Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services

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October 2011

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Exhibits

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I. Introduction

People with chronic conditions are at center stage in efforts to transform health care delivery from encouraging more—and more-costly—services to promoting prevention, primary care, and care coordination. Fragmentation and lack of coordination in health care services are increasingly regarded as not only a source of frustration for patients, but also as both impediments to quality care and drivers of health care costs. The Affordable Care Act accordingly charges Medicare with payment and delivery reforms to improve care and slow cost growth not only for its beneficiaries, but to jumpstart and influence system-wide change.

But not widely recognized is that many of the most expensive Medicare beneficiaries—and the people for whom better care, more efficiently provided, will generate perhaps the most significant savings—are people whose illness creates the need for long-term services and supports (that is, help with routine activities of life, like bathing and preparing meals) as well as medical care. The 15% of Medicare beneficiaries who have both chronic illness and long-term care needs (as indicated by functional limitations in routine activities) experience disproportionately high Medicare spending and account for about one-third of Medicare's total spending. Medicare's spending for beneficiaries with both chronic conditions and functional limitations averaged about $15,800 per person in 2006, twice the average amount for Medicare beneficiaries with 3 or more chronic conditions but without functional limitations ($7,900).

The purpose of this policy brief is to demonstrate that innovation in care delivery for this costly and vulnerable population merits top priority in improving quality of care and controlling health care costs. Our first goal is to demonstrate why, in targeting effective delivery reform initiatives, policymakers and providers must look beyond the presence of chronic conditions, even multiple chronic conditions, to the presence of long-term services and supports needs; and, equally important, look beyond "dual eligibles"—people enrolled in both Medicare and Medicaid—to the even larger number of Medicare beneficiaries with long-term services and supports needs who are not eligible for Medicaid.

Our second goal is to document the feasibility and importance of coordinating care across the full range of services, encompassing long-term care as well as medical care for people who

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need both, by looking at examples of promising approaches. Although Medicare does not pay for long-term care and only dual eligibles receive Medicaid (which does), helping patients and families recognize and do their best to address personal assistance needs can help prevent unnecessary and costly medical care. An individual who needs, but doesn't get, help managing multiple medications, for example, is bound to experience preventable and costly episodes of illness. Similarly, a person who has difficulty walking and does not receive adequate assistance may not keep important appointments with physicians and physical therapists. Although cross-the-spectrum coordination is not widespread, examples of delivery models that include this type of coordination as part of primary care provide significant lessons on which future delivery reform can build.

Our third objective is to show how Medicare can promote better, more efficient care—by making this high-cost population and coordination across the full range of services they require part and parcel of payment and delivery reform. Through its authority to promote innovation, as authorized by the Affordable Care Act, the Centers for Medicare and Medicaid Services are setting priorities for the nation's providers and for private insurers. Given the scope of their costs and their needs, people with chronic conditions and functional limitations must move to the top of the list. The Centers for Medicare and Medicaid Services should therefore use their authority to launch a Medicare payment and delivery reform pilot to promote provider initiatives that:

- Focus on people who need long-term services and supports
- Coordinate services across the continuum to address their long-term services and supports needs along with their medical needs, and
- Work, in general, for all Medicare beneficiaries with long-term care needs, regardless of income or Medicaid eligibility.

To encourage widespread adoption of these initiatives, the pilot should be designed to accommodate the varied size and capacity of primary care physician practices; improve upon, but not replace, the fee-for-service payment system; and facilitate Medicaid participation for dual eligibles.

In sum, by highlighting the significance of functional limitations in identifying high-cost Medicare beneficiaries, the promise of delivery strategies that coordinate care across the full range of services (including long-term services and supports as well as medical care) to better serve these beneficiaries, and the role Medicare can play in encouraging providers to pursue these strategies, this policy brief makes the case for incorporating comprehensive care coordination for the people who need long-term services and supports into payment and delivery reform.

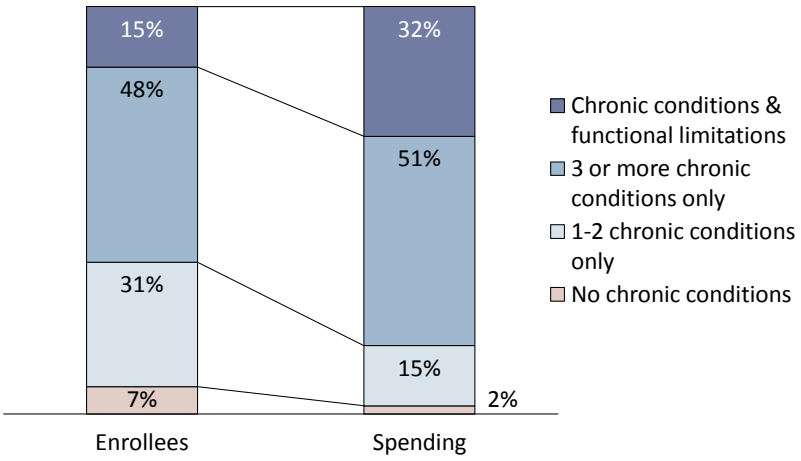
II. Medicare Beneficiaries with Chronic Conditions and Functional Limitations

Calls for better care coordination in Medicare typically focus on people whose chronic conditions generate complex medical needs and disproportionately high spending. Less well recognized is that for many people with chronic conditions, complex medical needs are accompanied by the need for assistance from others with the routine activities of life—that is, by a need for long-term services and supports. Long-term services and supports—also called long-term care—consist primarily of personal assistance with routine activities (such as bathing, dressing, preparing meals, and managing medications) and include both the unpaid assistance provided by relatives and friends and the paid services people receive in their homes, or in nursing homes, assisted living facilities, and other settings.

With rare exceptions analyses have not explored the implications of a combination of needs—complex and basic—for health care spending.[1] The impact is substantial: the 15% of Medicare enrollees with chronic conditions and functional limitations (that is, a need for long-term services and supports) account for one-third of Medicare spending (see **Figure 1**). (For definitions and data source, see **Box 1**.) In comparison, enrollees with substantial chronic illness—as indicated by the presence of 3 or more chronic conditions—represent roughly equal shares of the Medicare population and Medicare spending. That means it is the high cost associated with enrollees with the combination of chronic illness and functional limitations—and not the cost of those with multiple chronic conditions alone—that drives the disproportionate share of Medicare spending associated with enrollees with multiple chronic conditions.

Figure 1
The 15% of Medicare enrollees who have chronic conditions and functional limitations account for 32% of Medicare spending

Distribution of Medicare enrollees and spending, by groups of enrollees



Source: Avalere Health, LLC analysis of the 2006 Medicare Current Beneficiary Survey, Cost and Use file.
For definitions and sample size, see box titled "About the Data Analysis."

For a comparison group of enrollees who have substantial chronic illness without functional limitations, we focus on enrollees with 3 or more chronic conditions (instead of those with any number of conditions). This defines a more meaningful comparison group for two reasons. First, since the overwhelming majority of Medicare enrollees (over 90%) have at least one chronic condition, that criterion alone does not provide a particularly helpful comparison group. Second, the group with 3 or more chronic conditions is roughly similar to the group with chronic conditions and functional limitations in terms of number of chronic conditions—for example, people with 5 or more chronic conditions represent about 35% and 40% of each group, respectively.

Box 1

About the Data Analysis

To develop the findings presented here, we collaborated with colleagues at Avalere Health on an extension of an analysis conducted by Avalere of data from the Medicare Current Beneficiary Survey, Cost and Use file for 2006, the most recent year available at the time.

In the analysis, we considered individuals to have functional limitations (and therefore to need long-term services and supports) when they receive hands-on or standby assistance from another person with at least 1 of 5 activities of daily living or ADLs (bathing, dressing, eating, transferring from bed or chair, and using the toilet) or at least 3 of 5 instrumental activities of daily living or IADLs (light housework, managing medications, managing money, preparing meals, and using the telephone). For people without ADL need, we chose the criterion of needing assistance with 3 or more IADLs to approximate people with a moderate level of need due, for example, to cognitive impairment.

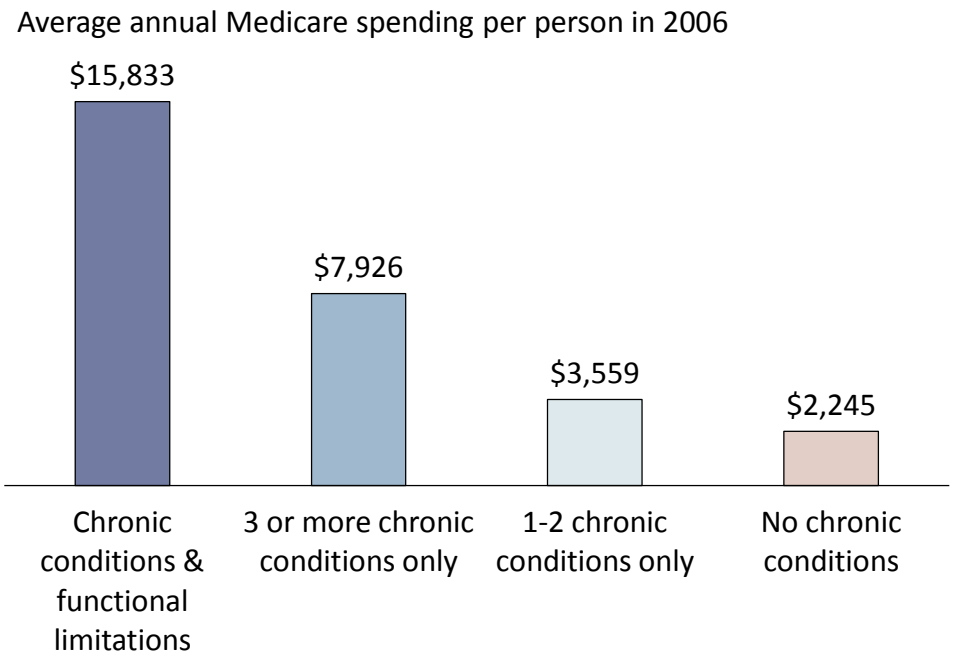
Individuals were considered to have chronic conditions when they indicated that they had ever been diagnosed with any of the following conditions: arthritis, Alzheimer's Disease, broken hip, cancer (excluding skin), congestive heart failure, depression, diabetes, hypertension, mental illnesses (excluding depression), myocardial infarction, osteoporosis, Parkinson's Disease, pulmonary diseases (such as emphysema, asthma, and Chronic Obstructive Pulmonary Disease), stroke, and other heart conditions. The findings presented in the figures exclude Medicare beneficiaries with functional limitations and no chronic conditions; they represent just under 0.5% of all Medicare beneficiaries.

The analysis is based on Medicare beneficiaries enrolled in the traditional, fee-for service Medicare program and therefore excludes beneficiaries enrolled in Medicare Advantage plans. The analysis also excludes individuals who died during the year; sensitivity analysis indicated that the main findings and patterns in the results are not affected by this exclusion. If decedents were included, specific estimates would change by relatively small amounts. The unweighted sample size in the analysis was 9,202, which represents an estimated national total of 33.7 million Medicare beneficiaries enrolled in the traditional Medicare program in 2006. A related set of *Data Briefs* produced by Avalere and The SCAN Foundation are available at http://www.thescanfoundation.org/sections/foundation-publications?tsearch=52.

That it is beneficiaries who have functional limitations in conjunction with chronic illness, not chronic illness alone, that explain high spending is apparent from the comparison of average per beneficiary spending in **Figure 2.** Average Medicare spending for chronically ill beneficiaries with functional limitations is twice as high as for beneficiaries with 3 or more chronic conditions and no functional limitations—about $15,800 compared with $7,900 in 2006. This level is more than four times the average spending for enrollees with 1 or 2 chronic conditions and no functional limitations ($3,600 in 2006). While about one-fourth of Medicare beneficiaries with chronic conditions and functional limitations reside in nursing homes, the majority do not—and for both groups, Medicare spending is significantly higher than for beneficiaries with 3 or more chronic conditions and no functional limitations.[2]

Figure 2

Average spending is nearly twice as much for enrollees with chronic conditions and functional limitations as for those with 3 or more chronic conditions only

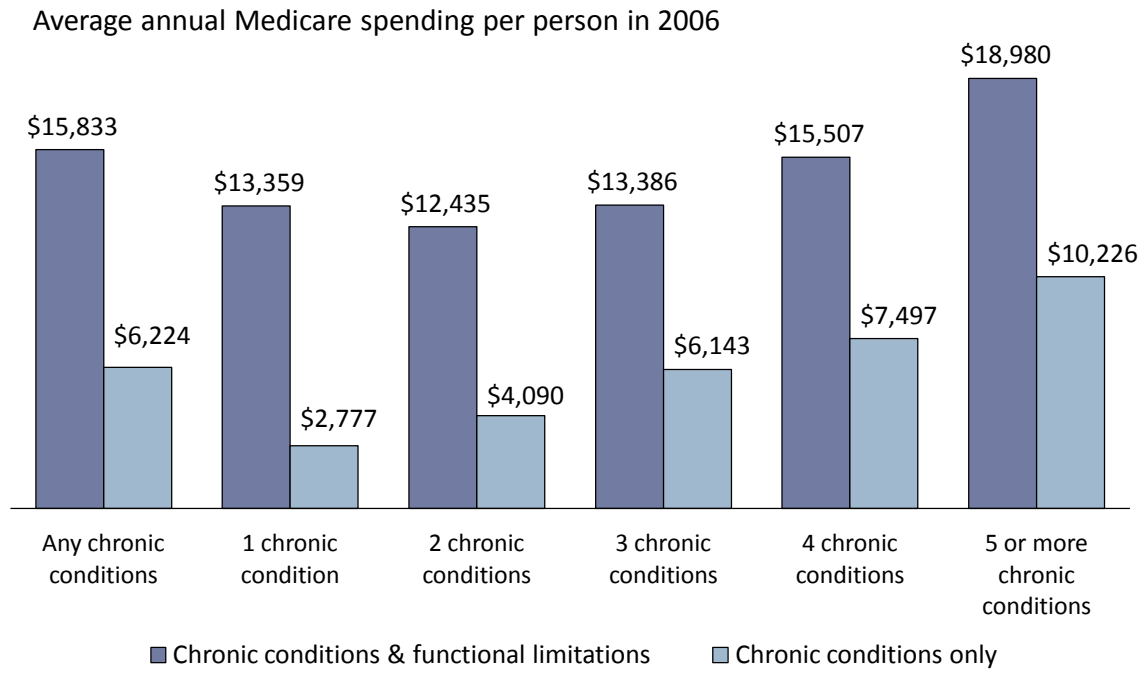


Source: Avalere Health, LLC analysis of the 2006 Medicare Current Beneficiary Survey, Cost and Use file.

The pattern of higher spending for chronically ill people with limitations than for chronically ill people without holds true no matter what the number of chronic conditions (see **Figure 3**). Among enrollees with chronic conditions only (that is, without functional limitations), average annual spending in 2006 ranged from $2,800 (for people with 1 chronic condition) to $10,200 (for those with 5 or more chronic conditions). In comparison, the amount for those with functional limitations ranged from about $13,000 for those with 1 to 3 chronic conditions to nearly $19,000 for those with 5 or more chronic conditions—about (or more than) twice as high as those without functional limitations at every level of chronic illness. Indeed, average spending for beneficiaries with 5 or more chronic conditions and without functional limitations ($10,200) was lower than average spending for beneficiaries with only one chronic condition who also have functional limitations (about $13,400).

Figure 3

Medicare enrollees with chronic conditions and functional limitations have higher spending per person than enrollees with chronic conditions only

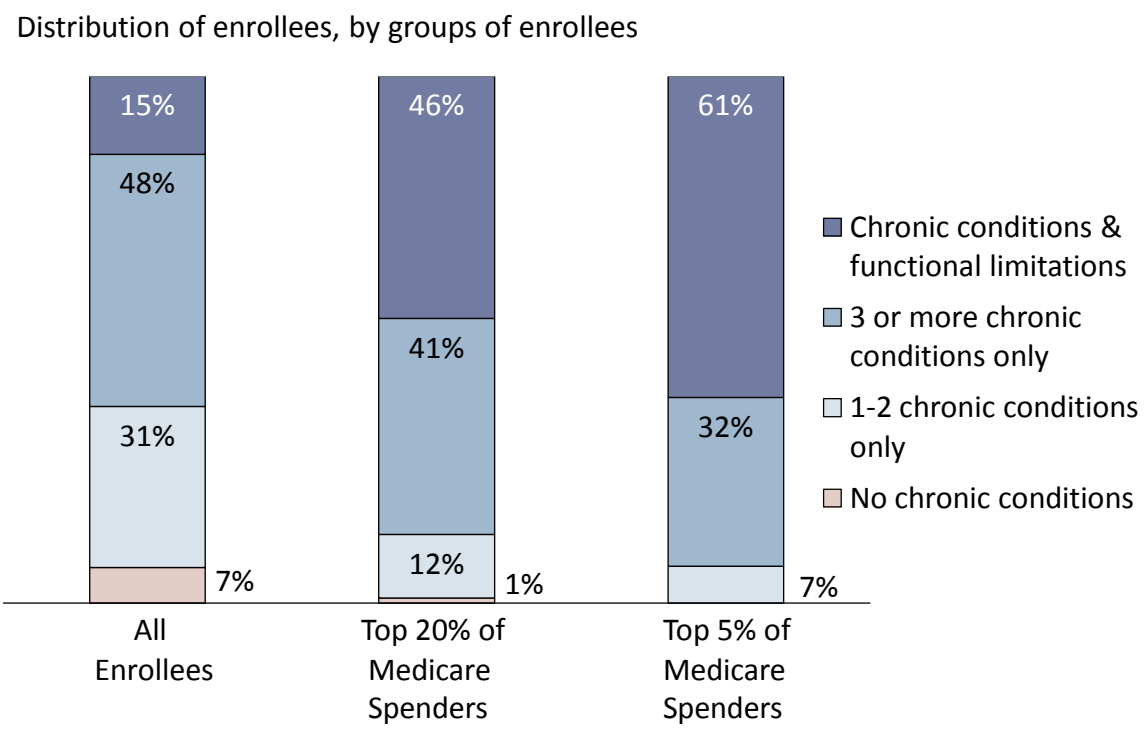


Source: Avalere Health, LLC analysis of the 2006 Medicare Current Beneficiary Survey, Cost and Use file.

Not surprisingly, beneficiaries with long-term care needs rank among Medicare's highest spenders. Nearly one out of every two beneficiaries in the top 20% of Medicare spending have functional limitations as well as chronic conditions (see **Figure 4**). Among Medicare's top 5% of spenders, the proportion is even higher. Three out of five of these highest-cost Medicare beneficiaries are chronically ill people who need long-term care.

Figure 4

Among Medicare enrollees in the top spending quintile, nearly half have chronic conditions and functional limitations



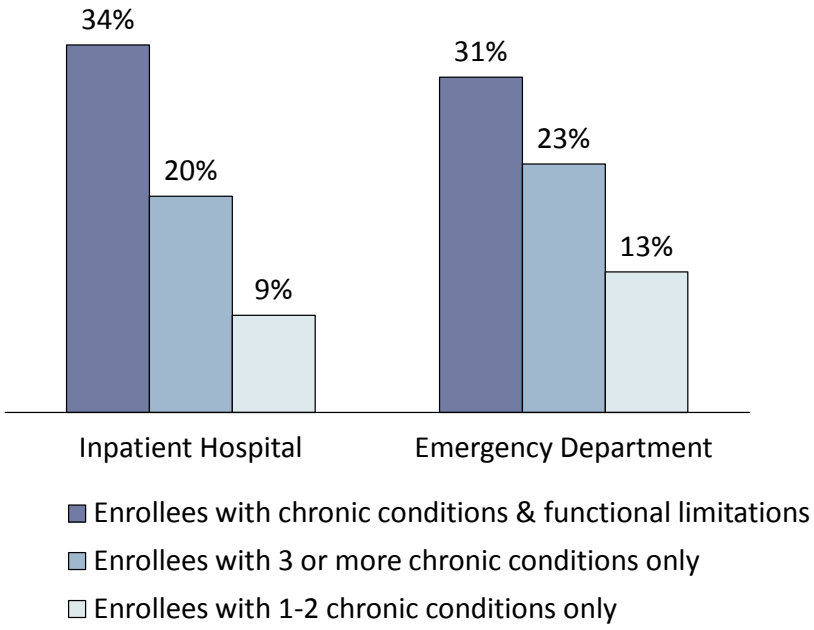
Source: Avalere Health, LLC analysis of the 2006 Medicare Current Beneficiary Survey, Cost and Use file.

As shown in **Figure 5,** enrollees with the combination of chronic conditions and long-term care needs are far more likely than other beneficiaries to use both hospital inpatient and emergency department services. One-third had hospital stays in 2006, compared with 20% of enrollees with 3 or more chronic conditions without functional limitations and 9% of enrollees with 1-2 chronic conditions only.

Figure 5

Enrollees with chronic conditions and functional limitations are more likely to use hospital inpatient and emergency department services

Percent of enrollees using each type of service during the year



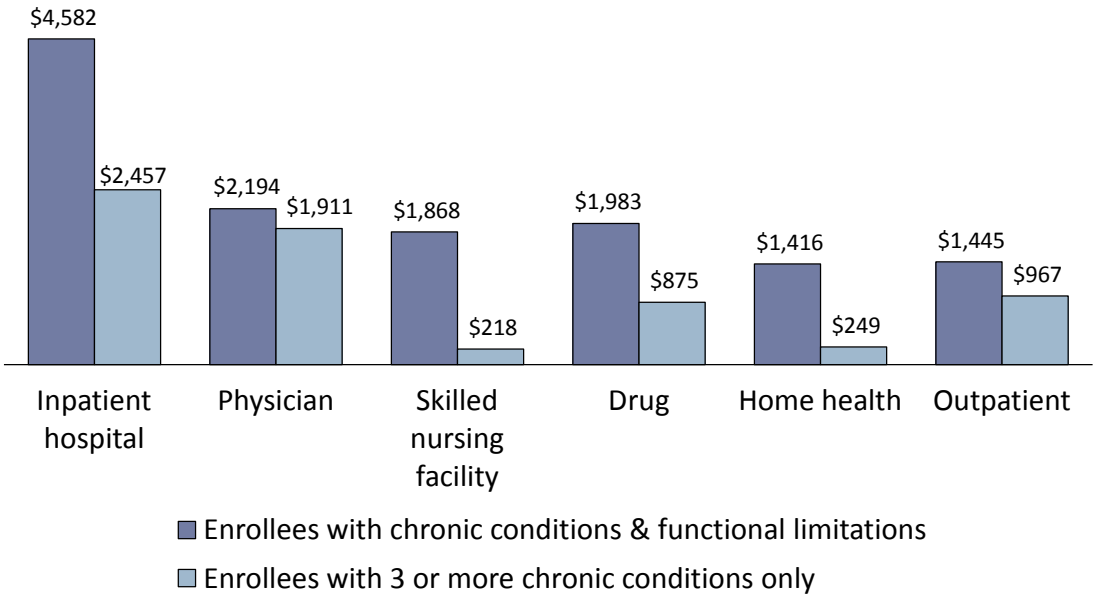
Source: Avalere Health, LLC analysis of the 2006 Medicare Current Beneficiary Survey, Cost and Use file.

As a result, average spending per person on hospital services was nearly double for enrollees with chronic conditions and functional limitations, compared to those with 3 or more chronic conditions only—$4,600 compared with $2,500 in 2006 (see **Figure 6**). The difference in hospital spending is the largest source of the overall difference in average spending between these groups, though average spending for all service types shown in Figure 6 is higher for the group with chronic conditions and functional limitations.

Figure 6

Higher hospital spending is the largest source of higher spending for enrollees with chronic conditions and functional limitations

Average annual Medicare spending per person for selected types of services



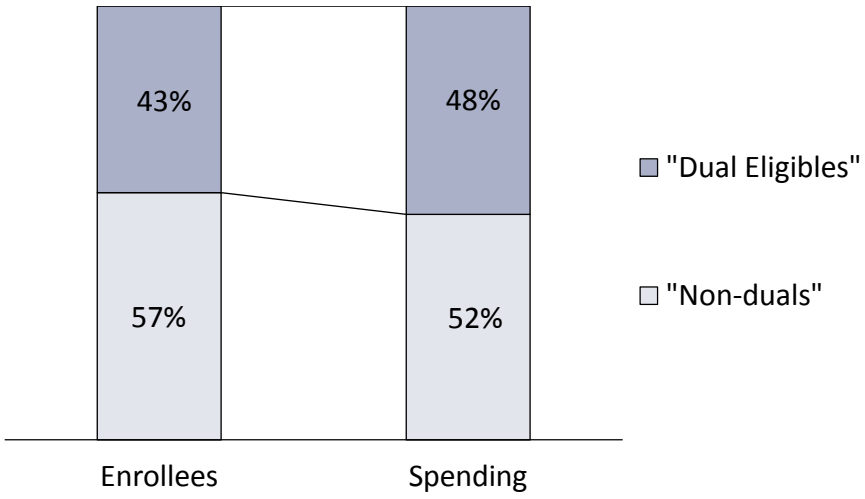
Source: Avalere Health, LLC analysis of the 2006 Medicare Current Beneficiary Survey, Cost and Use file.

Among Medicare enrollees with chronic conditions and functional limitations, less than half (43%) are dual eligibles, who account for slightly less than half (48%) of total spending on this group (see **Figure 7**). Spending patterns for these Medicare enrollees with Medicaid (dual eligibles) and those without ("non-duals") are therefore similar. That fact underscores the importance of addressing the full continuum of needs for all Medicare enrollees with chronic conditions and functional limitations, whether or not they are enrolled in Medicaid (dual eligibles).

Figure 7

Fewer than half of Medicare enrollees with chronic conditions and functional limitations are dually-eligible for Medicare and Medicaid

Distribution of Medicare enrollees with chronic conditions and functional limitations and their Medicare spending, by dual eligibility



Source: Avalere Health, LLC analysis of the 2006 Medicare Current Beneficiary Survey, Cost and Use file.

III. What Types of Promising Models Coordinate Across the Full Continuum of Care?

A number of programs to improve care coordination have been tested in recent years, and others are currently underway or being developed. A common feature of these programs is reliance on care coordinators and other services not covered under Medicare fee-for-service rules. Programs vary widely in design, target populations, and goals. So far, most private and public efforts at improving care coordination concentrate on medical care and do not extend coordination to long-term services and supports.[3] Nonetheless, examples of innovative programs that coordinate across the full spectrum of care exist. These examples offer insights into how this type of coordination can be delivered and experiences on which future efforts can build.

In this section, we describe six promising models. We selected these models because they:

- Include coordination of long-term services and supports, as part of comprehensive primary care
- Illustrate different approaches to organization and operation, and
- Show potential for improving the quality of care and efficiency of service, based on research evidence.

We also focused on models that can be adopted in a fee-for-service payment context, although we included one Medicare Advantage plan, paid on a capitation basis, to illustrate its approach to coordination. Among the models are two that were developed and evaluated in Medicare demonstrations—one in the Medicare Coordinated Care Demonstration and the other in the Medicare Care Management for High-Cost Beneficiaries Demonstration. We present these models as promising examples that offer a foundation for further development—not as a complete set of all initiatives. Other promising models not discussed here include the long-standing Program of All-Inclusive Care for the Elderly (PACE) and newer innovations such as the Vermont Blueprint for Health.[4]

Key elements of all the models include the following:

- A core of comprehensive primary medical care
- Assessment of patients' long-term service and support needs, including caregiver assessment
- Coordination of long-term care as well as medical care (same person or team involved in coordinating both)
- Ongoing collaboration between care coordinators and primary care physicians
- An ongoing relationship between care coordinators and patients (and family)
- Particular attention to supporting patients during transitions between care settings, and
- Commitment to "person-centered" care which takes into consideration the preferences of patients and entails collaboration of providers and patients.

Because the models described here include services that Medicare does not typically pay for—such as the time spent by care coordinators and by members of the multi-disciplinary team who support them—these models require payment sources for these services. Five of the examples described have received support for coordination services through research projects (some in Medicare demonstrations, some private). The sixth example is a managed care plan receiving capitation payments from Medicare and Medicaid that pay for a comprehensive set of medical and long-term care services including coordination activities.

Finally, in considering these models, it is important to note that the circumstances facing "dual eligibles" with chronic conditions and long-term care needs and the providers that serve them are different from those facing other Medicare beneficiaries with similar conditions and needs. Dual eligibles receive Medicaid support for long-term services and supports (though what they can get varies immensely depending on where they live). Medicare beneficiaries who are not eligible for Medicaid do not and financing for those services will mostly need to be paid for out-of-pocket. Recognizing this difference between these groups, our interest centers on how to coordinate services for people with long-term services and supports needs, whether or not they are "duals"—that is, with or without explicit financing for long-term services and supports. The models we explore, we believe, can and should work for both populations**.**

The following six delivery arrangements use two distinct approaches to how coordination is organized (that is, to who does the coordinating and where they are located): within the primary care physician practice or outside the primary care practice. Using this distinction helps in thinking about how Medicare can develop initiatives to reach the broadest possible range of primary care providers. The similarities as well as some of the differences in these six programs are summarized in **Table 1**.

Care coordinators located within primary care physician practices

Guided Care, Geriatric Resources for Assessment and Care of Elders (GRACE), Massachusetts General's Care Management Program, and the Commonwealth Care Alliance are prime examples of delivery models that place care coordinators in physician practices to enhance primary care to address the full range of patient needs. Alongside this critical common feature are some significant differences in what coordination entails, who does it, and for what kinds of patients.

Guided Care, developed by researchers at Johns Hopkins University, is an interdisciplinary delivery model that relies on a specially-trained registered nurse, employed by a primary care practice (of any size) to manage and coordinate care for its patients—specifically, older patients with complex health care needs and high expected service use.[5] Each nurse has a caseload of about 55 to 60 patients and works with 2 to 5 physicians.[6] In a pilot program testing Guided Care, the cost of employing the nurses averaged approximately $145 per patient per month.[7]

Table 1. Overview of Selected Models of Comprehensive Primary Care that Coordinate Across the Continuum of Care

	Guided Care	GRACE	Massachusetts General Hospital	Commonwealth Care Alliance (CCA)	Health Quality Partners (HQP)	Community Care of North Carolina
Approach	Care coordinators located within primary care physician practices				Care coordinators located outside primary care physician practices	
Target Population	Originally age 65+ with expected high service use. Expanded to other populations with complex needs.	Originally, age 65+ with income below 200% of federal poverty level. Expanded to other populations with complex needs.	Medicare fee-for service enrollees, all ages, with high severity of disease.	Medicaid enrollees with complex medical needs. In Senior Care Options program: age 65+ with Medicaid and complex needs (most are dually-eligible).	Originally, age 65+ with one or more specified conditions. Currently, age 65+ and higher-risk (selected conditions and hospital stay in past year).	Historically Medicaid (non-Medicare) enrollees. In new demonstration: dually-eligible starting in 2010, Medicare-only starting in 2012.
Organizational/ Service Base	Primary care practices.	Primary care practice affiliated with a large health care system.	Primary care practices affiliated with a large health care system.	Physician practices contracting with health plan (CCA) that receives capitated payments for delivery of medical and long-term care services.	Non-profit health quality program.	14 regional, non-profit community networks.
Coordination responsibility	Registered nurse, employed by the primary care physician, coordinates care for 55-60 patients.	Support team (nurse practitioner and social worker) delivers and coordinates care for about 125 patients with support from interdisciplinary geriatrics team.	Case manager (registered nurse), located in primary care practice, coordinates care for 180-220 patients with support from program's interdisciplinary team.	Nurse practitioner located in physician practice, delivers and coordinates care for about 45 patients, leads interdisciplinary team; can call in other professionals as needed.	Care manager (registered nurse), based at HQP, coordinates care for about 80 patients; also leads preventive health group activities such as gait and balance training.	Care coordinator (registered nurse, social worker, or other) based at a network. For "aged, blind, disabled" category, caseload of 1500-3500 of which 5%-10% require coordination at a time.
Coordination activities for long-term services and supports	Patient and caregiver assessment; caregiver education and support; referrals to services.	Patient and caregiver assessment; assistance linking to services provided by support team (with support from community resource specialist in geriatrics team).	Assessment; assistance linking to services provided by case manager and community resource specialist (in program's interdisciplinary team).	Assessment; integrated delivery of continuum of services coordinated by nurse practitioner.	Assessment; long-term care planning and referrals; assistance in arranging needed services and services.	Referrals to services.
Status	Tested in research trial in 8 primary care physician practices in 2006-2009. Ongoing in some study sites and in new organizations.	Tested in research trial in 2002-2006. Ongoing in study site and in new organizations.	Tested in the Medicare Care Management for High-Cost Beneficiaries Demonstration in 2006-2009; demonstration extended to 2012.	Ongoing; serving dual-eligibles as a Medicare Advantage Special Needs Plan that also contracts with the state Medicaid program.	Tested in the Medicare Coordinated Care Demonstration in 2002-2008; demonstration extended to 2013. Also developing a program in a new site.	Ongoing for Medicaid (non-Medicare) enrollees. Testing in the Medicare Health Care Quality Demonstration (currently enrolling duals; adding Medicare-only in 2012).

The Guided Care nurse's responsibilities include patient and caregiver assessment, care planning, monitoring the patient's conditions, supporting patient self-management of chronic conditions, and coordinating care among providers and during transitions between care sites (such as hospital to home). The nurse contacts each patient once per month in person or, more often, by phone.

The nurse's specific role in coordinating long-term services and supports includes: patient assessment; caregiver assessment, education, and support; and assisting patients and families in connecting with long-term services and supports they may need. In general, the nurse's role is to help individuals and families identify needs and options, and to encourage them to arrange for the services they may need. However, a nurse may take a more direct role in arranging services when individuals and their caregivers are unable to do so themselves. One study estimated that Guided Care nurses spend about 10% of their time in a typical week educating and supporting caregivers, and an additional 5% assisting patients and families in obtaining community resources.[8]

Guided Care was tested in a pilot program involving 14 primary care teams located in 8 primary care practices. Studies have found positive results on quality of care and satisfaction among patients, caregivers, and physicians.[9] A recent study, based on 20 months of experience, found that service use was lower for patients in Guided Care, compared with a control group, although statistical significance was not attained for most results.[10] Given the factors that may have contributed to the lack of significant effects—including a relatively limited sample size, recognition that teams are still learning how to manage care effectively, and possible need for a longer time frame to see full effects on patients' health—the results are sufficiently encouraging to suggest that further exploration of this approach would be worthwhile.

GRACE (Geriatric Resources for Assessment and Care of Elders), like Guided Care, is an interdisciplinary delivery model, but it involves a different patient population, team structure, and setting. As originally tested, GRACE focuses on low-income seniors (with income less than 200% of the federal poverty level), many of whom have chronic illness and high health care costs.[11] Care coordination is provided by a two-person support team consisting of a nurse practitioner and a social worker who are employed by the primary care practice and collaborate with the patient's primary care physician. In addition, the support team and primary care physician rely for coordination on a geriatrics interdisciplinary team consisting of a geriatrician, pharmacist, mental health social worker, and community resource specialist. Unlike Guided Care, which is designed for physician practices of varying sizes, GRACE was designed to be tested by a large primary care practice (Indiana University Medical Group-Primary Care) affiliated with a large healthcare system (Wishard Health Services in Indianapolis, Indiana), for which the members of the geriatrics team work. Currently, GRACE is underway or under development in other sites with differing populations, including a program in Indiana to coordinate care for dually-eligible seniors with functional limitations who receive long-term services and supports though the Medicaid home and community-based services waiver.[12] The description that follows is for GRACE as originally tested in a controlled research study.

Each support team manages care for about 125 patients. For each patient, the support team conducts an initial comprehensive, in-home assessment, which includes several elements relevant to assessing long-term services and supports needs, such as functional assessment, review of social supports, and a home safety evaluation.[13] The support team presents the assessment to the geriatrics team and together they generate an individualized care plan guided by a set of program-specified protocols for common geriatric conditions (such as health maintenance, medication management, difficulty walking/falls, malnutrition/weight loss, and "caregiver burden"). The support team reviews the care plan with the primary care physician and makes modifications as needed. The support team is responsible for implementing the care plan through at least one in-home visit, at least monthly contacts (over the telephone or in-person), and an in-home meeting after an emergency room visit or hospital stay. The geriatrics team reviews the patient's status and care plan at scheduled intervals and if the patient has significant change in health status, a hospital stay, or an emergency department visit. The staff salaries and benefits and other costs of the GRACE program, as tested in 2002-2006, averaged about $105 per patient per month.[14]

GRACE's objective is to improve coordination and access to services across the full range of a patient's needs and the full continuum of care. The support team assists patients in linking to community-based long-term services and supports, including locating and arranging services, and helping patients apply for programs for which they may be eligible. When a GRACE patient is eligible for Medicaid home and community-based services, the support team works with the Medicaid case manager to coordinate care.

Results from a two-year study period found that people enrolled in GRACE, compared with a control group, were more likely to receive evidence-based interventions, and experienced improved health status and fewer emergency department visits.[15] In addition, among the subset of patients considered at higher risk of hospitalization, patients enrolled in GRACE experienced fewer hospital stays in the second year of the program than patients in the control group.

An analysis of costs concluded that for higher risk patients, GRACE was cost-neutral during the first two years—with lower hospital costs offsetting higher spending for primary and chronic care and cost of the GRACE program—and cost-saving in the third year because of continued lower hospital costs.[16]

Massachusetts General Hospital and Massachusetts General Physicians Organization Care Management Program is another program in which nurse care managers are co-located with primary care physicians. The program is being tested in the Medicare Care Management for High-Cost Beneficiaries demonstration.[17] The program involves Medicare enrollees identified as high-cost based on prior Medicare spending and having a high level of disease severity. Like GRACE, Massachusetts General's Care Management Program is designed for a large physician organization affiliated with a large healthcare system. This context enables the program to draw upon the developed infrastructure, such as electronic medical records, and availability of affiliated professionals.

In Massachusetts General's Care Management Program, case managers (registered nurses) are located at primary care physician practices, where each case manager becomes part of the staff and works with 180 to 220 patients.[18] Case managers additionally "float" to one to two small physician practices that have only a few patients in the program. The program pays physicians $150 per year per for their participation in a range of activities involved in the program such as working with the case manager to develop and modify patient care plans. The Care Management Program also includes mental health, pharmacy, and end-of-life support components. Other team members who provide support to the case managers include a community resource specialist and a financial counselor who provided support in insurance-related issues, as well the program's management and administrative staff.

The program is designed to provide coordination and support to patients across the continuum of care. Case managers' responsibilities include assessing patient needs, collaborating with physicians in developing treatment plans, explaining to patients their medical treatment and support service options, helping patients obtain needed services, and supporting patients in managing their medical conditions. Case managers interact with patients over the telephone or in-person during a visit to the primary care office, during a hospital stay, or at the patient's home when needed. In the area of long-term services and supports, the case manager and community resource specialist provide considerable assistance to patients. Case managers consult with the community resource specialist for assistance in connecting patients with services. In addition, the community resource specialist works directly with patients, for example, in helping with transportation and housing needs.

Massachusetts General's program is distinct from programs previously described in that the demonstration is also testing a financing arrangement that includes "pay-for-performance" financial incentives. These include both a "fee-at-risk" savings target and shared savings for reductions beyond the target. Under this arrangement, the program's monthly fee per person ($120 per participant during the initial 3-year phase) is contingent on the program achieving a specified savings target equal to its fee plus a specified percentage of Medicare's spending for a comparison beneficiary group. The specified percentage was 5% for the first participant group and 2.5% for a second group of participants (the second group constituted roughly one-fourth of participants in the initial phase of the demonstration). If the target is not met, the fee is reduced. The program is also eligible to a share of any savings beyond a 5% threshold—savings of more than 5% up to 10% are paid to Massachusetts General's program, savings of more than 10% are shared between the program and Medicare.[19]

An evaluation of the demonstration after its first three years found positive results in several areas including beneficiary satisfaction, quality of care, lower mortality, and Medicare savings. The program reduced the rate of increase in hospitalizations and emergency room visits, and realized significant Medicare savings, compared with a control group. Savings were 12% for the initial participant group and nearly 16% for the smaller second group, more than meeting the required targets. For the initial group, for every one dollar Medicare paid in management fees to the program, Medicare received $2.65 in savings on health services.[20]

Commonwealth Care Alliance (CCA), a non-profit health plan in Massachusetts, offers our final and distinct example of coordinators located in physicians' practices. CCA is a non-profit health plan that uses an interdisciplinary team to provide an integrated range of medical and long-term care to people with complex medical needs who have Medicaid coverage, the majority of whom are dually-eligible for Medicare and Medicaid.[21] For dually-eligible patients, CCA receives a monthly capitation payment from each program, Medicare and Medicaid. In turn, CCA is responsible for—and accepts financial risk for—providing all Medicare and Medicaid benefits to which enrollees are entitled. CCA is, then, the only non-fee-for-service model among our examples and actually provides, rather than just coordinates, long-term services and supports. Like Guided Care, GRACE, and Massachusetts General's Care Management Program, CCA locates a care coordinator in the physician practice—but unlike those models, CCA is responsible not only for coordinating care and delivering primary care, but also for delivering a comprehensive range of services encompassing medical care and long-term services and supports.

CCA's delivery system is organized around independent primary care physician practices that have a sizable number of patients who are eligible to participate in CCA. Participating physician practices agree to have a nurse practitioner in the practice (typically recruited jointly) who serves the practice's CCA-enrolled patients. Each nurse practitioner coordinates care and, in contrast to most of the other models, is also actively engaged in delivering primary care, for about 45 patients. CCA provides services through multidisciplinary teams, led by the nurse practitioners, which also include geriatric social workers, community health workers, physical therapists, and behavioral health and palliative care clinicians. Nurse practitioners are empowered to call in other specialists as needed. In addition, through CCA, a nurse is available to patients at all times and on all days. CCA uses varying approaches to paying for the nurse practitioner (care coordinator): in some cases, CCA employs and pays the nurse directly; in others, a practice chooses to pay the nurse directly (for which it receives a monthly amount from CCA). In addition, CCA pays physician practices a monthly amount for each patient enrolled in CCA to cover physician services related to coordination that are not directly billable.

CCA's experience indicates that investments in care coordination and services can be offset, or more than offset, by savings from significantly reducing hospital and nursing home use. CCA reports that among people age 65 and older enrolled in its Senior Care Options program, hospital use in 2007 was 55% of the level estimated for a comparable patient group in a fee-for-service environment.[22] Nursing home placement among seniors eligible for nursing home care, during 2005-2009, was 30 percent of the rate for comparable seniors in fee-for-service. As reported by CCA, the rate of growth of medical spending for people in Senior Care Options was significantly lower than fee-for-service growth rates.

Care coordinators located outside physician practices

An alternative approach to coordinated delivery locates care coordinators outside the physicians' practices. The following are two very different models—one a participant in a Medicare demonstration for beneficiaries with chronic illness, now targeted to those at relatively higher risk of high spending (those with a hospital stay in the past year); the other, a

Medicaid initiative, recently extended to also include Medicare beneficiaries. Both rely on monthly per-person payments to support coordination services—but coordination is far more intensive in the first model than in the second. However, it should be emphasized that the second model is just getting underway for the Medicare population.

Health Quality Partners—a not-for-profit health care quality research organization in eastern Pennsylvania—developed one of fifteen programs tested in the Medicare Coordinated Care Demonstration, beginning in 2002, and is the only one of those programs that is still being tested (under an extension of the demonstration through June 2013).[23] Originally, Medicare fee-for-service enrollees were eligible for Health Quality Partner's program if they were age 65 or older and had one or more of six specified chronic conditions (heart failure, coronary heart disease, diabetes, asthma, hypertension, or high cholesterol). Beginning in October 2010, the current extension of the demonstration is involving a somewhat different and higher risk population: Medicare enrollees are eligible if they are 65 or older, had a hospital stay during the prior year, and have at least one of four specific conditions (heart failure, coronary heart disease, diabetes, or chronic obstructive pulmonary disease).[24] The current targeting to a higher-risk population reflects lessons learned from earlier phases showing that the intervention had greater effects on Medicare service use and spending for higher-risk patients.[25]

Health Quality Partners employs and trains experienced registered nurses to coordinate care for enrolled patients. The nurse care managers are based at Health Quality Partners and meet with patients in a variety of settings, including patients' homes, physicians' offices, hospitals, community centers, faith-based organizations, and community-based offices leased by Health Quality Partners. Nurses also lead group activities, which include weight management, physical activities, and gait and balance training. Although nurses are not based in physician practices (and do not have access to physicians' medical records for their patients), nurses communicate and collaborate with physicians in coordinating care. All of a physician's participating patients are assigned to the same nurse. Nurses have a caseload of about 80 patients. For higher-risk patients, nurses average about 19 contacts per year, with about half the contacts occurring in-person.[26]

Nurse care managers establish long-term relationships with enrolled patients. The care managers' coordination activities include assessments, disease-specific monitoring, self-management skill building, medication management, support during transitions among care settings, lifestyle behavior change, and communication with physicians (including accompanying patients to doctor's appointments). Nurse care managers play a large role in coordinating long-term services and supports including comprehensive assessment, long-term care planning and referrals, and assisting patients in arranging for needed supports and service. Nurses often provide referrals, such as to a local office on aging, but will also directly communicate with the office on aging and with providers to determine affordable options and arrange for services (such as home-delivered means and personal assistance).

A recent evaluation of the program examined more than six years of experience during 2002 to 2008.[27] During this period, Medicare paid a monthly program fee to Health Quality Partners of

$110 or $130 per patient, depending on patient severity (and $50 for lower-risk patients who had enrolled earlier in the demonstration). The evaluation found that while the program did not achieve savings overall for this time period, it did achieve savings greater than the program fee for the subgroup of high-risk patients. For high-risk patients (who constituted about 14% of all participants), the program reduced hospitalizations by 39% and Medicare's average monthly expenditures (including the program fee) by 28%, compared with a control group.

Community Care of North Carolina is a public-private partnership between the State of North Carolina and 14 regional, non-profit community networks—consisting of primary care practices, hospitals, social service agencies, and health departments—that together provide services statewide.[28] The networks employ care managers and other professionals (such as pharmacists, psychiatrists, and medical directors) who support the participating primary care physician practices, which serve as medical homes for covered patients.[29] The networks also engage in population-based activities, such as disease management and prevention. Since 1998, Community Care has served "Medicaid-only" beneficiaries (that is, beneficiaries who are not also covered by Medicare).

Under a Medicare Health Care Quality Demonstration, Community Care is expanding its population by extending coverage to Medicare enrollees in selected counties—first to people dually-eligible for Medicare and Medicaid (beginning in 2010), and later on to people with Medicare only (in the third year of the demonstration).[30] Although Community Care is only beginning to focus on the people and services that are our concern, its characteristics are worthy of consideration as a basis for future efforts. First, it offers another example of network-based, rather than physician-practice-based care coordination—potentially applicable to a broader range of providers than may be able to adopt the co-located coordinator approach. Second, as a model of a state's effort to extend a delivery mechanism developed for its Medicaid population to Medicare enrollees, it illustrates the capacity states can bring to innovative delivery for dual eligibles.

Care managers—who are usually registered nurses or social workers—typically work out of a network office, although some are located with their assigned physician practice. Each participating primary care physician practice is assigned a care coordinator (more than one if a practice has sufficient enrollees). Care managers are responsible for helping to identify patients who are high-risk, providing disease management education, helping patients coordinate care and link to other services available in their community, and collecting and reporting data on quality improvement measures.[31]

For patients identified as high-risk, care management activities include: assessment (which may be conducted at patient's home); working with the primary care physician and the patient and family in developing a care plan; and coordinating care among providers and sites of care to implement the care plan.[32] Compared with other programs described above, the care managers in Community Care generally have less in-person contact with patients. As implemented so far, Community Care has focused on medical care and disease management, with little involvement in long-term services and supports.

Care managers have large caseloads of patients, among whom only a small portion is actively managed at a time. A typical caseload of enrollees in Medicaid's "aged, blind, and disabled" eligibility category is 1,500 to 3,500 per care manager—with the assumption that only 5% to 10% will need care management at any one time.[33] As of 2010, the state pays each network $13.72 per person per month for enrollees in Medicaid's "aged, blind, and disabled" category[34]—equivalent to roughly $135 to $270 per person for the 5%-10% who are actively managed. Nearly all the dual-eligibles in the Medicare demonstration will be in the "aged, blind and disabled" category.[35] For other enrollees (mainly children and younger women), a typical caseload is 5,000 to 7,500 individuals[36] and the state pays each network $3.72 per person per month.[37] Physicians receive a monthly payment per enrollee for serving as a medical home—$5.00 for "aged, blind and disabled" enrollees and $2.50 for the rest of their enrollees.[38]

Several assessments of Community Care have found both improvements in care and savings for the Medicaid program.[39] A recent analysis estimated that, controlling for risk, average costs for people enrolled in Community Care were less than expected (given patients' risk) in 2008 and 2009, while costs for a comparison population of Medicaid patients who were not enrolled in Community Care were higher than expected (given their risk profile).[40]

IV. Proposal for a Medicare Payment Reform Pilot: Care Coordination in Primary Care for People with Chronic Conditions and Functional Limitations

How can a pilot encourage the spread of cross-continuum coordination?

The innovations just described offer experience that can be incorporated as the Medicare program implements payment reform initiatives authorized by the Affordable Care Act—many of which entail an emphasis on patient-centered primary care and coordination of services. Given their high costs and multiple care needs, people who have both medical and long-term care needs may naturally become part of—and benefit from—innovations aimed at the general Medicare population. However, failure to target them specifically risks missing the opportunity to learn what works best for these high-cost Medicare beneficiaries.

To fill this critical gap, we propose that Medicare develop a specific pilot program aimed at coordinating the full spectrum of services for people needing both medical care and long-term services and supports. Under the Affordable Care Act, the Center for Medicare and Medicaid Innovation is authorized to develop and evaluate pilot payment methods and, when they prove successful in lowering costs and sustaining or improving quality, the Secretary is authorized to expand these methods. A pilot designed for Medicare beneficiaries with functional limitations and complex, high-cost medical care needs will not only launch specific delivery arrangements for this vulnerable population, but also provide lessons on elements that can be incorporated in developing delivery reform for the general population.

The goal of this pilot will be to:

- Apply what has been learned from existing delivery models designed to serve high-cost patients to models designed specifically to serve high-cost patients with functional limitations
- Require that long-term services and supports needs be part of assessment and care coordination, and
- Provide financial incentives to providers based on performance measures that include long-term services and supports as well as medical care.

Compared with an upcoming Medicare demonstration authorized by the Affordable Care Act—the Independence at Home Demonstration—the pilot we propose would test a differing and broader set of delivery models and reach a broader (although overlapping) population of beneficiaries. The Independence at Home Demonstration, scheduled to begin in January 2012, will test a delivery model that provides primary care services to certain Medicare beneficiaries in their homes.[41]

In addition, by developing a new pilot that directly ties widespread interest in primary care coordination to the less-well-recognized needs of people with functional limitations, Medicare

can substantially extend its investment in learning how best to serve a population that is too often left behind.

What should a pilot look like? The answer will involve numerous policy decisions, including which patients to include, where the coordination function is located, how payment policies can support and encourage comprehensive care coordination, and how the pilot can involve an option for Medicaid participation for dual eligibles.

Which patients should participate in the pilot?

Developing a pilot delivery model for people with chronic conditions and functional limitations obviously requires decisions on how best to define those beneficiaries. The models we have discussed vary in their criteria for enrollment. Most of them have focused on high-cost or high-risk populations and have used a variety of measures to identify them. It is not obvious which specific measures will be most successful for the population with functional limitations on whom this pilot will focus.

In choosing criteria, however, experience suggests the importance of identifying beneficiary characteristics that, under current arrangements, are indicators of an elevated risk of hospital use, potentially-preventable through better primary care.[42] Evaluations of two programs that involved patients with a range of risks—GRACE and Health Quality Partners—found the programs were effective in lowering hospital use and spending for the subset of patients who were high-risk (and did not yield significant savings in aggregate for their full patient populations).[43]

Requiring program participants to have functional limitations will in itself target the pilot to beneficiaries with higher average costs. It may additionally be most effective to select a higher-risk group within this target population. Pilot programs could explore whether such additional targeting is useful and which criteria to use in doing so.

Selection of criteria for participation should take into account patterns of care among Medicare enrollees with functional limitations. In selecting functional limitations measures as criteria for participation, it is important that the pilot engage individuals with low to moderate levels of functional limitations as well as those with high levels. The program may be valuable to people with functional limitations at relatively early stages of progressive conditions, as well as to people with extensive long-term services and supports needs.

Where is the coordination function located?

Care coordinators who are employed by physicians' practice would seem to have the greatest potential for transforming the way primary care physicians do business—making assessments, developing and monitoring care plans in collaboration with physicians, and coordinating services for patients. But employing care coordinators seems feasible only for practices with significant numbers of beneficiaries who satisfy the participation criteria. The alternative

approach—relying on a network—is less common among initiatives for which there is evidence of success but nevertheless has value in reaching a broad scope of practices for which a small percentage of patients are likely to satisfy eligibility criteria.

The key element in success seems to have less to do with the physical location, or even a particular employment relationship, of the care coordinator than with the coordinator's establishment of a strong and continuing relationship with patients and physicians. One way this is achieved is by having all of physician's participating patients assigned to the same care coordinator (or support team, as in GRACE) and for the physician and coordinator to work collaboratively. Regular and ongoing contact with patients and their families—as opposed to just intermittent telephone or other "reminders"—also appears critical to establishing trusting relationships between coordinators and patients, and distinguishes the patient-centered primary care enhancement aimed at here from a more mechanical management approach.[44]

Although location of the coordinator within the practice might seem to facilitate relationship-building between the coordinator and the physician, location outside the practice might—by creating some distance from the practice—actually enhance a focus on the patient, enabling a coordinator to serve more as a patient advocate than might sometimes be possible within the practice. Further, a network approach has the potential to connect small, independent practices to the sophisticated support teams (specialists in pharmacy, mental health, community services, and so on) that delivery initiatives integrated into larger health systems, like GRACE and Massachusetts General, and CCA are organized to provide. The Community Care of North Carolina networks offer some of these resources.

A network approach also has the advantage of providing a focus for engaging states in promoting coordination—if, as in North Carolina, Medicaid or another state agency takes a leadership role in creating, supporting, and overseeing provider networks focused on identifying long-term care needs and facilitates (even when not necessarily paying for) access to appropriate services.

How can payment policy support coordination activities?

Coordination of services, even across the full continuum, is not the same as full integration of medical care and long-term services and supports, which practitioners advocate as ideal to manage services efficiently.[45] For an organization with a strong delivery system—and with strong quality performance criteria—receiving a capitation payment not only assures providers of resources to invest in coordination (such as the costs of a nurse or social worker, as well as data systems) but also gives providers maximum flexibility to redirect resources currently spent on expensive institutional care, whether in the hospital or in a nursing home, to coordination, prevention, primary care, and support services provided at home. These advantages are key to arguments that have been made for combined Medicare-Medicaid capitation payments for dual eligibles.

But experience tells us it is unsafe to assume that capitation payments will necessarily lead to coordinated, efficient, and high-quality care—either because the necessary organizational

arrangements will not develop or because the incentive to under-spend in order to achieve financial success will endanger provision of necessary care. That capitation does not automatically produce effective care coordination was the primary lesson from the health maintenance organization (HMO) revolution—and subsequent backlash—of the 1990s. Further, in today's environment, it is not clear that, in general, Medicare Advantage plans are more effective than traditional Medicare in integrating care, Medicare's special needs plans are actually coordinating care for high-needs beneficiaries,[46] or Medicaid managed care plans have the networks or managerial capacity to serve often highly-disabled populations.[47]

The goal behind much of payment reform must therefore be to create coordinated, person-centered delivery systems where they do not currently exist, without putting patients at risk in the process. And achieving this goal requires a payment system that provides resources to support coordination, without providing excessive incentives to profit from under-service or too little support to make coordination effective. From the payer's perspective, what is needed is assurance that resources provided for coordination not only be directed at promoting delivery efficiencies, but also be no greater (and ideally less) than the savings efficiencies are expected to produce. To achieve these goals, a pilot can employ a combination of coordination payments, a share of savings that exceed those payments, and strong performance standards related to patients' long-term services and supports and medical care experiences.

Per member per month payments for care coordination in the fee-for-service models reviewed above serve this purpose and give some idea of the magnitude of payment needed to achieve positive results. Across the models, they amount to roughly $100 to $150 per patient per month for older adults with complex needs. However, a somewhat larger payment may be needed to serve the more extensive needs of the proposed pilot population. Evidence from several of these programs indicates that it may be possible to offset the program's costs—or even more than offset these costs—with savings from reduced hospital costs, emergency room visits, and other services, while achieving higher quality care.

The experiences from these models also inform requirements as to what provider applicants for these payments should have to promise in return—that is, the qualifying conditions providers should have to satisfy. Generally stated, an applicant should demonstrate: dedicated personnel taking responsibility for initial and ongoing review of each patient's needs and services—aimed at developing, implementing, and monitoring an effective care plan; regular contact with health professionals and agencies or organizations in the community involved in the patient's care and; and engagement and support of the patient and the patient's family caregivers as key participants in promoting health and assuring appropriate care.

Monthly per patient payments for care coordination, even when tied to specific activities and services, may make coordination possible, but they do not create incentives to make it work. Incentives require an accountability mechanism—tying the revenues providers can earn to some measure of performance. That means standards for quality of care—similar to those under development for accountable care organizations (ACOs) and other delivery innovations—but with additional measures that capture patient and caregiver experience for people with functional limitations. In developing such performance measures, careful risk adjustment will

clearly be required, so as not to inappropriately reward or penalize providers serving patients at higher risk of outcomes such as admission to a nursing home.

Providers who satisfy these performance standards should be rewarded with a portion of any additional savings they achieve, as in the Medicare Care Management for High-Cost Beneficiaries Demonstration, either to be used as they see fit or to invest any such savings in expanded support for potentially uncovered services (like personal assistance for a limited period). The provider could be rewarded by receiving a share of Medicare's savings compared with an estimate of what Medicare would otherwise have spent on services for participating beneficiaries. Shared savings should apply, however, only for savings above the care coordination fee. Providers should be held accountable or "at risk" at least for this amount—by reconciling payment after some period of time so that Medicare payments are no greater than they were projected to be in the absence of the coordination payment. The objective in setting these terms should be to encourage the efficiencies in service delivery that coordination is aiming for, avoiding rewards so great as to encourage underservice, and to allow Medicare as well as participating providers to benefit from efficiencies achieved.

How could Medicaid participate for dual eligibles?

Historically, neither Medicare nor Medicaid has acted as an effective steward of dual eligibles' care. State Medicaid officials have argued they have little incentive to invest in preventing duals' unnecessary hospitalizations, for example, since savings would come to Medicare and not to Medicaid. But, absent that investment, allowing states greater control over Medicare dollars—as some have proposed—raises the very real potential that these dollars would provide states fiscal relief, rather than assure enhancement of quality care. At the same time, Medicare has shown little leadership in improving care for this highly vulnerable population, taking no responsibility for the long-term care needs of this highly vulnerable population and focusing on efficiencies in acute care with little regard for the population who need long-term care as well.

Today, states are being charged with, and supported by the Centers for Medicare and Medicaid Services in the development of new payment mechanisms for dual eligibles—whether through the development of managed care arrangements, in which both Medicare and Medicaid can participate (or integrate their capitation payments) or coordination arrangements associated with fee-for-service. The latter, the Centers for Medicare and Medicaid Services have recognized, might come in conjunction with Medicare payment reforms.[48]

The pilot proposed here allows for Medicaid participation—and for Medicaid to share with Medicare in savings that might result from such reform. Using the shared savings approach outlined above, and designed to assure accountability, Medicaid as well as Medicare could share in savings from efficiencies if states, like applicants for care coordination payments, demonstrate investment in care coordination.[49] States could, for example, support long-term services and supports coordination—by combining the "health home" payments authorized by the Affordable Care Act—with Medicare's care coordination payment to strengthen and extend coordination activities. Going further, states could invest in the development of networks—not

simply of primary care providers but also of long-term services providers—home care agencies, nursing home agencies, Area Agencies on Aging, and so on—and in arrangements that connect the two. North Carolina may provide a model for building such networks through a public, non-profit partnership.

V. Conclusion

Transforming health care delivery to better coordinate care is at the top of the policy agenda. But the people whose chronic conditions create a need for long-term services and supports are not. This brief aims to put this population and strategies to coordinate the full range of their care needs on the policy radar screen. In short, effective health reform requires explicit initiatives to improve care for people with chronic illness and functional limitations.

The case is compelling. The 15% of Medicare beneficiaries who need both complex medical care and basic long-term personal care account for about a third of Medicare spending. Fewer than half of these beneficiaries are also Medicaid beneficiaries (or "dual eligibles"). They are Medicare beneficiaries of all incomes who have a combination of medical and long-term care needs and high Medicare spending. Indeed, three out of five of Medicare's highest-cost patients (the top 5%) have both chronic conditions and functional limitations.

It is these beneficiaries, not beneficiaries with chronic conditions alone, who account for a disproportionate share of Medicare spending—with average per beneficiary spending for chronically ill beneficiaries needing long-term care (about $16,000) twice the average spending per beneficiary with more than three chronic conditions and no long-term care needs. At every level of chronic illness (number of chronic conditions), Medicare spending is higher for beneficiaries who need long-term services and supports than for beneficiaries who do not.

These facts challenge policymakers promoting delivery reform:

- First, to expand their focus beyond beneficiaries with chronic conditions to chronically-ill beneficiaries with functional limitations.
- And, when they do expand their focus, to extend care coordination to include long-term services and supports as well as medical care.

Experience from some innovative delivery programs, described in this brief, suggests ways to coordinate care across the full continuum that can improve both the efficiency and quality of patient care. But neither people who need long-term care nor the long-term care component of coordination has been an explicit focus of these programs.

To fill that gap, what's needed is a Medicare pilot specifically directed at improving primary care to coordinate care delivery across the full range of patient needs for people with chronic conditions and functional limitations. Experience to date suggests the pilot's success will be enhanced by:

- Explicitly targeting the pilot to beneficiaries whose characteristics, under existing delivery arrangements, are most predictive of potentially preventable hospitalizations, in order to maximize impact on unnecessary and costly care;
- Allowing different approaches—both networks that hire and manage care coordinators and coordinators employed by physicians' practices—in order to maximize the range of providers who can participate;

- Paying monthly amounts per enrolled patient to participating providers sufficient to support coordinators and other currently uncovered care management services that are tied to demonstrated capacity to actually monitor and manage patient care;
- Holding participating providers accountable for savings that offset these care coordination payments and allowing participating providers who satisfy quality standards to benefit from spending less than projections—in order to assure Medicare value for the dollars the program invests and to encourage real changes in provider behavior; and
- Encouraging states to participate in the pilot for dual eligibles provided they, like participating providers, actually invest in delivery improvement—allowing states, too, to share in Medicare savings.

Creating a pilot aimed directly at patients with chronic conditions and functional limitations can generate much needed lessons about how best to serve this particularly vulnerable and expensive population, at the same time we pursue health care delivery reform for the general population. Their needs—and their costs—are too substantial to explore change a step at a time. But, as we focus on this population, we must recognize that the ultimate goal of a targeted pilot is not to isolate people who need long-term care in tailored delivery arrangements. Rather, it is to assure that we learn as quickly as possible what it will take to assure the whole system's capacity to serve people with long-term care as well as medical care needs appropriately and effectively, wherever and whenever these needs arise.

Acknowledgements

In preparing this brief, we benefited greatly from the work of many colleagues. At the top of the list is the team at Avalere Health—especially Anne Tumlinson, Elana Stair, Weiwen Ng, and Sally Prendergast—who conducted the analysis of Medicare data on which we relied. A number of experts helped us understand existing delivery models and influenced our thinking about options moving forward. Although we bear full responsibility for the analysis and recommendations we present, we are particularly appreciative of both previous work by and conversations with Bob Berenson, Chad Boult, Randy Brown, Ken Coburn, Steve Counsell, Robert Greenwood, Denise Levis Hewson, Maryellen Keller, Nancy McCall, Bob Master, Sherry Marcantonio, Harold Miller, Murray Ross, and Brenda Sulick. For reviewing and providing valuable comments on an earlier draft, we are indebted to Bob Berenson, Chad Boult, Steve Counsell, Bob Master, Bill Scanlon, and Anne Tumlinson. Nicole Cafarella and Isabel Perera at the Center for American Progress provided excellent research support. Finally, we are grateful not only for the financial support of The SCAN Foundation, but also for the thoughtful contributions Gretchen Alkema, Kali Peterson, and Lisa Shugarman made to this project.

This paper was supported by a grant from The SCAN Foundation. The SCAN Foundation is dedicated to creating a society in which seniors receive medical treatment and human services that are integrated in the setting most appropriate to their needs. For more information, please visit www.TheSCANFoundation.org.

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