



Health Insurance Reform Project Helps Design Program to Improve Health Care for Medicare Recipients With Multiple Chronic Illnesses

Health Insurance Reform Project: Medicare, Access and Quality

SUMMARY

From 2003 to 2004, staff from the Health Insurance Reform Project, a nonprofit, nonpartisan program at [George Washington University](#), worked with staff from the federal [Centers for Medicare & Medicaid Services \(CMS\)](#) to help design a program to improve the quality of care and life for people with multiple chronic illnesses.

The program—called Medicare Health Support—helps [fee-for-service Medicare](#) beneficiaries adhere to their physicians' health care advice and obtain appropriate medical care to reduce their health risks.

One month after this grant began, Congress authorized Medicare Health Support programs with the 2003 [Medicare Modernization Act](#).

Key Results

In four small, "off-the-record" meetings, project staff helped CMS staff obtain expert, nonpartisan input on the design, implementation and evaluation of Medicare Health Support:

- A January 2004 meeting to discuss how to shape the program to improve fee-for-service Medicare performance.
- A June 2004 meeting to discuss opportunities and challenges in monitoring the performance of the program.
- A July 2004 meeting to see what Medicare could learn from Medicaid's disease management programs.
- A December 2004 meeting (shortly after the end of the grant period) to identify hurdles and strategies for enhancing the integration of program data by using health information technologies.

Funding

The Robert Wood Johnson Foundation (RWJF) supported this project through a grant of \$214,129.

THE PROBLEM

According to the [Kaiser Family Foundation](#), [fee-for-service Medicare](#) served more than 35 million adults in 2002. As of 2005, this cost more than \$200 billion annually, with costs projected to grow dramatically in the future. Most of these 35 million adult beneficiaries have multiple chronic health problems, which account for a disproportionate share of all U.S. health care expenditures.

According to [CMS](#), among the more than 40 million total Medicare beneficiaries:

- Some 14 percent of Medicare beneficiaries have congestive heart failure, but they account for 43 percent of Medicare spending.
- Some 18 percent of Medicare beneficiaries have diabetes, yet they account for 32 percent of Medicare spending.

RWJF STRATEGY

RWJF has been interested in a variety of health insurance coverage issues since 1987. The Foundation funded the Health Insurance Reform Project (HIRP), a nonprofit, nonpartisan program based at George Washington University, since 1995.

With three RWJF grants HIRP developed reports describing important emerging practices in health care/insurance markets that have significant implications for the future of private markets and for public programs such as Medicare and Medicaid, which operate in those markets. (See [Grants Results](#) on ID#s 027243, 030390 and 035292.)

Starting in 2001, with three further grants from RWJF, staff from HIRP began helping CMS develop a program to improve chronic care for fee-for-service Medicare beneficiaries. Staff worked to develop and advance new ideas to improve federal health policy, focusing primarily on improving quality in Medicare and expanding health insurance coverage nationally. (See [Grant Results](#) on ID#s 041223, 041828 and 048295.)

THE PROJECT

Under this grant, staff with the Health Insurance Reform Project worked with CMS to improve chronic care management under fee-for-service Medicare. Through small, "off-the-record" meetings, staff helped CMS obtain expert, nonpartisan input on program design, implementation and evaluation.

Shortly after this grant began, Congress authorized the Chronic Care Improvement Program—soon after renamed [Medicare Health Support](#)—under the 2003 Medicare Modernization Act. The law called for the creation of approximately 10 regional programs serving 150,000–300,000 beneficiaries. The programs would run for three years and would be evaluated through randomized controlled trials.

Project Director Sandra Foote described the program in a report entitled *Chronic Care Improvement in Medicare FFS: Cosmetic or Transforming?* The report, along with others published through the Health Insurance Reform Project, is available [online](#).

RESULTS

The project yielded the following results:

- **In four small, "off-the-record" meetings, project staff helped CMS staff obtain informative, nonpartisan input from national experts on the design, implementation and evaluation of Medicare Health Support:**
 - ***A January 2004 meeting*** with some 12 experts to discuss how to shape the program to improve fee-for-service Medicare performance. Participants examined:
 - Synergies and points of tension among existing private sector strategies, including:
 - Provider sponsored medical quality and health information technology initiatives.
 - Payer-sponsored disease management.
 - Pharmacy-benefit management.
 - Pay-for-performance initiatives, which would require provider organizations to refund some or all of their fees to the federal government if they did not meet agreed-upon standards for quality improvement, savings to Medicare, and increased satisfaction levels in their assigned beneficiary populations.
 - How Medicare policies could be structured to stimulate the development of new models of chronic care management that are cost-effective and scalable.
 - ***A June 2004 meeting*** with some 12 experts to discuss opportunities and challenges in monitoring the performance of the program. Participants identified important clinical metrics that the program is likely to affect and crucial issues concerning data definition, data collection and measurement.
 - ***A July 2004 meeting*** with some 12 experts to see what Medicare could learn by examining program implementation and operational issues experienced by some

of Medicaid's disease management programs. The meeting underscored the importance of:

- Utilizing pharmacy-use data to influence and improve chronic care delivery to beneficiaries.
 - Exploring potential collaborations between Medicare and state Medicaid programs in implementing the new fee-for-service Medicare Health Support programs.
- *A December 2004 meeting* with some 50 experts to identify hurdles and strategies for enhancing the integration of program data by using health information technologies. Participants discussed:
- Lessons learned from community collaborations already or soon to be exchanging information.
 - Opportunities to leverage Medicare's involvement to accelerate connectivity.

LESSONS LEARNED

1. **Provide "off-the-record" opportunities for executive branch staff to learn from programs and leaders in the field.** Each of the four meetings provided unique opportunities for one-on-one dialogue at critical times during the Medicare Health Support program's implementation. This kind of learning is extremely difficult to come by at the executive level, yet it is critical to good policy-making and program implementation. (Project Director/Foote)

AFTERWARD

The Health Insurance Reform Project closed at the end of this grant. Project Director Foote went to work for CMS, heading up [Medicare Health Support](#) during the final design phase.

In December 2004, CMS announced the selection of the eight health care systems that would run the regional pilot Medicare Health Support programs. (For a list of the programs, see [Appendix 1](#).) As of February 2006, more than 100,000 people had enrolled in the programs.

According to CMS, Medicare Health Support marks "a major milestone in the shift toward prevention and quality improvement for chronically ill beneficiaries under Medicare fee-for-service."

In a press release, CMS reported that the initial "response from beneficiaries, their caregivers and physicians has been extremely positive." A CMS summary of the program is online.

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APPENDIX 1

Medicare Health Support programs (in order by date started)

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Oklahoma

LifeMasters Supported Selfcare, Inc.
started August 1, 2005

Northwest Georgia

CIGNA Healthcare
started September 12, 2005

Washington and Maryland

American Healthways, Inc.
started August 1, 2005

Illinois

Aetna Health Management, LLC
started September 1, 2005

Western Pennsylvania

Health Dialog Services Corporation
started August 15, 2005

Central Florida

Green Ribbon Health
started November 1, 2005

Mississippi

McKesson Health Solutions, LLC
started August 22, 2005

Tennessee

XLHealth Corporation, Inc.
started January 16, 2006

APPENDIX 2

Glossary

Fee-For-Service Medicare plans pay doctors for each of the health care services they provide, as opposed to paying them a per-patient per-month capitated rate.

BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Reports

Foote SM. *Chronic Care Improvement in Medicare FFS: Cosmetic or Transforming?* Research Brief No. 13. Washington: Health Insurance Reform Project, 2004. Also available [online](#).