Improving Care for the Chronically Ill

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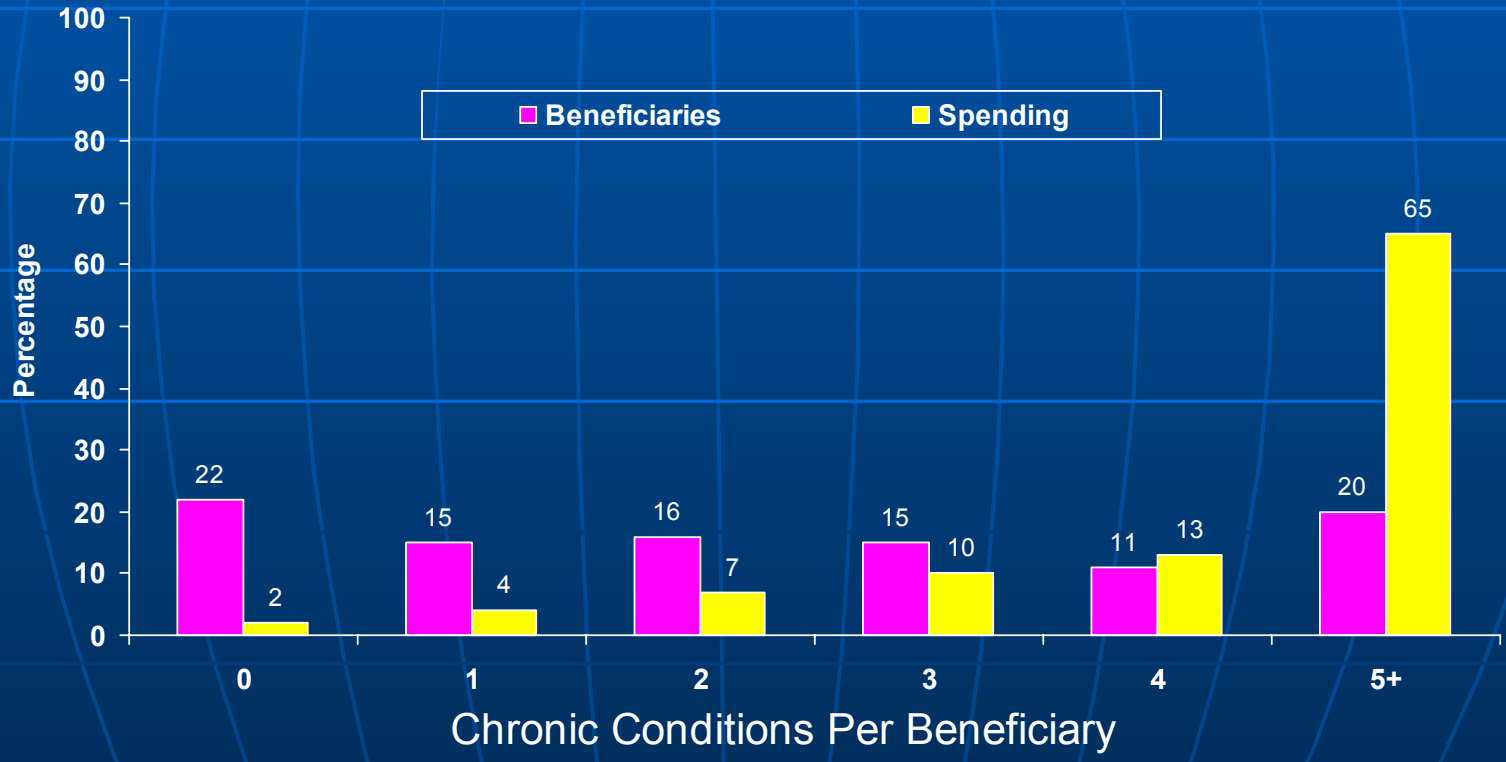
Medicare Spending for Beneficiaries' with Chronic Conditions

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



Source: Partnership for Solutions

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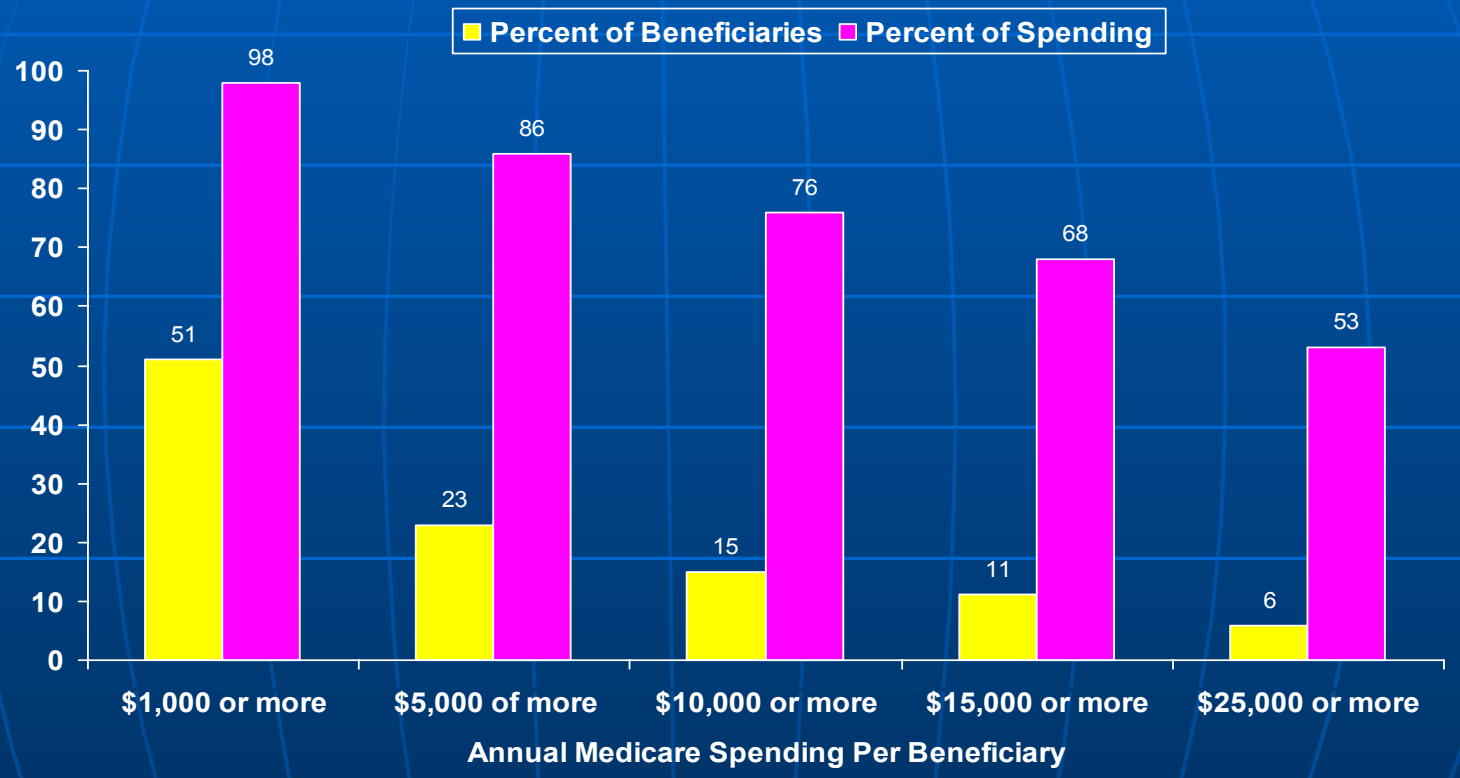
Concentration of Medicare Expenditures



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

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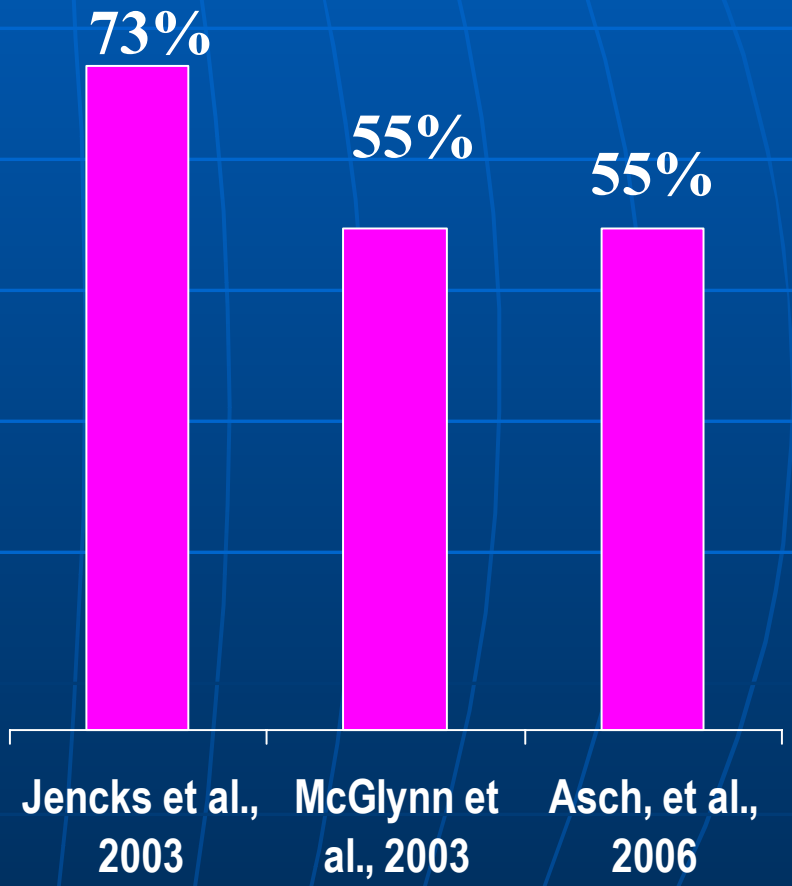
Improvement Opportunities

- 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



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The Healthcare Delivery System

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

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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

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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

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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

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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

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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

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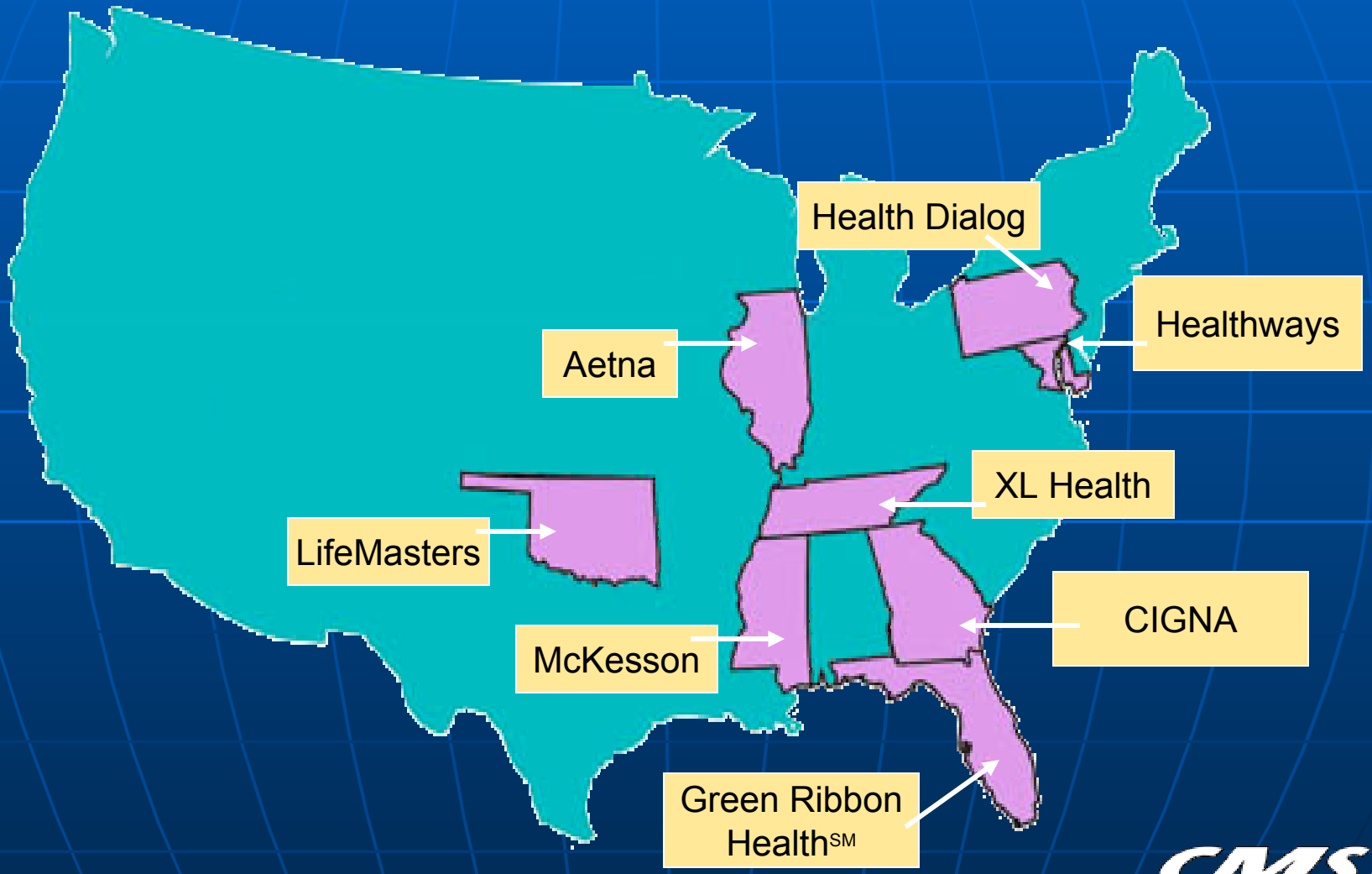
Locations of MHS Programs



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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

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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

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So How Do We Change the System?

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Where Are We Going?

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

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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

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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

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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

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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

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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

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Physician Group Practice: Process & Outcome Measures

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

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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

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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

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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

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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

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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

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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

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Medicare Care Management Performance Demonstration

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

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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

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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;

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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."

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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

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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

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For More Information

- www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp#TopOfPage
- www.cms.hhs.gov/CCIP

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