Can Better Care Coordination Save Medicare?

The Alphabet Soup of Care Delivery Transformation
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Randy Brown

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Overview

1. **What does the evidence tell us about likely care coordination effects in fee-for-service Medicare?**
2. **What ACA provisions are likely to produce savings for Medicare?**
3. **What can we do to enhance the likelihood of success?**
4. **What are the major barriers to success?**

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The Best Evidence on Effective Care Coordination

- **CBO review of 30+ programs (1/12) found little favorable evidence**
  - Telephonic-only disease management programs didn't work
  - More personal care coordination programs didn't save enough
  - Value-based purchasing yielded little or no savings
- **Other studies show some significant favorable effects—but only for high risk patients**
  - Transitional care (Naylor, Coleman)
  - Medicare Coordinated Care Demonstration—4 sites
  - Care Management Plus model (Dorr; OHSU)
  - Geriatric Resources for Assessment and Care of Elders (GRACE) model (Counsell)
  - Mass. General Hospital high cost program

What distinguishes successful interventions?

Care Coordinators:

1. **Have frequent face-to-face contact with patients (~ 1/month)**
2. **Build strong rapport with patients' physicians through face-to-face contact at hospital or office**
3. **Use behavior-change techniques to help patients increase adherence to medications and self-care**
4. **Know when patients are hospitalized and provide support for transition home**
5. **Act as a communications hub among providers and between patient and providers**
6. **Have reliable information about patients' Rx and access to pharmacists or medical director**

Proposed Models in the ACA

- **Models of care suggested in ACA that have promise of improved care coordination:**
  - Patient-centered medical homes for high risk patients
  - Advanced payment ACOs
  - Geriatric assessment and comprehensive care plans (GRACE)
  - Care coordination through HIT and telehealth (high risk patients)
  - Community-based health teams to improve self-management
  - Fully integrated care for dual eligibles
  - Home health providers who offer multidisciplinary care teams
  - Replication of successful programs from MCCD for high risk patients
- **But success will depend on *how implemented***
  - And evidence suggest net savings will be modest
- **Bundling models had better results, but create new silos**
- **Structure of managed care plans offers greater potential**

How Can We Increase Likelihood of Success?

Whether FFS, ACO, or managed care solutions are tried:

- **Require key features of successful past programs**
- **Focus effort on high risk patients**
- **Feed back information to programs and physicians**
- **Build in studies of operational issues**
- **Test replicability of proven core features in other settings**

Potential Barriers to Success

1. **Excessive attention to rapid cycle learning**
   - Quick answers are often wrong answers
   - Takes time to learn, train, adapt, build rapport
   - So use intermediate outcomes and build in tests of program implementation issues (Mahoney)
   - Don't sacrifice rigor of evidence for speed
   - Building on prior successes should shorten time to improvement

2. **Lack of political will**
   - Failure to withstand pressure from special interests will thwart attempt to save—fees/premiums have to be set low enough

3. **Lack of information and incentives for providers**
   - Physicians need data on *quality and efficiency* (own and others)
   - Payment to providers should be tied to both factors
   - Resource use reporting should provide this