

Disease Management Initiatives and the Ability to Reduce Costs of Chronic Care

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With approximately sixty-three million people suffering from a chronic illness in 2005, accounting for 78% of total health spending currently (Bodenheimer, Chen & Bennett, 2009), the prevalence of and cost burden associated with chronic illnesses are projected to continue rising, unless something is done to control costs and manage the prevalence of these chronic illnesses. Through disease management efforts, the plan of care is structured to encourage prevention of complications through evidence-based practices, such as patient education and self-care. However, the question becomes whether or not CMS's Medicare Health Support (MHS) initiative actually has the ability to reduce health care costs related to certain chronic illnesses.

INTRODUCTION

There were approximately sixty-three million people who suffered from a chronic illness in 2005, accounting for 78% of total health spending currently (Bodenheimer, Chen & Bennett, 2009). Both of these statistics, the prevalence of and cost burden associated with chronic illnesses, are on the rise and projected to continue rising, unless something is done to control costs and manage the prevalence of these chronic illnesses. Chronic illnesses, defined as diseases lasting three (3) months or more (Anonymous, 2000), can be managed through the process of disease management, which is “a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant” (Anonymous, 2009). Through disease management efforts, a patient’s plan of care is structured to encourage prevention of complications, using evidence-based practices. Disease management efforts, through the use of patient education and self-care, have the goal of improving the overall health of that patient. Therefore, as defined, disease management plays a major role in the patient care given to those suffering from chronic illnesses. Although disease management is “a term used to describe a wide range of approaches designed to identify patients with potentially costly health conditions and encourage adherence to recommended treatment plans and self-care strategies” (Mays, Au, & Claxton, 2007, p. 1683), this prevalence is rising at an alarming rate with costs associated rising just as fast, becoming a concern for health care administrators and public health workers alike.

As a result of the prevalence of chronic illnesses among Americans, specifically the elder population, the Center of Medicare and Medicaid Services (CMS) developed, implemented and evaluated various disease management demonstrations to identify practices that could reduce health care costs related to

chronic illnesses. Specifically, the Medicare Health Support (MHS) initiative for chronic care improvement was conducted among Medicare beneficiaries, focusing on the major chronic illnesses of diabetes and heart failure. The question regarding this demonstration becomes that of whether or not the demonstration actually displayed the ability to reduce health care costs related to these chronic illnesses. Unfortunately, our position on the topic is that our health care system in the United States does not support these demonstrations in a manner in which health care costs can be reduced.

Statement of Healthcare Policy Question

Behind every health care organization is an underlying financial statement that drives the operations and direction of that organization. In the United States, much of that underlying financial burden is due to the prevalence of chronic disease among Americans. In 2005, there were sixty-three million people who suffered from a chronic illness (Bodenheimer, Chen & Bennett, 2009). Chronic illness, according to the United States National Center for Health Statistics, is defined as an illness lasting three (3) months or more (Anonymous, 2000). Also, the five major chronic illnesses are ischemic heart disease, diabetes, COPD, asthma and heart failure (Anonymous, 2009). As a result of the prevalence of chronic illnesses and the related demand for health care services, the Center for Medicare and Medicaid Services (CMS) has planned, developed, implemented, and evaluated various demonstrations searching for an answer as to how to control or reduce the costs associated with disease management of chronic illnesses, without sacrificing the quality of patient care and health outcomes. CMS adopted the idea of disease management, centered on patient education and self-care, as a way of attempting to reduce the rising health care costs seen in the Medicare beneficiary population.

Although CMS conducted various demonstrations, for the purpose of this paper, we will be looking specifically at the Medicare Health Support (MHS) initiative for chronic care improvement. The major chronic illnesses included in this demonstration were diabetes, COPD and congestive heart failure. Initially, this pilot was to “offer self-care guidance and support to Medicare beneficiaries who have one or more of the three chronic conditions: complex diabetes, congestive heart failure, and chronic obstructive pulmonary disease” (Anderson, 2005, p.305). This demonstration began in August 2005 and ended August 2008 (Bott, Kapp, Johnson, & Magno, 2009). There were eight (8) organizations with a total of 206,000 beneficiaries per program (Bott, et al., 2009) (Appendix A). This program was established and implemented to “improve outcomes and to curtail increasing health care costs” (Bott, et al., 2009, p.88), through the use of evidence-based methods to bring care to patients with chronic illnesses. The MHS demonstration consisted of randomly selected eligible beneficiaries, where agreement was based on the intent-to-treat design. In addition, participating organizations were paid a per month fee for beneficiaries, where “the initial financial target was 5% savings net of fees” (Bott, et al., 2009, p.89).

Unfortunately research has shown that these demonstrations have either not have notable success, have been unsuccessful, or are currently inconclusive. When evaluation of this demonstration was performed and reviewed, it showed that “fees increase Medicare costs of 5-11 percent with little savings to date to offset these costs” (Bott, et al., 2009, p.91). On the other hand, as a result of a thorough analysis of data collected during this demonstration, it was determined that “80-90 percent of all hospital admissions of patients were for reasons other than the index conditions” (Bott, et al., 2009, p.94) suggesting the demonstration may have displayed different conclusions if focus had been placed on just heart failure or diabetes, not the two illnesses jointly, or on all chronic illnesses to better identify symptoms that may lead to hospitalization or readmission. Furthermore, improvements regarding quality and satisfaction were found to be “small and inconsistent” (Bott, et al., 2009, p.91). Therefore, the health care policy question becomes, *Have disease management initiatives demonstrated an ability to reduce the costs of chronic care?*

Position on the Issue

Before discussing our position on the issue, it is important that we address the major concerns that have led us to take the position we have on this topic. There are three questions that remain unanswered pertaining to the ability of these CMS demonstrations to actually result in significant reduction health care

costs. These three questions are as follows: (1) does the delivery of care model support the anticipated reduction of costs?, (2) does the workforce have the ability to support these demonstrations and the efforts to reduce healthcare costs associated with chronic illnesses?, and (3) is the reimbursement system structured in a manner that facilitates these efforts to display reductions in healthcare costs? After examining each of these questions, a thorough understanding of the current health care system in the United States will be known and can then be compared to the efforts of the CMS demonstrations to determine if significant reduction in health care costs was probable.

The first concern is related to the current delivery of care model used to provide patient care to those suffering from chronic illnesses. It was suggested that there are three scenarios in which this care can be provided, according to Bodenheimer, et al. (2009). These three scenarios are: “(1) care primarily provided by specialists experts in particular diseases, (2) care chiefly offered by primary care physicians (PCPs), or (3) care organized through multidisciplinary teams” (Bodenheimer, et al., 2009, p.67). With each of these scenarios, there are benefits and risks associated with each. For instance, with the specialist experts scenario, the risk would be the lack of continuity for the patient’s total care as the specialist expert would only treat the patient for his chronic illness or illnesses. The benefit of this scenario is that these specialist experts may be better than generalists at treating the chronic illness or illnesses of that patient.

However, after reviewing each of the scenarios, it was concluded that the use of multidisciplinary teams was the best practice for the treatment of patients with chronic illnesses. According to Bodenheimer, et al. (2009), “ample evidence demonstrates that multidisciplinary teams in primary care—providing the information and shared decision making that many PCPs lack the time to offer—can improve care, and at times lower costs, for patients with chronic diseases.” We agree with the data presented by Bodenheimer, et al. (2009), specifically because the multidisciplinary team approach brings primary care personnel together with public health personnel, providing the most comprehensive delivery of care to those suffering from chronic illnesses by understanding that patient education and self-care is necessary between primary care visits. This patient education and self-care is essential to the management of chronic illnesses and prevention of associated complications.

The second concern is related to the health care workforce being able to support the delivery of care provided to patients suffering from chronic illnesses. Currently, there are “approximately the same number of physicians per capita as other industrialized countries, [but] the number of U.S. PCPs per capita is considerably lower” (Bodenheimer, et al., 2009, p.69). PCPs in the United States only make up about thirty-five percent of the clinical workforce, compared to about fifty percent on a worldwide level. In addition to the lower number of PCPs, forty percent of clinicians in the United States work in primary care. With these statistics, it suggests that the United States workforce cannot support the aforementioned scenario of care being provided chiefly by primary care. In addition to physicians, registered nurses face a demand that is expected to “reach 500,000 in 2025” (Bodenheimer, et al., 2009, p.70), which further impacts the ability of chiefly primary care physicians to provide adequate, appropriate care to those suffering from chronic illnesses. Even with the projected demands for both primary care physicians and registered nurses, there is one area of the workforce that is growing. That area is that of community health workers (CHWs). It is through this area that, with the use of multidisciplinary teams, the burden and demand on primary care physicians and clinicians is lessened as more disciplines are involved.

Community health workers are “lay members of the communities who often share ethnicity, language, socioeconomic status, and life experiences with their patients” (Bodenheimer, et al., 2009, p.71). Returning to the fact that the disease management initiatives put forth by CMS are dependent on the patient’s ability to be educated and provide self-care to manage his chronic illness, the CHWs are able to “provide culturally appropriate health education, assist people in receiving care they need, and offer counseling on health behavior” (Bodenheimer, et al., 2009, p.71). Through the use of multidisciplinary teams, CHWs are able to provide patient education, as well as assist patients in providing self-care and get the necessary primary care services to manage the chronic illness or illnesses. With the involvement of CHWs in patient care, the chance of associated complications is reduced and the necessary care is received, especially to those who may be underserved or suffer access barriers in today’s health care system.

The final concern is related to the reimbursement system that may help the reduction of health care costs related to chronic illnesses. In the traditional fee-for-service system, ambulatory care visits are paid on a per visit basis, while visits to nurse care managers, CHWs, or health educators are not typically reimbursed. “Nonphysicians are generally not eligible to be paid by the Medicare program unless the service is ‘incident to’ a physician’s service, and even then, payment is possible only under certain circumstances” (Anderson, 2005, p.308). With the need for patient education and self-care for disease management for chronic illnesses to be successful, the fee-for-service reimbursement system becomes a costly way for these patients to receive care, and this care is often inadequate, lacking the education to continuously monitor the associated conditions of the chronic illness. Therefore, the reimbursement system for those with chronic illnesses should be restructured to create more cost-effective delivery of care. One suggested solution is that of payment reform that reflects a system of “risk-adjusted per patient payment with incentives for quality, services provided by nonclinician team members, and population-oriented panel management” (Bodenheimer, et al., 2009, p.71).

Given the three major concerns voiced here, it is evident that the current system in terms of delivery model, workforce capacity, and reimbursement structure cannot support the desired reductions in health care costs anticipated by the CMS demonstration efforts to manage chronic illnesses and the related care. In lieu of this, Bodenheimer, et al. (2009) stated that “without a [multidisciplinary] team, it takes 10.6 hours per day for a lone clinician to provide good chronic care to an average patient panel.” With the projected shortages in both physicians and nurses and the increase in CHWs, delivering care to those suffering from chronic illnesses can be best done through multidisciplinary teams as a result of the review and analysis of these three issues. Additionally, it is our opinion that the current system in place does not encourage the use of multidisciplinary teams, and in turn support the desired reduction in health care costs anticipated by the CMS disease management initiatives. Therefore, our position on the issue is that disease management initiatives have not demonstrated the ability to actually reduce health care costs associated with chronic care.

Relevance to Federal or State Health Policy

With reviewing the 2005 Medicare beneficiary population, it was found that “a total of 83 percent of Medicare beneficiaries have at least one chronic condition” (Anderson, 2005, p.305). Also, as the number of chronic illnesses increase, the statistics become more alarming. For instance, “23 percent of beneficiaries with five or more chronic conditions account for 68 percent of the [Medicare] program’s spending...[and] see an average of nine physicians on an outpatient basis and four hospital-based physicians annually” (Anderson, 2005, p.307). With the prevalence of chronic illnesses among Americans, the issues related to chronic illnesses prevalence and costs are an issue of federal health policy, resulting in the passing of legislation related to chronic care coordination and disease management, as well as quality improvement initiatives and other relevant topics.

In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act, Title VII, Subtitle C, Sections 721-723, created the Chronic Care Improvement Program. This program had similar goals and objectives as the MHS demonstration, as it was created to “increase adherence to evidence-based care, reduce unnecessary hospital stays and emergency room visits, and help beneficiaries avoid costly and debilitating complications” (Anderson, 2005, p.305). This legislation involved chronic care improvement under the traditional fee-for-service program, Medicare Advantage quality improvement, and chronically ill beneficiary research, data and demonstration strategy. “Section 721 of the Medicare Modernization Act of 2003 (MMA) authorized development and testing of voluntary chronic care improvement programs, now called Medicare Health Support, to improve the quality of care and life for people living with multiple chronic illnesses” (Department of Health and Human Services: MMA 2003).

Congress designed the MHS demonstration to “address perceived current failings of the health care system for chronically ill, Medicare FFS beneficiaries and to allow for a large-scale, randomized evaluation of DM’s ability to improve quality of care and reduce health care costs” (Cromwell, McCall, Burton, 2008, p.48). Furthermore, the MHS demonstration took into account a business perspective, as Medicare health support organizations (MHSOs) were held accountable for positive results achieved.

“The MHS program represents a fundamental shift in the way the Centers for Medicare and Medicaid Services (CMS) pays for health care. Traditionally, Medicare has paid and rewarded providers for the delivery of units of service. Through Medicare Health Support, CMS has embraced a population-based model that pays for pre-defined and measurable outcomes within a business framework” (DMAA: Medicare Health Support Resources). This also served as a supplement to pay-for-performance initiatives, as increasing concern shifted to the reduction of costly medical errors as well.

With legislation to support the operations of the MHS demonstration and Congressional oversight through CMS, the results are fairly unexpected. Although participation in the MHS pilot ranged from 65 to 93 percent, it was suggested that “unobserved differences in their beneficiary mix may affect their likelihood of achieving the pilot’s required savings targets” (Cromwell, et al., 2008, p.53). After evaluation at six months, it was determined that, due to the intent-to-treat clause in the participation requirements for payers, beneficiaries selected were found to be a “healthier and less costly subset of the intervention group” (Cromwell, et al., 2008, p.58). At the end of the demonstration, it was still concluded that, in addition to existent limitations within the study, the goal of cost reduction was not achieved. With insignificant reductions in health care costs, it is important to further examine the economic implications of such a demonstration before it can be determine that the MHS demonstration was actually not able to reduce the costs of chronic care.

Economic Analysis

The Medicare Health Support (MHS) demonstration was created as a cost-controlling pilot, with features including the intent-to-treat and prerandomization of participants. “More than half of Medicare beneficiaries have multiple chronic conditions, and these beneficiaries account for 96 percent of annual Medicare spending (\$418 billion in 2007)” (Foote, 2009, p.99). As the costs of chronic care increase, the idea of self-management becomes a major concern, because, “despite savings in some categories, self-management costs more than traditional care. It also produces better health outcomes. The net cost was \$3,380 (1997 dollars) for year healthy year gained from self-management—about \$5,000 today” (Russell, 2009, p.42). Therefore, there is a need to look into these statistics more closely to determine if the CMS’s MHS demonstration was capable to reducing chronic care costs through patient education and self-care.

With that, the MHSOs “predicted they would achieve budget neutrality or better within 12 months of the pilot’s start” (Cromwell, et al., 2008, p.50). Simple cost benefit analyses can be performed to determine budget neutrality through the use of the return on investment (ROI) calculation. On the ROI index, showing “the amount of money saved for every dollar spent” (Cromwell, et al., 2008, p.48), an ROI of 1.0 reflects budget neutrality. For instance, the ROI for managing multiple chronic illnesses ranged from 4.4 to 10.9, according to Goetzel, et al. (2005). To ensure the MHSOs were capable of serving its beneficiaries, CMS took action by “requiring MHSOs to achieve at least 5 percent gross savings on Medicare claims costs...or return all of the management fees they had received” (Cromwell, et al., 2008, p.48). Although 5 percent does not seem like a large monetary amount, it adds up when the MHSO is receiving monthly fees of \$74-159 per eligible beneficiary and there are a total of 206,000 beneficiaries in each program.

As the terms were defined and data was collected, financial analyses were conducted to determine the overall success of the MHS pilot. Growth rates, in terms of per beneficiary per month (PBPM), were reviewed using a difference-in-difference analysis to determine growth rates in monetary values for both the intervention and comparison groups. It was concluded that “six of the eight MHSOs exhibited lower relative rates of growth in Medicare PBPM payments” (Cromwell, et al., 2008, p.55) in the first 6 months of the pilot study. However, only the savings of two of those six groups proved to be statistically significance, defined as a difference-in-difference trend of \$62-90 or 4.4-5.8 percent of the comparison group.

Shifting from growth rates to refund rates, it was concluded that the pilot was successful in “each MHSO’s early success in meeting the original pilot’s financial requirement of 5 percent net savings over a 3-year period” (Cromwell, et al., 2008, p.57). MHSOs had to reduce certain percentages based on its associated comparison group, ranging from 5.3 to 11.2 percent. However, savings ranged from -3.7

percent to +6.3 percent. For MHSO 6 at +6.3 percent, this group was able to recover nearly half of its monthly fee, in addition to the required 5 percent through Medicare savings after 6 months. Therefore, in terms of savings, six of eight of the MHSOs were successful, although success beyond the required 5 percent may have been minimal; and only two MHSOs suffered dissavings that would have to be recovered over the last 2 ½ years of the demonstration.

As a result of both the analysis of growth rates and reduction rates, evidence suggests the MHS demonstration did not display notable reductions in the cost of chronic care. Although some MHSOs may have displayed characteristics of potential savings, no such evidence was recorded and this demonstration is still said to be insignificant in terms of cost reductions.

CONCLUSIONS

To recap, the health policy question was whether or not disease management initiatives have demonstrated an ability to reduce the costs of chronic care; and we investigated the reasons as to why disease management initiatives, specifically the MHS demonstration, had **not** demonstrated the ability to reduce costs of chronic care. In support of our position, we showed that the current United States health care system cannot support notable reduction in health care costs associated with the care of those suffering from chronic illnesses. The current delivery of care model needs to engage multidisciplinary teams into the everyday care of those with chronic illnesses, as the health care workforce faces shortages among primary care physicians and clinicians required to provide adequate and appropriate care. It was stated that “a team-based approach in chronic care management programs for heart failure patients meets the AHA’s principles for high-quality disease management programs and the Disease Management Association of America’s key component of disease management programs” (Sochalski, et al., 2009, p.186). Also, we believe the reimbursement system needs to be restructured to encourage proper reimbursement for services rendered by those suffering from chronic illnesses. The costs accrued when using a fee-for-service system will deplete any source of funding, as evident in the current United States system. Shifting to a non-visit-based system may suggest substantial savings in health care costs for those with chronic illnesses. For these reasons, the health care system does not support proper evidence as to whether or not the MHS demonstration was able to significantly reduce the cost of chronic care.

In addition, in order to reevaluate this demonstration, it would be important to review the criteria of eligible beneficiaries as the intent-to-treat clause may have skewed the participant pool and demographics may have impacted access to care. We believe this demonstration was well build, but poorly evaluated as it was more like a case study or experimental attempt at something well-engineered, but unsure of its capabilities in terms of evaluating measures of success. One suggests that “the first step is to reassess the ongoing DM programs with a focus on establishing the specific parameters under which a specific intervention provides evidence of success” (Bott, et al., 2009, p.97). However, we believe changes must come from within the health care system itself, and be the direct result of health care policy workers, who have studied and analyzed such cost reduction demonstration and draw conclusions based on their findings.

Even though the demonstration appears to have the ability to potentially result in cost reduction of chronic care when implemented in a system that supports such evidence of success, there are still the underlying healthcare policy concerns, especially regarding workforce regulations (i.e. the use of multidisciplinary teams) and wellness initiatives, not yet discussed. So what should healthcare policy reform look like? Bodenheimer, et al. (2009) suggests reform should represent (1) the legislation of a national policy that “half of U.S. clinicians practice in primary care,” (2) a change in payment for PCPs “from fee-for-service to non-visit-based payment,” and (3) “dramatic public health policy related to tobacco control, physical activity, and healthy eating.” The final suggestion made by Bodenheimer, et al. (2009) brings up a topic that is secondary to the prevalence of chronic illnesses, and that is the lack of healthy lifestyles among Americans. Risky health behaviors, such as smoking, can contribute to the comorbidities related to chronic illnesses and raise a new set of concerns for health policy workers regarding wellness initiatives. These risky behaviors were not criteria considered when determining

participant eligibility, but, if considered, may have resulted in additional savings. However, the issue still stands as to the cost reduction of the highly prevalent chronic illnesses among Americans and what will happen next with the MHS demonstration.

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APPENDIX A

MEDICARE HEALTH SUPPORT PROGRAMS

MHSO	Selected Program Features	Geographic Area
Aetna Life Insurance Company, LLC	<ul style="list-style-type: none"> • Advance Practice Nursing Program for home health and nursing homes • Customized care plans • Caregiver education • Blood pressure monitors and weight scales provided based on participant need • Physician communication • Physician web access to clinical information • 24-hour nurse line 	Chicago, IL counties
American Healthways	<ul style="list-style-type: none"> • Personalized care plans • Direct-mail and telephonic messaging • Supplemental telephonic coaching • Gaps in care generate physician prompts • Intensive case management services as necessary • Remote monitoring devices (weight, blood pressure (bp), and pulse) based on participant need • Physician web access to clinical information • Physician communication • 24-hour nurse line 	MD and DC
CIGNA Health Support, LLC	<ul style="list-style-type: none"> • Personalized plan of care • Telephonic nurse interventions • Oral and written communication in addition to telephonic coaching • Home monitoring equipment (weight, bp, and glucometers) based on participant need • Intensive case management for frail elderly and 	Northwest GA

		<ul style="list-style-type: none"> institutionalized participants, as required • Data exchange with physicians • 24-hour nurse line 	
Health Services Corporation	Dialog	<ul style="list-style-type: none"> • Personal health coaches develop individual care management plans • Health education materials (web-based, faxed or mailed) • In-home biometric monitoring • Behavioral health case management and intensive case management as needed • Data exchange with physicians • Active involvement of other community agencies • 24-hour nurse line 	Western PA
Humana, Inc.		<ul style="list-style-type: none"> • Trademarked Personal Nurse (PN) program model • Group education and support sessions • Biometric monitoring equipment, including glucometers and weight scales as necessary • Core telephonic support supplemented with RNs, social workers, and pharmacists in the field interacting with providers and beneficiaries with complex needs • Data exchange with physicians • On-site meetings with physicians and CME (continuing medical education) programs • Physician web access to clinical information • Electronic medical recordkeeping systems will be piloted in five small physician-group practices • Active involvement of other community agencies • 24-hour nurse line 	Central and South FL
LifeMasters Supported SelfCare		<ul style="list-style-type: none"> • Single nurse as primary contact for beneficiary • Supported self-care model including education, medication compliance, behavior change • Home visits as appropriate • Team of local and call center-based nurses, physicians, pharmacists, and health educators • Digital weight scale and bp monitors • Physician communication including customized care plans, alerts, decision support applications; access to patient care record and biometric monitoring data • Physician outreach includes in-person orientation for 	OK

	<p>highvolume physician practices</p> <ul style="list-style-type: none"> • Physician web access to clinical information • Active involvement of other community agencies • 24-hour nurse line 	
McKesson Health Solutions	<ul style="list-style-type: none"> • Extensive physician involvement, including on-site staff support • Data exchange with physicians • Physician web access to clinical information • Telephonic outreach • Mail, fax, workbooks • Remote monitoring and biometric equipment for selected high-risk participants • Pharmacist review of medications and collaboration with physicians • Management of long-term care residents and intensive case management, including end-of-life • 24-hour nurse line 	MS
XLHealth Corporation	<ul style="list-style-type: none"> • Biometric monitoring including glucometers and weight scales as necessary • RNs, social workers, and pharmacists in the field, interacting with providers and beneficiaries with complex needs • Medication counseling sessions by pharmacists at retail pharmacies • Specialized program for higher risk patients • Medication management and compliance • Data exchange with physicians • Physician web access to clinical information • 24-hour nurse line 	Selected counties in Tennessee

*Source: <http://www.cms.hhs.gov/MLN MattersArticles/downloads/mm3953.pdf>