



## **Enhancing Value in Medicare: Chronic Care Initiatives to Improve the Program**

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Invited testimony

Special Committee on Aging

United States Senate

Hearing on "The Future of Medicare:  
Recognizing the Need for Chronic Care Coordination"

May 9, 2007

I would like to thank Michelle Serber for her assistance in assembling the information contained in this testimony and preparing the testimony itself, and Karen Davis and Stephen Schoenbaum for their helpful comments and suggestions.

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## **Enhancing Value in Medicare: Chronic Care Initiatives to Improve the Program**

Thank you, Chairman Kohl, Senator Lincoln, and Members of the Committee, for this invitation to testify on chronic care initiatives in Medicare. I am Stuart Guterman, senior program director for the Program on Medicare's Future at the Commonwealth Fund. The Commonwealth Fund is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable populations, including low-income people, the uninsured, minority Americans, young children, and elderly adults. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy.

### **Introduction**

The Medicare Program, created in 1965, was designed to ensure access to needed health care for the elderly population—half of whom lacked insurance to protect them against the potentially catastrophic costs of major illness.<sup>1</sup> It has served that purpose well for more than 40 years. Over that time, Medicare has become one of the most popular government programs, generating consistently high satisfaction levels among its now 43 million elderly and disabled beneficiaries.

Medicare was designed to deal primarily with the effects of acute illness, which was seen at the time of its implementation as the major threat to the health and financial security of the aged. While the health care delivery and financing system in the United States remains largely oriented toward acute care, demographic and other trends are putting pressure on that system—and on Medicare particularly—to change. Health care spending overall is growing more rapidly than our economy can sustain, and Medicare faces the additional pressure of a wave of post-World War II baby boomers set to begin retiring within the next few years.<sup>2</sup>

At the same time, for all we spend on health care, there are significant issues with the safety, quality, and efficiency of care, and that care is poorly coordinated across providers.<sup>3</sup> This problem is especially important for Medicare, whose aged and disabled beneficiaries need and use more health care and are more likely to have chronic conditions than the rest of the population.<sup>4</sup> Consequently, Medicare must play a more proactive role in making sure that appropriate, high-quality, and efficient health care is available for the elderly and disabled.

In response to these imperatives, the Centers for Medicare and Medicaid Services (CMS) is implementing an array of initiatives to address the evolving needs of the Medicare program and its beneficiaries. Many of these initiatives have been developed under CMS's demonstration authority, which allows the agency to waive certain Medicare payment rules that determine what services are covered and how they are paid in order to test potential improvements; others have been specifically mandated by Congress.

This testimony will describe Medicare's initiatives to improve care for beneficiaries with chronic conditions. I will then discuss what these initiatives may tell us about how to accomplish that goal.

### **The Need for Enhanced Value**

Like many other countries, the United States population is aging. In 2000, the proportion of individuals age 65 and older in the U.S. was 12.5 percent; this share is projected to grow to 16.6 percent by 2020, an increase of one-third.<sup>5</sup> Older individuals are more likely to have one or more chronic conditions. A 2004 Commonwealth Fund survey of older adults asked respondents if a physician had told them they had any of six conditions—hypertension or high blood pressure, heart disease or heart attack, cancer, diabetes, arthritis, or high cholesterol—and the rate of reported conditions increased significantly with age: 67 percent of respondents aged 50 to 64 cited at least one chronic condition, versus 84 percent of those aged 65 to 70 (Figure 1).<sup>6</sup> Other studies have shown that the 20 percent of Medicare beneficiaries with five or more chronic conditions account for 66 percent of Medicare spending (Figure 2)—and they receive services from an average of almost 14 physicians in a given year.<sup>7</sup>

The health care delivery and financing system, however, is not set up to serve individuals with multiple chronic conditions. Studies have shown that Medicare beneficiaries with these conditions are more likely to have preventable hospitalizations, experience adverse drug interactions, undergo duplicate tests, and receive contradictory information from doctors.<sup>8</sup> Moreover, the high Medicare costs they incur appear to be consistent over time: a 2005 Congressional Budget Office report found that nearly half of the beneficiaries in the top 25 percent of the Medicare population with respect to cost in 1997 (a group that accounted for approximately 85 percent of total Medicare spending) were again in the top 25 percent the following year.<sup>9</sup> That report also determined that of the high-cost beneficiaries in 2001, more than 75 percent had been diagnosed with one or more of seven major chronic conditions.

Neither traditional fee-for-service Medicare nor Medicare Advantage (MA) is currently configured to provide adequate care for these beneficiaries. The fee-for-service payment model still dominates in the United States—particularly in Medicare. Although the proportion of Medicare beneficiaries enrolled in managed care arrangements has grown recently, more than 80 percent of them remain in the traditional fee-for-service program, which provides no incentive for the coordinated care needed by the chronically ill.<sup>10</sup> Additionally, fee-for-service payment encourages specific, condition-oriented care, by which an individual with multiple conditions is treated by multiple providers.<sup>11</sup> Moreover, the fee-for-service model allots more generous payments for procedures and specialists' services, thereby discouraging physicians from entering the primary care fields that are more compatible with the role of care coordination.

Although managed care would appear to be better suited to providing the kind of coordinated care needed by chronically ill Medicare beneficiaries, the MA program and its predecessors historically also have been flawed in this respect. The incentives provided under capitated payment are more consistent with better coordination, but that does not mean that plans respond to those incentives in that way; moreover, the lucrative payment provided under current MA rules may actually diminish the power of those incentives.<sup>12</sup> Capitation also can provide a strong incentive to avoid chronically ill enrollees if the payment system fails to adjust properly for the costliness of the individual enrollee and, although MA plan payment rates will be fully risk-adjusted in 2007, recent analyses indicate that the incentive to avoid sicker enrollees may persist.<sup>13</sup>

Meanwhile, Medicare is likely to face increased fiscal pressure over the next few years: as baby boomers approach retirement, the country's ratio of workers to beneficiaries is declining. As a result of the aging population and the new drug benefit, the Medicare Trustees estimate that program expenditures will grow from \$336 billion in 2005 to \$799 billion in 2015 (Figure 3).<sup>14</sup> Medicare spending as a share of gross domestic product (GDP)—at 2.7 percent in 2005—is expected to rise to 4.6 percent by 2020.<sup>15</sup> In addition, the Medicare Hospital Insurance Trust Fund is projected to be insolvent by 2019. These projections will soon be pushed to the forefront of the political debate, as the 2007 Medicare Trustees' Report triggered a "Medicare funding warning," which by law requires that the president submit a proposal to Congress to address Medicare spending growth.<sup>16</sup>

In addition to an aging population, the increased prevalence of chronic conditions, and rapid spending growth, the Medicare program and the health care system as a whole must also deal with sub-par performance on many cost and quality indicators. The

National Scorecard on U.S. Health System Performance compiled by the Commonwealth Fund's Commission on a High Performance Health System indicates that there is much room for improvement.<sup>17</sup> The 16 percent of the United States' GDP attributable to health spending is double the proportion of most industrialized countries; after a pause in the late 1990s, this percentage has been growing more rapidly in recent years.<sup>18</sup> Yet these greater expenditures do not appear to translate into better care, with the United States lagging behind other countries on indicators such as mortality and healthy life expectancy.

Moreover, both the quality of care and efficiency with which it is provided are highly variable across the United States.<sup>19</sup> Multiple quality indicators demonstrate large variation between top and bottom groups of hospitals, states, and health plans. For example, although top-performing hospitals reach 100 percent adherence to basic clinical guidelines for treating patients with heart attacks, congestive heart failure, and pneumonia, the national average is only 84 percent.<sup>20</sup> Variations also exist in mortality rates: an analysis of Medicare beneficiaries' mortality rates over the years 2000-2002 indicates a spread of 33 percentage points between the risk-adjusted mortality ratios in the 10 percent of hospitals with the lowest rates and the 10 percent of hospitals with the highest rates.<sup>21</sup>

This highly variable quality of care is delivered by a system that is too often poorly coordinated, which puts patients at risk and raises costs. Care coordination is necessary at the time of hospital discharge and during transitions following discharge. Yet, according to a 2005 Commonwealth Fund survey, only 67 percent of hospitalized patients in the United States reported having their medications reviewed at the time of discharge, compared to as much as 86 percent in Germany.<sup>22</sup> Additionally, a lack of discharge planning occurs all too frequently. On average, U.S. patients with congestive heart failure receive hospital discharge instructions only 50 percent of the time.<sup>23</sup>

Medicare's role in addressing these issues is unique: comprising one-fifth of all personal health care spending, it is both highly vulnerable to the forces affecting the broader health system and potentially an important driver of change.<sup>24</sup> The fact that Medicare is financed by a near-universal payroll tax and also by general tax revenues, together with the fact that almost everyone who turns 65 will become a Medicare beneficiary, make it particularly visible, important, and accountable to the American people. It is readily apparent that changes are needed, and Medicare can and must serve as a springboard for policies that improve health care, not only for its beneficiaries but also for the entire population.

CMS has already begun to respond by developing a variety of initiatives aimed at improving the quality and coordination of services provided to Medicare beneficiaries. This testimony considers demonstrations, pilots, and other initiatives that focus on improving the availability and coordination of care for beneficiaries with chronic conditions.

### **Chronic Care Initiatives<sup>25</sup>**

Patients with chronic conditions typically receive fragmented health care from multiple providers and multiple sites of care; this problem is amplified for beneficiaries with multiple chronic conditions. Not only is such disjointed care confusing and ultimately ineffective, it can present difficulties for patients, including an increased risk of medical errors. Additionally, the repeated hospitalizations that frequently accompany such care are extremely costly to both patients and Medicare. As the nation's population ages, the number of chronically ill Medicare beneficiaries is expected to grow dramatically, with serious implications for access, quality, and Medicare spending.<sup>26</sup>

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. These initiatives are based on the belief that disease management programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes without increasing costs.<sup>27</sup> In a study reviewing the literature on disease management programs, though, the Congressional Budget Office (CBO) concluded that: “while there is evidence that disease management programs could be designed to reduce overall health costs for selected groups of patients, little research exists that directly addresses the issues that would arise in applying disease management to the older and sicker Medicare population.”<sup>28</sup>

Two features, however, make the case for effective disease management particularly strong in the Medicare context. First, the greater prevalence of chronic illnesses among the Medicare population provides more opportunity for improving the appropriateness, effectiveness, and efficiency of care. Second, unlike private insurers, the Medicare program keeps its enrollees for life. This means that efforts to improve the coordination of care for chronic conditions can be consistently and continuously applied over a long period; it also means that the benefits of such efforts will accrue to the program rather than to some other payer.

The demonstration projects conducted by CMS in this area are intended to test the value of alternate approaches to improving care for beneficiaries with chronic conditions, while also making Medicare a more aggressive and effective purchaser of this care.<sup>29</sup> The majority of Medicare’s chronic care initiatives have focused on the coordination of care for chronically ill beneficiaries in the traditional Medicare fee-for-service program, but several of them have addressed the structural impediments that managed care plans have faced in attempting to provide appropriate care to this population. These initiatives are summarized in Table 1, and in the following discussion.

**Table 1. Chronic Care Initiatives**

<i>Initiative</i>	<i>Description</i>
Medicare Case Management Demonstration	The first of the Medicare chronic care initiatives, designed to test case management for beneficiaries with catastrophic illnesses and high medical costs.
Medicare Coordinated Care Demonstration	To examine whether coordinated care programs can improve medical treatment plans, decrease avoidable hospital admissions, and further benefit chronically ill beneficiaries without increasing program costs.
Medicare Disease Management Demonstration	To evaluate the effect of disease management services, coupled with a prescription drug benefit, on the health outcomes of Medicare beneficiaries diagnosed with advanced-stage congestive heart failure, diabetes, or coronary disease.
Medicare Health Support	Pilot program to test population-based chronic care programs that provide self-care support, education, and coordination of care to beneficiaries.
Care Management for High-Cost Beneficiaries Demonstration	To study a variety of provider-centered care management models—including intensive-care management, increased provider availability, structured chronic care programs, restructured physician practices, and greater flexibility in care settings—for high-cost beneficiaries.
Special Needs Plans (SNPs)	Authorized by the Medicare Modernization Act to focus on individuals with special needs, including beneficiaries who are institutionalized, dually eligible for Medicare and Medicaid, or suffering from severe or disabling chronic conditions.
End-Stage Renal Disease (ESRD) Managed Care Demonstration	To test the feasibility of year-round open enrollment in managed care for beneficiaries with ESRD. Each site provides service integration, case management, and extra benefits, and is paid a higher rate to reflect the additional costliness of enrollees with ESRD.

ESRD Disease Management Demonstration	To test the effectiveness of disease management models for increasing quality of care for ESRD patients while ensuring that this care is provided more effectively and efficiently.
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Source: CMS Web site, <http://www.cms.hhs.gov>.

*Improving Chronic Care in Fee-for-Service Medicare*

The first of the Medicare chronic care initiatives was the **Medicare Case Management Demonstration**, which studied the appropriateness of providing case management services to beneficiaries with catastrophic illnesses and high medical costs. This demonstration was implemented at three sites beginning in October 1993 and continued through November 1995.<sup>30</sup> The target conditions and case management protocols differed across the sites, but all three generally focused on increased education regarding proper patient monitoring and management of the target condition.<sup>31</sup> The project evaluation found that, while the projects successfully identified and enrolled populations of Medicare beneficiaries likely to have much higher than average Medicare costs, there was an unexpectedly low level of enthusiasm for the project from beneficiaries. This was attributed to the lack of physician involvement or sufficiently focused interventions, and to the lack of a financial incentive to reduce Medicare spending.

The **Medicare Coordinated Care Demonstration** was mandated by Congress in the Balanced Budget Act of 1997. This project was designed to test whether providing coordinated care services to Medicare fee-for-service beneficiaries with complex chronic conditions could yield better patient outcomes without increasing program costs. The demonstration (and a similar parallel project) originally involved a total of 15 sites, both in urban and rural areas, that focused on complex chronic conditions, including: congestive heart failure; heart, liver, and lung diseases; diabetes; psychiatric disorders; Alzheimer’s disease or other dementias; and cancer.<sup>32</sup> Enrollment in these programs began in April 2002, and at its maximum reached about 21,000 patients in the intervention and control groups combined. However, the five largest programs accounted for almost 60 percent of the total enrollment, while three of them enrolled fewer than 100 beneficiaries in their intervention groups.

Among the initial findings from the demonstration was that beneficiary recruitment in the fee-for-service market can be a challenge. The most successful of the programs had close ties to physicians and other providers, which helped reach the appropriate beneficiaries and overcome skepticism about enrolling. Through the first two years of the demonstration, however, few effects were found on beneficiaries’ overall



satisfaction with care, patients' adherence or self-care, and Medicare program expenditures.<sup>33</sup>

The **Medicare Disease Management Demonstration**, mandated in the Benefits Improvement and Protection Act of 2000, was intended to provide disease management, as well as a comprehensive drug benefit, for up to 30,000 eligible beneficiaries. This project, which began in Spring 2004, was of particular interest because it was designed to provide the first indication of how well prescription drugs can be used to help chronically ill beneficiaries in the context of the Medicare program. The three sites selected were fully at risk for any increase in Medicare spending among their enrollees.<sup>34</sup> The sites encountered greater-than-anticipated difficulties in identifying and enrolling beneficiaries, however; and, given the magnitude of the risk they faced, the demonstration was unable to continue to conclusion.

A major initiative mandated in the Medicare Modernization Act of 2003 (MMA) was the Medicare Voluntary Chronic Care Improvement Program, now known as **Medicare Health Support**. This pilot program, which was implemented in August 2005 and will run for three years, was expected to involve about 160,000 beneficiaries at eight participating sites around the United States (Figure 4) with high prevalence of diabetes and congestive heart failure.<sup>35</sup> The participating organizations are responsible for increasing adherence to evidence-based care and reducing unnecessary hospital stays and emergency room visits in an entire geographic area.<sup>36</sup> They each receive a per-beneficiary-per-month fee for their care coordination services, and in return are responsible for meeting quality, outcome, and patient satisfaction objectives while reducing total spending for their populations by at least 5 percent. If they fail to meet these requirements, they are responsible for reimbursing Medicare up to the total amount of their fees.

One unique aspect of this project is that, unlike the other initiatives described here—in which beneficiaries were recruited to participate by explicitly indicating a willingness to “opt in”—eligible beneficiaries in Medicare Health Support areas were assumed to be participating in the demonstration unless they explicitly indicated that they wanted to “opt out” of it. The evaluation of the success of each site in meeting goals related to clinical quality outcomes, beneficiary satisfaction, and impact on program spending will be based on comparisons of beneficiaries who participated in the pilot programs with similar groups of beneficiaries who had indicated they were willing to participate but were instead randomly assigned to a control group. Based on these results,

the Secretary of Health and Human Services has the authority to expand the breadth and scope of this program.

Another project developed by CMS is the **Care Management for High-Cost Beneficiaries Demonstration**. This project, which began enrollment in Fall 2005 and is operating in six sites, aims to study various care management models for high-cost/high-risk beneficiaries.<sup>37</sup> It is explicitly designed to use provider-directed, rather than third-party, models of chronic care management; and to test the ability of these sites to coordinate care for participating beneficiaries by providing them with clinical support beyond traditional settings to manage their conditions. As in Medicare Health Support, each of the sites in this demonstration receives a monthly fee for each beneficiary participating in the program and must achieve program savings while meeting established performance standards; otherwise, they must return all or part of their fee. The sites are employing a variety of features, including support programs for health care coordination, physician and nurse home visits, use of in-home monitoring devices, provider office medical records, self-care and caregiver support, education and outreach, tracking and reminders of individuals' preventive care needs, 24-hour nurse telephone lines, behavioral health care management, and transportation services.

#### *Improving Chronic Care in Medicare Managed Care*

As mentioned earlier, several aspects of the financing mechanism that became an integral part of the managed care model—particularly in Medicare—are incompatible with the original vision of coordinated care as it applies to chronically ill enrollees. Although capitation should provide a strong incentive to help chronically ill enrollees manage their conditions and avoid expensive hospital stays, it also provides an even stronger incentive for plans to avoid chronically ill enrollees in the first place: they are much more costly than the average enrollee, and—although Medicare adjusts the payment rates that managed care plans receive for the higher anticipated costliness of some types of individual enrollees—that risk adjustment—which has been gradually phased in over 10 years (finally taking full effect in 2007) still tends to adjust too little for the most expensive patients.<sup>38</sup> Consequently, plans still face potentially severe financial penalties for making themselves attractive to chronically ill populations. Medicare managed care plans, moreover, were prohibited (until 2006) from specializing in subsets of the population. Consequently, a plan that was designed to be particularly well suited to treating beneficiaries with a particular condition or cluster of conditions (such as congestive heart failure, asthma, or other chronic respiratory diseases) also had to be prepared to offer the full range of services to the entire beneficiary population, which it might not have been prepared to do.

One initiative intended to address this shortcoming is the inclusion in the MMA of a provision (Section 231) authorizing **Special Needs Plans** (SNPs). This provision allows for the creation of MA plans that focus on individuals with special needs, including beneficiaries who are: institutionalized, dually eligible for Medicare and Medicaid, or suffering from severe or disabling chronic conditions. SNPs are not paid differently from other MA plans (so their payment will not be fully risk-adjusted until 2007), but—unlike other MA plans—they are permitted to target individuals in the specified groups, and CMS has been flexible in certain other MA administrative requirements as well. In 2007, there are 470 SNPs, with more than 800,000 enrollees: 311 SNPs, with more than 600,000 enrollees, were approved for dual eligibles (a population that itself includes a high proportion of beneficiaries with chronic conditions); 85 SNPs, with more than 135,000 enrollees, were focused on institutionalized beneficiaries (many of whom are both dually eligible and suffering from chronic conditions); and 74 SNPs, with more than 80,000 enrollees, were focused specifically on beneficiaries with chronic conditions.<sup>39</sup>

A population that is particularly in need of better coordinated care is Medicare beneficiaries with End-Stage Renal Disease (ESRD); people with ESRD not only require dialysis but also have other chronic conditions. In 2003, there were 351,000 Medicare beneficiaries with ESRD, with Medicare spending an average of \$46,330 per person for their health care.<sup>40</sup> Despite their need for coordinated care, beneficiaries with ESRD are not permitted to enroll in MA plans unless they were enrolled prior to the onset of the condition, because of the extreme risk that this population presents. In an attempt to develop an approach that would permit these beneficiaries to participate in Medicare Advantage (then called the Medicare Risk Program), an **ESRD Managed Care Demonstration** was launched in 1996, with enrollment beginning in 1998. This demonstration was conducted at sites in California and Florida (with a third site in Tennessee discontinuing operations after enrolling just 50 beneficiaries).<sup>41</sup> Each site provided service integration, case management, and extra benefits in exchange for being paid a higher payment rate (with adjustments to reflect the additional costliness of enrollees with ESRD).

The evaluation concluded that enrollees in the demonstration fared as well as, or in some cases better than, a representative sample of fee-for-service comparison beneficiaries. However, government expenditures were found to be higher than if the same enrollees had remained in fee-for-service Medicare; this was because the demonstration enrollees were, on average, younger and healthier than the general ESRD

population. Moreover, despite the increased payment by the government, the demonstration sites experienced financial losses in one case and only small gains in the other.

With an extensively reworked risk adjustment mechanism that was thought to reflect better the costliness of ESRD enrollees, CMS in 2005 announced an **ESRD Disease Management Demonstration** to test the capability of disease management models to increase quality of care while ensuring that this care is provided more effectively and efficiently.<sup>42</sup> Enrollment in this new demonstration began at three sites in the fall of 2005, with coverage beginning in January 2006.<sup>43</sup> Under this demonstration, 5 percent of the plans' fees are reserved for incentive payments related to quality improvement.

### **What Can These Initiatives Tell Us?**

As we have discussed, the application of disease management approaches to the Medicare program—both in traditional fee-for-service Medicare and in Medicare Advantage—is a very promising proposition, given the increasing prevalence of chronic conditions among beneficiaries and the large proportion of spending accounted for by those beneficiaries. Although many of the initiatives described above are ongoing, there are several conclusions that one can infer from the currently available evidence:

- Engaging Medicare beneficiaries in these kinds of initiatives can be challenging; the more successful initiatives work more closely with physicians to help identify patients who can be helped most and to establish credibility with those patients.
- Designing approaches to reach different populations in different circumstances and environments, and successfully implementing those approaches, can be complicated.
- Improvements in health care for groups of individuals seems to be achievable, but the jury is still out on whether savings can be reliably achieved.

Still, given the current lack of coordination throughout our health system, it is hard to believe that a way can't be found to improve on both quality and efficiency. And given both the amount of care needed by Medicare beneficiaries with multiple chronic conditions and the amount of resources spent on that care, it is imperative that we continue to try to find ways to provide better coordination and higher quality care for this population.

## **Conclusions**

Medicare has undertaken an array of initiatives to address chronic care issues. However, it is still much in need of good ideas for policies that address the evolving needs of its beneficiaries and the health system overall, and should continue to pursue other initiatives in the future.

In this testimony, we review some of those activities and describe their objectives and outcomes. Two things are clear: the potential for improving both the coordination of care for Medicare beneficiaries and the efficiency with which that care is provided are tremendous; and there is much that needs to be done to accomplish that improvement. Figuring out exactly what will work in that regard is a much more difficult proposition.

We need a more explicit and transparent mechanism for both identifying the directions of new initiatives at one end and moving from pilot to policy at the other. Such transparency would make the process more effective and timely, as well as increasing the level of accountability—among CMS staff and leadership, as well as the Congress—for developing initiatives that have real potential to improve Medicare’s policies. The results we seek are greater quality and effectiveness of health care for Medicare’s beneficiaries while controlling the precipitous increases in cost that threaten the program’s fiscal viability.

## Figures

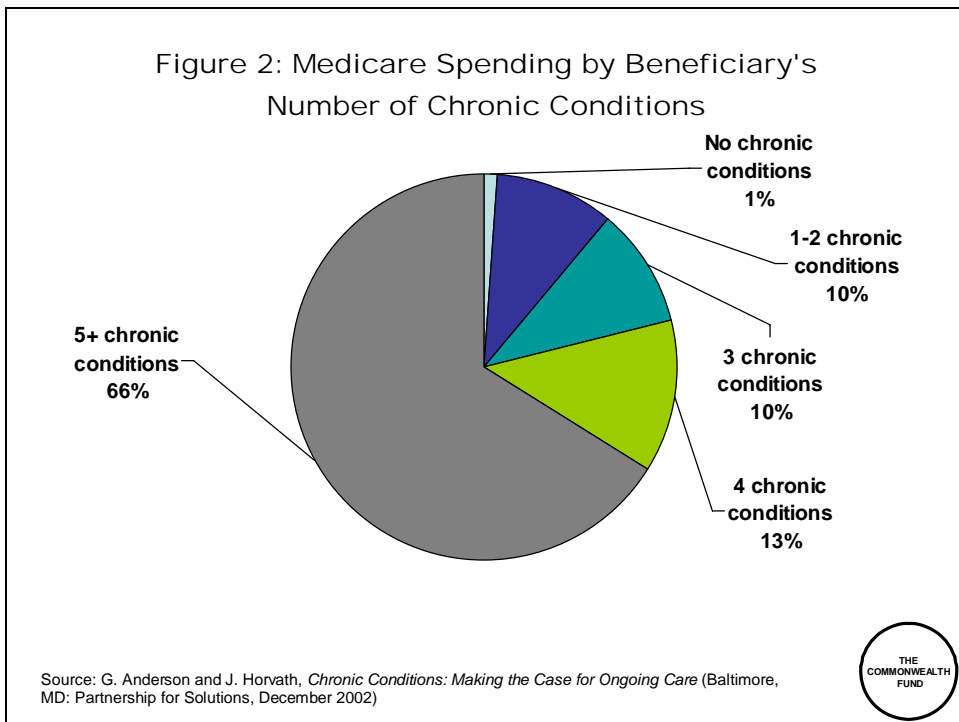
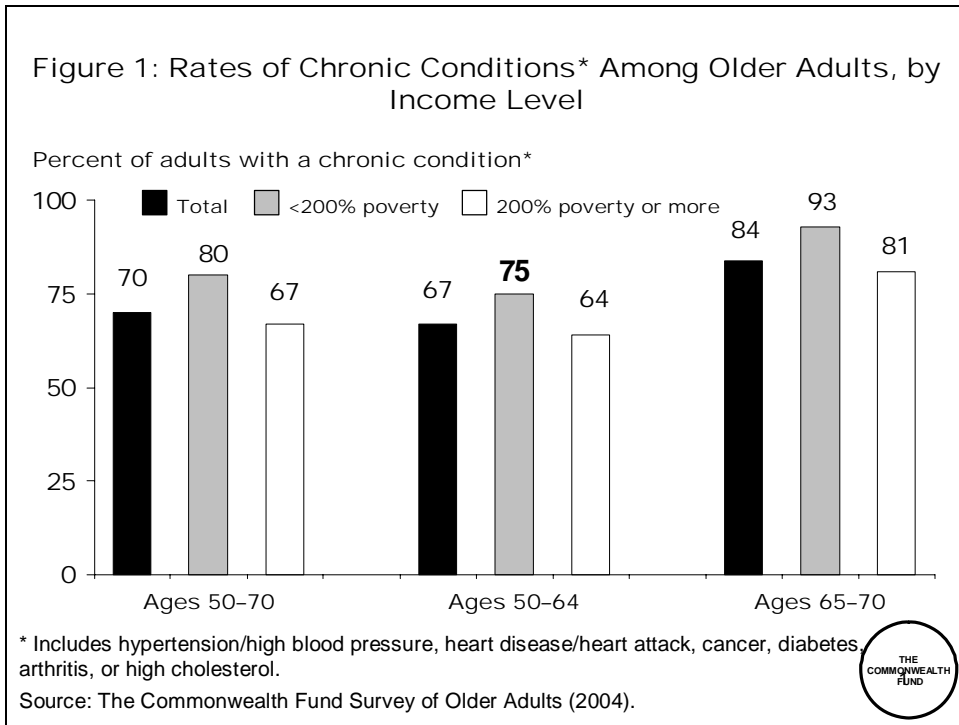
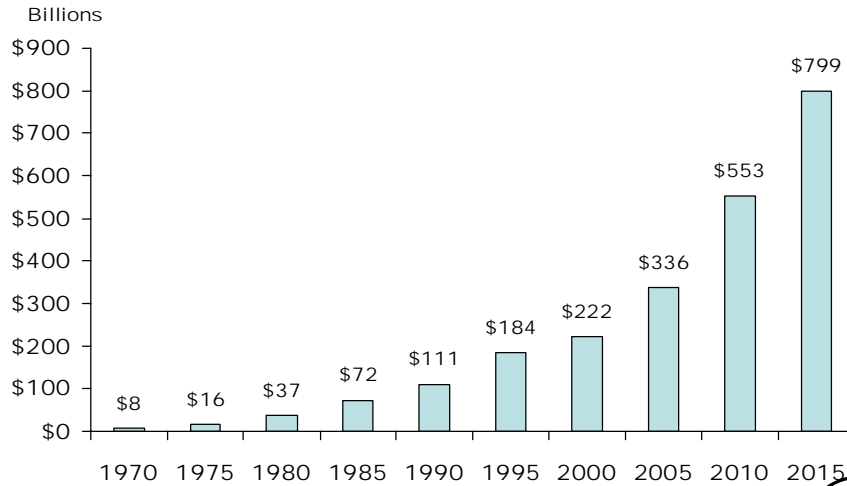


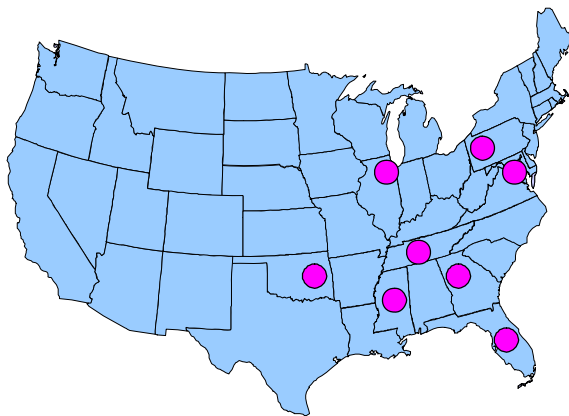
Figure 3: Medicare Expenditures, 1970-2015



Note: Figures for 2010 and 2015 are projected.  
 Source: 2007 Medicare Trustees' Report.



Figure 4: Medicare Health Support Organizations and Locations



- LifeMasters Supported SelfCare, Inc (OK)
- Health Dialogue Services Corp., (Western PA)
- American Healthways, Inc. (Washington, DC and MD)
- McKesson Health Solutions, LLC (MS)
- CIGNA Health Support, LLC (Northwest GA)
- Aetna Health Management, LLC (Chicago, IL)
- Green Ribbon Health (Central FL)
- XLHealth Corp. (Select counties, TN)

Source: "Medicare Health Support." [www.cms.hhs.gov](http://www.cms.hhs.gov) (Accessed November 20, 2006).



## Notes

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<sup>1</sup> K. Davis and S. R. Collins. “Medicare at Forty,” *Health Care Financing Review*. 27(2). (Winter 2005-2006): 53-62.

<sup>2</sup> The Commonwealth Fund Commission on a High Performance Health System, “Why Not the Best? Results from a National Scorecard on U.S. Health System Performance” (The Commonwealth Fund, September 2006).

<sup>3</sup> Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2006 Annual Report* (Washington, DC: U.S. Government Printing Office, May 1, 2006).

<sup>4</sup> G. F. Anderson, “Medicare and Chronic Conditions,” *New England Journal of Medicine*, July 21, 2005 353(3):305-09.

<sup>5</sup> G. F. Anderson and P. S. Hussey, “Population Aging: A Comparison Among Industrialized Countries,” *Health Affairs*, May/June 2000 19(3): 191-203.

<sup>6</sup> S. R. Collins, K. Davis, C. Schoen, M. M. Doty, S. K. H. How, and A. L. Holmgren, “Will You Still Need Me? The Health and Financial Security of Older Americans,” (New York: The Commonwealth Fund, June 2005).

<sup>7</sup> Partnership for Solutions, “Medicare: Cost and Prevalence of Chronic Conditions,” Fact Sheet (Baltimore: Johns Hopkins University and the Robert Wood Johnson Foundation, July 2002).

<sup>8</sup> J. L. Wolff, B. Starfield, and G. F. Anderson, “Prevalence, Expenditure, and Complications of Multiple Chronic Conditions and the Elderly,” *Archives of Internal Medicine*, November 11, 2002 162(20):2269-76.

<sup>9</sup> U.S. Congressional Budget Office, “High-Cost Medicare Beneficiaries,” (Washington, DC: CBO, May 2005).

<sup>10</sup> U.S. Congressional Budget Office, “Fact Sheet for CBO’s March 2007 Baseline: Medicare” (Washington, DC: CBO, March 7, 2007).

<sup>11</sup> S. Guterman, “U.S. and German Case Studies in Chronic Care Management: An Overview,” *Health Care Financing Review*, Fall 2005 27(1): 1-8.

<sup>12</sup> B. Biles, L. Hersch Nicholas, B.S. Cooper, E. Adrion, and S. Guterman, “The Cost of Privatization: Extra Payments to Medicare Advantage Plans—Updated and Revised” (New York: The Commonwealth Fund, November 2006).

<sup>13</sup> B. Biles, L. H. Nicholas, and S. Guterman, “Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?” (New York: The Commonwealth Fund, May 2006).

<sup>14</sup> Centers for Medicare and Medicaid Services, *2007 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, DC: CMS, 2007), p. 30, <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2007.pdf>, accessed April 2007.

<sup>15</sup> *Ibid.*, p. 33.

<sup>16</sup> As specified in the Medicare Modernization Act of 2003, the “Medicare funding warning” is generated when the Medicare Trustees’ Reports in two consecutive years indicate that the proportion of Medicare spending from general revenues will exceed 45 percent within seven years.

<sup>17</sup> Commonwealth Fund Commission, *Why Not the Best?* 2006.



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<sup>18</sup> G. F. Anderson, B. K. Frogner, R. A. Johns, and U. E. Reinhardt, "Health Care Spending and Use of Information Technology in OECD Countries," *Health Affairs*, May/June 2006 25(3): 819-31.

<sup>19</sup> Commonwealth Fund Commission, *Why Not the Best?* 2006.

<sup>20</sup> C. Schoen, K. Davis, S. K. H. How, and S. C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive (September 20, 2006): w457-w475.

<sup>21</sup> Ibid.

<sup>22</sup> Commonwealth Fund Commission, *Why Not the Best?* 2006.

<sup>23</sup> Ibid.

<sup>24</sup> Medicare Payment Advisory Commission, "National Health Care and Medicare Spending," In *A Data Book: Health Care Spending and the Medicare Program* (Washington, DC: MedPAC, June 2006). <http://www.medpac.gov>

<sup>25</sup> The descriptions of the projects in this section are based on information at the Centers for Medicare and Medicaid Services Web site, <http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp#>, accessed April 24, 2007.

<sup>26</sup> S. Guterman, "Eliminating Barriers to Chronic Care Management in Medicare," testimony before the U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Health, February 25, 2006.

<sup>27</sup> By "disease management" we mean programs that are aimed at improving the quality and coordination of care for patients with single or multiple chronic conditions, in an effort to provide more effective care, eliminate avoidable acute care episodes, and improve outcomes.

<sup>28</sup> Congressional Budget Office, "An Analysis of the Literature on Disease Management Programs." Report to Don Nickles, Chairman, Senate Budget Committee, October 13, 2004.

<sup>29</sup> S. Guterman, "Disease Management in Traditional Medicare: A Square Peg in a Round Hole?" testimony before a Special Forum of the U.S. Senate, Special Committee on Aging, November 4, 2003.

<sup>30</sup> Participating sites included AdminiStar Solutions, Iowa Foundation for Medical Care (IFMC), and Providence Hospital. AdminiStar Solutions recruited Medicare CHF patients throughout the state of Indiana; IFMC recruited Medicare CHF and COPD patients seen at any of 10 participating hospitals in Des Moines, western Iowa, and eastern Nebraska; and Providence Hospital (in Southfield, Mich.) took Medicare beneficiaries with CHF, COPD, or a range of other chronic problems who were patients of the hospital's staff and resided in the Detroit metropolitan area.

<sup>31</sup> J. L. Schore, R. S. Brown, and V.A. Cheh, "Case Management for High-Cost Beneficiaries," *Health Care Financing Review*, Summer 1999 20(4) 87-101.

<sup>32</sup> The organizations originally participating in this demonstration were: Avera McKennan Hospital of Sioux Falls, S.D.; Carle Foundation Hospital of Urbana, Ill.; CenVaNet of Richmond, Va.; CorSolutions Medical, Inc. of Buffalo Grove, Ill. (site in Texas); Erickson Retirement Communities of Baltimore, Md.; Georgetown University Medical Center of Washington, D.C.; Hospice of the Valley of Phoenix, Ariz.; Jewish Home and Hospital of New York, NY; Mercy Medical Center of Mason City, Iowa; Medical Care Developments of Augusta, Maine; PennCARE of Allentown, Pa.; Quality Oncology, Inc., of McLean, Va. (site in Broward County, Fla.); QMED, Inc., of Laurence Harbor, N.J. (site in Northern Calif.); University of Maryland at Baltimore; and Washington University of St. Louis, Mo., with StatusOne Health of Hopkinton, Mass. (site in St. Louis, Mo.).

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<sup>33</sup> R. Brown, D. Peikes, A. Chen, J. Ng, J. Schore, and C. Soh. *The Evaluation of the Medicare Coordinated Care Demonstration: Findings for the First Two Years*. (Princeton, NJ: Mathematica Policy Research, March 21, 2007).

<sup>34</sup> The three participating sites were CorSolutions of Rosemont, Ill. (site in the Shreveport-New Orleans corridor of LA.); XLHealth of Baltimore, Md. (site in Texas); and HeartPartners of Santa Ana, Calif. (site in Calif. And Ariz).

<sup>35</sup> As of December 2006, the number of beneficiaries participating in the demonstration was about 120,000, but one site—LifeMasters Supported SelfCare, Inc. operating in Oklahoma—was scheduled to drop out at the end of the month.

<sup>36</sup> The organizations participating in Phase I of Medicare Health Support are LifeMasters Supported SelfCare, Inc. (site in Okla.); Health Dialog Services Corp. (site in Western Pa.); American Healthways, Inc. (site in Washington, D.C., and Md.); McKesson Health Solutions, LLC (site in Miss.); CIGNA Health Support (site in Northwest Ga.); Aetna Health Management, LLC (site in Chicago, Ill.); Green Ribbon Health (site in Central Fla.); and XLHealth Corp. (site in Tenn.).

<sup>37</sup> The organizations participating in this demonstration are ACCENT (site in Ore. and Wash.); Care Level Management (sites in Calif., Texas, and Fla.); Massachusetts General Hospital and Massachusetts General Physicians Organization (site in Boston, Mass.); Montefiore Medical Center (site in the Bronx, N.Y.); RMS Disease Management, LLC (site in Nassau and Suffolk Counties in N.Y.), and Texas Senior Trails (site in Texas panhandle area).

<sup>38</sup> G.C. Pope, J. Kautter, R.P. Ellis, A.S. Ash, J.Z. Ayanian, L.I. Iezzoni, M.J. Ingber, J.M. Levy, and J. Robst, “Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model,” *Health Care Financing Review* Summer 2004 25(4):119-141.

<sup>39</sup> T. DeCaro, “Special Needs Plans: Strategies for Serving Special Populations,; presentation to America’s Health Insurance Plans, April 23, 2007.

<sup>40</sup> *Health Care Financing Review Medicare and Medicaid Statistical Supplement, 2005* (July 2006), p. 56.

<sup>41</sup> Lewin Group and University Renal Research and Education Association, *Final Report on the Evaluation of CMS’s ESRD Managed Care Demonstration* (Falls Church, Va.: Lewin Group, June 2002).

<sup>42</sup> Centers for Medicare and Medicaid Services, “CMS Announces Demonstration Sites for Beneficiaries with End-Stage Renal Disease,” press release (Washington, DC: CMS, Oct. 31, 2005).

<sup>43</sup> The organizations participating in this demonstration are DaVita, with SCAN Health Plan (which is offering an MA SNP in parts of San Bernardino and Riverside Counties, Calif.); Fresenius Medical Care North America, with Sterling Life Insurance Co. (which is offering an MA private fee-for-service plan in Philadelphia and Pittsburgh, Pa., and Dallas, Houston, and San Antonio, Texas); and Fresenius Medical Care North America, with American Progressive Life and Health Insurance Co. (which is offering an MA private fee-for-service plan in Boston and Springfield, Mass.).