

DM DISEASE MANAGEMENT ADVISOR™

Medical home payment structure offered

Report issued in preparation of CMS demonstration project

The advanced medical home concept has been praised by health plans, physicians, and DMAA: The Care Continuum Alliance, which has voiced its support for the concept.

The overall theory of putting a patient's care coordination into the hands of the provider has caught on despite the fact that the shape and breadth of the advanced medical home model remains in question.

What kind of role will DM play? Will DM vendors offer complementary services for providers rather than health plans? And, perhaps most importantly, what do you pay providers for overseeing care coordination?

There have been several commercially run medical home projects, and CMS' Physician Group Practice (PGP) demonstration project touches upon aspects of the medical home. CMS is also preparing to test the

concept with its Medical Home Demonstration Project, which starts 2009.

The project will take place in up to eight states in rural, urban, and underserved areas in which providers will provide "comprehensive and coordinated" patient-centered medical care, according to the legislation that created the project.

In preparation for the demonstration project, CMS and Mathematica Policy Research conducted research and developed a medical home design earlier this year. As part of the demonstration legislation, CMS was mandated to consult the AMA/Specialty Society RVS Update Committee (RUC) to make recommen-

"These values are quite robust and will revolutionize primary care as it's delivered in this country."

—William Rich, MD

dations about the project's payment structure. The RUC makes annual recommendations to CMS about new and revised physician services and performs reviews of the Resource-Based Relative Value Scale every five years.

After two months of work, the RUC released its medical home payment recommendations April 29. The response to the recommendations has been mixed, with healthcare bloggers particularly concerned about the suggested time commitment and pay structure.

However, RUC officials say the payment model would adequately pay providers for the care coordination needed in the medical home. **William Rich, MD**, RUC chair, says the recommendations took into account physician work relative value units and practice expense input recommendations, such as electronic medical record costs and nurse care coordination.

"I think everyone was pleased. My understanding is there are some bloggers who don't understand financial implications that are complaining that the values aren't

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high enough. They haven't looked at the practice expenses. These values are quite robust and will revolutionize primary care as it's delivered in this country," says Rich.

One problem the RUC found was the nonstandard way in which commercial medical home projects have paid providers for care coordination. "It was very apparent that the current evaluation of medical homes was done with no rationale at all," Rich says. "They just picked numbers out of the air to get some demonstration projects going on the commercial side." To figure out the payment structure, the RUC drew on Mathematica's work to offer three medical home tiers, depending on capabilities:

- Tier 1 (entry level) requires 10 of the designated core capabilities
- Tier 2 (typical) requires 16 of the designated core capabilities
- Tier 3 (optimal) requires 18 of the designated core capabilities and three of an additional 10 requirements

Note: For more information on tiering and capabilities, see "Proposed method of tiering medical home qualification" on p. 4.

To provide an example of a possible payment scenario, the RUC describes a hypothetical practice that includes one doctor, one nurse case manager, and 250 participating beneficiaries. The RUC estimates a Tier 3 practice could receive more than \$160,000 for taking part in the demonstration. (See "Medical home payments" on p. 6 for more details.)

Rich says the medical home payment structure is a "huge increase" for primary care. Although primary care would benefit from the medical home payments, other areas of healthcare realize the potential benefits of care coordination, and the medical home could resolve duplications of services and unnecessary hospital readmissions, he says. "Everyone realizes there are some real programs going on for the chronically ill, especially those most at risk who have multiple diseases," Rich adds.

Response to recommendations

Vince Kuraitis, JD, MBA, principal and founder of Better Health Technologies in Boise, ID, who supports the medical home concept, is one of the bloggers who has questioned the RUC's recommendations. Kuraitis wrote a four-part series of blog entries about the topic.

His concern is that the RUC's process is viewed as anti-primary care and that the recommendations could underfund the medical home and cause physicians not to take part. "I think it makes a difficult process even more difficult," he says.

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Pennsylvania kicks off medical home project

CMS is not the only one testing the advanced medical home. Health plans and states are also exploring whether the medical home can improve patient outcomes and lower long-term costs.

Pennsylvania is one of the most recent states to give the medical home a try. In the first phase of the Prescription for Pennsylvania healthcare reform program, Gov. Ed Rendell presented a program that will include 220,000 patients, 150 PCPs, and six health insurers in Southeastern Pennsylvania.

Supporters say providers will track patient care and conditions, which will also reduce costs for chronic care by improving control and averting emergency room visits and admissions.

The healthcare reform program also looks to improve access to care, patient self-management skills, quality of care measured by evidence-based clinical processes, and outcomes measures.

When he announced the program, Rendell said more than 40% of Pennsylvanians with chronic conditions do not receive recommended care to manage their diseases.

Rendell suggested that developing a medical home in which healthcare providers “adopt evidence-based protocols proven to help manage chronic disease” will help patient health.

“It will also have economic benefits, as healthier employees mean improved productivity for our businesses, and taking appropriate preventive measures can reduce the need for many expensive emergency room visits and translates to lower insurance premiums overall. That’s why this report—this blueprint—is critical for improving quality of life and to save money,” he said.

Independence Blue Cross in Philadelphia, one of the insurers involved in the three-year program, anticipates making physician care coordination payments in the \$5–\$6 million-dollar range.

The actual investment will depend on how many practices participate as well as the level of documented transformation their practices achieve through the National Committee for Quality Assurance’s (NCQA) Physician Patient Connections—Patient-Centered Medical Home (PCMH) certification, says **Ruth Stoolman**, PR manager at Independence Blue Cross.

The Pennsylvania program will include:

- A team approach that includes physicians, nurses, case managers, and health educators
- Open-access scheduling to enhance patient access to timely care and to allow physicians more time to see sick patients
- Improved patient education and promotion of self-management of chronic conditions
- Improved communications, including e-mail and phone
- More decision support for patients
- Outside practice coaches to help implement the necessary changes and help guide practices on how to achieve their goals

“This model will radically change how primary care is delivered, how that care is paid for to promote quality, and to move people toward taking an active role in their own health,” Stoolman says. “Over time, we expect that we’ll see fewer avoidable emergency room visits and hospitalizations due to better and ongoing management of chronic conditions like diabetes and asthma, better quality of life for people with these chronic conditions, and longer life expectancies.”

She adds that the program should also improve provider and member satisfaction.

Independence Blue Cross will also offer free technology to participating practices that will allow the insurer and providers to track, monitor, and remind patients about health information and also help to better identify gaps in patient care.

Advocates for the Pennsylvania program hope the collaborative will serve as a benchmark in how the model is designed and implemented throughout the country.

“It should be emphasized that patient education is a critical component of the PCMH—empowering patients to understand their conditions and take an active role in their care,” Stoolman says.

“No matter how successful physicians are in reaching all the stated NCQA goals, unless their patients are actively involved in managing their care, any notable improvements in quality outcomes will be limited,” she adds.

Proposed method of tiering medical home qualification

| Tier 1: Entry level | Tier 2: Typical | Tier 3: Optimal | |
|--|--|--|--|
| All 10 of the following requirements | All 16 of the following requirements | All 18 of the following requirements | Three of the following additional requirements |
| Continuity | | | |
| Obtains mutual agreement on the role of the medical home between physician and patient | Obtains mutual agreement on the role of the medical home between physician and patient | Obtains mutual agreement on the role of the medical home between physician and patient | Uses scheduling process to promote continuity with the clinician |
| Clinical information systems | | | |
| Uses data to identify and track medical home patients | Uses data to identify and track medical home patients | Uses data to identify and track medical home patients | Uses electronic prescribing tools to reduce medical errors, promote use of generics, and assist in medication management |
| | | | Use of secure electronic communication between the patient and the healthcare team |
| | | | Use of secure systems that provide the patient access to personal health information |
| Delivery system redesign | | | |
| Implements processes to promote access and communication | Implements processes to promote access and communication | Implements processes to promote access and communication | Measures performance on clinical quality and patient experiences |
| Organizes and trains staff members in roles for care management (including staff feedback) | Organizes and trains staff members in roles for care management (including staff feedback) | Organizes and trains staff members in roles for care management (including staff feedback) | Reports to physicians on performance |
| Organizes clinical data for individual patients (problem lists, medication lists, risk factors, structured progress notes) | Organizes clinical data for individual patients (problem lists, medication lists, risk factors, structured progress notes) | Organizes clinical data for individual patients (problem lists, medication lists, risk factors, structured progress notes) | Uses data to set goals and takes action to improve performance |
| Uses health assessment to characterize patient needs and risks | Uses health assessment to characterize patient needs and risks | Uses health assessment to characterize patient needs and risks | |
| Measures implementation of access and communication processes | Measures implementation of access and communication processes | Measures implementation of access and communication processes | |
| Uses integrated care plan to guide patient care | Provides previsit planning and after-visit follow-up for medical home patients | Provides previsit planning and after-visit follow-up for medical home patients | |
| | Uses integrated care plan to guide patient care | Uses integrated care plan to guide patient care | |

| Tier 1: Entry level | Tier 2: Typical | Tier 3: Optimal | |
|--|--|---|---|
| All 10 of the following requirements | All 16 of the following requirements | All 18 of the following requirements | Three of the following additional requirements |
| Decision support | | | |
| | Adopts evidence-based clinical practice guidelines on preventive and chronic care | Adopts evidence-based clinical practice guidelines on preventive and chronic care | Uses searchable electronic data to generate lists of patients and remind patients and clinicians of services needed Implements system to generate reminders (paper-based or electronic) about preventive services at the point of care |
| Patient/family engagement | | | |
| | Documents patient self-management plan (including end-of-life planning and home monitoring) Provides patient education and support Encourages family involvement | Documents patient self-management plan (including end-of-life planning and home monitoring) Provides patient education and support Encourages family involvement | |
| Coordination | | | |
| Tracks tests and provides follow-up | Tracks tests and provides follow-up | Tracks tests and provides follow-up | |
| Tracks referrals, including referral plan and patient report on self-referrals | Tracks referrals, including referral plan and patient report on self-referrals | Tracks referrals, including referral plan and patient report on self-referrals | |
| Reviews all medications a patient is taking, including prescriptions, over-the-counter medications, and herbal therapies/supplements | Reviews all medications a patient is taking, including prescriptions, over-the-counter medications, and herbal therapies/supplements | Reviews all medications a patient is taking, including prescriptions, over-the-counter medications, and herbal therapies/supplements Coordinates care and follow-up for patients who receive care in inpatient and outpatient facilities Uses medication reconciliation postdischarge to avoid interactions or duplications | |

Source: AMA/Specialty Society RVS Update Committee.

Medical home

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Another concern is the lack of technology mentioned in the recommendations, says Kuraitis. In his view, the medical home will need care management technological support, which might include call center technology and staffing, predictive modeling/stratification software, remote patient monitoring hardware and software, medical management software, personal health records, patient Web portals, and caregiver Web portals. But the recommendations did not take that technology into account, he says.

Thomas Wilson, PhD, DrPH, an epidemiologist at Trajectory Healthcare, LLC, and founder and board chair of the Population Health Impact Institute in Loveland, OH, is also concerned about the recommendations.

Part of his problem is the RUC itself. Rather than have the RUC make the recommendations, Wilson says an advisory group composed of consumers and PCPs should review the concept and create a fair payment model. "I think the medical home is a wonderful concept and disease management is a wonderful concept—both in theory. What I want to see with the medical home as they go forward with it, let's have open transparent methods to access how well it works so we can all learn from it."

Medical home payments

Depicting a hypothetical practice with one doctor, one nurse case manager, and 250 participating beneficiaries, the AMA/Specialty Society RVS Update Committee estimated these payment scenarios for a medical home.

| | Tier 1 | Tier 2 | Tier 3 |
|----------------------------------|----------|-----------|-----------|
| Physician | \$2,364 | \$2,837 | \$3,346 |
| Case manager | \$5,145 | \$6,965 | \$8,841 |
| Professional liability insurance | \$190 | \$190 | \$190 |
| Electronic medical record | \$0 | \$50 | \$1,015 |
| Patient education booklet | \$97 | \$97 | \$97 |
| Month total | \$7,796 | \$10,139 | \$13,489 |
| Year total | \$93,555 | \$121,671 | \$161,871 |

Source: AMA/Specialty Society RVS Update Committee.

Although critics have questioned the payment model, the American College of Physicians praised the RUC for its work. The organization of 125,000 internal medicine physicians and medical students was one of four physician groups that released a joint statement in support of the medical home concept in March 2007.

In response to the RUC's recommendations, David Dale, MD, FACP, president of the American College of Physicians, sent a letter to Rich on May 17 praising the RUC's report. "The RUC's work on this project is an important step in defining and quantifying the work that is associated with this new model of medical care," wrote Dale.

CMS actuaries are now crunching the numbers and will provide their own recommendations to the federal agency later this year. Unlike the RUC, which focused solely on trying to create a payment structure that adequately pays physicians for the added work, the actuaries will have to take into account the demonstration project's cost neutrality requirement. ■

Creating a payment structure

When developing the Medical Home Demonstration Project payment structure, **William Rich, MD**, chair of the AMA/Specialty Society RVS Update Committee (RUC), says the RUC reviewed other medical home projects to gauge the physician time, workload, and practice expenses.

Most of the costs in a medical home are not for new technology, such as electronic medical records, but for human capital, Rich says, adding that the RUC was able to review propriety costs and data to determine how much time and money would be involved in coordinated and preventive care.

The RUC made the following calculations for how much time it believes a physician would typically spend per patient per month depending on tier and included the physician work relative value units (RVU):

- Tier 1: 6.5 minutes; 0.25 work RVUs
- Tier 2: 7.8 minutes; 0.30 work RVUs
- Tier 3: 9.2 minutes; 0.35 work RVUs

MEDICARE

DISEASE MANAGEMENT

Medicare Health Support program nearing its close

CMS' announcement that it was ending the Medicare Health Support (MHS) demonstration project caused a spasm of criticism from the DM industry earlier this year. Despite the efforts of high-powered legislators who requested an extension to the MHS program, CMS still plans to end the project this year.

The project began in 2005 as a way to test DM programs in the Medicare population in the areas of HF and diabetes. MHS has traveled a rocky road in the past three years, with three of the eight awardees (LifeMasters Supported SelfCare, McKesson Health Solutions, and CIGNA) dropping out of the project.

A CMS official says MHS is just the latest demonstration project with DM interventions that did not prove worthwhile for the Medicare population. (CMS policy does not permit public attribution of comments by its staff members.)

Other DM-inspired demonstrations have focused on COPD, CHF, and diabetes, and have included call center nurses, health educators, social workers, and other population-based care coordination. Most of the projects have been "largely disappointing," says the official.

"Overall, we have not seen significant impacts on behaviors for the Medicare beneficiaries who are participating in the project. We're not seeing significant impact on utilization of services and therefore on costs," says the official.

Those involved in the project and industry leaders following the demonstration have complained that CMS has not been providing up-to-date information. **Thomas Wilson, PhD, DrPH**, an epidemiologist at Trajectory

Healthcare, LLC, and founder and board chair of the Population Health Impact Institute in Loveland, OH, says CMS has not offered enough program information to allow individuals to independently judge the program's successes and failures.

Wilson says the methods by which claims are made should be transparent, adding that if results only are disclosed, they are unintelligible unless the methods used to produce them—including risk adjustment techniques—are also provided.

"What we have learned is that we have not learned as much as we would have liked," Wilson says. "My general feeling about this whole thing is

"What we have learned is that we have not learned as much as we would have liked."

—Thomas Wilson, PhD, DrPH

that it's taxpayer money and there should be more transparency regarding the methods that are being used to assess performance—both clinical and financial."

The interim report on the project's first six months, released in summer 2007, provided the healthcare community with some useful lessons. However, since that report, CMS has not been offering that kind of information, Wilson says. "The answer to questions 'Did it work?' and 'Did it not work?' must be based on replicable evidence—methods and results—available to the public. We still don't know the basis of CMS' opinion," he adds.

Part D pharmacy claims data is one example of the information breakdown, says **Michael F. Montijo, MD, MPH, FACP**, senior vice president of solutions and government lead at Healthways in Nashville. CMS did not give the companies the claims data until more than two years into the program, he says.

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MHS program

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Not having that kind of real-time data affected Healthways' ability to intervene with at-risk patients, Montijo says. "The ability to use that effectively was obviously diminished," he adds.

Paul Serini, executive vice president of XLHealth in Baltimore, which is involved in the MHS project, as well as CMS' chronic condition special needs plans (SNP), likened the MHS project to giving the companies only half of a toolkit. The DM vendors in the MHS program are not provided with pharmacy claims data to more effectively track participants. That is not the case in the SNP.

"Our ability to do what we do best and help the member is greatly enhanced in a SNP model because, as the health plan provider, we have real-time visibility for both medical and pharmacy claims," Serini says.

One thing the MHS project revealed was a sicker patient population than was expected. Serini says MHS beneficiaries were "twice as sick as SNP [beneficiaries]. That means you better have a lot more on-the-ground nurses and a lot more programs to do a lot more things than you thought you may have needed at the beginning."

Rachel Haltiwanger, vice president of operations at XLHealth's Tennessee MHS program in Brentwood, says on-the-ground nurses communicate regularly with the beneficiaries and their physicians.

For the physicians, nurses provide another connection to the patients, and for the beneficiary, nurses serve as advocates and healthcare experts who understand the system's maze.

"Having someone be the champion to help them navigate through the medical management is important in making sure that they can get the appropriate care they need, raising awareness of warning signs that put them at risk, and educating them on the importance of follow-up," Haltiwanger says.

A CMS official says the federal agency heard complaints from both sides of the sickness debate. Some companies said the CMS patients were too sick, whereas

others said they were not sick enough to allow for adequate program savings.

The CMS official says the DM companies may have had trouble saving money and improving outcomes in MHS because the industry isn't used to caring for an older population.

"It's sicker and older than the population that disease management vendors are used to dealing with. They do some work in Medicare Advantage, but Medicare fee-for-service beneficiaries are generally older and sicker than Medicare Advantage beneficiaries and they are older and sicker than the commercially insured population where most of disease management takes place," says the official.

One problem was that several beneficiaries dropped out of the project because of death, losing benefits, or being moved into hospices, Montijo says.

"This high level of attrition, of which there was around 15% a year for most of the programs, produced a design where beneficiaries were dying faster than they could be reached to start the program. All beneficiaries must consent to participate, and that is the first step. I don't think anyone realized how heavily weighted the success of the program was to the early days of the program. The maximum opportunity for savings in the design was day one, and the least opportunity would be the last day," Montijo says.

MHS comings, goings

The following Medicare Health Support (MHS) awardees are still taking part in the project and serving these regions:

- ▶ Green Ribbon Health—Central Florida
- ▶ XLHealth Corporation—Tennessee
- ▶ Aetna Health Management, LLC—Chicago
- ▶ Health Dialog Services Corporation—Western Pennsylvania
- ▶ Healthways, Inc.—Washington, DC, and Maryland

Source: CMS.

He says the beneficiaries could be divided into the following three groups:

- ▶ Those who reduced costs on their own while in the program
- ▶ The high-cost population who did not improve
- ▶ The high-cost population whose health costs decreased over time

The first group could have benefited from less intensive and less costly wellness programs rather than DM. Intervening with the second group increased costs while not reversing their sickness trends. And the third group is where DM companies had an effect. “The cohort design gave you a population that was not as homogenous as what we thought it might be,” Montijo says.

The MHS project taught Healthways that to achieve the greatest effect, it was more important to target the neediest individuals in ways that would help them respond. The company has taken that lesson and is starting to implement it in other product designs.

Healthways offered face-to-face services to those who were institutionalized, while providing intensive care management that included outbound phone calls to the remaining beneficiaries. That targeting led to a higher degree of sophistication using predictive models to find

those who were at risk and whom Healthways’ services could help. “We honed and honed predictive models to better identify those who we should and those who we shouldn’t be intervening with,” Montijo says.

That outreach generated a high level of engagement. More than 87% of Medicare beneficiaries who were approached to take part in Healthways’ Washington, DC, and Maryland project participated. Moreover, Healthways received thousands of cards and letters from beneficiaries, physicians, and caregivers about the importance and value of this program.

Healthways has taken the lesson of targeted outreach from the MHS project and implemented it across its commercial population. With the program ending, the DM industry must wait until late 2009 or early 2010 for the independent analysis of the MHS program. Until then, DM will wonder why the MHS program was not extended and whether programs within MHS can be emulated.

“The methods that a vendor, especially a government vendor, uses to assess the value of their service should not be a secret,” Wilson says. “While a DM service can certainly have proprietary tools as part of its intervention package, the methods that are used to assess the value of those services—especially when delivered to a government purchaser—should not be a secret.” ■

New marketing regulations proposed for SNPs

CMS has proposed new regulations in hopes of protecting beneficiaries enrolled in Medicare Advantage (MA) and special needs plans (SNP).

The proposed plan would prohibit cold calling and expand the current prohibition on door-to-door solicitations, prohibit sales activities at educational events, require state-licensed agents for MA organizations that use independent agents to market MA and Part D plans, and require MA organizations to use commission structures for agents and brokers. (See the sidebar on **MDM** p. 4.)

The proposed rules also look to protect beneficiaries of SNPs, which provide coordinated care to individuals

in institutions such as nursing homes. These provisions include a requirement that 90% of new SNP enrollees have special needs and a provision that protects beneficiaries from being billed for cost-sharing that is not their responsibility. The proposal would also give CMS greater flexibility in determining penalty amounts, which could be as much as \$25,000 for each enrollee affected by the violation.

“These proposed changes will have a direct, positive impact on people with Medicare,” Kerry Weems, acting administrator of CMS, said in a statement. “The

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SNPs

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Medicare Advantage program is a valuable source of enhanced benefits and coordinated care for beneficiaries, and it should not be undermined by the actions of a limited number of unscrupulous sales agents.”

XLHealth, the owner and operator of the largest chronic condition SNP (C-SNP), with a total of 65,000 beneficiaries, supports the proposals.

XLHealth runs C-SNPs in Texas, Arkansas, Missouri, Maryland, South Carolina, and Georgia for beneficiaries with HF, diabetes, COPD, and/or end-stage renal disease. The new rules will raise the bar for companies offering MA and SNPs, says **Paul Serini**, executive

vice president of XLHealth, adding that inappropriate broker activity affects the companies offering MA plans and can cause beneficiaries to feel wronged.

XLHealth supports the new proposed regulations, but if there is a downside, it's that the proposed changes represent the difficult nature of offering SNPs, Serini says, noting that there are many shifting regulations, which makes managing the programs difficult. “We are running as fast we can, and if the rules keep changing every six months, it makes it very difficult to set business policies that are understood throughout the organization and at the broker community level,” Serini says. ■

New proposed MA, SNP regulations

The proposed plan marketing standards would:

- ▶ Prohibit cold calling and expand the current prohibition on door-to-door solicitation to cover other unsolicited circumstances. Any appointment with a beneficiary to market healthcare-related products would have to be limited to the scope that the beneficiary agreed to in advance. Cross-selling of nonhealthcare-related products to a prospective Medicare Advantage (MA) or Part D enrollee would also be prohibited.
- ▶ Prohibit sales activities at educational events, such as health information fairs and community meetings, or in areas such as waiting rooms where patients primarily intend to receive healthcare-related services, as well as limit the value and type of promotional items offered to potential enrollees.
- ▶ Require that MA organizations that use independent agents to market MA and Part D plans use state-licensed agents for such marketing, and require that MA organizations report to states, in a manner consistent with state appointment laws, where they are using those agents.
- ▶ Require MA organizations to establish commission structures for sales agents and brokers that are level across all years and MA plan product types (e.g., HMOs, PPOs, and private fee-for-service plans).

Commission structures established for prescription drug plans would have to be level across the sponsors' plans as well.

These requirements are designed to discourage churning of beneficiaries from plan to plan each year in a manner that earns agents and brokers the highest commissions and would ensure that beneficiaries are receiving the information and counseling necessary to select the best plan based on their needs.

The rule also proposes new protections for beneficiaries enrolled in special needs plans (SNP), which would:

- ▶ Require that 90% of new enrollees in SNPs be special needs individuals to ensure that SNPs focus on the population for which these MA plans are designed.
- ▶ More clearly establish delivery-of-care standards for SNPs.
- ▶ Protect beneficiaries from being billed for cost-sharing that is not their responsibility. For SNPs that target beneficiaries who are eligible for both Medicare and Medicaid, the rule would establish standards designed to ensure that those beneficiaries are able to access essential services that are available through Medicaid in addition to those benefits available through the SNP.

Source: CMS.

Study says heart failure program too costly

Call center-based programs put into question

A telephonic DM program for HF patients in South Central Texas was not cost-effective, but the study's authors say the program could have saved money if it had been targeted to the right patients.

Published in the February *Academy Journal of Managed Care*, the study, "Cost-Effectiveness of Telephonic Disease Management in Heart Failure," was "one of the first studies to assess the cost-effectiveness of DM in HF in a large sample with a follow-up period exceeding 12 months," wrote the authors.

The authors concluded that "the intervention was effective, but costly to implement and did not reduce utilization. It may not be cost-effective in other broadly representative samples of patients."

"I think in our sample, we learned that careful targeting is important," says **Brad Smith, PhD**, senior analyst at the Altarum Institute in San Antonio, who coauthored the study. "You really want to pick the patients who most likely will benefit based on the evidence. From our study, that would suggest the patients who are the sickest."

Conducted by the University of Texas Health Science Center in San Antonio and funded through the U.S. Department of Defense, the randomized controlled trial's disappointing results mirrored other reviews of call center-based HF programs. One such study, "Effect of Moderate or Intensive Disease Management Program on Outcome in Patients With Heart Failure," published in the February 11 *Archives of Internal Medicine*, failed to show that a DM intervention reduced mortality or HF rehospitalizations.

In the Texas study, the authors evaluated the cost-effectiveness of a telephonic DM intervention with HF patients. The randomized controlled trial of 1,069 community-dwelling patients in South Central Texas focused on patients with systolic and diastolic HF. The enrollment period was 18 months per subject, and stretched from 1999–2003. The study randomized participants into one of three study groups: usual care, DM, and augmented

DM. Those in the intervention arms were assigned a disease manager, an RN who educated the patient and provided medication management with the patient's PCP. In addition, patients in the augmented group were given in-home devices for enhanced self-monitoring, including those for measuring blood pressure.

Because there were no differences in outcomes between the DM and augmented DM group, when performing the cost analysis, researchers pooled the two groups into one intervention group.

To gauge costs, the study authors created a list of utilization events, including patient self-report data, reviews of electronic hospital records, and physician and clinical medical records. They also analyzed the cost of care for all causes and took into account intervention costs, which were based on fees paid to the DM subcontractor. The researchers did not calculate work-related costs, such as absenteeism and presenteeism, because participants were largely of retirement age.

The study found that the intervention failed to save money, and the difference in total costs observed among the sample was almost entirely attributable to the costs of the intervention.

It also found that DM showed "statistically significant survival advantages among all patients," although "analyses of direct medical and intervention costs showed no cost savings associated with the intervention."

The findings do not surprise **Randall Williams, MD**, CEO of Pharos Innovations in Northfield, IL, which sells technology that helps payers and providers manage their chronic disease populations. Pharos is involved with two physician groups totaling about 40,000 Medicare beneficiaries in CMS' Physician Group Practice (PGP) demonstration project.

Pharos' Tel-Assurance system enrolls HF patients in telephony and Web-based daily interaction, which requires patients to log in or call each day and report their

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Heart failure program

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test results, behavior, and medication compliance. The system captures the data, and the algorithms identify which patients need a care management nurse, either in the physician's or payer's office, depending on the client.

Through Pharos' program, Park Nicollet Health Services in St. Louis Park, MN, and Billings (MT) Clinic averted one HF admission per year per enrollee in the first two years of the PGP. Pharos' Tel-Assurance program enjoys a 3:1 ROI, Williams says.

He explains that the problem with the call center-based DM program in the Texas study is that it didn't reduce hospitalizations enough to outweigh the program's costs and didn't allow frequent enough communications with patients.

Williams says DM is successful with HF patients when the program is designed properly.

"I wasn't surprised that it didn't demonstrate hospitalization reduction. That said, there are several well-done analyses where they do and where the model is different, which I think is the explanation [for the study's negative results]," he says.

Williams says the keys to creating a cost-effective HF DM program that averts hospitalizations are:

- ▶ Provider-level connection with the patient, whether through a nurse, pharmacist, or physician.
- ▶ Frequent patient intervention. The call center model of contacting patients every month or two is not effective because it doesn't track patients between calls. On the other hand, technology is allowing DM programs to track patients daily.
- ▶ A low enough intervention unit cost that allows for a positive ROI.

Williams likened the program costs for the Texas project to CMS' Medicare Health Support demonstration project, which CMS is ending this year because it allegedly has not been cost-effective. "I think the model is wrong," he says.

Both programs also had per-patient-per-month charges of more than \$150. If a program is created with that kind of cost, Williams says the program must avert many hospital days to see a benefit. "You can avert hospitalizations, but at what cost?" he says.

The DM programs have created a parallel process to the physician's office, says **Emad Rizk, MD**, president of McKesson Health Solutions in Broomfield, CO, who agrees with the study that targeted interventions are important. Companies must focus on the most costly HF patients, he says.

DM should learn from the study and create leaner programs that utilize technology, Williams says.

"I think it should tell DM that episodic interactions with heart failure patients are not frequent enough and they need to figure out how to do that at or below the cost structure they are working at," he says.

Past studies

Smith says his study differs from others that have been published in academic HF journals (and those conducted, but not published, by DM companies) because the earlier studies focused on HF patients recently discharged from the hospital. This created a regression to the mean, skewing the data, because those who are tested when they are sickest will most likely improve during the study, he says.

Another problem is the duration of many studies. Reviewing HF patients' clinical improvements and health-care costs for a few months does not provide a review that is long enough, says Smith.

A third problem is that many of the other studies did not provide a control group, so they were, in fact, demonstration projects rather than studies.

Smith says a benefit to his study is that the program encompassed community-dwelling patients rather than those in facilities. Although there are limitations to strictly focusing on HF patients in South Central Texas, Smith says having community-dwelling patients gave researchers a more representative picture of HF patients. ■

Disease Management Advisor announces new editorial board

For the past six months, **Disease Management Advisor** has been developing a new editorial advisory board to reflect the changing DM industry. We are confident that the board will help us build on **Disease Management Advisor's** foundation with new ideas. The members are introduced below.

Premila Kumar, MD, PAHM



Premila Kumar is the Care Management Programs manager at Horizon Blue Cross Blue Shield of New Jersey. She develops and oversees all clinical operations of the asthma, COPD, Hepatitis C, multiple sclerosis, diabetes, coronary artery disease, weight management, and heart failure health education programs. Prior to Horizon, Kumar was health education manager of DM programs at CIGNA Health Care Tri-State Region.

Vince Kuraitis, JD, MBA



Vince Kuraitis is principal and founder of Better Health Technologies (BHT), LLC, in Boise, ID. BHT consults with companies in developing strategy, partnerships, and business models for chronic disease management and eHealth applications delivered in homes, workplaces, and communities. BHT's clients include Intel Digital Health Group, Philips Electronics, Amedisys, Joslin Diabetes Center, Ascension Health System, Samsung Electronics, Siemens Medical Solutions, Medtronic, Varian Medical Systems, and Disease Management Association of America.

Harlan Levine, MD



Harlan Levine is chief medical officer at OptumHealth Care Solutions in Golden Valley, MN. In his role as lead clinician, Levine drives innovative healthcare solutions that help people get the right care at the right time in the right place. He

oversees clinical policy and health content for consumers, and works closely with health plan and employer customers. Before joining OptumHealth, Levine held physician leadership roles at Salick Health Care, Logic Health Systems (SalickNet), and PacifiCare.

Alfred Lewis, JD



Alfred Lewis is president of Wellesley, MA-based Disease Management Purchasing Consortium International, Inc., which provides strategy, measurement, outcomes benchmarking, and procurement services in support of the DM and wellness efforts of more than 100 health plans, employers, and states.

Ariel Linden, DrPH, MS



Ariel Linden is president of Linden Consulting Group in Hillsboro, OR, which consults with payer and provider organizations in the area of health and medical management strategies. He is an accomplished health services researcher and has published more than 60 peer-reviewed manuscripts, book chapters, and abstracts regarding evaluation strategies for determining program effectiveness. In addition, he currently holds a joint faculty position in the school of medicine and the school of nursing at Oregon Health and Science University in Portland.

Gordon Norman, MD, MBA



Gordon Norman is executive vice president of science and innovation at Reno, NV-based Alere, a company that leverages technology and services to improve healthcare, one person at a time. He joined Alere in 2005 when Alere purchased PacifiCare's DM business and has since

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New board

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served in multiple executive roles there in business development, clinical quality, informatics, and product innovation. Prior to joining Alere, Norman served as executive director of PacifiCare's dedicated DM unit and vice president of healthcare quality. He was also regional medical director and senior plan medical director at PacifiCare of California. He is currently chair-elect of the board of DMAA: The Care Continuum Alliance.

Stan Nowak



Stan Nowak is founder, president, and CEO of Silverlink Communications, based in Burlington, MA. He is responsible for defining the strategic direction for Silverlink and achieving execution milestones. Nowak brings more than 15 years of management experience in IT, telecom services, and private utility sectors, working for companies such as StorageNetworks, GTE, and InterGen (Bechtel).

Jaan Sidorov, MD, MHSA, FACP



Jaan Sidorov owns and operates Sidorov Health Solutions in Harrisburg, PA. He is a healthcare consultant with more than 20 years of experience in primary care, DM, and population-based care coordination. He is a primary care general internist and former medical director at Geisinger Health Plan. He is also a fellow of the American College of Physicians and a former board of directors member of DMAA: The Care Continuum Alliance.

Alexis Skoufalos, EdD



Alexis Skoufalos is vice chair of education and assistant professor in the Department of Health Policy at Jefferson Medical College in Philadelphia. She is responsible for all of the department's educational programs and conferences,

advisory boards, and publications. Prior to joining Jefferson, she was senior manager of organizational development at Bancroft NeuroHealth, a provider of specialized services for individuals with developmental disabilities and neurological impairments.

Holly Snyder, MBA, CPA



Holly Snyder is president of Nationwide Better Health in Columbus, OH. Snyder has 20 years of experience in fields including healthcare, financial services, government, and public accounting. She was vice president of business development and performance management at Nationwide Strategic Investments.

Warren Todd, MBA



Warren Todd is founder and executive director of Flemington, NJ-based International Disease Management Alliance, a nonprofit whose mission is to help DM and prevention leaders worldwide to share information and best practices. Todd published the first book on DM, and was a past president and executive director of DMAA: The Care Continuum Alliance.

Thomas Wilson, PhD, DrPH



Thomas Wilson, an epidemiologist at Trajectory Healthcare, LLC, specializes in evaluation of programs and products to understand and effect defined populations, including DM, case management, payment-for-performance, predictive algorithms, and electronic medical records. He is also founder and board chair of the Population Health Impact Institute in Loveland, OH, a nonprofit educational and accreditation organization advocating for transparent and credible evaluations of population health management programs. ■

Five questions with ... Mack Bryson



Disease Management Advisor is kicking off a new feature, “Five questions with ...” this month.

In each issue, we’ll profile an industry leader to get his or her thoughts on the leading issues in DM and population health.

This month, we feature **Mack Bryson**, CEO of HealthScreen Disease Management in Jacksonville, FL. In 2007, HealthScreen moved from the traditional regional market to a national model. Bryson talks about those experiences and what it takes to go national.

DMA: Describe your company and its offerings.

Bryson: HealthScreen is a fee-based, patient-nurse-centered disease management program.

Our philosophy is that for any disease management program to be successful, there are three basic components that must be achieved:

- ▶ There must be a behavioral change by the individuals participating in the disease management program
- ▶ In order for there to be a behavioral change, there must be compliance to treatment and daily care protocols by the individuals participating in the disease management program
- ▶ In order to accomplish these, there must be active monthly management of the chronically ill

DMA: Why did HealthScreen Disease Management decide to move from the traditional regional market to a national model?

Bryson: Over the years, HealthScreen developed clients that had national exposure.

This, coupled with the fact that we decided to develop a brokerage component, compelled us to create a national strategy in deliverables, as well as marketing capability.

DMA: What does a DM vendor need in order to go national?

Bryson: In order for a DM vendor to expand on a national scope, it is imperative that the program offered be scalable and flexible. This must be accomplished with

minimal effort and without compromising the integrity of the core foundations of the disease management program, such as enrollments, incentive structures, case management, etc.

HealthScreen does not utilize a boilerplate mentality in the structure of our programs. We tailor each disease management and/or smoking cessation program to the needs of the client.

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Upcoming audioconference

July 22—Health Literacy: Four Ways to Create a Successful Program, featuring **Dexter L. Campinha-Bacote, MD**, medical director at Aetna, and **Gloria G. Mayer, Ed.D, RN, FAAN**, president and CEO of the Institute for Healthcare Advancement in La Habra, CA.

This 60-minute audioconference will focus on the importance of health literacy and how to properly educate and engage members. It will also offer strategies to help healthcare professionals deliver information to consumers in a way that engages them and enhances compliance outcomes. Participants will learn how to:

- ▶ Identify the scope of the current health literacy issue
- ▶ Recognize the importance of developing universal health literacy standards
- ▶ Formulate a plan for presenting a business case for health literacy to leadership
- ▶ Implement a health literacy program that reaches members regardless of background or education level
- ▶ Recognize what to expect in the future with health literacy

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Five questions

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DMA: What are the biggest benefits and drawbacks to expanding nationally?

Bryson: The greatest benefits are obvious, with an increase in name recognition, client base, etc. There is an added benefit in the collection of data on a national scope. Through analysis, we can then determine whether certain conditions are more prevalent in specific areas of the country than others.

The most obvious drawbacks would be in the area of logistics. In today's Internet age, this is less of a problem than it was years ago. As HealthScreen has always utilized personally assigned nurses, we have a substantial database of nurses that are available for our plan participants. We maintain an ongoing national recruitment policy for qualified registered nurses.

DMA: What do you predict for the DM market in the next two or three years?

Bryson: I believe that the disease management industry will play a greater role in addressing the healthcare issues on a national scale. As the awareness of successful disease management programs becomes more commonplace, I believe there will be an increase in the consolidation of these markets. We are already seeing this to some degree.

There also appears to be a movement developing to move away from the capitated pricing models. We are

speaking with more and more clients who have experienced dissatisfaction over the lack of performance of these models and are looking for a program that only charges based on those receiving active monthly management and following established treatment and daily care protocols.

Employers are becoming more educated in their expectations of successful disease management programs. They are beginning to realize that it is physically and financially impossible to have a dramatic impact on healthcare costs as relates to the chronically ill for \$2 [per employer per month]. The realization is beginning to set in that the most expensive disease management program is the one that does not work.

These employers are now looking at impacts on claims trend, clinical values, utilization, etc. Employers are also realizing that a disease management initiative without a structure for accountability on the part of the participant is at risk for being seen as another entitlement program rather than a true benefit. ■

Questions? Comments? Ideas?

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