Justification for Emergency PRA Clearance

Evaluation of Practice Models for Dual Eligibles and Medicare Beneficiaries with Serious Chronic Conditions

The Affordable Care Act (ACA) established the Federal Coordinated Health Care Office (FCHCO) to more effectively integrate benefits under Medicare and Medicaid and improve coordination between the federal government and states for dual eligibles (individuals with both Medicare and Medicaid coverage). Dual eligibles are among the most vulnerable beneficiaries – most face multiple and severe chronic conditions that require complex and intense care – and must navigate two separate health care programs that often lead to fragmented, inefficient, and costly care. This project will explore patterns of care and best practice models for dual eligibles, other Medicare beneficiaries with complex health needs, and those participating in the Program for All-Inclusive Care for the Elderly (PACE).

Findings from this qualitative research will inform the pressing work of the FCHCO, supporting initiatives and policies that improve care coordination for dual eligibles, as well as other provisions outlined in the ACA regarding coordination of care for beneficiaries with serious chronic conditions. Specifically, the ACA calls the FCHCO to support state efforts to coordinate and align acute- and long-term care services for dual-eligible individuals with other items and services furnished under the Medicare program [Section 2602 (d)(2)]. The ACA also requires the FCHCO to support coordination of contracting and oversight between states and the Centers for Medicare & Medicaid Services (CMS) regarding integration of Medicare and Medicaid [Section 2602 (d)(2)]. These provisions require this project to provide important information by mid-2011.

The project will comprise qualitative information gathering through open-ended discussions with providers, local health care leaders, patient advocates, quality improvement specialists, and professionals involved in implementing care coordination initiatives. These discussions will be held in-person during site visits to 16 hospital referral regions (HRRs) that vary in cost and quality to determine factors associated with that variation. The team will conduct eight to 10 one-to one-and-a-half hour discussions per site visit with either individuals or small groups of professionals.

Because no list of potential discussants exists, the team will identify interviewees by first reaching out to federal employees at CMS regional offices and Quality Improvement Organizations contracted with CMS to generate an initial candidate/organization list for each of the 16 HRRs. The research team will supplement this information with a search of publicly available information describing the characteristics of the local provider networks and market conditions not apparent from the initial CMS data analyses by HRR.

Based on this information, the research team will prepare a fact sheet for each HRR, which will include information on market characteristics, such as managed care penetration; high-volume providers (including health systems, hospitals, large multi- and single-specialty physician groups, individual practice associations); prominent program initiatives; basic demographic and geographic information about the populations of interest; and any other factors the project team

deems relevant to addressing the research questions. The fact sheet will further inform development of the initial list of interviewees within each HRR to be included as part of a four- to five-day site visit.

If necessary, the team will conduct no more than three screening interviews with individuals within each targeted HRR, only following Office of Management and Budget approval of the screening tool provided as part of this Paperwork Reduction Act (PRA) application. If necessary, these interviews will take approximately 20 minutes each and will be conducted telephonically. The screening interviews will allow the project team to further vet the initial site visit discussant list the research team will have developed. Screening calls will only be made for HRRs where the research team believes the initial list of interviewees may be improved by including additional and/or potentially more relevant individuals to be visited for this research. The research team will provide CMS with summary information regarding backgrounds of the most relevant eight to 10 discussants or small sets of individuals/organizations for their review and approval before scheduling the in-person, open-ended, discussions at the 16 selected sites.

HRRs will be selected by CMS with the assistance of the L&M team and reflect a mix of dual-eligible enrollment levels, severe chronic illness prevalence rates, and diversity in geography, urban/rural balance, and socio-economic considerations. Topic areas that will be addressed during these discussions will include:

- History, goals, and objectives of care models/interventions for duals and the seriously chronically ill in the HRR;
- Community-, provider-, patient-level factors associated with quality, costs, and outcomes;
- Barriers/opportunities to participation in models/interventions that improve care; and
- Role of health information technology and personal health records in interventions.

No personally identifying patient information will be collected or discussed at any time. Notes from each discussion will be summarized and entered electronically into an Access database (one record per interview) and then reviewed for themes and trends to describe:

- Similarities and differences in care provided among and across the HRRs;
- Experience and challenges serving Medicare beneficiaries and dually eligible individuals who have serious chronic conditions to identify best practices which merit further exploration; and
- Detailed findings of the two site visits focusing on PACE programs along with exploration of best practices and barriers for PACE model expansion.

This contract began on Sept. 27, 2010, and requires the team to conduct a literature review, receive a list of HRRs from CMS for the site visits, conduct intensive pre-field work through a snowball approach to properly identify discussant candidates and organizations for the team to meet with during the site visits and complete all of the data-collection activities by the end of March 2011 so a final report can be submitted to CMS by mid-June 2011. This aggressive timeframe calls for the team to be in the field conducting the site visits by early January 2011 in order to complete all 16 site visits (which will be four to five days in length each) by the March 2011 timeframe.

Due to the urgency and the short time frames associated with this requirement and the importance of the research in furthering the work of the FCHCO in order to meet the requirements of the ACA, CMS does not have sufficient time to follow the normal PRA notice and comment periods associated with the normal approval process. We are requesting an emergency review and approval for the information collection request so that the team may begin field work in mid-January 2011. Delaying the existing project beyond the current due dates will delay implementation activities of the FCHCO's responsibilities as outlined under the ACA, Section 2602. As a result, emergency review and approval is crucial.