Recent Medicare Initiatives to Improve Care Coordination and Transitional Care for Chronic Conditions

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The Affordable Care Act\(^1\) included a number of key initiatives designed to improve chronic care coordination and transitional care for people with chronic conditions. This Fact Sheet updates information on these and other related Medicare initiatives that may improve quality of care for beneficiaries while also producing savings for the Medicare program. In some cases, family caregivers may benefit as well.

The Affordable Care Act (ACA) created several Medicare initiatives that promise to improve care coordination and transitional care for beneficiaries with chronic conditions, including the following:

- HHS Partnership for Patients
- Medicare Community-based Care Transitions Program
- Post-discharge Transitional Care Management
- Medicare Hospital Readmission Reduction Program
- Home Health Services for Caregivers of Alzheimer’s Patients
- Medicare Independence at Home Demonstration
- Patient-centered Medical Homes (Advanced Primary Care Practices)
- CMS Innovation Center Initiatives – Testing Medicare Models for Chronic Care Coordination

HHS Partnership for Patients

In April 2011, the Department of Health and Human Services (HHS) announced a public-private partnership that would help improve quality, safety, and affordability of health care for all Americans. HHS is investing substantial federal funding, made available under ACA. The Medicare Community-based Care Transitions Program (CCTP), described below, will receive $300 million of that funding. The Centers for Medicare & Medicaid Services (CMS) Innovation Center, described below, will contribute an additional $500 million to support new demonstrations related to reducing hospital-acquired conditions. According to CMS, the goals of this initiative are to reduce avoidable 30-day readmissions by 20 percent and reduce preventable hospital-acquired conditions by 40 percent.\(^2\)

Medicare Community-Based Care Transitions Program

The ACA provides for CMS to test delivery models that will improve transitional care from the hospital to home or other settings, and reduce readmissions for high-risk Medicare beneficiaries.\(^3\) Under the ACA, the goal of CCTP is to improve transitional care for high-risk beneficiaries while reducing Medicare program spending. Under CCTP, hospitals with high
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readmission rates must partner with a community-based organization with a governing body that includes multiple health care stakeholders, including consumers. High-readmission hospitals include those in the top quartile for the state on two of three “Medicare hospital compare” measures (heart attack, heart failure, and pneumonia). A community-based organization can partner with any hospital, not just hospitals with high readmission rates. CMS prefers that applicants include more than one hospital. CMS hopes that partnerships between hospitals with high readmission rates and community-based organizations will deploy transitional care teams using the best evidence-based practices with support from other clinical resources and community services. However, anecdotal evidence suggests that many interested organizations may find it difficult to qualify as community-based organizations and that establishing effective collaborative partnerships with hospitals may present a significant challenge.

Applicants receive preference if they serve the medically underserved; small communities; rural areas; or Administration on Aging programs, such as Aging and Disability Resource Centers, which may provide transitional care services to multiple providers. In addition, CMS will consider applications from physician practices, particularly primary care practices, Medicare Quality Improvement Organizations, organizations that have established similar care transition interventions with state Medicaid agencies, and organizations that have established relationships with “medical homes” serving Medicare beneficiaries. CMS encourages applicants to collaborate with Medicare Advantage plans and commercial health plans as part of a comprehensive, all-payer approach to reducing avoidable readmissions.

Applicants must include analysis and explanation of community-specific reasons for high readmission rates. CCTP participants are required to deliver at least one of five transitional care services, including: 1) initiating care transition services at least 24 hours before discharge, 2) providing post-discharge education, 3) providing assistance to ensure timely patient interactions with post–acute care providers, 4) providing patient self-management support (or caregiver support), or 5) conducting medication management review. Although multiple interventions are permitted, they must not be duplicative or conflicting.

Transitional care services must be targeted to beneficiaries in traditional fee-for-service Medicare who are at high risk due to multiple chronic conditions, cognitive impairment, depression, multiple readmissions, or other chronic diseases or risk factors determined by CMS. Applicants must explain how targeted beneficiaries will be identified by describing:

- how care transition strategies will incorporate culturally appropriate and effective care transition beneficiary-centric approaches to ethnically diverse beneficiaries, and
- how other community and social supports and resources will be incorporated to enhance the beneficiaries’ post-hospitalization management outcomes.

Applicants are not expressly asked to address the role of family caregivers in care transitions. However, on their own initiative, applicants may include a role for family caregivers as part of the proposed care transition services.

CMS has emphasized that CCTP is a payment-for-services demonstration, not
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a grant program. Payment is limited to transitional care services delivered directly to high-risk beneficiaries. These services may not include otherwise-covered Medicare services, such as discharge planning. CMS will reimburse participants based on a fixed fee per discharge not exceeding $400, depending on the case-mix severity of the target population, intensity of services, and expected Medicare savings.10

Starting in April 2011, CMS began accepting applications on a rolling basis and will continue as long as funding permits.11 This program was authorized to spend up to $500 million over 5 years. However, in March 2013, under pressure to cut federal spending, Congress reduced funding for CCTP by $200 million. CMS has not indicated when funding might run out for this program. Successful applicants are awarded a 2-year participation agreement. Those that achieve targeted performance thresholds of reducing 30-day all-cause readmission rates and that demonstrate financial sustainability may be extended on an annual basis for the remainder of the program.

As of March 2013, CMS had awarded CCTP agreements to 102 sites that, combined, were expected to deliver transitional care services to about 700,000 beneficiaries in 40 states.12

Although a formal evaluation of CCTP is not required by statute, CMS has indicated that it will monitor the performance of hospitals and organizations on several measures, including readmission, mortality, patient satisfaction, the Care Transition Measure (a measure of the quality of care coordination during transitions13), and the Patient Activation Measure (a measure of engagement in self-care14). In addition, CMS will conduct an independent evaluation to assess the program’s cost and effectiveness at reducing readmissions, improving quality, and providing support for caregivers.15

Congress provided funding for CCTP through mandatory appropriations, making money automatically available from the Medicare Trust Funds, rather than through the less-predictable congressional appropriations process.16 Under the ACA, this program is not subject to budget neutrality requirements during the 5-year testing phase, and HHS has discretion to expand the program. However, HHS can exercise this discretion only if the program reduces Medicare spending without reducing quality. As a result, CMS will only consider CCTP applications that anticipate net savings. Although imposing a net savings requirement for participating organizations may limit the potential impact of this program on quality of care for high-risk beneficiaries with chronic conditions, this limitation is necessary for the continuation and expansion of this program.

Post-Discharge Transitional Care Management

Starting in January 2013, Medicare will pay for post-discharge Transitional Care Management (TCM) services following an inpatient admission for any beneficiary who meets specific coverage criteria established by CMS under new Medicare physician payment rules.17 CMS is implementing this initiative nationwide as part of the physician fee schedule. Targeted patients need not be at high risk of rough transition or readmission, as required by CCTP and suggested by studies.18 Discharge must have been from an inpatient facility, including an acute hospital, skilled nursing facility, long-term care hospital, or inpatient rehab facility; based on hospital outpatient observation status; or because of partial hospitalization for mental illness.
TCM services include communication with the patient and/or family caregiver within 2 days following discharge, and a face-to-face visit with a community physician or other qualified clinician within 7 to 14 days (or sooner, if medically necessary). In time, CMS hopes to eliminate the physician visit. TCM services include a wide range of important non-face-to-face services, such as reviewing the discharge summary, assessing the patient’s post-discharge needs, adjusting the plan of care, conducting medication reconciliation, educating the patient and/or family caregiver, coordinating care with other health care professionals, and assisting with arranging needed community services.

Under the new rules, providers may target the discharged patient and/or caregiver for TCM services of:

- Moderate complexity, including:
  1. communication (direct contact, telephone, and electronic) that must be initiated within 2 business days of discharge; 2) medical decision making of moderate complexity; and 3) a face-to-face visit within 14 days of discharge; or

- High complexity, including TCM services similar to those of moderate complexity except that 1) medical decision making must be of high complexity, and 2) a face-to-face visit must occur within 7 days of discharge.

TCM services may be performed by a physician or other qualified health professional, including nurse practitioner, physician assistant, clinical nurse specialist, or nurse mid-wife. A registered nurse may also perform certain non-face-to-face TCM services. CMS expects primary care physicians and other qualified health professionals to provide most TCM services but acknowledges that, in some cases, certain specialists, such as cardiologists and oncologists, will be in the best position to furnish these services.

Payment for TCM services covers 30 days following discharge, not the longer, 90-day window suggested by some studies. Separate billing for discharge management is also allowed but cannot be counted as the first TCM visit, as this would amount to double billing. Beneficiaries are subject to routine Part B cost-sharing requirements for TCM services.

**Medicare Hospital Readmission Reduction Program**

As an incentive to reduce hospital readmissions and improve transitional care, starting in October 2012, CMS began reducing Medicare payments by up to 1 percent (rising to 3 percent in FY 2015) for hospitals with excess all-cause 30-day readmissions for three conditions: heart attack, heart failure, and pneumonia. The program will be expanded to seven conditions in FY 2015.

In 2010, the national median 30-day readmission rate for heart attack was 20 percent, heart failure was 25 percent, and pneumonia was 18 percent. The hospital-specific readmission measure is based on 3 years of data and adjusted for case-mix so that hospitals that care for older, sicker patients are on a level playing field with hospitals that care for lower-risk patients. Hospital-specific readmission rates are made publicly available on the Medicare Hospital Compare website. According to CMS, approximately two-thirds of U.S. hospitals will receive penalties totaling about $280 million in FY 2013.

According to CMS, the goal of this program is to improve quality of care and reduce avoidable morbidity and mortality by encouraging hospitals to invest in interventions to reduce complications and smooth care transitions to the community through such initiatives as the Community-based Care Transitions Program described above.
Home Health Services for Caregivers of Alzheimer’s Patients

In limited geographic areas, Medicare covers the education and training of family caregivers for Alzheimer’s patients with behavioral disturbances.26 This benefit is offered as part of Medicare coverage of home health services, rather than as a demonstration program. As part of a unique beneficiary-centered care plan, family caregivers of these beneficiaries may receive skilled nursing education and training about how to simplify the patient’s environment to improve communication; reduce wandering; and maximize the chances for successfully performing activities of daily living, such as bathing, dressing, and eating.

These Medicare home health services are available only in the southeastern region under a Local Coverage Determination adopted by the regional Medicare contractor, Palmetto GBA, located in South Carolina. According to Palmetto’s Medical Director, the rationale for this policy is to 1) educate the medical community and the public regarding the role of behavioral and environmental interventions; and 2) address provider attitudes, beliefs, and behaviors (because not many health care providers know about teaching and training).27 Coverage requires 1) characterization of behavioral disturbances, 2) beneficiary-specific interventions, and 3) beneficiary-specific goals.

While this policy may provide much needed support for caregivers and improve care for beneficiaries, it may also reduce use of other Medicare services, such as hospital and skilled nursing facility care. However, data regarding the utilization and direct cost of this service to Medicare or its impact on beneficiaries, caregivers or use of other Medicare services have not been made publicly available.

Medicare Independence at Home Demonstration

The Medicare Independence at Home Demonstration28 is a 3-year demonstration program being conducted by the CMS Innovation Center, described below, to test a service delivery and shared-savings payment model using “house calls” to deliver primary care to beneficiaries with multiple chronic conditions. According to CMS, the goal of this demonstration is to work with the patient and family to develop a plan of care and treatment goals that will provide home-based primary care and coordinate care across settings to improve quality of care, quality of life, and patient outcomes, while reducing hospital days, nursing home days, and total Medicare costs.29

Starting in December 2011, CMS selected 18 primary care practices with experience delivering home-based care to chronically ill patients.30 These “mobile” interdisciplinary primary care teams are led by a physician or nurse practitioner and include physician assistants, pharmacists, social workers, and other staff. The target population is narrowly defined to include up to 10,000 fee-for-service Medicare beneficiaries who have 1) two or more chronic illnesses, 2) two or more functional dependencies, 3) at least one hospital admission, 4) used rehabilitation therapy services within the past year, and 5) high costs.31 This 3-year demonstration will receive mandatory appropriations of $5 million per year for 5 years.

Participating providers continue to bill for services and receive payment from Medicare under standard fee-for-service rules subject to beneficiary cost-sharing requirements. Participants bear risk for actual costs that exceed expected spending per beneficiary for Medicare Parts A and B combined, but excluding Part D. If actual costs are less than expected costs, participants that achieve minimum savings...
requirements ranging from 2 percent to 14 percent, depending on practice size, will be eligible to share 80 percent of savings that exceed 5 percent. CMS will retain the first 5 percent of savings.32

Although the Independence at Home Demonstration is ongoing as of 2013 and has not yet been evaluated, evaluation of a similar program, the Home-Based Primary Care Program, operated by the Department of Veterans Affairs (VA), found that it reduced VA costs by 24 percent and Medicare costs by 11 percent.33

Patient-Centered Medical Homes (Advanced Primary Care Practices)

CMS is participating in a multi-payer initiative to demonstrate the effectiveness of Patient-Centered Medical Homes, also referred to as Advanced Primary Care Practices. This 3-year demonstration, which started in 2011, uses a team approach to primary care to address the needs of high-risk patients with chronic conditions through care coordination, support for care transitions across settings, improved access, patient education, community support, health promotion, and disease prevention.34

In eight states, major payers, including Medicare, Medicaid, private insurers, and employer plans, are participating in this demonstration, which is expected to include more than 1,200 advanced primary care practices serving more than 900,000 Medicare beneficiaries. Although each state will determine eligibility criteria for participating providers, the typical advanced primary care practice includes primary care physicians, nurse practitioners, specialists, physician assistants, and other health professionals. In order to participate in the Medicare portion of this demonstration, beneficiaries must be covered by traditional fee-for-service Medicare and receive primary care from a participating practice.

Participating practices continue to bill for services and are paid by Medicare under standard fee-for-service rules subject to beneficiary cost-sharing requirements. Practices also receive payment for otherwise non-covered services, usually through a monthly fee for each participating beneficiary (typically less than $10 per month). Participating practices may also receive pay-for-performance incentives for meeting quality targets, shared savings if their cost per beneficiary is less than expected, and additional amounts for costs incurred to transform their practices into a medical home for such things as health information technology.

This demonstration is expected to be budget-neutral for Medicare over its 3-year course. However, CMS has authority to expand the implementation of medical homes nationwide if they reduce Medicare spending without reducing quality, or improve quality without increasing Medicare spending.35

CMS Innovation Center Initiatives—Testing Medicare Models for Chronic Care Coordination

Starting in 2011, an Innovation Center was created within CMS to test promising models of care delivery and payment reform, such as care coordination and transitional care models described above.36 Funding for the Innovation Center includes mandatory appropriations of $1 billion per year for 10 years. Some of the other demonstrations that are being designed and tested to improve care coordination and smooth transitions include the following:37

- Accountable Care Organizations designed to provide coordinated care and improve management of chronic conditions while lowering costs;
- Bundled payments for improved care of acute and post–acute care episodes;
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- Care Management for High Cost Beneficiaries to increase adherence to physician prescribed care, reduce unnecessary hospital stays and emergency room visits, and help beneficiaries avoid debilitating and costly complications;

- Geriatric assessments and comprehensive care plans to coordinate care for Medicare beneficiaries with chronic conditions; and

- Home health providers and interdisciplinary teams to provide chronic care management services to Medicare beneficiaries.

During the testing phase, Innovation Center demonstrations are not subject to budget neutrality requirements. Each model will be evaluated on spending and quality. HHS has discretion to expand any model—including implementation on a nationwide basis—that is expected to 1) reduce federal spending without reducing quality, or 2) improve quality without increasing federal spending.

Conclusion

CMS is testing a number of payment and delivery model reforms that have the potential to improve care coordination and transitional care for beneficiaries with chronic conditions. In limited instances, these initiatives may also provide support for family caregivers. To the extent that these initiatives succeed in reducing Medicare spending below expected levels without reducing quality of care, HHS has the authority to expand these initiatives.

Endnotes

1 Patient Protection and Affordable Care Act (ACA); PL 111-148.


3 ACA § 3026.

4 Medicare Community-Based Care Transitions Program Solicitation for Applications (CCTP SFA). Available at: http://innovation.cms.gov/initiatives/CCTP/.

5 For the complete list of high-readmission hospitals, see CMS website at: http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/CCTP_FourthQuartileHospbyState.pdf.


7 ACA § 3026.

8 Medicare Community-Based Care Transitions Program Solicitation for Applications.

9 Ibid.


11 75 Fed Reg 67751 (Nov 3, 2010); “Medicare Community-based Care Transitions Program Solicitation for Applications.” At: http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/CCTP_Solicitation.pdf. In July, 2012, CMS announced that it would stop accepting CCTP applications in September 2012. However, as of January 2013, CMS continued to accept CCTP applications until funding was no longer available.


13 The Care Transition Measure indicates whether the quality of a patient’s transitional experience (good, fair, or poor) shows a relationship between the quality of care coordination received by patients following discharge or a visit to a health care facility and the likelihood of a subsequent emergency room visit or


15 Op. Cit. CCTP SFA.

16 ACA § 3026.

17 77 Fed Reg 68891 (Nov 16, 2012).


19 High complexity medical decision-making requires that the patient is either seriously ill or the physician must review a significant amount of primary data.


22 ACA § 3025; CMS Readmissions Reduction Program. At: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html


26 Medicare Contractor for Home Health (Palmetto GBA), Local Coverage Determination (LCD) for Home Health Skilled Nursing Care-Teaching and Training: Alzheimer’s Disease and Behavioral Disturbances (L31532). At: http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LcdId=31532&ContrId=227&ver=11&ContrVer=1&CntrcrSelected=227*1&Cntrcr=227&name=Palmetto+GBA+(11004%2c+HHH+MAC)&DocStatus=Active&LCntrcr=227*1&bc=AgAACAAJAAAA&.

27 Feliciano, Harry, Senior Medical Director, Palmetto GBA; Personal Communication (Jan 25, 2013).

28 ACA § 3024.


31 Op. Cit. IAHDS.

32 Ibid.


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36 Affordable Care Act § 3021.