

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4 - A-06
(June 2006)

Subject: Update on Disease Management

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1 Council on Medical Service Report 3 (I-97), established a series of principles on the conduct of
2 disease management programs (Policy H-285.944, AMA Policy Database). Since 1997, the House
3 of Delegates has considered at least two reports that addressed disease management. Council on
4 Scientific Affairs Report 11 (A-04) provided an in-depth analysis of disease management processes
5 and efficacy, reaffirmed Policy H-285.944, and directed the American Medical Association to
6 educate physicians on the impact of disease management programs on patients and their treating
7 physicians (Policy D-285.976). In addition, Council on Medical Service Report 5 (A-05)
8 established Policy H-155.995[3], which supports greater evaluation of the use of disease
9 management, case management, pay-for-performance, and end-of-life care programs for high-cost
10 patients, so that their cost-containment impact and projected future savings can be better assessed.

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12 In May 2004, the AMA Private Sector Advocacy unit created a pamphlet entitled “Demystifying
13 Disease Management: What You Need to Know for Your Patients and Your Practice.” The
14 pamphlet explores the potential impact of disease management, offers some interactive strategies,
15 and is available to AMA members at [http://www.ama-assn.org/ama1/x-](http://www.ama-assn.org/ama1/x-ama/upload/mm/368/dmpamphletcorrected.pdf)
16 [ama/upload/mm/368/dmpamphletcorrected.pdf](http://www.ama-assn.org/ama1/x-ama/upload/mm/368/dmpamphletcorrected.pdf).

17 The Council initiated an update on disease management and presents its findings for the
18 information of the House. This report discusses the evolution of the disease management industry;
19 describes disease management initiatives in Medicare and Medicaid; summarizes findings on the
20 return on investment; discusses the role of accreditation and regulation; notes the increasing
21 importance of performance measures; and presents AMA policy related to disease management.

22

23 THE EVOLUTION OF DISEASE MANAGEMENT

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25 The evolution of the disease management industry since 1997 has been marked by rapid growth
26 and consolidation. The Disease Management Association of America (DMAA) was founded in
27 1999, two years after the recommendations contained in Council Report 3 (A-97) were adopted as
28 Policy H-285.944. DMAA currently has 50 member disease management companies of the
29 estimated 100 companies nationally. Disease management originally was a managed care tool
30 focused on larger employers, and was something of a replacement for utilization management
31 during the “managed care backlash” of the late 1990s.

32

33 Compared with the climate in 1997, disease management programs now rely less on
34 pharmaceutical management and there are fewer single-disease vendors. The tendency now is to
35 promote patient awareness and self-care, and to address multiple diseases or conditions. Acting in
36 this capacity, disease management programs often provide education that physicians are not
37 currently paid to provide. According to a September 2005 report in the trade publication “Inside
38 Disease Management,” some disease management vendors are considering programs designed for
39 the “middle market” of smaller employers and self-funded companies. As noted in the next
40 section, Medicare is now funding disease management pilot projects for fee-for-service

1 beneficiaries. The growth of fee-for-service disease management is expected to continue as
2 programs gain expertise.

3
4 An August 2005 article in Managed Care Magazine, "12 DM Trends You Should Know About,"
5 described key components of the evolution of disease management. According to the article, large
6 disease management firms now offer to manage dozens, rather than a single or small number of
7 diseases or conditions. In addition, disease management is often outsourced to specialized vendors.
8 The article reported that a 2004 survey of health plans found that 63% use both in-house and
9 outsourced disease management programs; 32% use only in-house programs; and 5% use only
10 outsourced vendors. Increasingly, the article reported, employers are asking disease management
11 programs to address wellness programs, such as smoking cessation and weight loss.

12 13 MEDICARE AND MEDICAID FEE-FOR-SERVICE

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15 As previously noted, disease management was originally a managed care construct. Both Medicare
16 and Medicaid increasingly are focusing on managing the care of their fee-for-service beneficiaries
17 who are known to have chronic or disabling conditions.

18 19 Medicare Health Support

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21 In December 2004, the Centers for Medicare and Medicaid Services (CMS) defined a new strategy
22 for Medicare fee-for-service patients with chronic illnesses. The new program, Medicare Health
23 Support, replaced the Chronic Care Improvement Program (CCIP), although CCIP continues to be
24 widely cited in industry literature. Medicare Health Support awarded nine well-established disease
25 management vendors with contracts to conduct three-year pilot projects. The areas to be served
26 have a high prevalence of diabetes and congestive heart failure among Medicare beneficiaries. The
27 areas represent a mix of rural and urban areas and include ethnically and culturally diverse
28 populations.

29
30 Approximately 180,000 Medicare fee-for-service beneficiaries who have congestive heart failure
31 and complex diabetes will be screened for participation. Targeted beneficiaries will be assigned
32 randomly to either an intervention group or a control group. Those in the intervention group will
33 be notified of the opportunity to participate through a letter from the Medicare program. The letter
34 will describe the program and give the beneficiary the opportunity to decline to be contacted by a
35 Medicare Health Support organization if he or she does not want to participate.

36
37 The pilot projects, authorized by the Medicare Prescription Drug, Improvement and Modernization
38 Act of 2003, are tasked with helping participating patients adhere to their physicians' plans of care
39 and obtain the medical care they need to reduce their health risks. By better managing and
40 coordinating the care of beneficiaries with chronic conditions, CMS hopes to help increase
41 adherence to evidence-based care, reduce unnecessary hospital stays and emergency room visits,
42 and help participants avoid costly and debilitating complications. The disease management
43 organizations operating the programs are required to assist participants in managing all
44 co-morbidities, relevant health care services, and pharmaceutical needs as well as unique individual
45 needs and cognitive impairments.

46
47 CMS has developed a "fact sheet" to inform physicians about the project, available on the Web.
48 There is anticipation that the Medicare pilot projects will accelerate the market consolidation and

1 evolution of disease management over the next year or two. The Secretary of the Department of
2 Health and Human Services is authorized to expand the program if the Secretary finds programs or
3 program components that have proven to be successful in improving clinical outcomes, increasing
4 beneficiary satisfaction, and meeting Medicare spending targets for their assigned populations.

5
6 Medicaid

7
8 Disease management is used in many states as a way to improve care and reduce the significant
9 expenditures of the Medicaid program on chronic illnesses and disabilities. The Kaiser Family
10 Foundation (KFF) issued a report in September 2004 entitled "Medicaid Disease Management:
11 Issues and Promises," which highlighted the difficulty of documenting cost savings. The KFF
12 report noted that Medicaid disease management programs typically do not address mental health
13 issues and often exclude dual eligibles, despite their great need, because the cost savings would
14 largely benefit the Medicare program rather than the Medicaid program. In addition, KFF
15 indicated that commercial disease management vendors may need to take measures to ensure that
16 they are sensitive to Medicaid enrollees, who may be more difficult to contact and have more
17 mitigating factors that could prevent them from adhering to their treatment plans. According to the
18 KFF report, most disease management programs operate independently of physicians to avoid
19 being perceived as burdensome or interfering. KFF indicates that some states are seeking a more
20 active role for physicians. The KFF report also found that states increasingly are targeting disease
21 management to fee-for-service beneficiaries, in addition to those in capitated managed care plans.
22 This shift has been accomplished by the rapid growth of stand-alone Medicaid disease management
23 programs.

24
25 RETURN ON INVESTMENT

26
27 The expectation of disease management is that it will improve care and save money. Improved
28 patient compliance with treatment regimens is expected to prevent hospitalizations and other costly
29 interventions. However, the evaluation of disease management remains elusive. The evaluation of
30 disease management success is typically attempted by determining a "return on investment" (ROI).
31 The ROI analysis of disease management emphasizes capturing the financial benefit that results
32 from decreased use of health care resources, which in turn, results from the beneficial effects of
33 disease management. Employers increasingly are using consulting firms to audit their contracted
34 disease management programs for ROI. Information about patient satisfaction is used as a measure
35 of the beneficial impact of disease management. In one meta-analysis, quality of care was
36 measured using clinical, utilization, safety, and patient satisfaction indicators.

37
38 An October 2004 report of the Congressional Budget Office (CBO), "An Analysis of the Literature
39 on Disease Management Programs," analyzed the cost effectiveness of disease management
40 programs in an effort to determine how such programs could be applied to Medicare. Although,
41 the CBO determined that it is inconclusive whether disease management programs pay for
42 themselves, it noted that disease management may be worthwhile even if costs are not reduced.
43 The Council believes that studies of ROI should not be limited to economic factors and should
44 recognize non-economic factors, such as improvements in the quality of life. In addition, studies of
45 ROI should compare disease management programs with physician offices, given comparable
46 access to social services and tools. The pressure to demonstrate positive results for disease
47 management is likely to increase with Medicare Health Support. CBO indicated it would continue
48 to monitor the disease management programs developed by CMS.

1 The conclusion reached in Council on Scientific Affairs Report 11 (A-04) was that the ROI
2 depends, in part, on the disease. By reviewing the medical literature, the report outlined the disease
3 management process; presented the pros and cons of disease management services; and assessed
4 the effectiveness of disease management for managing chronic diseases. The report indicated that
5 poorly designed disease management programs can circumvent the treating physician, a practice
6 opposed by AMA policy. For example, the report noted that some disease management programs
7 might try to switch patients to less costly medical supplies or equipment, thus confusing patients.
8 Patient confusion would be compounded if treating physicians are not notified of such changes.
9 Furthermore, the report noted that disease management programs frequently use clinical practice
10 guidelines to assess treatment plans. If the disease management program profiles individual
11 physicians to create "report cards," physicians may be penalized if their practice patterns vary from
12 the guidelines, even if equally effective.

13
14 Council on Scientific Affairs Report 11 (A-04) also reviewed the chronic care model and compared
15 it with disease management. The recommendations contained in the report reaffirmed Policy
16 H-285.944, the principles established by Council on Medical Service Report 3 (I-97), and called for
17 the AMA to continue to educate physicians on the impacts of disease management programs on
18 patients and their physicians.

19
20 ACCREDITATION AND REGULATION

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22 Accreditation is a key component of the disease management industry. URAC (formerly known as
23 the Utilization Review Accreditation Commission), the National Committee for Quality Assurance
24 (NCQA), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), have
25 established principles for the accreditation or certification of disease management programs.
26 JCAHO's principles are for hospital-based programs, NCQA's principles are for HMOs, and
27 URAC's principles focus on private disease management vendors. Similar to the role of
28 accreditation in other industries, accreditation for disease management programs is used to
29 distinguish vendors.

30
31 Accreditation also plays a role in the quality assessment of disease management programs. In
32 January 2006, the DMAA announced that it would develop, by the end of the year, a uniform
33 method for measuring and evaluating disease management outcomes. The DMAA hopes to
34 establish "best practices" for evaluating disease management programs. Currently, URAC's
35 standards contain variously weighted sets of measures for "Methodology for Outcomes
36 Measurement," "Requirements for Measuring Program Performance by Clinical Condition," and
37 "Consumer Reported Outcomes Measurement."

38
39 According to the National Conference of State Legislatures (NCSL), 25 states have laws that
40 specifically address disease management. The first year any of the laws listed on the NCSL Web
41 site were enacted was 2002, with the majority of laws enacted in 2003 and 2004. Many of these
42 laws establish task forces or panels to evaluate efficacy of a disease management program, or
43 compel state agencies to establish or contract with disease management vendors. Others direct
44 state departments of health to establish a disease management program for various specific
45 conditions or diseases in their Medicaid programs.

46 Two states have laws that specify the financing of patient incentives to participate in disease
47 management. New Hampshire and Rhode Island permit health insurers in the small group and
48 individual markets to discount the premium rate for health benefit plans that include significant

1 financial incentives for covered persons to participate in wellness or disease management
2 programs. South Dakota requires health plans to include disease management programs that
3 contain cost containment mechanisms. Enrollees who do not enroll in cost containment activities
4 receive financial penalties in the form of higher out-of-pocket costs.

5
6 Two other states have laws that appear to address issues pertaining to oversight of disease
7 management. California requires disease management organizations to obtain physician prior
8 authorization before providing services or medication management. California also prohibits the
9 use of medical information to solicit, or to offer for sale, any products or services and specifies that
10 disease management organizations are subject to confidentiality laws. Washington directs state
11 purchased health care policies to be based on scientific and medical evidence, and to explore
12 strategies for disease management and demand management programs.

13 14 DEVELOPMENT OF PERFORMANCE MEASURES

15
16 There is a growing link between disease-based performance measures and quality improvement
17 (QI) programs. These links are seen in private sector programs, such as Bridges to Excellence,
18 and in public sector pilot projects sponsored by Medicare. The Council believes that the Physician
19 Consortium for Performance Improvement convened by the AMA with participation by a large
20 number of specialty and state medical societies, CMS, NCQA, and others, should play an important
21 role in these efforts. The Consortium's rigorously reviewed performance measures are often
22 derived from generally accepted disease management guidelines. These measures are emerging as
23 useful tools to assist physicians and other clinicians in efforts to assess clinical performance and QI
24 progress using a standards and consensus-based approach. The need for simple, affordable
25 information technology tools (e.g., disease and patient registries and new electronic health record
26 functionality) to document and aggregate data and easily display reports of these measures, is also
27 becoming more apparent in the overall disease management process.

28 29 AMA POLICY RELATED TO DISEASE MANAGEMENT

30
31 AMA policy related to disease management is largely supportive of its use, if conducted in a
32 manner consistent with AMA policy. A number of policies emphasize the need to measure the
33 efficacy of disease management, which has resulted in recent reports from AMA councils. Taken
34 together, AMA policy addresses the critical issue facing disease management: measuring the value
35 of disease management and maintaining physician control of the process.

36
37 Policy H-285.944, which was established with the adoption of the recommendations in Council on
38 Medical Service Report 3 (I-97), contains principles related to both disease management and
39 demand management. The principles related to disease management strongly encourage health
40 insurance plans and managed care organizations that provide disease management to involve the
41 patient's physician in the disease management process as much as possible, and to minimize
42 arrangements that may impair the continuity of a patient's care across different settings. Policy
43 H-285.444 supports the development of disease management systems that adhere to the following
44 principles, and encourages any public or private entities that evaluate such programs for purposes
45 of certification or accreditation to utilize these principles in conducting their evaluation:

- 46 (1) The primary goal of both disease management should be as follows: (a) to improve
47 outcomes by providing timely and appropriate preventive, therapeutic and restorative
48 services. Cost savings and care efficiencies resulting from such services are a secondary but

- 1 legitimate objective. (b) To promote cooperation between primary care and specialty care
2 physicians to provide a continuum of care for specific health care needs.
- 3 (2) Disease management should continue to place major emphasis on educating and empowering
4 patients to more successfully manage their own health and intelligently use care resources.
- 5 (3) The clinical practice guidelines used in disease management should be developed by
6 physicians knowledgeable in dealing with the conditions addressed, and should be updated
7 regularly.
- 8 (4) The decision to participate or not participate in a disease management program should
9 always be the prerogative of the patient, who should be fully informed of any plan coverage
10 conditions attendant on such decisions.
- 11 (5) Physicians should be able to deviate from disease management practice guidelines without
12 incurring sanctions or jeopardizing coverage for services, when in their judgment such
13 deviation is indicated by the medical needs or desires of individual patients.
- 14 (6) Attention to the performance of physicians in disease management programs should be
15 triggered by concern with a physician's overall practice patterns rather than by deviation
16 from practice guidelines in a single case. Emphasis in remedial activities should be on
17 helping the practitioner to correct any overall performance problems identified by peer
18 review, rather than on sanctions.
- 19 (7) Non-physicians who function as care coordinators in disease management programs should
20 be certified or licensed as physician assistants or nurse practitioners, or have at least a
21 comparable level of training.
- 22 (8) The overall authority for decisions to use or not use specialized care and ancillary or
23 supportive services or products for patients enrolled in a disease management program
24 should rest with the primary or principal care physician providing care in the program.
- 25 (9) The primary or principal care physician in a disease management program should strive to
26 assure effective collaboration among the different programs and personnel needed for care of
27 patients with comorbidities, and should be routinely informed by such personnel of the
28 services they provide.
- 29 (10) Physicians who provide care in disease management programs should be fully licensed to
30 practice medicine in the jurisdiction of the program's location, and should be professionally
31 and legally accountable for any adverse patient events resulting from that care.
- 32 (11) In disease management programs conducted by drug manufacturers, the choice of
33 pharmaceuticals used in program formularies and for care of individual patients should not
34 be restricted to those of the sponsoring manufacturer, but should be based on the clinical
35 judgment of participating physicians and validated outcome studies.

36
37 Policy D-285.979 calls for the AMA to: (1) reevaluate the concept of disease management as a
38 way to provide more cost effective delivery and improved quality of medical care to patients with
39 chronic disease involving cooperation between physicians and teams of allied health care workers,
40 including pharmacists, registered nurses, benefit managers, home health care, etc.; and (2) educate
41 physicians about the benefits of properly designed and implemented disease management programs
42 that are consistent with AMA policy. In response to Policy D-285.979, Council on Scientific
43 Affairs Report 11 (A-04) evaluated disease management programs and recommended the
44 reaffirmation of Policy H-285.944, and established a directive to educate physicians on the impact
45 of disease management programs on patients and their treating physicians (Policy D-285.976).
46 Similarly, Council on Medical Service Report 5 (A-05) established Policy H-155.995[3], which
47 supports greater evaluation of the use of disease management, case management, pay-for-
48 performance, and end-of-life care programs for high-cost patients, so that their cost-containment

1 impact and projected future savings can be better assessed. Policy H-290.982[17] supports case
2 management and disease management approaches to the coordination of care, in the Medicaid
3 managed care and the fee-for-service environments. Policy H-285.956[5] supports a disease
4 management approach to the care of behavioral health problems. Policy H-285.931[3] supports
5 physician involvement in the development of clinical practice guidelines and disease management
6 protocols, and Policy H-285.921 calls on Managed Behavioral Health Organizations to share their
7 written disease management protocols with primary care and other treating physicians. Policy
8 H-140.919[2] states that any health plan communications to patients promoting improved outcomes
9 through evidence-based approaches (e.g., promotion of preventive measures or disease
10 management programs) should be designed to reinforce the primacy of the patient-physician
11 relationship, and be sensitive to confidentiality issues and patients' concerns about their health
12 status. Policy H-315.983[20] supports privacy standards that would prohibit pharmacies from
13 using prescription refill reminders or disease management programs as an opportunity for
14 marketing purposes.

15
16 DISCUSSION

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18 The disease management industry is undergoing tremendous growth and change, and is likely to
19 become much more sophisticated in the near future. In 2005, URAC completed a study of the
20 medical management industry and concluded that many medical management firms integrate their
21 disease management function with their utilization management and case management functions.
22 In late 2005, the CMS initiated Medicare Health Support, a three-year disease management project
23 for Medicare fee-for-service patients with chronic illnesses. In 2006, the DMAA announced plans
24 to develop standards for measuring and evaluating disease management outcomes.

25
26 The Council believes disease management programs should focus primarily on patient education
27 and supporting the patient/physician relationship, and should not interfere with physician practices.
28 However, with the continued lack of accurate evaluative methodologies, physicians can expect
29 increased pressure to report on disease management performance measures and clinical outcomes.
30 This pressure may be particularly strong as Medicare Health Support enters its evaluative phase.
31 Already, there is pressure to link physician participation in disease management with pay-for-
32 performance efforts. In a 2005 article, *Managed Care Magazine* described Medicare Health
33 Support as the "event of the decade," which it predicted will catalyze disease management industry
34 consolidation.

35
36 AMA policy related to disease management remains germane. For example, Policy
37 H-285.944[5,6] states that physicians should be able to deviate from disease management practice
38 guidelines without incurring sanctions when in their judgment such deviation is indicated by the
39 medical needs or desires of individual patients, and that attention to the performance of physicians
40 in disease management programs should be triggered by concern with a physician's overall practice
41 patterns rather than by deviation from practice guidelines in a single case. The Council will
42 continue to monitor the evolution of the disease management industry.

References for this report are available from the AMA Division of Socioeconomic Policy
Development.