Subtitle C - Chronic Care Improvement

Voluntary Chronic Care Improvement Under Traditional Fee-For-Service (Section 721 of the Conference Agreement, Section 721 of the House Bill, and Section 442 of the Senate Bill).

Present Law

No provision.

A hearing was held by the Ways and Means Committee, Health Subcommittee on February 25, 2003 on the importance of providing chronic care management in fee-for-service Medicare. Statistics from the Robert Wood Johnson Foundation state 84% of Medicare beneficiaries have one or more chronic conditions and account for 95% of Medicare spending. With Americans living longer due to advances in medical procedures and increased availability to medications, Medicare costs will continue to escalate. Thus, chronic care programs should be implemented in both traditional fee-for-service and private plans to target these individuals, improve health outcomes and save money.

The Centers for Medicare & Medicaid Services (CMS) has run demonstration programs in the Medicare program targeting high cost seniors. Currently, CMS is managing more than a dozen disease management demonstration projects. The BBA allowed for the continuation of demonstration projects that were cost-effective, improved quality of care and patient/beneficiary satisfaction. These demonstration sites enrolled more than 7,600 Medicare beneficiaries. CMS has also started on disease management demonstrations authorized by BIPA of 2000, to provide disease management services to Medicare beneficiaries with congestive heart failure, diabetes, or coronary heart disease. CMS estimates that enrollment will include around 30,000 Medicare beneficiaries. BIPA also required a physician group demonstration to encourage coordination and reward physicians for improving beneficiary health outcomes. CMS has demonstrated significant progress in integrating chronic care management programs into fee-for-service Medicare and HMOs. The following provision would increase the number of chronic care management programs (also known as disease management programs) in fee-for-service Medicare, with the intention of expanding these programs nationwide if health outcomes improve and Medicare costs decrease.

Additionally, a 1999 survey showed 56% of employers offer disease management services to their employees, along with 67% of HMOs and 64% of POS plans. Private plans continue to offer disease management programs to reduce costs, improve health outcomes, and increase patient and provider satisfaction. Because many of these health plans offer chronic care -280- management programs already, it is important to require Medicare Advantage to offer these programs, as well.

House Bill

The Secretary would be required to establish a process for providing chronic care

improvement programs for Medicare beneficiaries in fee-for-service Medicare (Parts A and B) who have certain chronic conditions such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), stroke or other diseases identified by the Secretary for inclusion in the program. The Secretary would establish administrative regions (called CCMA regions) within the United States for the chronic care improvement programs. Within each region, the Secretary would select at least two contractors under a competitive bidding process on the basis of the ability of each bidder to achieve improved health outcomes of beneficiaries and improved financial outcomes of the Medicare program. A contractor could be a disease improvement organization, health insurer, provider organization, a group of physicians, or any other legal entity that the Secretary determines appropriate. Contractors would be required to meet certain clinical, quality improvement, financial, and other requirements specified by the Secretary. Subcontractors could be used by the contractors. The Secretary would be able to phase-in implementation of the program beginning one-year after enactment.

Each program would be required to have a method for identifying targeted Medicare beneficiaries who would be offered participation in the program. The Secretary would be required to assist the program in identifying beneficiaries. Each beneficiary would be assigned to only one contractor that would be responsible for guiding beneficiaries in managing their health, including all co-morbidities. Initial contact with a Medicare beneficiary would be from the Secretary who would provide information about the program, a description of advantages in participating, notification that the contractor could contact the beneficiary directly concerning participation, the voluntary nature of program participation, and a means to decline participation or decline being contacted by the program. Each program would be required to develop an individualized, goal-oriented chronic care improvement plan with the beneficiary. The chronic care improvement plan would be required to contain: a single point of contact to coordinate care; self-improvement education for the individual and support education for health care providers, primary caregivers, and family members; coordination between prescription drug benefits, home health, and other health care services; collaboration with physicians and other providers to enhance communication of relevant clinical information; the use of monitoring technologies, where appropriate; and information about hospice care, pain and palliative care, and end-of-life care, as appropriate. In developing the chronic care improvement plan, programs would be required to use decision support tools such as evidence-based practice guidelines to track and monitor each beneficiary across care settings and evaluate outcomes using a clinical information database. The program would be required to meet any additional requirements that the Secretary finds appropriate. Programs that have been accredited by qualified organizations would be deemed to have met such requirements as specified by the Secretary.

Contractor payments for each chronic care improvement program would be required to result in Medicare program outlays that would otherwise have been incurred in the absence of the program for the three-year contract period. The Secretary would be required to assure that there would be no net aggregate increase in Medicare payments, in entering into a contract for the program over the 3-year period, including program outlays, administrative expenses (that would not have been paid under Medicare without

this demonstration), and contractor fees. Contracts for chronic care improvement programs would be treated as a risk-sharing arrangement. In addition, payment to contractors would be subject to the contractor meeting clinical and financial performance standards established by the Secretary.

Program contractors would be required to report to the Secretary on the quality of care and efficacy of the program in terms of process measures (such as reductions in errors of treatment and rehospitalization rates), beneficiary and provider satisfaction, health outcomes, and financial outcomes. The Secretary would be required to submit to Congress annual reports on the program including information on progress made toward national coverage, common delivery models, and information on improvements in health outcomes as well as financial efficiencies resulting from the program. The Secretary would also be required to conduct a randomized clinical trial to assess the potential for cost reductions under Medicare by comparing costs of beneficiaries enrolled in chronic care improvement programs and beneficiaries who are eligible to participate but are not enrolled.

Appropriations of such sums as necessary to provide for contracts with chronic care improvement programs would be authorized from the Medicare Trust Funds, but in no case would the funding be permitted to exceed $100 million over 3 years.

The provision would be effective upon enactment and the Secretary would be required to begin implementing the chronic care improvement programs no later than 1 year after enactment.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires the Secretary to establish and implement chronic care improvement programs. If the programs are established, they are required to improve clinical quality and beneficiary satisfaction and achieve spending targets for Medicare for beneficiaries with certain chronic health conditions.

The chronic care improvement (CCI) program is required to (1) have a process to screen each targeted beneficiary for conditions other than the specified chronic conditions, such as impaired cognitive ability and co-morbidities, in order to develop an individualized, goal-oriented care management plan; (2) provide each targeted beneficiary participating in the program with the care management plan; and (3) carry out the plan and other chronic care improvement activities. The care management plan is required to be developed with the beneficiary and, to the extent appropriate, include: (1) a designated point of contact responsible for communications with the beneficiary and for facilitating communications with other health care providers; (2) self-care education for the beneficiary (through approaches such as disease management or medical nutrition

therapy) and education for primary caregivers and family members; (3) education for physicians and other providers and collaboration to enhance communication of relevant clinical information; (4) the use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment; and (5) the provision of information about hospice care, pain and palliative care, and end-of-life care. To the extent that a care management plan includes medical nutrition therapy, such services should be delivered by a registered dietician or nutrition professional as defined in Section 1861 of the Social Security Act (42 U.S.C. 1395x.) The Secretary is required to develop a method for identifying targeted beneficiaries who may benefit from participation in a chronic care improvement program and to communicate with the targeted beneficiary regarding the opportunity to participate. Targeted beneficiaries who are eligible to participate cannot be enrolled in a plan under Medicare Part C and must have one or more of the threshold conditions including: congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), or other diseases or conditions specified by the Secretary. Beneficiary participation is voluntary.

In carrying out the care management plan, the chronic care improvement organization is required to: (1) guide the participant in managing the participant's health (including all co-morbidities, relevant health care services, and pharmaceutical needs) and in performing activities as specified under the elements of the care management plan of the participant; (2) use decision-support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and (3) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

The establishment of the chronic care improvement program is conducted in 2 parts. In phase I, the developmental phase, the Secretary is required to enter into contracts with chronic care improvement organizations for the development, testing, and evaluation of chronic care improvement programs using randomized controlled trials. The first contract is required 12 months after enactment for a 3-year period. The Secretary is required to enter into contracts to ensure that chronic care improvement programs cover geographic areas in which at least 10 percent of Medicare beneficiaries reside. The Secretary is further required to ensure that each chronic care improvement program includes at least 10,000 targeted beneficiaries along with a sufficient number of Medicare beneficiaries to serve as a control group. The Secretary is required to contract for an independent evaluation of each chronic care improvement program. The evaluation is required to include quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates; beneficiary and provider satisfaction; health outcomes; and financial outcomes, including any cost savings to Medicare.

If the Secretary finds that the chronic care improvement programs have improved the clinical quality of care, improved beneficiary satisfaction, and achieved specified spending targets, then the Secretary is required to expand the program to additional geographic areas not covered during phase I. Phase II may include national expansion of the program and is required to begin no later than 6 months after the completion of phase

I (nor earlier than 2 years after phase I began). The Secretary is also required to evaluate phase II programs using the same criteria used in the phase I evaluation.

Chronic care improvement organizations are required to monitor and report to the Secretary on health care quality, cost, and outcomes, in a time and manner specified by the Secretary. The organizations are also required to comply with any additional requirements the Secretary may specify. The Secretary may deem chronic care improvement organizations which are accredited by qualified organizations to have met requirements that the Secretary may specify.

The Secretary is not permitted to contract with an organization to operate a chronic care improvement program unless the organization meets the requirements for a chronic care improvement program and such clinical, quality improvement, financial, and other requirements as the Secretary deems to be appropriate for the target beneficiaries to be served; and the organization demonstrates (to the satisfaction of the Secretary) that it is able to assume financial risk for performance under the contract. Each contract is required to specify performance standards for each of the specified evaluation factors including clinical quality and Medicare spending targets, against which the performance of the chronic care improvement organization under the contract is measured. Contractual adjustments are required if the contractor fails to meet specified performance standards. Further, the contract is required to provide for full recovery by the government of any amount by which the fees paid to the contractor exceed the estimated savings to Medicare that are attributable to the implementation of the contract. The Secretary is required to ensure that aggregate Medicare benefit expenditures for targeted beneficiaries participating in the chronic care improvement program do not exceed estimated Medicare expenditures for a comparable population in the absence of such a program.

Appropriations of such sums as necessary to provide for contracts with chronic care improvement programs would be authorized from the Medicare Trust Funds, but in no case would the funding be permitted to exceed $100 million over 3 years, beginning October 1, 2003.

The Secretary is required to submit an interim report to Congress on the scope of implementation of the program, the design of the programs, and the preliminary cost and quality findings based on the evaluation criteria no later than 2 years after implementation. No later than 3-1/2 years after implementation, the Secretary is required to submit an update to the interim report to Congress. The Secretary is further required to submit to Congress 2 additional biennial reports on the chronic care improvement programs. The first is due no later than 2 years after the update report.