

NHPCO 2010 Conference: Developing the Care Continuum
Boston, Massachusetts
August 2010

Care Management Models for the Chronically III

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Overall Goals of Health Care Reform

- Create incentives that empower health care providers to take broader accountability for patient care and outcomes and enable them to benefit from doing so
- Create incentives to improve care coordination across providers and settings
- Slow growth in federal health spending
- Increase value of health care dollars spent



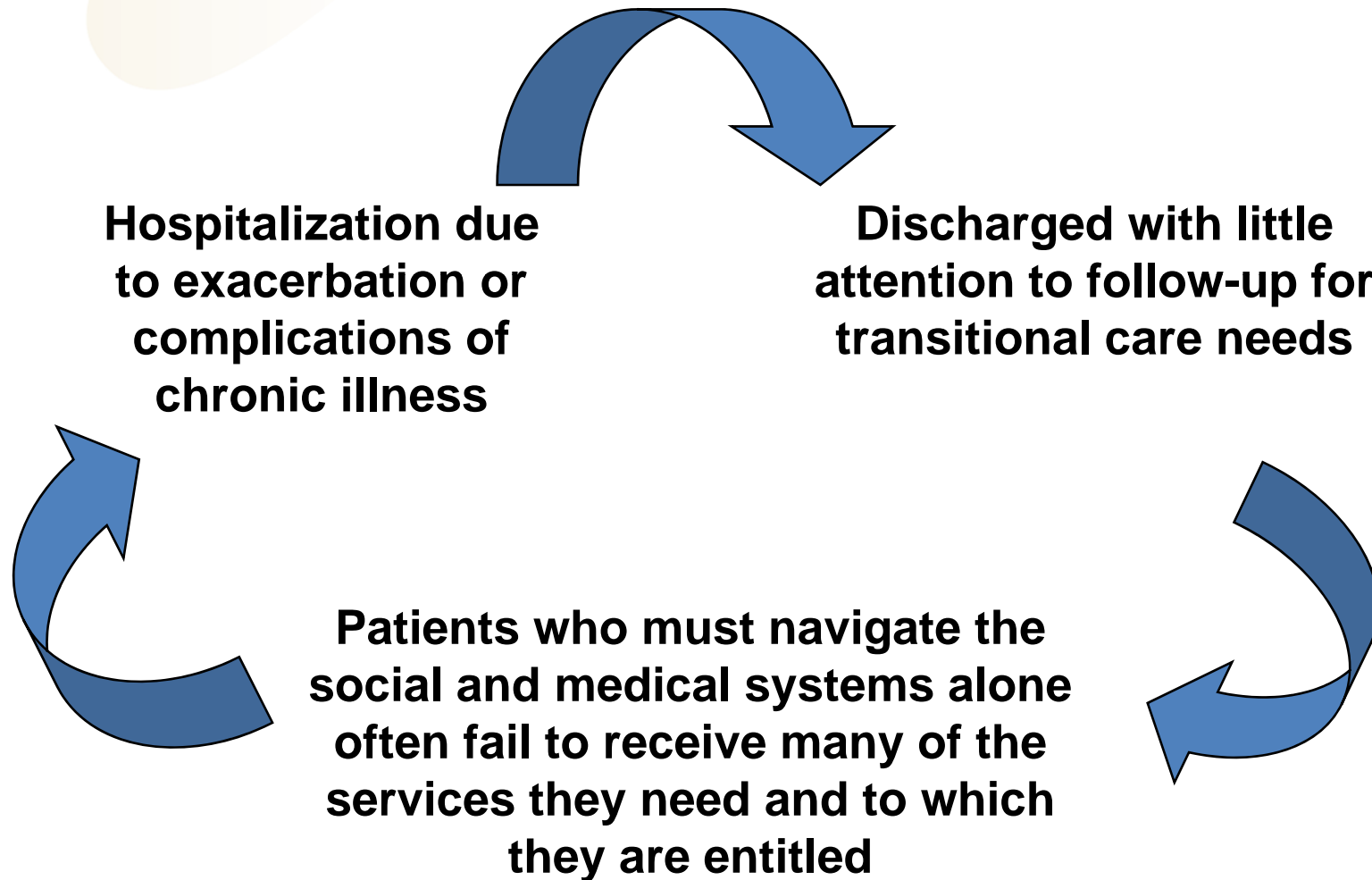
Moving Forward Health Care Delivery and Payment Changes

- **Short-term:** Next three years, production model payment system remains largely in place—with Medicare payment reductions, but most delivery system changes not yet effected
- **Mid-term:** Three to seven years out, health delivery reforms phase in, and new payment incentives begin to tip the balance
- **Long-term:** Disease/chronic care-centered systems of care become the predominant clinical and competitive model

Adapted from Sg2 Chairman's Letter January 2010: Imperatives for Growth and Performance

Why Focus on Chronically Ill?

Current Health Care System for Chronically Ill



Improving Care Coordination for Persons with Chronic Conditions

- Align Medicare and Medicaid
- Enhance linkages between health and long-term support services
- Improve provision of primary care to persons with multiple chronic conditions
- Smooth transitions from one care setting to another



CMS Federal Coordinated Care Office

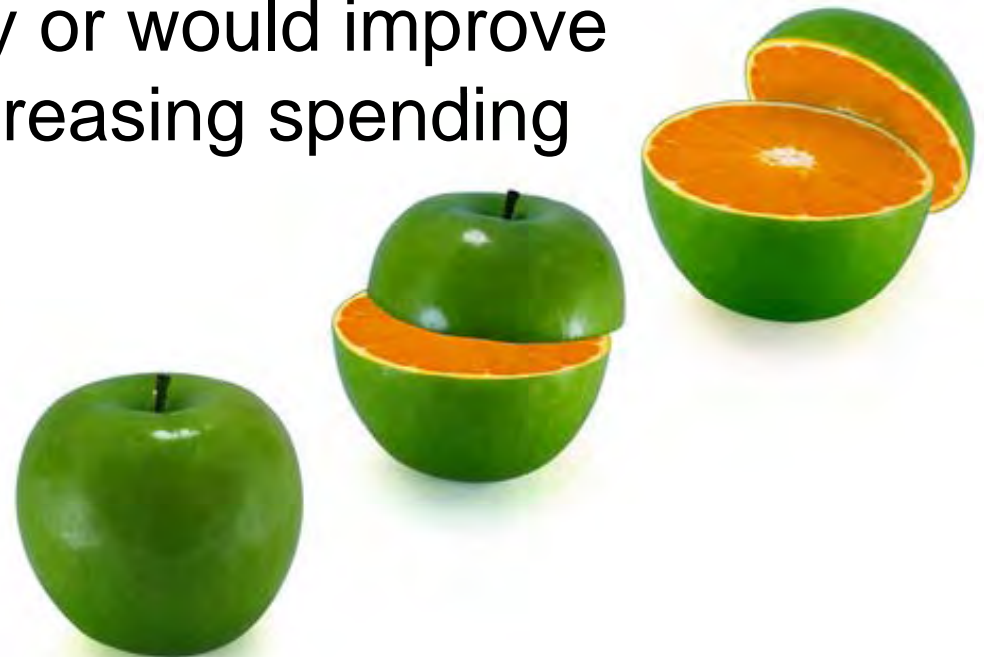
- Must be established **no later than March 1, 2010**
- Purpose:
 - More effectively integrate Medicare and Medicaid benefits; and
 - Improve coordination between federal government and the states
- Annual to Congress must contain **legislative** changes to improve care coordination and benefits for dual-eligibles

CMS Center for Medicare and Medicaid Innovation

- Must be established no later than **January 1, 2011**
- Established to test innovative payment and delivery models to reduce program expenditures and enhance quality of care
- Five of 20 projects identified include care coordination:
 - Patient-centered medical homes
 - Use of geriatric assessment and comprehensive care plans to coordinate care
 - Promotion of care coordination through salary-based payment
 - Support for care coordination for chronically ill through use of health information technology
 - Treatment of individuals with chronic conditions and history of prior year hospitalizations through interventions under the Medicare Coordinated Care Demonstration

What's Different from Past Demonstrations?

- No requirement for initial budget neutrality
- Removes five-year limit for demonstrations
- Expansion, including nationwide implementation, can occur if the model would reduce spending without reducing quality or would improve patient care without increasing spending



New Models of Care



Medicare Advantage Special Needs Plans (SNP)

- SNPs are important model for integrating financing and care for duals in states (other than PACE)
- SNP authority extended until December 31, 2013
- Secretary has authority to implement frailty adjustment for fully integrated dual-eligible SNPs that have contract with the state that includes provision of LTC
- Beginning in 2012, NCQA approval needed
- For 2011 and periodically thereafter, periodic adjustments of risk adjustments required

Medical and Health Homes

- Can begin on **January 1, 2011**
- New state plan option to create medical/health homes for Medicaid enrollees with chronic conditions
- Health teams will provide comprehensive care management, care coordination, and health promotion; transition care to inpatient and other settings; offer patient and family support; refer to community and social support services; and use health IT where feasible
- \$25 million grant program to support program development
- Enhanced FMAP of 90 percent for first eight quarters

Accountable Care Organizations

- Not a pilot—three-year contracts with CMS
- New shared savings program, effective January 1, 2012
- Integration of physicians, hospitals, post-acute providers, outpatient, and ancillaries with a minimum of 5,000 beneficiaries
- Responsible for all Part A and Part B care

Accountable Care Organizations

(continued)

- *Objective:* reduce overall Medicare costs
- *Incentive:* ACOs share in cost savings after a minimum level of savings achieved
- *Payment model:* partial capitation model or any other model that will improve quality and efficiency
- *Key to success:* ACO must be able to manage care across the continuum

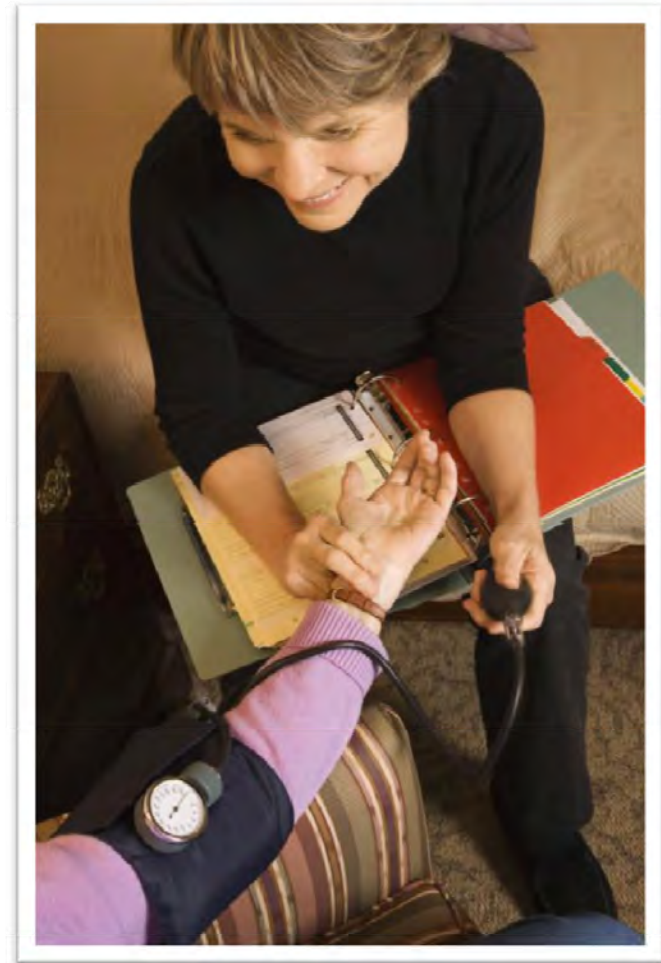


Medicare Independence at Home Demonstration

- Must begin no later than **January 1, 2012**
- Test provision of physician/NP-directed home-based primary care and care coordination across all treatment settings
- Eligible beneficiaries are those with:
 - Two or more chronic conditions;
 - Non-elective hospital admission within past 12 months
 - Previous acute or subacute rehabilitation services; and,
 - Two or more functional dependencies

Medicare Independence at Home Demonstration (continued)

- Participating practices must furnish services to at least 200 beneficiaries and can share in savings that exceed 5 percent
- Total demonstration can serve no more than 10,000 beneficiaries



Bundled Episodic Payment

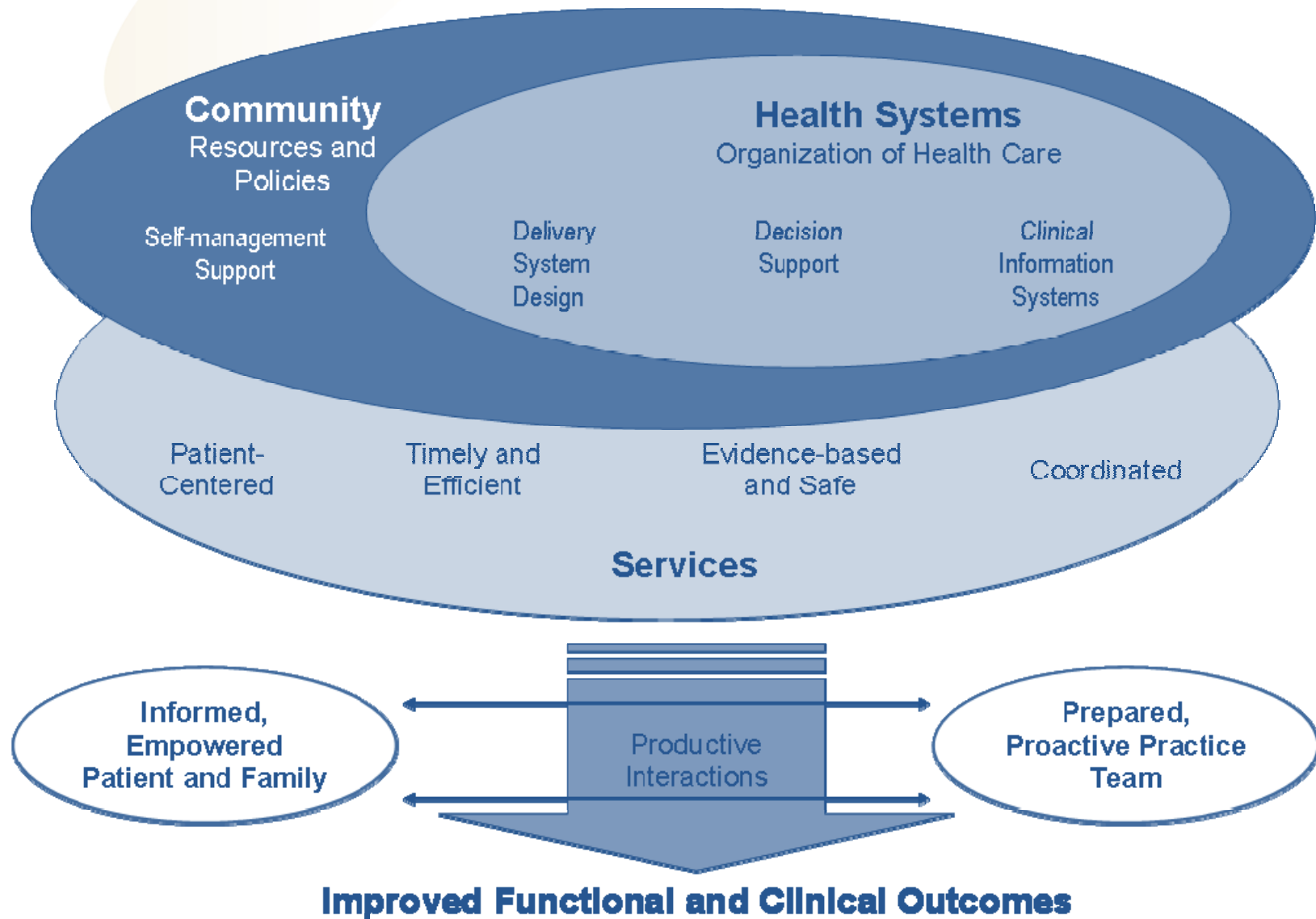
- Pilot begins **January 1, 2013**; if spending reductions, expand at least by January 1, 2016
- Bundling = payment to single provider entity of one amount for full range of care during hospitalization episode
 - Episodic payment related to acute hospitalization: -3 through +30 days
 - Hospitalization, re-hospitalization, post-acute care, outpatient hospital services including ED, physicians
- Initial focus on one or more of 8 conditions
- Payment: either single bundle or via bids



Implementation Dates of Models of Care

Models	Implementation Dates
Medicare SNP	Continues until 12/31/2013
Medical and Health Homes	Can begin on 1/1/2011
Accountable Care Organization	Begins 1/1/2012
Medicare Independence at Home Demonstration	Must begin no later than 1/1/2012
Bundled Episodic Payment	Begins 1/1/2013

Effective Chronic Care Delivery



Thank You



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