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ARE COMMERCIAL DISEASE MANAGERS WILLING AND PREPARED TO ENTER THE MEDICARE MARKET?*

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Recently, the public policy debate on Medicare reform has turned to adding a prescription drug benefit. Currently, approximately a third of Medicare beneficiaries lack pharmaceutical coverage. Lack of coverage appears to be particularly detrimental to the chronically ill Medicare subpopulation that often needs prescription medications on a daily basis.

Several Congressional proposals would establish disease management demonstration projects concurrently with a prescription drug benefit. Theoretically, implementation of disease management programs that improve coordination of drug therapy with hospital and physician care services would contribute to a more cost-effective drug benefit.

This paper presents results from a Tufts Center for the Study of Drug Development survey describing current disease management practice in the United States. The survey results suggest willingness on the part of commercial disease managers to negotiate performance- and (insurance) risk-based contracts with Medicare. However, at present, disease managers enroll only a small number of Medicare beneficiaries; less than 20% of their total enrollment. Disease managers also have very limited experience with government agency contracts, which comprise less than 5% of their total contracts. In addition, comparatively few disease managers surveyed focus specifically on diseases that are highly prevalent among Medicare beneficiaries, such as Parkinson's, Alzheimer's, End-Stage Renal Disease, and Chronic Obstructive Pulmonary Disease. These survey findings suggest that disease managers are not currently fully prepared to enter the Medicare market en masse.

Key Words: Disease management; Medicare prescription drug benefit; Insurance risk

INTRODUCTION

THE MEDICARE fee-for-service program has traditionally been more generous in terms of reimbursement of acute care episodes such as hospitalization and physician visits, and less so with respect to most long-term care, home health, and preventive services. Since each service is typically delivered, billed, and reimbursed separately, the functional and financial separation of treatment components may have inhibited more cost-effective care.

Component management occurs if both health care providers and payers of health care services view health as well as budgetary matters through a specific window of care and/or administrative budget for which they are responsible (1). Examples of component management include the following scenarios:

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- When hospital-based providers narrowly focus on health as well as budgetary issues that take place within the inpatient setting,
- When a pharmacy director attempts to minimize the pharmacy budget regardless of the impact on total health care costs, and
- When insurers reimburse a drug used in the hospital, but do not cover the same medication for the same illness once the patient is discharged.

Disease management promises a new, more cost-effective approach to handling health as well as budgetary issues. Instead of managing health care components in piecemeal fashion, they would be managed across functional divisions in health care, such as the inpatient and outpatient settings, and across administrative budgets, such as the inpatient, physician service, and pharmacy budgets.

Following Pareto's rule (2), a high proportion of Medicare hospital admissions and expenditures is accounted for by a small number of Medicare beneficiaries who experience chronic patterns of acute hospital use. It is estimated that the chronically ill Medicare population (which comprises 10% of the total Medicare population) accounts for close to 60% of the total costs of the Medicare program (3). Targeted interventions, such as disease management programs, aimed at chronically ill Medicare beneficiaries could reduce the number of hospital days and expenditures, particularly among patients who are repeatedly hospitalized (4).

With the passage of the Medicare Catastrophic Coverage Act of 1988, disease management demonstration projects targeted at Medicare beneficiaries identified as high users of hospital care received a federal focus. The 1988 act would have combined a prescription drug benefit with a disease management component. But, the 1988 act was repealed in 1989 (5).

By 1999, adding a Medicare prescription drug benefit returned as a legislative priority in Washington (6). In 2001, policymakers were debating the merits of concurrently instituting a set of disease management programs as a vehicle to coordinate care for Medicare beneficiaries across functional (specialty) and administrative health care components.

DISEASE MANAGEMENT PROCESS

In late 2000, the Tufts Center for the Study of Drug Development carried out a survey to gain insight into the current practice of commercial disease management in the United States. The Tufts Center for the Study of Drug Development surveyed 31 leading disease management organizations that together account for approximately 50% of all covered lives currently managed in the United States. The disease managers surveyed included 17 so-called independent disease managers (IDMs), 8 managed care organizations (MCOs), and 6 pharmacy benefit managers (PBMs). One-third of the firms surveyed covered fewer than 10000 lives, another third of those surveyed covered between 10000 and 50000 lives, and the remaining firms each covered more than 50000 lives. The survey was conducted using a three-page questionnaire. Forty-nine disease managers were surveyed. Thirty-one responded with completed questionnaires.

We asked each survey respondent for its definition of disease management. From the 31 definitions provided by the respondents, we distilled the following working definition of disease management:

> Disease management, as practiced in the United States today, is a continuous, coordinated health care process that seeks to manage and improve the health status of carefully defined patient populations over the entire course of a disease. Disease managers appoint nurse case managers or primary care physicians to coordinate care both across disease states, and, within a disease category, across specialties such as primary and other specialist care. Disease management targets high-risk, high-cost patients with chronic conditions whose optimal treatment depends on appropriate medication use. Disease managers identify patients to enroll, stratify patients into risk groups, intervene through patient and/or physician education and compliance measures, and monitor medication regimen, drug-drug interactions, and health outcomes.

The definition above is broad and encompasses a wide range of disease management services. Seventeen of the survey respondents adopted a broad definition of disease management. The remaining 14 respondents adopted a narrower definition of disease management, limited in scope mainly to the provision of information to physicians and patients regarding appropriate medication use.

We asked disease managers to report their allocation of resources into three categories of services: prescription drug formulary management, monitoring (compliance and drug-drug interactions), and prevention (patient and physician protocols). The survey respondents reported that, on average, about 30% of their budget resources were allocated to formulary management, 20% to monitoring, and the remaining 50% to preventive services.

The disease managers in our survey reported that 30% of their contracts were with large employers (with over 1000 employees), 65% were with a wide variety of health plans, and about 5% were with government agencies. Disease managers may be paid on a fee-for-service basis (paid separately for each service rendered), a capitated rate (a fixed payment per month per enrollee), or some mix of fee-for-service and capitation. Surprisingly, a third of the disease managers surveyed stated that the majority of their contracts are fully capitated, implying that they bear financial risk. Less than one fifth exclusively sign fee-for-service contracts. Figure 1 illustrates the cash flows involved in the disease management process. Figure 2 shows the data flows between the same entities involved in the disease management process.

MEDICARE COORDINATION CARE DEMONSTRATION PROJECTS

The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) is carrying out a series of disease management demonstration projects that will measure possible efficiencies resulting from providing Medicare payments to help support a pharmacy benefit to Medicare beneficiaries. These projects seek to demonstrate how managing an outpatient prescription drug benefit for a select group of chronically ill Medicare beneficiaries with the help of disease managers will result in a more efficient use of Medicare Part A (hospital) and Part B (health care provider) services.

In July 2000, CMS solicited applications from disease and case managers to carry out the largest coordinated care demonstration

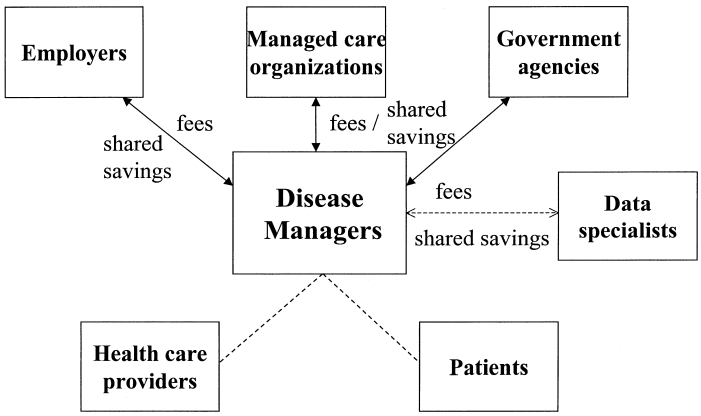

FIGURE 1. Cash flow and disease management. Disease managers contract with large employers, health plans, and government agencies to provide a multitude of services mainly to chronically ill patients. Data specialists may also contract with disease managers. There is usually no cash flow between patients, health care providers, and disease managers.

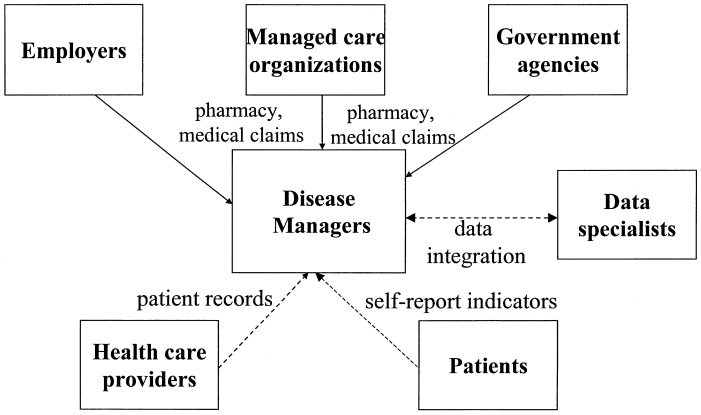

FIGURE 2. Data flow and disease management. The employers, health plans, and government agencies that contract with disease managers provide pharmacy and medical claims data. Health care providers often provide patient records. Patients sometimes provide self-report indicators. Disease managers and data specialists exchange data, particularly with respect to pharmacy and medical claims data integration.

project thus far (7–10). In January 2001, 15 winning proposals were chosen from 58 applications, based on their proposed set of coordinated care services, the diseases managed, empirical evidence of prior success, payment methodology, and budget neutrality. The latter criterion implies that federal expenditures under the demonstration can be no greater than what they would have been in the absence of the demonstration. Eight of the awardees are case managers and seven are disease managers. CMS expects the sites to begin serving up to 25000 beneficiaries collectively by January 1, 2002. Initially, the projects will operate for four years, but CMS can make components found to be cost-effective a permanent part of the Medicare program, and can expand the number of demonstration projects if it chooses. Medicare beneficiary participation is voluntary. Furthermore, beneficiaries do not have to pay for the disease management services. Examples of services are home health nurse visits, patient and physician education programs, and social service assistance to ensure compliance with established medical regimens, and forwarding of patient reports to physicians.

A monthly, all-inclusive (capitated) rate will be paid by CMS for the coordinated care services provided under the demonstration program. Capitation was chosen as a payment method because it creates economic incentives to move the focus of care away from high-cost settings (hospitals) and types of treatment (acute care) to health care services that can better affect the incidence and prevalence of disease in the first place.

In January 2001, CMS expanded the United Mine Workers of America demonstration project (11). CMS first entered into a demonstration with the United Mine Workers of America Health and Retirement Funds in 1990 to test a method of paying the funds for providing comprehensive health benefits to approximately 60000 Medicare beneficiaries. Medicare pays the funds a monthly (capitated) lump sum based on the number of beneficiaries for all Medicare Part B services other than those administered by Part A fiscal intermediaries. For Part A services, the funds and CMS share risk for services administered by the Part A fiscal intermediaries. As part of the expanded demonstration, CMS will continue the existing payment and incentive arrangement, and will pay 27% of the annual costs of the funds' prescription drug program.

DISEASE MANAGER WILLINGNESS TO NEGOTIATE WITH CMS

The demonstration projects described in the previous section are designed as test cases before a prescription drug benefit together with disease management services can be provided for all Medicare beneficiaries. Several Congressional bills proposing a Medicare prescription drug benefit contain provisions for similarly designed demonstration projects. For example, a House Republican bill passed in June 2000 (12) stipulated a three-year demonstration project, beginning in 2003, to evaluate the impact of disease management services on the costs and health outcomes of Medicare beneficiaries with certain chronic illnesses, including congestive heart failure (CHF), COPD, and diabetes.

Under HR 4680 bill, voluntary participants would be entitled to additional prescription drug benefits in addition to those already offered in the prescription drug component of the bill. These benefits would be paid for by the enrolling disease manager. Specifically, disease managers would pay for each participating beneficiary's premium, deductible, and cost-sharing under the prescription drug component.

A Congressional Budget Office study of HR 4680 suggests that disease managers are reluctant to contract with Medicare (13). The *Pink Sheet* said, "A disease management program pilot project included in the House Medicare drug benefit bill (HR 4680) may have difficulty attracting private sector contractors" (14). Uncertainty regarding whether disease managers would participate involves the interpretation of how their fee would be negotiated. The bill requires that the capitated fee paid to the disease managers be negotiated in a manner that would guarantee a net reduction in expenditures under the Medicare program for participating beneficiaries. The Congressional Budget Office assumes that disease managers would decline to participate if they had to guarantee a net reduction in expenditures. The chief reason given by the Congressional Budget Office is that disease managers are not directly provided any gatekeeper authority to control access to or reimbursement for benefits under Parts A, B, and D (prescription drugs).

However, when presented with a vignette containing a brief summary of the demonstration project outlined in HR 4680, 80% of our survey respondents answered "yes" to the question "would your firm be willing to negotiate fees based on a guarantee of a net improvement in the Medicare program's cost-effectiveness for participating beneficiaries?" (A disease management program is considered cost-effective if the additional benefits provided by the program are worth at least as much as the additional program costs.) In addition, 64% of the survey respondents answered "yes" to the question "would your firm be willing to negotiate fees based on a guarantee of a net reduction in expenditures under the Medicare program for participating beneficiaries?" (Note that MCO disease managers were far less likely to be willing to negotiate fees based on a guarantee of a net reduction in spending. Only 25% of the MCOs surveyed reported their willingness to negotiate such a fee, compared to over 70% of PBMs and IDMs surveyed.)

The disease managers' stated willingness to negotiate risk- and performance-based contracts appears to be in stark contrast to the position espoused by the PBM industry regarding bearing of financial (insurance) risk. The PBM trade association recently released a statement that insurance risk, which would imply PBMs being at risk for the full cost of pharmaceuticals, is not a core PBM function (15,16).

DISEASE MANAGERS' PREPAREDNESS TO ENTER THE MEDICARE MARKET

The majority of disease managers surveyed appear willing to negotiate risk- and performance-based contracts with Medicare. However, are they prepared to enter a market that is particularly tricky given that it is the last market yet to undergo a transformation to

managed care, and its population requires disproportionately high levels of chronic care?

The disease managers surveyed currently enroll a relatively small number of Medicare beneficiaries; less than 20% of their total enrollment. More than 70% of the Medicare beneficiaries served by the survey respondents are enrolled in so-called Medicare+ Choice plans that contract with CMS on a fixed sum per beneficiary basis. Eleven of the 31 disease managers reported not having enrolled a single Medicare beneficiary. Ten of the 20 survey respondents who enroll Medicare beneficiaries noted "significantly" higher average costs per patient among their Medicare pool, compared to their non-Medicare population.

Only a small number of disease managers surveyed manage diseases prevalent primarily among the Medicare population, such as Parkinson's (one respondent), Alzheimer's (none), and COPD (five respondents). And, while 28 of 31 disease managers manage diabetes, a disease highly prevalent among Medicare beneficiaries, less than 30% of the enrollees in the diabetes programs were Medicare beneficiaries (Figure 3). Merely 7 of 31 report managing CHF, a disease that is both highly prevalent among Medicare beneficiaries and the leading cause of hospitalization among beneficiaries. While close to 90% of the disease managers surveyed have diabetes disease management programs, less than 30% of the enrollees in these programs are Medicare beneficiaries. And although close to 50% of the enrollees in CHF programs are Medicare beneficiaries, only 7 disease managers reported having a CHF program.

Disease managers have very limited experience with government agency contracts. Survey respondents reported that fewer than 5% of their total number of contracts are with government agencies such as Medicaid, State Pharmacy Assistance Programs, and the Veterans Administration.

To be cost-effective, disease managers in the predominantly fee-for-service Medicare setting would need to reduce hospital admissions, the largest single Medicare expenditure. Programs that only reduce physician service costs or emergency room visits are unlikely to save Medicare enough money to cover program costs. However, less than one half of survey respondents reported that they could demonstrate quantitative evidence of reductions in hospital admissions, or even

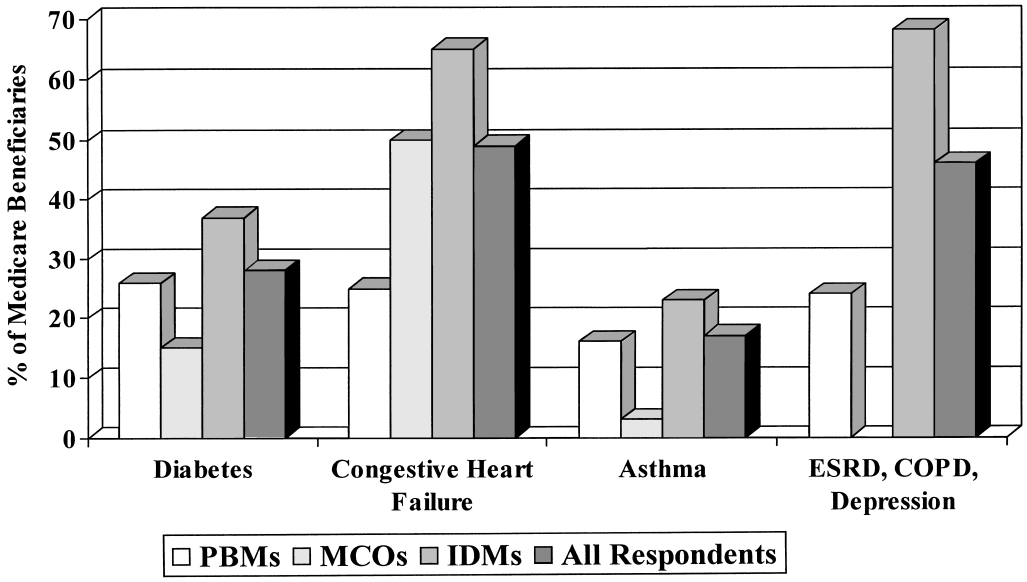

FIGURE 3. Percentage of Medicare beneficiaries per disease category.

reductions in total medical costs per time period, for their current enrollees.

The measures used to indicate potential cost savings relevant in the Medicare context include tests that provide proven benefits, for example, for diabetic patients, eye and foot exams and a series of blood tests. More than 90% of the disease managers surveyed adhere to national standards (for instance, National Diabetes Association guidelines). Other more financially tangible measures reported by the survey respondents include cost reductions in terms of reduced hospital admissions and length of hospital stays (Figure 4). The vast majority of disease managers surveyed use reductions in hospital admissions, hospital days, and emergency room (ER) visits to calculate cost savings. A solid majority also uses quality of life indices. Fewer than half use mortality reduction and doctor visit reduction indices to calculate cost savings.

In economic terms, being cost-effective would mean providing disease management services up to the point at which the added costs of disease management are equal to the added benefit produced. This implies that the costs of disease management implementation would need to be included in cost savings calculations. While 80% of the disease managers surveyed included disease management implementation costs in their cost savings calculations, 60% separated out pharmacy cost savings. Of those who separated out pharmacy cost savings, 30% reported not calculating total medical cost savings.

CONCLUSIONS

In order to promote cost-effective care, disease management promises to better coordinate health care delivery components as well as information such as pharmacy and medical claims. Such coordination is not occurring under traditional fee-for-service delivery systems, such as Medicare. However, despite the fact that the disease management industry appears to be booming, only a small portion of the growth in industry revenue has accrued from the Medicare market. The Tufts Center for the Study of Drug Development survey reveals that notwithstanding disease managers' willingness to enter the Medicare market, disease managers currently enroll only a small number of Medicare beneficiaries (less

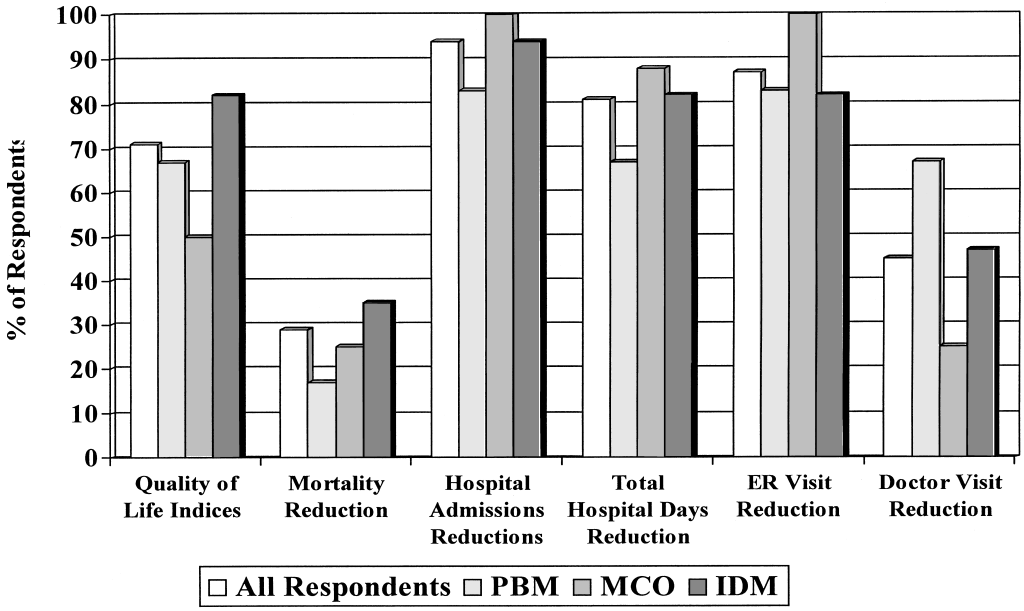

FIGURE 4. Outcome measures used to calculate cost savings.

than 20% of their total enrollment). Disease managers also have very limited experience with government agency contracts (less than 5% of their total number of contracts). In addition, comparatively few disease managers surveyed focus specifically on diseases that are highly prevalent among Medicare beneficiaries, such as Parkinson's, Alzheimer's, ESRD, and COPD. These survey findings indicate that, at present, disease managers may not be fully prepared to enter the Medicare market.

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