

**Strategies for Winning a Contract:
The CMS Chronic Care Improvement
Phase I RFP**

Disease Management Audioconferences

The Leading Forum on Innovations in Chronic Care and Disease Management

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May 25, 2004 (15 minutes)

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1) Strategies for Winning A Contract

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- **An important acknowledgement: CMS did a good job with the CCI-I (Chronic Care Improvement, Phase 1) request for proposal!**
 - **Strategies will differ for:**
 - **DM companies and health plans experienced in DM contracting and program design**
 - **Provider consortia who are relatively inexperienced in DM contracting and program design**

- **What will winning proposals look like?**
 - **The Foundation: Demonstrate proficiency at the basics -- a rigorous understanding of DM contracting and program design elements**
 - **Differentiators: Demonstrate creativity at the “discretionary” elements**
 - **Physician integration**
 - **Working with community organizations, local, state agencies**
 - **Integrative information infrastructures**
 - **Application of information and communication technologies**

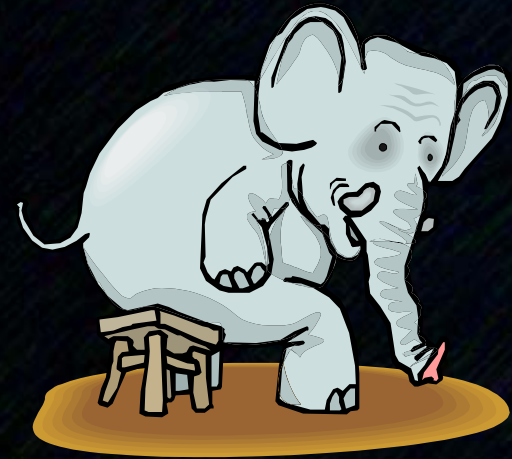
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- **Experience at DM will go a long way**
 - **Provider consortia have some potential advantages**
 - **The Affirmative Action clause in the RFP**

“If a consortium has no prior experience to draw from, the applicant should, to the best of its ability, provide the relevant experiences of one or more of the components of the consortium” (p. 56)
 - **Potential NOT to have to bear the cost of reinsurance (assuming the consortium has a strong balance sheet)**
 - **“Discretionary” elements of RFP better fit provider competencies**

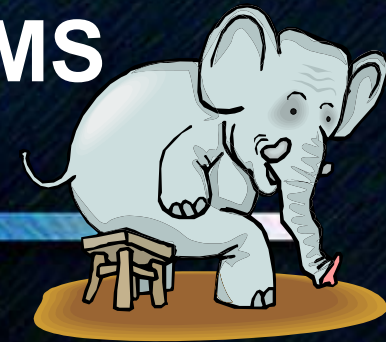
- **CMS is playing a strong hand with this RFP**
 - BIPA contracting process: 60+ applicants, 3 contracts
 - Large contracts are being made available
 - Tremendous learning opportunity for awardees
 - Many applicants (e.g., leading DM service companies) will be hard pressed to answer to their Boards and investors if they do NOT win a contract
- **However, CMS has overplayed the strength of its hand**
 - Complex, challenging RFP process
 - It's possible (perhaps probable) that many potential applicants will choose NOT to bid. Ironically, the non-bidders are most likely to be the provider consortia that CMS is trying so hard to attract.

The Elephant in the Living Room

"An elephant in the living room" is often used as a metaphor of what it's like to live in a home with alcoholism -- everyone knows it's there, but no one talks about it. Admitting there is an elephant is a first step toward recovery.



Describing the Elephant in the CMS CCI-I RFP

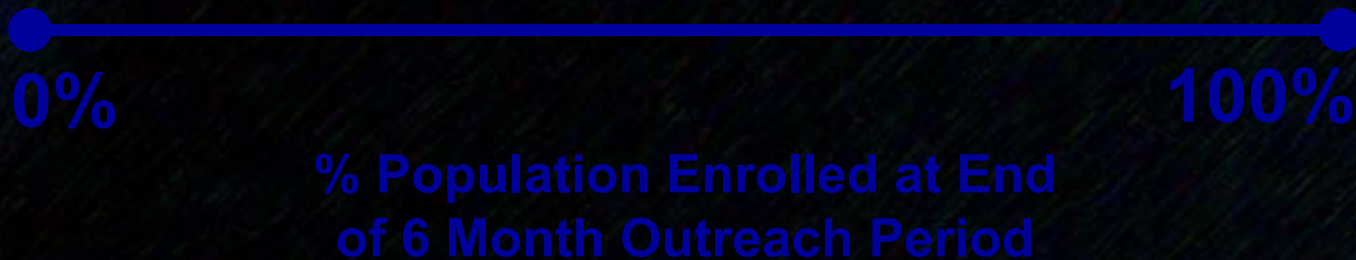


- 1) **Financial accountability for the entire population, including those:**
 - who opt out
 - who cannot be contacted
 - who choose not to participate when contacted
 - ...and more???

- 2) **The risk of low enrollment (after the 6 month outreach period)**
 - Acquiring contact information
 - Frail, potentially confused population
 - Getting patients to say “Yes” to participation
 - History to date: opt-out vs. opt-in programs vary dramatically

Recommendations for Dealing with the Elephant

- Understand the risks. Conduct financial sensitivity analysis with “% enrolled” as the independent variable.



- **Understand the relationship between enrollment levels and profitability**

- **X**: % enrollment needed to provide CMS with 5% net savings; the contractor retains 100% fees
- **Y**: % enrollment projected to provide CMS with 0% net savings; the contractor refunds 100% fees



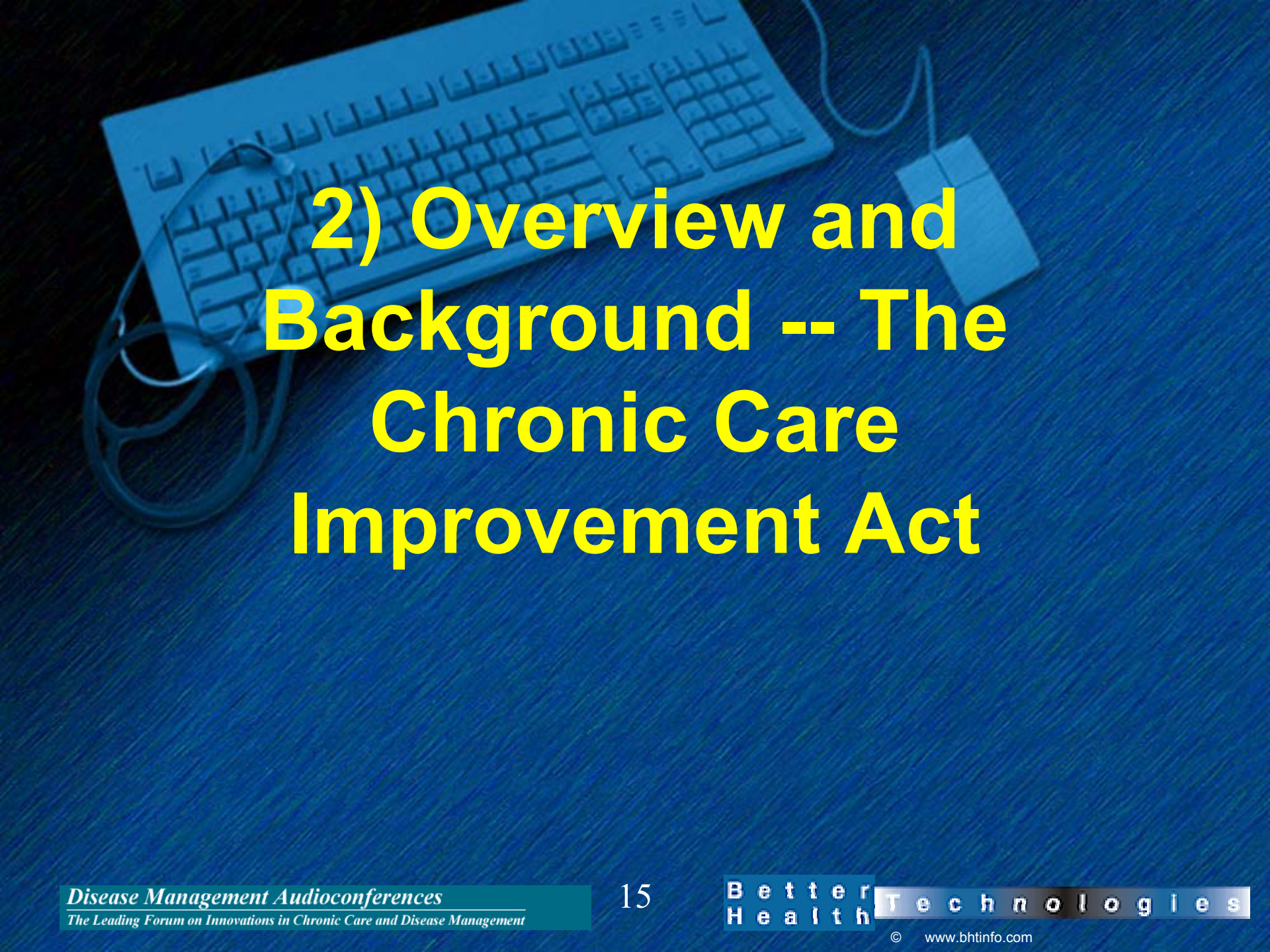
- Bargain with CMS for an “out” clause. “If we do not achieve **X%** enrollment at the end of the outreach period, the whole deal is off.”
- Understand your “best alternative to a negotiated agreement” (BATNA). When negotiating with CMS, understand the point(s) at which you are better off walking out the door.
- Negotiate for sharing upside savings. Now that you understand where **X** is, why wouldn't you want to propose sharing successes beyond **X**?

- **Maximize enrollment**

- Recognize that you cannot recover from low enrollment failures after the 6 month outreach period
- Bargain with CMS to assist with the enrollment process
- Front load resources during the 6 month outreach period
 - Finding potential participants
 - Getting verbal acceptance to participate

Summary

- Different route to success for experienced vs. inexperienced bidders
- **Winning Proposals:**
 - The Foundation: Demonstrate proficiency at the basics
 - Differentiators: Demonstrate creativity at the “discretionary” elements
- Plan for the single biggest uncertainty in the RFP -- the % enrollment you can achieve after the 6 month outreach period



2) Overview and Background -- The Chronic Care Improvement Act

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- **Sections 721-23 of the Medicare Modernization Act (MMA) are known as the Chronic Care Improvement Act. With this program, Medicare will pilot coverage of chronic care services to fee-for-service beneficiaries. The Act is aimed at improving clinical quality, improving beneficiary and provider satisfaction, and reducing Medicare spending.**

- **The legislation calls for a two-phased approach**
 - Phase I requires a three-year pilot project. The Centers for Medicaid and Medicare Services (CMS) is required to enter into contracts with chronic care improvement organizations (CCIOs) using randomized controlled groups.
 - Phase II. If results of Phase I indicate improved clinical quality of care, improved beneficiary satisfaction and achieved spending targets, CMS is required to expand the program nationwide. Phase II reflects the full implementation of the program for all beneficiaries.

Timeline Summary

- December 8, 2003 -- MMA legislation enacted
- **April 20, 2004 -- CMS releases the CCI-I (Chronic Care Improvement, Phase 1) RFP**
- August 6, 2004 -- proposals due back to CMS
- Mid-Fall 2004 -- awardee selection
- Late-Fall 2004 -- negotiations with presumptive awardees
- December 8, 2004 -- latest date on which CMS can announce the first contract
- December 2005 -- Interim progress report due from Medicare to Congress
- December 2006 -- earliest date on which Medicare could announce that the projects are successful and begin Phase II -- national implementation of contracting
- December 2007 -- end date for 3 year demonstration projects (assuming all contracts are announced in December 2004)
- May 2008 -- Final project analysis report due from Medicare to Congress
- May 2008 -- Latest date at which Phase II can begin if Phase I projects prove successful

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- The CCI-I RFP informs interested parties of an opportunity to apply to implement and operate a chronic care improvement program as part of Phase I under Section 721 of the MMA.
 - The RFP is 75 pages long!
 - The RFP is available on the [Chronic Care Improvement Program](#) page of the Medicare website.
 - The RFP incorporates CMS' thinking-to-date about broader chronic care improvement opportunities, as well as laying out the path for prospective applicants to submit applications. **THIS IS A VERY IMPORTANT DOCUMENT!**

Don't Be Confused by Other Medicare Chronic Care Improvement Projects and/or other MMA Demonstration Projects.

- **For the past several years, Medicare has already been experimenting with various ways of financing and delivering chronic care improvement services to chronically ill patients. These programs are described on the [Demonstration Projects and Evaluation Reports](#) page on the Medicare website.**
- **The MMA also authorizes many other demonstration projects. These are summarized on the [CMS Demonstrations Projects under the Medicare Modernization Act \(MMA\)](#) page of the Medicare website.**

Acronyms

- **CMS:** - Centers for Medicaid and Medicare Services
- **CCI-I:** Phase I of the CMS Chronic Care Improvement project
- **CCI-II:** Phase 2 of the CMS Chronic Care Improvement project
- **CCIO:** Chronic Care Improvement Organization -- organizations that are awardees of Chronic Care Improvement contracts from CMS
- **DM:** disease management
- **MMA:** Medicare Modernization Act
- **RFP:** request for proposal



3) Just the Facts Ma'am -- A Summary of the CMS CCI-I RFP

Highlights From the CMS Website

Highlights of the Program

- ✓ In Phase I, the pilot phase, there will be approximately 10 regional CCI programs, collectively serving approximately 150,000 - 300,000 chronically ill beneficiaries, in regions where at least 10% of Medicare beneficiaries reside. The Phase I programs will operate for 3 years and be evaluated through randomized controlled trials.
- ✓ The program will offer self-care guidance and support to chronically ill beneficiaries to help them manage their health, adhere to their physicians' plans of care, and assure that they seek (or obtain) medical care that they need to reduce their health risks.
- ✓ The programs will include collaboration with participants' providers to enhance communication of relevant clinical information. The programs are intended help to increase adherence to evidence-based care, reduce unnecessary hospital stays and emergency room visits, and help participants avoid costly and debilitating co-morbidities and complications.
- ✓ Initially, the programs will be focused on beneficiaries who have Congestive Heart Failure (CHF), Complex Diabetes, or Chronic Obstructive Pulmonary Disease (COPD) because these beneficiaries have heavy self-care burdens and high risks of experiencing poor clinical and financial outcomes.
- ✓ The new programs are NOT single-disease focused. They will be designed to help participants manage all their health problems.
- ✓ Participation will be entirely voluntary. Eligible beneficiaries do not have to change plans or providers or pay extra to participate. They will be able to stop participating at any time. They will not restrict access to care.
- ✓ Selected organizations will be required to refund some or all of their fees to the federal government if they do not meet agreed-upon standards for quality improvement, savings to Medicare, and increased satisfaction levels in their assigned beneficiary populations.
- ✓ This is a flexible business model. Health insurers, disease management organizations, physician group practices, integrated delivery systems, and consortia of these entities or other legal entities the Secretary determines appropriate are all eligible to apply to become CCI organizations.

Purpose/Design of the RFP (pp. 15-39)

- 1) **Eligible Organizations: DM organizations, health insurers, integrated delivery systems, physician groups, a consortium of entities, and anybody else that CMS “deems appropriate”**
- 2) **Identification of Intervention Groups**
 - CMS is focusing on patients with CHF, complex diabetes, COPD
 - CMS will identify eligible beneficiaries through claims data
 - Beneficiaries will be randomized into intervention and control groups

3) Identification of Potential Geographic Areas. CMS is interested in applications that target areas

- with higher than average prevalence of CHF or complex diabetes, or COPD
- with low Medicare quality rankings
- that do not conflict with current chronic care improvement projects

4) Outreach to Intervention Group

- Beneficiary participation will be “voluntary”
- Eligible beneficiaries in the intervention group will receive a letter and given an opportunity to opt-out of participation.
- Organizations awarded contracts will then be expected to confirm participation with those who do not decline to participate.
- Applicant’s proposals are expected to specify detailed outreach protocols; the outreach period will be 6 months.
- The control group will be passive -- they will not be offered participation, nor will they be aware of their status

5) Program Characteristics

- Programs must develop a care management plan for each participant
 - Guide the participant in managing their health
 - Use decision support tools such as evidence based guidelines
 - Develop a clinical information database
- CMS expects “transparency” of proprietary protocols and systems, but does not expect to transfer any intellectual property rights

6) Billing and Payment

- Each awardee will be paid a Per Member Per Month Fee for each participant
- “The fee amounts to be paid to awardees may vary because we envision testing a range of program models that may have different cost structures. We will establish fee amounts by agreement with each awardee.”

7) Performance Standards: Clinical Quality, Beneficiary Satisfaction and Savings Guarantees

- Applicants are expected to set forth projected improvements in clinical quality and savings
- Awardees will be penalized financially for not meeting agreed upon performance standards; applicants will be expected to propose performance guarantees for quality improvement and beneficiary satisfaction
- Performance will be measured on the entire intervention group (including those who chose not to be contacted, those who dropped out, and those unable to be reached)
- Awardees are required to guarantee 5% net financial savings to Medicare

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- Organizations must assume financial risk for performance. In the event that 5% net savings are not achieved, the awardee will be required to refund the difference to the government, up to the total amount of fees paid to the awardee (i.e., awardees assume financial risk for fees, not insurance risk)

8) Reconciliation Process

- An independent contractor will monitor outcomes
- Applicants will need to demonstrate financial solvency (presumably through a strong balance sheet and/or by obtaining reinsurance)

9) Program Monitoring

- CMS will conduct ongoing program monitoring
- Awardees will be expected to provide ongoing program monitoring information

10) Independent Formal Evaluation

- CMS will hire an independent contractor for formal evaluation of program results
- Experience of intervention groups will be compared to control groups

Requirements for Submission

Awardee Selection Process (pp. 39-41)

- **Awardee Selection Process. There will be a 2 stage process.**
 - **Stage 1:**
 - **Prospective applicants will be given a de-identified set of Medicare claims data**
 - **Applicants will analyze the data and submit an application and bid**
 - **Applicants should base their proposals on 20,000 beneficiaries in the intervention group**
 - **Stage 2:**
 - **CMS' review panel will evaluate applications and will recommend applicants for the second stage of the process**
 - **Applicants selected as finalists will be provided actual historical data for the applicable target population in the applicant's proposed geographic area.**

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- Finalists will be allowed to propose adjustments in proposed payments or savings guarantees
 - The CMS administrator will make final decisions

Requirements for Submission

Application (pp. 41-67)

- 1) Cover Letter
- 2) Application Form
- 3) Executive Summary
- 4) Rationale for Proposed Geographic Area and Target Population
- 5) Chronic Care Improvement Program Design
 - *A plan for outreach*
 - *A plan to assess and stratify participants*
 - *Frequency and type of interventions*
 - *Appropriate services and educational materials for participants*
 - *Adequate mechanisms for ensuring physician integration with the program*
 - *Adequate mechanisms for ensuring coordination with State and local agencies*
 - *Adequate mechanisms for supporting participants with more intensive needs*
 - *Data to be collected, data sources, and data analyses*

6) Organizational Structure and Capabilities

- *Staff*
- *Facilities*
- *Equipment*
- *Strong working relationships with local providers*
- *Strong working relationships with community organizations*
- *Appropriate information and financial systems*
- *Clinical protocols to guide care delivery and management*
- *Ongoing performance monitoring*
- *Organizational background and references*
- *Accreditation*

7) Performance Results


- **Past Performance: Clinical Quality, Beneficiary and Provider Satisfaction and Savings**
- **Performance Projections**
 - **core set of clinical quality indicators**
 - **projected savings for each year**
 - **projections on operational metrics**

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- 8) *Payment Methodology & Budget Neutrality***
 - 9) *Implementation Plan***
 - 10) *Supplemental Materials (Appendices)***

Application Evaluation Process

Criteria (pp. 67-72)

- **Application Evaluation Criteria and Weights**
 - **Rationale for Proposed Geographic Area and Target Population (5 points)**
 - **Chronic Care Improvement Program (25 points)**
 - **Organizational Capabilities and Structure (25 points)**
 - **Performance Results: Past Performance and Performance Projections (25 points)**
 - **Payment Methodology & Budget Neutrality (20 points)**



4) The Bigger Picture -- Analysis and Commentary on the CMS CCI-I RFP

Overview of Analysis and Commentary

- 1) CMS did a good job with the CCI-I RFP!
- 2) CMS *understands* the problems posed by chronic care patients
- 3) CMS has set chronic care improvement as a priority -- the issue is not “whether”, but “how?”
- 4) CMS *wants* this pilot to be successful
- 5) Tried and True: CMS’ is adopting use of many practices that are already established in current DM programs
- 6) Challenging and New: CMS is encouraging innovative practices in chronic care improvement
 - a) Multiple objectives for chronic care improvement programs
 - b) Technology integration
 - c) Provider participation in chronic care contracts
 - d) Physician integration into chronic care
 - e) Core set of clinical quality indicators
- 7) A major criticism: the RFP reinforces the short-term focus of current disease management programs

1) CMS did a good job with the CCI-I RFP!

- The CCI-I RFP embraces the positive role that government can play in improving health care quality and information technology.
- In 2002 the Institute of Medicine issued a report entitled Leadership by Example: Coordinating Government Roles in Improving Health Care Quality. This report explores how the federal government can leverage its unique position as regulator, purchaser, provider, and research sponsor to improve care.

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- In a speech on April 27, President Bush highlighted the role that the Federal government can play in advancing health care information technology:

“...the federal government can lead because we're spending a lot of money in health care. We're a large consumer on behalf of the American people. Think about it -- Medicare, Medicaid, veterans' benefits, federal employee health insurance plans, I mean, there's a lot of money going through the federal government, and therefore it provides a good opportunity for the federal government to be on the leading edge of proper reform and change.

2) CMS *understands* the problems posed by chronic care patients

- **The RFP concisely summarizes Medicare's challenges with chronic care patients (pp.6-9):**
 - **“Widespread failings in chronic care management are a major national concern. Many of these failings stem from systemic problems rather than lack of effort or intent by providers to deliver high quality care. Medicare beneficiaries are disproportionately affected because they typically have multiple chronic health problems.**
 - **“Beneficiaries who have multiple progressive chronic diseases are a large and costly subgroup of the Medicare population: Medicare beneficiaries with five or more chronic conditions represent 20 percent of the Medicare population but 66 percent of program spending.**
 - **“The current health care delivery system is structured and financed to manage acute care episodes, not to manage and support individuals with progressive chronic diseases. Providers of care are organized and paid for services provided in discrete settings (for example, hospitals, physician offices, home health care, long-term care, preventive services, etc.)”**
- **“So what?” you ask?**
- **Framing the problem accurately should not be taken for granted. Look where the lack of understanding about existence or non-existence of WMDs got us!**

3) CMS has *set* chronic care improvement as a priority -- the issue is not “whether”, but “how?”

“We are not testing whether Chronic Care Improvement is a good idea, but how to incorporate these services into traditional fee-for-service Medicare at scale.”

Source: [CMS Website](#), FAQ about the Chronic Care Improvement Program

4) CMS *wants* this pilot to be successful

- CMS recognizes the cost problems created by an aging population with chronic conditions
- The RFP is structured around immediate (low hanging fruit) opportunities for chronic care improvement
 - CHF
 - Complex diabetes
 - COPD
- CMS is asking bidders to focus on geographic areas with
 - High prevalence of each chronic condition
 - Lower than average existing Medicare quality ratings

5) Tried and True: CMS' is adopting use of many practices that are already established in current DM programs

- A focus on the highest cost/risk patients (as opposed to the entire population of Medicare members with a chronic condition)
- Identification of intervention groups (predictive modeling)
- Outreach to intervention groups
- Program characteristics and interventions
- Requirement for contracting organizations to guarantee savings and assume financial risk for performance
- etc.

6) Challenging and New: CMS is encouraging innovative practices in chronic care improvement

6a) Multiple objectives for chronic care improvement programs

- “The principal objectives of CCI-I are to develop and test new strategies to improve quality of care and beneficiary and provider satisfaction cost-effectively for chronically ill FFS Medicare beneficiaries that are scalable, replicable and adaptable nationally.” (p. 5)
- The RFP cites other objectives as well (p. 3):
 - improve chronic care
 - accelerate the adoption of health information technology
 - reduce avoidable costs
 - diminish health disparities among Medicare beneficiaries nationally.

6b) Technology integration

- “health information technology is expected to improve quality and fundamentality change the way health care is provided (Institute of Medicine, IOM 2004) by providing actionable evidence at the point of care, reducing errors, duplicate tests, unnecessary admissions, adverse events, and rejected claims.” (p. 12)
- The RFP requires use of IT in patients’ care management plans (p. 28)
 - Decision support tools, e.g., evidence based practice guidelines
 - Clinical information data base
- The RFP challenges bidders to integrate other IT tools (pp. 16, 29)
 - in-home monitoring devices
 - integrative information infrastructures
 - new applications of information and communication technologies
 - expert clinical systems
 - predictive modeling
 - interoperative electronic health records
 - information technology used at the point of care

6c) Provider participation in chronic care contracts

- While the RFP asks bidders to document previous outcomes, it also contains....
- The Affirmative Action clause
 - “If a consortium has no prior experience to draw from, the applicant should, to the best of its ability, provide the relevant experiences of one or more of the components of the consortium” (p. 56)
- CMS has been very encouraging to provider consortia. CMS wants to see providers bid for contracts.

6d) Physician integration into chronic care

- The RFP requires bidders to demonstrate “adequate mechanisms for ensuring physician integration with the program” (p. 47)
 - “Describe the program’s strategy to encourage physicians and other providers to actively participate in the program.
 - “Describe how the program will integrate beneficiaries’ physicians and other providers into the program and ensure that the program enhances patient-provider relationships.
 - “Describe how the program will ensure exchange of patient information with applicable providers in an effective, timely, and confidential manner across care settings.
 - “Describe how the program will facilitate access to timely and accurate patient information at the point of care. If the program includes incentives for the physician to adopt or use decision-support tools or other health information technology, describe the basis and impact of these incentives.”

6e) Core set of clinical quality indicators

- In 2002-03 the Disease Management Association of America (DMAA) attempted to establish standardized outcomes measures for DM.
- DMAA's attempt was NOT successful.
- Medicare is adopting a core set of clinical quality indicators for the RFPs (see next page for an example).
- Since Medicare is the largest single payor in the US, will these clinical indicators become *defacto* standardized outcome measures?

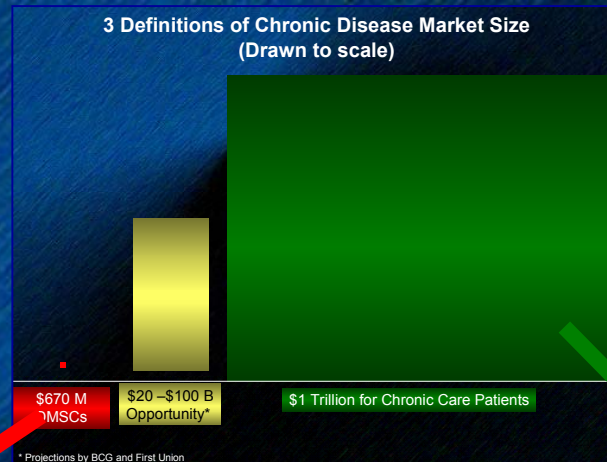
Example: core clinical quality indicators for heart failure

Heart Failure							
Measure	Data Source *	Projected % Improvement in Intervention Group Over Prior Year			Projected % Change Compared to Control Group		
		1YR	2YRS	3YRS	1YR	2YRS	3YRS
Assessment of left ventricular ejection fraction							
Blood Pressure controlled (< 130/85)							
Use of angiotensin converting enzyme inhibitors (ACE-I)/angiotensin receptor blockers (ARB) or hydralazine/isosorbide for patients with LVEF < .4							
Dose of ACE-I							
Use of beta-blockers for patients with LVEF < .4							
Monitoring daily weights							
Sodium intake counseling							
Compliance with medication regimen							
Spironolactone for patients with AHA/ACC III or IV classification							
Daily aspirin, other antiplatelet or anticoagulant							

7) A major criticism: the RFP reinforces the short-term focus of current DM programs

- To date, disease management business models have been very focused:
 - Health plans (and more recently employers), have been the primary purchasers of DM programs
 - Short-term focus -- ROI usually expected within 1 year
 - Focus on 4-6 top diseases/conditions: CHF, COPD, multiple comorbidities, etc.
 - See DM Today and DM Tomorrow, next slide
- The CMS RFP continues this focused approach
- However, the greater promise of disease management improvement processes goes to improvement in both short- and long-term clinical and financial outcomes.

DM Today



DM Tomorrow

DM Business Model

- Prevent unnecessary hospitalizations and ER visits
- Save \$\$ short term for payor
- Quality w/o ROI only “sells” for a few diseases
- 4 to 6 top diseases
- Done “to” the patient
- Care coordinator = 3rd party
- Local/regional focus
- Outsource vs. build

Emerging DM Models

- Optimize patient health status & clinical outcomes
- Save \$\$ long term for payor or patient
- Health care consumerism/ patient empowerment
- 100+ conditions/diseases
- Done “by” the patient
- Care coordinator = patient or doctor
- Not geographically bound
- Assembly from components viable

-
- **As the payor of last resort, it is disappointing that Medicare continues to reinforce the short-term focus of current DM programs. One would hope and expect government to be able to take on a longer-term perspective.**
 - **However, the political reality is that CMS must demonstrate quick and tangible results from its chronic care improvement projects.**
 - **Thus, this flaw -- the focus on short-term results -- is not fatal. It can be corrected in future programs.**



APPENDIX

Better Health Technologies

- **Creating value for patients and shareholders**
- **Strategy, business models, partnerships**
- **Disease/care management and e-health**
- **Consulting/Business Development**

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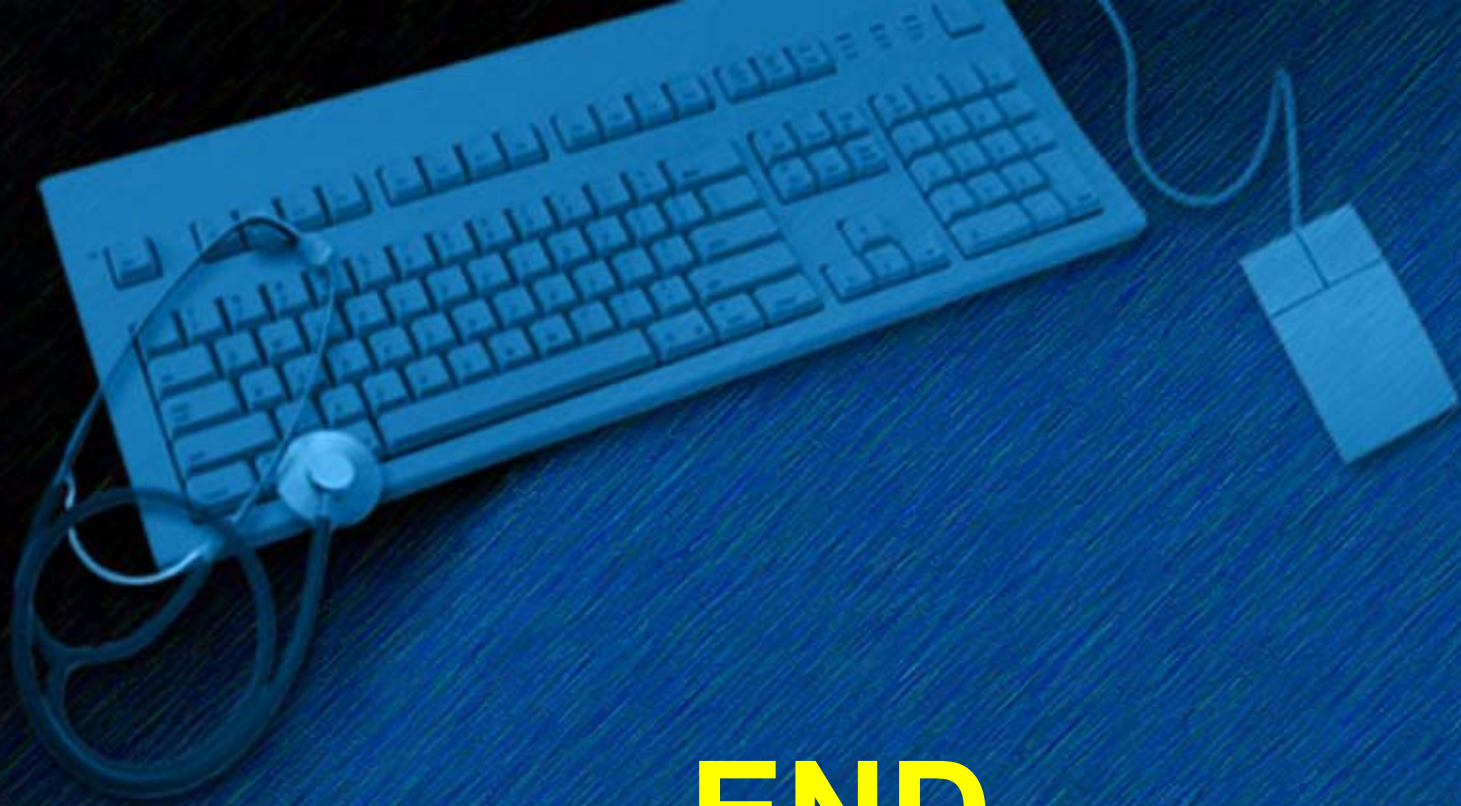
Better Health Technologies' Clients

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Cardiobeat
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Medical Peace
Stress Less
DiabetesManager.com
CogniMed
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Benchmark Oncology
SOS Wireless
Click4Care
eCare Technologies
The Healan Group
FitSense Technology
Health Mobius

Established organizations

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-- Global Research Group
-- Samsung Advanced Institute of Technology
-- Digital Solution Center
Medtronic
-- Neurological Disease Management
-- Cardiac Rhythm Patient Management
Sears Methodist Retirement System
Siemens Medical Solutions
Joslin Diabetes Center
National Rural Electric Cooperative Association
Disease Management Association of America
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Varian Medical Systems
VRI
Washoe Health System
S2 Systems
CorpHealth
Physician IPA
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