Medicare Tests Chronic Care Management Fee

Projects seek to strengthen the relationship between chronically ill patients and their doctors.

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

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Financial incentives and technology support for physicians are two “carrots” Medicare is testing to help improve chronic care disease for its beneficiaries.

Primary care groups are collaborating with health care contractors to test a model of care that supports the physician’s role in managing chronic disease.

The voluntary Medicare Chronic Care Improvement Program, a demonstration project created as part of the Medicare Modernization Act of 2003, is expected to reach approximately 180,000 fee-for-service Medicare beneficiaries with multiple chronic health conditions.

Not all the details have been worked out, but the American College of Physicians and other primary groups plan to work with two health care contractors “to find out how these models will work in the context of the project,” Robert Doherty, ACP’s senior vice president for governmental affairs and public policy, said in an interview.

Developed by Edward H. Wagner, M.D., an internist and epidemiologist, the chronic care model features an evidence-based team approach and physician incentives for improved care. It also emphasizes information technology and online, real-time clinical decision support.

Health Dialog Services Corp. will run the project in Pennsylvania, and McKesson Health Solutions was awarded a contract in Mississippi. Those companies were the only two that proposed the physician-guided, patient-centered model of care in their bids to Medicare, Mr. Doherty said.

Three physician groups—the ACP, the American Academy of Family Physicians, and the American Geriatrics Society—will collaborate with McKesson on its project. McKesson “is doing all the ground work on the project, but all three physician groups will serve as subcontractors,” Mary Frank, M.D., AAPF president, told FAMILY PRACTICE NEWS.

Sandee Wadhwa, M.D., vice president of government programs at McKesson, said the company “wanted to test a model that supports and enables the physician’s care plan and strengthens the relationship between chronically ill patients and their doctors.”

The McKesson test includes a chronic care management fee to recognize the time and effort involved in this initiative, Dr. Wadhwa said in an interview. “We are also placing additional community- and office-based support to improve adherence to physicians’ treatment plans,” he said. The project is expected to begin in June or September.

That CMS awarded the contracts is a sign the agency was willing to look at the model’s effectiveness, Mr. Doherty said.

Testing only parts of it, however, “won’t give the model the full evaluation that’s ultimately needed,” he added. For that reason, the ACP plans to submit a white paper to Congress, outlining a more ambitious request to test the model in its entirety in a separate demonstration project.

Most bidders in Medicare’s chronic care demonstration project are large health care organizations. “We believe there should be a larger demonstration, to take the components developed by Dr. Wagner and test their effectiveness in smaller physician practices,” Mr. Doherty said.

The ACP will be submitting the model along with a series of proposals that address broader payment issues for physicians. “Our sense is, we may need additional authority to test the model—that Congress should enact legislation to allow CMS to launch another demonstration project to allow full evaluation of the model,” Mr. Doherty said. The academy cited several studies from the Institute of Medicine, Rand Corp., and CMS, indicating that care for chronically ill patients was fragmented and costly because of a lack of coordination under fee-for-service. This makes the large-scale testing of a patient-centered chronic care model “crucial to the health system’s viability.”

Key elements of Dr. Wagner’s model include:

- Mobilizing community resources to meet patient needs—for example, encouraging patients to participate in effective community programs.
- Reorganizing the health care system to encourage open and systematic handling of errors and quality problems to improve care and providing incentives to improve quality of care.
- Empowering and preparing patients to manage their health and health care, emphasizing the patient’s personal role in managing their health.
- Ensuring the delivery of effective clinical care and self-management support, such as providing clinical case management services for complex patients and giving care that patients understand and that fits with their cultural and background.
- Promoting clinical care that is consistent with scientific evidence and patient preferences, including evidence-based guidelines into daily clinical practice.
- Organizing patient and population data to facilitate care, such as identifying subpopulations for proactive care, and sharing information with patients and providers to coordinate care.

Primary Care = Chronic Care

Primary care doctors have not been proactive in ensuring regular interactions with their chronically ill patients. At a health policy conference last November, he asserted that the care of the chronically ill is “not planned, and it’s dependent on the doctor, the doctor’s memory, and disorganized written records.”

Management of these patients usually relies on symptoms and lab results—not long-term disease control and prevention. “Most patients are receiving rushed admonitions to shape up, not counseling and supportive interventions that work,” said Dr. Wagner, who directs Improving Chronic Illness Care (ICIC), a national program of the Robert Wood Johnson Foundation.

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PPAC: New Drug Pricing System Needs Correction Mechanism

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

WASHINGTON — Physicians should be reimbursed retroactively for any payment miscalculations that occurred under Medicare’s new system to reimburse for in-office infusions, the Practicing Physicians Advisory Council recommended.

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