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MATHEMATICA
Policy Research, Inc.

Evaluation of Medicare Disease Management Programs: LifeMasters Final Report of Findings

Final Report
Appendices

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APPENDIX A

DETAILED LIFEMASTERS ELIGIBILITY CRITERIA

TABLE A.1

GEOGRAPHIC AND BENEFITS INCLUSION CRITERIA

Beneficiaries can only be randomly assigned if they reside in Alachua, Brevard, Broward, Duval, Lake, Marion, Miami-Dade, Orange, Palm Beach, Seminole, or Volusia counties. After random assignment, patients must reside in Florida.
Receives full Medicaid benefits, has Medicare Part A and Part B, and has Medicare as primary payer

TABLE A.2

DISEASE SPECIFICATION CRITERIA[a]

Congestive heart failure	ICD-9: 398.91, 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 428.xx DRG: 127
Coronary artery disease	ICD-9: 410.0-414.99, PX 360-363.9, V81.0 DRG: 104-118, 120-122, 124-129, 132-133, 138-140, 143-145
Diabetes	ICD-9: 250.XX DRG: 294-295

[a]Patients must have at least one of the listed ICD-9 or DRG codes on a claim in the 24 months prior to enrollment. Patients who meet criteria on this table must also have criteria listed in Table D2.3 and must not meet any of the exclusion criteria listed in Table D2.4 to be eligible for the demonstration.

TABLE A.3

AT-RISK SPECIFICATION CRITERIA[a]
(All Codes Are ICD-9, Unless Otherwise Specified)

Priority 1 Criteria	
Disease-specific inpatient or outpatient hospitalization in the 24 months prior to enrollment	Use codes from Table D2.2
Disease-specific emergency room visit in the 24 months prior to enrollment	Use codes from Table D2.2
Any inpatient or outpatient hospitalization in 24 months prior to enrollment for people with the CHF criteria in Table D2.2.	Any hospitalization revenue code or DRG
Any inpatient or outpatient hospitalization in 24 months prior to enrollment for hypertension.	See Table D2.5
Amputation in the 24 months prior to enrollment	See Table D2.6
Cardiac procedures/devices in the 24 months prior to enrollment	See Table D2.7
Renal disease/nephropathy/dialysis in the 24 months prior to enrollment	See Table D2.8
Neuropathy in the 24 months prior to enrollment	250.6, 250.60–250.63, 337.1, 357.2
Retinopathy in the 24 months prior to enrollment	362.0, 362.01, 362.02
Hyperglycemic hyperosmolar non-ketotic coma in the 24 months prior to enrollment	250.20
Diabetic ketoacidosis in the 24 months prior to enrollment	250.31
Morbid obesity in the 24 months prior to enrollment	278.01
Chronic obstructive pulmonary disease diagnosis in the 24 months prior to enrollment	491.2x, 492.xx, 493.2x, 496.xx DRG: 88
Co-morbidity in the 24 months prior to enrollment	Any person with any combination of two or more of the target diseases.
Gangrene in the 24 months prior to enrollment	250.70 plus 785.4
Unstable angina in the 12 months prior to enrollment	411.1x
Diabetes with skin ulcer in the 12 months prior to enrollment	250.8
Foot ulcer in the 12 months prior to enrollment	707.10, 707.13, 707.12, 707.15, 707.14, 707.15
Other Cardiac complications in the 12 months prior to enrollment	See Table B.9
Peripheral vascular disease in the 12 months prior to enrollment	443.22, 443.81, 443.9, 440.2, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.3, 440.30, 440.31, 440.32, 440.8, 440.9
Priority 2 Criteria	
At least one diabetes clinical indicator in 12 months prior to enrollment (for members with diabetes criteria from Table D2.2)	See Table D2.10
Obesity in the 24 months prior to enrollment	278.0, 278.00
Hypertension in the 24 months prior to enrollment	401–404.xx, DRG 134
Dyslipidemia in the 24 months prior to enrollment	272.0; 272.1; 272.2; 272.3; 272.4; 272.9
Cardiac diagnostic tests in the 24 months prior to enrollment	See Table D2.11
Age	>80
Smoker	305.1

[a]In order to meet the definition of at risk and be included in the demonstration, the patient must have one or more of the Priority 1 criteria or two or more of the Priority 2 criteria.

TABLE A.4

EXCLUSION CRITERIA APPLIED AT ENROLLMENT

Inpatient psychiatric stay in the 12 months prior to enrollment	Any member with an inpatient stay of at least 15 days with a primary psychiatric diagnosis (see Table D2.12)
Nursing home resident in the 12 months prior to enrollment	Any member with at least 90 continuous days in a nursing home
Organ transplant in the 12 months prior to enrollment	Any member with an organ transplant: CPT4: 47133–47136, 33930–33945, 48550–48556, 38240–38241 ICD-9: V42x, V43.2; CPT4: 50300–50330
Enrolled in a Medicare managed care program, enrolled in a CMS demonstration program, age less than 18 years, receiving hospice care in a Medicare certified program, or classified as end stage renal disease	As noted in the Medicare enrollment database

TABLE A.5

HYPERTENSION CODES

ICD-9 Codes 401, 401.0, 401.1, 401.9, 402, 402.00, 402.10, 402.11, 402.90, 402.91, 403, 403.0, 403.1, 403.9, 404, 404.0, 404.1, 404.9
DRG Codes 134, 127, 316

TABLE A.6

AMPUTATION CODES

ICD-9 Diagnosis Codes 997.6, 997.60–997.62, 997.69, E878.5, V49.7, V49.70–V49.77
ICD-9 Procedure Codes 84.1, 84.10, 84.11, 84.12, 84.14, 84.15, 84.17, 84.3, 84.91
CPT4 Codes 27590–27592, 27594, 27596, 27598, 27880–27882, 27884, 27886, 27888, 28800, 28805, 28810, 28820, 28825
HCPC Codes E0959, E1170–E1172, E1180, E1190, E1200, K0100
DRG Codes 113, 114, 213

TABLE A.7

CARDIAC PROCEDURES AND DEVICES CODES

ICD-9 Diagnosis Codes V45.02, V45.01, V53.31
ICD-9 Procedure Codes 88.51–88.54, 37.21, 37.23, 37.26, 37.27, 39.50, 36.01, 36.02, 36.05, 36.09, 36.0, 36.11–36.17, 36.19, 37.78, 37.80–37.83, 37.85–37.87, 0.50, 0.52, 0.53
CPT4 Codes 33200, 33201, 33206–33208, 33210–33218, 33220, 33222–33226, 33233–33238, 33240–33246, 33250, 33572, 33979, 33980, 33967–33974, 92962–92987, 93501, 93510, 93511, 93514, 93524–93529, 93542, 93543, 93545–93556, 93640–93642, 93724, 93731–93732, 93733–93736, 93741–93744

TABLE A.8

RENAL DISEASE, NEPHROPATHY, AND DIALYSIS CODES

ICD-9 Diagnosis Codes

250.04, 403, 403.0, 403.00, 403.01, 403.1, 403.10, 403.11, 403.9, 403.90, 403.91, 404, 404.0, 404.00, 404.01–404.03, 404.1, 403.10–403.13, 403.9, 403.90–403.93,405.01, 405.11, 405.91, 581.81, 582.9, 583.81, 584, 584.5–584.9, 585, 586, 791.0

ICD-9 Procedure Codes

39.27, 39.42, 39.43, 39.53, 39.93, 54.98, 55.4, 55.51–55.54, 55.6

CPT4 Codes

36800, 36810, 36815, 50300, 50340, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90945, 90947, 90989, 90993, 90997, 90999

UB92 Revenue Codes

800–804, 809, 820–825, 829–835, 839–845, 849–855, 859, 880–882, 889

DRG Codes

316, 317

TABLE A.9

OTHER CARDIAC COMPLICATIONS CODES

ICD-9 Diagnosis Codes (must accompany coronary artery disease, congestive heart failure, or hypertension diagnosis)

426, 426.0, 426.10, 426.11–426.13, 426.2–426.4, 426.50–426.54, 426.6, 426.8, 426.81, 426.89, 426.9, 427, 427.0–427.3, 427.31, 427.41, 427.42, 427.5, 427.60, 427.61, 427.69, 427.80, 427.81, 430, 431, 432.0, 432.1, 432.9, 433, 433.0-433.3, 433.8, 433.9, 434, 434.0, 434.1, 434.9, 435, 435.0, 435.2, 435.8, 435.9, 436, 785.1, 786.02, 786.05, 786.09

Other ICD-9 Diagnosis Codes

93.36, 428.0 or 428.1 and 518.81, 428.0 or 428.1 and 786.09

DRG Codes (must accompany coronary artery disease, congestive heart failure, or hypertension diagnosis)

138, 14

TABLE A.10

DIABETES CLINICAL PROCEDURE CODES

CPT4 Codes

83036, 82042–82044, 80061, 83715, 83716, 83721, 67101, 67105, 67107, 67108, 67110, 67112, 67141, 67145, 67208, 67210, 67218, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 92287, 99204, 99205, 99214, 99215, 99242–99245

TABLE A.11

CARDIAC DIAGNOSTIC TEST CODES

ICD-9 Procedure Codes
89.41–89.43, 88.72, 89.44, 37.28, 88.78, 88.71, 93.36

CPT4 Codes
93000, 93010, 93012, 93014–93018, 93224–93237, 93307–93350, 93662, 93784–93790, 78460–78465, 78472, 78473, 78478, 78480, 78481, 78483, 76536

UB92 Revenue Codes
482, 483, 340

TABLE A.12

PSYCHIATRIC DIAGNOSIS CODES

ICD-9 Procedure Codes
290, 290.0–290.4, 290.40–290.43, 290.10–290.13, 290.20, 290.21, 290.8, 290.9, 293–299, 293.0, 293.1, 293.8, 293.81–293.83, 293.89, 293.9, 294.0, 294.1, 294.8, 294.9, 295.x-296.x, 295.x0–295.x5, 296.00–296.06, 296.10–296.16, 296.20–296.26, 296.30–296.36, 296.40–296.46, 296.50–296.56, 296.60–296.66, 296.80–296.82, 296.89, 296.90, 296.99, 297.0–297.3, 297.8, 297.9, 298.0–298.4, 298.8, 298.9, 299.0, 299.00, 299.01, 299.1, 299.10, 299.11, 299.8, 299.80, 299.81, 299.9, 299.90, 299.91, 300-302, 300.x–302.x, 300.00–300.02, 300.09–300.16, 300.19–300.23, 300.29, 300.81, 300.89, 301.10–301.13, 301.20–301.22, 301.50, 301.51, 301.59, 301.81–301.84, 301.89, 302.50–302.53, 302.70–302.76, 302.79, 302.81–302.85, 302.89, 306–316, 306.0–310.0, 306.1–306.9306.50–306.53, 306.59, 307.1–307.9, 307.20–307.23, 307.40–307.49, 307.50–307.54, 307.59, 307.80, 307.81, 307.89, 308.1–308.4, 308.9, 309.1–309.4, 309.21–309.24, 309.28, 309.29, 309.8, 309.81–309.83, 309.89, 309.9, 310.1, 310.2, 310.8, 310.9, 312.0–312.4, 312.00–312.03, 312.10–312.13, 312.20–312.23, 312.30–312.35, 312.39, 312.8, 312.81, 312.82, 312.89, 312.9, 313.0–313.3, 313.21–313.23, 313.8, 313.81–313.83, 313.89, 313.9, 314.0–314.2, 314.00, 314.01, 314.8, 314.9, 315.0–315.5, 315.00–315.02, 315.09, 315.31, 315.39, 315.8, 315.9

APPENDIX B

SUMMARY OF KEY FINDINGS FROM THE LIFEMASTERS PATIENTS SURVEY

TABLE B.1

SELECTED PROCESS MEASURES FROM LIFEMASTERS PATIENT SURVEY
(Percentage, Unless Otherwise Noted)

	N	Treatment Group	Control Group	Difference	p-value
Preventive Care					
Received Flu Shot in the Past Year	592	46.8	44.5	2.3	.578
Ever Received Pneumonia Vaccine	552	48.5	46.8	1.7	.682
Among Those 40 Years Old or Older, Had Blood Stool Test, Sigmoidoscopy, or Colonoscopy in the Past Year	575	36.1	35.9	0.1	.972
Service Arranging					
Nurse, Disease Manager, or Social Worker Helped Arrange Care	603	34.6	21.2	13.4	.000***
If Unable to Do by Themself, Beneficiary Reported Being Able to Get Help With…					
Telephone	127	96.2	91.7	4.5	.280
Transportation	316	85.1	73.9	11.1	.014**
Preparing meals	212	89.0	87.2	1.8	.695
Housework	372	79.6	78.5	1.1	.789
Taking medication	150	95.7	96.6	-0.9	.785
Education					
Beneficiary Reported Being Taught How To …					
Follow a healthy diet	571	60.2	57.6	2.6	.522
Exercise	548	49.6	46.5	3.1	.466
Recognize warning signs to seek urgent care	570	45.6	42.9	2.7	.515
Among Those Reporting They Had Help From a Medical Professional Arranging Care, Beneficiary Received Material to Explain Condition or Treatment	182	66.1	37.7	28.4	.000***
Prescription Drug Benefit					
Average Number of Medications Reported	591	7.3	6.5	0.9	.010***
0 medications[a]	19	2.1	4.3	-2.2	.107
1-3 medications	85	13.2	15.5	-2.3	
4-6 medications	214	34.7	37.6	-2.9	
7-9 medications	138	22.9	23.8	-0.8	
10 or more medications	135	27.1	18.8	8.3	
If Had New Prescription Medicines or Refilled a Prescription in the Past Three Months, Patient Reported Having Trouble Getting Enough Medications	512	26.1	27.4	-1.3	.735
Reasons Patient Had Trouble Getting Any Types of Medications…					
Not covered by insurance	598	27.6	35.6	-7.9	.037**
Of those with drug insurance, exceeded insurance limit	586	20.0	27.7	-7.7	.029**
Average Monthly Out of Pocket Cost[b]	525	$24	$30	-$6	.129

Source: Mathematica survey of a random sample of patients, conducted July through November 2006. Mean duration of enrollment of respondents was 13.2 months (range 9.9 – 18.6 months). Survey response rate was 71 percent.

[a]Chi squared test used to determine equivalence of distribution.
[b]Excludes one control group member who reported an average out-of-pocket cost of $2,000.

*Significantly different from zero at the .10 level, two-tailed test.
**Significantly different from zero at the .05 level, two-tailed test.
***Significantly different from zero at the .01 level, two-tailed test.

TABLE B.2

SELECTED OUTCOME MEASURES FROM LIFEMASTERS PATIENT SURVEY
(Percentage, Unless Otherwise Noted)

	N	Treatment Group	Control Group	Difference	p-value
Functional Status					
Able To Do These Activities Independently					
Use telephone	610	73.4	83.8	-10.4	.002***
Travel	610	41.4	53.6	-12.2	.003***
Prepare meals	607	60.5	69.5	-9.0	.021**
Housework	609	35.4	40.4	-5.0	.208
Take medication	612	69.6	80.9	-11.3	.001***
Eat	613	92.4	96.8	-4.3	.018**
Dress/undress	612	73.9	85.1	-11.2	.001***
Transfer from bed or chair	610	79.1	85.1	-6.0	.052*
Bathe	609	67.1	77.0	-9.8	.007***
Get to bathroom on time	603	54.5	60.9	-6.3	.116
Mental and Physical Health Status					
Felt Calm and Peaceful Most or All of the Time in the Last Four Weeks	603	42.6	51.5	-8.9	.030**
Felt Downhearted and Blue Most or All of the Time in the Last Four Weeks	590	30.2	25.8	4.5	.225
Bothered by Poor Sleep Most or All of the Time in the Last Four Weeks	601	44.8	39.2	5.5	.170
Pain Interfered with Usual Activities in the Last Four Weeks	599	73.3	76.6	-3.3	.358
If Pain Interfered with Activities, Felt Some or a Lot of Control Over Pain	421	84.6	83.1	1.5	.673
Primary Condition Interfered a Lot or Somewhat with Enjoyment of Life in the Last Four Weeks	567	37.5	41.1	-3.6	.379
Beneficiary Felt Primary Condition Placed a Burden on Family in the Past Four Weeks	550	37.0	36.5	0.5	.897
Beneficiary Felt Depressed About Living with Primary Condition in the Past Four Weeks	572	39.8	38.6	1.2	.766
Beneficiary Felt Satisfied with Sexual Functioning in the Past Four Weeks	541	12.2	10.8	1.4	.616
Mean SF-12 Physical and Mental Health Summary Scales					
Physical Health Summary Score (mean)[a]	497	34.6	35.4	-0.8	.288
Range 1 (10-27)[b]	111	23.6	21.2	2.4	.188
Range 2 (28-35)	189	40.9	35.3	5.6	
Range 3 (36-70)	197	35.5	43.5	-8.0	
Mental Health Summary Score (mean)[c]	497	43.3	45.3	-2.0	.066*
Range 1 (6-43)b	249	54.5	45.9	8.7	.134
Range 2 (44-55)	135	25.6	28.6	-3.0	
Range 3 (56-72)	113	19.8	25.5	-5.7	

TABLE B.2 *(continued)*

	N	Treatment Group	Control Group	Difference	p-value
Knowledge and Ability					
Understands a Healthy Diet	495	77.1	83.7	-6.6	.064*
Understands Proper Way to Exercise	532	61.9	69.3	-7.4	.074*
Adherence and Health-Related Behavior					
Smoked in the Past Six Months	613	16.1	15.9	0.3	.930
If Beneficiary Reported Smoking in the Past Six Months, Tried to Quit	97	79.2	81.6	-2.5	.760
Visit Doctor with List of Questions Most or All of the Time	582	50.5	43.1	7.4	.073*
Follow Healthful Eating Plan Most or All of the Time (in past 4 weeks)	502	66.8	68.2	-1.4	.735
Exercise Regularly	579	50.9	54.4	-3.5	.403
Contacting Disease Manager					
Tried to Reach Disease Manager for Assistance	182	22.0	22.0	-0.1	.990
Able to Reach Disease Manager if Beneficiary Tried[d]	24	91.7	—	—	—

Source: Mathematica survey of a random sample of patients, conducted July through November 2006. Mean duration of enrollment of respondents was 13.2 months (range 9.9 – 18.6 months). Survey response rate was 71 percent.

[a]The score can range from 10 to 70. Higher values indicate better health. The mean value for the Physical Health Summary Score for a representative sample of U.S. adults aged 65 to 74 was 43.7, with a range of 13 to 59. The mean value for a sample of U.S. adults aged 75 and older was 38.7, with a range of 17 to 57 (Ware et al. 1998).

[b]Chi squared test used to determine equivalence of distribution.

[c]The score can range from 6 to 72. Higher values indicate better health. The mean value for the Mental Health Summary Score for a representative sample of U.S. adults aged 65 to 74 was 52.1, with a range of 19 to 70. The mean value for a sample of U.S. adults aged 75 and older was 50.1, with a range of 22 to 69 (Ware et al. 1998).

[d]Because the control group sample size is so small (13 tried to contact a disease manager), we do not report results for the control group here.

*Significantly different from zero at the .10 level, two-tailed test.
**Significantly different from zero at the .05 level, two-tailed test.
***Significantly different from zero at the .01 level, two-tailed test.

APPENDIX C

SUPPLEMENTARY TABLES OF FINDINGS FROM THE EVALUATION

TABLE C.1

DISTRIBUTION OF MONTHS OF ENROLLMENT FOR THE TREATMENT AND CONTROL GROUPS

	Treatment Group	Control Group
Patients in the Month 1 to 12 Follow-up Cohort		
Mean Number of Eligible Months (in first 12 months of enrollment)	10.75	10.75
Number of Eligible Months		
6 months or fewer	11.1	10.9
More than 6 months to 9 months	7.2	7.5
More than 9 months to 12 months	81.8	81.6
Number of Patients	**36,959**	**14,797**
Patients in the Month 13 to 24 Follow-up Cohort		
Mean Number of Eligible Months (in second 12 months of enrollment)	7.99	8.02
Number of Eligible Months		
6 months or fewer	41.4	41.5
More than 6 months to 9 months	12.1	12.1
More than 9 months to 12 months	46.5	46.4
Number of Patients	**23,545**	**9,395**
Patients in the Month 25 to 36 Follow-up Cohort		
Mean Number of Eligible Months (in third 12 months of enrollment)	5.78	5.77
Number of Eligible Months		
6 months or fewer	57.0	57.2
More than 6 months to 9 months	21.4	21.3
More than 9 months to 12 months	21.6	21.6
Number of Patients	**7,701**	**3,119**
All Patients in the Research Sample Over All Months of Operations		
Mean Number of Eligible Months	17.45	17.46
Number of Eligible Months		
6 months or fewer	11.1	10.9
More than 6 months to 12 months	15.0	15.5
More than 12 months to 18 months	34.1	33.9
More than 18 months to 24 months	19.0	18.6
More than 24 months	20.8	21.1
Number of Patients	**36,959**	**14,797**

Sources: MPR Enrollment File, Medicare Enrollment Database, and Medicare claims data.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

The 1 to 12 and 13 to 24 month patient cohorts include all sample members enrolled early enough to potentially be observed for 12 or 24 months. For example, only patients enrolled in the demonstration on or before January 2006 were included in the Months 13 to 24 Follow-up Cohort. The 25 to 36 month patient cohort includes anyone with more than 24 months of enrollment.

TABLE C.2

PRE-ENROLLMENT CHARACTERISTICS OF ALL TREATMENT AND CONTROL GROUP PATIENTS RANDOMLY ASSIGNED TO THE LIFEMASTERS DEMONSTRATION FROM JANUARY 2005 THROUGH SEPTEMBER 2006
(Percentages, Unless Otherwise Noted)

	Treatment Group	Control Group	Treatment-Control Difference
Demographic Characteristics			
Age at Enrollment			
Average age (in years)	68.5	68.5	0.0
Younger than 65	29.6	29.6	0.0
65 to 69	16.8	16.5	0.3
70 to 74	17.9	17.8	0.1
75 to 79	15.7	16.1	-0.4
80 to 84	11.1	10.8	0.3
85 or older	8.9	9.2	-0.3
Gender (Male)	33.8	33.8	0.0
Race			
White	54.4	53.8	0.6
Black	23.6	23.9	-0.3
Asian	1.6	1.6	0.1
Other[a]	20.4	20.8	-0.4
Ethnicity (Hispanic)	18.2	18.6	-0.4
Original Reason for Medicare: Disabled	42.3	42.0	0.3
Medical Conditions Treated During the Two Years Before Enrollment			
Coronary Artery Disease	69.3	69.8	-0.5
Congestive Heart Failure	37.3	37.1	0.2
Stroke	40.4	40.7	-0.3
Diabetes	64.3	64.1	0.2
Cancer	20.4	20.0	0.4
Chronic Obstructive Pulmonary Disease	48.4	47.9	0.4
Dementia (Including Alzheimer's Disease)	16.7	16.5	0.1
Peripheral Vascular Disease	37.4	37.3	0.2
HIV/AIDS	3.3	3.3	0.0
Depression	26.4	27.4	-1.0**
Asthma	24.1	23.5	0.6
Bipolar Disorder	4.9	5.2	-0.3
Schizophrenia	6.4	6.7	-0.3
Coagulation Disorders	8.4	7.9	0.5
Sickle Cell Anemia	0.3	0.2	0.1
Number of Conditions Above			
0	1.5	1.5	0.0
1	9.7	9.1	0.6
2	14.7	15.6	-0.8
3	17.4	17.6	-0.2
4	17.1	16.9	0.2
5 or more	39.5	39.3	0.3
Number of Patients			

TABLE C.2 *(continued)*

	Treatment Group	Control Group	Treatment-Control Difference
Hospitalizations, Expenditures, and Number of Physicians			
Annualized Number of Hospitalizations in the Two Years Before Enrollment[b]			
Average	0.7	0.6	0.0
0	49.8	50.2	-0.4
1.0 or less	33.1	33.0	0.1
1.1 to 2.0	10.1	10.1	0.0
2.1 to 3.0	3.7	3.6	0.1
3.1 or more	3.3	3.2	0.2
Had One or More Hospitalizations in Each of the Two Years Before Enrollment	16.3	16.7	-0.3
Days Between Last Hospital Discharge and Enrollment			
No hospitalization in the past two years	49.8	50.2	-0.4
Still in hospital when randomized	1.5	1.4	0.1
0 to 30	4.8	4.7	0.1
31 to 60	3.7	3.8	0.0
61 to 180	11.1	10.9	0.2
181 to 365	12.3	12.2	0.1
366 to 730	16.7	16.8	0.0
Medicare Expenditures per Month in FFS During the Two Years Before Enrollment			
Inpatient[c]	$396	$383	$14
SNF	$55	$50	$5**
Home health (Part A)	$28	$27	$1
Total Part A	$480	$461	$19**
Other Part B[d]	$435	$411	$24
Outpatient[e]	$113	$114	-$1
Physician services	$60	$58	$2
DME	$169	$166	$4
Home health (Part B)	$107	$104	$3
Total Part B	$884	$853	$31
Total Expenditures	$1,364	$1,314	$50**
Medicare Expenditures per Month in FFS During the Two Years Before Enrollment			
$0 to 250	25.6	25.9	-0.2
$251 to 500	17.8	17.8	0.0
$501 to 1,000	19.3	19.3	0.0
$1,001 to 2,000	17.8	18.4	-0.6
$2,001 to 3,000	8.5	8.1	0.4
More than $3,000	10.9	10.6	0.4
Had Medicare Expenditures per Month in Top Quartile Both Years Before Enrollment[f]	14.1	13.7	0.4
Average Number of Physicians Billed in the Year Prior to Enrollment[g]	12.4	12.3	0.2
Number of Patients	**36,959**	**14,797**	

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

[a]Other includes North American Native and other races.

[b]Calculated as 12 × (number of hospitalizations during two years before month of enrollment) ÷ (number of months eligible). For example, if a beneficiary was eligible all 24 months and had two hospitalizations during that time, that beneficiary would have one hospitalization per year [(12 × 2) ÷ 24]. If another beneficiary was eligible for eight months during the previous two years and had two hospitalizations during those eight months, that beneficiary would have three hospitalizations per year [(12 × 2) ÷ 8].

[c]Inpatient hospitalization data includes claims for stays at short-term, critical access, long-term, rehabilitation, and psychiatric hospitals. [d]Other costs include hospice, lab/radiology, and other Part B costs.

[e]Outpatient utilization includes all outpatient claims, outpatient care provided in a hospital, renal dialysis facility, clinic, ambulatory surgical center, or health center.
[f]The quartile is calculated for the combined treatment and control groups in each year.

[g]Calculated as the number of unique physician identification numbers.

**Treatment-control differences are significant at the 0.05 level, two-tailed t-test.
***Treatment-control differences are significant at the 0.01 level, two-tailed t-test.

DME = durable medical equipment; FFS = fee for service; SNF = skilled nursing facility.

TABLE C.3

PRE-ENROLLMENT CHARACTERISTICS OF TREATMENT AND CONTROL GROUP PATIENTS RANDOMLY ASSIGNED TO THE LIFEMASTERS DEMONSTRATION FROM JANUARY 2005 THROUGH SEPTEMBER 2006, AMONG THOSEWHO QUALIFIED FOR THE LIFEMASTERS REDESIGN
(Percentages, Unless Otherwise Noted)

	Treatment Group	Control Group	Treatment-Control Difference
Demographic Characteristics			
Age at Enrollment			
Average age (in years)	71.1	71.0	0.1
Younger than 65	22.7	22.7	-0.1
65 to 69	16.4	16.6	-0.2
70 to 74	18.6	18.4	0.2
75 to 79	18.0	17.9	0.1
80 to 84	12.8	12.3	0.5
85 or older	11.6	12.2	-0.6
Gender (Male)	35.4	35.9	-0.5
Race			
White	52.8	52.8	0.1
Black	19.8	19.8	0.1
Asian	1.2	1.3	0.0
Other[a]	26.1	26.2	-0.1
Ethnicity (Hispanic)	24.0	24.3	-0.3
Original Reason for Medicare: Disabled	36.5	35.7	0.7
Medical Conditions Treated During the Two Years Before Enrollment			
Coronary Artery Disease	83.5	83.6	-0.1
Congestive Heart Failure	60.8	61.0	-0.2
Stroke	49.2	49.6	-0.4
Diabetes	73.5	72.2	1.2
Cancer	23.6	23.5	0.2
Chronic Obstructive Pulmonary Disease	60.0	59.3	0.7
Dementia (Including Alzheimer's Disease)	21.0	21.0	0.0
Peripheral Vascular Disease	47.7	48.2	-0.5
HIV/AIDS	3.1	3.1	0.0
Depression	29.6	30.6	-1.0
Asthma	28.6	27.5	1.2
Bipolar Disorder	4.7	5.1	-0.4
Schizophrenia	6.3	6.4	-0.1
Coagulation Disorders	12.0	11.6	0.4
Sickle Cell Anemia	0.5	0.3	0.1
Number of Conditions Above			
0	0.5	0.5	0.0
1	3.2	2.7	0.5
2	7.9	8.6	-0.7
3	13.9	13.9	0.0
4	17.1	17.0	0.1
5 or more	57.5	57.3	0.2
Number of Patients			

TABLE C.3 *(continued)*

	Treatment Group	Control Group	Treatment-Control Difference
Hospitalizations, Expenditures, and Number of Physicians			
Annualized Number of Hospitalizations in the Two Years Before Enrollment[b]			
Average	0.9	0.8	0.0
0	40.6	41.6	-1.0
1.0 or less	35.9	35.5	0.4
1.1 to 2.0	13.3	12.8	0.4
2.1 to 3.0	5.4	5.1	0.3
3.1 or more	4.8	4.9	-0.1
Had One or More Hospitalizations in Each of the Two Years Before Enrollment	22.1	22.3	-0.1
Days Between Last Hospital Discharge and Enrollment			
No hospitalization in the last two years	40.6	41.6	-1.0
Still in hospital when randomized	2.0	1.9	0.1
0 to 30	6.1	5.5	0.6
31 to 60	4.4	4.6	-0.2
61 to 180	13.3	12.9	0.4
181 to 365	14.6	14.3	0.2
366 to 730	19.1	19.2	-0.1
Medicare Expenditures per Month in FFS During the Two Years Before Enrollment			
Inpatient[c]	$550	$533	$18
SNF	$69	$62	$7
Home health (Part A)	$38	$39	$0
Total Part A	$659	$635	$24
Other Part B[d]	$540	$529	$12
Outpatient[e]	$147	$144	$3
Physician services	$84	$82	$3
DME	$258	$253	$5
Home health (Part B)	$204	$200	$3
Total Part B	$1,232	$1,207	$26
Total Expenditures	$1,891	$1,841	$50
Medicare Expenditures per Month in FFS During the Two Years Before Enrollment			
$0 to 250	15.0	15.3	-0.3
$251 to 500	14.6	13.7	1.0
$501 to 1,000	19.4	19.6	-0.2
$1,001 to 2,000	21.1	22.5	-1.4
$2,001 to 3,000	11.6	11.3	0.3
More than $3,000	18.3	17.6	0.6
Had Medicare Expenditures per Month in Top Quartile Both Years Before Enrollment[f]	23.0	22.1	0.9
Average Number of Physicians Billed in the Year Prior to Enrollment[g]	14.4	14.1	0.2
Number of Patients	**13,090**	**5,253**	

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Patients were eligible for the redesign if they had claims for CHF or claims for at least two of the three target conditions, and if they resided in Alachua, Broward, Marion, Miami-Dade, Orange, Palm Beach, Seminole, or Volusia counties.

[a]Other includes North American Native and other races.

[b]Calculated as 12 × (number of hospitalizations during two years before month of enrollment) ÷ (number of months eligible). For example, if a beneficiary was eligible all 24 months and had two hospitalizations during that time, that beneficiary would have one hospitalization per year [(12 × 2) ÷ 24]. If another beneficiary was eligible for eight months during the previous two years and had two hospitalizations during those eight months, that beneficiary would have three hospitalizations per year [(12 × 2) ÷ 8].

[c]Inpatient hospitalization data includes claims for stays at short-term, critical access, long-term, rehabilitation, and psychiatric hospitals.

[d]Other costs include hospice, lab/radiology, and other Part B costs.

[e]Outpatient utilization includes all outpatient claims, outpatient care provided in a hospital, renal dialysis facility, clinic, ambulatory surgical center, or health center.

[f]The quartile is calculated for the combined treatment and control groups in each year.

[g]Calculated as the number of unique physician identification numbers. This includes non-physician practitioners.

**Treatment-control differences are significant at the 0.05 level, two-tailed t-test.
***Treatment-control differences are significant at the 0.01 level, two-tailed t-test.

DME = durable medical equipment; FFS = fee for service; SNF = skilled nursing facility.

TABLE C.4

PRE-ENROLLMENT CHARACTERISTICS OF TREATMENT AND CONTROL GROUP PATIENTS RANDOMLY ASSIGNED TO THE LIFEMASTERS DEMONSTRATION FROM JANUARY 2005 THROUGH SEPTEMBER 2006, AMONG THOSE WHO DID NOT QUALIFY FOR THE LIFEMASTERS REDESIGN
(Percentages, Unless Otherwise Noted)

	Treatment Group	Control Group	Treatment-Control Difference
Demographic Characteristics			
Age at Enrollment			
Average age (in years)	67.1	67.1	-0.1
Younger than 65	33.4	33.4	0.0
65 to 69	17.1	16.5	0.6
70 to 74	17.5	17.4	0.1
75 to 79	14.4	15.1	-0.7
80 to 84	10.2	10.1	0.2
85 or older	7.4	7.5	-0.2
Gender (Male)	32.9	32.7	0.3
Race			
White	55.2	54.4	0.8
Black	25.6	26.1	-0.5
Asian	1.9	1.7	0.2
Other[a]	17.3	17.8	-0.5
Ethnicity (Hispanic)	15.1	15.5	-0.4
Original Reason for Medicare: Disabled	45.5	45.4	0.1
Medical Conditions Treated During the Two Years Before Enrollment			
Coronary Artery Disease	61.6	62.2	-0.6
Congestive Heart Failure	24.5	24.0	0.4
Stroke	35.5	35.8	-0.3
Diabetes	59.3	59.6	-0.3
Cancer	18.7	18.1	0.5
Chronic Obstructive Pulmonary Disease	42.0	41.7	0.3
Dementia (Including Alzheimer's Disease)	14.3	14.1	0.2
Peripheral Vascular Disease	31.8	31.3	0.6
HIV/AIDS	3.5	3.4	0.1
Depression	24.6	25.6	-1.0
Asthma	21.7	21.3	0.4
Bipolar Disorder	5.0	5.2	-0.2
Schizophrenia	6.5	6.9	-0.4
Coagulation Disorders	6.4	5.9	0.5
Sickle Cell Anemia	0.2	0.2	0.0
Number of Conditions Above			
0	2.1	2.1	-0.1
1	13.2	12.6	0.6
2	18.5	19.4	-0.9
3	19.3	19.6	-0.3
4	17.2	16.9	0.3
5 or more	29.7	29.4	0.3
Number of Patients			

TABLE C.4 *(continued)*

	Treatment Group	Control Group	Treatment-Control Difference
Hospitalizations, Expenditures, and Number of Physicians			
Annualized Number of Hospitalizations in the Two Years Before Enrollment[b]			
Average	0.5	0.5	0.0
0	54.8	54.9	-0.0
1.0 or less	31.6	31.6	-0.0
1.1 to 2.0	8.3	8.5	-0.2
2.1 to 3.0	2.8	2.8	-0.0
3.1 or more	2.5	2.2	0.3
Had One or More Hospitalizations in Each of the Two Years Before Enrollment	13.2	13.6	-0.4
Days Between Last Hospital Discharge and Enrollment			
No hospitalization in the last two years	54.8	54.9	-0.0
Still in hospital when randomized	1.3	1.2	0.1
0 to 30	4.1	4.3	-0.2
31 to 60	3.3	3.3	0.1
61 to 180	9.9	9.8	0.1
181 to 365	11.1	11.1	0.0
366 to 730	15.5	15.5	-0.0
Medicare Expenditures per Month in FFS During the Two Years Before Enrollment			
Inpatient[c]	$311	$300	$12
SNF	$48	$43	$5
Home health (Part A)	$22	$21	$1
Total Part A	$383	$366	$17
Other Part B[d]	$377	$346	$31
Outpatient[e]	$94	$98	-$4
Physician services	$47	$46	$1
DME	$121	$118	$3
Home health (Part B)	$54	$51	$3
Total Part B	$693	$658	$35
Total Expenditures	$1,076	$1,024	$52
Medicare Expenditures per Month in FFS During the Two Years Before Enrollment			
$0 to 250	31.4	31.7	-0.2
$251 to 500	19.5	20.1	-0.5
$501 to 1,000	19.3	19.1	0.1
$1,001 to 2,000	16.0	16.1	-0.1
$2,001 to 3,000	6.8	6.3	0.5
More than $3,000	6.9	6.7	0.2
Had Medicare Expenditures per Month in Top Quartile Both Years Before Enrollment[f]	9.2	9.0	0.2
Average Number of Physicians Billed in the Year Prior to Enrollment[g]	11.4	11.2	0.2
Number of Patients	**23,869**	**9,544**	

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Patients were eligible for the redesign if they had claims for CHF or claims for at least two of the three target conditions, and if they resided in Alachua, Broward, Marion, Miami-Dade, Orange, Palm Beach, Seminole, or Volusia counties.

[a]Other includes North American Native and other races.

[b]Calculated as 12 × (number of hospitalizations during two years before month of enrollment) ÷ (number of months eligible). For example, if a beneficiary was eligible all 24 months and had two hospitalizations during that time, that beneficiary would have one hospitalization per year [(12 × 2) ÷ 24]. If another beneficiary was eligible for eight months during the previous two years and had two hospitalizations during those eight months, that beneficiary would have three hospitalizations per year [(12 × 2) ÷ 8].

[c]Inpatient hospitalization data includes claims for stays at short-term, critical access, long-term, rehabilitation, and psychiatric hospitals.

[d]Other costs include hospice, lab/radiology, and other Part B costs.

[e]Outpatient utilization includes all outpatient claims, outpatient care provided in a hospital, renal dialysis facility, clinic, ambulatory surgical center, or health center.

[f]The quartile is calculated for the combined treatment and control groups in each year.

[g]Calculated as the number of unique physician identification numbers.

**Treatment-control differences are significant at the 0.05 level, two-tailed t-test.
***Treatment-control differences are significant at the 0.01 level, two-tailed t-test.

DME = durable medical equipment; FFS = fee for service; SNF = skilled nursing facility.

TABLE C.5

MEAN VALUES OF CONTROL VARIABLES USED IN REGRESSION ANALYSES BY TREATMENT STATUS
(Percentages, Unless Otherwise Noted)

	Treatment	Control
Demographic Characteristics		
Resides in Miami-Dade county at enrollment	31.3	31.4
Resides in a North Florida county at enrollment[a]	46.4	46.5
Age at Enrollment[b]		
Younger than 65	29.6	29.6
At least 65 but less than 70	16.8	16.5
At least 70 but less than 75	17.9	17.8
At least 75 but less than 80	15.7	16.1
At least 80 but less than 85	11.1	10.8
85 or older	8.9	9.2
Gender (Male)	33.8	33.8
Race		
Black	23.6	23.9
Other[c]	58.2	57.5
Ethnicity (Hispanic)	18.2	18.6
Original Reason for Medicare: Disabled	42.3	42.0
Medical Conditions Treated During the Two Years Before Enrollment		
Coronary Artery Disease	69.1	69.0
Congestive Heart Failure	33.2	33.4
Diabetes	59.0	58.5
Chronic Obstructive Pulmonary Disease	48.3	47.9
HIV/AIDS	3.3	3.3
Depression	26.4	27.4
Bipolar Disorder	4.9	5.2
Coagulation Disorder	8.4	7.9
Percent with Five or more Chronic Medical Conditions[d]	39.5	39.3
Hospitalizations, Expenditures, and Number of Physicians		
Had a Hospitalization in the Year Before Enrollment	33.1	32.7
Had One or More Hospitalizations in Each of the Two Years Before Enrollment	16.3	16.7
Medicare Expenditures per Month in FFS in the Year Before Enrollment[e]		
First Quartile (25% or less)	24.9	25.4
Second Quartile (26% to 50%)	25.0	24.9
Third Quartile (51% to 75%)	25.0	25.1
Fourth Quartile (76% or more)	25.2	24.6
Medicare Expenditures per Month in FFS in the Year Prior to the Year Before Enrollment in Highest Quartile	25.0	24.7
Days since Last Hospital Discharge in the Year before Enrollment	48.5	48.0
Number of Physicians Billed in the Year Prior to Enrollment[f]	12.4	12.3

Source: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

[a] North Florida includes Alachua, Brevard, Duval, Lake, Marion, Orange, Seminole, and Volusia counties.

TABLE C.5 *(continued)*

[b] Sample members less than 65 years old comprise the reference group in regression analyses.
[c] Other includes White, Asian, North American Native and other races. This group is the reference category for regression analyses.
[d] Conditions include coronary artery disease, congestive heart failure, stroke, diabetes, cancer, chronic pulmonary obstructive disease, dementia, peripheral vascular disease, depression, asthma, bipolar disorder, schizophrenia, coagulation disorder, sickle-cell anemia, and HIV/AIDS.
[e] The lowest cost quartile is the reference category for regression analyses.
[f] Calculated as the number of unique physician identification numbers.

FFS = fee-for-service

TABLE C.6

EMPIRICAL DISTRIBUTION OF THE NUMBER OF HOSPITALIZATIONS PER PATIENT, AMONG PATIENTS IN THE COHORTS DEFINED BY MONTHS 1 TO 12, 13 TO 24, AND 25 TO 36 AFTER ENROLLMENT

	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value
Months 1 to 12 After Enrollment				
0	66.3	66.4	-0.1	0.906
1	18.2	18.0	0.2	
2 or More	15.5	15.6	-0.0	
Number of Patients	**36,959**	**14,797**		
Months 13 to 24 After Enrollment				
0	74.4	73.5	0.9	0.254
1	14.6	15.0	-0.5	
2 or More	11.0	11.4	-0.4	
Number of Patients	**23,545**	**9,395**		
Months 25 to 36 After Enrollment				
0	78.0	78.0	0.1	0.414
1	12.8	13.5	-0.7	
2 or More	9.2	8.5	0.6	
Number of Patients	**7,701**	**3,119**		

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Analyses of months 1 to 12 and months 13 to 24 after enrollment include sample members enrolled early enough in program operations to potentially be observed for 12 or 24 months. For example, only patients enrolled in the demonstration on or before January 2006 were included in the follow-up measures for months 13 to 24 after enrollment. Analyses for months 25 to 36 include anyone with more than 24 months of enrollment.

††Treatment and control group distributions are significantly different from 0 at the 0.05 level, chi-squared test.
†††Treatment and control group distributions are significantly different from 0 at the 0.01 level, chi-squared test.

TABLE C.7

EMPIRICAL DISTRIBUTION OF EMERGENCY ROOM VISITS PER PATIENT, AMONG PATIENTS IN THE COHORTS DEFINED BY MONTHS 1 TO 12, 13 TO 24, AND 25 TO 36 AFTER ENROLLMENT

	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value
Months 1 to 12 After Enrollment				
0	70.7	70.2	0.5	0.433
1	18.1	18.6	-0.5	
2 or More	11.2	11.2	-0.1	
Number of Patients	**36,959**	**14,797**		
Months 13 to 24 After Enrollment				
0	78.8	78.4	0.4	0.434
1	14.6	15.1	-0.5	
2 or More	6.6	6.5	0.1	
Number of Patients	**23,545**	**9,395**		
Months 25 to 36 After Enrollment				
0	85.4	85.7	-0.3	0.648
1 or More	14.6	14.3	0.3	
Number of Patients	**7,701**	**3,119**		

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Analyses of months 1 to 12 and months 13 to 24 after enrollment include sample members enrolled early enough in program operations to potentially be observed for 12 or 24 months. For example, only patients enrolled in the demonstration on or before January 2006 included in the follow-up measures for months 13 to 24 after enrollment. Analyses for months 25 to 36 include anyone with more than 24 months of enrollment.

††Treatment and control group distributions are significantly different from 0 at the 0.05 level, chi-squared test.
†††Treatment and control group distributions are significantly different from 0 at the 0.01 level, chi-squared test.

TABLE C.8

COMPARISON OF ARC FINAL RECONCILIATION FIGURES AND MPR REGRESSION ESTIMATES OF PER-MEMBER-PER-MONTH COSTS FOR THE REDESIGN SAMPLE, FOR ALL MONTHS OF OPERATIONS

	Treatment		Control	
	MPR	ARC	MPR	ARC
Sample Size	13,090	13,116	5,253	5,268
Member Months	290,354	297,797	116,901	119,781
PMPM Costs	$2,372	$2,430	$2,479	$2,526

Sources: Medicare Enrollment Database, National Claims History file, and Standard Analytic File (MPR columns).

Monitoring Report XII: LifeMasters CMS Medicare Dual Eligible Demonstration, Actuarial Research Corporation, May 5, 2008.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the 36-month follow-up period the sample member meets CMS's demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations in the group.

Sample size differences are due to differences in data sources (both Medicare EDB and claims data) used by ARC and MPR. While ARC used the most recently available claims data for their monitoring report in May 2008, MPR used updated EDB (accessed in July 2008) and claims to determine eligibility for the demonstration. Most of the differences were due to updated claims data from which MPR identified 177 patients who were ineligible at the time of enrollment due to a psychiatric hospitalization of 14 or more days or an organ transplant in the 12 months before enrollment.

ARC estimated member months and PMPM costs over 37 months, from January 2005 through January 2008. MPR estimated member months and PMPM costs over 36 months, from January 2005 through December 2007.

Patients were eligible for the redesign if they had claims for CHF or claims for at least two of the three target conditions, and if they resided in Alachua, Broward, Marion, Miami-Dade, Orange, Palm Beach, Seminole, or Volusia counties.

ARC = Actuarial Research Corporation; CMS = Centers for Medicare & Medicaid Services; EDB = enrollment database; MPR = Mathematica Policy Research, Inc; PMPM = per-member-per-month.

TABLE C.9

AVERAGE MEDICARE EXPENDITURES PER MEMBER PER MONTH ENROLLED, THROUGH ALL MONTHS OF PROGRAM OPERATIONS, FOR EXPENDITURES TRUNCATED AT THE 99TH PERCENTILE
(Regression Adjusted)

	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value
Average Medicare Payments per Month in Fee for Service				
Part A	$659	$655	$4	0.728
Part B	$1,133	$1,154	-$21	0.075
Total	$1,819	$1,841	-$22	0.268
Sample Size	**36,959**	**14,797**		

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix B for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the 36-month follow-up period the sample member meets the Centers for Medicare & Medicaid Services' demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations in the group.

Includes all patients who were enrolled from January 2005 through September 2006 who were eligible for the demonstration in their first month of enrollment.

**Difference between the treatment and control groups is significantly different from 0 at the 0.05 level, 2-tailed t-test.
***Difference between the treatment and control groups is significantly different from 0 at the 0.01 level, 2-tailed t-test.

TABLE C.10

DISTRIBUTION OF AVERAGE MONTHLY MEDICARE EXPENDITURES AMONG ALL PROGRAM ENROLLEES, THROUGH ALL MONTHS OF PROGRAM OPERATIONS

	Percentage of Patients in Each Decile of Average Monthly Medicare Expenditures		
	Treatment Group	Control Group	*p*-Value
Decile 1 (Top 10 Percent)	10.0	9.9	0.027 ††
Decile 2	10.1	9.9	
Decile 3	10.2	9.4	
Decile 4	9.9	10.3	
Decile 5	9.8	10.5	
Decile 6	10.1	9.7	
Decile 7	10.0	10.0	
Decile 8	10.1	9.8	
Decile 9	9.8	10.4	
Decile 10 (Lowest 10 Percent)	10.0	10.1	
Sample Sizes	**36,959**	**14,797**	

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Includes all patients enrolled from January 2005 through September 2006 and eligible for the demonstration in their first month of enrollment.

To determine deciles, we examined the distribution of average monthly Medicare expenditures across all treatment and control group members combined. Decile 1 includes beneficiaries with average monthly expenditures in the top 10 percent of that combined distribution while decile 10 includes beneficiaries with average monthly Medicare expenditures in the lowest 10 percent of that distribution.

††Treatment and control group distributions are significantly different from 0 at the 0.05 level, chi-squared test.
†††Treatment and control group distributions are significantly different from 0 at the 0.01 level, chi-squared test.

TABLE C.11

MEDICARE EXPENDITURES FOR PART A AND PART B SERVICES IN MONTHS 1 TO 12, 13 TO 24 AND 25 TO 36 AFTER ENROLLMENT
(Regression Adjusted)

	Months 1 – 12				Months 13 - 24				Months 25 - 36			
	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value
Part A												
Inpatient[a]	527	516	11	0.473	556	555	0	0.985	675	702	-28	0.525
Skilled nursing facility	100	97	4	0.414	99	98	1	0.927	119	119	0	0.991
Part B												
Other costs[b]	336	344	-8	0.466	356	376	-20	0.019**	276	283	-7	0.482
Hospice	0	0	0	0.671	0	0	0	0.714	--	--	--	--
Lab/radiology	128	129	-2	0.412	171	180	-9	0.006***	146	150	-4	0.332
Other	208	214	-7	0.536	185	195	-11	0.128	130	133	-3	0.699
Home health[c]	234	234	1	0.937	439	457	-17	0.196	996	1,083	-87	0.019**
Durable medical equipment	151	154	-3	0.374	233	235	-2	0.747	216	229	-14	0.120
Outpatient[d]	141	143	-2	0.623	180	185	-5	0.281	256	296	-40	0.001***
Physician services	163	162	1	0.595	180	182	-2	0.570	210	217	-7	0.326
Total Costs	1,653	1,649	4	0.871	2,043	2,088	-45	0.203	2,747	2,929	-182	0.012**
Number of Patients	**36,959**	**14,797**			**23,545**	**9,395**			**7,701**	**3,119**		

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

All patients enrolled from January 2005 through September 2006 are included in the analysis of all program months. Analyses for months 1 to 12 and months 13 to 24 after enrollment include sample members enrolled early enough in program operations to potentially be observed for 12 or 24 months. For example, only patients enrolled in the demonstration on or before January 2006 were included in the follow-up measures for months 13 to 24 after enrollment. Sample members with more than 24 months of enrollment are included in the months 25 to 36 analysis.

[a]Inpatient hospitalization data includes claims for stays at short-term, critical access, long-term, rehabilitation, and psychiatric hospitals.
[b]Other costs include hospice, lab/radiology, and other Part B costs.
[c]Home health costs include costs covered by Medicare Part A and Part B.
[d]Outpatient utilization includes all outpatient claims, outpatient care provided in a hospital, renal dialysis facility, clinic, ambulatory surgical center, or health center.

**Significantly different from zero at the 0.05 level, two-tailed t-test.
***Significantly different from zero at the 0.01 level, two-tailed t-test.

TABLE C.12

AVERAGE MEDICARE EXPENDITURES PER MEMBER PER MONTH ENROLLED, THROUGH ALL MONTHS OF PROGRAM OPERATIONS, FOR EXPENDITURES TRUNCATED AT THE 99TH PERCENTILE AMONG SAMPLE MEMBERS ELIGIBLE FOR THE REDESIGN
(Regression Adjusted)

	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value
Average Medicare Payments per Month in Fee for Service				
Part A	$824	$853	-$29	0.220
Part B	$1,485	$1,551	-$66	0.004***
Total	$2,342	$2,445	-$103	0.006***
Sample Size	**13,090**	**5,253**		

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix B for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the 36-month follow-up period the sample member meets the Centers for Medicare & Medicaid Services' demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations in the group.

Includes all patients who were enrolled from January 2005 through September 2006 who were eligible for the demonstration in their first month of enrollment, and eligible for the LifeMasters redesign.

Patients were eligible for the redesign if they had claims for CHF or claims for at least two of the three target conditions, and if they resided in Alachua, Broward, Marion, Miami-Dade, Orange, Palm Beach, Seminole, or Volusia counties.

**Difference between the treatment and control groups is significantly different from 0 at the 0.05 level, 2-tailed t-test.
***Difference between the treatment and control groups is significantly different from 0 at the 0.01 level, 2-tailed t-test.

TABLE C.13

MEDICARE EXPENDITURES FOR PART B SERVICES IN MONTHS 1 TO 12, 13 TO 24 AND 25 TO 36 AFTER ENROLLMENT AMONG THE REDESIGN POPULATION
(Regression Adjusted)

	Months 1 - 12				Months 13 - 24				Months 25 - 36			
	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value
Part A												
Inpatient[a]	689	721	-33	0.279	693	718	-25	0.531	695	722	-26	0.592
Skilled nursing facility	118	120	-2	0.797	124	129	-5	0.614	123	123	-0	0.990
Part B												
Other costs[b]	410	438	-29	0.186	371	398	-27	0.060	274	278	-4	0.725
Hospice	0	0	0	0.682	0	0	0	0.753	--	--	--	--
Laboratory/radiology	164	169	-5	0.214	184	190	-5	0.337	144	147	-3	0.455
Other	246	270	-24	0.250	187	209	-22	0.070	130	131	-1	0.924
Home health[c]	425	433	-8	0.640	613	663	-50	0.058	1023	1112	-89	0.032**
Durable medical equipment	214	220	-6	0.384	259	262	-3	0.748	215	227	-12	0.203
Outpatient[d]	174	179	-5	0.458	189	203	-14	0.104	254	297	-43	0.001***
Physician services	202	206	-4	0.392	213	222	-9	0.173	214	221	-7	0.364
Total Costs	2,233	2,318	-85	0.080	2,462	2,595	-133	0.036**	2,798	2,980	-182	0.024**
Number of Patients	**13,090**	**5,253**			**8,452**	**3,388**			**6,164**	**2,503**		

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix B for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Includes all patients enrolled from January 2005 through September 2006 and eligible for the redesign.

Patients were eligible for the redesign if they had claims for CHF or claims for at least two of the three target conditions, and if they resided in Alachua, Broward, Marion, Miami-Dade, Orange, Palm Beach, Seminole, or Volusia counties.

[a]Inpatient hospitalization data includes claims for stays at short-term, critical access, long-term, rehabilitation, and psychiatric hospitals.
[b]Other costs include hospice, laboratory/radiology, and other Part B costs.
[c]Home health costs include costs covered by Medicare Part A and Part B.
[d]Outpatient utilization includes all outpatient claims, outpatient care provided in a hospital, renal dialysis facility, clinic, ambulatory surgical center, or health center.

**Significantly different from zero at the 0.05 level, two-tailed t-test.
***Significantly different from zero at the 0.01 level, two-tailed t-test.

TABLE C.14

THE PERCENTAGE OF PATIENTS WITH A HOSPITAL ADMISSION AND THE AVERAGE ANNUALIZED NUMBER OF ADMISSIONS IN MONTHS 1 TO 12, 13 TO 24, AND 25 TO 36 AFTER ENROLLMENT, AND ALL MONTHS OF PROGRAM OPERATIONS AMONG THE REDESIGN POPULATION
(Regression Adjusted)

Sample Sizes		Any Admission (Percentage)					Average Annualized Number of Admissions per Year				
Treatment Group	Control Group	Treatment Group	Control Group	Treatment-Control Difference	Percentage Change	*p*-Value	Treatment Group	Control Group	Treatment-Control Difference	Percentage Change	*p*-Value
Months 1 to 12 After Enrollment											
13,090	5,253	41.77	42.15	-0.38	-0.89	0.615	0.94	0.97	-0.03	-2.74	0.340
Months 13 to 24 After Enrollment											
8,452	3,388	40.25	41.57	-1.32	-3.17	0.163	0.92	0.96	-0.04	-4.13	0.266
Months 25 to 36 After Enrollment											
6,164	2,503	39.56	39.60	-0.03	-0.08	0.977	0.85	0.85	-0.00	-0.49	0.924
All Months of Program Operations											
13,090	5,253	61.62	62.20	-0.58	-0.94	0.430	0.92	0.94	-0.03	-2.68	0.276

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix B for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the 12- or 24-month follow-up period the sample member meets the Centers for Medicare & Medicaid Services' demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations in the group.

All patients enrolled from January 2005 through September 2006 and eligible for the redesign are included in the analysis of all program months. Other analyses include sample members enrolled early enough in program operations to potentially be observed for 12 or 24 months. For example, only patients enrolled in the demonstration on or before January 2006 were included in the analysis of months 13 to 24 after enrollment. Analyses for months 25 to 36 include anyone with more than 24 months of enrollment.

Patients were eligible for the redesign if they had claims for CHF or claims for at least two of the three target conditions, and if they resided in Alachua, Broward, Marion, Miami-Dade, Orange, Palm Beach, Seminole, or Volusia counties.

**Difference between the treatment and control groups is significantly different from 0 at the 0.05 level, 2-tailed t-test.
***Difference between the treatment and control groups is significantly different from 0 at the 0.01 level, 2-tailed t-test.

TABLE C.15

EMPIRICAL DISTRIBUTION OF THE NUMBER OF HOSPITALIZATIONS PER PATIENT, AMONG PATIENTS IN THE COHORTS DEFINED BY MONTHS 1 TO 12, 13 TO 24, AND 25 TO 36 AFTER ENROLLMENT, AMONG THE REDESIGN POPULATION

	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value
Months 1 to 12 After Enrollment				
0	60.2	60.2	-0.0	0.832
1	20.0	19.7	0.3	
2 or More	19.8	20.1	-0.3	
Number of Patients	**13,090**	**5,253**		
Months 13 to 24 After Enrollment				
0	61.7	60.2	1.5	0.210
1	19.3	19.5	-0.2	
2 or More	19.0	20.3	-1.3	
Number of Patients	**8,452**	**3,388**		
Months 25 to 36 After Enrollment				
0	73.7	73.8	-0.1	0.548
1	15.0	15.6	-0.6	
2 or More	11.2	10.5	0.7	
Number of Patients	**6,164**	**2,503**		

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix B for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the 12- or 24-month follow-up period the sample member meets the Centers for Medicare & Medicaid Services' demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations in the group.

All patients enrolled from January 2005 through September 2006 and eligible for the redesign are included in the analysis of all program months. Other analyses include sample members enrolled early enough in program operations to potentially be observed for 12 or 24 months. For example, only patients enrolled in the demonstration on or before January 2006 were included in the analysis of months 13 to 24 after enrollment. Analyses for months 25 to 36 include anyone with more than 24 months of enrollment.

Patients were eligible for the redesign if they had claims for CHF or claims for at least two of the three target conditions, and if they resided in Alachua, Broward, Marion, Miami-Dade, Orange, Palm Beach, Seminole, or Volusia counties.

††Treatment and control group distributions are significantly different from 0 at the 0.05 level, chi-squared test.
†††Treatment and control group distributions are significantly different from 0 at the 0.01 level, chi-squared test.

TABLE C.16

INPATIENT READMISSIONS WITHIN 30, 60, AND 90 DAYS OF A DISCHARGE THROUGH ALL MONTHS OF PROGRAM OPERATIONS, AMONG THE REDESIGN POPULATION
(Regression Adjusted)

	Number of Patients		Number of Discharges		Percentage Resulting in Readmission			
	Treatment Group	Control Group	Treatment Group	Control Group	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value
Percentage of Hospital Discharges that Result in Readmission								
30 Days	6,644	2,680	14,425	5,962	23.91	24.04	-0.13	0.772
60 Days	6,331	2,565	12,047	4,973	32.43	32.87	-0.44	0.443
90 Days	6,030	2,446	10,393	4,280	37.62	38.45	-0.83	0.272
Percentage of Hospital Discharges that Result in Readmission or Truncated by Death								
30 Days	6,774	2,731	14,767	6,105	25.84	26.02	-0.18	0.717
60 Days	6,559	2,650	12,541	5,162	35.26	35.57	-0.31	0.554
90 Days	6,341	2,557	10,973	4,514	41.14	41.91	-0.77	0.284

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix B for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Includes all patients with qualifying hospital admission enrolled from January 2005 through September 2006 and eligible for the redesign.

Patients were eligible for the redesign if they had claims for CHF or claims for at least two of the three target conditions, and if they resided in Alachua, Broward, Marion, Miami-Dade, Orange, Palm Beach, Seminole, or Volusia counties.

A readmission is defined as any inpatient admission that occurs within 30 (60 or 90) days of qualifying discharge. A qualifying hospital discharge is included in this table if the discharged patient is enrolled in the 30 (60 or 90 days) following that discharge and that patient did not have a previous discharge in the last 30 (60 or 90) days. In the first measure, a dicharge is excluded if the patient died during the inpatient admission or was transferred to another acute care facility.

††Treatment and control group distributions are significantly different from 0 at the 0.05 level, chi-squared test.
†††Treatment and control group distributions are significantly different from 0 at the 0.01 level, chi-squared test.

TABLE C.17

THE PERCENTAGE OF PATIENTS WITH AN OUTPATIENT EMERGENCY ROOM VISIT AND THE AVERAGE ANNUALIZED NUMBER OF VISITS IN MONTHS 1 TO 12, 13 TO 24, AND 25 TO 36 AFTER ENROLLMENT
AND ALL MONTHS OF PROGRAM OPERATIONS, AMONG THE REDESIGN POPULATION
(Regression Adjusted)

	Sample Sizes		Any Use (Percentage)					Average Annualized Number of Visits per Year				
	Treatment Group	Control Group	Treatment Group	Control Group	Treatment-Control Difference	Percentage Change	*p*-Value	Treatment Group	Control Group	Treatment-Control Difference	Percentage Change	*p*-Value
Months 1 to 12 After Enrollment												
	13,090	5,253	31.79	32.01	-0.22	-0.68	0.764	0.60	0.60	-0.00	-0.68	0.864
Months 13 to 24 After Enrollment												
	8,452	3,388	30.99	30.99	0.00	0.01	0.997	0.58	0.56	0.02	2.61	0.614
Months 25 to 36 After Enrollment												
	6,164	2,503	27.68	26.97	0.72	2.65	0.489	0.44	0.45	-0.00	-0.98	0.889
All Months of Program Operations												
	13,090	5,253	50.81	51.03	-0.22	-0.42	0.783	0.57	0.56	0.00	0.64	0.856

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix B for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the follow-up period the sample member meets the Centers for Medicare & Medicaid Services' demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations in the group.

All patients enrolled from January 2005 through September 2006 are included in the analysis of all program months. Other analyses include sample members enrolled early enough in program operations to potentially be observed for 12 or 24 months. For example, only patients enrolled in the demonstration on or before January 2006 were included in the analysis of months 13 to 24 after enrollment. Analyses for months 25 to 36 include anyone with more than 24months of enrollment.

Patients were eligible for the redesign if they had claims for CHF or claims for at least two of the three target conditions, and if they resided in Alachua, Broward, Marion, Miami-Dade, Orange, Palm Beach, Seminole, or Volusia counties.

**Difference between the treatment and control groups is significantly different from 0 at the 0.05 level, 2-tailed test.
***Difference between the treatment and control groups is significantly different from 0 at the 0.01 level, 2-tailed test.

TABLE C.18

EMPIRICAL DISTRIBUTION OF NUMBER OF EMERGENCY ROOM VISITS PER PATIENT, AMONG PATIENTS IN THE COHORTS DEFINED BY MONTHS 1 TO 12, 13 TO 24, AND 25 TO 36 AFTER ENROLLMENT, AMONG THE REDESIGN POPULATION

	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value
Months 1 to 12 After Enrollment				
0	70.5	70.5	0.0	0.937
1	18.5	18.7	-0.2	
2 or More	11.0	10.8	0.2	
Number of Patients	**13,090**	**5,253**		
Months 13 to 24 After Enrollment				
0	71.2	71.1	0.0	0.844
1	18.5	18.8	-0.3	
2 or More	10.4	10.1	0.3	
Number of Patients	**8,452**	**3,388**		
Months 25 to 36 After Enrollment				
0	82.5	83.1	-0.6	0.506
1 or More	17.5	16.9	0.6	
Number of Patients	**6,164**	**2,503**		

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix B for a complete set of diagnostic eligibility criteria specified by LifeMasters.

The months 1 to 12 and 13 to 24 analyses include sample members enrolled early enough in program operations to potentially be observed for 12 or 24 months. For example, only patients enrolled in the demonstration on or before January 2006 were included in the analysis of months 13 to 24 after enrollment. Analyses for months 25 to 36 include anyone with more than 24 months of enrollment.

All analyses only include those patients eligible for the redesign. Patients were eligible for the redesign if they had claims for CHF or claims for at least two of the three target conditions, and if they resided in Alachua, Broward, Marion, Miami-Dade, Orange, Palm Beach, Seminole, or Volusia counties.

††Treatment and control group distributions are significantly different from 0 at the 0.05 level, chi-squared test.
†††Treatment and control group distributions are significantly different from 0 at the 0.01 level, chi-squared test.

TABLE C.19

PART B UTILIZATION IN MONTHS 1 TO 12, 13 TO 24, AND 25 TO 36 AFTER ENROLLMENT AND ALL MONTHS OF PROGRAM OPERATIONS, AMONG THE REDESIGN POPULATION
(Regression Adjusted)

	Sample Sizes		Any Use (Percentage)					Average Annualized Number of Visits per Year				
	Treatment Group	Control Group	Treatment Group	Control Group	Treatment-Control Difference	Percentage Change	*p*-Value	Treatment Group	Control Group	Treatment-Control Difference	Percentage Change	*p*-Value
Months 1 to 12 After Enrollment												
Laboratory/Radiology	13,090	5,253	96.58	96.57	0.00	0.00	0.991	17.66	17.98	-0.32	-1.76	0.244
Other[a]	13,090	5,253	81.33	82.24	-0.92	-1.11	0.123	11.96	12.56	-0.59	-4.73	0.057
Home Health	13,090	5,253	37.50	38.63	-1.13	-2.92	0.115	45.19	45.41	-0.22	-0.47	0.875
Outpatient[b]	13,090	5,253	75.64	74.24	1.40	1.89	0.039**	5.39	5.38	0.02	0.31	0.883
Physician Services	13,090	5,253	98.14	98.17	-0.03	-0.03	0.884	32.66	32.75	-0.09	-0.26	0.904
Months 13 to 24 After Enrollment												
Laboratory/Radiology	8,452	3,388	96.72	96.58	0.14	0.14	0.706	18.87	19.20	-0.34	-1.76	0.380
Other[a]	8,452	3,388	82.44	83.30	-0.85	-1.02	0.244	11.88	12.82	-0.94	-7.34	0.011**
Home Health	8,452	3,388	41.99	43.05	-1.06	-2.47	0.244	57.74	60.40	-2.66	-4.40	0.179
Outpatient[b]	8,452	3,388	75.37	76.08	-0.71	-0.93	0.401	5.53	5.88	-0.36	-6.08	0.021**
Physician Services	8,452	3,388	98.04	98.03	0.02	0.02	0.954	33.59	34.94	-1.36	-3.88	0.161
Months 25 to 36 After Enrollment												
Laboratory/Radiology	6,164	2,503	95.12	95.36	-0.24	-0.25	0.634	17.56	17.68	-0.12	-0.67	0.783
Other[a]	6,164	2,503	83.49	83.22	0.27	0.32	0.753	10.51	10.82	-0.32	-2.91	0.424
Home Health	6,164	2,503	54.32	56.16	-1.84	-3.27	0.090	78.31	82.79	-4.48	-5.41	0.094
Outpatient[b]	6,164	2,503	76.09	75.62	0.47	0.62	0.637	6.28	6.89	-0.61	-8.78	0.004***
Physician Services	6,164	2,503	97.48	97.65	-0.17	-0.17	0.646	32.47	34.12	-1.65	-4.83	0.186

TABLE C.19 *(continued)*

	Sample Sizes		Any Use (Percentage)					Average Annualized Number of Visits per Year				
	Treatment Group	Control Group	Treatment Group	Control Group	Treatment-Control Difference	Percentage Change	*p*-Value	Treatment Group	Control Group	Treatment-Control Difference	Percentage Change	*p*-Value
All Months of Program Operations												
Laboratory/Radiology	1,3090	5,253	98.76	98.64	0.12	0.12	0.508	17.93	18.21	-0.28	-1.53	0.245
Other[a]	13,090	5,253	92.13	92.54	-0.41	-0.44	0.328	11.56	12.17	-0.61	-5.04	0.013**
Home Health	1,3090	5,253	57.01	57.52	-0.51	-0.89	0.478	53.74	55.23	-1.49	-2.69	0.268
Outpatient[b]	13,090	5,253	88.12	87.39	0.74	0.84	0.154	5.54	5.72	-0.19	-3.26	0.075
Physician Services	13,090	5,253	99.19	99.17	0.02	0.02	0.880	32.66	33.40	-0.74	-2.22	0.225

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix B for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the follow-up period the sample member meets the Centers for Medicare & Medicaid Services' demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations in the group.

All patients enrolled from January 2005 through September 2006 and eligible for the redesign are included in the analysis of all program months. Other analyses include sample members enrolled early enough in program operations to potentially be observed for 12 or 24 months. For example, only patients enrolled in the demonstration on or before January 2006 were included in the analysis of months 13 to 24 after enrollment. Analyses for months 25 to 36 include anyone with at least 25 months of enrollment.

Use of hospice services and durable medical equipment were excluded from this table because very few patients used these services.

Patients were eligible for the redesign if they had claims for CHF or claims for two of the three target conditions and if they resided in Alachua, Broward, Marion, Miami-Dade, Orange, Palm Beach, Seminole, or Volusia counties.

[a]Other costs include hospice and other Part B costs.
[b]Outpatient utilization includes all outpatient claims, outpatient care provided in a hospital, renal dialysis facility, clinic, ambulatory surgical center, or health center.

**Difference between the treatment and control groups is significantly different from 0 at the 0.05 level, 2-tailed test.
***Difference between the treatment and control groups is significantly different from 0 at the 0.01 level, 2-tailed test.

TABLE C.20

MEDICARE EXPENDITURES AMONG BENEFICIARIES WHO DID NOT MEET LIFEMASTERS REDESIGN CRITIERIA
IN THE 12 MONTHS BEFORE AND THE 10 MONTHS AFTER THE REDESIGN
(Regression Adjusted)

	12 Months Before Redesign Began				Redesign Period (10 Months)			
	Treatment	Control	Difference	*p*-Value	Treatment	Control	Difference	*p*-Value
Average Medicare Payments per Month in Fee for Service								
Part A	$453	$434	$20	0.249	$547	$592	-$45	0.046**
Part B	$795	$790	$5	0.732	$815	$806	$9	0.559
Total	$1,248	$1,223	$25	0.316	$1,362	$1,398	-$37	0.229
Number of Patients	**18,087**	**7,197**						

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Includes all beneficiaries not eligible for the LifeMasters redesign who still met all other demonstration eligibility criteria on March 1, 2007. Observations are weighted according to the proportion of the follow-up period the sample member meets CMS's demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations.

Patients were eligible for the redesign if they had claims for CHF or claims for at least two of the three target conditions, and if they resided in Alachua, Broward, Marion, Miami-Dade, Orange, Palm Beach, Seminole, or Volusia counties.

**Difference between the treatment and control groups is significantly different from 0 at the 0.05 level, 2-tailed t-test.
***Difference between the treatment and control groups is significantly different from 0 at the 0.01 level, 2-tailed t-test.

TABLE C.21

MEDICARE EXPENDITURES IN THE FIRST 24 MONTHS AFTER ENROLLMENT, BY PRIMARY COMPONENTS OF EXPENDITURES AND COUNTY OR REGION OF RESIDENCE AT ENROLLMENT
(Regression Adjusted)

	Miami-Dade				Broward/Palm Beach				North Florida[a]			
	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value	Treatment Group	Control Group	Treatment-Control Difference	*p*-Value
Part A												
Inpatient[b]	$561	$572	-$11	0.683	$526	$527	-$0	0.989	$500	$471	$29	0.232
Skilled nursing facility	$64	$73	-$9	0.113	$120	$128	-$9	0.393	$120	$103	$17	0.035**
Part B												
Other costs[c]	$551	$612	-$61	0.007***	$299	$284	$15	0.321	$172	$160	$12	0.092
Hospice	$0	$0	$0	0.655	$0	$0	-$0	0.645	$0	$0	$0	0.558
Lab/radiology	$215	$232	-$17	0.001***	$123	$118	$5	0.112	$81	$78	$2	0.122
Other	$336	$381	-$45	0.038**	$176	$166	$10	0.473	$91	$82	$9	0.155
Home health[d]	$513	$533	-$19	0.334	$246	$242	$3	0.789	$83	$82	$0	0.931
Durable medical equipment	$318	$329	-$11	0.178	$106	$99	$7	0.158	$77	$78	-$1	0.702
Outpatient[e]	$237	$239	-$2	0.784	$118	$120	-$2	0.741	$90	$93	-$3	0.447
Physician services	$184	$187	-$3	0.431	$182	$181	$1	0.833	$145	$142	$3	0.376
Total Costs	$2,428	$2,545	-$117	0.017**	$1,597	$1,581	$16	0.719	$1,187	$1,130	$57	0.099
Number of Patients	**10,344**	**4,167**			**7,451**	**2,955**			**11,550**	**4,637**		

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix B for a complete set of diagnostic eligibility criteria specified by LifeMasters.

[a]North Florida counties include Alachua, Brevard, Duval, Lake, Marion, Orange, Seminole, and Volusia.
[b]Inpatient hospitalization data includes claims for stays at short-term, critical access, long-term, rehabilitation, and psychiatric hospitals.
[c]Other costs includes hospice, lab/radiology, and other Part B costs.
[d]Home health costs include costs covered by Medicare Part A and Part B. The Part B portion of home health costs makes up 92 percent of costs for Miami-Dade residents, 81 percent for Broward/Palm Beach residents, and 62 percent for North Florida residents.
[e]Outpatient utilization includes all outpatient claims, outpatient care provided in a hospital, renal dialysis facility, clinic, ambulatory surgical center, or health center.

**Significantly different from zero at the 0.05 level, two-tailed t-test.
***Significantly different from zero at the 0.01 level, two-tailed t-test.

TABLE C.22

ANALYSIS OF MEDICARE EXPENDITURES AND HOSPITAL ADMISSIONS BY COUNTY OF RESIDENCE AT ENROLLMENT AND FOR ALL PATIENTS IN THE RESEARCH SAMPLE, THROUGH MONTHS 1 TO 12 AFTER ENROLLMENT
(Regression Adjusted)

	Miami-Dade	Broward/Palm Beach	North Florida[a]	Overall Research Sample
Sample Size				
Treatment	11,552	8,248	17,159	36,959
Control	4,653	3,268	6,876	14,797
Average Medicare Payments per Month in Fee for Service				
Treatment	$1,937	$1,570	$1,582	$1,653
Control	$1,998	$1,563	$1,559	$1,649
Percentage difference	-3.02	0.42	1.47	0.25
p-Value	0.277	0.902	0.664	0.871
Average Annualized Number of Hospital Admissions per Year				
Treatment	0.68	0.78	0.78	0.76
Control	0.66	0.81	0.75	0.76
Percentage difference	3.83	-3.42	3.73	-0.33
p-Value	0.431	0.372	0.357	0.863

Sources: Medicare Enrollment Database, National Claims History File, Standard Analytic File, and program intake data.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the follow-up period the sample member meets CMS's demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations.

Includes all patients enrolled from January 2005 through September 2006.

[a]North Florida counties include Alachua, Brevard, Duval, Lake, Marion, Orange, Seminole, and Volusia.

*Difference between the treatment and control groups is significantly different from 0 at the 0.10 level, 2-tailed test.
**Difference between the treatment and control groups is significantly different from 0 at the 0.05 level, 2-tailed test.
***Difference between the treatment and control groups is significantly different from 0 at the 0.01 level, 2-tailed test.

TABLE C.23

ANALYSIS OF MEDICARE EXPENDITURES AND HOSPITAL ADMISSIONS BY COUNTY OF RESIDENCE AT ENROLLMENT AND FOR ALL PATIENTS IN THE RESEARCH SAMPLE, THROUGH MONTHS 13 TO 24 AFTER ENROLLMENT
(Regression Adjusted)

	Miami-Dade	Broward/Palm Beach	North Florida[a]	Overall Research Sample
Sample Size				
Treatment	8,788	5,911	8,846	23,545
Control	3,529	2,357	3,509	9,395
Average Medicare Payments per Month in Fee for Service				
Treatment	$2,339	$1,873	$1,898	$2,043
Control	$2,322	$1,704	$1,844	$2,088
Percentage difference	0.77	9.92	2.94	-2.16
p-Value	0.907	0.301	0.695	0.203
Average Annualized Number of Hospital Admissions per Year				
Treatment	0.70	0.85	0.77	0.74
Control	0.60	0.74	0.71	0.76
Percentage difference	16.48	15.02	8.68	-2.96
p-Value	0.253	0.234	0.436	0.264

Sources: Medicare Enrollment Database, National Claims History File, Standard Analytic File, and program intake data.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the follow-up period the sample member meets CMS's demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations.

Includes all patients enrolled from January 2005 through January 2006 who also have more than 12 months enrolled.

[a]North Florida counties include Alachua, Brevard, Duval, Lake, Marion, Orange, Seminole, and Volusia.

*Difference between the treatment and control groups is significantly different from 0 at the 0.10 level, 2-tailed test.
**Difference between the treatment and control groups is significantly different from 0 at the 0.05 level, 2-tailed test.
***Difference between the treatment and control groups is significantly different from 0 at the 0.01 level, 2-tailed test.

TABLE C.24

ANALYSIS OF MEDICARE EXPENDITURES AND HOSPITAL ADMISSIONS BY COUNTY OF RESIDENCE AT ENROLLMENT AND FOR ALL PATIENTS IN THE RESEARCH SAMPLE, THROUGH MONTHS 25 TO 36 AFTER ENROLLMENT
(Regression Adjusted)

	Miami-Dade	Broward/Palm Beach	North Florida[a]	Overall Research Sample
Sample Size				
Treatment	5,119	2,212	370	7,701
Control	2,097	888	134	3,119
Average Medicare Payments per Month in Fee for Service				
Treatment	$2,875	$2,270	$2,333	$2,747
Control	$3,102	$2,289	$2,058	$2,929
Percentage difference	-7.30	-0.86	13.37	-6.23
p-Value	0.006***	0.903	0.743	0.012**
Average Annualized Number of Hospital Admissions per Year				
Treatment	0.80	0.94	0.99	0.83
Control	0.80	0.95	0.66	0.83
Percentage difference	-0.10	-0.77	50.29	-0.21
p-Value	0.986	0.933	0.469	0.965

Sources: Medicare Enrollment Database, National Claims History File, Standard Analytic File, and program intake data.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the follow-up period the sample member meets CMS's demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations.

Includes all patients with more than 24 months of enrollment.

[a]North Florida counties include Alachua, Brevard, Duval, Lake, Marion, Orange, Seminole, and Volusia.

*Difference between the treatment and control groups is significantly different from 0 at the 0.10 level, 2-tailed test.
**Difference between the treatment and control groups is significantly different from 0 at the 0.05 level, 2-tailed test.
***Difference between the treatment and control groups is significantly different from 0 at the 0.01 level, 2-tailed test.

TABLE C.25

ANALYSIS OF MEDICARE EXPENDITURES AND HOSPITAL ADMISSIONS FOR PATIENTS WITH DIABETES, CAD, AND TWO OR MORE TARGETED CONDITIONS CUMULATIVE THROUGH ALL MONTHS OF PROGRAM OPERATIONS
(Regression Adjusted)

	With Diabetes	No Diabetes	With CAD	No CAD	Two or More Targeted Conditions	Only One Targeted Condition
Sample Size						
Treatment	21,813	15,146	25,543	11,416	17,372	19,587
Control	8,656	6,141	10,216	4,581	6,962	7,835
Average Medicare Payments per Month in Fee for Service						
Treatment	$2,021	$1,587	$1,877	$1,765	$1,976	$1,707
Control	$2,043	$1,608	$1,921	$1,731	$2,041	$1,682
Percentage difference	-1.10	-1.31	-2.26	1.95	-3.18	1.51
p-Value	0.443	0.553	0.102	0.429	0.039**	0.434
Average Annualized Number of Hospital Admissions per Year						
Treatment	0.80	0.70	0.78	0.69	0.83	0.68
Control	0.82	0.69	0.80	0.69	0.85	0.68
Percentage difference	-2.09	0.96	-1.50	0.62	-2.42	0.80
p-Value	0.304	0.739	0.428	0.860	0.248	0.770

Sources: Medicare Enrollment Database, National Claims History File, Standard Analytic File.

Notes: Patients are identified as having CHF, CAD, or diabetes based on data in all medical claims in the two years before enrollment. Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the follow-up period the sample member meets CMS's demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations.

For the 'Two or More Target Conditions' subgroup analysis, the indicators for whether the patient had CHF, CAD, or diabetes were excluded from the regression as control variables.

**Difference between the treatment and control groups is significantly different from 0 at the 0.05 level, 2-tailed test.
***Difference between the treatment and control groups is significantly different from 0 at the 0.01 level, 2-tailed test.

CAD = coronary artery disease; CHF = congestive heart failure.

TABLE C.26

ANALYSIS OF MEDICARE EXPENDITURES AND HOSPITAL ADMISSIONS BY NUMBER OF CHRONIC MEDICAL CONDITIONS, CUMULATIVE THROUGH ALL MONTHS OF PROGRAM OPERATIONS
(Regression Adjusted)

	Less than 5	5 or More
Sample Size		
Treatment	22,346	14,613
Control	8,985	5,812
Average Medicare Payments per Month in Fee for Service		
Treatment	$1,698	$2,053
Control	$1,667	$2,151
Percentage difference	1.88	-4.54
p-Value	0.291	0.006***
Average Annualized Number of Hospital Admissions per Year		
Treatment	0.71	0.82
Control	0.71	0.85
Percentage difference	1.14	-3.80
p-Value	0.631	0.104

Sources: Medicare Enrollment Database, National Claims History File, Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the follow-up period the sample member meets CMS's demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations.

Chronic conditions measured in the two years before enrollment included coronary artery disease, congestive heart failure, stroke, diabetes, cancer, chronic obstructive pulmonary disease, dementia, peripheral vascular disease, ESRD, depression, and asthma. Medicare claims for all types of services, except for durable medical equipment, lab tests, and imaging services, were used to identify patients receiving treatment for the ICD-9 codes associated with these conditions. All diagnoses listed on the claims were searched (that is, we did not restrict our search to the primary diagnosis).

**Difference between the treatment and control groups is significantly different from 0 at the 0.05 level, 2-tailed t-test.
***Difference between the treatment and control groups is significantly different from 0 at the 0.01 level, 2-tailed t-test.

ICD-9 = International Classification of Diseases, ninth edition.

TABLE C.27

ANALYSIS OF MEDICARE EXPENDITURES AND HOSPITAL ADMISSIONS BY RACE AND ETHNICITY, CUMULATIVE THROUGH ALL MONTHS OF PROGRAM OPERATIONS
(Regression Adjusted)

	Black	Latino	Other
Sample Size			
Treatment	8,706	6,729	21,524
Control	3,530	2,752	8,515
Average Medicare Payments per Month in Fee for Service			
Treatment	$1,954	$1,771	$1,835
Control	$1,974	$1,924	$1,823
Percentage difference	-1.05	-7.97	0.69
p-Value	0.677	0.003***	0.671
Average Annualized Number of Hospital Admissions per Year			
Treatment	0.81	0.71	0.76
Control	0.85	0.72	0.75
Percentage difference	-4.74	-1.69	0.40
p-Value	0.152	0.672	0.859

Sources: Medicare Enrollment Database, National Claims History File, Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the follow-up period the sample member meets CMS's demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations.

Patients were initially classified as either Latino or not. Non-Latinos were subsequently categorized as either Black or Other.

**Difference between the treatment and control groups is significantly different from 0 at the 0.05 level, 2-tailed test.
***Difference between the treatment and control groups is significantly different from 0 at the 0.01 level, 2-tailed test.

TABLE C.28

ANALYSIS OF MEDICARE EXPENDITURES AND HOSPITAL ADMISSIONS BY AGE,
CUMULATIVE THROUGH ALL MONTHS OF PROGRAM OPERATIONS
(Regression Adjusted)

	Younger than 65	65 to 79	80 or older
Sample Size			
Treatment	10,935	18,628	7,396
Control	4,385	7,449	2,963
Average Medicare Payments per Month in Fee for Service			
Treatment	$1,709	$1,912	$2,118
Control	$1,750	$1,918	$2,134
Percentage difference	-2.36	-0.30	-0.75
p-Value	0.327	0.862	0.785
Average Annualized Number of Hospital Admissions per Year			
Treatment	0.67	0.79	0.99
Control	0.69	0.79	0.98
Percentage difference	-2.94	0.14	0.56
p-Value	0.392	0.953	0.869

Sources: Medicare Enrollment Database, National Claims History File, Standard Analytic File.

Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the follow-up period the sample member meets CMS's demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations.

**Difference between the treatment and control groups is significantly different from 0 at the 0.05 level, 2-tailed test.
***Difference between the treatment and control groups is significantly different from 0 at the 0.01 level, 2-tailed test.

TABLE C.29

COMPARISON OF ALL STATISTICALLY SIGNIFICANT ESTIMATES FROM LINEAR MODELS AND LOG-LINEAR REGRESSION MODELS FOR PER-MEMBER-PER-MONTH EXPENDITURES

	Sample Size		Linear Regressions		Log-Linear Regression Models	
	N_T	Nc	Percentage difference, treatment PMPM expenditures vs control PMPM expenditures	*p*-Value	Percentage Difference (based on model coefficient), Treatment vs. Control	*p*-Value
Table III.4 (Complete Research Sample)						
Part B expenditures	36,959	14,797	-2.6	0.026**	0.0	0.937
Table III.6 (Complete Research Sample)						
Months 13 to 24						
Part B	23,545	9,395	-3.3	0.018**	-1.1	0.536
Months 25 to 36						
Part B	7,701	3,119	-7.4	0.001***	-5.0	0.137
Total Part A and Part B	7,701	3,119	-6.2	0.012**	-4.2	0.253
Table III.10 (Redesign Population)						
Resides in redesign region						
With CHF	8,364	3,384	-6.6	0.027**	-2.5	0.482
With CAD and diabetes	4,726	1,869	-7.8	0.028**	-5.8	0.162
Table C.20 (Non-Redesign Population)						
Part A	18,087	7,197	-8.2	0.046	-7.7	0.0859
Table C.21						
Miami-Dade Residents						
Other costs (overall)	10,344	4,167	-10.0	0.007***	-4.4	0.049**
Lab/radiology			-7.3	0.001***	-3.1	0.149
Other (sub-category)			-11.8	0.038**	-5.6	0.080
Total Part A and Part B			-4.6	0.017**	-1.8	0.383
Table C.24						
Miami-Dade Residents	5,119	2,097	-7.3	0.006***	-4.7	0.256
Complete research sample	7,701	3,119	-6.2	0.012**	-4.2	0.253
Table C.25 (Complete Research Sample)						
Two or more target conditions	17,372	6,962	-3.2	0.039**	-1.3	0.463

TABLE C.29 (*continued*)

	Sample Size		Linear Regressions		Log-Linear Regression Models	
	N_T	Nc	Percentage difference, treatment PMPM expenditures vs control PMPM expenditures	*p*-Value	Percentage Difference (based on model coefficient), Treatment vs. Control	*p*-Value
Table C.26 (Complete Research Sample) 5 or more chronic conditions	14,613	5,812	-4.5	0.004***	-2.9	0.138
Table C.27 (Complete Research Sample) Latino	6,729	2,752	-8.0	0.003***	-3.7	0.192

Sources: Medicare Enrollment Database, National Claims History file, and Standard Analytic File (MPR columns).

Purpose of the Table: This table shows that all but one statistically significant finding from linear models were also not significant.

Methodological Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the 36-month follow-up period the sample member meets CMS's demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations.

**Difference between the treatment and control groups significantly different from 0 at the 0.05 level, 2-tailed t-test.
***Difference between the treatment and control groups significantly different from 0 at the 0.01 level, 2-tailed t-test.

CAD = coronary artery disease; CHF = congestive heart failure; PMPM = per-member-per-month.

TABLE C.30

COMPARISON OF ALL STATISTICALLY SIGNIFICANT ESTIMATES FROM LINEAR MODELS AND LOG-LINEAR REGRESSION MODELS FOR PER-MEMBER-PER-MONTH EXPENDITURES AMONG PATIENTS IN THE REDESIGN POPULATION

	Sample Size		Linear Regressions		Log-Linear Regression Models	
	N_T	N_C	Percentage difference, treatment PMPM expenditures vs control PMPM expenditures	*p*-Value	Percentage Difference (based on model coefficient), Treatment vs. Control	*p*-Value
Table III.7	13,090	5,253				
Part B			-4.9	0.004***	-4.0	0.029***
Total Part A and B			-4.3	0.010***	-3.6	0.056
Table III.8						
Months 13 to 24	8,452	3,388				
Part B			-6.1	0.005***	-4.6	0.0776
Total Part A and B			-5.1	0.036**	-4.4	0.1325
Months 25 to 36	6,164	2,503				
Part B			-7.4	0.002***	-5.3	0.1368
Total Part A and B			-6.1	0.024**	-4.3	0.2639
Table C.13						
Months 13 to 24	8,452	3,388				
Total Part A and B			-5.1	0.036**	-4.4	0.133
Months 25 to 36	6,164	2,503				
Home health			-8.0	0.032**	-14.0	0.080
Outpatient			-14.5	0.001***	-6.5	0.314

Sources: Medicare Enrollment Database, National Claims History file, and Standard Analytic File.

Purpose of the Table: This table shows that all but one statistically significant finding from linear models were also not significant.Methodological Notes: Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the 36-month follow-up period the sample member meets the Centers for Medicare & Medicaid Services' demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations.

Patients were eligible for the redesign if they had claims for CHF or claims for at least two of the three target conditions, and if they resided in Alachua, Broward, Marion, Miami-Dade, Orange, Palm Beach, Seminole, or Volusia counties.

**Difference between the treatment and control groups is significantly different from 0 at the 0.05 level, 2-tailed t-test.
***Difference between the treatment and control groups is significantly different from 0 at the 0.01 level, 2-tailed t-test.

CAD = coronary artery disease; CHF = congestive heart failure; PMPM = per-member-per-month.

TABLE C.31

CLAIMS-BASED QUALITY-OF-CARE MEASURES IN MONTHS 1 TO 12 AFTER ENROLLMENT, BY ELIGIBILITY FOR THE REDESIGN
(Regression Adjusted)

	Redesign				Non-Redesign			
	Treatment	Control	Treatment-Control Difference	*p*-Value	Treatment	Control	Treatment-Control Difference	*p*-Value
All Enrolled Patients								
Number of patients	13,090	5,253			23,869	9,544		
Any potentially preventable hospitalization[a]	10.3	11.1	-0.8	0.048**	11.2	11.1	0.2	0.677
Preventive care								
Colon cancer screening[b]	7.5	7.8	-0.3	0.452	7.6	7.4	0.2	0.470
Screening mammography for females[c]	22.3	22.7	-0.4	0.682	17.9	18.2	-0.3	0.565
Patients with Diabetes								
Number of patients	9,114	3,600			12,699	5,056		
Potentially preventable hospitalizations and complications								
Any cardiac hospitalization[d]	4.0	4.9	-0.9	0.008***	4.6	4.1	0.5	0.175
Average number per 100 patients	4.4	6.6	-2.2	0.001***	5.8	5.3	0.5	0.379
Any diabetes hospitalization[e]	2.8	2.8	-0.0	0.898	2.8	3.5	-0.7	0.019**
Average number per 100 patients	4.0	3.9	0.1	0.935	3.6	4.7	-1.1	0.036**
Any peripheral vascular or extremity complication[f]	26.8	26.1	0.7	0.343	28.9	28.0	1.0	0.205
Average number per 100 patients	36.3	35.1	1.2	0.484	40.7	39.5	1.2	0.389
Any microvascular complication[g]	16.7	17.0	-0.2	0.737	18.6	18.7	-0.1	0.914
Preventive care								
Any diabetes education[h]	3.3	2.9	0.4	0.196	3.3	3.1	0.2	0.563
Average number of diabetes education visits	0.2	0.2	0.0	0.347	0.2	0.2	0.0	0.252
Any claims for blood glucose self-monitoring supplies	53.7	53.4	0.3	0.719	56.6	54.9	1.7	0.036**
Any therapeutic shoes	12.1	12.4	-0.4	0.545	12.1	11.5	0.6	0.260
Any eye examination	59.5	60.0	-0.5	0.570	59.2	59.4	-0.3	0.755
Any podiatry visit	58.5	58.5	0.0	0.962	62.1	60.3	1.8	0.023**
Average number of podiatry visits	1.6	1.6	0.0	0.769	1.8	1.7	0.1	0.148
Any blood test for cholesterol or lipids	78.0	78.3	-0.3	0.680	79.4	77.9	1.5	0.024**
Any blood test for hemoglobin A1c (HbA1c)	68.3	68.4	-0.2	0.841	68.5	66.6	1.8	0.018**
Any urine test for protein	21.9	22.9	-1.0	0.226	24.4	22.8	1.6	0.018**
Patients with Congestive Heart Failure								
Number of patients	8,364	3,384			3,913	1,557		
Potentially preventable hospitalizations and complications								
Any hospitalization for fluid/electrolyte problems[i]	0.5	0.4	0.0	0.757	1.1	0.9	0.2	0.610
Any congestive heart failure hospitalization	8.5	8.8	-0.3	0.572	8.4	8.4	0.0	0.970

TABLE C.31 *(continued)*

	Redesign				Non-Redesign			
	Treatment	Control	Treatment-Control Difference	*p*-Value	Treatment	Control	Treatment-Control Difference	*p*-Value
Preventive care								
Any assessment of left ventricular function	57.0	57.8	-0.8	0.418	59.4	57.3	2.1	0.147
Patients with Coronary Artery Disease								
Number of patients	11,230	4,518			14,313	5,698		
Any cardiac hospitalizations	4.8	5.7	-0.8	0.018**	4.7	4.3	0.5	0.186
Average number of cardiac hospitalizations per 100 patients	5.6	7.2	-1.7	0.006***	5.9	5.4	0.5	0.397
Preventive care								
Any blood test for cholesterol or lipids	75.2	75.8	-0.6	0.475	77.3	77.0	0.3	0.633

Sources: Medicare Enrollment Database, National Claims History File, and Standard Analytic File.

Notes: Includes sample members enrolled early enough in program operations to potentially be observed for 12 months. Beneficiaries' first month of enrollment is the second calendar month after the month of randomization. Demonstration-wide eligibility requirements at the time of enrollment included (1) enrolled in fee-for-service Medicare, (2) enrolled in Part A and Part B Medicare, (3) Medicare is primary payer, (4) received full Medicaid benefits, (5) not in hospice care, and (6) not classified as having end-stage renal disease (ESRD). In addition, in the 12 months before enrollment, patients cannot have (1) had an inpatient psychiatric admission of more than 14 consecutive days, (2) been long-term nursing home residents, or (3) had an organ transplant. During the follow-up period, patient observations are truncated when they fail to meet any of these eligibility criteria (with the exception of Part A coverage or being classified as an ESRD patient) or move from the program's service area. See Appendix A for a complete set of diagnostic eligibility criteria specified by LifeMasters.

Observations are weighted according to the proportion of the follow-up period the sample member meets CMS's demonstration-wide requirements and is alive. Weights are normalized for treatment and control group members to sum to the number of observations in the group.

Patients were eligible for the redesign if they had claims for CHF or claims for at least two of the three target conditions, and if they resided in Alachua, Broward, Marion, Miami-Dade, Orange, Palm Beach, Seminole, or Volusia counties.

[a]Any hospitalizations for any of the conditions for which we search.

[b]Fecal occult blood testing, screening colonoscopy, sigmoidoscopy, or barium enema.

[c]Females only: in the Redesign sample, there were 3,370 control group members and 8,462 treatment group members. In the Non-Redesign sample, there were 6,428 control group members and 16,014 treatment group members.

[d]Any hospitalizations for acute myocardial infarction, coronary artery bypass graft surgery, percutaneous transluminal angioplasty, or coronary artery stenting.

[e]Any hospitalizations for diabetes with hyperosmolarity, diabetes with ketoacidosis, diabetes with other (nonhyperosmolar and non-ketotic) complications, diabetes with other (non-hyperosmolar and non-ketotic) coma, or diabetes without mention of complications.

[f]Any hospitalizations or other services for femoral-bypass procedure, peripheral circulatory disorders, lower-limb amputation, incision and drainage of bone cortex, skin and subcutaneous debridement for gangrene, cutaneous gangrene, leg cellulitis, diabetic arthropathy or neurological disorders, osteomyelitis, or incision and drainage below fascia.

[g]Any hospitalizations, claims, or change in enrollment status for diabetic eye disease, laser treatment for diabetic eye disease, nephropathy, or new ESRD.

[h]Any claims for individual or group diabetes outpatient self-management training services, or for education/training services, including diabetes diet training.

[i]Any hospitalizations for hyperkalemia, hypernatremia, hypokalemia, hyponatremia, or other fluid/electrolyte problems.

**Difference between the treatment and control groups significantly different from 0 at the 0.05 level, 2-tailed t-test.
***Difference between the treatment and control groups significantly different from 0 at the 0.01 level, 2-tailed t-test.