

## Abstract

*Health care policymakers are focusing attention on how best to coordinate and manage the care delivered to individuals with multiple chronic health needs. The focus on this population is not an American phenomenon, but a global health care trend. The reason is simple: a small proportion of these chronically ill individuals comprise a large proportion of health care costs. In the US, Federal and State policymakers have implemented numerous care management approaches to achieving positive health outcomes while at the same time realizing cost savings for government payers. It is incumbent upon health care policymakers to identify evidence-based models of care to properly treat individuals with multiple chronic conditions to achieve desired outcomes and reduce overall health care costs. This paper presents a brief history of interventions utilized by US State Medicaid programs (a Federal-State jointly funded health insurance program for low-income individuals) to improve outcomes and control costs. Two models in particular – patient-centered medical homes and consumer driven care models – are receiving worthy attention as the country grapples with how best to manage the care and the costs for those with multiple chronic conditions.*

## 1. Managing Care for those with Multiple Chronic Conditions

On the basis of the national census data (NSP) collected by the Główny Urząd Statystyczny in 2002, the number of disabled people with an officially determined disability (defined as the inability to work) amounts to 14 percent of the entire population in Poland.<sup>1</sup> Almost 60 percent of those individuals over the age of 60. The percentage of disabled people in the subsequent age brackets as well as the level of disability increases with age and at 75 almost half of the population has an officially determined disability (provided either by insurance institutions or by territorial self-government offices).<sup>2</sup> The number of elderly people (65+) is currently estimated at about 3.2 million, and those over the age of 80 are expected to increase in the next 25 years. Between 2010 and 2015 the number of people over 75 will increase by almost 500,000, as the total population of the country decreases.<sup>3</sup> It is estimated that about 2 million persons will have functional limitations.<sup>4</sup>

In Poland's Long Term Care (LTC) system, the family is still identified as the main caregiver for elderly people with limitations on the activities needed for daily living. According to the statistical data, about 80 percent of people aged 65+ don't use any institutional care or home care provided by a third party.<sup>5</sup> This tendency to provide care in the family is unlikely to continue in the future, both because of demographic and social development reasons. A World Bank expert has put forth the thesis that by 2020 the care needs of the elderly in Poland will increase so much that there will be a social shock.<sup>6</sup>

<sup>1</sup> GUS, *Osoby niepełnosprawne oraz ich gospodarstwa domowe [People with disability and their households]*, Narodowy Spis Powszechny, Warszawa 2003, p. 24.

<sup>2</sup> Ibidem, 41-42.

<sup>3</sup> GUS, *Prognoza ludności na lata 2008–2035 [Population projection for Poland 2008–2035]*, Warszawa, 2009, p. 147, 164-170.

<sup>4</sup> Szukalski P., *Projekcja liczby niepełnosprawnych seniorów do 2030 r. [Projection of the disabled elderly 2030]*, in: J. Kowaleski i P. Szukalski (red.), *Nasze starzejące się społeczeństwo. Nadzieje i zagrożenia [Our Society Getting Older. Hopes and Threats]*. Wydawnictwa Uniwersytetu Łódzkiego, Łódź, 2004, p. 106-112.

<sup>5</sup> AZER (Badanie ankietowe: Aktywność Zawodowa, Edukacyjna i Rodzinna) [Labour force, education and family activities survey], GUS, IBnGR, SGH and UW, Warszawa, 2007.

<sup>6</sup> Koettl J., *Challenges of Financing and Provisioning of long-term care in Eastern Europe*, Presentation at the 5th Health and Aging Conference of the Geneva Association, Warsaw, 2009.

Only recently did the health care system reform of 1999 provide an opportunity for the development of public LTC institutions that are separate from hospitals. Institutional care is simultaneously provided in the social sector.<sup>7</sup> At the present stage of LTC development, there is no specific regulation that comprehensively covers the issues of care services for the elderly, the institutions providing these services, the rules of access to them, and the ways of financing them. The new Act on Medical Activities, approved by Sejm and Senate in March (3/18/ and 3/30/2011), and now waiting for President's signature, will still need executive regulations to more clearly define the ways of organization of home-based care, its financing and maybe in the future also possibilities of patients personal budgets.

This issue is emphasized even further given the current global economic crisis. Individuals with multiple chronic illnesses account for a disproportionately high percentage of total health care spending. In order to ensure that enough public funds are available for the many social service programs, it is incumbent upon health care policymakers and directors to identify the most clinically appropriate and cost effective models to deliver care to this population.

While the American health care system is not a prime example of health care efficiency and cost effectiveness it can provide insights as to the models of care that can be utilized in Poland to care for individuals with MCC. This paper presents to Polish policymakers a brief history of community-based care management models that have been utilized to provide more coordinated, cost-effective care to the MCC population. Two such models – patient-centered medical homes and consumer-driven care – utilize lessons learned from decades of experimenting, and we believe these lessons can be useful to Polish policymakers.

## 2. American experience – a brief history of State health care for low-income populations

More than one in four Americans are diagnosed with multiple concurrent chronic conditions (MCC),<sup>8</sup> which can be defined as “conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living.”<sup>9</sup> Examples of MCC include arthritis, asthma, chronic respiratory conditions, diabetes, heart disease, human immunodeficiency virus infection, and hypertension, among others. In addition to comprising physical medical conditions, chronic conditions also include problems such as substance use and addiction disorders, mental illnesses, dementia and other cognitive impairment disorders, and developmental disabilities. The trend is alarming, patients with chronic diseases are increasing – by 2020, the number of people with multiple chronic conditions is expected to increase to 157 million, up from 125 million in 2000.<sup>10</sup>

The prevalence of MCC among individuals increases with age and is substantial among older adults. As the number of chronic conditions in an individual increases, the risks of the following outcomes also increase: mortality, poor functional status, unnecessary hospitalizations, adverse drug

<sup>7</sup> Golinowska, S. 2010. *The system of long-term care in Poland*. European Network of Economic Policy Research Institutes. Brussels. ENEPRI. [http://www.ancien-longtermcare.eu/sites/default/files/Poland\\_-\\_Country\\_Report-revised\\_proofread.pdf](http://www.ancien-longtermcare.eu/sites/default/files/Poland_-_Country_Report-revised_proofread.pdf) (Accessed 03/23/2011), p. 2.

<sup>8</sup> Anderson, G. 2010. *Chronic Care: Making the Case for Ongoing Care*. Princeton, NJ: Robert Wood Johnson Foundation. 2010. <http://www.rwjf.org/files/research/50968chronic.care.chartbook.pdf> (Accessed 03/23/2011), p. 11.

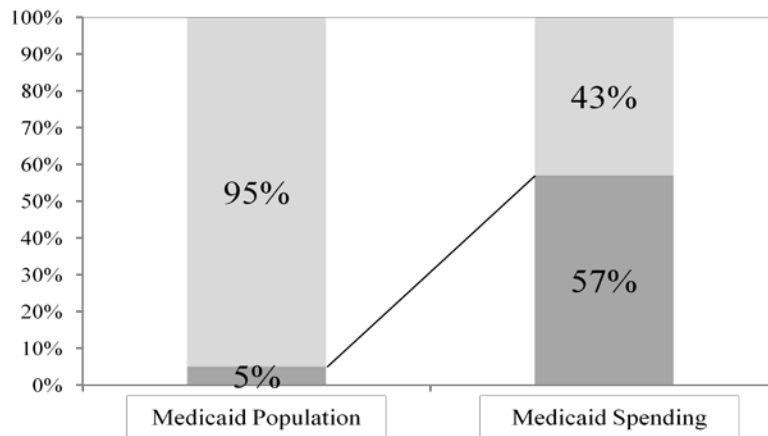
<sup>9</sup> Warsaw G. 2006. Introduction: advances and challenges in care of older people with chronic illness. *Generation* 2006;30(3). Also in: Hwang, W. et al. 2001. Out-of-pocket medical spending for care of chronic conditions. *Health Affairs*. 2001;20. pp. 267–278.

<sup>10</sup> Anderson, G. 2010. *Chronic Care: Making the Case for Ongoing Care*. Princeton, NJ: Robert Wood Johnson Foundation. 2010. <http://www.rwjf.org/files/research/50968chronic.care.chartbook.pdf> (Accessed 03/23/2011), p. 7.

events, duplicative tests, and conflicting medical advice.<sup>11,12,13</sup> This is not necessarily surprising but foreshadows the issues that the US and European Union countries will be facing with an aging population.

The resource implications for addressing this increase in MCCs are immense: in the US's Federally funded program for the elderly and disabled – Medicare – 66 percent of total health care spending is directed toward care for the approximately 27 percent of Americans with MCC.<sup>14</sup> It has been noted that increased spending on chronic diseases among Medicare beneficiaries is a key factor driving the overall growth in spending in the traditional Medicare program.<sup>15</sup> Individuals with MCC have faced substantial challenges related to the out-of-pocket costs of their care, including higher costs for prescription drugs and total out-of-pocket health care.<sup>16</sup>

The implications for State-funded health care programs – called Medicaid – mirror those of the Federal program. Medicaid is a means-tested health insurance program administered by State governments but jointly funded by the Federal government. It is designed to provide health coverage to the poor. There are more than 58 million Americans covered by the various State Medicaid programs, each program is designed by each state and, therefore, can vary with regards to populations covered and benefit packages offered.



Source: Kaiser Commission on Medicaid and Uninsured and Urban Institute estimates based on Medicaid Statistical Information Summary, March 2004.

<sup>11</sup> Lee, T. A. et al. 2007. Mortality rate in veterans with multiple chronic conditions. *J Gen Intern Med*;22(Suppl 3). pp. 403–407.

<sup>12</sup> Vogeli C. et al. 2007. Multiple chronic conditions: prevalence, health consequences, and implications for quality, care management, and costs. *J Gen Intern Med* 2007;22(Suppl 3). pp. 391–395.

<sup>13</sup> Wolff, J. L. et al. 2002. Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. *Arch Intern Med* 2002;162(20). Ppp. 2269–2276.

<sup>14</sup> Anderson, G. 2010. *Chronic Care: Making the Case for Ongoing Care*. Princeton, NJ: Robert Wood Johnson Foundation. 2010. <http://www.rwjf.org/files/research/50968chronic.care.chartbook.pdf> (Accessed 03/23/2011). p. 18.

<sup>15</sup> Thorpe K. E. et al. 2010. Chronic conditions account for rise in Medicare spending from 1987 to 2006. *Health Affairs*. 2010;29(4). pp. 1–7.

<sup>16</sup> Anderson, G. 2010. *Chronic Care: Making the Case for Ongoing Care*. Princeton, NJ: Robert Wood Johnson Foundation. 2010. <http://www.rwjf.org/files/research/50968chronic.care.chartbook.pdf> (Accessed 03/23/2011). p. 27, 33.

As with the general population trends, health care costs are concentrated within Medicaid populations. According to the Kaiser Commission on Medicaid and the Uninsured, almost 60 percent of Medicaid spending is incurred by only five percent of the population<sup>17</sup>. Of those highest cost individuals, about 60 percent were found to have co-occurring physical and behavioral health conditions. And when a chronic physical condition is combined with a mental illness costs can be 60 to 75 percent higher than those without a mental illness<sup>18</sup>. In one State that PCG has recently worked with, five percent of its members drive 43 percent of the cost and 10 percent drive 70-80 percent of costs.

In the US State governments are required to balance their budgets each year. This means that either revenue needs to increase or state programs must decrease so that total revenues equal total costs. The global financial crisis has hit US State revenues hard, forcing state policymakers to make difficult cuts to social programs. State Medicaid programs comprise a large portion of every State budget and so have been particularly scrutinized during the budget crises.

Over the years, State Medicaid programs have gone through an evolutionary process for how best to manage care for individuals with MCC. Each generation of intervention has been built upon lessons learned from prior experiments. Beginning in the 1980s, Medicaid programs turned to managed care as an alternative to traditional fee-for-service financing and delivery systems. Federal legislation in 1981 (the Omnibus Budget Reconciliation Act, or OBRA) allowed state Medicaid programs to implement both risk-based managed care arrangements and primary care case management (PCCM) programs. Prior to the new waiver authority, less than one percent of the managed care population was enrolled in some form of managed care<sup>19</sup>. Today, more than 70 percent of Medicaid enrollees are in some form of Managed care<sup>20</sup>.

Many states focused their first efforts in managed care on PCCM programs by the mid-1980s, with the goal of increasing access to care<sup>21</sup>. The Federal oversight agency for Medicaid defined PCCM services as “case management-related services, including the locating, coordinating, and monitoring of health care services provided by a physician, physician group practice, or an entity employing or having other arrangements with physicians (including nurse practitioners, certified nurse midwives, and physician assistants at the state's option), under a PCCM contract with the state.”<sup>22</sup> Generally, states offered physicians a small payment in hopes that more providers would accept Medicaid beneficiaries. Then each beneficiary would choose or be assigned to a participating physician that would serve as his or her “medical home.” States also hoped to save money through PCCM programs by reducing inappropriate usage of emergency rooms (ER), specialists, and other higher-cost care settings.

<sup>17</sup> Boyd C. et al. 2010. *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*. Center for Health Care Strategies, Inc. p. 1.

<sup>18</sup> Kronick R. G. et al. 2009. *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions*. Center for Health Care Strategies, Inc. p. 1.

<sup>19</sup> Kaiser Family Foundation. *Medicaid: A Timeline of Key Developments*. Interactive timeline about policy developments. <http://www.kff.org/medicare/medicaretimeline.cfm> (accessed 03/21/2011).

<sup>20</sup> Own analysis based on data from Kaiser Family Foundation. <http://www.statehealthfacts.org>, (accessed 03/21/2011).

<sup>21</sup> Rawlings-Sekunda, J. et al. 2001. *Emerging Practices in Medicaid Primary Care Case Management Programs*. U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation. p. 6.

<sup>22</sup> Richardson S. K. 1998. HCFA: *PCCM Services without Waiver*. Letter from Director, Center for Medicaid and State Operations. p. 2. <https://www.cms.gov/smdl/downloads/smd012198a.pdf> (accessed 03/23/2011).

The results were mixed. Some studies showed improvement in access and utilization of primary care, and some states even showed reduced costs (including New York,<sup>23</sup> and Arkansas<sup>24</sup>), but others saw no reduction in costs (including Maryland,<sup>25</sup> Missouri,<sup>27</sup> and Utah<sup>28</sup>). In some of the latter states, utilization patterns for emergency rooms, specialty care, and prescription drugs did not change.

One lingering concern regarding traditional PCCM programs is that such programs generally operated in a fee-for-service reimbursement environment<sup>29</sup>. Such arrangements lack the inherent incentives to control utilization of healthcare services found in risk-based approaches, such as through contracts with managed care organizations (MCOs). However, some states viewed PCCM as better suited than MCOs in certain areas, such as rural regions where it is usually more difficult for MCOs to maintain an adequate population base to be financially viable. States also felt PCCMs would be more palatable to physicians than risk-based managed care.<sup>30</sup> Concerns remain regarding risk-based managed care, due to the inherent financial incentives to provide fewer services for the elderly and disabled Medicaid populations with special needs. Through the 1990's, many states had moved Medicaid-eligible mothers and children into risk-based MCO contracts, but comparatively few states had experience enrolling their populations with special needs, chronic illnesses.<sup>31</sup>

New models of care may be needed to address the challenges of the chronically ill population and other subgroups of the Medicaid population that have special needs. Keys to these alternative approaches is a model of organizing chronic care promoted by Group Health Cooperative of Puget Sound, which improved the quality and cost-effectiveness of care for patients with chronic diseases.<sup>32</sup> This "chronic care model" calls for systems of care that incorporate evidence-based treatment protocols, patient tracking and referral systems, as well as team-based care that includes extensive care coordination.<sup>33</sup> The chronic care model has contributed to a new generation of Medicaid PCCM program – commonly referred to as "enhanced PCCM." These programs incorporate medical home concepts with chronic care management programs that work in concert with each other.

An example of an enhanced PCCM program can be found in the State of Oklahoma's Medicaid program. Interest from the provider community has led the state, in collaboration with providers, to develop an enhanced payment model for medical homes in the existing *SoonerCare Choice* PCCM

<sup>23</sup> Rosenthal T. C. et al. 1996. Medicaid Primary Care Services in New York State: Partial Capitation vs. Full Capitation. *Journal of Family Practice* 42:4. pp. 362-368.

<sup>24</sup> Muller, A. Baker, J. A. 1996. Evaluation of the Arkansas Medicaid Primary Care Physician Management Program. *Health Care Financing Review* 17:4. pp. 117-133.

<sup>25</sup> Schoenmann J. A. et al. 1997. Primary Care Case Management for Medicaid Recipients: Evaluation of the Maryland Access to Care Program. *Inquiry* 34:2. pp. 155-170.

<sup>26</sup> Gadomski A. et al. 1998. Impact of a Medicaid Primary Care Provider and Preventive Care on Pediatric Hospitalization, *Pediatrics* 101, no. 3, p. E1.

<sup>27</sup> Hurley, R. E. et al. 1989. Going into Gatekeeping: an Empirical Assessment. *Quality Review Bulletin* 15:10. pp. 306-314.

<sup>28</sup> Long, S. H. Settle, R. F. 1988. An Evaluation of Utah's Primary Care Case Management Program for Medicaid Recipients. *Medical Care* 26:11. pp. 1021-1032.

<sup>29</sup> Fee for Service (FFS) is a reimbursement methodology where providers are paid a rate for delivering a specific services. It is the primary payment model utilized by Federal and State health care programs.

<sup>30</sup> Rawlings-Sekunda, J. et al. 2001. Emerging Practices in Medicaid Primary Care Case Management Programs. U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation. p. 7.

<sup>31</sup> Gold, M. et al. 1996. Medicaid managed care: lessons from five states. *Health Affairs* 15:3. pp. 153-166.

<sup>32</sup> Bodenheimer, T. et al. 2002. Improving primary care for patients with chronic illness: the chronic care model. Part 2. *JAMA* 288(15). pp. 1909-14.

<sup>33</sup> Takach, M. et al. 2010. *Strengthening Primary and chronic Care: State Innovations to Transform and Link Small Practices*. The Commonwealth Fund. p. 5.

program. The new model was implemented in January 2009 and was designed to shift the program away from a partially capitated managed care model to a monthly payment for care coordination and case management, in combination with a fee-for-service component for office visits. The model also includes a pay-for-performance bonus program. *SoonerCare Choice* members with chronic disease(s) that have been identified as being at high risk for adverse outcomes and increased likelihood of a health care crisis have access to the Health Management Program. This is a comprehensive program aimed at benefiting both *SoonerCare Choice* members with chronic conditions, as well as the *SoonerCare Choice* primary care providers through practice facilitation to implement system changes to enhance quality of care and enhance proactive, preventive disease management (DM).

Like Oklahoma, the States of Washington, Missouri, and Illinois are combining medical homes initiatives with existing or new care management programming. The Washington Legislature mandated a disease management program for Medicaid in 2001. After focusing on disease management for several years, Washington Medicaid decided to move towards a chronic care management/medical home model instead. Legislation in Missouri required that Medicaid participants be provided a health care home by 2011. Approximately 2,000 physicians participate in Missouri's current care coordination initiative. In 2006, Illinois Medicaid implemented two separate programs, Illinois Health Connect (PCCM) and Your Healthcare Plus (Disease Management). Savings through both programs have been reported to total roughly 4 percent savings.<sup>34</sup>

Other non-peer reviewed findings from enhanced PCCM and DM program have reported cost savings, but some Medicaid officials are privately skeptical of such calculations. Medicare evaluations of other disease management programs were not viewed as successful. Some researchers caution that evaluation efforts should recognize that a five- to 10-year time horizon is needed to see the full health and economic effects of a medical home initiative.<sup>35</sup>

Care management and care coordination are the most important enhancements to PCCM programs that states have provided. They are also the most difficult enhancements to design, implement, and maintain effectively, and the most costly. If done well, however, these enhancements are likely to have the largest payoff over time in terms of lower cost growth and higher quality.

There are some key lessons to take from various models that studies have shown to work. They include: Patients who are at risk of hospitalization must be targeted, communication with the patient must be personalized and not just telephonic, care coordination efforts must include the physicians, care coordinators must have access to timely hospital admission and emergency room data, patients should help in the management of their own care, and care coordination efforts should be properly staffed with the appropriate levels of nurses and social workers<sup>36</sup>. These are valuable lessons to be considered when developing any model intent on coordinating care.

<sup>34</sup> Illinois Health Connect and Your Healthcare Plus Case Statement. 2010. The Robert Graham Center. Washington, DC. <http://www.graham-center.org/online/graham/home/publications/monographs-books/2010/ilafp-case-statement.html> (accessed 12/13/2010). p. 14.

<sup>35</sup> Stange K. C. et al. 2010. Defining and Measuring the Patient-Centered Medical Home. *Journal of General Internal Medicine* 25(6). pp. 601–612.

<sup>36</sup> Verdier, J. et al. 2009. *Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States*. Center for Health Care Strategies. p. vii.

Unfortunately, the locust of attention on these models is on a place that is not equipped with the resources to fully coordinate the care of individuals with MCC – the physicians. Linking enrollees with the appropriate specialty care and social support services can be time-consuming and resource-intensive, and most physician offices are not staffed and organized to perform these activities. As such, State governments assist with care management and care coordination activities for Medicaid patients by providing financial, informational, and staff support directly to provider offices, either with state agency resources and staff, or by contracting with outside vendors. While the clinical, information technology, and management resources needed to perform these functions are substantial, if done well they can substantially enhance the capabilities of providers and improve the quality of care for enrollees with costly and complex care needs. Over time, these enhancements may also lead to reductions in cost growth.<sup>37</sup>

To address the challenges of managing multiple chronic conditions among the growing number of individuals, U.S. Department of Health and Human Services developed a *Strategic Framework*<sup>38</sup> comprising four overarching goals:

**Goal 1:** Foster health care and public care health system changes to improve the health of individuals with MCC

**Goal 2:** Maximize the use of proven self-care management and other services by individuals with MCC

**Goal 3:** Provide better tools and information to health care, public care, and social services workers who deliver care to individuals with MCC

**Goal 4:** Facilitate research to fill knowledge gaps about, and interventions and systems to benefit, individuals with MCC

Two models of care that have proven worthy of consideration to help the nation meet these strategic goals and are likely to play a larger role in American health care in coming years are patient-centered medical homes and consumer self-direction models of care. Both contain many of the key components of successful care management programs described above.

### **3. Patient-Centered Medical Home model**

To address gaps in care coordination, several models that have emerged in recent years emphasize patient-centered multidisciplinary care, provider communication and cooperation to smooth transitions across settings, and incorporation of public health and community resources. The Patient Centered Medical Home (PCMH) is now being touted as a promising model for improving quality and containing costs across the healthcare delivery system. Although there is no single standard definition of a medical home, there is a general agreement on a set of principles underpinning the concept, and most medical homes share common elements. Medical homes should include:

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<sup>37</sup> Verdier, J. et al. 2009. *Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States*. Center for Health Care Strategies. p 31.

<sup>38</sup> U.S. Department of Health and Human Service. 2010. *Multiple Chronic Conditions: A Strategic Framework. Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions*. [http://www.hhs.gov/ash/initiatives/mcc/mcc\\_framework.pdf](http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf) (accessed 02/17/2011). p. 6.

- **Personal physician** – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Physician directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation** – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- **Care is coordinated and/or integrated** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- **Quality and safety** are hallmarks of the medical home.
- **Enhanced access** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- **Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home.
- Central to the success of a medical home is the ability to implement an **effective healthcare IT infrastructure** (e.g., electronic medical records) to collect and make multiple uses of healthcare data, utilize the latest health information technology and evidence-based medical approaches, as well as maintain updated electronic personal health records.

The popularity and interest in the medical home model and its use with chronic care management are reflected in the Patient Protection and Affordable Care Act (PPACA) – the US’s Federal reform legislation passed last year. The PPACA established a new “State Option to Provide Health Homes for Enrollees with Chronic Conditions.” This option allows States to enroll Medicaid beneficiaries with chronic conditions, which include serious and persistent mental illness and substance use disorders, into health homes effective January 1, 2011. As the new State option to provide health homes emerges as a potential vehicle to improve the quality of care and to control costs for Medicaid beneficiaries with chronic conditions, the experience of PCMH models takes on added importance. Many of the results are promising – from both a clinical and cost savings perspective – but they are not without contradictory study results that cannot prove cost savings. In addition, upfront funding to support the establishment of medical homes may limit states’ ability to pursue a medical home program.

This push toward medical homes is based on an approach that persons with MCC should have access to community and other public health services, as well as improved medical care coordination.

Achieving this coordination for individuals within a system comprising numerous independent providers, and including coordination across acute- and long-term care systems, has been difficult. Unfortunately, the current model of fee-for-service medical care offers few financial incentives to coordinate care.

PCG has analyzed the outcomes of prominent national medical home initiatives, and their reported effects on healthcare utilization and costs.

Organization	Quality Outcomes	% Inpatient Admission Reductions*	% ER Visit Reductions	Return on Investment
Group Health Cooperative of Puget Sound	4% increase in meeting HEDIS quality measures	16%	29%	1.5:1
Geisinger Health System	Improvement in quality of preventive care (74%), coronary artery disease (22%), diabetes (34.5%)	18%	n/a	2:1
Veteran's Health Administration	Reduced overall mortality, greater compliance with testing	31% risk reduction for patients with chronic obstructive pulmonary disease (COPD)	27%	Not Reported
HealthPartners Medical Group	Increase in receiving optimal care for diabetes (129%), heart disease (48%)	24%	39%	Not Reported
Intermountain Healthcare	3.4% reduction in mortality	8% overall, 22% for patients with diabetes	n/a	Not Reported
BC/BS of South Carolina	Improvements in 6 of 10 quality metrics	10.4%	12.4%	Not Reported
BC/BS of North Dakota	18% increase in patients receiving full preventive care services	6%	24%	Not Reported
Metropolitan Health Networks – Humana	Increase in breast and colorectal cancer screenings and flu vaccination rates	4.6%	n/a	Not Reported
Johns Hopkins Guided Care	None reported	24%	15%	Not Reported
Genesee Health Plan	137% increase in mammography screening rates, 36% reduction in smoking	15%	50%	Not Reported

Source: PCG's own analysis.

Most of the existing pilots of the PCMH indicate that the quality of care improves and that inpatient admissions and emergency room usage are reduced. Only time will tell how utilization patterns and cost trends change over time for the larger population.

#### 4. Consumer Self-Direction

Even the highest quality provision of care to individuals with MCC alone will not guarantee improved health outcomes for this population. Individuals must be informed, motivated, and involved as partners in their own care. Self-care management can be important in managing risk factors that lead to the development of additional chronic conditions.

Consumer Self-Direction (CSD) focuses on most cost-intensive populations – the chronically ill – by supporting an individualized plan of care to improve social and health outcomes. It is a service model that empowers eligible members by providing choice and control over the services they receive while living at home. Consumer direction transfers decision and service management authority from state employees and traditional agencies to participants and their families. The key to CSD is an individualized

budget, tailored to meet individual needs, that allows the consumer a wide range of hiring and purchase power within authorized limits. CSD initiatives include:

- Resources allocated to meet the specific needs of the consumer/patient (a budget),
- Ties spending to expressed needs and quality of services and not to quantity,
- Removes barriers patients/consumers face to effective treatment and management of chronic illness,
- Streamlines administrative health care costs and unnecessary spending,
- Rebalances information, knowledge and freedom in direction of consumer and his/her case manager; and,
- Introduces new market dynamics and customer-focused incentives as money follows the consumer.

The origins of consumer-directed services in the United States date back to the 1950s, although consumer direction programs were rare during most of the 20<sup>th</sup> century. In the 1990s, consumer direction was promoted at the federal level thanks to a combination of advocacy and research demonstrating the positive program outcomes. In 1998, the Robert Wood Johnson (RWJ) Foundation with the Federal government to fund the first round of Cash and Counseling Demonstration and Evaluation grants in three states: Arkansas, Florida, and New Jersey. These Cash and Counseling programs allowed Medicaid consumers with developmental and physical disabilities as well as older adults to use their budgets to hire their own providers and purchase a variety of goods and services. The demonstration was designed as an experiment to compare recipients of consumer-directed services to recipients of traditional services. The Cash and Counseling model was so successful that the RWJ Foundation later expanded the program to 11 additional states. In 2008 the Federal Administration on Aging and the Veterans Administration, began providing grant awards to states for Community Living Programs, using consumer direction for elders and veterans. Most recently, the CLASS Act, included in the US's Health Care Reform legislation (PPACA), utilizes consumer direction as a service option beginning in 2015.

The development of self-directed care in the United States has been to a great extent mirrored by developments in made in the European long-term care marketplace. The study of a US-based health care monitoring foundation The Commonwealth Fund states that over the past decade there has been an international trend towards consumer-directed care<sup>39</sup>. In addition, in recent years, there has been increased interest in extending self-directed care into other health services areas as a way of increasing patient-centered care.

Consumer-directed care uses a variety of names internationally. In England the program is referred to as direct payments or individual budgets. In the Netherlands and Germany, it is called personal budget. Germany also uses the term cash payments for care. In these countries, self-directed care is

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<sup>39</sup> Alakeson, V. 2010. *International Developments in Self-Directed Care*. U.S. Department of Health and Human Services. [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Feb/1370\\_Alakeson\\_intl\\_devel\\_selfdirected\\_care\\_ib\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Feb/1370_Alakeson_intl_devel_selfdirected_care_ib_v2.pdf) (accessed 03/14/2011).

offered as an option to individuals who are eligible to receive publicly funded long-term care services. Eligibility for adults is based on a combination of severity of functional impairment and level of income and assets. Children's eligibility may be determined by severity alone without taking family income into consideration, as in the Netherlands.

Countries pursuing SDC (have tended to adopt one of two models<sup>40</sup>:

1. **A cash payment for care** (in countries such as Germany and Austria), provided to those eligible for long-term care services. The cash allowance can be spent however the recipient chooses and the money does not have to be accounted for. The only restriction is that individuals receiving the allowance and their relatives must ensure that adequate care is obtained. The well-being of the care recipient is reviewed every three to six months. If care is deemed insufficient, the cash allowance is withdrawn in favor of services provided by a home care agency. In practice, the majority of the cash allowance goes to pay informal caregivers.
2. **The budgeted or planned model** (which was adopted initially in England, the Netherlands, and the United States) maintains a more direct connection between a participant's needs and the goods and services purchased to meet those needs. This model tends to follow a three-step process: development of an individualized budget, planning for services, and budgeted funds are transferred to the consumer for expenditure. Once an individual has completed a spending plan, payments are made directly by the financial management organization and requests for payment are only fulfilled if they accord with an approved spending plan.

Despite significant differences in programs across US and EU examples, evaluations reveal a consistently positive picture. Chronic disease self-care management programs have generated a significant evidence-base. While quality and consumer satisfaction increases, there also appears to be a positive impact on costs. The initial 1998 Cash and Counseling program comparing self-directing consumers to consumers receiving traditional services in New Jersey, Alabama, and Florida found that self-directing consumers had lower acute care costs than consumers receiving additional services.<sup>41</sup> A 2010 study on the In-Home Supportive Services (IHSS) program in California, which provides care for more than 430,000 consumers who are elderly or disabled, also found that consumer direction is less expensive than traditional care for consumers at the greatest risk of institutional placement.<sup>42</sup> The study acknowledged that even for consumers with less acute needs for whom the program may not have been cost effective, the program still had the benefit of increasing their quality of life significantly.

During the first two years of the initial consumer direction program in Massachusetts, the cost of serving 100 consumers who enrolled from community programs decreased an average of 15 percent when compared to costs the year before enrollment.<sup>43</sup> More recently, consumer-directed programs in Virginia,

<sup>40</sup> Alakeson, V. 2010. *International Developments in Self-Directed Care*. U.S. Department of Health and Human Services.

[http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Feb/1370\\_Alakeson\\_intl\\_devel\\_selfdirected\\_care\\_ib\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Feb/1370_Alakeson_intl_devel_selfdirected_care_ib_v2.pdf) (accessed 03/14/2011). p. 2.

<sup>41</sup> Brown, R. et al. 2007. *Cash and Counseling: Improving the Lives of Medicaid Beneficiaries who Need Personal Care or Home and Community Based Services*. Mathematic Policy Research, Inc. p. 55, 71.

<sup>42</sup> Taylor, M. 2010. *Considering the State Costs and Benefits: In-Home Supportive Services Program*. California Legislative Analyst's Office (LAO). pp. 21-22.

<sup>43</sup> Fenton, M. Fox, C. 2006. When Consumers Can Choose, What Do They Choose? Public Partnerships, LLC. Presentation at the 2006 HCBS Waiver/NASUA Conference, Minneapolis, MN.

Tennessee, and West Virginia have dramatic annual growth rates (as great as 90 percent) and one reason states have cited for encouraging this growth is that the programs are significantly more cost effective than traditional community based service models.<sup>44</sup>

Another finding supporting consumer direction is that consumer-directed programs often lead to an increased quality of life for the consumer. When consumers elect consumer direction, they are given the authority to manage at least a portion of their budget. Being able to say how, when, and who performs the services for them is one of the most appealing features of consumer direction for consumers. In the Massachusetts pilot, self-directing consumers experienced significantly greater choice and decision making, and were significantly more likely to feel safe in their homes and neighborhoods than consumers receiving traditional services.<sup>45</sup>

More recent data mirrors earlier findings. In 2007, the Virginia Medicaid program's consumer direction program reported 94 percent consumer satisfaction with the program and 93 percent would recommend the program to a friend. Similarly, a 2008 West Virginia survey yielded a 98 percent satisfaction rate with the consumer direction program.<sup>46</sup> Consistently low dropout rates coupled with continued new enrollments also speak to high levels of consumer satisfaction, since most consumers are eligible for other waiver or state plan programs.

Consumer directed care results are not just an American phenomenon. In the Netherlands, for example, 17 percent of total funds allocated to individual budgets went unspent in 2005, showing that individuals are less apt to waste money when they are responsible for it. In England, long-term care services purchased directly by individuals have been shown to cost between 20 percent and 40 percent less than the equivalent services provided by local government.<sup>47</sup>

## 5. Conclusion

While the Polish and American health care systems differ in numerous ways, there are lessons that Polish policymakers can learn from the US's experience developing care management models for the MCC population. Some of these lessons include:

- Keep the patient at the center of the care decisions – educate patients to become more informed and active participants in their care.
- Measure quality – defining quality and determining how it will be measured are important steps to ensure proper use of public funds.
- Invest in Information Technology (IT) – data is central to properly measuring the health care system's performance. Investment should be made at the individual provider level so as to create an electronic record system for more coordinated care, and investment should be made at the

<sup>44</sup> Public Partnerships, LLC program data.

<sup>45</sup> Human Services Research Institute. 2006. *Benchmarks and Trend in ISO Performance: Annual Quality Report*. Cambridge, MA.

<sup>46</sup> Public Partnerships, LLC, program data.

<sup>47</sup> Alakeson, V. 2010. *International Developments in Self-Directed Care*. U.S. Department of Health and Human Services. [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Feb/1370\\_Alakeson\\_intl\\_devel\\_selfdirected\\_care\\_ib\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Feb/1370_Alakeson_intl_devel_selfdirected_care_ib_v2.pdf) (accessed 03/14/2011). p. 4.

policymakers level so that program efficiency and effectiveness can be measured and appropriate rates be developed to achieve policy goals.

- Incentive provider and patient behavior through proper payment methodologies – there is no one methodology that works for all models. Likely a mix of grant funding and payments for specific services can be used to create the right incentives.
- Learn from other models of care – the US examples cited in this paper highlight the iterative nature of developing models of care that meet the needs of the MCC population. Policymakers can learn from this US experience, and the experiences of other EU nations, in developing models of care that suit the Polish health care system.

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