Chronic Care Model to Be Tested in Pilot Project

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Financial incentives and technology support for physicians are two "carrots" Medicare is testing to help improve chronic disease care for 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 under the Medicare Modernization Act of 2003, is expected to reach about 180,000 fee-for-service Medicare beneficiaries with chronic health conditions such as complex diabetes or heart failure.

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

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

Health Dialog Services Corp. will run the project in Pennsylvania, and McKesson Health Solutions got the contract for 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.

The ACP, the American Academy of Family Physicians, and the American Geriatrics Society—will collaborate with McKesson. The company "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 this newspaper.

Sandeep Wadhwa, M.D., vice president of government programs at McKesson, said the firm "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." Slated to begin in June or September, the pilot test includes a chronic care management fee to recognize the time and effort involved in the initiative, he said. "We are also placing additional community- and office-based support" to improve adherence to physicians' treatment plans."

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, Mr. Doherty said. "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.

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. ■

Primary Care Has Room to Improve

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

Care of the chronically ill "is not planned, and it's dependent on the doctor, the doctor's memory, and disorganized written records," he said at a healthy policy meeting last November.

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.

The ACP white paper cited studies from the Institute of Medicine, Rand Corp., and CMS, showing that care for the chronically ill 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.

POLICY & PRACTICE

Portable Health Plans

Patients can take their health insurance coverage with them when they change or lose a job, under the final regulations that implement the last piece of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). According to a statement by the Health and Human Services Department, it is important that American workers, who often change jobs several times in the course of their lives are able to respond to the modern workplace without having to fear for their health insurance. The regulations allow greater portability and availability of group health coverage during a time of job transition, setting limits on preexisting condition exclusions that could be imposed, and requiring group health plans and insurance issuers to offer "special enrollment" to certain patients who lose eligibility for other group health coverage or health insurance, or to otherwise eligible new dependents. The regulation goes into effect for plan years starting on or after July 1.

Computer Entries Lead to Errors

Automation isn't necessarily a foolproof way to improve patient safety and reduce medical errors, a report from the U.S. Pharmacopeia (USP) found. Computer entry errors were the fourth leading cause of medication errors according to MEDMARX, USP's national medication error reporting system. These errors have steadily increased and represent about 12% of all MEDMARX records from 1999 through 2003. Performance deficits—where an otherwise qualified physician makes a mistake—were the most frequently reported cause of errors. Distractions were the leading contributing factor, accounting for almost 57% of errors associated with computer entry. The report provided an analysis of 235,159 medication errors voluntarily reported by 570 hospitals and health care facilities nationwide.

Reduced Benefits for Retirees

Businesses are asking retirees to pay more for their health coverage as they struggle to control rising costs, the Kaiser Family Foundation reported. In the past year, 79% of firms increased their retirees' contributions for premiums, and 85% expect to do so in the coming year. In addition, 8% of employers surveyed eliminated subsidized health benefits for future retirees in 2004. For 2005, 11% said they are likely to terminate coverage for future retirees. However, 58% said they were likely to continue offering prescription drug benefits and accept the tax-free subsidy created by the new Medicare law. The survey included responses from 333 large private-sector firms that offer retiree health benefits.

Spending for Power Wheelchairs

Federal safeguards did not go far enough to curb Medicare's spending growth for power wheelchairs, the Government Accountability Office found. Medicare spending for the wheelchairs rose more than fourfold from 1999 to 2003, raising concerns that some of the payments may have been improper. Following the indictment of several power wheelchair suppliers in Texas who fraudulently billed Medicare, GAO was asked to examine earlier steps taken by the Centers for Medicare and Medicaid Services to respond to improper payments. CMS' contractors started informing the agency in 1997 about escalating spending for wheelchairs, and some started taking steps to respond to improper payments, yet the agency didn't assume an active role until 2003. Since then, CMS has worked to prevent fraudulent suppliers from entering the Medicare program, but it has not revised its form to collect better information for power wheelchair claims reviews, the GAO found.

Medicaid's Benefits to the States

An annual fiscal survey of the states failed to examine the benefit of Medicaid to the states' economies, according to Families USA. The report released by the National Governors Association (NGA) and the National Association of State Budget Officers indicated that state spending for Medicaid, including federal funds, has surpassed state spending on primary and secondary education. Yet, in examining state general fund expenditures, states spent more than twice as much on education than they did on Medicaid. "When analyzing the NGA survey's findings on Medicaid, it is important to count the economic benefit that Medicaid holds for states," said Families USA Executive Director Ron Pollack. "A recent Families USA study found that on average every $1 million invested in Medicaid by states generates nearly 34 jobs, $1.2 million in wages, and $3.3 million in business activity," he added. During fiscal 2005, Medicaid is estimated to grow as much as 12% due in part to expiring federal fiscal relief. Long-term growth is expected to be 8%-9%, well above expected state revenue growth, the NGA's report said.

Global Smallpox Stockpile

The United States has pledged 20 million doses of smallpox vaccine toward the global stockpile managed by the World Health Organization. The vaccine doses will physically remain in the U.S. Strategic National Stockpile, but will be available for use by the WHO in the event of an emergency. The global stockpile is designed to help those countries that have no smallpox vaccine and are not prepared to respond to an outbreak of the disease. The global stockpile will only be used if at least one case of smallpox is confirmed in the human population. U.S. government officials have been urging the creation of a WHO Smallpox Vaccine Bank, which would create a physical stockpile of vaccine in Geneva and a virtual global stockpile of pledged vaccine stocks around the world.

—Jennifer Silverman