ESTABLISH A CHRONIC CARE MANAGEMENT BENEFIT UNDER MEDICARE

ISSUE: As issues related to acute illnesses are addressed and resolved by the health care system, chronic illness has become the key health care concern of the Medicare population. This chronically ill population requires different services and supports than are currently covered under the traditional acute care benefit structure of Medicare. The absence of coverage for supportive, preventative, and care management services for the chronically ill leads to hospitalizations, emergent care, and serious exacerbations of underlying illness. Care management of this population can save significant expenditures in Medicare and greatly add to the quality of life these citizens enjoy in their final years. Currently, Medicare operates a pilot "Chronic Care Improvement Program" that does not provide the direct, face-to-face support that is necessary for productive care management. Relying on statistical analyses, broad-based educational efforts, and very limited direct intervention, the pilot program falls short of the care management that can be provided by home care nurse.

Additional concepts of chronic care management are emerging. Congress is considering such proposals as a medical home model. A medical home model is a physician –centered approach wherein physicians are reimbursed to focus on managing the medical needs of individuals with one or more chronic illness diagnoses. However, there are serious weaknesses in the medical home model. Specifically, there is a severe shortage of physicians with training in managing chronically ill individuals in the community setting. In addition, physicians lack the infrastructure necessary to extend services outside their office practices using modern technologies, data driven actions, and home visitations of patients. Finally, a medical home model does not integrate the wide variety of non-medical services and supports that are needed to achieve the comprehensive goals of effective chronic care management.

RECOMMENDATION: Congress should establish a separate care management benefit under Medicare that is available for designated categories of chronically ill individuals such as COPD, CHF, diabetic, and certain neurological disorder-afflicted patients. The service should be provided by professional nurses and others within home health agencies to ensure a discipline-integrated, community care-based approach to care management. The patient care should be under the guidance and supervision of the patient's attending physician who should be included as a member of the care team. The services should include:

1. an interdisciplinary team approach to care management that includes physicians, nurses, therapists, medical social workers, and pharmacists
2. evidenced-based care plan development
3. direct patient care services in the home setting

4. the application of telehealth services for appropriate remote monitoring as needed by the individual patient
5. care counseling, care coordination, medication management, and oversight of services related to activities of daily living.
6. the use of interoperable electronic health care records and efficient electronic-based communication tools
7. patient education and support
8. integration and support of informal caregivers such as family members

The Chronic Care Management program should be initially implemented on a pilot basis with authority provided to Medicare to extend the services beyond the pilot at Medicare's discretion.

Reimbursement for the services should be on a shared risk basis wherein partial payment is made to the provider for certain direct care services with additional payment based on performance that demonstrates Medicare savings through such cost reductions as avoidance/prevention of re-hospitalizations, emergent care, and acute exacerbations of a chronic illness.

RATIONALE: The existing Medicare benefit structure encourages individuals to await condition deterioration before attending to ongoing health-related needs. Higher-cost care for acute episodes results from the absence of direct care management of the chronic care population. A care management benefit can help avoid these complications and costs.

A chronic care management delivery system is already available through existing home health agencies that possess the skill and experience in managing chronically ill individuals in the community. Through the existing infrastructure of home health agencies, an effective chronic care management system can be created with minor refinements and minimal re-engineering of the delivery system to achieve nearly immediate cost savings and improved patient care.