ASSESSING AMERICA'S HEALTH RISKS: HOW WELL ARE MEDICARE'S CLINICAL PREVENTIVE BENEFITS SERVING AMERICA'S SENIORS?

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

MAY 23, 2002

Serial No. 107–110

Printed for the use of the Committee on Energy and Commerce

Available via the World Wide Web: http://www.access.gpo.gov/congress/house

U.S. GOVERNMENT PRINTING OFFICE
80–672PS WASHINGTON : 2002

For sale by the Superintendent of Documents, U.S. Government Printing Office
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ASSESSING AMERICA'S HEALTH RISKS: HOW WELL ARE MEDICARE'S CLINICAL PREVENTIVE BENEFITS SERVING AMERICA'S SENIORS?

THURSDAY, MAY 23, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. James C. Greenwood (chairman) presiding.

Members present: Representatives Greenwood, Burr, Bass, and Fletcher.

Staff present: Joe Greenman, majority professional staff member; Brendan Williams, legislative clerk; Karen Folk, minority professional staff member; Bridgett Taylor, minority professional staff member; and Chris Knauer, minority investigator.

Mr. GREENWOOD. Good morning. The hearing will come to order.

We are the—good morning to the witnesses. One of the benefits of you and all of those in attendance, we expect that there will be members coming and going, and we're going to begin now, because we ought to.

I've scheduled this hearing today to examine the importance of incorporating wide-ranging preventive practices into common patient care and in particular into the Medicare program. Health care experts expend a lot of time and energy addressing this issue, and Members of Congress have voiced their interest in encouraging the use of preventive medical services by their constituents. Yet there still appear to be some gaps in our knowledge about the effectiveness of these programs and about what programs are most appropriate for inclusion in Medicare.

We're all familiar with the phrase "an ounce of prevention is worth a pound of cure." Beyond conventional wisdom, this is something health care providers have come to recognize as a valuable part of medical care. Preventive services which entail not only the early detection of disease but also practices that actually prevent the onset of disease have been associated with a substantial reduction in morbidity and mortality. Despite these widely acknowledged benefits, a gulf exists between the potential health gains from delivering the most innovative forms of prevention and the gains we presently achieve for beneficiaries of U.S. public health care programs.

Bear in mind that extending Medicare coverage to any service that aims to prevent disease requires an act of Congress. This means that the ongoing evaluation of the best practices and the prevention of chronic illness is the responsibility of Members of Congress. Since most of us in this body are not medical providers, let alone clinical researchers, we must rely on others to provide us with the information that will form our decisions on what benefits should be covered by Medicare.

Since 1980, Congress has amended Medicare law several times to add coverage for certain preventive services. Preventive services currently available to Medicare beneficiaries are primarily used for the early detection of noncommunicable diseases like cancer or the immunization of beneficiaries from common sicknesses like influenza and pneumonia.

We know there are other preventive services that could be offered to beneficiaries. Many of us read the news articles that are appearing on a more and more routine basis that report the results of preventive care studies. These studies have continued to support the notion that the most promising role for prevention in current medical practice may lie in changing personal health behaviors of patients long before clinical disease develops.

The importance of this aspect of clinical practice is evident from a growing body of literature linking some of the leading causes of sickness and death in the United States, such as heart disease and cancer, to a handful of personal health behaviors. Yet the Medicare program does not cover services designed to improve the health status of most at-risk beneficiaries. The most common behaviors related to the onset of chronic illness cannot be addressed by benefits currently available in the Medicare program, although these benefits are becoming more widely available through private health coverage.

To improve the performance of the Medicare program in this regard, Congress must find the most effective means of incorporating these benefits that demonstrate an ability to improve the health status of older Americans. Medical research and technology has expanded the body of options available for addressing the prevention and treatment of chronic illness. Prevention can play a role in improving the health of medical beneficiaries, as well as offer the potential for controlling health care costs if the preventive services are soundly structured.

Today we will hear from a number of witnesses who are experts in the fields of public health, prevention programs and medical research.

In an effort to obtain the best information in understanding how best to achieve these reforms, I have asked the U.S. General Accounting Office to assist us. The GAO has prepared a study on the current state of preventive services available in the Medicare program. This will be helpful in reminding us what is and is not covered by Medicare.

Additionally, the GAO will tell us what it has learned about the initiatives that the Centers for Medicare and Medicaid Services, CMS, has conducted to encourage utilization of the preventive benefits already offered by Medicare and how the rates of utilization of these services have changed over time.

I'm pleased to announce that the GAO will be assisting us by preparing a follow-up study that will address issues related to the challenges of evaluating and crafting preventive services for the benefit of those served by U.S. public health programs. I look forward to seeing the positive results that this partnership will yield in the months to come.

Let me stress, finally, that, given the complexities inherent in this issue, today's hearing is the beginning of a process on prevention promotion in our public health programs. Before we know how best to act, we will have to answer difficult questions, such as what is the role of government in trying to change the health-related behavior of the general public? Are these efforts beneficial? Are they ethical? Who will be trusted to generate the evidence, and who will be responsible for using this evidence to implement policy?

Today we will hear from witnesses who bring a great deal of expertise to this important topic and will help us begin to address these questions. I thank all of the witnesses for their testimony today.

[The prepared statement of Hon. James Greenwood follows:]

PREPARED STATEMENT OF HON. JAMES GREENWOOD, CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

Good morning. I have scheduled this hearing today to examine the importance of incorporating wide-ranging preventive practices into common patient care—and, in particular, into the Medicare program. Health care experts expend a lot of time and energy addressing this issue and Members of Congress have voiced their interest in encouraging the use of preventive medical services by their constituents. Yet there still appear to be some gaps in our knowledge about the effectiveness of these programs, and about what programs are most appropriate for inclusion in Medicare.

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Bear in mind that extending Medicare coverage to any service that aims to prevent disease requires an act of Congress. This means that the ongoing evaluation of the best practices in the prevention of chronic illness is the responsibility of Members of Congress. Since most of us in this body are not medical providers, let alone clinical researchers, we must rely on others to provide us with the information that will inform our decisions on what benefits should be covered by Medicare.

Since 1980, Congress has amended Medicare law several times to add coverage for certain preventive services. The preventive services currently available to Medicare beneficiaries are primarily used for the early detection of noncommunicable diseases, like cancer, or the immunization of beneficiaries from common sickness, like influenza and pneumonia.

We know there are other preventive services that could be offered to beneficiaries. Many of us read the news articles appearing on a more-and-more routine basis that report the results of preventive care studies. These studies have continued to support the notion that the most promising role for prevention in current medical practice may lie in changing personal health behaviors of patients long before clinical disease develops. The importance of this aspect of clinical practice is evident from a growing body of literature linking some of the leading causes of sickness and death in the United States, such as heart disease and cancer, to a handful of personal health behaviors.

Yet the Medicare program does not cover services designed to improve the health status of most at-risk beneficiaries. The most common behaviors related to the onset of chronic illness cannot be addressed by benefits currently available in the Medi-

care program—although these benefits are becoming more widely available through private health coverage.

To improve the performance of the Medicare program in this regard, Congress most find the most effective means of incorporating those benefits that demonstrate an ability to improve the health status of older Americans. Medical research and technology has expanded the body of options available for addressing the prevention and treatment of chronic illness. Prevention can play a role in improving the health of Medicare beneficiaries as well as offer the potential for controlling health costs, if the preventive services are soundly structured.

Today, we will hear from a number of witnesses who are experts in the fields of public health, prevention programs and medical research. In an effort to obtain the best information in understanding how best to achieve these reforms, I have asked the US General Accounting Office (GAO) to assist us. The GAO has prepared a study on the current state of preventive services available in the Medicare program. This will be helpful in reminding us what is, and is not, covered by Medicare. Additionally, the GAO will tell us what it has learned about the initiatives that the Centers for Medicare and Medicaid Services (CMS) has conducted to encourage utilization of the preventive benefits offered by Medicare and how the rates of utilization of these services has changed over time.

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Let me stress, finally, that, given the complexities inherent in this issue, today's hearing is the beginning of a process on prevention promotion in our public health programs. Before we know how best to act, we will have to answer difficult questions such as what is the role of government in trying to change the health related behavior of the general public? Are these efforts beneficial? Are they ethical? Who will be trusted to generate the evidence and who will be responsible for using this evidence to implement policy?

Today, we will hear from witnesses who bring a great deal of expertise to this important topic—and will help us begin to address these questions. I thank all the witnesses for their testimony today.

Mr. GREENWOOD. I note that there is a vote pending, and there are no other members to make opening statements. However, we have a written statement submitted by Mr. Dingell which will be made a part of the official record.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. ERNIE FLETCHER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OKLAHOMA

Chairman Greenwood, I am pleased you are having this hearing today to look into the health of our Nation's Seniors. We have an obligation to ensure that Medicare's clinical preventive benefits are serving all our Seniors and to ensure that the preventive medical treatments are incorporated and promoted in a comprehensive Medicare system that will not bankrupt our children and grandchildren and will allow Medicare to be around for a long time to come.

Medicare has provided health care security to millions of Americans since 1965. Almost 400 new drugs have been developed in the last decade alone to fight diseases like cancer, heart disease, and arthritis. However, Medicare has not kept up with rapid advances in medical care. Congress has a moral obligation to fulfill Medicare's promise of health and security for America's Seniors and people with disabilities. It is essential that Congress take steps to improve preventive care. Preventive care has proven to be highly effective in reducing the seriousness of many diseases and in improving the recovery time and quality of life for those who suffer from them. At the same time as we consider improving preventive benefits, we must fundamentally reform Medicare to ensure that it is a strong and viable system for our Seniors.

At a time when health care costs are soaring and the number of uninsured Americans is approximately 40 million, Congress must be careful to not place health care mandates on Medicare that will force our young workers to pay more for the benefits than they can afford.

President Bush reminded us in his State of the Union Address that health care reform was a domestic priority for his Administration. Congress must turn attention to Medicare and Medicaid reform, the problem of the uninsured and high costs now.

We have a ripe opportunity to improve the health of all Americans and make health insurance more affordable for all Americans.

Some say an ounce of prevention is worth a pound of cure. In this case access to preventive health care services is the prevention that will cure many problems we face today in our health care system. Noted businessman and presidential advisor Bernard M. Baruch once stated: "There are no such things as incurables; there are only things for which man has not found a cure." This statement is just as true for illness as it is for problems with America's health care system including Medicare. While we cannot solve all ills overnight, it's important for Congress and the President to work together to provide common sense and creative cures for improving health care to benefit all Americans.

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Thank you Chairman Greenwood, and let me commend you for holding this oversight hearing on the role of preventive medicine in our nation's public health programs.

Americans today enjoy better overall health care than at any time in the nation's history. Rapid advancements in medical technologies, increased understanding of the genetic foundations of health and illness, improvements in the effectiveness of pharmaceutical treatments, and other developments have helped to develop cures for many illnesses and to extend and improve the lives of Americans, especially those with chronic diseases.

These steady improvements are certainly a blessing. But by themselves, they cannot address some of the most significant challenges to improving the health of the coming generation of Medicare beneficiaries.

Just this week, The Washington Post reported a recent AARP study that showed Americans over 50 are living longer and suffering with less disability than previous generations of midlife adults. But they are more likely to be overweight or obese, live with multiple chronic health conditions and depend more on prescription drugs.

If we are to realize the full potential of the investments we have made to improve the quality of health care in this country, we must undertake a serious effort to assess not only how best to treat these chronic diseases but also how to implement what we know about changing the behaviors that cause these diseases.

Fortunately, over the past decade, a growing body of evidence has emerged that shows that behavioral and social interventions offer great promise to reduce disease morbidity and mortality. But as yet, this potential to improve the public's health has been poorly tapped.

Today, we have an opportunity to begin to address how to improve the performance of programs such as Medicare through the use of preventive health services that address the behaviors that lead to the onset of chronic diseases. These preventive health services, in fact, could play an important role in our effort to modernize the Medicare program.

We are beginning to see some good examples of what will emerge in the marketplace. Private sector health plans are showing how best to incorporate cutting edge and nontraditional benefits for the patients they serve. There are numerous examples of Medicare+Choice Organizations that have improved health care for their Medicare beneficiaries through innovations focused on nutrition screening, exercise and fitness programs, and disease management programs, for example, which craft interventions to cater to beneficiaries with specific chronic illnesses. These services are provided without any additional reimbursement, as value added services.

Today, we will hear from a representative from one such Medicare+Choice Organization that has implemented these types of programs. I look forward to hearing about the benefits seen in offering such a program to Medicare beneficiaries.

Let me also add that, if we are to succeed, eventually, in improving the quality of health care for our Medicare beneficiaries, we must focus on the need to enact comprehensive reforms. Our public health programs must coordinate efforts to conduct and gather research on the most effective means of preventing chronic diseases. Health policy leaders must begin to work together to determine how best to offer as sound benefits those clinical preventive services that have been proven effective. Providers and health plans, both public and private, must work together to develop uniform guidelines for working with beneficiaries to guide them to the usage of the medical services that will truly improve their health status.

Undertaking an effort to achieve comprehensive Medicare reform should ultimately lead to the systemic changes necessary for strengthening the longevity of this vital program—and bringing 21rst Century style health care to Medicare. We

can begin this important process by taking measures this year to strengthen the Medicare+Choice program and add a prescription drug benefit. Creating a wider variety of health plan options, along with access to affordable prescription drugs, will begin to provide Americans with the innovation and choices needed to ensure their long term health.

We can also make major improvements to the Medicare Program by moving towards a more competitive method of delivering health care services to beneficiaries. Our Committee has spent a great deal of time thinking through how the Federal Employees Health Benefits Program (FEHBP) may be replicated in Medicare. FEHBP, unlike traditional Medicare, doesn't require a statutory change to incorporate important new preventive services into its benefit package. One of the principal reasons why Medicare currently covers such few preventive benefits is because seniors need to wait for an Act of Congress. This could change if we move aggressively toward an FEHBP style, competitive model of delivering health care to seniors.

I look forward to hearing the presentations of the witnesses today and I thank you all for your testimony.

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

I would like to thank Chairman Greenwood for convening a hearing on the important topic of improving Medicare for seniors and the disabled.

This hearing will focus specifically on increasing seniors' use of preventive services, including cancer screenings and immunizations. We should not, however, lose sight of the one preventive benefit that we all agree must to be added to Medicare—prescription drug coverage. Prescription drugs can prevent seniors with diseases from getting sicker and enable others to manage chronic illnesses so they can live productively. In short, prescription drugs are the most important preventive benefit we can give seniors and the disabled.

Although there is consensus that Congress needs to create a Medicare drug benefit, some may argue that we cannot afford to add a comprehensive benefit at this time. At one point, there may have been arguments that adding preventive services to Medicare was too expensive. But we did it. We don't need more study, more evaluation, or more demonstration projects to determine whether prescription drugs are really the right way to improve the Medicare program. I hope that my colleagues will join me this year and create a dependable, comprehensive, defined prescription drug benefit that is affordable to all seniors, regardless of whether they choose to participate in Medicare+Choice or fee-for-service.

Today's witnesses will inform us about the progress that has been made since Congress added a number of preventive services to Medicare several years ago. The American Health Quality Association will testify that their member organizations that contract with Medicare have increased utilization rates of these benefits in the fee-for-service program. Still, more work needs to be done to ensure that all seniors can take advantage of these services. In particular, we need to examine whether the 20 percent coinsurance rate is keeping seniors from getting the preventive care they need.

Some people may argue that the best way to increase coverage for preventive services is to pay Medicare+Choice plans extra dollars to provide them. It is important, however, to remember that over 85 percent of seniors are enrolled in the fee-for-service program. Some of these seniors have no Medicare+Choice plans available to them, while others choose to stay in the traditional plan because it better meets their needs. Relying solely on Medicare+Choice plans to provide more preventive services would not improve care for the majority of seniors. Worse yet, this approach would create a deliberate inequality in a program that owes its success to its universality.

I look forward to the testimony from today's distinguished panels and working with Chairman Greenwood to improve the Medicare program.

Mr. GREENWOOD. Okay, I should also advise you that it looks like we may be in for some procedural battling today. I will hope that these disruptions will be at a minimum, but I need to run over and vote now. So we will recess only for about 15 minutes, and then we'll look forward to your testimony. Thank you.

[Brief recess.]

Mr. GREENWOOD. The subcommittee will come to order. It appears that we have about an hour before the next dilatory move.

So we welcome our witnesses. The first panel consists of Dr. Janet Heinrich, who is the Director of Health Care and Public Health Issues at the U.S. General Accounting Office. Mr. Tom Grissom is the Director for the Centers for Medicare Management, Centers for Medicare and Medicaid Services; Dr. David W. Fleming, Acting Director of the Centers for Disease Control and Prevention; Dr. Carolyn Clancy, Acting Director, Agency for Healthcare Research and Quality; and Dr. Dale Bratzler, Principal Clinical Coordinator of the Oklahoma Foundation for Medical Quality, Incorporated, on behalf of the American Health Quality Association.

We welcome all of you. I assume that you are aware that this is an investigative hearing, and it is our custom in this committee to hold—take our testimony under oath. Do any of you object to giving your testimony under oath? Okay.

Now, pursuant to the rules of this committee and pursuant of the rules of the House, you're entitled to be represented by counsel during your testimony. Do any of you wish to be represented by counsel?

Seeing no such requests, then I would ask that you rise and raise your right hands.

[Witnesses sworn.]

Mr. GREENWOOD. Okay. You are under oath, and you may give your testimony.

We will begin with Dr. Heinrich. Welcome. Good morning.

TESTIMONY OF JANET HEINRICH, DIRECTOR, HEALTH CARE—PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE; TOM GRISSOM, DIRECTOR, CENTERS FOR MEDICARE MANAGEMENT, CENTERS FOR MEDICARE AND MEDICAID SERVICES; DAVID W. FLEMING, ACTING DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; CAROLYN CLANCY, ACTING DIRECTOR, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND DALE BRATZLER, PRINCIPAL CLINICAL COORDINATOR, OKLAHOMA FOUNDATION FOR MEDICAL QUALITY, INC., THE AMERICAN HEALTH QUALITY ASSOCIATION

Ms. HEINRICH. Good morning. Mr. Chairman, we're very pleased to be here as you review the existing preventive health care services offered in the Medicare program and consider proposals for expanding these benefits. At your request, we are issuing a report today that examines beneficiaries' use of preventive services and actions taken by the Centers for Medicare and Medicaid Services, CMS, to increase utilization.

As originally conceived, the Medicare program covered only services for the diagnosis and treatment of illness and injury; and, as you noted, since 1980 Congress has amended the Medicare law several times to add coverage for certain preventive services. These services include immunizations for pneumonia, hepatitis B, influenza screening for five types of cancer, as well as screening for osteoporosis and glaucoma. Except for flu and pneumonia immuni-

zations and laboratory tests, Medicare requires some cost sharing by beneficiaries.

In our review of preventive services offered under Medicare, we found that utilization has increased over time, but it really does vary significantly by service. Beneficiaries received screenings for breast and cervical cancer at high rates, less so for immunizations, and the lowest screening rates were for colorectal cancer.

Relatively few beneficiaries receive all of the services that are covered. For example, although 91 percent of female beneficiaries receive at least one service, only 10 percent received the whole array of covered preventive services, for example, cancer, breast and colon cancer screening, as well as the immunizations.

In considering the strategies for improving utilization, it is clear that targeting specific population groups can be effective. Our review of utilization rates also showed variation by State, ethnic group, income and education level. Although the national breast cancer screening rates are about 75 percent—at least they were in 1999—rates for individual States range from a low of 66 to a high of 86 percent. Among ethnic groups, the biggest differences occurred in use of immunization services, with over half of whites receiving immunization against pneumonia and only about a third of Hispanics and African Americans.

Beneficiaries with higher incomes and levels of education tend to use preventive services more than those at lower levels. It is evident from the work that CMS has conducted thus far that a variety of efforts are needed to increase the use of services.

CMS has sponsored reviews of studies to identify interventions that are most effective at increasing utilization. While these studies suggest no one approach works in all situations, several show promise. For example, allowing health care providers to forgo some compensation by waiving deductibles has been successful, and reminders to physicians or patients can effectively improve cancer screening rates.

Another positive step CMS has taken is to contract with the quality improvement organizations to increase use of three services. These are the immunizations for flu and pneumonia and for breast cancer screening. These organizations are developing reminder systems and conducting activities to educate patients and providers. They are also starting demonstrations to increase use of preventive services by minorities and low-income beneficiaries. Evaluating these efforts to identify the most effective approaches will be extremely important for further improvements in the Medicare program.

As the Congress considers broadening Medicare's coverage of preventive services, you will likely consider the recommendations of the U.S. Preventive Services Task Force, a group of experts who evaluate evidence to determine effectiveness of preventive services for different age and risk groups. Medicare covers many but not all of the services recommended by the task force. For example, the task force recommends blood pressure and cholesterol screening, services not explicitly covered by Medicare now.

This is true for a variety of counseling services as well. Older people do report that they are having their blood pressure and cholesterol checked. It is not clear, however, that counseling intended

to change unhealthy behaviors is occurring during regular office visits, nor has research established the effectiveness of well-defined clinical counseling to actually change risky behavior.

In conclusion, it is important to recognize the difficulty of translating some of the preventive service recommendations into covered benefits. Nevertheless, we believe that it is important to regularly review Medicare coverage of preventive services as information on effectiveness of these services becomes available. It is also important to continue to explore approaches to encourage older Americans to use existing covered services.

Thank you. I'm happy to answer any questions.

[The prepared statement of Janet Heinrich follows:]

PREPARED STATEMENT OF JANET HEINRICH, DIRECTOR, HEALTH CARE—PUBLIC HEALTH ISSUES, UNITED STATES ENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee: We are pleased to be here today as you review existing preventive health care services offered in the Medicare program and consider proposals for expanding these benefits. At your Subcommittee's request, we have been examining several issues related to preventive services and have prepared a report that is being released today.[1] My statement today highlights some of the key aspects of that report.

Preventive health care services, such as flu shots and cancer screenings, can extend lives and promote the well-being of our nation's seniors. Medicare now covers 10 preventive services—3 types of immunizations and 7 types of screening—and legislation has been introduced to cover additional services.[2] However, not all beneficiaries avail themselves of Medicare's preventive services. Some beneficiaries may simply choose not to use them, but others may be unaware that these services are available or covered by Medicare.

You asked us to examine two questions regarding preventive services for older Americans:

- To what extent are Medicare beneficiaries using covered preventive services?
- What actions have the Centers for Medicare and Medicaid services (CMS), which administers Medicare, taken to increase beneficiaries' use of preventive services?

Our data on the extent to which beneficiaries are using covered services are taken primarily from a survey conducted by the Centers for Disease Control and Prevention (CDC), another agency that like CMS is within the Department of Health and Human Services. The survey collects information on the use of several preventive services covered under Medicare, including immunizations for influenza and pneumococcal disease, and screening for breast, cervical, and colon cancer.

In summary, although use of Medicare covered preventive services is growing, it varies from service to service and by state, ethnic group, income, and level of education. For example, in 1999, 75 percent of women had been screened within the previous 2 years for breast cancer, compared with 55 percent of beneficiaries who had ever been immunized against pneumonia. However, even for a widely used preventive service such as breast cancer screening, state-by-state usage rates ranged from 66 to 86 percent. Among ethnic groups, differences were greatest for immunizations. For example, 1999 data show that about 57 percent of whites and 54 percent of "other" ethnic groups had been immunized against pneumonia, compared to about 37 percent of African Americans and Hispanics.[3] Among income and educational groups, variation was greatest for cancer screening.

To help ensure that preventive services are being delivered to those beneficiaries who need them, CMS sponsors activities—called "interventions"—aimed at increasing use. CMS currently funds interventions aimed at increasing the use of three services—breast cancer screening and immunizations against flu and pneumonia—in each state. CMS also pays for interventions that focus on increasing use of serv-

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[1] U.S. General Accounting Office, *Medicare: Beneficiary Use of Clinical Preventive Services,* GAO-02-422 (Washington, D.C.: April 12, 2002).

[2] A bill introduced last year proposes adding visual acuity, hearing impairment, cholesterol, and hypertension screenings as well as expanding the eligibility of individuals for bone density screenings. *See* H.R. 2058, 107th Cong. § 203 (2001).

[3] "Other" ethnic groups include survey respondents who reported an ethnicity other than African American, Hispanic, or white.

ices by minorities and low-income beneficiaries who have low usage rates. The techniques being used in some of these interventions, such as allowing nurses or other nonphysician medical personnel to administer vaccinations with a physician's standing order, have been found effective in the past. CMS is evaluating the effectiveness of current efforts and expects to have the evaluation results later in 2002.

TYPE OF SERVICES COVERED

When the Medicare program was established in 1965, it only covered health care services for the diagnosis or treatment of illness or injury. Preventive services did not fall into either of these categories and, consequently, were not covered. Since 1980, the Congress has amended the Medicare law several times to add coverage for certain preventive services for different age and risk groups within the Medicare population. These services include three types of immunizations—pneumococcal disease, hepatitis B, and influenza. Screening for five types of cancer—cervical, vaginal, breast, colorectal, and prostate—are also covered, as well as screening for osteoporosis and glaucoma. Except for flu and pneumonia immunizations, and laboratory tests, Medicare requires some cost-sharing by beneficiaries. Most beneficiaries have additional insurance, which may cover most, if not all, of these cost-sharing requirements.[4]

For a number of reasons, not all Medicare beneficiaries are likely to use these services. For some beneficiaries, certain services may not be warranted or may be of limited value. Screening women for cervical cancer is an example. Survey data show that 44 percent of women age 65 and over have had hysterectomies—an operation that usually includes removing the cervix.[5] For these women, researchers state that cervical cancer screening may not be necessary unless they have a prior history of cervical cancer.[6] Also, patients with terminal illnesses or of advanced age may decide to forgo services because of the limited benefits preventive services would offer. Research has shown, for example, that the benefits of cancer screening services, such as for prostate, breast, and colon cancer, can take 10 years or more to materialize. Finally, the controversy over the effectiveness of some services, such as mammography and prostate cancer screening, may add to the difficulty in further improving screening rates for these services.

To help determine which preventive services are beneficial among various patient populations, the U.S. Department of Health and Human Services established a panel of experts in 1984, called the U.S. Preventive Services Task Force. The task force identifies and systematically evaluates the available evidence to determine the effectiveness of preventive services for different age and risk groups, and then makes recommendations as to their use. Task force recommendations were first published in the Guide to Clinical Preventive Services in 1989, and are periodically updated as new evidence becomes available. These recommendations are for screening, immunizations, and counseling services that are specific for each age group, including people 65 and older. See table 1 for the task force recommendations for various preventive services including those currently covered by Medicare.

Table 1: Preventive Services Covered by Medicare or Recommended by the Task Force

Service	Task force recommendation for age 65+	Year first covered by Medicare as preventive service	Medicare cost-sharing requirement [a]
Immunizations			
Pneumococcal	Recommended	1981	None
Hepatitis B	No recommendation	1984	Copayment after deductible
Influenza	Recommended	1993	None
Tetanus-diphtheria (Td) boosters	Recommended	Not covered	N/A
Screening			
Cervical cancer—pap smear	Recommended [b]	1990	Copayment with no deductible [c]
Breast cancer—mammography	Recommended [d]	1991	Copayment with no deductible
Vaginal cancer—pelvic exam	No recommendation	1998	Copayment with no deductible [c]
Colorectal cancer—fecal-occult blood test	Recommended	1998	No copayment or deductible
Colorectal cancer—sigmoidoscopy	Recommended	1998	Copayment after deductible [e]

[4] U.S. General Accounting Office, *Medigap Insurance: Plans Are Widely Available but Have Limited Benefits and May Have High Costs,* GAO-01-941 (Washington, D.C.: July 31, 2001).

[5] Data are from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), 2000.

[6] CDC researchers report that among the general population, over 80 percent of hysterectomies are performed for noncancerous conditions such as fibroids and endometriosis.

Table 1: Preventive Services Covered by Medicare or Recommended by the Task Force—Continued

Service	Task force recommendation for age 65+	Year first covered by Medicare as preventive service	Medicare cost-sharing requirement [a]
Colorectal cancer—colonoscopy	No recommendation	1998	Copayment after deductible [e]
Osteoporosis—bone mass measurement	No recommendation	1998	Copayment after deductible
Prostate cancer—prostate-specific antigen test and/or digital rectal examination.	Not recommended	2000	Copayment after deductible [c]
Glaucoma	No recommendation	2002	Copayment after deductible
Vision impairment	Recommended	Not covered	N/A
Hearing impairment	Recommended	Not covered	N/A
Height, weight, and blood pressure	Recommended	Not covered	N/A
Cholesterol measurement	Recommended	Not covered	N/A
Problem drinking	Recommended	Not covered	N/A
Counseling			
Diet and exercise, smoking cessation, injury prevention, and dental health.	Recommended [f]	Not covered	N/A
Postmenopausal hormone prophylaxis	Recommended	Not covered	N/A
Aspirin for primary prevention of cardiovascular events.	Recommended	Not covered	N/A

[a] Applicable Medicare cost-sharing requirements generally include a 20 percent copayment after a $100 per year deductible. Each year, beneficiaries are responsible for 100 percent of the payment amount until those payments equal a specified deductible amount, $100 in 2002. Thereafter, beneficiaries are responsible for a copayment that is usually 20 percent of the Medicare approved amount. For certain tests, the copayment may be higher. See 42 U.S.C. § 1395(a)(1).

[b] The task force found insufficient evidence to recommend for or against an upper age limit for pap testing, but recommendations can be made on other grounds to discontinue regular testing after age 65 in women who have had regular previous screenings in which the smears have been consistently normal.

[c] The costs of the laboratory test portion of these services are not subject to copayment or deductible. The beneficiary is subject to a deductible and/or copayment for physician services only.

[d] The task force recommends routine screening for breast cancer every 1 to 2 years, with mammography alone or along with an annual clinical breast examination, for women aged 50 to 69. The task force found insufficient evidence to recommend for or against routine mammography or clinical breast examination for women aged 40 to 49 or aged 70 and older.

[e] The copayment is increased from 20 to 25 percent for services rendered in an ambulatory surgical center.

[f] The task force recommends these counseling services on the basis of the proven benefits of modifying harmful or risky behaviors. However, the effectiveness of clinician counseling to change these behaviors has not been adequately evaluated.

Source: U.S. General Accounting Office, Medicare: Beneficiary Use of Clinical Preventive Services, GAO-02-422 (Washington, D.C.: Apr. 12, 2002) and U.S. Preventive Services Task Force, Guide to Clinical Preventive Services, 2nd ed. (Washington, DC, 1996) and related updates.

As table 1 shows, Medicare explicitly covers many, but not all, of the preventive services recommended by the task force. However, beneficiaries may receive some of the preventive services not explicitly covered by Medicare. For example, even though blood pressure and cholesterol screening are not explicitly covered under Medicare, in 1999, nearly 98 percent of seniors reported that they had had their blood pressure checked within the last 2 years, and more than 88 percent of seniors reported having their cholesterol checked within the prior 5 years.[7] Other task force recommended services—such as counseling intended to change a patient's unhealthy or risky behaviors—may also be occurring during office visits.[8] Determining the extent to which these preventive counseling services occur is difficult, in part, because the content of such services is not well defined. It is also interesting to note that the task force recommends these counseling services on the basis of the proven benefits of a good diet, daily physical activity, smoking cessation, avoiding household injuries such as falls, and avoiding dental caries (tooth decay) and periodontal (gum and bone) disease. However, the effectiveness of clinician counseling to actually change these patient behaviors has not been established.

USE OF PREVENTIVE SERVICES IS GROWING BUT VARIES WIDELY

Use of preventive services offered under Medicare has increased over time. For example, in 1995, 38 percent of beneficiaries had been immunized against pneumonia, compared with 55 percent in 1999. Similarly, the use of mammograms at recommended intervals had increased from 66 percent in 1995 to 75 percent in 1999. While these examples show that use of preventive services generally is in-

[7] Survey data are from the CDC's BRFSS 1999.

[8] Counseling women regarding hormone replacement therapy, and all beneficiaries regarding the use of aspirin for the prevention of cardiovascular events is not necessarily intended to change behavior. Rather, it is intended to provide the patient current information on both the potential benefits and risks of these therapies. The task force recommends that the decision to undertake these therapies should be based on patient risk factors for disease and a clear understanding of the probable benefits and risks of these therapies.

creasing, they also show variation in use by service. Beneficiaries received screenings for breast and cervical cancer at higher rates than they did immunizations against flu and pneumococcal disease. Of the services for which data are available, colorectal screening rates were the lowest, with 25 percent of the beneficiaries receiving a recommended fecal occult blood test within the past year, and 40 percent receiving a recommended colonoscopy or sigmoidoscopy procedure within the last 5 years.

Relatively few beneficiaries receive multiple services. While 1999 utilization data show progress in improving receipt of preventive services, and in some cases relatively high rates of use for individual services, a small number of beneficiaries access most of the services. For example, although 91 percent of female Medicare beneficiaries received at least 1 preventive service, only 10 percent of female beneficiaries were screened for cervical, breast, and colon cancer, and immunized against both flu and pneumonia.

Although national rates provide an overall picture of current use, they mask substantial differences in how seniors living in different states use some services. For example, the national breast cancer screening rate for Medicare beneficiaries was 75 percent in 1999, but rates for individual states ranged from a low of 66 percent to a high of 86 percent. Individual states also ranged from 27 percent to 46 percent in the extent to which beneficiaries receiving a colonoscopy or sigmoidoscopy for cancer screening.

Usage rates also varied based by beneficiary, income, and education. Among ethnicity groups, the biggest differences occurred in use of immunization services. For example, 1999 data show that about 57 percent of whites and 54 percent of "other" ethnic groups were immunized against pneumonia, compared to about 37 percent of African Americans and Hispanics. Similarly, about 70 percent of whites and "other" ethnic groups received flu shots during the year compared to 49 percent of African Americans. Beneficiaries with higher incomes and levels of education tend to use preventive services more than those at lower levels.

EFFORTS UNDERWAY TO INCREASE USE OF SOME PREVENTIVE SERVICES

CMS has conducted a variety of efforts to increase the use of preventive services. These include identifying which approaches work best and sponsoring specific initiatives to apply these approaches in every state.

Studies Identify Effective Methods to Increase Use of Services

To identify how best to increase use of preventive services needed by the Medicare population, CMS sponsors reviews of studies that examine various kinds of interventions used in the past.[9] Among the CMS-sponsored reviews was one that examined the effectiveness of various interventions for flu and pneumonia immunizations and screenings for breast, cervical, and colon cancer.[10] This evaluation, which consolidated evidence from more than 200 prior studies, concluded that no specific intervention was consistently most effective for all services and settings.

While no one approach appears to work in all situations, the CMS evaluation concluded that system changes and financial incentives were the most consistent at producing the largest increase in the use of preventive services.

- **System changes.** These interventions change the way a health system operates so that patients are more likely to receive services. For example, standing orders may be implemented in nursing homes to allow nurses or other nonphysician medical personnel to administer immunizations.
- **Incentives.** These interventions include gifts or vouchers to patients for free services. Medicare allows providers to use this type of approach only in limited circumstances.[11] For example, in order to encourage the use of preventive services, providers may forgo some compensation by waiving coinsurance and deductible payments for Medicare preventive services. In addition, other types of incentives—such as free transportation or gift certificates—are also allowed so long as the incentive is not disproportionately large in relationship to the value of the preventive service.

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[9] CMS also conducts a variety of health promotion activities to educate beneficiaries about the benefits of preventive services and to encourage their use. These include the publication of brochures on certain covered services and media campaigns.

[10] Health Care Financing Administration, *Evidence Report and Evidence-Based Recommendations: Interventions that Increase the Utilization of Medicare-Funded Preventive Services for Persons Age 65 and Older,* Publication No. HCFA-02151 (Prepared by Southern California Evidence-based Practice Center/RAND, 1999).

[11] Under regulations that became effective on April 26, 2000, Medicare providers may offer certain incentives for preventive services. Under no circumstances may cash or instruments convertible to cash be used. *See* 42 CFR § 1003.101.

Other interventions found to be effective—though to a lesser degree than the categories above—are reminder systems and education programs.

• **Reminders.** These interventions include approaches to (1) remind physicians to provide the preventive service as part of services performed during a medical visit or (2) generate notices to patients that it is time to make an appointment for the service. Studies show that reminders to either physicians or patients can effectively improve rates for cancer screening. However, if a computerized information system is present in a medical office, computerized provider reminders are consistently more cost-effective than notifying the patient directly. Patient reminders that are personalized or signed by the patient's physician are more effective than generic reminders.

• **Education.** These interventions include pamphlets, classes, or public events providing information for physicians or beneficiaries on coverage, benefits, and time frames for services. The review found that while the effect of patient education is significant, it has the least effect of any of these types of interventions.

CMS Is Sponsoring Efforts to Increase Use of Services

CMS contracts with 37 Quality Improvement Organizations (QIOs), each responsible for monitoring and improving the quality of care for Medicare beneficiaries in one or more states, in the District of Columbia, or in U.S. territories.[12] QIO activities currently aim to increase use of three Medicare preventive services—immunizations against flu and pneumonia and screening for breast cancer.

QIOs are using various methods of increasing the use of these preventive services. For example, they are developing reminder systems, such as chart stickers or computer-based alerts, that remind physicians to contact patients on a timely basis for breast cancer screening. QIOs are also conducting activities to educate patients and providers on the importance of flu and pneumonia shots. CMS has taken steps to evaluate the success of these efforts. CMS officials explained that the contracts with the QIO organizations are "performance based" and provide financial incentives as a reward for superior outcomes. CMS officials expect information on the results by the summer of 2002.

CMS plans to expand these efforts by QIOs. While the current efforts include only 3 of the preventive services covered by Medicare, CMS is also planning to include requirements for the QIOs to increase the use of screening services for osteoporosis, colorectal, and prostate cancer in future QIO contracts. CMS is not currently planning to include QIO contract requirements for the remaining preventive services covered by Medicare—hepatitis B immunizations or screenings for glaucoma and vaginal cancer.

Other specific efforts have been started to increase use of preventive services by minorities and low-income Medicare beneficiaries in each state. CMS-funded research on successful interventions for the general Medicare population 65 and older concluded that evidence was insufficient to determine how best to increase use of services by minority and low-income seniors. To address this lack of information, CMS has tasked each QIO to undertake a project aimed at increasing the use of a preventive service in a given population. For example, the QIO may work with community organizations, such as African American churches, in order to convince more women to receive mammograms. CMS expects to publish a summary of QIO efforts to increase services for minorities and low-income seniors after the spring of 2002.

Finally, other studies or projects that CMS has under way aim to identify barriers and increase use of services by certain Medicare populations. For example, the Congress directed CMS to conduct a demonstration project to, among other things, develop and evaluate methods to eliminate disparities in cancer prevention screening measures.[13] These demonstration projects are in the planning stages. A report evaluating the cost-effectiveness of the demonstration projects, the quality of preventive services provided, and beneficiary and health care provider satisfaction is due to the Congress in 2004.

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[12] CMS formerly referred to this program as the Peer Review Organization program. During the course of our review CMS began referring to these entities as Quality Improvement Organizations. CMS officials told us that CMS plans to formalize the name change in a future *Federal Register* notice.

[13] *See* the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106-554, Appendix F, § 122, 114 Stat. 2763, 2763A-476 *classified* to 42 U.S.C. § 1395b-1 nt.

CONCLUDING OBSERVATIONS

Medicare beneficiaries are making more use of preventive services than ever before, but there is still room for improvement. While most preventive services are used by a majority of beneficiaries, few beneficiaries receive multiple services. Also, disparities exist in the rates that beneficiaries of different ethnic groups, income and education levels use Medicare covered preventive services. CMS has activities underway that have the potential to increase usage of preventive services. However, the full effect of these activities will not be known for quite some time.

As the Subcommittee and Congress consider broadening Medicare's coverage of preventive services, it is important to recognize the difficulty of translating some preventive service recommendations into covered benefits. For example, inclusion of behavioral counseling services may be beneficial, but reaching consensus on common definitions of these services remains a major challenge. Establishing Medicare coverage for some screening activities such as blood pressure and cholesterol screening may not be necessary since most beneficiaries already receive these services. Nevertheless, we believe that it is important to regularly review Medicare's coverage of preventive services as information on the effectiveness of such services becomes available. It is also important to continue to explore new approaches to encourage beneficiaries to avail themselves of the preventive services Medicare covers.

This concludes my prepared statement, Mr. Chairman. I will be happy to respond to any questions that you or Members of the Subcommittee may have.

Mr. GREENWOOD. Thank you so much.

Dr. Grissom.

TESTIMONY OF TOM GRISSOM

Mr. GRISSOM. Thank you, Chairman Greenwood. It is a pleasure to be here. Thank you for giving me the opportunity to talk with you about coverage of preventive services within the Medicare program. We, too, like you, believe that preventive services and health screenings do extend lives and improve and promote wellness throughout the country.

The President, the Secretary and the Administrator of CMS strongly support preventive health care and recognize the need to strengthen and improve the Medicare program by moving its benefits package from the current reactive acute care model to one which comprehensively and systematically emphasizes health promotion and disease prevention.

When the program was established in 1965, it was essentially and exclusively for the diagnosis and treatment of illness or injury and is limited to this day by that Medicare statute. The law then reflected the health care system at that time. Since then Congress, recognizing the changes in health practice, began to modify the law first—or most importantly in the BBA and later in BIPA in 2000 to increase benefits for preventive services, and over time has lowered the threshold, increased the coverage and reduced copays and deductibles, trying to make the Medicare program commensurate with or mirror private health care.

In addition to the benefits offered under the original fee-for-service, the Medicare law allows for private health plans, Medicare+Choice and the risk plans, which give beneficiaries expanded benefits especially in the area of vision care, dental care, smoking cessation counseling, as well as disease management and care coordination. The administration's goal is committed to providing even greater availability of these important preventive and innovative benefits by making these private plans available more widely and to more beneficiaries.

Additionally, as part of his overall framework for Medicare in the 21st century, President Bush has proposed giving seniors better coverage of these benefits by making them cost-free. I'm sure this morning we'll talk about the barriers to access and the utilization rates of these services, and there is clear evidence that cost may be an obstacle for certain kinds of beneficiaries and dual eligibles.

We know that simply offering these benefits is not enough to guarantee their utilization. We work at CMS with a variety of other agencies, with our quality improvement organizations to develop and use efficient approaches and methods to reach out to beneficiaries. Education is absolutely essential to improving utilization of these services. We include health promotion information as part of our Medicare information campaigns. We work with the National Cancer Institute, CDC, the National Diabetes Institute, the National Eye Institute on media campaigns at the local and the national level. We integrate these messages in our promotional materials, our Medicare and You handbook, and through the use of our 1-800 hotline. I have an example of those materials, Mr. Chairman, and I would enjoy sharing them with you.

We are also utilizing increasingly tabs and insertions like this from the carriers to beneficiaries in their summary of notices so that they understand that they do have a benefit, and we're trying to coordinate those with national campaigns month to month throughout the year with the individual preventive services.

The QIOs, which are groups of physicians in all of the States, have a number of projects, Dr. Bratzler will testify later, in which they are focusing on improving coverage of the—the access to the benefits and utilization. There were also focuses on working with minority groups and ethnic groups and economically disadvantaged groups, where the utilization rate is the lowest. Lots of those programs are innovative. They are private-public partnerships, and we think that they are quite effective.

Additionally, we're trying to change the way the organizations work, and there is within our agency a regulation under way that would alter the conditions of participation for nursing homes, hospitals and home health that would allow flexibility in standing orders, so that there were no regulatory obstacles to beneficiaries receiving flu, hepatitis B and pneumococcal vaccinations without having to go through a physician's order.

There is the Healthy Aging Project, which we operate in conjunction with AHRQ and the Centers for Disease Control, in which we're trying to identify, test and disseminate evidence-based approaches to promote health and functional decline in older adults. We know that 70 percent of the decline in aging is a result of environmental, behavioral, lifestyle causes, and 30 percent only by virtue of genetics. Thus, we are trying to do risk appraisals, figure out the best way to identify risks and to create educational programs that will have timely follow-up and interventions that truly alter an individual's behavior. Not much is known about this, certainly not enough, and we are in partnership with Brandeis University to develop pilot programs and to do so in a way which is education-based.

We also have a demonstration project about to launch in CMS on smoking cessation. It is a result of BIPA 2000. It will focus on

seven States with four different treatment scenarios for about 40,000 beneficiaries, for which we think there is a great possibility and great opportunity for improvements.

Health risk appraisals focus on the area of diet and physical activity. There is plenty of empirical evidence to suggest that these are important. Secretary Thompson, both personally and professionally, has talked about how a little prevention won't kill you and is trying to give personal leadership to changes in individual behavior as leading to healthy lives. Again, our goal is to try increase access to and in promotion of these efforts at CMS and in the Medicare program.

We appreciate the opportunity to be here, and are thankful for the attention that you're bringing to this. Thank you, and I'll be glad to answer any questions.

[The prepared statement of Tom Grissom follows:]

PREPARED STATEMENT OF TOM GRISSOM, DIRECTOR, CENTER FOR MEDICARE MANAGEMENT, CENTERS FOR MEDICARE & MEDICAID SERVICES

Chairman Greenwood, Congressman Deutsch, distinguished Subcommittee members, thank you for inviting me to discuss Medicare coverage of preventive services. Preventive care services can extend lives and promote wellness among America's seniors. The President, the Secretary, and CMS strongly support preventive health care services for Medicare beneficiaries, and the Administration has proposed several initiatives related to prevention that I will discuss in greater detail later in my testimony. First, I would like to discuss the nature of preventive health care benefits in the Medicare program and what benefits are currently covered under Medicare.

BACKGROUND

When Medicare was established in 1965, the program covered only those health care services necessary for the diagnosis or treatment of illness or injury, as limited by the Medicare statute and reflecting the health care system at that time. Consequently, Medicare, as a general rule, did not cover routine screening or other purely preventive benefits. However, Congress recently has expanded the program to come closer to modeling the preventive care concepts in private health care programs and has added a number of preventive and screening benefits to the program. Both the Balanced Budget Act of 1997 (BBA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) significantly added to, or expanded, the preventive benefits covered by Medicare. These benefits include:

- *Screening Mammography:* BBA expanded coverage to include an annual screening mammogram for all women Medicare beneficiaries age 40 and over, and one baseline mammogram for women age 35-39. BIPA moved payment for screening mammography to the physician fee schedule and also specified payment for two new forms of mammography that use digital technology.
- *Screening Pap Smears and Pelvic Exams:* BBA provided coverage for a screening Pap smear and pelvic exam (including a clinical breast exam) every 3 years, or annual coverage for women of childbearing age who have had an abnormal Pap smear during the preceding 3 years, or women at high risk for cervical or vaginal cancer. BIPA increased the frequency of coverage for screening Pap smears and pelvic exams (including a clinical breast exam) from every 3 years to every 2 years for women at average risk.
- *Colorectal Cancer Screening:* BBA provided coverage for colorectal cancer screening procedures including: (1) annual fecal-occult blood tests for persons age 50 and over; (2) flexible sigmoidoscopy for persons age 50 and over, every 4 years; (3) colonoscopy for persons at high risk for colorectal cancer, every 2 years; and (4) other procedures the Secretary finds appropriate. Barium enemas are also covered as an alternative to flexible sigmoidoscopy or colonoscopy. BIPA expanded coverage of screening colonoscopies to include all beneficiaries, not just those at high risk for colorectal cancer.
- *Prostate Cancer Screening:* BBA provided coverage of annual prostate cancer screening for men over age 50, including: (1) digital rectal exams; (2) prostate-specific antigen (PSA) blood tests; and (3) after 2002, other procedures the Secretary finds appropriate.

- *Glaucoma Screening:* BIPA provided coverage of annual glaucoma screening for individuals at high risk for glaucoma, individuals with a family history of glaucoma, and individuals with diabetes.
- *Diabetes Self-Management Benefits:* BBA provided coverage for outpatient diabetes self-management training in both hospital-based and non-hospital-based programs, and for blood glucose monitors and testing strips for all diabetics.
- *Medical Nutrition Therapy Services:* BIPA provided coverage of medical nutrition therapy services for beneficiaries who have diabetes or a renal disease. Covered services include nutritional diagnostic, therapy and counseling services for the purpose of disease management, which are furnished by a registered dietician or nutrition professional, pursuant to a physician's referral.
- *Standardization of Coverage for Bone Mass Measurements:* BBA provided coverage for bone mass measurement procedures, including a physician's interpretation of the results, for estrogen-deficient women at risk for osteoporosis, and persons: (1) with vertebral abnormalities; (2) receiving long-term glucocorticoid steroid therapy; (3) with primary hyperparathyroidism; and (4) being monitored for response to an osteoporosis drug.
- *Vaccines Outreach Extension:* BBA extended, through FY 2002, the existing Influenza and Pneumococcal Vaccination Campaign conducted by our Agency in conjunction with CDC and the National Coalition for Adult Immunization. Medicare covers influenza, pneumococcal, and hepatitis B vaccinations, including payment for the vaccine plus payment for a physician's administration of the vaccine.

The BBA and BIPA also required CMS to conduct analyses of Medicare preventive benefits. Under the BBA, we worked in conjunction with the Institute of Medicine and the U.S. Preventive Services Task Force to conduct a study of short- and long-term costs and benefits of expanding or modifying preventive or other services covered by Medicare. This analysis was completed in December 1999. Similarly, we are currently working with the National Academy of Sciences in conjunction with the U.S. Preventive Services Task Force to conduct, as required under BIPA, a study on the addition of coverage of routine thyroid screening using a thyroid stimulating hormone test as a preventive benefit.

In addition to the prevention benefits added to the program since 1997, Medicare has begun to offer additional preventive health care services through the Medicare+Choice program. Unlike the Medicare fee-for-service program whose benefits are tied to statute, the private companies that provide Medicare+Choice have the flexibility to cover additional services, such as immunizations, exercise programs, cancer screening, and health education, that are not covered under the traditional Medicare benefits package. For example, one Medicare+Choice plan in California has a successful outreach program to increase influenza vaccination rates among their elderly and chronically ill beneficiaries to reduce mortality and morbidity among these at-risk populations. And a Boston Medicare+Choice plan has a comprehensive disease management program for its enrollees with diabetes. The result has been significant increases in the share of enrollees who receive preventive treatments like annual retinal eye exams and kidney tests, and better blood sugar control and cholesterol levels, all of which prevent the life-threatening complications of diabetes. The Administration is committed to providing greater availability of innovative preventive benefits by making private plan options more widely available to beneficiaries. This is key to improving beneficiary access to preventive benefits and to strengthening the overall Medicare program.

In addition, Medicare+Choice programs typically provide some form of disease management or care coordination program, a service not covered in traditional Medicare. Several studies have suggested that case management and disease management programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes. Coordination of care has the potential to improve the health status and quality of life for beneficiaries with chronic illnesses. We believe disease management has potential for preventing the worsening of chronic health conditions, and we are currently undertaking a series of disease management demonstration projects to explore a variety of ways to improve beneficiary care in the traditional Medicare plan.

THE ADMINISTRATION'S COMMITMENT TO PREVENTIVE CARE

Obviously, Medicare's coverage of preventive benefits has come a long way since the statute was written in the 1960s when the positive impact of preventive services was not fully understood. However, Medicare's coverage of preventive services can be improved. Under current law, Congress must enact legislation authorizing Medicare to cover specific preventive benefits. This approach can lead to fragmentation, and may not be consistent with a comprehensive, evidence-based approach to health

promotion. The President recognizes the need to improve and strengthen the Medicare program by moving its benefits package from a reactive, acute care model to one that comprehensively and systematically emphasizes health promotion and disease prevention. As part of his principles for strengthening Medicare, the President has proposed to give seniors better coverage of preventive treatments by making existing preventive benefits cost-free for seniors.

Secretary Thompson has reinforced the Administration's commitment to disease prevention by promoting healthy behavior as a priority for his Department, and even discussing in recent weeks his personal efforts to adopt a healthier lifestyle. To this end, HHS supports a number of programs to promote better health for all Americans, including:

- **Healthy Communities Innovation Initiative.** President Bush's fiscal year 2003 budget includes $20 million for a new Healthy Communities Innovation Initiative, an effort to bring together community-wide resources to help prevent diabetes, asthma and obesity.
- **Healthy People 2010.** Healthy People 2010, a comprehensive set of objectives for the nation to meet by the end of this decade, identifies the most significant preventable threats to health and establishes national goals to reduce these threats.
- **Leading Health Indicators.** The first annual report on the 10 leading health indicators, critical factors that have a profound influence on the health of individual communities and the nation, will be released this year. They represent the major public health concerns in the United States where individuals and communities can take action to realize significant health improvements.

HEALTH PROMOTION ACTIVITIES

Secretary Thompson, Administrator Scully, and I support the President's commitment to expand beneficiary access to preventive health services, and we are working on ways to improve health quality for America's most vulnerable citizens. As you may know, simply offering coverage for preventive health care services is not always enough to guarantee that Medicare beneficiaries take advantage of the benefits. That is why we strive to use efficient and cost effective approaches by partnering with other agencies and organizations, utilizing Medicare contractors to educate people with Medicare about covered preventive services and encouraging beneficiaries to use these services. To this end, we include health promotion information as a part of many education campaigns that address different aspects of the Medicare program or Medicare+Choice options. We have established partnerships with other HHS agencies, such as the Centers for Disease Control and Prevention (CDC) and the NIH's National Cancer Institute (NCI) to carry out health promotion initiatives, distribute outreach kits, and produce multi-media, multi-year campaigns involving numerous partners at the local and national level.

In addition, we integrate communications about preventive services with other Medicare educational initiatives, such as:

- The *Medicare and You* handbook, which is distributed to all beneficiary households, includes information on Medicare-covered preventive services. We also publish and distribute a brochure entitled, *Medicare Preventive Services . . . To Help Keep You Healthy that provides more detailed information about Medicare's preventive benefits, plus reminder cards showing how often beneficiaries should receive screenings.*
- Medicare carriers and intermediaries include messages on the importance of preventive services when they send out Medicare Summary Notices. These messages are sent during certain months of the year to correspond with health themes, such as Colorectal Cancer Awareness Month. The carriers and intermediaries also discuss these services and distribute materials to Medicare beneficiaries when they give talks on other Medicare issues. And they include articles on preventive services in their newsletters and on their websites.
- Our regional offices also are involved in outreach. They disseminate information on preventive services during other information campaigns, such as during our successful Regional Education About Choices in Health (REACH) campaigns.
- Our 1-800-MEDICARE help line and Medicare.gov Internet site also include information on preventive health services, including coverage, screening techniques, and where to locate additional information.
- We also use targeted promotions to educate beneficiaries about particular preventive services. For example, we have produced and distributed more than 23,000 "Screen-for-life" posters with tear-off sheets that beneficiaries can take with them to their physician as a reminder to discuss colorectal cancer screening options.
- Another example of a coordinated national activity was the presentation of "Beyond the Barriers: Effective Breast Cancer Early Detection Strategies for Older

Women." This national satellite videoconference was broadcast live last year to 133 sites in 40 states across the country.

In addition, we emphasize the importance of prevention in education campaigns on the radio and through television public service announcements, print materials and media kits, websites, and articles in journals and newsletters. Through these campaigns, we are targeting high-risk populations and health care practitioners whom we know have a tremendous influence in encouraging healthy behavior.

We are actively working to find out how best to increase use of preventive services needed by the Medicare population. We are studying a variety of successful interventions to test their effectiveness in the elderly population. In addition, we are working closely at the state level with our Quality Improvement Organizations (QIOs, formerly Peer Review Organizations) to monitor and to improve usage and quality of care for Medicare beneficiaries. We have set a goal for the QIOs of improving the utilization of flu and pneumonia vaccinations and breast cancer screening. To this end, the QIOs are actively reaching out to Medicare beneficiaries to increase the use of these three preventive services. They are also targeting racial and ethnic groups that have low rates of use. We are currently evaluating the success of these QIO efforts, and expect results later this year.

Through our work with the QIOs and through other research, we know that compelling evidence exists that race and ethnicity correlate with health disparities. We are exploring a demonstration project to identify and test cost-effective models of intervention that have a high probability of positively impacting one or more health outcomes; including health status, functional status, quality of life, health-related behavior, consumer satisfaction, health care costs, and appropriate utilization of covered services. We have contracted with Brandeis University to report on interventions that could be used among the targeted ethnic and racial minority populations. At the conclusion of the demonstrations, we will deliver a report to Congress on the cost-effectiveness of the projects, as well as the quality of preventive services provided and beneficiary satisfaction.

CMS' INNOVATIONS IN PREVENTIVE CARE SERVICES

A growing body of literature indicates that chronic disease and functional disability can be measurably reduced or postponed through lifestyle changes, and that healthy behaviors are particularly beneficial for the elderly. We have addressed some of the clinical preventive services that contribute to a healthy aging experience, and are just beginning to explore how to address behavioral risk factors, which account for 70 percent of the physical decline that occurs with aging, with the remaining 30 percent due to genetic factors. To this end, we developed the Healthy Aging Project in collaboration with the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Administration on Aging, and the National Institutes of Health. The Healthy Aging Project aims to identify, test, and disseminate evidence-based approaches to promote health and prevent functional decline in older adults.

We contracted with RAND to produce several reports synthesizing the evidence on how to improve the delivery of Medicare clinical preventive and screening benefits and exploring how behavioral risk factor reduction interventions might be implemented in Medicare. We have been using these reports to guide demonstration projects testing ways to improve Medicare beneficiaries' health—and have already identified ways to change our policies for the better. The first report, *Interventions That Increase the Utilization of Medicare-funded Preventive Services for Persons Aged 65 and Older,* states that organizational changes are effective in improving the delivery of preventive services. As a result of this research and a 14-state pilot conducted in collaboration with CDC, we are making regulatory changes. These changes will promote vaccinations, and encourage the use of standing orders for flu and pneumococcal vaccinations in all health care settings. Standing orders permit appropriate non-physician staff to offer these services.

In addition to the regulatory changes for standing orders that have come out of the Healthy Aging Project, we are using the research gleaned from this project to explore methods to encourage behavioral changes in the Medicare population, which could form the basis for the "next generation" of Medicare benefits.

Additionally, we, along with our partners at NIH and AHRQ, have developed a demonstration to test the most effective strategies for achieving smoking cessation in Medicare beneficiaries. The demonstration will compare the impact of offering three different approaches to smoking cessation on quit rates. We expect to start recruiting smokers to participate in the demonstration this fall. The study will be completed in 2004.

We also are developing a potential project that would examine the use of health risk appraisal programs with targeted follow-up interventions. We have reviewed evidence related to health risk appraisal programs and their effectiveness in achieving positive behavior change, particularly in the areas of diet and physical activity. There is evidence that these programs improve physical activity levels and reduce blood pressure. We are in the process of developing a test of how health risk appraisal programs could improve Medicare beneficiaries' health. We look forward to working with Congress as we continue to develop groundbreaking ways to integrate preventive health care services into the Medicare program.

CONCLUSION

Empirical evidence shows that preventive health care services are vital for improving the quality and duration of life. Just last month, Secretary Thompson, speaking at the National Press Club, emphasized his philosophy, "a little prevention won't kill you," and noted that even modest behavioral changes and increased attention to health can prevent or control myriad diseases and chronic conditions. We here at CMS, along with the Secretary and the President recognize the benefits that preventive health services provide. We are working to improve access to these services and to develop innovative ways to offer prevention-related health services to the Medicare population. In closing, I would like to thank Congressman Greenwood for his interest in preventive health care and the Committee for inviting me to testify today. We look forward to Congress' continued interest and support for this vital issue. I am happy to answer any questions.

Mr. GREENWOOD. Thank you, Mr. Grissom.

Dr. Fleming.

TESTIMONY OF DAVID W. FLEMING

Mr. FLEMING. Thank you, Mr. Chairman, for providing CDC the opportunity to be here with our colleagues today. We appreciate being given the time to talk with you about the prevention opportunities that are available to improve the health of America's seniors.

You know, unfortunately, there is one thing that links everybody in this room, and that is that we're all getting older, and we're not alone. The population of older adult in this country, both in number and in proportion, is increasing at a much faster rate than we've ever experienced before. And we have yet to encounter that rapidly rising tide of baby boomers that will begin to reach age 65 just 8 years from now.

We have a potential health crisis on our hands, but the operative word is "potential." Poor health is not an inevitable consequence of aging. While we can't live forever, the evidence is overwhelming that prevention works for older adults. We can postpone illness and disability so that the need for long-term care is reduced and our seniors are able to enjoy full, independent and healthy lives as long as possible.

And Medicare has brought the benefits of prevention to millions of older adults by capitalizing on research, by evaluating interventions, like you're going to hear about in a minute, with the Guide to Preventive Services, and covering services with preventive health care benefits.

So what role does CDC and public health have in this health care arena? You know, there is still much work to be done, and public health has a role in four of our most important strategies: First, to make sure that covered benefits are received. Unfortunately, just knowing what works and providing it isn't enough. If you build it, everyone doesn't come. Today, for example, instead of needlessly taking thousands of lives of otherwise healthy Americans each winter, influenza can be largely prevented. There is a

highly effective vaccine which has been recommended for use and is provided under Medicare, but millions of America's seniors don't receive it. Public health and epidemiological expertise can be used to identify system solutions, like reminder recall in providers' offices that you've heard about, like standing orders in nursing homes, like immunization registries at the local level that can be used within the health care system to improve the delivery of preventive services.

And we can work on the patient side, too. In the last flu season I called my 85-year-old dad and asked if he got his flu shot. He said "no;" and I said, "why?" He said, "no one offered it to me." And I said, "Did you think about asking for it?" He said, "no." And I said, give that a try. One week later he called and said, "I asked for it, I got it, and now I'm immunized."

Public health can play an important role in community education so that not only the medical system is trying to deliver preventive services, but the patients out there are actively trying to receive them as well. One successful model is a model called SPARC. That is a public-private partnership in Massachusetts, New York and Connecticut, and it serves a role of serving as a catalyst, as the glue to bring together seniors, health care providers and existing community resources. These kinds of programs have dramatically increased the use of Medicare-covered preventive services, and older adults around the country should have access to the same kinds of services that SPARC, for example, provides.

Now, second, we need to go beyond the medical services that can be provided in the physician's office. We need to use tried and true public health methods to help people make healthy choices, as you said in your opening statements, because contrary to widespread perception, it is never too late to start healthy habits and gain benefits.

Even the most frail elderly are capable of increasing their strength, balance and fitness. Just walking several days a week yields significant health benefits. In fact, physical activity may be the closest thing we have to a silver bullet against aging. Not only can seniors improve cardiovascular fitness, but exercise can reduce the impact of serious conditions like diabetes, the risk of falling and costly hip fractures, and help anxiety and depression.

Yet nowhere is the gap wider between what we know how to do and what we can provide in this area. Few seniors engage in regular activities that improve balance and strength, and seniors have too few opportunities to do the beneficial activities they like to do, like safe walking and gardening.

But, programs that influence these behaviors pay off. In heart disease, for example, medical interventions reap substantial benefits in added life expectancy, estimated by the Institute of Medicine at 4 to 1 when costs are considered. But interventions and behavioral change produce remarkable returns at the 30-to-1 investment level.

Third, we need to engage our partners in this. We need to take advantage of the aging network's resources. The Administration on Aging, for example, reaches into virtually every community in this country with its network of over 600 area Agencies on Aging. AOA has the mandate through the Older Americans Act to address

health promotion and disease prevention, yet much of the expertise in how to do that rests in public health. We need to work together, and some creative integration could lead the medical system, public health and the aging network, working together in communities and in the home, to provide prevention services such as how to prevent falls, reviewing medicines that our seniors are taking, and vision screening. We know that these interventions work. We just need to make use of the potential delivery systems that are already in place.

Fourth and finally, we need to look upstream. Those of us in this room who because of age are not yet Medicare-eligible hopefully someday will be, and if each of us were successful at just three things, maintaining healthy weight, engaging in moderate physical activity and not smoking, we could delay the onset of disability for a decade on average. Wise prevention investments today in our younger adult population will yield a generation of healthier seniors in the future.

So in conclusion, the science is compelling. We know that it is never too late to take advantage of the promise of prevention, but as a Nation, we focus primarily on providing quality health, really illness care, for our older adults. Our challenge now is to ensure that as life span lengthens, the added years are quality years, and we need to create a sustainable health care system that provides the very best opportunities and incentives to stay healthy for our seniors as long as possible.

I'd like to thank the committee for its leadership and commitment in this arena, and I wanted to let you know we think you're making a wise investment. Thank you very much.

[The prepared statement of David W. Fleming follows:]

PREPARED STATEMENT OF DAVID W. FLEMING, ACTING DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Thank you, Mr. Chairman, and Members of the Committee, for the opportunity to speak to you today about an issue that is of critical and increasing importance at the Centers for Disease Control and Prevention (CDC), and indeed for the American people. We at CDC are pleased to join our federal and non-federal partners in addressing the challenges facing Medicare, and identifying opportunities to improve the health of older.

Before talking more specifically about improving the health of older adults, I would like to provide some context. Chronic diseases account for nearly 75 percent of the deaths in this country, are the leading causes of disability and long-term care needs, and represent nearly 75 percent of all health-related costs. Although chronic diseases are not limited to older adults, these conditions, such as cardiovascular disease, cancer, diabetes, and arthritis are heavily concentrated in adults age 50 and over. Among the 10 leading causes of death, the top six are concentrated in older adults. Premature death and much of the illness and disability associated with these diseases is preventable, even among older adults.

This is critically important because we are now entering the time in our nation's history when the population of older adults—both in number and in proportion—is increasing at a much faster rate than we have ever experienced. The current anxiety and debate around Medicare costs is motivated by the aging of the baby boomers. The baby boom generation's leading edge is currently 56 years old. As this segment of the population ages, the proportion of adults age 65 and over in the U.S. will more than double, such that by 2030, 20 percent of all Americans will be older adults. If we don't take some steps now to do what we can to influence the health habits of the baby boomers, we may never catch up to the upcoming demands on the health care system.

Current health and aging trends may have enormous implications for the public health system, the health care system, and our existing network of aging and social

services. The cost of health care for a 65-year-old person is four times as much as that for a 40-year old. People age 65 and over even now consume 33 percent of our health care dollars, or more than $300 billion each year. By 2030, those costs will increase by 25 percent, for the sole reason that our population will be older—even before inflation and the costs of new technology are taken into account.

Recent CDC projections of just one major disease—diabetes—illustrate the magnitude of what we face if we don't act. Today diabetes alone accounts for about 6 percent of Medicare costs. The number of people with diabetes is expected to almost triple from 11 to 29 million by 2050. Aging baby boomers will contribute to the increased number of cases, but what's alarming is that among adults, diabetes rates increased 49 percent between 1990 and 2000, in large part due to unhealthy lifestyles. Clearly, we may not be able to sustain our current health care system unless we address in a more aggressive manner the prevention of chronic diseases and injuries. Until now, we have not maximized our prevention opportunities among older Americans. Too many believe the myth that older adults have lived beyond the time when prevention can be beneficial.

The evidence is convincing that prevention is worth the investment for the health and safety of older adults. A recent Institute of Medicine report noted that the return on investment in medical care for cardiovascular disease reaped benefits at 4 to 1, but investment in behavioral change returned a remarkable 30 to 1 advantage. We should bring the health advantages of prevention to older adults across the country.

We at CDC, together with Centers for Medicare and Medicaid Services (CMS), National Institutes of Health (NIH), the Administration on Aging (AoA), and others are committed to improving health and independence, and reducing long-term care needs among older adults. Medicare coverage has a critical role to play here—and we should maximize the use of currently covered services and identify additional effective prevention and control measures that can enhance the health of Medicare beneficiaries.

Through basic research at NIH and other institutions, CDC's prevention research programs, and other institutions, we know quite a lot about how to prevent or postpone illness, injury, and disability experienced by older adults today. Unfortunately, just knowing what works is not enough. Even when covered by Medicare, older adults often may not be receiving recommended preventive services.

For example, only two-thirds of adults age 65 and older reported receiving a flu shot in the previous year, and more than half report that they have never been vaccinated against pneumococcal disease—even though Medicare covers the cost of both immunizations.

Despite the lifesaving benefits of screening and early detection for chronic disease, one in five women age 65-69 has never had a mammogram, and half of older adults do not receive recommended screening for colorectal cancer. Again, Medicare covers both of these screening services.

It is clear that solving the basic research problem—developing proven prevention measures—is just the first step. There are significant gaps in getting what we know about prevention to individuals who can benefit. We are likely close to the limits of what the health care system as currently structured can do to increase preventive services. Research conducted at RAND with support from CMS showed that immunizations and screening improve when health care organizational changes are made and patients are involved in their own management. Clearly, improvements in prevention services for older adults will require creative approaches that support new ways of delivering preventive services and links to the community.

We can do better. To help ensure prevention benefits currently covered through Medicare reach beneficiaries, we would propose more closely linking CDC's public health expertise in disease prevention and health promotion with the aging expertise and extensive outreach capability of the aging network—the Administration on Aging and its state and local counterparts. This network, analogous in ways to the public health network but with a specific population focus, reaches into virtually every community in the country with its network of over 600 area agencies on aging and associated senior centers. CDC and AoA are currently working with state chronic disease directors and state units on aging to stimulate local prevention activities. To commemorate Older Americans Month in May, mini-grants of $5,000 to $10,000 will be announced that will allow state and local representatives to develop prevention programs that reflect local priorities.

While Medicare has made preventive services a priority through the PROs, some creative approaches for increasing preventive services have been tested that link the health care system to community-based resources.

At CDC, we provided some funding to a program aptly named SPARC, or Sickness Prevention Achieved through Regional Collaboration. This program, serving counties

where the borders of New York, Connecticut, and Massachusetts meet, acts as a broker to bring together existing health care and community resources. SPARC does not deliver services; instead, it consolidates and coordinates, serving as the missing catalyst, or the glue. Because providers do not see SPARC as a competitor, they welcome a service that helps them and their patients.

SPARC has helped the communities it serves achieve dramatic results in extending critical preventive health services to older adults. For example, Medicare data shows that in 1997 in Litchfield County, Connecticut, a community served by SPARC, pneumococcal immunizations increased at twice the rate compared to seven surrounding counties without the benefit of SPARC. The SPARC model has demonstrated its value in bringing lifesaving preventive services to older adults. Communities around the country could benefit from innovative and successful models like SPARC.

CDC also participated in CMS's recent effort to permit "standing orders" that allow institutions like nursing homes to routinely provide immunizations without requiring providers and staff to coordinate new written orders annually for individual patients. Support for this type of systems change is critical in improving prevention under Medicare.

While there are real gains to be achieved through the broader use of covered preventive services, Medicare has just begun to support benefits that target lifestyle issues so critical to reducing the toll of chronic illness.

Research has shown that practicing a healthy lifestyle is more influential than genetic factors in helping older people avoid the deterioration traditionally associated with aging. Several weeks of inactivity take a greater toll on the body than decades of aging. People who are physically active, eat a low-fat, high-fiber diet, and do not use tobacco products significantly reduce their risk for chronic disease, such as cardiovascular diseases, diabetes, chronic obstructive lung disease and arthritis, as well as for injuries related to falls. Perhaps more important, practicing just these three healthy habits delays the onset of disability by more than a decade on average. For a society concerned about the public and private costs of long-term care, delaying disability has enormous potential economic implications.

For the purposes of today's hearing, I'd like to focus on physical activity as a preventive tool that deserves Medicare's support. Besides reducing the risk for a variety of chronic diseases, regular activity also helps older adults reduce their risk of falling, alleviate anxiety and depression, maintain a healthy body weight, and improve joint strength and mobility. And yet, nowhere is the gap wider between what we know and what we do.

Two-thirds of older adults do not get regular physical activity. Less than half of older adults served by Medicare say that their healthcare provider asks them about physical activity. The potential exists to reverse this by ensuring that older adults have access to physical activity programs that address their unique health, lifestyle, functional, and motivational needs. Even the frailest of elders can benefit from low-stress activities tailored for their needs, such as gardening "which, by the way, is the third most popular physical activity among seniors. All individuals, and particularly older adults, should receive counseling from their health care providers on the benefits of physical activity.

Let me give you an example of what moderate physical activity can mean for people at high risk for diabetes, with its debilitating complications and enormous Medicare costs each year. In a recent NIH study, in which CDC collaborated, overweight adults with above-normal glucose levels who walked five times a week and lost as few as five pounds were able to reduce their risk of developing diabetes by nearly 60 percent. People in the study aged 60 and older were among those most successful in reducing their risk.

There is a groundswell of interest across the country in promoting physical activity among older adults. Over 800 candidate communities recently registered their intent to apply for funding available from the Robert Wood Johnson Foundation for the "Active for Life" program. Unfortunately, only eight sites will receive funding for this program to increase physical activity among older adults. Given the benefits of physical activity, CDC is currently working with the National Institute on Aging (NIA) and the Older Women's League to evaluate the effectiveness of NIA's recently developed physical activity materials in getting older adults to exercise.

There is recognized, science-based value in physical activity programs, but they aren't reaching older adults. Learning how to get the benefits of such programs out to seniors in communities across the country should be a national priority.

Physical activity also plays a key role in reducing an older person's risk of falling. One of every three older Americans—about 12 million seniors—falls each year, with devastating consequences. More than 10,000 will die from the fall; another 340,000 will sustain a hip fracture. Half of the older adults who break their hip in a fall

are never able to return home and live independently again. The risk of falling and loss of independence has been shown to be a primary concern for older adults. A recently-published study involving women age 75 and older found that 80 percent would rather be dead than experience the loss of independence and quality of life from a bad hip fracture and admission to a nursing home.

Risk factors for falls include: a previous fall, muscle weakness, problems with balance and walking, being underweight, vision and hearing loss, taking four or more medications or psychotropic drugs (such as sleeping pills and tranquilizers). Reducing the risk of falls would make an enormous impact on reducing disability and long-term care needs. Every year, falls among older people cost the nation more than $20 billion, and these costs will rise to an estimated $32 billion by 2020.

Weight resistance exercises and regimens such as Tai Chi help seniors maintain and improve balance, strength, and coordination at any age. Other means to address fall risk include insuring proper medication management for older people—a current priority of the Assistant Secretary for Health, Dr. Slater; making physical changes in the home environment; and educating seniors and their caregivers, formal and informal, about factors that contribute to falls. Simple changes in an older person's home, such as securing rugs and adding grab bars in bathrooms can quickly and easily reduce fall risk. Because vision problems can increase a person's risk for falling by as much as 60 percent, improved lighting in the home is also an effective strategy for preventing falls. Despite the known benefits of such measures, more than two million older Americans live in homes that have not had simple modifications that can reduce their risk of falls. One-fourth of older adults have an outdated or wrong eyeglass lens prescription, contributing to poor vision and the increased likelihood of falls.

Screening older adults for fall risk should be a routine part of medical care, just as we screen for cancer or diabetes complications. Such screening should include identifying adults who have previously fallen or who have multiple fall risk factors as I cited above, followed by appropriate and necessary treatment, for example, training to improve balance and muscle weakness, medication review and management, vision screening and correction, and assessment of and education on needed home modifications. Such efforts are already underway in other developed nations, where collaboration between government agencies and aging networks are providing easily accessed and effective physical activity and falls prevention programs for seniors.

Another area of importance to Medicare beneficiaries is medical errors occurring while hospitalized or as a resident of a long-term care facility. Based on a landmark report by the Institute of Medicine, medical errors are responsible for 44,000 to 98,000 deaths each year with additional healthcare costs of 17 to 29 billion dollars each year. CDC is working with several partners including the Agency for Healthcare Research and Quality, the Veterans Administration, and the Centers for Medicare and Medicaid Services, along with private sector partners, to better understand why these events occur, and to implement programs to prevent them.

Finally, I'd like to address one last area today that holds considerable promise in improving seniors' health and quality of life, and in reducing the demands on the health care system. That area is self-care for those with chronic diseases or for those at increased risk for disease or complications.

Self-care can be undertaken in a variety of ways and for a variety of conditions, from diabetes to arthritis. We know that people will "self-manage" their disease even when they are pursuing remedies with no known health benefits. Programs are widely available, but no criteria exist to determine what the programs should include. The challenge, and the opportunity, is to ensure that older adults receive the quality education they need to become knowledgeable about what they can do to take responsibility for their own health and disease management.

For an individual with diabetes, this might mean optimally managing blood glucose levels. The individual not only fares better physically but derives benefit and satisfaction from being an active participant in his or her own care. Self-management has been shown to be of particular value for people with arthritis, the leading cause of disability and a problem for almost two-thirds of Medicare enrollees. In selected states and in cooperation with the Arthritis Foundation, CDC supports an arthritis self-management education program that teaches people how to better manage their arthritis and lessen its disabling effects. This six-week course has been shown to reduce arthritis pain by 20 percent and physician visits by 40 percent. Again, however, there is a gap in getting the benefits of this program out to individuals. Currently, less than one percent of the 43 million Americans with arthritis participate in such programs and courses are not offered in all areas.

In conclusion, I would like to thank the Committee again for its leadership and commitment in the important area of older adult health. While the risk for disease

and disability clearly increases with advancing age, poor health does not have to be an inevitable consequence of aging. Far from being too old for prevention, Medicare recipients offer some of our most promising prevention opportunities. The science base is compelling, but we should refocus our attention on the real barriers to implementation and financing. Priority needs are evaluating promising programs in real-world settings and making the system flexible enough to accommodate the new types of benefits that are required. Our nation has contributed to an unprecedented increase in the human life span during the 20th century through improvements in public health and medical care. Since the 1960s we have been committed to providing health care for older adults. Our challenge now is to insure that added years are quality years and to create a sustainable health care system that provides the very best opportunities and incentives to stay healthy and independent as long as possible.

Thank you. I'd be happy to answer any questions.

Mr. GREENWOOD. Thank you very much.

Dr. Clancy. I probably should have said earlier, since we don't have a bevy of members here waiting to answer questions, don't worry too much about the red light. Just speak until you're finished.

TESTIMONY OF CAROLYN M. CLANCY

Ms. CLANCY. Good morning, Mr. Chairman, members of the subcommittee. I'm very pleased to be here today to discuss the work of the U.S. Preventive Services Task Force and the role of the Agency for Health Care Research and Quality, or AHRQ, which provides the task force with scientific and administrative support.

You might have seen Tuesday's Washington Post article this week about the task force's new recommendations urging primary care physicians to screen their adult patients for depression, or you may have seen this week's Newsweek article highlighting a recommendation recently released by the task force on the use of aspirin to prevent heart disease. Indeed, we could never have planned this, but it turns out that as we speak, people are calling in to hear more about aspirin and heart disease as well. These are both excellent examples of the work of the task force and AHRQ as its sponsor to improve the scientific basis in the quality of clinical preventive services.

The task force itself is an independent private sector panel of experts in prevention and primary care who review the scientific evidence and make recommendations on clinical preventive services. These services specifically include screening tests, immunizations and counseling. The work of the task force is a natural fit with AHRQ's mission to support research designed to improve the quality of health care, reduce its costs, improve patient safety, address medical errors and broaden access to essential services.

In 1999, the Congress directed AHRQ to provide scientific and administrative support to the task force, and in 2000, legislation required AHRQ to produce an annual report to the Congress on preventive services for older adults, and a copy of that has been submitted for the record.

I'd like to note since you're hearing from all of us who work together that the work of AHRQ and the task force complements the preventive services at the NIH and the Centers for Disease Control and Prevention. While AHRQ studies the use of clinical preventive services in everyday practice, NIH research identifies preventive interventions that work under ideal conditions, and for its part,

CDC assesses the effectiveness of community-based public health interventions, as Dr. Fleming has just noted before.

I'd like to now describe briefly how the task force formulates its recommendations and the support that we as an agency provide.

The recommendations of the task force are based on state-of-the-science evidence in health care. This is an interative process. This is actually the third task force to make recommendations based on evidence or on preventive services. The first such task force was convened in 1984, and the recommendations were released in 1989. A subsequent update was completed by the second task force in 1996 after 5 years of work.

To formulate its recommendations, the task force conducts comprehensive reviews of the scientific evidence regarding the effectiveness, risks and benefits of specific preventive services. Because reviewing all of this evidence is a significant task that requires specialized expertise, the task force works with two of AHRQ's 12 evidence-based practice centers, or EPCs, to do the analysis and synthesis. The task force reviews the evidence synthesized by the evidence-based practice centers and then makes recommendations.

Unlike its predecessors, the current task force is issuing its recommendations serially rather than a single update—a single volume at the end of its term. This allows them to provide updated information in a much more timely fashion. To date, this task force has released recommendations on screening for depression, on breast cancer, chlamydia, bacterial vaginosis in pregnancy, skin cancer, newborn hearing problems, cholesterol and the use of aspirin to prevent heart disease.

But it is very important that we believe that AHRQ's work on preventive services doesn't end with the task force recommendations. As part of our effort to translate research into practice, AHRQ also sponsors something called the Put Prevention Into Practice program, which translates the recommendations of the U.S. Preventive Services Task Force for clinicians, health systems and patients in order to increase the delivery of recommended preventive services.

Task force recommendations and the products of Put Prevention Into Practice are used widely throughout the health care system to improve the preventive services provided to the Nation's citizens. So just by way of example, I have here two booklets, one in English and one in Spanish, Staying Healthy Over 50, which is done in partnership with the AARP to try to get the message out broadly.

I'd like to now take a brief moment to discuss the important issue of clinical preventive services in the elderly. Just to echo what Dr. Fleming said, contrary to common misperception, you're never too old to benefit from effective preventive interventions, and prevention is especially important for older Americans, since the risk for many preventable conditions such as heart disease and cancer does rise steadily with age. The challenge, of course, is identifying which services are most effective for which patients and finding ways to make sure that those patients get the services from which they're likely to benefit.

Over the years the U.S. Preventive Services Task Forces have documented the scientific evidence that preventive services can significantly improve health. For older patients they have found com-

pelling evidence to recommend screening for a long list of conditions included with my written testimony.

We're pleased and gratified that the importance of clinical preventive services is now increasingly recognized throughout the health care system, and we feel that the impartial evidence-based recommendations of the task force have played a major role in this development.

As AHRQ notes in its report to Congress on preventive services, Medicare now covers nearly all of the screening recommendations provided—recommended by the task force. However, there is clearly more work to be done. A report on clinical priorities and prevention from the Partnership for Prevention documented the number of preventive service that, although of great benefit, are received by less than half of elderly patients in this country. They include, for example, smoking cessation counseling, colorectal cancer screening and pneumonia vaccinations.

AHRQ, which helps support the Partnership for Prevention report, is working to improve the provision of these services to the elderly and other underserved patients. In addition to our Put Prevention Into Practice program, we're working with other Federal agencies to support research and to identify and overcome barriers to the use of appropriate preventive care.

In conclusion, AHRQ and the U.S. Preventive Services Task Force are helping to ensure that the American public is receiving high-quality, evidence-based clinical preventive services. While we have achieved a great deal, and we're proud of that, we know that a lot more needs to be done. And I'd be happy to answer any questions.

[The prepared statement of Carolyn M. Clancy follows:]

PREPARED STATEMENT OF CAROLYN M. CLANCY, ACTING DIRECTOR, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman, I appreciate this opportunity to discuss the work of the U. S. Preventive Services Task Force (Task Force) and the role of the Department of Health and Human Services's (HHS) Agency for Healthcare Research and Quality (AHRQ), which provides the Task Force with scientific and administrative support. Because the Task Force chair and vice chair were unable to attend today's hearing, I have been asked to provide an overview of AHRQ's role in developing scientific evidence of the effectiveness of preventive health care services and how the Task Force, an independent group of prevention experts, uses that scientific evidence.

ROLE OF THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

The primary focus of the Agency for Healthcare Research and Quality (AHRQ) is on clinical services—the care patients receive from health care providers—and the health care systems through which those services are provided. AHRQ research provides the scientific evidence to improve the outcomes, quality, and safety of health care, reduce its cost, broaden access to effective services, and improve the efficiency and effectiveness of the ways we organize, deliver, and finance those services.

Clinical preventive services—which include common screening tests, immunizations, preventive medications like aspirin to prevent heart attacks, and counseling about lifestyle that are delivered by clinicians—are an important focus of AHRQ research. Our research develops new scientific evidence regarding their effectiveness and cost-effectiveness, synthesizes existing scientific knowledge, and assesses strategies for facilitating their delivery and appropriate use.

AHRQ's focus on the effectiveness of clinical preventive services—what works best in daily practice—complements the research at the National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC).

In addition, in 1999, the Congress directed the agency to provide scientific and administrative support to the U.S. Preventive Services Task Force, and legislation enacted in 2000 requires AHRQ to produce an annual report to Congress on what preventive services are effective for older Americans. A copy of our first report is attached to my testimony.

THE STRENGTHS AND LIMITATIONS OF EXISTING SCIENTIFIC EVIDENCE

To ensure that Americans benefit from our existing knowledge, AHRQ supports Evidence-based Practice Centers (EPCs) that undertake comprehensive reviews of the scientific evidence regarding the effectiveness, risks, and benefits of specific health care services. The evidence reports they produce provide unbiased summaries of existing knowledge without recommendations, so that those who need to make decisions about health care and health systems, such as patients, providers, health plans, insurers and policy makers, can make more informed decisions. In response to requests from the Task Force, AHRQ relies primarily upon two of these EPCs to assess the scientific evidence regarding clinical preventive services.

How do they do that? Before the EPCs can begin to synthesize the findings of available studies, they undertake a rigorous methodological review of each study, asking questions such as: Did the investigators use an appropriate research design for the question being asked? Did they control for other factors that might affect the outcome (what researchers call "threats to validity")? Did they use the right statistical tests and calculate them properly? Did they examine health outcomes that are most important to patients? Not surprisingly, there are many studies that do not survive scrutiny; they were poorly designed, poorly executed, or both. Unfortunately, the number of solid, well-designed, well-executed research studies is often smaller than policy makers would prefer.

Because a determination of effectiveness often has significant implications in controversies over coverage or reimbursement, it is critical that policy makers understand one important distinction. A conclusion that there is not evidence of the effectiveness of a service is different from a conclusion that the service is ineffective. "No evidence of effectiveness" can simply mean there are no studies on the subject, the studies that exist are flawed and cannot be trusted, or an existing good study involved so few patients that it is not generalizable. No judgment is implied regarding the effectiveness or ineffectiveness of the service; it simply means there are too few good scientific studies on the subject to guide your decision-making.

In its obligation to provide scientific support for the Task Force, AHRQ follows this same approach and identifies the strengths and limitations of the existing knowledge base but makes no recommendations.

THE U.S. PREVENTIVE SERVICES TASK FORCE

The U.S. Preventive Services Task Force is in its third incarnation. The HHS first convened a Task Force of independent prevention experts in 1984; their report was released in 1989, and then completely updated by the second Task Force in 1996. In 1999, Congress established the Task Force as an ongoing body so that it could regularly review and update its recommendations based upon new scientific findings. A list of the current membership of the Task Force is attached.

For each topic that the Task Force addresses, it requests an updated evidence report, which AHRQ then commissions from one of its EPCs. After reviewing the evidence report, the Task Force develops recommendations based upon the strength of the scientific evidence and their collective expert judgment regarding the balance of benefits and harms of a specific service. These recommendations are then circulated widely for comment from Federal agencies and private organizations, but the final recommendations reflect the conclusions of the independent Task Force, rather than policy decisions of HHS or any organization. Task Force recommendations are not binding on public or private sector providers or funders of care.

The Task Force requires evidence that a given intervention will actually improve important health outcomes, such as lowering morbidity or mortality, not simply detecting more disease or improving some laboratory test result. As a result, Task Force recommendations are sometimes more conservative than those of specialty groups. The principle that clinical recommendations should be based on careful and objective assessments of the evidence, rather than simply the opinions of experts, is at the heart of the movement known as "evidence-based medicine". These principles are especially important in prevention, because an intervention, such as testing for colon cancer, will be offered to large populations of healthy people.

The Task Force experience has demonstrated we still have substantial room for progress in providing preventive services that are supported by good evidence. Often the Task Force concludes that the existing evidence is not sufficient to prove or dis-

prove whether a service is effective, indicating that more good scientific studies are needed and that clinicians must use their own judgment with individual patients until more definitive research is completed.

Since its first report, the Task Force has been recognized for producing rigorous and unbiased assessments of what works in clinical prevention. As a result, the influence of its recommendations goes far beyond its primary mission, which is to make recommendations for doctors and nurses to guide clinical practice. In fact, its recommendations have formed the basis of prevention guidelines of the American Academy of Family Physicians and other professional societies, are used by health plans and insurers in developing their prevention policies, and have figured prominently in the development of health care quality measures and national health objectives. Finally, the Task Force's *Guide to Clinical Preventive Services* is used widely in undergraduate and post-graduate medical and nursing education as the definitive reference for teaching preventive care.

CLINICAL PREVENTIVE SERVICES AND THE ELDERLY

Primary care clinicians play a central role in prevention for older Americans. The average Medicare recipient makes 13 medical visits per year, providing opportunities for doctors and nurses to deliver a range of clinical preventive services, including screening tests, counseling, immunizations, and advice about preventive medications such as aspirin or hormone therapy.

Contrary to common misperceptions, one is never too old to benefit from effective preventive interventions. Prevention is especially important for older Americans, since preventive measures even at this age can help delay the onset of disease. The challenge in prevention is identifying which services are most effective for which patients and finding ways to ensure they are delivered to all eligible patients.

In its comprehensive 1996 report, and in updates released over the past 2 years, the Task Force has documented the scientific evidence that preventive services can significantly improve health. For older patients, it found compelling evidence to recommend that clinicians regularly provide the following services: screening for high blood pressure and high cholesterol; screening for cancers of the breast, colon, and cervix; screening for vision and hearing problems; immunization against influenza, pneumococcal disease and tetanus; and discussions with patients about aspirin to prevent heart attacks. In addition, the Task Force has noted the importance of counseling to reduce tobacco and alcohol use, to promote healthy diets and physical activity, and to prevent injuries. The general conclusions of the Task Force urge clinicians to be more selective in their use of some screening tests, pay more attention to behavioral health issues, and find opportunities to deliver preventive services outside of the traditional "annual check-up. "

MEDICARE COVERAGE

Thanks to the combined efforts of the Task Force and many other agencies and organizations committed to prevention, the landscape for prevention in 2002 is dramatically different from the one facing the first Task Force in 1984. At that time, delivery of preventive care was uneven, insurance coverage was rare, and attitudes of patients and providers were often skeptical.

As AHRQ notes in its report to Congress on preventive services, Medicare now covers nearly all of the screening services recommended by the Task Force. The one exception, cholesterol screening, is often covered as a part of follow-up care or treatment of other problems. Similar progress has been documented in the private sector—among employer-based health plans, over 90% cover mammograms and Pap tests, and over 85% cover routine physicals and gynecological exams.

ENSURING THAT AMERICANS BENEFIT FROM PREVENTIVE SERVICES

Mr. Chairman, deciding what works is only the first step toward quality preventive care. A report on clinical priorities in prevention from the *Partnership for Prevention,* developed with support from CDC and AHRQ, documented that a number of high priority services relevant to older Americans are delivered to less than half of the population nationally. These include smoking cessation counseling, colorectal cancer screening, and pneumococcal vaccination.

Addressing this problem—facilitating the use of effective and cost-effective health care services—is another aspect of AHRQ's mission, which we term "Translating Research into Practice." We do this in two ways. First, we develop a variety of materials and tools that help providers ensure that patients receive the right preventive service at the right time. An example is AHRQ's "*Put Prevention Into Practice*" effort that provides materials to help primary care clinicians effectively deliver preventive

services to patients, educates patients about the services they should receive, and asks patients to remind their physician if a useful service is not provided.

The second approach is through research designed to identify ways to overcome barriers that may lead to under-use of effective preventive services. For example, a recent research solicitation, co-funded by AHRQ and the NIH's National Cancer Institute, solicits research to identify the most effective ways to improve the delivery of preventive colorectal cancer screening services in the clinical setting.

We are also working closely with our colleagues at the Centers for Medicare and Medicaid Services (CMS) to increase the utilization of clinical preventive services by Medicare beneficiaries. Through an interagency agreement with CMS, we have funded our Evidence-based Practice Center at RTI International to develop messages for patients and providers about new preventive services covered under Medicare. AHRQ is also funding several projects examining the best ways to implement smoking cessation guidelines, and we support the ongoing efforts of the CMS to fund demonstration programs to assess the costs and benefits of expanding Medicare coverage for smoking cessation

CONCLUSION

In conclusion, Mr. Chairman, the effort to ensure that Americans benefit from effective clinical preventive services is a multi-pronged effort. It requires systematic scientific studies to fill the gaps in our knowledge regarding existing and emerging preventive services, objective assessments of what works by independent bodies like the Task Force, and continuing research on how to improve the delivery and quality of those services. In this way, we can continue the progress of the past two decades in prevention for older patients and the American public.

That concludes my testimony. I would be happy to answer any questions.

Mr. GREENWOOD. Thank you, Dr. Clancy.

Dr. Bratzler, do you like that with a short A or a long A?

TESTIMONY OF DALE BRATZLER

Mr. BRATZLER. Bratzler.

Good morning, Mr. Chairman, members of the subcommittee, and thank you for inviting me here today. I am the principal clinical coordinator of the Oklahoma Foundation for Medical Quality, which is the Medicare quality improvement organization for the State of Oklahoma, and I'm here today to testify on behalf of the American Health Quality Association, or AHQA. AHQA represents the national network of quality improvement organizations that were formerly called peer review organizations in the Medicare program.

The QIO's primary mission is to monitor and measurably improve the quality of health care delivered to Medicare beneficiaries. QIOs concentrate on systems of care rather than care delivered to one patient at a time. A systems-based approach improves the quality of care for all Americans receiving services at health care facilities that are working with the QIOs.

I want to make the point that QIOs are on the ground promoting preventive services by taking evidence-based preventive health practices from the bookshelf to the bedside. QIOs promote and enhance the delivery of preventive services to seniors and work to resolve barriers to greater utilization of these services.

The Centers for Medicare and Medicaid Services, or CMS, selects the clinical areas and the quality indicators that we work on, and they are based on public health importance and on the feasibility of measuring and improving quality on those specific indicators. These clinical conditions are important causes of morbidity and mortality among the Medicare population and the U.S. population as a whole and account for substantial numbers of hospitalizations and a large share of the health care costs of this country.

QIOs work to improve care for both fee-for-service Medicare beneficiaries as well as those enrolled in M+C plans. Although the data-gathering phase of our quality improvement techniques may differ depending on payment arrangements, in either case the QIOs tend to employ systems-based approaches to improving quality of care.

I'd like to give a few examples of ways the QIOs work to promote primary prevention. With respect to immunizations, we've heard a lot about immunizations already this morning. There is certainly universal agreement among health care providers regarding the value of immunizing seniors against influenza and pneumonia, and yet we know that immunization rates among our senior population are far below the Healthy People 2010 goals, even for patients in institutional settings that are very high risk, like nursing homes.

QIOs promote vaccination in two ways. First, QIOs educate consumers on the importance of receiving these vaccinations for both influenza and pneumonia. And second, QIOs promote screening of patients to check if they have received them so that doctors and nurses can provide vaccine when needed.

An example of one of the most successful interventions employed by QIOs is to promote implementation of standing orders to enhance vaccination rates. Regardless of the health care setting, the use of standing orders allows appropriately trained health care providers to administer vaccines to patients in need. Now, there are barriers. Despite the evidence that standing orders are sound intervention, I think Mr. Grissom already mentioned this morning that there has been a frustrating barrier in regulations in the Medicare condition of participation which basically prevented institutions from implementing standing orders without having an individually signed physician order for each patient. I know there is work ongoing now to correct that problem.

QIOs have also implemented programs to address barriers to immunization with disparate populations. In Oklahoma we surveyed African American and Caucasian beneficiaries to determine the cause of disparity in immunization rates between these two populations. We found that there were significant differences in patient understanding and physician education between the two groups regarding the need for pneumonia and influenza immunizations. Attached to my testimony you'll find table 1 and 2, which summarizes some of the key differences that we found between African American beneficiaries and Caucasian beneficiaries.

California's QIO also identified similar barriers to immunization among African American populations living in Alameda and Los Angeles Counties. They found that a recommendation from a trusted physician was a key motivator for vaccination, and they also found that the leaders of churches and community centers can be effective partners in improving awareness and building trust among African American seniors.

With respect to diabetes, we've heard of its real important role in terms of morbidity in the Medicare population. QIOs are directed by CMS to focus on prevention initiatives with diabetics. Examples would include prevention of blindness by promoting regular retinal examinations, and prevention of cardiac complications by promoting regular testing of lipid levels.

One of the barriers to patients receiving regular screenings is that many physicians do not have medical record information systems that allow them to access a list of their diabetic patients that ought to be receiving regular reminders for preventive care services. In many States, including Washington, Oregon and Wisconsin, QIOs provide physician offices with software that they can use to develop a disease registry or a patient data base that tracks the provision of preventive care and services and can generate physician reminders regarding preventive care. In many cases the QIO staff in those States is working directly with the physician to actually populate the data bases.

QIOs have also found disparities between racial groups and diabetes care. The Florida QIO routinely analyzes part B claims data by each zip code in the State and then takes this data to providers to show them the care received in their communities.

The South Dakota QIO working with local Native American reservation health facilities found that Native—the Native language is primarily spoken and not written, particularly among the elderly. So as a result of those interactions, the QIO is working to educate Native American elderly through radio and television messages translated into the local languages.

In my testimony is table 3 that summarizes the progress of some of the QIOs to date on our primary prevention efforts.

Now, let me finish by talking about some of the secondary prevention efforts. Mammography clearly is the gold standard diagnostic tool for early detection of breast cancer. The barriers associated with increased mammography rates may be due to access, especially in rural areas. I recently met with the primary care providers at a hospital in Harmen County in Oklahoma. It is the far southwest corner of the State, and the county's only resource for mammography is a mobile unit that comes to the county twice a year.

Even in areas of the country where there is better access to care, QIOs have found that patients may not be receiving adequate education counseling and reminders about the importance of getting a mammogram. My QIO delivered 3,000 tool kits to primary care physicians throughout the State. The tool kit contained educational resources including patient education videotapes and materials to assist physician offices in setting up mammography reminder systems.

Some populations are especially vulnerable to underusing mammography screening. In some Hispanic communities it is culturally inappropriate to speak about mammography. The Colorado QIO created a project to overcome these social barriers by having female leaders in the Hispanic community speak to other women in the Hispanic Roman Catholic churches, a place where they found that these conversations were safe to have. The Colorado QIO is also working with the staff of area clinics that care for largely Hispanic populations to make sure that the messages are reinforced by health care professionals that the patients trust so that patients are scheduled for mammograms.

The QIOs are also directed to increase utilization of certain pharmaceutical therapies that are known to decrease rehospitalization, recurrence and progressive worsening of diseases. We heard about

the aspirin issue for heart disease today. For example, patients who are discharged from the hospital following a heart attack should be on at least beta blockers and aspirin unless there are contraindications. These medications reduce mortality and reduce hospitalization. In table 4, we show some of the progress that QIOs have made in this area.

The QIOs are specifically working with hospitals to ensure that there are systems in place for every patient, including putting checklists in the patient records to remind clinicians of recommended practices, developing discharge screening procedures to make sure patients do not leave the hospital without appropriate prescriptions, and making sure that follow-up appointments are scheduled before they leave the hospital.

Finally, one barrier to more effective use of pharmacotherapy for secondary prevention is the lack of the Medicare outpatient drug benefit. As you do think about developing drug benefits for seniors, remember that the QIOs could work with those data sets, including health claims, medical records data and drug claims to improve continuity of care. QIOs can do this new work under any drug benefit structure, anything ranging from discount cards to a full prescription drug benefit.

Mr. Chairman, I hope the subcommittee will look to the national network of quality improvement organizations to expand outreach to Medicare beneficiaries and their caregivers about important preventive benefits under the Medicare program. Under current law QIO activities to promote prevention may be funded through the Medicare Trust Funds. I thank you for the time, and I'll certainly be happy to answer questions.

[The prepared statement of Dale Bratzler follows:]

PREPARED STATEMENT OF DALE BRATZLER, OKLAHOMA FOUNDATION FOR MEDICAL QUALITY CARE ON BEHALF OF THE AMERICAN HEALTH QUALITY ASSOCIATION

Good morning Mr. Chairman, Mr. Deutsch, and Members of the Subcommittee. Thank you for inviting me here today. I am Dr. Dale Bratzler, Principal Clinical Coordinator at the Oklahoma Foundation for Medical Quality, the Medicare Quality Improvement Organization (QIO) for the state of Oklahoma. I am here today testifying on behalf of The American Health Quality Association (AHQA). AHQA represents the national network of Quality Improvement Organizations (QIOs, formerly known as Peer Review Organizations).

The QIOs' primary mission is to monitor and measurably improve the quality of health care delivered to Medicare beneficiaries. QIOs concentrate on systems of care, rather than the care delivered to one patient at a time. This systems approach improves the quality of care for all Americans receiving services at health facilities working with QIOs. I am here today because the vast majority of the quality improvement tasks assigned to QIOs are preventive in nature whether they are primary prevention efforts, which prevent the onset of a disease, or secondary prevention efforts, which prevent the recurrence or progression of a diagnosed disease.

This panel already understands the importance of preventive health services. I want you to know that QIOs are on the ground promoting these services by taking evidence based preventive health practices from the "bookshelf to the bedside." I am here to tell you what QIOs do to promote and enhance the delivery of preventive services to seniors, and resolve the barriers to greater utilization of preventive services. I will also describe some additional interventions that QIOs are using to target vulnerable and underserved populations across America. CMS requires every QIO to perform this additional, targeted outreach.

The work of the QIOs in the Medicare program is defined by the Centers for Medicare and Medicaid Services (CMS). CMS selects the clinical areas and the quality indicators that the QIOs use based on their public health importance and their feasibility in measuring and improving quality. All of the clinical conditions discussed in my testimony this morning are important causes of morbidity and mor-

tality among the Medicare population, and the U.S. population as a whole, and account for substantial numbers of hospitalizations and a large share of health care costs.

Here are some examples of what QIOs do to enhance the utilization of services recognized by experts as best practices:

- We teach clinical staff how to abstract data from patient medical records to evaluate performance and track progress in improving care.
- We interpret a vast amount of medical information obtained through medical records and health care claims data, as well as develop interventions specific to a particular hospital or doctor's patient population's needs.
- We develop "toolkits" with step-by-step instructions on how to assess and change systems of care to make sure the right things are done in certain ways all the time.
- We implement various kinds of reminder systems that not only help prompt patients to seek care, but also prompt clinicians to provide certain types of care.
- We develop software or paper-based tracking systems or provide access to online services that a facility would not otherwise have.

It is important to note that QIOs work in the fee for service Medicare system as well as with Medicare+Choice (M+C) managed care plans. Although the data-gathering phase of our quality improvement techniques may differ depending on the payment arrangements, in either case QIOs employ a systems improvement approach.

Here is the way QIOs work to promote primary prevention through immunizations and diabetic care.

Immunizations

There is universal agreement among health care providers regarding the value of immunizing seniors against community acquired pneumonia and influenza. Yet, immunization rates among the senior population are generally very low, especially in the institutional settings like nursing homes. QIOs promote vaccines in two ways: First, QIOs educate consumers on the importance of receiving vaccinations for pneumonia and influenza. Second, QIOs promote screening of patients to check if they have received these vaccines, so doctors and nurses can provide the vaccine when needed.

One of the most successful interventions employed by the QIOs to enhance immunization rates is the implementation of "standing orders." Regardless of the health care setting, the use of standing orders allows appropriately trained health care providers to administer immunizations to patients in need.

Despite the evidence that standing orders are a sound intervention strategy, there are barriers to implementing standing orders programs nationally. A particularly frustrating barrier is the regulatory prohibition of standing orders contained in Medicare facility "Conditions of Participation" rules. Medicare CoPs generally prohibit the use of standing orders in institutional settings. Another barrier is manufacturers' recent inability to supply the market with adequate quantities of vaccine doses.

QIOs have also implemented programs to address barriers to immunization within disparate populations. My QIO in Oklahoma surveyed African American and Caucasian beneficiaries to determine the cause of the disparity between immunization rates for these two populations.

We found that there were significant differences in patient understanding and physician education between the two groups regarding the pneumonia and influenza immunizations. Attached to my testimony the Subcommittee will find Table 1 and Table 2 that summarize the answers to four key questions that our survey asked about each vaccine.

California's QIO, which is called CMRI, identified similar barriers to immunization among the African American populations living in Alameda and Los Angeles counties. Through discussion groups and a telephone survey, CMRI identified barriers such as lack of awareness about the need for vaccination and misconceptions about adverse effects of vaccinations. They found that a recommendation from a trusted physician is a key motivator for vaccination. They also found that leaders of churches and community centers could be effective partners in improving awareness and building trust among African American seniors.

Diabetes

QIOs are directed by CMS to focus on two primary prevention initiatives with diabetics: prevention of blindness through regular retinal exams and prevention of cardiac complications through regular testing of lipid levels. The QIOs are also engaged in a high priority secondary prevention effort to decrease the progression of diabetes

by testing diabetics regularly for glycosylated hemoglobin (a blood test that measures a diabetic's exposure to unacceptably high glucose levels over a long period of time).

One of the barriers to patients receiving regular screenings is that most physicians do not have medical record information systems that allow them to access a "list" of diabetic patients that ought to be receiving regular reminders for preventive care services. Medical records are not filed by disease state, so patients who need reminders cannot be easily identified. In many states, including Washington, Oregon, and Wisconsin, QIOs provide physician offices with software that they can use to develop a disease registry, or patient database, that tracks the provision of preventive care and can generate physician reminders regarding preventive care. In many cases, the QIO staff work directly with the physician to populate the database and minimize the burden on physicians when they start-up reminder systems.

QIOs have also found disparities between racial groups in diabetes care. The Florida QIO, called Florida Medical Quality Assurance, also uses the faith-based approach to community-wide education of the African American population in the state. They developed educational materials to train ministers and others within the church to help parishioners recognize and manage their condition. At the same time, FMQA analyzes Part B claims data by each zip code in the state and then takes this data to providers to draw attention to the disparities in diabetes care that exist in their communities.

The South Dakota QIO is working closely with local Native-American reservation health facilities to increase diabetes hemoglobin testing. During the development of relationships with diabetes educators in the field, the QIO found that the native language is primarily spoken and not written, particularly among the elderly. As a result, the QIO is working to educate Native American elderly through radio and television messages translated into local languages.

Attached to my testimony is Table 3 that summarizes the progress of some of the QIOs to date related to our primary prevention efforts. The table shows the median statewide "failure rate" for these QIO indicators. The "failure rate" is the percentage of people who are eligible for a particular kind of care, and are appropriate candidates for the care, but were not receiving this care as of 1998. The results of projects to reduce the failure rate are in from two-thirds of the QIOs right now. We expect complete results later this summer.

QIOs also promote secondary prevention in mammography, heart attack, and congestive heart failure.

Mammography

Mammography continues to be the gold standard diagnostic tool for early detection of breast cancer. QIOs strive to increase the number of cases of breast cancer diagnosed in "Stage 1," when the cancer is most responsive to treatment. The barriers associated with increased mammography rates are primarily due to access, especially in rural areas. In my state, Harman County is a rural county in the extreme Southwestern portion of Oklahoma. This county's only resource for mammography services is a van that visits that county only two days each year. Even in areas of the country where there is better access to care, QIOs have found that patients may not be receiving adequate education, counseling, and reminders about the importance of getting a mammogram.

My QIO delivered 3000 "Mammogram Toolkits" to practitioners throughout the state. The toolkit contained instructions, which included an educational video, to teach physician offices how to set up mammogram reminder systems.

Some populations are especially vulnerable to underusing mammography screening. In some Hispanic communities, it is culturally inappropriate to speak about mammography. The Colorado QIO, the Colorado Foundation for Medical Care, created a project to overcome these social barriers by having female leaders in the Hispanic community speak to other women in Hispanic Roman Catholic Churches—a place where these conversations are safe to have. The Colorado QIO is also working with the staff of area clinics that care for largely Hispanic populations to make sure the messages are reinforced by health care professionals that patients trust, so patients are scheduled for mammograms.

In California, the QIO developed a multi-lingual, culturally appropriate program targeted to Asian Pacific Islander women who suffer high rates of breast cancer. Because one-third of this target population is not proficient in English, CMRI developed educational literature in Chinese, Tagalog, and Vietnamese. Both the National Cancer Institute and CMS plan to conduct focus group tests across the country to implement a nationwide rollout of this program.

Heart Attack and Congestive Heart Failure

The QIOs are directed to increase the utilization of certain pharmaceutical therapies that are known to decrease rehospitalization, reoccurrence, and progressive worsening of these diseases. For example, patients who are discharged from the hospital following a heart attack should be on at least beta-blockers and aspirin. When these medications are administered together and appropriately, mortality rates (both 30 days and one year after their first heart attack) and the readmission rates due to another heart attack can be reduced by up to one third.

Table 4, attached to my testimony, shows the failure rate in these secondary prevention indicators and the progress that some of the QIOs have made in reducing those rates. To improve these secondary prevention failure rates, QIOs employ several techniques to assure that a system is in place that helps every patient, including: putting checklists in patient records to remind clinicians of the best practices that should be followed; developing discharge screening questions and checklists to make sure patients do not leave the hospital without the appropriate prescriptions; making sure follow-up appointments are scheduled with their doctors before they leave the hospital.

Congress has a lot to say about one barrier to more effective use of secondary prevention for heart attack. The work of the QIOs in the area of pharmacotherapy is focused only on the inpatient setting right now in the absence of Medicare outpatient drug data. As you develop a drug benefit for seniors, remember that the QIOs are ready and willing to extend their quality improvement work to the outpatient environment. They can present physicians with a complete picture of their patient populations, which will greatly improve the continuity of care in the health care system. QIOs can do this new work under any drug benefit structure from discount cards to a full prescription drug benefit. As long as the QIOs have access to the claims data that will be generated, they can expand their work to promote secondary prevention.

Mr. Chairman, I hope that the Subcommittee will look to the national network of Quality Improvement Organizations to expand outreach to Medicare beneficiaries and their caregivers about important preventive benefits covered under the Medicare program. Under current law, QIO activities to promote prevention may be funded through the Medicare trust funds.

Table 1

Evaluating Disparity

Why didn't you get the flu shot?

	African Americans N=1252	Caucasians N=660	P
Didn't know I needed one	20%	9%	<0.001
Afraid it will make me sick	40%	26%	<0.001
The doctor did not recommend it	28%	17%	<0.001
I don't like needles or shots	18%	8%	<0.001

*Based on a survey of 26,194 Oklahoma Medicare patients (31.4% response rate).

Table 2

Evaluating Disparity

Why haven't you ever taken the pneumonia vaccine?

	African Americans N=1408	Caucasians N=918	P
Didn't know I needed one	43%	43%	0.724
Afraid it will make me sick	21%	8%	<0.001
The doctor did not recommend it	42%	41%	0.567
I don't like needles or shots	13%	5%	<0.001

*Based on a survey of 26,194 Oklahoma Medicare patients (31.4% response rate).

Table 3

QIO Primary Prevention

Increased Utilization of Flu/Pneumonia Vaccines
(data for 36 states)

	Median State Failure Rate At Baseline	Median State Failure Rate At Remeasurement	**Median State Improvement in Failure Rate**
State Immunization Rates			
Influenza	25.2	22.3	**11.6**
Pneumonia	52.6	41.1	**21.9**
Hospital Screening and Immunization Rates			
Influenza	88.5	78.1	**11.7**
Pneumonia	81.4	72.1	**11.4**

Table 4

QIO Secondary Prevention

Increased Use of Preventive and Timely Services for Breast Cancer, Heart Attack, and Diabetes
(data for 36 states)

	Median State Failure Rate At Baseline	Median State Failure Rate At Remeasurement	**Median State Improvement in Failure Rate**
Mammography	44.5	39.7	**10.8**
Heart Attack (AMI)			
Aspirin at discharge	16.5	14.3	**13.3**
Beta blocker at discharge	24.7	16.9	**31.6**
Diabetes			
Glycosylated hemoglobin blood test	43.0	30.7	**28.6**
Eye examinations	25.2	24.1	**4.4**
Measure lipid profiles (''cholesterol'')	39.4	23.2	**41.1**

Mr. GREENWOOD. Thank you, Dr. Bratzler.

Thank you all.

The Chair recognizes himself for 10 minutes for questions.

I think I'm fairly typical in that the only thing that keeps me healthy is—the most important factor—I just turned 51. So I need to pay a little more attention to that. But the most important factor is that somebody calls me and says that it is time for your annual checkup, and when it is time for my annual checkup, I go in and do all of the tests and the screens and all of that. And without that, I mean, I certainly—I certainly would not wake up one morning and say I think I need and want a colonoscopy. It requires somebody to say, come in. Okay. This is where you are on this milestone. This is what you need to do.

And so the first question I have is what do we know? What information do we have with regard to what percentage of Medicare beneficiaries even get an annual physical, because I just—I think to me intuitively that seems to be—if every Medicare beneficiary had an annual checkup—and I know that there are barriers to this. I know that physicians are rushed and don't feel that they have the time to go through a comprehensive checklist that I might get when I go over to the Capitol for my physical. I know that there are—I don't think beneficiaries are regularly notified unless they take the initiative or unless they're already into a regime with a physician about annual checkups.

What do we know, if anything, about how many beneficiaries even get an annual exam?

Mr. GRISSOM. There are a lot of people looking at me.

The Medicare program and the way in which the claims processing operates is based on the presentation by the patient with a symptom or a problem. There is no covered benefit for annual physicals. We have not done a screening of the entire claims processing data base to ascertain whether or not people are presenting for physicals. We would typically not pay for that. They would have to present with a symptom or an illness or an injury, and in the course of that, it follows, well, would they be—would there be follow-up? Would the physician ask, have you had your physical? Would the physician look at the medical record? Would the physician have a way of indexing the care received versus the benefits?

The answer to that question is some doctors do. Some doctors don't. We do know this: That in all of our surveys of beneficiaries, when we ask them, why did you not get a flu vaccine, why did you not have colorectal screening, why have you not had glaucoma, the reasons are always the same and in the same proportion.

The second answer is, the doctor didn't tell me. The doctor didn't say anything. I didn't hear from the doctor, which is why our efforts have been focused on beneficiary education, and through Dr. Bratzler's group, the QIOs on physician education.

Mr. GREENWOOD. Let me interrupt you, because it seems to me to be a colossal mistake not a cover the basic annual checkup. My understanding is that Medigap policies and Medicare+Choice policies do, and my assumption is that they do that because they have decided it saves them money to do that.

Ms. CLANCY. Without getting into the issue of what the law covers or not, I have been reminded that the average beneficiary makes about 13 visits a year. So the real challenge is, how do you ensure the provision of preventive care in the visits they are already making.

This is not easy. For many people it is within the context of something called the annual exam that they are likely to do it. At the same time, the additional challenge for older people, whether or not you cover the annual exam, is going to be to make sure that they get the preventive care they need because, as you get older, you have more competing illnesses, and sometimes those acute needs tend to drive out paying attention to preventive services.

Mr. GREENWOOD. The average beneficiary makes 13 visits to some sort of health care provider a year?

Ms. CLANCY. Usually many providers.

Mr. GREENWOOD. I can imagine that, as Dr. Grissom just described, the way the fee-for-service program works essentially is, you present with something wrong with you, and you get reimbursed for that service; but there is no systematic way of making sure that all your systems are checked.

If I didn't have an annual inspection on my automobile, I just take it in every time it ran out of oil or when the tires went bald and I went off the road, that would be a very expensive way to maintain my automobile. Yet I would never take it in for someone to do all of the preventive maintenance.

It seems to me to be an obvious reform that we ought to make.

There ought to be incentives in the system for both the health care provider and the beneficiary to get that annual exam, and maybe they would be making seven trips to the providers instead of 13 and would save a lot of money.

Mr. BRATZLER. I would say your illustration is excellent. Patients do not wake up thinking about what preventive services they need. That is the limitation of consumer education efforts. I don't think that they will work.

Also, when you go to the physician, particularly if the patient has a lot of chronic medical problems, there are lots of issues to deal with, and that is why we are focusing hard on putting systems into place to build those reminder systems so they think about routinely needed preventive services and, perhaps, recall systems to bring patients back in to get those services.

Mr. GREENWOOD. Dr. Grissom, you mentioned that CMS is developing a potential project that would examine the use of health risk appraisal programs with targeted follow-up interventions. What stage is the project in? Is there anything Congress can do to speed up the process of development of an approval to get a project like this up and running?

Mr. GRISSOM. We are in the process of developing that. I can't give you a specific deadline or timetable. We commissioned a report from Brandeis on risk appraisals, which we have received with recommendations from them on what to do and how to go forward.

I can get you a specific answer. I am not aware of anything that Congress can do that is keeping us from moving forward on that project. But I will be glad to give you a written response.

Mr. GREENWOOD. Is there data within or without the Medicare system that would indicate whether or not, if we had a system where there was a minimal incentive for an annual health check; and it seems to me that it is covered. I could imagine other incentive systems where you would have a different payment in your Part B premium or your Social Security check would go up or a different deductible for your hospitalization, if you got the annual checkup; and it would seem to me, in order for that to be a good and comprehensive health checkup, you would need to reimburse physicians in such a way that they would be incentivized to spend the time to go down a comprehensive list of screens, et cetera.

What do we know in the whole history of health care as to what data—where would I turn to find out whether that would, A, significantly increase health, reduce expensive treatments; and B, be less costly to the health care system as a whole?

Mr. GRISSOM. I asked this question of our clinicians at CMS before I came over. Their answer is, and this is really fortunate, is because there is no evidence, it is not definitive. There is no scientific evidence that increased physicals, by themselves, would improve health outcomes.

Mr. GREENWOOD. Is that because no one has done the study?

Mr. GRISSOM. It is because no one has done the studies. And No. 2, it assumes that there are other ways that people can obtain preventive services and immunizations and vaccinations without having a physical.

The way the Medicare program works now is, you can call your physician up and say it is time for my mammogram; or can I come

in for my flu shot. If the physician looks at your record and you need it, and the physician offers a service, they have an opportunity to bill.

Mr. GREENWOOD. We know most people do not do that, right?

Mr. GRISSOM. Not nearly enough people do that because not nearly enough Medicare beneficiaries understand the benefits.

Mr. GREENWOOD. The best utilization for immunizations is about a half among Caucasians, and it goes down to a third for minorities, is my understanding.

Mr. GRISSOM. It is a little different. Let me give the correct immunization rates. For pneumococcal vaccination, and that is a lifetime vaccination, 63 percent of beneficiaries are covered. Last year, 73 percent of beneficiaries had a flu shot.

Mammograms, in the 10-year baseline period it has gone from 37 percent mammograms, annual mammograms, up to 54 percent.

Pap smears and cervical pelvic exams is in the area of 35 percent.

AMA reported yesterday that in the last year, the rate of mammograms has gone up in 43 out of 47 States. The rate for flu vaccination is up in 44 out of 49. Pneumococcal up in 48 out of 49. Trailing is cholesterol which is not a covered benefit; cholesterol screening only went up in 13 States. Cervical cancer screening up in 13 of 49 States.

We are making improvements, but those are gross numbers, by State, and they are not the same across all populations. The rate of increase and the numbers of people getting those screenings is not what it should be.

Mr. GREENWOOD. My time has expired, and I want to recognize Mr. Strickland. It just seems to me that even the best of those utilization rates are sort of rifle shots, whereas we know if someone came in for a comprehensive physical exam, and if someone talked to them about their physical activity and getting a flu shot and talked to them about smoking.

Mr. GRISSOM. And exercise, right.

Mr. GREENWOOD. All of those things in a comprehensive form, it would seem to me to be much more beneficial. That is what people with good health care systems get.

Mr. Strickland is recognized for 10 minutes.

Mr. STRICKLAND. Thank you, Mr. Chairman.

The managed care organizations seem to emphasize the fact that one of the real advantages of the Medicare+Choice program is that the beneficiaries are much more likely to get preventive services. I am wondering, do we know that for sure? Is there anything in the research that you are aware of that would indicate that that, in fact, is the case?

If you are in a managed care plan, you are more likely to get an annual physical, for example, than if you are in a fee-for-service plan?

Ms. HEINRICH. In the process of doing the work for this report, we did come across studies that looked at managed care organizations and utilization of preventive services as opposed to fee-for-service. It is difficult, though, because there are not many studies that actually target the 65-and-over population. Much of the information is for younger age groups.

What we do find is that the strongest relationship in terms of utilization of preventive services is economic level and education level. Oftentimes, when you adjust for that, the differences that you might see in use by people in managed care as opposed to people in fee-for-service may disappear.

Others may have some information on that.

Mr. STRICKLAND. Does anyone else have a desire to respond to that question?

Mr. BRATZLER. I can give you anecdotal data.

I am in a State that has relatively low managed care penetration. And so when we go in and measure performance on preventive services like immunizations, diabetic screening and things like that, we look at a practice which includes both managed care, Plus Choice, and Medicare fee-for-service. We do not find much difference, mainly because we do not find that physicians in their practices, particularly when they have a mixed practice, treat the patients any differently based on payer source. That is in a State with relatively low penetration.

Mr. FLEMING. Regardless whether someone is in managed care or fee-for-service, the more approximate predictor is that the receipt of predictive services is going to be whether or not there is a reminder recall system in place so that when the patient comes in, the physician knows the preventive services that are needed, whether or not there is a copay or preventive services can be delivered for free. There is a whole list of interventions that are independent of whether they are fee-for-service or managed care that you can put in place to increase the likelihood that preventive services are being delivered.

Mr. STRICKLAND. So is it a correct statement that although we seem to accept the fact that managed care does provide greater access to preventive services, we do not know that for sure, based upon the research that is available to us?

Mr. GRISSOM. Based on our surveys of beneficiaries that are in the risk programs, we know that they do get more preventive services than the fee-for-service beneficiary. We also know that the more managed the managed care program, the more likely they are to get those preventive services.

The old Kaiser model of HMOs that existed still does exist, but was more predominant years ago in which patients had a long-term, standing relationship with a group of physicians in a fixed facility, it did result in that.

Mr. STRICKLAND. The reason I am smiling is some people may find it surprising that I used to be a strong advocate of the concept of an HMO because it seems to me that in the early days of this movement, what you described was much more likely to occur. There was an emphasis on keeping people well rather than treating them when they get sick; and prevention was a big part of the justification for the HMO movement.

But it seems to me that in recent times, perhaps because of cost constraints or whatever, that there is less and less emphasis on the preventive aspects of a managed care program.

Ms. HEINRICH. One thing I would add is that managed care organizations have changed over time, and there are a lot of variations

in how they are structured and the kind of services that they do provide.

I know one study that was done by CMS, doing a comparison of beneficiaries by managed care versus fee-for-service, was really old data. I think it was data from 1996, and at that point in time your fee-for-service Medicare system did not have the same array of services that Medicare now offers. I don't think it is so clear.

I think you are right, it is not clear that beneficiaries in managed care necessarily receive more preventive services than those in fee-for-service.

Mr. STRICKLAND. If I can direct a question to Mr. Grissom, I was struck by the chairman's question earlier regarding whether or not, as I understood the question, we know for sure that an annual exam, for example, is going to lead to cost savings. I believe that was the gist of the question, and I think your answer was that we don't know that for sure; is that correct?

Mr. GRISSOM. My answer is, I am not aware of any science-based evidence that an annual physical would either in the short term or long term reduce health care costs or improve health care outcomes.

Mr. STRICKLAND. I just find that fascinating, because I think that is such a basic bit of information that is crucial to what we are trying to do in terms of provide the best, most efficient care and treatment.

Is it possible, and I am wondering whether it is because the research has not been done. Or is it because of the way that we factor in cost savings under our system up here that preventive care may not demonstrate a benefit for 10 or 15 years or 20 years into the future, and so as we look at potential cost savings, we are looking more in the near-term paradigm, and that we may be experiencing cost savings, but we are unable to factor that into the scoring that we do here in the Congress, or you do at CMS or whatever? Is that a possibility?

Ms. CLANCY. If I can jump in here, your comments and the comments and the questions of the Chair have been focused on the annual physical exam. In general, the focus of the U.S. Preventive Services Task Force and other expert bodies has been to focus on the specific components of what takes place within a physical exam, specific services, because, for example, what a 51-year-old man needs in terms of detecting disease early and preventing future diseases is different than an 18-year-old man or a 25-year-old woman.

For that reason, most of the literature is organized around whether specific services are cost effective or not. There are very specific examples. Some services save money, a small subset. Immunizations generally fall into that category. Some actually delay the onset of bad outcomes, and over the time horizon, that is to say, they can be shown to be cost effective.

Where possible, the Preventive Services Task Force actually presents the information if cost effectiveness analyses have been done, but they are not systematically and routinely done when gathering the evidence on effectiveness.

Mr. FLEMING. Just to follow up on that point, there is much evidence that shows that the delivery of the preventive services that

we are talking about yield substantial returns on that investment in terms of improving quality of life, generally far more so than waiting until somebody becomes sick and investing that same amount of money in acute medical care.

I think the issue is whether or not it is best to think about delivering those preventive services all at once in some sort of separate exam where we essentially divorce prevention from routine medical care; or alternatively, looking toward a system where preventive services are naturally integrated into every visit that someone seeks.

If you are a smoker, hearing once a year at an annual exam that you should not smoke will provide some incentive to quit, but the better incentive is, every time you as a smoker come in, including the times that you are in there for your bronchitis or pneumonia as a result of your smoking, you hear that message from your provider that you need to quit. That is going to be the more effective way of delivering preventive services.

Mr. STRICKLAND. Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. GREENWOOD. Thank you.

I recognize the gentleman from New Hampshire, Mr. Bass, for 10 minutes.

Mr. BASS. Thank you, Mr. Chairman. I was not that enthusiastic when I read the title for the hearing, which is about half a paragraph long, but this is a very interesting hearing.

The fundamental issue here obviously is how the Medicare system is able to deal with issues that are not traditional to its original mission, and it is a most interesting subject. Mr. Strickland has gotten into the issue of Medicare+Choice versus fee-for-service.

I would like to recount the first exposure I had to this issue in 1996 or 1997 when our former Speaker walked into a Republican Caucus in July and announced that every Member, during the August recess, was going to do an event to support the cause of finding a cure for diabetes, and that we were going to increase the budget for NIH. The Medicare system was going to be studied because we were going to do everything that we could to make sure diabetics were properly treated, because 26 percent of the total cost of Medicare is associated with one illness, which is diabetes. That is the answer, and we didn't have to worry about anything else related to Medicare.

Dr. Coburn, a former Member, stood up and said, Mr. Speaker, that makes a lot of sense, sort of; but the real issue here is diet, and you can't legislate diet. A doctor cannot guarantee that a potential diabetic follows a diet.

I will not go on to discuss the Speaker's response to that, but suffice it to say that it was not government's issue to determine what diet is.

What we are really talking about here is providing services that have very little to do with, or may not have a lot to do with, prescriptions or operations or annual physicals and so forth, but being able to make a system such as the Medicare system responsive and flexible enough to be able to work these issues and do it successfully in light of the debate which is occurring as to whether or not the traditional Medicare system works as well as perhaps some

other alternative health care delivery systems that have been around for awhile.

My only question is: Is it possible that Medicare will have to change some of its reimbursement policies to not only provide reimbursements to qualified nonphysicians, outside of the Medicare+Choice program, who provide assistance to seniors that may not be clinical in nature?

Does anybody want to answer that?

Mr. GRISSOM. Congressman, as you well know, in 1997 in the BBA, there was a benefit for diabetes self-management written into law which was to increase patient education, and it reimbursed physicians for providing that service. And then in 2000 with BIPA, we had the first medical nutrition therapy benefit, and it was to help people with their diet, and that referral to a physician occurs because they are probably under the care of a physician for diabetes. That benefit does allow reimbursement directly to nutritional therapists or registered dieticians and does not depend on a physician for that service.

Mr. FLEMING. Just to reinforce that point, to get back to your question about diabetes, studies recently done by NIH show that the best way to prevent someone who is at risk of getting diabetes is not through medication and not through legislation, but through counseling about diet and physical activity and creating circumstances in their home life and in their environment where they can eat the right things and they can exercise.

So if we really are looking for ways to reduce health care costs from diabetes in the future, the place to focus now is on people who are at risk and making sure that they have the nutritional counseling that they need and advice about exercise and they have an understanding about the kinds of things that they need to do to prevent getting that disease in the future.

Mr. BASS. Mr. Grissom answered by saying there is indeed a benefit or system or a way in which this issue, diabetes specifically, can be addressed.

My question is: Is Medicare going to be able to be a flexible enough system to address this issue in such a fashion? First of all, the management of chronic illness, some seniors have as many as 5 or 6 chronic illnesses to manage, and can this system—that was established 35 years ago, I think, to treat illness in one manner—going to be able to in its current configuration, deal with this and do it successfully?

Mr. GRISSOM. We are authorized by Congress to do some disease management and coordination-of-care demos, and we have 5 or 6 demos for which proposals are out on the street which will do precisely what you are suggesting, which is disease management, especially in the area of chronic diseases, mostly congestive heart failure and diabetes; and they are going to be available not only in the Medicare+Choice but in the Medicare fee-for-service program, which is an effort by the Secretary, the Administrator, to push these kinds of alternative treatment schemes down into the fee-for-service area.

Additionally, we do at Medicare commit increasingly significant sums of money to partnerships and educational programs in this particular area with the Association of State and Territory Offi-

cials, with the National Diabetes Foundation, to try to reach out to significant groups responsible within the family or within the individual subculture for care and care-giving decisions to educate in the area of diabetes.

So both in demonstrations and in education, I think we have the tools, and I think we are using them appropriately to address the problems that you are concerned with.

Ms. CLANCY. I think you are highlighting some very important problems.

Last year, the Institute of Medicine published a report called "Crossing the Quality Chasm," and they used "chasm" instead of "gap" to signify a huge gap between the kind of quality of care we could provide across the system, across the life span, and what is actually being provided on average. Medicare faces that problem, but it confronts all payers, and it is a very big focus of the research that we are supporting.

One of the strategies that has been used that Medicare has been very much part of, and is part of accreditation and so forth, is actually reporting on how we are doing. Where health plans do participate in accreditation, there are reports in terms of clinical preventive services, they do have better results than the State average.

Next year, my agency will be submitting to the Congress a national report on the quality of care in this country, and I think that can be an important lever to drive change. The issues that you are identifying are fundamental to how we deliver care, and most health care systems right now are struggling.

Mr. BASS. This may not require an answer. I ask it anyway. Does managed health care work better on providing preventive services than fee-for-service or Medicare? Is that too simple a question?

Ms. CLANCY. No. It is breathtakingly clear.

The problem has been that the definition of managed care has changed almost continuously over the past 10-20 years. Overall, most studies would say that managed care systems have an edge in terms of providing preventive services. I think people disagree about what that means. Is that because the care system is doing it, or because managed care tends to attract people who are healthier and more interested in prevention and, in some cases, the plans have less cost-sharing? In general, their track record is pretty good.

Ms. HEINRICH. Although there have been studies, I know we did one, which was a comparison of managed care and fee-for-service, on the treatment following cardiac arrest; there was really no measurable difference. So the evidence is mixed.

Mr. BASS. Thank you. Mr. Chairman, I will end by saying I wish I could compare in my own home State Medicare+Choice with fee-for-service. Unfortunately, the reimbursement formula discriminates against rural America.

I yield back the balance of my time.

Mr. FLETCHER [presiding]. Thank you. I am sorry I wasn't here for the testimony, I have reviewed most of them. I thank you for coming here today, and I want to thank the chairman, who is out just briefly, for hosting this hearing.

Prevention is one of the areas I was involved in in a former life, and if the election goes well it will continue to be a former life. I think it looks good so far. In any case, thank you all for coming.

Let me make a statement and see if you concur with this or not. Managed care, early on, changed probably the perspective of physicians and the practice of medicine in the sense that a lot more emphasis was put on prevention and chronic disease management, and probably changed a little bit the way the practice of medicine has evolved, particularly in the reports that I used to get back on the vaccination rates for children, the rates of mammograms on women that were of the proper age to receive those under the recommendations, as well as other issues.

Would you say—and I think it has already been stated—the degree of prevention and screening depends more on the practice than on the insurance product? However, if you reimburse for those, things you are more likely to get them than not?

I just want to hear a few comments.

Mr. BRATZLER. That is our experience in Oklahoma where, in our metropolitan areas, we have managed care penetration; it is practice dependent, it is not based on who is actually paying for the care. I do think that incentivizing certain preventive services would probably increase services. In our State, we do not find differences between managed care patients and fee-for-service patients. We see differences, though, between practices.

Ms. CLANCY. In general, the literature is pretty consistent that knowing the right thing to do on the part of providers or patients does not necessarily mean that it gets done. Knowing it is the first step; the next step is having a supportive practice environment and an incentive for change, which can be financial and otherwise.

Mr. GRISSOM. The reason that CMS in the Medicare program has focused on outreach to minority groups, ethnic groups, and economically disadvantaged groups is because the evidence is overwhelming that there is a high association between certain demographic groups and their access or utilization of these benefits and services.

Underlying that data is probably also a subset of providers to whom certain individuals go by demographic, ethnic and economic group, and thus, there is a high degree of correlation between types of providers with their practices and types of patients.

None of that has much to do with who is paying for it.

Mr. FLETCHER. It seems to be a pretty good consensus there.

Let me ask a specific question. Dr. Fleming, I think it is in your report on page 5, you say a recent Institute of Medicine report noted that the return on investment in medical care for vascular disease reaped benefits, four to one, but investments in behavioral change returned a remarkable 30 to 1 advantage.

What is the scale? What are the units there?

Mr. FLEMING. I will be happy to provide that report to you as well. The bottom line of what the Institute of Medicine was saying, medical therapy to treat an illness, once someone has heart disease, does provide that person improved quality of life, but it is fairly expensive and in general cannot remove the symptoms entirely.

In contrast, if you can work with that person on preventive measures by changing their behavior—stopping smoking, diet, exercise, for example—such that they never develop heart disease in the first place, first, those interventions tend to be less expensive; and second, the return on them, which is the absence of symptoms versus reduced symptoms, is far greater.

So if you have a fixed number of dollars to spend and your goal is to improve quality of life, investing those dollars in behavioral interventions early to prevent illness is going to yield a better return than investing those dollars late once illness has occurred.

Mr. FLETCHER. Is this four to one?

Mr. FLEMING. We can provide the report, but to do these economic analyses, you have to look at what the cost of intervention is and then look at the quality of life that is produced and assign some economic value to that improved quality of life.

Mr. FLETCHER. It is an estimated economic value due to the quality of life and the ability of the individual to continue in the workplace, et cetera?

Mr. FLEMING. Continue in the workplace and carry out day-to-day activities, yes.

Mr. FLETCHER. Dr. Clancy, when I was practicing, it was always very difficult to decide what screening tests were good and cost effective. We also were concerned at one time on the liability because we had posted in our charts, we went through the prevention task forces and posted what we needed, and if we missed someone, we documented our own record of not getting something done.

Let me ask you, and you mentioned, obviously there is some very clear evidence on some studies, or on some diagnostic procedures or clinical procedures that shows a tremendous advantage; and others, it is rather murky. And I think this goes to the physical exam, which is something that we are all familiar with, but the content of that is really important, and it is tailored to the individual person and risk factors as well.

What are you doing as far as what you see on the horizon? And you mentioned in here some studies that are not clear, that are not effective, maybe not good studies in general. What do you see coming in a way of being able to more pinpoint diagnostics, clinical interventions, et cetera, for prevention and disease management?

Ms. CLANCY. You have highlighted something that I think gives people great angst about the use of evidence to inform practice, which is that lack of evidence of effectiveness is not the same thing as saying that something does not work; and that makes people very nervous, especially if we start to tie payment to evidence and so forth.

The evidence the Task Force considers in making their recommendations generally comes out of an evidence report, which is a systematic review of the available scientific evidence, on that particular service. Frequently they will review services for which the evidence is indeterminate. Part of that report actually articulates priorities for research which we try to share with our colleagues at NIH and so forth, to try to make sure that for areas where there are important questions and great concerns and issues of public health, that they are aware of what the specific questions are that need to be addressed by research.

PSA may be one, for example. The U.S. Preventive Services Task Force has not recommended it as effective because the jury is still out. The studies are being done right now, but that is the process.

Mr. FLETCHER. In light of that, though, we are all doing PSAs because of the hopeful fact that the studies may indicate that we do save lives and decrease morbidity and mortality.

Mr. Grissom, it is good to have you here from Kentucky, and let me ask you, I was looking through what particular preventive measures and diagnostic tests are available on Medicare. Just looking at this, it looks like we in Congress tend to practice a lot of medicine here. We have to look at your evidence data, weigh it, and see what it is going to cost, and every time we want something new on the regular Medicare fee-for-service, we say let us authorize that or not.

Let me ask you how effective that is, given what Dr. Clancy and Dr. Fleming have mentioned, and I am sure some of the others, in the fact that medicine is evolving very quickly. The questions are not easy, and the answers are even more difficult.

Does a program where you have the flexibility like the Federal employees health plan or Medicare+Choice, does that give you a lot more flexibility to have plans that meet the needs and evolve with the science of medicine, rather than the typical Medicare situation where we have to come up here and fight politically to get things done?

Mr. GRISSOM. I was doing good on a panel of doctors until the chairman became a doctor.

You are absolutely right. The fee-for-service program is a disease diagnostic and treatment program, and the Secretary is authorized by that statute to make decisions and has great discretionary authority to decide what is an appropriate service for the treatment and diagnosis of those illnesses and diseases.

In the preventive area, there is no discretion, and so it is Congress telling us specifically when they want this to be covered as a benefit, when screening is appropriate. And I am sure it gives clinicians great pause to see that in 1997 the recommendation was for every 3 years, and for women at high risk or child-bearing age; and 3 years later the threshold goes down, and it is every 2 years, or all persons regardless of age.

What you are seeing is a progression, expansion, increase of the universe, increase in frequency.

I think there are those—I don't think there are any problems, but I think there are those that think that this process could be improved upon, and that legislation is not ordinarily science-based and that these are very heavy decisions that the Congress is making and that there may well be opportunities to give others some authority or discretion to make those decisions.

I am unaware, in those payment plans that you referred to, whether or not they routinely have those benefits or that there is greater utilization of them than there is in the fee-for-service or Medicare+Choice program. But we are bound by statute, and the discretion and flexibility in the prevention area does not exist as it does for diagnosis and treatment procedures.

Mr. FLETCHER. I was going to get some comments from the rest of the panel because the fee-for-service Medicare, which has been

a tremendously effective program, is probably the ultimate managed care program when you have 535 folks up here managing every preventive measure that is reimbursed.

I wonder, from your comments, do the other possibilities that I mentioned and some other ways of managing Medicare seem a little more positive and better, to be sure that we are able to address the needs of our seniors regarding disease prevention and chronic disease management?

Ms. HEINRICH. Certainly in our work we did not actually examine the process that Congress uses to determine coverage for preventive services. I know that there have been suggestions that various groups in the private sector, or CMS, consider evidence, the evidence phase that is developed by the U.S. Preventive Services Task Force; that these organizations could make recommendations based on evidence to the Congress, and then the Congress could consider them as one possibility.

I think it is really important that we understand that not all the recommendations from the Preventive Services Task Force are so easily translated into a benefit for the 65-and-over population. I think we have to think through very carefully the evidence and differentiate, for example, the difference between a behavior being good and healthy and reducing risk, and understanding that we do not necessarily know how best to counsel people to achieve that behavior.

Mr. FLEMING. The fact is that the reality of these issues that we are confronting is changing. This is an evolving time. The numbers of people that are elderly are increasing. Our understanding of what works and does not work is changing, and our knowledge regarding preventive services is growing. I don't know what the right system is for incorporating that into Medicare.

I do know whatever system you choose to put in place is one that is going to have to deal with these complex issues. It is going to have to be flexible and adapt to changing knowledge over time, and it is going to have to be knowledge-driven. There is science that can tell us what to do, and whatever system you put in place needs to be able to take that knowledge and incorporate it into policy.

Ms. CLANCY. I like the image of "535 managers of the Medicare program." You have alluded to managing what the program covers and what is the scope. I think that is one part of the puzzle, and I know Dr. Gold is going to speak to that.

The second thing is what happens at the level of practice. That is a local phenomenon, and that is where the quality improvement organizations are important. With the help of science, to help clinicians know how to make sure that they get the preventive services delivered is important.

For example, we know from a lot of studies that people with multiple chronic illnesses are far less likely to get prevention. Why should that be? The very people you would like to reach and are in there all the time are the people least likely to get recommended preventive services.

There are a lot of factors that contribute to that, but I don't think that is something that is going to be dictated at the level of the scope of the program or what the structure and the financing is. I think that is going to be much more local.

Mr. BRATZLER. I am not going to try to make recommendations about what Congress should do about changing the Medicare program for preventive services, but there needs to be flexibility to have pilot projects to test some of these preventive measures to see if they work. I think the Medicare stop-smoking program is an outstanding example of a pilot that is coming up that may result in recommendations for a new preventive service that should be provided to all Medicare patients, if it is a successful project—so continuing to have flexibility to the pilots when there is evidence from AHRQ and others.

Mr. FLETCHER. I thank you, and I will turn the hearing back over to the chairman.

Mr. GREENWOOD. Just a few additional questions.

Mr. Grissom, you mentioned a couple of times that Medicare is statutorily structured for the diagnosis and treatment of diseases, and does not have a mandate on prevention. What would happen if we went into that statute and added preventive services to the mandate?

Mr. GRISSOM. I looked at the literature, and I do not think that there is any preventive service or screening that is absolutely—that all clinicians would say, this is the next thing or that this is what we need to do.

I think Dr. Clancy probably can speak to the recommendations from the United States Preventive Services Task Force. I believe probably that cholesterol screening is one that is in play. However, I think what we are seeing for a variety of reasons, blood pressure screening and cholesterol screening, because they can be done in a shopping center, are increasingly being done, being accessed by a lot of seniors. I think, except for cholesterol screening and some thyroid monitoring, there is no consensus on what else ought to be covered.

The issue, though, that I think you are maybe also alluding to is, if it could be shown that an annual physical, because it either increased access to preventive services or it was, in itself, a preventive service—if it could be shown to be beneficial, would the Secretary use authority or discretion to implement that, is a good question. I must say I don't have the answer. I know that we don't have scientific evidence upon which to make the determination.

Those are the things that I think in the area of preventive screening are next steps or in play.

Ms. CLANCY. I think there is a very solid body of literature that says that economic barriers are a very important deterrent to the receipt of effective clinical preventive services, so higher cost-sharing and not having coverage for the service actually do effect people not getting the service. To that extent, there is an opportunity if preventive services are covered.

At the same time, in addition to focusing on quality of care prevention, we also have a lot of economists who study economic behavior. So if Congress were simply to say, we will cover preventive services, I think you could set your watch until new things people wanted covered would be defined as prevention, so you would need to be specific about what you mean by "preventive services."

Mr. GREENWOOD. According to GAO's report, CMS's current efforts to increase beneficiary utilization of Medicare-funded preven-

tive services for persons 65 and older centered around four components reviewed in a 1999 evidence report prepared by RAND. These are systems change, financial incentives, reminders and education.

The key conclusion that the report drew was that organizational and systems change, such as the use of standing orders, which has been referred to, and the use of financial incentives, were the most consistent at producing the largest increase in the use of preventive services.

What kind of financial incentives were the most effective? Are you familiar with that, Dr. Grissom?

Mr. GRISSOM. I think the financial incentives were, A, reimbursement for those services for physicians; and, B, the existence of copays and deductibles.

As you are aware, the President has recommended removing the remaining barriers to copays and deductibles. Since the start of this administration, we have tried to address physician fees on the administration of vaccines as well as all preventive services. Secretary Thompson has specifically addressed the issue of mammography, mammograms, and we have increased coverage for different kinds of digital mammographies, and we intend to address that issue again this year in the physician fee schedule.

I think those are the kinds of incentives that our report has focused on and referred to.

Ms. HEINRICH. Just one comment.

There were some other examples, for example, travel reimbursement or gift certificates that have been used; but again you have mixed evidence about how effective they are. But there are some other examples of what you can do.

Mr. GREENWOOD. When we have health fairs back home, we give a spaghetti lunch and people come in and get their blood pressure tested.

Ms. HEINRICH. Right. It seems logical that removing economic barriers should be a very effective strategy, but when you look at utilization, you see that the use of immunizations is relatively low. There is no copay formula.

Mr. GREENWOOD. It goes back to the comment made earlier, which is when you ask, why didn't you utilize this service, nobody told me that I could. Nobody said that it was out there.

Mr. GRISSOM. We need to get all of the rates up, but the rates are highest for those screenings for which there is no copay or deductible.

Mr. GREENWOOD. I thank each and every one of you for spending the last couple of hours with us.

We will call forward the next panel which consists of Dr. Marthe Gold, Logan Professor and Chair, Department of Community Health and Social Medicine, City University of New York Medical School; Dr. Christine Himes, Director of Geriatrics, Group Health Cooperative in Seattle; Viola Quirion, on behalf Alliance for Retired Americans in Washington; and Dr. Jessie Gruman, President and Executive Director, Center for the Advancement of Health, also in Washington.

Welcome to all of you, and thank you for being with us this afternoon. If you were here when we began the hearing, you heard me

say that this is an investigative hearing and it is our custom to take testimony under oath.

Does anyone object to giving your testimony under oath? And you are entitled to be represented by counsel. Do any of you wish to be represented by counsel?

Nothing to hide, okay.

In that case, I will swear you in.

[Witnesses sworn.]

Mr. GREENWOOD. We will start with Ms. Quirion.

TESTIMONY OF VIOLA QUIRION, ON BEHALF OF ALLIANCE OF RETIRED AMERICANS; MARTHE R. GOLD, LOGAN PROFESSOR AND CHAIR, DEPARTMENT OF COMMUNITY HEALTH AND SOCIAL MEDICINE, CITY UNIVERSITY OF NEW YORK MEDICAL SCHOOL; CHRISTINE HIMES, DIRECTOR OF GERIATRICS, GROUP HEALTH COOPERATIVE; AND JESSIE C. GRUMAN, PRESIDENT AND EXECUTIVE DIRECTOR, CENTER FOR THE ADVANCEMENT OF HEALTH

Ms. QUIRION. Thank you, Chairman Greenwood and members of the subcommittee, for this invitation to testify today. I am Viola Quirion from Waterville, Maine. I am a member of the Alliance for Retired Americans.

Before I go further in my testimony, I would like to stop all distractions or anything. I figure you might wonder why I have a hat which says Washington, DC, and that is because I forgot my wig at home. I decided to buy a hat, and I bought one with Washington, DC, because I love Washington.

Although I have been fighting for this for 9 years, for affordable health care and prescription drugs, and it is pretty discouraging we have not gone very far with it; but I am still confident and I have hope in all you people that this year it will come.

Mr. GREENWOOD. And you look great in your cap.

Ms. QUIRION. Thank you.

I am accompanied today by John Carr, the President of the Alliance for Retired Americans, which was established in January 2001. It now has 2.5 million members across the Nation. Retirees from affiliates of the AFL-CIO, community-based organizations and individual seniors have joined the Alliance to create a strong, new voice for retired workers and their families.

I want to congratulate you for holding this hearing, as I believe that preventive services under the Medicare program are very important. Because of Medicare coverage of pap smears, mammograms and flu shots, many lives have probably been extended. I think physical exams also should be considered a preventive service. For many people on limited income, however, that 20 percent copayment for preventive services may be an immediate luxury they cannot afford even though it may ultimately be life-saving.

It is not in my testimony, but I believe that preventive service and mammograms were not always covered by Medicare, and physical exams were not. In my case, it would have saved a lot of illnesses. I will go, later on, and you will see it would have helped me a lot if I would have had these.

I am from Waterville, Maine. I worked in the Hathaway shirt factory for 44 years until I retired in 1994. I live on two small pen-

sions and Social Security, which comes to $1,466 a month. I never had to worry about health care expenses until I retired. I now have a supplemental plan to cover some of the costs Medicare does not cover, but it is not sufficient for everything.

I was diagnosed with ovarian cancer in late December 2000, and had surgery in January 2001. The surgeons who operated found that different parts of the cancer had cemented together my ovaries and many parts, so they could not cut into it because I would have bled to death.

Consequently, I took a series of chemotherapy treatments lasting 5½ hours each time. It took 7 days for me to recover after each of these treatments. For these treatments, I was in a nursing home for 6 months.

In December of 2001, I had knee surgery. While recovering at home, I suffered from a number of infections. I needed intravenous transfusions, but since Medicare does not pay for those at home, I had to go into a skilled nursing home facility for 6 weeks where they are covered. Consequently, Medicare paid for the skilled nursing care and the IVs which were much more costly than the $400 treatments I could have received at home. Although IV transfusions may not be considered a preventive service, it does not make sense to me to spend extra money unnecessarily.

Currently, I am taking 1½ hour chemotherapy treatments for the ovarian cancer and don't experience negative aftereffects. The blood test shows that the mass is dissolving. I am happy to say that Medicare does cover the chemo treatments, but follow-up is just as critical to survival as preventive service.

I am here today primarily to tell you the importance of prescription drugs as a preventive measure that has extended and enhanced everyday life for millions of Americans. Technological advances in treating disease include use of new drugs that can arrest or cure many cancers, heart disease, high blood pressure and other life-threatening conditions. Prescription drugs save costs in reducing surgeries in hospitals and nursing home care. However, new drugs are more expensive than old drugs and three times more costly than generic drugs.

Because of my—they give me blood work before every chemo, and at one point my blood was low; they talk about giving me a drug that would have cost me $2,000 for a cancer drug. That is more than I earn every month. So if it ever comes to that, I'll just have to wait and die, because there is no way even the Canadian drugs would pay for something as heavy as that.

I have taken seven bus trips to Canada over the past years, which were sponsored by the Maine Council of Senior Citizens and the Alliance for Retired Americans. I take Prilosec for stomach ailments, which in the U.S. costs me $5 a pill, and Relafin for my back and knees. I estimate that I save $1,000 every trip.

Unfortunately, it took me a week to recover from the last trip because of my knees. I probably won't be able to make any more trips, but I'm not alone. There are so many people who could benefit from these trips, but are physically unable to board a bus.

And the last trip that I made, it was January when I came out of the nursing home. I needed prescription drugs, but I also had some new ones, and of course I wasn't in a condition to go to Can-

ada. So I had one drug that cost me $301.54, one $264.78, $34.98, $16.78, which is a total of $558.08. My monthly expenses are my rent, $271; my supplement insurance, $113.50; phone, $25; cable, $23; a total of $432.50. So with my income of $1,466, that left me for the month for food $125.58. And, of course, I couldn't buy it for the month because they keep changing my prescriptions, and I had to make sure that I had extra money to pay for something in case they changed them, because I couldn't make the trip to Canada.

So the real point, however, is that we should not have to make these trips at all. Prescription drugs should be one of the benefits of the Medicare program.

Despite all of the hopes placed in the Medicare Choice program, it is not a solution. The share of Medicare Choice enrollees with prescription drug coverage declined from 84 percent in 1999 to 67 percent in 2001. At the same time, premiums, copayments are more costly. In half of the 33 States, Medicare Choice plans that provide drug coverage, the average premium rose more than 100 percent in the past 3 years.

Sadly for Maine's residents, even if some were able to afford these increases, it doesn't make any difference. There is no Medicare Choice program in Maine. So trying to add preventive service coverage here would be no help either.

The Alliance for Retired Americans has developed a set of principles for comprehensive Medicare prescription drug program. The program should provide full access to all medically necessary medications. Most importantly, the benefits should be affordable. It should include a monthly premium of no more than $25, 20 percent coinsurance, a $100 deductible, and a $2,000 out-of-pocket annual cap.

Mr. Chairman and members of the committee, I would like to close by telling you about a husband and wife that I met on the bus trips who both take a number of medications. However, they can't afford them. They have "resolved" this dilemma by taking turns buying their medications. One month, they pay for the husband's prescription drug; the next month, it is his wife's turn and so on. Neither bus trips nor cutting back on medication that are necessary not only for health but for life itself are the answer.

As you probably know, the State of Maine has taken steps on behalf of its citizens to ensure affordable prescription drugs because of inaction on the Federal level. However, the Maine Rx Program has been challenged in the courts by the pharmaceutical companies all the way up to the Supreme Court.

While we in Maine support our State's action, we also believe this is a national policy problem. The real solution is within the power of Congress, and that is to add a prescription drug benefit to the Medicare program, as well as increase access to the preventive services.

And I would also encourage you to go after the general attorney to get our bill out of captivity and bring it to Maine so at least we would be covered until something else is done.

Thank you very much.

[The prepared statement of Viola Quirion follows:]

PREPARED STATEMENT OF VIOLA QUIRION, ALLIANCE FOR RETIRED AMERICANS

Thank you, Chairman Greenwood and all of the Members of this subcommittee, for this invitation to testify today. I am Viola Quirion from Waterville, Maine and a member of the Alliance for Retired Americans. I am accompanied today by John Carr, president of the Maine Council of Senior Citizens. The Alliance for Retired Americans, which was established in January 2001, now has 2.5 million members across the nation. Retirees from affiliates of the AFL-CIO, community-based organizations and individual seniors have joined the Alliance to create a strong new voice for retired workers and their families.

I want to congratulate you for holding this hearing as I believe that preventive services under the Medicare program are very important. Because of Medicare coverage of pap smears, mammograms and flu shots, many lives have probably been extended. I think physical exams also should be considered a preventive service. For many people on a limited income, however, the 20 percent co-payment for most preventive services may be an immediate luxury they cannot afford even though it may ultimately be life-saving.

As I mentioned, I am from Waterville, Maine. I worked in the Hathaway shirt factory there for 44 years until I retired in 1994. I live on two small pensions and Social Security, which comes to $1,466 a month. I never had to worry about health care expenses until I retired. I now have a supplemental plan to cover some of the costs Medicare does not cover, but it is not sufficient for everything.

I was diagnosed with ovarian cancer in late December 2000, and had surgery in mid-January, 2001. The surgeons who operated found that different parts of the cancer had cemented together in my ovaries and if they tried to cut it out, I would have bled to death. Consequently, I took a series of chemotherapy treatments lasting 5 ° hours each time. It took 7 days for me to recover after each of these treatments. For these treatments and my recovery, I was in a nursing home for six months.

In December of 2001, I had knee surgery. While recovering at home, I suffered from a number of infections. I needed intravenous transfusions but since Medicare does not pay for those at home, I had to go into a skilled nursing facility for six weeks where they are covered. Consequently, Medicare paid for the skilled nursing care and the IVs which was much more costly than the $400 treatments I could have received at home. Although IV transfusions may not be considered a preventive service, it does not make sense to me to spend extra money unnecessarily.

Currently, I am taking 1½ hour chemotherapy treatments and don't experience negative after effects. And the numbers on the blood tests show that the mass is dissolving. I am happy to say that Medicare does cover the chemo treatments. Follow-up is just as critical to survival as preventive services.

I am here today to tell you of the importance of prescriptions drugs as a preventive measure that has extended and enhanced the quality of everyday life for millions of Americans. Technological advances in treating diseases include use of new drugs that can arrest or cure many cancers, heart disease, high blood pressure and other life-threatening conditions. Prescription drugs have saved costs in reducing surgeries and hospital and nursing home care. However, new drugs are more expensive than old drugs and three times more costly than generic drugs.

I have taken 7 bus trips to Canada over the past few years which were sponsored by the Maine Council of Senior Citizens and the Alliance for Retired Americans. I take Prilosec for stomach ailments, which in the U.S. costs me $5 a pill, and Relafin for my back and knees. I estimate that I saved $1,000 every trip. Unfortunately, it took me a week to recover from the last trip because of my knees. I probably won't be able to make any more. But I am not alone, there are so many people that could benefit from these trips but are physically unable to board a bus.

The real point is, however, that we should not have to make these trips at all. Prescription drugs should be one of the benefits of the Medicare program. Despite all the hopes placed in the Medicare+Choice program, it is not a solution. The share of Medicare+Choice enrollees with prescription drug coverage declined from 84 percent in 1999 to 67 percent in 2001. At the same time, premiums and co-payments are more costly. In half of the 33 states with Medicare+Choice plans with drug coverage, the average premium rose more than 100 percent in the past 3 years. Sadly for Maine residents, even if some were able to afford these increases, it doesn't make any difference—there is no Medicare+Choice plan in Maine. So trying to add preventive services coverage here would be no help either.

The Alliance for Retired Americans has developed a set of principles for a comprehensive Medicare prescription drug program. The program should provide full access to all medically necessary medications. Most importantly, the benefit should be

affordable. It should include a monthly premium of no more than $25, 20 percent co-insurance, a $100 deductible, and a $2,000 out-of-pocket annual cap.

Mr. Chairman and members of the committee, I would like to close by telling you about a husband and wife that I met on the bus trips who both take a number of medications. However, they can't afford them. They have "resolved" this dilemma by taking turns buying their medications. One month, they pay for the husband's prescription drugs, the next month, it is his wife's turn and so on. Neither bus trips nor cutting back on medications that are necessary, not only for health but for life itself, are the answer. As you probably know, the state of Maine has taken steps on behalf of its citizens to ensure affordable prescription drugs because of inaction on the federal level. However, the Maine Rx Program has been challenged in the courts by the pharmaceutical companies all the way up to the Supreme Court. While we in Maine support our state's actions, we also believe this is a national policy problem. The real solution is within the power of Congress and that is to add a prescription drug benefit to the Medicare program as well as increase access to other preventive services.

Thank you.

Mr. GREENWOOD. Well, thank you, Ms. Quirion, and you're a courageous woman to come here and be with us and wait for your turn, and I thank you for it. I'm proud of you for doing it.

Ms. QUIRION. You're welcome.

Mr. GREENWOOD. We're going to try like heck, and we'll succeed here in the House, in moving a bill out to expand Medicare+Choice funding. It should never have been allowed to drop down in reimbursements so that it couldn't cover prescription drugs; and we're going to have a prescription drug benefit in that bill and fight like heck to get it through the Senate after we get it through here. But I'm pretty sure we will get it through the House and that will happen next month.

Dr. Gold.

TESTIMONY OF MARTHE R. GOLD

Ms. GOLD. Good afternoon. Thank you for inviting me to testify today, Mr. Chairman, and members who are not here.

My name is Marthe Gold. I'm Logan Professor and Chair of the Department of Community Health and Social Medicine at the City University of New York Medical School, and I served as a member of the Institute of Medicine's Committee on Medicare Coverage Extensions, whose report was issued in 2000. I'm pleased to be here.

My comments today will draw from conclusions of the IOM report that are relevant to this hearing, and I'm also going to draw from my own background in cost-effectiveness analysis, clinical preventive services and patient care as a practicing physician at Settlement House in New York City Community Health Center.

As you've heard and as you know, primary prevention is directed toward averting health problems. Secondary prevention is aimed at discovering existing abnormalities before they do harm. And tertiary prevention, which is really a form of treatment, is intended to prevent worsening of complications in individuals who have an established disease. Some of us in the prevention community don't think that there is too much of a difference; it is just a matter of a continuum.

By definition, preventive interventions are administered to people who are not experiencing illness, and therefore the possibilities of side effects, false positive findings and costs of care must always be weighed against the health improvements the interventions pro-

vide. On a population basis, preventive services should, at minimum, create more good than harm.

Medically delivered prevention has been undersubscribed in this country as other insurers, along with Medicare, have increased their coverage. We've seen that uptake of the services has improved. Insurance is certainly necessary, but not sufficient for increasing uptake of preventive services. This uptake has particularly benefited the low-income individuals whose health is known already to be poorer and whose life expectancy is shorter than other Americans.

Medicare extends coverage to Americans age 65 or over and to some individuals with disabilities or permanent kidney failure. With certain exceptions, Congress explicitly excluded coverage for primary and secondary prevention and outpatient prescription drugs, among other services.

Over the years selective preventive services have been added on a case-by-case basis through congressional action. As a result, Medicare now covers many, but not all secondary and tertiary preventive services that would be of value to its beneficiaries. Medicare also covers some services whose value is unproven.

For example, in 2000, Congress extended Medicare coverage to prostate-specific antigen and digital rectal exam, to screen for prostate cancer, despite evidence-based recommendations by some scientific and professional bodies to the contrary. In the case of PSA, the combination of yet unproven survival advantage and the not-infrequent serious side effects associated with treatment of prostate cancer led the U.S. Preventive Services Task Force, the American College of Physicians and the American College of Preventive Medicine to specifically recommend against the use of routine screening by PSA. Two studies conducted early in the 1990's estimated that an initial screening of PSA would cost between $6 to $28 billion.

From the other side, Medicare fails to cover a number of effective preventive services. For example, the Task Force recommends blood pressure screening and screening for vision and hearing impairment, depression and problem drinking. In addition, it recommends that patients be educated and/or counseled about tobacco cessation, diet, alcohol, dental hygiene, physical activity, fall prevention and other safety-related issues. None of these are currently covered by Medicare.

In 2001, Partnership for Prevention sponsored a prioritization project which had contributions from scientists from CDC, CMS and AHRQ. That prioritization project ranked preventive services on the basis of the burden of disease they prevented and their cost effectiveness, and they placed tobacco-cessation counseling and screening for vision impairment among adults age 64 and over as two of the top three most valuable services, neither of which is included. Childhood immunizations were ranked No. 1, just so you understand the continuum there.

Blood pressure and cholesterol screening had priority scores that were equivalent to those of vaccination for influenza, a Medicare-covered service. Priority scores for screening for blood pressure and cholesterol were predicated on pharmaceutical treatment of elevations of blood pressure and cholesterol to bring them to normal levels. Obviously, medication is not covered by Medicare.

Prevention wisely accomplished should save pain, mental anguish and cost. Why then would a public program like Medicare pay $75,000 for coronary artery bypass surgery in some situations and decline to pay for the smoking cessation counseling and blood pressure and cholesterol-lowering agents that would obviate the need for some of these surgeries? Why would Medicare pay for the hip fractures suffered by elderly Americans and not cover the screening and counseling of elders that could substantially decrease the falls that cause the fractures?

The IOM report on Medicare coverage of clinical preventive services made several points about the coverage decisionmaking process. In brief, the cost accounting framework that supported IOM committee recommendations and is used by the Congressional Budget Office looks at costs and offsets over a 5-year period of time, a period that is too short for many preventive interventions to achieve their benefit. Formal cost-effectiveness analysis where the health effects of differing interventions are compared over an appropriate timeframe and evaluated along with their costs would provide a truer picture of both the economic and the health impact of medical care.

Second, the IOM committee strongly endorsed the utility of evidence-based reviews of health services for guiding clinical and policy decisions. Reviews guide clinicians and health care organizations to abandon practices that are clearly not beneficial and to apply and recommend practices that are identified as worthwhile. They support governments and others who pay for care in revising coverage, reimbursement, quality assessment and related policies to discourage nonbeneficial services.

The committee also favored more extensive reliance on formal cost-effectiveness analysis for informing coverage determinations. The status quo coverage apparatus makes it difficult to compare the expected benefit's harms and costs of different health care decisions. The procedure relied on by Congress for estimating the cost to Medicare of covering a new service provides an incomplete picture of the value for money for such an action.

Finally, the committee suggested that methods toward rationalizing coverage policy for preventive and other Medicare services should be pursued. For example, Congress could encourage and provide funding support for AHRQ, CMS and other relevant agencies in preparing evidence evaluations and cost-effectiveness analyses. Congress could also direct CMS to assess the services recommended by the U.S. Preventive Services Task Force in the context of the Medicare program and to make coverage recommendations. The systematic analysis of the potential benefits, harms and costs of covering additional services would protect against the piecemeal addition of less valuable services at the expense of more valuable ones.

To conclude, more systematic evaluations of the effectiveness and cost effectiveness of health care interventions and using that information to inform coverage decisions will create a more effective and efficient health care system that better meets the needs of Americans. For those of us in the prevention community who have long been troubled by the practice of scrupulously holding preventive interventions to stringent standards of accountability and cost-sav-

ing while leaving many other interventions unexamined, a more systematic approach to coverage policy would indeed be a breath of fresh air.

[The prepared statement of Marthe R. Gold follows:]

PREPARED STATEMENT OF MARTHE R. GOLD, ARTHUR C. LOGAN PROFESSOR AND CHAIR, DEPARTMENT OF COMMUNITY MEDICINE AND SOCIAL MEDICINE, CITY UNIVERSITY OF NEW YORK MEDICAL SCHOOL AND MEMBER, COMMITTEE ON MEDICARE COVERAGE EXTENSIONS, DIVISION OF HEALTH CARE SERVICES, INSTITUTE OF MEDICINE

Good morning, Mr. Chairman and members of the Committee. My name is Marthe Gold. I am Logan Professor and Chair of the Department of Community Health and Social Medicine at the City University of New York Medical School and served as a member of the Institute of Medicine's Committee on Medicare Coverage Extensions. The Institute of Medicine is part of the National Academy of Sciences, a private, nonprofit organization that was chartered by Congress in 1863 to advise the government on matters and technology. The committee report on its findings and recommendations was published in 2000.

My closing comments ("Report Findings") will cover certain conclusions of the IOM report that are relevant to this hearing. I will also draw on my background in cost-effectiveness analysis, clinical preventive services, and patient care as a family practitioner, currently seeing patients in a community health center in East Harlem, in New York City.

Preventive Services

It would be lovely if we could live long lives without disability or illness, and slip off softly in our sleep somewhere in our 9th or 10th decade. Second best is to catch illness early, and intervene in a manner that reasonably maintains health and longevity. Prevention supports both of these scenarios. Primary prevention is directed towards averting a health problem, e.g., we immunize to prevent infectious illness, we fluoridate to prevent tooth decay, we stop people from smoking and avoid heart and lung disease. Primary prevention can occur at the population health level—in communities through public health educational campaigns—or it can occur in clinical settings. Primary prevention leads us toward scenario one. Secondary prevention is aimed at discovering existing abnormalities before they do us harm; hopefully before they interfere too much with quality of life and life span. We catch cervical cancer early with Pap tests, or decrease the risk of heart disease by lowering cholesterol or blood pressure. Secondary prevention occurs in the medical care setting. Tertiary prevention, in reality a form of treatment, aims to prevent worsening of complications for patients who already have a specific disease. Examples of tertiary prevention include controlling blood sugar in diabetic patients and performing coronary artery bypass grafting on individuals with narrowed coronary arteries to prevent heart attacks.

Medically delivered prevention has been under subscribed in this country. There are many reasons for this, a number of which will have been discussed by others at this hearing, but certainly a major factor historically has had to do with insurance coverage. As insurance coverage has improved through Medicare and other insurers, so has uptake of preventive services. Low income individuals and uninsured persons whose health is known to be poorer and whose life expectancy shorter, have lower levels of uptake of preventive services. We know from the health services research literature that as insurance covers preventive services, more low income persons make use of them.

Although an ounce of prevention is held to be worth a pound of cure, there is always fine print to be read. Preventive interventions, by definition, occur in asymptomatic people. They can cause uncomfortable side effects (e.g. pain or perforation associated with colonoscopy, untoward effects of immunizations); precipitate worry, pain and unnecessary further testing in association with false positive results (e.g., a mammogram detects a mass that after biopsy turns out not to be malignant); interfere with peoples' self perception by assigning them a disease "label" (people assigned a diagnosis have been found to miss more work post-labeling); and use up financial resources. On a population basis, preventive services should, at minimum, create more good than harm. In addition, they should represent a reasonable investment of resources. Money used in one place is not available for use elsewhere. Certainly the IOM committee was mindful during its deliberations of Congress's budget rules for itself that require that decisions to increase most types of federal spending be accompanied by explicit decisions to reduce spending elsewhere, or to raise taxes.

Medicare Coverage (and lack thereof) of Preventive Services

Medicare extends coverage to Americans age 65 or over and to some individuals with disabilities or permanent kidney failure. From the outset, the program has focused on coverage for hospital, physician and certain other services that are "reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the function of a malformed body member" (section 1862 of the Social Security Act.) With certain exceptions, Congress explicitly excluded coverage for primary and secondary prevention and outpatient prescription drugs, among other services. Over the years, selected preventive services have been added on a case-by-case basis through Congressional action.

Given the considerations outlined, sensible policy making would favor that all services that are insured and promoted by Medicare are ones that are known to be appropriate and effective in increasing the health of Americans. This is not currently the case. For example, in 1998, Congress extended Medicare coverage to bone densitometry (to screen for osteoporosis) and in 2000, to prostate-specific antigen (PSA) and digital rectal examination (to screen for prostate cancer) despite evidence-based recommendations by scientific and professional bodies such as the U.S. Preventive Services Task Force (USPSTF), the American College of Physicians, the American College of Preventive Medicine, and the Canadian Task Force on Preventive Health Care. In the case of PSA, for example, the combination of no known survival advantage and the not infrequent serious side effects associated with treatment of prostate cancer, led the USPSTF to specifically recommend against the use of routine screening by PSA. Two studies conducted a decade ago estimated that an initial screening of PSA would cost 6 to 28 billion dollars (Kramer et al, 1993; Optenberg SA and Thompson IM, 1990.)

From the other side, sensible policy would favor Medicare coverage of all appropriate and effective preventive services. This, also is not the case. For example, the USPSTF recommends blood pressure screening, and screening for vision and hearing impairment, depression and problem drinking. In addition it recommends that patients be educated and/or counseled about tobaccos cessation, diet, alcohol, dental hygiene, physical activity, fall prevention and other safety-related issues. None of these are currently covered by Medicare. A 2001 prioritization project that ranked preventive services on the basis of *burden of disease prevented and cost-effectiveness* placed tobacco cessation counseling and screening for vision impairment among adults aged >64 in the top three services. The report was co-authored by prevention specialists and researchers from the Centers for Disease Control, the Agency for Healthcare Research and Quality, and Partnership for Prevention (Coffield et al, 2001.)

The priorities project ranked blood pressure and cholesterol screening equivalently with vaccination for influenza—a Medicare covered service. Priority scores for screening for blood pressure and cholesterol were predicated on pharmaceutical treatment of elevations of blood pressure and cholesterol to bring them to normal levels. And yet, as you are well aware, Medicare does not provide coverage for drugs. Low and moderate income individuals are often left with highly treatable risk factors for diseases that they lack the economic wherewithal to control.

Prevention, wisely accomplished, should save pain, mental anguish, and cost. Why then would a public program pay $75,000 (Peigh, 1994) for coronary artery bypass surgery and decline to pay for the smoking cessation counseling and blood pressure and cholesterol lowering agents that would obviate the need for some of these surgeries. Why would Medicare pay for the hip fractures suffered by elder Americans, and not cover the screening and counseling that could substantially decrease the falls that cause the fractures?

Coverage Determinations

Coverage determinations for the Medicare program currently take in a range of considerations, many of them non-aligned. When Congress considers preventive care and other interventions that are now statutorily excluded from Medicare coverage, costs are routinely weighed as part of the decision making. When CMS makes coverage determinations about new technologies that fit under existing categories of covered services, its decisions are not directly governed by the "budget neutrality'" rules that Congress has adopted for itself. Instead, CMS applies criteria of effectiveness. These, in turn, are not applied to established technologies and interventions.

Congress has been restrained in its addition of new services to the Medicare package. A major component of the Balanced Budget Act of 1997 was a set of measures intended to slow the growth in program spending and at least delay the date at which Medicare spending is projected to exceed revenues. The cost-accounting that supported IOM committee recommendations on coverage of the services we examined was that used by the Congressional Budget Office, which looks at costs and

off-sets over a five year period of time. Often, however, a short time horizon will not permit an adequate evaluation of the long-term costs or savings associated with an intervention. For example, smoking cessation treatment or cholesterol lowering medications may not show their benefit till a decade or two after the intervention has occurred. Formal cost-effectiveness analysis, where the health effects of differing interventions are compared over an appropriate time frame and evaluated along with their costs, provides a truer picture of both the economic and health impacts of medical care.

During the first three decades following the establishment of Medicare, Congress was highly sensitive to issues of clinical effectiveness and cost-effectiveness. For example, at the behest of Congress, the now defunct Office of Technology Assessment (OTA) undertook state-or the-art analyses of the cost-effectiveness of several preventive services. A study of congressional coverage decisions from 1965-1990 identified evidence of favorable cost-effectiveness ratios as one factor differentiating preventive services approved for coverage from those not approved.

Report Findings

The IOM committee strongly endorsed the utility of evidence-based reviews of health services for guiding clinical and policy decisions. For both new technologies and current practices, these reviews help make clear the extent to which there is good evidence about the benefits and harms of a particular intervention. At the same time they highlight important health problems for which good evidence is still missing and point the way toward needed research. Reviews place pressure on clinicians to abandon practices that are clearly not beneficial and to apply and recommend practices that are identified as worthwhile. They support governments and others who pay for care in revising coverage, reimbursement, quality assessment, and related policies to discourage nonbeneficial services and encourage effective care.

The committee also favored more extensive reliance on formal cost-effectiveness analyses for informing coverage determinations. Our point was not that cost-effectiveness analyses should be conducted on all currently covered services Medicare services (a massive task) nor that cost-effectiveness should be the only criterion for coverage decisions. It was, rather, that the status quo coverage apparatus makes it difficult to compare the expected benefits, harms, and costs of different health care decisions. The procedure relied on by Congress for estimating the costs to Medicare of covering a new service—the one adopted for the report of the committee—provides an incomplete picture of the value for money of such an action.

The committee's endorsement of the tools of evidenced-based medicine and cost-effectiveness analysis led it to be strongly concerned by the fluctuating policy support for technology assessment and evidence-based recommendations for clinical practice and coverage policy. Ironically, at a time when the methodology for assessing effectiveness and cost-effectiveness has been strengthened by the health services research community, the coordination of decision making for coverage appears to have eroded.

The committee believed that it is possible to take some steps toward rationalizing coverage policy for preventive and other services. For example, a modest step in this direction would be for Congress to encourage and provide funding support for AHRQ, CMS, and other relevant agencies in preparing evidence evaluations and cost-effectiveness analyses. With respect to preventive services, Congress could direct CMS through the Secretary of Health and Human Services to assess the services recommended by the USPSTF in the context of the Medicare program and to make coverage recommendations. The systematic analyses of the potential benefits, harms, and costs of covering additional services would protect against the piecemeal addition of less valuable services at the expense of more important ones. At the clinical level, this is likely to play out with doctors and other health professionals placing emphasis on higher priority services for their patients.

Enlarging the apparatus for systematic evaluations of the effectiveness and cost-effectiveness of health care interventions and using that information to inform coverage decisions will create a more effective and efficient health care system that will better meet the needs of Americans. For those of us in the prevention community, who have long been troubled by the practice of scrupulously holding preventive interventions to various form of accountability, while leaving many extant interventions unexamined, a more systematic approach to coverage policy would indeed be a breath of fresh air.

Thank you for the opportunity to present these views. I would be pleased to answer any questions.

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Mr. GREENWOOD. Thank you, Dr. Gold.

Dr. Himes.

TESTIMONY OF CHRISTINE HIMES

Ms. HIMES. Thank you very much.

It is amazing to me when I came here. I'm a primary care doc. I'm the way other side of the spectrum. I'm the person who sits in the room with patients every day and talks about these kinds of issues.

I'm also the Director of Geriatrics for Group Health Cooperative, and it has been interesting to me to listen this morning to all of the comments about the good old guys in managed care and how the days used to be. And the truth is, having been first birthed in 1947, group health, I think, is still one of the old guys, and we've benefited tremendously from our relationships with the Medicare program.

In 1976, we became the first demonstration project for Medicare risk, and in 1982, became one of the first-ever risk contracts. So I've enjoyed a very long history of relationship not only with Medicare but the ability afforded by risk contracts, and now Medicare+Choice, to really take a systems view and look at, how do we take care of our patients.

Our charge to ourselves has always been, if we said we were the very best health care organization for seniors in the world, what would that look like and how do we try to get there? And as I listen today, I've been—I've never been to Congress before.

This area is a personal area of passion of mine, healthy aging. We were asked to come and talk primarily because of some physical activity programs we have, which are my biggest passion areas, and I brought some—so you all could benefit from having some little exercise—tools while you sit here for these long hours, I think. So I'll make a few comments about that in your everyday practice a little while later.

But I want to talk about, I think, two things that have not been mentioned so far today.

We depend—our system depends on being able to step back and look at all of the evidence that is available. We look at all of the wonderful reports that are put out by all of the folks who have been on this panel, as well as all of the literature in general; and the geriatric literature over the past 15 or 20 years has really provided us with a really clear way, I think personally, of where to go.

And when I look at you all here on this committee and hear about your responsibilities and how you think about them in terms of Medicare, I think we're the same. I think you have the same charge on the national level that I have for our 60,000 Medicare recipients at Group Health. So I'll share what I know. I'll be happy

to share anything in the future that I can be helpful or that Group Health can be helpful in clarifying, and really am very happy and privileged that you all are taking such a close look at preventive services for seniors.

Prevention is an interesting idea that really changes as we get older. In our 50's, it is different than it is for people who are 65 or than it is for people who are 75, 85, 95. Many of the cancer screens that you've heard about earlier today and even many of the medications that are used, whether it is aspirin or whether it is beta blockers, et cetera, as people get older and older, there is not clear evidence anymore about the efficacy of those interventions on the prevention scale, partly because we think of prevention traditionally in our own minds as preventing premature disease.

What is premature disease when you are 85 or 95 or 100 years old? Hard to know. So the truth is, really prevention as we get older and older is a question of how do we prevent our life from falling apart? How do we prevent a downward spiral where our quality of life is the pits? How are we to live our lives the best ways that we can for all of our lives?

The geriatric literature shows us really clearly something about prevention. There is a set of syndromes, called the "geriatric syndromes," which include urinary incontinence, depression, all of those really obnoxious things that totally screw up quality of life. All of them lead you in an amazing downward spiral, and all of them have some very clear evidence-based interventions that can really make a difference in people's quality of life.

There is a wonderful report that was just put out, sponsored by the Robert Wood Johnson Foundation and AAHP, called "Improving Care of Older Adults With Common Geriatric Conditions"; and it is probably the best literature and most current literature review around the geriatric conditions.

But if we talk about getting older, we want to focus on geriatric conditions. The most important geriatric condition is lack of physical activity. If there is one prescription physicians can write in their office that is the most important prescription, it is a prescription for regular physical activity. At Group Health, we've developed a series of physical activity programs that we'll be happy to talk about more in the question-and-answer time, if you'd like—or they are in the written testimony—that really address that one problem, and in doing so, improve very clearly not only the costs and utilizations for seniors, but also quality of life and allowing or helping seniors to be the best they can be for all of their lives.

Thank you.

[The prepared statement of Christine Himes follows:]

PREPARED STATEMENT OF CHRISTINE HIMES, GROUP HEALTH COOPERATIVE, GROUP HEALTH PERMANENTE MEDICAL GROUP

I. INTRODUCTION

Mr. Chairman and members of the Subcommittee, thank you for inviting me to testify today on the important topic of preventive benefits offered under the Medicare program. I am Dr. Chris Himes, primary care physician and Director of Geriatrics for Group Health Cooperative, based in Seattle, Washington. I also am a member of the Group Health Permanente Medical Group, which with 1,217 physicians, is among the largest medical groups in the state of Washington. Group Health Permanente contracts exclusively with Group Health Cooperative.

Founded in 1947, Group Health is a not-for-profit and with nearly 600,000 members, is the nation's largest consumer-governed health care organization. Group Health has a long-standing commitment to serving Medicare beneficiaries. Shortly after Medicare's creation, we began working with the government to design a program that would allow Medicare to work with prepaid health care organizations like Group Health. In 1976, we were the first organization to partner with the government under what was then referred to as the Medicare risk program. At present, we serve nearly 60,000 Washington state beneficiaries under Medicare+Choice.

Since our founding, Group Health has focused on preventive care programs to help people stay healthy, while at the same time making sure people receive the comprehensive care they need when they are ill. Pre-payment has been fundamental to our ability to pursue both of these objectives simultaneously. Pre-payment allows us to direct resources to areas of greatest need and to be creative and innovative in designing programs. Simply stated, when you are not paid on an encounter-by-encounter or procedure-by-procedure basis, you can shift your focus to include longer-term improvement in health outcomes.

Group Health has developed programs related to chronic illnesses common in the elderly including depression, diabetes, and heart disease. We also have initiatives in prevention and acute care for conditions such as breast, cervical, and colorectal cancer. At present, work is underway to unify these initiatives with other special needs of seniors, such as fall prevention. Although the programs span a wide spectrum of health care conditions and approaches, they all reflect the collaborative relationships between an organization, patients, clinicians, and other providers.

II. PROMOTING HEALTHY AGING: PREVENTIVE CARE MODEL

Today, I'd like to focus on the concept of "healthy aging"—a topic that has long been a passion of mine. The concept of "healthy aging" is not a magical or fanciful quest for the "fountain of youth", but rather a clearly attainable road to being the "best we can be"—physically, mentally and spiritually. Healthy aging is not dependent on high cost medical technology—although certainly, technology can sometimes extend the length of life, improve functional ability and overall quality of life.

To achieve healthy aging, individual relationships between patients and their providers must take center stage; providers need to understand fully their patients needs, desires and things that most impact their ability to live their lives well. Patients need to have confidence that their providers will listen and partner with them to make the best choices for their own lives and circumstances.

With the baby boomers aging and individuals over age 85 becoming our nation's fastest growing population segment, the definition of good preventive health care models are changing and expanding. In addition to disease prevention, the focus is gradually shifting to include a greater emphasis on helping people live with chronic illness and maintaining and improving functional abilities and quality of life.

Helping our providers keep up with changes and the best approaches to care—including ways to promote healthy aging—is one of the most important contributions of Group Health's care delivery model. Our focus on evidence-based medicine—a systematic approach to collecting and critically evaluating available scientific evidence on treatment options—seeks to offer practitioners and patients the information they need to make informed decisions about treatment options. It also helps ensure that health care dollars are being spent on treatments that have proven benefits.

For today's—and tomorrow's—Medicare beneficiaries, the growing body of geriatric literature clearly points the way. In achieving healthy aging, studies point to the need for regular geriatric assessments and evidence-based interventions in areas known to threaten functional ability, commonly called the "geriatric syndromes" (e.g., physical inactivity, depression, urinary incontinence, falls, cognitive impairment, medication-related complications and poor nutrition). For the most part, these interventions are low cost and do not involve advanced technologies. Yet, studies have clearly shown that assessments, certain interventions and close follow-up of these syndromes can help avoid deterioration in health and costly complications, while dramatically improving the quality of life for seniors in six to twelve months. From a medical perspective that is a relatively fast timeframe for improvement, especially when considering that beneficiaries often experience geriatric syndromes for lengthy periods of time.

III. GROUP HEALTH'S WORK TO IMPROVE BENEFICIARIES' HEALTH AND WELL-BEING THROUGH EXERCISE

Today, I want to focus on perhaps one of the best examples of a low-cost, low-technology intervention that can have a dramatic impact on seniors' health and

well-being: Group Health's simple, but pioneering research and resulting strategies in promoting senior fitness.

Group Health not only has focused on learning from the geriatric literature, but also has made significant contributions to it over the last twenty-five years. In the 1980s, researchers from Group Health's Center for Health Studies and their colleagues at the University of Washington examined key determinants of overall health outcomes for seniors. The results were quite clear. There are only two statistically significant predictors: social isolation has a negative impact on health, while regular physical activity had a very positive effect on health. In assessing the types of physical activity, the researchers found—and many others have since validated—that in addition to endurance activity, such as walking, gardening, swimming, muscle strengthening and flexibility exercises are also important, especially for seniors with functional deficits or balance problems as they age.

The joint Group Health-University of Washington work led to the development of an exercise program known as Lifetime Fitness, offered by Group Health at local senior centers through a community partnership with Senior Services of Seattle-King County. Group Health paid the start-up costs for the weights used for muscle strengthening and the training and salaries for the exercise instructors. Senior centers provided the space and logistics for the classes, which were offered to all comers in the community, three times a week in five-week sessions.

Each class has segments that focus on improving balance, flexibility, and aerobic capacity. Participants perform exercises both standing up, holding the back of a chair for balance, as well seated in chairs. In addition to the actual exercise components, the class offers participants a chance to socialize—they talk about their weekends, their grandchildren, and visits with their families. Couples exercise together; group lunches are occasionally arranged after class.

Based on the positive response from participants, Group Health soon expanded the availability of classes throughout our entire service area by partnering not only with community senior centers, but also with YMCA's. Lifetime Fitness is now offered in 34 locations.

To further contribute to the evidence-base in healthy aging, the same Group Health Cooperative-University of Washington research team, in partnership with Senior Services of Seattle-King County Health Enhancement Project, developed and tested a model of geriatric assessment with accompanying interventions and follow-up by a nurse practitioner. Over the study period, a nurse practitioner stationed in a senior center that offered Lifetime Fitness classes performed regular assessments on patients 70 years and older from Group Health and Pacific Medical Center who participated in Lifetime Fitness. The improvements in health and well-being were dramatic as evidenced by reductions in "geriatric syndrome visits." The nurse practitioner, along with a social worker, was able to demonstrate significant cost and utilization savings—a 72 percent reduction in six to twelve months.

It became clear that regular exercise was key to the intervention's success. The study's positive findings with respect to avoided deteriorations in health and costly complications served as a catalyst for Group Health to move regular assessment and intervention support into all primary care settings. Senior Services, a local not-for-profit organization, also expanded the Health Enhancement Program to senior centers around the country.

IV. INTEGRATING FITNESS INTO GROUP HEALTH'S MEDICARE+CHOICE PLAN

Once we understood that increasing physical activity for all seniors was the most important key to healthy aging, Group Health began to develop a "full spectrum" of exercise opportunities that could be individualized according to patient preference and ability. Whether robust and healthy or frail, living independently or in nursing homes, Group Health is working to bring the benefits of exercise to all our Medicare members. Today, in addition to Lifetime Fitness, Group Health offers Medicare+Choice enrollees a benefit called "Silver Sneakers" which enables them to join local health clubs and YMCA's at which they can take senior-focused fitness classes. At present, 1,300 Medicare beneficiaries participate in Lifetime Fitness, of whom 1,000 are Group Health Medicare+Choice members. Nearly 10,500 Group Health Medicare+Choice members have participated in Silver Sneakers. In April alone, 3,748 Group Health Medicare beneficiaries—6.3 percent of our membership—used their Silver Sneakers benefit.

In addition, Group Health is "rolling out" our new geriatric assessment protocol to all primary care clinics. Physicians will be asked to write "exercise prescriptions" for all of their senior patients and to conduct regular follow-up on their progress. We have developed a set of tools and supports, as well as planned training for all practitioners in addressing and monitoring geriatric syndromes. The key message in

this training is that recommending exercise is among the most important prescriptions to write, individualize, and assure compliance.

While these two exercise programs have been overwhelmingly successful in improving quality of life, they are beyond the ability of many seniors with disabilities and multiple chronic diseases. These seniors, however, often have the most to gain from increasing physical activity. Virtually all guidelines and care coordination programs for conditions such as diabetes, heart disease, chronic obstructive pulmonary disease, hypertension, depression, osteoporosis, arthritis, to name a few, call out exercise as a central strategy to improve health.

Let me give you a few examples of why this can be so effective and life changing for the most frail among us. Group Health currently has an exercise program beginning at our nursing home, Kelsey Creek, and has started our first program in a retirement community next to one of our clinics. For several years in my own practice, I have written exercise prescriptions based on individual needs and preferences for all senior patients, promoting the value of regular exercise in managing virtually every medical condition and disability. In doing so, there was a particular group of patients who caught my attention—my patients who visited me often with various ailments and complaints that did not have a specific etiology. Simply stated, they were in "downward spirals".

As I did with all my patients, I encouraged them to exercise and get out socially but they just couldn't. They lacked the motivation and will, and they had real obstacles—chronic pain, significant medical diseases and functional deficits, depression, social isolation, lack of transportation; the list goes on. Perhaps most importantly each of these people was facing huge losses—death of their spouse, a move from their life long home to a retirement apartment. They felt like they were simply burdens on their families and friends. They most common word they used to describe themselves was "useless".

I knew that these were the very people who would benefit most from an exercise regimen so I decided to start a muscle strengthening and flexibility program at Group Health's Northgate Medical Center, where I practice, tailored specifically to their needs and disabilities. I asked this group to commit to coming to class three times a week for four and a half months, stay for lunch together once a week after class, and participate in a community performance at the end to share with their families and community all I knew they would accomplish. Within weeks I could see them getting stronger, becoming an incredible support group for each other, and perhaps most importantly, truly embracing and enjoying life again.

It's been two and a half years since the first class, and they are still coming. Some have died, they are old and frail. But at their funerals, each of their families talked about how much better their mom's last year of life had been as a result of the "dancing ladies and their few good men" program. As for the rest, I don't see them as much for these "unspecified ailments", though I regularly see them at the lunches and in class where we talk about a whole range of healthy aging issues. With sponsorship from Group Health, the group recently made an exercise video of this class to be used as an inspiration and entry-level in-home exercise option for our frail populations.

V. UPDATING MEDICARE TO INCLUDE BENEFITS THAT PROMOTE HEALTHY AGING

Limited health care resources mandate that physicians, health plans and payers alike identify new and innovative ways to improve the overall health outcomes for the Medicare population and control costs. Care coordination programs for high-risk, high-cost conditions have and continue to promote cost-effective delivery of services and avoid deteriorations in health. That said, we as a nation must persist in looking "upstream" for additional strategies. In my view, one such strategy is the promotion of healthy aging.

Regular geriatric assessments and follow-up of geriatric syndromes are key to healthy aging. The most important of these follow-up activities is increasing regular physical activity for all patients, whether they are healthy or frail. We know that fitness can make a difference not only in terms of beneficiaries' physical and mental well-being, but also in terms of expenditures. A recent controlled analysis of health cost and utilization of 1,124 Group Health Medicare+Choice members enrolled in Lifetime Fitness who were compared to 3,342 age and gender "matched" control beneficiaries. The baseline per year expenditures on members of the control group and individuals who participated in more than 120 Lifetime Fitness Classes were virtually the same: $3,932 and $3,940 respectively. However, the change in the subsequent year's expenditures differed dramatically: costs for individuals who did not participate in Lifetime Fitness increased by $1,175, while costs for Lifetime Fitness participants decreased by $71. The study also showed that costs for members who

increased their participation by just one time a week decreased by 14 percent, while the annualized number of inpatient days fell by half a day.

Writing and assuring compliance with exercise prescriptions is the single most important intervention physicians can do for their patients. Health plans need to continue to develop a full spectrum of exercise opportunities for their members and their communities, in partnership with community, private and governmental organizations. Toward this end a national effort, cosponsored by the Center for Disease Control and the Robert Wood Johnson Foundation, is currently underway bringing health plans, government agencies, seniors themselves and community organizations together in support of the "National Blueprint on Increasing Physical Activity Among Adults Age 50 and Older". The Blueprint work will continue to support the development of the exercise and behavior change literature base, as well as broadly "spreading the word". Group Health, as well as many others like us, fully embrace and support this work, understanding its central importance to the health of the health, our members, and ourselves.

VI. CONCLUSION

There is no doubt that the Medicare benefits package needs to be updated. As a practitioner, I applaud Congress' work in recent years to improve the availability of important preventive benefits for our nation's Medicare beneficiaries. But as I have presented here today, prevention of illness or deterioration in health does not always result from a screening test, but rather it can result from even more simpler, fundamental, low cost approaches like fitness programs. As Congress continues its work in this important area, I urge you to continue to think creatively and to take a broader perspective on seniors' health.

Our Medicare members have told us loudly and clearly that they want to live life fully with dignity and grace. Group Health is committed to fulfilling their request. As you can tell, we are proud of our accomplishments, but we know that more can and must be done to ensure that all Medicare beneficiaries achieve "healthy aging." We again want to thank you for the opportunity to share our work in this area and to contribute to the Subcommittee's deliberations on this important issue.

Mr. GREENWOOD. Thank you.
Dr. Gruman.

TESTIMONY OF JESSIE C. GRUMAN

Ms. GRUMAN. Thank you, Mr. Chairman. I represent the Center for the Advancement of Health, which is an independent, nonpartisan, nonprofit organization that promotes the greater recognition of how nonbiological factors affect health; that is, what we do and where we live and what we eat and what resources are available to us influence health and illness. The fundamental aim of the Center is to ensure that everything we're learning about health through scientific inquiry, not just what we're learning about physiology and genetics, is applied and translated into policy and practice to improve the health of individuals in the public. And it is that mission that brings me here today.

As Dr. Fleming in the previous panel pointed out, no single group of Americans more—has more to gain than the elderly from putting into practice the medical—what medical evidence strongly suggests, and that is that behavior matters. From avoiding risky behavior to taking pills on time, to getting appropriate medical screenings, a solid core of evidence exists on how to stay healthy and productive for as long as we can.

In the past 5 years, Congress has doubled the funding for the National Institutes of Health, and the payoff should be seen in dramatically improved health outcomes in the years ahead. Or maybe not. The investment we've made in basic science is going to be diluted if we do not translate these advances into use, and use implies systematic changes in the behavior of doctors, of health sys-

tems and of individuals. Let me give you an example of what I'm talking about.

Biomedical researchers tell us that we are on the verge of seeing a new genetic test that will tell people their genetic risk for colon cancer. This development is a triumph of science. If anything, it vindicates our Nation's investment in discovery of research at NIH by promising a tectonic shift in the burden of colon cancer, the cause of 56,000 deaths a year in the United States. But this incredible advance coming from basic science necessitates a more powerful understanding of behavior if we are going to make use of it.

From this one test alone, many new questions will need to be answered in order to realize the promise of fewer colon cancer deaths. For example, how do you persuade people to take a test that may indicate with a pretty high degree of certainty that they are going to get a deadly disease? What environmental and behavioral factors influence whether people who test positive actually get colon cancer or not?

And following on that, what life-style changes can individuals make to reduce the probability that they will get colon cancer? What constitutes good medical care for patients who test positive on such a test? What are the implications of this test for insurance generally and for Medicare in particular to cover the cost of the test, to cover the cost of monitoring and to cover the cost of treatment for those who test positive? How will we train and deploy a workforce of genetics counselors to introduce the entire U.S. population to the idea that they ought to have a test that very well may change their lives and prospects?

Now, these are questions that are not going to be answered by geneticists or biochemists or biologists. Rather, they are questions that will be answered by experts in learning, in cognition, in human factors, organizational development, health research, epidemiology, economics, psychology and sociology, and others probably.

Basic biological science was the starting point of the test, but scientific attention must then be paid to changes in the behavior of patients, of doctors, of insurers, of managed care executives and others if we are to successfully complete the production arc from laboratory to living room. Without systematic attention to these questions, the most sophisticated genetic test is functionally as useless as a cell phone on the dark side of the moon.

As the GAO report shows, even time-tested effective technologies, mammograms and immunizations are not finding their way often enough to the people who need them. Physicians forget to recommend them, patients don't ask for them, they're confused about how often they need them, they fail to comply with their doctor's orders.

One recent action by the CMS is an important and, unfortunately, too-rare instance of really attending to the behavior that connects the technology to its target: CMS's review that you mentioned earlier of the evidence on interventions that are directed at doctors, health care facilities and individuals to increase vaccine use. Based on that review, CMS implemented standing orders to increase the chances that the right immunizations get to the right seniors at the right time.

But behavior doesn't just matter in realizing the health benefits of clinical preventive services covered by Medicare. There is overwhelming scientific evidence, as we discussed earlier, that demonstrates the great gains to be had by reducing behavioral risks, including smoking, increasing physical activity, preventing falls. All are extraordinarily important, but until quite recently have not been viewed by CMS as part of the Medicare mandate for prevention.

The new CMS-sponsored stop-smoking demonstration project is the agency's first effort to systematically address a major behavioral risk factor for disease and disability, and evidence has been gathered by the Healthy Aging Program on the feasibility of pilot programs to assess risk, prevent falls, better manage chronic conditions; and each of these might have an important role to play in a Medicare program that aims to help Americans live as well as they can for as long as they can.

Mr. Chairman, it would be a terrible waste of the Nation's health and wealth if the bulk of the health research that Congress has sponsored sits in the file cabinets in Bethesda and is not used to benefit the American public. The pharmaceutical and technology industries are responsible for bringing some of that knowledge to the marketplace, but they are not responsible for ensuring that we know—that what we know about quitting smoking or getting people to participate in screening tests becomes part of routine health care and community services.

There are several ways that Congress can act to make certain that we realize the full benefits of all of our investments in health research. First, by raising the priority within CMS for addressing behavioral risks like physical activities, reducing the impact of falls, assessing health risks.

Second, by increasing the extent to which CMS makes use of the evidence on how to overcome behavioral barriers in implementing preventive services and other medical care services, as the Agency did with it standing orders for immunizations.

Third, by fostering better cooperation among Federal agencies with responsibilities for senior health. Center for Medicare and Medicare services, CDC, Administration on Aging, AHRQ and NIH all have important roles to play to ensure that the evidence drives the implementation of effective programs to improve health and prevent disease.

And finally, by balancing the Federal research portfolio better between basic and applied research. Just as we plan retirement security in our investment portfolio, by creating a mix of stocks and bonds and cash, the Nation's science portfolio must also be balanced. Basic discovery research, balanced by research on application, translation and behavior.

The challenge before us is to figure out how to make sure that when medical breakthroughs are made, they get translated at the right time by the right people in ways that are going to make a difference. Because when it comes to health, biology matters and drugs matter and genetics matter, but behavior really matters, and it is not just the behavior of individuals, it is the behavior of individuals, health care professionals and systems.

Thank you.

[The prepared statement of Jessie C. Gruman follows:]

PREPARED STATEMENT OF JESSIE C. GRUMAN, PRESIDENT AND EXECUTIVE DIRECTOR, CENTER FOR THE ADVANCEMENT OF HEALTH

Thank you, Mr. Chairman.

I represent the Center for the Advancement of Health, an independent, non-partisan nonprofit organization funded by the John D. and Catherine T. MacArthur Foundation. The Center promotes greater recognition of how non-biological factors affect health—that is, how what we do, where we live, what we eat, and the resources available to us influence health and illness. The fundamental aim of the Center is to ensure that everything we are learning about health through scientific inquiry —not just physiology and genetics—is translated into policy and practice to improve the health of individuals and the public.

It is this mission that brings me here today. As Dr. Fleming has pointed out in his testimony, no single group of Americans more than the elderly has as much to gain from putting into practice what medical evidence strongly suggests—that behavior matters.

From avoiding risky behavior, to taking your pills on time, to getting appropriate medical screenings, a solid core of evidence exists on how to stay healthy and productive for as long as we can. In the past five years, Congress has doubled the funding for the National Institutes of Health, and the payoff should be seen in dramatically improved health outcomes in the years ahead. Or maybe not.

The investment we have made in basic science will be diluted if we do not translate these advances into use—and use implies systematic changes in the behavior of doctors, health systems and individuals.

Let me give you an example of what I am talking about. Biomedical researchers say that we are on the verge of seeing a new genetic test that will tell people whether or not they will get colon cancer. This development is a triumph of science; for many, it vindicates the nation's investment in discovery research at NIH by promising a tectonic shift in the burden of colon cancer, the cause of 56,000 deaths a year in the United States. But this incredible advance coming from basic science necessitates a more powerful understanding of human behavior if we are to make the best use of it.

From this one new test alone, many new questions will need to be answered to realize the promise of fewer colon cancer deaths. For instance:

1. How do you persuade people to take a test that may indicate with high certainty that they are going to get a deadly disease?
2. What environmental and behavioral factors influence whether people who test positive actually get the disease? And following on that, what lifestyle changes can individuals make to reduce the probability that they would?
3. What programs can we put in place to help people change and maintain those long-held habits?
4. What constitutes good medical care for patients who test positive on this test?
5. How can we ensure that physicians routinely provide such care?
6. What are the implications of this test for insurance generally and for Medicare in particular—to cover the cost of the test, to cover monitoring and to cover treatment for those who test positive?
7. How will we train and deploy a workforce of genetics counselors to introduce the entire U.S. population to the idea that they ought to have a test that may very well change their lives and prospects?

These are questions that will not be answered by geneticists or biochemists or biologists. Rather, they are questions that will be answered by experts in learning, cognition, human factors, organizational development, health services research, epidemiology, economics, psychology and sociology.

Biological science was the basis of developing the test. But that is only the first of several steps required to convert this discovery into an effect on the health of the population. Scientific attention must be paid to changes in the behaviors of patients, doctors, insurers and managed care executives if we are to successfully complete the production arc from laboratory to living room. Without systematic attention to these questions, the most sophisticated genetic test is as useless as a cell phone on the dark side of the moon.

Even time-tested, effective technologies—mammograms and immunizations—are not finding their way often enough to the people who need them. Physicians forget to recommend them, patients don't ask for them, are confused about how often they need them and fail to comply with their doctors' advice to get them. The technology is brilliant but it requires human behavior to make it work.

One recent action by CMS is an important, and unfortunately too rare, instance of attending to the behavior that connects the technology to its target. CMS reviewed the evidence on interventions directed at doctors, health care facilities and individuals to increase vaccine use, and, based on this review, implemented with CDC an effective pilot program in nursing home, creating standing orders to increase the possibility that the right immunizations get to the right seniors at the right time. CMS is proposing to take the next step to facilitate the delivery of immunizations and the use of standing orders in health care facilities.

But behavior doesn't just matter in realizing the health benefits of the clinical preventive services covered by Medicare. There is overwhelming scientific evidence demonstrating the great gains to be had by reducing behavioral risks. Quitting smoking, increasing physical activity and preventing falls, are extraordinarily important but until quite recently have not been viewed by CMS as part of the Medicare prevention mandate.

The new CMS-sponsored stop-smoking demonstration project is the agency's first effort to systematically address a major behavioral risk for disease and disability. And evidence has been gathered on the feasibility of pilot programs to assess risk, prevent falls and better manage chronic conditions. Each of these might have an important role to play in a Medicare program that aims to help Americans live as well as they can for as long as they can.

Mr. Chairman, it would a terrible waste of the nation's health and resources if the knowledge generated by the health research sponsored by Congress sits in file cabinets in Bethesda and is not used to benefit the American public.

The pharmaceutical and technology industries are responsible for bringing some of that knowledge to the marketplace, but they are not responsible for ensuring that what we know about quitting smoking or getting people to participate in screening tests becomes part of routine health care and community services.

There are several ways Congress can act to make certain that we realize the full benefit of our investment in health research. Congress can:

1. *Raise the priority within CMS for addressing behavioral risks in the Medicare program,* for example, by supporting demonstration projects to help seniors increase physical activity, reduce the impact of falls, manage chronic conditions, reduce alcohol and substance abuse and improve nutrition. These risks are critically important for seniors, and their health stands to gain from widespread availability of services to support behavior change to reduce them. We applaud the efforts of CMS to address expansion of prevention efforts to include smoking and other risk behaviors based on careful scientific review. Increased commitment on the part of CMS would expedite program and benefit design and feasibility assessment that would ultimately result in more effective prevention efforts.

But medical care, even with Medicare reimbursement, is neither organized nor equipped to shoulder the entire burden for reducing risk behaviors among seniors.

2. *Foster better cooperation among federal agencies*—CMS, CDC, AHRQ, AoA and NIA—to ensure that evidence drives the implementation of effective programs to improve health and prevent disease. Each agency brings different knowledge and resources to solving the problem of the health of seniors. Each agency is connected to seniors in different ways—through state and local health departments, local senior services or specialized research programs. More frequent communication and stronger collaboration among these agencies would benefit those individuals and families that each of these agencies claim to serve.

But the federal government is by no means the only advocate for the health of seniors, and federal agencies play only a partial role in ensuring that the prevention programs for seniors are widely available.

3. *Encourage public-private partnerships* among federal agencies with responsibility for seniors and the organizations that can act on evidence-based strategies to improve the health of individual seniors in the communities in which they live. The most effective programs will be ones that integrate the authority of health care with delivery capacity of local services that support seniors in living full lives.

4. *Increase the extent to which CMS makes use of evidence on how to overcome behavioral barriers* in implementing preventive services. In implementing standing orders for immunizations, CMS showed that it understood just covering a service as a benefit is not enough; consistent policies and practices are necessary to get the right preventive procedure to be used right. More attention must be paid to ensuring that health care systems, group practices, physicians and other health professionals are encouraged to act on the evidence of the most effective means of ensuring that clinical preventive services reach the right individuals in a timely manner.

5. *Finally, by promoting better balance of basic and applied research in the federal health research portfolio.* Just as we plan retirement security in our investment portfolio by creating a mix of stocks and bonds and cash, the nation's science port-

folio must also be balanced—with an emphasis on application, translation and behavior.

Although it is not the direct responsibility of this subcommittee, I would make the point that while funding for the NIH is going up by 16 percent this year, funding for the lead agency for translating research—AHRQ—is being reduced by 16 percent. I am told that at CDC, less than 1 percent of its budget is spent figuring out how to apply what it spends the other 99 percent learning.

The challenge before us is to figure out how to make sure that when medical breakthroughs are made, they get translated at the right time, to the right people, in ways that will make a difference. Because when it comes to health, biology matters, pharmaceuticals matter, genes matter, but behavior really matters.

Thank you, Mr. Chairman.

Mr. GREENWOOD. Thank you. Appreciate it. All of you.

The Chair recognizes himself for 10 minutes for questions.

Ms. Quirion, you, in your comments, mentioned—sort of referred to the fact that perhaps if you'd had some preventive care early on, or some access to some advice, information, that you might have spared yourself some of—you might have been spared some of what has befallen you.

Ms. QUIRION. I think I would have found out sooner that I had ovarian cancer, and they might have did the surgery very successfully. But because that I didn't have a pap smear, because they didn't pay for them, or annual checkup, I had the pain——

Mr. GREENWOOD. That's what I wanted to get at. You had no idea that you——

Ms. QUIRION. No idea whatsoever. I've always been active, but I had abdominal pain that I knew there was something wrong. So I went to see my doctor right away. She was very alarmed.

Mr. GREENWOOD. Were you going for any kind of regular—you weren't going for regular physicals?

Ms. QUIRION. I go once a year for a checkup, but not a physical because they didn't pay for it. So right away she suspected it wasn't good, and she sent me to all specialists. She called me in her office the next day to tell me that I had ovarian cancer. And there are four stages, and they found out that my stage was 3.2. So it might not have been as serious if I could have detected it before.

Mr. GREENWOOD. And when you said you had an annual checkup, but not a physical, what do you mean?

Ms. QUIRION. Well, they just checked the blood pressure and the blood work for sugar and something like this.

Mr. GREENWOOD. But it wasn't a thorough physical exam?

Ms. QUIRION. No, not a final one.

Mr. GREENWOOD. Let me address a question to Dr. Himes, if I may.

Within the Medicare+Choice program that you work for, what are the utilization rates of preventive services covered—that are also covered by traditional Medicare, like flu and pneumonia vaccine, breast cancer screening, for the Medicare beneficiaries under your care?

Ms. HIMES. We just looked that up because we heard that question earlier. For flu shots, our latest available data is 84 percent; for mammograms, 83 percent; for cholesterol testing, 78 percent for primary and secondary prevention of heart disease.

Mr. GREENWOOD. I'm assuming that those rates are higher than they are for—I don't know if you have that data, but they're higher

than they are for—they sound to be probably much higher than they are for——

Ms. HIMES. For the general community.

Mr. GREENWOOD. For the general community, certainly, for the fee-for-service folks.

Which raises the question, of course, how did you get those rates that high? What do you do that encourages——

Ms. HIMES. We do several things on all kinds of levels. The first is patient education and awareness about all of those things, now on the Web site, but it used to be in a whole variety of ways through pamphlets, through cards that we have people carry around in their pocket that say what adult screening schedules and preventive care schedules should be.

Mr. GREENWOOD. Let me interrupt you for a second. I apologize for doing it, but I want to get something clear.

Ms. HIMES. Please.

Mr. GREENWOOD. Do you have 60,000 lives?

Ms. HIMES. Yes.

Mr. GREENWOOD. How do they compare demographically to the country at large? Do they tend to be—because there's a self-selecting process that goes——

Ms. HIMES. Right. We have a Center for Health Studies Research wing that works with the University of Washington, and—oh, I think two times now, one in the early 1990's and one in the late 1990's—we had CHS do a look at our community, the western Washington area—catchment area and compare Group Health patients, according to chronic disease scores, with our community in general. And it looks like we're about the same. So it doesn't look——

Mr. GREENWOOD. In terms of disease?

Ms. HIMES. In terms of chronic diseases.

Mr. GREENWOOD. But I was referring to——

Ms. HIMES. Oh, I'm sorry. Are you referring to weights?

Mr. GREENWOOD. The demographics—the educational, the income demographics. Do your 60,000 folks tend to be younger, healthier, wealthier, better educated than the average; or do you think that they are fairly much a cross-section?

Ms. HIMES. What we think is, their demographics in general are essentially the same as the community in general. In part, that is because most of our folks, 80 percent of our folks, have been with us forever; and so originally joining the program as young adults, aged into the program. We've been around for 54 years.

So we've had a very stable number of Medicare recipients over the years, and in recent years have added another, oh, 13,000 or 14,000 with the new influx of Medicare+Choice enrollees, but essentially kept our stable population. It appears to reflect demographically, and in terms of burden of illness, our community.

Mr. GREENWOOD. Ms. Quirion, I should point out to you that I believe your Congressman is here, Mr. Allen is here too.

Ms. HIMES. We then have registries that allow us to follow up on immunization registries and general disease registries that allow us to follow up on patients through our primary care practices. So we feed back to our primary care physicians and nurses

on a regular basis four times a year what their rates are for all of these screening tests on mammographies, immunizations, et cetera.

And finally, then, organizationally, we put systems in place to remind patients so that, for example, patients get postcards in the mail to remind them when their mammogram is due; they get postcards about flu shots, et cetera. So there are a whole variety of systems that get put in place.

That is really, in many ways, the benefit of the Medicare+Choice program for us.

Mr. GREENWOOD. Is there a program for—a Healthy Aging initiative, or is that something separate?

Ms. HIMES. It is part of our, in general, preventive health care promotion initiative. I mean, it includes the entire organization, if that is the question.

Mr. GREENWOOD. Okay.

For any of you, I—Ms. Quirion, it was clear to me from your response that you think that if Medicare covered—paid for a regular physical examination, that you would have come in regularly to get them, and that might have spared you a lot of the suffering.

Let me ask the other three of you. You've listened to the rest of this hearing. I'm interested in your views on that very forward and simple question, because as I said earlier, it seems intuitive to me that if Medicare, A, reimbursed physicians for a fairly comprehensive annual physical exam, like most people with good health care plans get, that a lot of—there would be a lot of advantage to that, both in steering people toward screening activities, toward looking at the questions that have been raised here with things like blood pressure, vision, hearing, depression problems, tobacco cessation, dental hygiene, physical activity, fall prevention. All of those things could be part of the questioning process that went on in an annual physical exam, it seems to me.

I don't know in my own mind yet whether I think it actually saves the Medicare program money in the long run or not, but it seems it would promote a heck of a lot of well-being and prevent a lot of suffering.

I'd like your thoughts on that, Dr. Gold, Dr. Himes and Dr. Gruman.

Ms. GOLD. The short answer is yes.

It is interesting. When you look at what the Task Force suggests, they sort of say, every exam should be an opportunity for prevention, and I think that that is great wisdom for a practicing doctor. But I think the reality in today's world is that you're seeing a lot of people who have a lot of difficulties, and to actually seize that opportunity and create that time to spend the time counseling, or to do some of the risk assessment, just doesn't—it gets lost in the shuffle.

Mr. GREENWOOD. And that is true in any—when something is bugging me, when I've got a headache or something is hurting me, and I go see the doctor in the Capitol, he doesn't take that opportunity to ask me 25 questions about the rest of my health care. He gives me what I need, and I'm out of there. And I would assume that is the same with Medicare beneficiaries as well.

Ms. GOLD. I think that is exactly right.

A number of years ago—I was in Washington for a number of years, and we did a study for Health and Human Services that looked at the cost of sort of bundling preventive services into an annual visit, and did some costing out for Medicare; and that might be an interesting report to get to you folks. It really added, at that time, perhaps $18 or $20 a year, as I recall, to the overall expenditure per capita; and that seems like a pretty good deal.

The only other thing I want to say, and it is just sort of a throwaway line, is the notion that prevention should be cost saving is one that really sticks in my craw a little bit. That is not—the design of health care is not to be cost saving. The design of health care is to promote health.

I think the whole notion of cost-effectiveness analysis, which is a different issue—how much health do you buy for the money you invest—is actually a lot more useful way to be thinking about Federal investments.

Mr. GREENWOOD. If I can interrupt you on that, I quite agree with that. It helps, because of the straitjacket of budget tiering around here, if we can show that something pays for itself. So it just makes our life a heck of a lot easier.

But the fact of the matter is that, A, if preventive health care keeps our parents and eventually ourselves happier and healthier and avoids Ms. Quirion's suffering, that is what the whole system is supposed to be there for; and that is justified in itself.

But there are so many other related costs that can be prevented. For instance, wage loss. I mean, you think of how many people are not out in the world earning a living because they've lost their wages. But if Dr. Himes and Dr. Gruman can respond as well——

Ms. HIMES. A couple of points: The first is that, just for your information, we do, of course, pay for—or there is no extra, added expense, except for copay in some cases, and often not that—for a physical exam; and we get 25 percent of our seniors who self-select for a physical every year. So just to let you know in kind of a general way in our population.

But a second part of all of this is this big bugaboo of a question of what is entailed in a complete physical. And that is a very interesting question, and what I would argue here, and the one point I really want to make that I tried to make earlier and made in my written statement, is that what we do know from the literature—and some of this literature, we've contributed at group 2 at Group Health—is that if, as people get older, you focus the preventive care or health promotion visit on the geriatric syndromes that really interfere with functional status and that include physical activity, et cetera, smoking cessation and all of the things we've talked about today—if you focus on those things, rather than distracting your time on the millions of complaints you could possibly talk about, then in only—we have really clear data that in only 6 to 12 months you can make huge decreases in costs, in utilization; so that physicals for seniors, if you will, that are done in the geriatric assessment model really do show very quick results, quicker than any other preventive care work that we do around diabetes or anything else—so something to very seriously take a look at covering.

Thank you.

Mr. GREENWOOD. Thank you.

Ms. GRUMAN. I have two comments, kind of add-on to those. One is that it strikes me that all these questions about a physical exam kind of raise the problem of something that has just been a really important health policy issue for a while, which is what is the role of the primary care physician, and particularly for older people, what is the role of the geriatrician in serving that role of the primary care physician, which is not only to coordinate prevention care, but also, once you find something, to coordinate the rest of the care?

And, you know, this is an issue that managed care tried to kind of manage into place, and I think with not too much success. Raising the capacity of primary care physicians to serve as—in this very care-coordinated role, as well as professional, in a 7-minute office visit has been a really tough thing.

And that actually raises——

Mr. GREENWOOD. Let me interrupt you. What drives—I mean, this is somewhat of a—I think I know the answer to this question, but what drives it to be 7 minutes instead of 20 minutes?

Is it not what Medicare will pay for that?

Ms. GRUMAN. No. I think it probably has more to do with how people are organizing their patients these days; and, you know, probably also how much time they spend complaining about being in managed care programs. You know, it cuts down on the medical visit.

Anyway, I think that it does raise another—two—that kind of raises two other issues. And one is that it is possible that there is a need to really expand the kind of people who deliver those—who help to deliver the kinds of preventive services that we're talking about, primarily if you move into the zone of doing counseling or referring people to other kinds of expertise, for example, with smoking cessation.

I think a more creative approach to what is covered—I mean, is a telephone call covered to coordinate care versus only an office visit? Can Medicare—can CMS support telephone counseling lines and nurse advice lines that would help to cut down on some of the kind of extra time that physicians might take to take care of their patients and to really address all of these preventive issues that are important?

And I think that the final point that your question raises is something that actually came up in your first question. You said something, your first question to the first panel when you said something about, well, you know, if I could just go to the doctor and get my exam, then I would be healthy. And I'd just like to remind us all that going to the doctor and having an exam once a year is not the thing that is going to make us healthy, that that hour is one tiny piece of time when you're under the supervision of a physician, but the things that you do every day—what you eat and how you exercise, or don't—really make much more of a difference than that 1 hour.

So just to kind of keep that in perspective, I think, is important.

Mr. GREENWOOD. Well, I think it is exactly the case. I think what I'm trying to get at is this recurring information that we hear that if you look at the people with the worst health outcomes, they seem to be the ones who are not availing themselves of any of the pre-

ventive modalities—not the screenings, not the—and not the smoking cessation and not the diet and not the activity.

And if you ask, why is that, it seems to me that the recurring answer is—in large measure is because nobody has suggested it to them. Nobody counseled them about it. Nobody pointed them in that direction.

And obviously there are a lot of ways we can try to communicate with these beneficiaries, other than in the doctor's office, but it is just my intuitive sense that having that regular opportunity to know that you can go in and spend some quality time with your primary care physician or geriatrician and cover a variety of issues, it would seem to be a very effective way at steering people to all of these, both tests and behaviors.

Ms. GRUMAN. I think that you're right, that there's an incredible authority that that still resides with physicians and the ability of physicians to use that, to not only say, you know, you need to take these drugs in this way, but also there are other things that you need to be thinking about.

And to help people set priorities is really critically important. I think there need to be other ways of linking that advice to individuals—individuals to services in the community, that it's not just—it can't just be a one shot, gee, I think you should stop smoking, and not be able to give people other ways to kind of act on that advice.

Mr. GREENWOOD. Thank you.

The Chair recognizes the gentleman from Kentucky, Dr. Fletcher, for 10 minutes.

Mr. FLETCHER. Well, thank you, Mr. Chairman, and I thank the panelists. I wasn't here for all of it; I had some constituents come to visit. But again, thank you for your testimony.

One of the things—let me address this to—I think, Dr. Himes, you talked about physical fitness, and I know we have referenced here the New England Journal of Medicine. There was a study that was reported in the New England Journal of Medicine that talked about poor physical fitness as an indicator of poor outcomes and even a stronger indicator than some of the other things we usually look at—whether it is smoking or some of the other high potential for risk things.

And I know you mentioned in the Medicare+Choice—are there plans that provide for physical fitness, and what can we do, and what are the roadblocks that we face here in, say, in the typical Medicare fee-for-service from trying to put more emphasis on the physical fitness programs?

Ms. HIMES. The literature clearly shows that if you look at all of the indicators or all of the things that we commonly think of as screwing up people's lives as they get older, that physical fitness, on the very positive side, is the one thing that statistically, significantly is relevant in terms of positive health care outcomes for all seniors, if you look at the entire Medicare population.

The only other thing that is statistically significant actually is social isolation on the very negative side.

So physical activity then becomes a real mainstay. It is the biggest bang for the buck, as I personally look at it, individually for my patients and for others.

The question then becomes, what do we do about that as an organization? If I look at Group Health's 60,000 seniors, what do I say we're going to do about that? In the—for us, once we understood that literature base, we then went on to look at, okay, what kind of exercise is the most important? It turns out that not only aerobic or endurance exercise, but muscle-strengthening and flexibility is really important. And it also turns out that actually, as with everything, people who are the most disabled or the most frail are the folks who have the most to benefit.

So in looking at those populations, then how do you develop exercise programs that health care organizations can sponsor to send people to? Because you're exactly right, if you don't have programs to send people to, I can talk until I'm blue in the face to an individual patient in my office about starting to exercise, but if I don't have some specific ways for that person to exercise, especially the more disabled they are, it rarely does any good.

So we developed a program called the Lifetime Fitness Program, which we actually just finished doing some outcome studies around, and showed about a 20 percent decrease over 1 year for a Lifetime Fitness participant as compared to our senior Medicare population in general, in terms of both overall costs and health care utilizations. And 3 or 4 years ago, we decided that we would start to cover as a Medicare benefit some exercise programs.

We contracted with local health clubs for a program called Silver Sneakers, and with local senior centers for our Lifetime Fitness Program and started to offer those two programs as benefits for our Medicare recipients. Since that time, I've sent a lot of my—I write prescriptions for patients, and I send a lot of my patients to those programs.

A lot of folks won't go, especially my most disabled people, so I started a program, actually in my own clinic just for my folks, to see what would make a difference for them and what would get them to exercise; and we just made a video of these guys there called "The Dancing Ladies and Their Few Good Men," and they've become an inspiration to many people. So we are making a home exercise video.

So I think that bottom line here is that health care organizations, Medicare—Medicare programs in general need to be promoting, but not only promoting, really developing and sponsoring physical activity programs for the entire range of folks, whether they live in nursing homes, whether they live at home, whether they can go to a health club, or whether they live in an assisted living facility. We need to figure out ways to get people exercising across the board.

And just for you all's information, there is a brand-new effort that has just started called the "National Blueprint on increasing Physical Activity in Folks 50 Years and Older," that is sponsored by the Robert Wood Johnson Foundation and the CDC. And we are going to make a difference.

Mr. FLETCHER. Okay. Thank you.

Let me ask, one of the—you know, in my practice, one of the problems I had—and the chairman mentioned this. When a patient comes in with an acute problem, the last thing they want to hear is a lecture on probably something else, because they are not feel-

ing well, they've got a problem, their family is concerned about that, and it's just—you know, not now, this is not the time.

So I think the utilization of a lot of extenders, or other individuals that can help in the educational process, is very important. Physicians do, and studies seem to have a certain degree of credibility that is very important to emphasize those things.

One of the things that we were never able to implement—and I'm very interested in what I call e-medicine—is the fact of having information come up that's specific for the patient, based on evidence, but additionally in what's probably considered some of the best practices, so that that pops up electronically to provide information to the patient, can be some reinforcement.

And Dr. Gruman, let me ask you, what work is being done in that regard? And what can we look forward to, or some of the things we could do in Medicare to help implement some tools for practitioners to really start putting a greater emphasis on prevention?

Ms. GRUMAN. I think there's a tremendous amount of work that is being done to try to develop different technologies, using the Web, using various kinds of search engines to find the best—to match the right information to the right person at the right time.

Right now, there's a bit of a forest-and-the-trees problem in that consumers have one sense of what information they need and how to set the sort—set the—kind of the filter; and physicians have another—another set of concerns that may—in many cases, includes keeping a lot of that information out of the physician-patient relationship because it's just too confusing. They'd much rather have the old-fashioned relationship, where physicians get to tell the patients what to do and what not.

So I think we actually are in a time of great change right now. I think that—in terms of the Medicare program, I think that looking at the range of ways that patients can interact with authoritative sources and ensuring that those authoritative sources really are good and having some flexibility about how those things are covered and what kind of access people have is really important.

For example, I know that the demonstration project on smoking cessation that CMS is going to be sponsoring features a 1-800 QUIT LINE; and, you know, if they can generate enough demand through physicians telling their patients that they should stop smoking and that they should use this, that could be a really wonderful extender.

I think that there are lots of other kinds of technologies that are available, like that, that just—that really haven't—haven't even really been considered. Because no one has really said to CMS, you know, you've got to figure out a way to help physicians use their time better; and what are the central things that we could support, we could control quality on, that wouldn't involve kind of licensing a whole other guild to deliver services, but would in fact serve to make accessible to individuals information that they need in order to stay healthy?

And I think kind of liberalizing, or asking CMS to really look at some of those technologies, would be a really wonderful thing.

Mr. FLETCHER. Thank you.

Ms. Quirion, you mentioned that if some of the preventive measures would have been available and paid for and things, that it would have helped you tremendously.

One of the things I noticed—or one of the things in my experience—it's probably been presented here in the last couple of panels—is, it's extremely difficult to get information out to the general population on the importance of prevention in a way that will spur them to actually act in common and do something about it. And I wondered, since you represent a lot of folks on behalf of this—a lot of retired Americans, what can we do?

And let me just throw out something. You know, when we go get a driver's license, there are certain things we have to know before we get the privilege of driving on the roads. What can we do to make sure that there is some personal responsibility here for seniors, but we do what—through Medicare, whatever, to make sure that there's a certain educational level regarding the prevention and their responsibility for the health care, to make sure they get there?

I'm just wondering if you have any ideas on that for us.

Ms. QUIRION. Well, all that they say here is true, about smoking and drinking, and that's something I've never done. And I exercised, and I worked. After I stopped working and I retired, I took another job, a second job, and I've been working hard for 12 years. So I did all those things.

I try to eat well. But that did not prevent the fact that if I would have had a physical, anything like this, it would have prevented it from being—being in the state that I was, and I would have had a better chance really of recovering better from this. I might have had the surgery, no chemo.

And there's a lot of people that die of those things, and I think never even know what they have. They don't tell their physician the reason—I went there because I started to have abdominal pain, and I knew that there was something wrong, but some don't do that. They just—once they discover it, it's too late for them, period.

Mr. FLETCHER. Dr. Gold, would you have some comments on that, as far as educating the general population and the responsibility there that might be included in some Medicare programs, whether it's some educational things that encouraged or incentivized or required?

Ms. GOLD. It's interesting. I've been thinking about incentivizing, but I've been thinking about it in a slightly different way. I was thinking about the UK experience where physicians are actually incentivized to deliver preventive services, so in your panel you get paid your per capita rate.

But if you can bring more people in for preventive services because that is seen as a social good—which, I would argue, is the same in the United States as in the UK—it might be worth thinking about setting priorities of clinicians and physicians more toward prevention.

Medicare has been sort of heavy-handed in the way it reimburses for technological procedures, and so light-handed in the way it deals with the sort of less technological and more behaviorally based kinds of things. So that is one reflection.

The other thing I would say, having spent my clinical career really serving low-income populations—first, rural and now, urban—some of the notion of education, I think, is a tricky one. You know, how many lower-income Americans sit in their living room with computers? How many less-educated people, you know, have had that benefit? You know, 30 years from now, we may be fine, but that is not where we are now.

And I think that there is something else also about health which is very intimate, and the whole notion of the relationship one develops with a primary care provider and the sort of power-of-the-profession thing is a real one, and so it is fine. I mean, I think it's enhancements you plug into your computer, and up comes your—you should do this thing. But the reality is that a lot of people are pushed toward taking action because somebody is concerned about them and makes a specific, tailored point about them, the individual.

Mr. FLETCHER. So let me sum up. Do you think something where incentivizing the providers or the physicians is going to have a greater impact than a direct response to the general population; for example, making sure that there's—that they become familiar with preventive measures that have been shown to be effective?

Ms. GOLD. I think that would be a great thing, and I think that particularly in underserved populations or underinsured populations, where there's an excess of morbidity anyway, when the patients are coming in, you're sort of riveted on the diabetes out of control, the hypertension out of control. To get those practices and those doctors to find ways—innovative ways, different programs at the grass-roots level that bring people in—takes some extra work on the part of those organizations and those providers; and I think if you can build in that kind of incentive, that is a great policy piece to think about.

Mr. FLETCHER. Thank you. My time has expired.

Mr. GREENWOOD. We thank the gentleman.

And I think—ultimately, as I grapple with this issue, I think you need to have incentives for the provider. I think you have to pay providers a decent reimbursement for a good, thorough examination, and I think that we need to think of the incentives for the patients.

I mentioned earlier—you know, I'm just playing around with these thoughts—but whether your premium changes or you lose—you have a benefit in terms of a deductible for hospitalization because you've avoided hospitalization by doing certain things, I think you can keep it pretty simple and figure out some ways to attract people in to get these exams.

Let me just—one final question. And we've covered the fact that we all think it is in the best interest of us as a society, out of just pure compassion and quality of life, to do these things so that the people live longer, healthier, happier lives; but we do have to, here in Washington, deal with this darn issue of cost effectiveness and does it save us money in the long run.

It seems that there is a dearth of really good information on that subject and it is shocking to me. It is shocking to me that not CMS, not CDC, no one has really been able to say, yes, this is such an obvious question, it has been asked a thousand times and the an-

swer is very clear with regard to how preventive services do or do not save dollars, and how to maximize that.

My question is: What do you think we ought to do about this dearth of knowledge? Is this something that the CMS ought to be tasked to, in a very comprehensive way with supercomputers, be gathering all of this information from the field and doing longitudinal studies; or do you think we need to pay for somebody like the Academy of Sciences or GAO to do a massive study? Is the data all sitting there and we just need to collect it from insurance companies? What do you think we ought to do so we can be real smart about this question of cost effectiveness?

Ms. GOLD. Let me go back to this whole notion of the continuum between primary, secondary, and tertiary prevention. Tertiary prevention is real treatment.

One question which arises when beginning to scrutinize everything in terms of its cost effectiveness is will you do everything; and the answer is you can never do everything because it would take a lot of person-power hours. The analytic piece itself would be challenging. There are lots of procedures that we do in medicine which have been grandfathered and grandmothered in. We will never really know how effective they are. They just sort of state what goes on.

I am very much a proponent of thinking about how effective what we do in medicine is. Evidence-based medicine has been extremely helpful to me on a personal practitioner basis and also in the teaching that I do.

I do think that incorporating the cost piece is really important. There have been some sort of major breakthroughs in standardization of cost-effectiveness analysis over the last several years. I think in reality many of the Federal agencies are not adequately funded to be able to incorporate some of those kinds of evaluations. If there were a concerted effort from the Congress to say we really would like to know as we begin to grow the Medicare program in different ways, what the health effect we are getting for the investment is, that would be an extremely large contribution to sane policymaking.

Again the problem we have to solve is to think smartly about what set of services we are going to put that charge around, and how are you going to make those decisions. We can look at top medical conditions for which Medicare is paying, and say is there effectiveness information? I think it is a large charge. I think it is a very, very important one, but will be a difficult one to figure out exactly how you want to approach.

Ms. HIMES. I think there are two issues. Essentially one is, what is good preventive care? Coming up with that idealized model, if you will, of what we want to be telling seniors or docs that they should be doing for seniors in the preventive care mode is essential. I don't think there is clear agreement on that, overall, at this point in time. There is lots of individual evidence around individual preventive measures but I think you are right, the overall piece is not there.

Then my personal bias is that CMS and Congress ought to sponsor a series of demonstration projects to just look very, very clearly at how can systems do this. In my own system the question of our

network model versus our group model, where we have got physicians out there in the world who have very few group health practitioners and other physicians who contract exclusively with group health, we have learned a lot from those two separate models. We focus much more on patient education in that external world; much more on physician education, and patient, in the internal world.

So I think a series of demonstration projects really looking at what is good preventive care, No. 1, and then how do you put it out there. And what, not only money does it save, but what changes does it make in the quality of life of folks.

Ms. GRUMAN. I think it is a really interesting question that you would raise, and especially the assumption that someplace out there, there should be all of this information. It is not like prevention is just a new thing that we do not know anything about.

I think this goes back to a point that I made earlier which is that the NIH budget for this year is $23 billion; and the budget for the Agency for Health Care Research and Quality, which is the federally mandated organization whose role it is to translate research into policy and practice, has a budget of $307 million. That is slightly over 1 percent of the NIH budget.

We have this huge bonus of new science coming down the pike, and we don't even know what the right preventive services package is. I think we need to really think about balancing the research portfolio so that some of these questions can be answered, and not just for the Medicare population. These are questions that really need to drive health care generally in this country.

Mr. GREENWOOD. Okay. I want to thank each of you, particularly you, Mrs. Quirion, for your courage in being with us. We will take your words to heart.

I thank each of you for your testimony, and the hearing is adjourned.

[Whereupon, at 1:20 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF THE AMERICAN HEART ASSOCIATION

Mr. Chairman and distinguished members of the Subcommittee on Oversight and Investigations: The American Heart Association commends you for holding this hearing entitled *"Assessing America's Health Risks: How Well Are Medicare's Clinical Preventive Benefits Serving America's Seniors? How Will the Next Generation of Preventive Medical Treatments be Incorporated and Promoted in the Health Care System?"* on May 23, 2002. The Association presents to the subcommittee the following statement, and we appreciate the opportunity to be heard on this important topic.

The American Heart Association works to reduce disability and death from heart attack, stroke and other cardiovascular diseases through research, the development and distribution of consumer education materials, and grassroots advocacy. The American Heart Association currently spends over $380 million of its own resources annually on research support, public and professional education, and community programs. The Association does not accept government funding.

Nationwide, the organization has grown to include more than 22.5 million volunteers and supporters who carry out its mission in communities across the country. The Association is the largest nonprofit voluntary health organization fighting heart disease, stroke and other cardiovascular diseases, which annually kill about 960,000 Americans.

Heart disease, stroke and other cardiovascular diseases have been America's number one killer since at least 1919, and today these diseases account for more than 40 percent of American deaths. These conditions are a major cause of disability as well. Heart disease alone, for example, is the major cause of premature, permanent

disability of American workers and accounts for nearly 20 percent of Social Security disability payments.

Nationwide nearly 62 million people, or 1 in every 5 Americans, live with one or more of these diseases. Both genders and all age groups suffer from these diseases, and in many cases, cardiovascular diseases strike down otherwise healthy individuals for reasons not yet fully understood.

Tens of millions of Americans have major risk factors for these diseases that can be modified with appropriate interventions: an estimated 50 million have high blood pressure, more than 41 million adults have elevated blood cholesterol (240 mg/dL or above), 48 million adults smoke, more than 108 million adults are overweight or obese and nearly 11 million have physician-diagnosed diabetes. Clearly, as the "baby boomer" generation ages, the number of Americans afflicted by these often lethal and disabling diseases will increase substantially.

What is perhaps most shocking is the cost of cardiovascular diseases. These conditions cost Americans more than any other disease—an estimated $330 billion in medical expenses and lost productivity in calendar year 2002 alone. Three of the top five hospital costs for all payers (excluding childbirth and its complications) and three of the top five Medicare hospital costs are cardiovascular diseases.

While the American Heart Association strives to find breakthroughs in the *treatment* for these conditions through our support of research, the organization is also devoted to the *prevention* of cardiovascular diseases as well. We strongly believe that mortality rates can be drastically lowered, and disability from cardiovascular diseases can be greatly reduced through scientifically proven prevention methods.

Congress has discussed preventive measures in recent months and has passed many into law in recent years. While the Association supports breast, vaginal, prostate and colon cancer screenings, glaucoma screenings, bone mass measurements, pneumococcal and influenza immunizations, and all of the other preventive measures that Congress has enacted on behalf of Medicare beneficiaries since 1981, none of these measures focus on the number one and number three killers in the nation—heart disease and stroke.

Periodic cholesterol screenings, healthy diets combined with even moderate amounts of exercise, and kicking the cigarette habit for those who smoke have all produced dramatic results. It is important to note that scientific studies have shown these results can be achieved in both young and elderly individuals alike, and that it is never too late to have an impact on your long-term health outcomes through preventive measures.

CHOLESTEROL AND LIPID SCREENING

Perhaps the best example of a preventive benefit that Congress should add to the Medicare Program as quickly as possible is coverage for periodic screening of cholesterol and lipid levels. The American Heart Association urges Congress to add coverage for this important preventive test. Consider the following:

- In separate federal initiatives conducted by NIH and AHRQ (discussed below), both agencies published recommendations over a year ago stating that all elderly Americans should undergo periodic screening of their cholesterol and lipid levels.
- In relation to other health care costs and preventive benefits, the annual cost of adding this coverage to the Medicare Program would be relatively modest (even without considering the potential financial savings of preventing acute events such as heart attacks and strokes).
- Cholesterol screening is becoming more widely recognized by Americans as an important aspect of basic health care, and as such, Medicare coverage of cholesterol and lipid screening would be meaningful to Medicare beneficiaries.

The need for covering cholesterol and lipid screening as a preventive service under Medicare has never been clearer. In May of 2001, *two separate panels from the National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality (AHRQ) concluded that elderly individuals of all age ranges can substantially lower their risk of heart attack by aggressively treating abnormal cholesterol and lipid blood levels.* Previously, these agencies had established upper age limits within their federal cholesterol screening guidelines, but they changed these recommendations last year in the face of overwhelming scientific evidence. Nonetheless, although these federal recommendations highlight the importance of cholesterol screenings for elderly patients, many Medicare beneficiaries are not able to benefit from these simple tests under current Medicare coverage policy.

Currently, Medicare beneficiaries are only covered for cholesterol and lipid testing if they already suffer from known illnesses such as heart disease, stroke, diabetes or other disorders associated with elevated cholesterol levels. In many cases, seniors

eligible for these tests are already victims of a condition cholesterol screening might have caught and helped prevent. By adding cholesterol screening as a covered benefit for ALL seniors enrolled in the Medicare program, Congress will enable Medicare beneficiaries and their physicians to learn of otherwise silent problems and seek appropriate treatment in advance of a disabling or deadly event. This will help drastically reduce the number of cardiovascular disease and stroke deaths each year and will greatly reduce the number of individuals disabled by these conditions.

With this in mind, the American Heart Association is leading an effort to enact H.R. 3278 and S. 1761—The Medicare Cholesterol Screening Coverage Act of 2001. We ask that your committee consider these bills as you investigate Medicare's preventive benefits. Congressmen Dave Camp (R-MI) and William Jefferson (D-LA) introduced this important bill in the United States House of Representatives late in 2001. Senators Byron Dorgan (D-ND), Ben Nighthorse Campbell (R-CO) and Jeff Bingaman (D-NM) introduced a companion bill in the United States Senate. This legislation will guarantee Medicare coverage of preventive screenings for cholesterol and other lipid levels.

SMOKING CESSATION COUNSELING

As the nation's largest health care purchaser, the federal government has a vital role to play in promoting effective, affordable tobacco use cessation services. Research consistently has shown that smoking cessation saves lives, reduces smoking-related health care costs, and is one of the most cost-effective health interventions available. Unfortunately, some government financed health care programs, including Medicare and Medicaid, do not provide reimbursement for some of the most effective smoking cessation treatments recommended by the Department of Health and Human Services' Clinical Practice Guideline for treating nicotine addiction. The facts supporting expanded coverage of effective smoking cessation treatments are compelling.

Tobacco use is our nation's number one cause of preventable death. Tobacco use causes more than 400,000 deaths each year among smokers and contributes to profound disability and pain in many others.[1] About half of all long-term smokers die prematurely of diseases caused by smoking.[2] The U.S. Surgeon General has concluded that reducing tobacco use is the *single most important action* this nation can take to reduce death from heart disease and other chronic diseases.[3]

Tobacco users would like to quit but success rates are low. Approximately 50 million Americans are now addicted to tobacco products.[3] More than 70 percent of all smokers report that they would like to break their addiction, but have not been able to do so.[3]

Effective, therapies exist to double or triple successful quit-rates but these life-saving measures are significantly underused.[4] Research consistently demonstrates a sharp increase in successful tobacco cessation among smokers who seek assistance. In general, those who receive no assistance are about twice as likely to fail in their quit attempts. When optimal professional counseling and smoking cessation drugs (nicotine replacement therapy and/or Zyban) are combined, success rates can triple.[4]

Smoking cessation is extremely cost-effective compared to health interventions already covered by public and private health providers. Smoking cessation coverage has been found to be more cost effective than many widely accepted reimbursable medical interventions.[4] For pregnant women, smoking cessation interventions result in fewer low birth weight babies and perinatal deaths, fewer physical, cognitive, and behavioral problems during infancy and childhood, and also yield important health benefits for the mother.[4] Providing both counseling and smoking cessation drugs is significantly more cost-effective than providing either treatment alone because a much higher percentage of patients will successfully quit using the combined ap-

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[1] U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General.* Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000.

[2] Peto R, et al. *Mortality from Smoking in Developed Countries, 1950-2000.* New York, NY: Oxford University Press, 1994.

[3] U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General.* Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000.

[4] Fiore MC, Bailey WC, Cohen SJ et al. *Treating Tobacco Use and Dependence. Clinical Practice Guideline.* Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000.

proach.[4] Over a five to six year period, smokers experienced 30 to 45 percent more hospital admissions than former smokers.[5]

Congress should act now to promote effective tobacco use cessation therapies. The American Heart Association favors reimbursement of tobacco use cessation treatments as part of all health care programs, including those financed by the federal government.

Immediate priorities for congressional action include:

- Adding a smoking cessation counseling benefit for all Medicare beneficiaries and ensuring that any prescription drug benefit for Medicare beneficiaries includes coverage of smoking cessation drugs. Smoking cessation provides significant health benefits for smokers of all ages.[4]
- Providing prescription and non-prescription smoking cessation drugs in the Medicaid program. Current Medicaid law allows states to exclude FDA-approved smoking cessation therapies from coverage. Moreover, less than half of the states provide coverage for smoking cessation products in their Medicaid program even though the states won $246 billion over the next 25 years from the tobacco industry in 1998 settlements of Medicaid claims. Full coverage of smoking cessation is urgently needed by the Medicaid population, which bears a disproportionate burden of the death and disease caused by tobacco. About 57 percent of Medicaid recipients are current or former smokers.[6]
- Clarifying that the maternity care benefit for pregnant women in Medicaid covers smoking cessation counseling and services. This is critically important for the health of the mother and child. Women who stop smoking before becoming pregnant or during the first trimester of pregnancy reduce their risk of miscarriage or of having a low birth weight baby to that of women who have never smoked.[4] A counseling benefit is essential because use of smoking cessation medications may not be appropriate for this population.
- Ensuring that the Maternal and Child Health (MCH) Program funds may be used for smoking cessation counseling and medications, and that smoking cessation is considered part of quality maternal and child health services.

These proposals are based on the June 2000 clinical practice guideline for treating nicotine dependence, which represents the state of the art in tobacco use cessation.[4] These proposals focus exclusively on improving delivery of effective tobacco use cessation through existing health programs and are contained wholly or in part in H.R. 3676, the Medicare, Medicaid, and MCH Tobacco Use Cessation Promotion Act of 2001, sponsored by Representatives Mary Bono and Diane DeGette. Companion legislation was introduced in the United States Senate (S. 622) by Senator Richard Durbin.

Costs for these benefits would be modest. For instance, ensuring that Medicaid recipients have access to proven smoking cessation drugs would cost $200 million over 10 years, according to a 2000 estimate by the Office of Management and Budget.

DISEASE MANAGEMENT AS AN APPROACH TO CONFRONTING CHRONIC ILLNESS

The incorporation of disease management benefits into the Medicare program may improve health care quality for Medicare beneficiaries as well as contain costs. Disease management is a promising and evolving approach to confronting the challenges represented by chronic illness. As government, health plans and clinicians have adopted disease management models to fit their own needs and goals, the various meanings of disease management have evolved and diversified. In practice, it can cover a range of potential activities, from distributing pamphlets to patients instructing them on self-management techniques related to their particular condition to relying on a case manager to develop patient-specific care plans.[7] Although the term is widely and inconsistently used, all disease management programs share the common goal of improving quality of life and care outcomes for people with chronic illness.

Increasingly, disease management is being offered as an approach to health care management in the public and private sectors. Hundreds of so-called "disease management programs" exist for a wide array of chronic illnesses, including congestive heart failure, diabetes, asthma and depression. Federal agencies are currently eval-

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[5] Wagner, EH et al. "The Impact of Smoking and Quitting on Health Care Use." *Archives of Internal Medicine,* 1995;155:1789-1795.

[6] Harris JE. Written Testimony Before the Senate Judiciary Committee Hearings on the "Proposed Global Tobacco Settlement: Who Benefits?" Washington, D.C., July 30, 1997.

[7] Jeff Tieman, *Disease Management Making a Case for Itself Clinically and Financially,* Modern Healthcare, July 9, 2001.

uating the cost effectiveness and patient outcomes of programs that rely on disease management techniques to deliver patient care; a number of states are offering disease management services through their Medicaid programs; key members of Congress are introducing legislation to fund new disease management initiatives; and pharmaceutical benefit managers (PBMs) are contracting with states to provide disease management services through pharmaceutical assistance programs for seniors.

The American Heart Association finds the concept of disease management promising, but also urges the Subcommittee to consider two issues—

(1) any quality standards or performance measures for cardiovascular disease and stroke must be based on appropriate, objective and scientifically-derived evidence-based guidelines; and

(2) quality of care must be prioritized over cost-containment or other financial incentives in all disease management initiatives. Disease management should be primarily about improving patient outcomes and only secondarily about cost containment.

For disease management to truly put patients first, clinical guidelines must rely on a template that emerges from medical community consensus. For example, appropriate clinical guidelines for some disease states may require minimum staffing levels. Additionally, appropriate disease-specific programs should reach low-risk patients as well as high-risk patients to best serve long-term health needs. In short, to focus on appropriate patient-centered clinical guidelines, medical community standards must serve as the fundamental framework for any disease management program that hopes to draw widespread approval and acceptance.

In addition to the use of appropriate clinical guidelines, it is critical to ensure that disease management programs are driven by the clinical needs of patients rather than mere cost containment or financial profit. While we recognize the need for cost containment and careful allocation of health care resources, the improvement of quality care must be the primary goal of any disease management program.

The American Heart Association is at the forefront of investigating ways to improve the quality of care for patients with cardiovascular disease and stroke. We have developed and are currently operating a number of patient-centered programs. In essence, our existing programs, when viewed together, represent a form of disease management. We are extremely proud of the process through which our guidelines are developed and place great emphasis on ensuring objectivity and sound science.

Our work on disease management is ongoing. We are currently reviewing various models of disease management, particularly in the area of cardiovascular disease and stroke. We are analyzing the effectiveness of these models and hope to use this information to refine our current programs and efforts, if needed. The American Heart Association considers disease management an important and timely issue and looks forward to working with Congress as it continues to consider the appropriate integration of disease management into the Medicare program.

The American Heart Association is eager to work with your subcommittee, with others in Congress, and with the Administration as you work on these and other health care reforms. We invite you to call upon our organization for any assistance you may need in these endeavors. The Association feels strongly that Congress should enact changes to Medicare and other federal programs that are based on sound science, honor good medical practices, and are meant to provide patients with the best possible care.

Again, we commend the subcommittee for holding this hearing and greatly appreciate the opportunity to comment on a few of the items we feel will greatly improve the clinical preventive benefits received by the over 40 million seniors currently enrolled in the Medicare program.

PREPARED STATEMENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

The College of American Pathologists (CAP) is pleased to submit this statement for the record of the Subcommittee on Oversight and Investigation's hearing on issues associated with Medicare's Clinical Preventive Benefits. The College is a medical specialty society representing more than 16,000 board-certified physicians who practice clinical or anatomic pathology, or both, in community hospitals, independent clinical laboratories, academic medical centers and federal and state health facilities.

The College is aware that much has been learned about providing a robust approach to quality health care for seniors since 1965, when Congress created the Medicare program and chose not to include coverage of preventive benefits. Preventive services have become a cornerstone of quality, cost-effective health care delivery

and should be readily available to our nation's seniors. A specific example of where Medicare falls short on prevention is the need for all women who are or have been sexually active to have an annual Pap test and pelvic examination. Medicare lacks such coverage for many women in the program.

Medicare provides annual screening Pap test coverage only for women defined by the program as being at "high risk" of cervical cancer. To help women understand Medicare coverage policies for the Pap test, the Centers for Medicare and Medicaid Services offers a 14-page brochure. But this well-intentioned document is complicated and confusing. Given this approach, it's not surprising that many Medicare beneficiaries are not utilizing this valuable service. Simply adopting an annual Pap test coverage policy for Medicare would go far toward clearing up this confusion. Physicians, in consultation with their patients, should decide how often to perform this test and not be restricted by anything less than annual Pap test coverage. Reasons for this are detailed below.

No cancer screening test in medical history has proved as effective for early detection of cancer as the Pap test. Since the introduction of the Pap test shortly after World War II, death rates from cervical cancer have decreased 70 percent in the United States. But despite the test's unparalleled record of success, thousands of American women still fail to have an annual Pap examination. It is sad to note that of those women who die of cervical cancer, 80 percent had not had a Pap test in the five years preceding their deaths, studies show. The benefits of annual Pap tests are clear: A 1999 report from the Agency for Healthcare Research and Quality (AHRQ), titled "Evaluation of Cervical Cytology," showed that the lifetime number of cervical cancer cases decreases from 506 to109 in a cohort of 100,000 women with annual Pap test screenings and cervical cancer deaths decrease from 116 to 21 with annual Pap tests. The report concluded that annual Pap tests could result in 65 percent fewer cervical cancer deaths compared with screenings once every two years.

Access to annual Pap tests is particularly important to women in the Medicare program. The 1999 AHRQ report revealed that 40 percent to 50 percent of all women who die of cervical cancer are older than 65.

Recognizing the limitations of Medicare's coverage policy and the importance of annual Pap tests, the College has called for annual screening Pap test coverage under Medicare. Congress responded by passing the "Medicare, Medicaid and S-CHIP Benefits Improvement and Protection Act of 2000" (BIPA), which, last year, improved Medicare's coverage of Pap tests and pelvic and clinical breast examinations from once every three years to once every two years for all women in the program. While BIPA did much to expand Medicare access to the Pap test, it fell short of ensuring that all women beneficiaries have access to the test on an annual basis.

The College believes that lack of Medicare coverage for the annual screening Pap test often precludes early detection and diagnosis of disease and results in greater costs to the Medicare program for treating serious medical conditions that could have been prevented. The College is now supporting legislation that would provide annual coverage for the screening Pap test and pelvic examination. The "Providing Annual Pap Tests to Save Women's Lives Act of 2001" (H.R. 1202, S.258) would establish an annual Pap test benefit for all women in Medicare. Passage of the bill is crucial to preventing death and disability among America's elderly women.

The College thanks the subcommittee for the opportunity to present its views on this important issue and offers its support and continued assistance as Congress works to improve women's health.