



Advising the Congress on Medicare issues

Encouraging care coordination in FFS Medicare

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Why is care coordination needed?

- Beneficiaries see multiple providers
- Prevalence of chronic conditions increasing
- Those with chronic conditions:
 - High proportion of Medicare expenditures
 - Not all receiving high quality care

Health system and payment not designed to promote coordination

- Current FFS payment design focuses on:
 - Acute illness and injury; not care planning over time
 - Individual providers; not patient care across settings
 - Face-to-face reimbursement; not self-management training, or ongoing monitoring
- Limited physician time and training for care coordination
- Clinical information systems not widely used by health system

MedPAC research

- Goal: Identify key care coordination tools and strategies that Medicare could encourage in FFS
- Analysis based on:
 - Interviews w/plans, groups of providers, care management organizations, researchers, quality experts, and CMS
 - Claims analyses on patterns of care
 - Published literature on effectiveness of care coordination

Research findings

- Primary tools for care coordination
 - **Care manager** (usually a nurse): monitors patient progress, and educates patients for self-management (symptoms, medication use, life-style change)
 - **Information system**: to identify most needy patients, track progress and share information
- Physician office involvement improves program effectiveness
- Payments to programs usually risk-based
- Programs usually target complex patients, often w/multiple chronic conditions
- Results of programs: Costs savings vary depending on type of patient, intervention, and time frame; quality improves

Organizational structure of potential models

- **Model 1: Provider-based organization**
 - Care coordination program is integrated within the provider organization (physician group practice or integrated health system)
 - Two payments:
 - At-risk or shared savings payments for care coordination program
 - Monthly fee to provider organization

- **Model 2: Care management organization plus physician office**
 - Smaller physician offices interact with external care management organizations
 - Two payments:
 - At-risk or shared savings payments to external organization
 - Monthly fee to individual provider (e.g., physician, nurse practitioner)

Financial incentives of potential models

- Care management program: Shared savings and/or at-risk fee for care management functions
- Physician office: Criteria-based fee to physician for interacting w/program (model 1 to group, model 2 direct to individual physician)

Eligibility and enrollment in both models

- CMS uses claims to identify beneficiaries eligible for each program
- Program further defines focus
- Physicians identify and refer additional eligible patients
- Beneficiaries designate physician office

Accountability

- Care management program:
 - Savings built into risk-based payment mechanism
 - Quality measures (process and outcomes), including patient experience
- Model 2: Physician office reports additional clinical quality measures

Revaluing E&M for time spent with complex patients

- Current E&M codes may not adequately account for the time and effort needed for complex patients. Concern is compounded for practitioners with high shares of complex patients.
- Two fee-schedule mechanisms:
 - Increase selected E&M payments, or
 - Establish new FFS billing codes for time spent with complex beneficiaries