



# Disease Management in Fee-for-Service Medicare: An Overview

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# Why disease management in FFS Medicare?



# Medicare's population

- 20% of beneficiaries
  - Have 5+ chronic conditions
  - Incur 66% of Medicare spending
- High rates of hospital admissions for chronically ill
  - Many seem preventable

# The healthcare delivery system

- Acute care focused
- Fragmented
  - Medicare beneficiaries see 6.4 MDs and fill 20 prescriptions annually
  - Beneficiaries with 5+ chronic conditions see 14 MDs and fill 57 prescriptions annually
- Modeled on medical management
  - Lacking self-management
- Reactive system
  - Challenge is to be proactive

# Why DM?

- Intuitive appeal – it just makes sense
  - Opportunity to improve lives *and* reduce costs
- Claims of huge effects in other markets
- Enormous savings potential in a program that needs to contain costs
  - High prevalence means large target population



# What models has CMS tested?

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- 7 demonstrations/pilots
- 35 sites in 22 states
- Since 1999
- 18 months' to 8 years' experience
- 300,000 beneficiaries
- Over \$750 million in fees, most subject to recoupment



# Demonstrations & pilots

- Home telemedicine w/ nurse case management
- Case management
- Care coordination
- Disease management for severely chronically ill, w/ prescription drugs
- Disease management for dual eligibles
- Medicare Health Support (Chronic care improvement program)
- Care management for high-cost beneficiaries

# Population targeted

- Often: CHF, diabetes, CAD
- Some: COPD, cancer
- Some just high cost/high risk regardless of conditions
- Require holistic management of the beneficiary

# Interventions

- Largely telephonic (or mail)
- With or without remote monitoring technology (weight, BP, glucose)
- Varied on-the-ground components
- Varied degree of physician involvement
- Vendor receives monthly payment per beneficiary (\$75-\$175, more for enrollment-based models and Rx)



# Varied designs

- Enrollment (opt-in), population-based (consent or opt-out)
- No financial risk, risk on fees only, full insurance risk
- Budget neutrality or 5% net of fees
- Risk on quality metrics
- Shared savings
- Randomized and quasi-experimental control groups (not pre-post)



# What are the findings?



# Not living up to the promise

- Quality of care generally high at start, has not significantly improved
- Beneficiary and physician satisfaction not significantly different between treatment and control groups
- Behavior change not in sufficient volume across these populations to impact cost or suggestive of long-term savings
- Program savings far less than promised

# Findings

- Only 7 programs at or near budget neutrality
  - Extended and/or restructured
- Scattered modest effects if any on:
  - Adherence/compliance
  - Self-care activities
  - Clinical quality indicators
- No impact on mortality
- Participants/families like the programs

# Savings?

- Utilization generally not impacted
- Any decrease in claims costs falls far short of covering fees
- Fees generally result in *increasing* Medicare's costs, not net savings
  - Increases often \$1,000-\$2,000/yr. (5-10%) or more
  - Spending 1-3 times as much on DM as on physician visits for these beneficiaries
- Break even point: <\$20 per beneficiary per month



# The beneficiaries

- Some too ill, some too well, to engage or to benefit
- FFS generally more frail than Medicare managed care or commercial populations
- Costs are often not for index condition
- Significant social needs and mental health issues add to challenge
- Longstanding conditions/behaviors
- High mortality rates

# Clinical measures

- Difficulty of getting beyond claims-based measures
  - Suggests limited contact with treating physicians
  - What info are vendors using to manage these patients?

# What shows promise?

- No single necessary or best approach
- Experienced RNs yield better outcomes
- More in-person contacts yield better outcomes



# Next steps for CMS?

# What Next?

## ■ Extensions of current programs

- Are existing positive results sustainable?
- Can the programs be replicated?
- What elements work under what conditions?

## ■ Study chronically ill beneficiaries

## ■ Other Medicare demonstrations

- Senior Risk Reduction
- Medical Home

# Senior Risk Reduction Demonstration

- Provide health coaching based on individual health risk appraisals
- 3 organizations
- ~ 60,000 beneficiaries, ages 67-74
- Aimed at prevention
- Pilot conducted in 2008; demo to begin in spring 2009



# Medical Home Demonstration

- Transformation of primary care practice
  - Personal physician
  - Team approach
  - Comprehensive, coordinated care
  - Expanded access
- Care management fee & shared savings
- Timeline
  - 2009: Site announcement, physician recruitment, practice qualification
  - 2010: Demo begins



**For more information, go to:**

<http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp?intNumPerPage=all&submit=Go>