Medicare Tests Chronic Care Management Fee

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

BY JENNIFER SILVERMAN
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Financial incentives and technology support for physicians are two "carrots" Medicare is testing to help improve chronic disease care 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., AAFP president, told FAMILY PRACTICE NEWS.

Sandeep 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 full 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 AAFP in the meantime has decided not to wait for the Medicare project's outcome to begin using Dr. Wagner's model in physician practices.

"The academy decided a year ago that we would teach Dr. Wagner's model to our members through continuing medical education and lectures," Dr. Frank said. The AAFP is in the process of finalizing an educational tool kit to help physicians integrate the model into practice.

Management of chronic disease is just one element of the AAFP's new model of family medicine and part of its Future of Family Medicine project, Dr. Frank explained. Ultimately, the goal is to integrate patients into this model of care, so they can enhance their role as part of the care team, she said. ■

Primary Care = Chronic Care

Primary care doctors have not been proactive in ensuring regular interactions with their chronically ill patients, according to Dr. Wagner.

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 longer-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.

The ACP's white paper 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 central 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 backgrounds.
- ► Promoting clinical care that's consistent with scientific evidence and patient preferences, embedding 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.

PPAC: New Drug Pricing System Needs Correction Mechanism

BY JENNIFER SILVERMAN
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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.

The "average sales price" (ASP) is something federal regulators "are concocting, and they don't know how accurate it's going to be," said PPAC member Barbara L. McAneny, M.D., an oncologist from Albuquerque, N.M., who drew up the council's recommendation.

The Centers for Medicare and Medicaid Services should establish a correction factor for each quarter it updates pricing on the ASP, to prevent physicians from treating patients at a loss or being put in the position of denying treatment, she said. PPAC is an independent panel that advises CMS on physician payment issues.

The ASP was authorized by the Medicare Modernization Act of 2003, replacing the former system of overpayments for drugs and underpayments for their administration. The intent was to make fair payments for both services.

This year and next, Medicare will pay physicians the ASP plus 6%, although in 2006, physicians will have the option of obtaining the drugs directly from a supplier selected by Medicare through a competitive bidding process.

CMS officials told the panel that the agency would update pricing for the ASP on a quarterly basis. Dr. McAneny countered that this wouldn't allow for any mistakes in pricing made along the way.

"Suppose the ASP is set at $60 for a drug, but you can only purchase that drug for $100," she later said in an interview. This means physicians would be getting paid only $60 for that drug from January through April—and losing $40 every time they administer the drug.

CMS might be able to correct the price on April 1, but that doesn't compensate for the losses physicians incurred over the first quarter of the year, Dr. McAneny said. As a result, the agency may end up getting complaints from half the physicians in the country about the cost of a drug. By putting in a correction mechanism, the agency can make the change retroactive, she said.

A report from the Government Accountability Office indicated that physicians may not get shortchanged under the ASP. Medicare payments for cancer drugs may decline next year, but payments are actually expected to exceed physicians' costs by 6% on average, the GAO found. The American Society of Clinical Oncology responded that the study underreported some costs and the report's methodology was flawed.

"GAO has always said that everything's going to be fine" with the ASP, Dr. McAneny said. Nevertheless, "we need a plan B in case they're wrong."

The ASP replaces the average wholesale price, a number that drug makers had been giving to the government for each drug administered. Medicare in the past paid physicians 95% of the average wholesale price for in-office administration of a drug to a Medicare beneficiary; however, the physician was not paid an administration fee.

The ASP system comes with mixed benefits: Physicians now will get paid an administration fee but they won't be getting paid as much for the drugs themselves as they were under the average wholesale price system.

PPAC also requested that physicians be allowed Internet access to a list of drugs that CMS compiled by manufacturer to determine ASP. "This will be very helpful to the physician community—not just oncology—but for everybody who wants to purchase drugs … under the average selling price, and [to] know who they can purchase these drugs from," Dr. McAneny said. ■