Evaluation of Care and Disease Management Under Medicare Advantage Survey
Crosswalk Document and Track Changes Document
CMS-10255

The changes are detailed below.

1) For questions B9 and C10 about how plans proactively identify members who need care or disease management, the instructions over the answer categories have been changed from "MARK ONE" to "MARK THE MOST COMMON". There was a comment on providing the ability to check all that apply instead of only one because it is different for different methods and the commentor's organization used them all. In response to this comment we changed the instructions to collect only the most common frequency, as allowing respondents to check all that apply could potentially dilute the value of information captured by this question. This change should not increase respondent burden.

2) A new question B10a has been added after question B10:

B10a. Do care managers serve only members covered under this (Medicare) contract, or do they also serve members covered under other (non-Medicare) contracts?

1 ☐ Care managers serve only members with Medicare

2 ☐ Care managers also serve younger members covered under commercial contracts or other non-Medicare covered members

This question was added because it is important that care managers understand the needs of elderly people in general and not just those covered under the MA contract. There was a comment to "Include a question at this point on whether the case managers are dedicated to Medicare or a geriatric population or do they also manage employed commercial populations." This change and the one below should add about one minute to respondent burden. This estimate is based on the questionnaire having about 100 questions and 45 minutes of burden or about one half minute per question. We recommend that the burden estimate remain at 45 minutes given the large variance in the average with interviews ranging from 20 and 120 minutes and only nine cases used to compute the average.

3) A new question has been added which is similar to B10a above except it is about disease management staff.

After C11 question C11a was added:

C11a. Do disease managers serve only members covered under this (Medicare) contract, or do they also serve members covered under other (non-Medicare) contracts?

1 ☐ Disease managers serve only members with Medicare

2 ☐ Disease managers also serve younger members covered under commercial contracts or other non-Medicare covered members

The justification for this change is the same as for new question B10a above.

OMB No.: XXXX-XXXX
Expiration Date: XX/XX/20XX

MATHEMATICA
Policy Research, Inc.

MPR ID Number: |__|__|__|__|__|__|__|__|__|__|

Medicare Advantage Contract Number: |__|__|__|__|__|

Evaluation of Care and Disease Management under Medicare Advantage

Mail Survey

April 2, 2008 ~~***December 17, 2007***~~

Draft

OVERVIEW AND IMPORTANT INSTRUCTIONS: *PLEASE READ*

This survey has been designed to collect information on care and disease management programs provided by Medicare Advantage contractors. The survey is being conducted for the Centers for Medicare & Medicaid Services (CMS) by Mathematica Policy Research, Inc. (MPR).

Individual responses to this survey will be kept confidential. Answers from all responding contract holders will be tabulated and provided to CMS in aggregate form only. Responses will not be linked to individual contracts, plans, or respondents.

OVERVIEW OF THE SURVEY

The first section (A) of this survey asks a few questions about the contract holder's arrangements with providers and the maintenance of member-level electronic data.

Sections B and C ask about care and disease management interventions with members, respectively. For the purposes of this survey we draw the following distinction between care management and disease management:

> First, **care management**, sometimes referred to as care coordination, case management, or complex case management. For the purposes of our survey, by care management we mean:
>
> A group of services for members who have multiple medical or behavioral health conditions or who are medically complex. It often involves assigning a member to a single staff person or team to monitor the member's clinical care and services, to assist with transitions between care settings, and to help the member access needed health and support services.
>
> By contrast, by **disease management** we mean:
>
> Services that: teach members how to adhere to their physicians' treatment plans; monitor member clinical status and adherence to treatment recommendations; and monitor provider adherence to evidence-based practice guidelines. Disease management is typically targeted to members with specific chronic diseases, such as heart failure or diabetes. Such diseases often have complex treatment regimens, and maintaining adherence requires the sustained efforts of patients and physicians.

Section D asks about care and disease management interventions with physicians.

Section E asks contractors operating Special Needs Plans (SNPs) to compare care and disease management programs under the SNP with programs offered under regular Medicare Advantage plans.

Section F asks how your organization assesses the effectiveness of its care and disease management programs.

INSTRUCTIONS

1. Please answer only about the care or disease management programs provided under the contract with Medicare specified on the cover to this document.

2. If your organization contracts out some or all of its care or disease management services (for example, to a disease management vendor), please answer questions both in terms of your organization AND others with whom you contract.

3. We recognize that some contract holders may view their care and disease management services as a single program. If this is the case for your organization, we nevertheless request that you make the operational distinction inherent in the working definitions provided above, and answer both survey sections B and C.

4. All questions in this document refer to the **current** status of your Medicare Advantage contract, unless otherwise noted.

5. When questions refer to interactions with "members" please also include members' health care decision makers, as appropriate.

6. When filling out this questionnaire, always proceed to the next question unless special instructions tell you to go elsewhere.

7. Most questions can be answered by simply placing a check mark in the appropriate box. For a few questions you will be asked to write in a response. Feel free to elaborate on any responses in the questionnaire margins or to provide additional thoughts or documentation about your program at the end of the questionnaire.

8. Please return the completed questionnaire **within the next two weeks** in the enclosed return mail envelope to Mathematica Policy Research, Inc., P.O. Box 2393, Princeton, New Jersey 08543-2393, ATTN: Todd Ensor, or fax it to (609) 799-0005. If you have any questions, please call Todd Ensor at (609) 275-2326.

PLEASE FILL IN:

TODAY'S DATE: |__|__| / |__|__| / |__|__|__|__|
MONTH DAY YEAR

YOUR NAME AND TITLE:_____ _____

WORK TELEPHONE NUMBER/EXT.:(|__|__|__|)-|__|__|__|-|__|__|__|__|-|__|__|__|__|

YOUR E-MAIL ADDRESS:_____@_____

Section A:	Background on Provider Arrangements and Electronic Data Systems

A1. For this Medicare Advantage contract, please check whether each of the following types of arrangements with *primary care* physicians represents a majority, a minority, or is never used by your organization.

MARK FOR EACH TYPE OF ARRANGEMENT

Primary Care Physicians	Majority	Minority	Never Used	Don't Know
a. Hiring staff physicians.....	1 ☐	2 ☐	3 ☐	4 ☐
b. Contracting directly with individual physicians.....	1 ☐	2 ☐	3 ☐	4 ☐
c. Contracting for physician services through a medical group	1 ☐	2 ☐	3 ☐	4 ☐
d. Contracting for physician services through an Individual Practice Association (IPA)	1 ☐	2 ☐	3 ☐	4 ☐
e. Contracting for physician services through a Physicians Health Organization (PHO) or Integrated Delivery Service (IDS)	1 ☐	2 ☐	3 ☐	4 ☐
f. Please list and rate other types of contracting arrangements	1 ☐	2 ☐	3 ☐	4 ☐

_____

_____

A2. For this Medicare Advantage contract, please check whether each of the following types of arrangements with *specialty care* physicians represents a majority, a minority, or is never used by your organization.

MARK ONE FOR EACH TYPE OF ARRANGEMENT

Specialty Care Physicians	Majority	Minority	Never Used	Don't know
a. Hiring staff physicians.....	1 ☐	2 ☐	3 ☐	4 ☐
b. Contracting directly with individual physicians.....	1 ☐	2 ☐	3 ☐	4 ☐
c. Contracting for physician services through a medical group.....	1 ☐	2 ☐	3 ☐	4 ☐
d. Contracting for physician services through an Individual Practice Association (IPA).....	1 ☐	2 ☐	3 ☐	4 ☐
e. Contracting for physician services through a Physicians Health Organization (PHO) or Integrated Delivery Service (IDS).....	1 ☐	2 ☐	3 ☐	4 ☐
f. Please list and rate other types of contracting arrangements.....	1 ☐	2 ☐	3 ☐	4 ☐

_____

A3. Which of the following types of providers share financial risk with your plan? *(Please exclude pay for performance arrangements here; these are addressed in A4.)*

MARK YES OR NO FOR EACH	Yes	No
a. Physicians	1 ☐	0 ☐
b. Hospitals	1 ☐	0 ☐
c. Nursing homes	1 ☐	0 ☐
d. Home health agencies	1 ☐	0 ☐
e. Pharmacy benefit manager (PBM)	1 ☐	0 ☐
f. Disease or care management vendor	1 ☐	0 ☐
g. Please list other types of providers	1 ☐	0 ☐

_____

A4. For which types of providers are payments adjusted based on attaining care quality or efficiency goals (sometimes referred to as "pay for performance or P4P")?

MARK YES OR NO FOR EACH	Yes	No
a. Primary care physicians	1 ☐	0 ☐
b. Specialty physicians	1 ☐	0 ☐
c. Hospitals	1 ☐	0 ☐
d. Nursing homes	1 ☐	0 ☐
e. Home health agencies	1 ☐	0 ☐
f. Pharmacy benefit manager (PBM)	1 ☐	0 ☐
g. Disease or care management vendor	1 ☐	0 ☐
h. Please list other types of providers	1 ☐	0 ☐

_____

A5. Which of the following types of member-level electronic data are directly maintained by your organization?

MARK YES OR NO FOR EACH	Yes	No
a. Enrollment or disenrollment dates	1 ☐	0 ☐
b. Service use or charges	1 ☐	0 ☐
c. Prescription drug use or charges	1 ☐	0 ☐
d. Procedure codes, such as CPTs	1 ☐	0 ☐
e. Clinical indicators, such as lab test results	1 ☐	0 ☐
f. Quality-related process of care information, such as receipt of prevention screening or immunizations	1 ☐	0 ☐
g. Assessments or care plans	1 ☐	0 ☐
h. Please list other types of member-level electronic data your plan maintains	1 ☐	0 ☐

_____

For the purposes of this survey we draw the following distinction between care management and disease management:

By **care management** (sometimes referred to as care coordination, case management, or complex case management) we mean:

A group of services for members who have multiple medical or behavioral health conditions or who are medically complex. It often involves assigning a member to a single staff person or team to monitor the member's clinical care and services, to assist with transitions between care settings, and to help the member access needed health and support services.

By **disease management** we mean:

Services that: teach members how to adhere to their physicians' treatment plans; monitor member clinical status and adherence to treatment recommendations; and monitor provider adherence to evidence-based practice guidelines. Disease management is typically targeted to members with specific chronic diseases, such as heart failure or diabetes. Such diseases often have complex treatment regimens, and maintaining adherence requires the sustained efforts of patients and physicians.

Section B asks about care management and Section C asks about disease management. If plans under your contract provide both care and disease management, please answer the questions in both Sections B and C.

Section B: Characteristics of Care Management Programs

B1. Is care management available to members served under this contract? *Please do **not** include as care management short-term or single-event services available to all members, such as pre-admission screening or the services of a health advocate.*

1 ☐ Yes — **Go to B2**

0 ☐ No — **Go to Section C**

B2. Is care management provided by staff employed by the contract holder, a vendor, network providers (such as primary care physicians), or others not directly employed by the contract holder?

MARK ALL THAT APPLY

1 ☐ Contract holder staff

2 ☐ Vendor

3 ☐ Plan network provider

4 ☐ Provided by other non-contract holder staff *(Please specify)*

_____

_____

B3. If NON-contract holder staff provide care management, are they responsible for any of the following?

MARK YES OR NO FOR EACH	Yes	No
a. Initial identification of members for care management	1 ☐	0 ☐
b. Ongoing identification of members for care management	1 ☐	0 ☐
c. Feeding back member data to the contract holder	1 ☐	0 ☐
d. Communicating with other providers that serve members (such as hospitals, nursing homes, or pharmacy benefits managers)	1 ☐	0 ☐
e. None of the above; contract holder staff provide all care management	1 ☐	0 ☐

Remember, if your organization contracts out some or all of its care management services, please answer the remaining questions in Section B both in terms of your organization AND others with whom you contract.

B4. Typically, care management involves direct intervention with members. But it may also involve working with members' physicians (for example, by promoting adherence to evidence-based care guidelines).

Does care management under this contract include patient-oriented intervention, physician-oriented intervention, or both?

MARK ONE

1 ☐ Physician-oriented intervention only — **Go to C1 (the rest of the questions in Section B pertain to interventions with members)**

2 ☐ Member-oriented intervention only — **Go to B5**

3 ☐ Both physician- and member-oriented intervention — **Go to B5**

B5. Approximately what percentage of members who were enrolled under this contract in 2007 used care management (that is, they were directly contacted by care managers)? ***Your best estimate is fine.***

|__|__|__| % Percent using care management in 2007

B6. Please indicate the criteria used to determine member eligibility for care management.

MARK YES OR NO FOR EACH	Yes	No
a. High cost of care or high service use (past or expected in the future).....	1 ☐	0 ☐
b. Specific health events or procedures (such as surgeries).....	1 ☐	0 ☐
c. Gaps in care (such as the lack of needed diagnostic testing).....	1 ☐	0 ☐
d. High prescription drug use.....	1 ☐	0 ☐
e. Functional limitations.....	1 ☐	0 ☐
f. Specific diagnoses or conditions, or medical complexity.....	1 ☐	0 ☐
g. Specific lab values or clinical indicators out of range.....	1 ☐	0 ☐
h. Need for palliative or end-of-life care.....	1 ☐	0 ☐
i. Please list other criteria used to determine eligibility for care management.....	1 ☐	0 ☐

_____

_____

B7. Please indicate the approaches used to <u>identify members</u> for care management.

MARK YES OR NO FOR EACH	Yes	No
a. Claims review or predictive model (based on service or prescription drug use, costs, diagnoses, or procedures).....	1 ☐	0 ☐
b. Clinical or diagnostic data review (including review of Medicare Advantage risk scores).....	1 ☐	0 ☐
c. Provider referral.....	1 ☐	0 ☐
d. Nonclinical staff referral (including customer service or pre-certification staff).....	1 ☐	0 ☐
e. Member self-referral.....	1 ☐	0 ☐
f. Administration of a health risk assessment.....	1 ☐	0 ☐
g. Please list other approaches used to identify members for care management.....	1 ☐	0 ☐

_____

_____

B8. Please indicate the criteria your organization uses to exclude members from care management.

MARK YES OR NO FOR EACH	Yes	No
a. Terminal illness or participation in hospice	1 ☐	0 ☐
b. Dementia	1 ☐	0 ☐
c. End Stage Renal Disease (ESRD)	1 ☐	0 ☐
d. Please list other criteria used to exclude members from care management	1 ☐	0 ☐
e. No exclusion criteria used	1 ☐	0 ☐

_____

_____

B9. How often does your organization (proactively) identify members who may need care management?

~~MARK ONE~~MARK THE MOST COMMON

1 ☐ At enrollment only
2 ☐ Daily
3 ☐ Weekly
4 ☐ Monthly
5 ☐ Several times a year
6 ☐ Annually
7 ☐ Other *(Please specify)*

_____

_____

B10. Please indicate the types of professional staff providing care management under this contract. (Please remember to include any staff NOT directly employed by your organization who provide such care.)

MARK YES OR NO FOR EACH	Yes	No
a. Nurses:		
1. Advance practice nurses	1 ☐	0 ☐
2. Registered nurses	1 ☐	0 ☐
3. Licensed practical or vocational nurses	1 ☐	0 ☐
b. Staff other than nurses:		
1. Social workers	1 ☐	0 ☐
2. Physical, occupational, speech, or respiratory therapists	1 ☐	0 ☐
3. Behavioral health specialists or therapists	1 ☐	0 ☐
4. Pharmacy staff	1 ☐	0 ☐
5. Registered dietician	1 ☐	0 ☐
6. Primary care physicians	1 ☐	0 ☐
7. Please list other types of staff providing care management….	1 ☐	0 ☐

_____

_____

B10a. Do care managers serve only members covered under this (Medicare) contract, or do they also serve members covered under other (non-Medicare) contracts?

1 ☐ Care managers serve only members with Medicare

2 ☐ Care managers also serve younger members covered under commercial contracts or other non-Medicare covered members

B11. Some care management programs formally assign members receiving care management to levels, for example depending on the complexity of the members' problems. Does your care management program have different levels?

1 ☐ Yes — **Please answer questions in the rest of Section B for the care management level to which most members are assigned.** (Continue to B12)

0 ☐ No — Continue to B12

B12. Does care management include a *comprehensive* assessment of member health and health-related needs (for example, an assessment that goes beyond a brief health risk assessment)?

1 ☐ Yes — **Go to B13**

0 ☐ No — **Go to B17**

B13. Please indicate the types of staff who conduct comprehensive assessments.

MARK ALL THAT APPLY

1 ☐ Clinical staff directly employed by or contracted with your organization (such as nurses, social workers, or physicians)

2 ☐ Non-clinical staff directly employed by or contracted with your organizations (such as customer relations or outreach staff)

3 ☐ No staff involved; assessments are self-administered

B14. How is comprehensive assessment data collected?

MARK ALL THAT APPLY

1 ☐ In person with the member or health care decision maker

2 ☐ By telephone with the member or health care decision maker

3 ☐ By mail to the member or health care decision maker

4 ☐ Through records, claims, or prescription-refill review

5 ☐ Please list other sources of or approaches to collecting assessment data

_____

_____

B15. Do care managers develop care plans based on comprehensive assessments?

1 ☐ Yes — **Go to B16**

0 ☐ No — **Go to B17**

B16. How are the care plans used?

MARK ALL THAT APPLY

1 ☐ To guide care manager practice or make it more consistent across members

2 ☐ To document goals for members

3 ☐ To facilitate communication with physicians

4 ☐ To facilitate care continuity

5 ☐ To document compliance with accreditation requirements

6 ☐ Please list other ways care plans are used

_____

_____

B17. What is the <u>usual</u> mode of contact with *individual* members in care management? (Do not include mass mailings of health-related literature.)

MARK ONE

1 ☐ In person

2 ☐ Telephone

3 ☐ Mail

4 ☐ Email or internet website

B18. How is the frequency of member contact determined?

MARK ALL THAT APPLY

1 ☐ Pre-set minimum

2 ☐ Formula or algorithm-driven frequency based on claims or other records

3 ☐ Staff judgment based on member need

4 ☐ Please list other ways frequency of member contact is determined

_____

_____

B19. Does care management include the use of a home tele-monitoring or other similar device to monitor members' vital signs, symptoms, or clinical indicators? *Please include use of devices as part of pilot programs as well as standard operations.*

1 ☐ Yes — **Go to B20**

0 ☐ No — **Go to B22**

B20. What does the device(s) measure?

MARK YES OR NO FOR EACH		Yes	No
a.	Blood pressure	1 ☐	0 ☐
b.	Heart rate	1 ☐	0 ☐
c.	Blood glucose (glucometer readings)	1 ☐	0 ☐
d.	Weight	1 ☐	0 ☐
e.	Blood oxygen saturation (pulse oxygen or O_2 saturation)	1 ☐	0 ☐
f.	Peak flow	1 ☐	0 ☐
g.	Protime (PT/INR, blood coagulation)	1 ☐	0 ☐
h.	Patient answers to simple questions on symptoms and behavior	1 ☐	0 ☐
i.	Please list other types of measurements collected	1 ☐	0 ☐

_____

_____

B21. How often, on average, are readings transmitted from members to care managers?

MARK ONE

1 ☐ More than once a day
2 ☐ Daily
3 ☐ Weekly
4 ☐ Other *(Please specify)*

_____

B22. Do members in care management receive education about how to better manage chronic conditions or disabilities?

1 ☐ Yes — **Go to B23**
0 ☐ No — **Go to B24**

B23. How is education provided to members in care management?

MARK YES OR NO FOR EACH		Yes	No
a.	Staff follow curriculum with individual members	1 ☐	0 ☐
b.	Staff follow curriculum addressing groups of members	1 ☐	0 ☐
c.	Staff follow checklists	1 ☐	0 ☐
d.	Staff use scripts provided by computer algorithm	1 ☐	0 ☐
e.	Staff use teachable moments	1 ☐	0 ☐
f.	Staff provide written material to members	1 ☐	0 ☐
g.	Staff provide videos or DVDs to members	1 ☐	0 ☐
h.	On-line education available to members	1 ☐	0 ☐
i.	Please list other ways education is provided	1 ☐	0 ☐

_____

_____

B24. Does care management include managing or assisting members with care setting transitions such as hospital or nursing home discharges?

1 ☐ Yes — **Go to B25**
0 ☐ No — **Go to B27**

B25. How do care managers identify care setting transitions?

MARK YES OR NO FOR EACH	Yes	No
a. Staff receive information based on pre-admission screening or benefit advisory review	1 ☐	0 ☐
b. Staff routinely review facility admissions logs	1 ☐	0 ☐
c. Hospitals routinely notify contract holder of all members admitted or discharged	1 ☐	0 ☐
d. Staff relies on primary physicians to report transition	1 ☐	0 ☐
e. Staff relies on members or caregivers to report transition	1 ☐	0 ☐
f. Please list other ways care transitions are identified	1 ☐	0 ☐

_____

_____

B26. How do care managers respond to setting transitions such as facility discharges?

MARK YES OR NO FOR EACH	Yes	No
a. Work with facility staff throughout stay	1 ☐	0 ☐
b. Work with facility staff only in advance of discharge	1 ☐	0 ☐
c. Assist with implementing facility discharge plan	1 ☐	0 ☐
d. Make arrangements with providers identified in discharge plan	1 ☐	0 ☐
e. Telephone members to follow up on discharge arrangements	1 ☐	0 ☐
f. Visit members to follow up on discharge arrangements	1 ☐	0 ☐
g. Review member medications either by telephone or visit	1 ☐	0 ☐
h. Please list other ways your staff help with a facility discharge	1 ☐	0 ☐

_____

_____

B27. Does care management include identifying and resolving member problems related to medications?

1 ☐ Yes — **Go to B28**

0 ☐ No — **Go to B30**

B28. How are member problems with medications identified?

MARK YES OR NO FOR EACH	Yes	No
a. Pharmacy Benefit Manager (PBM) identifies problems.....	1 ☐	0 ☐
b. Care managers, pharmacists, or other staff review reports on prescription drug claims (possibly using software that identifies potential problems).....	1 ☐	0 ☐
c. Care managers administer screening instrument to members concerning medications taken.....	1 ☐	0 ☐
d. Members discuss medications and problems with care managers during routine contacts.....	1 ☐	0 ☐
e. Primary care physicians or other providers report medications and related problems to care managers.....	1 ☐	0 ☐
f. Please list other ways problems with medications are identified.…	1 ☐	0 ☐

_____

_____

B29. How do care managers respond to member problems with medications?

MARK YES OR NO FOR EACH	Yes	No
a. Ask pharmacist to review medications to identify solution.....	1 ☐	0 ☐
b. Notify primary care physician to resolve.....	1 ☐	0 ☐
c. Notify all relevant physicians to resolve.....	1 ☐	0 ☐
d. Disease manager (or pharmacist) can adjust some medications using standing protocols.....	1 ☐	0 ☐
e. Provide member education or refer member to Medication Therapy Management Program (MTMP).....	1 ☐	0 ☐
f. Notify member of problem and suggested solution.....	1 ☐	0 ☐
g. Please list other ways care managers respond to problems with medications.....	1 ☐	0 ☐

_____

_____

B30. Does care management include assisting members with access to support services such as personal care, transportation to medical appointments, assistance applying for Medicaid, or financial assistance programs?

1 ☐ Yes — **Go to B31**

0 ☐ No — **Go to B34**

B31. How do care managers identify member need for support services?

MARK ALL THAT APPLY

1 ☐ Periodically assess need for support services of members receiving care management

2 ☐ Physicians or other providers refer members requiring support services

3 ☐ Please list other ways members needs are identified

_____

_____

B32. How do care managers assist members who need support services?

MARK YES OR NO FOR EACH	Yes	No
a. Give members a provider referral list	1 ☐	0 ☐
b. Recommend certain providers to members	1 ☐	0 ☐
c. Make service arrangements for members with providers	1 ☐	0 ☐
d. Follow up on services provided	1 ☐	0 ☐
e. Please list other ways members are assisted with support services	1 ☐	0 ☐

_____

_____

B33. Do plans operating under this contract pay for any support services not covered by Medicare?

1 ☐ Yes

0 ☐ No

B34. Do care managers assess the availability of care from family members, health care decision makers, friends, or other unpaid helpers?

1 ☐ Yes

0 ☐ No

B35. Do care managers coordinate with family members, health care decision makers, or other unpaid helpers during care setting transitions and other events?

1 ☐ Yes — **Go to B36**

0 ☐ No — **Go to B37**

B36. What assistance do care managers provide to family members, health care decision makers, or other unpaid helpers during care setting transition and other events?

MARK YES OR NO FOR EACH	Yes	No
a. Inform helpers of support services.....	1 ☐	0 ☐
b. Refer helpers to respite services.....	1 ☐	0 ☐
c. Teach or train helpers to perform specific tasks.....	1 ☐	0 ☐
d. Please list other ways your plan coordinates with informal caregivers.....	1 ☐	0 ☐

_____

_____

B37. What is the duration of care management, on average, for members using this service? ***Your best estimate is fine.***

|__|__|__| Number of

1 ☐ Days
2 ☐ Weeks
3 ☐ Months
4 ☐ Program duration is not limited — **Go to B40**

B38. Please describe one or two main criteria for discharge from your care management program.

_____

_____

B39. During 2007, approximately what percentage of care management program users were discharged within one year of start of care management? ***Your best estimate is fine.***

|__|__|__| % Percentage discharged within one year

B40. Approximately what percentage of members who received care management in 2007 were in each of the following age groups? ***Your best estimate is fine.***

	PERCENT
a. 18 to 64.....	|__|__|__| %
b. 65 to 74.....	|__|__|__| %
c. 75 to 84.....	|__|__|__| %
d. 85 or older.....	|__|__|__| %
e. Check here if data not available.....	☐__

B41. Approximately what percentage of members who received care management in 2007 were female or male? ***Your best estimate is fine.***

	PERCENT
a. Female.....	|__|__|__| %
b. Male.....	|__|__|__| %
c. Check here if data not available.....	☐_

B43. Approximately what percentage of members who received care management in 2007 had none, one, two, or three or more chronic health conditions? ***Your best estimate is fine.***

	PERCENT
a. No chronic conditions.....	|__|__|__| %
b. One chronic condition.....	|__|__|__| %
c. Two chronic conditions.....	|__|__|__| %
d. Three or more chronic conditions….	|__|__|__| %
e. Check here if data not available……	☐

Section C: Characteristics of Disease Management Programs

C1. Is disease management available to members served under this contract?

As noted earlier in the instructions, for the purposes of this survey, by disease management we mean:

Services that: teach members how to adhere to their physicians' treatment plans; monitor member clinical status and adherence to treatment recommendations; and monitor provider adherence to evidence-based practice guidelines. Disease management is typically targeted to members with specific chronic diseases, such as heart failure or diabetes. Such diseases often have complex treatment regimens, and maintaining adherence requires the sustained efforts of patients and physicians.

1 ☐ Yes — **Go to C2**

0 ☐ No — **Go to Section D**

C2. Is disease management provided by staff employed by the contract holder, a vendor, network providers (such as primary care physicians), or others not directly employed by the contract holder?

MARK ALL THAT APPLY

1 ☐ Contract holder staff

2 ☐ Vendor

3 ☐ Plan network provider

4 ☐ Provided by other non-contract holder staff *(Please specify)*

_____

_____

C3. If a NON-contract holder staff provide disease management, are they responsible for any of the following?

MARK YES OR NO FOR EACH	Yes	No
a. Initial identification of members for disease management.....	1 ☐	0 ☐
b. Ongoing identification of members for disease management.....	1 ☐	0 ☐
c. Feeding back member data to the contract holder.....	1 ☐	0 ☐
d. Communicating with other providers that serve members such as hospitals, nursing homes, or pharmacy benefits managers.....	1 ☐	0 ☐
e. None of the above; contract holder staff provide all disease management.....	1 ☐	0 ☐

Remember, if your organization contracts out some or all of its disease management services (for example, to a disease management vendor), please answer the remaining questions in Section C both in terms of your organization AND others with whom you contract.

C4. For what diagnoses is disease management offered?

MARK YES OR NO FOR EACH	Yes	No
a. Congestive Heart Failure (CHF).....	1 ☐	0 ☐
b. Other chronic cardiac diagnoses such as Coronary Artery Disease (CAD).....	1 ☐	0 ☐
c. Diabetes.....	1 ☐	0 ☐
d. Chronic Obstructive Pulmonary Disease (COPD).....	1 ☐	0 ☐
e. Other chronic respiratory diagnoses (such as asthma).....	1 ☐	0 ☐
f. Chronic kidney disease.....	1 ☐	0 ☐
g. High cholesterol.....	1 ☐	0 ☐
h. High blood pressure.....	1 ☐	0 ☐
i. Other diagnoses *(Please specify)*.....	1 ☐	0 ☐

_____

C5. Typically, disease management involves direct intervention with members. But it may also involve working with members' physicians (for example, by promoting adherence to evidence-based care guidelines).

Does disease management under this contract include patient-oriented intervention, physician-oriented intervention, or both?

MARK ONE

1 ☐ Physician-oriented intervention only — **Go to D1 (the rest of the questions in Section C pertain to interventions with members)**

2 ☐ Member-oriented intervention only — **Go to C5a**

3 ☐ Both physician- and member-oriented intervention — **Go to C5a**

C5a. Is disease management under this contract a population-based or opt-in program?

MARK ONE

1 ☐ Population-based, including all members with targeted diagnoses or conditions

2 ☐ Population-based, with opt-out provisions for members who do not wish to participate

3 ☐ Opt-in (members with targeted diagnoses or conditions are invited to participate and must agree to participate)

C6. Approximately what percentage of members who were enrolled under this contract in 2007 used disease management (that is, they were directly contacted by disease managers)? ***Your best estimate is fine.***

|__|__|__| % Percent using disease management in 2007

C7. Please indicate the criteria used to determine member eligibility for disease management, in addition to medical diagnosis.

MARK YES OR NO FOR EACH	Yes	No
a. High cost of care or high service use (past or expected in the future)	1 ☐	0 ☐
b. Specific health events or procedures (such as surgeries)	1 ☐	0 ☐
c. Gaps in care (such as the lack of needed diagnostic testing)	1 ☐	0 ☐
d. High prescription drug use	1 ☐	0 ☐
e. Specific diagnoses or conditions (in addition to those mentioned in C4) or medical complexity	1 ☐	0 ☐
f. Specific lab values or clinical indicators out of range	1 ☐	0 ☐
g. Please list other criteria used to determine eligibility for disease management	1 ☐	0 ☐

C8. Please indicate the approaches used to identify members for disease management.

MARK YES OR NO FOR EACH	Yes	No
a. Claims review or predictive model (based on service or prescription drug use, costs, diagnoses, or procedures).....	1 ☐	0 ☐
b. Clinical or diagnostic data review (including review of Medicare Advantage risk scores).....	1 ☐	0 ☐
c. Provider referral.....	1 ☐	0 ☐
d. Nonclinical staff referral (including customer service or pre-certification staff).....	1 ☐	0 ☐
e. Member self-referral.....	1 ☐	0 ☐
f. Administration of a health risk assessment.....	1 ☐	0 ☐
g. Please list other approaches used to identify members for care management.....	1 ☐	0 ☐

_____

_____

C9. Please indicate the criteria your organization uses to exclude members from disease management.

MARK YES OR NO FOR EACH	Yes	No
a. Terminal illness or participation in hospice.....	1 ☐	0 ☐
b. Dementia.....	1 ☐	0 ☐
c. End Stage Renal Disease (ESRD).....	1 ☐	0 ☐
d. Please list other criteria used to exclude members from disease management.....	1 ☐	0 ☐

_____

_____

e. No exclusion criteria used.....	1 ☐	0 ☐

C10. How often does your organization (proactively) identify members who may need disease management?

~~**MARK ONE**~~**MARK THE MOST COMMON**

1 ☐ At enrollment only
2 ☐ Daily
3 ☐ Weekly
4 ☐ Monthly
5 ☐ Several times a year
6 ☐ Annually
7 ☐ Other *(Please specify)*

_____

C11. Please indicate the types of professional staff providing disease management under this contract. (Please remember to include any staff NOT directly employed by your organization who provide such care.)

MARK YES OR NO FOR EACH	Yes	No
a. Nurses:		
1. Advance practice nurses	1 ☐	0 ☐
2. Registered nurses	1 ☐	0 ☐
3. Licensed practical or vocational nurses	1 ☐	0 ☐
b. Staff other than nurses:		
1. Social workers	1 ☐	0 ☐
2. Physical, occupational, speech, or respiratory therapists	1 ☐	0 ☐
3. Behavioral health specialists or therapists	1 ☐	0 ☐
4. Pharmacy staff	1 ☐	0 ☐
5. Registered dieticians	1 ☐	0 ☐
6. Primary care physicians	1 ☐	0 ☐
7. Please list other types of staff providing disease management	1 ☐	0 ☐

_____

_____

C11a. Do disease managers serve only members covered under this (Medicare) contract, or do they also serve members covered under other (non-Medicare) contracts?

1 ☐ Disease managers serve only members with Medicare

2 ☐ Disease managers also serve younger members covered under commercial contracts or other non-Medicare covered members

C12. Some disease management programs formally assign members receiving disease management to levels, for example depending on the severity of the members' conditions. Does your disease management program have different levels?

1 ☐ Yes — **Please answer questions in the rest of Section C for the disease management level to which most members are assigned.** (Continue to C13)

0 ☐ No – Continue to C13

C13. Does disease management include a comprehensive assessment of member health and health related needs (for example, an assessment that goes beyond a brief health risk assessment)?

1 ☐ Yes — **Go to C14**

0 ☐ No — **Go to C18**

C14. Please indicate the types of staff who conduct comprehensive assessments.

MARK ALL THAT APPLY

1 ☐ Clinical staff directly employed by or contracted with your organization (such as nurses, social workers, or physicians)

2 ☐ Non-clinical staff directly employed by or contracted with your organizations (such as customer relations or outreach staff)

3 ☐ No staff involved; assessments are self-administered

C15. How is comprehensive assessment data collected?

MARK ALL THAT APPLY

1 ☐ In person with the member or health care decision maker

2 ☐ By telephone with the member or health care decision maker

3 ☐ By mail to the member or health care decision maker

4 ☐ Through records, claims, or prescription-refill review

5 ☐ Please list other sources of or approaches to collecting assessment data

_____

_____

C16. Do disease managers develop care plans based on comprehensive assessments?

1 ☐ Yes — **Go to C17**

0 ☐ No — **Go to C18**

C17. How are the care plans used?

MARK ALL THAT APPLY

1 ☐ To guide disease manager practice or make it more consistent across members

2 ☐ To document goals for members

3 ☐ To communicate with physicians

4 ☐ To facilitate care continuity

5 ☐ To document compliance with accreditation requirements

6 ☐ Please list other ways care plans are used

_____

_____

C18. What is the <u>usual</u> mode of contact with individual members in disease management? (Please do not include mass mailings of health-related literature.)

MARK ONE

1 ☐ In person

2 ☐ Telephone

3 ☐ Mail

4 ☐ Email or internet website

C19. How is the frequency of member contact determined?

MARK ALL THAT APPLY

1 ☐ Pre-set minimum

2 ☐ Formula or algorithm-driven frequency based on claims or other records

3 ☐ Staff judgment based on member need

4 ☐ Please list other ways frequency of member contact is determined

_____

_____

C20. Does disease management include the use of a home tele-monitoring or other similar device to monitor members' vital signs, symptoms, or clinical indicators? *Please include use of devices as part of pilot programs as well as standard operations.*

1 ☐ Yes — **Go to C21**

0 ☐ No — **Go to C23**

C21. What does the device(s) measure?

MARK YES OR NO FOR EACH		Yes	No
a.	Blood pressure	1 ☐	0 ☐
b.	Heart rate	1 ☐	0 ☐
c.	Blood glucose (glucometer readings)	1 ☐	0 ☐
d.	Weight	1 ☐	0 ☐
e.	Blood oxygen saturation (pulse oxygen or O_2 saturation)	1 ☐	0 ☐
f.	Peak flow	1 ☐	0 ☐
g.	Protime (PT/INR, blood coagulation)	1 ☐	0 ☐
h.	Patient answers to simple questions on symptoms and behavior	1 ☐	0 ☐
i.	Please list other types of measurements collected	1 ☐	0 ☐

_____

_____

C22. How often, on average, are readings transmitted from the member to disease managers?

MARK ONE

1 ☐ More than once a day
2 ☐ Daily
3 ☐ Weekly
4 ☐ Other *(Please specify)*

_____

C23. Do members in disease management receive education about how to better manage chronic conditions?

1 ☐ Yes — **Go to C24**
0 ☐ No — **Go to C25**

C24. How is education provided to members in disease management?

MARK YES OR NO FOR EACH	Yes	No
a. Staff follow curriculum with individual members	1 ☐	0 ☐
b. Staff follow curriculum addressing groups of members	1 ☐	0 ☐
c. Staff follow checklists	1 ☐	0 ☐
d. Staff use scripts provided by computer algorithm	1 ☐	0 ☐
e. Staff use teachable moments	1 ☐	0 ☐
f. Staff provide written material to members	1 ☐	0 ☐
g. Staff provide videos or DVDs to members	1 ☐	0 ☐
h. On-line education available to members	1 ☐	0 ☐
i. Please list other ways education is provided	1 ☐	0 ☐

_____

_____

C25. Does disease management include managing or assisting members with care setting transitions such as hospital or nursing home discharges?

1 ☐ Yes — **Go to C26**
0 ☐ No — **Go to C28**

C26. How do disease managers identify care setting transitions?

MARK YES OR NO FOR EACH	Yes	No
a. Staff receive information based on pre-admission screening or benefit advisory review	1 ☐	0 ☐
b. Staff routinely review facility admissions logs	1 ☐	0 ☐
c. Hospitals routinely notify contract holder of all members admitted or discharged	1 ☐	0 ☐
d. Staff relies on primary physicians to report transition	1 ☐	0 ☐
e. Staff relies on members or caregivers to report transition	1 ☐	0 ☐
f. Please list other ways care transitions are identified	1 ☐	0 ☐

_____

_____

C27. How do disease managers respond to setting transitions such as facility discharges?

MARK YES OR NO FOR EACH	Yes	No
a. Work with facility staff throughout stay	1 ☐	0 ☐
b. Work with facility staff only in advance of discharge	1 ☐	0 ☐
c. Assist with implementing facility discharge plan	1 ☐	0 ☐
d. Make arrangements with providers identified in discharge plan	1 ☐	0 ☐
e. Telephone members to follow up on discharge arrangements	1 ☐	0 ☐
f. Visit members to follow up on discharge arrangements	1 ☐	0 ☐
g. Review member medications either by telephone or visit	1 ☐	0 ☐
h. Please list other ways your staff help with a facility discharge	1 ☐	0 ☐

_____

_____

C28. Does disease management include identifying and resolving member problems related to medications?

1 ☐ Yes — **Go to C29**

0 ☐ No — **Go to C31**

C29. How are member problems with medications identified?

MARK YES OR NO FOR EACH	Yes	No
a. Pharmacy Benefit Manager (PBM) identifies problems.....	1 ☐	0 ☐
b. Disease managers, pharmacists, or other staff review reports on prescription drug claims (possibly using software that identifies potential problems).....	1 ☐	0 ☐
c. Disease managers administer screening instrument to members concerning medications taken.....	1 ☐	0 ☐
d. Members discuss medications and problems with disease managers during routine contacts.....	1 ☐	0 ☐
e. Primary care physicians or other providers report medications and related problems to disease managers.....	1 ☐	0 ☐
f. Please list other ways problems with medications are identified.…	1 ☐	0 ☐

_____

_____

C30. How do disease managers respond to member problems with medications?

MARK YES OR NO FOR EACH	Yes	No
a. Ask pharmacist to review medications to identify solution.....	1 ☐	0 ☐
b. Notify primary care physician to resolve.....	1 ☐	0 ☐
c. Notify all relevant physicians to resolve.....	1 ☐	0 ☐
d. Disease manager (or pharmacist) can adjust some medications using standing protocols.....	1 ☐	0 ☐
e. Provide member education or refer member to Medication Therapy Management Program (MTMP).....	1 ☐	0 ☐
f. Notify member of problem and suggested solution.....	1 ☐	0 ☐
g Please list other ways disease managers respond to problems with medications.....	1 ☐	0 ☐

_____

_____

C31. What is the duration of disease management, on average, for members using this service? ***Your best estimate is fine.***

|__|__|__| Number of

1 ☐ Days
2 ☐ Weeks
3 ☐ Months
4 ☐ Program duration is not limited — **Go to C34**

C32. Please describe the one or two main criteria for discharge used by your disease management program.

_____

_____

_____

C33. During 2007, approximately what percentage of disease management program users were discharged within one year of start of disease management? ***Your best estimate is fine.***

|__|__|__| % Percentage discharged within one year

C34. Approximately what percentage of your current disease management program members are in each of the following age groups? ***Your best estimate is fine.***

		PERCENT
a.	18 to 64.....	|__|__|__| %
b.	65 to 74.....	|__|__|__| %
c.	75 to 84.....	|__|__|__| %
d.	85 or older.....	|__|__|__| %
e.	Check here if data not available.....	☐

C35. Approximately what percentage of your current disease management program members are female or male? ***Your best estimate is fine.***

		PERCENT
a.	Female.....	|__|__|__| %
b.	Male.....	|__|__|__| %
c.	Check here if data not available.....	☐

C36. Approximately what percentage of members in your disease management program have none, one, two, or three or more chronic health conditions? ***Your best estimate is fine.***

		PERCENT
a.	No chronic conditions.....	|__|__|__| %
b.	One chronic condition.....	|__|__|__| %
c.	Two chronic conditions.....	|__|__|__| %
d.	Three or more chronic conditions…	|__|__|__| %
e.	Check here if data not available…..	☐

Section D:	Physician Interventions under Care or Disease Management

D1. Are physicians expected to collaborate with your care or disease managers, for example, by calling them with new information about patients or participating in multi-disciplinary team meetings?

1 ☐ Yes, required by contract

2 ☐ Yes, encouraged to collaborate (but not contractually required)

0 ☐ No, not expected

D2. Are physicians provided with decision support tools such as evidence-based practice guidelines or patient-specific reports showing gaps in care?

1 ☐ Yes

0 ☐ No

D3. Does your organization offer feedback on provider performance concerning patients receiving care or disease management services?

1 ☐ Yes

0 ☐ No

Section E:	Care and Disease Management Differences Between Regular Medicare Advantage Plans and Special Needs Plans (SNPs)

E1. Does this contract include one or more regular (traditional) Medicare Advantage (MA) plans AND one or more Special Needs Plans (or SNPs) that offer care management or disease management?

1 ☐ Yes, contains regular MA plan and SNP — **Go to E2**

0 ☐ No, contains just regular MA plan(s) or just SNP(s) — **Go to Section F**

E2. What are the main differences between care and disease management under the contract's SNP compared to under the contract's regular Medicare Advantage plans?

1 ☐ No difference — **Go to E4**

2 ☐ Some differences — **Go to E3**

E3. Please indicate the main differences between your care or disease management under SNP and under the contract's regular Medicare Advantage plans.

MARK ALL THAT APPLY

1 ☐ Higher proportions of SNP members use services (or use services at higher levels of complexity, if use of such levels reported above)

2 ☐ Services are of longer duration under the SNP

3 ☐ Staff have smaller caseloads under the SNP

4 ☐ Services are more structured under the SNP (for example, staff rely more on written protocols)

5 ☐ Please describe other differences with your SNP

_____

_____

E4. Is one of your SNPs designated by CMS as a dual-eligible plan? (Dual-eligibles are those who are eligible for both Medicare and Medicaid.)

1 ☐ Yes — **Go to E5**

0 ☐ No — **Go to F1**

E5. Does this dual-eligible SNP have a contract with the Medicaid program in the state which includes its service area?

1 ☐ Yes — **Go to E6**

0 ☐ No — **Go to F1**

E6. Please indicate how having a Medicaid contract has affected SNP members?

MARK ALL THAT APPLY

1 ☐ Provides better access to home- and community-based services

2 ☐ Provides an incentive to move members from nursing homes to the community

3 ☐ Provides better coordination of services covered by Medicare and Medicaid

4 ☐ Please describe other ways that the Medicaid contract has affected SNP members

_____

_____

Section F: Evidence of Effectiveness and Assessment of Costs

F1. Does your organization determine the success of its care and disease management services using any of the following criteria?

MARK YES OR NO FOR EACH	Yes	No
a. Reduced costs of care	1 ☐	0 ☐
b. Reduced rates of preventable admissions	1 ☐	0 ☐
c. By whether specific care is received, such as diagnosis-specific screenings or immunizations	1 ☐	0 ☐
d. By specific health outcomes, such as improved clinical indicators for levels of blood pressure, cholesterol, or blood glucose	1 ☐	0 ☐
e. Improved member satisfaction	1 ☐	0 ☐
f. By meeting operational performance standards, such as care or disease manager frequency of contact with members	1 ☐	0 ☐
g. Please describe other ways your plan may define success	1 ☐	0 ☐

_____

_____

F2. What data (or other information) does your organization use to determine the success of care and disease management?

MARK YES OR NO FOR EACH	Yes	No
a. Claims for covered services	1 ☐	0 ☐
b. Clinical data collected directly	1 ☐	0 ☐
c. Clinical data providers report to the plan	1 ☐	0 ☐
d. Self-reported (member) health or satisfaction	1 ☐	0 ☐
e. Please describe other ways your plan measures success	1 ☐	0 ☐

_____

_____

f. Does not formally determine success	1 ☐	0 ☐

F3. To determine success, do you compare these measures to the following values?

MARK YES OR NO FOR EACH	Yes	No
a. National or local managed care benchmarks….	1 ☐	0 ☐
b. National or local fee-for-service benchmarks….	1 ☐	0 ☐
c. Members' baseline values.....	1 ☐	0 ☐
d. Please describe other bases for comparisons…	1 ☐	0 ☐

_____

_____

e. Does not formally determine success.....	1 ☐	0 ☐

F4. Is your care or disease management program viewed as a separate marketable plan benefit, a management tool, or both?

MARK ALL THAT APPLY

1 ☐ Separate marketable plan benefit

2 ☐ Utilization and risk management tool

3 ☐ Quality management tool

4 ☐ Please describe other purposes for care and disease management under this contract

_____

_____

F5. Please describe how the estimated costs of care or disease management are represented in the organization's Medicare contract bid.

MARK ALL THAT APPLY

1 ☐ Costs spread across several medical service categories

2 ☐ Costs spread across several administrative categories

3 ☐ Costs appear in a single category (*Please specify*_____*)*

4 ☐ Please describe other approaches to representing costs in the contract bid

_____

F6. Does your organization account for the actual costs of care or disease management separately from other plan costs?

1 ☐ Yes

0 ☐ No

F7. Does your organization contract to a vendor for all or part of its care or disease management program?

Please check response to B2 or C2

1 ☐ Yes, either B2 or C2 indicates use of a vendor — **Go to F8**

0 ☐ No, neither B2 nor C2 indicates use of vendor — **Go to F10**

F8. Does your contract with the vendor guarantee your organization savings?

1 ☐ Yes — **Go to F9**

0 ☐ No — **Go to F10**

F9. How are these savings computed?

_____

_____

F10. Does your organization also provide care or disease management in the fee-for-service sector?

1 ☐ Yes — **Go to F11**

0 ☐ No — **Go to F12**

F12. Please indicate barriers your organization may have encountered in implementing care or disease management programs in a fee-for-service environment.

MARK ALL THAT APPLY

1 ☐ Inadequate information available to manage of all Medicare services

2 ☐ Insufficient control over provider behavior

3 ☐ Inability to negotiate with support service providers

4 ☐ Please describe other barriers you face in implementing these programs under fee-for-service

_____

_____

F13. Please attach examples of internal evaluations of care or disease management your organization has conducted, if willing to share them with CMS.

F14. Thank you for completing the questionnaire. Please return it in the enclosed postage paid envelope. If you have additional information about your care or disease management program that you think may be of interest to this evaluation, please include it with the completed questionnaire.

If you have misplaced the envelope, please send your completed questionnaire to:
Todd Ensor at Mathematica Policy Research, Inc. (MPR), P.O. Box 2393, Princeton, NJ 08543-2393.