Medicare HEALTH SUPPORT

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Legislative Mandate

"The Secretary shall provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs in accordance with this section. Each such program shall be designed to improve clinical quality and beneficiary satisfaction and achieve spending targets with respect to expenditures under this title for targeted beneficiaries with one or more threshold conditions."

***Section 721 of P.L. 107-183, Medicare Prescription Drug, Improvement and Modernization Act of 2003**

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Key Features

- Randomized control group
- Large scale
- 8 programs launched
- Intent-to-treat model
- Voluntary participation
- No cost to participants
- Overlay to Medicare fee-for-service
- Fees at risk

Target Population

- Identified and invited by CMS
- Medicare FFS
- Diabetes and/or heart failure threshold conditions
- HCC risk score 1.35+
- Limited exclusion criteria
- May move in/out of eligibility

Examples of Interventions

Flexible and evolving

- Access to clinical professionals
- Health education
- Remote biometric monitoring
- Referral to community services
- Physical activity programs
- End of life planning
- Provider engagement

Evaluation

- Clinical quality
- Beneficiary and provider satisfaction
- Financial targets

- Reports to Congress
- First report issued June 2007
- Next report due February 2009

Evaluation Components

- Case studies
- Beneficiary surveys
- Provider interviews and survey
- Analysis of Medicare claims data
- Clinical and programmatic data provided by the programs

Research Questions

- ***Reach*** – How well do programs engage their intended audiences?
- ***Implementation*** – How well are programs able to implement their planned programs?
- ***Effectiveness*** – To what degree are programs able to improve outcomes and achieve targeted savings?

Early Feedback

Fee for Service ≠ Managed Care

- No gatekeeper or PCP
- No preauthorization
- Lag in claims data
- Data sharing concerns

Beneficiary Responses

- Some beneficiaries hard to locate
- Generally high participation, ranges from 65% to 92% in first 6 months
- Anecdotes of praises

Beneficiary Characteristics

- Multiple providers
- Multiple comorbidities
- Psychosocial needs
- Limited resources
- Baseline care levels high

Key Findings from Report to Congress

1. Equivalence at randomization, but differences at start
2. Participants are healthier and less costly
3. At the 6 month point, fees far exceed savings

Equivalence at randomization, but differences at start

- Unanticipated
- Operational necessity for a lag between identification and start
- CMS has committed to an actuarial adjustment

Participants healthier and less costly

- Ranges from 65-92% at 6 months
- Recruitment strategies varied
- Healthier more likely to participate
- Lower participation from high cost
- Lower participation for duals (Medicare/Medicaid)

At the 6 month point, fees far exceed savings

- CMS paid fees on full intervention group for initial 6 months
- Savings requirement is 5% net of fee
- Low participation may make savings targets especially challenging

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General information:

www.cms.hhs.gov/CCIP

Report to Congress:

www.cms.hhs.gov/Reports/Downloads/McCall.pdf

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