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SQUARE PEG IN A ROUND HOLE? DISEASE MANAGEMENT IN TRADITIONAL MEDICARE

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TUESDAY, NOVEMBER 4, 2003

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 9:58 a.m., in room SD–628, Dirksen Senate Office Building, Hon. Larry Craig (chairman of the committee) presiding.

Present: Senator Craig.

OPENING STATEMENT OF SENATOR LARRY CRAIG, CHAIRMAN

The CHAIRMAN. Good morning, everyone. Let me thank you all for coming to the Special Committee on Aging's forum on disease management.

We have, for a period of time, studied disease management and now, of course, are increasingly concerned about fitting it into a variety of health care approaches that we are looking at here in the Congress of the United States. Disease management for people with chronic illness is a critically important emerging innovation in America's health care system. Last fall this Committee held a hearing on the challenges of moving disease management into Medicare for those with chronic conditions. This forum is a follow-up to last year's hearings.

I am Senator Larry Craig and as Chairman of the Aging Committee, as we studied these things through hearings we have decided to institute this forum because of the progressive nature of these interests and developments. A variety of think groups have worked their way through these developments and provide them for the Congress. Of course, as you know, we are not an authorizing committee. But we believe the special committee can play a critical role in building an informational base and a record by which the authorizing committees can work. We have done that in a variety of ways in the past. Certainly, this is one of them.

Today's panelists will focus on the technical details of evaluating disease management demonstrations and how good a fit disease management may or may not be with the Medicare fee-for-service program. Our panelists today are Stuart Guterman, Director for the Office of Research, Development and Information at the Centers for Medicare and Medicaid Services; Mark Miller, Executive Director of the Medicare Payment Advisory Commission; and Jeff Lemieux of the Centrist Organization and the Progressive Policy Institute.

The Senate and the House Medicare bills both include provisions for disease management and we hope this forum will aid the conferees in their deliberations. As you know, those deliberations are hopefully shaping to some finality as we begin to look at the final product. This forum, I think, is a great opportunity for all of us to listen and to learn while building a record on policy considerations.

So with that in mind, let me introduce to you Bruce Steinwald. Bruce is the Director of Economics and Payment Issues in the Health Division at the U.S. General Accounting Office. So, Bruce, we do appreciate your willingness to chair and moderate this panel. Thank you very much.

Mr. STEINWALD. Thank you, Senator. I am very pleased to be here today for this Special Committee on Aging panel discussion of the role that disease management might play in the traditional fee-for-service Medicare program. I would like to thank Senator Craig for his foresight in setting up this panel discussion and for inviting GAO to participate.

Senator Craig has already introduced me and the panelists so I will skip over that. Basically the ground rules will be, each of the panelists will speak in turn. The representative from CMS will have 10 minutes roughly and the other panels about eight. We will not take any questions. We will get through all the formal remarks first. Then we will have a session of questions and answers. In my role as moderator I will ask the first set of questions. But in the meantime, the Committee staff will circulate three-by-five note cards giving members of the audience an opportunity to write down their questions, which will be passed forward. The Committee staff have asked me then to cull those questions, summarize them, and then ask them on your behalf, if that is OK.

For most of the session we expect to have a dialog. That is to say, the panelists will individually speak but I expect that for most of the remainder of the morning we will have a discussion among the panelists and the moderator. Our goal is to generate—through generating this dialog is to raise awareness of what we know and what we do not know, and what we need to know about how good the fit is between disease management and Medicare fee-for-service, and what we need to do and what we need to learn to make that fit better.

So with no further ado we will turn to our first panelist, Stuart Guterman.

STATEMENT OF STUART GUTERMAN, DIRECTOR, OFFICE OF RESEARCH, DEVELOPMENT AND INFORMATION AT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, WASHINGTON, DC

Mr. GUTERMAN. Thank you, Bruce. I want to thank Chairman Craig and Senator Breaux and the other distinguished Committee members for inviting me here today to discuss Medicare's efforts to improve the care provided to its beneficiaries through disease management.

The Medicare population increasingly consists of people with chronic conditions. Researchers at Johns Hopkins University determined that 78 percent of beneficiaries have at least one chronic condition. Chronically ill beneficiaries are heavily burdened by

their illnesses and they often have multiple conditions and have to deal with multiple providers. The same Johns Hopkins study found that 20 percent of Medicare beneficiaries have at least five chronic conditions, and that those people see an average of 13.8 different physicians in a given year.

In the traditional Medicare fee-for-service program, however, physicians are paid for the individual services they provide and there is no incentive to provide the coordinated care that chronically ill beneficiaries need. In fact because such coordination involves effort and resources and there is no payment corresponding to that effort coordinated care is in effect discouraged.

The Medicare+Choice program should be an appropriate for providing coordinated care but the current payment system and some of the rules under which plans currently operate in fact penalize them for enrolling beneficiaries who are chronically ill and, therefore, expected to be 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. The 78 percent of Medicare beneficiaries with at least one chronic condition account for 99 percent of Medicare spending each year, and the 20 percent of beneficiaries with at least five chronic conditions account for almost two-thirds of all program spending.

We need to find better ways to coordinate care for these beneficiaries. Toward that end, CMS is looking at disease management approaches, which have been developed and applied in the private sector, to combine adherence to evidence-based medical practice with better coordination of care across providers. We are developing an array of demonstration projects to test our ability to apply these approaches in the context of the Medicare program.

Let me lay out our objectives. There are multiple objectives in this approach. One is to improve access to the care that Medicare beneficiaries need. Another is to improve the coordination of the care so it can be provided more effectively and efficiently. Another is improving the performance of physicians by making them more involved and responsive to the patient needs. Finally, we are trying to improve the ability of patients themselves to be involved and participate in their own care.

These demonstrations will need to test and evaluate what needs to be done in order to get disease management programs up and running, how best to provide disease management services, which of these services work and which do not 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. One is what should be the focus of disease management programs? How should these approaches be designed and applied? Another which is a major question in the current context of Medicare is what are the data requirements and how can it be achieved?

The data requirements in disease management context are related to at least three sets of activities. One is to identify potential enrollees. A second is to monitor their needs as disease management is applied. A third is to be able to evaluate the results of disease management approaches. This is a major challenge for the Medicare program. We have a very rich database, as most of you

know, but that database has been designed to process and pay bills for fee-for-service providers mostly. Our challenge is to redesign our ability to use our data to be able to apply them to these three functions.

Another question we have to address is what organizational structures work best? How do you establish the appropriate networks of providers? How do you conduct enrollment? How do you provide disease management services in the context of Medicare?

Another question we have to address is which disease management approaches work best? Who contacts enrollees? What do they do? How do they make sure there is follow-up, et cetera?

We also need to know how payment can be designed to be compatible with these approaches. That is another major challenge, because again, under the fee-for-service program we have a payment system that pays for individual services, and under the Medicare+Choice program, as I will address in a couple of minutes, there are some drawbacks to being able to coordinate care the way Medicare+Choice should be able to.

There are several alternative approaches to take. One is a disease management fee that you can pay specifically for disease management services. Another is to incorporate more encouragement within the capitated payment systems to do so.

Another question we have to answer at the end of all this is how can these issues be appropriately evaluated? How do we know if we have succeeded? How do we know what that indicates about how to proceed with these programs?

Let me briefly review where we are today. The first in our series of disease management activities was the coordinated care demonstration project. It was mandated in the Balanced Budget Act of 1997. It has 15 sites, including commercial disease management vendors, academic medical centers, and other provider-based programs. It focuses on beneficiaries with congestive heart failure, heart, liver, and lung diseases, Alzheimer's and other dementia, cancer and HIV/AIDS. We have sites in both urban and rural areas. This is in a fee-for-service context. These organizations are paid a disease management fee, and currently they have about 13,000 enrollees that are evenly split between intervention and control groups.

The sites that are included in this coordinated care demonstration include Carle Foundation Hospital in eastern Illinois, Medical Care Development in Maine, Health Quality Partners in eastern Pennsylvania, and Washington University Status One in St. Louis, Missouri. There is also a separate demonstration that is not formally part of the coordinated care demonstration but incorporates approaches that are parallel, being conducted by Lovelace Health Systems in Albuquerque, NM, to provide coordinated care services to Medicare beneficiaries with congestive heart failure or diabetes.

We are testing whether these coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes. As of now, all 16 of these plans have been in operation for at least one year. As I said, the total enrollment is about 13,000.

Initial findings indicate that beneficiary recruitment in the fee-for-service market can be a challenge. While the majority of plans

are at or near their enrollment targets, several plans have invested more time and resources than they had initially expected to get there. The most successful plans, we find, have established close ties to physicians and other providers and have focused on obtaining physician support during the planning stages of the project. Although evaluation results are not yet available, the programs overall appear to be well-received by both participating physicians and enrollees. We are planning to submit a report to Congress on this demonstration in the spring of 2004.

Another project that we have just recently gotten waiver approval for is the disease management demonstration for beneficiaries with advanced stage congestive heart failure, diabetes, or coronary heart disease that was mandated in the Benefits Improvement and Protection Act of 2000. This demonstration includes three sites. What is interesting about this is that these sites receive a disease management fee that includes drug coverage not just for drugs related to the target conditions but for all drugs being used by enrollees in the program.

Participating organizations in this demonstration are at risk for total Medicare costs. The demonstration is limited to 30,000 enrollees total. The three sites which have just had their waiver applications approved by the Office of Management and Budget are CorSolutions of Buffalo Grove, IL; Diabetex/XLHealth of Baltimore, MD; and HeartPartners of Santa Ana, CA, which is a joint venture among PacifiCare, QMed, and Alere Medical. We are hoping to get these projects started in January 2004.

Another project which is in the pipeline is the physician group practice project that was mandated in the Benefits Improvement and Protection Act of 2000. We released a solicitation in which we announced we would make at least six awards. We have received the applications which are to coordinate Part A and Part B services. We are planning on sharing savings if outcomes are improved and if savings are achieved. The implementation of this demonstration project is pending waiver approval but we are in the stage where the waiver package is being developed and considered.

We have got a couple of other projects in process that address the issue of disease management in a capitated environment. We have got a capitated disease management project for which we put a solicitation out on the street. Under this project, we would be paying a 100 percent risk-adjusted capitated rate to organizations that take on the responsibility for patients with specific diseases and coordinate the care for those patients.

This project is actually designed to overcome two barriers that currently exist in the Medicare+Choice program. One is that, as of now, only 10 percent of the payment rate is risk-adjusted, which means that plans that attract more chronically ill beneficiaries who are going to be more expensive face a financial penalty if they do so. So this capitated disease management will involve 100 percent risk-adjusted payment rate to be able to adjust the payment to suit the enrollee population more appropriately.

The other is that the current rules prohibit plans from specializing in enrollees with certain conditions. Under the capitated disease management project, we will waive that prohibition so that we

will be seeing plans that are able to specialize in particular groups of beneficiaries that they feel they can treat more effectively.

We have also got a project that will do the same thing for patients with end-stage renal diseases. We are currently in the process of evaluating the proposals that we have received in response to our solicitation.

In the future, we plan to piece all of these projects together in order to develop a new role for Medicare as of more aggressive purchaser of health care for its beneficiaries. We want to achieve better coordination of care. We want to be able to collect information, to be able to measure and disseminate information on quality, and we want to be able to eventually pay for quality of care. All of these pieces fit together in order to try to fit into our efforts to make Medicare a better, more aggressive purchaser of health care, to be able to provide better care for our beneficiaries.

Thanks for having me here, and I will take questions at the appropriate time.

Mr. STEINWALD. We will hold onto the questions for a little bit. Now we will hear from Mark Miller from MedPAC.

STATEMENT OF MARK MILLER, EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION, WASHINGTON, DC

Mr. MILLER. I would also like to thank Senator Craig, Senator Breaux, and the members of the Committee for holding this forum. I am the Executive Director of the Medicare Payment Advisory Commission. As probably many of you know, we make recommendations and put analysis in front of the Congress in a couple of reports during the course of the year.

I am pleased to be here this morning to discuss the role of disease management and coordinated care. But the forum comes at sort of an awkward time for us. We have just begun our work on this issue, looking at disease management and how you integrate it into the traditional Medicare program. What I can say at this point is that the Commission believes that these programs do have promise to improve the quality of care for Medicare beneficiaries, but there are a number of questions that need to be addressed. As part of my talk today I am going to discuss those issues.

I will try and walk through our work plan and the questions that I think are outstanding. You can think of the questions that we are going to address in the following way: This is summarized, of course. Issues of targeting the program to beneficiaries most likely to benefit from them; the notion of defining the relationship between the physician, the beneficiary, and the program; aligning payments to program objectives; and measuring the effectiveness of the program. Many of the things that I am going to say coincide with what Stu has said, so some of this should sound relatively familiar.

Our analysis is going to approach this in a couple of different ways. We are going to look at Medicare claims data. We are going to look at Medicare beneficiary survey data. We are going to review the literature on disease management. There we are also going to work with stakeholders out in the field to gather information on what the state-of-the-art is out there.

The reason that I think this issue attracts policymakers and the Commission's attention is that when you look at fee-for-service, and some of these statistics are going to sound familiar, you see things like 5 percent of the beneficiaries account for about half of the expenditures in Medicare; in the case of congestive heart failure, 14 percent of the beneficiaries accounts for 40-some-odd percent of the expenditures; beneficiaries with three chronic conditions or more account for more than 80 percent of Medicare expenditures. I think it is statistics like these that capture policymakers' attention and make them want to think about how disease management models can be applied to traditional Medicare.

What the Commission is interested in is how disease management can improve the delivery and coordination of care, whether it can maintain or improve the quality of care and functioning of patients in Medicare, and whether it can reduce program and beneficiary expenditures.

Disease management comes in a lot of different varieties and has a lot of different ways that it approaches the issues, but fundamentally, beneficiaries who are either high-cost are targeted—or you target beneficiaries who are either high-cost or expected to become high-cost, and then you engage in things like coordinating care, patient education, monitoring signs and symptoms, assuring that the patient follows their treatment regimen, and then ultimately help the physician practice evidence-based medicine.

There are a number of populations that MedPAC is going to focus on in its analysis. We are going to look at the claims data to identify beneficiaries that have certain conditions. These are the conditions that disease management programs are usually designed for, now in the non-elderly population: congestive heart failure, diabetes, end-stage renal disease, conditions like that. But we are also going to try to look at the population and determine whether we can identify populations that have conditions that lead to more serious conditions. So, for example, we will look at chronic kidney disease because that is the precursor to ESRD.

A couple of other sets of beneficiaries that we will look at are beneficiaries with multiple chronic conditions and beneficiaries who are high-cost as identified through claims analysis. The notion here is that if you can identify a beneficiary who is already expensive or has chronic conditions, the question becomes, does it still present an opportunity for disease management to have an impact either on their quality of care, or the program or beneficiary expenditures.

Two other populations that we are going to look at are dual eligibles, beneficiaries who are eligible for both Medicare and Medicaid, and beneficiaries at the end of life. Expenditures in the last year of life in the Medicare population obviously account for a lot of expenditures in Medicare in total.

We are looking at these populations, and a broad-brush they can be identified, they are often growing, they account for large blocks of expenditures, and either have conditions that could benefit from evidence-based medical care, or alternatively from better coordination of their care.

What I would like to do with my remaining time is walk through a couple of policy issues. This list is not exhaustive and I think in

many ways overlaps with Stuart's list. There are issues of targeting, which I have already mentioned. I have tried to identify for you at the macro level the kinds of beneficiaries that we are going to focus our analysis on. But we also need to get inside disease management programs because they also target within those populations. So you may have a set of diabetics, rank them according to their risk, and have different interventions for different levels of risk. There are issues like that that we think need to be explored and put before the Congress.

Stuart touched on this issue as well. We think that the physician's role is absolutely critical. If the physician is involved and accepting of these programs, these programs have a much greater degree of success. But a physician's involvement can be thought of as a continuum. You can think of consulting with the physicians at the front end to create protocols, making them aware of the program, but have the disease management program delivered by other professionals such as nurses. Or you can try and build your disease management model around the physician, have the physician target the patient, educate the patient, and so forth. Most often what occurs in the field is that physicians are consulted and know about the program but the programs are delivered by nurses. But as I said, it is important to have the physician's buy-in.

There is a set of questions that involve the beneficiaries. I will not go through all of them, but one key question will be whether these programs should be designed as opt-in or opt-out programs. An opting-in program maximizes the beneficiaries' choice. They can choose whether they want to go into the program. An opting-out program is where the beneficiary is identified as a candidate for the program but chooses to get out of it. There the notion is that you may have a greater ability to capture a population that might be affected by disease management.

Payment issues are huge and I am not going to go through all of them but a couple of issues are: who should get paid, what should be the size of the payment, what services are expected in exchange for the payment, and then finally, whether the disease managers bear any risk at all. Currently in the field, if a disease management organization accepts risk it accepts it only for its administrative fee. It does not accept insurance risk, at least that I am aware of.

There are also some administrative issues. These include questions like what entities in traditional fee-for-service would be delivering the disease management. Will it be physicians, group practices, disease management organizations, managed care plans, that type of thing. Next there is the issue of data. Programs will have to start with Medicare claims data, which is not unreasonable, but there are questions about how the data have to be enriched. The timeliness of the data will be important in order to support these programs.

Here I am mostly talking about delivering data to whatever entity is administering the disease management. There also other data issues obviously.

The very last issue I will mention, and again Stuart has already done this is, the notion of measurement and accountability. It becomes very complicated—within a demonstration environment you

can do things like identify a control group. If you have a national program, how you measure success will become a little bit more difficult if you do not have a clearly defined control group. It is not impossible but it becomes more difficult.

Then finally, some of these programs have to have a time period in order to demonstrate results and there is a question about how much time should elapse before you should expect to see results in terms of quality or savings, if they materialize.

With that, I look forward to your questions.

Mr. STEINWALD. Thank you, Mark. Now let us hear from a non-fed, Jeff Lemieux.

STATEMENT OF JEFF LEMIEUX, CENTRIST POLICY, NETWORK AND PROGRESSIVE POLICY INSTITUTE, WASHINGTON, DC

Mr. LEMIEUX. Thank you. Ex-fed, I guess. My name is Jeff Lemieux and I work for a small startup think tank called Centrists.org, and I also work for the well-established Progressive Policy Institute. I would like to echo Stu and Mark's thanks for the Committee members inviting us here to talk about disease management and Medicare.

Let me start with a few theoretical comments and then move to the disease management and chronic care initiatives in the Medicare bills that are being negotiated in conference committee, and to some thoughts about how those might come out and what impacts they might have.

The Progressive Policy Institute definitely agrees that finding better ways to treat people with chronic illnesses is the next great challenge in health care delivery, and that any new benefits or other changes in Medicare should work toward better chronic care and be consistent with chronic care improvements.

There are two main approaches to chronic care. One is a disease management approach where an organization targets people with a particular ailment and reaches out to them and their families and their health care providers with information, with self-care initiatives, home monitoring, and things like that. Then there are more intense case management services for people with multiple chronic illnesses where they literally need to have a health provider, a physician or a nurse or a doctor's office taking charge of their care, coordinating their care with community services and with various health providers to try and avoid duplication and avoid health providers working at cross-purposes.

In economic theory, comprehensive health plans like HMOs generally have a good incentive to provide excellent chronic care services. They can evaluate investments in chronic care improvements and make tradeoffs. They may be able to spend more money on improving a patient's compliance with medication regimens on one hand, so they can save money on hospitalizations on the other. They can evaluate payoffs from improving chronic care services.

Now in general, traditional fee-for-service in Medicare does not have this easy way of making tradeoffs. Medicare's benefit contractors are separated into different silos. We have Part A contractors that pay for hospitalization, Part B pay for outpatient services, and if we pass this Medicare bill we will have a Part D to pay for drug benefits for at least most beneficiaries. It is awkward for each of

those contractors to say, if I invest more in chronic care services within my area, someone else will get the payoff. So that is a problem in fee-for-service.

Besides encouraging HMOs and PPOs to join or rejoin Medicare, the House and Senate prescription drug bills address chronic care in the fee-for-service program with two basic approaches. The first approach is highlighted in the House bill where instead of having demonstrations they would move to a complete, full-fledged program for disease management that would encourage disease management providers, organizational entities, to come forward and contract with CMS. They would also break the country up into separate chronic care improvement areas where the administration of this program could be devolved down more to the local level. I will get back to that in just a second.

The second approach is something that was highlighted in the Senate's complex care demonstration program which would establish—the program as written in the law is vague but I think as it is coming out of the conference committee it would establish—essentially pay for performance procedures like both Mark and Stuart talked about, which would attempt to reimburse physicians in a way that I will talk about in just a minute.

Before I get to the details of the conference agreement, let me go back and just mention this idea of experimenting in lots of different ways. No health policy analyst can really say we know how to improve chronic care. Even the clinicians, who know much more about it than certainly I do, do not have a magic answer to the chronic care problem. So I think the theme of everything we do in Medicare should evolve around experimentation, especially localized experimentation close to the health providers and the problems of local communities, and evaluation where organizations like GAO and CBO and MedPAC and other groups spend a great deal of time trying to figure out what works so that local areas can do what works and avoid what does not.

Back to the conference agreement. There is some progress moving toward trying to go beyond just the standard disease management organization approach to trying to find ways to compensate individual health care providers, especially in geriatrics, taking care of complex cases. The problem with this has always been a budgetary problem. If we provide additional reimbursements, how do we know we are going to get more and better health care as a result? Can we be sure as a public program that everybody is not just signing up for these extra reimbursements?

What I think they are moving toward, which I think is a very good idea, is a situation where providers could enroll with local quality improvement organizations and say, "Look, I will volunteer to make investments in chronic care, in information technology, and in working with my patients, and in return I will open the books for CMS and the local quality improvement organization to evaluate how this is going, so that CMS can really get a good idea of whether or not these programs are working." This is the sort of thing that I think can work in fee-for-service where you are not saying to one provider, you are going to get this reimbursement and denying it to another. It would be a partnership between the local organization and the provider.

Whether or the conferees will stick with this localized structure that was in the House bill is unclear. There was also a big pool of funds in the Senate bill, and whether or not that will still be available at the end for chronic care improvements is unclear.

Finally, I think the conferees will have to make a tough choice on whether or not they are going to emphasize straightforward disease management with the organizational approach or to invest a lot of time in this effort to try to find a way to reimburse physicians directly for chronic care services and then evaluate those very carefully for cost effectiveness.

Thanks.

Mr. STEINWALD. Thank you, Jeff.

Once again, I would like to remind you that we are accepting questions from the audience on cards and I encourage you to fill out a card if you have a question. If you would like the panelist to address a particular issue related to disease management, please avail yourself of this opportunity.

OK, guys—we are a bit gender deprived up here today. Here is what I plan to do, if it is OK with you. I want to start out with directing the first set of questions to an individual but give every panelist the opportunity to weigh in. So I will start with Stuart, ask him a question and then by weighing in then we will get our dialog going.

We are short on data about outcomes. We seem to be long on data about who the potential targets of disease management programs might be. We know what we spend and for what. We think that there is a population that could benefit, but the question is how to get to them and how to affect programmatic changes that yield the kinds of outcomes that we would like, both for the beneficiaries and for the program. Stuart, in your testimony you noted that some of the disease management demonstration programs to date have had some difficulty recruiting beneficiaries. I wonder what implications this might have for a broader disease management program under Medicare.

Mr. GUTERMAN. Actually I heard two questions there, one embedded in your preamble, so let me address both of them. One is in terms of enrolling beneficiaries, we found that they tend to be reluctant to sign up for programs where they are not familiar with the organization that is running the program. That is one of the reasons why the disease management organizations that have worked through the physicians have been much more successful in enrolling beneficiaries. But I think we are going to face that issue. Disease management is something that is different. Medicare beneficiaries particularly tend to be fairly reluctant to try new things unless they have a very well-established reason from someone they trust that it is going to work.

We think as these things build momentum it will be easier to enroll beneficiaries. We are also trying to focus—one of the major things so far that we have learned from the chronic care demonstration is what people have done right and what they have done wrong in terms of how to enroll beneficiaries. We hope to take advantage of what they have done right and apply it in future efforts.

You did mention outcomes, however, and—I guess there are a couple ways to describe our attitude going into this. One is, that

is why we do demonstrations, to be able to get evidence on whether things we want to try out work and how they work. One of the things we will be looking at, clearly, is whether beneficiaries are better off, whether they think they are better off, whether they have better health outcomes under disease management.

But the thing really preceding that is we are very excited about this because, as a couple of us mentioned, there is a lot of money on the table here, and it is hard to believe that we cannot do a better job than is currently being done. If beneficiaries see 13.8 physicians a year, different physicians in a given year, it is hard to believe that a system that emphasizes those physicians coordinating their care cannot do better than a system that currently does not provide any incentive for them to interact.

Mr. STEINWALD. Mark or Jeff?

Mr. MILLER. I think I would emphasize the notion that you have to have the physician at some level involved, because I think that beneficiaries will listen to their physicians. Also, it will help if the beneficiary views it as an additional service and something that they can benefit from. I do not necessarily have the answer, as to how that is communicated. Also I think that the beneficiary has to feel that in making this choice it does not somehow affect their benefits more broadly. I think they need to understand that before they will move towards it.

Mr. STEINWALD. Stuart, I am not picking on you, I am just going in order. The BIPA demonstrations are required to guarantee savings to the Medicare, as I recall, and that was in your testimony. One open issue is, what is a reasonable timeframe to expect savings from disease management programs to be realized? How is this all set up in the demonstration program so that you will know whether and when savings are in fact realized?

Mr. GUTERMAN. Under the BIPA demonstration, actually the terms were very explicit in the legislation so that we—and since it is a 3-year demo the assumption, I guess, of Congress was that we could see savings before the end of that timeframe. The thing is that the organizations that are participating at the three sites actually are quite enthusiastic about their ability to save money right away under this demo, partly because what they are focusing on is people with more advanced stages of the diseases that they are focusing on, and partly because the demonstration project gives them the ability to use drugs to help manage diseases. Pharmaceuticals have a major role in trying to manage some of these chronic conditions.

So we expect to see savings right away. Now clearly there are some other circumstances and other conditions where the timeline would be different.

Mr. STEINWALD. Jeff.

Mr. LEMIEUX. One of the things I just wanted to point out is that in the bills being conferenced, they all talk about budget neutrality, but they do not really define what the period of budget neutrality is. Some of them have pots of money available as if they assume that this will require some upfront investment to get a longer-term payoff.

What I wanted to point out is that for these programs to work there is going to have to be a fair degree of stability that could

have to last a long time. For example, I mentioned that HMOs, Medicare+Choice plans, have an incentive built in to provide good chronic care services only if they believe that those patients are going to still be enrolled two or three or four or five or six years down the road. If the program seems less stable or if they do not know what their enrollment will be or cannot guess it with some probability, then they will have less of an incentive to make investments in chronic care. The same thing would apply to disease management organizations. The stability and the length of the program, and knowing that Congress and CMS are behind these programs for a long period of time would be important in the investments they would want to try and make.

Mr. STEINWALD. Thank you. Mark, you mentioned targeting several times. I have got a two-part question for you. One is, if you rely on program data, claims and other program data, what is the lag between the time that a beneficiary develops the conditions which might be suitable for participation in a disease management program and the time in fact the program can identify them?

A second related question is, is there any reason why we could not identify these people upon enrollment to the program? Do we know what proportion of those with chronic conditions have them upon enrollment, or are they developed after enrollment?

Mr. MILLER. In terms of targeting, I think the claims data gives you the starting point and you can look at diagnoses and services used. If that is given to a disease management entity, they can often start with that population and drill down and gather additional information to sort out who is at risk. That is some of what they do. So that is one point.

I think that a person does not necessarily have to have an acute episode in order to be identified, if a person is going to a physician and their comorbidities are put onto physician claims. I know there have been some issues with the diagnosis codes on physician claims but they do seem to be getting better. Even before they hit a hospitalization for a diabetic event you might be able to pull that person out of the data. But the administrative data is fairly clumsy. It is not impossible to do that, but it is a clumsy way.

But I do believe that it offers information to begin to identify populations, and I think it is probably not all that different than what disease management organizations in the non-elderly sector start with, except that those databases often have drug data in addition to this and that can be an indicator.

As to enrollment, I think if you listen to disease management organizations—and I am not saying that this is my view—if they will tell you that you can discern a lot of information in a conversation with a beneficiary just about their home situation, what kinds of drugs they are taking, how they are feeling. I mean, literally whether they are feeling depressed and those types of things. One would argue that perhaps when somebody is enrolling in Medicare you could do something like that. But I think there is a real issue of resources if you are going to do that for every person who is enrolling into Medicare, and there may be issues of privacy.

Mr. GUTERMAN. On the use of data, I think that is one of our major challenges. I think that is clearly something we are going to have to deal with. As we develop future projects we are trying to

figure out better ways to get a hold of our own data faster so that we can use them more effectively to identify beneficiaries who would be more amenable to this kind of approach.

But if you look at the data, there are still—these are chronic illnesses. They are not acute illnesses. So even under current conditions you can still capture a lot of manageable time with a condition with the data we have. So I think there is always an incentive to get better and to capture these beneficiaries before their first spike, the first serious hospital admission. But even if you wait until the clinical data are in through the claims system as it stands now, you can still capture these people for a long enough time that you can use to manage their conditions better than they are being managed.

Mr. LEMIEUX. I just wanted to say, Mark's comment about drug data I think is extremely important. It is a little bit of water under the bridge, but the idea of having a drug benefit under which virtually every Medicare beneficiary has a card with electronic transfer of information would be a pretty good early predictor of people with certain conditions that CMS could turn around very quickly.

I just also wanted to mention the importance of physicians in the community knowing about these programs and being able to refer their patients at that point.

Then finally, consider for patients with multiple chronic conditions. These are the most expensive patients, the patients most in need of having care coordination. Even the lagged claims data that CMS currently has is going to be able to point out these people. Maybe not in time to do a lot of prevention, but certainly in time to do some management and care coordination.

Mr. STEINWALD. Let me follow up on the matter of the drug benefit. Mark, in your view, and others as well, if the Congress passes a prescription drug benefit, does that heighten the need for or the potential benefit from disease management?

Mr. MILLER. I do not know that it heightens the need. I think it gives two additional tools to a disease management effort. He provides data that you can use to identify patients, just as Jeff and Stuart just said, and it is one of the tools that disease management organizations use to manage patients.

Mr. STEINWALD. Jeff, in your testimony you observed that disease management is ideal for an integrated care environment. But you also observed that so far Medicare+Choice plans have had mixed success in implementing disease management. Would you elaborate on that? Why is that? Should we be more or less optimistic about disease management in an expanded managed care proposal as envisioned in the Medicare reform bills?

Mr. LEMIEUX. Let me take off that very last clause, as envisioned in the Medicare reform bills and just speak a little bit more theoretically. I think that the HMOs and Medicare+Choice, and even to some extent looser managed integrated health plans like PPOs, if they have the full range of benefits available, if they can afford to provide the full range of benefits under the Medicare system, then they can initiate programs that would in fact involve tradeoffs. Investments in home monitoring, investments in compliance with drug regimens, and so on, can pay off in other areas. I think that is a powerful investment.

I think that over the last five to 10 years the Medicare+Choice program has been volatile enough that only some of the plans are making these investments. Some feel as though they have a stable enough situation in Medicare that it pays to make investments in a big way. Others rushed into the program in the mid-1990's to take advantage of what were perceived to be favorable reimbursement rates. When the reimbursement rates turned unfavorable, they left just as quickly. So it has not been a stable place where an executive of these plans can say, look, we can make investments that will pay off five and 10 years down the road because we are in this market for good.

Now in another semi-theoretical point, if we were to go to a working competitive system that encouraged private plans to enter Medicare, we would probably also benefit by giving the Government-run fee-for-service plan more flexibility. If it turned out, under a competitive, say, premium support system, that these private plans were more efficient than the Government-run plan, then Congress would be sure to give Medicare the sorts of flexibility that it needs to compete with them. This could be a win-win situation.

Whereas, if we had a stable place for the private plans, they could do disease management better. If we had a more flexible situation for the public plans, the public plan managers could really go to work on this in a bigger way.

Mr. STEINWALD. Stuart.

Mr. GUTERMAN. As I mentioned in my testimony, there are two non-theoretical barriers that Medicare+Choice plans face now. One is that, currently plans, the rates that plans are paid are only risk-adjusted for 10 percent of their payment, which means that—and the rest of it is determined by a rate that is more or less geared to the cost of the average Medicare beneficiary. At least they do not get paid more for enrolling costlier than average Medicare beneficiaries. So we think that as we transition to a fully risk-adjusted payment rate that will provide the financial cover for plans that engage in programs that make them more attractive to chronically ill beneficiaries and remove the current financial disincentive for them doing so.

The other is that in the capitated disease management project that we have got on the street, the other feature is that we are trying to encourage plans to specialize in groups of beneficiaries that they can deal with most effectively. We think that giving them that kind of leeway will allow us to see how the demonstration works out, and it might also open up the Medicare+Choice environment-or whatever it involves into—to being more open to disease management.

Mr. STEINWALD. Jeff, in your testimony you suggested that a national disease management program should have a degree of decentralization. Why do you believe that Medicare's centralized structure hampers coordinated care? What do you think are the tradeoffs between a centralized and decentralized program?

Mr. LEMIEUX. I do not have any evidence. It is a speculation. But I think it is a speculation that is based on a decent logic. Different areas of the country have different issues that might be the most important issues. In certain parts of the country, diabetes might be extremely important. In other parts of the country, the most impor-

tant disease management might be remote monitoring and communications in rural areas.

So it just seems to make sense to me to do as much as we can in Medicare to get local Medicare officials, administrators and clinicians, medical directors, on the ground in as many different localities as possible to see what is available, to see what the local hospitals and clinics and community organizations can do, and to try and coordinate those efforts locally rather than through headquarters.

That is not a knock against headquarters. Headquarters has enough to do. I am advocating that we expand Medicare's administrative capability to include a local administrative component that would be specifically charged with working the chronic care and disease management angle so that it would just be better able to find out what is available and try as many alternatives as possible and then evaluate them to see what works.

My feeling is that if we put an administrator in northern Louisiana and another one in southern Arkansas, and the northern Louisiana folks could show dramatic improvements in a variety of areas, and the people in southern Arkansas were not doing very much, then we could take a couple people from northern Louisiana and put them in Arkansas. In other words, just see what works in different areas and let the areas almost compete against each other to try and make progress in these areas.

Mr. STEINWALD. Mark or Stuart, any reaction to that?

Mr. MILLER. I think this goes back to Jeff's earlier comment, along the lines of creating a stable environment for plans and giving greater flexibility to the traditional program in order to administer these types of programs. I think that is an issue that is key if they are going to have any success.

Mr. GUTERMAN. On the issue of doing things at the local level, all of the disease management organizations that are participating in our demonstration projects have specified service areas. We recognize that it is necessary to work pretty close to the ground to be able to perform disease management. We anticipate that even if we ended up getting to the point where we could apply this programwide it would still be locally administered in terms of actually doing the disease management, and maybe centrally administered in terms of coordinating the different areas.

Mr. STEINWALD. Thanks. Those are my initial questions. Now I would like to turn to questions from the audience, if that is OK. We still have an opportunity, if anyone would like to ask a question, write it on a card and send it forward. We can still accept them. Keep those cards and letters coming, please.

To what degree is the goal of disease management—by the way, I think every one of these questions is directed to the panel, so anybody who wants to, jump in. To what degree is the goal of disease management cost reduction? Is there a cost-quality tradeoff in disease management?

Mr. GUTERMAN. I can take that. I have frequently been asked, is the purpose of this to provide better care and perhaps save money, or to save money and perhaps provide better care? My answer is, to provide better care and perhaps save money, although I think it that we can do both. We have got possibilities, an area

under the possibilities curve where we are where I think we can improve both in terms of coordinating care better and providing better quality care for beneficiaries and in saving money. In fact, they are not necessarily even tradeoffs because—let me give you an example.

If a person with congestive heart failure goes to his cardiologist and gets a blood-thinning medication and then feels light-headed and goes to his internist to get a blood-thickening medication, that is neither good for the patient nor is it good for the program. If the person ends up in the hospital it ends up being a major expense for the program. If we could have avoided that conflict and avoided that unnecessary utilization, then we would make both the program better off in a purely fiscal sense, but also, more importantly, make the patient better off because they would not have had to go through the illness in the first place.

Mr. LEMIEUX. Just a quick comment. Your question points out what was so interesting about the $6 billion pool of money that was put in the Senate bill. It started in 2009, and if at that point we had done enough experimentation to know that we had lots of ways to do disease management and chronic care that did save money or that were budget neutral, we could continue those. But if we found some that were not budget neutral, or that we could not prove were budget neutral but they still seemed like very worthy initiatives that were really good for beneficiaries and good for the program, then that pool of money would allow those to continue, which is an interesting idea.

Mr. MILLER. I think this is the kind of question that ultimately has to be answered, in my instance, by the Commission. It is not an answer that I can give. But I think a way to think about the question for the Commission and the Congress ultimately is, if all of these things improve quality but did not raise costs any more, they would probably still be interested in moving forward with them. That would be my sense.

Mr. STEINWALD. This is a longer one so pay attention. The private sector (insurers and corporations) for the working age population seems to be moving away from the disease management approach with the exception of congestive heart failure. They seem to be finding that disease management does not save money. First, do you agree with this characterization of the private sector experience? Second, what makes us think that Medicare's experience will be any different?

Mr. GUTERMAN. This issue has come up, and I am no expert as to what is happening in the private sector but I will cite some testimony that was actually made before MedPAC, I think at their last meeting when Glen Mays of the Center for Studying Health Systems Change pointed out that there was a lot of excitement in the private sector about disease management but that there was relatively little evidence that it saved them a whole lot of money at this point. You probably would want to look at, for those who have become disenchanted, with disease management, what they did and why they became disenchanted.

But I will address the issue of what makes Medicare different because I think that is a very important distinction. I think Medicare has two big advantages. One is that the chronically ill population

is a very large chunk of our beneficiary population, and a growing one. So I think we have the mass there to make it more worthwhile to devote some effort to figuring out how to deal with those chronic illnesses better.

The other is that unlike private plans which have enrollees for maybe a year or two at a time, we have them for life. So we can make the kind of investment that it takes to really get these programs to work because we have a longer timeframe where we know that we will be the recipient of the benefits, to the extent that there are financial benefits, and to the extent that there are benefits in terms of improved treatment of our beneficiaries.

Mr. MILLER. I was going to say that I think the experience in the private sector has been mixed. I agree that there is no—I think I say that both in the testimony and I think this came out at our public meeting—there is no clear evidence that it saves money. I think there has been a mixed experience. I think some of our work in going out and talking to stakeholders is to try and get a feel for some of that, why some of them went into it, why some of them walked away from it, if we can identify those people. The other part of my answer was going to be what Stuart said, you do end up with the beneficiary for a longer period of time in Medicare.

Mr. STEINWALD. Could you discuss the role that e-health currently plays in disease management, and how it could be better utilized in the future?

Mr. GUTERMAN. E-health is a very interesting subset of this. I believe that disease management organizations can use e-health to improve their ability to manage conditions for an enrolled population. We have in fact got a demonstration project underway to look at it the impact of better communication and computerized communication techniques to manage populations.

But it has been asserted that we should pay for those services, because after all how much does an e-mail cost and so many physicians have found e-mail to be a very effective way of communicating to the populations. The answer is simply that we have found that if you pay for it, it will happen. It will not be restricted to e-mails that are tremendously productive.

So our approach right now is to encourage disease management organizations to use whatever methods they can without specifying what methods they should use, so that they have the freedom to put together a package that is successful for them, and to just put them at risk for, in most cases, for some part of their fee or their whole fee and let them deal with the consequences.

Mr. LEMIEUX. I was just going to add, in addition to communications through e-mail, it seems like it would be important to try and use these programs to leverage the creation of electronic medical records. It could be a requirement on the part of patients wishes to enroll in these programs and getting additional benefits and services, then you have to have had developed for you an electronic medical record that you keep. Or it could be part of the physician's responsibility in one of these programs. But using these initiatives to spur the creation of electronic medical records to prevent duplication or working at cross-purposes would be a nice outcome if it could be arranged.

Mr. GUTERMAN. Actually, in response to Jeff's comment, there is a tremendous amount of interest, not only in CMS but throughout the Department of Health and Human Services, in improving the state of information technology in the health care sector. We are actually trying to develop some projects where we can combine the advances in information technology and the ability to manage people with chronic conditions. The physician group practice demonstration is one example of that, where all of the sites in that demonstration will be large, multispecialty group practices with pretty sophisticated information technology systems. We think that that is something that eventually is going to really be a big help in trying to manage people with chronic conditions as well.

Mr. STEINWALD. Here is a question about nutrition, although I think it maybe could be enlarged a little bit to include the treatment of potentially beneficial services that are not currently benefits. The specific question is, nutrition is not typically incorporated into disease management protocols even though it has proven to be cost-effective. How will nutrition be incorporated into disease management programs? As I say, we could enlarge that to include other kinds of services that are not typically covered.

Mr. LEMIEUX. This brings up the same point that Stuart just made on e-mail. If you provide payment for it, lots of it will happen. This is why it is so important to make sure that these initiatives are tightly controlled and evaluated, and that they involve some investment on the part of the providers or the patients or their families, so that it is not just a new fee that Medicare is going to pay that does not really turn out to change much clinically on the ground.

Mr. STEINWALD. If you build it and pay for it, they will come.

Risk adjustment. How effective are risk adjustment methods for Medicare beneficiaries, and have they ever been implemented with any success in disease management models?

Mr. GUTERMAN. Let me address the first part of that, as I understand it. We are unveiling a new, improved risk-adjustment methodology beginning January 1 in the Medicare+Choice program. It is going to be applied to 30 percent of the payment rate for Medicare+Choice plans. We think that it does pretty well in capturing the higher cost of riskier beneficiaries. We are going to continue trying to improve that approach, because there are always questions of how precise you have to be, and there are always limits on how precise you can be in terms of predicting each individual's cost.

But we think it overall makes the system much more amenable to having payment reflect the populations that are actually enrolled in various Medicare+Choice plans. We think it is important, particularly in Medicare+Choice, in encouraging plans to do more disease management because, as I said, right now there is a fairly substantial penalty potentially for attracting beneficiaries who are chronically ill.

In terms of the fee-for-service side, I do not know particularly of any risk-adjustment applications. I have heard of disease management organizations stratifying enrollees with particular conditions. So they will take a congestive heart failure patient and they will group them into stages and charge a higher fee for managing pa-

tients who have more advanced stages of their condition. That is a sort of risk adjustment. But we are not planning to formally apply risk adjustment beyond anything like that to our fee-for-service disease management projects.

Mr. MILLER. Actually I do not think I have much to add to that. That is what I was going to say. Within the capitated plans you have the issue of risk adjustment, and I am not aware on the fee-for-service side in the private sector specifically beyond the tiering of risk among patients with certain conditions. So I am not sure I follow the question.

Mr. LEMIEUX. Maybe the question is, can risk adjustment really ever work? Because there is a group of people who are skeptical that it is really going to work well, and a group of people who are very optimistic that it will continue to get better and better and less burdensome for the health plans and more predictive.

Certainly drug data, if we had it in Medicare, might be able to help risk adjusters a little bit, and maybe significantly. I think that any time we are looking forward to additional use of private health plans, or if our disease management organizations turn toward extensive case management and near capitation or partial capitation, then we will have to have good risk adjusters.

In the past, the health plans have viewed risk adjusters as—in mid–1990's they felt as though a risk adjuster might not be so good for them because they felt as though maybe they had healthier than average patients. Then the risk-adjusters got a reputation in the community for being very burdensome and also being coupled with other formula changes that would reduce private health plan payments, so there became a fear factor.

No one knows but it seems probable, just looking at the marketplace, that the enrollees of private health plans have gradually moved toward something that is very close to a neutral risk with respect to comparisons with the fee-for-service program. I think if health plans will get over their fear factor a little bit, begin to really embrace risk adjustment in the coming five to 10 years as they realize that it could be to their advantage.

Mr. STEINWALD. Just to follow up, what about instead of risk adjustment, risk assumption? A number of the disease management models involve the assumption of risk by some entity who presumably performs services for a fee or a capitation. Is that essential in your view, to make disease management work in Medicare, or is that just one of several models?

Mr. GUTERMAN. I think, another way of putting risk assumption is that you are paying these organizations a price for managing the beneficiaries that they work with, and that if they are going to do that effectively I think they have to have some incentive to be able—some responsibility for the outcome of what they do. In return for that, I think we would rather not be very prescriptive about what they do to manage the conditions as long as it leads to better care.

So I think it is a less intrusive way to give the organizations the freedom to do what they do, and of course, protect the program, but also to put the responsibility with the organizations that are doing the disease management.

Mr. MILLER. The hard answer of yes or no, the way you put the question, would be one that I would have to have the Commission opine on, but I certainly think that it would be one of the models that they would want considered in fee-for-service.

Mr. STEINWALD. We have a couple of questions here that relate to the Medicare bill and the Medicare conference. Jeff, they are both directed to you although I am sure Mark and Stu will want to weigh in. What are the best and worst disease management proposals in the house and Senate bills?

Mr. LEMIEUX. They are all good. They are trying really hard to do the right thing. It is not easy. Fee-for-service is not naturally amenable to chronic care. But the House bill, as I said, has a permanent program with a regional evaluation and organization structure that seems very promising. It is more dedicated toward organization disease management than individual physician disease management. The Senate bill is moving toward, or has at least one component that would create a large demonstration that would involve individual physician or clinic-based payment systems. As I mentioned, I think they are working with CMS and others to try and figure out how best to do that so that physicians can actually enroll and be monitored so that we will be sure that these programs were achieving a good cost-effectiveness.

But I think they are doing exactly what needs to be done, which is experimenting in as many ways as they think might be workable and then trying to evaluate them very carefully and see what works, because we cannot sit down and write a law that will be the right law, but we can try lots of different things and see what happens.

Mr. STEINWALD. Given that the conference will need to reconcile the House and Senate approaches, where would you like to see that come out, within the realm of political feasibility?

Mr. LEMIEUX. Personally, I think that the more investment we try to make in this area is probably a good idea. So I would try and take the House's proposal for a permanent program instead of the Senate's demonstration for organizationally based disease management. I think with the right safeguards, the Senate's physician-based disease management program could also be included.

As I mentioned before, the extra pot of money that they put in at the last minute in the Senate after 2009 is also very intriguing. It would give the flexibility to continue some programs that did not necessarily save money, but that could be very effective from a clinical point of view, and that might be worth considering.

Now the flip side of all this is that the bills already probably cost a lot more than $400 billion, which was the ostensible limit, so not all these things are going to be kept in the bill. I would just hope that disease management is one of the things that they do try to emphasize.

Mr. STEINWALD. A follow-on to that though is, given the fact that the demonstration programs currently underway have not yielded findings yet, is it not somewhat premature to be enacting such a large-scale continuation of demonstrations or even programmatic changes? That is for all of you.

Mr. MILLER. The only thing I would say about that is that our analysis is headed toward the June 2004 report. If they have acted

prior to that point then I think our research agenda will be how to make these programs work. For our organization, we would just turn to that type of analysis as opposed to the analysis that we are doing now which is exploring the landscape.

Mr. STEINWALD. Of course, the conference might still be in session in June 2004.

Mr. MILLER. I just want to be clear that you said that. [Laughter.]

Mr. LEMIEUX. You have to consider the alternative. If the alternative is to not try to make changes in fee-for-service Medicare and to allow fee-for-service Medicare to continue to be a payer that is essentially blind to how things are working out, and that allows uncoordinated care to flourish, and that does not compensate coordinated care very well and the extra efforts that are needed, that is not really a tenable situation in the long run. So the investment that we make now to try to teach fee-for-service how to better manage its care and be more like a private health plan, in a sense, that is a good investment.

Mr. STEINWALD. Let us take a different tack. Here is someone that is thinking outside the box. We admire that. Is there any evidence that disease management in Medicare fee-for-service could reduce variations in practice patterns across the country? Should this be a goal?

Mr. MILLER. I am not aware of any evidence in the literature that would drive it to reduce the geographic variations. Arguably, to the extent that there is evidence-based medicine and that becomes much more widely understood and practiced, in theory it might have that outcome. But I am not aware of any evidence that I could cite that it actually does that.

Mr. LEMIEUX. Let me just throw in that the goal of having a decentralized evaluation structure is precisely to drive that change, to force people to look at different regions of the country and see what they are doing right and wrong, and try and mimic those successes and avoid the failures, in a more systematic way.

Mr. STEINWALD. We have not talked a lot about models from other programs. What about Medicaid in its primary care case management demonstrations, and even its less well known cash and counseling demonstrations? Are there any lessons there for Medicare? Are these models applicable to Medicare?

Mr. GUTERMAN. I am far from an expert on the Medicaid side of it, but my understanding is that at least some of the programs are fairly excited about what they are experiencing in terms of improved results, and savings as well. Certainly, we need to consider what the Medicaid program is doing in order to apply to Medicare. In fact there is some overlap because some of the projects that we have got in development are specifically designed to look dually eligible Medicare-Medicaid beneficiaries.

Mr. STEINWALD. Anything that constitutes low-hanging fruit? Let us say from the experience of private sector programs, if we could figure out a way to fit it into Medicare that would almost certainly yield benefits to beneficiaries and/or the program, in particular certain disease areas? I suppose the ones that were selected for demonstrations were selected for a reason.

Mr. MILLER. I think that the private sector has gone after specific conditions like congestive heart failure, diabetes, end-stage renal disease because one of the ways that they can actually have a benefit relatively soon is to forestall hospitalizations that are associated with those conditions. Hospitalization are expensive and they see that as a way to get savings and improve the quality of care for the beneficiary.

I think your point stands. It is those programs that are most common because I think they believe that they are the most approachable on the admissions and most clear where there is evidence-based medicine to guide the decision.

Mr. GUTERMAN. Actually, I would point out a private sector program that has hit the street already called Bridges to Excellence where General Electric and Verizon and Federal Express and several other large employers have collaborated. They are currently operating in, I believe, Cincinnati, in the Cincinnati-Louisville area. Their broader plan is to have three components, and this brings in the IT component as well. They are going to have an office system called physician office link where they are going to have physician practices sign up and if they meet certain conditions they will be willing to put money on the table for each patient that is enrolled that is a member of one of those employers plans. Then they also have separate components that they are developing for cardiac and for diabetes patients.

We are interested in that actually and we have been talking to them about how we could adapt that kind of approach to Medicare. But it is clear that if these private employers are willing to put money on a table for better management of these conditions that they view them—the argument is convincing that they might reap some benefits from that.

Mr. STEINWALD. At this time we have exhausted the questions from the audience and most of mine. I would like to give the panel an opportunity, each individually, to make one closing statement. Maybe the orientation of this is what you think the audience should take home from today's panel. Stuart, why don't you begin?

Mr. GUTERMAN. Our approach is to try and work to improve the way the Medicare program operates, and we are developing initiatives in several areas that we are excited about. One of them is disease management. We have an array of disease management projects. We have got a couple more in the pipeline that are going to come out soon. There is overlap between disease management and developments in information technology that I think ought to be recognized because you need—the better the information systems available, the more able you are to manage people with chronic conditions, where you need to communicate across providers and you need to keep information over time for these beneficiaries.

Also, I would mention, the initiative we have to collect information on quality, and to disseminate that information, and then even in one of our projects to pay for performance based on that information. These things all link together because I think the availability of information technology makes it easier to coordinate care. In fact one might argue that it is necessary to coordinate care. It also makes it easier to have information available on quality of care by allowing providers to report that information and the Medicare pro-

gram to disseminate that information and act on that information eventually by modifying the payment system to reflect quality of care.

So all those things fit together and we envision that in the future we will be able to work toward a better Medicare program. One that is more effective both in terms of delivering higher quality care and also in terms of being more efficient, and a more efficient.

Mr. MILLER. What I would say is just to remind listeners that we are the front end of our work and we have just started. I think the Commission thinks that this is an important area to look at, both for private plans in Medicare but also for fee-for-service Medicare, and that it can be useful in strengthening that program and making it a more rational purchaser and a more rational provider of care.

While disease management may have promise, there are a lot of questions that are unanswered about whether the models work in and of themselves. Even if they do work, how do you integrate them into Medicare fee-for-service's current structure? That is some of the issues that I tried to lay out.

I also think, and this is sort of along the lines of what Stuart was saying, we also have other recommendations that we believe play into this. We have made recommendations in terms of linking payment and quality outcomes as well as other areas where we are trying to make fee-for-service a more prudent purchaser. This could, if the evidence supports it, become part of that overall picture.

In the work that we are doing for the June report, if there is no action on the part of Congress then we will help lay out the issues for the Congress. If the Congress does take action, then we have done the groundwork in terms of building data and looking at the literature to get in behind that and begin to figure out how to make those programs work.

Mr. LEMIEUX. I would just like to try and remind the audience of what we originally meant by Medicare reform. In the original vision of Medicare reform, which started percolating the mid-1990's, there were two basic ideas. One was to try and slow down the growth of Medicare costs, and the other was to try and accelerate the modernization of Medicare benefits. The idea was that we should have a large component, or at least a substantial component of private sector involvement in Medicare precisely to spur innovation on both of those fronts, to see what sorts of benefits people like, and see what sorts of cost-saving possibilities can be invented in the private sector.

Then the other half of it was to try and give the Government-run program, which most beneficiaries are going to remain in for decades and decades, a more flexible and business-like approach and be less involved with having to write regulations for tightly prescribed Federal laws, and more involved with running the program as a business. Now the flip side of giving the Government-run program that sort of flexibility is accountability, either directly through public evaluation of results and so on, and then accountability through competition to some extent.

But the original goals were to do precisely these things increase the speed of benefit modernization and slow the growth of costs,

and that is why we are having this discussion and that is why it is so important that we think about disease management as a way to do both of those things.

Mr. STEINWALD. Thank you, panelists. I guess where I come out, relating back to the title of the panel session, square peg in a round hole; well, maybe, but sometimes you can force that peg in and make it stick. We seem to be somewhere between a feeling of cautious optimism and open-minded skepticism about the workability of disease management in fee-for-service Medicare. I guess we do not have the answers to those questions or that question, but at least we have the prospect of obtaining more information in the not-too—distant future, and we certainly have a Congress that is interested in the concept and pursuing it.

So please join me in thanking our panelists for their presentations. [Applause.]

Thanks to the Senate Special Committee on Aging for sponsoring this session. Thank you. We are adjourned.

[Whereupon, at 11:29 a.m., the Committee was adjourned.]

APPENDIX

STATEMENT FROM THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

The 94,300 members of the American Academy of Family Physicians offer this statement for the record on "Disease Management in Traditional Medicare."

The Academy applauds your Committee for holding a hearing that recognizes federal funds are increasingly directed toward beneficiaries with chronic illness within the Medicare program. The Robert Wood Johnson Foundation Partnership for Solutions initiative estimates that about two-thirds of Medicare dollars go to participants with 5 or more longstanding conditions. This is a startling figure for a program that not only costs taxpayers billions of dollars, but also is not geared toward chronic care management. Examining "what works" for chronic care is crucial as Medicare costs spiral upward and budget pressures to hold down spending increase.

The Academy has a continuing and expanding interest in improving chronic care. Specifically, we are in the second generation of a project entitled "Quality Enhancement Program" (QEP), which includes a focus on improving chronic illness care within family physicians' offices. The impetus for this initiative has been the Chronic Care Model (CCM), which was developed by Edward Wager, MD, who is National Program Director for the Partnership for Solutions program. The model is premised on the fact that care for most people with chronic illness takes place in primary care settings.

In November 2003, the AAFP convened an advisory committee to discuss specific initiatives to help family physicians design, document and be recognized for quality health care. Although quality improvement was the reason for the meeting, chronic care management was a particular focus. As a result of this 2-day session, the Academy has decided to improve family physician training through web-based information, one-on-one interventions, new and innovative residency programs and the media. The new program will begin as a demonstration project targeting 2500 members. While a significant activity for a private organization, our focus on improving chronic care management for our members is only a fraction of what federal support could do to support disease care in the US health car system.

IMPORTANCE OF PRIMACY CARE TO HEALTH CARE IN THE US

According to the Graham Center for Policy Studies in Family Practice and Primary Care, 82 percent of Americans have a usual source of medical care and a majority of them, 62 percent, name a family physician as that source of care. And, regardless of self-reported health status, people benefit from having a usual source of care even if they are uninsured. Specifically, utilization of health services by individuals with a usual source of care (doctor's office visits, admission to a hospital and purchase of prescription medicine) was higher than for those without a usual source of care. Moreover, difficulties obtaining health care and doing without needed services was higher in people without a usual source of care.

Furthermore, according to the Center, of people 65 years and older who report a usual source of care, 60 percent identify a family physician. The Medicare population not only relies heavily on family doctors but 72 percent of respondents identified an individual. Family physicians were also more likely to be identified as the source of care for rural and Hispanic seniors, and those with less than a high school education.

Moreover, another Graham Center study shows that Americans depend on family physicians more than any other specialty. Of the 3142 counties in the United States, 1184 (38 percent) are designated full or partial county HPSAs, which translates to more than 41 million Americans. In a hypothetical exercise, the study removed all family physicians from the US counties. When this was done, that figure nearly doubled—the large majority of US counties became full or partial county HPSAs.

These data lead to our view that care for patients with chronic diseases must be integrated by the primary care physician—rather than disease management companies or other entities.

IMPORTANCE OF CARE INTEGRATION

Additional information from Partnership for Solutions reveals that 66 percent of Americans over the age of 65 currently have a least one chronic condition, and the majority go on to be afflicted with a number of illnesses. Data from the Medicare Standard Analytic File (1999) shows that the number of physicians actually increases with each condition. Specifically, Medicare beneficiaries without chronic conditions saw an average of 1.3 physicians in 1999. Beneficiaries with a single chronic illness saw an average of 3.5 physicians while those with two saw an average of 4.5 physicians. Seniors with six chronic conditions saw an average of 9.2 physicians in 1999. These figures argue for a single primary care physician who can provide cost-effective and integrated care for those in Medicare.

In addition, the most common chronic conditions, i.e. hypertension, heart disease, diabetes and arthritis, can be cared for and controlled in ambulatory settings. When care for these conditions is poorly coordinated, increased hospitalization and higher costs are the result. For example, an article published in the *Annals of Internal Medicine* (Wolff et al.) showed that 7 out of 1,000 Medicare beneficiaries with a single chronic condition were hospitalized for a condition that was unnecessary. Eighteen out of 1,000 beneficiaries with two conditions were needlessly admitted, while 36 out of 1,000 seniors with three conditions were sent to the hospital. The figure for Medicare beneficiaries with six conditions was 161 out of 1,000.

Appropriate care integration could ensure patients get the care they need, keep them out of the hospital and save them and the Medicare program substantial amounts of money.

ACTIONS THE FEDERAL GOVERNMENT CAN TAKE

The AAFP has made it a priority to support the efforts of family physicians in the US who every day coordinate the care of their chronically ill patients. After all, it is the nation's family doctors who provide the most care to the chronically ill. The federal government should support these efforts, as well. Specifically, this support should come in additional Medicare demonstration projects that provide financial, consultative and best practice models to encourage primary care practices to move from their current acute care focus to one that is based on managing chronic care. While individual practices develop novel and innovative ways to manage care, these efforts are not supported, systematized or made available nationally.

CURRENT LEGISLATION IN THE US CONGRESS

The House and Senate Medicare bills both contain provisions on chronic care management. Some provisions focus more on disease management companies, while others rely more on a "payment for performance" structure.

Our concern is that legislation focusing primarily on disease management companies, absent the integral role of an integrating physician, is counterproductive. We believe that federal support of disease management entities will take chronic care in the wrong direction: many insurers will work with many organizations, which will manage many diseases—in many, many different ways. The health care system will become further fragmented, more costly and without any perceptible health benefit for the elderly, chronically ill patient, who, in fact, should be our chief concern.

The Academy is concerned particularly about a focus on disease management organizations and single, targeted conditions. Not only do these entities lack experience in managing multiple conditions, but Medicare beneficiaries typically have more than one disease.

We are also concerned about the lack of physician involvement in some of the disease management programs; systems vary. For example, under the current House Medicare bill provisions, the Center on Medicare and Medicaid Services (CMS) would contact the beneficiaries, inform them of these voluntary disease management programs, and then ask disease management organizations to follow up absent any requirement for primary care physician involvement. Not only do patients enroll at higher rates in these programs when a physician they know is involved, according to current CMS demonstration projects, but, more importantly, a patients' primary care physician must work in collaboration with the patient to coordinate and oversee the care.

While we understand that there is an impetus to incorporate the Institute of Medicine's call for patient-centered care, enrolling patients in several contracts and agreements to manage their diseases is directly contrary to the notion of patient-centeredness. What patients tell us is that they want a physician who will work with them, as an individual, to manage and coordinate their care.

Consequently, the Academy is more supportive, in general, of projects that focus on physicians serving eligible beneficiaries. Specifically, "pay-for performance" programs, such as those in S1, the Senate Medicare bill, that allow physicians to contract through quality improvement entities seem better geared toward primary care. Physicians would serve as the primary contact; maintain health information; meet outcome measures; promote self-care and report quality and outcomes measures electronically.

The Academy is at the vanguard of a movement to incorporate electronic medical records in physicians' offices. This project is part of our goal to provide tools to physicians so that they can redesign their offices for our current health system, and provide better quality care. Specifically, on November 12, 2003, we announced an initiative called "Partners for Patients," which involves a number of strategic business alliances to provide electronic health record technology to medical practices. We believe that in small- or medium-sized medical practices, an electronic health record system is the "central nervous system" for clinical patient management, including chronic care. The electronic health records systems that our partners and we are developing will help to ensure patients receive the most timely, appropriate and efficient medical care available.

CONCLUSION

The AAFP understands that the demonstration projects in the Medicare bills are different means to seek additional information on what constitutes effective chronic care. We also realize that CMS currently has several demonstrations in progress that seek answers to the same question, and that the Medicare Payment Advisory Commission (MedPAC) is also seeking data on ways to provide quality chronic care in a cost-effective manner.

As an emerging issue of crucial significance, care for chronically ill patients should be on everyone's policy agenda. Our belief, however, is that any new system must use primary care practice as the foundation on which to build this care. Americans are currently receiving most of their health care from primary care physicians and they are satisfied with it. The federal government's role should be to ensure that primary care is at the core of any chronic care program.