Update

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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
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
Flexible Interventions

Medical Care Support

Coordination & Communication

Beneficiary Self-Care Support

Health Risk Reduction
New Population-Based Model

Fees at risk: QI, $, satisfaction

Targeted Beneficiaries

Beneficiaries’ Physicians

MHS Organization

CMS

Data exchange

Fee per person/month

BETTER HEALTH
BETTER MEDICARE
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
National Organizations Helping to Promote Understanding of MHS

AARP
American Diabetes Association
American Heart Association
Visiting Nurse Associations of America
Federation of American Hospitals
NATIONAL HEALTH COUNCIL
BlueCross BlueShield Association
Easter Seals
HEALTHCARE LEADERSHIP COUNCIL
NCQA
Measuring the Quality of America’s Health Care
DMAA
Creating the Future of Aging Services

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

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**

Multiple Health Risks

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


Percent of Medicare Spending

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

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

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
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
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
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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http://www.cms.hhs.gov/medicarereform/ccip/

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