

The Medicare Health Care Quality Demonstration Program: The Promise and Opportunity of the 646 Waiver

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In 2003, Congress established the Medicare Health Care Quality Demonstration Program (Section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003). The program has become known as the 646 Demonstration. The goal of the 646 Demonstration is to improve the “quality of care and services delivered to Medicare beneficiaries through system redesign that fosters best practice....”¹ A competitive process was used to select health care organizations (physician group practices, integrated delivery systems, and regional coalitions of physician group practices and integrated delivery systems) to participate in this five-year demonstration.

The Centers for Medicare and Medicaid Services (CMS) intended to use this demonstration to identify, develop, test, and disseminate major and multifaceted improvements to the health care system. Projects approved under the demonstration were expected to implement a plan that would “address gaps in care, quality, and efficiency by combining system redesign—improvements in clinical and non-clinical process and structures within systems and organizations—with payment changes that alter the financial incentives.”¹

The application process was conducted in two phases. The first rounds of applications were submitted on January 30, 2006, and the second rounds of applications were submitted on September 29, 2006. Because CMS required that participating organizations in the 646 Demonstration be nongovernmental, the 14 Community Care networks established a new non-profit entity, NC Community Care, Inc., (Community Care) to represent them in the application process. Community Care applied in the second round of requests for proposals issued by the CMS.

Community Care’s interest in participating in a Medicare demonstration began in 2006 after the North Carolina General Assembly directed Community Care to extend its medical home and community-based care management system to aged, blind, disabled, and dual-eligible (those who are eligible for both Medicaid and Medicare coverage) recipients. Because any work Community Care did in improving the care

and care outcomes for dual-eligibles would also benefit Medicare, there was interest in exploring the possibility of involving Medicare funding and patients in the effort. The North Carolina Department of Health and Human Services encouraged and actively participated in this exploration process. After discussion with CMS leadership, it was determined that the 646 Demonstration would be the best fit for the goals set by the General Assembly.

Under the 646 Demonstration ...Community Care will extend its medical home and community-based care management system to dual-eligible and Medicare-only populations.

There were several other reasons that participation in a Medicare demonstration became an attractive option, including:

- Community Care had historically focused on women and children enrolled in Medicaid and had large numbers of pediatric and family medicine physicians participating in the program. When Community Care was asked to extend its program to aged, blind, and disabled recipients, it became important to engage more physicians serving adults as well as community-based providers. By including Medicare patients, the program would be better able to capture the attention of adult physicians.
- There had always been barriers to improving care for the dual-eligible population. If approached from the Medicaid side, you were looking primarily at the long-term care

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services and expenses; if approached from the Medicare side, the focus was on the hospital and other acute-care services and expenses. One never had either the full patient picture or the incentive to work on all facets of care. By joining the Medicare and Medicaid pieces, Community Care would have both the data and the incentive to address the patient's complete care.

- The 646 Demonstration was seen as an opportunity to place Community Care's physician-directed and community-based approach in the national dialogue as the health reform debate began to take shape.

Demonstration Design

Under the 646 Demonstration, when finally approved, Community Care will carry out an intervention that "combines a physician-directed care management approach with the use of health information technology (HIT) to connect providers, support care management and delivery, measure performance, and implement pay-for-performance financial incentives."¹ Community Care will extend its medical home and community-based care management system to dual-eligible and Medicare-only populations.

After considerable negotiation with CMS, North Carolina's demonstration design took shape. During years one and two, Community Care will manage approximately 44,000 dual-eligible beneficiaries who receive care from 165 Community Care practices in 26 counties. At the beginning of year three, an estimated 170,000 Medicare-only beneficiaries, who receive care from those 165 practices, will be added to the demonstration. From years three to five, Community Care will manage approximately 214,000 Medicare-only and dual-eligible beneficiaries. As part of the demonstration there will also be a comparison group, which will be composed of the beneficiaries who receive their care from approximately 200 practices in 32 North Carolina control counties. The intervention,

control, holdout, and exempt counties are shown in Figure 1. Exempt counties were excluded from the demonstration because they were part of another CMS demonstration. Counties that were not intervention, control, or exempt counties were deemed holdout counties and would be able to participate in other CMS demonstrations.

Unlike the Medicaid programs, where recipients are enrolled with Community Care practices and networks, there is no enrollment under the 646 Demonstration. Assignment of a beneficiary to an intervention or control practice is based on whether a beneficiary obtained a qualifying service from a participating practice during the demonstration period. The assignment of beneficiaries to a practice will be transparent to the beneficiary. Participation will not limit Medicare benefits nor limit the ability of beneficiaries to seek care from any Medicare provider. Community Care will continue working with the Division of Medical Assistance to enroll dual-eligible beneficiaries into Community Care for the Medicaid portion of their care.

Demonstration Population

Although we are waiting on access to the Medicare files to better understand the Medicare-only portion of the 646 Demonstration, the program has been able to analyze the Medicaid files to capture a good picture of the dual-eligible participants. Based on an analysis conducted for the period April 11, 2007–March 31, 2008, characteristics of the potential dual-eligible participants were compiled and selected data from that analysis are presented in Table 1.

What Will Community Care Do To Improve Participant Care and Care Outcome?

Building on the work of Community Care's Chronic Care Program, which is currently being rolled out to all North Carolina counties by the 14 Community Care networks to

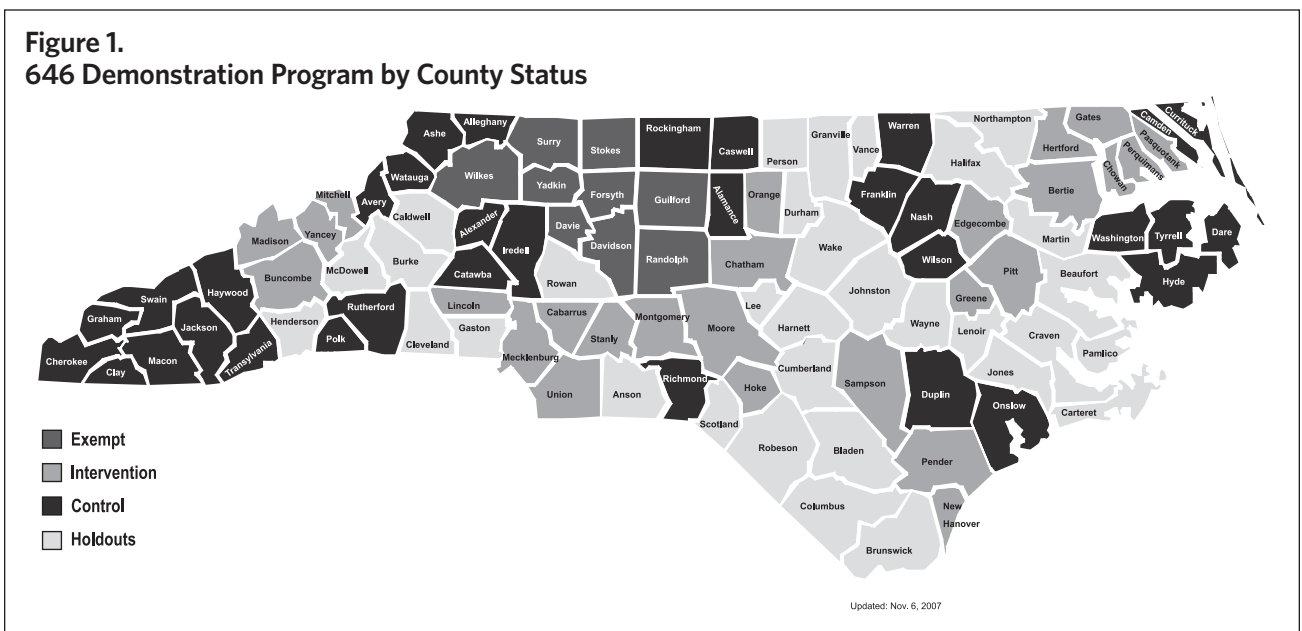


Table 1.
Characteristics of Potential Dual-Eligible
Participants in the 646 Demonstration Program

Medical Condition	Percent of Patients with Condition
Hypertension	73%
Three or more chronic diseases	54%
At least one emergency room visit	40%
Diabetes	39%
Mental health condition	32%
At least one hospitalization	26%
Ischemic vascular disease	24%
Chronic obstructive pulmonary disease	19%
Asthma	13%
Chronic kidney disease	11%

Top Five Admissions:

- Psychosis
- Syncope and collapse
- Renal failure
- Heart failure
- Chronic obstructive pulmonary disease

address the care needs of the aged, blind, and disabled Medicaid represents, the focus will be on at-risk patients. Community Care physicians, hospitals, health departments, and other community providers will work together to improve care outcomes in the following areas:

- Assist patients in transition (20% of Medicare patients discharged from the hospital are readmitted within 30 days. Fewer than 50% of those readmitted had seen their primary physician after discharge).
- Assist patients with multiple chronic illnesses (67% of Medicare dollars go to support care for patients with three or more chronic illnesses.)
- Address medication reconciliation.
- Support the medical home with care management support, information, and best practice.
- Assist the medical home in building the processes to improve chronic illness care.

- Strengthen the communication between community providers.
- Develop an information center to provide timely and meaningful data and reports.

With the arrival of the aged, blind, and disabled (and soon, the 646) populations, Community Care has had to re-engineer its model, which began as a program that focused on single diseases such as asthma or diabetes. With the new populations, the program has had to migrate to a multi-disease focus where medical homes and care managers must take a more patient-centered and holistic approach and where links with practices, community providers, and selected specialty practices must be strengthened.

How Success Will Be Determined

For each year of the demonstration, quality and expenditure targets will be set by CMS. Although specific targets have not yet been set, the following rules will apply:

- Control group growth rates will determine Community Care expenditure targets.
- There will be truncated claims expenses and savings thresholds.
- Bonus payments cannot exceed 50% of total annual savings.
- At least 50% of bonus payments are contingent on meeting quality targets.
- Quality targets, which will be based on measures adopted and used by Community Care, will be proposed by Community Care and approved by CMS.

The earliest Community Care will receive any savings is by the end of year two. Community Care will work with the North Carolina Department of Health and Human Services and the federal CMS to determine how any savings will be used. As originally proposed, it is expected that a significant percent will be set aside to fund access to care for the low-income uninsured population.

Although Community Care does not yet have a start date for its participation in the 646 Demonstration, it is now listed on the CMS's website as an approved project that will begin operation in 2009. We are now working with CMS on the completion of the Cooperative Agreement, which is the final step in the process. **NCMJ**

REFERENCE

1 Department of Health and Human Services, Centers for Medicare and Medicaid Services. Medicare program solicitation for proposals for the Medicare Health Quality Demonstration. March 28, 2006.