

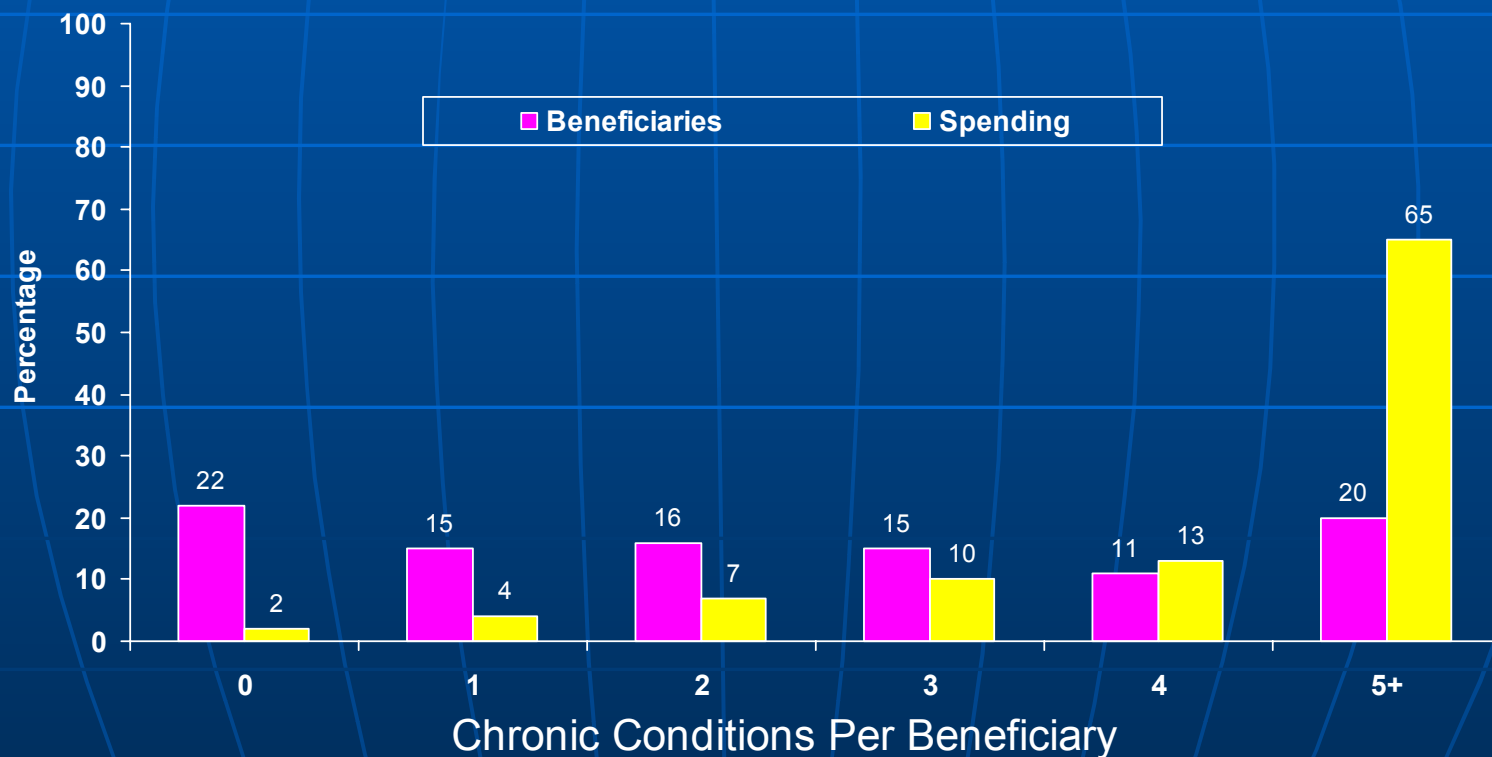
# Improving Care for the Chronically Ill

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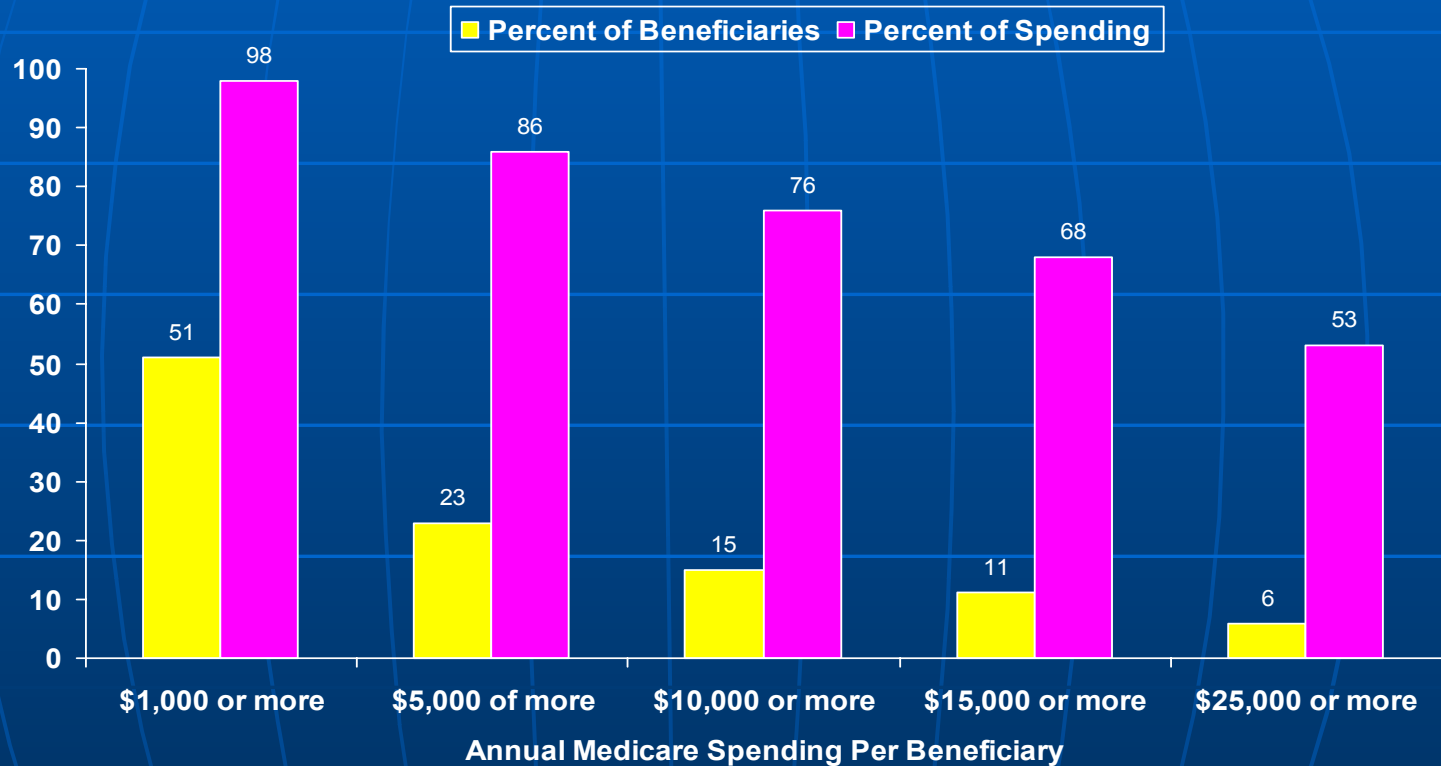
# Medicare Spending for Beneficiaries' with Chronic Conditions

The 20 percent of beneficiaries with 5+ chronic conditions incur 66 percent of Medicare spending



Source: Partnership for Solutions

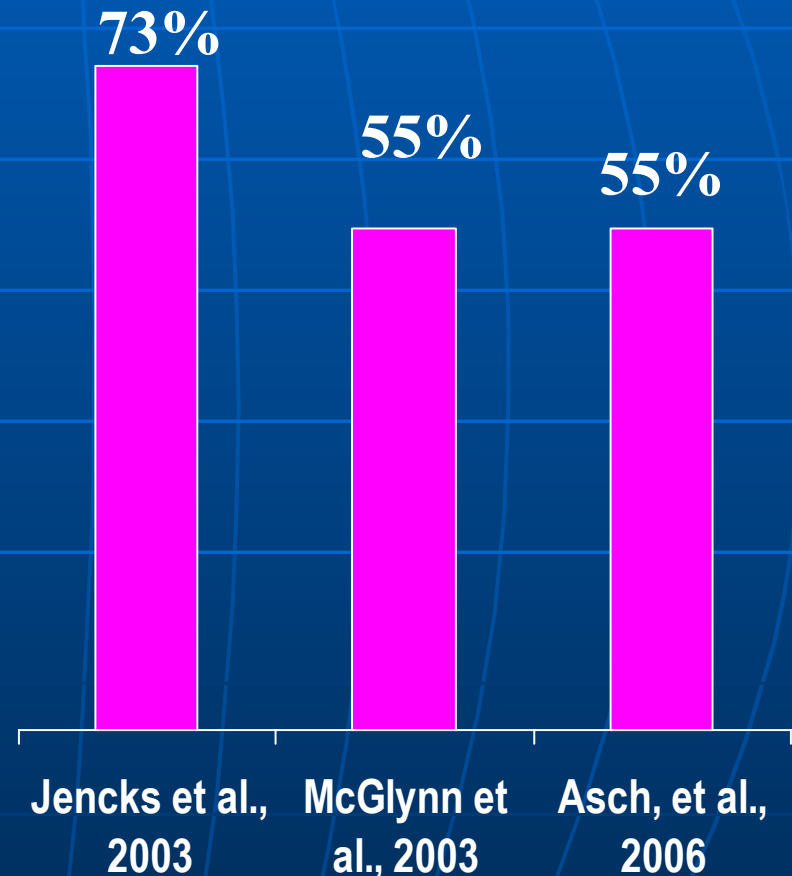
# Concentration of Medicare Expenditures



Source: CMS, Office of Research, Development, and Information

# Improvement Opportunities

- Significant gaps in care
- Recent studies show
  - 73% seniors receive appropriate care
  - Between 51% and 59% of adults receive recommended care
- Opportunities for providing the right care at the right time in the right place



# The Healthcare Delivery System

- Acute care focused
- Fragmented
- Modeled on medical management
  - Lacking self-management
- Reactive system
  - Challenge is to be proactive

# Fragmentation of Care

- Chronic care failings widespread
- Fragmentation is a serious problem
  - On average, Medicare beneficiaries see 6.4 MDs and fill 20 prescriptions annually
  - Beneficiaries with 5+ chronic conditions see 14 MDs and fill 57 prescriptions annually

# Evolution of CMS Initiatives

## Enrollment models

- Coordinated care – 2002
  - Sites not at risk
- Disease management w/ Rx drug benefit –2003
  - Organizations at full risk for guaranteed savings

# Evolution (cont'd.)

## Population models

- LifeMasters disease management – 2004
  - Population-based focusing on dual eligibles (up to 30,000 participants)
  - Fee risk and shared savings
- Medicare Health Support – 2005
  - Population-based, fee risk for guaranteed savings



# MHS Implementation

## Phase I

- 8 pilot programs
- Randomized control trial: 20,000 beneficiaries in treatment, 10,000 in control group, per site

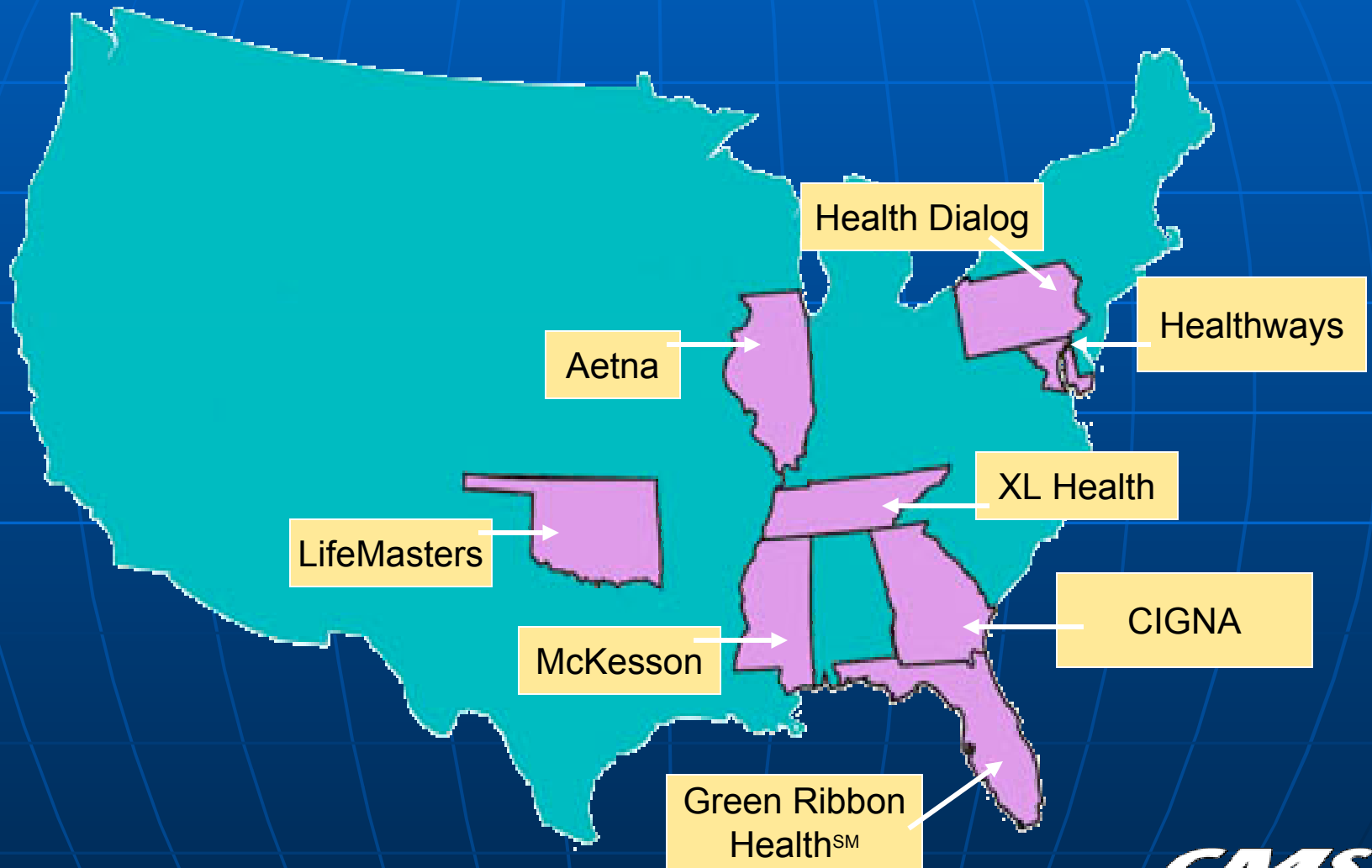
## Phase II

- Evaluation outcomes drive expansion
  - Savings targets, clinical quality metrics, beneficiary satisfaction
- Expansion could follow in 2-3.5 years

# MHS Key Features

- Pilot programs
- 24/7 personalized support for chronically ill beneficiaries
- Voluntary participation
- Free of charge
- No change in plans, benefits, choice of providers or claims payment
- Holistic approach

# Locations of MHS Programs



# Shifting Focus

- Increasing scale of projects
- Changing financial risk to vendors or providers
  - Withholds, savings guarantees
- Opt-out versus opt-in enrollment
- Nature of physician involvement

# Where Are We Now?

- Fundamental intervention is same:  
coordinated care = disease  
management = chronic care  
improvement
- Jury is still out in terms of results
- Band-aids on a broken system

# The Healthcare Delivery System

Still:

- Acute care focused
- Fragmented
- Modeled on medical management
- Reactive system

# So How Do We Change the System?

# Where Are We Going?

- Medicare Advantage Special Needs Plans
  - Chronically ill or others
- ESRD disease management
  - Managed care option w/ quality withhold



# Value-Based Purchasing Strategies

- System efficiencies across providers
  - Care coordination
  - Managing transitions across settings
- Shared clinical information
  - Reduce duplicative tests and procedures
- Improve processes and outcomes
  - Increase guideline compliance

# Value-Based Purchasing Strategies

- Patient education
  - Self-care support
- Reduce avoidable hospital admissions, re-admissions, emergency room visits
- Substitute outpatient for inpatient services
  - Less invasive procedures for more invasive procedures
- Reduce lengths of stay

# Where Are We Going in FFS?

- Physician group practice
  - FFS payment + shared savings/performance bonus
    - Business risk only
- Care management for high-cost beneficiaries
  - Provider-driven alternative to MHS

# Physician Group Practice Demonstration Overview

- Medicare FFS payments
- Performance payments derived from practice efficiency & improved patient management (shared savings)
  - Financial Performance
  - Quality Performance
- Budget neutral

# Physician Group Practice: Goals & Objectives

- Encourage coordination of Medicare Part A & Part B services
- Promote efficiency thru investment in infrastructure and care processes
- Reward physicians for improving efficiency, quality and outcomes

# Physician Group Practice: Process & Outcome Measures

- Congestive heart failure
- Coronary artery disease
- Diabetes mellitus
- Hypertension
- Cancer screening

# Physician Group Practice Models & Strategies

- Care management
  - Disease management & case management strategies
  - Managing care across transitions
- Increased access – nurse call lines, primary care physicians, geriatricians
- Enhanced patient monitoring through EMRs, disease registries
- Increase quality through evidence-based guidelines

# High Cost Beneficiaries Demo

Goal: Test ability of direct-care provider models to coordinate care for high-cost/high-risk beneficiaries in traditional (“original”) fee-for-service Medicare by providing support to manage their chronic conditions and enjoy a better quality of life



# Demonstration Strategies

- Physician and nurse home visits
- Use of in-home monitoring devices
- Electronic medical records
- Self-care, caregiver support, education
- 24-hour nurse telephone lines
- Behavioral health management
- Transportation services

# Under Development

- Medicare care management performance
  - Physician practice-based care management
    - Incentives for health IT adoption and use
- Medicare health care quality
  - Restructured delivery system and integration of health IT

# Medicare Care Management Performance Demonstration

- MMA Section 649
- Goals:
  - Improve quality and coordination of care for chronically ill Medicare FFS beneficiaries
  - Promote adoption and use of information technology by small to medium-sized physician practices

# Medicare Care Management Performance Demonstration

- Pay for performance for MDs who:
  - Achieve quality benchmarks for chronically ill Medicare beneficiaries
  - Adopt and implement health information technology, use it to report quality measures electronically
- Budget neutral

# Medicare Care Management Performance Demonstration

- ~ 800 practices participating in four states
  - Arkansas
  - California
  - Massachusetts
  - Utah
- Technical assistance to physician practices by quality improvement organizations

# Quality & Outcome Measures: Examples

- Diabetes mellitus – HgA1c, blood pressure, lipids
- Congestive heart failure – left ventricular function, ACE inhibitor, beta blocker
- Coronary artery disease – LDL cholesterol, antiplatelet therapy
- Prevention – mammogram, flu vaccine, pneumonia vaccine

# Medicare Health Care Quality (MHCQ) Demonstration

*"... demonstration projects that examine health deliver factors that encourage the delivery of improved quality in patient care, including—*  
*(1) incentives to improve the safety of care;*  
*(2) appropriate use of best practice guidelines by providers and services by beneficiaries;*  
*(3) reduced scientific uncertainty through examination of variations in the utilization and allocation of services, and outcomes measurement and research;*

# Medicare Health Care Quality (MHCQ) Demonstration

*(4) shared decision making between providers and patients;*

*(5) provision of incentives for improving the quality and safety and achieving efficient allocation of resources;*

*(6) appropriate use of culturally and ethnically sensitive health care delivery; and*

*(7) financial effects on the health care marketplace of altering incentives delivery and changing the allocation of resources.”*



# Medicare Health Care Quality (MHCQ) Demonstration

- System redesign
- Payment models incorporating incentives to improve quality and safety of care and efficiency
  - Best practice guidelines
  - Reduced scientific uncertainty
  - Shared decision making
  - Cultural competence

# MHCQ System Redesign

- Hardwire quality into delivery system
  - Make it easy to do the right thing
- Institute of Medicine aims for improvement
  - Safety, timeliness, effectiveness, efficiency, equity, patient-centeredness
- Integrate health information technology
  - Inform practice, connect clinicians

# For More Information

- [www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp#TopOfPage](http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp#TopOfPage)
- [www.cms.hhs.gov/CCIP](http://www.cms.hhs.gov/CCIP)