

Update

Sandra M. Foote
Senior Advisor, Chronic Care Improvement
Centers for Medicare & Medicaid Services

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The MHS Challenge

Develop and test new programs designed to help targeted chronically ill beneficiaries reduce their health risks

Section 721: “Voluntary Chronic Care Improvement in Traditional Fee-For-Service” of the Medicare Prescription Drug, Improvement and Modernization Act of 2003

Phase I: Developmental



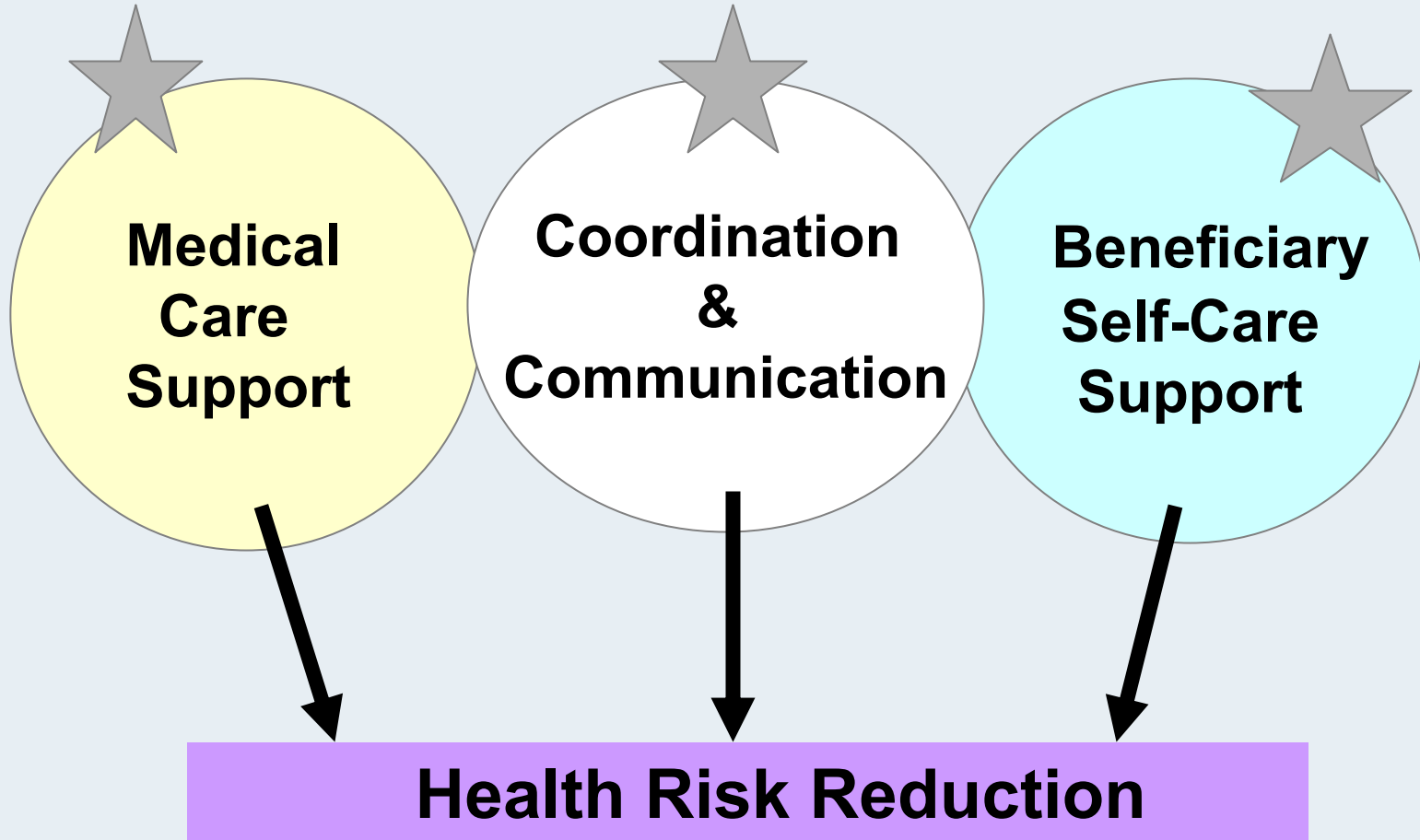
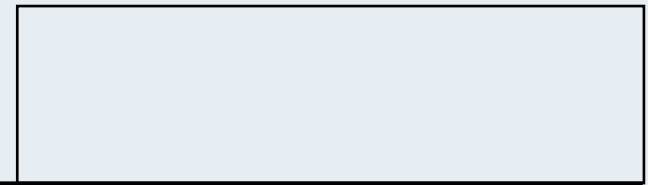
- 8 pilot programs starting in 2005
 - 20,000 beneficiaries per program; 10,000 per control group—randomly assigned
 - Phase II: Expansion to follow in 2–3.5 years, if pilots (or components) are successful
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Key Program Features

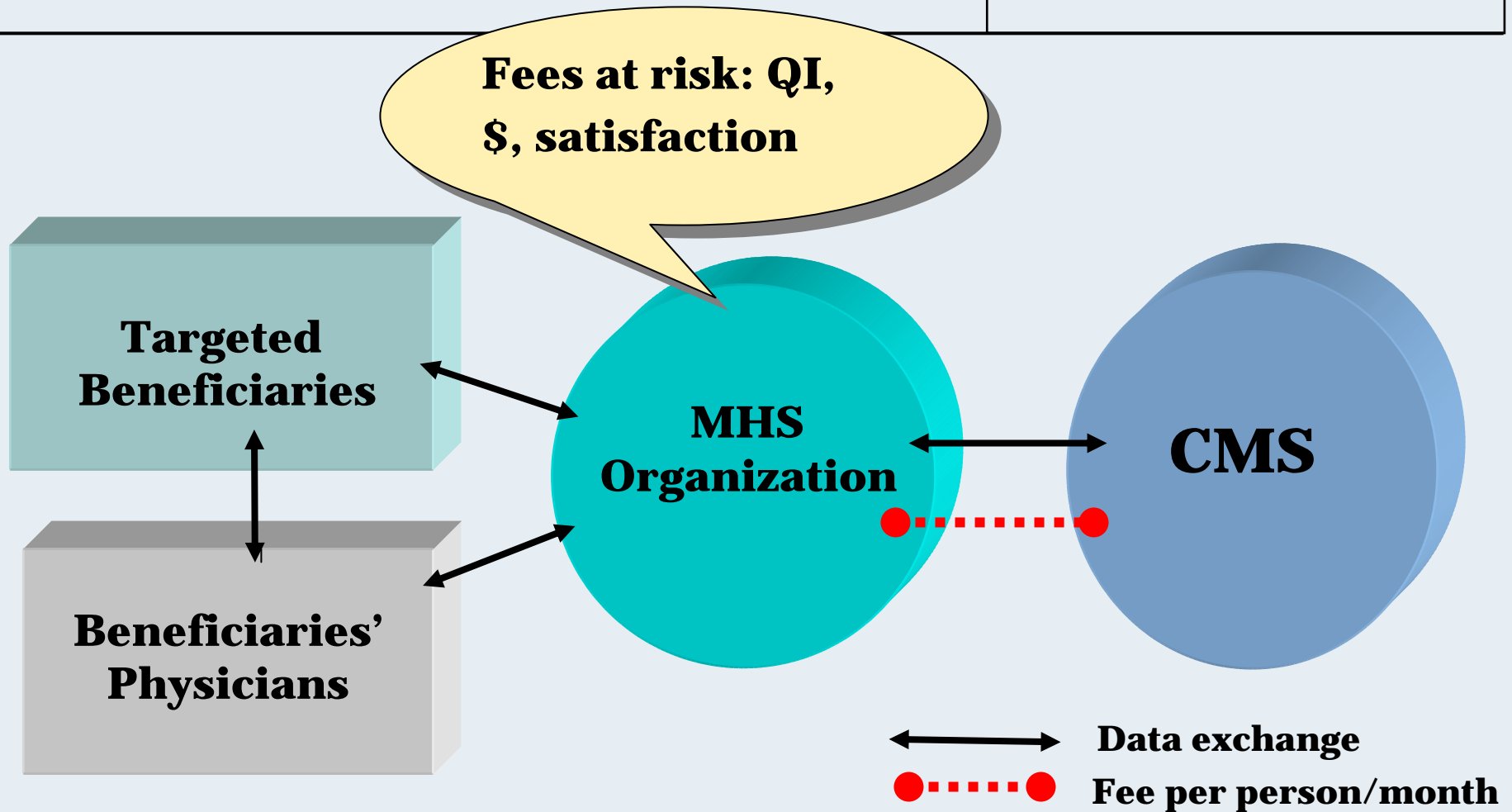


- Voluntary
 - No charge to participants
 - No change in Medicare benefits, choice of providers or claims payment
 - Supportive, not restrictive
 - Not a substitute for current care
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Flexible Interventions



New Population-Based Model

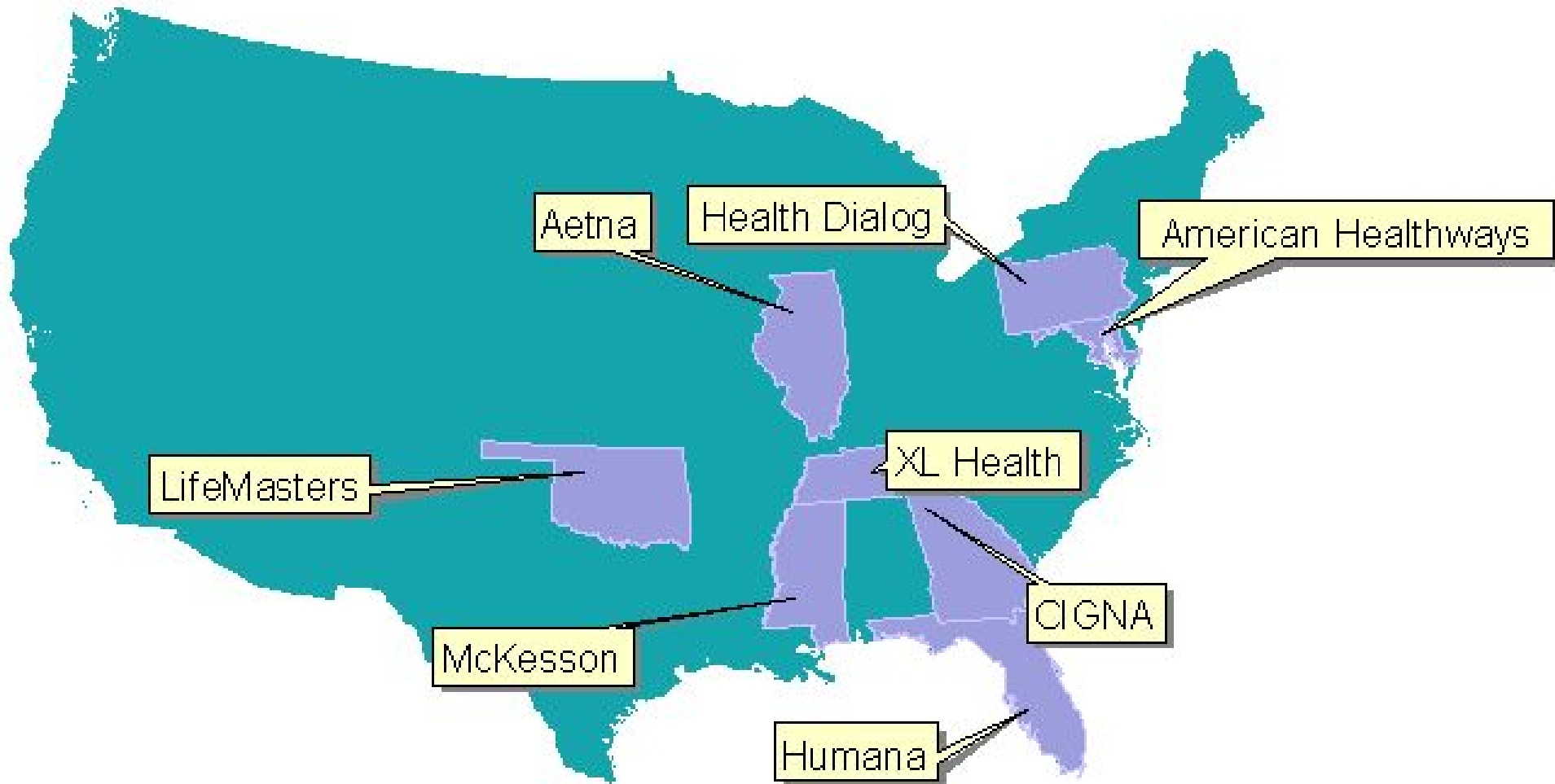


Advantages of Model



- Flexibility to customize and innovate
 - Incentives for regional collaborations
 - Emphasis on cost-effectiveness
 - Savings measured across provider “silos”
 - Sufficient scale to detect significant impacts on population health
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Phase I Programs



National Organizations Helping to Promote Understanding of MHS



...AND MANY OTHERS!

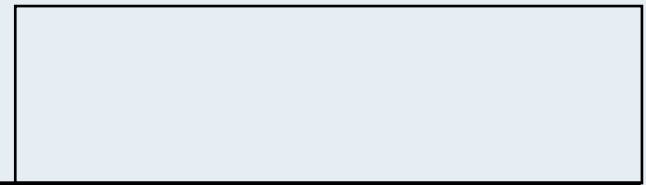
Emerging Partnerships

Many new national and regional alliances developing with awardees

Examples:

- American College of Physicians
 - American College of Cardiology
 - American Academy of Family Physicians
 - American Geriatric Society
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Who is eligible?



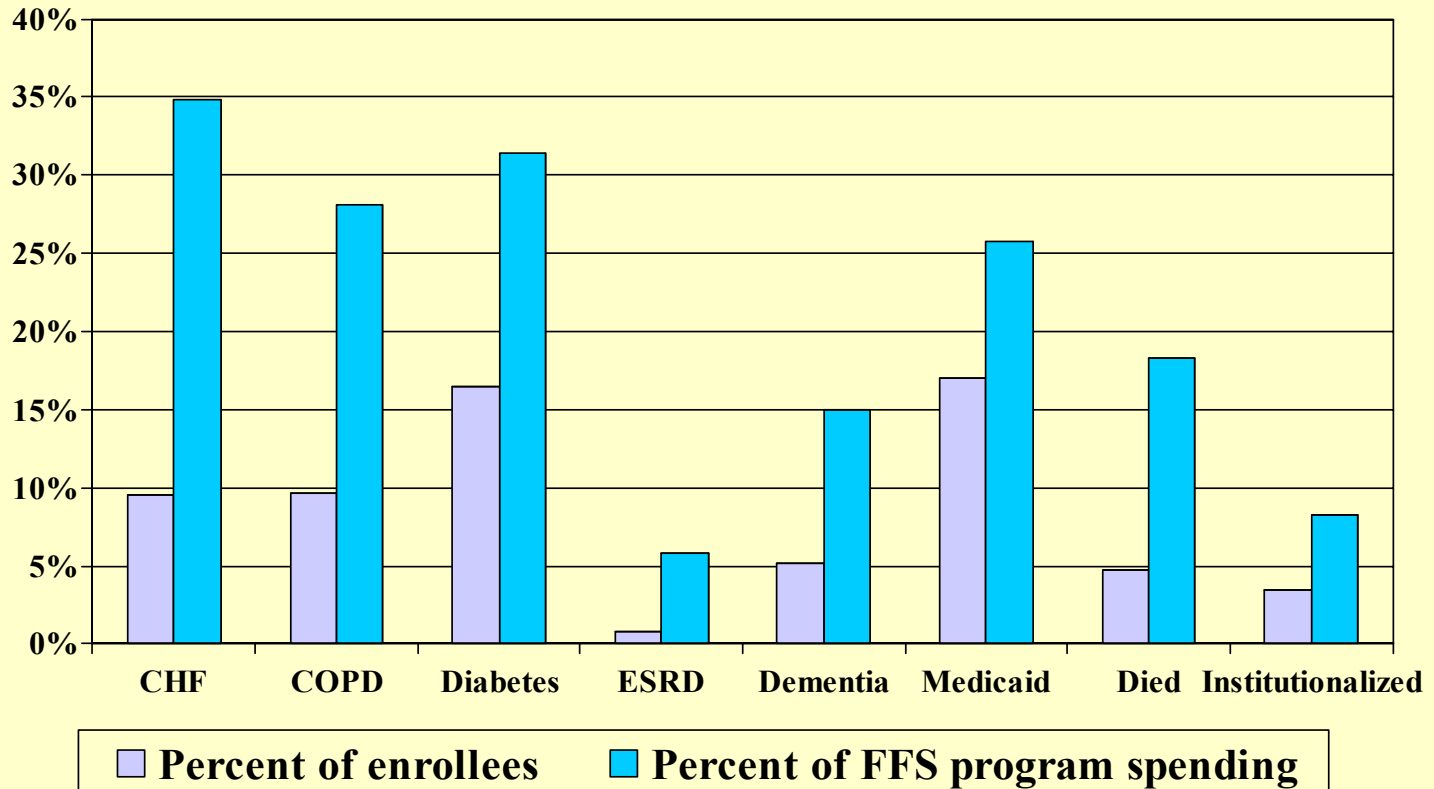
Medicare Fee-For-Service only

**Pre-selected by CMS through claims review,
applying selection criteria (e.g., not in hospice)**

All have diabetes and/or congestive heart failure

**Only individuals invited by CMS can participate
in Phase I programs**

Subgroups Driving Cost



NOTE: Spending is for treatment of all conditions, by enrollee subgroup, 2002

SOURCE: C. Hogan and R. Schmidt, MedPAC Public Meeting, 03/18/2004

Multiple Health Risks

63% of Medicare beneficiaries have 2 or more chronic conditions *

On average, Medicare beneficiaries see **6.4 MDs** and fill **20 Rx** per year*

23% of beneficiaries have 5 or more chronic conditions**

*Medicare Standard Analytic File, 1999. Anderson GF. Testimony on Promoting Disease Management in Medicare -www.partnershipforsolutions.com/statistics/

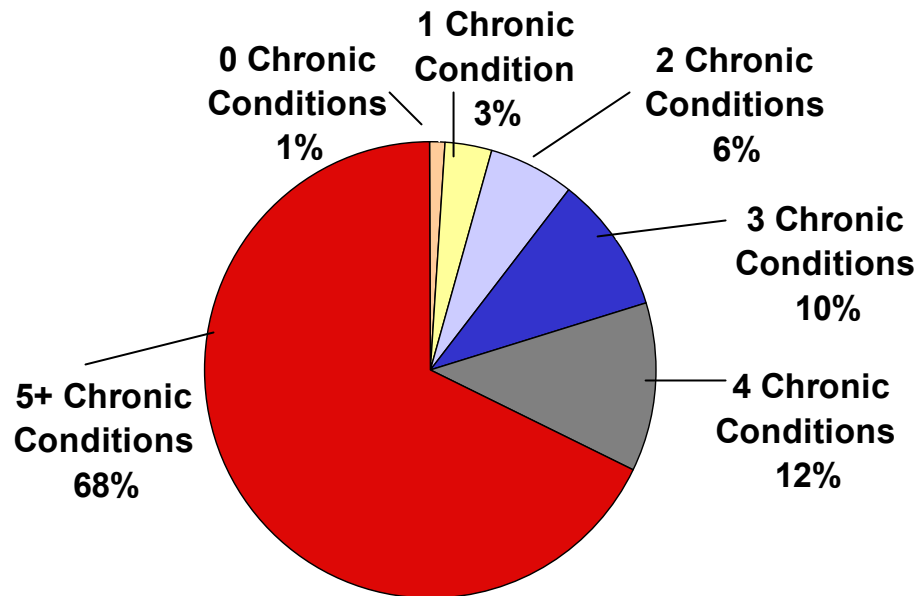
**Medicare Standard Analytic File, 2001. Anderson GF. N Engl J Med 2005; 353; 305-309

Multiple Health Risks

On average, beneficiaries with 5 or more chronic conditions see **14 MDs*** and fill **57 Rx** per year.**

*http://partnershipforsolutions.com/DMS/files/Medicare_fact_sheet.pdf

** Older Americans, 2004. Federal Interagency Task Force on Aging-Related Statistics



Percent of Medicare Spending

Johns Hopkins University, Partnership for Solutions: Medicare Standard Analytic File, 2001

Coping with Co-Morbidities



“Comorbidity is associated with poor quality of life, physical disability, high health care use, multiple medications and increased risk of adverse drug events and mortality. Optimizing care for this population is a high priority.”

Boyd CM et al., JAMA, 2005, 294: 716-724.

How to Optimize Care?



1650 active Clinical Practice Guidelines (CPGs) in
National Guideline Clearing House in July, 2005*

“Ideally CPGs would help physicians select from among
multiple evidence-based recommendations those
with the greatest benefit to a given patient.”*

Need EMR to compute priorities and MD to evaluate
with patients in context of their personal goals

O'Connor PJ. JAMA, 2005, 294:741-743.

MHS Value Added

- Enable better care planning
 - Synthesize person-level input from multiple sources
 - Add data points
 - Apply clinical decision support tools incorporating multiple CPGs
 - Support beneficiary follow-through on care plans
 - Coach and reinforce
 - Track changes in health status
 - Generate preventive care reminders and medical care alerts
 - Link caregivers in ways EMRs (and even RHIOs) do not
 - Monitor changes in clinical quality for targeted populations
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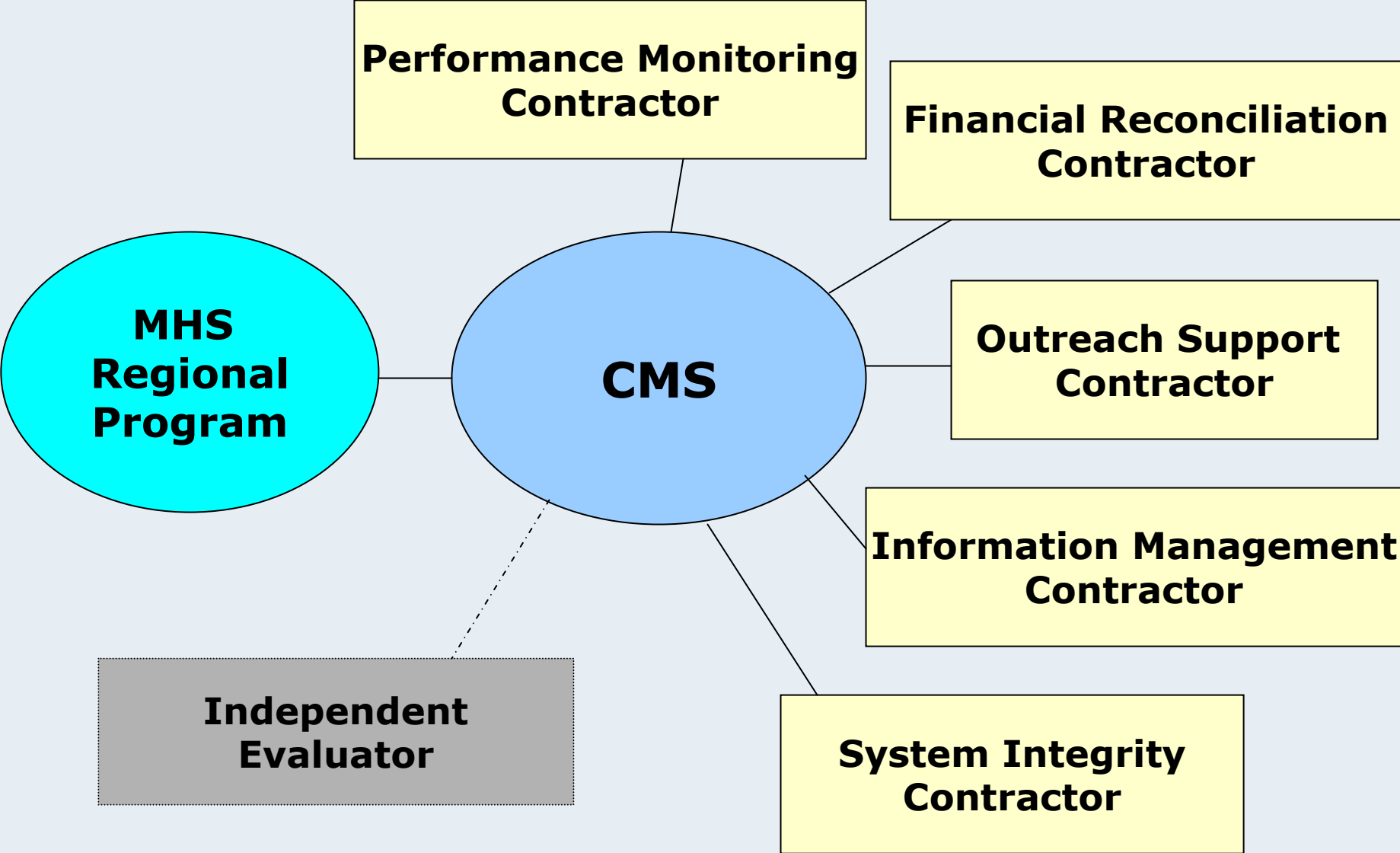
Envisioned Results

- Improved health and quality of life
 - Lower average Medicare costs
 - Reduced complications, emergencies and hospital admissions
 - Increased adherence to evidence-based care
 - Better coordination of care through use of new health information and communication technologies
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More Envisioned Results

- Programs well accepted by physicians
 - Focus on total health, not selected diseases
 - Adaptable, scalable and replicable nationally
 - Quality and cost outcomes sustainable over time
 - Administrative model works
 - Business model (fees at risk) successful
 - Programs effective in dually eligible populations
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CMS Program Management



Where is MHS leading?



New strategies to improve chronic care cost-effectively on a national scale

- Focus on prevention
 - New partnerships
 - Fostering innovation
 - Accountability for performance
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More Information



Website:

<http://www.cms.hhs.gov/medicarerereform/ccip/>

Contact information:

sandra.foote@cms.hhs.gov
