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Good morning, I am John Rusche, Senior Vice President and Chief Medical Officer of Regence BlueShield of Idaho. Regence BlueShield of Idaho is licensed as a mutual health insurance company and holds a certificate of authority to operate a health plan throughout the state of Idaho. We belong to the Regence Group, the Pacific Northwest and Intermountain Region's largest affiliation of health care plans, including Regence BlueCross BlueShield of Utah, Regence BlueShield (Washington state) and Regence BlueCross BlueShield of Oregon.

Regence BlueShield of Idaho finances health care for almost 270,000 Idahoans—about one resident in five—through traditional and managed care benefit plans and administrative services agreements.

I am pleased to have the opportunity to speak with you today about disease management. Regence BlueShield of Idaho believes in disease management because we are committed to offering the finest in preventive medicine to our members, and to seeking the most advanced and most medical-practice-friendly programs for our providers.

Disease management for seniors is an especial interest of Regence BlueShield of Idaho because of our strong commitment to Medicare. We offer a wide range of Medigap supplemental insurance options—packages A, C, F, G, and J—to Medicare beneficiaries. And we enroll about 6,000 seniors in our Medicare cost contract HMO, "HealthSense 65."

My testimony today will cover four points:

- Our view of disease management—what it is, and what it can do;
- How we use disease management in our plan;
- The effects of our disease management program; and
- The potential for disease management in Medicare.

## **Background on Disease Management**

In any population, a high percentage of health-care dollars are spent on a relatively small percentage of patients, many of whom have chronic diseases such as asthma, diabetes, or coronary artery disease. For instance, in Medicare 12 percent of all Medicare enrollees accounted for more than 75 percent of all Medicare fee-for-service program payments. In our population, 2.5% of our members account for 40% of our healthcare costs, 5% for 65% of costs. Many of these high-cost beneficiaries are chronically ill with certain common conditions. If we as a health-care system can identify and actively manage these patients' chronic diseases through education, prevention, and follow-up, then patients can be expected to experience fewer complications and may be able to avoid hospitalization or invasive treatments. That, in a nutshell, is the premise of disease management.

More formally, the Disease Management Association of America defines disease management as “a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.” A comprehensive disease management program should:

- Support the physician-patient relationship and plan of care.
- Emphasize prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies; and
- Continuously evaluate patient outcomes with the goal of improving overall health. (DMAA, 2002.)

In general, disease management programs are designed to work by helping the chronic-disease patient to be an active participant in his or her care (patient self-management) and by providing the care providers with the most up-to-date medical information and support. The main goal is to keep

chronic diseases under control, to prevent acute episodes or complications that require hospitalizations or other expensive interventions.

By reducing a patient's need for expensive hospitalizations and other health treatment, disease management offers the possibility of not only improving health, but also saving money. That makes disease management especially appealing to employers who are facing continued rising costs of giving health benefits to their employees. In Idaho, as across the country, employers are expressing interest in adopting disease management programs to improve employee health and quality of life, avoid unnecessary health care expenditures, increase employee satisfaction, improve worker productivity, and retain workers. (EBRI, August 2002).

#### **Disease Management in Regence BlueShield of Idaho**

On a national level, disease management programs may be enjoying an unprecedented level of acceptance, taking their place as permanent fixtures in many benefit plans, but in rural pockets of the country, such programs are still uncommon. (Managed Care Week, July 15, 2002.) The distributed population and lessened delivery capacity makes it more difficult and less efficient for many models of disease management.

None-the-less, it is in the rural areas, those with less opportunities for patients to find the best care themselves that care management programs make sense. Programs tailored to identified high risk populations makes sense, helping the providers and receivers of care recognize how "best medical evidence" of services improves the clinical outcome and lowers the cost. In the summer of 2001, Regence BlueShield of Idaho sought to remedy this deficit in Idaho by undertaking a comprehensive disease management program for Coronary Artery Disease (CAD) and Stroke.



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Why coronary artery disease? Cardiovascular disease is the leading cause of death in this country, and costs associated with its treatment comprise the largest percentage of health care expenditures in the United States. According to the American Heart Association, in 1998 cardiovascular disease will account for 42 percent of all deaths and approximately \$235 billion in total costs in the United States. CAD will represent 50.1 percent of these costs or \$118 billion. Our Regence BlueShield of Idaho population is quite similar, with Cardiovascular diseases and their treatments representing the single highest category of claims costs. A significant portion of these dollars pays for hospitalizations that may be preventable by the simple application of current best practice standards.

Having targeted CAD for disease management, we next undertook to decide the best way to carry out a disease management program. Disease management programs may be owned and administered by various types entities: not only health plans, but also specialty disease management companies, pharmaceutical firms, pharmacy benefit managers (PBMs), or medical provider groups. Because Regence BlueShield of Idaho is in the business of financing coverage—not delivering care—we decided to team up with an outside vendor for this program.

After exhaustive analysis we concluded that QMed's clinical information technology approach precisely matched our mission. Their capabilities, first, to find patients who are at risk of these conditions, but who may be without symptoms, and second, to help our physicians manage them via a state-of-the-art information technology, are unique. In fact, CMS has selected QMed to provide disease management for coronary artery disease under one of the Medicare Coordinated Care Demonstration projects.

### **Regence Cardiovascular Program Summary**

The goal of our disease management program is to aid primary care providers in modifying the current approach of acute and episodic intervention for the treatment of CAD and stroke toward a

greater focus on preventive therapy. Once a patient is enrolled in the program, a coordinator manages the program's operations, ensuring little additional work for the physician or office staff.

### **Identify Patients**

Focusing the effort is an essential requirement of successful program. We felt that a critical first step was selecting patients who would most benefit from a CAD disease management program. We determine eligibility by the following criteria, some of which is obtainable from our claims data systems, the rest extracted from patients' medical records (with the patient's consent):

- Documented CAD defined as those with a history of myocardial infarction, stroke, TIA; angiographically documented coronary obstructions;
- CABG , PTCA and /or CEA;
- Stable angina pectoris or a history of angina in the past; or inducible ischemia, whether symptomatic or silent; or the detection of ambulant ischemia during a previous ambulatory ECG recording;
- Positive carotid vascular studies;
- Recent onset of chest pains consistent with angina.

Males and females over the age of 40 with any two of the following risk factors:

- Family history of coronary artery disease appearing in a first degree relative before the age of 60.
- Hyperlipidemia and elevated lipoprotein
- Diabetes
- Hypertension
- Smoking

### **Stratify Patients**

With the aid of a medical database based on national guidelines, cardiologists working for QMed risk stratify patients into high and low-risk groups, and put together patient-specific treatment plans. One unique feature of our program is that the risk stratification of patients is monitored 24 hours day, and quickly changed when patients experience cardiovascular disease events.

### **Intervention**

I mentioned earlier that disease management programs are designed to work by (1) giving the care providers the most up-to-date medical information and support, and (2) by helping the chronic-disease patient to be an active participant in his or her care.

To help primary care providers, we send reports that indicate for each eligible patient a high, moderate, or low risk stratification, and patient-specific recommendations to optimize medical therapy. Following national guidelines, the goals are to eliminate ischemia, normalize lipids, improve blood pressure, increase use of anti-thrombotics, and use beta blockers for post-myocardial infarction patients.

We also offer extensive support physicians through one-on-one meetings, an active physician advisory group, and continuing medical education opportunities.

To promote patient self-management, we schedule face-to-face nurse and patient encounters where patients receive one-on-one training. We also send patients training and educational materials tailored to their diagnoses, a regular newsletter, a monthly status report, and automatic reminders for follow-up care.

### **Physician Buy-In**

Obviously, this type of disease management program can only work if physicians buy into it. In addition to valuable educational support, we offer physicians modest financial remuneration for participating. We pay attending physicians \$25 per member enrolled for time involved with identifying eligible members and reviewing medical charts. We pay an additional \$50 per member enrolled for following each member's test results after subsequent visits and reviewing recommendations.

### **Program Effectiveness**

In the year since starting the program, we have been fairly successful in recruiting physicians. Two months before the program's start, we sent special recruitment letters to the 440 or so primary care providers in our network. To date, more than one-half of those providers have agreed to participate; 12 percent have declined to participate; and the rest have not yet decided whether or not to participate.

Aside from reduction in expensive health-care costs, we plan to track the effects of the CAD program on (1) quality of life outcomes; and (2) physician satisfaction. Quality of life comprises the program's ability to help the member better understand CVD, to improve patients' energy level, and to do other physical activities. Improved quality should show up as perceived improvements in the quality of care and services provided.

To track physicians' attitudes, we will measure satisfaction with the following aspects of the program:

- Timely scheduling of patients once identified;
- Efficient and professional handling of telephone and face-to-face contact ;
- Quality of content of written patient reports;
- Utility of the recommendations made to assist physician in the management of CVD patients.

As the program is little more than one year old, it is too soon to measure its effectiveness. But we do know that for another commercial HMO population, QMed's program appeared to reduce heart attacks by 32.7 percent; it reduced bed days per thousand CAD patient by 31 percent; it abolished ischemia in 60 percent of patients, and it reduced angioplasties by more than 20 percent. In addition, we know that research and case studies show positive results from other individual disease management programs. Though there may not yet be conclusive evidence that disease management programs, in general, improve health or reduce costs in the long term, many employers have seen improved health and decreased costs as a result of their programs, and growing numbers of employers are convinced that disease management will help save money. (EBRI, 2002).

### **Disease Management in Medicare**

The five million or so Medicare beneficiaries enrolled in HMOs already benefit from varying approaches to disease management, not least because CMS requires that all Medicare HMOs conduct a baseline and establish a treatment plan for people with complex or serious medical conditions.

For instance, in our Medicare HMO, HealthSense 65, we use predictive algorithms to perform psychosocial and medical needs assessment on the highest risk enrollees. We have found that among our highest risk members, all enrollees had adequate access to medical care, but almost two-thirds had unmet psychosocial needs, from isolation to transportation to hunger and nutrition. Using a social worker, we were able to integrate high-risk patients into available community programs at a relatively low cost.

We see great potential in extending similar disease management approaches to the 35 million beneficiaries in traditional, fee-for-service Medicare. Currently, one major obstacle to disease

management in the Medicare fee-for-service population is identifying and recruiting suitable beneficiaries when their risk is highest. Our CAD disease management program offers one model for maneuvering around this obstacle—partnering with physicians to review charts, and using sophisticated algorithms to identify the highest risk patients.

Though we pay physicians on a fee-for-service basis for participating in the disease management program, disease-based contracts with providers may be priced in a variety of ways. A case manager or disease management organization may receive a sum per member per month to work with high-risk patients (without taking risk for health care costs). A “per case” program would provide an individual health adjustment or a flat rate payment for a condition such as cancer. This is how we pay QMed for our cardiovascular program. And many disease management organizations put their charges “at risk,” receiving decreased payments unless cost savings and quality parameters are met. Some health plans even pass the entire insurance risk for identified members to specialty care management vendors.

Physician and provider organizations often participate as both vendor and provider of care. Under “diagnosis capitation,” a primary care physician might receive a higher capitation rate for a patient with a condition like diabetes or asthma, or a specialist might become the gatekeeper. “Episode of care capitation” is a sum paid to a specialist to cover the patient's health care costs over a defined period of time or spell of illness. Similarly, under “contact capitation,” a specialist may receive a capitated payment to cover services from the time the patient is referred by the primary care physician to the end of a treatment or payment cycle. “Treatment capitation” often covers all health care costs related to a finite course of treatment, such as the care of a high-risk neonate. Other disease management program shift financial risk to physicians by seeking guarantees of improved patient health and a certain level of savings.



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## **Conclusion**

Disease management has a tremendous potential to improve patients' health, strengthen physician-patient relationships—and to save money. And as we have found in Idaho, to improve the level of services not easily available through a limited delivery network. We commend CMS for its interest in testing models aimed at beneficiaries who have one or more chronic conditions that are related to high costs to the Medicare program, among them coronary heart disease. Our CAD disease management program, and our risk assessment methods for our Medicare HMO enrollees, point to approaches that might be useful models for Medicare in the future.