

# THE NEED FOR A NATIONAL CHRONIC CARE IMPROVEMENT BENEFIT

May 3, 2007

Seattle, Washington

- I. The U.S. is facing a rapidly **gathering storm** in the area of health care financing.<sup>1</sup>
  - A. Health care is the **number one fiscal problem** for:
    1. The federal government;
    2. Most state governments;
    3. American business; and
    4. American citizens.
  - B. The current rate of growth in health care cost **can bankrupt the United States**. The problem is six times worse than the Social Security funding problem.
    1. The status quo is **not an option**.
    2. The nation's financial condition **is worse than generally reported**.
    3. We **cannot grow our way out** of the problem.
  - C. The **“unsustainable rate of growth”** in health care costs is illustrated by the fact that:
    1. Cash flow in the Medicare Health Insurance Trust Fund went negative in 2006 and will be exhausted in 2019.<sup>2</sup>

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<sup>1</sup> Economic information about the health care fiscal crisis is from the Medicare Trustees' Report of May 2006, a speech by the Comptroller General, David Walker (November 7, 2006) and a report by the Governmental Accountability Office (GAO) to House and Senate Leadership (November).

<sup>2</sup> 2007 Annual Report of the Medicare Trustees, 3.

2. More than 45% of total Medicare revenues will be funded out of general revenues over the next seven years.
    - a. This is the **second “Medicare funding warning”** by the Medicare Trustees which, under section 801 of the Medicare Modernization Act (MMA 2003), will require the President to propose emergency legislation and will require Congress to consider it on an expedited basis.
  3. The Medicare program is facing approximately **\$30 trillion in unfunded obligations**. Approximately \$8 trillion of that was added by the Medicare Prescription Drug Benefit contained in MMA 2003.
- D. The nation is also facing a **“demographic tsunami”** that will not recede.
1. The **post-war baby boomers** will fully hit the health care system in 2010, but the increased demand for health care will not subside because more people will live longer and have more chronic illnesses.
  2. By 2030, the number of **Medicare beneficiaries will double** from approximately 40 million to approximately 80 million while the number of workers per beneficiary will be cut in half.
- E. We also have more than **46 million Americans without health insurance**, and that number is growing.
- F. We **spend more per capita** for health care than most industrialized countries, but
1. We have below average life expectancy;
  2. Above average medical errors; and
  3. above average infant mortality.

II. The **solutions** currently under consideration are **not effective or popular**.

A. Health savings accounts (HSAs):

1. Generally linked with high deductible insurance (this is simply cost shifting in disguise);
2. Not favored by Democratic leadership, leads to “two-tiered” medicine;
3. Generally selected by wealthier, healthier, lower cost, patients who are not the principal drivers of growing health care costs;
4. Results in avoidance of necessary as well as unnecessary care.

B. Pay for performance (P4P):

1. Could result in higher costs if all practitioners meet the performance standards;
2. Resented by physicians;
3. Not sought or demanded by consumers;
4. Unlikely to generate near term savings.

C. Health IT (electronic health records “EHRs” and “interoperable” information systems):

1. Costly (\$280 billion over 10 years and \$16 billion each year thereafter);
2. Currently unfunded at a time when hospitals and physicians face downward pressure on reimbursement;
3. Most potential savings accrue to non-providers while the savings come from the providers responsible for investing in health IT;

4. Public has strong privacy concerns as additional breaches of electronic information systems in both government and private sector are reported in the media.

D. Increased cost sharing:

1. Very unpopular with middle class voters who determined the outcome of the last election.

E. Increased taxes:

1. Unpopular with nearly everyone, especially conservative Republicans and many Democrats.

F. Cuts in coverage or benefits:

1. Likely to shorten any political career.

G. Managed care:

1. No longer viewed as a cost saver;
2. Unpopular with patients and practitioners.

III. To have a significant impact on the unsustainable rate of growth in health care costs, **we must fundamentally alter** the health service **delivery** model rather than only the health service **financing** model.

- A. We must switch from the traditional approach of treating the chronically ill first and foremost in the hospital to treating these patients in their residences with **hospitalization as a last resort**.

- B. Such an approach keeps the chronically ill and the disabled **independent longer**.

- C. For any solution to be successful, it will have to be supported by **three legs of the health policy stool**:

1. Consumers;

2. Practitioners;
3. Payers.

D. The good news—

1. **80% of the cost of health care is related to 15% of the patients.** Thus, we should be able to substantially reduce the cost of health care by focusing first on this segment of the patient population. Solutions developed here can then be expanded to the rest of the patient population.
2. Most of these patients are suffering from **multiple chronic illnesses and disabilities.** This is also the segment of the patient population that will grow most rapidly over the next twenty years.
3. The high costs associated with these patients result from **repeated hospitalizations.**
4. These patients generally **get poor health care and poor outcomes** because the care is fragmented and uncoordinated with no follow up or monitoring. They have an average of 5 physicians and take an average of 15 medications.
5. High hospitalization rates and other resource consumption for these patients **produce worse outcomes.**<sup>3</sup>
6. More than **500 programs exist** across the country that shows significant savings in this patient population with physician-directed chronic care coordination.

- E. A program designed to provide coordinated care for these patients was approved by **Congress in sections 721-722 of MMA 2003.** The specifications for **Chronic Care Improvement (CCI)** were designed by the Farragut West Group organized by Powers, Pyles.

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<sup>3</sup> “The Care of Patients with Severe Chronic Illness”, The Center for the Evaluative Clinical Sciences, Dartmouth Medical School (2006).

1. The program began as a **three-year pilot** at eight locations in August of 2005.
2. CMS is **authorized by statute to expand nationwide** within two to three years of the end of the pilot.
3. The program **needs improvement** to cure defects inserted by CMS such as:
  - a. Failing to allow participation by organizations with the most experience;
  - b. Not requiring the programs to be physician directed; and
  - c. Not providing for patient choice and creating a government subsidized monopoly for favored entities.

IV. The Independence at Home program developed by the Farragut West Group **addressed all three legs** of the health reform policy stool.

- A. It is accepted by patients because **participation is voluntary** (like the hospice benefit). It is also popular with families who need assistance with the care of chronically ill relatives and can check on the status of relatives who live separately.
- B. It is **accepted by physicians** because it is physician directed.
- C. It is **popular with payers** because it guarantees savings.
- D. Breakthrough features:
  1. The effectiveness of each program is measured annually using two types of **“performance standards”** that measure outcomes and savings.
  2. The performance specifications compare the **total Medicare costs** of comparable patients in the general Medicare population with the total Medicare costs consumed by **patients enrolled** in the Independence at Home program. (Avoids the “silo” effect.) The programs **must show a**

**minimum of 5% savings** and good outcomes to be permitted to continue.

3. The programs may **split the savings above 5%** with the government. This generates revenue and an incentive to invest in information, monitoring and diagnostic technologies that can be used in the home.
4. **Focuses on the highest cost**, most poorly served patients first (those suffering from heart disease, COPD, and complex diabetes) and expands to other diseases (like Alzheimer's disease, Parkinson's disease and cancer) as technology improves.
5. The patients **do not give up standard Medicare** fee-for-service coverage.
6. The Independence at Home programs are **at risk for only the fees paid** for chronic care coordination.
7. **Care givers must be certified** in home care of the chronically ill.
8. **The potential for immediate and long term savings** and improved outcomes is unlimited due to the incentive for innovation that technology permits.
  - a. **Traditional health IT** will be used (with patient permission) to collect and compare the costs of enrolled versus non-enrolled patients and to allow the attending physician to coordinate all care.
  - b. **Telehealth** will be used to monitor the patients in their homes, to anticipate and avoid visits to the emergency room or hospital, and assist care givers in the home.
  - c. **Miniaturized diagnostic technology** will be used to allow a physician or nurse practitioner to provide virtually any service in the home that otherwise would have been provided in an emergency room.

- E. The Independence at Home programs present a rare opportunity to **reduce health care costs** in a way that will be **popular with patients** and their families.
1. There are **few other solutions** that:
    - a. Significantly **reduce the cost of health care** immediately and into the foreseeable future;
    - b. **Provide better health care** and better outcomes;
    - c. **Generate investment capital** for further innovation and technology; and
    - d. Provide the health care and independence that **most Americans want**.
  2. These programs are **truly “patient centered”** in that they are voluntary, and health IT systems are used to protect and facilitate the patient’s right to health information privacy in accordance with traditional standards for the ethical practice of medicine.

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