The Changing Paradigm for the Financing and Delivery of Chronic Condition Care

Paul Wallace, MD
The Permanente Federation
Kaiser Permanente
paul.wallace@kp.org
Correlation Between Per Capita Expenditure on Health Care and GDP, 2002-2003

The figure for Japan is 2002 estimate; the figures for Australia, Austria, China, Hungary, Ireland, Israel, Poland, Sweden and United Kingdom are of 2002; the figures for Canada, France, Iceland, Norway and Switzerland are 2003 estimates. The rest are of 2003.

Source: OECD Health Data 2005 and WHO. ©Stuart H. Altman

Diabetes
Heart Failure
Coronary Artery Disease
Depression
Chronic Pain
Cancer
Asthma and COPD
Dementia
Falls
Obesity
... Co-morbidities

1% of people

30% total cost

Premium level

% of People

0% total cost

0% 20% 40% 60% 80% 100%

0% 20% 40% 60% 80% 100%

20% of people

70% of people
Opportunity: The Demographics of Chronic Conditions

Chronic Condition Population Demographic Trends: 1995 - 2030

Hopeful... In 2005

EXHIBIT 8
THE DMPC ANTICIPATES SIGNIFICANT GROWTH IN REVENUES AMONG DMOs

Sources: Health Industries Research Companies (2005); data were updated by the Disease Management Purchasing Consortium in November 2005.
As an emerging industry, the estimates for the true DM market size can vary significantly. While previous estimates were for “pure-play DMOs”, JP Morgan and Matria estimate the total potential market to be up to $30 billion by 2010, including the public sector.

JP Morgan 2010 Market Estimates
Potential Market (in billions)

- Fortune 1000 Ers: $10 billion (36%)
- Small/Mid Employers: $2 billion (8%)
- Medicare: $3 billion (11%)
- Medicaid: $13 billion (45%)

Total = $30 Billion

Medicare Health Support

Medicare Health Support Preliminary Findings

Locations of MHS Programs

Health Dialog
American Healthways
XL Health
CIGNA Health Support
Green Ribbon Health℠
LifeMasters
McKesson
Aetna

Medicare HEALTH SUPPORT

Kaiser Permanente®
National and Local Support for MHS

...And many more!
Hopeful...
Medicare Coordinated Care Demonstrations

“The findings in brief indicate that patients and physicians were generally very satisfied with the program, but few programs had statistically detectable effects on patients’ behavior or use of Medicare services.”

Treating only statistically significant treatment-control differences as evidence of program effects, the results show:

- Few effects on beneficiaries overall satisfaction with care
- An increase in the percentage of beneficiaries reporting they received health education
- No clear effects on patients adherence or self-care
- Favorable effects for only two programs each on: the quality of preventive care, the number of preventable hospitalizations, and patients well-being
- A small but statistically significant reduction (about 2 percentage points) across all programs combined in the proportion of patients hospitalized during the year after enrollment
- Reduced number of hospitalizations for only 1 of the 15 programs over the first 25 months of program operations

No reduction in expenditures for Medicare Part A and B services for any program

Kaiser Permanente
Many of the programs had unexpected difficulty enrolling the target number of patients...

The programs that were most successful in enrolling patients were those that had a close relationship with physicians before the demonstration started and those with access to databases (such as clinic or hospital records) to identify potentially eligible patients.

... six of the programs are not cost neutral, four probably are not, and five may be cost neutral, over their first 25 months of operations.
Can Disease Management Reduce Health Care Costs By Improving Quality?

We cannot reduce costs by improving quality unless treatments for the chronically ill are themselves cost-saving.

by Bruce Fireman, Joan Bartlett, and Joe Selby

PROLOGUE: During the past decade disease management programs (DMPs) have been sweeping the country. In 2000 a survey of forty-five health plans revealed that more than half had such programs in place a scant few years after the concept began to emerge. Disease management has become a buzzword in government and

>Saved >$200M relative to overall cost trend

>Did not produce absolute savings
Evidence for the Effect of Disease Management: Is $1 Billion a Year a Good Investment?

Soeren Mattke, MD, DSc; Michael Seid, PhD; and Sai Ma, PhD

**Objective:** To assess the evidence for the effect of disease management on quality of care, disease control, and cost, with a focus on population-based programs.

**Study Design:** Literature review.

**Methods:** We conducted a literature search for and a structured review of studies on population-based disease management programs, as well as for reviews and meta-analyses of disease management interventions. We identified 3 evaluations of large-scale population-based programs, as well as 10 meta-analyses and 16 systematic reviews, covering 317 unique studies.

In the face of double-digit healthcare inflation, evidence of systemwide poor healthcare quality, and an aging population, disease management seems an intuitively appealing way to improve the quality and reduce the cost of care, as well as to enhance health outcomes for the chronically ill. In broad terms, disease management refers to a system of coordinated healthcare interventions and communications to help patients address chronic disease and other health conditions. Commercial health plans and large employers are embracing this strategy, with 96% of the top 150 US payers offering some form of disease management service¹ and with 83% of more than 500 major US employers using programs to help individuals manage their health conditions.²

*Am J Manag Care. 2007;13:670-676*
April 7, 2008

HEALTH PLANS

Medicare Finds How Hard It Is to Save Money

By REED ABELSON

An ambitious three-year experiment to treat people with chronic conditions like congestive heart failure and diabetes cost more than it saves.

The test borrowed a practice used in Europe of patients to check whether being healthier can help patients save money.

After paying eight outside companies, Medicare is still trying to determine whether the effort saved money.

April 7, 2008

For One Company, Role in Medicare Experiment Has Hurt Stock

By REED ABELSON

For Healthways, one of the companies involved in a disease-management experiment conducted by Medicare, the health of its stock has been put to the test.

The company’s shares, which fell 16 percent on a single day in January after Medicare cast doubt over the experiment’s prospects, is now down about 40 percent for the year to date.

Healthways is one of eight companies Medicare enlisted in a three-year experiment to see whether disease management could prevent expensive hospital visits for people with chronic conditions like congestive heart failure and diabetes. The preliminary findings suggest that such an approach may cost more than it saves.

Of the eight companies, Healthways is the only one whose main business is disease management and also has publicly traded shares.
Back to the model...

1. Community
   Resources and Policies Organization of Health Care

2. Health System
   Delivery System Design
   Decision Support
   Clinical Information Systems

3. Self-Management Support

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Functional and Clinical Outcomes
A Health Care System...

(Everyone and every thing else)
Payment Evolution...linkage to delivery system design

Move from exclusively managing revenue towards managing a budget

Progress to anything but pure Fee For Service...

Alternatives to 100% Fee for Service

- Pay for performance
- Episode-based pricing – Case rates
- Partial capitation – Care Management fees
- Full capitation
Accountability:
Medical Homes (and Neighborhoods)

Customizing the Medical Home for Population Care:
- HIT
- Decision support
- Predictive modeling
- Practice models

The Medical Neighborhood
- Scale economies
- Shared services
- Integrated Primary and Specialty Care
Principles of the Patient-Centered Medical Home

The following principles were written and agreed upon by the four Primary Care Physician Organizations – the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association.

**Principles:**
- Ongoing relationship with personal physician
- Physician directed medical practice
- Whole person orientation
- Coordinated care across the health system
- Quality and safety
- Enhanced access to care
- Payment recognizes the value added
Who’s behind it?

- Primary Care Specialty Society Promotion and Advocacy
  - Primary Care survival and evolution of role(s)
  - Calls for an augmented Generalist/“comprehensiv-ist” approach (vs. increased reliance on a Specialist/“partial-ist” defined system)

- Models cited:
  - Community Care of North Carolina and CareOregon (Medicaid and Safety Net)
  - Many Small Practice Pilots
  - Integrated Delivery Systems
    - Self-promoted – Geisinger
    - Noted by others – KP and Group Health
What is it? Standards...

Involvement of NCQA

- Physician Practice Connections (PCP) Program
- PCP-Medical Home

- Access and Communication
- Patient Tracking and Registry Functions
- Care Management
- Patient Self-Management Support
- Electronic Prescribing
- Test Tracking
- Referral Tracking
- Performance Reporting and Improvement
- Advanced Electronic Communications
Building a Medical Neighborhood for the Medical Home

Elliott S. Fisher, M.D., M.P.H.

Recent efforts to improve primary care in the United States have focused largely on the development and implementation of practice models and payment reforms intended to create a “medical home” for patients. The notion of a medical home makes intuitive sense and indeed has great promise. But unrealistic expectations about this approach abound, and insufficient attention is being paid to several important barriers to the clinical and financial success of the home model.

The concept of a medical home first emerged in pediatrics it was recognized that with special needs patients would be best served from a delivery model that actively coordinated the clinical and social services many patients require. Recently, organizations representing the major primary care societies—the American Academy of Family Practice, the

Creating Accountable Care Organizations: The Extended Hospital Medical Staff

A new approach to organizing care and ensuring accountability.

by Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum, and Daniel J. Gottlieb

ABSTRACT: Many current policies and approaches to performance measurement and payment reform focus on individual providers; they risk reinforcing the fragmented care and lack of coordination experienced by patients with serious illness. In this paper we show that Medicare beneficiaries receive most of their care from relatively coherent local delivery systems comprising physicians and the hospitals where they work or admit their patients. Efforts to create accountable care organizations at this level—the extended hospital medical staff—deserve consideration as a potential means of improving the quality and lowering the cost of care. [Health Affairs 26, no. 1 (2007): w44–w57 (published online 5 December 2006; 10.1377/hlthaff.26.1.w44)]
Is this relevant to KP?

- **Linkage to HealthCare Reform** – *Combining Payment Reform with Care Delivery Reform*

- **Business case:**
  - Improved Prevention and Chronic care; and/or...
  - Gatekeeper and UM

- **Implications for Primary Care (and Specialty Care) Roles, Expectations, and Accountabilities (...and Compensation)**
HIT/Infrastructure Implications:

More than an EMR…

➢ Registries
➢ Predictive Modeling
➢ Outreach
➢ ‘Panel mgmt’
➢ …

http://www.pcpcc.net/
How might it happen?

- Public and Private Purchaser Involvement
  - CMS Medical Home Demos
  - State Medical Home Initiatives
  - Employers
Opportunity...

- Who will be the *application service provider* (ASP) for population care services to the Medical Home?

- Who will be the *knowledge service provider* (? KSP) for population care services to the Medical Home?
Challenge vs. *Obligation*: Changing the future composition of the top 1%...

Who do you think will be in the top 1% in 2023?
Cardiovascular Mortality (Northern California)

Deaths /100,000


KP-rate

Non-KP rate
Exponential Growth of Bariatric Procedures

Figure 2. Estimated Number of Bariatric Procedures Performed in the United States: 1992–2008
KP Costs in Joint Replacements

KP Joint Replacement Products
Spend and Forecast in $Millions

$0 $25 $50 $75 $100 $125 $150 $175 $200 $225 $250

Costs and Purchases of Biologics

Biotech & Related Biological Drug Purchases Totals - California (North & South Combined)

<table>
<thead>
<tr>
<th>Year</th>
<th>Purchases ($)</th>
<th>Cost PMPM ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>$62,273,979</td>
<td>$0.93</td>
</tr>
<tr>
<td>1998</td>
<td>$82,182,830</td>
<td>$1.23</td>
</tr>
<tr>
<td>1999</td>
<td>$113,512,906</td>
<td>$1.61</td>
</tr>
<tr>
<td>2000</td>
<td>$137,402,477</td>
<td>$2.39</td>
</tr>
<tr>
<td>2001</td>
<td>$235,785,780</td>
<td>$3.10</td>
</tr>
<tr>
<td>2002</td>
<td>$318,662,818</td>
<td>$4.26</td>
</tr>
<tr>
<td>2003</td>
<td>$365,591,565</td>
<td>$4.91</td>
</tr>
<tr>
<td>2004</td>
<td>$433,063,729</td>
<td>$5.71</td>
</tr>
<tr>
<td>2005</td>
<td>$518,942,263</td>
<td>$6.63</td>
</tr>
<tr>
<td>2006</td>
<td>$582,793,231</td>
<td>$7.43</td>
</tr>
<tr>
<td>2007</td>
<td>$638,344,716</td>
<td>$8.14</td>
</tr>
<tr>
<td>2008</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Financial Planning

Dogbert the Financial Planner

With advances in health care, you could live to be 200.

If you have a good financial plan, only the last 120 years will be spent in squalor.

I recommend a diversified portfolio.

AND BACON.
Moving towards an Integrated Delivery System: Key investments of $$$ and effort

Shift to a focus on managing budgets, not revenue:
- **Evolve beyond 100% FFS**
  - Care management fees
  - Episode pricing

Shared accountability for both primary and specialty care:
- **Build Medical Neighborhoods**
  - Population management
  - Referral management

Infrastructure Investment:
- **HIT – move beyond the EMR**
  - Registries/Health Information Exchange
  - Personal Health Records

Knowledge Generation:
- **Rapid Learning/“Managing the Gray Areas”**
  - Comparative population effectiveness
  - Care models
Is there critical mass of change to collectively create a new Health Care System?

Knowledge Generation
Payment Evolution from FFS
HIT for Population and Personal Care
Medical Neighborhoods

(Everyone and every thing else)
The Patient at the Center of Care

Illustration by Tom Benthin, Copyright © Kaiser Permanente