



## **Disease Management Association of America**

### **Position Statement Advancing the Integration of Accredited Disease Management Programs in Federal Health Care Programs**

#### **I. EXECUTIVE SUMMARY**

Comprehensive Disease Management (“DM”) programs have demonstrated their effectiveness in improving health status, health care quality, patient and provider satisfaction, and financial outcomes for populations with congestive heart failure, diabetes, coronary artery disease, chronic obstructive pulmonary disease, end-stage renal disease, asthma, obesity, and other chronic illnesses. A majority of large private payors have already launched major DM programs and have signaled their commitment to DM as the core element of their new medical management strategy, and accreditation for DM programs is now available. Physicians who have had access to DM programs -- both through the health plans they contract with and independently of such plans -- have also reported significant benefits from these programs. Through DM programs, physicians are able to monitor their patients more comprehensively and continuously and to improve the efficiency of their practices by being more proactive in their patients’ care.

Commercial, Medicare+Choice, and Medicaid managed care plans have paved the way as laboratories for disease and population management programs. As a result, while reducing their own costs for chronic diseases, these payors have provided significant benefits to their members and customers that continue to be unavailable to beneficiaries enrolled in the traditional FFS Medicare program (“FFS Beneficiaries”).<sup>1</sup> CMS is, however, exploring the application of DM to FFS Medicare through a number of demonstration projects, while the Congressional Budget Office (CBO) and the Agency for Healthcare Research and Quality (AHRQ) are conducting programmatic studies on DM. Unfortunately, even a significant percentage of the Medicare+Choice population may not be able to continue enjoying the benefits of DM as the withdrawal of a significant number of health plans from the Medicare+Choice program has left more than one million people without managed care coverage and, therefore, without access to the DM services on which they rely.

The Disease Management Association of America<sup>2</sup> (“DMAA”) fully supports and commends the Congress and the Centers for Medicare and Medicaid Services (“CMS”) for

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<sup>1</sup> The term “traditional fee-for-service” Medicare is used to refer to Medicare Parts A and B and to distinguish it from Medicare+Choice. “Fee-for-service” includes compensation to Part A providers and Part B suppliers on a prospective payment system, DRG, and RBRVS basis as well.

<sup>2</sup> DMAA is the only association in the United States dedicated exclusively to the DM industry. DMAA draws members from throughout the United States and has representatives from all segments of the DM industry, including health plans, hospitals, employers, pharmaceutical companies, physicians, and stand-alone DM organizations.

promoting the expansion of DM programs in its efforts to modernize Medicare, revitalize Medicare+Choice, support State Medicaid programs and place renewed emphasis on preventive health and chronic illness. DMAA is working to provide the necessary assistance, information and resources to further these efforts.

In this Position Paper, DMAA calls upon Members of Congress and the Administration to take a number of further steps to promote the integration of DM in Federal government health care programs, including the following:

- Fee-For-Service Medicare. Coverage of accredited DM programs under FFS Medicare will promote the use of these services by beneficiaries and reduce program costs. While the federal government has designed and implemented small-scale demonstrations and grant initiatives to improve access to DM programs, the private sector has concluded large-scale, real world efforts that have repeatedly demonstrated proof of concept and significant clinical and financial returns of such programs. The evidence of efficacy and cost-efficiency are now valid, reliable, and replicable enough to warrant offering accredited DM programs to FFS Beneficiaries nationwide, on a par with the benefits that have long been available to managed care enrollees. Congress should move forward to implement such coverage in the FFS program, using successful private sector models as a reference. Medicare should contract directly with DM organizations to provide this service ideally on a population basis. DM programs should be prospectively compensated on an equitable and competitive basis that recognizes investment and includes incentives to maximize *both* clinical and financial outcomes. Toward this goal, CMS should identify the changes in administrative infrastructure that would be needed to make DM a more central component of FFS Medicare and work to implement those changes.
- Medicare + Choice. DMAA supports steps that encourage the integration of accredited DM services into Medicare. Presently, the Medicare+Choice program provides the best opportunity for beneficiaries to obtain DM services and, for this reason, DMAA supports efforts to improve payments to Medicare+Choice organizations to stem the withdrawal of Medicare + Choice organizations from the program. DMAA also believes that current initiatives to provide risk adjustment payments that reflect the cost of providing outpatient DM services to CHF patients should be continued and expanded to all chronic conditions and, at a minimum, to CAD, COPD and Diabetes.
- Prescription Drug Legislation. DM programs are ordinarily provided and most effective in populations where prescription drug coverage is available as part of a comprehensive approach to the management of the patient's condition. Chronically ill individuals are often prescribed multiple medications to control their condition. Promoting access to prescription drugs and adherence to drug regimens is one of the central methods that fully accredited DM organizations use to prevent complications that inhibit quality of life and raise the cost of care. DM organizations have the expertise and sustained levels of patient contact to provide the necessary beneficiary education and assistance that advances drug-

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DMAA seeks to advance the use of DM programs as a means to build a better system of care that will predictably improve quality and reduce costs in private and public sector health care programs. DMAA also works to promote research, accreditation, education, the science of DM, and to increase effectiveness of DM programs.

specific quality of care objectives (e.g., beneficiary compliance, appropriate drug utilization, avoidance of interaction problems) as a component of a comprehensive approach to the management of chronic illness. And DM organizations are well-positioned to guard against the service fragmentation that could result from adding a prescription drug benefit to Medicare. As the 108<sup>th</sup> Congress considers legislation to add a prescription drug benefit to Medicare, the DMAA believes that such legislation must have strong provisions to integrate accredited DM programs into any new drug benefit.

- Medicaid. A growing number of States are now embracing DM initiatives to control costs and improve quality in their Medicaid programs. Congress has facilitated this effort through recent changes in federal law, but additional steps should be taken to make it easier for States to incorporate DM into Medicaid. In particular, Congress should address the challenge of providing DM services to the Medicare/Medicaid dual eligible population.

## **II. DISEASE MANAGEMENT – DEFINITION AND ACCREDITATION.**

### **A. Definition of Disease Management**

DM is an approach to patient care that seeks to limit “preventable” adverse medical events by maximizing patient adherence to prescribed treatments and to health-promoting behaviors. For patients with chronic diseases, the anticipated benefits of DM include superior clinical outcomes; improved functional capacity and quality of life; lower health care costs; reduced need for hospitalization, surgery or other invasive care; and greater access to care. DM differs in part from traditional case management in that DM focuses on providing preventive care and education for people with chronic illnesses, and utilizes population-based evidence to aid in "plan of care" decisions made by providers and patients, whereas case management focuses on making individual treatment decisions.

DMAA has established an industry-standard definition of qualified DM programs and entities. The DMAA definition -- established in consultation with primary care and specialty physicians, and incorporating private practice, health plan and institutional perspectives -- has become the standard definition and is relied upon widely. The definition is cited by CMS in its February 22, 2002 solicitation for proposals to conduct the DM demonstration projects authorized in the Benefits Improvement and Protection Act of 2000 (BIPA), by DM accreditors, and by payors and providers:

Disease management is a multidisciplinary, systematic approach to health care delivery that: (1) includes all members of a chronic disease population; (2) supports the physician-patient relationship and plan of care; (3) optimizes patient care through prevention, proactive, protocols/ interventions based on professional consensus, demonstrated clinical best practices, or evidence-based interventions; and patient self-management; and (4) continuously evaluates health status and measures outcomes with the goal of improving overall health, thereby enhancing quality of life and lowering the cost of care. Qualified Disease Management programs should contain the following components:

- Population Identification processes;

- Evidence-based practice guidelines;
- Collaborative practice models that include physician and support-service providers;
- Risk identification and matching of interventions with need;
- Patient self-management education (which may include primary prevention, behavior modification programs, support groups, and compliance/surveillance);
- Process and outcomes measurement, evaluation, and management;
- Routine reporting/ feedback loops (which may include communication with patient, physician, health plan and ancillary providers, in addition to practice profiling); and
- Appropriate use of information technology (which may include specialized software, data registries, automated decision support tools, and call-back systems).

## **B. DM Accreditation**

DM organizations may voluntarily apply for accreditation by the National Committee for Quality Assurance (NCQA), which has a specific DM accreditation program. NCQA is an independent organization that evaluates health care in three different ways: through accreditation (a rigorous on-site review of key clinical and administrative processes); through the Health Plan Employer Data and Information Set (HEDIS® -- a tool used to measure performance in key areas like immunization and mammography screening rates); and through a comprehensive member satisfaction survey. NCQA has a specific accreditation and certification for DM organizations.<sup>3</sup> Depending on the structure of the entity, a DM organization may also pursue accreditation from the American Accreditation Healthcare Commission (URAC) or the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). Such accreditation serves to maintain the high quality of DM services and to standardize many of the new processes and terms that have evolved with the development of DM.

## **III. EVIDENCE OF CLINICAL AND FINANCIAL SUCCESS**

### **A. Outcomes Improvements and Cost-Containment Associated with Disease Management Programs**

People with chronic illnesses such as diabetes and congestive heart failure ("CHF") account for more than 60 percent of the medical care dollars spent in the United States.<sup>4</sup> It is expected that CHF alone will account for \$22.2 billion in direct health care costs in 2003.<sup>5</sup> DM

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<sup>3</sup> Criteria for accreditation and certification can be found at:

<http://www.ncqa.org/Programs/Accreditation/DM/dmmain.htm>

<sup>4</sup> *Broad Disease Management Interventions Reducing Health Care Costs for Plan Members with Congestive Heart Failure*. Joel C. Hoffman, Ernst & Young, LLP. Citing United States Department of Health and Human Services, Centers for Disease Control and Prevention. New Brunswick (NJ): The Robert Wood Johnson Foundation.

<sup>5</sup> American Heart Association. *Heart Disease and Stroke Statistics — 2003 Update*. Dallas, Tex.: American Heart Association; 2002.

programs produce significant clinical improvements at the same time that they achieve financial savings by reducing the cost for care of patients with chronic illnesses. Consider, by way of example, the following study results:

- A peer-reviewed study of the American Healthways, Inc. (“AMHC”) Healthways’ Diabetes NetCare<sup>SM</sup> program shows a “17.1 percent or \$114 per diabetes member per month reduction in total direct health care costs for the first year of operation.”<sup>6</sup> Patients also demonstrated improved adherence to recognized standards of care. For example, 74 percent of patients took their A1c test, a signal measure of a diabetic’s health status, versus 61 percent in the base year; 16 percent took cholesterol exams versus 4 percent in the base year; and 12.2 percent took foot exams versus 2.5 percent in the base year.<sup>7</sup> AMHC patients experienced reduced admissions per 1000 by an average of 15.6 percent, reduced days per 1000 by 21.7 percent, and reduced average length of stay by 7.2 percent.<sup>8</sup> Indeed, “[h]ospital costs decreased by \$47 per diabetic plan member per month, or \$564 per year.”<sup>9</sup>
- LifeMasters Supported Self-Care, Inc. (“LifeMasters”) has demonstrated that a multidisciplinary DM program including patient education, interactive vital sign-monitoring, nurse support and physician intervention can significantly reduce utilization and improve quality of care. One study published in a peer reviewed cardiology journal followed the progress of a population of CHF patients enrolled in the LifeMasters program through a San Francisco-based managed care organization.<sup>10</sup> Evidence compared against baseline data showed significant improvements 12 months post enrollment. Clinical impact included 48 percent reduction in inpatient (acute) days, 36 percent reduction of inpatient admissions, 31 percent decrease in emergency department visits, and a 20 percent decline of average length of stay. Per member per month financial savings of the same study group over the same enrollment period averaged a total reduction in disease-specific claims of 54 percent, while an average reduction in all claims associated with the group improved by 42 percent on average. In addition, SF-36 patient satisfaction survey results showed a 16 percent improvement in functional status and quality of life.<sup>11</sup>
- CorSolutions, Inc. demonstrated impressive results for its business partner, Highmark, through implementation of a DM program for Highmark’s chronic population. For the health plan’s target patient group, hospital admissions declined 65 percent, hospital days declined 52 percent, the number of patients receiving appropriate drug therapy rose 43 percent, and optimal drug regimen adherence climbed to 58 percent.<sup>12</sup> Finally, CorSolutions has been able to reduce total costs for nearly 13,000 patients in the Medicare+Choice program by about 50 percent compared to a baseline of \$22,236, or an

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<sup>6</sup> Robert J. Rubin et al., *Clinical and Economic Impact of Implementing a Comprehensive Diabetes Management Program in Managed Care*, 83 J. Clin. Endocrinol. and Metab. 2635, 2640 (1998) (Attachment B).

<sup>7</sup> [http://www.americanhealthways.com/res\\_art01.pdf](http://www.americanhealthways.com/res_art01.pdf) (visited January 18, 2003).

<sup>8</sup> [http://www.americanhealthways.com/res\\_art01.pdf](http://www.americanhealthways.com/res_art01.pdf) (visited January 18, 2003).

<sup>9</sup> Rubin, at 2641.

<sup>10</sup> Am Heart J 1999;138: 633-40.

<sup>11</sup> *Id.*

<sup>12</sup> Jean Lawrence, *High Marks for Chronic Care*, HealthCare Business, DM6, 14 (June 2000).

actual savings of \$11,000 per patient per year. These results are based on fully-reconciled administrative data available for this subset of total patients managed.<sup>13</sup>

- A coronary artery disease (CAD) study conducted over twenty one months found that a physician decision supported disease management model by QMed, Inc. reduced the incidence of heart attacks by 30 percent, hospitalizations for angina or suspected infarction by 32 percent, cardiac catheterizations by 20 percent and coronary angioplasties by 22 percent, while coronary artery bypass grafting was unchanged. Costs for CAD, the most costly among Medicare members, declined 17 percent. The model used in this study has been selected in both the Care Coordination demonstration and the CHF and CAD demonstration.<sup>14</sup>
- Participants in Humana’s CHF DM program run by CorSolutions “eat less salt, can walk farther, are more mobile, and generally have a higher quality of life and a lower mortality rate” than those enrollees not utilizing CorSolutions’ DM programs. Humana saved “an estimated \$22 million in costs through disease management last year.”<sup>15</sup>
- In a study reported in the American Journal of Kidney Disease, 1,541 Medicare patients were enrolled in a renal DM program in 1998-1999. These patients demonstrated survival rates that were 19-35 percent better than those of ESRD patients in traditional fee-for-service Medicare, and hospitalization rates were 45-54 percent lower than for the fee-for-service group.<sup>16</sup>
- A study conducted over a two year period with a Medicaid Primary Care Case Management population compared approximately 4,500 participants in an asthma DM program specifically designed for low-income patients with a control group of 8,700 beneficiaries. Using as key measures claims for emergency room visits and claims for asthma-related drugs, a cost-effectiveness analysis projected a savings to Medicaid of \$3-\$4 for each dollar spent on DM.<sup>17</sup>

AMHC, LifeMasters, QMed, and CorSolutions are not unique in achieving results such as those described above. As the industry matures, other companies are also demonstrating the economic and qualitative value of DM services in the commercial, Medicare+Choice, and Medicaid arenas. DMAA member company calculations indicate that the difference between

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<sup>13</sup> MEDICARE + CHOICE DISENROLLMENT: CONSEQUENCES AND OPPORTUNITIES, presented to CMS by CorSolutions, Inc., Aug. 9, 2000.

<sup>14</sup> Levin et al, *Risk Stratification and Prevention in Chronic Coronary Artery Disease: Use of a Novel Prognostic and Computer-based Clinical Decision Support System in a Large Primary Managed-Care Group Practice*, DM Journal 5:197-213 (Winter 2002). The referenced demonstrations are discussed below in part III.C.3 of this paper..

<sup>15</sup> Chris Rauber, *Disease Management Can be Good For What Ails Patients and Insurers*, 29 Modern Healthcare 48, 51 (1999).

<sup>16</sup> American Journal of Kidney Disease, *Evaluation of Disease-state Management of Dialysis Patients*. Vol. 37, No. 5 (May 2001).

<sup>17</sup> Louis F. Rossiter, et al, *The Impact of Disease Management on Outcomes and Cost of Care: A Study of Low-Income Asthma Patients*. Inquiry 37: 188-202 (Summer 2002).

baseline costs in the FFS program and the company's claims-reconciled costs is over \$14,000.<sup>18</sup> Extrapolating savings across the Medicare program using a conservative figure of \$11,000 for both the Medicare+Choice and FFS programs, CHF DM alone could produce total Medicare savings of over \$8.3 billion annually. The FFS program would account for \$7 billion, or nearly 85 percent of the total savings opportunity, suggesting the critical need for testing the expansion of DM to this segment of Medicare.

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

## **B. Improvements in Access to Care**

### **1. Disease Management as a Safety Net**

Disease managers provide a safety net for seriously and chronically ill patients in between their physician visits and are frequently credited with helping chronic patients avoid preventable hospitalization, surgery, and other more invasive care. Without a DM program, it is unlikely that physicians can monitor patients effectively between (and even during) visits, due to constraints on their time and office staff.<sup>19</sup> Although disease managers are typically nurses, dietitians, social workers, and others who do not take the place of primary care physician, they bridge the care management gap that often exists for patients between physician office visits. DM programs typically provide access to health care professionals on a 24 hour per day/ 7 day per week basis. Disease managers also improve physicians' effectiveness by providing patient data and best practices protocols. Research has shown that primary care physicians have a positive view of, and have had positive experiences interacting with, DM programs.<sup>20</sup>

### **2. Accessibility for Rural Patients and Physicians**

Since most DM services can be fully implemented telephonically or via the Internet, rural patients in DM programs enjoy significantly improved access to care. In addition, to the extent that the DM programs succeed as expected, rural patients should not need as many visits to hospitals or specialty facilities, which may be distant from their homes. Finally, on-line and telephonic DM programs frequently offer patient self-management and informational tools without cost, which improves access to services by the uninsured and poor.

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<sup>18</sup> MEDICARE + CHOICE DISENROLLMENT: CONSEQUENCES AND OPPORTUNITIES, presented to CMS by CorSolutions, Inc., Aug. 9, 2000.

<sup>19</sup> Michelle Rogers, *A Winning Combination: CIGNA and American Healthways*, HealthCare Business DM2, 12 (June 2000).

<sup>20</sup> Alicia Fernandez, et al, *Primary Care Physicians' Experience with Disease Management Programs*, J. of Gen. Internal Med., pp. 163-167 (March, 2001).

### C. The Institute of Medicine's (IOM's) Findings that Disease Management is Vital to Improving Quality of Care

DM programs address issues raised by the Institute of Medicine ("IOM") regarding medical errors and quality of care. The IOM reports on medical errors<sup>21</sup> and the deteriorating quality of healthcare in America<sup>22</sup> argue that DM is not only integral to preventing medical errors, but also to protecting and improving overall health care quality, especially for the chronically ill. In the reports, the IOM Committee on Quality of Health Care in America cites extensive evidence that "the nation's health care industry has foundered in its ability to provide safe, high-quality care consistently to all Americans. Reorganization and reform are urgently needed to fix what is now a disjointed and inefficient system."

The IOM quality of care report properly stresses the issues posed by chronic conditions, and concludes that:

clinicians, health care organizations, and purchasers -- companies or groups that compensate health care providers for delivering services to patients -- should focus on improving care for common, chronic conditions such as heart disease, diabetes, and asthma that are now the leading causes of illness in the United States and consume a substantial portion of health care resources. These ailments typically require care involving a variety of clinicians and health care settings, over extended periods of time.

To address these issues, the IOM suggests that "private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care processes in accordance with the following rules:

- **Care based on continuous healing relationships.** Patients should receive care whenever they need it and in many forms, not just face-to-face visits.
- **Customization based on patient needs and values.** The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.
- **The patient as the source of control.** Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them.
- **Shared knowledge and the free flow of information.** Patients should have unfettered access to their own medical information and to clinical knowledge.

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<sup>21</sup> *To Err is Human: Building a Safer Health System*, Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Eds., Committee on Quality of Health Care in America, Institute of Medicine, National Academy Press, Washington, D.C. (1999). <<http://books.nap.edu/books/0309068371/html/R1.html#pagetop>>

<sup>22</sup> *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*, Committee on Quality of Health Care in America, Institute of Medicine, National Academy Press, Washington, D.C. (2001). <<http://www.nap.edu/books/0309072808/html/>>

- **Evidence-based decision-making.** Patients should receive care based on the best available scientific knowledge.
- **Safety as a system property.** Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.
- **The need for transparency.** The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or when choosing among alternative treatments.
- **Anticipation of needs.** The health system should anticipate patient needs, rather than simply reacting to events.
- **Continuous decrease in waste.** The health system should not waste resources or patient time.
- **Cooperation among clinicians.** Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care."

With regard to medical errors, the IOM emphasized that one of the chief culprits in medical errors is the lack of care management and coordination, resulting from the decentralized and fragmented nature of the health care delivery system, and the multitude of unaffiliated providers practicing in different settings without access to complete medical record information or coordination.

The IOM reports are, in all respects, a call to action for, and a validation of, the critical need to support and promote DM as a solution to many of the problems besetting the health care system, both public and private, managed care and fee-for-service. High-quality DM programs focus directly on the chronic conditions that the IOM reports consider most costly and ripe for new models of intervention, and improve clinical and financial outcomes in every one of the areas considered most problematic by the IOM.

#### **IV. DISEASE MANAGEMENT: PRESENT RELATIONSHIP TO MEDICARE AND MEDICAID**

##### **A. The Need for DM in Federal Health Care Programs**

When Medicare was created in 1965, beneficiaries were expected to enter the program at age 65, live a few more years, and pass on. Consequently, the Medicare program was originally rooted in the provision of acute care under a medical treatment model that largely ignored prevention, self-management, peer support, and management of complex, co-morbid conditions. However, advances in pharmaceutical and clinical management of chronic conditions have resulted in substantially longer life expectancies for Medicare beneficiaries. And, as numerous studies have shown, the vast majority of Medicare program costs are attributable to those suffering from numerous chronic conditions.

Specifically, the CBO recently reported that in 1997, 25% of the Medicare population consumed almost 90 percent of Medicare spending, while a Johns Hopkins study has shown that 90% of Medicare spending is attributable to beneficiaries with three or more chronic conditions.<sup>23</sup> State Medicaid programs similarly are burdened by the high costs associated with providing services to the proportion of beneficiaries suffering from numerous chronic conditions.

The obvious potential for disease management activities to favorably impact the high cost to government programs of providing care to chronically ill populations has attracted the interest of policy makers and, as a result, there has been some progress in promoting DM in Medicare and Medicaid. Medicare has recognized that an acute care system is no longer appropriate where the major killers and cost drivers of our era are chronic conditions. Moreover, it has reacted by exploring high-tech, innovative delivery systems, such as DM. Legislation on the topic has been introduced and advanced in both Houses of Congress, and a number of congressional hearings have been held to explore DM. The Bush Administration has also undertaken a renewed focus on the costs of chronic illness and the need to address this, in part, through the preventive use of prescription medication and behavior modification.

## **B. Private Sector Studies of Medicare Savings**

In addition to various government demonstrations and studies, literature from the private sector contains an expanding body of evidence regarding the savings DM can bring to Medicare. The following provides summaries of some current studies focusing on the cost effectiveness of DM programs:

- Measuring Outcomes of a Chronic Obstructive Pulmonary Disease Management Program. This study, focusing on members with asthma and COPD, showed a 24.7 percent cost-savings for the Medicare group of 1,700 beneficiaries.<sup>24</sup>
- Economic Impact of a Diabetes Disease Management Program in a Self-Insured Health Plan: Early Results. This study showed a 5 percent decrease in spending over three years for the study group and a 3 percent increase over the same time period for the control group.<sup>25</sup>
- Evaluation of Disease-State Management Dialysis Patients. 1,541 Medicare patients enrolled in a renal DM program in 1998 and 1999 had 19 to 35 percent better survival rates compared with ESRD patients in traditional FFS Medicare and hospitalizations

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<sup>23</sup> See, *Disease Management in Medicare: Data Analysis and Benefit Design Issues*, Statement of Dan Crippen, Director of Congressional Budget Office, before the United States Senate Special Committee on Aging, September 19, 2002.

<sup>24</sup> Barry Zajac, MHA, Measuring Outcomes of a Chronic Obstructive Pulmonary Disease Management Program, *Disease Management*, V5(1): 9-23 (2002).

<sup>25</sup> Jan Berger et al, Economic Impact of a Diabetes Disease Management Program in a Self-Insured Health Plan: Early Results, *Disease Management*, V4(2): 65-73 (2002).

for the renal program patients were 45 to 54 percent lower than the FFS Medicare group.<sup>26</sup>

- Does Diabetes Disease Management Save Money and Improve Outcomes? The per member per month cost averaged \$424 for Medicare patients enrolled in a diabetes DM program and averaged \$500 for non-program participants, a difference of 15.2 percent.<sup>27</sup>

As mentioned above, DMAA has commissioned a comprehensive review of DM literature as part of its "Outcomes Validation Project." It is anticipated that this project will create a complete reference of DM peer-reviewed publications that demonstrate the outcomes of DM programs.

### **C. Current Federal Activities and Challenges**

#### **1. Medicare+Choice**

In the Medicare+Choice<sup>28</sup> arena, DM services have established a significant track record of improving clinical and financial outcomes. The best Medicare+Choice organizations have offered disease management services which, since they are evidence-based, can achieve savings even while often indicating the need for more drugs, new technologies, or specialized care. Moreover, the costs of DM services are much less than the cost savings they generate and therefore are free to the patient, physician, Medicare+Choice health plan and Medicare itself. Many health plans have built their own internal disease and pharmaceutical management programs for certain diseases, but most have found it preferable to outsource to expert, specialized, accountable DM partners with proven financial and clinical outcomes.

CMS has actively encouraged the provision of DM services in Medicare+Choice plans. In May 2000, CMS announced that it would make extra payments to Medicare+Choice organizations that provide such services for patients with CHF (which is the most frequently billed inpatient code in the entire Medicare FFS system).<sup>29</sup> And, in June 2000, CMS's Medicare+Choice National Marketing Guidelines specifically mentioned DM services as useful preventive services that should be provided by Medicare+Choice plans.<sup>30</sup>

Under the CHF initiative, Medicare + Choice providers must identify beneficiaries with a greater than one-day stay for a principal inpatient diagnosis for CHF during a prior two-year period. They must then measure two quality indicators for all beneficiaries within this population for whom they have provided continuous coverage for 180 days and report this information to CMS together with a brief description of their DM program. Extra payment will be provided if

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<sup>26</sup> Allen A. Nissenson et al, Evaluation of Disease-State Management Dialysis Patients, *American Journal of Kidney Disease*, V37(5): 938-944 (2001).

<sup>27</sup> Jean Sidorov et al, Does Diabetes Disease Management Save Money and Improve Outcomes? *Diabetes Care*, V25(4): 684-689 (2002)

<sup>28</sup> See 42 C.F.R. part 422 (2001).

<sup>29</sup> Medicare+Choice Organizations to be Paid More for Outpatient Management of Congestive Heart Failure, Release from Health Care Financing Admin'n, May 9, 2000.

<sup>30</sup> See Medicare+Choice National Marketing Guidelines, June 8, 2000 at page 15.

the provider meets certain quality thresholds established by CMS.<sup>31</sup> The payment equates to approximately one-third of the full Principal Inpatient Diagnostic Cost Group – 16 (PIP-DCG-16) amount subject to the 10% risk-adjustment transition schedule.<sup>32</sup>

Because Medicare has encouraged the provision of DM services by Medicare+Choice organizations, over 6 million beneficiaries who are in Medicare+Choice organizations have, until recently, been able to take advantage of these services. However, over 200 health plans, citing a number of regulatory and financial reasons, have withdrawn from Medicare + Choice – an action that affects about 1 million beneficiaries. *This means that almost one million beneficiaries may return to traditional Medicare, and will no longer have access to disease management services that assist them with managing their chronic and serious diseases.*

## 2. Medicaid

As a result of the interest in the States in finding methods to control spiraling Medicaid costs and changes made by the Balanced Budget Act of 1997 (Public Law 105-33) ("BBA '97"), the use of DM programs for Medicaid populations has increased. BBA '97 allowed States to enroll many in their Medicaid populations in managed care without receiving a waiver from the federal government to do so (provided that certain requirements were met).<sup>33</sup> The Act also formally authorized the use of Primary Care Case Management (PCCM) programs to allow for the location, coordination and monitoring of primary care services.<sup>34</sup> Still other States have implemented DM programs through other pre-existing Medicaid coverage authorities, often in conjunction with waivers of federal freedom of choice requirements.<sup>35</sup>

Among the first States to become involved with adopting DM programs were Texas, Florida, North Carolina, Virginia, West Virginia, and Maryland. Today, over half the States have

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<sup>31</sup> See CMS, Operational Policy Letter (OPL) No. 129 (2000)

<sup>32</sup> Medicare + Choice has been endeavoring for some time to utilize payments to plans that more accurately reflect risk. Currently, after several attempts to arrive at a system that better measures risk and following legislative interventions to slow the transition from the old demographic-based system to a new system, 10% of payments are risk-adjusted using inpatient data. CMS' current inpatient data system measures 61 "selected significant disease" groups and has been significantly revised in response to complaints about the burdensome nature of the information reporting requirements imposed on health plans. The law requires that ambulatory data be incorporated beginning in January of 2004, at which time the risk adjustment percentage will rise to 30%. See CMS Fact Sheet: The New Risk Adjustment Model (August 28, 2002).

<sup>33</sup> BBA '97 allows States to require most Medicaid recipients – but not Medicare/Medicaid dual eligibles -- to enroll in Medicaid managed care organizations (MCOs) or in primary care case management programs. However, Medicaid MCO's must comply with the requirements of Section 1932 of the Social Security Act, which was added by BBA '97 and requires that beneficiaries be able to choose from at least two MCOs and that they be afforded certain quality and fraud & abuse protections.

<sup>34</sup> BBA '97 allows PCCM services either as a form of MCO or as an optional service under traditional Medicaid. Primary care case management services include the location, coordination and monitoring of primary care services and are provided through a contract between the State and a "primary care case manager" which can be either a physician (or at the state's option a physician assistant, nurse practitioner or certified nurse-midwife), a physician group practice, or an entity that "employs or arranges with physicians to furnish services". See 42 CFR 440.168.

<sup>35</sup> CMS has also indicated that in the case of pharmacists or other non-physician practitioners providing DM services, reimbursement under traditional Medicaid may be made through the authority for medical or remedial care provided by licensed practitioners (40 CFR 440.60). See CMS, Dear State Medicaid Director Letter No. 01-001 (January 19, 2001).

incorporated DM initiatives into their Medicaid programs, while others, such as California, are considering language to promote DM. There are a wide variety of State programs and approaches, many of which have shown promising results. For example, efforts in Virginia to manage the care of the asthma population produced impressive results and the State has expanded its Medicaid DM activities.

Florida has perhaps the most ambitious DM program in the country. Under this Medicaid Primary Care Case Management Program (called "MediPass"),<sup>36</sup> nine diseases have been managed through risk-based contracts with Disease Management Organizations ("DMOs"). The Florida Agency for Health Care Administration (the "Agency") has contracted with DM organizations to provide DM services to Medicaid recipients enrolled in MediPass who have been diagnosed with diabetes, HIV/AIDS, asthma, hemophilia, CHF and end stage renal disease (ESRD).

Colorado recently launched a DM and care coordination pilot project that its officials believe is the most ambitious and creative Medicaid DM demonstrations in the industry.<sup>37</sup> With five separate DM and care coordination pilots targeting asthma, diabetes, schizophrenia, breast and cervical cancer and neo-natal conditions, the Colorado Medicaid program hopes to show that it can save money, improve access to services, and improve the quality of care for its Medicaid FFS beneficiaries. Pharmaceutical companies are funding the demonstrations.<sup>38</sup>

Finally, Texas is designing DM assessment tools for Medicaid beneficiaries with asthma, chronic obstructive pulmonary disease, Alzheimer's, diabetes, HIV, and sickle cell disease.<sup>39</sup> Texas has also begun implementing DM programs focused on medication guidelines for certain psychiatric illnesses.

State Medicaid programs have run into some difficult issues in their attempts to implement DM programs including restricting federally mandated freedom of choice, adequacy of payment issues, and issues surrounding managed care as an option or as a requirement for Medicaid beneficiaries. BBA '97 includes some provisions that have aided the States in their attempts to implement the use of DM services by increasing the possibility that a State would not have to obtain a waiver of the federal freedom of choice requirements to provide DM services, but in many circumstances – including projects involving the dual Medicare/Medicaid eligible population – such waivers are required.

### **3. Demonstration Projects and Government Studies**

Medicare has constructed demonstration projects in which small numbers of FFS Beneficiaries have access to DM services. Outside of these planned demonstrations, however, the vast majority of FFS Beneficiaries do not have any form of coverage for DM services at the present time. The following demonstration projects are in process:

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<sup>36</sup> Details and applicable regulations can be found at: <http://cms.hhs.gov/medicaid/1915b/fl1915bfmp.asp>

<sup>37</sup> DM NEWS, Vol.8, No.8 (January 10, 2003).

<sup>38</sup> *Id.*

<sup>39</sup> Drug Topics, p. 81 ( May 20, 2002), [www.drugtopics.com](http://www.drugtopics.com)

- Coordinated Care Demonstration. Section 4016 of BBA '97 requires the Secretary to evaluate best practices in the private sector for methods of DM and coordinated care. The statute also directs the Secretary to design demonstration projects for the Medicare fee-for-service population based on the evaluation. The purpose of the demonstration is to evaluate models of DM and coordinated care that improve the quality of services provided to specific beneficiaries who have chronic illnesses and to reduce expenditures under Parts A and B of the Medicare program. On July 28, 2000, Medicare published a solicitation for proposals to participate in the coordinated care demonstration project<sup>40</sup>. Fifty-eight applications were received, 15 awards were made in January, 2001, and CMS began implementation on a rolling basis in April, 2002.<sup>41</sup> CMS recently expanded beneficiary enrollment for some organizations participating in the study that have met their targeted enrollment goals.<sup>42</sup>
- CHF, Diabetes, and CAD Demonstration. Section 121 of BIPA authorized a demonstration project for the Medicare FFS population to demonstrate the impact on costs and health outcomes of applying DM services, supplemented with coverage for prescription drugs, to specific Medicare beneficiaries with advanced-stage congestive heart failure, diabetes or coronary heart disease. Under the demonstration, up to three DM organizations will be paid a monthly premium for coordinating the care of patients in the studies. The demonstration will require each organization to improve health outcomes and reduce Medicare program expenditures. CMS published a solicitation for proposals for this demonstration in February of 2002, announced three awards in October, and issued carrier instructions (including the creation of three HCPCS codes for the billing of drugs under the demonstration) in November. The effective date of the demonstration project is April 1, 2003.<sup>43</sup>
- PPO Demonstration. On April 15, 2002, CMS announced a demonstration project to expand health plan options in Medicare+Choice by expanding PPOs, point-of-service plans, and other health care designs that allow enrollees more choice. CMS has indicated that it prefers to use DM as a mechanism for containing costs and improving quality. The demonstration plans will be considered Medicare+Choice plans and must offer all of Medicare's required benefits, but they will also have the flexibility to offer greater access to drug benefits and DM services.
- Intensive Case Management Demonstration. At Lovelace Health Systems in Albuquerque, New Mexico, CMS is testing whether intensive case management services for CHF and diabetes mellitus can be a cost-effective means of improving clinical outcomes, quality of life, and patient satisfaction.
- End-State Renal Disease Demonstration. CMS began implementing an end-stage renal disease ("ESRD") managed care demonstration project in 1996. The project provided

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<sup>40</sup> 65 Fed. Reg. 46466 (July 28, 2000).

<sup>41</sup> CMS archives information regarding the coordinated care demonstrations at <http://cms.hhs.gov/healthplans/research/coorcare.asp>.

<sup>42</sup> DM NEWS, Vol. 8, No. 5 (December 25, 2002).

<sup>43</sup> CMS Program Memorandum Transmittal AB-02-153 (November 1, 2002).

services for three years at Kaiser Permanente in southern California and at Advanced Renal Options in southern Florida. Results showed that enrollees exhibited comparable or better outcomes than those in FFS Medicare. Based on the results, CMS is considering a new ESRD demonstration.

In addition to CMS, the CBO is currently undertaking a series of studies related to DM. The CBO is investigating the patterns of spending and clinical characteristics of Medicare beneficiaries who are highly and persistently expensive (and thus strong candidates for DM); the potential for applying private sector DM programs to Medicare; and programmatic issues that must be addressed in designing a DM benefit under Medicare (including eligibility, enrollment, payment and integration into fee-for-service Medicare). The Health Resources and Services Administration (HRSA) is overseeing the Health Disparities Collaborative Project, which includes a major effort to improve quality of care for chronic illnesses such as diabetes through a population-based model of care involving community health centers. And the Department of Defense and Department of Veterans Affairs are collaborating on the South Texas Congestive Heart Failure Demonstration Project.<sup>44</sup> Finally, the Agency for Health Research and Quality (AHRQ) collaborated with the American Association of Health Plans Foundation to jointly issue a request for applications in 1998. AHRQ subsequently awarded \$10 million in funding to seven research teams to determine the impact of different features of health plans the quality of care provided to patients with chronic illnesses. Some of this research pertains to DM.<sup>45</sup>

Congress also included DM-related demonstration provisions in legislation to provide a prescription drug benefit under Medicare that passed the House of Representatives during the 107<sup>th</sup> Congress but was not enacted into law. Under this legislation,<sup>46</sup> HHS would have been directed to conduct a demonstration of the outcomes of applying DM to a population of no more than 30,000 Hispanic beneficiaries with diabetes who are not enrolled in Medicare+Choice through contracts with up to three DM organizations. Beneficiaries would receive coverage for the DM services and for prescription drugs regardless of whether those drugs relate to the treatment of their diabetes. The organizations would be paid a negotiated fee and the legislation further required that there be "no net increase and to the extent practicable a net reduction in expenditures under Medicare as a result of the project". The legislation also directed the GAO to conduct a study to compare DM programs under Medicare with such programs conducted in the private sector. The study would identify the cost effectiveness of such programs and any savings.

#### **D. Recent Policy Proposals**

Although Medicare has constructed demonstration projects in which a few traditional Medicare beneficiaries may have access to DM services, the vast majority of FFS Medicare beneficiaries do not have any form of coverage for care management services. As of September 2000, only 16 percent of Medicare beneficiaries had access to care management services. That means over 31 million Medicare beneficiaries could not take advantage of the benefits of DM

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<sup>44</sup> Agency for Healthcare Research and Quality, User Liaison Program: Federal Initiatives. <http://www.ahrq.gov/news/ulp/evidence/ulpevdnc7.htm>.

<sup>45</sup> See Agency for Health Research and Quality, Center for Organization and Delivery Studies: Partnerships. <http://www.ahrq.gov/about/cods/codspart.htm>.

<sup>46</sup> H.R. 4680, the Medicare Rx 2000 Act, 107<sup>th</sup> Cong., 2d Sess.

programs.<sup>47</sup> Both the previous Administration and Congressional leaders from each party have recognized the need to formally include DM programs in federal and state health care plans.

## 1. Executive Branch

The previous administration supported the inclusion of DM programs in health care plans and programs.<sup>48</sup> Legislation supported by the Clinton Administration proposed that the Secretary of HHS

have the authority to competitively pay qualified [disease management] entities who provide (or subcontract to provide) services including patient screening and assessment, review of medications, patient education, telephone consultations, physician interaction, home nursing visits, surveillance and reporting. To minimize fragmentation of care, Medicare could require single vendors to provide disease management for related conditions (e.g., congestive heart failure, hypertension, coronary artery disease, and diabetes). Medicare would set up the payment arrangements to achieve savings for the given diagnoses for participating beneficiaries. Beneficiaries would voluntarily choose to get their care from these providers, benefiting from the expertise and care coordination that is the hallmark of these disease management systems.

The Bush Administration has also clearly recognized the importance of DM in federal health care activities. As discussed above, both CMS and AHRQ are actively exploring DM, while the Secretary of Health & Human Services is supporting a package of innovative, interdisciplinary demonstrations aimed at addressing the both the causes and consequences of chronic illness. During recent Congressional testimony, CMS Deputy Administrator and Chief Operating Officer Ruben J. King-Shaw, Jr. indicated that "[a]nalysis of disease management is an integral part of the [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." Mr. King-Shaw further identified the "almost complete absence" of DM services in traditional Medicare as a "striking indication" of how outdated the Medicare benefits package has become.<sup>49</sup>

Even more recently, the Administration has renewed its focus on chronic illness and prevention. In his 2003 State of Union Address, the President specifically highlighted the need for a greater preventive focus under Medicare. And Secretary of Health & Human Services Tommy Thompson recently announced that the President's fiscal year 2004 budget would propose a \$100 million increase in funding for initiatives to combat diabetes, obesity and asthma through promoting healthy behaviors and health care and insurance initiatives to stress prevention, risk

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<sup>47</sup> AAHP *Analysis of CMS Medicare Managed Care Contract Reports*, presented in POLICY BRIEF: MEDICARE+CHOICE PROGRAM FACTS AND FIGURES, American Ass'n of Health Plans (June 2000).

<sup>48</sup> PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE FOR THE 21<sup>ST</sup> CENTURY, National Economic Council and Domestic Policy Council, Presented July 2, 1999.

<sup>49</sup> Statement of Ruben J. King-Shaw, Jr. on Promoting Disease Management in Medicare before the Senate Special Committee on Aging, Sept. 19, 2002.

factor reduction for chronic disease and management to reduce complications.<sup>50</sup> The Secretary has also called upon health insurers to place renewed emphasis upon disease prevention.<sup>51</sup>

## 2. Legislative Branch

In recent years, a number of federal legislators have recognized the value of DM and incorporated DM-related proposals in legislation proposing to revamp Medicare, to bolster FFS Medicare, or to add a prescription drug benefit to Medicare.

In the 107<sup>th</sup> Congress (2001-2002), Senator Graham of Florida introduced a Medicare reform and prescription drug bill. This legislation specifically authorized Care Coordination Services and Disease Management Services.<sup>52</sup> With regard to DM, the legislation would have specified disease management as a covered service under Part B of Medicare, defined the scope of DM services, and authorized CMS to contract with Disease Management Organizations for the provision of such services. Individuals would be eligible for such services if they had CHF, COPD, Diabetes or another diagnosis where aggregate savings to Medicare and improved quality of care could be expected to result from DM, and if they were referred for such services by a qualified provider or benefit provider. Legislation containing very similar language, and limited to five major chronic conditions was introduced by Representative Cardin in the House of Representatives.<sup>53</sup> And legislation was introduced in both the House and the Senate to address the provision of chronic care services to the Medicare population by, among other provisions, authorizing Medicare beneficiaries with defined chronic and disabling conditions to receive authorized "care coordination and assessment" services.<sup>54</sup>

Proposals to add a prescription drug benefit to Medicare have also addressed, to some extent, the need to provide DM services to the Medicare population. Representative Johnson's legislation on this subject<sup>55</sup>, which passed the House during the 107<sup>th</sup> Congress but was not enacted into law, would have set up a voluntary Medicare Outpatient Prescription Drug Benefit under a new Part D of Medicare. The new benefit would be administered either directly by Medicare + Choice providers or, in the fee-for-service context, by sponsors of Prescription Drug Plans (PDPs). The PDP sponsors would be entities – such as PBMs or plans – that competitively contract with CMS to provide the benefit. The bill provided for PDP sponsors to undertake cost and utilization management; quality assurance; and medication therapy management programs. The therapy management program would be designed to assure with respect to beneficiaries with chronic diseases or multiple prescriptions that drugs are properly used to achieve therapeutic goals and avoid adverse drug events. The bill stipulated that the programs were to be developed in cooperation with licensed pharmacists.

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<sup>50</sup> U.S. Dept. of Health & Human Services, News Release, "HHS Budget Proposal to Include \$100 Million Increase to Prevent Diabetes, Obesity and Asthma Across the Country," January 22, 2003.

<sup>51</sup> "Emphasis Disease Prevention, Health Secretary Tells Insurers," Washington Post, January 21, 2003.

<sup>52</sup> See Sec. 131 & 132 of S. 1135, The Medicare Reform Act of 2001, 107<sup>th</sup> Cong., 1<sup>st</sup> Sess.

<sup>53</sup> H.R. 5219, , 107<sup>th</sup> Cong., 2d Sess.

<sup>54</sup> H.R. 3188 & S. 1756, The Medicare Chronic Care Improvement Act of 2001, 107<sup>th</sup> Cong., 1<sup>st</sup> Sess.

<sup>55</sup> H.R. 4954, The Medicare Rx2000 Act, 107<sup>th</sup> Cong., 2d Sess.

## V. POLICY RECOMMENDATIONS

DMAA believes that comprehensive DM, if fully employed in Medicare and Medicaid, can:

- Achieve the objective of better addressing preventive care and chronic illness under Medicare and Medicaid.
- Improve the safety and quality of care by adhering to evidence-based treatment guidelines and outcomes data, and by providing patients with a safety net between physician and hospital visits, thereby reducing drug and treatment errors and improving care coordination.
- Improve access to care by around the clock nursing and high-tech contacts, and by assisting rural caregivers and their patients who do not have the benefit of easy entrée to in-person care.
- Improve patient self-management of, and responsibility for, preventing and treating their conditions by its innovations in patient-centered and collaborative education.
- Improve financial cost containment without sacrificing quality or patient satisfaction by serving as an alternative to the increasingly unacceptable cost-containment techniques of managed care, such as utilization review, gatekeeper restrictions, referral limitations, and drug restrictions.
- Enhance efforts in the public health arena by providing health improvement programs on a population basis; creating financial incentives to promote and deliver preventive interventions on a large scale using advanced outreach technologies, especially secondary preventive measures; and encouraging those segments of the private sector that have not yet embraced DM to do so.

DMAA supports the integration of accredited DM programs into FFS Medicare, Medicare+Choice, and Medicaid according to the following principles endorsed by DMAA:

- There should be no discrimination against FFS enrollees, who currently lack any access to the benefits of DM programs available to Medicare+Choice and certain Medicaid enrollees (or have lost access to these programs as a result of the loss of their Medicare+Choice coverage).
- Medicare and Medicaid FFS programs should directly contract with DM organizations to offer such benefits on a population basis.
- Medicare and Medicaid managed care programs should provide financial and other incentives to private health plans and public managed care programs and their enrollees to join HMOs, PPOs, MSAs, point of service plans, and other alternatives to traditional FFS.

- DM programs should be compensated for their services on an equitable and competitive basis that compensates them for their investments, provides them with incentives to maximize both clinical and financial outcomes. Historically fees paid to DM organizations are a fraction of the savings generated for their payor customers.

#### **A. FFS Medicare**

Most DM programs have been built on a platform of sophisticated information technology. Such an infrastructure has allowed them to develop empirical evidence of successful clinical and financial outcomes rivaling those attributed to other forms of direct treatment, such as pharmaceuticals, surgeries, and physician and hospital care. Coverage of DM under FFS Medicare will promote the use of these services by beneficiaries and reduce program costs. Congress and CMS should move forward to implement such coverage in the FFS program, using successful private sector models as a reference.

There are a variety of reimbursement mechanisms that might generate the best incentives and results for DM programs under FFS Medicare, and DM organizations are adept at working under a variety of compensation methods. However, direct payment for DM services and programs is the most appropriate approach. This approach tracks how other FFS Medicare services are paid and how much of the commercial sector reimburses for DM. DMAA believes that Medicare should contract directly with DM organizations to provide this service ideally on a population basis. DM programs should be prospectively compensated on an equitable and competitive basis that recognizes investment and includes incentives to maximize *both* clinical and financial outcomes. Toward this goal, CMS should identify and implement the changes in administrative infrastructure that would be needed to make DM a more central component of FFS Medicare.

*DMAA’s suggested legislative language, “Proposal For Direct Contracting Between Fee For Service Medicare And Disease Management Organizations,” is attached to this white paper as Attachment A.*

#### **B. Medicare+Choice**

DMAA supports steps that encourage the integration of accredited DM services into Medicare. Presently, the Medicare+Choice program provides the best opportunity for beneficiaries to obtain DM services and, for this reason, DMAA supports efforts to improve payments to Medicare+Choice organizations to stem the withdrawal of Medicare + Choice organizations from the program.

DMAA also believes that the risk adjustment system should be used to promote the use of DM. As CMS and Congress continue to move toward risk adjustments based on disease conditions and not demographics, it makes sense to build DM incentives into this new system. Specifically, the current CMS initiative whereby Medicare + Choice organizations are provided with an extra risk adjustment payment for the outpatient DM care provided to CHF patients provided that they meet certain quality measures should be continued and expanded to cover all chronic conditions and, at a minimum, CHF, CAD, COPD and Diabetes.

### **C. Medicare Prescription Drug Legislation**

DM programs are ordinarily provided and most effective in populations where prescription drug coverage is available as part of a comprehensive approach to the management of the patient's condition. Chronically ill individuals are often prescribed multiple medications to control their condition and promoting access to prescription drugs and adherence to drug regimens is central to preventing complications that inhibit quality of life and raise the cost of care. DM organizations have the expertise and sustained levels of patient contact to provide the necessary beneficiary education and assistance that advances drug-specific quality of care objectives (e.g., beneficiary compliance, appropriate drug utilization, avoidance of interaction problems) as a component of a comprehensive approach to the management of chronic illness. And DM organizations are well-positioned to guard against the service fragmentation that could result from adding a prescription drug benefit to Medicare.

Inclusion of DM in FFS Medicare could occur via a prescription drug bill. Although a less desirable approach than building DM into original Medicare's structure as a new covered service, inclusion of DM in prescription drug legislation would be a viable alternative to covering DM in FFS. Under such legislation, CMS should still directly contract with and make direct payments to DMOs, rather than indirectly covering or paying DMOs through third parties, such as pharmaceutical benefits managers or TPAs. A requirement that all beneficiaries receiving prescription drug benefits be enrolled in a DM program would be desirable and would aid in the management and cost-containment of the drug benefit itself. And only fully accredited DM programs should be supported through any prescription drug benefit program.

### **D. Medicaid**

Congress has facilitated the use of DM in Medicaid through BBA '97's changes promoting managed care and authorizing Primary Care Case Management. Additional steps should be taken to make it easier for States to incorporate DM into Medicaid. In particular, Congress should address the challenge of providing DM services to the Medicare/Medicaid dual eligible population.

