

02/23/11 - Chronic Disease Management

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Background

More than 40% of the U.S. population has one or more chronic condition.[1] Although the likelihood of having a chronic disease increases with age, approximately half of working-age Americans has at least one chronic condition.[2] The prevalence of chronic diseases is increasing in both the elderly and non-elderly populations, with a significant increase in the number of people with multiple chronic diseases.[3] Increased spending on chronic diseases in Medicare is a significant driver of the overall increase in Medicare spending over the last twenty years.[4]

Chronic disease management is a broad term that encompasses many different models for improving care for people with chronic disease. Elements of a structured chronic disease management program may include a treatment plan with regular monitoring, coordination of care between multiple providers and/or settings, medication management, evidence-based care, measuring care quality and outcomes, and support for patient self-management through education or tools.[5] (Chronic disease management is also frequently an element of medical homes, which will be discussed in a separate Implementation Brief.)

Although it is undisputed that chronic disease contributes to rising health care costs in the U.S., it is not certain that chronic disease management programs will reduce health care spending. The Congressional Budget Office has attempted to quantify the likely cost savings from chronic disease management programs but determined that the current body of evidence is inconclusive as to cost savings.[6] Nevertheless, given the high cost of treating chronic diseases, the Affordable Care Act (ACA) includes many provisions to encourage chronic disease management as part of the overall emphasis on improving the efficiency of health care.

Changes Made by the Health Reform Law (P.L. 111- 148)

Various provisions of the ACA encourage chronic disease management by incentivizing active self-management by patients, providing opportunities for reimbursement of providers for chronic disease management services, or providing federal support for the development of chronic disease management programs.

Reimbursement for chronic disease management services: The ACA establishes a list of "essential benefits" that must be covered by new plans offering in the small

group and non-group insurance markets, whether or not they are offered through health insurance exchanges. Essential benefits are not required for large group plans or plans regulated under ERISA. (For further discussion of health plan requirements, see the GPS Implementation Briefs on [grandfathered health plans](#) and [essential benefits](#).) The law requires coverage of "prevention and wellness services and chronic disease management" as part of the minimum set of essential benefits.[7]

Chronic disease management component of health plan reporting: By 2012, the Secretary of Health and Human Services (hereafter the Secretary) must develop reporting requirements for health plans "with respect to plan or coverage benefits and health care provider reimbursement structures that improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives . . . "[8] The reported information will be made available to the public online.

Early retiree reinsurance program requires cost-reduction for chronic and high-cost conditions: The ACA creates a temporary reinsurance program for employment-based plans that cover early retirees (ages 55 to 64). An employment-based plan is eligible for reimbursement under this program only if it "implements programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions." [9]

Center for Medicare and Medicaid Innovation testing of models to improve chronic disease care: The ACA instructs the Secretary to create a Center for Medicare and Medicaid Innovation (CMI) within CMS to test innovated payment and service delivery models that reduce cost and preserve or enhance care. The ACA includes a list of models, which strongly emphasize management of the chronically ill, but does not restrict the Secretary to those models. For more information, see the Implementation Brief on the Center for Medicare and Medicaid Innovation.[10]

Grants for medication management services: The ACA directs the Secretary to establish a grant program through the Center for Quality Improvement and Patient Safety (or other designated patient safety research center) to aid pharmacists in implementing medication management services for the treatment of chronic diseases.[11]

Extended patient navigator program: The law extends a demonstration grant program to provide patient navigator services, which assist patients in coordinating health care services for the diagnosis and treatment of chronic diseases.[12] The

program otherwise would have ended on September 10, 2010.

Advisory Group on Prevention, Health Promotion, and Integrative and Public Health: The law directs the President to create the National Prevention, Health Promotion, and Public Health Council and an Advisory Group that will "develop policy and program recommendations and advise the Council on lifestyle-based chronic disease prevention and management, integrative health care practices, and health promotion." [13]

Community-based prevention and wellness programs for Medicare: The Secretary is required to conduct an evaluation of community-based prevention and wellness programs, including the level of self-management of chronic diseases, and must develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries. [14]

New educational funding for health care workers who practice in the field of chronic care management: The ACA creates a grant program to provide new training opportunities for direct care workers [15] in long-term care settings. As a condition of receiving financial assistance, the worker must agree to work "in the field of geriatrics, disability services, long term services and supports, or chronic care management" for at least 2 years. [16] A separate provision of the ACA authorizes workforce development grants to institutions with geriatric education centers to offer short term, intensive courses focusing on geriatrics, chronic care management, and long term care. [17]

Implementation

Agency

The Department of Health and Human Services (HHS) is responsible for implementation of the various provisions discussed above. Provisions related to Medicare and Medicaid will be implemented by the Centers for Medicare and Medicaid Services (CMS) within HHS. Those provisions related to the essential benefits package and early retiree reinsurance program will be implemented by the Center for Consumer Information and Insurance Oversight (CCIIO) [18] within CMS.

Key Dates

Health plan reporting requirements: The Secretary must develop reporting requirements by March 30, 2014.

Early retiree reinsurance program: The reinsurance program ends on January 1, 2014.

Grants for medication management services: This Medicare program was required to begin by May 1, 2010.

Advisory Group: The report of the National Prevention, Health Promotion, and Public Health Council must be submitted to Congress and the President annually, beginning July 1, 2010, through January 1, 2015.

Evaluation of community-based prevention and wellness programs for Medicare beneficiaries: The Secretary's report, including recommendations for improving chronic disease self-management by Medicare beneficiaries, is due September 30, 2013

Workforce grants: Funding is authorized for direct care workers providing long-term care only for the period from 2011 through 2013. Funding is authorized for the geriatric workforce development provisions, which could fund short-term intensive courses on chronic disease management, from 2011 through 2014.

Process

Chronic disease management is embedded in different projects and funding opportunities, not a program in itself. Many of the programs and grants that include chronic disease management as an element are addressed in other Health Reform GPS briefs, including essential benefits,[19] the Center for Medicare and Medicaid Innovation,[20] and the various workforce grants.[21] Of particular relevance are the GPS briefs addressing value-based purchasing and quality improvement, both within federal programs like Medicare and for private insurance plans.[22]

Key Issues

One of the key challenges of defining chronic disease management services is that there is an array of chronic disease management models in both the private and public sectors. Also, there is mixed evidence about the effects of disease management on overall health spending.[23] Recognizing these problems, and recognizing that chronic disease management programs may vary based on the chronic disease in question and the needs of particular populations: How will chronic disease management be defined in the regulations implementing the various provisions above? Particularly where certain services must be determined to qualify as chronic disease management (as in the essential benefit package, temporary

reinsurance program, and certain grant programs), will there be a standard definition?

If chronic disease management is specifically defined, will it restrict the development of alternate models that might also be effective? Conversely, if regulations fail to adequately define chronic disease management, how will plans and other entities demonstrate that they satisfy federal requirements?

Of the various grants that may include chronic disease management as an element, what specific models will be funded?

How will the regulations addressing chronic disease management coordinate with the regulations addressing medical homes, care coordination, quality improvement, accountable care organizations, and other topics related to health system reform?

Funding for the Center for Medicare and Medicaid Innovation is specifically appropriated in the ACA and for the evaluation of Medicare community-based prevention and wellness programs, funding is to be transferred from existing sources. However, for other provisions with chronic disease management components, such as the workforce grants or medication management grants, will sufficient funding be appropriated for these programs to accomplish the goals of the law?

Agency Action

CCIIO (formerly OCIIO) has approved almost 3,600 employers and unions for the early retiree reinsurance program, which covers claims dating back to June 1, 2010 and ends on January 1, 2014, after which covered parties will have additional insurance options through the health insurance exchanges.[24]

President Obama issued an Executive Order on June 10, 2010, establishing both the National Prevention, Health Promotion, and Public Health Council and the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health within HHS.[25] On January 26, 2011, the President announced the appointment of thirteen experts to serve on the Advisory Group.[26]

For updates on programs and grants that include chronic disease management as an element, see the Implementation Briefs for those programs, including essential benefits,[27] the Center for Medicare and Medicaid Innovation,[28] and the various workforce grants.[29]

Authorized Funding Levels

Early retiree reinsurance program: The ACA authorizes \$5,000,000,000 for this program without any annual limit, but authorizes the Secretary to stop taking applications for the program to comply with the overall funding limit.

Center for Medicare and Medicaid Innovation: Funding for the CMI to design, implement, and evaluate payment and service delivery models is specifically appropriated in the ACA, including \$5 million for FY 2010, \$10 billion for the period of fiscal years 2011 through 2019, and \$10 billion for each subsequent 10-year fiscal period (beginning with fiscal year 2020). At least \$25 million must be made available to CMI each fiscal year.

Evaluation of community-based prevention and wellness programs for Medicare beneficiaries: The ACA directs the Secretary to transfer \$50,000,000 from the Federal Hospital Insurance Trust and the Federal Supplemental Medical Insurance Trust Fund to CMS to fund the necessary evaluation and report.

Workforce grants: \$10,000,000 is authorized for 2011-2013 to fund grants for direct care workers providing long-term care. For the geriatric workforce development provisions, which could fund short-term intensive courses on chronic disease management, \$10,800,000 is authorized for 2011-2014.

The law does not specifically authorize funding for the patient navigator continuation or the medication management grant program. The inclusion of chronic disease management in the essential benefit package is regulatory in nature and therefore does not directly the award of federal funds.

[1] Chronic diseases are "conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living." W. Hwang, et al., "Out of Pocket Medical Spending for Care for Chronic Conditions." *Health Affairs*. 20:268-9 (2001).

[2] C. Hoffman and K. Schwartz. "Eroding Access Among Nonelderly U.S. Adults with Chronic Conditions: Ten Years of Change." *Health Affairs*. 27:w340-w348 (2008).

[3] K. A. Paez, L. Zhao, W. Hwang. Rising Out-Of-Pocket Spending for Chronic Conditions: A Ten-Year Trend. *Health Affairs*. 28:15-25 (2009).

[4] K. E. Thorpe, Lydia L. Ogden, K. Galactionova. Chronic Conditions Account for Rise in Medicare Spending from 1987 to 2006. *Health Affairs*. 29:718-124 (2010).

[5] Congressional Budget Office, An Analysis of the Literature on Disease

Management Programs, October 13, 2004 (see Appendix: The Disease Management Association of America's Definition of Disease Management).

[6] Congressional Budget Office, Key Issues in Analyzing Major Health Insurance Proposals, December 2008 (see Ch. 7: Adopting Disease Management Programs).

[7] ACA §1302(b).

[8] ACA §2717(a).

[9] ACA §1102(b)(2).

[10]

<http://www.healthreformgps.org/resources/center-for-medicare-and-medicaid-innovation/>.

[11] ACA §3503.

[12] ACA §3510.

[13] ACA §4001(f).

[14] ACA §4202(b).

[15] Direct care worker includes home health aides, psychiatric aides, nursing assistants, and personal care aides. ACA §5002(b)(2).

[16] ACA §5302.

[17] ACA §5305(a).

[18] Formerly the Office of Consumer Information and Insurance Oversight (OCIO). See

<http://www.healthreformgps.org/resources/hhs-moves-key-health-reform-office-to-medicare-agency/>.

[19] <http://www.healthreformgps.org/resources/essential-benefits/>.

[20]

<http://www.healthreformgps.org/resources/center-for-medicare-and-medicaid-innovation/>. [21] <http://www.healthreformgps.org/topics/workforce-and-access/>.

[22]

<http://www.healthreformgps.org/topics/health-care-quality-and-delivery-system-reform/>.

[23] See, e.g., Rand Compare Literature Review on Disease Management, <http://www.randcompare.org/publications/disease-management>; Huang, E. S., Zhang, Q., Brown, S. E. S., Drum, M. L., Meltzer, D. O. and Chin, M. H. The Cost-Effectiveness of Improving Diabetes Care in U.S. Federally Qualified Community Health Centers. Health Services Research, 42: 2174-2193 (2007).

[24] <http://www.hhs.gov/news/press/2010pres/10/20101028a.html>.

[25]

<http://www.whitehouse.gov/the-press-office/executive-order-establishing-national-prevention-health-promotion-and-public-health>.

[26]

<http://www.whitehouse.gov/the-press-office/2011/01/26/president-obama-announces-more-key-administration-posts>.

[27] <http://www.healthreformgps.org/resources/essential-benefits/>.

[28]

<http://www.healthreformgps.org/resources/center-for-medicare-and-medicaid-innovation/>.

[29] <http://www.healthreformgps.org/topics/workforce-and-access/>.

Chronic diseases are "conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living." W. Hwang, et al., "Out of Pocket Medical Spending for Care for Chronic Conditions." *Health Affairs*. 20:268-9 (2001). C. Hoffman and K. Schwartz. "Eroding Access Among Nonelderly U.S. Adults with Chronic Conditions: Ten Years of Change." *Health Affairs*. 27:w340-w348 (2008). K. A. Paez, L. Zhao, W. Hwang. Rising Out-Of-Pocket Spending for Chronic Conditions: A Ten-Year Trend. *Health Affairs*. 28:15-25 (2009). K. E. Thorpe, Lydia L. Ogden, K. Galaktionova. Chronic Conditions Account for Rise in Medicare Spending from 1987 to 2006. *Health Affairs*. 29:718-124 (2010). Congressional Budget Office, *An Analysis of the Literature on Disease Management Programs*, October 13, 2004 (see Appendix: The Disease Management Association of America's Definition of Disease Management). Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals*, December 2008 (see Ch. 7: Adopting Disease Management Programs). ACA §1302(b). ACA §2717(a). ACA §1102(b)(2). <http://www.healthreformgps.org/resources/center-for-medicare-and-medicaid-innovation/>. ACA §3503. ACA §3510. ACA §4001(f). ACA §4202(b). Direct care worker includes home health aides, psychiatric aides, nursing assistants, and personal care aides. ACA §5002(b)(2). ACA §5302. ACA §5305(a). Formerly the Office of Consumer Information and Insurance Oversight (OCIIO). See <http://www.healthreformgps.org/resources/hhs-moves-key-health-reform-office-to-medicare-agency/>. <http://www.healthreformgps.org/resources/essential-benefits/>. <http://www.healthreformgps.org/resources/center-for-medicare-and-medicaid-innovation/>. <http://www.healthreformgps.org/topics/workforce-and-access/>. <http://www.healthreformgps.org/topics/health-care-quality-and-delivery-system-reform/>. See, e.g., Rand Compare Literature Review on Disease Management, <http://www.randcompare.org/publications/disease-management>; Huang, E. S., Zhang, Q., Brown, S. E. S., Drum, M. L., Meltzer, D. O. and Chin, M. H. The Cost-Effectiveness of Improving Diabetes Care in U.S. Federally Qualified Community Health Centers. *Health Services Research*, 42: 2174-2193 (2007). <http://www.hhs.gov/news/press/2010pres/10/20101028a.html>. <http://www.whitehouse.gov/the-press-office/executive-order-establishing-national-prevention-health-promotion-and-public-health>. <http://www.whitehouse.gov/the-press-office/2011/01/26/president-obama-announces-more-key-administration-posts>.

<http://www.healthreformgps.org/resources/essential-benefits/>.

<http://www.healthreformgps.org/resources/center-for-medicare-and-medicaid-innovation/>. <http://www.healthreformgps.org/topics/workforce-and-access/>.