

Applying disease management to Medicare: Data analysis of fee-for-service enrollees

ISSUE: The Commission is examining patterns of care and spending among fee-for-service beneficiaries in order to understand different approaches to providing disease management services. In particular, what are the implications of offering such services population wide versus targeting them toward certain types of beneficiaries, such as those with a history of high spending or specific clinical characteristics? Analyses have shown that a small proportion of beneficiaries account for a disproportionate share of Medicare expenditures. But if a key goal of disease management is to slow growth in program spending or provide higher quality of care with the same level of resources, it is also important to understand persistence in spending. If high-cost beneficiaries do not tend to remain persistently high cost over time, beneficiaries may need different types or intensities of services at different points in time. This makes the process of targeting care coordination more complex.

KEY POINTS: MedPAC contracted with Direct Research LLC to build a data set of all Medicare claims from the 1996-2002 period for a representative sample of fee-for-service (FFS) beneficiaries. For MedPAC's June report, we plan to examine trends in use of services and spending for the entire Medicare population as well as for certain subpopulations: beneficiaries with multiple chronic conditions; with end-stage renal disease and chronic kidney disease; those dually-eligible for Medicare and Medicaid; and those at the end of life. For the March meeting, we will review some preliminary results of that data analysis.

ACTION: At the March meeting, the Commission will discuss the data analysis and its implications for targeting disease management services to the Medicare population.

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The Medicare Modernization Act and chronic care improvement

ISSUE: The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established the foundation of a voluntary chronic care improvement program within fee-for-service (FFS) Medicare. The goals of that program are to coordinate care across providers, improve patients' compliance with treatment regimens, and encourage the use of evidence-based treatment guidelines. If the pilot program is found to improve outcomes and achieve savings targets, then CMS can expand it without further need for legislation. At issue is whether the program can meet the special needs of the Medicare fee-for-service population.

KEY POINTS: Few details about implementation of the chronic care improvement program are available yet. Nevertheless, the program is scheduled to begin by December 2004 and will be offered in geographic areas where, in aggregate, at least 10 percent of all Medicare beneficiaries live. Although designed to be budget neutral, the MMA authorizes initial payments of as much as \$100 million between 2004 and 2006 to organizations that bid to provide care coordination services.

MedPAC staff conducted numerous interviews with stakeholders to examine the application of disease management programs to FFS Medicare. For the March meeting, we will present some initial findings from those interviews on issues raised by Commissioners. Those issues include:

- Who will receive chronic care improvement services?
- Who will provide the services and how will they be paid?
- Can the special needs of Medicare beneficiaries be met by the program?
- How will Medicare evaluate the effectiveness of the program?

ACTION: The Commission should discuss the findings and conclusions set forth in the attached report, particularly the issues that Medicare should consider when implementing the chronic care improvement program. This analysis will form the basis of a chapter in June 2004 report.

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