

# An Outcomes-Based Demonstration to Enrolling Medicare Fee-for-Service Beneficiaries

DMLF Hollywood Florida  
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# Agenda

- CMS Perspective – Linda Magno
  - Overview of CMS' history with disease management demonstrations
  - Overview of the Dual Eligible Medicare Fee-for-Service Demonstration in Florida
    - Who is the Medicare Fee-for-Service Beneficiary?
    - Challenges to Receiving Care
    - Healthcare Influences in Florida
- The Demonstration Experience – Christobel Selecky
  - Implementing the CMS Demonstration in Florida
    - 2005 Original Program
    - 2007 Redesign
    - 2008 Extension
  - The Challenges Reaching, Enrolling and Engaging Eligible Beneficiaries
  - Researching, Testing and Evaluating Enrollment and Engagement
  - Implementing Lessons Learned

# CMS Perspective

# DM in Medicare FFS

- 7 demonstrations
- 35 sites
- Since 1999
- 18 months to 8 years' experience
- 300,000 beneficiaries
- Over  $\frac{3}{4}$  of a billion dollars exposed
  - pending budget neutrality recoupment

# Savings?

- Utilization generally not impacted
- Any decrease in claims costs falls far short of covering fees
- Fees generally result in *increasing* Medicare's costs, not net savings
  - Increases often \$1,000-\$2,000/yr. (5-10%) or more

# Clinical Measures

- Difficulty of getting beyond claims-based measures
  - Suggests limited contact with treating physicians
  - What info are vendors using to manage these patients?

# What Shows Promise?

- No single necessary or best approach
- Experienced RNs yield better outcomes
- More in-person contacts yield better outcomes

# The Healthcare Delivery System

- Acute care focused
- Fragmented
- Modeled on medical management
  - Lacking self-management
- Reactive system
  - Challenge is to be proactive

# For Demos Showing Promise

- Are their results sustainable?
- Can their program be replicated?
  - Different markets
  - Different vendors
  - Different population demographics

# Challenges

- Who is most likely to benefit?
- Easier to identify “sins of omission” than “sins of commission”
  - Quality measures add services, costs
  - No measures of over-utilization exist
- Engaging patients *and* their physicians
- Behavioral change

# Best Value for Medicare?

- Even if DM improves quality and satisfaction without covering program fees, is this the best use of Medicare Trust Fund dollars?
  - Fees are 1-3 times the cost of E&M visits for these beneficiaries
  - Should filling social service needs be part of the Medicare program, especially if it's not clear it improves health outcomes?

# The Demonstration Experience

# Summary

- Purpose of DM is to engage and motivate people to improve their health
- Engagement includes
  - Initial contact and enrollment into the program
  - Sustained relationship with the nurse
- Effective engagement should be approached deliberately
  - Segmentation
  - Market research
  - Analytics
  - Quantitative factor testing
  - CQI/feedback loop
- These techniques can result in increased engagement – even in challenging populations
- Increased engagement improves program outcomes

# Case Study: Dual Eligible Demonstration Project

# LifeMasters/CMS Dual Eligible Demonstration

- Objective: evaluate whether population based disease management can improve chronic care for Medicare at no additional cost
- Three year randomized control study
- Breakeven savings target – population basis
- Population: Dually eligible (Medicare/Medicaid) beneficiaries in southern Florida

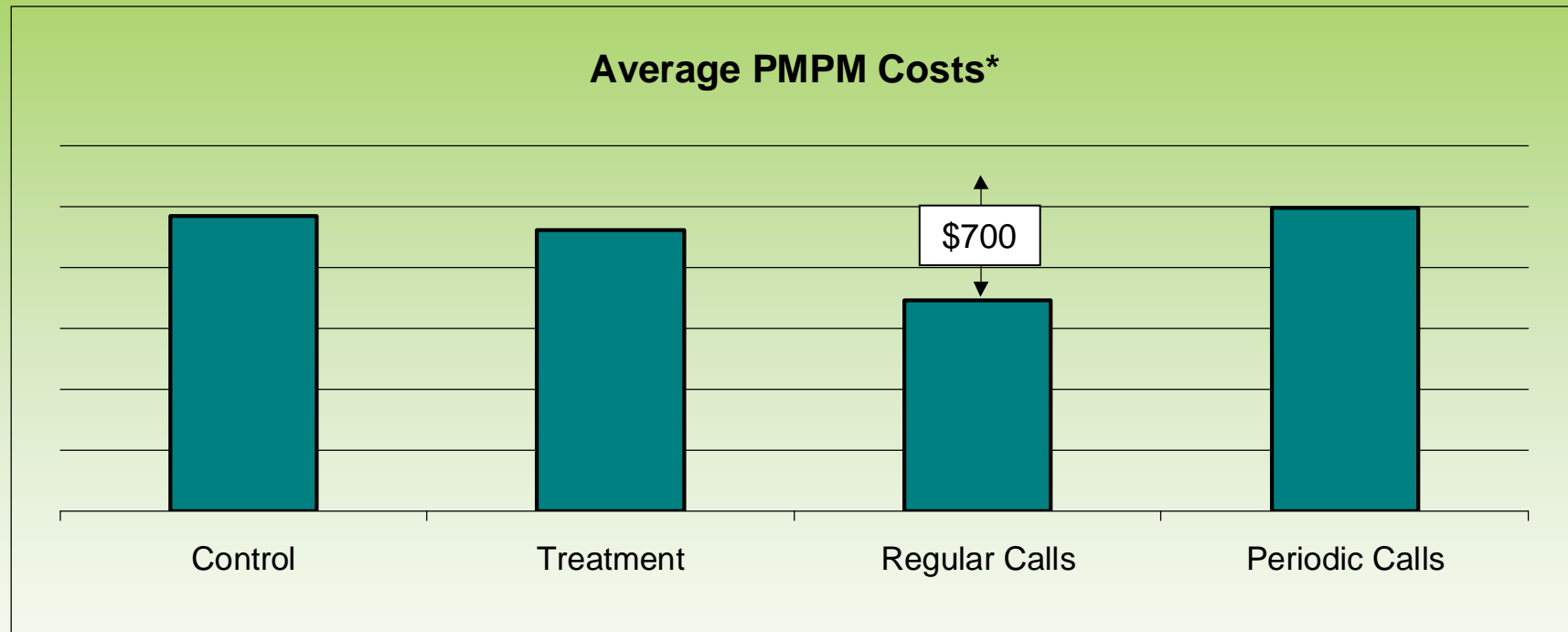
# Demonstration History

		Population	Program	Experience
Original Demo	1/2005	<ul style="list-style-type: none"> <li>•11 southern Florida counties</li> <li>•Primary diagnoses of CHF, CAD, Diabetes and any combo</li> <li>•30,000 treatment/ ~12,000 control</li> </ul>	<ul style="list-style-type: none"> <li>•18 month rollout of enrollment in waves; 1K to 3K each month</li> <li>•Regular telephonic DM – field and geriatric enhancements added in 2006</li> </ul>	<ul style="list-style-type: none"> <li>•Greater savings shown on CHF and any two or more co-morbidities</li> <li>•Greater savings in counties with longer time in enrollment</li> <li>•Overall program savings not on track to achieve target within required timeframe</li> </ul>
Redesign	1/2007	<ul style="list-style-type: none"> <li>•Eliminated 4 counties</li> <li>•Eliminated standalone CAD, Diabetes</li> <li>•~8,500 treatment group</li> <li>•Reactivated 2,619 previously unreachable beneficiaries</li> </ul>	<ul style="list-style-type: none"> <li>•Intensified engagement efforts</li> <li>•Intensified analytics</li> <li>•Enhanced intervention</li> </ul>	<ul style="list-style-type: none"> <li>•Savings target achieved for redesign population</li> <li>•Significant improvements in enrollment and engagement</li> </ul>
Extension	1/2008	<ul style="list-style-type: none"> <li>•7 southern Florida counties</li> <li>•Primary diagnoses of CHF and/or any comorbidities of CHF, Diabetes, and CAD</li> <li>•Refresh of 20,000 intervention/ ~8,000 control</li> </ul>	<ul style="list-style-type: none"> <li>•Three phase rollout of cohorts 5K-5K-10K</li> <li>•Further enhancements in intervention</li> <li>•Further enhancements in enrollment and engagement</li> </ul>	<ul style="list-style-type: none"> <li>•Enrollment ahead of historical performance</li> </ul>

# The “Redesign” Challenge

- Increase engagement levels quickly:
  - Needed to demonstrate results prior to December 2007 demonstration conclusion
- Change approach to appeal to unresponsive or unreachable beneficiaries:
  - LifeMasters had made a total of 57,246 calls between 01/01/2005 and 03/01/2007 attempting to engage the 6,640 targeted beneficiaries
    - 4,021 existing beneficiaries in magazine-only and unreachable status
    - 2,619 reactivated previously unreachable beneficiaries
- Overcome specific challenges for this population:
  - Elderly, frail, medically complex and often have cognitive impairments
  - Complex social and economic issues and struggle with basic needs like food, housing and utilities
  - English not a primary language; distinct cultural beliefs and practices
  - Their health care environment is plagued by medical fraud and abuse especially in Miami-Dade county which has created fear of unknown
  - The data LifeMasters receives from CMS does not contain phone numbers

# Why is Engagement so Important?



\* July 2006 – July 2007

# Our Approach



# Research Strategies

## Focused Participant Research

- Retained consultant with in-depth experience in consumer behavior and working with distinct cultural groups
- Five in person focus groups and 6 telephone in-depth interviews conducted May/June 2007
- Included participants, decliners and those that are unreachable
- Two groups conducted in English and three in Spanish

## Multi Variable Testing Process

- MVT uses statistics to test a number of different variables/solutions/business improvement ideas at the same time
- MVT quantitatively determines which ideas generate improvements and which hurt performance
  - 75% of ideas will not improve results
    - 53% will make no difference
    - 22% of ideas will hurt performance
  - 25% will help
- The MVT approach differs from traditional A/B testing because it allows you to test a variety of factors in the same test

# Focus Group Research Objectives

- Understand participants' view and role of LifeMasters
- Identify communications/programs that help or hinder enrollment and engagement
- Determine most motivating program attributes and associated benefits
- Understand link between program benefits and participants' needs
- Inform Multi-Variable Testing Process

# Overview of Key Findings

- Communications must set proper context and framework to introduce disease management
- Positive relationship with Medicare enhances credibility and gains interest
- Interest in enrollment is affected by varied degrees of perceived need

# Key Findings – Population Characteristics

- Similar in severity of condition, age, socio-economic status
- Positive relationship with Medicare/Medicaid
- High perceived need for program
- Challenging social, cultural and medical circumstances
- Not familiar with disease management or LifeMasters
- Communication channels crowded from other health care services
- Fear of fraud and scams

# Focus Group and Telephone Survey Results

- **Enrollment Communications**
  - Many do not recall the Welcome Packet
  - Multiple items/languages make the Welcome Packet difficult to understand
  - Minimal impact of the Welcome Packet renders the enrollment call the primary decision information channel
- **Decision Process and Influences**
  - Beneficiaries may be unprepared or puzzled when the enrollment call occurs
  - Detailed medical history is uncomfortable for some in the enrollment call
  - Health care decisions sometimes left to family members
  - Physicians may be facilitators or barriers to enrollment
- **Participant Perceptions of LifeMasters Program**
  - Grateful for the positive impact on life and health
  - Valued presence offering health care resources and expertise
  - Provides social/emotional benefits
  - Nurse considered a caring, trusted friend

# Focus Group and Telephone Survey Results

- Decliner Perceptions of LifeMasters Program

- Many do not recall being contacted
- Comprehension of LifeMasters program and benefits is weak
- Suspicion is a barrier
- Concern about the stability of companies offering medical services
- Education about program increases interest

- Living Well Magazine

- Living Well considered well-produced and informative
- Faithful readership
- Interest in self-care tips and recipes
- Connection between Living Well and LifeMasters may be vague.

# Dimensions of Need for the LifeMasters Program

## Low Perceived Need

## Moderate Perceived Need

## High Perceived Need

- Diagnosed long ago
- Stable/manageable conditions
- Knowledgeable, in control of condition

### Diagnosis/ Medical Status

- New/multiple condition
- Significant/frightening events
- Feel fragile, vulnerable, unsure

- Family/friends involved
- Good support network
- Close relationship with doctor(s)

### Support Network

- Isolated socially, linguistically, culturally or cognitively
- Lack of convenient health care
- Distant relationship with doctor

- Resources/skills, (Internet capability or support groups)
- Seek information/discuss condition with doctors/caregivers

### Control Orientation/ Capability

- Lack means/skills to seek information
- Want coaching/direction about managing their conditions

# MVT Methodology

MVT Process	LifeMasters Case
1. Choose a “high-payoff” goal or metric targeted for improvement	<i>Engagement (mediation)</i>
2. Define how you will measure success and validate the measurement system	<i>Increased rate of engagement</i>
3. Identify ideas to test Brainstorming Data analysis	<i>Initial list of 200 ideas</i>
4. Select subset of ideas that are practical, fast, and low cost to implement	<i>Narrowed list down to 30 ideas</i> <i>Direct Mail</i> <i>Enrollment Specialist Scripts</i> <i>Clinical Nurse Consultant Scripts</i>

# MVT Methodology

MVT Process	LifeMasters Case
5. Design and execute MVT screening experiment	<i>2/05/07 – 3/11/07 - Design 3/11/07 - 5/13/07 - Execution</i>
6. Measure and analyze screening results	<i>5/13/07 – 6/3/07</i>
7. Design and execute an MVT refining experiment	<i>Move directly to implementation due to time constraints</i>
8. Analyze results and choose winning factors	<i>6/3/07</i>
9. Implement winning factors	<i>6/3/07</i>

# Example: Direct Mail MVT Factors

Factor		(-) Level	(+) Level
<b>A</b>	Social Services Script Message	Do not include	Describe services offered
<b>B</b>	Outside Message	Standard message	Explicit Medicare / no-cost service
<b>C</b>	Give It to Your Doctor	Standard procedure	Custom piece for patient's PCP
<b>D</b>	Caregiver / Family Information	Do not include	FAQ list included in welcome packet
<b>E</b>	Pre-mailer	Do not include	Mailer, just prior to welcome packet
<b>F</b>	Testimonials	Testimonials not included	Testimonials (generic, CHF & Diabetes)
<b>G</b>	Targeted Message	Generic cover letter	Send disease-specific cover letter
<b>H</b>	Signature Required	Standard delivery	Signature required at delivery
<b>I</b>	Package	Std. white envelope	Box
<b>J</b>	Pill Box	Do not include	Provide pill box upon enrollment
<b>K</b>	Offer Invitation	Assumptive	Explicit offer to join program
<b>L</b>	Doctor's Name	Do not include	Doctor's name in cover letter
<b>M</b>	Newsletter in Welcome Packet	Yes	No
<b>N</b>	Physician Flyer	Old flyer	New flyer



# Direct Mail Factor Effects Differ by County

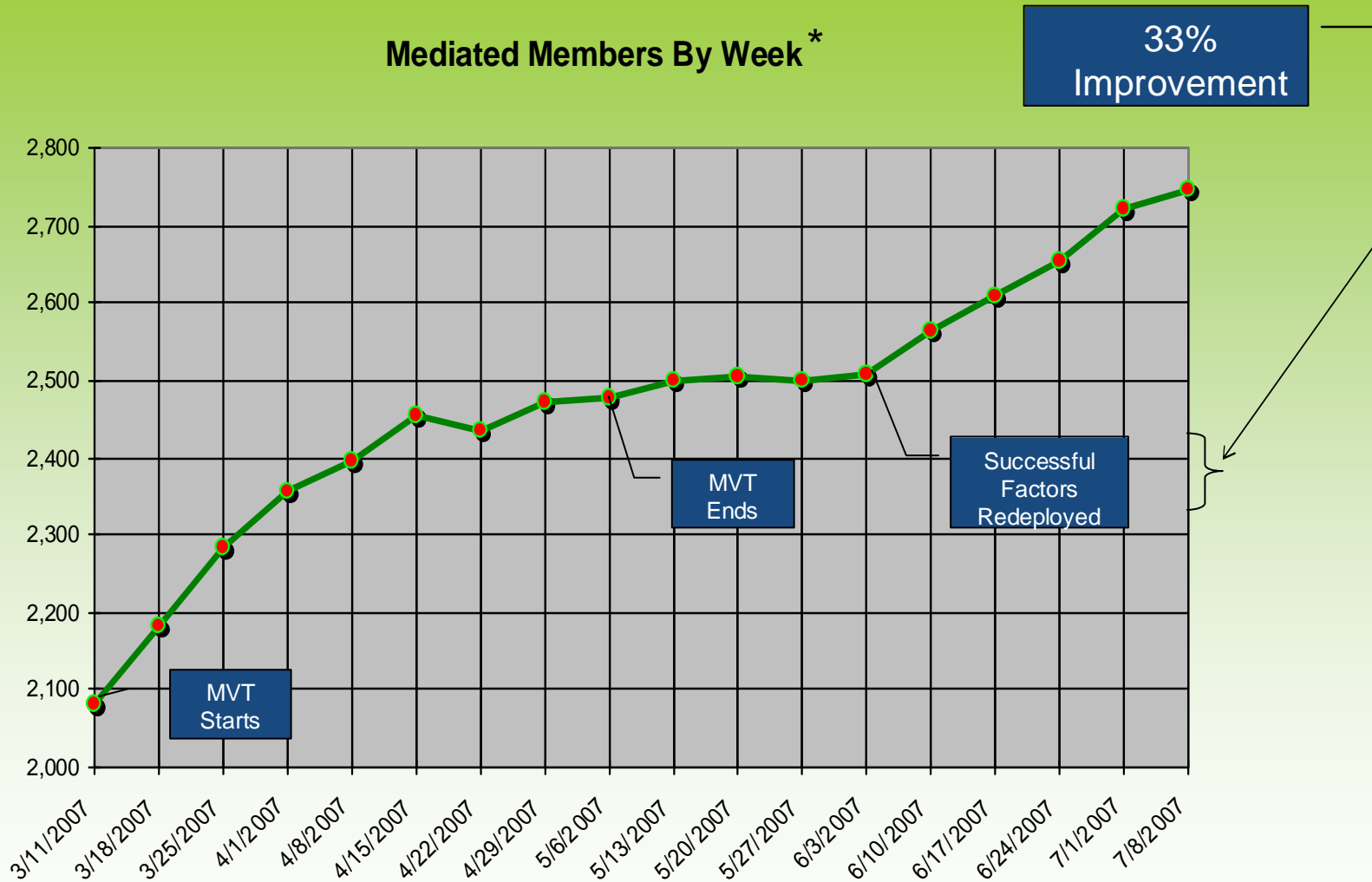
Direct Mail Screening MVT				% Enrollment Effects:															
				All Counties		Alachu		Broward		Marion		Miami Dade		Palm Beach		Seminole		Volusia	
Col	Factor Description	(-) Level	(+) Level	Gross	Net of Return Mail	Gross	Net of Return Mail	Gross	Net of Return Mail	Gross	Net of Return Mail	Gross	Net of Return Mail	Gross	Net of Return Mail	Gross	Net of Return Mail	Gross	Net of Return Mail
A	Social Services Script Message	Do not include	Describe services offered	-1.25	-1.11	6.25	6.25	-1.56	-1.72	-3.13	-5.21	0.42	0.52	-9.77	-9.08	-2.08	-1.56	1.25	1.25
B	Outside Message	Standard message	Explicit Medicare / no-cost service	0.27	0.26	0.00	0.00	-2.60	-3.21	3.13	2.60	0.93	1.01	-1.95	-1.45	6.25	6.77	0.00	-0.31
C	Give It to Your Doctor	Standard procedure	Custom piece for patient's PCP	1.88	1.97	6.25	6.25	3.13	3.38	9.38	10.42	-0.25	-0.36	-0.39	0.04	12.50	11.98	5.00	5.31
D	Caregiver / Family Information	Do not include	FAQ list included in welcome packet	2.05	2.14	0.00	0.00	-0.52	-0.12	9.38	9.38	1.10	1.27	3.52	3.12	2.08	2.60	7.50	8.13
E	Pre-mailer	Do not include	Mailer, just prior to welcome packet	1.07	1.06	6.25	6.25	4.17	4.56	0.00	0.00	-0.08	-0.06	2.73	1.82	-10.42	-10.94	6.25	6.56
F	Testimonials	Testimonials not included	Testimonials (generic, CHF & Diabetes)	0.98	0.84	6.25	6.25	-0.52	-0.73	9.38	10.42	1.27	1.28	-3.52	-4.61	4.17	4.69	0.00	-0.63
G	Targeted Message	Generic cover letter	Send disease-specific cover letter	-0.09	-0.11	-6.25	-6.25	-4.69	-4.69	12.50	14.06	1.10	0.99	-4.30	-4.05	8.33	8.85	-5.00	-4.69
H	Signature Required	Standard delivery	Signature required at delivery	-2.14	-2.15	-6.25	-6.25	-2.60	-2.33	0.00	-2.60	-0.76	-0.59	-8.98	-10.09	-6.25	-5.73	1.25	1.56
I	Package	Std. white envelope	Box	0.71	0.61	-12.50	-12.50	-2.60	-2.56	0.00	-0.52	2.11	2.15	2.73	2.65	0.00	0.52	-1.25	-1.56
J	Pill Box	Do not include	Provide pill box upon enrollment	-0.45	-0.31	12.50	12.50	0.00	-0.16	-3.13	-3.13	0.59	0.62	0.39	1.15	-10.42	-10.94	-5.00	-5.31
K	Offer Invitation	Assumptive	Explicit offer to join program	0.54	0.67	0.00	0.00	2.08	2.08	3.13	4.69	0.93	0.84	-3.52	-2.45	8.33	7.81	-6.25	-5.63
L	Doctor's Name	Do not include	Doctor's name in cover letter	-0.09	-0.32	-6.25	-6.25	-1.04	-0.99	0.00	1.56	-0.76	-0.92	1.95	0.60	4.17	3.65	2.50	2.50
M	Newsletter in Welcome Packet	Yes	No	1.61	1.66	12.50	12.50	0.52	0.78	6.25	5.21	1.27	1.28	3.52	4.77	-4.17	-3.65	1.25	1.25
N	Physician Flyer	Old flyer	New flyer	-0.18	-0.31	0.00	0.00	-1.04	-1.25	3.13	4.17	0.42	0.26	3.52	3.69	-16.67	-17.19	-1.25	-1.56

Control Limit	1.29	1.24	4.53	5.80	3.02	3.22	6.79	7.17	1.16	1.18	2.55	2.56	6.04	6.41	2.72	2.94
MVT Average	6.65	6.76	6.25	6.25	7.81	8.19	12.50	13.28	4.01	4.07	9.57	9.64	15.63	15.89	8.75	9.06
"Control" (All Minus Recipe)	5.00	5.01	0.00	0.00	4.17	4.17	0.00	0.00	4.05	4.05	12.50	12.50	0.00	0.00	10.00	10.00

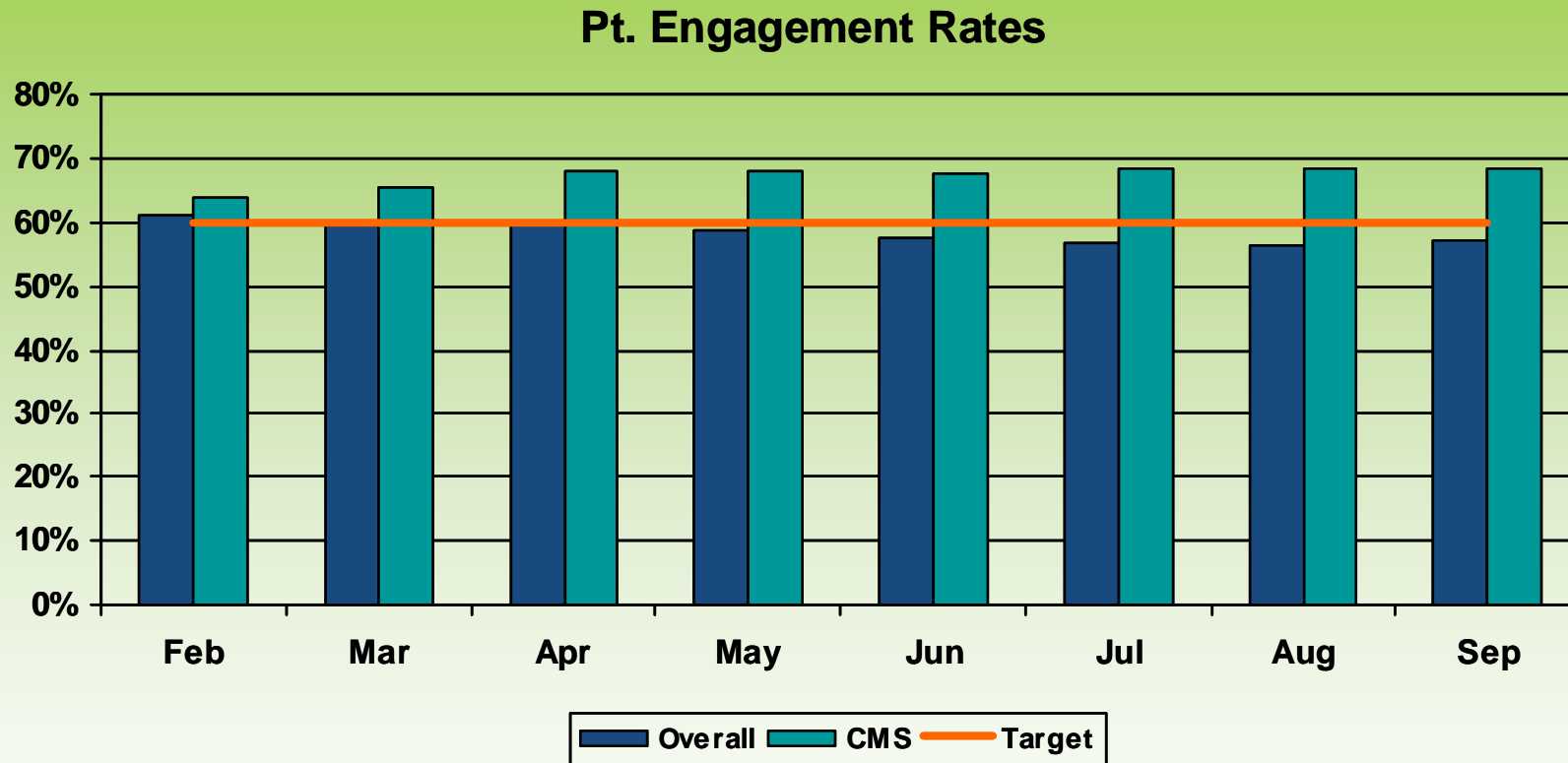


# MVT Impact on Engagement Experience

Mediated Members By Week \*



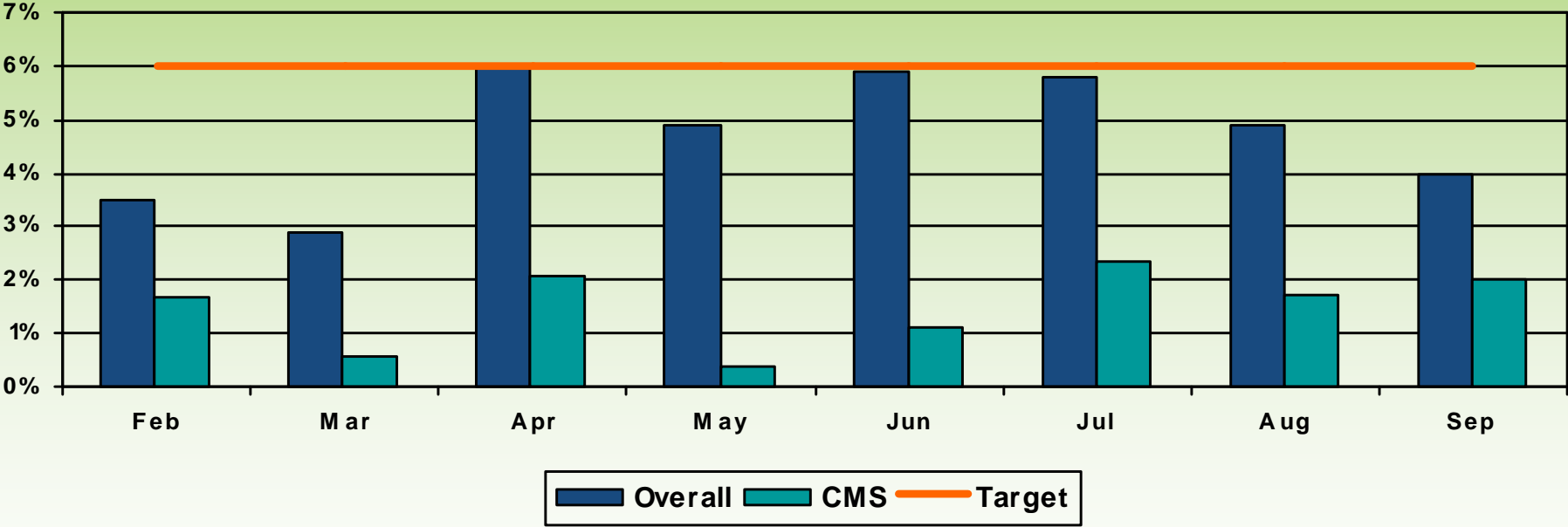
# Engagement Rates\* Show Sustained Improvement



\*Participant is available and participates in their scheduled calls with their nurse 60% of the time.

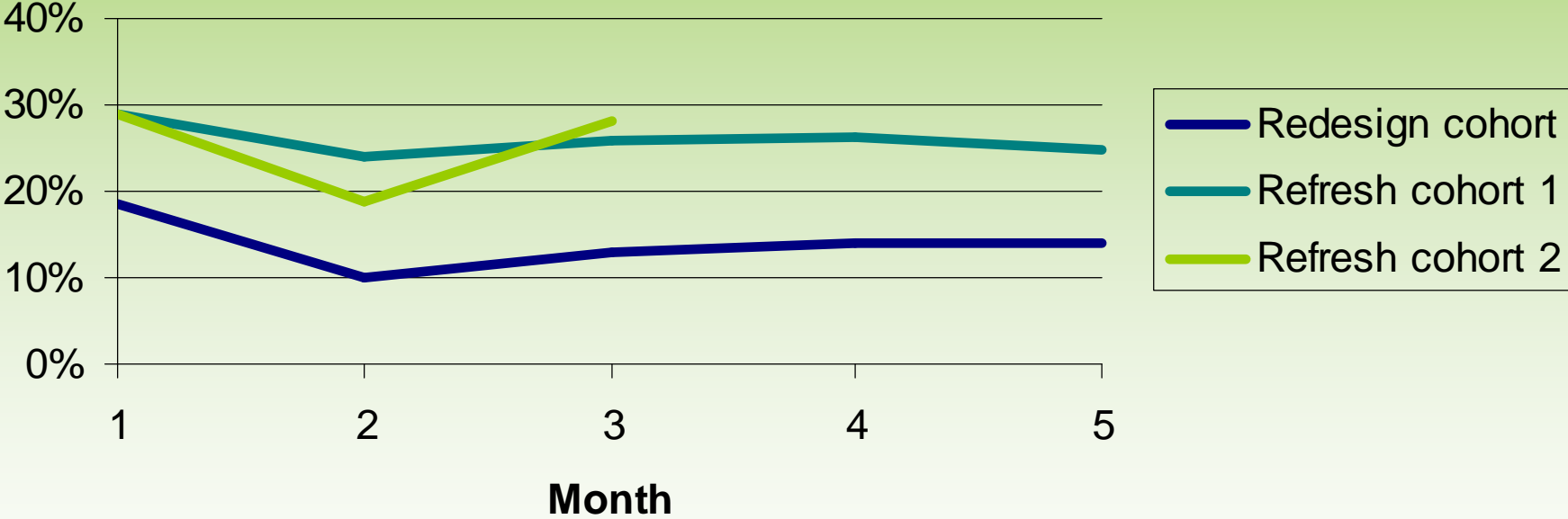
# More Beneficiaries are Staying in Mediation

## Controllable Loss from Scheduled RN Engagement



# Sustained Improvement in Demo Extension

### Mediation\* Percentage by Month

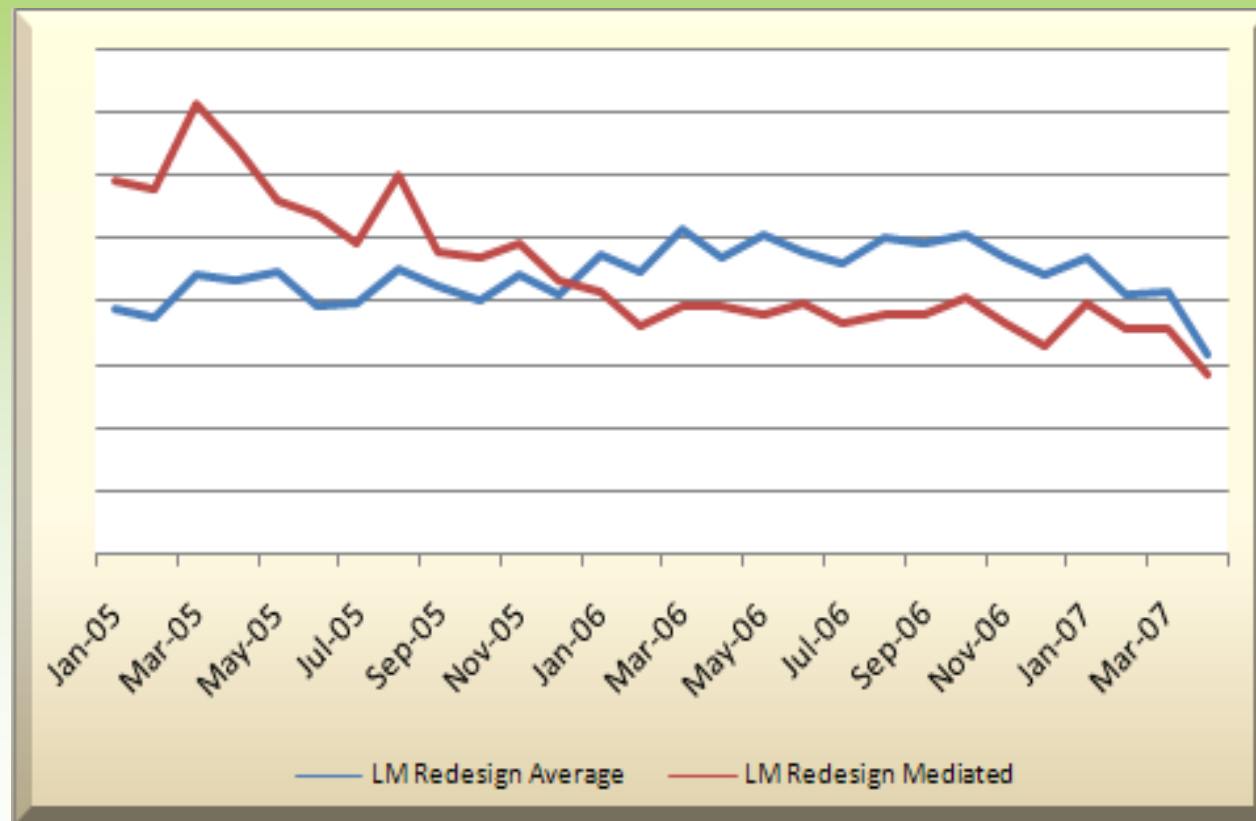


\* Monthly or more frequent scheduled RN Calls

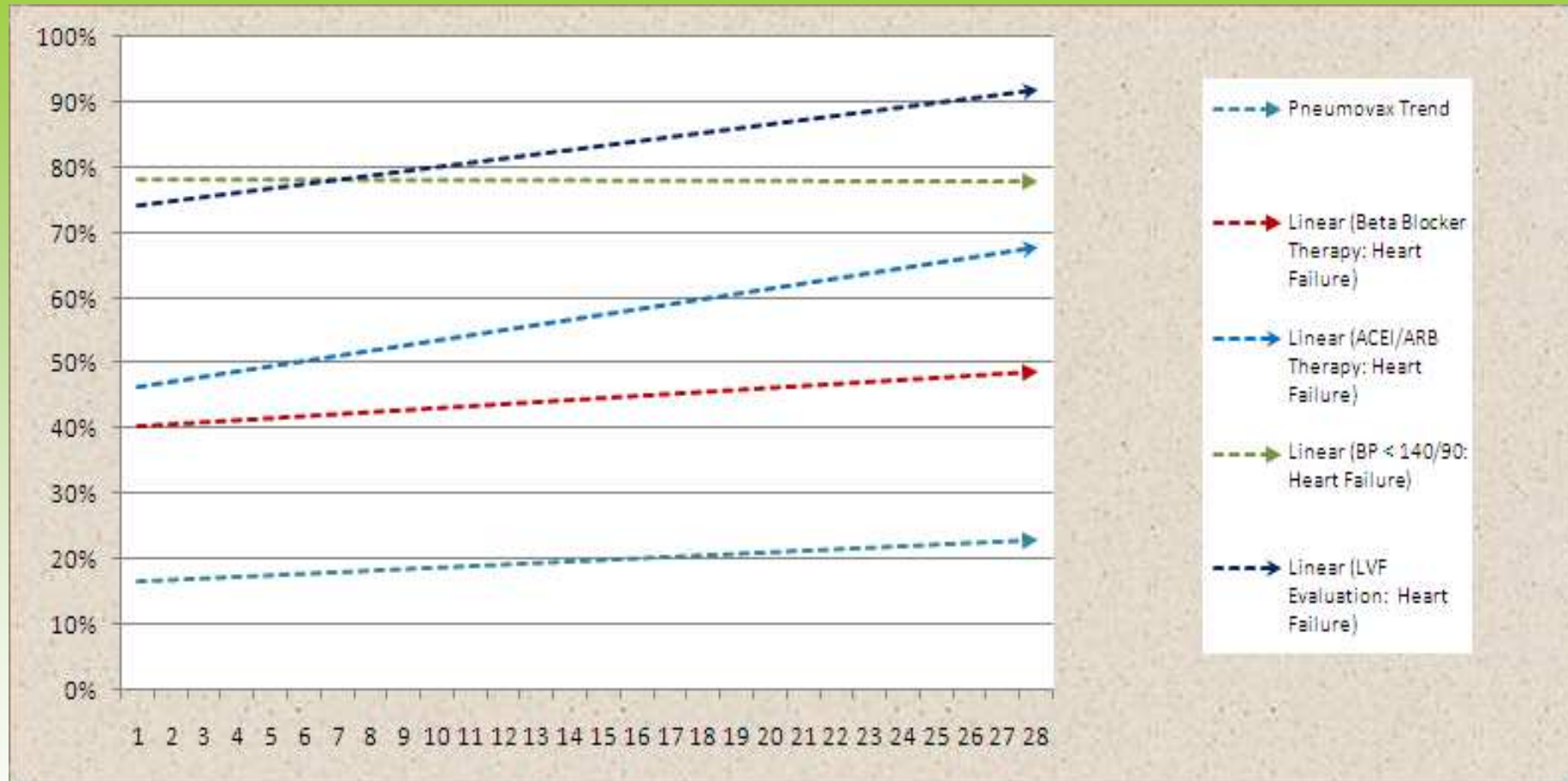
# Redesign PMPM Trends show strong savings from Mediated Pts. (LM Reported Results)

Savings from the demonstration program treatment group over the control group are being shown but are not yet public.

This graph shows the overall PMPM trends for both the redesign population in aggregate (blue) and mediated members only (red)

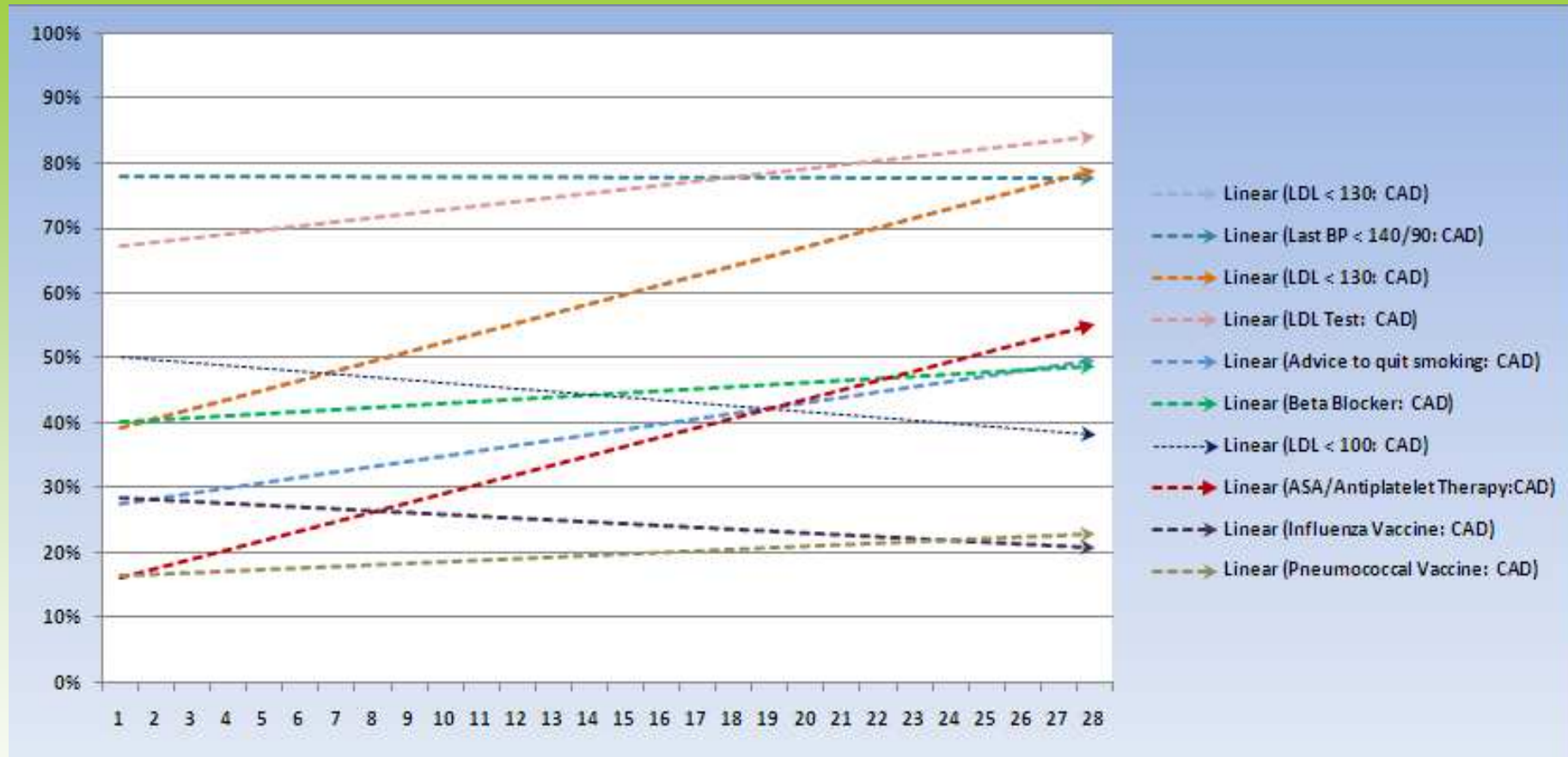


# CHF Clinical Metrics improved by length of time in program (months)



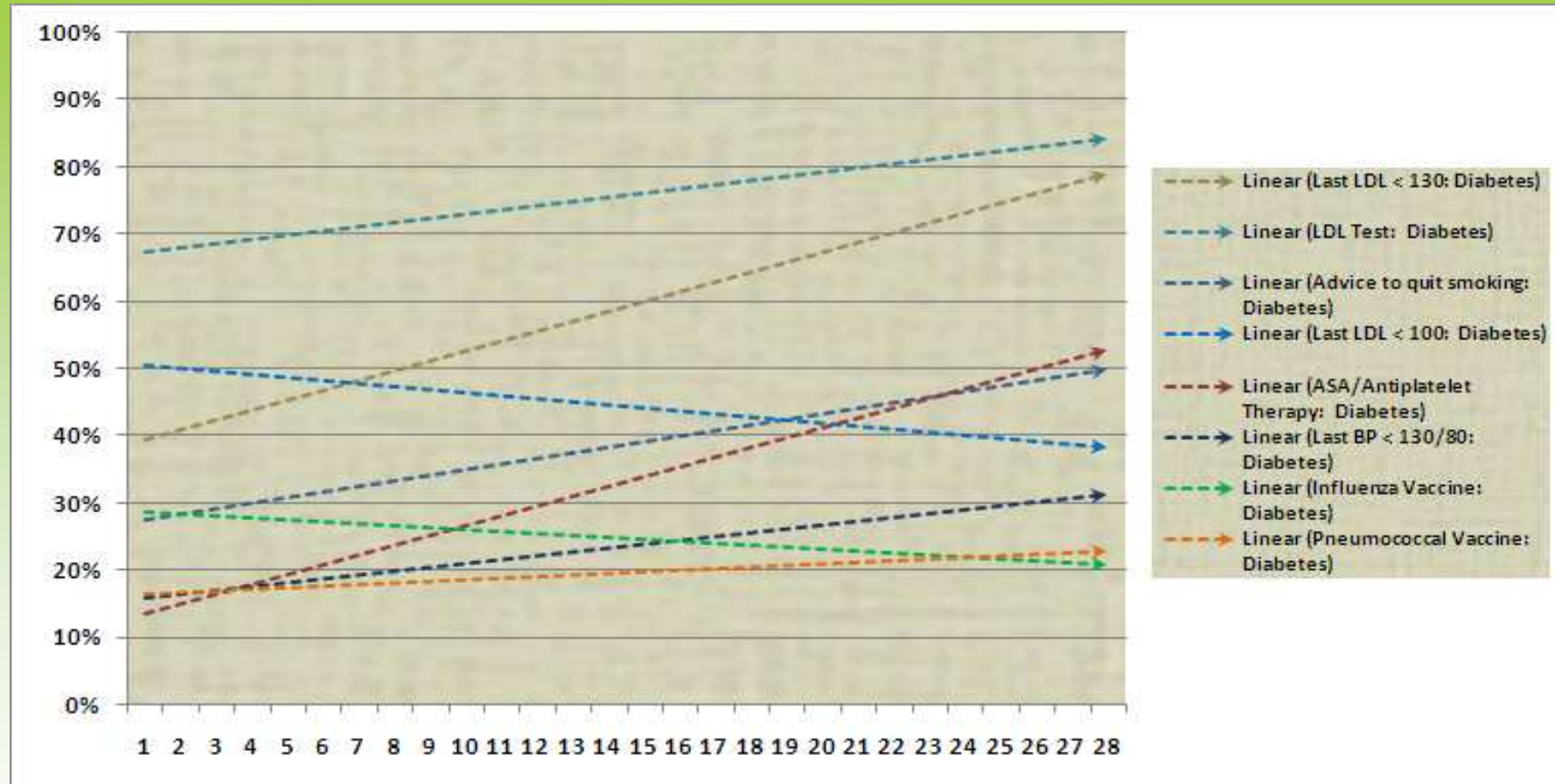
Improvement in all CHF metrics was noted with increased time in program excepting for BP control which remained flat (dotted lines = trend lines)

# CAD Clinical Metrics improved by length of time in program (months)



Improvement in all CAD metrics was noted with increased time in program excepting for BP control which remained flat and both Influenza Vaccination and LDL<100 which decreased (dotted lines = trend lines)

# Diabetes Clinical Metrics improved by length of time in program



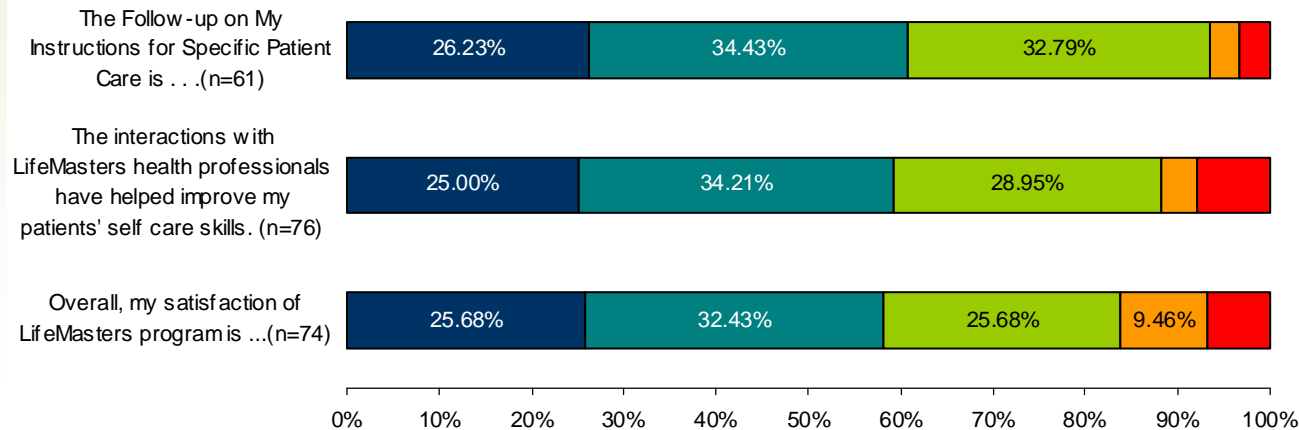
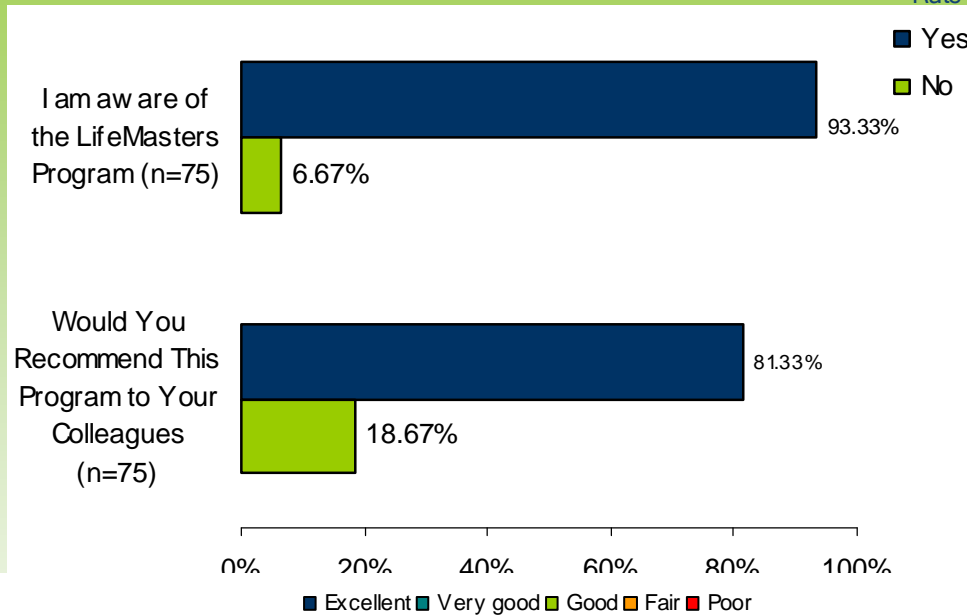
Improvement in all Diabetes metrics was noted with increased time in program excepting for both Influenza Vaccination and LDL<100 which decreased

(dotted lines = trend lines)

# Physician Satisfaction is positive

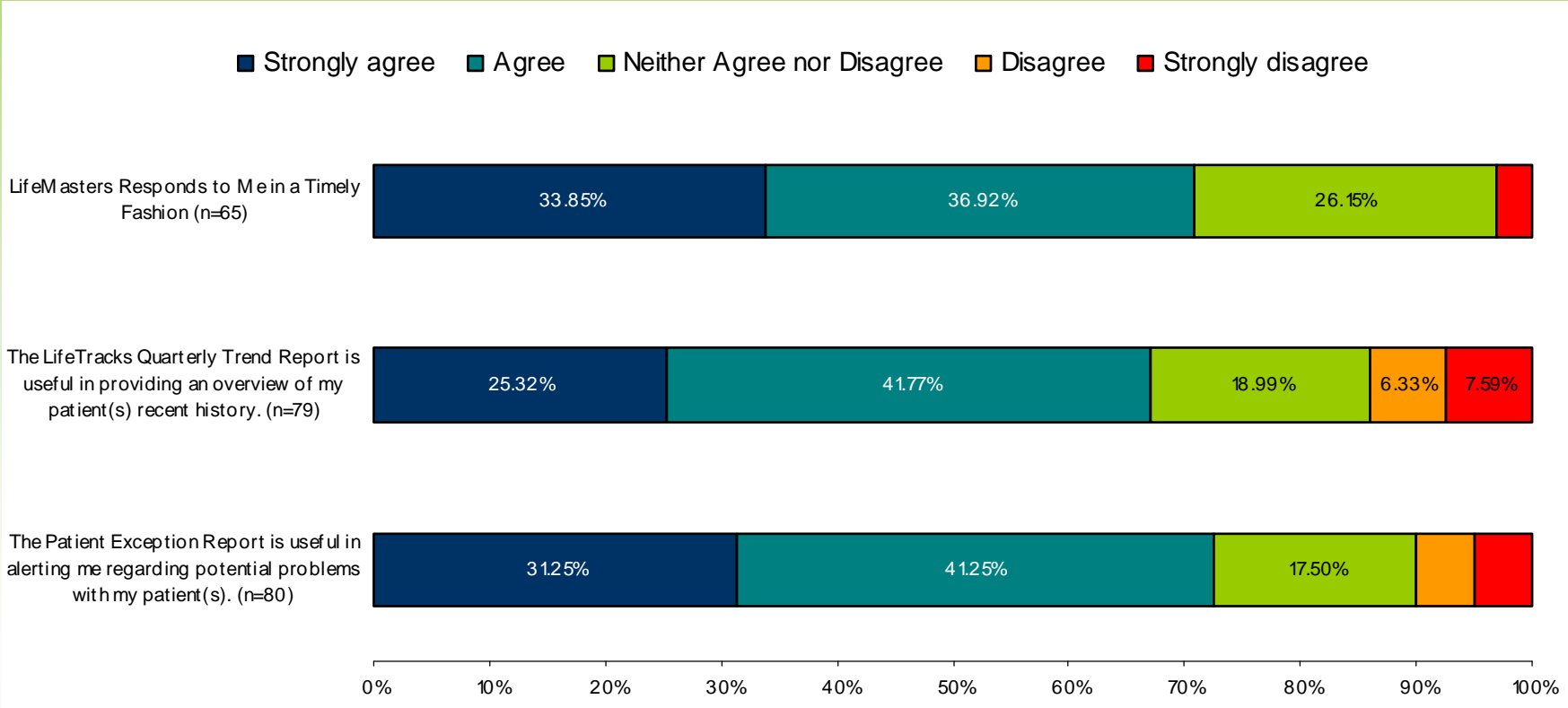
## Physician Satisfaction Survey Florida CMS Dual Eligibles From 01/01/2006 to 12/31/2006

Sent	1757
Returned	83
Rate	4.7%



# Physician Satisfaction is positive

## Physician Satisfaction Survey Florida CMS Dual Eligibles From 1/01/2006 to 12/31/2006



# Implementing Lessons Learned

# Areas of continued focus and strategies

## • Outreach

- 5 different data sources for contact information
- Local presence
- 1-800-Medicare
- MD strategy
- ER and Hospital admits and discharges

## • Intervention

- Dedicated nurse team in a dedicated call center
- Strict Spanish-language proficiency criteria
- Ongoing cultural competency training
- Primary nurse model
- Geriatric/frail elderly focused
- Local social services and RN team
- Seamless integration between field and call center
  - 6% managed in the field
- MVTs on intervention

Questions?