



Rx: Health Care FYI #54

Subject: *Using Patient Care Management to Improve Health Care*

From: *Rep. Tim Murphy (PA-18)*

Date: *April 16, 2007*

The problem: About 80% of health care dollars are spent treating chronic illnesses. Very often these are complex cases where patients are dealing with multiple doctors, treatments, medications and tests. Errors can result from confusion and miscommunication on these cases. Care management can be effective in reducing these errors. However, many insurance plans including Medicare and Medicaid do not reimburse for patient care management.

What is patient care management?

- Individualized health plans for patients with chronic illnesses that coordinate treatments among health care providers. Typically, they use nurses or caseworkers to monitor patient compliance (prescriptions, treatments, lab tests, appointments, diet, exercise, psychological status, etc.)

All chronic patients need patient care management programs:

- Nearly 80 percent of Medicare beneficiaries have at least one of the following chronic conditions: stroke, diabetes, emphysema, heart disease, hypertension, arthritis, osteoporosis, Parkinson's disease, or urinary incontinence.¹
- The costliest 5 percent of Medicare beneficiaries account for about half of all Medicare spending each year. Among this top 5 percent, 47 percent had congestive heart failure (CHF) and 35 percent had diabetes.²
- About 20 percent of beneficiaries have five or more chronic conditions, account for over two-thirds of Medicare spending, see about 14 different physicians in a year, and have almost 40 office visits.³
- The chances of an otherwise unnecessary hospitalization--for conditions that can and should be managed effectively on an outpatient basis--increase from about 1 percent for a beneficiary with just one condition to about 13 percent for a beneficiary with five conditions and about 27 percent for a person with eight chronic conditions.⁴
- A multispecialty expert physician study found that, during a three-year period, Medicare beneficiaries received certain recommended services less than two-thirds of the time for conditions with a high prevalence among the elderly population (such as heart disease, diabetes, breast cancer, and stroke).⁵

¹ Berenson, Robert A. and Jane Horvath, "The Clinical Characteristics of Medicare Beneficiaries and Implications for Medicare Reform" Prepared for the Center for Medicare Advocacy, Inc., Conference on Medicare Coordinated Care, Washington, DC, March 2002. 5.

² Lieberman, Steven M. Julie Lee, Todd Anderson, and Dan L. Crippen, "Reducing the Growth of Medicare Spending: Geographic Versus Patient-Based Strategies," Health Affairs.

Web Exclusive, December 10, 2003. W3-605.

³ Partnership for Solutions, Medicare: Cost and Prevalence of Chronic Conditions. Johns Hopkins University, Baltimore MD. July 2002.

⁴ Wolff J. et al. Archives of Internal Medicine, November 11, 2002.

⁵ Stephen M. Asch, Elizabeth M. Sloss, Christopher Hogan, Robert H. Brook, and Richard L. Kravitz, "Measuring Underuse of Necessary Care Among Elderly Medicare Beneficiaries Using Inpatient and Outpatient Claims," Journal of the American Medical Association, 284, no.18 (November 8, 2000): 2330.

Patient Care Management reduces health care costs:

- One study of 3,000 patients with diabetes enrolled in a patient care management program found these patients lowered their health care costs by over \$100 a month. This was accompanied by lower inpatient health care use and emergency room visits.⁶
- The University of Pittsburgh Medical Center reported that care management can reduce rehospitalizations of diabetics by as much as 75 percent.⁷
- The Washington Hospital in Washington, Pennsylvania reduced rehospitalizations of patients with heart disease by 50 percent.⁸

The federal government:

- The Medicare Modernization Act of 2003 (MMA) included the Medicare Voluntary Chronic Care Improvement Program, now known as Medicare Health Support. This pilot program, implemented in August 2005 and will run for three years, involving about 160,000 beneficiaries at eight sites around the country with high prevalence of diabetes and congestive heart failure. Providers 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, providers are responsible for reimbursing Medicare up to the total amount of their fees.
- CMS has also begun the Care Management for High-Cost Beneficiaries Demonstration project. This project, which began enrollment in Fall 2005 is operating in six sites and aims to study various care management models for high-cost/highrisk beneficiaries. No evaluation data is currently available. 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.
- H.R. 493, the Genetic Information Nondiscrimination Act of 2007, would deny health care services at onsite clinics at the workplace and other disease and patient care management programs which often include routine genetic tests to benefit the patient based on treatment of their condition. How we treat the transmission of genetic information could inhibit the coordination of care among health providers, slow down processing and care because of the need to evaluate each document to strip out or specially handle genetic information, and increase the opportunity for medical errors.

Recommendations:

- Use Medicare and Medicaid to provide financial incentives to health care providers to provide patient care management programs to reduce health care costs of patients with chronic diseases.
- Ensure that any legislation does not prohibit the ability of group health plans and health insurance issuers to give information to providers or individuals about genetic tests required for cost saving patient care management programs.

⁶ Sidorov, Jann. Does Diabetes Disease Management Save Money and Improve Outcomes? *Diabetes Care* 25:684-689, 2002.

⁷ Murphy, Tim. *Critical Condition. The State of the Union's Health Care.* 2006.

⁸ *Ibid.*