The BIPA Disease Management Demo Project: Improving Outcomes For Medicare Beneficiaries

Prepared for:
Disease Management Colloquium
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General Overview

- Started in late 90's as Diabetex, a diabetes DM Company with a primarily lower extremity focus

- Now focus on primarily seniors with complex diabetes and CHF, and the full range of co-morbid conditions
  - Changed name to XLHealth in late 2004
  - BIPA enrollment criteria includes 3 approximately equally sized categories: Complex Diabetes Without CHF; Complex Diabetes With CHF; CHF Without Diabetes

- BIPA Demo initial enrollment effective date is April 1, 2004
  - Award finalized in late 2003, and patient/provider recruiting started in Q1, 2003
  - While BIPA Demo is a "transforming event" for the Company from a revenue, number of lives and direct contracting with CMS perspective, the clinical model is the very similar to the existing business (pharmacy risk is new), and the Texas geography overlaps with existing business

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General Overview (cont.)

- High Touch: XLHealth's model relies heavily on market-based operations, and physical interaction with physicians, patients and their caregivers
  - Nurse Program manager and additional support in each of 6 metropolitan areas
- Physician Driven: XLHealth integrates deeply with patient's existing physicians and other caregivers, and uses existing physicians to drive the Care Team
- Lower Extremity Focus For Diabetes: XLHealth's Diabetes care management approach uses a Lower Extremity Focus to educate patients and monitor the need for intervention
- Best-of-Class Information System & Usage: XLHealth's internally developed information system effectively captures and prioritizes data, and allows us to assist in developing and following evidence-based medicine approaches

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Program Goals & Objectives

- Prove that for Medicare Beneficiaries with Complex Diabetes and CHF, a Disease Management program that incorporates a pharmacy benefit can generate Medicare Part A/B savings sufficient to offset DM and pharmacy costs
  - "find better ways to improve the quality of life for people with diabetes and chronic heart disease"
  - "determine the benefits of disease management programs for chronically ill persons"
  - "find ways to make these services available to people with Medicare"
- Improved quality leads to increased satisfaction and decreased cost for these chronically ill beneficiaries
- Effectively Provide DM to Medicare beneficiaries, so that Medicare will continue to use DM for predictably high cost, manageable beneficiaries
  - DM in Capitated Setting: HCC risk adjustment system, Specialized Plan legislation, Capitated Disease Management Demonstration, etc.
  - DM in a FFS Setting: Voluntary Chronic Care Improvement Program, etc.
  - DM in Medicaid: CMS/Medicaid DM efforts are also rapidly expanding

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Operational Goals & Objectives

- Identify target population
- Generate physician/market awareness and support
- Obtain patient consents
- Create “registry”
- Collect and store data, and create initial Tiers
- Patient outreach, including face-to-face assessments, to improve data/tiers
- Generate patient specific Action Plan and Communications Track, incorporating the patient, physician and caregivers
- Obtain/Maintain physician buy-in by genuinely improving their ability to take care of their most difficult patients, including by improving the economics of taking care of those patients
- Obtain/Maintain patient and caregiver buy-in as a result of more coordinated and higher quality care

Lessons Learned

- CMS is highly committed and excellent to work with
- "Contracting" process is flexible, yet rigorous, and should result in measurable and improved outcomes
- Obtaining data is not always as easy/quick as expected
- "There is a lot going on" for Medicare beneficiaries, which makes communication of new Program challenging, even when it appears to be highly favorable for those who qualify
  - We have been confused with Drug Cards, HMOs, other
  - Implication is that recruitment could be even harder if offering is less valuable (Drug Care enrollment is quite slow so far, even though "break even" is easy to achieve)
- Medicare is a big place, and that can cause confusion
  - 1800 Medicare not always able to confirm our existence
  - Providers confused re: eligibility and billing due to use of Group Health Plan systems
- Enrollment success requires an ongoing and multifaceted approach
- There will continue to be surprises…

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Next Steps

- Complete and then maintain full enrollment
- Utilize core clinical model to generate improved quality and reduced cost
- Continually evaluate opportunities for improvement
- Address surprises
- BIPA Demo health economics and outcomes research
- Use BIPA learning to improve CMS and other DM initiatives