Fact Sheet

Health Reform Initiatives to Improve Care Coordination and Transitional Care for Chronic Conditions

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Recent health care reform legislation will greatly increase the availability of health insurance and broadly impact the delivery of health care in America. This fact sheet looks specifically at how the legislation will improve care coordination and transitional care, particularly for people with chronic conditions.

The health care reform law creates several programs based on promising models for improving care for people with chronic conditions, who often experience difficult transitions across care settings that can compromise quality of care and increase costs. These new programs include the following:

- The Medicare Community-Based Care Transitions Program
- Incentives to reduce Medicare hospital readmissions
- The Medicare Independence at Home demonstration
- Medical Home models in Medicare and Medicaid
- Community Health Teams to support Medical Homes, regardless of payor type

Most, but not all, of these programs include some level of funding, evaluation, and discretion for the Secretary of the Department of Health and Human Services (HHS) to expand programs if they meet certain criteria.

Grants to Create a Medicare Community-Based Care Transitions Program

Health care reform legislation provides for HHS to make grants to hospitals with high readmission rates in partnership with community-based organizations that include multiple health care stakeholders, including consumers. Applicants will receive preference if they serve the medically underserved, small communities, rural areas, or Administration on Aging programs that provide transitional care services to multiple providers. Starting in 2011, this program will receive mandatory appropriations of $500 million over five years.

Grantees will be required to deliver at least one transitional care intervention, such as arranging post discharge services, providing patient self-management support (or caregiver support), or conducting medication management review.

Services will be targeted to beneficiaries in traditional fee-for-service Medicare who are at high risk on the basis of hierarchical condition category score[1] and other risk factors, such as cognitive impairment, depression, multiple readmissions, or other chronic diseases or risk factors determined by HHS.

While a formal evaluation is not required by statute, HHS will have discretion to expand the program if it reduces Medicare spending without reducing quality.

Incentives to Reduce Avoidable Medicare Hospital Readmissions

Starting in fiscal year (FY) 2012, as an incentive to reduce readmissions and improve transitional care, Medicare payments will be reduced by 1 percent (rising to 3 percent over time) for avoidable readmissions that exceed a threshold as yet to be determined. HHS will specify the readmission window (such as 30 days after discharge) during which incentives will be applied and identify three conditions to be targeted. This program will be expanded to seven conditions in FY 2015. HHS will make hospital-specific readmission rates publicly available on the Medicare Hospital Compare Web site.

Helping Medicare Beneficiaries Remain at Home

A new Medicare Independence at Home demonstration will pay physicians and nurse practitioners to deliver primary care services in the home. The demonstration will include up to 10,000 fee-for-service Medicare beneficiaries who have chronic illnesses, functional dependencies, and high costs, and who have had at least one hospital admission and have used rehabilitation therapy services within the past year.

Beginning in 2012, this three-year demonstration will receive mandatory appropriations of $5 million per year. After it ends, HHS will evaluate it and report to Congress.

Testing Medicare Models for Chronic Care Coordination

Starting in 2011, an Innovation Center will be created within the Centers for Medicare and Medicaid to test promising models of delivery and payment system reform. The following are some of the models that may be tested:

- Patient-Centered Medical Homes designed to address the needs of high-risk Medicare beneficiaries with chronic conditions
- Geriatric assessments and comprehensive care plans to coordinate care for Medicare beneficiaries with chronic conditions
- Home health providers and interdisciplinary teams to provide chronic care management services to Medicare beneficiaries

Funding for the Innovation Center includes mandatory appropriations of $10 billion every 10 years.

During the testing phase, models tested by the Innovation Center will not be subject to budget neutrality requirements. Each model will be evaluated on spending and quality. HHS has discretion to expand any model—including implementation on a nationwide basis—that is expected to (a) reduce federal spending but not reduce quality or (b) improve quality but not increase federal spending.

State Option to Create Medicaid Health Homes for Chronic Conditions

States may elect to offer Health Homes (also known as Medical Homes) that voluntarily enroll Medicaid beneficiaries with at least one of the following: two chronic conditions; one chronic condition and risk of an additional chronic condition; or a serious and persistent mental illness, all as defined by HHS.

Health Home services will include care coordination, care management, transitional care, and referral to community and social support services, such as meals-on-wheels and Aging and Disability Resource Centers. Providers will include Community Health Teams (described below) or other designated

providers, such as home health agencies, community health centers, group practices, and clinics.

Hospitals will be required to refer Medicaid beneficiaries with chronic conditions who visit the emergency room to a Health Home provider. Payments may be risk adjusted according to severity of illness or number of chronic conditions and may be made on a capitated basis (fixed monthly amounts) or other payment system to be determined.

States may receive planning grants of up to $25 million starting in 2011. States that elect to implement this program will receive increased federal matching funds of 90 percent for Health Home services during the first two years of operation. States will be required to track avoidable readmissions, estimate savings from improved chronic care coordination, and report lessons learned from the program

By 2017, the program will be evaluated for its impact on reducing emergency room visits and admissions to hospitals and skilled nursing facilities.

Community Health Teams to Support Medical Homes

Interdisciplinary Community Health Teams will be established to support Medical Homes. These teams will target patients with chronic conditions, regardless of payor type. Services will include chronic care coordination, discharge planning, 24-hour care management during transitions from a hospital or health care facility, mental health referrals, and medication therapy management through qualified programs.

Teams of qualified primary care providers will receive capitation payments (fixed monthly amounts) for each enrollee. Teams will be funded by grants from HHS to states or state-designated entities and Indian tribes, and must become financially self-sustaining within three years. This program does not include specific funding levels or evaluation requirements.

Endnotes

[1] Hierarchical condition category (HCC) scores are risk adjusters used for payment purposes and assigned to all Medicare beneficiaries on the basis of diagnoses, demographics, functional status, institutional status, and Medicaid status. While HCC scores are designed to predict acute care costs, they may not predict chronic care costs as well. See G. F. Riley, "Risk Adjustment for Health Plans Disproportionately Enrolling Frail Medicare Beneficiaries," *Health Care Financing Review,* vol. 21, no. 3 (Spring 2000): 135–48 (www.cms.hhs.gov/HealthCareFinancingReview/Downloads/00springpg135.pdf)

Fact Sheet 191, November, 2011

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