ELIMINATING BARRIERS TO CHRONIC CARE MANAGEMENT IN MEDICARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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U.S. HOUSE OF REPRESENTATIVES

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THURSDAY, FEBRUARY 25, 2003

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 4:10 p.m., in room 1100, Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 19, 2003
No. HL–2

CONTACT: (202) 225–3943

Johnson Announces Hearing on Eliminating Barriers to Chronic Care Management in Medicare

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on eliminating barriers to chronic care management in Medicare. **The hearing will take place on Tuesday, February 25, 2003, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 4:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include academics, health providers, and representatives from health plans with experience in disease management. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Americans are living longer due in part to advances in medical procedures and technologies. However, many Americans are living with serious, chronic illnesses, such as hypertension, asthma, diabetes, and heart disease. The Robert Wood Johnson Foundation estimates nearly half of all Americans are living with a chronic disease.

According to a January 22, 2003, Health Affairs article "Confronting the Barriers to Chronic Care Management in Medicare," approximately 78 percent of beneficiaries have at least one chronic disease, while 32 percent have four or more chronic conditions. Individuals with multiple chronic conditions are more likely to be hospitalized, have more physician and home health visits, and fill more prescriptions for drugs. Nearly two-thirds of all Medicare spending is for beneficiaries with five or more chronic conditions.

Such increases in spending often do not translate to better quality care. Medicare is payer of bills when seniors get sick. Medicare does not help them manage their chronic diseases to stay well. Some beneficiaries receive conflicting advice on their conditions, receive duplicate tests or are given conflicting prescriptions, or experience unnecessary hospitalizations or unnecessary pain.

Most integrated plans utilize disease management specialists to focus on enrollees with chronic diseases. Health care policy experts advocate early identification of patients at risk, treatment planning with a clear understanding of provider and patient roles, and patient self-monitoring and follow-up to improve health outcomes. Without a change in the law, however, traditional fee-for-service Medicare cannot evolve with these advances in the health delivery system.

For more than a decade, the Centers for Medicare and Medicaid Services (CMS) has run demonstration programs in the Medicare program, particularly for high cost or especially frail seniors. The CMS is currently managing more than a dozen demonstration programs on disease and case management.

In announcing the hearing, Chairman Johnson stated, "Medicare beneficiaries with chronic disease should benefit from advances in care management and ad-

vances in the science of medicine. It is unconscionable Medicare cannot incorporate these changes automatically. We need to explore and implement alternatives that provide the best care to seniors and disabled beneficiaries who are the most ill."

FOCUS OF THE HEARING:

The hearing will focus on the health benefits and cost saving potential of case and disease management programs.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, by the close of business, Tuesday, March 11, 2003. Those filing written statements that wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the Subcommittee on Health in room 1136 Longworth House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse sealed-packaged deliveries to all House Office Buildings.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, in Word Perfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Any statements must include a list of all clients, persons, or organizations on whose behalf the witness appears. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman JOHNSON. Good afternoon. The hearing will come to order. I apologize for the slightly late start, but it is unusual to hold hearings on a Tuesday afternoon for just this reason. There is so much business before the Committee, we did need to have this on a Tuesday. I understand Mr. Stark is literally on his way, and since he does not need to hear my opening statement, I am going to go ahead and start. He will make some comments when he arrives.

Today's hearing focuses on the important subject of chronic care management and its potential to improve healthcare and reduce costs in the Medicare program. This is not rocket science. I mean, it is incredible that this is the first hearing that we have really held on this issue. We held one on disease management a year ago, but that is kind of a subset. It is true that things have to develop

to a certain point in the real world before government can actually see and deal with them. This is a very important hearing, because we will pass a Medicare bill, and we must prepare Medicare to serve our seniors in the future and provide them with the quality care as well as affordable care that they desperately need. They are living longer. They are living with multiple chronic illnesses, and some of you would attest to that in your testimony, so I am just going to skip over that.

I do want to remind us all of the very sobering fact that the Medicare population will double in the next 27 years. From 35 million to 71 million seniors by 2030. Of our current adults, 84 percent have 1 or more chronic conditions, and 62 percent have 2 or more chronic conditions. Bottom line, we all know this impending crisis is rushing toward us. This burgeoning senior population is living longer with more chronic illnesses, and we simply must begin to think about how to change Medicare to meet this future.

Most integrated plans utilize care and disease management specialists to focus on enrollees with chronic diseases. Health care policy experts advocate early identification of patients at risk, treatment planning with a clear understanding of provider and patient roles and patient self-monitoring and follow-up to improve health outcomes. However, without a change in law, traditional fee-for-service Medicare cannot adopt these advances.

For more than a decade the Centers for Medicare & Medicaid Services (CMS) has run demonstration programs in the Medicare program, particularly for high cost or especially frail seniors. The CMS is currently managing more than a dozen demonstration programs in disease and case management. Stuart Guterman from CMS is here today to update us on the status of these programs. Hopefully it will give us some insight into what can work on a broader basis.

As the baby boom generation retires, the number of chronically ill beneficiaries will increase, and costs to Medicare will explode. Disease management programs, more integrated care across the board should help to defray some of these costs and improve health care outcomes at the same time.

We are pleased to welcome Jeff Lemieux, Senior Economist from the Progressive Policy Institute (PPI), who will discuss proposals to modernize Medicare, and integrate care and disease management into the program.

Dr. Ed Wagner, one of the country's top experts in his field, is the director of the MacColl Institute; and the senior investigator, Group Health Cooperative. As I mentioned, Stuart Guterman is here from CMS. Dr. Jan Berger is the Senior Vice President of Clinical Quality and Support and the Medical Director of Caremark. She'll discuss her company's practical experience in implementing chronic care management and whether it has improved health outcomes and saved money.

This will be a very important hearing for us, and we thank you all for participating.

Mr. Stark.

Mr. STARK. Thank you, Madam Chairman. We were talking about this last April, it seems, and I don't suppose much has

changed, but maybe we will have some new traction to deal with chronic illnesses.

As I suppose we will hear today, us Medicare beneficiaries are more likely than a few youngsters or nondisabled individuals to have chronic conditions; and some of us, even, many chronic conditions.

I suppose two-thirds of the Medicare spending goes toward items and services for beneficiaries with five or more, and I guess we could do a better job at encouraging the providers and patients to improve coordinating their care for patients.

I proposed legislation in the last Congress to create a new benefit to pay for coordination services for certain beneficiaries and near as I could tell, nobody paid any attention to it, at least in the Committee or our Subcommittee.

I submit it would be a good starting point if there is a genuine interest in addressing these issues, but we should consider this, I guess, in context.

The challenges related to the lack of well coordinated care that were identified by the Institute of Medicine (IOM) and others are endemic in our current health care system.

Virtually all of the problems identified, I suspect, by today's witnesses, are not limited to Medicare. They are present in most private plans and other government programs, including the Federal Employee Benefit Program.

So, attempts to use this issue is justification for a fundamental restructuring of Medicare I would view with some suspicion. There is talk in some areas about increasing the presence of private plans in Medicare, but one of the fatal flaws in the managed care industry and private plans in general is that there is no incentive for those plans to invest in the long-term health of their enrollees. Any plan that makes a serious investment in high quality, well coordinated care will inevitably attract sicker patients, drive up their costs and lose money.

So, when people switch plans, especially if there is an opportunity to do so, they will switch to those plans which offer better care and cost them more money. It is kind of a losing proposition.

The traditional Medicare program is in the unique position to avoid that quandary, and compared to the vast majority of private health plans, Medicare covers people for a very long time. The traditional Medicare program is thus poised to benefit financially from investing in beneficiaries to maintain and improve their health over the long term.

So, it is long past the time to make these improvements. We should improve the coverage of preventative benefits. As my Committee colleagues, Mr. Levin and Mr. Foley suggest, we should ensure that the program incorporates better management techniques, as I believe the Chairman and I agree.

Too many Members consistently refuse to make common sense improvements to the Medicare program, and then they inevitably suggest it must be privatized so it will be run properly, and those who follow this path have only themselves to blame for the current state of affairs. So, I look forward to our panel of experts to tell us how to reap the best results for our beneficiaries in the Medicare program. Thank you.

Chairman JOHNSON. Congresswoman Dunn, would you like to comment?

Ms. DUNN. Thank you very much, Madam Chairman, and I specifically want to spend a moment introducing Dr. Ed Wagner, who is from my district in Washington State and has come back here to share some of his experiences as he has used their chronic care model in treating illness. He is, as you said, Madam Chairman, the director of the MacColl Institute for Health Care Innovation at Group Health's Cooperative Center for Health Studies, and is also a professor at the School of Public Health and Community Medicine at the University of Washington. He has been a leader researcher in developing interventions that prevent disability and improve the health care and the health in general of older adults.

He developed a model for primary care patients that has been integrated into the practice of care at Group Health Cooperative, and it is one that we have been so impressed by and has been, if you don't mind my giving a plug to a potential piece of legislation, the basis for some work that I am doing right now, to put together a bill that would increase reimbursements to Medicare+Choice programs, and to provide a bonus payment for health care plans that implement programs to improve quality of care to patients.

Health plans like Group Health are improving the quality of care to patients through disease management, and I believe they should be rewarded for doing so. You will find in his testimony a really clear example of a woman who has run into problems through her—not necessarily the independent quality of her care, but the lack of integration of her care, and I am hopeful, Dr. Wagner, that you will address this. We are delighted that you are here today, and on behalf of the people I represent in Seattle, I want to thank you for good work you have done and welcome you to the panel.

Chairman JOHNSON. Thank you, Congresswoman.

Mr. Guterman, we will start with you and go right down the line and we will hear from everyone. Remember, you have 5 minutes. Your entire statement will be included in the record, but that way then we will have a chance for questions and some comments amongst you.

Mr. Guterman from CMS. Thank you.

STATEMENT OF STUART GUTERMAN, DIRECTOR, OFFICE OF RESEARCH, DEVELOPMENT AND INFORMATION, CENTERS FOR MEDICARE & MEDICAID SERVICES

Mr. GUTERMAN. Thank you, Chairman Johnson, Congressman Stark, and distinguished Subcommittee Members. I am Stuart Guterman. I am director of the Office of Research Development and Information at the Centers for Medicare & Medicaid Services, and I want to thank you for inviting me to discuss Medicare's efforts to improve the care provided to its beneficiaries through disease management.

Chronically ill beneficiaries are heavily burdened by their illnesses, and we feel that they are not as well served by the program, either in the fee-for-service or the Medicare+Choice systems as they could be.

In fee-for-service, the emphasis is on provision of services by individual providers providing no incentive, and, in fact, discouraging the coordinated care that chronically ill beneficiaries need.

Medicare+Choice should be an appropriate environment for providing coordinated care, but the current payment system and some of the rules that Medicare+Choice organizations operate under penalize them for enrolling beneficiaries who are chronically ill, and therefore, much more expensive than average.

Chronic diseases play a large role in generating both the growing level of utilization under Medicare and the finances of the program. As you have pointed out, researchers at Johns Hopkins University found that 78 percent of Medicare beneficiaries have at least 1 chronic condition, and counting for 99 percent of Medicare spending each year. Twenty percent of beneficiaries have at least 5 chronic conditions, accounting for 66 percent of all program's spending.

Clearly, there is a lot of money on the table here to improve the care that these beneficiaries receive. We need to find better ways to coordinate care for these beneficiaries, and disease management approaches have been developed to combine adherence to evidence-based medical practice with better coordination of care across provider, and I am looking forward to hearing what the rest of the panel members have to say about their experiences as well.

We are developing an array of demonstration projects to test our ability to apply these approaches in the context of the Medicare program. Both fee-for-service and the Medicare+Choice environment.

To that end, we will continue to pay in these demonstration projects many of the same providers that we pay now. What is new in these demonstrations is explicit additional payment for disease management services such as the nurse call lines, e-mail and patient education to forestall more costly covered services such as hospitalizations and emergency room visits. These services are not now covered as such under Medicare. For example, in our coordinated care demo, which I will talk about more in a minute, other services that are currently covered by Medicare are paid just as they are in the traditional Medicare program. We would also pay a monthly fee per member per month for disease management services on top of those.

Our objectives in these demonstrations are to improve access, to improve coordination of care, to improve the performance of physicians by making them more involved and responsive to patient needs, to improve the ability of patients to be involved and participate in their own care.

These demonstrations will need to test and evaluate what needs to be done to get disease management programs up and running, how best to provide these disease management services, which of these services work and which don't in the Medicare context, which conditions lend themselves best to disease management initiatives and the impact of different approaches. This involves answering several sets of questions: What should be the focus of disease management programs, what are the data requirements, and how can they be achieved, and here, by this issue, I am referring to really two things: One is the use of data to identify potential enrollees,

and the other is the use of data to monitor their needs as the projects go on.

What organizational structures work best? That is, how do you establish networks to provide these services and involve physicians in the process? How do you enroll beneficiaries once they are identified? How do you provide the services effectively? Which disease management approaches work best? That is, who contacts the enrollees? What do they do once they contact them and how do they make sure there is follow-up with these chronically ill patients? How can payment be designed to be compatible with these approaches? This is a major issue, both in the fee-for-service and the capitated payment and we think we are trying to develop approaches to deal with these.

Then how can all these issues be appropriately evaluated in terms of outcomes, costs and generalized ability to the program as a whole?

Where are we today on this issue? We have a number of demonstration projects currently underway, and a number that are still in development and in the pipeline. One that is currently in operation is the coordinated care demonstration that was mandated by the Balanced Budget Act 1997 which informs 15 sites and focuses on patients with congestive heart failure, hurt liver and lung diseases, Alzheimer's and other dementia, cancer and HIV/AIDS. The sites involved are in both urban and rural areas in a number of States, and it operates under fee-for-service payment system. Currently we have 7,600 enrollees, and these demonstrations will continue if they are cost-effective and if the quality and satisfaction are improved.

There is also a disease management demonstration that was mandated in the Benefits Improvement and Protection Act in 2000. We are working with three sites, but they are subject to Office of Management and Budget approval, so the decision isn't final.

The plan is to pay a disease management fee per member per month, which includes prescription drugs, and this is not only prescription drugs that are used to manage the particular chronic diseases that these beneficiaries suffer from, but also all of the prescription drugs that these patients need for all of their medical care. The hope is here that prescription drugs can be brought to bear on these conditions and help manage them more effectively. We are hoping to enroll up to 30,000 enrollees, and we are hoping to get this demonstration rolling in the summer of 2003.

We also have a physician group practice demonstration. The timeframe for applicants—the applications were received by the day after Christmas, and the applications have been panelled. We are planning on making at least six awards, and the interesting thing about this demonstration project is that we will share the savings with the physician group practices if outcomes are improved under those practices.

In the future, we are going to work on other demonstrations that apply alternative approaches and involve other groups of beneficiaries, and we can maybe talk about the kinds of things we are looking for in the question and answer period.

I want to thank you again for allowing me to describe what we are doing, and I will be happy to answer questions at the appropriate time.

[The prepared statement of Mr. Guterman follows:]

Statement of Stuart Guterman, Director, Office of Research, Development and Information, Centers for Medicare & Medicaid Services

Chairman Johnson, Congressman Stark, distinguished Subcommittee Members—first, thank you for inviting me to discuss Medicare's attempts to use disease management to improve the care provided to its beneficiaries. As the delivery of health care has evolved, individual health care providers routinely plan and coordinate services within the realm of their own specialties or types of services. However, rarely does one particular provider have the resources or the ability to meet all of the needs of a chronically ill patient. Ideally, as part of a fully integrated disease management program, a provider or disease management organization is dedicated to coordinating all health care services to meet a patient's needs fully and in the most cost-effective manner. I want to discuss with you in greater detail the challenges and opportunities we face in integrating disease management concepts into Medicare. The lack of disease management services in traditional Medicare is an indication of how outdated Medicare's benefit package has become. The demonstration projects being developed and implemented by the Centers for Medicare & Medicaid Services (CMS) can help ensure that America's seniors and disabled beneficiaries receive high quality care efficiently.

CMS is determined to work constructively with Congress to achieve these goals. We are currently undertaking a series of disease management demonstration projects designed to explore a variety of ways to improve beneficiary care in traditional Medicare. We are looking to these programs to bring Medicare into the 21st century and provide beneficiaries with greater choices, enhance the quality of their care, and offer better value for the dollars spent by beneficiaries and the government on health care. We appreciate your efforts to strengthen and improve Medicare, and we look forward to working with you on efforts to make disease management services more widely available, in Medicare—and across the health care system.

Background

Medicare beneficiaries with certain chronic diseases account for a disproportionate share of Medicare fee-for-service expenditures. These chronic conditions include, but are not limited to: asthma, diabetes, congestive heart failure and related cardiac conditions, hypertension, coronary artery disease, cardiovascular and cerebrovascular conditions, and chronic lung disease. Moreover, patients with these conditions typically receive fragmented health care from multiple providers and multiple sites of care. We need to find better ways to coordinate care for these patients and to do so more efficiently. Not only is such disjointed care confusing and ultimately ineffective, it can present difficulties for patients, including an increased risk of medical errors. Additionally, the repeated hospitalizations that frequently accompany such care are extremely costly to the patients, government, and private insurers, and are often an inefficient way to provide quality care. As the nation's population ages, the number of chronically ill Medicare beneficiaries is expected to grow dramatically, with serious implications for Medicare program costs. In the private sector, managed care entities such as health maintenance organizations, as well as private insurers, disease management organizations, and academic medical centers have developed a wide array of programs that combine adherence to evidence-based medical practices with better coordination of care across providers.

Several studies have suggested that disease management programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes without increasing program costs. There is little research on the overall benefits of disease management programs for seniors and thus, the CMS demonstration projects afford us the opportunity to test the value of these programs.

In the largest sense, both disease management and case management organizations provide services aimed at achieving one or more of the following goals:

- Improving access to services, including prevention services and necessary prescription drugs.
- Improving communication and coordination of services between patient, physician, disease management organization, and other providers.
- Improving physician performance through feedback and/or reports on the patient's progress in compliance with protocols.

- Improving patient self-care through such means as patient education, monitoring, and communication.

We are exploring a number of ways to pursue these goals even further in the Medicare program.

Where We Are Today

In order to identify innovative ways to incorporate disease management services into the Medicare program, we have a number of demonstrations underway.

Coordinated Care Demonstration

We are currently implementing a demonstration in 16 sites—including commercial disease management vendors, academic medical centers, and other provider based programs—to provide case management and disease management services to certain Medicare fee-for-service beneficiaries with complex chronic conditions. These conditions include: congestive heart failure; heart, liver and lung diseases; diabetes; psychiatric disorders; Alzheimer's disease or other dementia; and cancer. This demonstration was authorized by the Balanced Budget Act (BBA) of 1997 to examine whether private sector case management tools adopted by health maintenance organizations, insurers, and academic medical centers to promote the use of evidence-based medical practices could be applied to fee-for-service beneficiaries. Also, Lovelace Health Systems in Albuquerque, New Mexico, is providing coordinated care services to Medicare beneficiaries with congestive heart failure or diabetes. All of these programs were designed to address important implications for the future of the Medicare program as the beneficiary population ages, and the number of beneficiaries with chronic illnesses increases. We are testing whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among Medicare beneficiaries with chronic diseases.

To date, the 16 coordinated care demonstration sites have enrolled more than 7,600 Medicare beneficiaries in both intervention and control groups in care coordination and disease management programs. The BBA allowed for effective projects under a demonstration to continue and the number of projects to be expanded based on positive evaluation results—if the projects are found to be cost-effective and quality of care and satisfaction are improved.

These initial projects are varied in their scope, include both provider organizations as well as commercial companies, utilize both case and disease management approaches, are located in urban and rural areas, and provide a range of services from conventional case management to high-tech patient monitoring. In addition to Lovelace Health Systems, some of the sites we have selected include: Carle Foundation Hospital in Eastern Illinois; CenVaNet in Richmond, Virginia; Mercy Health Network in North Iowa; QMed in Northern California; and Washington University/ Status One in St. Louis, Missouri.

BIPA Disease Management Demonstration

An integral part of our overall strategy for testing disease management, this demonstration, required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, was designed to determine whether providing disease management services to Medicare beneficiaries with advanced-stage congestive heart failure, diabetes, or coronary heart disease can yield better patient outcomes without increasing program costs. As required by BIPA under this demonstration, disease management organizations will not only receive a fee for their services, but they will also receive payment for the cost of all the prescription drugs their patients are taking, whether or not the drugs are related to their patients' targeted, chronic condition(s). Coverage of prescription drugs is a unique aspect of this demonstration. Moreover, this demonstration was designed to determine not only the impact on costs and health outcomes of offering disease management services, but also the impact of prescription drug coverage on Medicare beneficiaries. Enrollment is expected to begin this summer and up to 30,000 beneficiaries can be covered at a time under this demonstration.

Telemedicine

Another demonstration authorized by the BBA is our Informatics, Telemedicine, and Education Demonstration Project. Currently, we have a 4-year telemedicine cooperative agreement aimed at evaluating the feasibility, acceptability, effectiveness, and cost-effectiveness of advanced computer and telecommunications technology to manage the care of Medicare beneficiaries with diabetes.

Physician Group Practice Demonstration

Additionally, as required by BIPA, we are developing a physician group practice demonstration which will seek to encourage coordination of Part A and Part B services, reward physicians for improving beneficiary health outcomes, and promote efficiency through investment in administrative structure and process. Under the 3-year demonstration, physician groups will be paid on a fee-for-service basis and may earn a bonus from savings derived from improvements in patient management. At least six physician group practices will be selected to participate in the demonstration.

Building for the Future

We are also considering future demonstration projects that will build on our past experiences, enhance the clinical management of the patients, provide for more effective coordination of services, and improve clinical outcomes. We are investigating how disease management projects could work with a diverse group of organizations, such as Provider Sponsored Organizations (PSO), integrated healthcare systems, disease management organizations, and Medicare+Choice plans. Such projects could test a variety of payment methodologies, including capitation and risk-sharing arrangements. We also want to develop specific health plan options for those beneficiaries with chronic illnesses. We want to enhance the clinical management of care to better serve the patients, provide for more effective coordination of services, and improve beneficiaries' clinical outcomes without increasing costs to the Medicare program.

Another potential area of investigation could be beneficiaries with end-stage renal disease (ESRD), potentially building on lessons learned from an ESRD demonstration program created under Social Health Maintenance Organization (SHMO) legislation. This demonstration created an integrated system of care for ESRD beneficiaries and tested its operational feasibility, its efficiency, and most importantly, whether such a system would produce health outcomes at least as good as the fee-for-service system. Our experience taught us that this approach can maintain or improve the quality of care for ESRD beneficiaries, and can result in high patient satisfaction and quality of life.

Additionally, we are investigating the feasibility of a demonstration in traditional fee-for-service Medicare that focuses on specific chronic diseases and is targeted at underserved areas in selected geographic regions. Our emphasis would be on early detection, patient outreach, patient education, and lifestyle modification.

Evaluation

The objective of our evaluations is to assess the effectiveness of these programs for chronic medical conditions. In particular, we are evaluating health outcomes and beneficiary satisfaction, the cost-effectiveness of the projects for the Medicare program, provider satisfaction, and other quality and outcomes measures. Using a combination of surveys, administrative claims and enrollment data, and site visits, we will focus on the impact of the demonstrations on quality of care, outcomes, and costs. We will pay particular attention to the impact of the demonstrations on the following types of measures: mortality, hospitalization rates, emergency room use, satisfaction with care, changes in health status and functioning, and program expenditures. We will examine whether the disease management interventions result in less fragmentation in care for the given chronic conditions. Finally, we will examine which characteristics of disease management programs appear to be most effective in reducing morbidity and improving quality of life for chronically ill Medicare beneficiaries. In each of these approaches, we expect that the costs to Medicare will be the same or lower through the efficiencies that will result in providing the most appropriate care. Through these demonstrations, we will continue testing and exploring new strategies for improving care and efficiency.

Conclusion

Disease management is a critical element for improving the nation's health care and its delivery system. Along with the Secretary, the Administrator and I want to take full advantage of all of the opportunities for increased quality and efficiency that disease management offers. Unfortunately, seniors are far less likely than other Americans with reliable access to modern, integrated health care plans to have access to disease management services. Through our disease management demonstrations, we are working to give seniors the same access to modern disease management services that other Americans enjoy. We look forward to continuing to work cooperatively with you, Chairman Johnson, Congressman Stark, this Subcommittee, and the Congress, to find innovative and flexible ways to improve and strengthen the Medicare program while making sure that beneficiaries, particularly

those with chronic conditions, have access to the care they deserve. I thank you for the opportunity to discuss this important topic today, and I am happy to answer your questions.

Chairman JOHNSON. Thank you very much, Mr. Guterman.

Mr. Lemieux.

STATEMENT OF JEFF LEMIEUX, SENIOR ECONOMIST, PROGRESSIVE POLICY INSTITUTE

Mr. LEMIEUX. Thank you, Madam Chairman, and Mr. Stark, Subcommittee Members. I am Jeff Lemieux from the Progressive Policy Institute, and we have recently published a couple of papers arguing that Medicare is not well suited to provide disease management or care coordination services in its current structure, and we believe the next great challenge for Medicare will be addressing these shortcomings and shifting the program's emphasis toward chronic care.

Rather than talking about the need for chronic care and disease management that we already know about, and the various trials and tribulations in Medicare's current structure in providing those services, let me suggest a couple of things that I think might help steer the debate on prescription drugs and Medicare reform that we are likely to have this year toward chronic care.

First, let me suggest a couple things I think that wouldn't help. The first thing would be if we created a new Medicare drug benefit in another separated silo, a separated benefit in Medicare that wasn't linked to the other benefits in the program. We already have a fair amount of benefits in Medicare that aren't very well linked. We have part A and part B, and sometimes that can be an impediment to coordinated care. I think that Congress should essentially just scrap the idea of a stand-alone, premium-based drug benefit, precisely because it would create a new silo without a lot of work.

In general, health benefits should be integrated under one administrative structure, so that the insurer or the carrier has the ability and the incentive to evaluate tradeoffs. For example, adding additional drug benefits that are known to prevent hospitalizations or the extra costs of hospitalizations. Even if benefits can't be fully integrated, it is nice to try and find linkages where possible so that policy makers can evaluate those tradeoffs.

Second, I think it would be helpful to remember to try and provide more accountability and assessment of new benefits in Medicare as we add them. The PPI believes that all new benefits should help reorient the Medicare program toward more optimal care of chronic illness, and that they should be accompanied by new processes to spur systematic improvements in health quality and outcomes.

Our proposal, as I said, has been detailed in a couple of reports in my prepared remarks. Let me just mention a couple of things about it in brief.

The plan is similar to a Medicare proposal that was put forward last summer by several of your colleagues in the House, Representatives Dooley, Tauscher, Jim Davis, Ron Kind, Charlie Stenholm

and Adam Smith, and I encourage you to consider their plans in your deliberations in this Subcommittee and in the full Committee. Let me briefly describe what they were attempting to do and what we propose.

First, we propose to try and achieve far greater accountability in Medicare through a systematic decentralization of the program's administration, so that local Medicare administrators and medical directors are directly empowered to create disease management and health improvement programs targeted to the needs of beneficiaries in their area.

Second, on benefits, we believe a universal zero premium catastrophic drug benefit structure would help link, not further fragment, Medicare benefits, and would provide the sort of information that Medicare administrators and medical directors would need to target disease management programs.

Third, on choices we would like to see a much expanded menu of private comprehensive insurance plans like health maintenance organizations (HMO) and preferred provider organizations (PPO) in Medicare which, in theory, have the strongest incentives to provide disease management and care coordination services. We would also like to see a new type of Medigap coverage and several other things that are mentioned in my prepared remarks.

Let me talk just a little bit more about the first element of our proposal, which is the accountability element. This is somewhat different from the sort of thing we have seen in Congress before. We are proposing to try and create in Medicare a health care version of the CompStat system which has helped New York City dramatically reduce violent crime rates. What CompStat does is it holds local precinct commanders responsible for reporting and reducing crime in their sectors.

We propose to divide the country into approximately 150 or so health care catchment areas, establish a local Medicare office in each area with a Medicare medical director and a local administrator, empower those officials with the authority to initiate new programs for disease management, education and other items that would be budget neutral over a 10-year period, and that would help the seniors and workers with disabilities on Medicare in their districts with the most important problems that they are facing.

We believe that those local officials should be required to collect information on the outcomes of treatment and of the most frequently occurring chronic diseases, morbidity and mortality rates, emergency room admissions, access to and use of preventive care, patient satisfaction, availability of private plan options like HMOs and PPOs, availability of comprehensive disease or care management programs that would be available to fee-for-service beneficiaries, and other measures of performance of the Medicare program within their jurisdiction.

The local Medicare officials should be ranked annually on their ability to foster improvements in health quality and outcomes in their regions, and Congress, under our proposal, would establish a new Congressional agency patterned after the Joint Committee on Taxation, to oversee the local official's actions, their proposals, their programs and their rankings. Ideally local administrators with poor performance results would be replaced, and Medicare's

central bureaucracy could be reduced as the local officials were put in place.

What we are trying to set up here is local experimentation based on local needs. If telemedicine is important in one area and diabetes control is important in another, the local administrator should be best equipped to know that that is the case and how to address the problem, and then we want to assess their performance so that if the administrators of Medicare are doing a very good job in Arkansas but Tennessee is not doing so well, we should find out why, evaluate the trends and encourage the administrators in Tennessee to pick up the slack or perhaps even replace them.

In conclusion, Medicare modernization probably at its very deepest level means establishing a fundamental basis of accountability for improving Medicare's performance and senior's health quality and outcomes. I believe that no budgetary shortfall should stop us from making the structural reforms necessary. It is wrong to say that because we no longer have enough money for a generous add-on drug benefit, we should therefore do nothing. On the contrary, we should reform Medicare and create a new results-based management structure, which in turn will accommodate the introduction of new benefits when the budget permits. Thank you.

[The prepared statement of Mr. Lemieux follows:]

Statement of Jeff Lemieux, Senior Economist, Progressive Policy Institute

Thank you Madam Chairman, Representative Stark, Committee Members, for inviting me. The Progressive Policy Institute (PPI) believes that the next great challenge for Medicare will be shifting the program's emphasis toward chronic care. Medicare has always been a reliable bill payer when beneficiaries suffered an acute health care crisis requiring hospitalization or extensive medical procedures. Now, Medicare must learn how to better help the increasing number of seniors with chronic illnesses stay out of the hospital and maintain the best possible health and quality of life. This, we believe, is key to improved health outcomes, higher quality health care, and greater value for every health dollar spent.

PPI explains the need for a dramatic shift toward chronic care in a recent policy report: ***Healthy Aging vs. Chronic Illness, Preparing Medicare for the Next Health Care Challenge***, by David B. Kendall, Kerry Tremain, Jeff Lemieux, and S. Robert Levine, M.D. I have brought copies of that report; if possible, I recommend it be added to the record of this hearing.

Because Medicare covers seniors and workers with long-term disabilities—precisely the people most likely to have chronic or ongoing health problems—Medicare beneficiaries have the most to gain from continuity of care and comprehensive, coordinated care management systems.

In the broadest use of the term, "disease management" can range from simple educational programs to specialized programs tailored to help people manage a particular disease, such as diabetes, to comprehensive case management systems for patients with multiple chronic conditions.

However, Medicare is not well suited to provide disease management services at any level, for four reasons:

1. **Medicare's fee-for-service program cannot pay for performance.** Medicare's fee-for-service program pays for health services rendered, regardless of quality, provider, or likely outcome. The program has effectively become an entitlement program for health providers: If a licensed health provider treats a Medicare beneficiary, payment will follow. Such a system cannot steer patients with particular needs to health providers best able to provide the most appropriate assistance and care.
2. **Medicare's benefits are inadequate.** Comprehensive, integrated benefits are a vital part of disease management programs. The most obvious inadequacy in Medicare's fee-for-service benefit package is the absence of an outpatient prescription drug benefit. Other inadequacies can include lack of reimbursement for home monitoring devices and services, and difficulties reimbursing health

providers for the extra time, planning, and communication services that patients with chronic conditions need to avoid acute health crises.

3. **Medicare's benefits are poorly structured and hard to change.** Medicare benefits reflect health insurance standards from the mid-1960s. However, because it literally takes an act of Congress to change them, Medicare's benefit structure has not changed very much since then. In the 1960s, health insurance couldn't do much more than pay bills for a hospitalization or an episode of care. Now, with our success in saving the lives of patients in crisis, we have more and more seniors living with chronic illness. As a result, health care needs have changed. However, Medicare's benefits have not adapted. As currently structured, the Medicare program's disjointed Part A and Part B benefits inherently impede coordination of care for beneficiaries with chronic illness.
4. **Medicare's HMO program is a mess.** In theory, private comprehensive health plans like HMOs have the greatest incentives to provide comprehensive disease management programs, and, in fact some Medicare HMOs do a very good job. However, many have dropped out of the Medicare program or slashed their benefits. Medicare's HMO program is a take-it-or-leave-it affair: HMOs enter the program when reimbursements are high and exit the program when reimbursements are low. Medicare's new PPO demonstration program, which includes risk sharing and a more long-term partnership between plans and the government, holds promise for restoring private plan options for seniors.

To foster improved chronic care and disease management in Medicare, PPI encourages Congress to consider two simple tests for any legislative proposal:

- **No new silos.** Separated, unlinked, or uncoordinated benefits can thwart disease management efforts. Congress should scrap the idea of a premium-based stand-alone drug benefit. In general, health benefits should be integrated under one administrative structure, so that the insurer has the ability and the incentive to evaluate tradeoffs—for example, adding drug benefits known to reduce the incidence or cost of hospitalizations. Even if benefits cannot be fully integrated under one insurance carrier, at the very least they should be linked, so that information can be shared between primary and supplemental insurers. Adding another separate, add-on benefit to Medicare's current, outdated structure would work against disease management and comprehensive, coordinated care for people with chronic illnesses.
- **No new benefits without accountability.** It doesn't make sense to add benefits without making fundamental changes to Medicare's processes, so that we can learn whether or not the benefits improved seniors' health. Even preventive and screening benefits should be accompanied by permanent evaluation systems designed to identify and help people who are at risk for particular problems or are coping with multiple ailments. All new benefits must help reorient the Medicare program toward more optimal care of chronic illness and be accompanied by new processes to spur systematic improvements in health care quality and outcomes.

PPI's 'ABC' Proposal to Modernize Medicare

CMS needs the flexibility to create disease and care management programs for Medicare beneficiaries. However, Congress is not going to give the CMS bureaucracy vast new powers without greatly enhanced accountability and oversight systems. Moreover, disease management is inherently a local system, requiring cooperation between local health providers, community institutions, consumer and seniors' groups, and, in some cases, local government agencies. CMS cannot run effective localized disease management and health improvement programs from its headquarters in Baltimore.

PPI proposes a package of Medicare reforms that would achieve three basic ends:

- a radical decentralization of Medicare's administration, so that local Medicare administrators and medical directors are directly empowered to create disease management and health improvement programs targeted to the needs of beneficiaries in their area;
- a drug benefit structure that helps link, not fragment, Medicare benefits and provides information to target disease management programs; and
- a much expanded menu of private insurance plans in Medicare, along with locally-run comprehensive disease and care management programs for fee-for-service beneficiaries with specific or multiple chronic conditions.

PPI's proposal is explained in greater detail in the report **An 'ABC' Proposal to Modernize Medicare**, and it is very similar to the Medicare proposal announced

last year by several House Members, including Representatives Cal Dooley (D–Calif.), Ellen Tauscher (D–Calif.), Jim Davis (D–Fla.), Ron Kind (D–Wisc.), Charles Stenholm (D–Texas), and Adam Smith (D–Wash.). Here are some basics:

Accountability. Medicare officials should be held accountable for measuring and improving the health of older Americans. They should be given the freedom to make improvements at the local level, in accordance with local needs, with clear public disclosure of results and Congressional oversight. The model for the PPI's proposal is the "CompStat" system developed in New York City to help fight crime. In that system, crime trends were tracked in real-time, and local police commanders were given flexibility to deploy resources as needed in their precincts in exchange for real accountability for their crime-fighting plans and success. Unsuccessful commanders who did not have a credible plan for performance improvement were replaced.

We propose that Congress create approximately 150 local Medicare administrative regions and staff each local area with a Medicare medical director and Medicare local administrator. We believe those officials should be given flexibility to create new programs to improve health in their areas, with budget authority to create local programs that are budget-neutral within a 10-year period. Local officials would be ranked annually on their ability to foster improvements in health quality and outcomes in their regions, and Congress would establish a new congressional agency, patterned after the Joint Committee on Taxation, to oversee the local officials' actions, proposals, programs, and ratings. Local administrators with poorer performance results would be replaced. Medicare's central bureaucracy would be reduced as the local officials were put in place.

Benefits. PPI believes the most realistic and workable Medicare drug benefit would be a universal, zero-premium catastrophic benefit, provided mostly through the supplemental insurers that already serve Medicare beneficiaries, including employment-based plans, Medigap plans, and state programs. (Seniors without any supplemental benefits would choose a discount card that also provided the catastrophic drug benefit.) The catastrophic benefit would be based on total drug spending; PPI proposes that the catastrophic benefit explicitly allow seniors to have additional coverage under the catastrophic "deductible" without forfeiting their catastrophic benefits. By contrast, Congressional proposals that base a catastrophic drug benefit only on "out-of-pocket" drug spending would be unfair to beneficiaries who have and want additional drug coverage, and could disrupt the employment-based retiree coverage many seniors receive. PPI's preferred approach is more expensive for the government, but it is more practical and workable. Under PPI's proposal, low-income seniors would be eligible for additional drug benefits, including "up-front" benefits that started at much lower levels of drug spending.

We believe that universal catastrophic drug coverage would create tremendous side benefits by building an information-based infrastructure for disease and care management programs. CMS would obtain real-time data from the supplemental insurers and other plans and discount cards administering the benefit, so that Medicare would know when a patient hit the catastrophic deductible, and Medicare's liability was triggered. Therefore, Medicare would have a nearly real-time database of all beneficiary drug expenditures, which would help local Medicare administrators target quality improvement and disease management programs to particular demographic groups or regions. The new data could also dramatically improve risk adjustment methods, which would help private comprehensive plans stay in Medicare.

Choices. PPI proposes to revitalize Medicare's HMO program and expand the PPO demonstration program nationwide. We would establish a new type of Medigap coverage that included some up-front drug benefits; however, to keep the cost down, the "New Medigap" plan would not have absolute first-dollar coverage of beneficiaries' coinsurance for Medicare's other benefits. Beneficiaries could enroll annually in private plans, New Medigap options, and new comprehensive disease management programs, and have premiums deducted from their Social Security checks.

Practicality and Scalability

PPI's proposed drug benefit could be scaled up or down based on budgetary constraints. In our model, the generosity of the benefit—literally the level of the catastrophic drug deductible—would not affect the proposal's workability. There would be no adverse selection, since the benefit would be free and universal. There would be no need for late enrollment penalties, and employer-based retiree coverage and state pharmaceutical assistance programs would be encouraged, not disrupted. In many cases, seniors would automatically receive the new benefit through their current supplemental coverage—they would not have to adjust their coverage at all.

Conclusion—A New Approach to Medicare Reform

PPI believes we must switch the Medicare debate from arguments about how much to spend on a stand-alone, add-on drug benefit to a discussion of what sort of benefits would create the most value in improved health per additional dollar of health spending, and how can we create measurement and accountability systems to assess that value.

At its deepest level, Medicare modernization means establishing a fundamental basis of accountability for improving Medicare's performance, and seniors' health quality and outcomes. No budgetary shortfall should stop us from making the structural reforms necessary. It is wrong to say that because we no longer have enough money for a generous add-on drug benefit, we should therefore do nothing. On the contrary, we must reform Medicare and create a new results-based management structure, which, in turn, will be able to accommodate the introduction of new benefits designed to improve health outcomes, when the budget permits.

Chairman JOHNSON. Thank you.

Dr. Wagner.

STATEMENT OF ED WAGNER, M.D., DIRECTOR, MACCOLL INSTITUTE FOR HEALTHCARE INNOVATION, CENTER FOR HEALTH STUDIES, GROUP HEALTH COOPERATIVE, SEATTLE, WASHINGTON

Dr. WAGNER. Thank you, Madam Chairman. I am Ed Wagner. I appreciate very much Congresswoman Dunn's generous introduction. My interest is in the quality of the care received by the 100-plus million Americans with 1 or more chronic illnesses. We hear much about the growing numbers of people. We hear much about the growing costs. What underlies this concern is that the evidence is that probably less than half of those people are receiving optimal chronic illness care.

In my written testimony, I describe a composite Medicare recipient drawn from work across the country that we have been doing trying to improve the quality of chronic illness care. This woman suffered needless morbidity and two preventable hospitalizations because of breakdowns in the continuity of her care, in the quality of the information and support she was given to care for her illness, and because of confusion around the management of differing physicians.

The evidence is that these problems are built into our system, unfortunately. Although finances are certainly a barrier, as previous speakers have testified to, there is, in the words of the Institute of Medicine, perhaps, a larger problem. In the "Crossing the Quality Chasm" report, the IOM Committee says current care systems cannot do the job. Trying harder will not work. Changing care systems will.

Our work has been to try to identify the specific aspects of practice systems, that if enhanced and improved, will lead to better care and better outcomes for patients like the one described in my written testimony.

We have tried to summarize this evidence and experience in a form that is useful for medical practices, health plans and other organizations that want to do a better job. That is the chronic care model mentioned by Congresswoman Dunn.

The chronic care model is simply a summary of evidence as to what works in the management of patients with one or more chron-

ic diseases. It emphasizes the interconnectedness of information systems, of educational support, of different organizational structures of practice, the use of things like e-mail that was mentioned in previous testimony.

The question is, can busy, now somewhat underfinanced medical systems make these changes? Our work under a grant from the Robert Wood Johnson Foundation has given us an opportunity to try to use the chronic care model and other modern quality improvement approaches to help a large number of health systems, most in the fee-for-service, not the Medicare+Choice sector, improve their care.

Using the Breakthrough Series model pioneered by Don Berwick's Institute for Health Care Improvement, we have now worked with almost 1,000 health care systems, the largest group of which are the Bureau of Primary Health Care's Community and Migrant Health Centers (Bureau).

About two-thirds of the organizations involved have been able to make these changes and report measurable improvements in the care of their patients. So, I think there is hope and there is some experience that we can draw on.

The next question is, will these changes lead to reductions in the cost of care? We think so. In the Journal of the American Medical Association article that was distributed to the Subcommittee, we examined the literature looking for rigorously done interventions that used approaches like the chronic care model and also assessed the impact on costs. We found 27 such studies, involving people with asthma, congestive heart failure, and diabetes. Eighteen of the studies reported, in a reasonably short period of time, reductions in health care utilization and costs. So, we believe that cost reduction is possible.

Additional barriers are, as I indicated the deficiencies in the information technology available to most medical care systems, and the lack of non-physician personnel in offices to provide the coordination, education and support for patients.

We recommend, whatever the Medicare legislation, however it evolves, that it invests in improving our basic medical care system. How might that happen? One approach would be to disseminate in the public sector the best and most cost-effective patient information software such as disease registries that would help practices overcome some of the information technology deficits that they have.

Second, develop a system of quality measurement that is dependable, that is comprehensive and that could be linked to reward structures as some of the previous speakers have mentioned.

Third, support regional and national chronic disease improvement efforts, such as the Breakthrough Series that I described earlier and in more detail in the written testimony.

Last, I do believe that fee-for-service is a significant barrier to integrated, coordinated care. So, anything that can be done to stabilize Medicare+Choice and reward those health plans that are doing a better job would be in, I think, the patients' best interest. Thank you very much.

[The prepared statement of Dr. Wagner follows:]

Statement of Ed Wagner, M.D., Director, MacColl Institute for Healthcare Innovation, Center for Health Studies, Group Health Cooperative, Seattle, Washington

I. Introduction

Madam Chairwoman, and Members of the Subcommittee, I appreciate the opportunity to share with you some experiences and insights from my research aimed at improving the quality of care received by people with chronic illnesses. I am Ed Wagner, Director of the MacColl Institute for Healthcare Innovation at the Center for Health Studies, Group Health Cooperative in Seattle. Group Health Cooperative is a consumer-governed, nonprofit health care system that coordinates care and coverage. The Cooperative includes medical centers, an associated physician group practice, a research center, and a charitable foundation. At present, Group Health serves 588,000 members.

Group Health was founded more than 50 years ago with the mission to "transform health care." Research has been an integral part of fulfilling that mission. In establishing the Center for Health Studies twenty years ago, Group Health's Board of Trustees further solidified the Cooperative's commitment to research. The Center's work focuses on promoting prevention and effective treatment of major health problems—benefiting Group Health members and the general public. The MacColl Institute for Healthcare Innovation serves to bridge the worlds of research and delivery-system change, both nationally and within Group Health.

The MacColl Institute is also the national program office for the Robert Wood Johnson Foundation's (RWJF) program on Improving Chronic Illness Care, which supports health care organizations in their efforts to improve care delivered to people with chronic illness. The following experiences and opinions stem from both Group Health's quality improvement and research work, and my work with hundreds of medical practices and health plans across the country committed to improving care.

II. Prevalence of Chronic Illness in America

Recent estimates suggest that well over one hundred million Americans suffer from one or more chronic illnesses, including almost 90 percent of Medicare beneficiaries. Chronic illness afflicts nearly half of our population and affects essentially every American family. In our conversations with people who live with a chronic illness or who care for close family members with chronic illness, we repeatedly hear about their difficult experiences in receiving care. Survey data suggest that these are not isolated anecdotes. A recent RWJF poll found that over one-half of middle-age and older Americans disagreed with the statement that one could receive high quality chronic illness care in America. To give life to the problem, I'd like to share with you a composite case history based on real patients around the country that we've encountered in our work.

III. Case History: Ms. G.

Ms. G., a 69-year-old widowed grandmother, has had diabetes for ten years and high blood pressure and heart disease for the past two years. She has a primary care physician whom she likes, but sees only when she is having trouble. She is moderately obese. With her childcare responsibilities for her grandchildren, she finds it difficult to eat properly or exercise. She attended a class to help learn more about controlling her diabetes when she was first diagnosed with diabetes, but has received only intermittent and occasionally conflicting information since. Her kitchen drawer is full of different diet sheets. She's not sure which one is the best and has stopped using them. As a result, Ms. G.'s diabetes is not well controlled. Her doctor visits are brief, focused on the problem at hand, and often don't leave time to address issues she faces in trying to manage her chronic conditions in her busy life.

Ms. G.'s heart disease progressed to congestive heart failure and she began accumulating fluid and becoming short of breath. One night, her shortness of breath became so severe that she called 911. She was taken to the emergency room and admitted to the hospital under the care of a cardiologist. During hospitalization, she was started on new medications, improved rapidly, and was discharged a couple of days later. The hospital nurses were nice, but busy and could only give Ms. G. limited instruction on what she was to do at home. She left the hospital with new diet plans, and six different prescriptions drugs, three of which were new or changes from her original drug regimen. Tests performed during her hospitalization indicated impaired kidney function and she was referred to a nephrologist.

Upon discharge, Ms. G. was urged to make appointments with the cardiologist, the nephrologist, and her primary care internist. Although feeling much better, she

was confused about her medications, diet, and the need for additional doctor visits. A phone call to her internist's office revealed that the doctor wasn't aware of her hospitalization or new medications. She filled the prescriptions and tried to figure out how each of the six drugs was to be taken. Given their expense, she thought that some of the drugs could be taken only if she didn't feel well. Over the next few weeks, she returned to her usual responsibilities, began again to experience trouble breathing, and tried to decide which physician she should see first. Two weeks later while chasing after her three-year-old grandson, she became acutely short of breath, called her daughter and was returned to the ER, where she was found to have relatively severe congestive heart failure and was readmitted to the hospital.

Although she receives care from competent providers and institutions, Ms. G. is clearly not doing well. Repeated surveys reveal that Ms. G. represents the majority of Americans with chronic illness, who—without optimal treatment—are experiencing morbidity and high health care costs that could be prevented. In the remainder of my testimony, I'd like to discuss some of factors that contribute to Ms. G's poor outcomes and high costs, what research and experience indicate can be done to improve care, and the role that Medicare may play in accelerating improvement for people like Ms. G.

IV. The Barriers to High Quality Chronic Illness Care

The major problem facing Ms. G., and the nearly 35 million Medicare beneficiaries like her, is that she is receiving care from a system that was not designed to meet her needs. High quality chronic illness care would help assure that: (1) she receives the most effective clinical treatments based on scientific evidence, and (2) she has the information, skills, and confidence to make good decisions and choices in managing her health and illness. The general structure and practice of medical care makes it difficult for chronically ill patients to receive these two critical elements in their care. This is a central message of the recent Institute of Medicine (IOM) report, *Crossing the Quality Chasm*. Simply stated, our care systems are not designed for Ms. G.; they are also unfortunately not rewarded for doing better by Ms. G.

Fee-for-service payment presents the biggest single barrier to improving chronic illness care and reducing costs. It rewards high tech providers and treatments when people with major chronic illnesses want and need low tech information, comfort, and guidance. Additional disincentives within fee-for-service Medicare to improving chronic illness care have been elucidated in Dr. Robert Berenson's recent, excellent *Health Affairs* paper, and in the recent National Academy of Social Insurance report, *Building a Better Chronic Care System*. Current regulations and practices limit Medicare's ability to support the types of services proven to be effective in managing chronic illnesses. For example, current Medicare policies make it extremely difficult to obtain reimbursement for the activities of non-physician members of a practice team who, in the most effective practices and programs, play critical roles in providing education, emotional support, care coordination, and follow-up with the chronically ill. As a result, many practices no longer can afford nurses and other staff, compounding difficulties in caring for patients with complex illnesses, like Ms. G. Also, current Medicare reimbursement emphasizes brief physician visits and discourages other important and less costly forms of patient interaction that are important to successful chronic disease management, such as telephone care and group visits. From the provider's perspective, Medicare policies reward and reinforce the status quo.

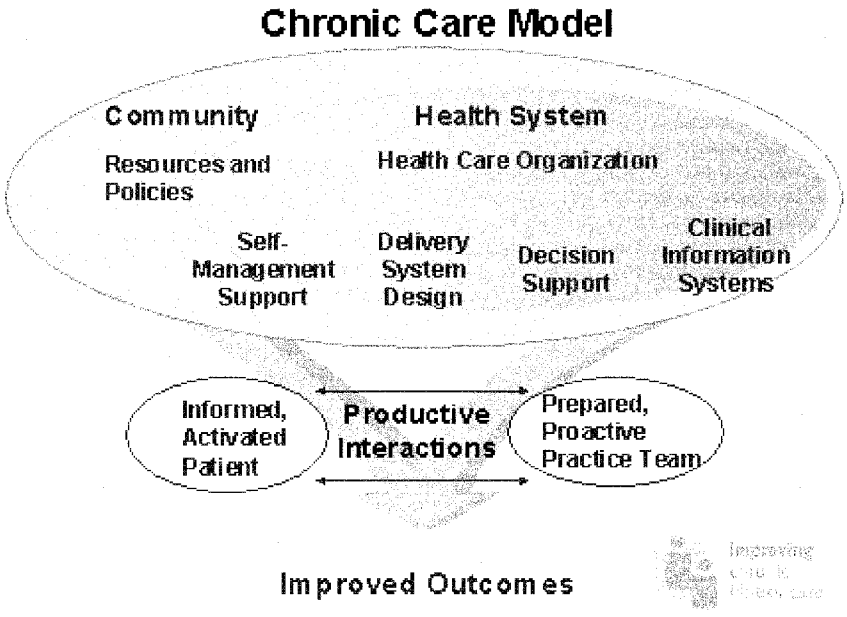
V. What Can Be Done to Address Barriers? The Chronic Care Model

Over the past couple of decades, accumulating experience and evidence are clarifying how medical care systems should be changed to meet Ms. G's needs. A growing number of studies have shown that patients like Ms. G. with diabetes, with heart failure, with depression, with stroke are much more likely to receive effective care and experience less morbidity when cared for in systems redesigned, at least in part, for them. What are the characteristics of these systems that do better for patients with chronic illness? They begin with the assurance of a "continuous, healing relationship" as articulated in the IOM's, *Crossing the Quality Chasm*. Given the complexity of Ms. G's interlocking chronic conditions and her confusing, costly, and potentially conflicting treatments, one care team must bear responsibility for collaborating with her in developing and executing a coherent plan of care. This care team, whether led by a generalist physician, a nurse practitioner, or specialist, must have the systems in place to assure that she receives effective clinical treatment and self-management support, and that her care from other doctors and settings is understandable and coordinated. These assurances and routine performance of these

essential tasks are very difficult to achieve in typical American medical practices unless practice systems are substantially overhauled.

A growing body of scientific evidence strongly suggests that a multi-faceted, interconnected set of structural and functional changes to medical practice can substantially improve care. For example, in the paper provided to the Subcommittee members by Bodenheimer, Wagner, and Grumbach published in *JAMA*, we examined 39 rigorous studies that tested diabetes improvement programs in outpatient settings. While 32 improved at least one aspect of care, the five most successful programs included the most comprehensive set of practice changes. Each of the five had components directed at increasing patients' self-management competence, providers' expertise, care organization, and clinical information availability and utility. Over the past decade, we have tried to translate this evidence into action to improve the quality of care received by Group Health enrollees with diabetes, heart disease, and other conditions. Experience at Group Health confirms that the quality of chronic illness care—as measured by the Health Plan and Employer Data and Information Set (HEDIS®) and other performance indicators—can be substantially improved through systematic application of a coordinated set of system changes. We also found that improvements in care for our large population of patients with diabetes were associated with a ten to twelve percent reduction in the total costs of their care.

Based on Group Health's experience and the science, we tried to synthesize and organize evidence about health system change into a framework or model to help health care organizations translate it into action—the Chronic Care Model. The Model recognizes that health care organizations operate as part of a larger care community. Important community resources and influences can impact care of their chronically ill patients. The Model incorporates elements of successful interventions and programs such as in the diabetes improvement programs described above.



Practices need guidelines and protocols to guide care, and practice systems organized to assure adherence to those protocols. For patients to be competent self-managers, they need ongoing information and support to set goals, solve problems, and develop skills in managing their life, their illness, and its treatment. Effective practices look to community resources like peer support groups or exercise programs that promote better self-management. Instead of rushed, problem-oriented doctor visits, high quality practices use planned, structured interactions with patients and families to assure appropriate treatment and that information systems that remind, provide feedback to patients and providers on their performance, and prevent pa-

tients from falling between the cracks in our care system can guide and support these planned interactions. Finally, these practice enhancements are unlikely to occur without the organization and leadership that makes chronic illness care a priority, that routinely monitors the performance of the system, and provides incentives to its staff to do better.

Is the Chronic Care Model Pie in the Sky?

With generous support from RWJF, the MacColl Institute and our partner organizations are using the Chronic Care Model and modern quality improvement methods to assist large numbers of medical practices and health systems to improve care. The Breakthrough Series approach, developed by the Boston-based Institute for Healthcare Improvement led by Dr. Donald Berwick, brings together large numbers (10–120) of health care organizations to work with faculty on improving care for one or more chronic conditions. To date, approximately one thousand different health care organizations ranging from small (one or two doctor offices) to large medical groups or health plans have participated in a Breakthrough Series. The Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care is the largest single sponsor of the Series as a central strategy in its Health Disparities Initiative. This landmark effort has involved nearly one half of the Bureau's seven hundred community health centers. Other Breakthrough Series partners include quality improvement organizations, purchaser coalitions, state health departments, and professional organizations with activities underway or planned in Washington, Oregon, New Mexico, Arizona, Alaska, Indiana, Illinois, Wisconsin, Vermont, Maine, and North Carolina.

We and our partners have been trying to carefully evaluate the impact of these activities. Results suggest that approximately two-thirds of participating practice organizations implement system changes and enhancements that have measurable positive impacts on their patients. Many have extended these changes throughout their system. Breakthrough Series have addressed care for people with diabetes, congestive heart failure, depression, other heart disease and hypertension, arthritis, HIV/AIDS, and other major illnesses. The RAND Corporation is conducting a major evaluation of the quality and cost impacts of the early Breakthrough Series and the results should be available later this year.

Our experience in the Breakthrough Series and related quality improvement activities suggests that medical practices of all types, large and small, fee-for-service and capitated, suburban and inner city, can—with motivated leadership—improve care for their chronically ill patients. Our experience also indicates that these organizations, and the countless others that don't participate in the Breakthrough Series, face major environmental barriers to improving their systems of care. These include financial disincentives such as those listed above, computer systems designed to send out bills but not take care of patients, and increasingly lean practice staffing.

Will Improving Chronic Illness Care Save Money?

In the *JAMA* paper discussed previously, we looked for rigorous studies of programs to improve congestive heart failure, asthma, or diabetes that also analyzed the program's impacts on health care costs. We found 27 articles that met our criteria. Of these, 18 found reductions in health care utilization and costs. I believe that we can say with some confidence that, for most chronic diseases, activities that improve patient health (better blood sugar, less fluid retention, fewer symptoms, and better function) will reduce expensive health care utilization.

VI. How Might Medicare Reform Improve Chronic Illness Care?

Major chronic illnesses such as suffered by Ms. G. require high quality, coordinated medical care. Although disease management vendors may have staff and tools that can complement medical care, they are not a substitute for it. It is my strong view that we will not achieve major improvements in health or reductions in cost for our Medicare beneficiaries unless we take steps to improve the quality of the basic care they receive, unrealizable as that may seem. Below I offer a series of recommendations followed by another recommendation—the development and implementation of a system to recognize providers who deliver high-quality care—presented in more detail for the Subcommittee's consideration.

1. CMS should support the dissemination of, and provide technical assistance for low cost electronic information systems shown to be important adjuncts in care improvement. This should begin with dissemination of an electronic patient registry that stores key, but not all, clinical information about

the chronically ill, and uses it to provide reminders of needed services, facilitates planning care, prevents patients from getting lost between the cracks, provides performance feedback to the practice, and provides quality measures for Medicare. As reliable, more comprehensive electronic medical record systems become more available and affordable, these should be disseminated.

2. CMS should extend and improve measures of the quality of chronic illness care, and require their routine reporting. The measures should include, to the extent possible, indicators of disease control and severity, and not just processes of care (e.g. doing recommended tests or prescribing recommended drugs). These measures could and should be collected as part of the data systems mentioned above.

3. CMS should encourage and support regional quality improvement activities directed at improving basic care for the chronically ill through its contracts with Quality Improvement Organizations and other mechanisms. The Bureau of Primary Health Care's Health Disparities Initiative provides a relevant model as it supports its program of the Breakthrough Series with a national infrastructure that provides quality improvement and information system support to any Community Health Center involved in quality improvement.

4. Congress and CMS must continue their efforts to stabilize the Medicare+Choice program by addressing payment and other issues that have hindered its success. More than 25 years ago, Group Health Cooperative was among the first organizations in the nation to serve Medicare beneficiaries through a pre-paid model of care. Today, nearly 60,000 Washington state Medicare beneficiaries have chosen Group Health's Medicare+Choice plan for their coverage.

Pre-payment has enabled Group Health and other organizations 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 have incentives to shift your focus to include longer-term improvement in health outcomes. The pre-paid model of care also has enabled Group Health and other plans to develop highly integrated and coordinated care delivery systems by creating opportunities for physicians, hospitals, other health providers, and facilities to associate with each other. This type of integration makes it easier for providers to communicate with one another. Communication among providers, as presented in the case study of Ms. G., is crucial to successfully caring for chronically ill patients.

5. Congress should establish a program that recognizes providers for delivering high quality care to chronically ill beneficiaries. Medicare is in a unique position to provide leadership in changing the patterns of medical care that have led to inadequate chronic care. Encouraging what we know to be the best medical care and treatment of chronic conditions should be a leading objective of Medicare. Group Health Cooperative has been working with the Alliance of Community Health Plans to develop a two-pronged approach to paying for better care in Medicare. Undertaking changes will certainly be gradual. Medicare will need to implement policies that encourage providers to adopt new strategies. Rewarding health plans and providers who deliver excellent chronic care is one of the best ways to accomplish this.

To do this, though, you need to have measures against which providers can be assessed; you need to collect comparable and reliable data and analyze it; and then you need to establish a method for ranking or scoring performance, allocating rewards accordingly. Some modest steps can be undertaken quickly, but a more expansive effort that encompasses all of Medicare will require a long-term commitment to this approach in the Congress.

Unfortunately, common measures and data collection don't exist for many of Medicare's providers. Moreover, as I have pointed out above, the payment system within fee-for-service Medicare sets up disincentives to improved chronic care. Beginning to make these changes as part of reforms in Medicare should be a high priority. In the meantime, however, Medicare could begin to test the concept of rewarding quality care in Medicare managed care plans—where, thanks to the capitated payment method and the National Committee for Quality Assurance's (NCQA) performance measures that have been used for health plans for many years—the capability to measure and begin to pay for performance already exists. On a yearly basis, Medicare collects data from every Medicare health plan on the effectiveness of clinical care and on beneficiary satisfaction, through the HEDIS® and CAHPS® measures. Based on this data—which looks at both process and outcome measures, including such things as use of beta blocker treatment after a

heart attack, and comprehensive diabetes care—and the ranking methodology that NCQA has already developed, CMS and the Congress could develop a parallel program in Medicare that would pay a little more per capita to those plans that perform very well.

I would hasten to add, though, that while we could learn a lot through this modest effort, it should be only a bridge to a longer-term and more robust initiative in Medicare to improve quality across all types of providers and delivery systems. As I noted above, payment disincentives are one of the major barriers to providing good chronic care in the fee-for-service side of Medicare.

The Institute of Medicine (IOM) could help to address some of the clinical issues that would need to be part of a broader payment for quality initiative. Through one of its authoritative studies, the IOM could identify the appropriate clinically-based measures, and the strategies needed to implement and refresh them over time. Such a study could provide Congress with recommendations, based on clinical evidence, an evaluation of the strategies for rewarding and encouraging quality and better chronic care that are already beginning to be used in the private and public sectors, and new ideas that are just now on the drawing board.

VII. Conclusion: Ms. G. Revisited

If her doctor's practice followed the Chronic Care Model, Ms. G.'s care may have proceeded in the following manner. Ms. G.'s doctor's staff checks its electronic patient registry and finds that Ms. G.'s diabetes is not well controlled, and that she hasn't had a preventive check-up in several months. She is scheduled for a structured visit with her doctor and a nurse educator. At the visit, Ms. G. receives her flu shot and recommended tests for monitoring her diabetes. The doctor finds that Ms. G. has mild heart failure, schedules her for a cardiologist evaluation, and advises her to reduce the salt in her diet. Ms. G. discusses her diet and exercise regimen with the nurse educator who helps her set new goals for reducing salt and calories, and a modest exercise program. The nurse educator telephones Ms. G. a week later to see how she is doing with her new goals, and with any new medicines prescribed by the cardiologist. Further phone calls reveal that Ms. G. feels better, her diabetes is better controlled, and the heart failure is causing no symptoms. She is scheduled in two months for another structured visit.

I thank the Members of the Subcommittee for the opportunity to discuss this important issue with you and would be happy to answer any questions you may have.

Chairman JOHNSON. Thank you very much, Dr. Wagner.

Dr. Taler.

STATEMENT OF GEORGE A. TALER, M.D., DIRECTOR, LONG TERM CARE, DEPARTMENT OF MEDICINE, WASHINGTON HOSPITAL CENTER, ON BEHALF OF THE AMERICAN GERIATRICS SOCIETY, NEW YORK, NEW YORK

Dr. TALER. Congresswoman Dunn——

Chairman JOHNSON. Excuse me. You have to turn your mike on and speak right into it.

Dr. TALER. Congresswoman Dunn and Members of the Subcommittee, thank you for allowing me to testify today on an important issue, advancing the management of chronic care under Medicare. I am George Taler, board certified geriatrician and director of long-term care at the Washington Hospital Center, and I appreciate the opportunity to participate today on behalf of the American Geriatric Society.

Before I begin to discuss chronic care and disease management-related issues, it is necessary to place geriatrics in context. Geriatricians are primary care-oriented physicians who complete at least an additional year of fellowship training in geriatrics, following training and certification in family medicine or internal medicine, and who are experts in caring for older persons.

Geriatric medicine emphasizes care coordination that helps frail elderly patients maintain functional independence and perform the activities of daily living and improves their overall quality of life.

Using an interdisciplinary approach to medicine, the geriatric team cares for the most complex and frail of the elderly population, often in special settings such as nursing homes, hospice and as in my practice, in the patient's home.

We are actively engaged in pursuing system innovations in the care of the elderly, especially those with advanced or multiple chronic illnesses.

Today, chronic diseases are the major cause of illness, disability and death in this country, and the Partnership for Solutions, a Robert Wood Johnson Foundation-funded initiative, of which we are a partner, has found that 78 percent of the Medicare population has at least 1 chronic condition; 20 percent of the Medicare population has 5 or more chronic conditions or comorbidities. In general, the prevalence of chronic conditions increases with age. Twenty-eight percent of those 85 and older have 5 or more chronic conditions. That is about average for my practice.

There is a strong pattern of increased utilization as the numbers of conditions increase. Using data again from the Partnership for Solutions, the average beneficiary has over 15 physician visits annually and sees over 6 unique physicians a year. There is almost a fourfold increase in visits by patients with five or more conditions, compared with visits by patients with one chronic condition.

Individuals with five or more chronic conditions are a large portion of my patient base, and geriatrics tends to provide care coordination services to those patients based on their need for extensive family and patient consultation, heavy use of pharmaceuticals and high need for transitional care as these patients move through the health care system.

We are not reimbursed for providing these services, and in fact, most geriatricians are unable to sustain private practices because of their commitment to care for this patient base.

At this time, I would like to discuss disease management and care coordination services in this context. A portion of today's hearing focuses on disease management. We believe that disease management is an appropriate practice for certain Medicare beneficiaries who do not have multiple chronic conditions.

However, disease management does not address the real key issues involved with frail elderly patients that have multiple chronic conditions. First, disease management does not always address the needs of persons with more than one condition. Imagine putting one of my patients with diabetes, hypertension, heart failure and dementia into a disease management program for each of these conditions. Most of the people who are most costly to Medicare have multiple conditions, and care for these patients cannot be segmented into different disease management programs.

Second, a major component of disease management involves self-management in patient education. These simply do not work for patients with Alzheimer's disease or related dementia, 60 percent of my practice.

Diabetes self-management often involves patient education or patient self-management, which is inappropriate for such bene-

ficiaries; and likewise, disease management for asthma and hypertension depends on patient compliance with treatment recommendations, and this would simply not be effective.

Third, when used for patients with multiple comorbidities, disease management can disrupt a patient's critical relationships with their primary care physician. Some disease management programs use specialists that focus on only specific interventions tailored to one condition. The nature of chronic illness requires a comprehensive, coordinated approach, that uses a variety of interventions, which change over time, and which contain both clinical and nonclinical components, such as coordination with community-based services and environmental changes to support functional independence.

Finally, disease management does not always address functional issues brought on by old age or the complications that arise from multiple conditions.

We must go beyond disease management for our Medicare population with multiple chronic conditions and consider other options that will improve their care, such as the Medicare care coordination benefit. For this reason, we strongly support the Geriatric Care Act, H.R. 102, and Senate bill 387. This bill would authorize Medicare coverage of geriatric assessment and care coordination for eligible Medicare beneficiaries.

Eligible persons are those with at least two activities of daily living limitations, a complex medical condition or severe cognitive impairment. Some examples of appropriate care coordination services include coordination with other providers, including telephone consultations; monitoring and management of medications, especially those with polypharmacy; and patient and family caregiver education and counseling through both office visits and telephone consultations; and finally, helping patients through the transition from chronic to terminal care.

One other option has to do with physician training and physician ability to care appropriately for people with chronic conditions. The Geriatric Care Act would also provide for a limited Medicare Graduate Medical Education (GME) exception to hospitals' specific caps to train additional geriatricians who specialize in providing care coordination services and who are also in shortage across the Nation.

Changes such as these should be strongly considered by Congress as it debates how to modernize the Medicare system. We would like to work with you to enact these changes, and we thank you for including us in today's hearings.

[The prepared statement of Dr. Taler follows:]

Statement of George A. Taler, M.D., Director, Long Term Care, Department of Medicine, Washington Hospital Center, on behalf of the American Geriatrics Society, New York, New York

Madame Chair and Members of the Subcommittee:

Thank you for allowing me to testify today on an important issue—eliminating barriers to chronic care management in Medicare.

I am Dr. George A. Taler, a Board certified geriatrician and Director of Long Term Care in the Department of Medicine at the Washington Hospital Center. I appreciate the opportunity to participate today on behalf of the American Geriatrics Society (AGS), an organization of over 6,000 geriatricians and other health care professionals dedicated to the care of older adults.

Today I will discuss the needs of the chronically ill Medicare beneficiary, particularly those individuals with multiple chronic conditions who are in need of care coordination services as well as some aspects of disease management that relate to this population.

Brief History of Geriatrics

Before I begin to discuss chronic care issues, it is necessary to place geriatrics in context. Geriatricians are physicians who are experts in caring for older persons. Geriatric medicine promotes preventive care, with emphasis on care management and coordination that helps patients maintain functional independence in performing daily activities and improves their overall quality of life. With an interdisciplinary approach to medicine, geriatricians commonly work with a coordinated team of other providers such as nurses, pharmacists, social workers, and others. The geriatric team cares for the most complex and frail of the elderly population.

Geriatricians are primary-care-oriented physicians who are initially trained in family practice or internal medicine, and who, since 1994, are required to complete at least one additional year of fellowship training in geriatrics. Following their training, a geriatrician must pass an exam to be certified and then pass a recertifying exam every 10 years.

The Frail Elderly/Chronically Ill Population

Americans are not dying typically from acute diseases as they did in previous generations. Now chronic diseases are the major cause of illness, disability and death in this country, accounting currently for 75% of all deaths and 80% of all health resources use. The Partnership for Solutions, a Robert Wood Johnson founded initiative of which we are a partner has found that about 78% of the Medicare population has at least one chronic condition while almost 63% have two or more. Of this group with two or more conditions, almost one-third (20% of the total Medicare population) has five or more chronic conditions, or co-morbidities.

In general, the prevalence of chronic conditions increases with age—74% of the 65 to 69 year old group have at least one chronic condition, while 86% of the 85 years and older group have at least one chronic condition. Similarly, just 14% of the 65–69 year olds have five or more chronic conditions, but 28% of the 85 years and older group have five or more.

Utilization Patterns

There is a strong pattern of increasing utilization as the number of conditions increase. Using data again from the Partnership for Solutions, 55% of beneficiaries with five or more conditions experienced an inpatient hospital stay compared to 5% for those with one condition or 9% for those with two conditions. 19% of Medicare beneficiaries have an inpatient stay.

In terms of physician visits, the average beneficiary has just over 15 physician visits annually and sees 6.4 unique physicians in a year. There is almost a fourfold increase in visits by people with five chronic conditions compared to visits by people with one chronic condition. The number of unique physicians seen increases almost two and half times for people with five or more chronic conditions relative to those with just one chronic condition.

The average Medicare beneficiary fills almost 20 prescriptions. Within this average, the under 65 year old population fills on average 6.3 prescriptions and those 65 years and older fill 19.1 on average. We found that beneficiaries with no chronic conditions fill an average of 3.7 prescriptions per year while those with any chronic conditions fill an average of 22.7.

The Partnership for Solutions found that there is a strong trend in utilization of prescriptions when examined by number of chronic conditions.

- Average annual prescriptions filled jumps from 3.7 for all people studied with no chronic condition to 49.2 for people with five or more chronic conditions.
- Growth in usage between those with no chronic conditions and those with one chronic condition is over 180 percent—from 3.7 to 10.4 prescriptions filled.
- Usage grows 72% between one and two chronic conditions, from 10.4 to 17.9 prescriptions filled.
- There is a 48% growth in average annual usage between four and five chronic conditions (33.3 to 49.2).

Policy Implications

Individuals with 5 or more chronic conditions are a large portion of my patient base. Geriatricians tend to provide care coordination services to these patients based on their need for extensive family and patient telephone consultation, heavy pharmacological usage, and high need for transitional care as these patients move from

different settings in the health care system. We are not reimbursed for providing these services and, in fact, most geriatricians are unable to sustain private practice because of their commitment to care for this patient base. At this time, I would like to discuss disease management and care coordination services in this context.

A portion of today's hearing focuses on disease management. We believe disease management is an appropriate practice for certain Medicare beneficiaries who do not have multiple chronic conditions, such as those with only diabetes, asthma or hypertension. However, disease management does not address several key issues involved with frail elderly patients that have multiple chronic illnesses and/or dementia.

First, disease management does not always address the needs of persons with more than one chronic condition. Imagine putting my patient with diabetes, hypertension, dementia, asthma, and COPD into a disease management program for each of these conditions. Most of the people who are most costly to Medicare have multiple conditions and the care for these people can not be segmented into different disease management programs. In fact, many of these individuals with one or more chronic conditions also have Alzheimer's disease or another dementia. Disease management focusing on diabetes without taking dementia into account wouldn't be successful.

Second, a major component of disease management involves self-management and patient education. These simply do not work for persons with Alzheimer's disease or a related dementia. Diabetes self management often involves patient education or patient self management which is inappropriate for a beneficiary with Alzheimer's disease or related dementia. Likewise, disease management for asthma and hypertension depends on patient compliance with treatment recommendations; this would not be effective for persons with Alzheimer's disease or related dementia.

Third, disease management does not always address functional issues brought on by old age or the complications that arise from multiple chronic illnesses.

Finally, when used for patients with multiple comorbidities, disease management can disrupt a patient's critical relationship with a primary care physician. Some disease management programs utilize specialists that focus only on specific interventions tailored to one condition. The nature of chronic illness requires a comprehensive, care coordination based approach that utilizes a variety of interventions which change over time and which contain both a clinical and a non-clinical component.

There are indications in the data that there is a lot of care provided to beneficiaries with chronic conditions—particularly those with multiple chronic conditions. There are also indications that the care may not be well-coordinated and that for beneficiaries with multiple chronic conditions there are adverse outcomes. We believe the lack of a care coordination benefit is a major reason for this outcome.

For instance, the Partnership for Solutions has found that as the number of chronic conditions increase, so too do the number of inappropriate hospitalizations for illnesses that could have received effective outpatient treatment. These poor outcomes are likely a result of poor care coordination among the many services used and providers seen. It may be that different providers are recommending conflicting treatments that result in poor outcomes including adverse drug events. It could be that one condition is receiving treatment, while other chronic conditions go unattended and then become acute episodes.

There is other data to support this theory. A recent national survey of people with serious chronic conditions completed by Gallup for the Partnership for Solutions found that:

- 26 percent report receiving contradictory advice from different doctors in the past year;
- 20 percent report they were often or sometimes sent for unnecessary or duplicate tests or procedures;
- 23 percent report that they often or sometimes received conflicting information from different health care providers; and
- 25 percent report that they were often or sometimes diagnosed with different medical problems for the same set of symptoms from different providers.

Other Partnership for Solutions data shows that physicians think that care coordination is both important and difficult to do. A national survey of physicians who provide more than 20 hours of direct patient care during the week demonstrated that almost two-thirds of these physicians reported that their medical education training was not adequate to the task of caring for people with chronic conditions and 17 percent reported that they had problems coordinating care with other physicians. Most importantly, physicians in our survey think that poor care coordination leads to poor outcomes.

This data suggests that we must go beyond disease management for our Medicare population with multiple chronic conditions and consider other options worth exploring that will improve their care. These options would be modest, but important, steps to improve care for beneficiaries and modernize the Medicare fee-for-service program. As you can see, we know a great deal about Medicare beneficiaries and their conditions, as well as the lack of coordination within the system that affects them.

Thus, we believe that chronically ill Medicare beneficiaries will receive better care and have better outcomes if a new care coordination benefit is created. The AGS believes it is critically important to create this new benefit under the fee for service Medicare program. Doing so could make significant progress toward a more integrated system for all beneficiaries. For these reasons, we strongly support the Geriatric Care Act (H.R. 102/S. 387).

This bill would authorize Medicare coverage of geriatric assessment and care coordination for eligible Medicare beneficiaries. Eligible persons are categorized as those who: (1) have at least 2 activities of daily living limitations; (2) have a complex medical condition, as defined by the Secretary of Health and Human Services (HHS); or (3) have a severe cognitive impairment.

Eligible individuals will have a designated care coordinator who must enter into a care coordination agreement with the HHS Secretary. The coordinator may include physicians, physician group practices, or other non-physician health care professionals in collaboration with a physician.

Examples of appropriate care coordination services include: (1) multidisciplinary care conferences; (2) coordination with other providers, including telephone consultations with relevant providers; (3) monitoring and management of medications, with special emphasis on clients using multiple prescriptions (including coordination with the entity managing benefits for the individual; and (4) patient and family caregiver education and counseling (through office visits or telephone consultation), including self-management services.

Another modest change to Medicare would be to provide incentives to physicians and other providers to provide care coordination services to frail elderly beneficiaries. Unlike the traditional method of disease management, which targets enrollees with particularly high cost conditions, it may be useful to look at some of the people who are having the most difficult time with multiple medical conditions (whatever those conditions may be). We could focus on people with four or five chronic conditions who, for whatever reason, have difficulty self-managing one or more of their conditions. These are people who typically see many physicians, who fill a large number of prescriptions, who need an array of health care services, and who are at risk of poor outcomes if the clinical care and other care are not well-coordinated.

For this group of target beneficiaries, there could conceivably be a physician payment adjustment that compensates physicians for the additional visit and other office time necessary to work with these patients. This type of adjustment could be available to all physicians treating any Medicare patient who meets the criteria.

One other option that is not mutually exclusive with anything else discussed here has to do with physician training and physician ability to care appropriately for people with chronic conditions. One other component of the Geriatric Care Act would provide for limited changes to the Medicare graduate medical education (GME) program to train additional geriatricians who specialize in providing care coordination services and who also are in shortage across the nation. This would allow for a limited exception to the per hospital cap on GME for small numbers of geriatricians.

We would like to work with this Committee and the Congress to legislate these important changes and we thank you for including us in today's important hearing. Changes such as these should be strongly considered as the Congress debates how to modernize the Medicare system.

Chairman JOHNSON. Thank you very much.

Dr. Berger.

STATEMENT OF JAN BERGER, M.D., SENIOR VICE PRESIDENT, CLINICAL QUALITY AND SUPPORT, CAREMARK RX, INCORPORATED, BIRMINGHAM, ALABAMA

Dr. BERGER. Thank you, Madam Chairman and distinguished Members of the Subcommittee. My name is Dr. Jan Berger, and I

am the senior vice president for clinical quality and support for Caremark. I am also a practicing physician. I am here today representing Caremark Rx, Incorporated. It is an honor to be here to discuss an issue that is important to Medicare, essential to Caremark's health management strategy and an issue which I have been personally involved for almost 20 years, that being disease management. As requested by the Subcommittee, a full copy of my testimony has been submitted for the record.

Let me start by providing you with some information on Caremark. Caremark employs over 4,000 people throughout the United States. We provide pharmacy and health management services through our three lines of business that include pharmacy benefit services, biotech and injectable therapy service and CarePatterns disease management services. Caremark is the only pharmacy benefit provider that has received full patient and practitioner disease management accreditation by the National Committee of Quality Assurance (NCQA).

Caremark's clients are confronted with some of the same challenges facing the Committee as it looks to ways to integrate chronic care management into the Medicare program. First, as you have heard, there is a lack of coordination of care among all care givers and the patient. The effects of this lack of coordination are especially apparent in the chronic condition population. For Medicare, as noted in the Chairman's announcement of these hearings, 32 percent of beneficiaries have 4 or more chronic conditions. These individuals account for a disproportional share of total Medicare spending.

Second, there is a lack of consistency of treatment according to evidence-based guidelines. For example, according to NCQA, only 32 percent of individuals with diabetes and hyperlipidemia are being appropriately treated with diet, exercise or medication.

Studies have demonstrated the clinical and financial benefits associated with getting individuals with chronic conditions treated to guidelines. A final challenge to our clients was to manage their total medical expenditures and not only focus on the pharmacy component of spending. For the Medicare program, we believe a disease management program by itself may yield some benefits, but without an accompanying pharmacy benefit, would have limited impact.

Our CarePatterns programs were built to meet these challenges, utilizing nationally recognized clinical guidelines and protocols to educate both patients and providers. CarePatterns participants receive regularly scheduled calls from nurse educators. They also receive customized educational mailings and reminders regarding key clinical tests, diet, lifestyle and comorbidity management. Collaboration with the treating physician is a necessary and key component of our program.

I would like to give you an example of the success we have seen with our program in an over-65 population. One of Caremark's clients, the National Association of Letter Carriers (NALC), has a large over-65 population with a high prevalence of chronic conditions whose expenditures were rising at a rate higher than that of their overall population. The leadership at NALC came to Caremark to help them find solutions to address these challenges.

Along with their already interesting pharmacy benefit, disease management programs for diabetes, asthma, ulcer and arthritis were offered to the beneficiaries starting in 1998. Participation in the disease management programs were both voluntary and confidential.

I would now like to discuss the outcomes of the diabetes disease management program for NALC. The average age of the diabetes program participant was 75; 2,745 individuals participated in this program. The average age of the nonparticipant control group was 73. This group included approximately 9,000 participants. The full details of the study, which were published in Disease Management Journal, volume 4, number 2, 2001, are attached for your review.

Through an agreement with the client's benefit plan, Caremark received the medical claims data to perform an analysis of this program. By any measure, the program was successful. Program participants experienced a decrease in medical spending of 9 percent from baseline and 17 percent from the projected trend. When pharmacy costs are included in the analysis, total health care spending, which included both medical and pharmacy, still decreased by 3 percent.

Conversely, the nonparticipant control group saw an increase in total medical spending of 5 percent in the program year. Together they generated a total savings of nearly $4 million, or 4.7 percent of the total spending for individuals with diabetes in the first year of this program.

This translates to approximately $1,400 in saving per participant. Participants also reported a significant increase in their quality of life and high satisfaction with this program.

The leadership at NALC has subsequently added additional programs. A disease management program by itself may yield some benefits, but without an accompanying pharmacy benefit will have limited impact. Studies have demonstrated the importance of appropriate pharmacy utilization in managing chronic conditions such as diabetes, heart disease and asthma, but the results from our study demonstrate a pharmacy benefit alone is not enough.

The individuals in the study that did not participate in the care pattern disease management programs had access to the same medical and pharmacy benefits as those that did participate, yet their total medical spending continued to rise while that of the participants decreased. It is only through a program of total health management that includes coordinated interventions in behavior, treatment protocols, and pharmacy regimens that a plan sponsor such as Medicare and an individual will see an improved clinical, quality of life, and financial outcomes.

Thank you very much for this opportunity to address the Subcommittee, and I will be happy to take any questions.

[The prepared statement of Dr. Berger follows:]

Statement of Jan Berger, M.D., Senior Vice President, Clinical Quality and Support, Caremark Rx, Incorporated, Birmingham, Alabama

Thank you Madam Chairman and distinguished Members of the Committee. My name is Dr. Jan Berger. I am the Senior Vice President for Clinical Quality and Support for Caremark. I am also a practicing physician. I am here today representing Caremark Rx, Incorporated. It is an honor to be here to discuss an issue that is important to Medicare, is central to Caremark's health management strat-

egy, and is an issue with which I have been personally involved for almost twenty years, that being disease management. As requested by the Committee, a full copy of my testimony has been submitted for the record.

Let me start by providing you with some information on Caremark. Caremark is headquartered in Birmingham, Alabama, with most of our operations centered in Northbrook, IL. Caremark employs over 4,000 people in over 30 facilities throughout the United States and provides pharmacy and health management services through our three lines of business. First, Caremark provides pharmacy benefit services to over 23 million people in all fifty States and Puerto Rico. Second, we provide biotech and injectable therapies to physicians and patients. Third, Caremark provides disease management services through our CarePatterns disease management programs. Our commitment to this area is demonstrated by the fact that Caremark is the only pharmacy benefits provider that has received full patient and practitioner disease management accreditation by the National Committee for Quality Assurance.

Caremark's clients are confronting some of the same challenges facing the committee as it looks at ways to integrate chronic care management into the Medicare program. First, there is a lack of coordination of care among all caregivers and the patient. The effects of this lack of coordination are especially apparent in the chronic condition population. For Medicare, as noted in the Chairman's announcement of these hearings, 78 percent of Medicare beneficiaries have one chronic condition. 32 percent have four or more chronic conditions. These individuals account for a disproportionate share of total spending. Secondly, there is a lack of consistency of treatment according to evidence-based guidelines. For example, according to NCQA, only 32 percent of individuals with diabetes and hyperlipidemia are being appropriately treated with diet, exercise or medication. Studies have demonstrated the clinical and financial benefits associated with getting individuals with chronic conditions treated to guidelines. A final challenge to our clients was to manage their total medical expenditures and not only focus on the pharmacy component of spending. For the Medicare program, we believe that a disease management program by itself may yield some benefits, but without an accompanying pharmacy benefit would have had a very limited impact.

Our CarePatterns programs were built to meet these challenges, utilizing nationally recognized clinical guidelines and protocols to educate both patients and providers. The focus is on the participant as a whole rather than on acute episodes, and provides an integrated systems-based approach that facilitates communication among different providers. CarePatterns participants receive regularly scheduled calls from nurse educators. They also receive customized educational mailings and reminders regarding key clinical tests, diet, lifestyle, and co-morbidity management. Collaboration with and intervening on the treating physician where appropriate are necessary and key components of the program.

I would like to give you an example of the success we have seen with our program in an over-65 population. One of Caremark's clients, the National Association of Letter Carriers (NALC), has a large, over-65 population with a high prevalence of chronic conditions whose expenditures were rising at a rate higher than that of their overall population. The leadership at NALC came to Caremark to help them find solutions to address these challenges. Along with their already-existing pharmacy benefit, disease management programs for diabetes, asthma, ulcer and arthritis were offered to beneficiaries starting in 1998. Individuals were identified through pharmacy claims data and invited to enroll in the program.

Participation in the disease management programs was both voluntary and confidential. Through an agreement with the NALC benefit plan, Caremark received the medical claims data to perform an analysis of the program. The data allowed us to compare the outcomes of the program participants to their projected trend, and to those individuals with the same conditions that did not enroll in the plan. The average age of the diabetes program participants was 75. The average age of the non-participant control group was 73. Due to high levels of co-morbidities among both participants and non-participants and to avoid counting the same savings in more than one program, our published study focused on the diabetes population. The full details of the study may be found in the Disease Management Journal, Volume 4, Number 2, 2001.

By any measure the program was successful. Program participants experienced a decrease in medical spending of 9 percent from baseline, and of 17 percent from the projected trend. When pharmacy costs are included in the analysis, total health care spending, which includes both medical and pharmacy, still decreased by 3 percent. Conversely, the non-participant control group saw an increase in total medical spending of 5 percent in the program year when overall plan spending on a per person basis remained stable. 2,745 individuals participated in the diabetes program.

Together they generated a total savings of nearly $4 million, or 4.7 percent of total spending for individuals with diabetes in the first year of the program. Participants reported a significant increase in their Quality of Life (QOL) and high satisfaction with the program.

Since the initial implementation, the leadership at NALC has subsequently added additional programs that target coronary artery disease, chronic obstructive pulmonary disease, and heart failure.

A disease management program by itself may yield some benefits, but without an accompanying pharmacy benefit will have a limited impact. Studies have demonstrated the importance of appropriate pharmacy utilization in managing chronic conditions such as diabetes, heart disease and asthma. But the results from our study demonstrate that a pharmacy benefit alone is not enough. The individuals in the study that did not participate in the CarePatterns disease management programs had access to the same medical and pharmacy benefits as those that did participate, yet their total medical spending continued to rise while that of the participants decreased. It is only through a program of total health management (such as that outlined by Slezak and Stine in Benefits Quarterly, First Quarter, 2003 edition, "The Role of the PBM in Total Health Management Strategies for Individuals with Chronic Conditions") that includes coordinated interventions on behavior, treatment protocols and pharmacy regimens that a plan sponsor such as Medicare and an individual will see improved clinical, quality-of-life, and financial outcomes.

Thank you very much for this opportunity to address the Committee, and I would be happy to take any questions you may have.

Chairman JOHNSON. I thank the panel. There really is no controversy about the fact that seniors are aging and there is more of them and that they live with chronic illnesses. I also think there is broad agreement that management works. One of the most difficult issues is whether or not one can develop a payment to coordinate care, or whether you have to change the system so that the coordination is inherent in the structure. I want each of you to express your opinion on this issue of a payment for coordination versus other changes that creates structural coordination.

Now, I am coming to this from an experience in a system that has not been able to define the difference between a comprehensive physical and a detailed physical for payment purposes. I am also coming as a Member who spent a year and a half trying to help Washington figure out what partial hospitalization meant so that it could pay its providers who were caring for our elderly. I am currently getting the government up to my district so that they can determine how they will define an intensivist, because they have defined it in the law, they have a payment code, but all requests for payment are rejected. This is not new. This code has been there.

On the other hand, the intensivist in the intensive care unit is saving Medicare money hand over fist by coordinating intensive care.

So, even in the narrow focus of specific care categories, where we actually have payment capability for some integrated care, we often are unable to accept documentation of that fact, and we leave our providers exposed to the Inspector General. If you think a payment structure is the answer, then I need for you to be able to document to me that the definitions will be clear enough so the Inspector General will not be down the provider's back. Also, that they will be broad enough so something resembling management can occur.

We are now, as you may know, looking at the average wholesale price. The big controversy here is that we care manage oncology

services. We pay for it through the drug benefit, but we care manage. When you get in to look at what the practice expense factor should be, we pay for a lot of things in oncology service delivery that we don't pay for under Medicare. So, we are having trouble developing a code that will make a lot of new activities eligible that are actually care management in the delivery of cancer treatment.

So, rather than letting this big issue hold us back about whether there should be a care coordination payment or there should be systems changes, I want to hear you discuss this issue. That is my only question, so that is all my time. So, I just want to hear you comment, and then we will move on to Pete.

Mr. GUTERMAN. Madam Chairman, I would address that by saying that we recognize that there are certainly problems built into both parts of the Medicare program. One of the objectives of our demonstration projects is to be able to test out different potential solutions, and we have tried to design different forms of management fees that can be applied sort of to cover disease management services explicitly, and we have also in the demonstration projects that are up and running and the ones that we hope to do in the future will be soliciting innovative ideas for ways to structure both the services and the payment for those services so that we can provide the best services for our beneficiaries.

Mr. LEMIEUX. Mrs. Johnson, I think that the answer from our point of view would be that we should have a payment for care coordination services, and we should have structural processes in place to make sure that it is done under controlled conditions and that we can tell that it is working and that it is improving seniors health. Stu mentioned the nationally administered disease management demonstrations, which are great ideas. Our only value added to that would be to try to decentralize those demonstrations and make them local, and then also beef up Congress' ability to keep an eye on how well they are doing.

Dr. WAGNER. Well, I would be contradicting myself if I didn't say structural changes. I do believe that a care coordination reimbursement or package on top of unchanged practice will probably be money down the drain. On the other hand, there is no question that such a payment, if combined with structural changes, could both reward and contribute to further investment in those system changes would be a good idea.

Dr. TALER. I think that structural change is absolutely necessary, and that care coordination payments should emanate from how we wish to see that structural change occur. From my perspective, I think in some ways we are looking at the wrong issue. I would like to see structural change based around patient-centered care, rather than around their illness. I think most of the demonstration programs and most of the ideas that we have been seeing are focused around diseases and not patient needs. People want to stay at home as long as they can. They want to be as independent as they can be. They wish to avoid the health care system as much as possible. When that time comes, they wish to die at home and not in a nursing home and not in a hospital. I think we need to look at systems that provide that level of care to individuals so that they can maintain their independence at home as long as possible and feasible.

As we create those new structures, I think we can then look at what kind of payments make sense to entice health care providers to develop new systems of care along those lines.

Chairman JOHNSON. Thank you.

Dr. BERGER. I think the care coordination payments can be structured in several different ways because we know that there are a variety of models and approaches for care coordination, as you have heard today. It can be either on the active enrollee that we are participating with in their care coordination, or it can be across a population basis if you can specify and identify those populations that are in need of this care coordination.

You asked about the issue of how do we define what these activities should be. In light of disease management and how we are working with it, we have used the Disease Management Association of America's definition of disease management to help us delineate those necessary activities in order to have a positive outcome for all that are participating.

Chairman JOHNSON. Thank you. There are many thoughts in what each of you said as succinctly as you could. I recognize Mr. Stark.

Mr. STARK. Thank you, Madam Chairman. Let me just see if I can get to all in focus, and please excuse any damnation by comparison here. I am just trying to get you in focus with my own experience. Dr. Wagner, you are a staff model, group model similar to Kaiser? Okay. That is so I can focus there.

Dr. Taler, you practice in a group or practice in what I would call a solo practitioner? I am just trying to——

Dr. TALER. I am in a geriatrics group, and we are totally fee-for-service.

Mr. STARK. Okay. Well, there you go. Now, between the two of you, the management of chronic care would be just part of your program in Washington State, right? I mean, that is just—and as I suspect it is at Kaiser. I mean, it is just part of the system. If you have a campus system, exposure to Kaiser is you just bled right across the hallway or the lawn or whatever it is to go over and see somebody else or get your prescription, and it is all coordinated and the patient's records are all swapped. Probably you sit around and talk about patients with some multi-discipline; if you have got a sticky one you sit and talk with other specialists about what is going. Is that? Okay. How do you, Dr. Taler, in a fee-for-service, what I would call a primary care family doctor for old folks like me, right? How do you provide the services that Dr. Wagner's organization would provide? You have to coordinate. You have to—do you do it through your hospital? I mean, what is the practical—how do you do it?

Dr. TALER. Our program is a hospital-based house call practice.

Mr. STARK. Okay.

Dr. TALER. So, we provide primary care in the patient's home.

Mr. STARK. Keep going.

Dr. TALER. The care coordination is done through regular team meetings and on the fly communications through cell phones.

Mr. STARK. Now, you mean teams within your group practice?

Dr. TALER. Correct.

Mr. STARK. Okay.

Dr. TALER. Our coordination with the community providers, with housing support, with other specialists who are involved in the care is currently unfunded.

Mr. STARK. So, let me see if I can say that a different way. You are doing it.

Dr. TALER. Yes.

Mr. STARK. As part of your physician/patient relationship. Your, at least as far as Medicare is concerned, if somebody has got diabetes and they have an office visit, and if there is a code for that, it doesn't make any difference if you have got to call six other people to arrange appointments, you get the same fee?

Dr. TALER. Correct.

Mr. STARK. You don't get anything extra if a 40-year-old employed individual happened to come in to a family practitioner and had diabetes; they would get the same rate or they get a regular fee—if they were disabled, let us say, so they were still under Medicare—the same rate that you would charge? I mean, there is nothing—there is no difference if you are managing care or if just come in for one office visit. Is that what you are suggesting?

Dr. TALER. Under the current system, that is the way it is. Yes.

Mr. STARK. Okay. Well, do you—Dr. Wagner would like to get paid more, but so would Kaiser and so would all the managed care operators for their services. I understand that. You would like to get paid for what I would call a more intensive service to a physician because you are not capitated so you are not expected to do all these other services. It seems to me that we would have no trouble paying you, but you guys have to come up with the—and define what that service is. I mean, it is sort of like me suggesting that I should dream up a new kind of operation and how much to pay for it. I mean, you dream up the operation and I suppose there is staff at CMS that can tell you how much we ought to pay you for it if it is not new and unusual, we don't use it yet. I think we are trying to do two things here, and I don't think we are—I think we are all right, with the help of CMS, but I think those of you who are professionals have a—should in fact come up with, as you did, I guess, in the resource-based relative value scale. I mean, you guys got together—I am not sure your folks did, Dr. Wagner, but Dr. Taler's group did—and decided in some agreement what they ought to get paid on an index basis. Well, I would urge you to come to us.

Dr. Wagner, do you sell any of the information that you get from your patients or your studies or your operation? Do you make that commercially available to pharmaceutical companies?

Dr. WAGNER. Absolutely not.

Mr. STARK. Now, you do, Dr. Berger?

Dr. BERGER. No, we do not.

Mr. STARK. What is this item then in your U.S. Securities and Exchange Commission (SEC) report, the source of revenue resulting from data access?

Dr. BERGER. The information that we——

Mr. STARK. It says it is the sale of participant blinded pharmaceutical claim data.

Dr. BERGER. That is correct. The information that we get for our disease management programs is separate from the informa-

tion that we receive from our pharmacy benefits services. They are totally independent.

Mr. STARK. You sell some of that data?

Dr. BERGER. No. The data we received from disease management is not——

Mr. STARK. What about the data you get from pharmaceutical data, or your pharmaceutical management?

Dr. BERGER. From our pharmaceutical management?

Mr. STARK. Yeah.

Dr. BERGER. I would have to have the people who utilize that data and work with that data daily come and speak to you and respond to that.

Mr. STARK. I am just curious. I mean, it is listed in your SEC filing as a substantial source of data, and I just wondered who you sold it to. Thank you, Madam Chairman.

Chairman JOHNSON. Representative Dunn.

Ms. DUNN. Dr. Wagner, from your research, you developed the chronic care model that integrates six core elements into the practice of care, Group Health. How does an organization like Group Health decide which parts of its research on chronic care can be applied in practice to patient care? What factors do you take into consideration?

Dr. WAGNER. Group Health has had for years a very deliberative process managed by a multi-disciplinary committee that reviews all suggested changes to our clinical programs as well as benefits. The single most important criterion is the scientific evidence as to whether it works or not. That is overwhelmingly what most of the discussion revolves around. Once the conclusion is reached that something has a solid base of scientific evidence proving that it works better than anything else, then the discussion gets to the logistics and the cost of how we try to put it into the system. That is really the way it works.

Ms. DUNN. In order to add benefits to the Medicare program Congress has to pass legislation. You know that can be a very long and a very slow process. As a researcher and as a practitioner, do you believe that we need to create a process at CMS to determine coverage of preventative or chronic care management benefits?

Dr. WAGNER. I am not one to comment on whether Congress or CMS should determine benefits, it would certainly help if there were a speedier and a more scientifically driven process. That to me is more critical than perhaps whether the responsibility or accountability for decisionmaking should shift.

Ms. DUNN. What are the barriers to implementing a chronic care model or disease management program in the private sector and in the Medicare system? What are the unique challenges that you face in either of these, in both of these systems?

Dr. WAGNER. Well, I think the major challenges that we have encountered in working with these some thousand systems, most fee-for-service, are the leadership's commitment to improvement in this era of financial strain for most of the health system. Information technology and the absence of sufficient patient information to support modern chronic disease management is also a barrier. One of the adverse effects of the financial stress on all medical systems right now is the loss of non-physician staff to support the physi-

cians. Those non-physician staff, nurses, et cetera, are absolutely critical to modern chronic disease care. Number four is finance, no question.

Ms. DUNN. Thank you very much. Thank you, Doctor.

Chairman JOHNSON. Thank you.

Mr. Doggett.

Mr. DOGGETT. Mr. Guterman, you indicated in your testimony that the demonstration projects would continue if they were cost effective, I believe was your testimony.

Mr. GUTERMAN. In the coordinated care area.

Mr. DOGGETT. The coordinated care area. So, I gather from that testimony that it is premature to determine whether these programs are saving or are likely to save any money in the immediate future.

Mr. GUTERMAN. We haven't completed that. We haven't completed that analysis.

Mr. DOGGETT. They may be a good idea; they may not, from a cost savings standpoint?

Mr. GUTERMAN. From a cost savings standpoint.

Mr. DOGGETT. It may actually cost us more, because the data is not in yet?

Mr. GUTERMAN. Right.

Mr. DOGGETT. The same with reference to quality of care. There is not any evidence, is there, that providing—that these Medicare+Choice plans provide a higher quality of care than traditional Medicare beneficiaries receive? Is there?

Mr. GUTERMAN. The results I think are mixed on that in the literature. Our aim in these demonstration projects is to improve the coordination of care in both. As I said in my oral testimony, there are problems in both the fee-for-service and Medicare+Choice arenas in terms of encouraging the appropriate coordination of care for chronically ill beneficiaries.

Mr. DOGGETT. Did you hear the President's State of the Union Address?

Mr. GUTERMAN. Yes, sir.

Mr. DOGGETT. My recollection was that he was pretty firm about saying that he didn't want to turn health care over to HMOs; he wanted to turn it over to physicians and to nurses and to other health care providers. I gather if we ever see his Medicare plan, it is going to rely on turning over much more of the care to HMOs.

Mr. GUTERMAN. I couldn't speak to that.

Mr. DOGGETT. Is your part of the department involved in providing any information for that plan?

Mr. GUTERMAN. I haven't seen that, and I believe it is still being worked on.

Mr. DOGGETT. Thank you. Dr. Taler, we of course are now in year three of this Administration, and they have yet to come forward with any specific legislation on prescription drug benefits, and I gather after the strong reaction against what were the leaked out portions of their plan, they have kind of backed off doing it this time. What is it that you find superior in the Geriatric Care Act that you mentioned to the approach that some of the other witnesses have suggested today?

Dr. TALER. I think that there are two specific elements. One is the comprehensive geriatric assessment. Within that, we need to look very carefully at what makes good sense for the management of a disease but also what makes sense within the preferences and goals of that individual. Another domain that we need to look at are what kind of social supports would augment the medical care plan and support the caregiver in continuing their independence at home. Third, what kind of environmental changes are necessary to support that individual given their functional limitations. So, a payment for a more comprehensive evaluation that looks beyond medicine but looks at the whole patient and looks at what they want the most, which is to maintain their independence.

The second is the clinical care coordination that emanates from that comprehensive assessment to keep those programs in place, and as the patient's condition continues along its natural trajectory that things change. I think one of the most difficult parts of medicine is that transition from chronic care to terminal care, and that also as people move from one setting of care to the next, that there is continuity across those settings.

So, care coordination helps to support physicians in maintaining the relationship rather than focusing on the disease or focusing on the small business of your office; it is really focused around providing patient care over the remainder of their life.

Mr. DOGGETT. I know you don't have any demonstrations like Mr. Guterman has been working on, but do you have any opinion as to whether there would be any cost savings associated with that? Is this all likely to be a cost addition to the Medicare program?

Dr. TALER. We don't have any studies per se. I can only tell you from my own experience in my own practice. When we have looked at patients who have the same demographics and the same illnesses, and also comparing our own patients prior to entry into our program versus afterward, we are able to show a reduction in hospitalizations of about 10 percent, reduction of emergency room visits of about 15 percent, reduction in length of stay of about 2 days per hospitalization. I think one of the most dramatic differences—and you have to put that into the context of Washington, DC—71 percent of people in the District die in hospitals; 66 percent of the patients in our practice die at home.

Mr. DOGGETT. Thank you.

Chairman JOHNSON. Very interesting.

Mr. Johnson of Texas.

Mr. JOHNSON. Thank you, Madam Chairman. Dr. Taler, one of the provisions in the bill that is out there, 101, lifts the graduate medical education cap for geriatric students. As you know, Congress set limits on the number of GME resident slots it would pay for in the Balanced Budget Act. Overall those programs are unable to fill their current number of slots, so many hospitals have fewer residents than the number of positions Medicare is willing to pay to hospitals. So, what is the purpose of lifting the cap for geriatric residents if these hospitals can't fill the current slots? Tell me, if you agree that they should be lifted, what specific hospitals benefit from that?

Dr. TALER. I think that part of the problem in filling slots is the difficulty of geriatric practice as it is currently funded and currently structured, and I think that what we are looking at providing is actually an overall change in the way in which geriatrics is practiced and funded; if there were additional funds for comprehensive geriatric assessment and if there were funds for coordination of care, that those would support geriatric practice and make it more attractive financially as well as professionally. We then anticipate that there would be a greater demand for those positions. If there is a greater demand, then we anticipate that we would also like to have broader representation throughout academic hospitals. There is one other thing that we are doing.

Mr. JOHNSON. So, are you telling me the academic hospitals are the ones that would benefit from that?

Dr. TALER. Actually, all teaching hospitals would. If you were to look at what are the spin-off dollars for geriatric practices, currently most practices in academics are losing money and, when looked at in a silo fashion, are under attack. If you look at the spin-off dollars that come from those geriatric practices, they provide a substantial amount of support for the overall hospital enterprise. In Arkansas, there is a geriatric health care center. It probably just about breaks even, but they were able to demonstrate that they spin off approximately $17 for every dollar that they generate. That kind of information will get out to other health care centers, and they will recognize the value of providing services for geriatric patients. Without geriatric staff and without geriatric fellows, it is very difficult to get those enterprises up and running.

Mr. JOHNSON. Okay.

Mr. Lemieux, I agree with you that CMS isn't doing a very good job, and I think all of us probably would agree. Your testimony states that Medicare's fee-for-service program cannot pay for performance. Programs become an entitlement program for health care providers. If a licensed health provider treats a Medicare beneficiary, payment will follow. Since Medicare's structure is set by statute and governed by CMS coverage in coding process, you are saying often seniors don't have access to the latest and best health products and services. How would you fix that?

Mr. LEMIEUX. Well, I didn't mean to imply that I thought that CMS was doing a bad job, just that the nature of fee-for-service in a public——

Mr. JOHNSON. Well, I will imply it if you won't. Go ahead.

Mr. LEMIEUX. Our idea is that it is very difficult for the fee-for-service program sometimes to pay for these sorts of care coordination programs or services that we have been talking about, also for remote monitoring devices and other things just by the nature of the program. Our only insight into how to fix that is to—we all agree that CMS needs the flexibility to design disease management programs, care coordination protocols. However, I don't think that Congress is very likely to give CMS vast new power to go off and do whatever it wants unless there is a tremendous amount of new oversight over that process. I also think that disease management tends to be something that is best organized at a local level rather than at a national basis, especially comprehensive care management services as opposed to simple education.

So, the idea of trying to send CMS out into the field and have local medical directors working with providers and seniors group and consumer organizations and other institutions at the local level seems like the place where they need to be to make these sorts of demonstration programs the most effective.

Mr. JOHNSON. Will they believe the statistics or the results? It seems to me they are always about 2 or 3 years behind.

Mr. LEMIEUX. Yes. It is difficult in our current program to evaluate trends especially in costs because the data come in so slowly. One thing that we are very hopeful on is in the context of a universal catastrophic drug benefit every Medicare beneficiary would have a drug card from Medicare, probably provided from one of their supplemental coverage sources. Medicare would get the data because Medicare would have to know when its liability began. With a real-time data base of seniors' drug utilization patterns, we might be better able to target disease management for particular things to particular regions of the country or particular demographic groups.

Mr. JOHNSON. Thank you. Thank you, Madam Chairman.

Chairman JOHNSON. Mr. Cardin.

Mr. CARDIN. Thank you, Madam Chairman.

Mr. Guterman, I want you to know that I think CMS is doing a good job, particularly in light of the budget restrictions that we impose and the parameters in which we ask you to work. I really want to congratulate our Chairman, because I think she has really been looking at ways in which we can streamline the system to make it easier for CMS to do its work. That is what we should be looking at, ways to facilitate the adoption of new technology accompanied by rational reimbursement levels. We can obviously do a better job, and that is one of the reasons we are having this hearing and to see whether we can't determine ways to provide disease management.

Madam Chairman, there are two things that I have taken out of this hearing: First is that there is a need for disease management to be better handled under the Medicare reimbursement structure. Whether we make structural changes or provide direct reimbursement, there is a need for us to examine better ways to deal with disease management.

The second thing I noticed, Mr. Guterman, in the demonstration program, is that you are covering prescription medicines for the diseases affecting the individuals. So, as we look at covered services it seems to me that if we are going to have disease management we need to cover the prescription medicine costs of those ailments.

The Chair is aware that I have been interested in moving forward on this issue, I believe we should cover prescription medicines within Medicare; but if we can't cover all prescription medicines at a reasonable level, then we at least should cover those illnesses for which disease management is necessary, whether it is diabetes or high blood pressure or rheumatoid arthritis or severe depression or other types of diseases where we know that medicines are absolutely essential to disease management. We should at least cover those medicines. I think we should cover all, but if we don't have

the money to do it, let us set a priority and cover those that are most critical for disease management.

Dr. Wagner, I see you shaking your head in the affirmative, so I will call you then to respond to that, because maybe I will get a——

Dr. WAGNER. Oh, good. I agree with you. I would add one addition, that we should certainly cover the critical medicines that are essential to improving health of patients with these conditions. What would make it more affordable is if we picked and chose in some scientific way the more cost effective among the options, because there are options in the treatment of most of these conditions.

Mr. CARDIN. That is part of good disease management and practices. I would very much encourage that; most of the proposals here have been aimed at encouraging individuals to use the most cost effective way.

Mr. Guterman, I take it this was a conscientious decision that you couldn't have good disease management without covering the prescription medicines of the people in the program?

Mr. GUTERMAN. Well, actually it was Congress that mandated the coverage of prescription drugs under the Beneficiary Improvement Protection Act (BIPA) in this project. One of the things we hope to learn is how drugs can be used best in disease management activities from this demonstration, and we will be paying careful attention to that, and I think that is one of the critical aspects of this project.

Mr. CARDIN. Let me make another observation that Mr. Doggett made, and that is if we are going to expand covered services for better disease management, I expect that the Congressional Budget Office will score it as additional cost, even though we all know that it will reduce hospital days, it will save in all the areas that Dr. Taler raised: Clearly we are going to see significant cost savings. We have to be prepared to understand that this effort will require us to cover the extra initial costs in order to effect a more cost-effective system in the long run, and we should be prepared to do that. Thank you, Madam Chairman.

Chairman JOHNSON. I would like to ask the panel if you would all agree if we are going to really provide coordinated care we are going to have to cover some things we don't now cover, both in services and in people services?

Mr. GUTERMAN. Yes. I think that is one of the things we are doing.

Chairman JOHNSON. In addition to prescription drugs. I mean, in all of your plans there is a social service management component where there is a lot of telephone calls, there is remote monitoring. There are all kinds of things that you are going to have to cover that Medicare does not cover now. Right? So, it is important to recognize that it isn't just about prescription drugs. There are services that Medicare doesn't provide that you can't manage care without.

The second thing I want to be sure is that we notice for us to pay for those softer services the payments are not going to the doctor's office. Even there we have trouble. Remember, we have five levels. People would be appalled if they knew the amount of private

information we know about them that the auditors get to know about them in order to determine what level of service. Are you comfortable that you can actually define the soft services necessary for care management and that we could have an auditing system that wouldn't drive your offices absolutely nuts and leave you exposed to fraud and abuse charges? Anyone can comment.

Dr. TALER. Let me weigh in on that one. There is currently a code for care plan oversight. It is limited to recipients of skilled nursing services through the home care benefit. Physicians or nurse practitioners often provide services for these patients that include either consultation with other health care providers, the home care nurse, physical therapist, or other consultants, as they have team meetings, as they review records in order to have a better grasp of the overall care, and as you document time spent in those endeavors. If these services consume at least 30 minutes in a calendar month you are allowed to bill a Current Procedural Terminology code and are reimbursed at about $120 to $125, depending on your region.

Chairman JOHNSON. You have used that, and it works satisfactorily?

Dr. TALER. Yes. There are physicians around the country, especially those who are involved more with homebound patients, who have recognized that that is a mechanism for supporting their services while those patients are receiving the home care benefit.

Chairman JOHNSON. I just got a note that Dr. Wagner is going to have to leave. The second question I want to ask, and I will put it on the table and anyone can comment, is that the breakthrough series demonstrations—and I am particularly interested on Mr. Guterman commenting on this after Dr. Wagner. The breakthrough series is almost entirely—I believe it is entirely—in either community health centers or staff model groups?

Dr. WAGNER. No. Not at all. Of the 1,000 organizations we work with, over 500 are——

Chairman JOHNSON. Oh, good. All right.

Dr. WAGNER. Are private.

Chairman JOHNSON. The ones I have heard about are all community health centers. So, I want to be sure that we are thinking about how do we do this where there is not a staff model or a community health center, because they are just not around.

Dr. WAGNER. Oh, no. That is the biggest single program, but it is still a minority of the systems that have been involved.

Chairman JOHNSON. The management component can function just as well?

Dr. WAGNER. It sure helps having an organized system like the Bureau does. Yes. The answer is yes. I would like to, if I might, address your previous question. I agree with you that if we try to define disease management or care coordination as a set of specific services, they will be subject to abuse. I suspect they will be abused, and that is why I would prefer not to view it as a set of services, but as a demonstrated system of care that can meet the needs of patients with chronic illness. There are some measures now to try to identify——

Chairman JOHNSON. So, in other words, we should focus on holding the system accountable rather than defining all the little

parts because the parts are going to change. In 10 years they are going to be different. I would think that accountability you pointed to earlier, some of you in your testimony——

Dr. WAGNER. Parts can be gamed.

Chairman JOHNSON. Oh, very much. I mean, I don't know who decides appropriateness of this team meeting. Okay, thanks. Thanks, Dr. Wagner, for being with us. We appreciate it.

Mr. GUTERMAN. Madam Chairman, if I may address your question as well. I think at CMS our approach is rather than specifying individual services, also to just have a bundle for disease management. All of our demonstrations involve either—involve some sort of payment on a per member, per month basis, and that we feel that that rather than prescribing which exact services are provided that we have the entity that is managing these patients be at some risk for the effectiveness for the package that they decide to put together and apply to this.

Chairman JOHNSON. So, even though you are doing this within the fee-for-service system, you are using a capitated payment for this function?

Mr. GUTERMAN. There are—we are trying different approaches, but that is certainly the approach in the BIPA demonstration, and we are using accountability in the coordinated care demonstration to accomplish the same goal. We will of course be collecting information on which services actually seem to work best, and when we get the information on that we will know better, you know, what works and what doesn't. We think that in the interest of flexibility, that it is better to define the bundle and let the practitioners define what they do.

Chairman JOHNSON. I think if we do this without preserving flexibility, we defeat ourselves.

Any other comments from the panel? Thank you very much for your time, for your written testimony, and for your involvement in this process, and we look forward to working with you.

[Whereupon, at 5:44 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

AdvancePCS
Washington, DC 20005
March 4, 2003

The Honorable Nancy Johnson
Chairwoman, Subcommittee on Health
Committee on Ways and Means
1136 Longworth House Office Building
Washington, DC 20515

Dear Chairwoman Johnson:

On behalf of AdvancePCS, I would like to formally request the inclusion of our statement into your hearing record for your hearing entitled "Confronting the Barriers to Chronic Care Management in Medicare," on Tuesday, February 25, 2003.

AdvancePCS is the nation's largest independent provider of health improvement services, touching the lives of more than 75 million health plan members and managing more than $21 billion annually in prescription drug spending—totaling over 525 million pharmacy claims.

Our statement was submitted last year to the Senate Special Committee on Aging for their hearing entitled "Disease Management and Coordinating Care: What Role Can They Play in Improving the Quality of Life for Medicare's Most Vulnerable?" At that hearing, on September 19, 2002, our Chief Science Office, Alan Wright, focused on AdvancePCS' commitment to pursuing research in and implementation of

disease management programs, the current status of and future plans for AdvancePCS' disease management programs, and lastly the potential value of disease management to the Medicare program.

We are very interested in the work of your committee on this issue and would like to be of assistance in any way. Please feel free to contact me with any questions regarding this statement.

Regards,

Wendy C. Parker
AVP Federal Affairs

Statement of Alan Wright, M.D., Chief Science Officer, AdvancePCS

Thank you, Senators Breaux and Craig. I would like to thank the Committee for calling this hearing today on disease management. Our company, AdvancePCS, has been creating and implementing disease management programs to improve the delivery of healthcare in this country for many years. We are pleased that the Congress is interested in integrating disease management into the Medicare program and look forward to working with you as you begin to examine this important opportunity.

My name is Alan Wright and I am a physician and the Chief Science Officer for AdvancePCS. I have worked for AdvancePCS for ten years. During my tenure here, I have been responsible for the development and oversight of disease management products and I am currently focused on integrating new and emerging technologies into our programs.

AdvancePCS is the nation's largest independent provider of health improvement and pharmacy benefit management services, touching the lives of more than 75 million health plan beneficiaries. Our clients include a broad range of health plan sponsors, such as Blue Cross and Blue Shield plans, self-insured employers and other employer groups, labor unions and government agencies—including the Federal Employees Health Benefit Program (FEHBP). On behalf of our clients, we administer and monitor over 550 million prescription claims each year representing over $28 billion in annual prescription drug spending.

AdvancePCS is committed first and foremost to health improvement; we offer our clients a wide range of health improvement products and services designed to enhance the quality of care delivered to beneficiaries, and manage their costs. The company's core capabilities include prescription benefit plan design consultation, home prescription delivery, and formulary development and management. Within these programs, we also set up retail pharmacy networks, negotiate drug discounts, and administer claims.

The delivery of these services is in part facilitated by AdvancePCS' contractual relationships with retail pharmacies and prescription drug manufacturers. The company's pharmacy relationships extend to over 59,000 pharmacies, virtually all retail pharmacies in the United States.

AdvancePCS' more advanced health improvement capabilities include clinical programs, disease management and specialty pharmacy services. We believe these services are critical components to helping our clients balance their cost containment and quality improvement goals.

AdvancePCS is an independent, publicly traded company. We employ approximately six thousand employees and have operations in 18 States, Washington, DC and Puerto Rico. We provide services to beneficiaries in every State of the Union, Washington, DC and in Puerto Rico.

My testimony today is divided into three parts:

- The first section will describe disease management and highlight AdvancePCS' commitment to pursuing research in and implementation of disease management programs. It will also address the company's internal structures as well as the external partnerships we pursue to facilitate continuous improvement of our disease management interventions.
- The second section will highlight the current status of and future plans for AdvancePCS' disease management programs—how we launched into this area, how our programs work, and how they will evolve in the future.
- The final section will focus on the potential value of disease management to the Medicare program and discuss our support for continuing efforts in this arena.

AdvancePCS' Focus on Disease Management

Providing care for the chronically ill is a constant challenge for our healthcare system and one that we strive to address day after day. We have been developing and delivering disease management interventions to a broad range of population groups since the early 1990s. These programs all seek to optimize the healthcare of, and maximize the health and quality of life for people with chronic illnesses. While change in disease progress is often incremental, the results our programs achieve in terms of quality of life, self-esteem, and cost efficiencies, are significant.

Disease management programs apply managed care approaches to address the healthcare system's challenge of caring for the chronically ill. Relying on a wide range of models, including case management and interdisciplinary teams, disease management programs improve the overall health of targeted populations. AdvancePCS' client population-based approach enables us to offer *everyone* with a given disease services tailored to individuals' disease severity. We work closely with individual patients to minimize the pace of their health deterioration.

The benefits of our disease management programs are numerous. Aggressively managing chronic illness typically enables individuals to require less invasive care, which enhances their quality of life and reduces medical costs. In addition to providing health and financial benefits, disease management also reinforces care standards and strengthens the physician-patient relationship.

Program Development

AdvancePCS develops disease management programs internally using established national guidelines from such sources as the Joint National Committee on Hypertension sponsored by the American Medical Association, the National Institutes of Health, the American Heart Association, and the American Diabetes Association. We select programs for development based on the potential quality of life and cost impacts for a population.

We rely on a team of internal and external clinical experts to develop leading programs. The range of clinical expertise used includes physicians, nurses, pharmacists, patient educators, and health economists. When a health improvement program has a pharmaceutical care component, pharmaceutical companies may be enlisted to provide supporting materials.

The qualitative and quantitative effectiveness of AdvancePCS' disease management programs are measured using specific indicators that compare results to clinical benchmarks and/or goals. We enhance programs periodically based on changes in clinical guidelines, feedback from practitioners, patient experiences and/or program effectiveness.

Using the principles of continuous quality improvement, AdvancePCS' programs, in collaboration with and on behalf of our client sponsors, are executed in compliance with the National Committee for Quality Assurance (NCQA) criteria. When possible, the programs also incorporate the Health Plan Employer Data Information Set (HEDIS) indicators. All of AdvancePCS' programs advocate appropriate care through the effective application of data and scientific evidence. In 2002, we achieved the new NCQA Disease Management Accreditation.

Health Care Research Division

Effective disease management depends on a firm foundation in quality improvement and medical research. Our disease management programs are based on proven outcomes. With Innovative Medical Research, Inc.'s (IMR, an AdvancePCS subsidiary) research methodology, we explore intervention alternatives, measure outcomes, and then implement the most effective interventions through our disease management programs.

Our research is organized in centers focused on population-based issues. For example, our Center for Healthier Aging is dedicated to the development of programs targeting the specific needs of older individuals, while our Center for Priority Populations focuses on interventions for the Medicaid population.

Partnerships

AdvancePCS also partners with a range of government entities to ensure we remain on the cutting edge of research; in turn, we hope that our expertise can be helpful to Federal agencies looking to address healthcare quality and outcomes. One example is our longstanding collaboration with the Agency for Healthcare Research and Quality (AHRQ) in their Centers for Education and Research on Therapeutics (CERTs). We were one of the first private-sector companies to partner with the CERTs to focus on community-based research programs to improve patient safety through reduced drug-drug interactions.

Another mutually beneficial AdvancePCS and government partnership we have developed is with the Food and Drug Administration (FDA). Working with the FDA, we help to facilitate post-marketing drug surveillance, and assess and moderate the risk of adverse drug outcomes.

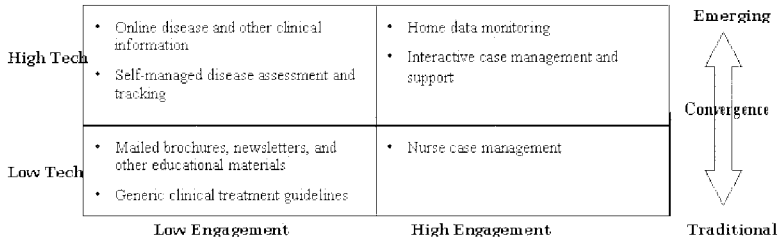
Another example of our continuous improvement efforts includes past work with a leading healthcare foundation. We have participated in Robert Wood Johnson funded research to study a group of Medicaid patients with asthma. The study purpose was to understand patient and physician knowledge levels, beliefs, and views on asthma care. As expected, the research showed that there is a significant knowledge gap between best practices and actual practices among both patients and physicians. A knowledgeable patient is key to achieving the desired health outcomes.

Disease Management Programs—Yesterday, Today and Tomorrow

Acting on behalf of our plan sponsors, we initiated our disease management programs in the early nineties with targeted mailings to patients and expansion of traditional managed care case management programs. Initially, we emphasized implementation and action, focusing less on results. Although these programs laid the groundwork for today's disease management methodologies, we had no way of measuring whether or not they were effective or successful.

Our programs have evolved over time. They now emphasize efficiency of interventions and quantifiable results. We have a built-in total quality improvement feedback loop to help us identify which program components are most effective. Our disease management programs are now tailored to specific conditions with interventions that extend from Internet publication of information to personal nurse counseling. (See Chart A).

Chart A: Examples of Disease Management Services



Our existing disease management programs use targeted interventions to educate and support our plan sponsors' beneficiaries and their caregivers. We maximize the number of methods available to communicate and educate patients, recognizing that compliance, and ultimately program success, result from informed, knowledgeable patients. Today's state of the art programs primarily rely on three forms of patient and physician communication.

- First, we use **telephonic outreach** to assess and educate patients, and to evaluate self-care. Through direct telephone conversations, we communicate with our patients about the value of appropriate care management and encourage positive health-seeking behavior.
- Second, we use **mail-based interventions** to disseminate disease-specific member education material and invite individuals to join our programs. The mail also allows us to conduct patient and physician profiling to measure program success as well as evaluate patient/pharmacy utilization patterns and compliance with recommended regimens.
- Finally, our **web-based communication** provides yet another opportunity for us to share relevant educational materials and interface with patients.

A good disease management program begins with the development of plan-sponsored, defined program goals and quantifiable outcome objectives. Using industry standard HEDIS measures, AdvancePCS closely tracks health outcomes to monitor the impact of our programs. We recognize that progress can be slow in disease management and that results are incremental—while we aim for 100 percent compliance, we recognize that incremental achievements are often what are achievable in the short run.

Results from one of our diabetes programs illustrate our focus on outcomes. In this program, we saw a 6 percent improvement in the rate of eye exams for diabetic patients over a 3-year period, a significant step in preventing blindness among these

patients. While this was only one of our outcomes measures in this program, it is representative of the type of outcomes that may be possible and that help to reduce the costs associated with disease.

AdvancePCS is continuously working to enhance the company's existing disease management interventions, integrating new technologies and research as it becomes available. For example, our researchers currently are using proven behavioral models, as well as remote patient monitoring devices, to understand interventions that result in behavioral change. Regular program review enables us to determine how we as a company can have the greatest impact on our patients.

Finally, patient privacy is a priority in all of our disease management programs. We work closely, in collaboration, with our plan sponsors to ensure the protection of patient confidentiality in consideration of all applicable state and Federal regulations.

Disease Management and the Medicare Program

Progress to Date

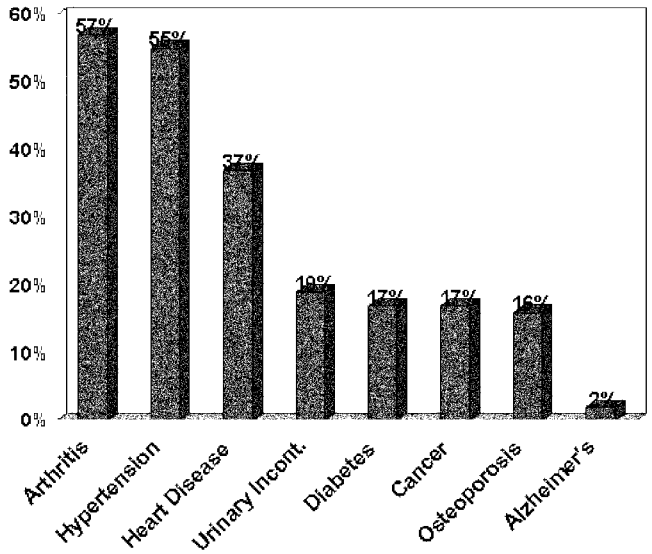
Congress and the Administration have already made some progress in bringing disease management approaches into the Medicare program. The coordinated care demonstrations that were part of the Balanced Budget Act have begun to test fee for service approaches and disease management. The Beneficiary Improvement and Protection Act demonstration that was announced this year will go a step further in testing innovative fee for service approaches.

There is more that can be done. We look forward to the future demonstration projects that CMS is contemplating. Models that are consistent with the approach we successfully employ in the private sector, structured around performance risk and targeted across a population, would provide another testing ground for CMS.

Looking Forward

The Medicare program could greatly benefit from appropriately designed and tailored disease management programs. As we all know, chronic conditions are most prevalent in the senior population and are a major contributor to high Medicare costs. According to the Kaiser Family Foundation, 57 percent of Medicare beneficiaries have arthritis, 55 percent have hypertension, 37 percent have heart disease, 19 percent have cancer, and the list continues. (See Chart B). Some of these more common diseases that afflict the Medicare population are particularly amenable to disease management interventions.

Chart B: Most Common Conditions Among Medicare Beneficiaries



Source: Kaiser Family Foundation Medicare Chartbook. Non-institutionalized Medicare Beneficiaries, 1999.

The health benefits of disease management that we have seen in the commercial population could likely be replicated within the Medicare population, potentially producing even greater improvements in health outcomes. However, given the complexity of care needs for the Medicare population, our expertise leads us to believe that one would need to refine such disease management programs based upon ongoing experience in order to realize the significant improvement and savings opportunity potential.

Even so, there are a number of disease management programs that could be adopted within Medicare today, by focusing on the pharmaceuticals already covered by Medicare. Medicare Part B covers drugs for chronic conditions such as arthritis (e.g., HylanG–F20, Remicade), cancer (e.g., Taxol, Gemzar, Paraplatin, Taxotere), and emphysema (e.g., Albuterol). Given the high cost of these drugs and established treatment protocols for these conditions, disease management programs would be an ideal way to help manage the care of these beneficiaries while also addressing the high Medicare costs.

AdvancePCS is working to adapt the company's existing disease management programs and develop new interventions that incorporate the therapies already covered by Medicare Part B. We only expect this focus to increase in the future as more biotechnology drugs focused on chronic diseases are approved.

Ultimately, implementation of disease management into the Medicare program on a large scale will require Medicare payment reform. We look forward to working with Congress on achieving payment flexibility wherever necessary and giving CMS the tools it needs to effectively integrate disease management into Medicare. Congress can also support CMS by ensuring that the agency has broad authority and latitude within the Medicare program to test new models.

As we face the challenges of the future, growing drug costs, an aging population, the growing biotech industry—the compounding effect will be a Medicare program with spiraling costs. Disease management interventions directly address these challenges by delivering cost-effective, high quality care to the chronically ill populations.

Thank you for the opportunity to testify before the Committee today. I would be happy to answer your questions.

Statement of the American Association of Health Plans

Madam Chair and Members of the Subcommittee, the American Association of Health Plans (AAHP) appreciates the opportunity to provide a written statement on the important topic of health benefits and cost saving potential of chronic care management programs. AAHP represents more than 1,000 HMOs, PPOs, and similar network plans providing coverage to more than 170 million Americans. AAHP member plans are dedicated to a philosophy of care that puts patients first by providing coordinated, comprehensive health care.

Over 100 million Americans of all ages have one or more chronic conditions. With aging, the chances of developing a chronic condition such as arthritis, heart disease, diabetes, depression, or a respiratory ailment increase. In recent years, a growing body of scientific evidence has underscored the efficacy of proactive management of physical and mental health, as well as the social issues related to these conditions.

Health plans have long understood that formal programs of disease management can be extremely effective in helping members to maintain or improve their quality of life despite having a chronic condition. These programs are built on the knowledge of what interventions can improve patient outcomes and scientific evidence that outreach to those with chronic conditions, coupled with educational programs and consistent monitoring, can effectively manage many conditions. In order to have the best outcomes, patients need to be active participants in their care, monitoring their blood sugars, checking their weights, and exercising on a regular basis. While empowering patients for self-management is a key goal, health plans understand that caregivers must also be supported through access to programs specifically designed to meet their needs, and health care providers benefit from health plan reminders and support of patient care. Disease management programs have many of these components: patient education and support, active outreach to remind patients of the care they need, support and education for caregivers, and reports and reminders to the patients' physicians.

Medicare+Choice Plans Offer Innovative Disease Management Programs

Medicare+Choice has been on the cutting edge of developing innovative health care coordination programs. In fact, nearly every health plan that participates in

the Medicare+Choice program has at least one disease management program today, and the average health plan has four such programs. A recent AAHP survey, based on responses from 131 health plans, also found that 97 percent had implemented disease management program or chronic care programs for diabetes, 86 percent had programs for asthma, and 83 percent had programs for congestive heart failure. Health plans are also developing programs for end-stage renal disease, depression, and cancer.

A recent AAHP report about innovations by Medicare+Choice plans outlines dozens of examples of the many programs health plans are implementing on behalf of Medicare+Choice enrollees:

- PacifiCare is improving health care for patients with congestive heart failure through a program that makes sure they are on the correct medications and helps enrollees make lifestyle changes involving weight management, diet, exercise, and smoking cessation. This program also helps physicians provide care consistent with evidence-based guidelines by sharing information such as a list of congestive heart failure patients who may not be asking for ACE inhibitors that could stabilize their cardiac conditions.
- Harvard Pilgrim Health Care has implemented a disease management program that uses a combination of strategies—patient education, intensive interventions for high-risk enrollees that includes phone calls from nurse practitioners and mailings to beneficiaries, sharing of best practices, and community outreach—to improve clinical outcomes of care for Medicare+Choice enrollees who have diabetes.
- A disease management program developed by Geisinger Health Plan is lowering blood pressure readings for Medicare+Choice enrollees by distributing quarterly newsletters on blood pressure control and by involving nurses in educating seniors who have hypertension, in one-on-one and group sessions, and lifestyle modifications and medication management.
- Another Geisinger Health Plan program, recently featured on National Public Radio, provides reminders to patients with diabetes to visit their primary care physicians and interventions from nurse practitioners that help them maintain healthy blood sugar readings.
- A *Care Coordination*SM program implemented by UnitedHealthcare allows members to work directly with their physician to determine the best way to coordinate their own health care needs. Care Coordination is designed to make it easier to get care while identifying and addressing gaps in care. It encompasses hospital admission counseling, health education, prevention and reminder programs, inpatient care advocacy, phone calls to high-risk members post-hospitalization, identification and support programs for members with complex and chronic illnesses and long-term assessment and education programs to support members with asthma, cardiovascular disease and diabetes.
- Fallon Community Health Plan is improving the clinical and functional status of Medicare+Choice enrollees who have congestive heart failure through a program that includes educational seminars led by pharmacists and nutritionists and one-on-one discussion between care managers and patients. Chronic conditions require patients to take medication even when they are feeling well. One important aspect of disease management programs is the reinforcing of the need to stay on these medications and to ask about side effects that could cause patients to stop taking them.
- In the early 1980's, Group Health partnered with the University of Washington to examine key determinants of seniors' health and found that regular exercise and social interaction were the two most important factors. Since then, other studies have validated their findings. There is no segment of the population for whom exercise is not important. Whether an individual is 65 or 95, whether they are already physically active or restricted to wheelchairs, whether they are healthy or have painful crippling conditions, exercise can make a difference. With this in mind, Group Health set out to bring the benefits of exercise to individuals who have disabilities or serious, chronic medical conditions such as heart disease, chronic obstructive pulmonary disease (COPD), arthritis, diabetes, and depression.
- Aetna U.S. Healthcare has launched a program to educate Medicare+Choice enrollees and their doctors about the potential for dangerous drug interactions and adverse events relating to the use of multiple medications.
- Kaiser Permanente Northwest has implemented a program to improve the healing process and the quality of life for immobile, frail elderly Medicare+Choice enrollees who are at high risk for developing chronic wounds such as pressure ulcers.

In recognition of the value of disease management programs for congestive heart failure (CHF), CMS has implemented a program that provides "Extra payment in Recognition of the Costs of Successful Outpatient CHF Care." Under this program, qualifying Medicare+Choice organizations that meet CMS performance criteria could receive extra payments for enrollees with CHF who were not hospitalized due to effective management of their disease. AAHP supports this program and recommends that CMS consider similar programs for other disease states.

Conclusion

AAHP appreciates this opportunity to submit written testimony and thanks the Subcommittee for considering this important issue. The main goal of organized disease management is to help patients continue or improve their current level of functioning and reduce the risk of preventable disability. For Medicare+Choice beneficiaries, these patient-centered programs offer efficient and supportive ways to learn more about their illnesses, understand treatment options, and access services. These programs have also demonstrated effectiveness in helping enrollees with behavioral health conditions such as depressive disorders that are often overlooked in the older adult population. In general, the management of chronic disease requires the knowledge of what needs to be done and means of identifying when there are gaps. Since the Medicare benefit is designed to pay for services delivered, not monitoring for services that are missed, the programs include many activities that are not covered under the traditional Medicare benefit. These services include patient education, calls from nurse case managers to remind patients of optimal care, phone calls from the health plan to remind patients to keep their appointments and to have the screening necessary to avoid complications, education of caregivers, and reminders and reports to physicians about the status of their patients and the services they have received or missed.

Ideally, all Medicare beneficiaries should have access to these services. However, in the current Medicare FFS system, coverage for benefits to help those with chronic conditions, such as prescription drugs, extended nursing home or home health services, are not provided. In addition, the traditional Medicare FFS program does not adequately address the needs of those with chronic conditions. In fact, the traditional Medicare FFS system does not historically promote disease management but instead is based on treatment goals to improve or cure a condition. These aims are in contrast to the treatment goals for those individuals with chronic conditions, which are to maintain the ability to function and/or to prevent additional deterioration. Medicare+Choice programs have demonstrated that disease state management programs are an important component of a comprehensive, integrated health care benefit.

The future success of these innovative disease management programs offered by Medicare+Choice plans depends on the long-term stability of the Medicare+Choice program. As effective as Medicare+Choice plans are at using disease management strategies to improve health care quality for Medicare beneficiaries, we cannot succeed without adequate funding and a sensible regulatory environment. The current system has forced many plans to make difficult decisions regarding their participation in the Medicare+Choice program. Regrettably, this loss of choices means that fewer Medicare beneficiaries have access to the high quality health care services that are delivered through the disease management programs that Medicare+Choice plans are implementing.

Statement of the American Association for Homecare, Alexandria, Virginia

The American Association for Homecare (AAHomecare) would like to take this opportunity to thank the Ways and Means Health Subcommittee, Chairwoman Johnson, and Ranking Member Stark for their continued involvement in Medicare Regulatory Reform. AAHomecare is a national association whose members represents a continuum of home healthcare including suppliers of durable medical equipment (DME), orthotics and prosthetics, home health agencies (HHAs) and suppliers of re/hab and assistive technology. As a representative of both DME suppliers and HHAs, AAHomecare supports the Subcommittee's effort to improve the regulatory, appeals and contracting processes under the Medicare program. However, we would like to take this opportunity to express some of our concerns regarding specific provisions in H.R. 3391, which we believe may affect a provider's or supplier's due process rights.

CORRECTION OF MINOR ERRORS AND OMISSIONS

H.R. 3391 establishes a process for correcting minor errors and omissions on claims without requiring the provider or supplier to go through the expense of an appeals process. Currently, most claims are denied because the claims failed to comply with one or two technical requirements. For instance, a provider or supplier may have failed to secure the physician's signature on all verbal orders prior to billing, or may have failed to include any minor treatment changes. These omissions or errors are easily correctible, but because supplier or provider are required to appeal claims, payment can be delayed for up to a year. This can put a substantial amount of financial stress on a provider or supplier and can severely interfere with their capacity to continue their business operation.

AAHomecare strongly supports the Subcommittee's position that providers and suppliers should not have to undergo an appeal simply because of a minor error or omission. By allowing them to correct discrepancies in claims submitted to a carrier, without an appeal, the Subcommittee is ensuring a more efficient and cost-effective Medicare system. Furthermore, this provision is a useful tool in ensuring, not only that a provider or supplier will not undergo economic hardship, but also that a beneficiary will have continued access to services. We urge that any regulatory reform should include a provision such as this for correction of minor errors and omission.

NEW EVIDENCE AND ALJ HEARINGS

While we are supportive of the general intent behind the regulatory reform provisions of H.R. 3391, we are extremely concerned by Section 403(a)(3). Under Section 403(a)(3) a supplier or provider may not introduce evidence in an appeal that was not presented at the reconsideration hearing conducted by the Qualified Independent Contractor (QIC), unless there is good cause which precluded the admittance of such evidence before or during reconsideration.

The Centers for Medicare and Medicaid Services (CMS) are adopting a similar stance to the one potentially created by Section 403(a)(3). On November 15, 2002, CMS issued its proposal for the implementation of BIPA, which included a provision that would severely curtail evidence presented by a supplier or provider during an ALJ hearing. Specifically, the proposed rule 405.1019 states submission of any new evidence that was not presented to the QIC must be accompanied by a written statement. Under this proposed rule the statement must explain why the evidence was not previously submitted to the QIC, and the ALJ can only admit the evidence if good cause exists.

Both Section 403(a)(3) and the CMS proposed Section 405.1019 significantly restrict the opportunity a provider or supplier has to offer additional and new evidence during an ALJ hearing, in effect requiring a full and early presentation of evidence at the QIC level. CMS has based this proposed regulation, on its long held belief that a high reversal rate on appeals is due to the presentation of new evidence at the ALJ level. While it is true that many claims have been reversed at the ALJ level, the decisions to reverse denials are not arbitrary but rather are founded on the new evidence substantiating a provider's contention that the overpayments are unfounded.

Furthermore, a provider's and supplier's right to introduce new evidence should be safeguarded by any regulatory reform. Often, the ALJ will reverse a denial based on evidence that was unavailable to the interest party during the QIC review.

For example, the probe sample data and methodology used by the carrier is not available to a supplier or provider before the ALJ hearing. A supplier or provider will have to request the probe sampling methodology from the carrier after the reconsideration decisions have been rendered. Therefore, the interested party does not have immediate access to this information from the carrier, but must wait for the information to be turned over. Once the interested party received the information, he or she would need to consult with experts and expend a significant amount of resources to review the sample methodology after receiving it, so as to determine whether the contractor's sample lacks statistical weight or whether the methodology used was erroneous.

We strongly urge this Committee to make sure that any regulatory reform allows providers and suppliers to introduce evidence of erroneous sampling techniques during an ALJ hearing. Many cases that reaches the ALJ have been reversed after the interested party presented evidence showing that the sampling methodology was biased or that a sample was incorrectly taken. In order to maintain due process and ensure fairness, a provider or supplier should be allowed to introduce this type of evidence.

Currently, providers and suppliers can provide live testimony and may introduce new evidence during an ALJ hearing. They are not required to provide good cause or submit a statement by explaining why the information was not included. In fact,

the ALJs have come to rely on provider and supplier testimony as an aid when deciding whether the interested party did have a reasonable basis to believe that the claim would be covered. This has helped to ensure fairness and due process during appeals. Both H.R. 3391 and 67 CFR 405.1019 would prohibit live testimony that has repeatedly helped exemplify why the contractors denial was incorrect.

In one case, the fiscal intermediary denied $20,000 in home health claims representing an entire year of services for a patient who suffered from Multiple Sclerosis (MS). The reason given for the denial was that the patient's physician had not prescribed the commonly used medicine for MS. The denial stated that the drug Athcar was not identified by the Physicians Desk Reference for treatment of MS, despite other references that list it as an alternative. In this case the physician had prescribed it as an alterative because the patient could not afford the commonly prescribed Interferon. At the ALJ level, the HHA introduced evidence from the treating physician and relied on other authoritative reference to show why the Athcar had been used instead of Interferon. The physician was also able to show how the alternate medication had been effective. Based on this testimony, the ALJ was able to reverse the denial.

Conversely, H.R. 3391 and 67 CFR 405.1012 would allow contractors to present any additional evidence, change the basis of their denial of the claims and present additional testimony that they believe is pertinent. Under both H.R. 3391 and CMS' proposed rule, contractors would be required to provide the ALJ with any additional information requested by the ALJ, so as to aid it in understanding the contractor's position and helping it formulate its decision. Allowing contractors to testify and present new evidence during the appeals process while denying the same opportunity to an interested party would severely go against due process and fairness. In essence, this would severely undermine the position of suppliers and providers because they would not be allowed to present evidence to contradict the contractor's new arguments, and would not be allowed to adapt their position to reflect contractor changes in arguments during an appeal.

AAHomecare urges the Subcommittee to establish a standard that does not limit the type of information presented during an ALJ hearing. We recommend that any regulatory reform should allow suppliers and providers to present testimony of a treating physician opinions, expert opinions, and provider and supplier testimony, as necessary, to the ALJ. Furthermore, a supplier or provider should be allowed to present evidence which was previously not available, or which at the time was not relevant to the claim set forth by the contractor. It is important to ensure that regulatory reform legislation should distinguish between new evidence that involves readily available clinical documentation from the provider or supplier from other Medicare evidence such as expert opinion, clarifying treating physician opinions and documentary evidence from providers or suppliers that are not directly involved in a disputed claim, if due process is to be maintained.

LIMITED USE OF EXTRAPOLATION

The use of extrapolation can often lead to significant problems for both DME suppliers and HHAs. Often the sampling methodology used during extrapolation lacks any semblance of statistical validity, which in turn can result in a significant expenditure of resources by providers and suppliers. Furthermore, the use of extrapolation often results in the drastically inflated overpayment. This large inflation will force many providers and suppliers to pay hundreds of thousands of dollars, and forces some into bankruptcy.

In one instance, the ALJ ruled in favor of an HHA after throwing out the denials as well as finding the extrapolation and the sampling methodology used by the physical intermediary as erroneous. While the HHA received a favorable verdict, it had suffered irreparable harm, leading to its bankruptcy even before the decision was rendered. This case is of particular concern, given that the home health agency was the only provider in that area for medically complex home health patients.

Currently, the Durable Medical Equipment Regional Carriers (DMERCs) also use extrapolation in determining overpayments. Not unlike HHAs, DMEs are faced with inflated overpayments that are based on erroneous sampling methodology. However, what is particularly disturbing is that the DMERCs use extrapolation and base their denials on rules that have not come into effect at the time the service was rendered. For these reasons, AAHomecare strongly urges that the use of extrapolation and sampling methodology should be curtailed.

AAHomecare believes that H.R. 3391 addresses many of the concerns shared both by HHAs and DME suppliers. We support limiting the circumstances in which a Medicare contractor can request a provider or supplier to produce records or supporting documentations, to those two circumstances delineated in Section 405(f)(3):

1. where either there is a sustained high level of payment error, or

2. where documented education intervention has failed in correcting the payment error.

Despite the limited use created by Section 405(f)(4), there is still a great room for Medicare contractors to interpret Section 405 which may lead to unjustified use of extrapolation. Therefore, AAHomecare urges that the Subcommittee clearly define the phrase "high level of payment error." The Subcommittee needs to provide contractors with guidance (preferably detailed written guidelines within this bill) as to what constitutes a high payment error. If this term is not defined, the contractor could apply his own subjective definition of "high level of payment error." By clearly defining what constitutes a "high level of payment error" the Subcommittee can prevent the inconsistent application of extrapolation by different Medicare contractors, as well as by the same contractor when reviewing different health supplier or provider claims.

We would further urge the Subcommittee to add a provision that would state that any payment errors will not be deemed to exist where the provider can show that there exists some basis in the law to support the claim as submitted. In this instance, we feel that it is important to create a sense of security amongst providers and suppliers, that they can in fact rely on existing laws and regulations when submitting a claim. We strongly believe that a supplier or provider should not be required to second guess the law, nor be penalized for submitting claims based on a reasonable interpretation of law. Under such a provision, the Medicare contractor would be allowed to deny individual claims, but the provider or supplier could rely on law relied on when appealing.

REGULATORY REFORM SHOULD NOT INCLUDE CONSENT SETTLEMENTS

Section 405(f)(5) of H.R. 3391 grants to the Secretary the power to settle a projected payment with a provider or supplier by the use of a consent settlement. Before offering a consent settlement, the Secretary is required to inform the suppliers or providers of the contractors finding of overpayment. The supplier or provider is then given the opportunity to either accept the consent settlement or undergo statistical valid random sampling.

Routinely, Medicare contractors have used consent settlement agreements to strong-arm a provider into waiving their right to appeal, despite their honest and usually well-founded belief that the denial was an error. Often, a home health provider will settle its claims with the contractor, not because it supports the contractor's finding, but rather because of the costs they will incur if they fail to accept. Providers and suppliers who do not settle will be forced to incur greater costs associated with appealing the decision as illustrated in the example below.

In one post payment audit, the fiscal intermediary denied 56% of a sample of claims submitted by one small HHA. This percentage was extrapolated to a $65,000 overpayment. In this case, the provider refused to accept a consent settlement agreement and appealed all claims to the ALJ. The ALJ in turn reversed over 95% of the denials. Although, the HHA did receive a favorable outcome, it incurred substantial costs associated with the appeal over the four years that it took from the time of denial to the time of reversal.

If a provider or supplier chooses not to accept a proffered settlement, then the contractor may apply the Statistically Valid Random Sample (SVRS). An SVRS examines a larger number of claims, usually consisting of 200–400 claims. Such an investigation by its very nature is largely disruptive to the operation of home health agencies and DME providers, and may force the business to cease all business activity. Therefore, it is not surprising that many providers and suppliers feel the need to settle, despite their honest belief that the initial probe sample findings where inaccurate because of the exorbitant costs associated with SVRS.

AAHomecare urges the Subcommittee to reconsider including consent settlements in H.R. 3391 or any other regulatory reform legislation. While the Subcommittee has addressed at least one problem associated with consent settlements, i.e. limiting the use of extrapolation, we believe that the detrimental effects associated with consent agreements outweigh any potential benefits. If the Subcommittee allows the use of consent settlements, it will unwittingly provide contractors with a tool by which it may strong-arm service providers into settling, even if consent settlements are used only in a fraction of reviewed claims. Those providers who challenge the sampling methodology may be forced into economic hardship associated with a SVRS or a lengthy appeal. The Subcommittee may unwittingly place the provider or supplier in a position in which it can no longer provider any services. This is of particular concern where the home health provider or DME supplier provide a specialized type of service in an area.

AAHomecare further recommends that if the Subcommittee decides to include consent settlements in H.R 3391, it should create a provision that allows a provider to settle, while still maintaining the right to appeal the sample probe methodology used by the provider. A provider or supplier should be allowed to appeal the probe method without undergoing an SVRS, otherwise they may be subjected to unjust financial burdens.

DEFERRING RECOUPMENT DURING APPEAL

H.R. 3391 prohibits any recoupment of overpayment until the conclusion of the reconsideration hearing. We applaud this Subcommittee's continued effort to create an insulating mechanism to protect providers from wrongful payment recoveries. Currently, providers and suppliers are required to make payment before going forth in their appeals process, causing many of these companies to undergo substantial financial hardship for a claim where an error exists in the overpayment determination.

While AAHomecare agrees that the Secretary should not be allowed to recoup overpayments until the conclusion of a reconsideration hearing, we believe that this Subcommittee should further extend this provision by limiting recovery until the claim has run its full course throughout the appeals process and a final and binding decision has been rendered. As Tom Scully testified last year, physicians, providers and suppliers should have the same rights taxpayers enjoy. A taxpayer who is audited has the right to withhold payment, as long as interest accrues, while an appeal is pending. Both suppliers and providers should be entitled to the same right throughout their entire appeal process. Instead, HHAs and DME suppliers are required to pay the amount after the reconsideration hearing, not allowing the party to avail himself of the benefits of an ALJ hearing.

AAHomecare fully appreciates that a substantial controversy exists concerning further delaying recoupment beyond reconsideration. However, we base this recommendation on two well-founded premises. First, recoupment of an extrapolated amount often results in eliminating an opportunity for a provider or supplier to seek an appeal. If a provider or supplier is forced to make payment of potentially hundreds of thousands of dollars, they will undergo a severe financial burden if they continue to incur the cost associated with an appeal. Second, it is administratively difficult to recompute the amount of the extrapolated overpayment after each level of appeal where some of the sample claims are usually reversed.

We also recommend that any extrapolation should be dropped if the provider or supplier obtains a reversal of 10% or more of the sample claim denial on appeal. In such a case, the sample denials would seem to not be a statistically valid representation of denied claims in the universe of claims. If the overpayment represents more than 10% of the provider or supplier revenue, we believe that the interested party should be able to repay the amount during a three-year period. By this means, the Subcommittee could ensure that companies will not suffer financial hardship that will cause the HHA or DME supplier to either cut back on the services it provides or file for bankruptcy.

AAHomecare would further recommend that an additional provision be added to H.R. 3391. We believe that the Subcommittee should establish a provision that would protect home health providers where overpayment relates to an error in the administration of benefits by Medicare itself. HHAs are susceptible to unknown amounts of liability due to Medicare's own inability to appropriately process Medicare home health PPS claim. A year ago, CMS determined that its system failed to make the payment adjustment when a patient was admitted to another home health agency or readmitted to the same agency within 60 days of discharge.

AAHomecare recommends that the Subcommittee include legislation that would limit the ability of CMS to institute retroactive payment adjustments on any claims to more than one year previous. Financial integrity cannot be maintained by a provider or services who is required to carry on an indeterminate amount of financial liability from one year to the next.

OASIS:

As of December 2002, CMS have instituted changes aimed at decreasing the burdens associated with the collection of information under the Outcome and Assessment Information Set (OASIS). CMS eliminated two OASIS collection time point and seventeen data items. Thirteen of the seventeen data items consist of demographic information, which have been moved to the tracking sheet and should be completed by agency office staff.

AAHomecare supports the implication of OASIS and the reduction of paperwork. AAHomecare recommends that certain policy changes should be incorporated as soon as possible. We believe that the Subcommittee should also instruct the Sec-

retary to request CMS to lengthen the definition of "in patient stay" from 24 hours to 72 hours. We also feel that it is important to instruct the CMS to widen the recertification window from 5 days to at least 10 days to ensure greater flexibility among for an agency to schedule assessment during the patient scheduled visits. Lastly, we urge the Subcommittee to instruct the Secretary to take steps to make OASIS electronic program specification and the risk adjustment methodology readily available to the public and allow the public to submit comments on any program specification changes.

GUIDANCE BY SECRETARY OR AGENT

We strongly support limiting any sanctions on providers or suppliers if they reasonably rely on the guidance of Section 102(c) of H.R. 3391. Providers and suppliers should not be subject to repayment of amounts that they received in reasonable reliance on the guidance from the Secretary or an agent of the Secretary.

CONCLUSION

We appreciate this opportunity to express our concerns and present our suggestions to the Subcommittee. We greatly value your continued effort on these matters. AAHomecare strongly believes that there is much at stake in regulatory reform, and recommend that any legislation adopted should maintain due process and fairness. H.R. 3391 is a good starting point for Medicare appeal and regulatory reform. We hope that these comments and suggestions are helpful and look forward to working with you to pass a regulatory reform legislation that will further the objective of efficiency and fairness.

Statement of American Healthways, Nashville, Tennessee

American Healthways applauds the Subcommittee for their leadership on the issue of disease management. We absolutely concur with Chairman Johnson's belief that, "Medicare beneficiaries with chronic disease should benefit from advances in care management and advances in the science of medicine."

Without question, disease management programs are:

- Effective in improving and managing patient health;
- Promoting enhanced patient and physician satisfaction; and
- Reducing the costs of care, particularly for those suffering from chronic diseases such as diabetes, heart failure, cardiac disease, asthma and COPD.

In fact, peer-reviewed results from American Healthways clearly demonstrate that well-conceived disease management programs can deliver these outcomes for commercial, Medicare+Choice and Medicare Fee-for-Service (FFS) populations.

As the leader in the industry, American Healthways has shown statistically significant improvements in patient outcomes while at the same time reducing aggregate costs of care—producing first year savings in a diabetes program for Medicare FFS patients of approximately $800 per patient.[1] Since 1996, American Healthways' aggregate savings for all programs for all customers have been greater than $750 million.

Yet despite this well-documented, empirical evidence, Federal law does not provide the majority of Medicare beneficiaries access to comprehensive, evidence-based disease management programs. Absent such legislation, care for the millions of beneficiaries suffering from chronic diseases will continue to be fragmented, and their costs to the Medicare Trust Fund will continue to be significantly higher than they would otherwise be.

In the face of new budgetary demands for a comprehensive prescription drug benefit as well as much needed modernizations to the existing Medicare program, the continued loss of these proven savings adversely impacts patients, physicians, and taxpayers. With the onset of millions of Baby Boomers into the Medicare program in the near future, we must explore and implement responsible alternatives that provide the best and most cost-effective care to all our seniors and disabled Americans.

We thank Chairmen Johnson and Thomas for holding today's hearing. We look forward to working with Members of Congress and interested parties to advance this issue for the benefit of beneficiaries.

[1] Cap Gemini Ernst & Young Study: Diabetes Care Coordination Program Performance Evaluation for FFS Medicare Members with Diabetes, 2002.

Statement of the American Heart Association

Heart Disease and Stroke Contribute Significantly to Chronic Illness

The American Heart Association is dedicated to improving the quality of care available to patients suffering from or at risk for heart disease, stroke and other cardiovascular diseases. Heart disease is the nation's leading cause of death. Stroke is the number three killer. Both are leading causes of significant, long-term disability.

Over 61 million Americans—about 1 in 5—suffer from some form of cardiovascular disease, ranging from high blood pressure to myocardial infarction, angina pectoris, stroke, congenital heart and vascular defects and congestive heart failure. It is expected that heart disease, stroke and other cardiovascular diseases will cost the nation $351.8 billion in 2003, including $209.3 billion in direct medical costs.[1]

As Congress considers reform of the Medicare program, the enormous burden that chronic diseases present to beneficiaries and to the Medicare program must be addressed. According to recent research, 78 percent of Medicare beneficiaries have at least one chronic illness. Almost 32 percent of beneficiaries have four or more chronic diseases, and this group drives almost 79 percent of program spending.[2]

The American Heart Association applauds the Committee on Ways and Means Subcommittee on Health for holding a hearing to examine the barriers to chronic care management. Effective ways to better manage Medicare beneficiaries with chronic illness must be explored and tested. While our testimony focuses on disease management as one approach for addressing chronic illness, the Association looks forward to continuing to work closely with Members of the Subcommittee to address this and other important strategies for managing chronic illness.

Disease Management as an Approach to Confronting Chronic Illness

The growing desire by public and private payers to manage individuals with chronic conditions and to contain rising health care costs has resulted in a growing interest in disease management strategies. This interest is driven in part by the demographics of an aging population.

Disease management has emerged as a potential strategy for enhancing the quality of care received by patients suffering from one or more chronic conditions. Cardiovascular disease, including congestive heart failure and hypertension, are often the focus of disease management programs. Given this growing interest in disease management, the American Heart Association recently convened a group of volunteer experts in cardiovascular disease and disease management to study the issue and prepare an in-depth report examining the trend and it's potential impact on the quality and cost of health care. The goal of the project was to develop core principles for disease management of patients with cardiovascular disease. We would be pleased to share additional information about our research with Members of the Subcommittee.

The American Heart Association Urges Policymakers to Focus on Quality

After conducting extensive research, the American Heart Association established a set of principles to guide its work in disease management. We believe that these general principles should be applied to disease management programs in both the public and private sectors and consistently across disease states and patient populations. Although a number of existing disease management programs seek to balance cost containment and quality, quality and improved patient outcomes must always be the priority.

Principles for Disease Management

The American Heart Association recommends the following guiding principles for disease management:

(1) The main goal of disease management should be to improve the quality of care and patient outcomes.

Evaluation of disease management programs should be based on more than just a reduction in health care expenditures. The emphasis should be on the "value" of disease management (i.e., the extent to which disease management efforts result in better quality for a given investment rather than on cost savings alone). Improvements in quality of care and patient outcomes should be the primary indicator of successful disease management. The use of performance standards in assessing quality of care and outcomes is critical in evaluating success.

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[1] Statistics compiled from the American Heart Association Heart Disease and Stroke Statistics—2003 Update.

[2] Robert A. Berenson & Jane Horvath, *Confronting Barriers to Chronic Care Management in Medicare*, January 22, 2003, Health Affairs online (www.healthaffairs.org).

(2) Scientifically derived, evidence-based, consensus-driven peer reviewed guidelines should be the basis of all disease management programs.

Disease management strategies should be derived when available from scientifically-based guidelines such as those written by the American Heart Association/American Stroke Association and groups such as the American College of Cardiology and the American Academy of Neurology. These guidelines represent consensus in the cardiovascular disease and stroke communities regarding appropriate treatment and management of patients with cardiovascular disease and stroke. Careful attention must be given to the appropriate translation of these scientifically based guidelines into disease management practices.

(3) Disease management programs should increase adherence to treatment plans based on best available evidence.

An important focus of disease management should be to influence the behavior of providers, patients and other caregivers to better understand and adhere to treatment plans that will help improve patient outcomes. The targets of such efforts may include a broad community of caregivers, e.g., physicians, nurse practitioners, family members and community-based organizations. To be meaningful, it is essential that such treatment plans be derived from the best available clinical and scientific evidence. The evidence and resulting treatment plans should be revisited periodically to reflect evolving standards and scientific knowledge.

(4) Disease management programs should include consensus-driven performance measures.

Improved quality of care and outcomes for patients with cardiovascular disease and stroke should be the pivotal measurement upon which the success of a disease management program is evaluated. To measure improved quality of care and outcomes, consensus-based performance measures should be used to evaluate a disease management program's effectiveness. Performance measures used in evaluating disease management programs should be those measures that are developed by a broad consensus-driven process such as the National Quality Forum and/or others. Ideally, these performance measures should be evidence-based.

(5) All disease management efforts must include ongoing and scientifically based evaluations, including clinical outcomes.

Disease management programs have not traditionally undergone rigorous scientific evaluation regarding their impact on patient outcomes. The true measure of any health intervention is whether patients are better off having received the service or care provided. This determination requires a meaningful examination of clinical outcomes. Frequent scientifically-based evaluations should be included as a critical component of any disease management program, and these evaluations should allow for continued improvement in the program to maximize benefit.

(6) Disease management programs should exist within an integrated and comprehensive system of care, in which the patient-provider relationship is central.

Disease management services should not substitute for the patient-provider relationship(s), particularly the physician-patient relationship that is critical to the delivery of effective care. Instead, disease management programs should be one of several strategies employed to support and enhance the patient-provider relationship, resulting in an overall improvement in the quality of care and coordination of care delivered to patients with cardiovascular disease and stroke.

(7) To ensure optimal patient outcomes, disease management programs should address the complexities of medical co-morbidities.

Many disease management programs are designed to treat single disease states. A significant population of patients with chronic disease suffers from multiple co-morbidities. Some of the greatest challenges in caring for these patients involve the complex interactions of these co-morbidities. Disease management programs and guideline committees should develop algorithms and management strategies to fully address patients with co-morbidities.

(8) Disease management programs should be developed to address members of the under-served or vulnerable populations.

Currently, most disease management programs arise from employer-based, private health plans. Although a number of states have begun using disease management approaches within their Medicaid programs, in general, most disease management programs serve an employed, insured and healthier population. Disease management programs should be developed to incorporate or to specifically address the unique challenges of the under-served and vulnerable populations.

(9) Organizations involved in disease management should scrupulously address and avoid potential conflicts of interest.

Organizations that provide disease management services should act in the best interest of the patient and avoid conflicts of interest. The primary goal of disease management organizations should be to improve patient outcomes. Efforts to achieve secondary goals such as product marketing or product sales, should not adversely affect the primary goal of improving patient outcomes. To the extent any conflict of interest arises that may compromise the primary goal of improving patient outcomes, it should not be pursued.

The American Heart Association Provides Leadership and Consensus

It is fitting that the American Heart Association adds its voice to the many that are currently speaking to the issue of disease management. 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. Our scientific and programmatic efforts have increased and evolved with the dynamic advances made in cardiovascular and stroke care. Importantly, the American Heart Association represents not just providers but all stakeholders in cardiovascular and stroke care—physicians, nurses, emergency medical support personnel and others. Most significantly, the American Heart Association represents the patient.

Conclusion

It is critical to ensure that disease management programs are driven by the clinical needs of patients rather than by cost containment or financial profit alone. While we recognize the need for cost containment and careful allocation of health care resources, improving quality of care must be the primary goal of any disease management program. While disease management has the potential to have a profound affect on patients with chronic illness, additional study is needed to better document the impact on quality of care and cost containment. The Association recommends:

- Disease management programs in the public and private sector adhere to the principles delineated above.
- Before adopting disease management for all Medicare and Medicaid beneficiaries, the Association recommends that Congress continue to evaluate disease management techniques until objective outcomes research has demonstated efficacy. Continued evaluation of disease management programs is critical.

The American Heart Association appreciates the opportunity to provide these comments to the Committee on Ways & Means Subcommittee on Health on this timely and important issue, and we look forward to working with the Subcommittee as it continues to consider the appropriate integration of disease management into the Medicare program.

Statement of the American Pharmaceutical Association

The American Pharmaceutical Association (APhA) appreciates the opportunity to provide our perspective on the important topic of chronic disease management. APhA is the national professional society of pharmacists, representing approximately 50,000 pharmacists. Chronic care management, best provided through collaboration between physicians, pharmacists, and other health care providers is valuable for the most important person in the health care system: the patient. It is an appropriate step towards preventing the long-term human and financial costs associated with chronic disease.

Considerable evidence demonstrates that improved patient health and cost savings are achieved when pharmacists play an integral role in the health care team. A 1990 study by the HHS Inspector General concludes, "there is strong evidence that clinical pharmacy services add value to patient care and reduce healthcare utilization costs. . . . Such value includes not only improvements in clinical outcomes and enhanced patient compliance, but also reductions in health care utilization costs associated with adverse drug reactions." Clearly, there is much to be gained with implementing chronic care management that includes pharmacist-provided medication therapy management services.

Disease management represents the evolution of health care and its response to the onset of chronic diseases—which until pharmaceuticals became more prevalent were often deadly diseases. Little else provides as great a return on investment as

disease management when dealing with the chronic care population. A recent analysis using 1999 Medicare claims data showed that approximately 78 percent of Medicare beneficiaries have at least one chronic disease; almost 32 percent have four or more, and these patients drive almost 79 percent of program spending.[1] Clearly, it is necessary for us to address the situation before it becomes a crisis.

We are encouraged by the Administration's attention to the issue, particularly the recent announcement of the Centers for Medicare & Medicaid (CMS) new demonstration projects. Clearly they have recognized that disease management allows health care practitioners to provide focused, coordinated care resulting in better patient outcomes while using our scarce health care resources more efficiently. Medication therapy management is a critical component of any successful chronic care management program and encourage the Committee to consider including authorization and payment for this pharmacist-provided care in any of their proposals.

An Evolution to "Self-Care"

Patients have become "self-managers" of their care, as they function in outpatient settings, including their homes. The greater number of diseases being treated with pharmaceuticals combined with the higher level of medication complexities demands that we partner with patients to manage their care. Assisting patients with managing their chronic diseases has been proven to result in a positive impact. Pharmacists—the medication experts—are the best equipped and most appropriate health care providers to manage the pharmacy component of chronic care management.

Others support this concept of self-care and the need for non-physician provider involvement, including the *Journal of the American Medical Association* which reported, "Under a system designed for acute rather than chronic care, patients are not adequately taught to care for their own illnesses. Visits are brief and little planning takes place to ensure that acute and chronic needs are addressed. Lacking is a division of labor that would allow non-physician personnel to take greater responsibility in chronic care management. . . . For chronic conditions, patients themselves become the principal caregivers."[2]

No Better "ROI"

Challenges in chronic care management include making the best use of medications, including helping patients to comply with medical regimens. The inclusion of pharmacists in chronic care management programs yields a significant return on investment. Studies showcase the positive impact pharmacists have on managing the chronic conditions associated with stroke, asthma, high cholesterol, and diabetes. The data calls for the inclusion of pharmacists as a participating member of the health care team when developing chronic disease management programs.

One of the most successful chronic care management programs is Project ImPACT: Hyperlipidemia. Project ImPACT was a two-year, community-based demonstration project of the America Pharmaceutical Association Foundation[3] documenting the contributions pharmacists make in reducing the risk of heart attack and stroke for patients with high cholesterol. Project ImPACT involved 397 patients, 26 pharmacy practice sites in 12 States, and over 60 pharmacists and 180 physicians. Once patients were enrolled, the process of collaborative care included the pharmacist taking blood samples, conducting follow-up visits, and informing physicians about the patient's progress.

The study showed that the risk for heart attack is reduced by one-third when patients, pharmacists, and physicians collaborate. Specifically, 90% of the patients stayed on their medications, a compliance rate of two to four times better than the average 40% reported in the literature for similar studies. Project ImPACT shows that pharmacists, working together with patients and their physicians, can save lives and make a significant contribution in reducing the annual expenditure of $100 billion spent on treating coronary artery disease.

Lack of Payment: A Barrier to Chronic Care Management in Medicare

While there are several components to a good chronic care management program, management of the patient's drug regime is at the heart of any program. Pharmacists are the critical member of the health care team needed to manage this care. As non-physician providers, however, pharmacists face an uphill battle when trying to provide these services to the patients they serve. Currently, the Social Security Act's definition of "covered services" does not include medication therapy manage-

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[1] R.A. Berenson and J. Horvath, "The Clinical Characteristics of Medicare Beneficiaries and Implications for Medicare Reform."

[2] JAMA, October 9, 2002—Vol. 288, No. 14.

[3] Funded by Merck & Co. Inc.

ment services of pharmacists. Lack of payment by Medicare is a key obstacle in implementing these cost-saving, life-enhancing programs.

This lack of payment reflects the practice of pharmacy and construct of Medicare when the program was created. Obviously, health care, including the practice of pharmacy, has evolved since the creation of Medicare. Amending Medicare to include medication therapy management services provided by pharmacists would better reflect pharmacists' integral part of the health care team. Without this change, the most well-intentioned programs may never materialize due to lack of compensation. Payment for the provided services, in addition to the drug product, is critical to any program's success.

All Medicare beneficiaries should receive the attention they need to avoid medication-related complications. Drug therapy management goes far beyond the pharmacists' traditional dispensing services, with pharmacists working collaboratively with physicians to match therapies to patients' unique needs, to streamline multiple drug regimens, or to monitor patient response and advise physicians on changes in dosage, medicine, or delivery method.

If we were to design Medicare today, it is highly unlikely that we would pay for the services necessary to diagnose a patient's disease but not cover the treatment, both the product and the services provided by practitioners, necessary to address the disease. We encourage the Committee to consider paying for these pharmacist-provided medication management therapy services. Such a simple step would make significant inroad in addressing these preventable, costly health problems.

Statement of the American Society of Health-System Pharmacists, Bethesda, Maryland

The American Society of Health-System Pharmacists (ASHP) is pleased to submit this statement for the record of the Subcommittee on Health's hearing on eliminating barriers to chronic care management in Medicare.

ASHP is the 30,000-member national professional association that represents pharmacists who practice in hospitals, long-term care facilities, home care, hospice, health maintenance organizations, and other components of health care systems. ASHP believes that the mission of pharmacists is to help people make the best use of medicines. Assisting pharmacists in fulfilling this mission is ASHP's primary objective.

Pharmacist medication therapy management services are important to improving patient care, particularly for high-risk patients with chronic conditions or taking multiple medications. ASHP facilitates pharmacists in this role by offering educational programming and clinical information to assist pharmacists in creating an environment in which medication therapy management services can be fully utilized. ASHP promotes and encourages pharmacists to complete postgraduate residency training and to seek board certification in specialty practice. ASHP also advocates that state legislators and licensing boards update their pharmacy practice acts and regulations to explicitly authorize pharmacists to work in a collaborative relationship with physicians and others on the health care team to improve medication use. Currently, thirty-nine states, the Indian Health Service, the Department of Veterans Affairs, and other federal facilities authorize pharmacists to provide medication therapy management services.

The Medicare program ***does not*** recognize nor compensate pharmacists for providing these services. ASHP, as part of a coalition including six national pharmacist organizations, is seeking to amend Medicare statutes to include pharmacists as providers of medication therapy management services. We firmly believe this will eliminate an important barrier in the Medicare program to improved chronic care management.

Pharmacists Have an Integral Role to Play in Any Successful Chronic Care Management Program

Health care in the United States, particularly chronic care, relies extensively on a growing array of complex medications. In fact, the average Medicare beneficiary fills almost 20 prescriptions each year. Beneficiaries with chronic conditions average more than 26 prescriptions a year.

Because medications are a significant component of most treatment strategies, pharmacists must be involved in all stages of planning and implementing disease management and/or case management programs. The entire health care team, including patients, physicians, nurses, and other practitioners, should have access to the pharmacist, the health care professional with specialized academic and profes-

sional training focused most extensively on pharmacotherapeutics and medication therapy management.

Pharmacists are experts in drug therapy utilization and management. Working closely and collaboratively with physicians, the pharmacist can serve as a trusted counselor to help streamline drug therapies prescribed by a number of different specialists and match effective therapies with patients' unique needs. The pharmacist can also play a vital role in educating patients about their medications and the condition for which they are prescribed, completely reviewing the patient's medication history, monitoring the patient's drug therapy over time, screening for adverse effects, and monitoring for patient compliance.

These services are already being provided on a widespread basis for a number of chronic conditions, including asthma, cardiovascular disease, depressive disorders, diabetes, and pain. It is important to point out however, that 32 percent of Medicare beneficiaries have four or more chronic conditions. Thus, a more comprehensive approach to caring for patients is often needed. Pharmacists have a unique expertise that allows them to focus on a patient's overall drug regimen rather than on any one disease state.

Over the past two decades, ASHP has seen pharmacists become increasingly involved in improving patient care through the provision of medication therapy management services. This is due in part to the growth in managed care organizations that have a financial incentive to reduce the frequency of expensive and largely preventable medication-related complications. Under managed care programs, pharmacists have expanded their function to include reviewing drug therapies for appropriateness, monitoring patients' responses to therapy, and counseling patients about compliance, potential drug interactions, and other matters. Many plans have even moved to support specialized pharmacist-run clinics for patients with chronic diseases like hypertension, asthma, and diabetes.

ASHP's 2001 national survey of the ambulatory care responsibilities of pharmacists in managed care and integrated health systems confirms that there has been a dramatic rise in the number of practice sites at which pharmacists provide this type of care, jumping from 38% to 69% of those surveyed from 1999 to 2001. With the continued growth of medication use and the focus on improving therapy while controlling health care spending, this number is expected to continue to grow.

Research Demonstrates That Integrating Pharmacists into the Health Care Team Improves Care, Reduces Health Care Spending

Drug-related morbidity and mortality are significant problems in the United States. The 1999 Institute of Medicine report, "To Err is Human: Building a Safer Health System," noted that medication-related complications are a leading cause of death in the United States. A study published in the March/April 2001 edition of the Journal of American Pharmaceutical Association also reported that medication-related complications among ambulatory patients cost the United States an estimated $177.4 billion in 2000, a number that has more than doubled since last studied in 1995.

According to the 1999 IOM report, "[b]ecause of the immense variety and complexity of medications now available, it is impossible for nurses or doctors to keep up with all of the information required for safe medication use. The pharmacist has become an essential resource . . . and thus access to his or her expertise must be possible at all times."

Pharmacist involvement on the health care team helps to avoid unnecessary or counter productive treatments and streamlines the overall drug regimen to improve patients' quality of life. In addition, pharmacists help avoid medication-related complications that result in unnecessary physician office and emergency room visits, and therefore increased health care spending. A study in the March/April 2001 edition of the Journal of the American Pharmaceutical Association demonstrates that for every $1 spent on prescription drugs, $1.60 is currently spent correcting problems associated with prescription drug use. Including pharmacists on the health care team represents a meaningful response to this expensive problem.

As noted previously, many managed care programs and other private payers have recognized this benefit and have begun to utilize pharmacists in this role. This includes the city of Asheville, NC, which offered certain disease state management and medication therapy management services to city employees and found that these services decreased cost, improved care, and improved work absentee rates.[1]

[1] The Asheville Project. *Pharmacy Times*. Romaine Pierson Publishers, Inc. Westbury: NY. October 1998. Updated, Asheville Project Continues to Produce Positive Results. *America's Pharmacist*. May 2000:43–44.

Several State Medicaid programs and demonstration projects have also designed case management programs that utilize pharmacist medication therapy management services. For example, the Iowa Medicaid program designed a benefit to allow physicians and pharmacists to work together to closely scrutinize the total drug regimens of their most complex patients, those taking at least four medications and with at least one of twelve disease states. Eligible patients who participated in the program received an initial assessment by the pharmacist who then made written recommendations to be reviewed by the patient's physician. The pharmacist then worked with the patient to resolve any problems and provide follow-up assessments. The December 2002 final report of the Iowa Medicaid Pharmaceutical Case Management Program found that the program served to significantly improve medication safety and did not result in any increased costs to the Medicaid program.[2] This suggests that payment for professional patient care services was offset by reductions in emergency room and outpatient facility utilization.

The report notes:

- Pharmacists detected 2.6 medication-related problems per patient.
- The most common recommendation (52%) made by pharmacists was to start a new medication, indicating that many patients have untreated conditions.
- Pharmacists also recommended discontinuation of medications 33% of the time.
- Physicians and pharmacists responding to the survey agreed that inter-professional discussions led to better quality of care, better health outcomes and increased continuity of care.

The medical literature overwhelmingly recognizes and supports the value of including pharmacists on the health care team as means to improve patient care and control health care spending.

The Current System is a Barrier to the Role Pharmacists Play in Chronic Care

Some third-party payers are heeding the medical literature and covering pharmacist participation on the health care team. However, the Medicare program currently does not recognize nor compensate pharmacists for providing medication therapy management services. Thus access to pharmacist medication therapy management services remains inconsistent among different patient populations, with our nation's most "high-risk patients," Medicare beneficiaries, having significantly limited access to these services.

In order to ensure access to pharmacist medication therapy management services, Congress should amend Medicare Part B to recognize pharmacists as providers of service in a similar manner as nurse practitioners, physician assistants, registered dieticians, and other non-physician providers are recognized.

Six national pharmacy organizations, the Academy of Managed Care Pharmacy, American College of Clinical Pharmacy, American Pharmaceutical Association, American Society of Consultant Pharmacists, American Society of Health-System Pharmacists, and the College of Psychiatric and Neurologic Pharmacists, have created the Pharmacist Provider Coalition to promote legislation to recognize pharmacist as providers in the Medicare program. Legislation was introduced in the House in the 107th Congress, H.R. 2799, the Medicare Pharmacist Services Coverage Act, and is expected to be introduced again soon in the 108th Congress.

In an effort to eliminate a significant barrier to chronic care management, ASHP strongly urges this Subcommittee to pass legislation that would ensure Medicare beneficiaries have access to pharmacist medication therapy management services.

Statement of Michael Matthews, Chief Executive Officer, Central Virginia Health Network, L.C., Richmond, Virginia

Millions of Medicare patients suffer from multiple chronic illnesses that affect the quality of their lives and, as we well know, drive up healthcare spending. These individuals require complex care to address a variety of needs, and those with the most severe illnesses account for the greatest spending. Nearly two-thirds of Medi-

[2] PCM Evaluation Team from the University of Iowa Colleges of Public Health, Pharmacy, and Medicine, "Iowa Medicaid Pharmaceutical Case Management: Report of the Program Evaluation." As posted on the Iowa Pharmacy Association's website, www.iarx.com, on 02/25/2003.

care costs are spent on beneficiaries with five or more chronic conditions.[1] Nationally, payers incurred about $510 billion in medical costs in 2000,[2] and Congressional Budget Office testimony given last September before the Special Committee on Aging indicates that in 1997, almost 90 percent of all Medicare costs stemmed from the costliest 25 percent of Medicare patients.[3]

These patients include people like a 77-year-old man with type 2 diabetes whose health has improved significantly since he enrolled on September 13, 2002, in a care management program we offer at CenVaNet (Central Virginia Health Network, L.C.), an integrated delivery system comprised of 10 not-for-profit hospitals and 900 community-based physicians. Like many Medicare patients, this man was unable to control his diabetes on his own, and his high blood sugar levels made him feel fatigued.

By coaching this elderly man on the phone, through mailings and even during three personal visits to the man's home, our nurse care managers helped him learn to take an active role in better managing his disease. Our care managers also coordinated with his doctors to adjust his insulin dosage appropriately and schedule the tests he needed. Such proactive intervention is possible with the help of a user-friendly software platform that helps care managers identify potential problems and direct patients to appropriate healthcare providers, while providing evidence-based national treatment guidelines, medical information and other resources.

Since enrolling in our program, this particular patient has seen some significant changes. He now exercises and monitors his blood sugar levels every day, follows diet recommendations and takes his medicine as instructed by his physician. Importantly, his blood sugar levels also have improved, making him less likely to end up in the emergency room or be hospitalized, thus avoiding costly health complications in the future.

This man is not alone. CenVaNet has seven care managers (registered nurses and social workers), each treating between 50 and 70 patients, who provide in-home, telephonic and online care management focusing on four chronic diseases common in the Medicare population: congestive heart failure, chronic obstructive pulmonary disease, diabetes and asthma.

Our program is one of 16 sites nationwide participating in the Medicare Coordinated Care Demonstration (MCCD) project sponsored by the Centers for Medicare and Medicaid Services to evaluate the effectiveness and cost savings of such care management programs. We have enrolled more than 1,000 patients in this project, with about 460 patients actively receiving care management services (vs. those in the control group). Our successful recruitment effort has been possible because of the support of leading physician groups in our area.

Barriers to the Care of Chronically Ill Medicare Patients

Our care management program at CenVaNet seeks to address the four main barriers to treating chronically ill Medicare patients:

1. Lack of prescription drug coverage for Medicare patients—Many Medicare patients cannot afford their medicines, so they simply stop taking them. Scientific literature indicates that patient behaviors, including whether they comply with their doctors' instructions, have a real effect on clinical outcomes. In fact, the American Heart Association testimony given at this hearing stated that "An important focus of disease management should be to influence the behavior of providers, patients and other caregivers to better understand and adhere to treatment plans that will help improve patient outcomes."
2. Poor health literacy—People with multiple conditions may not be well informed about their diseases, and often are prescribed a variety of medicines, each with its own instructions on when and how to take it. When patients do not understand these instructions, they may take their medicines or follow other treatments incorrectly, leading to additional health problems. Unfortunately, the people who most need to understand their conditions and treatments tend to be those with the greatest deficits in knowledge, which leads to poor health status in these already at-risk patients.

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[1] Berenson and Horvath. "Confronting the Barriers to Chronic Care Management in Medicare." *Health Affairs*, January 22, 2003.

[2] Baker G. "Integrating Technology and Disease Management—The Challenges." *Healthplan Magazine*, September/October 2002, Vol. 43, No. 5.

[3] Crippen/Congressional Budget Office. "Disease Management in Medicare: Data Analysis and Benefit Design Issues." Testimony given September 19, 2002, before the Senate Special Committee on Aging.

3. Multiple data sources, which result in fragmented care—Our current healthcare system segments information about a patient's health into separate "silos" (hospitals, group practices, pharmacies, home care companies) that rarely have the capability of exchanging data with each other. Patients with multiple chronic conditions can visit several different physicians, and none will have a record of the medications the others prescribed. To provide more thorough care, medical professionals must coordinate their efforts, yet in many cases their information systems are not compatible and do not allow for such integration.
4. Lack of reimbursement for the care coordination needed—Medicare does not reimburse for the vital services of care managers, who address these problems in the healthcare system by educating patients and facilitating the physician/patient relationship. Nor does Medicare reimburse for the purchase of software platforms that integrate the different aspects of a patient's care.

This last barrier is a significant one. Proper reimbursement for care management services and technology may encourage more health organizations to take on the costly, complicated process of implementing a robust care management program, which involves:

- Determining which patients have a particular disease, and of those, which patients are most at risk for complications and may benefit most from appropriate intervention
- Recruiting and enrolling patients, which takes considerable time and effort
- Performing interventions, such as educating patients and coordinating care
- Obtaining care management support, such as a software platform, which requires:
  - Purchasing the technology
  - Training staff on its use
  - Implementing the system
  - Supplying ongoing maintenance and support
- Ensuring patient retention in the program
- Measuring and analyzing clinical, financial and behavioral outcomes
- Evaluating the program and making necessary adjustments

As the eHealth Initiative stated at this hearing, there is a need for the Medicare payment system to reimburse physician services for care coordination.

CenVaNet has Made Progress Overcoming These Barriers

Although there still are challenges to overcome, particularly in the area of reimbursement, CenVaNet has made significant progress, as our success with the 77-year-old diabetic man described above shows.

While Congress debates the issue of a Medicare prescription drug benefit, CenVaNet has taken a creative approach to pursuing other funding sources for our patients' prescription medicines. We educate patients about prescription drug savings cards and encourage providers to prescribe less costly medications, knowing that patients will be more likely to take medicines they can afford. We also are exploring grant funding opportunities.

Additionally, our care management program addresses health literacy through in-depth patient education efforts. We have sevencare managers dedicated to the Medicare demonstration project, and they offer not only telephone counseling, but also actual in-home visits with patients to provide more individualized care.

To supplement our care managers' patient education efforts, we offer other resources for patients to learn about their health, such as printed and electronic materials. Through the care management software technology developed by Pfizer Health Solutions Inc (PHS), the care management subsidiary of Pfizer Inc, our patients can take advantage of a vast library of reliable health information and access patient tools designed to improve their care and increase their knowledge of their chronic conditions.

This technology also addresses the problem of fragmentation of information. Care managers, physicians and patients are linked together by using the same software, increasing communication and improving the quality of care. We will further strengthen this connectivity by 2004, when automated interfaces will allow hospital labs, home care companies and others involved in a patient's care to download information directly into our software platform. This will eliminate the need for patients to recall which diagnostic tests they had performed and why. All of these capabilities are important steps in improving the care our Medicare patients receive.

Finally, we are encouraging Medicare reimbursement for care management services by participating in the Medicare Coordinated Care Demonstration project,

which we are confident will show that proactive care management is both clinically effective *and* cost-effective, and should qualify for Medicare reimbursement.

What Sets CenVaNet Apart?

The overwhelming number of patients we have enrolled in the Medicare demonstration project makes CenVaNet unique. Patient enrollment is a key component of making a care management program viable, and our enrollment figures are a testament to our success.

Many care management programs, especially in the commercial sector, do not take the extra step we do of providing home visits with patients; however, we find the personal interaction in a patient's home environment gives us greater insight into our patients' needs. In-home visits can even alert us to other problems, such as patients who do not have working smoke detectors in their homes, so our care managers can coordinate a solution with the local fire department.

Finally, early behavioral outcomes from our participation in the demonstration project are promising. As of January 2003, more patients with cardiovascular disease had become competent in the following areas after an average of six months of follow-up care at CenVaNet:

- Taking their medications (31 percent increase)
- Monitoring their own blood pressures and weight (increases of 31 percent and 23 percent, respectively)
- Understanding the symptoms of cardiovascular disease (15 percent increase)
- Managing their diet and nutrition (12 percent increase)

Although it is still too early in the five-year demonstration project to determine whether our patients' health has improved (i.e., through clinical outcome measurements such as blood pressure values, etc.), these changes in behavior indicate that patients are taking a more active role in managing their conditions, which can only benefit their overall health.

Conclusion

The Medicare demonstration project is an important step in overcoming the barriers to treating chronically ill patients in this population, and CenVaNet is proud to be a part of this study. The success of our program—as well as others—points to the need for Medicare reimbursement for care coordination services to help improve the quality of healthcare delivery, increase access to care and reduce the overall cost of care.

Statement of Christobel Selecky, Chair, Government Affairs Committee, Disease Management Association of America

I. Introduction

Thank you for the opportunity to submit testimony on behalf of the Disease Management Association of America (DMAA) on the need to eliminate barriers to chronic care management in Medicare.

Disease Management (DM) is fundamentally concerned with the management of chronic illness toward the twin goals of improving quality of life and reducing health care expenditures. Properly designed and administered DM programs can produce quality improvements and cost savings. This is not news in the private sector where DM has been incorporated into private health insurance. It is not news to Medicare+Choice, where DM is frequently utilized. And it is not news to FEHBP or Medicaid, where the use of DM is increasing. A growing body of evidence from these programs shows that DM works.

DM represents an important strategy to address the need, as detailed in such reports as the Institute of Medicine's "Crossing the Quality Chasm," to re-engineer our healthcare system to address the growing chronically ill population. Making DM available to the approximately 35 million fee-for-service Medicare beneficiaries currently denied these services would represent a major step forward in addressing this need.

The purpose of this testimony is to discuss the role that Disease Management (DM) should play in Medicare, and to address some of the definitional and benefit design issues that must be answered in order to better incorporate DM into Medicare.

In the testimony that follows, DMAA will—

- Explain what DM is and how it is distinguishable from other services.
- Explain how DM has been incorporated into Federal health care programs other than fee-for-service Medicare.

- Provide information concerning the cost savings and quality improvements that can result from a properly designed and administered DM program.
- Address some of the questions that have been raised about how to programmatically include DM in the fee-for-service Medicare program.

II. Understanding Disease Management

A. What is DM?

The central premise behind DM is elegant in its simplicity. Simply stated, the value proposition for DM is that "healthier people cost less." Put another way, if we can improve the health of the population, we will reduce their demands on the health care system and that reduced demand translates into lower costs. Chronic illness is a major driver of health care costs. One reason for this is that many chronically ill individuals experience acute episodes that require expensive (and often traumatic) treatment in institutional settings. The incidence of such episodes can be reduced or entirely avoided through proper management of chronic conditions, as can the progressive worsening of chronic conditions that leads to complications and co-morbidities. Thus, if health care payors can efficiently deliver interventions that result in improved management of their chronic condition to those beneficiaries, quality improvement and cost savings will result.

The types of illness that are most amenable to disease management interventions are those where evidence-based practices have been shown to reduce costs and improve quality of life. Candidates for DM services are typically identified through review of their health insurance and available medical data by health insurers and Disease Management Organizations (DMOs), or by their primary care providers. Disease managers then reach out to these individuals and, in concert with their physicians, enroll them in DM programs.

Many of the interventions that can be provided to individuals with these chronic illnesses are often relatively simple. For example, great progress can be made by promoting smoking cessation, improvements in diet and exercise, and teaching patients to better self-manage many aspects of their condition like blood glucose level self-monitoring and adherence with prescription drug regimens. These interventions are supported by *regularized*, *ongoing* communication between beneficiaries, care providers and disease managers through a variety of media including phone, mail and electronic, that serves to promote adherence, monitor clinical status, ensure a continuum of care, and to proactively identify and address situations that could lead to avoidable acute events. Most DMOs have proved adept at addressing populations with multiple conditions—this is important because of the high percentage of overlap (co-morbidity) among these diseases.

One challenge in delivering effective DM services lies with the fact that the beneficiary population can be a difficult one to impact. Often, the harmful behaviors and habits that DM programs seek to address have become highly ingrained over decades. In other cases, beneficiaries are depressed as a consequence of their condition, have grown skeptical of health care interventions, and may have developed hostility toward the health care system. DM programs have developed techniques for successfully reaching these populations and are able to uncover and motivate the underlying desire of most chronically ill individuals for improved quality of life.

Another important feature of Disease Management is the integration with the beneficiary's personal physician. Many DM programs assist the physician as well as the patient by helping to provide evidence-based practice guidelines specific to their patients and their conditions. DM programs develop programs and techniques for reaching out to physicians and have generally been successful in achieving positive physician satisfaction and participation.

DM has demonstrated that it works. Not making DM available to the Medicare fee-for-service population creates a situation whereby health care quality is not what it could be and the Medicare Trust Fund is tapped for billions of dollars per year in unnecessary spending. While the Center for Medicare and Medicaid Services (CMS) has recently initiated new DM demonstration projects that are comprehensive in approach, the three year delay in benefiting from these demonstration projects represents three years of delays in helping Medicare patients suffering from chronic disease.

B. Definition and Accreditation

After many years of development, the Disease Management community has been able to balance the need for continuing innovation with the desire for definitions and standards. In order to capture the essential elements that are required for a successful DM program, the DMAA several years ago worked to develop a definition of DM programs and entities. The DMAA definition—established in consultation with primary care and specialty physicians, and incorporating private practice,

health plan and institutional perspectives—has become the standard definition and is relied upon widely: [1]

> Disease management is a multidisciplinary, systematic approach to health care delivery that: (1) includes all members of a chronic disease population; (2) supports the physician-patient relationship and plan of care; (3) optimizes patient care through prevention, proactive, protocols/interventions based on professional consensus, demonstrated clinical best practices, or evidence-based interventions; and patient self-management; and (4) continuously evaluates health status and measures outcomes with the goal of improving overall health, thereby enhancing quality of life and lowering the cost of care. Qualified Disease Management programs should contain the following components:
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> - Population Identification processes;
> - Evidence-based practice guidelines;
> - Collaborative practice models that include physician and support-service providers;
> - Risk identification and matching of interventions with need;
> - Patient self-management education (which may include primary prevention, behavior modification programs, support groups, and compliance/surveillance);
> - Process and outcomes measurement, evaluation, and management;
> - Routine reporting/feedback loops (which may include communication with patient, physician, health plan and ancillary providers, in addition to practice profiling); and
> - Appropriate use of information technology (which may include specialized software, data registries, automated decision support tools, and call-back systems).

DM organizations may voluntarily apply for accreditation by the National Committee for Quality Assurance (NCQA), which has a specific DM accreditation program.[2] DM organizations may also pursue accreditation from the American Accreditation Healthcare Commission (URAC) or the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). These three national organizations have all recognized the importance of DM and created meaningful standards and programs that serve to maintain the high quality of DM services and to standardize many of the new processes and terms that have evolved with the development of DM. These accreditation programs, combined with the consensus definition of DM, provide a clear basis for the Department of Health & Human Services to identify DM organizations that should be eligible for contracting under Medicare.

C. Distinguishing Disease Management

There are a variety of other health care activities and interventions that seek to improve public health, address the costs and consequences of chronic illness, or better promote a continuum of care. Whatever their relative merits, it is important to understand how these terms and activities relate to DM.

First, it should be recognized that DM contains a preventive component but it is not co-extensive with "prevention." Preventing the onset of chronic or other major illness is a highly meritorious goal, and one that the Secretary of Health & Human Services has made a priority. Through promoting proper diet, exercise and lifestyle choice, it is hoped that the future incidence of conditions such as diabetes, COPD, CAD and CHF can be reduced. In addition, Federal policymakers have in recent years sought to improve the availability of primary and preventive health care, including screening to detect and address conditions that can lead to chronic illness. DM can be distinguished from these types of prevention efforts in that DM programs work with identified populations of individuals that already suffer from chronic illness (and with their personal physicians) to manage the consequences of those illnesses. As a general proposition, it is easier to demonstrate measurable cost savings and quality improvements through a DM program than through these other, more generalized forms of prevention.

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[1] The definition is cited by CMS in its February 28, 2003 solicitation for capitated Disease Management demonstration projects, in its February 22, 2002 solicitation for proposals to conduct the DM demonstration projects authorized in the Benefits Improvement and Protection Act of 2000 (BIPA), by DM accreditors, and by payors and providers.

[2] NCQA is an independent organization that evaluates health care in three different ways: through accreditation (a rigorous on-site review of key clinical and administrative processes); through the Health Plan Employer Data and Information Set (HEDIS®—a tool used to measure performance in key areas like immunization and mammography screening rates); and through a comprehensive member satisfaction survey. Criteria for accreditation and certification can be found at: http://www.ncqa.org/Programs/Accreditation/DM/dmmain.htm.

Nor is DM the same as "case management" although there are similarities. The cardinal distinction is that DM programs seek to proactively identify an entire population of individuals suffering from a chronic illness and to provide evidence-based educational, monitoring, and coaching interventions to that population. Case management by contrast generally denotes an intervention based around the particular health and economic circumstances of high-risk beneficiaries, regardless of their chronic health conditions, and frequently involving the coordination of social service and other non-health benefits.[3] While DM programs often provide case management-type services for identified beneficiaries, DM programs begin by identifying a group of beneficiaries that share common attributes (chronic illness) and then provide a more defined service to that group. Whatever their merits, it is much more difficult to demonstrate and realize cost savings on a population basis from heterogeneous case management services than from targeted, accredited DM programs.

The relationship between DM and "care coordination" also merits comment. Care coordination generally describes a *function* that should be—but too often is not—part of a competent health care system but that is always a central element of a competent DM program. While primary health care providers and health systems generally assert that they provide care coordination, in practice such service is often absent due to institutional barriers, the absence of an economic incentive to provide such service, or functional difficulties. In those provider environments where formal care coordination service is available, it typically reaches a smaller population of beneficiaries (e.g., the patients of an individual provider or group practice) than can be reached through a DM program. Case management programs also seek to promote care coordination but, as mentioned above, often with a smaller, more disparate population. Care coordination is an integral part of DM. Successful DM programs work closely with primary care, specialty and institutional providers to coordinate service, and research has shown that such providers typically recognize the value of this service to their patients and their practice.[4]

III. The Use of DM in Federal Health Care Programs

At this point in time, fee-for-service Medicare can be distinguished from other major Federal health care programs by the fact that disease management programs are not available to its beneficiaries. The involvement of other Federal programs with DM can be briefly summarized as follows:

A. Federal Employee Health Benefits Plan (FEHBP)

The Office of Personnel Management (OPM) administers FEHBP by qualifying certain plans to provide services under the program to current and retired Federal workers. FEHBP offers a range of plans including fee-for-service (FFS), PPO and closed plans and beneficiaries elect a plan under which to receive coverage. The Federal Government pays a portion of the monthly premium, and the beneficiary is responsible for the remainder. Plan costs vary. Health plans typically contract with health care clearinghouses to conduct a variety of claims processing and payment functions. Today, FEHB plans provide DM services to beneficiaries. For example, the FEHB plan offered through Blue Cross/Blue Shield of Delaware and other Blue Cross/Blue Shield plans across the country contract directly with a Disease Management Organization (DMO) for DM services. These programs have been shown to be successful in improving health status and reducing cost for members with chronic disease.

B. Medicare+Choice

Under Medicare+Choice, CMS contracts with a Medicare+Choice Organization (MCO)—typically a closed health plan or HMO—that enrolls beneficiaries for the receipt of all Medicare services covered by fee-for-service Medicare and sometimes additional services (e.g. prescription drugs). The MCO receives a capitated payment from CMS that may be adjusted for a variety of factors. DM services are often available under Medicare+Choice. The arrangement is similar to that seen under FEHBP—the MCO typically contracts directly with a DMO for the provision of DM services. In addition, M+C has promoted some minimal incentives to encourage successful DM interventions by providing an additional risk adjustment payment for outpatient DM services to CHF patients who demonstrate certain quality improve-

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[3] As MEDPAC has noted, "[b]oth case management and disease management programs seek to coordinate care for people who are at risk of needing costly medical services. The two programs differ in their emphasis and target populations. Case management tends to focus on medically or socially vulnerable "high risk" patients, while disease management programs focus on a single disease. . . . MEDPAC, Report to Congress, June 2002 at 54–55.

[4] A Fernandez, et al, *Primary Care Physicians' Experience with Disease Management Programs*, J. of Gen. Internal Med., pp. 163–167 (March, 2001).

ments. Again, these programs have been shown to be successful in improving health status and reducing cost for beneficiaries with chronic disease.

C. Fee-for-Service Medicare

As mentioned above, DM is largely unavailable to the fee-for-service Medicare population. However, one study is available and deserving of note. This unpublished study conducted by Dr. David W. Plocher, Vice President of Cap Gemini Ernst & Young, reviewed the first ten months of results on an American Healthways program involving approximately 6,000 Hawaii Medicare fee-for-service beneficiaries with diabetes. The study shows concurrent and statistically significant improvement in all clinical outcomes measures *and* a net, after-fee reduction in total health care cost of approximately $5.1 million, or 17.2% on an inflation adjusted basis. This study strongly suggests the potential for DM in fee-for-service Medicare.

D. Medicaid

A growing number of States are incorporating DM into both traditional and managed care Medicaid. Among the first States to become involved with adopting DM programs were Texas, Florida, North Carolina, Virginia, West Virginia, and Maryland. Today, over half the States have incorporated at least limited DM initiatives into their Medicaid programs, while others, such as California, are considering language to promote DM. There are a wide variety of State programs and approaches, many of which have shown promising results. Florida has perhaps the most ambitious DM program in the country. Under this Medicaid Primary Care Case Management Program (called "MediPass"), nine diseases have been managed through risk-based contracts with Disease Management Organizations ("DMOs"). The Florida Agency for Health Care Administration has contracted with DM organizations to provide DM services to Medicaid recipients enrolled in MediPass who have been diagnosed with diabetes, HIV/AIDS, asthma, hemophilia, CHF and end stage renal disease (ESRD).

IV. Demonstrated Cost Savings and Quality Improvement from DM

Evidence on the growing nexus between health care expenditures and chronic illness continues to mount. People with chronic illnesses such as diabetes and CHF account for more than 60 percent of the medical care dollars spent in the United States.[5] According to 1997 data, 25% of the Medicare population consumed almost 90 percent of Medicare spending while a Johns Hopkins study has shown that 90% of Medicare spending is attributable to beneficiaries with three or more chronic conditions.[6] As this data suggests, the cost implications for Medicare of more effectively managing chronic illness are potentially quite large.

Quality of life considerations aside, the cost effectiveness of successful DM programs results from the decreased utilization of other health care services—especially such institutional services as hospitalization and emergency department visits—to a degree that more than offsets costs. While the proper and comparative measurement of such costs and savings is no easy matter, a constantly growing body of evidence demonstrates the cost savings and outcome improvements that can result from DM.[7] And recent efforts, like the recently released Johns Hopkins Consensus Panel paper on measurement guidelines and metrics are helping to bring increased standardization concerning outcomes studies.

- A peer-reviewed study of the American Healthways, Inc. ("AMHC") Healthways' Diabetes NetCare℠ program shows a 17.1 percent or $114 per diabetes member per month reduction in total direct health care costs for the first year of operation.[8] Patients also demonstrated improved adherence to recognized standards of care. For example, 74 percent of patients took their A1c test, a signal

[5] *Broad Disease Management Interventions Reducing Health Care Costs for Plan Members with Congestive Heart Failure*. Joel C. Hoffman, Ernst & Young, LLP. *Citing* United States Department of Health and Human Services, Centers for Disease Control and Prevention. New Brunswick (NJ): The Robert Wood Johnson Foundation.

[6] See, *Disease Management in Medicare: Data Analysis and Benefit Design Issues*, Statement of Dan Crippen, Director of Congressional Budget Office, before the United States Senate Special Committee on Aging, September 19, 2002.

[7] DMAA has commissioned a comprehensive review of DM literature as part of its "Outcomes Validation Project." The purpose of the project is to create a complete reference of DM peer-reviewed publications that exhibits the outcomes of DM programs. 133 articles have been selected for full-length review. The Outcomes Validation Project is focused on formal evaluation of outcomes and hopes to increase awareness regarding methodologies and outcomes.

[8] Robert J. Rubin et al., *Clinical and Economic Impact of Implementing a Comprehensive Diabetes Management Program in Managed Care*, 83 J. Clin. Endocrinol. and Metab. 2635, 2640 (1998) (Attachment B).

measure of a diabetic's health status, versus 61 percent in the base year; 16 percent took cholesterol exams versus 4 percent in the base year; and 12.2 percent took foot exams versus 2.5 percent in the base year.[9] *AMH patients experienced reduced admissions per 1,000 by an average of 15.6 percent, reduced days per 1,000 by 21.7 percent, and reduced average length of stay by 7.2 percent*.[10] Indeed, "[h]ospital costs decreased by $47 per diabetic plan member per month, or $564 per year." [11]

- LifeMasters Supported Self-Care, Inc. ("LifeMasters") has demonstrated that a multidisciplinary DM program including patient education, interactive vital sign monitoring, nurse support and physician intervention can significantly reduce utilization and improve quality of care. One study published in a peer reviewed cardiology journal followed the progress of a population of CHF patients enrolled in the LifeMasters program through a San Francisco-based managed care organization.[12] Evidence compared against baseline data showed significant improvements 12 months post enrollment. *Clinical impact included 48 percent reduction in inpatient (acute) days, 36 percent reduction of inpatient admissions, 31 percent decrease in emergency department visits, and a 20 percent decline of average length of stay*. Per member per month financial savings of the same study group over the same enrollment period averaged a total reduction in disease-specific claims of 54 percent, while an average reduction in all claims associated with the group improved by 42 percent on average.[13]
- CorSolutions, Inc. demonstrated impressive results for its business partner, Highmark, through implementation of a DM program for Highmark's chronic population. *For the health plan's target patient group, hospital admissions declined 65 percent, hospital days declined 52 percent, the number of patients receiving appropriate drug therapy rose 43 percent, and optimal drug regimen adherence climbed to 58 percent*.[14] Finally, CorSolutions has been able to reduce total costs for nearly 13,000 patients in the Medicare+Choice program by about 50 percent compared to a baseline of $22,236, or an actual savings of $11,000 per patient per year. These results are based on fully-reconciled administrative data available for this subset of total patients managed.[15]
- A coronary artery disease (CAD) study conducted over twenty one months found that a physician decision supported disease management model by QMed, Inc. reduced the incidence of heart attacks by 30 percent, hospitalizations for angina or suspected infarction by 32 percent, cardiac catheterizations by 20 percent and coronary angioplasties by 22 percent, while coronary artery bypass grafting was unchanged. Costs for CAD, the most costly among Medicare members, declined 17 percent. The model used in this study has been selected in both the Care Coordination demonstration and the CHF and CAD demonstration.[16]
- Participants in Humana's CHF DM program "eat less salt, can walk farther, are more mobile, and generally have a higher quality of life and a lower mortality rate" than those enrollees not utilizing the programs. Humana saved an estimated $22 million in costs through disease management last year.[17]

With regard to Medicare specifically, the literature contains an expanding body of evidence regarding the savings DM can bring, including the following:

- Measuring Outcomes of a Chronic Obstructive Pulmonary Disease Management Program. This study, focusing on members with asthma and COPD, showed a 24.7 percent cost-savings for the Medicare group of 1,700 beneficiaries.[18]
- Economic Impact of a Diabetes Disease Management Program in a Self-Insured Health Plan: Early Results. This study showed a 5 percent decrease in spending

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[9] http://www.americanhealthways.com/res__art01.pdf (visited January 18, 2003).
[10] http://www.americanhealthways.com/res__art01.pdf (visited January 18, 2003).
[11] Rubin, at 2641.
[12] Am Heart J 1999; 138:633–40.
[13] *Id*.
[14] Jean Lawrence, *High Marks for Chronic Care*, HealthCare Business, DM6, 14 (June 2000).
[15] Medicare+Choice Disenrollment: Consequences and Opportunities, presented to CMS by CorSolutions, Inc., Aug. 9, 2000.
[16] Levin et al, *Risk Stratification and Prevention in Chronic Coronary Artery Disease: Use of a Novel Prognostic and Computer-based Clinical Decision Support System in a Large Primary Managed-Care Group Practice*, DM Journal 5:197–213 (Winter 2002). The referenced demonstrations are discussed below in part III.C.3 of this paper.
[17] Chris Rauber, *Disease Management Can be Good For What Ails Patients and Insurers*, 29 Modern Healthcare 48, 51 (1999).
[18] Barry Zajac, MHSA, *Measuring Outcomes of a Chronic Obstructive Pulmonary Disease Management Program*, *Disease Management*, V5(1): 9–23 (2002).

over three years for the study group and a 3 percent increase over the same time period for the control group.[19]

- Evaluation of Disease-State Management Dialysis Patients. 1,541 Medicare patients enrolled in a renal DM program in 1998 and 1999 had 19 to 35 percent better survival rates compared with ESRD patients in traditional FFS Medicare and hospitalizations for the renal program patients were 45 to 54 percent lower than the FFS Medicare group.[20]
- Does Diabetes Disease Management Save Money and Improve Outcomes? The per member per month cost averaged $424 for Medicare patients enrolled in a diabetes DM program and averaged $500 for non-program participants, a difference of 15.2 percent.[21]

Effectively run DM programs often involve certain increased expenditures that result from the provision of new services.[22] In addition, a DM program may result in greater utilization of certain other healthcare goods and services. In a number of DM programs this has proven true with regard to the utilization of prescription drugs because the programs' strive to promote access to and compliance with drug regimens. In this way, DM actually results in the most effective use of healthcare resources by funding potential cost increases caused by appropriate utilization from the cost reductions caused by the elimination of preventable hospitalizations and procedures. Typically, physician visits increase as well.

V. Applying DM to Fee-For-Service (FFS) Medicare

In testimony to this Subcommittee last year, the Congressional Budget Office (CBO) defined the challenge of providing DM under FFS Medicare as requiring the consideration of a number of questions, including: how beneficiaries would be identified and enrolled in DM programs, how Medicare would pay for DM services, and how it would capture the resultant savings. We would like to offer some thoughts on these issues.

At the outset, it should be understood that incorporating DM into FFS Medicare does *not* mean that Congress should simply authorize the reimbursement of DM as another covered Part B service. To do so would create a difficult situation where CMS, through its carriers, would need to become heavily involved in controlling utilization on a per-beneficiary basis through payment, coverage and other controls similar to those it employs for any Part B service. More fundamentally, any such approach to a DM benefit would not encourage the type of structure and organization necessary to provide DM services on an area-wide or population basis absent extensive intervention by CMS with individual providers.

Rather, it makes more sense and would result in less administrative burden for CMS to incorporate DM into FFS Medicare at a broader level. For example, CMS could be authorized to contract directly for DM services. This could be done through pending Medicare contractor reform legislation or in any other Medicare legislative vehicle. A possible alternative approach might involve the creation of the authorities and incentives necessary for carriers to contract with DMOs to provide coordinated DM services within a region (an arrangement that would be similar to what is done under FEHBP or M+C). This alternative, would likely be less efficient, however, with respect to the minimization of administrative costs. The vendor selection process would be facilitated by the existence of standardized definitions and external accreditation of DM programs and organizations, as well as through the application of other factors such as the ability to deliver services at scale, experience with Medicare beneficiaries and demonstrated and validated clinical and financial outcomes.

As discussed above, private sector health insurers, M+C organizations, DMOs, and FEHB plans review encounter information to identify candidates that would benefit from DM services, and to refer those candidates for DM services that are ordinarily provided by an accredited Disease Management Organization that has a contract with the insurer. The DMO then contacts the beneficiary (and, when appropriate, their physician) to deliver the DM program. Similar mechanics could be used to create a DM service under FFS Medicare if policy makers can effectively address

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[19] Jan Berger et al, *Economic Impact of a Diabetes Disease Management Program in a Self-Insured Health Plan: Early Results*, *Disease Management*, V4(2): 65–73 (2002).

[20] Allen A. Nissenson et al, *Evaluation of Disease-State Management Dialysis Patients*, *American Journal of Kidney Disease*, V37(5): 938–944 (2001).

[21] Jean Sidorov et al, *Does Diabetes Disease Management Save Money and Improve Outcomes? Diabetes Care*, V25(4): 684–689 (2002).

[22] It should be noted, however, that providing effective comprehensive DM services is not the same as providing the most intensive intervention possible. For example, telecommunications between beneficiaries and DMOs is ordinarily effective to facilitate enhanced clinical outcomes and cost savings and the added cost of a home visit is not necessary except in particularized circumstances.

the cardinal difference between FFS Medicare and these other forms of care, namely that the medical information necessary to identify candidate beneficiaries is processed through Part A Intermediaries, Part B Carriers and through CMS itself. This difference can be addressed in any one of several ways: CMS could undertake the data review function itself; CMS could direct its carriers and intermediaries to do so and provide guidance to providers on the identification of candidates; or CMS could contract with a DMO, clearinghouse or other entity to perform this function.

The first of the aforementioned options is likely the most administratively efficient. In the case that CMS chooses to utilize the resources and services of an outside company to perform this function, in order to protect patient health information, CMS, as a covered entity under the Health Insurance Portability and Accountability Act of 1996, HIPAA, would enter into agreements with the third parties to ensure the confidentiality of patient health information. These agreements would allow CMS to share patient health information with third parties for the purposes of treatment, payment, and health care operations. As defined under HIPAA, health care operations include the typical functions of DMOs including data review and identification of candidates for participation in DM programs. CMS would be permitted to share patient health information with a third party who would then utilize the patient information to identify candidates on behalf of CMS without compromising the confidentiality of such information.

With regard to the identification of proper candidates for DM services, it is elemental that only beneficiaries who are in need of and can benefit from DM services—namely, those suffering from an appropriate chronic illness—should be qualified to receive services. Identifying this population is not difficult, but must be undertaken with care to avoid using algorithms that identify an unnecessarily large number of false positives. These techniques are well developed in the private sector and CMS need only import this learning into fee-for-sevice Medicare. Again, reference to and use of only accredited DMOs is advisable to ensuring appropriate population identification.

As for enrollment, it is critical that participation be voluntary but, at the same time, DM programs create the most benefit by engaging as large a proportion of the population as possible. Private sector practice suggests that an opt-out approach to enrollment is the most effective method of meeting these twin goals.

Finally, payment could be approached in a number of ways. One method, utilized by essentially all commercial plans and in many Medicare+Choice plans and state Medicaid agencies, is to pay a monthly fee to the DMO on a per enrollee per month basis to cover the cost of the disease management services provided to a population of beneficiaries with chronic disease. Under this payment methodology, beneficiaries can retain their fee for service coverage and savings immediately accrue to the Medicare Trust Fund with some upside risk sharing possible for the DMO.

We appreciate the opportunity to submit this testimony to the Ways and Means Health Subcommittee concerning the need to address barriers to the incorporation of disease management in the Medicare fee-for-service program. As this testimony should make clear, we believe that DM can be successfully incorporated in FFS Medicare to improve the lives and well being of the chronically ill and we hope that our recommendations assist the Subcommittee in so doing.

Statement of Jaan Sidorov, M.D., Medical Director, Care Coordination Geisinger Health Plan, and Geisinger Health System, Danville, Pennsylvania

Chairman Johnson and Members of the Committee, I am Jaan Sidorov, MD, Medical Director, Care Coordination of Geisinger Health Plan (GHP). GHP, a part of the Geisinger Health System, is a not-for-profit health maintenance organization (HMO), serves the health-care needs of members in 38 counties throughout central and northeastern Pennsylvania. Begun in 1985, the Health Plan has steadily evolved into one of the nation's largest rural HMOs by providing high quality, affordable health-care benefits.

I appreciate the invitation to present our views on eliminating barriers to chronic care management in Medicare.

Overview

Disease management is a system of coordinated healthcare interventions and communications for populations in which patient self-care efforts are significant. The components included 1) population identification processes, 2) evidence based practice guidelines, 3) collaborative practice models, 4) patient self-management edu-

cation, 5) process and outcomes measurement, and 6) routine reporting and feedback.

Diseases in which disease management has been shown to result in improved outcomes are: Congestive Heart Failure (CHF), cardiac disease, Chronic Pulmonary Obstructive Disease (COPD), diabetes, asthma and cancer.

Geisinger Health Plan has implemented a ground breaking, national role model disease management program. For its 240,000 enrollees in northeastern and central PA, over 10,000 Medicare+Choice (+C) and Commercial insurance enrollees have avoided unnecessary hospitalizations, become better able to manage their diabetes, CHF, hypertension, COPD and asthma, simultaneously avoiding complications and reducing health care costs. The reason they have been able to do this is because they are enrolled in a health care insurance plan that is able to use premium to support this novel health care strategy. In addition, please note that disease management is a strategy that is more 'virtual' than the traditional one-on-one health care; the latter is hostage to the availability of providers, which in rural PA remains a challenge. Disease management—which is independent of location or level of service—is able to project services outside the outpatient clinic setting. We are not talking just home visits by non-physicians, but novel use of the telephone, the internet, groups visits etc.

Up until now, Medicare has not explicitly recognized disease management for beneficiaries who are not enrolled in a +C program. As a result, these individuals are at increased risk for unnecessary hospitalizations and are effectively shut out from taking the advantage of clinical programs that have been shown to improve clinical outcomes and reduce health care costs.

We salute Tommy Thompson, Secretary, HHS for his willingness to expand demonstration projects that will ultimately prove the value of disease management programs. Congress should approve expansion of these projects as well as the ongoing research being conducted by AHRQ, the CBO and GAO.

Recommendations for +C

HHS should actively encourage the expansion of "accredited" disease management programs for the +C program. One example of a good start is the extra payment provided to participating organizations that meet certain requirements for the treatment of enrollees with CHF. This should be expanded to other diseases. In addition to promoting the attainment of measurable outcomes, this would help slow the exit of Managed Care Organizations from the +C Program.

Recommendations for FFS Medicare

The Secretary of HHS may designate entities that can provide disease management services to eligible individuals—eligibility is determined by diagnoses such as CHF, Diabetes, Asthma, Coronary Artery Disease or Cancer or any other diagnosis that is deemed by the Secretary to be amenable to disease management services. This would mean that M'care could contract directly with organizations to provide services, preferably on a geographic or population basis.

Disease management services include but is not necessarily limited to health screening and assessment, coordination of providers and referrals to same, monitoring and controlling medications, patient education and counseling, nursing visits, consultations by phone, email or web-site, and transitioning to programs outside disease management if the enrollee elects to opt out.

The Secretary may enable entities to use cost sharing (within the limits of the law) with respect to health care items and services.

Entities should be qualified by criteria set by the Secretary. Qualifications should include JURAC, JCAHO, or NCQA accreditation.

The Secretary should also set performance standards regarding clinical outcomes, based on a standardized baseline assessment of individuals' health prior to entry into disease management with re-measurement at specified intervals. The Secretary should establish performance measures of baseline and follow-up aggregate costs.

Recommendations for the Pharmacy Benefit

Drug coverage is an important component of any total health care package, and disease management entities have a proven track record of educating and coordinating patient contact that provides optimum compliance and reductions in drug-drug interactions. As a pharmacy benefit is made available, disease management entities should be engaged in helping to assure that enrollees use the benefit to maximum advantage.

Thank you for the opportunity to present views on this most important issue. If I can be of any further assistance to the Committee, please feel free to contact me.

Attachments:

Sidorov, J., Shull, R., Tomcavage, J., Girolami, S.: Diabetes Disease Management Is Associated With Pharmacy Savings in a Managed Care.

Sidorov, J., Shull, R., Tomcavage, J., Girolami, S., Lawton, L., Harris, R.: Does Diabetes Disease Management Save Money and Improve Outcomes? *Diabetes Care* 25:684–689, 2002.

Diabetes Disease Management Is Associated With Pharmacy Savings in a Managed Care Setting

Jaan Sidorov, MD, FACP, CMCE, Robert Shull, Ph.D., Janet Tomcavage, RN, MSN, Sabrina Girolami, RN, Care Coordination Program Geisinger Health Plan. Geisinger Health Plan, Hughes Office Building, Danville, PA USA 17822–3020, Tel: 570–271–8763, Fax: 570–271–7860.

Objective

Little is known about the impact of disease management programs on medical costs for patients with diabetes mellitus. This study compared pharmacy costs for patients fulfilling HEDIS® criteria for diabetes who were in an HMO sponsored diabetes disease management program versus those who were not in diabetes disease management.

Research Design and Methods

We examined HMO paid pharmacy costs for all medications, insulin products, oral hypoglycemic agents (OHAs), diabetes supplies and other pharmaceuticals among 1,362 continuously enrolled Geisinger Health Plan (GHP) members who fulfilled HEDIS® criteria for diabetes and had an insurance benefit for prescription drug coverage from January 1, 2000–December 31, 2001. Two groups were compared: those patients who were enrolled in an "opt-in" diabetes disease management program versus those patients who were not enrolled. Multiple linear regression was used to control for the impact of age and gender on pharmacy costs.

Results

Of 1,362 patients fulfilling HEDIS® criteria for the diagnosis of diabetes mellitus with prescription drug insurance coverage, 1,273 (93.5%) were enrolled in this diabetes disease management program ("Program") versus 89 (6.5%) who were not enrolled ("Non-program"). Both groups were similar in male/female ratio (Program M/F=52.4%/47.6% vs. Non-program M/F=58.6%/41.4.1%, p=0.07), and Program patients were 1.9 years younger than Non-program patients (56.0 years vs. 57.9 years, p=0.15). Mean per member per month overall paid pharmacy claims (PMPM) for Program patients was $92.24 (standard deviation or STD = $99.18) versus a mean of $143.98 (STD = $136.78) among Non-program patients (see Table). This difference was statistically significant (t=4.63, p<.0001). The mean PMPM for insulin products ($20.17 Program vs. $15.49 Non-program), other diabetes medications ($29.71 Program vs. $25.39 Non-program) and diabetes care supplies ($4.31 Program vs. $5.77 Non-program) were not statistically different between the two groups. Program patients experienced a lower mean PMPM of $61.06 (STD = $81.91) for all other medications vs. Non-program patients, who had a mean PMPM of $123.34 (STD = $131.97). This difference remained statistically significant after controlling for age and gender (p<.0001).

Category	Total Pharmacy PMPM*	Insulin PMPM	Other diabetes medication PMPM	Diabetes supplies PMPM	Other medications*
Program **N=1,273** **(standard deviation)**	$92.24 ($99.18)	$20.17 ($19.68)	$29.71 ($33.58)	$4.31 ($6.67)	$61.06 ($81.91)
Non Program **N=89** **(standard deviation)**	$143.98 ($136.78)	$15.49 ($14.79)	$25.39 ($27.27)	$5.77 ($6.71)	$123.34 ($131.97)

*Statistically significant after controlling for age and gender, p<0.001.

Conclusions

In this HMO, an opt-in disease management program appeared to be associated with a significant reduction in overall pharmacy costs. The savings we observed were among pharmacy costs that were not directly associated with diabetes care, which may be partially explained by improved control of diabetes. In addition, these data suggest that diabetes disease management is not necessarily associated with an increase in costs for medications directly related to diabetes care.

Statement of Richard M. Wexler, M.D., Medical Director, Medical Care Development Inc/Maine Cares, Augusta, Maine

Maine Cares (ME Cares) is a coalition of 32 rural and urban Maine hospitals that offer community-based, telephonic disease management programs for patients with heart failure (HF) and coronary heart disease (CHD). Medical Care Development (MCD) is a Maine-based not-for-profit corporation that plans, develops and operates health programs. MCD serves as the facilitating organization for the ME Cares coalition.

Since implementing our program over two years ago, we have seen significant improvement in our HF and CHD patients that previously may not have had access to disease management services. We know that community-based programs combined with the right technological support are effective in improving the lives of our patients. We believe that the ME Cares program may serve as a model for Medicare, and we are honored to have been chosen to participate in the Medicare Coordinated Care Demonstration. On behalf of ME Cares, I would like to thank Representative Johnson and the Ways and Means Subcommittee on Health for holding this important hearing.

An Innovative Approach to Disease Management

Every year, nearly 30,000 hospitalizations in Maine are caused by heart disease at a cost of more than $400 million. Maine also has an older-than-average population, more than half of who live in rural areas. In the effort to improve and reorganize HF and CHD management, the ME Cares coalition of hospitals was formed based on the shared beliefs that: 1) the care of ambulatory patients with chronic illness is aided by building an infrastructure to extend the scope and reach of traditional office-based care; 2) community-based programs will encourage resource development that will benefit patients with chronic illness as well as patients at-risk; 3) physician support will increase the likelihood of success of the program; and 4) physician support is more apt to occur if the program is locally accessible and available to patients regardless of their payer affiliation.

When we developed the ME Cares coalition health plan based programs were at various stages of development using plan staff or contracted out to private firms. From the patient's perspective, there would undoubtedly be a disruption of care should their employers switch health plans. From the provider's perspective, complexity of interfacing with numerous plans and programs posed a significant problem, so our challenge was to create a community-based care management support program that was an alternative to the diverse health plan-based programs.

Our first order of business was to develop a set of key program elements. These include: explicit patient eligibility criteria and physician enrollment orders; regular communication between the nurse, patient and physician to coordinate care and optimize care management; patient-specific goals set at program entry and monitored throughout participation; individualized treatment plans for each patient; educational interventions on medications, diet, exercise, smoking cessation, stress management, and symptom identification and response; continuous telephonic access for patients to nurse support services; ongoing monitoring of medical regimen adherence; and active outreach to physicians to gain endorsement and feedback.

We then sought to establish standardization of care across coalition sites to assure quality. To achieve this, we decided that all participating hospitals should use the same information system that would support patient-specific care plans using evidence-based clinical guidelines and facilitate measuring outcomes. After reviewing several systems, we chose Pfizer Health Solutions' (PHS) disease management software technology for its ability to collect patient histories, key symptoms, clinical and laboratory data, and treatment status information. More importantly, PHS' software was user-friendly and enabled local providers to use the technology.

Proven Results

Today, ME Cares has grown to include 32 hospitals that provide health services to over 90% of Maine's population. Over 1,400 patients have enrolled in the HF and CHD programs and for the most part, care support services have been non-reimbursed services. Despite this limitation, the level of participation among providers has been exceptional.

When outcomes were measured in December of 2001, average patient participation lengths were 9.4 months for HF and 7.5 months for CHD. Outcomes were measured by the New York Heart Association (NYHA) physical activity classification, the Short-Form 12-Item Survey (SF–12) for mental and physical health scores, and symptom relief, adherence and cholesterol values. At follow-up, 78 percent of HF patients improved or maintained their NYHA class and improved their SF–12 mental scores. HF patients also reported a reduction of HF symptoms (shortness of breath, cough), less weight gain and leg swelling, increased self-monitoring and beta-blocker use. CHD patients had improved SF–12 mental and physical health scores, and experienced a reduction in mean LDL cholesterol.

Conclusion

Implementing a statewide, provider-sponsored care support program in Maine using PHS' care management technology significantly improved HF and CHD patient outcomes. What does this mean for Medicare? We know that disease management can improve quality of life and reduce hospitalizations, yet at the present time, these services are only available to Medicare+Choice members who represent only a small percentage of Medicare beneficiaries. Our model is significant to Medicare not only because our program has proven outcomes, but also because we operate outside the managed care and fee-for-service environment. It is our hope that our participation in the Medicare Coordinated Care Demonstration will clearly validate the importance of the ME Cares model for disease management in Medicare.

Statement of the Pharmacist Provider Coalition, Bethesda, Maryland

The Pharmacist Provider Coalition is pleased to submit this statement for the record of the Subcommittee on Health's hearing on eliminating barriers to chronic care management in Medicare.

The Pharmacist Provider Coalition is composed of six national pharmacy organizations, which represent pharmacists working in all sectors of pharmacy practice. The coalition partners joined forces to educate Members of Congress and the public about the role pharmacists play in the safe and effective use of medications and to provide patients access to pharmacist medication therapy management services under the Medicare program. Our membership consists of the following groups: the Academy of Managed Care Pharmacy, American College of Clinical Pharmacy, American Pharmaceutical Association, American Society of Consultant Pharmacists, American Society of Health-System Pharmacists, and the College of Psychiatric and Neurologic Pharmacists.

Need: Improved Care, Avoid Medication-Related Complications

On average, persons aged 65 and older take 5 or more medications each day.[1] The high utilization rate of medications is particularly common in patients who have one or more chronic conditions that call for drug treatment. These medications are often prescribed by several different physicians for concurrent chronic and acute conditions. As a result, these patients are at high-risk for medication-related complications, resulting in up to 11.5% of all hospitalizations.

Recently published research indicates that drug-related problems cost the U.S. health care system as much as $177 billion each year.[2] A substantial portion of this expense is preventable through collaborative medication management services provided by pharmacists working with patients and their physicians.

Solution: Access to Pharmacist Medication Therapy Management Services

Pharmacist medication therapy management services help to eliminate unnecessary or counterproductive treatments and assure that patients are receiving the most appropriate drug therapy for their medical conditions. For example, phar-

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[1] ASHP Consumer Survey, "Medication Use Among Older Americans," 2001.

[2] Ernst FR, Grizzle, AJ. Drug-Related Morbidity and Mortality: Updating the Cost-of-Illness Model. *Journal of the American Pharmaceutical Association*. 2001: Mar–Apr; 41(2):192–199.

macists working closely with the health care team can identify or prevent duplicate medications, drugs that cancel each other out, or combinations that can damage hearts or kidneys. Pharmacists may also find that a newer multi-action drug may be exchanged for two older drugs or an alternative drug may be substituted for another therapy that causes side effects and results in the patient either taking additional medication or stopping their medication—the result of which may lead to their medical condition worsening. Drug interactions, adverse effects, and low patient adherence with prescribed therapies are costly and preventable medical complications of usual care.

The specialized training pharmacists have in medication therapy management has been demonstrated repeatedly to improve the quality of care patients receive and to control health care costs associated with medication-related complications. As the Institute of Medicine report "To Err is Human: Building a Safer Health System" stated: "Because of the immense variety and complexity of medications now available, it is impossible for nurses and doctors to keep up with all of the information required for safe medication use. The pharmacist has become an essential resource . . . and thus access to his or her expertise must be possible at all times."

Current Medicare payment policies are woefully outdated and fail to recognize pharmacists as providers of health care services. This restricts the patient's ability to access pharmacist services. To ensure access, Medicare statutes must be updated to explicitly recognize services provided by pharmacists just as nurse practitioners, physician assistants, registered dieticians and other non-physician providers have been recognized in recent years.

Conclusion

Pharmacist medication therapy management services can and will make a real difference in the lives of patients with chronic conditions. This is a logical and very affordable step towards eliminating barriers to chronic care management and establishing the essential infrastructure of a Medicare prescription drug benefit. The Coalition strongly encourages the Subcommittee to pass legislation to provide patients access to pharmacist provided medication therapy management services under Part B of the Medicare program.

Thank you for the opportunity to present the views of pharmacists who care for Medicare patients on a daily basis.