



Chronic Care Management Pilots Show Early Promise

Controlling Medicaid costs and improving health outcomes

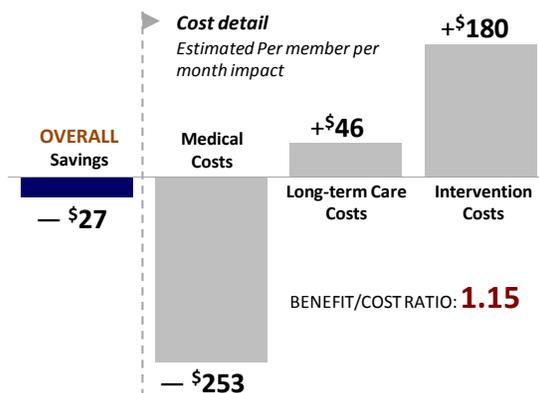
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The Chronic Care Management (CCM) program administered by the DSHS Aging and Disability Services Administration provides high-risk clients with enhanced nurse care management services in five pilot sites across Washington State. This briefing paper examines 22-month follow-up impacts on Medicaid costs and mortality for CCM clients, relative to a randomized waiting list control group. Due to the relatively small number of clients enrolled in the pilot and the extreme variability of costs among high-risk Medicaid patients, the findings summarized here did not achieve standard levels of statistical significance. However, the results show promising potential to improve health outcomes and control costs for patients with high medical risk and major functional limitations.

Key Findings

- CCM enrollees were less likely to have inpatient hospital stays involving emergency room activity. The overall estimated medical cost savings were \$253 per month enrolled in CCM.
- Nursing facility costs were lower and in-home care costs were higher for CCM enrollees. Overall long-term care costs were \$46 per month higher for clients enrolled in CCM, excluding pilot costs.
- Including the \$180 per month cost of enrollment in CCM, the program is estimated to have generated a small net savings of \$27 per month of enrollment.
- CCM enrollees were less likely to die in the 22-month follow up period. However, mortality impacts that were statistically significant at the 10-month follow-up have moderated over time.

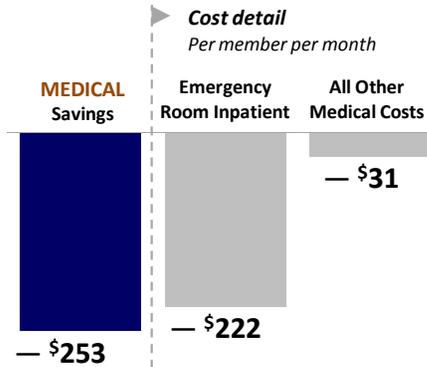
KEY FINDING | Early outcomes are promising



We analyzed outcomes for 233 clients offered enrollment in the CCM pilots in 2007, relative to 527 clients randomized to a waiting list. Of the clients offered enrollment, 87 clients enrolled in CCM, with an average enrollment period of 16 months. The cost impact analyses used an intent-to-treat difference-of-difference design that compared changes in costs over time between all clients randomized to the group offered treatment and all clients randomized to the waiting list.

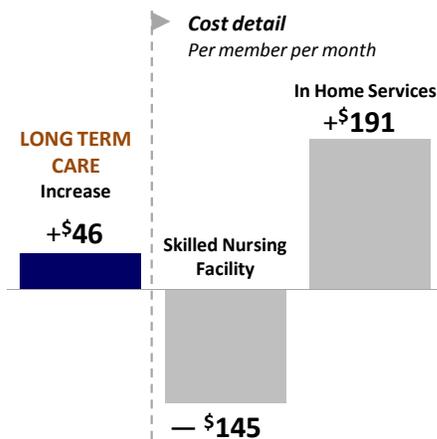


FINDING 1 | CCM enrollees have lower medical costs



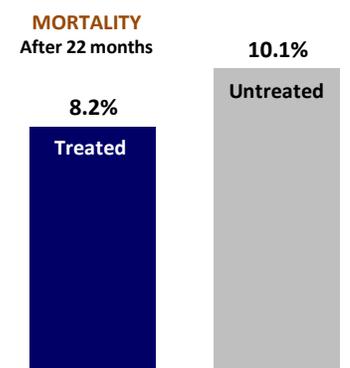
We compared changes in medical costs for clients offered the choice of enrolling in CCM services with changes in medical costs for clients randomized to the waiting list. Changes in per member per month medical service costs were measured from the February 2006 to January 2007 “pre period”, relative to the 22-month March 2007 to December 2008 “post period”. Estimated medical cost savings were \$253 per month enrolled in CCM, after translating the estimated savings from the intent-to-treat model to impacts per treated client per month enrolled. Medical savings were due almost entirely to a \$221 per member per month reduction in inpatient hospital admissions associated with emergency department activity.

FINDING 2 | CCM enrollees have lower nursing facility costs, higher in-home care costs



CCM clients showed a tendency toward reduced use of skilled nursing facility services, with an estimated reduction of \$145 per month enrolled in the CCM program. Balanced against this reduction was an offsetting increase in use of in-home care of \$191 per month enrolled in the CCM program. Taken together, long-term care costs increased by \$46 per client per month of enrollment in chronic care management. The CCM intervention cost of \$180 per client per month of enrollment is not included in this calculation.

FINDING 3 | CCM enrollees were less likely to die in the follow-up period



Clients randomized to the “offered treatment” group were somewhat less likely to die in the 22-month follow-up period than clients randomized to the waiting list. Previously reported impacts on mortality at the 10-month follow-up point showed that CCM clients were significantly less likely to die than members of the control group, but the strength of this impact has moderated over the longer follow-up period.

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Copies of this paper may be obtained at www.dshs.wa.gov/rda/ or by calling DSHS’ Research and Data Analysis Division at 360.902.0701. Please request REPORT NUMBER 8.28