



Forum Session Meeting Announcement

Friday, October 21, 2005
11:45am–12:15pm — Lunch
12:15pm–2:00pm — Discussion

Medicare Health Support: Working with Physicians?

A Discussion Featuring:

Sandra M. Foote, ScM

Senior Advisor, Chronic Care Improvement
Center for Medicare Management
Centers for Medicare & Medicaid Services

Kimberly S. Yarnall, MD

Associate Clinical Professor
Department of Community and Family Medicine
Duke University Medical Center

Vincent J. Bufalino, MD

President and Chief Executive Officer
Midwest Heart Specialists

Michael Schoenbaum, PhD

Health and Labor Economist
RAND Corporation

Location

**Reserve Officers Association
of the United States**
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
*(Across from the Dirksen Senate
Office Building)*

Registration Required

Space is limited. Please respond
as soon as possible.

Send your contact information by
e-mail to: nhpfmeet@gwu.edu

THE GEORGE
WASHINGTON
UNIVERSITY
WASHINGTON DC

Medicare Health Support: Working with Physicians?

OVERVIEW

In August 2005, the Centers for Medicare & Medicaid Services (CMS) launched a pilot program called Medicare Health Support (MHS) that will offer certain Medicare beneficiaries with chronic conditions a smorgasbord of education, self-management, and care coordination services. CMS has entered into cooperative agreements with MHS organizations (many known as disease management firms in the private sector) to provide these services. The program's goal is to provide better health and quality of life for beneficiaries and to create savings for Medicare. This Forum session will consider the program's objectives, strategies, and performance yardsticks; it will also examine physicians' roles in and reactions to the program.

For additional information - See Nora Super, "Medicare's Chronic Care Improvement Program: What Is Its Potential?" *National Health Policy Forum, Issue Brief 797, May 10, 2004; available at www.nhpf.org/pdfs_ib/IB797_ChronicCare.pdf.* ■

SESSION

Fee-for-service Medicare beneficiaries in nine states and the District of Columbia are being offered the opportunity to sign up for Medicare Health Support (MHS), a pilot program designed to improve quality of care and quality of life for beneficiaries living with multiple chronic illnesses. Beneficiaries will receive support, education, and coaching to help them stay healthier and avoid health risks. Meanwhile, the Centers for Medicare & Medicaid Services (CMS) expects their better-managed and coordinated care to cost less.

Formally called Voluntary Chronic Care Improvement under Traditional Fee-for-Service, MHS was initiated as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Section 721 of that act authorized the development, testing, and evaluation of a voluntary program for beneficiaries with chronic diseases. The legislation specified a pilot program rather than a more limited demonstration, providing that the program could be expanded nationwide and made permanent if the first phase was deemed successful.

Making care management and coordination available to beneficiaries on a large scale is a major step in Medicare fee-for-service. The MHS program

National Health Policy Forum
Facilitating dialogue.
Fostering understanding.

2131 K Street NW, Suite 500
Washington DC 20037

202/872-1390
202/862-9837 [fax]
nhpf@gwu.edu [e-mail]
www.nhpf.org [web]

Judith Miller Jones
Director

Sally Coberly
Deputy Director

Monique Martineau
Publications Director

Forum Session Manager
Lisa Sprague
Senior Research Associate

is also notable because it uses claims data to identify eligible individuals and establishes population-based goals and performance measurement. Beneficiaries pay nothing for MHS. Participation does not require them to change their providers, nor does it affect the way that claims are filed. Section 721 emphatically states that MHS is not to be construed as a new Medicare benefit with a corollary entitlement to participate.

Physicians are not required to participate in MHS, though their cooperation will be sought by MHS organizations (MHSOs). Some specialty-based medical societies have communicated their support of MHS to their membership. For example, Janet Wright, who heads a disease management oversight committee for the American College of Cardiologists, recently said in the group's online newsletter, "The demands of health care in 2005 are overwhelming and new approaches must be tried. The MHS programs will impact the health and healthcare for the majority of our patients in the very near future. ACC's active collaboration is critical to preserve our leadership position in the design, conduct, and delivery of cardiovascular health care."¹

Rationale

One in five Americans lives with multiple chronic conditions. For those over 65, the prevalence climbs to 62 percent.² Beneficiaries with five or more chronic conditions account for two-thirds of Medicare spending. Such beneficiaries are likely to have multiple physicians, raising issues of care coordination, and multiple prescription medications, increasing the likelihood of adverse drug events. Moreover, these patients present a challenge to a health care system that is centered on acute care. Prevailing patterns of primary care practice, which emphasize moving patients through the office or hospital quickly, do not foster coordination of treatment for multiple conditions. Duke researcher Dr. Truls Østbye and colleagues found that following the clinical practice guidelines for ten common chronic illnesses requires more time than primary care physicians have available for patient care overall; similar results were found with respect to prevention in a companion study led by Dr. Kimberly Yarnall.³

By including Section 721 in the MMA as enacted, lawmakers presumably were acting on a belief that beneficiaries could enjoy better health and consume fewer Medicare services if they were helped to monitor their health, coordinate their care, and adhere to their treatment plans. Whether this belief was justified will be tested in coming months as the pilot swings into full operation.

Disease management (DM) programs have been adopted in the private and Medicaid markets to the tune of an estimated \$1 billion in revenues to DM vendors in 2005. Sheer popularity might be read as a testament to their success. However, policymakers looking for proof in

the form of rigorous research studies have been stymied. The Congressional Budget Office (CBO) observed in 2004 that there is “insufficient evidence to conclude that disease management programs can generally reduce the overall cost of health care services.”⁴

In 2004, a group of researchers undertook an economic review of DM studies, with mixed results. Cornell researcher Dr. Ron Goetzel and colleagues found evidence that DM focused on patients with congestive heart failure generated a positive return on investment, whereas DM focused on those with depression cost more money than it saved. Asthma- and diabetes-focused DM programs were able to produce a positive return on investment in some cases, but by no means all. Like CBO, Dr. Goetzel and colleagues were limited by the small number of studies available that have sufficient financial information to be convincing. They suggest that DM be tested in both Medicare and non-Medicare populations, with financial results “subject to the same level of statistical rigor applied to studies focused on health outcomes.”⁵

Operation

CMS entered into cooperative agreements with nine MHSOs to offer the program to about 180,000 beneficiaries. Potential participants—diagnosed with diabetes or congestive heart failure, with or without other comorbid conditions—were identified through claims data. There are roughly 30,000 beneficiaries per MHSO. Of these 30,000, approximately 10,000 beneficiaries were randomly assigned to a control group and the remaining 20,000 or so were assigned to the intervention group. Letters signed by CMS administrator Dr. Mark McClellan were sent out to the intervention group. CMS also obtained letters from the AARP, the American Diabetes Association, and the American Heart Association, that MHSOs could send in follow-up mailings to potential participants, if desired.

Beneficiaries identified as eligible by CMS do not have to enroll for MHS, though they may opt out of the program if they choose. They are permitted to terminate their participation at any time. Services available to participants include, for example, group education and support sessions, a 24-hour nurse advice line, and in-home biometric monitoring.

MHSOs will contact participating beneficiaries’ physicians, to the extent that they can be identified from Medicare claims data. The physician will receive a letter, signed by Dr. McClellan, introducing MHS. The letter includes language reassuring the clinician that MHS is not intended to replace medical care and that its aims are to help beneficiaries understand and adhere to their prescribed care plans, to improve coordination of care, and to provide physicians with more timely and complete patient information.

MHSOs are charged with various clinical quality, beneficiary satisfaction, and information technology responsibilities. Specific performance

measures by which they will be evaluated have not been made public, though CMS has contracts to track performance in these areas. MHSOs will collect data for evaluation from multiple sources, including claims, reports from beneficiaries and physicians, and home monitoring results.

Each MHSO has negotiated with CMS the fee it will be paid per participating beneficiary. MHSOs could have to return a portion of these fees, however, if performance measures pertaining to quality improvement and beneficiary satisfaction are not met. Further, all fees could be paid back if the average cost of beneficiaries in the intervention group is not at least five percent less than those in the control group. In making this calculation, Medicare costs for the intervention group include MHSO fees as well as claims. In no event will refunds due exceed the total amount of fees received by the MHSO.

Expectations

The stated goals of MHS are to improve health and quality of life for beneficiaries and to lower costs to Medicare. Some see the program as the vanguard of a new approach to improving chronic care nationwide, emphasizing prevention and personal responsibility. Most observers are reserving judgment; like CBO, they wait for more convincing results.

Physicians' attitudes toward DM have long been mixed. To the extent that DM protocols support the physician's judgment and instructions, they are seen as helpful. Some physicians, however, complain that DM complicates rather than streamlines care, adding another player and set of rules. A subtext to this might be an objection to others' being paid money that could otherwise flow to physicians.

Questions for policymakers to consider looking forward are as follows:

- What is the role of the physician in a DM model? What efforts are or should be made to secure physician cooperation?
- What tools and/or assistance do primary care physicians need to manage their patients' health more effectively?
- How will MHSOs address comorbidities, such as depression, that frequently accompany the primary diagnosis triggering eligibility?
- To what extent does personal responsibility on the part of the patient weigh in the equation? What portion of the Medicare population is able to exercise such responsibility?
- Is the development of a new industry the best way to make sure that services are delivered properly to Medicare beneficiaries? Are there other ways?
- What are the appropriate criteria for evaluating the success of MHSOs?

SPEAKERS

Sandra M. Foote, ScM, is senior advisor, Chronic Care Improvement in the Center for Medicare Management at the Centers for Medicare & Medicaid Services (CMS). She joined CMS in June 2004 from The George Washington University, where she was director of the Health Insurance Reform Project. For most of her career, Ms. Foote was a founder, owner, and senior executive of Community Care Network, Inc., one of the largest preferred provider systems serving self-insured employers, group health insurers, and workers' compensation carriers.

Kimberly S. Yarnall, MD, is an associate clinical professor in the Department of Community and Family Medicine at the Duke University Medical Center. She has held various positions, including medical director and chief of the division of family practice, in the department since coming there as a resident in 1985. Dr. Yarnall's research interests include women's health, prevention, and primary care practice.

Vincent J. Bufalino, MD, is president and chief executive officer of Midwest Heart Specialists, a 55-physician cardiology practice in the Chicago area. As chairman of the Midwest Heart Foundation, a nonprofit research arm of Midwest Heart Specialists, he oversees approximately 30 clinical research trials. He is medical director of Edward Heart Hospital in Naperville, Illinois. Dr. Bufalino has been an active volunteer for the American Heart Association (AHA) for the past 20 years. He is past president of the AHA's Greater Midwest affiliate and is a current member of the AHA's board of directors, administrative cabinet, and disease management expert panel.

Michael Schoenbaum, PhD, is a health and labor economist at the RAND Corporation. His research focuses on the costs and benefits of interventions to improve health and health care, evaluated from the perspectives of patients, providers, taxpayers, and society. He is currently leading a project to help address comorbid depression in the new Medicare Health Support program; economic analyses of several other national trials to improve care for depression; and an analysis of the Palestinian health system, to identify policy options for improving health status, health care quality, and economic viability. Dr. Schoenbaum is also co-developer of RAND's Health Cost and Flexible Spending Account Calculators, Web-based modeling, and decision-support tools to help consumers make health benefits choices. He is based in RAND's Washington, DC, office.

ENDNOTES

1. Janet Wright, "Disease Management in 2005: Macro, Micro, and Medicare," in *Cardiosource*, American College of Cardiology, September 21, 2005; available at www.cardiosource.com/expertopinions/Programhlts/interviewDetail.asp?interviewID=230.

Endnotes / continued ►

Endnotes / continued

2. Partnership for Solutions, *Chronic Conditions: Making the Case for Ongoing Care* (Baltimore, MD: Johns Hopkins University, 2002), 11.
3. Truls Østbye *et al.*, "Is There Time for Management of Patients with Chronic Diseases in Primary Care?" *Annals of Family Medicine*, 3, (May-June 2005): 209–214, available at www.annfammed.org/cgi/content/full/3/3/209; and Kimberly S. Yarnall, *et al.*, "Is There Enough Time for Prevention in Primary Care?" *American Journal of Public Health*, 93, (April 2003): 635–641.
4. Congressional Budget Office, "An Analysis of the Literature on Disease Management Programs," October 13, 2004, 3; available at www.cbo.gov/showdoc.cfm?index=5909&sequence=0.
5. Ron Z. Goetzel *et al.*, "Return on Investment in Disease Management: A Review," *Health Care Financing Review*, 25, no. 5, (Summer 2005): 16; available at www.cms.hhs.gov/review/05summer/05summerpg1.pdf.



The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at www.nhpf.org.