



STATEMENT OF
RUBEN J. KING-SHAW, JR.
DEPUTY ADMINISTRATOR AND CHIEF OPERATING OFFICER
CENTERS FOR MEDICARE & MEDICAID SERVICES
ON
PROMOTING DISEASE MANAGEMENT IN MEDICARE
BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING

September 19, 2002



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Chairman Breaux, Senator Craig, distinguished Committee members – first, thank you for inviting me to discuss the significant role that disease management can play in improving people’s lives. And thank you to the other members of the Committee for your leadership on this issue. Analysis of disease management is an integral part of the Centers for Medicare & Medicaid Services’ (CMS) efforts to improve and strengthen Medicare and to improve the health care services provided to all Medicare beneficiaries and ultimately the health care of all Americans. As the delivery of health care has evolved, we all know that 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 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 in integrating disease management concepts into Medicare. The demonstration projects we are developing and implementing can help achieve the President’s goal to improve and strengthen Medicare while ensuring that America’s seniors and disabled beneficiaries receive high quality care efficiently.

The President proposed a framework for strengthening and improving Medicare that builds on many ideas developed in this committee and by other Members of Congress. That framework contains eight principles to guide our efforts:

- All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.

- Modernized Medicare should provide better coverage for preventive care and serious illness.
- Today's beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes.
- Medicare should make available better health insurance options, like those available to all Federal employees.
- Medicare legislation should strengthen the program's long-term financial security.
- The management of Medicare should be strengthened to improve care for seniors.
- Medicare's regulations and administrative procedures should be updated and streamlined, while instances of fraud and abuse should be reduced.
- Medicare should encourage high-quality health care for all seniors.

The President, the Secretary, the Administrator and I are determined to work constructively with Congress to achieve these goals. We are currently undertaking a series of disease management demonstration projects to explore a variety of ways to improve beneficiary care in the traditional Medicare plan. These demonstrations provide beneficiaries with greater choices, enhance the quality of their care, and offer better value for the dollars spent on health care. The almost complete absence of disease management services in the traditional Medicare plan is another striking indication of how outdated Medicare's benefit package has become. We appreciate your efforts to modernize, improve and strengthen the traditional Medicare plan, and we look forward to working with you on efforts that will make disease management services more widely available.

Disease management is a good example of why the President and Secretary Thompson have advocated immediate action to give seniors reliable private plan options in Medicare, and to prevent further pullouts of private plans from the Medicare program. Disease management services have been available to millions of seniors through private plans, yet inadequate and unfair payments are threatening those benefits. The most important step that Congress could take right now to allow seniors who depend on disease management to keep these valuable services, and to provide rapid access to such services to many more seniors who need them, is to fix the problems with the payment system for private plans.

BACKGROUND

A relatively small number of beneficiaries with certain chronic diseases account for a disproportionate share of Medicare 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. Such disjointed care is confusing and can present difficulties for patients, including an increased risk of medical errors. Additionally, the repeated hospitalizations that frequently accompany such care are extremely costly, 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.

We are already taking advantage of private sector expertise in disease management to give Medicare beneficiaries more services for their premiums, often with lower cost sharing and more benefits than are available under traditional Medicare. For example, Medicare+Choice plans provide many benefits that are valuable to seniors with serious and chronic health conditions, such as:

- *A Medicare+Choice plan in Boston that has a comprehensive disease management program for its enrollees with diabetes. This has resulted in significant increases in the share of enrollees who received annual retinal eye exams and are monitored for diabetic nephropathy and substantial improvements in the management of their Hemoglobin and cholesterol levels.*
- *A Medicare+Choice plan in Florida that has a comprehensive disease management program to monitor, facilitate, and coordinate care for enrollees with cancer. As a result, the number of acute hospital days per cancer case dropped by about 15% over two*

years and the share of inpatient admissions for complications with cancer has declined by 10 percent.

- *A Medicare+Choice plan in New York that has a case management program for those hospitalized for mental health disorders and nearly doubled the share of its enrollees who received follow-up care within 7 days of their hospital discharge. This is consistent with research that has shown that individuals who receive after-care following hospital stays for mental illness are more likely to be follow their treatment regimens and less likely to be readmitted to the hospital.*

Several studies have suggested that case management and disease management programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes. In a rapidly evolving health care environment, the best disease management programs fuse the strongest aspects of both disease management and case management. In the largest sense, both disease management and case management organizations provide services aimed at reaching 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.

These goals echo the President's principles of improving the Medicare program through better care for serious illness, delivering higher quality health care, and protecting Medicare's financial security. We are exploring a number of ways to pursue these goals in both the Medicare fee-for-service program and in the Medicare+Choice program.

DEMONSTRATION PROGRAMS IN FEE-FOR-SERVICE MEDICARE

The outdated benefit package in fee-for-service Medicare does not include disease management, and so beneficiaries in fee-for-service have not had access to these valuable services. To identify

innovative ways to include coordinated disease management services in an inherently uncoordinated fee-for-service system, we have a number of demonstrations both underway and in development.

In fact, we are close to finalizing a pilot project to test whether providing disease management services to Medicare fee-for-service beneficiaries with advanced-stage congestive heart failure, diabetes, or coronary heart disease can yield better patient outcomes without increasing program costs. Mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, the project will include payment for all prescription drug costs, whether or not they relate to the chronic health condition, without increasing costs to the Medicare program.

In addition to this new project, we are currently implementing a demonstration in 15 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, major depressive disorders, drug or alcohol dependence, Alzheimer's disease or other dementia, cancer, and HIV/AIDS. 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. This program was 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 15 demonstration sites have enrolled over 3,000 Medicare beneficiaries in both intervention and control groups in care coordination and disease management programs. The statute that authorizes these projects allows for the effective projects to be continued and the number of projects to be expanded based on positive evaluation results -- if the projects are

found to be cost-effective and that quality of care and satisfaction are improved. In addition, the components of the effective projects that are beneficial to the Medicare program may be made a permanent part of the Medicare program. 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. As part of the evaluation, we will be looking at mortality, hospitalization rates, emergency room use, satisfaction with care, and changes in health status and functioning.

In another fee-for-service demonstration, at Lovelace Health Systems in New Mexico, we are testing whether intensive case management services for CHF and diabetes mellitus can be a cost-effective means of improving the clinical outcomes, quality of life, and satisfaction with services for high-risk patients with these conditions.

PROVIDING RELIABLE COVERAGE OPTIONS THAT INCLUDE DISEASE MANAGEMENT

We are also undertaking several demonstration programs that may offer the disease management that is available to seniors in private plans. The projects represent a wide range of programs and approaches, and they address a number of chronic conditions. For instance, we recently announced that a total of 33 new health plans in 23 states will participate in the demonstration modeled after the preferred provider organization (PPO) coverage available to the vast majority of Americans under age 65. PPOs have been successful in non-Medicare markets in providing disease management services and other valuable benefits for patients with chronic illnesses, yet they have been almost nonexistent in Medicare. This demonstration is designed to evaluate the effectiveness of the PPO health care option in the Medicare market. The goal is to expand options and choices in the M+C program for Medicare beneficiaries.

Under this demonstration, networks of preferred providers (hospitals, physicians and other providers) will provide all of the basic Medicare benefits, plus additional benefits such as annual physicals, other preventive services, disease management, and prescription drugs. This new PPO option will be available to about 11 million Medicare beneficiaries—30 percent of all seniors—

in parts or all of 23 states: Alabama, Arizona, California, Florida, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Missouri, North Carolina, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Tennessee, Virginia, West Virginia and Washington.

Additionally, as required by BIPA, we are developing a physician group practice demonstration encouraging coordination of Part A and Part B services, rewarding physicians for improving beneficiary health outcomes, and promoting efficiency. 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.

BUILDING FOR THE FUTURE

We are also considering future demonstration projects that will expand options for Medicare beneficiaries in the Medicare+Choice program and the traditional Medicare program. In addition to stabilizing the existing Medicare+Choice program and providing more health plan options, like our PPO initiative, we want to develop specific health plan options for those beneficiaries with chronic illnesses. We are investigating disease management projects that would work with a diverse group of organizations, including Provider Sponsored Organizations (PSOs), integrated health care systems, disease management organizations, and Medicare+Choice plans. We want to enhance the clinical management of care to better serve the patients, provide for more effective coordination of services, and improve beneficiaries' health clinical outcomes and not increase costs to the Medicare program.

For example, we plan to test capitated payment arrangements with qualified organizations that will use the case management techniques to treat chronic diseases such as congestive heart failure, diabetes, and chronic obstructive pulmonary disease. This would allow a plan to specifically target treatment and coordination for chronic diseases. The payment models are intended to improve the coordination and quality of care for Medicare beneficiaries and to reduce costs to the Medicare program. The targeted populations could include beneficiaries eligible for both Medicare and Medicaid, as well as the frail elderly.

In another future demonstration, we intend to provide our beneficiaries with end-stage renal disease (ESRD) the opportunity to join an integrated care management system, building on lessons learned from our successful ESRD demonstration created under Social Health Maintenance Organization (SHMO) legislation. SHMOs are plans that offer special managed care services aimed at helping chronically ill beneficiaries maintain their independence. 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. Our demonstration will test the effectiveness of disease management models to increase quality of care for ESRD patients and reduce costs. We are exploring a model in which the ESRD providers would be paid a capitated amount for all health care of the enrolled beneficiaries based on the M+C rates that are currently in use for ESRD beneficiaries. These payments would be modified as risk adjustment methods for ESRD beneficiaries are developed over the next year or two. An incentive payment for quality is also being considered for the demonstration.

Additionally, we are investigating the feasibility of a larger scale population-based demonstration in the traditional fee-for-service Medicare targeted at specific chronic diseases like congestive heart failure, diabetes, and chronic obstructive pulmonary disease (COPD). Our emphasis will be on early detection, patient outreach, patient education, and lifestyle modification. Wanting to target selected geographic areas in this effort, we are particularly interested in underserved and disadvantaged populations in urban or rural areas. The solicitation could target organizations that are expert in reaching the designated populations and also have expertise in lifestyle modification and disease management. The payment method for this demonstration has not yet been developed, but we want to focus on holding contractors accountable for clinical and financial outcomes.

Our evaluations of all of these projects will inform our future efforts. In disease management, 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. We anticipate that better outpatient care and monitoring through the dynamic disease management model will reduce avoidable hospitalizations, avoid unnecessary services, and improve outcomes. The Agency also is exploring various payment options, including bundled,

case-rated methodologies for treating particular conditions, such as stroke or hip fracture, that may lend themselves to this type of payment system. We recognize, however, that costs for some individual cases, particularly those in which appropriate medical services were previously underutilized, could increase with coordination of services. 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 and this will more than offset the added expenses.

While these new demonstration programs hold promise, they are not yet fully tested and they are no substitute for the comprehensive coverage that many beneficiaries prefer through private plans. The most important step for helping Medicare build for the future, in terms of providing integrated benefits that keep patients healthy, is to create a stable and fair payment system for Medicare+Choice plans. In the meantime, 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 changes in Medicare's unfair payment system for private plans, we are working to give seniors the same access to modern disease management services that other Americans enjoy. We also are working to address the difficulties of providing effective disease management services in the fee-for-service plan. Our goal is to make disease management services widely available, enabling beneficiaries to enhance their quality of care and get better value for the dollars they spend on health care. We look forward to continuing to work cooperatively with you Chairman Breaux and Senator Craig, and 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.