
U.S. and German Case Studies in Chronic Care Management: An Overview

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In December 2004, the Bertelsmann Stiftung, The Commonwealth Fund, and AcademyHealth jointly sponsored a conference in Berlin, Germany on “Case Studies in Chronic Care Management.” This conference assembled representatives from the U.S. and German Governments, several organizations that had developed chronic care management initiatives in the two countries, and other health care and policy experts to discuss clinical, organizational, and financing issues. The case studies discussed at the conference are presented in this issue of the Review; this article describes some relevant considerations that are common to the U.S. and German health systems.

OVERVIEW

The differences between the U.S. health care system and those of other industrialized countries are well established, but attention primarily has focused on the higher level of spending in the U.S., the reasons that the U.S. spends more, and the absence of better quality of care corresponding to the high level of spending (Anderson et al., 2005). These are all significant issues, but an important aspect of international comparisons is to identify common problems in different countries and how each of these countries deals with these problems. Several recent studies have focused on these similar problems across countries, which open the door to

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developing common approaches to improving the quality of health care (Hussey et al., 2004; Schoen et al., 2004).

The Berlin conference on Chronic Care Management brought together a group of officials representing policymaking organizations¹ in the U.S. and Germany and individuals who participated in the planning and implementation of chronic care management initiatives in the two countries. The conference participants discussed those initiatives and their experiences, and were able to identify common features and dimensions along which the two countries differ and the lessons that can be drawn from them, and discuss their implications for policies to improve health care in both countries.

This overview provides a context for those articles, by describing some relevant considerations that are common to the U.S. and German health systems, and how the two countries can learn from the experiences related in the case studies. This overview concludes by describing how the issues raised by the German case studies, which included initiatives developed by both public and private organizations, and the U.S. case studies, all of which described initiatives in the private sector, can be applied to the context of the U.S. Medicare Program.

¹The Bertelsmann Stiftung aims to identify social problems in a broad range of areas and use and generate knowledge and expertise to develop and implement model solutions; the Commonwealth Fund has a mandate to promote a high performing health system by supporting independent research on health care issues and makes grants to improve health care practice and policy; and AcademyHealth supports health services research promoting its use in public and private decision-making.

SHIFTING NEEDS OF AN OLDER POPULATION

The U.S. and Germany, as well as other industrialized countries, share a problem that puts health care at the center of social concerns and at the same time makes it an evolving issue, and therefore more difficult to deal with: Populations in these countries are getting older and, as they age, the prevalence of chronic conditions is increasing. The proportions of the U.S. and German populations age 65 or over are projected to increase by 33 and 32 percent, respectively, in the first 20 years of this century (Anderson and Hussey, 2000). Longer life, combined with advances in treating acute illness, means that chronic conditions are more common. A recent study by Wolfe et al. (2002) found that 82 percent of Medicare beneficiaries have at least one chronic condition (such as asthma, arthritis, diabetes, or hypertension), and 65 percent have multiple chronic conditions. The same study found that beneficiaries with four or more chronic conditions are 99 times more likely to experience one or more potentially preventable hospitalization than those without any chronic conditions, and that this group accounts for the bulk of Medicare spending each year, averaging almost \$14,000 per beneficiary, compared with a little over \$200 per beneficiary with no chronic conditions.

Exacerbating the growing needs faced by older populations with more chronic illnesses is the fact that the health care financing systems in most industrialized countries were designed to address acute care needs. Until relatively recently, health insurance was designed primarily to defray the cost of hospital stays, because that was the dominant category of health care spending. That is rapidly becoming less true: in 1980, spending on hospital care

accounted for 47 percent of all personal health care expenditures in the U.S.; by 2003, that proportion had fallen to 36 percent (Centers for Medicare & Medicaid Services, 2005). Although hospital care still is the single largest category of health spending (even for people with chronic conditions), and it grew at a fairly robust rate of 7.3 percent per year between 1980 and 2003, other personal health spending grew at a much greater rate of 9.6 percent per year.

The challenge is to align the health care financing and health care delivery systems with the demographic changes that have shifted needs toward chronic conditions. Certainly, acute care needs are not a relic of the past, but the growing need for chronic care has not been adequately addressed by the health care system, either in the U.S. or in Germany. As cited in one recent study: "Care for chronic illnesses has become the most common reason why Americans seek medical care" (Anderson and Knickman, 2001).

DEVELOPMENT OF CHRONIC CARE IN THE TWO COUNTRIES

Although the population trends that have created the need for better chronic care approaches are common to the U.S. and Germany, the health care systems in the two countries are very different and, consequently, the way that the programs described in this issue evolved and how they are applied are different.

U.S.

In the U.S., the growth of managed care in the 1990s focused attention on better coordination of care as a way to control costs and improve care. In theory, the traditional managed care model should be at its best in addressing the needs of an

increasingly chronically ill population, with the emphasis on preventive and primary care and the requirement that care be explicitly coordinated by a physician gatekeeper. It was commonly accepted that the traditional fee-for-service (FFS) financing mechanism did not encourage the coordination of care, because it made no payment available to compensate for the resources required for such care. In fact, the time spent coordinating care took away from the time that could be spent providing more services that were well-compensated. In addition, procedures and specialists' services receive more generous payment, which discourages physicians from going into the primary care fields that are more compatible with the role of care coordination. Moreover, FFS payment encourages the treatment of individual conditions by individual providers, while many people with chronic conditions have multiple chronic conditions, which can be exacerbated (or at least not helped) by this type of specific-condition oriented care.

However, several aspects of the financing mechanism that developed around and became an integral part of the managed care model also were incompatible with the original vision of coordinated care as it applies to chronically ill enrollees. Although capitation (a fixed payment per plan enrollee per month) should provide a strong incentive to help chronically ill enrollees manage their conditions and avoid expensive hospital stays, it also provides an even stronger incentive to avoid chronically ill enrollees in the first place. Chronically ill enrollees are much more costly than the average enrollee, and the payment rates that managed care plans receive rarely are adequately adjusted for the higher anticipated costliness of some types of individual enrollees. This lack of adequate risk adjustment means that plans

face potentially severe financial penalties for making themselves attractive to chronically ill populations.

Moreover, in the case of Medicare, which has a much higher proportion of chronically ill beneficiaries than do private plans that cover the working population, managed care plans were (until 2006) prohibited from specializing in subsets of the population. Consequently, a plan that was designed to be particularly well-suited to treating beneficiaries with a particular condition or cluster of conditions (such as congestive heart failure or asthma and other chronic respiratory conditions) also had to be prepared to offer the full range of services to the entire beneficiary population, which it might not have been prepared to do.²

Some managed care plans persisted in attempting to develop ways of providing more appropriate care to their chronically ill enrollees. Many of these efforts involve third-party organizations that are contracted to provide services to specific sets of enrollees; this has become a flourishing industry.³

Despite the decline of the traditional indemnity insurance model in the U.S., most people are still treated under an arrangement that involves FFS payment to their providers. The prevalence of the traditional managed care model that was anticipated in the early 1990s has not materialized. In Medicare, this is true to an even greater extent, as 87 percent of Medicare beneficiaries remain in the traditional FFS program, with only 13 percent enrolled in managed care arrangements offered by private plans (U.S. Congressional Budget Office, 2005).

² The Medicare Modernization Act (MMA) of 2003 allows Special Needs Plans (SNPs) to participate in the Medicare Program beginning in 2006. However, their payment rates will be only partially risk adjusted until 2007, so SNPs will be only partially compensated for the often higher anticipated costliness of their targeted enrollee populations.

³ A quick query of the Disease Management Association of America's (2005) Web site produced a list of 46 different disease management organizations.

Germany

Unlike the U.S., in which health insurance for the working population is acquired (or not) with minimal government intervention, Germany has mandatory health insurance through its sickness funds for every worker whose income is below a specified level, and for certain other groups; 88 percent of the population is covered by this statutory health insurance—74 percent through the mandatory requirement, and another 14 percent voluntarily.⁴

Until 1996, people insured through the statutory health insurance generally had no choice of which sickness fund to join; they were assigned to a fund based on their residence or job. As a result, each sickness fund's enrollees were, by definition, representative at least of the groups who were assigned to them, and risk selection on an individual basis was not a problem. However, when workers could choose the fund in which they enrolled, two things happened: the sickness funds could (and had to, in order to survive) compete with one another, so they had to start paying attention to the cost of providing care to their enrollees; and enrollment in each sickness fund no longer would necessarily be representative of any larger population, nor would it necessarily be stable from year to year. A risk structure compensation (RSC) scheme was devised to adjust, at least in part, for the potential for selection across plans, but competitive pressures and persistent differences in the risk profiles of the individual sickness funds were a continuing concern.

In 2001, legislation was passed to address the increasing variation in the risk pool, the disincentives to enroll chronically ill people, and the inability to develop more integrated approaches to providing care

for the population. The legislation provided for a two-stage improvement in the RSC: in 2002, incentives would be in place for the sickness funds to develop approaches to coordinate care for chronically ill enrollees; and in 2007, the RSC would be improved by incorporating additional morbidity factors (similar to the risk-adjustment mechanism that has been phased in over the past decade in the Medicare Program in the U.S.).

Common Issues

In both the U.S. and Germany, the increased attention to the growing population with chronic conditions has spawned the development of multiple initiatives in coordinated care and disease management. The case studies presented in this issue provide some examples of how those initiatives have approached several considerations related to chronic care management. These include:

- **Selection of Conditions on which to Focus**—Some conditions may be more amenable to chronic care management approaches and some less. Also, because many people with chronic conditions have more than one such condition, strategies must deal with the whole person, and not just the specific condition. Better coordination of care for a subset of the patient's several conditions may not be better coordination at all.
- **Selection of Individuals on whom to Focus**—This issue has at least two dimensions: first, it may be difficult to identify individuals with specific chronic conditions from easily accessible data; second, different approaches may be more or less effective for different types of individuals, based on both clinical and personal attributes.
- **Interaction with Providers**—Physicians may be reluctant to deal with what they

⁴ Much of the discussion in this section is based on Busse, 2004; he was a participant at the Berlin conference.

perceive as third-party interference in their practices and with their patients, but the involvement of the physician is crucial in identifying and connecting with the patient, securing the patient's compliance in managing his or her condition, monitoring the patient's progress and needs, and coordinating care among what are likely to be several primary care providers.

- **Financial Incentives**—Again, this issue has multiple dimensions: as previously described, the current health care system not only fails to encourage appropriate coordination of care for chronically ill people, but in fact discourages such coordination; the necessity and ability not only to remove existing financial barriers, but actually to provide payment targeted at appropriate behavior, must be considered.
- **Individual Versus Population-Based Approaches**—The current tendency is to address the needs of individual people. Even when the presence of multiple conditions is accounted for, the effects of chronic care management are most likely to be apparent at a population level, rather than for each individual. Development and evaluation of policies from this broader perspective may produce better and more effective approaches.

CHRONIC CARE INITIATIVES AND THE MEDICARE PROGRAM

Prospects for Disease Management in Medicare

In a study reviewing the literature on disease management programs, the U.S. Congressional Budget Office (CBO) (2004) concludes that “while there is evidence that disease management programs could be designed to reduce overall health costs

for selected groups of patients, little research exists that directly addresses the issues that would arise in applying disease management to the older and sicker Medicare population.” The CBO report presents results from studies of private sector initiatives (in the U.S), which indicate that, although such programs may in fact improve health care processes, they do not generally reduce costs.

Although the CBO report is not optimistic about the ability of disease management approaches to reduce Medicare spending, the following three considerations should give heart to proponents of such approaches:

- Unlike the younger population, on which the initiatives cited by CBO were focused, the Medicare population contains a much higher proportion of people with chronic conditions. This has two implications favorable to Medicare: (1) it is easier to identify beneficiaries who could benefit from chronic care initiatives, because they are a larger group (so fewer resources are required to find them); and (2) because beneficiaries with chronic conditions account for the bulk of Medicare spending each year, both the potential savings from improved coordination of care and the amount of resources available with which to attempt to achieve those savings is immense.
- Also unlike the younger population, which obtains insurance through their employers and can move among different insurers depending on the arrangements made by those employers and their tenure in particular jobs, almost all of the Medicare population will have coverage through that program for the rest of their lives. That means that in contrast to private insurers, Medicare stands to appreciate even longer-term savings

from better coordination of chronic care.

- Finally, even if there are no savings to be obtained from better coordination of care for the chronically ill, improvements in the process of health care for this population is a worthy objective in itself. Remember that the underlying purpose of the Medicare Program specifically, and the health care system in general, is not to save money, but to improve the health status of the population. If a specific initiative or set of initiatives can accomplish this, we are getting more for our money, which certainly is important in budgetary considerations.

Another CBO report (2005) found that high Medicare costs are very consistent over time for individual beneficiaries: for beneficiaries who were among the top 25 percent of the Medicare population in 1997 (a group that accounted for approximately 85 percent of total Medicare spending), almost one-half were also in the top 25 percent in the following year. They also find that “More than 75 percent of high-cost beneficiaries were diagnosed with one or more of seven major chronic conditions in 2001. More than 40 percent of high-cost beneficiaries had coronary artery disease, and about 30 percent had each of three other conditions—diabetes, congestive heart failure, and chronic obstructive pulmonary disease.”

Medicare Demonstrations

Recognizing the potential both to improve care for a population that is not well-served by the incentives embedded in FFS payment, CMS has developed and is conducting several initiatives aimed at testing how chronic care can be improved for Medicare beneficiaries. The first of these is the Medicare Coordinated Care Demonstration, which was mandated by Congress in the Balanced Budget Act of 1997. This

project was designed to test whether providing coordinated care services to Medicare FFS beneficiaries with complex chronic conditions can yield better patient outcomes without increasing program costs. The project originally involved 15 sites in both urban and rural areas in 16 States, focusing on various chronic conditions. Enrollment in these programs began in April 2002, and there are about 15,000 enrollees including the control group. Although the original terms of the demonstration has ended, most of the sites have been continued until more complete evidence can be collected and analyzed on their performance.

The Medicare Disease Management Demonstration, mandated in the Benefits Improvement and Protection Act of 2000, provides disease management for up to 30,000 eligible beneficiaries, as well as a comprehensive drug benefit. This project, which began in spring 2004, will provide the first indication of how well prescription drugs can be used to help chronically ill beneficiaries in the context of the Medicare Program. The three sites—California/Arizona, Texas, and Louisiana—will be at risk for higher Medicare spending among their enrollees.

The Physician Group Practice Demonstration began in April 2005 and involves 10 large, multispecialty physician groups that will receive bonus payments for improving the coordination of care for their patients. The size of the bonus will depend on savings on total Medicare spending compared to costs for other beneficiaries in the same areas, subject to improvement according to several quality measures to be collected during the project.

Another demonstration awaiting final approval is the End-Stage Renal Disease Management Demonstration, which will provide a per beneficiary per month payment to organizations that will be responsi-

ble for coordinating not only the dialysis services received by end stage renal disease patients, but all Medicare services, to which these patients are entitled by virtue of their condition. These beneficiaries are high users of medical care because they tend to have multiple medical problems, and are in great need of better coordinated and less fragmented care for their conditions.

Another project in development is the Medicare Care Management Performance Demonstration, which was mandated in the 2003 MMA. This project will provide financial incentives to physicians who improve their office systems including health care information technology, and use those improvements to more effectively coordinate care for selected groups of chronically ill Medicare patients. It will provide a direct link between health care information technology, chronic care management, and financial incentives in the physician office setting.

Medicare Health Support

A major initiative mandated in the MMA is the Medicare Voluntary Chronic Care Improvement Program, now known as Medicare Health Support. This pilot program, which was implemented in eight sites by late 2005, will involve about 180,000 beneficiaries in nine sites around the U.S. with high prevalence of diabetes and congestive heart failure. The participating organizations will be responsible for increasing adherence to evidence-based care and reducing unnecessary hospital stays and emergency room visits in an entire geographic area.

The Care Management for High-Cost Beneficiaries Demonstration which is awaiting final approval, will study various care management models and is similar in concept to the Medicare Health Support

Program, explicitly designed to use provider-centered, rather than third-party models of chronic care management.

CONCLUSIONS

The changing demographics of the populations in industrialized countries around the world are shedding new light on the needs of the chronically ill, and putting new pressure on health care delivery and financing systems—regardless of their location or their underlying structure—to devise better ways of coordinating care. The case studies presented in this issue of the *Review* are examples of some creative initiatives that have been implemented in the U.S. and Germany. Although the contexts for these initiatives may vary, they have a great deal in common, and health policymakers in the U.S. and Germany (and other countries) can learn from the information presented in these articles and from further information that will be forthcoming as those initiatives mature and their results becomes available.

The Berlin conference was extremely valuable in that key people in the public and private sectors in both countries could exchange thoughts and ideas about how to improve health care for the chronically ill, what factors went into the design of these programs, and what considerations may be relevant in evaluating their performance. The hope is that, with the information presented in this issue, we might achieve greater understanding of the problems we face and how they might be addressed, so that we can be in a better position than before to address these problems.

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