The Perspective of the Industry on the Role of Disease Management and Chronic Care in Medicare, Medicaid, and Health Reform

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Divergent Results from MHS

- Disease management and population health improvement strategies have shown positive results in multiple settings, including Medicare, Medicaid, privately insured populations
- Many of these successful programs had different conditions than Medicare Health Support pilots
- Despite some gains, interim MHS results diverge from pattern of results elsewhere; we need deeper understanding of why, in order to remedy

How to Reconcile & Leverage

- Probe cumulative experience to identify what works for whom in different settings
- Expect incremental progress, not quantum leaps with novel models
- Assess cost-effectiveness to determine impact on value of care
- Expand methods of inquiry, learning beyond traditional approaches

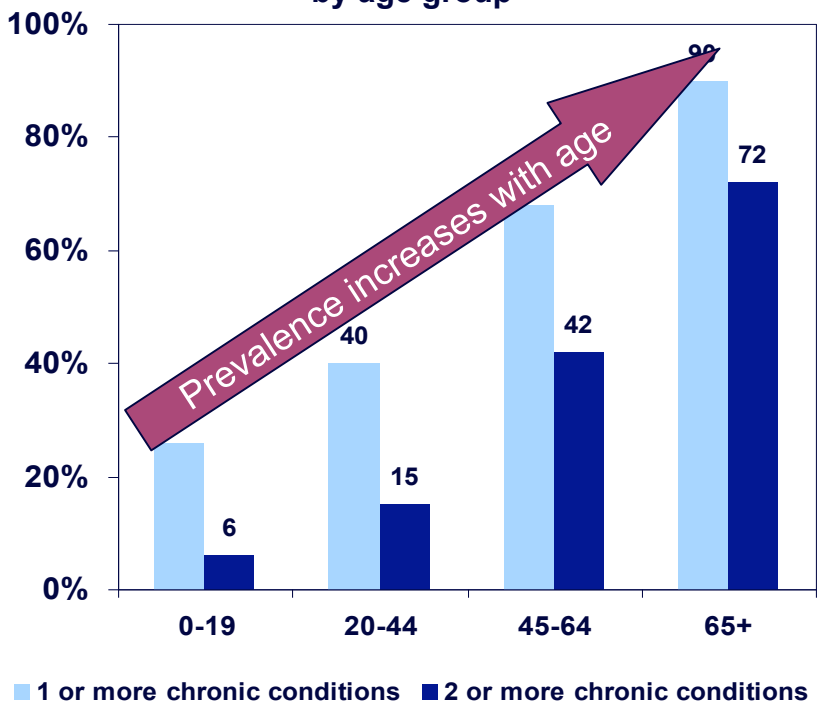
The Industry Can Help

- Industry should do better job of extracting, sharing learnings
- Explore patient-centric medical home models for convergence of care management and primary care
- Offer experience and expertise to CMS, providers, others in hard work of perfecting population health improvement incrementally

Chronic Disease Driving Cost

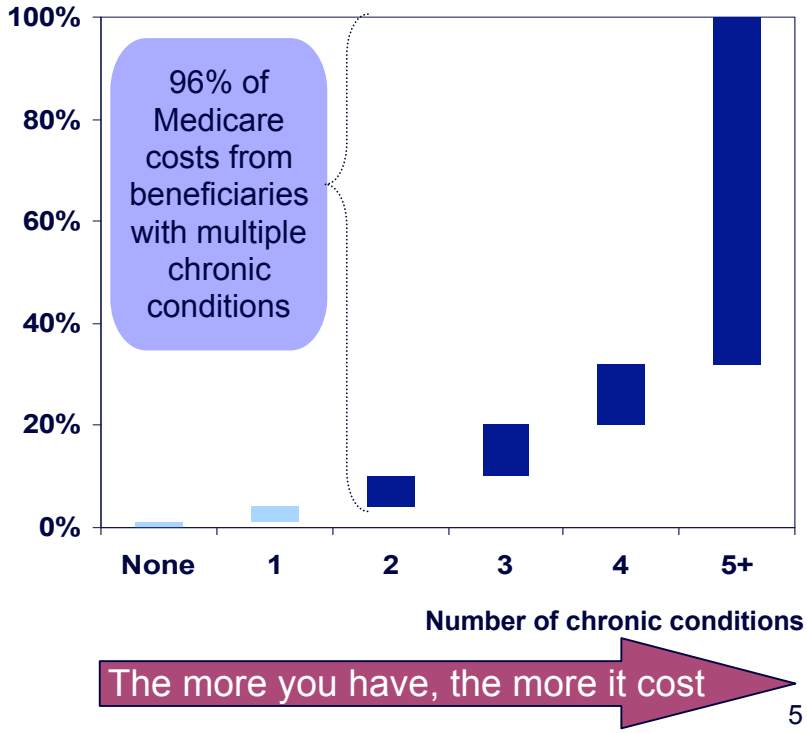
~ Three quarters of seniors have multiple chronic conditions . . . .

Percent of U.S. population with chronic conditions by age group



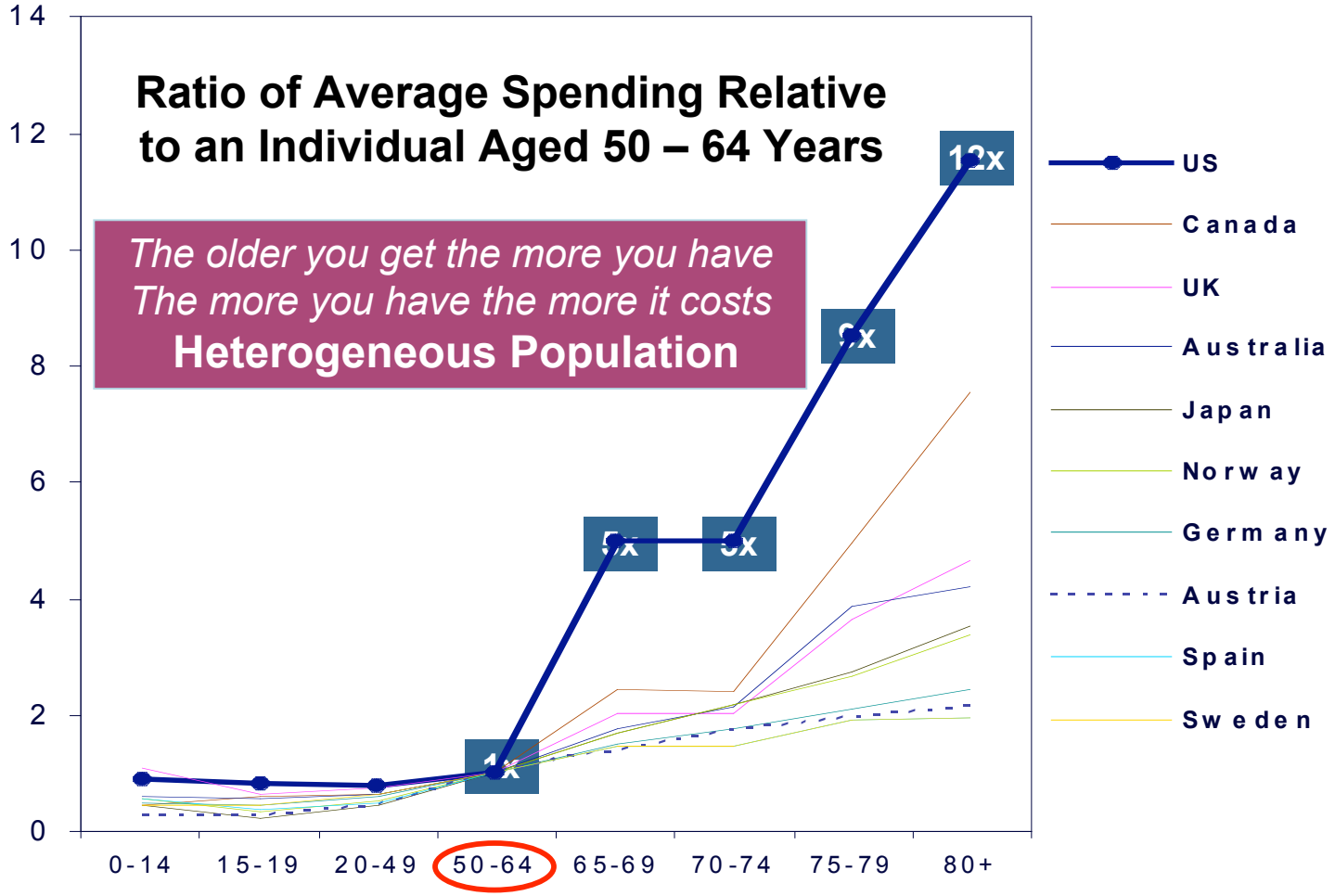
. . . . accounting for 96% of Medicare costs

Percent of Medicare expenses by beneficiary chronic condition status



Source: Anderson, G. Chronic Conditions: Making the case for ongoing care. Johns Hopkins University. November 2007.

Compounding Effects



Laurence Kotlikoff and Christian Hagist, "Who's Going Broke?" National Bureau of Economic Research, Working Paper No. 11833, December 2005, p. 25 (various sub-sources by country dated 2000-2003)

Medicare Health Support (MHS)

- Eight pilots, assigned specific geographies
  - Different approaches selected to maximize learning
  - Allowed to modify program design based on learning
- Selection of sicker individuals than average FFS Medicare
  - HCC[1] score of 1.35 or greater required for eligibility
  - Average HCCs for pilots ranged 2.2 – 2.5
  - 20-30% of pilot participants are >300% "sicker" than average Medicare FFS beneficiary

(1) Hierarchical Condition Category

Population Attributes – MHS vs. FFS Medicare

- PBPM Cost per Beneficiary per Month 3.0 X
- Hospital Admission Rate 2.5 X
- Hospital Bed-Days 2.5 X
- Skilled Nursing Facilities Admit Rate 1.5 X

- **Older, sicker, higher mortality**
  - Seeing ~ 7-10 physicians on average
  - Take ~10-20 medications at any point in time
  - About 1% dying each month

Source: Healthways MHS program experience

Targeting Subpopulations

- Identification and segmentation of high risk populations
  - Once identified, traditional risk scores do not further distinguish important sub-groups

- Development or refinement of predictive models identifying segments of the high-risk population

Outcomes - Will We Learn Everything We Want to Know?

- No consistent approach: each a virtual case study
- Selection of sicker individuals than average FFS Medicare
- Effect of mortality and rapidly declining cohort size

Summary

- Cost and quality are the challenges, and chronic conditions are driving cost
- The Medicare population is heterogeneous and important subgroups need to be identified and managed appropriately
- MHS has led to important advances in evolving care support for the high risk, high disease burden subpopulation
- Partnership and collaboration with CMS is core to success
- The "cure" will require prevention *and* better chronic condition management