Targeting High-Cost Medicare Beneficiaries to Improve Care and Reduce Spending: Finding the Bull’s-Eye

A DISCUSSION FEATURING:

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FORUM SESSION ANNOUNCEMENT

FRIDAY, MARCH 9, 2012
11:45AM–12:15PM—Lunch
12:15PM–2:00PM—Discussion

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

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In 2011, Medicare spent approximately $560 billion to provide health insurance coverage to 49 million elderly and disabled beneficiaries, accounting for 15.5 percent of the federal budget. The Congressional Budget Office (CBO) projects that, by 2022, Medicare spending will grow to over $1 trillion. Given concerns about the federal deficit, it is not surprising that policymakers are continually searching for ways to reduce costs and make the Medicare program more efficient. The Patient Protection and Affordable Care Act (PPACA), for example, created a new Center for Medicare and Medicaid Innovation (CMMI) at the Centers for Medicare & Medicaid Services (CMS) and provided $10 billion in funding over nine years to conduct an array of demonstrations whose goals are to reduce costs and improve care for Medicare and Medicaid beneficiaries.

Several current and proposed CMMI activities are the latest in a long line of disease management and care coordination demonstrations and pilots that have targeted selected groups of beneficiaries expected to incur higher costs. A wide variety of targeting criteria have been used in previous efforts including the presence of at least one chronic condition, a prior hospitalization, high prior Medicare expenses, anticipated future high expenses based on predictive modeling, or some combination of these criteria. However, according to several analyses, including a recent CBO report, previous demonstrations and pilots have had relatively little success in producing savings, especially when the costs of the intervention are taken into account. One possible explanation for these results is that the demonstrations did not, in fact, target individuals for whom cost savings were most likely to be achieved. Indeed a number of demonstrations did result in some savings in care costs that were outweighed by the costs of the intervention. A summary of recent CMS demonstrations and their targeting criteria is provided in Table 1 (next page).

The history of Medicare pilots and demonstrations indicates that, on the whole, targeting has been problematic. Despite the absence of overall cost savings in prior efforts, many new and suggested demonstrations continue to rely on familiar targeting criteria such as the presence of a chronic condition(s), a prior hospitalization, or dual eligibility status. New research on high-cost Medicare beneficiaries suggests that these criteria may not be adequate.

The most expensive Medicare beneficiaries, on average, are those who have multiple (three or more) chronic conditions and functional impairments. In 2006, Medicare spent more than twice as much on these individuals compared with beneficiaries who had three or more chronic conditions but no functional limitations. While many
TABLE 1

Medicare Disease Management and Care Coordination Demonstrations

<table>
<thead>
<tr>
<th>Demonstration</th>
<th>Number of Programs</th>
<th>Fees at Risk*</th>
<th>Target Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Coordinated Care Demonstration</td>
<td>15</td>
<td>No</td>
<td>Various; most commonly patients with CHF, CAD, chronic lung disease, or diabetes</td>
</tr>
<tr>
<td>Medicare Health Support Pilot</td>
<td>8</td>
<td>Yes</td>
<td>Patients with CHF or diabetes</td>
</tr>
<tr>
<td>Demonstration of Care Management for High-Cost Beneficiaries</td>
<td>6</td>
<td>Yes</td>
<td>Various; all with high Medicare costs before the demonstration, high predicted costs, or both; some with particular chronic conditions</td>
</tr>
<tr>
<td>Demonstration of Disease Management for Dual-Eligible Beneficiaries†</td>
<td>1</td>
<td>Yes</td>
<td>Dual-eligible beneficiaries with CHF, CAD, or diabetes</td>
</tr>
<tr>
<td>Demonstration of Informatics for Diabetes Education and Telemedicine</td>
<td>1</td>
<td>No</td>
<td>Patients with diabetes</td>
</tr>
<tr>
<td>Demonstration of Disease Management for Severely Chronically Ill Beneficiaries</td>
<td>3</td>
<td>Yes</td>
<td>Patients with advanced-stage CHF, CAD, or diabetes</td>
</tr>
</tbody>
</table>

* In demonstrations in which fees were at risk, the programs were allowed to keep only that portion of the fees that was offset by a reduction in Medicare spending. In the Demonstration of Care Management for High-Cost Beneficiaries, the programs were not allowed to keep the entire fee unless they reduced Medicare spending for their beneficiaries by at least 5 percent, net of the fee.

† Dual-eligible beneficiaries are covered by Medicare and Medicaid at the same time.

Note: CHF = congestive heart failure; CAD = coronary artery disease.


of these high-cost Medicare beneficiaries are “duals” —eligible for both Medicare and Medicaid—the majority (57 percent) are not. These data suggest that Medicare demonstrations that target beneficiaries with chronic conditions or a prior hospitalization, for example, without consideration of functional status may miss significant opportunities to achieve overall cost savings by serving too broad a population. Similarly, demonstrations that target only the duals—and exclude non-dual high-cost Medicare beneficiaries—will also pass up potential savings.

This Forum session will describe the characteristics and spending patterns of high-cost Medicare beneficiaries, examine the track record of targeting within Medicare demonstrations and pilots, and profile the experience of one health system’s efforts to target and manage high-cost Medicare beneficiaries.
SPEAKERS

Judith Feder, PhD, is an Institute Fellow at the Urban Institute’s Health Policy Center and professor of public policy in the Public Policy Institute at Georgetown University. Dr. Feder will discuss the findings of a recent analysis of high cost Medicare beneficiaries conducted with Georgetown colleague Harriet Komisar, PhD. Randall Brown, PhD, a vice president at Mathematic Policy Research, Inc., and director of health research for the New Jersey office, has participated in the evaluation of several demonstrations/pilots at the Centers for Medicare & Medicaid Services. He will provide an overview of the targeting criteria that have been used in prior efforts and lessons learned regarding how to make those criteria more effective. Thomas Foels, MD, is chief medical officer at Independent Health in Buffalo, New York. Dr. Foels will describe the processes his organization uses to target and manage high-cost beneficiaries enrolled in Medicare Advantage plans.

KEY QUESTIONS

• What are the characteristics of high-cost Medicare beneficiaries? What conditions or factors are most predictive of high levels of services use? Use of expensive services?

• Why have Medicare care coordination demonstrations failed to achieve net savings? How big a role has targeting played in determining these outcomes?

• Have some targeting criteria been more effective than others? Would better data about beneficiaries’ conditions and functional abilities improve the chances of success?

• What has a health system operating under capitation learned about targeting high-cost Medicare beneficiaries? Can lessons learned in managed care plans be translated to a fee-for-service environment? What information would “traditional” Medicare need to target interventions more effectively?

ENDNOTES


4. Harriet L. Komisar and Judy Feder, “Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordination Care Across All Services,” Georgetown University, October 2011, available at www.thescanfoundation.org/sites/scan.lmp03.lucidus.net/files/Georgetown_Tnsfrming_Care.pdf.