interventions** that identify patients with chronic conditions at high risk of hospitalization in the coming year, conduct initial assessments and care planning, and provide ongoing monitoring of patients’ symptoms and self-care working with the patient, primary care physician, and caregivers to improve the exchange of information. The Medicare Coordinated Care Demonstration (MCCD) initiated in 2002 and, for selected programs, continuing today, provided the major source of insights into the details of effective interventions and what distinguishes them from interventions that have not been successful.

Brown further found that six key components distinguished the successful MCCD programs from the ineffective ones¹²:

- **Targeting:** patients at substantial risk of hospitalization in the coming year were those most likely to be impacted by the intervention. While individuals at high risk of multiple hospitalizations and extreme costs might be thought to provide the greatest opportunity for savings through care coordination, in some cases these individuals have diseases that have progressed so far that improving patient adherence or communications among providers will not reduce the likelihood of a hospitalization.
- **In-person contact:** successful interventions had substantial amounts of in-person contacts with their patients. While many of the contacts were by telephone, the successful programs averaged nearly one in-person contact per month during

⁹ M. Bella, Testimony on Health Reform in an Aging America before the Special Committee on Aging, U.S. Senate, March 4, 2009. Note that data are not readily available to provide detailed analyses of the number of the dual eligible population who have multiple chronic conditions and functional impairments.

¹⁰ ADLs: eating, bathing and showering, using the toilet, dressing, walking across a small room, and transferring (getting in and out of bed or chair). IADLs: preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone, doing laundry, getting around outside the home, and taking medications.

¹¹ R. Brown, op. cit., pp. 2 - 3.

¹² Ibid, pp. 3 – 4.

patients' first year in the program, far higher than most of the unsuccessful MCCD programs.

- **Access to timely information on hospital and emergency room admissions:** learning about acute episodes as (or very shortly after) they occur is a critical factor. Patients are particularly vulnerable for readmissions after a hospitalization or emergency room visit, and the incident provides a heightened opportunity to explain how better adherence and self-care may prevent such occurrences.
- **Close interaction between care coordinators and primary care physicians:** two primary factors affected the strength of the relationship – the opportunity to interact face-to-face on occasion and having the same care coordinator working with all the program patients for a given primary care physician.
- **Services provided:** all of the successful programs focused their interventions on assessing, care planning, educating, monitoring, and coaching patients on self-management. Teaching patients how to take medications properly was a particularly distinguishing factor of successful programs. In addition, some patients require social supports, such as assistance with daily living activities, transportation, or overcoming isolation. The successful programs emphasized the importance of having staff who could arrange such services for patients, when needed.
- **Staffing:** the care coordination interventions rely on registered nurses to deliver the bulk of their intervention, with each patient assigned to a particular nurse coordinator to create rapport and preserve continuity with both the patient and the primary care physician. For some patients, social workers provide valuable assistance with assessing eligibility for and arranging services such as home delivered meals, transportation, emergency response systems, advanced care planning, and coordination with home health agencies.

Evidence from Medicaid to Address the Needs of Populations with Both Chronic Medical Conditions and Functional Limitations

The types of care coordination services required by the population with both multiple chronic conditions and functional and/or cognitive impairments typically include both medical care and long-term services and supports to address limitations in performing ADLs and IADLs. Care coordination for this population, therefore, spans the traditional boundary between acute and post-acute care

covered by Medicare¹³ and long-term services and supports covered by Medicaid and some programs of the Administration on Aging. Because fee-for-service Medicare basically does not cover these support services, determining the effective components of the social support dimension of care coordination requires expanding the domain of study beyond traditional fee-for-service Medicare (the focus of Medicare demonstrations) to include research and demonstrations in Medicaid, Medicare Advantage, and services provided through the Administration on Aging

From its origins in 1965, Medicaid has covered nursing home care. Medicaid's coverage of community-based long term care services began when states were permitted to offer an optional personal care benefit in 1975 and then, beginning in 1981, a broad range of home and community-based services (HCBS) covered under Section 1915(c) waivers.¹⁴ HCBS is the chief source of social and long-term support services for nursing-home eligible beneficiaries who wish to remain in their own homes or in other community settings. (Appendix A provides a list of Medicaid Home and Community-Based Waiver Services.) Home and community-based waiver services range from case management, home care, and personal care to adult day care and transportation. Most publicly financed home and community-based services programs administered by states (and financed by either federal and/or state programs) employ "care management" (also called "case management") personnel to use standardized assessment tools for determining an individual's eligibility for services, identify service needs, develop a plan of care to meet these needs, and provide ongoing monitoring to assure that appropriate care is being provided.¹⁵

Given their administrative and shared financial responsibility for Medicaid, states have often been innovators in developing models of both delivering and financing care coordination. State experience with case management and care coordination in Medicaid provides important insights into effective models for the broader population with multiple chronic conditions requiring both medical and social support services. (These efforts are summarized below and then considered in the sections on State/Community Entities and on Health Plans and Integrated Care.)

Since the mid-late 1990s when many states turned to commercial managed care plans as the principal mechanism for operating their Medicaid programs, the majority of low-income families on Medicaid have received health coverage through private managed care

¹³ Medicare covers "acute care" expenses of hospitalization, outpatient care, skilled nursing facility and home health care services for persons who need post-acute skilled or rehabilitative services of relatively short duration (Medicare Part A); physicians' and other professional services billed under the Medicare Physician Fee Schedule (Medicare Part B); and pharmaceutical expenses (Medicare Part D).

¹⁴ C. Tinney, op. cit, p.6.

¹⁵ C. O'Shaughnessy, et al., *Long-Term Care: Consumers, Providers, Payers, and Programs*, Congressional Research Service Report to Congress RL33919, March 15, 2007, p. 32.

organizations under contract with the state to provide preventive and acute care services through contracted provider networks.¹⁶ In most states, the more complex and expensive segments of the Medicaid population, the elderly and disabled, have not been included in managed Medicaid and have continued to be covered through fee-for-service. However, a number of states have turned to managed care approaches for long-term care services, making a single contractor responsible for arranging services and accepting risk for paying for services provided. Contractors may be health plans, community services agencies, provider organizations, counties, or other entities¹⁷. At least three successful managed care, capitated risk models for caring for this population have emerged:

- **An organization assumes risk for Medicaid long-term care services only**, i.e. institutional and home and community-based services. Wisconsin's much acclaimed Family Care Program provides an example of this model.
- **An organization is responsible for both long-term care services and for Medicaid-covered primary and acute care services**. The Wisconsin Partnership Program provides an example of this model.
- **An organization assumes responsibility for Medicare services as well as the complete array of Medicaid acute and long-term care services**. PACE (Program of All-inclusive Care for the Elderly) is an example of a provider-based program in this model. The Minnesota Senior Health Options (MSHO), initially developed under Medicaid Section 1115 demonstration authority, now operates through capitation arrangements with nine Medicare Advantage Special Needs Plans (SNPs) in 83 counties, serving over 35,000 beneficiaries as of April 2008.¹⁸

The evolution of MSHO into a program operated through Special Needs Plans (SNPs) is a pattern that has been followed in other states, including Massachusetts and New Mexico. The requirements for "care management" that must be met by all SNPs as of 2010, as specified in the CMS 2010 Call Letter for Medicare Advantage Organizations, provide an excellent delineation of the components of care coordination we are addressing:

"Care management" (a term equivalent to this paper's use of the term "chronic care coordination") has been defined through the Medicare Improvements for

Patients and Providers Act (MIPPA) and subsequent CMS regulation (4138 IFC and 4131 F) as an evidence-based model of care having the following components for each eligible beneficiary:

- Target an exclusive dual-eligible, SNP-specific chronic condition, or institutional special needs population.
- Conduct an initial and annual comprehensive health risk assessment.
- Establish an interdisciplinary care team to manage care.
- Develop and implement an individualized care plan having objectives, measurable outcomes, and specific services and benefits.
- Establish a provider network having medical specialists appropriate to the target special needs population.
- Assure that providers apply nationally recognized practice protocols and guidelines that are documented.
- Establish integrated systems of communication to promote coordination of care.
- Coordinate care across healthcare settings and providers; (e.g., transitions of care).
- Train employed and contracted staff on the organization's model of care.
- Deliver services to vulnerable individuals within the target population; (i.e., the frail/disabled, those having multiple chronic conditions, and those near the end-of-life).
- Establish lines of accountability within the SNP to assure full implementation of the care management system¹⁹.

¹⁶ D. Rowland et al., "Medicaid as a Platform for Broader Health Reform: Supporting High-Need and Low-Income Populations", Kaiser Commission on Medicaid and the Uninsured, May 2009, p. 7 – 8.

¹⁷ National Health Policy Forum, "State Long-Term Care Strategies: Approaches to Managing Care and Controlling Costs" Meeting Announcement April 25, 2008, p. 3.

¹⁸ Center for Health Care Strategies, "Snapshot of Integrated Care Programs for Dual Eligibles," March 2009, p. 2.

¹⁹ Center for Drug and Health Plan Choice, Centers for Medicare & Medicaid Services, "2010 Call Letter for Medicare Advantage Organizations," March 30, 2009, pp. 33- 34.

II. ORGANIZATIONAL LOCI FOR EFFECTIVE CHRONIC CARE COORDINATION

Five basic types of organizations have demonstrated some success as the focal point for assembling and managing the components of effective chronic care coordination, but as will be discussed in more detail below, for different target populations: (1) medical practices, (2) hospitals, (3) integrated delivery systems, (4) state/community organizations, and (5) health plans, specifically Medicare Advantage Special Needs Plans (SNPs) and Integrated Care Programs for Dual Eligibles. Within each type, a number of successful models have been developed and will be briefly described.

As one considers the components of these models and interventions, it quickly becomes apparent that many of the same elements are involved, but the organization in the leadership position differs. These differences in the organizational leadership role often derive from the unique requirements of a particular segment of the population (e.g., those with cognitive impairments and the dual eligibles), unique environments and capabilities in certain states (e.g. long-standing commitments to serving the elderly and vulnerable populations in states like Minnesota, Wisconsin, Washington, and Massachusetts), organizational capacity (e.g. the integrated delivery system that the Geisinger Health System has created over the last decade or more), and the personal creativity, commitment, and professional discipline of key individuals (e.g., Chad Boulton, M.D., the creator and champion of the Guided Care model; Mary Naylor, RN, Ph.D., the developer and advocate of the Transitional Care Nurse model; Eric Coleman, M.D., the designer and champion of the Transitional Coach model; and Robert Master, M.D., the creator and motivating force of the Commonwealth Care Alliance.)

Because successful approaches have often at least partly reflected the commitment and expertise of particular individuals testing their approaches in particular organizational environments, the issues of replicability and scalability for broad Medicare populations are challenging ones.

1. Medical Primary/ Principal Care Practices

Having a consistent relationship with a physician who delivers primary and acute care, manages chronic conditions, coordinates referrals to specialty services, and is an ongoing accessible source of medical expertise and trust is widely recognized as an important contributor to patient health and well-being. Unfortunately, this model of health care is increasingly difficult for millions of Americans to obtain, not only because of the rising numbers of the uninsured, but also because of the demands and expectations placed upon primary care physicians and decreasing financial margins. As some authors have pointed out, this creates “a challenging work

environment . . . increasing attrition in the current workforce, and diminishing recruitment of new physicians to primary care.”²⁰

As a possible solution to the challenges confronting primary care, the concept of the Patient Centered Medical Home has been jointly developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. The set of joint principles published in February 2007 specifies the following characteristics for the PCMH²¹: a personal physician, a physician-directed medical practice, a whole person orientation, *care coordinated and/or integrated across all elements of the health care system*, emphasis on quality and safety, enhanced access to care, and payment that includes both continued fee-for-service for selected services and a monthly per beneficiary fee to cover care coordination [emphasis added].

PCMH has gained wide attention and support over the past several years. In Section 204 of the Tax Relief and Health Care Act of 2006, Congress required CMS to establish a demonstration to test the PCMH model in fee-for-service Medicare. The Medicare Payment Advisory Commission (MedPAC) in its June 2008 Report to Congress made recommendations on stringent eligibility requirements for practices, identified requirements for data that CMS should provide to medical homes, and highlighted key beneficiary issues. Section 133 of the Medicare Improvements for Patients and Providers Act of 2008 provided additional funding for this demonstration and granted CMS authority to expand the program if quality and cost targets are met.²² Section 1302 of the House health care reform bill America’s Affordable Health Choices Act (H. R. 3200), introduced on July 14, 2009, proposes to repeal this demonstration and replace it with a “Medical Home Pilot Program” that would evaluate two medical home models: an “independent patient-centered medical home model” and a “community-based medical home model” to address a number of the concerns about the current CMS demonstration approach noted below.²³

A lot has been written about challenges to the PCMH model, including whether current definitions over-emphasize practice infrastructure to the detriment of both patient-centered aspects of care and chronic care coordination; whether nurse practitioners (NPs) and “principal” physicians, that is, specialists who may be the source of continuing care for patients with particular

²⁰ D. Meyers and C. Clancy, “Primary Care: Too Important to Fail,” *New England Journal of Medicine* 150(4): 272-273, February 17, 2009.

²¹ “Joint Principles of the Patient Centered Medical Home,” Patient-Centered Primary Care Collaborative, February 2007, <http://www.pcpcc.net/node/14> accessed 2/22/09

²² Senate Finance Committee, *Call to Action: Health Reform 2009*, November 12, 2008, p. 39; M. Miller, “MedPAC Initiatives Promoting Primary Care,” Slide Presentation to National Health Policy Forum “Building the Medical Home: Evaluating the Blueprints,” June 27, 2008.

²³ H.R.3200, America’s Affordable Health Choices Act of 2009, Section 1302, pp. 461 - 479.

clinical conditions, such as Parkinson's disease and age-related macular degeneration qualify as offering medical homes for patients with particular chronic conditions; and whether small practices, which remain the dominant mode of physician practice, are able to support the multidisciplinary team envisioned under most chronic care coordination approaches.²⁴

The House bill, for example, would include both primary care and principal care physicians as well as NPs. The community-based model would make it possible for small practices to participate by encouraging the formation of non-profit community-based or state-based organizations that could provide "medical home services in collaborations with and under the supervision of the primary or principal physician or nurse practitioner designated by a beneficiary" and would employ the nurses, nurse practitioners, and other community health workers to assist physicians in chronic care management activities.²⁵

Depending on the interest of the practice, it may be that some practices are better able to provide care coordination services mostly focused on clinical issues – primarily to the patients with one or more chronic conditions but who have not yet developed serious limitations in activities of daily living or where end-of-life issues have become paramount. Clearly the specialty of the provider matters. Physicians, nurse practitioners, social workers or other professionals trained in geriatrics may be better able to manage a medical home oriented to patients with serious limitations in activities of daily living and who may have progressive geriatric syndromes, such as incontinence and loss of balance, than can typical primary care or principal specialist physician practices.

An ongoing issue is whether small practices have enough patients that fit into the more challenging categories of chronic care patients to warrant the practice reorientation (called by some "practice transformation") that would be needed to develop Wagner-like integrated approaches to caring for patients who would benefit from that intensity. A possible approach that may make chronic care coordination feasible even for small primary care practices is Guided Care, developed by Dr. Chad Boulton and colleagues at the Lipitz Center for Integrated Health Care at the Johns Hopkins Bloomberg School of Public Health.²⁶ In Guided Care, a specially trained registered nurse is based in a primary care office working closely with 3 – 4 providers and health information technology to provide state-of-the-art care for 50 - 60 high-risk Medicare

beneficiaries with chronic conditions and complex health needs. The Guided Care Nurse assesses patient needs and preferences, creates an evidence-based "care guide" and patient-friendly "action plan," supports chronic disease self-management, facilitates transitions between care sites, enhances communication among various providers, educates and supports caregivers, and facilitates access to state/community services.

The Guided Care nurse, working in concert with the rest of the practice, assumes primary responsibility for working with the particular subpopulation of patients with more serious chronic illness. Preliminary results from clinical trials currently in progress suggest that Guided Care improves the quality of chronic care; reduces hospital days, skilled nursing facility days, emergency department visits, and home health care episodes; improves satisfaction of physicians and caregivers; and achieves net cost savings for the insurer. If the Medicare Medical Home Demonstration proceeds as currently designed, the 400 medical practices selected to participate will receive technical assistance from the Lipitz Center.²⁷

One of the major concerns about the Medicare Medical Home Demonstration at this point is its ability to fulfill expectations of cost savings, given the present design. As noted in Randy Brown's paper, "The Promise of Care Coordination,"

"A practice that meets the qualifications to be a 'patient-centered medical home' currently would have several characteristics associated with effective care coordination: co-location of care coordinators with primary care physicians, having the same care coordinator for all of a physician's patients, access to timely information on hospitalizations, and opportunity for substantial in-person contact between the care coordinator and the patient. . . . In defining the Medicare beneficiaries eligible for inclusion in the medical home, the conditions and severity level shown to be responsive to care coordination interventions should be targeted."²⁸

Several bills have also been introduced in Congress to support other medical practice-based approaches to improving care coordination for high-cost Medicare beneficiaries with multiple chronic conditions and targeted much more to patients with impairments who may be at or approaching end-of-life clinical status. The Independence at Home Act sponsored by Senator Wyden would target the frail elderly with limited function largely confined to home whose needs could best be met by physicians, nurses, and other professionals organized to provide comprehensive care in the home through home visits. The

²⁴ R.A. Berenson et al., "A House Is Not A Home: Keeping Patients at the Center Of Practice Redesign," *Health Affairs*, 27(5): 1219-1230, 2008.

²⁵ H.R. 3200, op. cit. p. 468 – 473.

²⁶ Boulton himself identifies a number of other programs that share many features with Guided Care, including Care Management Plus, Geriatric Resources And Care for the Elderly (GRACE), Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) for depression, and team-based care for depression. C Boulton et al. *Guided Care: A New Nurse-Physician Partnership in Chronic Care*. (Springer Publishing: New York, 2009).

²⁷ C. Boulton, "Guided Care: New Hope for Older Persons with Chronic Conditions," Slide Presentation and Fact Sheet, National Health Policy Forum "Promising Models of Care Coordination for Adults with Multiple Chronic Conditions: Getting Closer to the Holy Grail?" April 3, 2009.

²⁸ R. Brown, op. cit., p.7.

Geriatric Assessment and Chronic Care Coordination Act (GACCCA) being developed by Senator Lincoln is similar to the PCMH but would focus in particular on frail elders. Presumably, geriatrics practices would be supported under this approach. Strengthening the financial viability and professional attractiveness of primary care may also help to reverse the recent sharp decline in physicians' interest in providing primary care.

2. Hospitals

In many communities, hospitals are best positioned to convene the various professionals needed to comprise a chronic care coordination team, possess the managerial know-how, and have the "deep pockets" to be able to capitalize the start up of a chronic care coordination enterprise. In addition, patient case finding often occurs in the hospital, sometimes as a result of an acute deterioration that resulted in the hospitalization. Further, it is often during an acute inpatient stay that mobilized family members and a range of hospital personnel participate with the patient in a reassessment of the patient's capacity to function independently and/or generate a reconsideration of the patient's life goals. For example, palliative care conferences with patient and family often occur during an acute care hospitalization.

More practically, in increasing numbers of communities, physicians are becoming employed by hospitals and may be geographically located on the hospital's campus.²⁹ For all these reasons, in some places, the hospital is the logical candidate to be the locus of care coordination. In the Medicare Coordinated Care Demonstration, two of the four successful participants are hospitals: Washington University in St. Louis and Mercy Hospital in Iowa.³⁰

To the extent that hospitals and physicians, increasingly employed by hospitals, are able to align their interests, the hospital, affiliated physicians and other professionals who may be on the hospital staff begin to offer the potential for functioning as an integrated delivery system (IDS), as discussed in the next section. But even without becoming a real IDS, more closely aligned hospitals and physicians can respond to altered payment incentives to improve chronic care coordination.

In particular, hospitals have significant potential for improving transitions of care, that is, the transition from an inpatient stay to either a post-acute care facility or to the patient's home. By improving the discharge planning process, pushing out discharge summaries to community and nursing home physicians, and assuring that hospitalists communicate with the physicians who will assume responsibility for patients after discharge, hospitals can reduce the odds that patients will experience

clinical deterioration requiring re-hospitalization within a short time after discharge. Further, Mary Naylor at the University of Pennsylvania and Eric Coleman at the University of Colorado have developed practical transition models that use hospital-based advanced practice nurses or nurse coaches to interact with patients and their caregivers prior to discharge, ensure that they understand medication and other post-discharge instructions, and then have follow-up shortly thereafter in their homes and in appointments with their primary care physicians. Results from randomized clinical trials of these approaches show reductions in re-admissions, significantly improved patient outcomes, and reduced costs.³¹ The Quality Improvement Programs (QIOs) that contract with CMS currently are working in 14 states to promote seamless transitions across settings, including from the hospital to home, skilled nursing care, or home health care in order to reduce unnecessary readmissions to hospitals. Based on this experience, QIOs will be able to provide technical assistance to providers endeavoring to decrease preventable readmissions.³²

Unfortunately, the DRG-based payment system used in Medicare acts as a deterrent to hospitals doing these or adopting other, possibly complementary activities that should reliably reduce avoidable re-hospitalizations. Alternative payment approaches to better encourage hospitals to participate in chronic care coordination and to reduce avoidable re-hospitalizations will be discussed in Section III.

3. Integrated Delivery Systems (IDSs)

Recently, there has been discussion of so-called Accountable Care Organizations (ACOs), which introduce the idea of virtual organizations made up of physicians and, possibly, hospitals that voluntarily come together for purposes of receiving bundled payments and accepting accountability for patients assigned to them based on their patterns of use from claims data in prior periods.³³ The more straight-forward organizational models would consist of multispecialty group practices, independent practice associations (IPAs) and physician-hospital organizations (PHOs). Rather than attributing patients to an organization based on retrospective patterns of care, there could be an *a priori* establishment of a compact between patient and organization of responsibility for care, although the compact would not need to include formal "gatekeeper"

²⁹ R.A Berenson, P.B. Ginsburg, J.H. May. "Hospital-Physician Relations: Cooperation, Competition or Separation? *Health Affairs*, Web Exclusive, Dec 5, 2006

³⁰ C. Schraeder, personal communication.

³¹ M. Naylor et al., "Transitional care of older adults hospitalized with heart failure: A randomized, controlled trial" *Journal of the American Geriatrics Society* 52:675-684, 2004; E. Coleman et al., "The care transitions intervention: Results of a randomized controlled trial," *Annals of Internal Medicine* 166: 1822-1828, 2006.

³² Centers for Medicare & Medicaid Services, "Fact sheet: CMS Awards Contracts for Quality Improvement Organizations' 9th Statement of Work", August 5, 2008, p.3.

³³ Medicare Payment Advisory Commission (MedPAC). Accountable Care Organizations. Chapter 2 in *Report to the Congress: Improving Incentives in the Medicare Program*. Washington DC: MedPAC, June 2009.

functions to regulate patient access to the health care system.

Just as some versions of the patient-centered medical home include an enhanced set of capabilities applicable to all patients, not just those with later stages of chronic conditions, the true IDS provides care for all patients. By including specialists as well as primary care physicians and a range of other health professionals, including nurses trained to provide care for patients with chronic conditions, as in the Guided Care approach, the IDS is in a position to develop a range of approaches relevant to each of the different patient populations discussed earlier.

Under appropriate payment approaches, the IDS organization, rather than the third-party payers, allocates functions and dollars, consistent with organizational culture and local health care delivery circumstances. Payment proceeds as long as the organization satisfactorily meets expectations of cost, quality, and patient experience. As discussed in Section III, various payment approaches can be used, but they all should move away from pure fee-for-service to create incentives for the IDS so that if it reduces health care spending by reducing ER visits and hospitalizations, these savings accrue to the benefit of the organization and not just to the third-party payer. Because such a disproportionate percentage of spending is attributable to patients with multiple chronic conditions and functional impairments, financial risk-bearing IDSs would surely focus a lot of their effort on improving care provided to these particular patients, as occurred in the Medicare Physician Group Practice (PGP) Demonstration.³⁴

In addition to performing standard credentialing and management functions closer to the practices than distant health plan “regulators,” even IPAs made up of independent physician practices are increasingly engaging their constituent practices in quality improvement activities and even purchasing electronic health records for them while ensuring interoperability across practice sites. The IPAs often house the chronic care coordination professionals, who interact with physicians in “virtual teams” to support patients with chronic conditions and the frail elderly at home.

The Medicare Physician Group Practice (PGP) Demonstration provides some confidence that the IDS approach would work in Medicare. For the purpose of monitoring clinical quality and determining “shared saving,” the PGP Demo assigned patients to organizations retrospectively based on prior use patterns determined from claims analysis and did not require an actual compact between patients and their organization, perhaps concerned about what might be pejoratively labeled “lock-

³⁴ M. Trisolini et al. *The Medicare Physician Group Practice Demonstration: Lessons On Improving Quality and Efficiency in Health Care*, (New York: The Commonwealth Fund, February 2008), available at <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2008/Feb/The-Medicare-Physician-Group-Practice-Demonstration--Lessons-Learned-on-Improving-Quality-and-Effici.aspx>.

in” or “gatekeeper,” concepts associated with managed care, not traditional Medicare. In the demonstration, organizations continued to be paid fee-for-service for services rendered. Importantly, however, at the end of an annual accounting period, participating organizations were eligible to share savings with Medicare if total spending on Parts A and B services was at least 2 percent less than total spending in a matched control population. To date, four of the ten organizations have generated enough savings in Part A and Part B expenditures to receive shared savings; the other organizations saved but not enough to begin receiving shared savings bonuses³⁵.

The modest success of the PGP Demo to date has occurred despite the lack of long term commitment by Medicare to continuing the fundamentally different payment model that encourages resource conservation. With a lack of assurance of long-term commitment, PGP Demo organizations typically engaged in straight-forward care management activities targeted to improving care for patients with particular chronic conditions, such as congestive heart failure, through approaches that could be “turned off” if necessary if the demonstration concluded.

Further, in the demonstration, basic payment still relied on diagnosis-related groups (DRGs) for hospitals and the physician fee schedule. So although organizations able to constrain growth of total expenditures might receive bonus payments, the basic engine of FFS payment remained intact and, thus, it is not surprising that the organizations did not engage in the major reengineering of care processes and overhaul of organizational culture that would be involved, for example, in converting hospitals from profit centers to cost centers. Additionally, the shared savings model used in the PGP Demo does not include any downside risk for organizations, again somewhat muting the new payment incentives that would internalize the rewards of efficiency. Nevertheless, the promise of the PGP Demo is not in the actual results to date, but rather in the perceptions by involved organizations that the approach, if expanded and extended, would permit IDSs to participate in traditional Medicare through a direct contracting approach without having to have a Medicare Advantage intermediary.

It should be remembered that patient-level characteristics provide different incentives. In contrast to the incentive to stint on preventive services because the financial benefits of avoiding or at least postponing the onset of chronic illnesses in general are not realized for many years, the incentives to provide effective chronic care coordination for already affected patients are well aligned for both the organization and the patient with multiple chronic conditions. Effective chronic care coordination both improves patient well-being and also reduces costly inpatient admissions for ambulatory-care-sensitive

³⁵ CMS, “Physician Groups Earn Performance Payments for Improving Quality of Care for Patients with Chronic Illnesses,” *Medicare News*, August 14, 2008.

conditions, such as CHF, COPD and diabetes. Potential perverse incentives could arise primarily for patients in the latter stages of chronic conditions, especially for those approaching consideration of palliative care. There would be concern about the perception – or reality – that risk-bearing or – sharing IDs would be influenced to stint on “rescue” opportunities, for example for patients with cancer, perhaps by moving prematurely to influencing patients and families to accept palliative care as the appropriate care modality.

Some organizational models have been formed specifically to address more integrated care for frail elderly patients rather than provide services for a broader population that might include frail elderly. One model, in particular, has successfully targeted a frail population in need of both medical and social support services – PACE (Program for All-inclusive Care for the Elderly), the first program tested by CMS to capitate all Medicare and Medicaid services for elderly beneficiaries requiring a nursing home level of care. The Balanced Budget Act (BBA) of 1997 then established PACE as a permanent State plan option within Medicaid.³⁶

Modeled on the system of acute and long-term care services developed by the On Lok Senior Health Services in San Francisco, PACE organizations are unique health care providers that fully integrate all Medicare and Medicaid covered benefits into a single benefit package at a comprehensive risk-adjusted monthly capitation payment provided by Medicare and by Medicaid to the contracting PACE organization. As both direct care providers and payers for care, PACE organizations create comprehensive health care delivery systems to address the needs of medically complex and functionally and/or cognitively impaired nursing home-eligible Medicare beneficiaries, approximately 90 percent dually eligible for Medicaid.

Under the PACE model, an interdisciplinary team, including nurses, social workers, and other professionals, coordinates services for each enrollee, and adult day health centers serve as the central locations for delivering medical and social services. Enrollees must choose a PACE physician. PACE emphasizes the use of comprehensive assessment and monitoring in order to maximize the probability that enrollees will be able to remain in the community.³⁷ As of April 2009, there were 68 PACE organizations operating in 31 states. Enrollment as of December 2008 was 17,147 participants.³⁸ The ongoing challenge for PACE is to get to scale – that is, to serve a

much larger number of Medicare beneficiaries in diverse geographic and cultural environments.

4. State/Community Organizations

The foundation for the lead organizational role that some state and community entities are playing in care coordination for older adults with multiple chronic conditions is often the state’s Medicaid program. State activity in this area has been facilitated by using Section 1115 demonstration waivers and Section 1915(c) Home and Community-Based Services (HCBS) waivers. Virtually all states have supported home and community-based services using the Section 1915(c) waivers for multiple populations in need of long-term care, including the elderly and people with disabilities. In some cases, states have used the aging services network, authorized and funded by the Older Americans Act and administered by the Department of Health and Human Services Administration on Aging, to plan, deliver, manage and coordinate home and community based services for the elderly (and in a few instances, for people with disabilities).³⁹ The aging services network refers to state agencies and sub-state “area agencies on aging (AAA’s).⁴⁰

According to a 2004 survey, state agencies on aging in 33 states were the designated operating agencies for Medicaid HCBS. Some states have redesigned their entire long-term care systems using Medicaid HCBS funds in combination with Older Americans Act and state funds to redirect service delivery toward home and community-based services from institutional care, to integrate access to services across multiple funding streams, and to create single points of entry to provide a “no wrong door” approach to access for long-term care services.⁴¹

A number of states have created innovative models for providing effective care coordination:

Washington State is widely recognized for its accomplishments in “rebalancing” the long-term care system, in FY 2006 allocating 54 percent of long-term care spending to HCBS (vs. 46 percent for institutional care), in comparison to a national average of 41 percent for HCBS.⁴²

At the core of this rebalancing is an efficient long-term service delivery system based upon a care management model that includes uniform comprehensive assessment by case managers for each eligible beneficiary, a service plan based on the assessment, and authorization of services. Case managers are assigned to each HCBS

³⁶ Centers for Medicare & Medicaid Services, “Long-Term Care Capitation Models: A Description of Available Program Authorities and Several Program Examples,” August 2007, p. 5.

³⁷ Ibid, p. 13.

³⁸ National PACE Association, “Program of All-inclusive Care for the Elderly: Key Features and Vital Statistics”, April 2009, provided at the Health Affairs-SCAN Foundation Conference “Long-Term Care in Health Reform,” May 7, 2009.

³⁹ C. O’Shaughnessy, *The Aging Services Network: Accomplishments and Challenges in Serving a Growing Elderly Population*, National Health Policy Forum Background Paper, April 11, 2008, p.21.

⁴⁰ Ibid, p. 4.

⁴¹ Ibid, p. 21 – 22.

⁴² T. Ng et al., “Medicaid Home and Community-Based Service Programs: Data Update,” Kaiser Commission on Medicaid and the Uninsured, December 2008, p. 1.

recipient and are also present in hospitals and nursing homes to actively assist with discharge. Washington is also participating in a pilot study to improve management of chronic conditions⁴³ and is developing a medical home model in Medicaid.

Community Care of North Carolina (CCNC) provides an oft-cited example of an approach that combines the attributes of a more responsive primary care practice with a community-based support system. Since 1998, North Carolina has used its Medicaid program as the basis for supporting CCNC, an enhanced medical home model of care that is centered around local non-profit community networks comprised of physicians, hospitals, social service agencies, and county health departments. CCNC, which has focused mostly on care provided to mothers and children and is about to initiate a test of the model for dual eligibles under Medicare demonstration authority, includes the following key components:

- Within each network, each enrollee is linked to a primary care provider to serve as a *medical home* that provides acute and preventive care, manages chronic illnesses, coordinates specialty care, and provides 24/7 on-call assistance.
- *Case managers* are integral members of each network and work in concert with physicians to identify and manage care for high-cost, high-risk patients.
- The networks work with primary care providers and case managers to implement a wide array of *disease and care management* initiatives that include providing targeted education and care coordination, implementing best practice guidelines, and monitoring results.
- The program has built-in data monitoring and reporting to facilitate *continuous quality improvement* on a physician, network, and program-wide basis.

In essence, a virtual team approach is used for chronic care coordination, with physicians in their more responsive medical home practices taking greater responsibility for the clinical component of care coordination and referring to the community-based professionals for needed clinical and social support activities, such as teaching patients and family both generic and condition-specific self-management skills. An analysis by Mercer found that in every year examined (FY2003 – 6), CCNC achieved savings relative to what the state would have spent under its previous primary care case management program. Estimated savings for FY2006 were \$150 – 170 million.⁴⁴

⁴³ K. Leitch, "Rebalancing the Long-Term Care System: A View from Washington State", Presentation to Multipurpose Senior Services Program Conference, Sacramento, CA, December 8, 2008.

⁴⁴ "Community Care of North Carolina: Putting Health Reform into Practice in Medicaid," Policy Brief, Kaiser Commission on Medicaid and the Uninsured, May 2009, p. 1.

A different analysis of CCNC cost performance from 2003 to 2006 did not confirm the overall cost savings but did find that the virtual team approach resulted in a somewhat different mix of service utilization, with reduced inpatient days and outpatient hospital spending and increased spending for possibly previously under-provided services, including dental services for children.⁴⁵

Statewide, in both urban and rural areas, physicians viewed the CCNC model as a positive alternative to the capitated arrangements with commercial managed care plans that were being adopted by the Medicaid programs in many other states. CCNC allowed physicians to maintain more control and protect their Medicaid reimbursement rates, which in North Carolina have historically been almost equal to Medicare reimbursement. Virtually all primary care providers agreed to participate in the CCNC networks as they formed. As of May 2009, the CCNC was comprised of 14 networks that included 3,200 physicians and covered more than 913,000 Medicaid beneficiaries, more than 67 percent of the state's Medicaid population.⁴⁶

The State of Vermont, following the prototype of the CCNC, has created the Blueprint for Health, a comprehensive statewide program to improve healthcare and prevention for the most prevalent chronic conditions that is based upon "helping primary care providers operate their practices as patient-centered medical homes, offering well-coordinated care supported by multidisciplinary teams, expanded use of health information technology, assisting the development of a statewide health information exchange network, and financial reform that sustains these processes and aligns fiscal incentives with healthcare goals."⁴⁷ Starting in 2008, three communities were selected to be part of the Blueprint Integrated Pilot Program (BPIPP), a public-private approach that has brought together the state Medicaid program, Blue Cross Blue Shield, Cigna, and MVP Health Plan, a not-for-profit HMO, to support five key components:

- Financial reform – enhanced provider payment that provides a quality-based per person per month (PPPM) payment to participating practices that have become Patient-Centered Medical Homes (PCMH), in addition to traditional fee-for-service payment. Costs to support Community Care Teams are shared across all payers.

⁴⁵ B Ormond and RR Bovbjerg, "Community Care of North Carolina as a Medical Home: New Evidence on Performance, Presentation at Academy Health Annual Research Meeting, Chicago, IL, June 29, 2009.

⁴⁶ *Ibid*, p. 3. Enrollment is mandatory for children, parents, disabled and elderly individuals who are not receiving Medicare (non-dual eligibles). Enrollment is voluntary for pregnant women, dual eligibles, and foster children. Nursing home residents are not included.

⁴⁷ Vermont Department of Health, "Vermont Blueprint for Health: 2008 Annual Report," January 2009, p. 3.

- Community Care Teams (CCTs) – local multidisciplinary teams that include nurse coordinators, social workers, behavioral specialists, and other health professionals to provide a core resource to all participating PCMH practices in a community for prevention, health maintenance, and guideline-based care coordination for patients with chronic diseases.⁴⁸
- Community activation and prevention – accomplished by including a Public Health Prevention Specialist as part of the CCT.
- Health Information Technology, including web-based clinical tracking, electronic prescribing, electronic medical records, and a health information exchange network.
- Multidimensional evaluation, including NCQA PCMH scores and other clinical process measures, health status measures, claims-based health care utilization and expenditures using a multi-insurer data base, and claims-based return-on-investment and financial impact modeling.⁴⁹

Health Quality Partners (HQP) provides an example of a community-based organization that has successfully partnered with primary care practices and hospitals to address the medical and social/behavioral needs of Medicare beneficiaries with multiple chronic conditions. A not-for-profit 501(c)3 healthcare quality improvement organization that describes itself as “a community-based health care extension service,” HQP provides nurse care management, including geriatric assessments and in-home interventions, self-management skill building, individual one-on-one sessions for high-risk patients, and group programs, such as weight management and fall prevention. HQP works in close collaboration with primary care physicians to provide the services of care managers, social workers, health educators and others and to link PCPs and their patients to community resources. HQP was one of the three organizations participating in the Medicare Care Coordination Demonstration (MCCD) that was cost-neutral. In its high-risk group, hospitalizations were 29 percent lower and Medicare Part A and Part B expenditures 20 percent lower, compared to the randomly assigned control group. HQP also consistently received high patient ratings, including the highest rankings on patient education and patient monitoring.⁵⁰

⁴⁸ As part of the pilot, all payers are sharing the costs to add ~5 full-time equivalents to existing resources at an annual cost of ~\$350,000 per team. CCT members are hired by the local hospital in each community, reflecting the fact that healthcare in Vermont is largely organized around hospital service areas.

⁴⁹ Ibid, pp. 4 – 6, 13

⁵⁰ K. Coburn, “Health Quality Partners’(HQP) Model of Community-Based Nurse Care Management,” PowerPoint presentation to the National Health Policy Forum, April 3, 2009

CCNC, the Vermont Blueprint, and HQP might all qualify to be considered “community-based medical homes” as proposed by the House America’s Affordable Health Choices Act.

5. Health Plans/Special Needs Plans (SNPs) and Integrated Care Programs for Dual Eligibles

Theoretically, Medicare Advantage (MA) plans, which are paid on a capitated basis for Medicare beneficiaries who elect to receive care from a selected MA plan, have a payment model consistent with that described for IDSs above. That is, they should have an incentive to adopt programs that improve care for patients with chronic care conditions because they have a positive return on investment for interventions that reduce costly, avoidable ER visits, specialty referrals, and hospitalizations. Indeed, some point to the success of disease management programs that many commercial and MA managed care plans have initiated, although there is no objective evidence that these programs do in fact reduce costs.⁵¹

Importantly, the evolving Medicare payment approach to MA plans includes risk adjustment for underlying patient health status, so that plans no longer have as strong a reason to try to avoid Medicare beneficiaries with serious chronic conditions; nevertheless, some analysts argue that the risk adjuster used in Medicare continues to underpay for enrollees with serious chronic conditions. Specifically, because the current payment method does not recognize the persistence of chronic disease, which results from vagaries of how physicians report presence of conditions on claims forms submitted to traditional Medicare, many MA plans are being significantly overpaid as a consequence. Also, because the methodology does not incorporate the latest research, payments associated with healthy MA beneficiaries are relatively too high and payments for MA patients with multiple and serious chronic conditions are relatively too low, perpetuating some incentive for risk selection.⁵² Additional work refining the current risk adjustment tool the CMS uses appears warranted. (In Section III, we discuss a “frailty adjuster” that has been used in some programs targeting frail elderly.)

Group and staff model health maintenance organizations share the attributes described above for IDSs, and, thus, organizations like Kaiser-Permanente have a business case and organizational structure and culture to adopt effective programs of chronic care coordination, with the same caveats as those described earlier in reference to IDS care for patients approaching end-of-life considerations. Most MA plans, however, never adopted or have abandoned capitation-like payment approaches in response to various factors, including providers’

⁵¹ Congressional Budget Office, *An Analysis of the Literature on Disease Management Programs* (Washington, D.C.: CBO, 2004)

⁵² G.F. Anderson, et al., “Incorporating New Research into Medicare Risk-Adjustment,” (manuscript in preparation).

preferences, and generally use fee-for-service payment approaches; accordingly they face similar challenges as does traditional Medicare in trying to promote chronic care coordination. Not surprisingly, private plans have shown a great deal of interest in the patient-centered medical home and are sponsoring demonstrations in a number of locations.

A unique opportunity for health plans to address care coordination and other requirements of Medicare beneficiaries with chronic conditions was provided in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). MA plans could develop Special Needs Plans (SNPs) that could be marketed exclusively to enrollees with special needs, including those living in nursing homes, dually eligible for Medicare and Medicaid, or having certain chronic or disabling conditions.⁵³ The response was immediate with the formation of 42 plans specifically targeted to dual eligibles in 2005, rising to 320 plans in 2007. As of April 2009, there were 415 active SNP contracts, including 252 dual-eligible SNPs, 100 chronic care SNPs, and 63 institutional SNPs. Overall, 1.3 million Medicare beneficiaries were enrolled in SNPs, with about 70 percent in dual-eligible SNPs.⁵⁴

With this proliferation also has come concern that requirements to be met by SNPs have not been sufficiently specific to assure that SNPs actually provide benefits appropriately tailored to the unique needs of this complex population.⁵⁵ The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 extended Special Needs Plan authority through 2010, but with much greater specificity. For the first time, Congress authorized, outside of demonstration authority, the development and implementation of care systems exclusively focused on caring for frail elders, adults with disabilities, and other Medicare beneficiaries with severe and disabling chronic conditions.⁵⁶ The 2010 Call Letter noted above reflects these enhanced expectations of SNPs.

Prior to the development of SNPs, programs that integrated benefits and financing sources for individuals dually eligible for Medicare and Medicaid began operating in Minnesota and Wisconsin in the late 1990s under a number of different Medicare and Medicaid waiver authorities. Massachusetts began such a program in 2004. In 2005 the Centers for Medicare & Medicaid Services began the Integrated Care Initiative to implement Special Needs Plans that, working in partnership with these three states, could make the full array of Medicare

and Medicaid benefits available through a single delivery system, providing quality care, better care coordination, and fewer administrative burdens.⁵⁷ An evaluation report by Brandeis University in March 2007 reviewed the experience of 11 contracting programs in these three states.⁵⁸

The Brandeis study found that while there were some differences among the programs and the states, in all three states Medicaid paid a capitation that included the costs of Medicare co-pays and deductibles, prescription drugs, ancillary services, community care waiver benefits, personal care attendant benefits and at least some risk for custodial nursing facilities. Sites were at full risk for costs, but the combination of risk-adjusted Medicare and Medicaid payments covered their high costs, and all plans were financially viable. All plans had responsibility to deliver Medicaid community care services, as well as at least some long-term nursing home care. Community services included:

- **HCBS waiver program services** e.g. personal care, homemakers, adult day care services, adaptive equipment, home modifications, and care coordination, generally managed by care coordinators
- **Personal care attendant (PCA) program services**, which consisted of PCA's managed by consumers themselves with administrative supports from the program.⁵⁹

The programs not only delivered Medicaid community care services, they also assessed beneficiaries' needs in their homes, developed care plans, and coordinated the delivery of these services with Medicare acute services. Three general models were used for connecting community care with acute care:

- A single coordinator (Minnesota Senior Health Options). Either a nurse or social worker managed community care and also coordinated with physicians and others in the acute care setting.
- The nurse/social worker team (Massachusetts Senior Care Organization). The team social worker managed community care, and the team nurse coordinated medical care. Physicians were the formal heads of teams but participated primarily at a distance through the nurse.
- Multidisciplinary or interdisciplinary team (Wisconsin Partnership Program). The team included a nurse,

⁵³P. Saucier, "Medicaid Managed Long-Term Care," AARP Public Policy Institute Issue Brief IB Number 79, 2005, p.13.

⁵⁴S Peterson and M Gold, "Tracking Medicare Health and Prescription Drug Plans Monthly Report for April 2009, Mathematica Policy Research Inc. Report prepared for the Kaiser Family Foundation.

⁵⁵C. Mulligan and C. Woodstock, "Medicare Advantage Special Needs Plans for Dual Eligibles: A Primer," The Commonwealth Fund Issue Brief, February 2008, p. 3

⁵⁶The SNP Alliance, "SNP Gold Standards Framework: A Policy Report from the SNP Alliance", National Health Policy Group, February 2009, p. 16.

⁵⁷Centers for Medicare & Medicaid Services, "Integrated Care Initiative Overview," http://www.cms.hhs.gov/IntegratedCareInt/01_Overview.asp accessed 4/6/2009.

⁵⁸C. Bishop, et al., "Medicare Special Needs Plans: Lessons from Dual-Eligible Demonstrations for CMS, States, Health Plans, and Providers," CMS Task Order Proposal (RTOP) No. CMS-04-016/VAC, March 2007, p. 5

⁵⁹Ibid, p. 10 – 11.

social worker, therapists, and nurse practitioner. The nurse worked closely with physicians.

Factors that appeared to aid closer collaboration between community and acute care included the interest of individual physicians, having a critical mass of the plan's patients in a practice, co-location of a care manager in a practice, and use of nurse practitioners or nurses to accompany patients on visits⁶⁰.

As of March 2006, total enrollments in the demonstration sites were approximately 35,000 in Minnesota, 2,000 in Wisconsin, and 4,500 in Massachusetts. The evaluation emphasized the complexity of developing and operating these plans, and the challenges of paying and regulating:

“The main challenge for health plans will be contracting for and taking risk for the full range of acute and long-term care services and developing coordination models that span acute and long-term care. The main challenges for states are first to choose among the targeting and benefit models and then to develop payment approaches and work out relationships among waiver services, PCA, and aging network organizations. To make integrated SNPs an attractive choice under Medicare Advantage, CMS will need to transition the supports that have been provided under demonstration authority into the SNP program for dual eligible beneficiaries. These include integrated approaches to financing, benefits, service delivery, marketing, and other areas of regulation.”⁶¹

The Commonwealth Care Alliance developed by Dr. Robert Master provides an example of an organization that has successfully addressed all of these challenges, has established a primary care system of 21 sites throughout Massachusetts that include on their staffs 20 social workers and 54 RNs/nurse practitioners focused on chronic care management and effective care coordination, and provide comprehensive medical and social support services for a dually eligible population 59 per cent of whom are functionally home-bound. Preventable hospitalizations for CHF have been significantly reduced, risk-adjusted inpatient days are 53 per cent of those for a comparable Medicare fee-for-service population, and nursing home placements have been reduced by 25 per cent compared to fee-for-service Medicaid.⁶²

While SNPs that have evolved from earlier state programs and that have been part of the Integrated Care Initiative have demonstrated their commitment and ability to providing effective care coordination for high-cost, high-need Medicare and dually eligible beneficiaries, evidence is not available on the performance of the vast majority of SNPs that have been formed in recent years.

⁶⁰ Ibid, p. 12 – 13.

⁶¹ Ibid, p. 15 – 16.

⁶² Commonwealth Care Alliance, “Outcome Data”, March 2009.

III. FINANCING AND PAYMENT OPTIONS

Payment options to support care coordination across these organizational loci within fee-for-service (FFS) Medicare involve a few basic options: modifying the Current Procedural Terminology (CPT) codes or levels of payment within the Medicare Physician Fee Schedule, creating a new risk-adjusted monthly fee per eligible beneficiary (a “Per Person Per Month”—PPPM fee) that could be tied to quality performance, and developing a “shared savings” model to reward more efficient service delivery that also achieves specified quality objectives across a defined Medicare population. Within managed (capitated) Medicare and Medicaid models, options center on combining these financing sources to meet the needs of the dually eligible population. Encouraging effective transitions from the hospital could include modifications to the current Inpatient Prospective Payment System (IPPS). Considered by organizational locus, the options are as follows:

1. Medical Primary/Principal Care Practices

To date, payment options to support chronic care coordination in medical practices have been discussed primarily in the context of the patient-centered medical home. For the most part, PCMH definitions, particularly that promulgated by NCQA and being adopted in many demonstrations, including the Medicare Medical Home Demonstration (MMHD), do not identify personnel who need to be supported but rather activities that must be carried out. The NCQA standards do not specify which specific professionals are needed to constitute an interdisciplinary team, e.g., nurses, social workers, nutritionists, part-time pharmacists, etc., but rather specify, to some extent, the care expectations that the PCMH must be able to meet. Indeed, some argue that even the current NCQA PCMH standards are focused too much on inputs, e.g., specific electronic medical records functions, and should be focused even more on outputs or outcomes.

There are two different approaches to estimating the additional costs to a practice for purposes of determining the incremental payments the practice would need to cover their added PCMH expenses. One approach involves micro-costing – essentially estimating the average, incremental costs to a practice by making assumptions about likely staffing and other input requirements for providing chronic care coordination services for a specified chronic care population served. Essentially this is the approach used by the AMA’s Resource-Based Relative Value Scale Update Committee (RUC) as specified in law for the MMHD. In this case, the RUC assumed that the main additional staffing requirement to be estimated was a disease management care nurse.

It should be noted that the MMHD model addresses primarily the medical dimension of care coordination and is not a fully integrated model merging community social

support and clinical activities. The RUC, supported by CMS staff, did not assume additional requirements for a social support component of chronic care coordination. The MMHD model has been designed to serve 86 percent of Medicare beneficiaries and does not address the specific chronic care coordination needs of the highest-cost top 25 percent of beneficiaries, many of whom would be in the most advanced segments of the patient typology presented earlier and would require social supports as well as clinical care coordination.

An alternative approach to costing a practice-based PCMH might be called a practice-level analysis. Rather than estimating the cost components of enhanced practices through micro-costing, the analytic approach compares the actual cost profiles of practices with different outputs or expectations as measured using available quality, cost and patient experience measures. The approach attempts to identify how practices that achieve different levels of chronic care coordination obtain these results, with specification of the added inputs, including personnel and the associated incremental costs. Using the NCQA standards (which, as described above, represent basically a medical model of chronic care coordination), researchers were not able to identify different costs associated with practices that scored differently on the NCQA PCMH self-assessment tool.⁶³

Fee-for-Service (FFS) Approaches: Payment levels aside, there are various ways to compensate practices for being a PCMH.

Perhaps the most straight-forward and simplest operationally for third-party payers already reimbursing on a FFS basis would be to continue to use available FFS payment methods. One approach would be to reward practices for doing PCMH activities (however determined) by raising the base payment for evaluation and management (E&M) services – mostly office visits – and hope that some of the additional resources would support medical home activities. While administratively simple, the concern is that the marginal incentive on the practice is to perform more E&M services at the expense of care coordination activities. Some physicians assert that if given additional E&M payments, they would not have to see as many patients and therefore would have more time to perform or supervise clinically-related care coordination activities and, less plausibly, social services-oriented coordination.

Another FFS approach would establish new reimbursable codes for specific, important care coordination activities. For example, one could describe the physician activities associated with the non-office visit work in assuring a good transition for a patient from inpatient to home, including discussions with hospitalists and personnel from

⁶³ S. Zuckerman et al. “Incremental Cost Estimates for the Patient-Centered Medical Home,” Paper in preparation.

care transitions programs, reviewing a discharge summary, performing a phone medication reconciliation discussion with the discharged patient, and arranging for a prompt follow-up visit. This would be an example of a discrete, reasonably well-defined set of activities that could be boiled down to a description in the Current Procedural Terminology (CPT) coding book so that physicians know what the expectations are for billing for services rendered. Another example of a new CPT code might be conducting a patient and family caregiver conference for a lengthy discussion about end of life/palliative care options.

In an even more ambitious approach that combines both process and outcome parameters, the Senate Finance Committee Report of April 29, 2009 describing payment options recommends providing a modest supplemental fee to a primary care physician for each patient who (1) has been discharged from the hospital after a stay classified in a DRG for one of the major chronic diseases, (2) receives at least one E&M service within 30 days after discharge, and (3) is not readmitted to a hospital for a stay classified as a chronic disease DRG within 60 days after the initial discharge.

Unfortunately, many of the high frequency, short-time-span activities involved with more robust patient-practice communication – a core expectation of both the PCMH and chronic care coordination – do not lend themselves very well to FFS reimbursement. Such activities include: patient and family phone calls and secure emailing, discussions with other clinicians and providers about clinical issues and with community and social service agencies about patient well-being more generally, and greater reliance and time spent with decision support technology to clarify diagnosis and treatment options. These are all activities that occur outside of established office visits and do not lend themselves to specific reimbursement for a few reasons. Usually, the actual reimbursement, e.g., for a short phone call, would involve greater transaction costs for claiming the payment than the service is worth. Further, these “softer” activities present program integrity challenges and could increase the volume of services without added value to beneficiaries because of the inherent FFS incentives to generate increased volume.⁶⁴

Combining FFS with Monthly Payments for Medical Home Services: Given the limitations inherent in FFS for these kinds of activities, two other payment models have been proposed to support PCMHs. The one being used in the MMHD and recommended in the Principles described earlier would continue to pay for all reimbursable services according to the established Medicare Physician Fee Schedule and then provide an additional per beneficiary monthly payment for performing medical home activities. In the MMHD, the additional payment is based upon both

⁶⁴ R.A. Berenson and J. Horvath, “Confronting the Barriers to Chronic Care Management in Medicare” *Health Affairs*, Web Exclusive, January 22, 2003

level of capability of the Medical Home (Tier 1, “typical” or Tier 2, “enhanced”) and level of complexity of the beneficiary as measured by the CMS HCC score, with beneficiaries with HCC scores less than 1.6 considered less ill and beneficiaries with scores greater than or equal to 1.6 considered more ill and complex for the physician to manage. The proposed monthly payments range from \$40.40 for a lower risk patient in a Tier 1 Medical Home to \$100.35 for a higher risk patient in a Tier 2 Medical Home.⁶⁵

In a variant of this approach, payments under applicable fee schedules would be reduced by perhaps 20-40% in order to free up additional dollars for generous monthly medical home payments. Arguably, this approach would reduce the pressure many physicians currently feel to see lots of patients in office visits as a greater proportion of revenues would be derived from chronic care coordination and other medical home activities. Payers might feel greater assurance that overall spending would be better constrained under this approach, especially if the medical home activities prove to increase quality and patient experience with care, but do not reduce spending.

Comprehensive Payments (Capitation in Drag): An alternative payment approach would combine the additional PCMH activities with the current FFS payments into a capitation-like, comprehensive payment or Per Person Per Month (PPPM) payment. The comprehensive payment would be risk-adjusted for underlying health status. In contrast to the typical experience with primary care capitation payments that were extensively used by managed care plans in the 1980s and 1990s and still exist to a lesser extent today, these comprehensive PPPM payments not only would be risk-adjusted but also would actuarially account for the additional work expectations of the practice in performing PCMH activities, a calculation that typically was not made for the practices that were functioning as gatekeepers under managed care.⁶⁶

An additional payment approach – pay-for-performance (P4P) – could be applied to all of the payment approaches described. Indeed, although payments to primary care practices by many managed care insurers were not labeled as P4P when used in past decades, in effect they were classic P4P incentive programs.⁶⁷ Common approaches used withholds and bonuses to penalize or reward practices for the performance of their “risk pools” for specialty and hospital care and for performance on basic quality and patient experience measures. In the context of Medicare today, similar approaches, but

⁶⁵ CMS, “Medical Home Demonstration Fact Sheet”, November 2008, p. 3.

⁶⁶ AH Goroll et al., “Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care”, *Journal of General Internal Medicine* 22:410-415, 2007.

⁶⁷ Schlackman, N., Integration of Quality Assessment and Physician Incentives, *Physician Executive*. 1 September 1990. Available at <http://www.thefreelibrary.com/Integration+of+quality+assessment+and+physician+incentives.-a09009450>.

enhanced by use of risk adjustment of risk pools, could be applied as well so that additional payments to practices would be based to a significant extent on actual performance on achieving better outcomes, particularly for patients with chronic conditions. Such measures could include quality of care measures, costs, and patient (and family) experience with care.

Some advocates of locating primary chronic care coordination responsibilities in medical practices want Medicare to adopt the shared savings payment approach tested in the PGP Demonstration for medical groups of 200 or more physicians, even for small medical practices. However, applying a formal shared savings approach to small practices with small numbers of patients raises concerns about statistical reliability and also presents a major operational challenge to find control groups or otherwise estimate what spending would have been without the intervention. P4P approaches, instead, could reward certain utilization performance, e.g., reduced use of emergency room visits or reduced inpatient admissions for ambulatory-care sensitive conditions, without a formal cost accounting to determine actual cost savings. Surveillance to detect risk selection behavior might be daunting if the shared savings model were applied even to small practices.

2. Hospitals

Without relying on formation of formal IDs/ACOs of hospitals with employed or affiliated physicians, payment policy for hospitals could be modified modestly to reward particular activities that would improve chronic care coordination. As noted above, transitional care interventions, such as those developed by Naylor and Coleman; reliably reduce 15-30 day post-discharge readmissions. Yet, most hospitals have a strong, negative business case for engaging these programs because they result in a loss of paid admissions. Under payment approaches other than capitation, the hospital business model relies on keeping beds full: under DRG-based case rates, with new admissions, and under per diem or discount from charges, long lengths of stay.⁶⁸ Only when the hospital is near full capacity, might a hospital have a business case for reducing admissions for patients with chronic medical conditions in order to assure bed availability for often more lucrative surgical patients. Virtually all payers provide hospitals a new payment for a readmission, even one that takes place on the same day. (Sometimes, as in Medicare, payment is denied on a case-by-case basis if medical review determines there was a quality- of- care problem that led to the readmission.) Hospitals typically take no responsibility for the patient post-discharge.

A number of approaches have been proposed for changing this negative business case so that hospitals

have a greater interest in improving the discharge planning process, interacting more effectively with the clinicians taking over responsibility for patient care post-discharge, and, perhaps, engaging with transitional care programs that effectively provide support to patients post-discharge to reduce the avoidable problems that may result in a re-hospitalization.

Under an option recommended by one of the authors (Berenson), hospitals would not receive a full DRG payment in Medicare for readmissions that occur within short periods of time – perhaps 15 days – for patients with so-called “potentially preventable readmissions,” which include a large number of mostly medical diagnoses. For these conditions, better hospital-to- community or post-acute care facility transition activities would result in reduced rates of readmissions. Part of the savings to Medicare from reduced readmissions would be put into the base DRG payment rates so that hospitals which do a good job of keeping readmissions down would get added payments in total. One can think of it as robust pay-for-performance that can nonetheless be implemented without major new data collection requirements. To align incentives – but not bundle payments – discharged patients’ community-based physicians should be reimbursed, even fee-for-service, for their activities outside of standard visits to assure a high quality transition and resumption of their patient responsibilities, possibly as a Patient-Centered Medical Home.

This approach to reducing but maintaining payments for readmissions might over time be expanded to ambulatory-care-sensitive conditions more generally – those conditions, such as congestive heart failure, for which good ambulatory care reliably reduces hospitalization rates. Working with robust programs of chronic care coordination, even under fee-for-service reimbursement paradigms, hospitals could theoretically have a more positive financial bottom-line by reducing admissions for chronic care patients. More likely, however, hospitals able to respond to this challenge would be better positioned to be an integrated delivery system paid under a different approach altogether.

3. Integrated Delivery Systems (IDSs)

As emphasized earlier, a main approach to payment for IDSs is to internalize to the organization the incentives for greater efficiency and cost savings rather than expect the organization to achieve savings for third-party payers. The classic approach to payment has involved the use of capitation – population-based payment – that provides a fixed, prospectively-set amount to the organization for the population served, regardless of the actual use of services by the affected population. Depending on the services for which the IDS agrees to take risk, the PPPM payment is more or less inclusive. Commonly, IDSs are at risk for professional services only or for professional and institutional services, referred to as “global capitation.” (In

⁶⁸ R Abelson “Hospitals Pay for Costly Readmissions” *The New York Times*, May 8, 2009

the past, some organizations were also at risk as part of the capitated amount for prescription drugs.)

Discussing the various strengths and weaknesses of professional and global capitation is beyond the scope of this paper. Suffice it to say, with improved techniques, including the use of risk adjustment to establish capitated rates based on the predictable health care needs of the applicable patient population, capitation (or a new label, such as “comprehensive payment,” as used earlier, because “capitation” has become a dirty word) could be used in traditional Medicare, as it is used in many state Medicaid programs and by commercial and Medicare Advantage HMOs, as the core payment approach for IDSs.

Wary of full risk-bearing because of bad experiences by many – but by no means all – capitated provider entities, many physician and hospital organizations have become reluctant to expand their commitment to capitation, preferring FFS payments. In fact, for various reasons, many health plans recently have been withdrawing their previous commitment to capitated, risk contracting, even to well-functioning IDSs.

One of the reasons is that some important IDSs are better able to use their integrated provider platform to gain market power and demand higher prices from insurers than they would otherwise be able to negotiate. Medicare is much better able to resist this problem, which generally occurs when payment rates are subject to market negotiations. Similarly, shifting risk to providers through capitation-like arrangements is legally permitted only in fully insured products, which are regulated by states. Self-funded, ERISA plans and insurance plans that use preferred provider organization-based networks generally must use FFS payment approaches. Given the gradual but continuing shift from HMO to PPO products, under which employees can experience higher cost-sharing than possible under HMOs, the capitated model for IDSs is losing market share, even in California with well developed IDSs of various kinds.

Medicare obviously does not face the kind of legally imposed restrictions on how it can pay providers for services rendered. Improved capitation would be available to Medicare as a model for promoting and rewarding real IDSs directly for more efficient care, which would surely include enhanced chronic care coordination. Implicit in this payment approach, Medicare would decide how much to pay and leave to the IDS the decisions on the components of a chronic care coordination team to hire or contract with in order to provide and be accountable for such care. One of Medicare’s main tasks would involve trying to assure that IDSs would not engage in care stinting, now that they would have a financial incentive to conserve resources.

Although there are significant management and leadership challenges in forming risk-bearing or risk-sharing medical groups and IPAs, the accumulated 20-year experience

with these organizations suggests that traditional Medicare could contract directly with these organizations without relying on a Medicare Advantage (MA) plan intermediary, thereby immediately saving the 5 to 8 percent additional administrative costs and profits that MA plans require to provide the Medicare benefit package. With improved risk-adjustment techniques and new availability of performance measures, including measures of patient experience with care as well as more standard primary and secondary prevention process and intermediate outcome measures, some flaws that plagued the use of capitation payments (widely used in the 1980s and 1990s) could be avoided. In particular, we need to assure the public that these organizations will not accomplish cost savings by the systematic under-provision of needed services; the public perception that capitation payment incentives lead to under-service may have contributed to the managed care backlash

The model from the Medicare Physician Group Practice (PGP) Demonstration lies between straight FFS and full-risk capitation. It combines usual FFS payments with a bonus payment that the participating delivery system can earn if, after meeting specified clinical performance measures centered around effective chronic care management, it achieves greater than 2 percent savings on projected Part A and B Medicare spending as calculated using a matched control group. Medicare shares in savings beyond 2 percent, and the group has no downside risk if their total spending comes in above projected – it keeps the FFS payments received, providing only limited incentives for efficiency.

Going forward, CMS could add risk-sharing to shared savings. Rather than rely on a control group to project what spending would have been so that rewards or penalties could be assessed, one proposal would set targets based on historical spending – three years has been suggested – projected forward using spending growth trends to set the spending benchmark against which an IDS’s or ACO’s spending performance would be measured. The ACO’s actual risk-adjusted spending against this historically-based benchmark would be the basis for determining whether the ACO gets to share in savings.⁶⁹ Note that this approach based on an organization’s historical spending accepts current geographic and intra-regional variations in spending, although trending for upcoming years might rely on absolute dollar increases rather than percentage increases so as not to further reward higher spending areas in real dollar terms.

Instead of using claims experience to assign patients to the IDS retrospectively – the approach used in the PGP Demonstration – our preferred alternative would encourage beneficiaries to elect an ACO as their care provider, although without a formal “lock in” or

⁶⁹ E Fisher et al., “Fostering Accountable Health Care: Moving Forward in Medicare *Health Affairs*,” 2009; 28(2): w219-w231.

“gatekeeper” mechanism to prevent beneficiary access to care from clinicians and institutional providers outside the ACO network of providers.

One additional payment issue would need attention, whether in a full or shared risk payment arrangement. Most proposals for setting spending targets and assessing performance against the targets require the use of the CMS risk adjuster. Risk adjusters, including the CMS Hierarchical Condition Categories (CMS-HCC) model used in Medicare Advantage, are dependent on clinicians providing full patient-specific diagnosis information, which is typically captured on standard claims forms submitted from physicians and hospitals for reimbursement. Under the HCC methodology, providing additional diagnoses generates a higher risk score and thus higher capitated payments.

This year, CMS will adjust payments to Medicare Advantage plans down about 3.5% because of documented increases in “coding intensity” which do not represent real increases in disease burden but rather are considered to be artifacts of incentives to code differently. This “up-coding” occurred even though MA plans are one step removed from provider coding, which occurs in the offices and clinics of network physicians. When the capitated entity represents the providers directly, that is, is a qualified IDS or ACO, the concern about coding intensity “creep” would be even greater. CMS would need enhanced surveillance mechanisms and enforcement capabilities to apply the shared or full savings/risk payment model.

One final point about the current risk adjuster used in Medicare has particular relevance to IDSs, such as PACE, and SNPs serving frail elderly – those for whom integrated chronic care coordination is most beneficial. Traditionally, capitation payments to PACE organizations have been risk adjusted not by the CMS-HCC model but rather by a unique “frailty adjuster.”⁷⁰ The programs received the same payment for every Medicare-eligible PACE participant (excluding ESRD participants) enrolled – that is, the county capitation rate multiplied by a single adjuster of 2.39. Since 2004, CMS has been phasing in the CMS-HCC model with the result that, effective 2008, the frailty adjuster was no longer used.

However, CMS is now phasing in a new frailty adjuster beginning in 2008 after various analyses have again confirmed that diagnosis-based risk adjusters do not fully predict the expenditures of the frail elderly, where frailty is generally defined in terms of functional impairments. CMS has adopted the approach taken by many researchers and clinicians of defining frailty as functional impairment, and using counts of difficulty in performing activities of daily living (ADLs) as the core measure of functional impairment as obtained from PACE enrollees’ responses to the Health Outcome Survey – Modified (HOS-Modified).

⁷⁰ <http://www.npaonline.org/website/article.asp?id=808>.

The frailty adjuster is prospective, meaning that Medicare expenditures in a given year are predicted by ADL information in the prior year.⁷¹

Accurate prediction for the frail elderly is especially significant because they do not comprise a uniform proportion of the enrollment of all Medicare capitated organizations, and their expenditures are considerably higher than the average beneficiary. This is a particularly important issue for organizations whose models of care focus disproportionately on the frail elderly.

4. State/Community Organizations

State/community-based entities with integrated chronic care coordination activities could be paid just as IDSs or MA plans if they are willing to be responsible for all health care spending for the relevant population. PHOs involving most of the community physicians in an area, for example, could house both clinical and social care coordination activities. Alternatively, separate payment only for the chronic care coordination activities could be made to the state/community entity while payments for medical services continued to the various physician and the providers. For example, the Middlesex, Connecticut, PHO-like entity that is one of the sites in the PGP Demonstration receives shared savings incentives even though it houses only the chronic care coordination activities – the community physicians and Middlesex Hospital continue to receive FFS payments from Medicare.

A number of other payment models exist to support the chronic care coordination function specifically. It is possible to reimburse the professionals who would comprise the state/community organization providing chronic care coordination services on a fee-for-service basis – with payment going either directly to the professionals or to an organization that employs the professionals. As discussed earlier in the PCMH section, it is very challenging to precisely define the professional activities involved with care coordination because they will involve frequent phone calls, emails, and other activities that do not lend themselves to precise definition for billing purposes and would likely generate significant administrative difficulties for the organization and for the third-party payer.

Even within the Medicare Physician Fee Schedule, there is precedent for reimbursing for time or for visits defined by time. For example, critical care services are paid as a function of physician time spent in evaluation and management of critically ill patients, essentially in 30-minute increments. For inpatient neonatal critical care services, payment is made per day for a range of specified services. Similarly, CPT codes for individual psychotherapy specifically distinguish levels of services

⁷¹ J Kautter, M Ingber, and JC Pope, “Medicare Risk Adjustment for the Frail Elderly,” *Health Care Financing Review* 25(4):119-41, 2008.

based on the amount of time spent face-to-face with the patient.

Presumably, similar time-based reimbursements could be developed for the specific activities of the nurse, social worker, and other professionals providing chronic care coordination services, although there would have to be greater flexibility provided to permit recognition of non face-to-face activities. The simplest – but most troublesome from a program integrity and cost perspective – would be to pay state/community-based organizations per diems for the range of services provided by the team of non-physician professionals involved with chronic care coordination.

FFS reimbursement to individual professionals in a community would likely exacerbate already fragmented care. FFS reimbursement to an organization providing a team orientation to care would be preferable but still contains perverse FFS incentives. Instructive might be the evolution of spending for home health services in Medicare. Traditionally, home health agencies had been reimbursed fee-for-service for individual visits and specific other skilled nursing, therapies, and social support activities. Faced with skyrocketing inflationary home health spending, the Balanced Budget Act of 1997 moved the payment approach to prospective payment for a 60-day episode of care, with resultant decrease in numbers of visits and of overall home health spending, for better or worse, presumably because of the altered incentives.⁷²

Prospective, episode-based payment is a plausible payment approach for chronic care coordination organizations. However, in contrast to most home health benefit-eligible patients who may need home health benefits to resolve particular problems requiring skilled nursing services, the Lynn typology and related work demonstrates that most serious chronic conditions are predictably progressive to death, albeit with different trajectories. Community dwelling patients who would benefit from integrated chronic care coordination services presumably would benefit from the additional services until death, unless they specifically entered a hospice program that assumed responsibility or were institutionalized. Put another way, an episode of chronic care is an oxymoron.

Therefore, it would be more appropriate to provide payment on a PPM basis as long as the patient continues to receive services from the particular state/community-based organization providing chronic care coordination in conjunction with physicians, functioning in virtual teams. Payment for the actual medical services would be separate. For example, in the North Carolina Community Care Network approach, all local CCNC networks are 501(c)(3)

⁷² N. McCall et al. "Utilization of Home Health Services before and after the Balanced Budget Act of 1997: What Were the Initial Effects?" *Health Services Research* 2003, 38(1, Part 1): 85-106; R.Schlenker, M. Powell, and G Goodrich, "Initial Home Health Outcomes under Prospective Payment," *Health Services Research* 2005, 40 (1):177-193.

non-profit organizations, which at a minimum include area primary care physicians, a hospital, the county Department of Social Services (Medicaid) office, and the county health department. Each network receives a \$3 per member per month Medicaid enhanced care management fee, which is used to hire local professionals or otherwise pay for the services that support the care coordination activities. Each network determines its budget based on the anticipated PPM fee and submits a budget to the state for review in advance. The state reviews each network's budget to assure that the bulk of funds support enhanced case management and disease management activities, in anticipation of possible state or federal audits. The \$3 amount was determined to be sufficient for activities related to the Medicaid population of mothers and children being served. A monthly fee of \$5 is provided for Medicare and dually eligible beneficiaries. Similarly, the monthly per member payment could be adjusted for larger networks that achieve economies of scale.⁷³

The Vermont Blueprint for Health Integrated Pilot Program has adapted an enhanced payment approach that is consistent across all major payers, except Medicare, to reward successful physician practices and to pay the salaries of the community based teams – payers share support for the costs of the Community Care Teams.⁷⁴ The Medicare Coordinated Care Demonstration (MCCD) similarly supported intervention costs using monthly per beneficiary payment as the basic approach. CMS selected 15 demonstration programs for the MCCD in January 2001 in a competitive awards process under which each program was allowed to define, within broad boundaries, its own intervention design and target population. CMS paid each program a negotiated monthly fee for each beneficiary in its treatment group, ranging from \$50 to \$444 per beneficiary, for each month the beneficiary remained eligible for and enrolled in the program.⁷⁵

Based upon clearer understanding of which elements of the various approaches to chronic care coordination have the best pay-off, an ongoing payment model would provide greater specificity and therefore more precision to calculating the monthly payment amounts, as suggested by Randy Brown's summary described earlier. Nevertheless, an ongoing ability to modify payments is likely to be needed, based on the characteristics of the patient population and whether other entities also receive payments for some part of chronic care coordination. For example, where patient-centered medical homes were themselves taking on much of the clinical care coordination activities, the payments to a state/community-based organization would exclude these

⁷³ S Wilhide and T Henderson, "Community Care of North Carolina: A Provider-Led Strategy for Delivering Cost-Effective Primary Care to Medicaid Beneficiaries," American Academy of Family Physicians, Washington, DC, June, 2006.

⁷⁴ Vermont Blueprint for Health op. cit., pp. 7-8

⁷⁵ D Peikes, et al. *Third Report to Congress on the Evaluation of the Medicare Coordinated Care Demonstration*, Mathematica Policy Research, Contract No. 500-95-0047 (09), January 3, 2008.

activities and, rather, focus only on social service and related components of care coordination. In communities where physicians were acting more like physicians in the CCNC, that is, being more attuned to physician roles as part of a virtual team and letting the state/community network address both clinical and social chronic care activities, the payments to the state/community organization would need to be larger. In the payment approach proposed for Community-Based Medical Homes, the House America's Affordable Health Choices Act provides two separate monthly fees for each high-need beneficiary who consents to receive medical home services, with one fee directed to the community-based organization and the other to the primary or principal care practice.⁷⁶

The Medicare Coordinated Care Demonstration did not have the kind of pay-for-performance incentives that were an inherent and important aspect of the PGP Demonstration. Just as P4P can be attached to medical home payments to reward physician practices for performance on quality, patient experience, and health spending, a monthly fee approach to paying community organizations could be complemented by performance rewards and penalties. Given the end-of-life considerations that many of the clients of the organizations would face, it would be preferable to have balanced measures of performance and not simply reward organizations for reducing spending in relation to a target.

5. Health Plans/ SNPs

Much of the discussion above related to paying integrated delivery systems applies as well to health plans in the Medicare Advantage Program. The Obama Administration has proposed a fundamental alteration in how payments to MA plans are determined by recommending a competitive bidding approach that would differ considerably from the current bidding approach. Because CMS has not yet conducted even a demonstration using this form of competitive bidding, for the purposes of this paper we assume that the current model of bidding against benchmarks set in reference to spending in the traditional Medicare program will remain the dominant approach used in Medicare.⁷⁷

Special Needs Plans face the added complexity of dealing with Medicaid policy as well as Medicare because of the need to link the Medicare benefit for medical services with Medicaid HCBS services to address both medical and social support dimensions of care coordination. The 2010 CMS Call Letter requires that new SNPs have a contract with the relevant state Medicaid program by October 1, 2009 to be able to market for 2010. From the beneficiary perspective, such contracts should help to achieve truly

integrated care because one entity, the SNP, will now be programmatically and financially responsible for assuring that all Medicare and Medicaid services are provided.⁷⁸ Following the model of the Integrated Care Initiative launched in 2005 in Minnesota, Wisconsin, and Massachusetts, Medicaid capitation covers the costs of Medicare co-pays and deductibles, community care waiver benefits, personal care attendant benefits and at least some risk for custodial nursing facilities, complementing the Medicare capitation the SNPs receive for each beneficiary to cover the costs of Medicare-provided benefits. In the integrated care model, SNPs are at full risk for costs, but the combination of risk-adjusted Medicare and Medicaid monthly payments have covered their high costs, and all plans have been financially viable. Given the difficult economic circumstances that many state Medicaid programs are currently facing, it is not clear that such payment levels can be maintained, and the impact on the ability of SNPs to provide care coordination across the medical and social support dimensions will be important to monitor carefully.

⁷⁶ H.R. 3200, op. cit., pp. 468 - 471.

⁷⁷ R.A. Berenson, "From Politics to Policy: A New Payment Approach in Medicare Advantage," *Health Affairs* 27(2): w156-w164, March/April 2008.

⁷⁸ M. Bella, op. cit., p. 2.

IV. CONCLUSIONS AND POLICY IMPLICATIONS

The contribution that effective care coordination can make to improved quality and outcomes of care for Medicare beneficiaries with multiple chronic conditions, to reducing hospital and nursing home utilization, and to reducing costs of care has great potential to improve the care for beneficiaries and to lower health care costs. Success has been demonstrated in a number of sites but scaling these approaches for national application needs broad testing and evaluation, some of which is proceeding. The inclusion of various models in the policy documents and draft legislation thus far released from both the House and Senate Committees developing health reform legislation is a testament to the extent of interest in and hope for the potential that care coordination could offer in addressing the limitations of the current delivery system in effectively managing the ever-increasing chronic disease burden in the U. S. population.

This paper has emphasized a number of key points important to keep in mind as final legislation is crafted and ongoing efforts to improve care coordination continue:

- **“One size does not fit all.”** The diversity in the population with multiple chronic conditions and/or functional limitations, the progression of needs over time for any given individual, and the considerable heterogeneity in market conditions and organizational capacity across the country require that multiple models be available.
- **Different models are more effective with different segments of the population.** Even while recognizing the heterogeneity in market structures and organizational capacities, it is nevertheless important to carefully target the care coordination model to the appropriate population segment, e.g., high-intensity coordination for high-risk beneficiaries.
- **Effective care coordination for people with multiple chronic conditions and/or functional limitations requires linkages between medical care and social support services.** The traditional medical dimension of care that may work reasonably well in responding to people with acute clinical problems is not sufficient to address the needs of many people with multiple chronic conditions and/or

functional limitations. Linkages to social service and other state/community-based resources are needed to improve or stabilize the medical condition of many patients. The availability of an interdisciplinary team of professionals, including nurses, social workers, pharmacists, and others, is therefore important to providing needed support. This team can be made available and supported in a number of different ways and may not have to be employed by the same organizational entity that provides medical care, as long as there is a close linkage between the medical and other components that comprise effective care coordination. Active engagement by the beneficiary and family (and other) caregivers is critical, but has often been an overlooked element in many current approaches.

- **Under current financing structures, both Medicare and Medicaid funding sources must be integrated to address the care coordination requirements of the dually eligible population with multiple chronic conditions and/or functional limitations.** The benefit structure of neither program alone covers the spectrum of medical and social support services needed by this population.
- **Fee-for-service payment is inherently limited for supporting care coordination activities and providing incentives for effective performance. Instead, payment approaches, such as a Per Person Per Month (PPPM) fee per eligible beneficiary, can be scaled to the care coordination model, risk-adjusted for patient complexity, and provide incentives based on the quality of care and care coordination, patient experience with care, and health spending for a defined population of patients.** Such approaches can be used in addition to or in place of fee-for-service payment.

Discussion at the June 3rd meeting highlighted one further conclusion – the need for much more robust testing of the various models and more rapid turnaround of findings than the current Medicare demonstration process can provide. The organizational resources and processes currently available to the Centers for Medicare & Medicaid must be significantly enhanced if the “promise of care coordination” is to be realized in a timeframe appropriate to the urgency of real health system reform.

APPENDIX A: MEDICAID HOME AND COMMUNITY-BASED WAIVER SERVICES

Below is a list of the wide array of services that states have opted to cover under the Medicaid home- and community-based waiver program. Each state may determine which services will be covered, and the amount, duration or scope of each particular services.

Some of the services are additional services beyond what is normally available under the Medicaid program (e.g., expanded dental benefits and/or prescription drugs). These types of services are not normally considered within the definition of long-term care services. However, national data do not exist that would disaggregate the Medicaid home- and community-based waiver expenditures into specific subtypes of services.

- Adult day care
- Services in community-based residential setting
- Assistive technology
- Personal care/Homemaker support services
- Nursing services
- Companion services
- Counseling/Mental health services
- Case management
- Consumer and family skills training
- Dental care
- Home and environmental access and modifications
- Home-delivered meals
- Hospice Interpreter
- Nutrition counseling and supplements
- Prescription drugs
- Medication management
- Emergency response, crisis intervention, and protective services
- Therapies: speech, physical, occupational
- Respite
- Massage/Acupuncture
- Transportation

Congressional Research Service, "Long-Term Care: Consumers, Providers, Payers, and Programs." March 15, 2007, p. CRS-51

APPENDIX B: AGENDA AND PARTICIPANTS IN JUNE 3, 2009 NATIONAL COALITION ON CARE COORDINATION (N3C) INVITATIONAL MEETING

Financing and Payment Options for Care Coordination:
A meeting convened by the National Coalition on Care Coordination (N3C)
Wednesday, June 3, 2009
9:00 am - 2:00 pm
Reserve Officers Association, One Constitution Avenue, NE, Washington D.C.

- 8:30 AM BEVERAGES AND A LIGHT BREAKFAST
- 9:00 am GREETINGS AND INTRODUCTIONS:
Jeannine Melly, Social Work Leadership Institute, New York Academy of Medicine, Acting Co-Chair of N3C and Robyn Golden, Rush University Medical Center and the American Society of Aging, Co-Chair of N3C
- 9:15 AM SUMMARY OF GOALS/ REVIEW OF THE DAY:
Bill Benson, Health Benefits ABCs, Moderator
Review of the working paper, "*Financing and Paying for Chronic Care Coordination*," to identify:
- The current policy and practices regarding federal reimbursement and payment for medical and social support care coordination;
 - Variations in payment mechanisms for various aging patient/client groups; and
 - Whether the paper, when revised, can serve as a guideline for financing and payment options for balanced and integrated medical and social support care coordination
- 9:20 AM PRESENTATION OF THE PAPER BY ITS AUTHORS:
Robert Berenson, Urban Institute and MedPAC (15 minutes)
Julianne Howell, Health Policy Consultant (15 minutes)
- 9:50 AM KEN COBURN:
Health Quality Partners, Discussant (10 minutes/discussion for 35 minutes)
- 10:35 AM BREAK
- 10:45 AM BILL SCANLON:
MedPAC, Discussant (10 minutes/discussion for 35 minutes)
- 11:30 AM JUDY FEDER:
Georgetown Public Policy Institute, Discussant (10 minutes/discussion for 35 minutes)
- 12:15 pm LUNCH (to be taken back to the table)
- 12:30 PM BILL BENSON, MODERATOR, AND PARTICIPANTS:
- Identification of opportunities and barriers
 - Summary
 - Next steps in moving the dialogue forward
- 2:00 PM CLOSE

**PARTICIPANTS: N3C CONFERENCE ON FINANCING AND PAYING FOR CHRONIC CARE COORDINATION
June 3, 2009**

Baker	Brett	American College of Physicians
Bella	Melanie	Center for Health Care Strategies
Benson	William	Health Benefits ABC's (HBABCS)
Berenson	Robert	The Urban Institute, MedPAC
Blancato	Robert	Matz, Blancato & Associates
Boult	Chad	Lipitz Center for Integrated Health Care, Dept. of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health
Bowles	Kathryn	University of Pennsylvania School of Nursing
Brown	Randall	Mathematica Policy Research, Inc.
Cavanaugh	Sean	United Hospital Fund
Chiplin	Alfred	Center for Medicare Advocacy, Inc.
Coberly	Sally	National Health Policy Forum, George Washington University
Coburn	Ken	Health Quality Partners
Coleman	Eric	Divisions of Health Care Policy and Research and Geriatric Medicine, University of Colorado
Dummit	Laura	National Health Policy Forum, George Washington University
Edwards	Barbara	Health Management Associates, Inc.
Feder	Judy	Georgetown Public Policy Institute
Foley	Maura	Medicare Advocacy Center
Friss-Feinberg	Lynn	National Partnership for Women and Families
Golden	Robyn	Rush University Medical Center
Gottlich	Vicki	Center for Medicare Advocacy, Inc.
Guterman	Stuart	Program on Medicare's Future, The Commonwealth Fund
Howell	Julianne	Health Policy Consultant
Justice	Diane	National Academy for State Health Policy
Kay	Terrence	CMS
Lee	Julie	Congressional Budget Office
Lindberg	Brian	Consumer Coalition for Quality Health Care
Lundebjerg	Nancy	American Geriatrics Society
Lynn	Joanne	Department of Health, Government of the District of Columbia
MacInnes	Gail	Grassroots and Public Policy
McConnell	Steve	The Atlantic Philanthropies
Melly	Jeannine	New York Academy of Medicine
Miller-Jones	Judy	National Health Policy Forum, George Washington University
Nolin	Mike	The Hilltop Institute, University of Maryland/Baltimore County.
O'Shaughnessy	Carol	National Health Policy Forum, George Washington University
Painter	Michael	Robert Wood Johnson Foundation
Peres	Judith	Office of the Assistant Secretary for Planning and Evaluation, Health and Human Services
Raphael	Carol	Visiting Nurse Service of New York
Scanlon	William	MedPAC
Simmons	June	Partners in Care Foundation
Sowers	Mary	Centers for Medicare and Medicaid Services
Sprague	Lisa	National Health Policy Forum, George Washington University
Spring	Julia	New York Academy of Medicine
Sulick	Brenda	Alzheimer's Association
Thorpe	Kenneth	Rollins School of Public Health, Emory University
Verdier	James	Mathematica Policy Research, Inc.
Wren	John	Administration on Aging, DHHS