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Guest Commentary

CMS cuts cord on MHS project too quickly


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There's probably not an American adult who isn't aware of the skyrocketing cost of healthcare. And, yet, a Cabinet-level federal agency charged with healthcare payment has taken the bizarre step of killing a project that might help bring these expenses down before all results and facts have been analyzed.

The two-phase trial begun in 2005, called the Medicare Health Support (MHS) project, was centered on exploring and thoroughly evaluating the effectiveness of disease management on the quality and cost of care to those with multiple chronic conditions. Those maladies range from diabetes to congestive heart failure.

Chronic-disease patients unquestionably are a heavy drain on the healthcare system. The Centers for Disease Control and Prevention estimates that chronic-disease patients account for 75% of America's healthcare bill.

The CMS seems to have ignored those facts and earlier this year said it intends to terminate the project, with the last of the pilots shutting down in December.

Begun in 2005, phase one of the three-year program was designed to assess the net cost of providing care to chronically ill patients with heart failure or diabetes, treating them through disease management—preventing or reducing the impact of a disease, including those effects resulting from the initial problem—versus other medical regimens.

But CMS is walking away from the MHS project, not just before the due diligence is completed, but when results indicate a potential positive outcome.

For example, in one disease-management study conducted by American Healthways on a population of Medicare+Choice Patients and unrelated to the CMS project, two sets of congestive heart failure patients were analyzed. In the study, audited by the big accounting firm, Ernst & Young, one group consisted of 16,000 patients covered by a commercial healthcare-insurance plan, while the other contained 47,000 people in a Medicare plan.

In the first year, the patient groups equally received normal care. In the second year, they both received care through a comprehensive disease-management program.

The results were compelling. Average healthcare claims per person in the commercial population decreased to $1,695 in the second year from $2,380 in the first year—a 28.8% decline. For the Medicare group, claims decreased to $1,519 from $1,905, a 20.3% decline over the same period.

In the second study, Blue Cross and Blue Shield of Minnesota analyzed two groups of 60,000 patients with one or more of 17 different chronic conditions over two years. (These conditions affect 12% to 15% of the Blues' commercial population, and account for 40% to 45% of all claims.) The first group was actively managed by a team of 120 nurses ("care support group"),

while the other was treated as normal but not actively managed ("reference group"). By the end of year two, the patient claims in the care support group were $500 lower (on an annualized basis) than those of the reference group. The Blues plan received a return on investment of at least $2.90 for each dollar invested in the program. More importantly, patient care improved as the care support group showed a big improvement in glucose levels; a 14% decrease in hospital admissions; and an 18% decrease in emergency room visits.

Given the results of these studies, how can CMS presumably believe that the interim results of phase one did not justify continued exploration into phase two? Are there other elements that could have contributed? Did patient enrollment, for example, take longer than planned? Did the program run long enough for the initial investment in areas such as patient recruitment and compliance to be offset by the long-term reduction in expensive care, such as emergency room visits?

Four U.S. senators—Lamar Alexander and Bob Corker, Republicans from Tennessee; and Edward Kennedy and John Kerry, Democrats from Massachusetts—have publicly questioned the idea that CMS has gathered enough data to make a thoughtful decision. In a letter to the CMS, the senators urged the department to reconsider its hasty decision. (Full disclosure: the senators come from states that are home to two of the MHS vendors.) Further, roughly 300 Washington-area physicians and other healthcare providers have added their voices to those urging the continuance of the MHS programs.

Even though CMS earlier this month agreed with one disease-management provider, Healthways, to alter its Phase One financial performance targets, which if satisfied, could trigger Phase Two, it still remains a long shot.

There is some good news on this front. The recently passed Medicare bill, which survived a presidential veto, calls for a study on the feasibility of establishing a Medicare Chronic Care Practice Research Network of providers who would test new models of care coordination and other care approaches for chronically ill beneficiaries, and expand those models to the larger Medicare patient population, if appropriate. Also, the bill calls for a thorough study of the methods of analysis and the program design of Medicare Health Support. Maybe this can get things back on track.

Obviously, there is no single solution to curtailing the ever-increasing cost of healthcare in the U.S. But not exploring all options surely isn't going to produce results.

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