

Statement of Kenneth E. Thorpe, PhD

Senate Committee on Health, Education, Labor, and Pensions

Hearing On

Delivery Reform:

The Roles of Primary and Specialty Care in Innovative New Delivery Models

Thursday, May 14, 10:00 a.m.

Dirksen 430

Good morning, Senators. Thank you for inviting me here today to discuss the urgent need to reform health care delivery in the United States and the pivotal role that primary care providers must play in a changed system. I am Ken Thorpe, chairman of the department of health policy and management at Emory University. I also lead the Partnership to Fight Chronic Disease, a national coalition of patients, providers, community organizations, business and labor groups, and health policy experts that is working with state partnerships to prevent chronic illness and reform how we deliver care to patients.

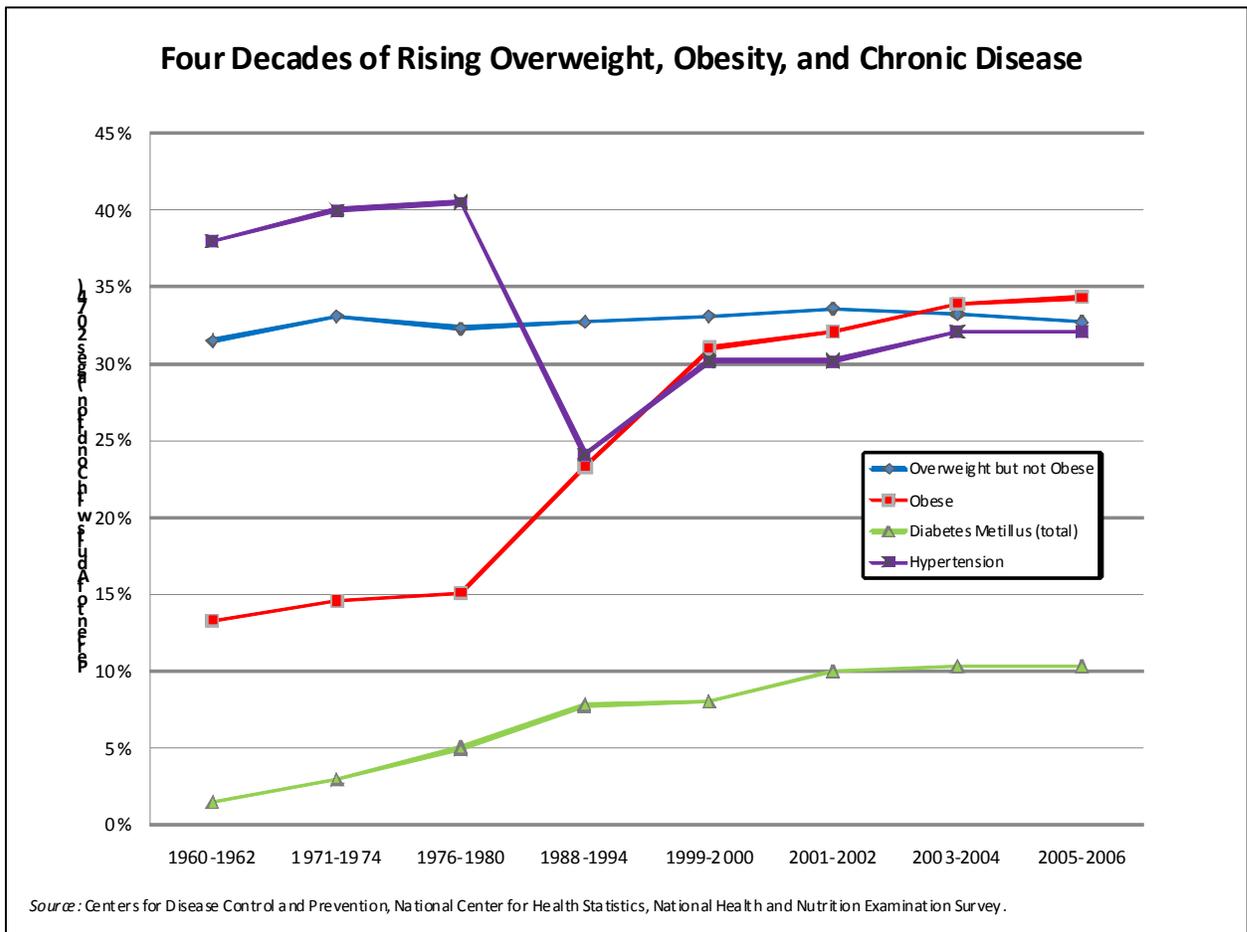
I believe a central challenge we face in health reform is how to integrate effective primary prevention and care coordination into the traditional fee-for-service (FFS) Medicare program. Success in integrating these care delivery components into Medicare will surely have spillover effects in how Medicaid and the private sector work to prevent and manage chronic illness as well. The following six facts highlight the nature of the challenge we face and provide insights about the design of a successful solution to the problem.

1. The majority of all U.S. medical practices (83 percent) are composed of just one or two physicians.¹ More than a third of primary care physicians (36 percent) work in these small practices.² Most Medicare patients are not treated through larger integrated group practices.

2. 81 percent of Medicare beneficiaries are enrolled in traditional FFS Medicare, and they account for about 79 percent of the program's overall health care spending.³ Today, there is no care coordination in the program, leading to high rates of preventable hospital admissions, readmissions, clinic and emergency room visits.⁴
3. In 2010, we will spend about \$395 billion in the traditional FFS Medicare program. Over 95% of total spending in Medicare is linked to chronically ill patients.
4. Multiple morbidities among these patients are common: More than half of Medicare beneficiaries are treated for five or more chronic conditions yearly.⁵ On average, the top spending 5 percent of Medicare beneficiaries account for roughly half the FFS program's costs.
5. Over 30% of the recent rise in Medicare spending in the last ten years is associated with the persistent rise in obesity in the Medicare population. (Exhibit 1, next page, graphically depicts rising rates of overweight, obesity, and two associated chronic conditions, diabetes and hypertension, in the United States over the last forty years.)

6. The increase in obesity-related chronic diseases among all Medicare beneficiaries and particularly among the most expensive 5 percent is a key factor driving growth in traditional FFS Medicare.⁶ Six medical conditions—all related to obesity: diabetes, hypertension, hyperlipidemia, asthma, back problems and co-morbid depression—account for most of the recent rise in spending in the Medicare population. Treatment for these patients is largely uncoordinated, and relies largely on therapeutic interventions in ambulatory care.⁷

Exhibit 1: Rising Rates of Overweight and Obesity and Associated Chronic Conditions



Today, Medicare spends nothing to help coordinate health care in the traditional fee-for-service program. As a result, Medicare spending is higher than it would be if care were coordinated. For instance, 20 percent of Medicare patients are readmitted within 30 days of leaving the hospitals. Well-managed and coordinated plans such as Geisinger, Puget Sound, and others have readmissions rates of half this amount. Moreover, since they manage and coordinate care their hospital admission rates are about 25 percent lower than unmanaged Medicare.

Nationally, the private sector and the federal government (through Medicaid) currently spend approximately 2.5 percent of total spending to invest in care management. Well-managed programs have been associated with savings of 5 to 7 percent—well over a 2 to 1 return on investment. To generate these savings, private plans, Geisinger, and others invested in new technology, transition care programs, and other care management tools.

Medicare spends nothing on care management—and so generates no savings from it. If Medicare took the best practice approaches with proven results from the private sector (formal transition care model, integration of the care management function and the physicians' office, financial and payment incentives) and made it available nationally in FFS Medicare, the program would save money.

The challenge is most of the good care management models are large clinics such as Mayo, Geisinger, Cleveland, and Marshfield. Their approach to preventing and managing disease has proven effective. However, these models are not replicable or scalable nationally.

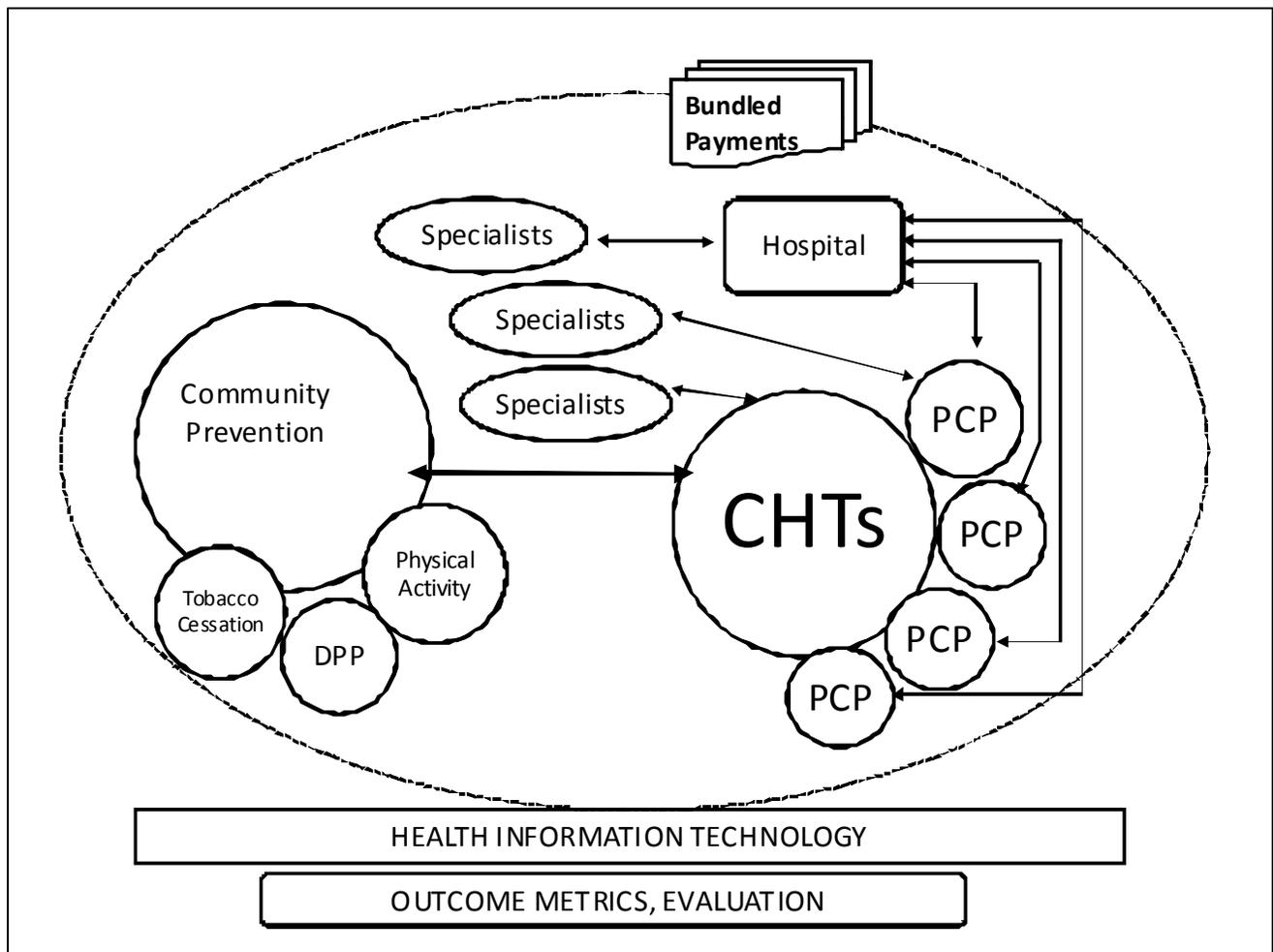
As an alternative, the key design features of these successful integrated system prevention and care management programs could be identified and incorporated into community settings to work with smaller physician practices. These community-based health teams would provide care coordination and prevention using the same tools and approaches used successfully in larger integrated practices like Geisinger. This approach would allow Medicare to quickly replicate these effective practices nationally.

The community health team concept is an approach already used in Vermont, North Carolina, Rhode Island and soon West Virginia and Pennsylvania. According to several evaluations from Mercer Consulting, North Carolina has saved between 5 to 15 percent annually in their Medicaid program with these models.

In Vermont and elsewhere, CHTs work with primary care practices, patients, and their families to prevent and manage chronic illnesses. These teams variably include care coordinators, nutritionists, behavioral and mental health specialists, nurses and nurse practitioners, and social, public health, and community health workers. These trained resources already exist in many communities, working for home health agencies,

hospitals, health plans, and community-based health organizations. To better leverage their systemic impact, dedicated teams are needed to work seamlessly with small primary care practices in communities across every state.

Exhibit 2: Schematic of Integrated Community Health Teams



The CHT model is replicable and scalable nationally and quickly, unlike other approaches. Like other payers, Medicare must make a very modest investment to coordinate care if it ever hopes to generate savings, reducing admission and readmissions in the program. A \$2.5 billion per year investment—or 0.6% of total Medicare FFS spending, and about 50 percent less than other payers currently invest to generate savings in their programs—would allow CHTs to work nationally with Medicare FFS patients.

Community health teams have the potential to reduce spending in the program and working in tandem with other health reform proposals (hospital bundled payments and penalties for high readmission policies) should generate savings higher than already scored by CBO. The Medicare program's fragmented benefit design and reimbursement policies discourage care coordination and disease management. At the same time, these very same conditions present opportunities for prevention, better care, and long-run cost savings.⁸ Health reform should seek to reduce the rate of rise in targeted chronic conditions (primary prevention) and implement evidence-based care management (secondary and tertiary prevention), starting with current FFS Medicare beneficiaries.

The most recent evaluation of the Medicare Coordinated Care Demonstration (MCCD) and several other randomized controlled trials substantiate the importance of five care elements that CHTs should provide: 1) monthly (or more frequent) in-person contact with patients, 2) targeting the right patients (treatment-control differences were

concentrated entirely in the highest severity enrollees), 3) patient education on medication adherence and other self-care, 4) transition care coordination to avoid preventable readmissions, and 5) close collaboration between care coordinators and physician practices.⁹

To realize fully both health gains and potential cost savings, each patient should have a care coordinator who works closely with primary care providers in executing the care plan developed by the primary care physician collaboratively with the patient. Depending on the patient's constellation of illness, several members of a CHT may be involved in working with the patient to execute the individualized care plan. Care plans should be developed for at-risk populations (pre-diabetic, overweight and obese, tobacco users) as well as patients with one or more diagnosed chronic conditions.

A critical CHT focus must be transitional care. Potentially avoidable readmissions have been identified as a major quality and spending problem in Medicare: About 18 percent of admissions result in readmissions within 30 days of discharge, accounting for \$15 billion in spending each year. Not all of these readmissions are avoidable, but some are, potentially as much as \$12 billion worth.¹⁰ The CHT care coordinator would track patients as they enter the hospital or skilled nursing facility, conduct an on-site visit, and, most importantly, work with the patient and admitting physician at discharge. The care coordinator would provide information and input to make sure the discharge plan and medication reconciliation for the patient are completed.

CHTs are a vital link to community-based prevention programs that can deliver effective primary prevention to avert disease as well as programs to detect and mitigate existing conditions and avert complications (secondary and tertiary prevention). Each team should have a public health practitioner familiar with effective community-based lifestyle, exercise, diet/nutrition, smoking cessation, and other risk-reduction programs (e.g., substance abuse and mental health). An emerging example of the value of these community-based resources is the replication of the diabetes prevention program (DPP) and other protocols shown through randomized trials to reduce dramatically the incidence of diabetes among pre-diabetics and other at-risk populations.

Absent an investment in to prevent and manage disease, Medicare has no workable tools for slowing the growth in spending and will save less. Cutting provider payments may save money in the short term, but could drive spending up in the longer term, as fewer physicians accept Medicare patients and those with chronic illnesses are untreated and their diseases unmanaged.

Chronic illnesses—mostly preventable—take an increasing toll on Americans’ health, productivity, and quality of life. Reversing or at least slowing the rise in incidence and prevalence is critical to better health and reduced health spending over the long term. The stimulus bill endows a national “Prevention and Wellness Fund” with \$1 billion, including \$650 million for “evidence-based clinical and community strategies

that delivery specific, measureable health outcomes that address chronic disease” in Title VII.

Reforming the way in which the U.S. health system provides care to chronically ill patients is also essential. Episodic, uncoordinated care is ineffective and inefficient for patients like most Medicare beneficiaries who have multiple, chronic comorbidities. Reforming the traditional FFS Medicare program would go a long way in spurring needed transformation in health care delivery. The United States leads industrialized nations in per capita and total health spending, but is last in preventable mortality. Preventing disease, particularly chronic illness, and providing better care for those with life-long illness, along with how we finance and pay for care, must change.

Thank you again for the opportunity to discuss these vital reforms. I’m happy to take your questions.

References

- ¹ Government Accountability Office, *Medicare Physician Payment: Care Coordination Programs Used in Demonstration Show Promise, but Wider Use of Payment Approach May Be Limited* (GAO-08-65), Washington, DC: GAO, 2008. <http://www.gao.gov/new.items/d0865.pdf> (accessed October 28, 2008).
- ² A. Liebhaber and J.M. Grossman, "Physicians Moving to Mid-Sized, Single-Specialty Practices," *Journal of General Internal Medicine* 20, no. 10 (2005): 953-957
- ³ P.R. Orszag, Director, Congressional Budget Office, "The Medicare Advantage Program: Enrollment Trends and Budgetary Effects," Testimony before the Committee on Finance, United States Senate, April 11, 2007.
- Centers for Medicare and Medicaid Services (CMS), "National Health Expenditures 2007 Highlights," <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/highlights.pdf> (accessed April 7, 2009).
- ⁴ B. Starfield, L. Shi, and J. Macinko, "Contribution of Primary Care to Health Systems and Health," *Milbank Quarterly* 83, no. 3 (2005):457-502.
- Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Promoting Greater Efficiency in Medicare* (Washington, DC: MedPAC, 2007).
- Medicare Payment Advisory Commission (MedPAC), Statement of Mark E. Miller, Executive Director (September 16, 2008), http://www.medpac.gov/documents/20080916_Sen_percent20Fin_testimony_percent20final.pdf (accessed April 1, 2009).
- ⁵ Centers for Disease Control and Prevention (CDC), "Chronic Disease Overview," 2005, <http://www.cdc.gov/nccdphp/overview.htm> (accessed April 1, 2009).
- ⁶ G.F. Riley, "Long-Term Trends In The Concentration Of Medicare Spending," *Health Affairs*, May/June 26, no. 3(2007): 808-816.
- ⁷ K.E. Thorpe and D.H. Howard, "The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity," *Health Affairs Web Exclusive*, 2006: w378-w388.
- ⁸ P.R. Orszag, April 11, 2007.
- Congressional Budget Office (CBO), *High-Cost Medicare Beneficiaries* (Washington, D.C.: CBO, May 2005), <http://www.cbo.gov/ftpdocs/63xx/doc6332/05-03-MediSpending.pdf> (accessed April 7, 2009).
- Institute of Medicine, *Rewarding Provider Performance: Aligning Incentives in Medicare* (Washington, DC: National Academies Press, 2006).
- E. Wagner, C. Davis, J. Schaefer, M. Von Korff, and B. Austin, "A Survey of Leading Chronic Disease Management Programs: Are They Consistent with the Literature?," *Managed Care Quarterly*, 1999 Vol. 7, No. 3, pp. 56–66.
- J. Chodosh, S. C. Morton, W. Mojica, M. Maglione, M. J. Suttorp, L. Hilton, S. Rhodes and P. Shekelle, "Meta-Analysis: Chronic Disease Self-Management Programs for Older Adults," *Annals of Internal Medicine* 143, no. 6 (2005): 427-438.
- T. Bodenheimer, E.H. Wagner, K. Grumbach, "Improving Primary Care for Patients with Chronic Illness," *Journal of the American Medical Association* 288, no. 19 (2002):1775-1779.
- T. Bodenheimer, E.H. Wagner, K. Grumbach, "Improving Primary Care for Patients with Chronic Illness: The Chronic Care Model, Part 2," *Journal of the American Medical Association* 288, no. 19 (2002):1909-1914.
- T. Bodenheimer, K. Lorig, H. Holman, K. Grumbach, "Patient Self-Management of Chronic Disease in Primary Care," *Journal of the American Medical Association* 288, no. 19 (2002):2469-2475.
- S.M. Foote, "Population-Based Disease Management Under Fee-For-Service Medicare," *Health Affairs Web Exclusive* 2003: W3- 342-356.
- Centers for Disease Control and Prevention, "Chronic Disease Overview" (2008), <http://www.cdc.gov/nccdphp/overview.htm> (accessed February 12, 2008).

D. Peikes, A. Chen, J. Schore, and R. Brown, “Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 15 Randomized Trials,” *JAMA* 301, no. 6 (2009): 603-618.

⁹ D. Peikes, A. Chen, J. Schore, and R. Brown, 2009.

B.W. Jack et al., “A Reengineered Hospital Discharge Program to Decrease Rehospitalization,” *Annals of Internal Medicine* 150, no. 3 (2009): 178-187.

E.A. Coleman et al., “Preparing Patients and Caregivers to Participate in Care Delivered Across Settings: The Care Transitions Intervention,” *Journal of the American Geriatrics Society* 52, no. 11 (2004): 1817-1825.

M.D. Naylor et al., “Comprehensive Discharge Planning and Home Follow-up of Hospitalized Elders: A Randomized Clinical Trial,” *Journal of the American Medical Association* 281, no. 7 (1999):613-620.

¹⁰ B. Starfield, L. Shi, and J. Macinko, “Contribution of Primary Care to Health Systems and Health,” *Milbank Quarterly* 83, no. 3 (2005):457-502.

Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Promoting Greater Efficiency in Medicare* (Washington, DC: MedPAC, 2007).

Medicare Payment Advisory Commission (MedPAC), Statement of Mark E. Miller, Executive Director (September 16, 2008), http://www.medpac.gov/documents/20080916_Sen_percent20Fin_testimony_percent20final.pdf (accessed April 1, 2009).