

Final Report of the Study Panel on Medicare
and Chronic Care in the 21st Century

Medicare in the
21st Century:

Building a Better
Chronic Care
System

January 2003

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MAKING MEDICARE RESTRUCTURING WORK

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National Academy of Social Insurance Study Panel on Medicare and Chronic Care in the 21st Century

David Blumenthal, *Chair*
Massachusetts General Hospital/Partners HealthCare
Boston, MA

Gerard Anderson

Johns Hopkins School of Public Health
Baltimore, MD

Patricia Archbold

Oregon Health Sciences University
Portland, OR

Richard Bringewatt

National Chronic Care Consortium
Bloomington, MN

Sophia Chang

Veterans Health Administration
Palo Alto, CA

Peter Fox

PDF Inc.
Chevy Chase, MD

Leslie Fried

American Bar Association
Washington, DC

Glenn Hackbarth

Consultant
Bend, OR

Lisa Iezzoni

Harvard Medical School
Boston, MA

Richard Kronick

University of California, San Diego
School of Medicine
La Jolla, CA

Carol Levine

United Hospital Fund of New York
New York, NY

Neil Powe

Johns Hopkins School of Public Health
Baltimore, MD

Edward Wagner

W.A. MacColl Institute for Health Care
Innovation
Seattle, WA

T. Franklin Williams

University of Rochester
School of Medicine and Dentistry
Rochester, NY

Project Staff

June Eichner

Study Director and Senior Research Associate

Kathleen M. King

Director of Health Security Policy

Virginia Reno

Vice President for Research

Reginald D. Williams, II

Health Security Policy Research Assistant

Contractors

Robert Berenson

AcademyHealth
Washington, DC

**Robert Kane and
Rosalie Kane**

University of Minnesota
School of Public Health
Minneapolis, MN

**Marty Lynch, Carroll Estes,
and Mauro Hernandez**

University of California, San Francisco
Institute for Health and Aging
San Francisco, CA

Bruce Vladeck

Mount Sinai School of Medicine
New York, NY



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Executive Summary

This report is about how Medicare could improve care for beneficiaries with chronic conditions. During the mid-1960s, acute care—not chronic care—was the major focus of medicine. When Medicare was instituted in 1965, it was modeled after the health insurance system of that time. Medicare was to function primarily as a claims payer; its benefit package and reimbursement systems were not designed for chronic conditions; preventive services were excluded; and reimbursement was paid only for in-person visits and procedures to individual providers. Since then, good chronic care and comprehensive coverage have become crucial to Medicare beneficiaries. Though some improvements have been made to Medicare, major changes in the provision and financing of chronic care for Medicare beneficiaries are needed. Medicare has the potential to refocus its Medicare program—as well as the nation’s health care system—and should take a leading role in improving chronic care.

This report is the final product of the Medicare and Chronic Care in the 21st Century study panel, a panel convened by the National Academy of Social Insurance as part of its *Making Medicare Restructuring Work* project. The panel was charged with determining the health care and related needs of Medicare beneficiaries with chronic conditions, how well Medicare meets their needs, features of the current Medicare program that support or impede good chronic care, and the experience of other chronic care models. The panel was also expected to set a new vision for Medicare to improve care and financing for beneficiaries with chronic conditions, and then propose recommendations to move toward that vision.

The report is divided into five sections:

- overview of Medicare and chronic conditions, including prevalence of chronic conditions, financial implications of chronic conditions, Medicare’s original intent, characteristics of “good” chronic care, and the panel’s guiding principles
- needs and preferences of beneficiaries with chronic conditions
- barriers to chronic care facing the Medicare program and its providers
- past initiatives to improve care to people with chronic conditions
- long-term vision and short- to mid-range recommendations

The study panel focused on original Medicare, Medicare’s traditional fee-for-service program. It chose this focus because 35 million of Medicare’s 40 million beneficiaries are covered under this system. The study panel also recommended changes to the Medicare+Choice (M+C) system, as changes to M+C may be easier to facilitate.

OVERVIEW OF CHRONIC CONDITIONS AMONG BENEFICIARIES

Though there are many ways to define the term “chronic condition,” the panel chose to define it as an illness, functional limitation, or cognitive impairment that lasts (or is expected to last) at least one year; limits what a person can do; and requires ongoing care. Chronic conditions are prevalent among Medicare beneficiaries, as most (87 percent) have one or more chronic condition and 65 percent have multiple chronic conditions. In addition, one-third of beneficiaries have one

or more chronic condition defined as serious. Though poor Medicare beneficiaries are the most likely to have a chronic condition, all beneficiaries are at-risk, either through heredity, environmental factors, diet, age, or chance.

The cost of managing chronic conditions is substantial. A disproportionate amount of Medicare dollars is spent on beneficiaries with chronic conditions. Beneficiaries with five or more chronic conditions account for 20 percent of the Medicare population but 66 percent of Medicare spending. Out-of-pocket spending increases with the number of chronic conditions: for beneficiaries with three or more chronic conditions and no supplemental coverage, 1996 mean annual out-of-pocket expenditures were \$1,492 (compared to \$455 for those with no chronic conditions). Beneficiaries' high out-of-pocket expenditures suggest that Medicare does not provide the financial protection that it was originally designed to ensure. In addition, though expenditures for chronic care are high, the Centers for Medicare & Medicaid Services (CMS) and its beneficiaries are not getting the best value possible for the dollars spent.

NEEDS AND PREFERENCES OF BENEFICIARIES WITH CHRONIC CONDITIONS ARE BEYOND WHAT MEDICARE CURRENTLY PROVIDES

The quality and scope of care for beneficiaries with chronic conditions are lacking. Though age and disability-specific care are a major priority for this population, most providers lack training in geriatrics and the assessment and management of functional status and cognition. Many beneficiaries with common chronic conditions do not receive care recommended by clinical guide-

lines. Systems of care do not facilitate coordination of care among beneficiaries' multiple providers, nor do they facilitate more accessible and efficient care, such as care provided by teams of providers, or by phone and email. Support for self-management and family care participation may also be negligible.

Medicare does not pay for a substantial share of beneficiaries' health care spending, which disproportionately affects those with chronic conditions. Beneficiaries must pay out-of-pocket for Part B premiums, deductibles, and coinsurance. Medicare also does not have a limit on beneficiary copayments for covered services. It does not cover prescription drugs, a major form of chronic care treatment, and provides few benefits to prevent chronic conditions or delay their progression. In addition, Medicare does not support many functional and quality of life needs. Sensory loss, for example, is not considered by Medicare to be a medical concern, and eyeglasses and hearing aid benefits are excluded from coverage by statute. Rehabilitative services are often not covered when the goal is to maintain or slow the deterioration of function. Also, durable medical equipment (DME) and home health care policies may limit beneficiaries' ability to function in society, as DME coverage requires that the equipment be used primarily in the home, while home health coverage requires that the beneficiary be "homebound."

THE MEDICARE PROGRAM FACES—AS WELL AS POSES FOR PROVIDERS—CONSIDERABLE BARRIERS TO CHRONIC CARE

Medicare does not adequately support providers in their treatment and management of chronic conditions. Its fee-for-service reimbursement system does not pay for many

of the services and tools important for the care of beneficiaries with chronic conditions, nor does it offer providers the flexibility to utilize new and efficient methods of operation. Though these limitations are characteristic of the general U.S. health care system, Medicare's barriers to improved chronic care may be more pronounced because Medicare beneficiaries are over twice as likely as the non-Medicare population to have a chronic illness, and are three times as likely to have a functional limitation. Also, under the 1965 statute, CMS has limited authority over its providers, as it is not permitted to "exercise any control over the practice of medicine or the manner in which medical services are provided." These and other statutes impede the provision of chronic care services.

Original Medicare's fee-for-service reimbursement policies do not support quality chronic and geriatric care. Reimbursement is not adjusted for the additional complexity and time it takes to care for chronic conditions. Payment to individual providers for discrete services (i.e., office visits and procedures) discourages a team approach to care and other means of care that may be more conducive to comprehensive and more efficient care. It also provides little incentive to keep beneficiaries well. Though a number of techniques have been developed to help providers manage care, most have not been incorporated into providers' care systems and are not reimbursable by Medicare. Capitated payments to health plans would appear to bypass such constraints. However, the experience of M+C found that payment by capitation did not assure increases in the quality of chronic care. It appears that regardless of organizational and financial arrangements, improving our present systems of care is difficult and will require comprehensive change.

Congress and CMS have implemented a number of quality improvement initiatives. Unlike for M+C, most of CMS' quality initiatives for original Medicare do not rely on regulatory requirements. Also, its initiatives do not focus on care at the physician level, the source of most chronic care, as it is constrained by the political and statistical difficulties of monitoring individual physicians. However, the National Committee for Quality Assurance (NCQA) has begun work to report on ways of measuring the quality of care provided by physician practices, beginning with large practices. NCQA and other large accreditation organizations have also set standards for accreditation, certification, and performance measurement of chronic disease management. As the quality of such information improves, CMS could incorporate such measures into original Medicare. This could lay the basis for paying more to providers who deliver high standards of quality of care.

One of the primary ways CMS tests new ideas is through research and demonstration projects. However, CMS' ability to innovate is limited by the Office of Management and Budget's (OMB) requirement that demonstration projects be budget neutral. Not only does OMB require that demonstration projects not increase Medicare expenditures over projected spending in the absence of the demonstration, but in the case of demonstrations enrolling dual eligibles, budget neutrality is calculated separately for each program so that savings in one cannot be used to offset increased spending in the other. The recent chronic care demonstrations are severely constrained by the requirement that they be budget neutral because CMS requires that the demonstrations provide drugs and services not covered under original Medicare. Thus, the evaluation of these demonstrations

will be based largely on the providers' ability to manage Medicare expenditures of participating beneficiaries—at a cost that may not be realistic—while de-emphasizing improvements to quality of care. How chronic care could best be managed under more realistic conditions—allowing modest cost increases that might be shared by beneficiaries, for example—will be left untested.

PAST INITIATIVES TO IMPROVE CARE TO PEOPLE WITH CHRONIC CONDITIONS PROVIDE VALUABLE EXPERIENCE

A number of initiatives have been implemented to improve care for people with chronic conditions. CMS' Program for All-Inclusive Care for the Elderly (PACE) and the Social HMOs (S/HMOs) have attempted to integrate the financing and delivery of medical care and community-based care systems for the frail elderly. Other efforts include Medicare case management demonstrations for high-cost beneficiaries, and its end-stage renal disease (ESRD) program, which redesigned the payment system for ESRD. Health plans have also implemented programs to improve chronic care. Kaiser Permanente's Northern California region's heart failure program, for example, has worked to improve the care system for patients with congestive heart failure. Another approach that health plans, provider groups, and CMS participate in is the Chronic Care Breakthrough Series Best Practice Collaborative, which utilizes the Chronic Care Model for its redesign of health care organizations' care systems.

These initiatives offer lessons that can be incorporated into mainstream Medicare. Most of these initiatives found that chronic care requires specialized training of and the

coordination of providers. They also suggest that financial incentives that align with program goals may be helpful. In addition, information systems are important to chronic care initiatives, as organizations must have the ability to track patients, diagnoses, and utilization. Experience also shows that sustained improvement requires comprehensive system change, and that it may not be possible to vastly improve systems of care on a budget-neutral basis.

RECOMMENDATIONS

The study panel's recommendations include its long-term vision for Medicare and six short- to mid-term recommendations. Its recommendations address changes across the range of policy sources, including Medicare statute; regulations; national coverage decisions; contractor manuals, memoranda, or other guidance; and policy interpretations by Medicare contractors, including local medical review policies.

Long-Term Vision

In the panel's long-term vision, Medicare would provide beneficiaries with access to needed services and financial protection from costs that pose barriers to chronic care. This would involve adding coverage for services not presently included in Medicare's benefit package, including function and quality of life-related services. Changes to the benefit package would be designed to meet the needs of beneficiaries. Medicare would also set reasonable limits for beneficiaries' health related out-of-pocket expenditures.

The panel's vision entails a dramatic shift to include a chronic care focus in Medicare. Providers' practices would be based on evidence-based guidelines. Concern for function

and quality of life would be integrated into the care system. There would be a seamless continuum across acute, chronic, long-term, and end-of-life care. All providers would use computerized information systems, which would support the sharing of electronic medical records among providers, medication order checks, and patient-specific protocols.

As the largest health care purchaser in the country, Medicare would actively work to improve the quality of chronic care. It would meet and surpass the quality standards set by the broader health care system. Quality of care would be measured and reported to the public. Medicare would make additional payments to providers who offer high quality care. Measures of quality of care would be sensitive to the unique conditions, issues, and diversity of concerns of beneficiaries with chronic conditions.

Reimbursement methods would cease to be an obstacle to chronic care, and would instead support quality chronic care delivery. Such methods would align incentives, adjust for risk factors, and offer providers the flexibility they need to provide good chronic care. Variations on prepayment and salaries to better support chronic care would be considered. Most providers would be affiliated with a provider network organization, a health plan, or integrated delivery system that offers them organizational support for chronic care.

Short- to mid-range recommendations

The following are the panel's short- to mid-term recommendations, some of which could be implemented immediately; others which may take five to ten years, though work on all should begin immediately.

Recommendation 1: Provide beneficiaries with financial protection from chronic conditions.

- Limit cost sharing requirements by adding an annual cap on out-of-pocket expenditures for covered services.
- Cover services necessary for beneficiaries' chronic care needs (as addressed in Recommendation 2).

Recommendation 2: Support the continuum of care beyond those services presently covered by Medicare.

- Address gaps in Medicare's benefit structure. Two significant gaps are prescription drugs and preventive health services.
- Strive to include services related to function and health-related quality of life.
 - Relax the requirement that to be covered for home care, beneficiaries must be homebound.
 - Cover durable medical equipment with the specific intent of maintaining or restoring function.
 - Provide for assistive devices that compensate for sensory or neurological deficits.
 - Support rehabilitation as a tool to improve, maintain, or slow the decline of function.
- Involve families of beneficiaries. Provide families information and education about Medicare policies and choices of health plans and providers. Add an explicit patient-family education benefit. Adequately compensate providers for family consultation through modification of Evaluation & Management codes.

**Recommendation 3:
Promote new models of care.**

- Foster delivery system change.
 - Encourage improved practice organization and care delivery.
 - Support geriatric assessment and management.
 - Integrate services for those dually eligible for Medicare and Medicaid.
- Increase providers' knowledge of chronic and geriatric care.
 - Use Graduate Medical Education funding to support chronic care training.
 - Support geriatric training for all physicians and train more academic geriatricians.
- Payment should support new models of care.
 - Risk-adjust Evaluation and Management (E&M) codes.
 - Improve models for risk-adjusting prepaid arrangements.
 - Test alternative payment models within original Medicare.

**Recommendation 4:
Strengthen CMS' role as a purchaser of care.**

- Measure and report on the quality of chronic care.
- Designate Medicare Partnerships for Quality Services demonstration (formerly called the Centers of Excellence) for select chronic conditions.

**Recommendation 5:
Support enhanced information systems.**

- Foster implementation of electronic information systems.

- Promote the collection and standardization of health and functional assessment data.

**Recommendation 6:
Implement and support funding for research and demonstration projects.**

- Sponsor a wide variety of chronic care research and demonstration projects and readily incorporate successful elements into the Medicare program.
- Focus projects on multiple chronic conditions.
- Redefine budget neutrality for the purpose of approving proposed demonstrations.
- Increase CMS' budget for research and demonstrations to improve chronic care.

Some of these recommendations will take longer to enact than others; some will cost the Medicare program more than others. The panel hopes that policymakers will move quickly to put as many of these recommendations in place as possible.

Along with a prescription drug benefit, the recommendations the panel believes would have the most substantial impact if enacted are:

- limiting cost-sharing requirements by adding an annual limit for out-of-pocket expenditures;
- supporting new models of care by risk-adjusting Evaluation and Management (E&M) codes;
- implementing information systems that track beneficiaries across multiple providers and care settings.

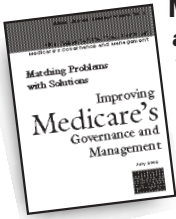
The three low-cost recommendations that the panel believes would significantly improve the quality of chronic care are:

- using Graduate Medical Education (GME) funding to support chronic care training;
- testing alternative payment models;

- measuring and reporting on the quality of chronic care.

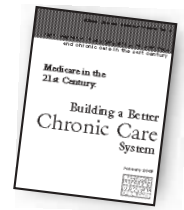
Medicare has for too long short-changed beneficiaries with chronic conditions. It has the opportunity to improve the value of care provided to its beneficiaries and must take the lead in improving chronic care.

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Matching Problems with Solutions: Improving Medicare's Governance and Management, July 2002, 79 pages, \$15.00

This report focuses on two tasks: examining whether a different governance structure might help the federal agency that runs Medicare, the Centers for Medicare & Medicaid Services (CMS), be more effective and identifying ways in which current Medicare management could be improved. In part because some panel members had different views on whether Medicare should be restructured, the panel concentrated its focus on making the current Medicare program work better.



Reflections on Implementing Medicare (Second Edition), January 2001, 61 pages, \$15.00

This report, originally printed in the spring of 1993, provides a historical reflection on the early days of a program enacted in 1965 to provide health care coverage to 19 million elderly Americans. This second edition was released by the study panel on Medicare Management and Governance as part of the Academy's Restructuring Medicare for the Long Term Project. The report provides useful insights into the intentions of Medicare's founders and an historical benchmark against which to gauge the program's evolution over the last three-and-a-half decades.



Financing Medicare's Future, September 2000, 101 pages, \$15.00

This report describes options for financing Medicare beneficiaries' health care under several possible approaches for changing the program's structure and benefits. It is the final report of a nonpartisan study panel convened by the National Academy of Social Insurance. The 12 members of the study panel represented a broad diversity of philosophical perspectives, disciplinary training, and professional experience.

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