Confronting the Barriers to Chronic Care Management in Medicare

Prepared for the Study Panel on Medicare and Chronic Care in the 21st Century
National Academy of Social Insurance
April 2002

By
Robert A. Berenson, M.D.

Introduction

Nobel laureate Kenneth Arrow's article, "Uncertainty and the Welfare Economics of Medical Care,"(Arrow) is often cited to make the case that the nature of medical care has special characteristics that makes health care markets different from typical, competitive markets. Among these characteristics, is the existence of uncertainty in the incidence of disease and in the efficacy of treatment and the asymmetry of information between the buyer—the patient—and the seller—the physician.

Less remembered and cited was a section of the paper on "The Theory of Ideal Insurance." In this section, Arrow emphasizes the core importance in insurance of the concept of "moral hazard,[1]"—"What is desired in the case of insurance is that the event against which insurance is taken be out of the control of the individual." That is, insurable events are those that the beneficiary does not wish to occur. When the insured wishes the event and can affect its occurrence, there is moral hazard.

In his discussion of moral hazard as applied to medical insurance, Arrow points to certain unique factors that affect a patient's actual use of services covered by medical insurance, such as her choice of physician and her attitude toward using medical services. Nevertheless, writing in 1963, Arrow emphasizes that insurance is more valuable, the greater the uncertainty in the risk being insured against, the reason, he explains, for putting greater emphasis on insurance against

[1] The term "moral hazard" is often misconstrued to imply personal blame or lack of appropriate morality. No such connotation is intended.

hospitalization and surgery than other forms of medical care.

In this context, Arrow specifically commented on the merits of insurance against chronic illness. “On a lifetime insurance basis, insurance against chronic illness makes sense, since this is both highly unpredictable and highly significant in costs. Among people who already have chronic illness, or symptoms which reliably indicate it, insurance in the strict sense is probably pointless.” (Emphasis added.) In essence, he was relying on the moral hazard argument that patients with chronic illness should desire to use health services and that physicians and other providers want to provide the care to them, thereby undermining the function and actuarial soundness of insurance.

In many ways, health insurance no longer is insurance in the “strict sense.” Insurance has become form of pooled prepayment for services, with the insurer helping to organize both the market for financing the pools and, in the era of managed care, the market for delivery of services. In addition, it is clear that current insurance products often deviate from the theory of ideal insurance by covering and paying for services that are often predictable and desired by patient and provider.

Nevertheless, it must be kept in mind that the Medicare statute was passed less than two years after Arrow’s publication and its basic structure remains largely intact. In fact, the enabling legislation represented a compromise between advocates of a social insurance program covering all health care for persons covered, on a compulsory basis, financed by payroll taxes, with a public assistance program as a safety net, on the one extreme, and those supporting only a public assistance program, at the other. (Myers)

In terms of program structure and benefits, the ultimate compromise reflected the settled opinion and prevailing insurance practices of the day, that there would be more complete coverage for hospital care—Part A—than for physician services—Part B. Indeed, the Johnson Administration's Bill—the King-Anderson bill—provided only for inpatient hospital services. Republican Representative Byrne emphasized the inadequacy of the Administration's bill because it lacked coverage for physician services and prescription drugs. Along the way there were proposals to include physician services, but limited to those services provided by hospital staff, e.g., for inpatient surgery. (Myers) At the last minute, Wilbur Mills, chairman of the House Ways and Means Committee, added voluntary Part B coverage for physician services but outpatient drugs were not included.[2] (Ball)

In statute and operations, the traditional Medicare fee for service program reflected indemnity insurance principles, for example, in covering inpatient hospital care per "spell of illness" (42 U.S.C. 1395x(a)) and covering services "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." (42 U.S.C. 1395 (a)(1)(A). Introduced along established indemnity insurance principles, over the years the agency administering the program has set up a routine process for considering any new service: determining that there is a statutory-based benefit category for the service, that the

---

[2] Reportedly, a main reason prescription drugs were not included was the relatively high transaction costs associated with submitting claims for then inexpensive outpatient pharmaceuticals. The same issue pertains to consideration of direct reimbursement for telephone calls and email (see discussion below).

service is “reasonable and necessary,” that there is an appropriate code for the service according to the applicable payment system, and, finally, that appropriate payment rates are established.

Moral hazard concerns persist

Consistent with commercial indemnity insurance principles of the day, preventive services, including physical examinations and routine immunizations, were excluded from coverage. Over time, certain “penny wise, pound foolish,” exclusions based on moral hazard principles have been reduced or eliminated. In commercial insurance, well baby care is now usually covered. In Medicaid, from its inception less oriented to strict insurance coverage than Medicare, early and periodic screening, detection and treatment (EPSDT) became a prominent requirement. Even in Medicare, specific preventive services, e.g., screening mammography and influenza vaccination have been added by statute, despite the remaining general exclusions for preventive services.

Nevertheless, despite some loosening of strict insurance principles, a consideration of how Medicare promotes or frustrates improved delivery for patients with chronic conditions must recognize that the traditional Medicare program still functions as an indemnity insurer, and, for the most part, currently is precluded from applying tools used by some private health plans and provider groups to more rationally and effectively managing care for special populations. Reliance of fee for service reimbursement fro physician services itself limits delivery system

innovation that are available to others.[3]

Take, for example, the question of whether Medicare should reimburse physicians for telephone calls or, now in the twenty first century, email between patients and physicians. Without question, the modern practice of medicine requires frequent patient contact outside of the defined, reimbursable patient visit to the physician or hospital outpatient department. In chronic disease care management, phone calls are viewed as essential to high quality and efficient care. (Wagner et al.)

However, from the viewpoint of an indemnity payer, coverage and payment for telephone calls and emails raise a series of troubling issues. For both provider and payer, payment for individual calls or email communications would be administratively very costly. Indeed, the transaction costs associated with submitting, paying and collecting, in most cases would be far more than the actual dollar amount of the reimbursement. In addition, there could be major problems achieving program integrity—assuring that the payments were being made appropriately for services actually rendered. The audit activities that would need to be established to assure proper payments for non-paper communications would be daunting, and certainly more intrusive even than the much criticized oversight requirements for relatively

---

[3] Many Medicare payment systems have moved to the concept of "per episode" payments, e.g., the hospital Prospective Payment System and home health prospective payment. Although physician payment is based on a fee schedule and, thus, is technically prospective, and although total expenditures for physician services are capped through the Sustainable Growth Rate mechanism, reimbursement is made for thousands of individual physician services.

straight forward office visits.[4] (Iglehart)

But most significantly, paying for routine phone calls and emails would likely produce an unprecedented moral hazard problem. It is one thing to cover preventive services that beneficiaries and providers desire and can control, although, even here, statutory provisions typically place evidence-based limits on the frequency with which these prevention services may be provided. For discrete services that involve their physical presence, such as office visits, patients typically experience "time costs," inconvenience, discomfort, etc., producing a natural brake on excessive utilization. Not so for phone calls and emails made in the comfort of home.[5]

From the practitioner's point of view, "excessive" patient generated phone calls and emails to the professional team caring for patients' chronic diseases would probably be desirable, consistent with the importance of promoting patient "self-management" responsibility and skills. (Wagner et al.) When phone calls and emails are not reimbursed, conscientious physicians that increase the amount of such contacts will surely suffer financially. In a very real sense, then, the fee for service payment restrictions on reimbursement for non-visit contacts does freeze innovation in how clinical care is practiced.

---

[4]A complicating issue would be the collection of the 20% co-insurance that is required under Part B payment rules. If required, patients would have to be billed for cents. If waived because the administrative costs of collection would be too great, any potential deterrent effect of co-insurance on utilization would disappear.

[5]Dr. Arthur Garson, Dean of Academic Operations at Baylor College of Medicine, at the October 25, 2001 workshop, "Creating a Vision: the Academic Health Center of the Future, sponsored by the Commonwealth Foundation, described the phenomenon of physicians experiencing "email fatigue" caused by the increasing onslaught of emails from motivated patients.

Yet, from the indemnity payer's point of view, the financial exposure either could be disastrous, or alternatively, in a context where there are expenditure limits, such as in the Medicare payment system for physicians, could shift expenditures among physicians in politically unsustainable ways.[6]

Other limitations to modernizing Medicare

In addition to being a constrained indemnity payer, other aspects of the traditional Medicare program from its inception contribute to its inability to adapt to the changing needs of beneficiaries, particularly around the provision of care to chronically ill. First, although program benefits have been enhanced since 1965, the program still lacks coverage for most prescription drugs. Although there are certain statutory and regulatory loopholes that permit limited, albeit important, coverage for certain pharmaceuticals that are used for specific chronic diseases (e.g., Avonex for multiple sclerosis, Visudyne for age-related macular degeneration), effectively, prescription drugs that are the staples of chronic disease management are not covered. The recent Surgeon General's Report of Mental Illness emphasized the point that the most important improvement in Medicare for care for beneficiaries with chronic problems, such as depression, would be a prescription drug benefit. (Mental Health)

Many beneficiaries obtain reasonable prescription drug coverage through supplemental

---

[6] The most straight-forward and practical way to compensate physicians and their staffs for engaging in non-visit based communications with patients would be with a monthly clinical management fee that would be made when beneficiaries have a high burden of chronic care that needs special coordination. This approach would, in essence, put the physician at risk for "excessive" communications. (See discussion later)

forms of insurance, particularly retiree health benefit programs and enrollment in Medicare+Choice HMOs. (Kaiser) However, retiree health programs are being scaled back significantly. The Medicare+Choice program is experiencing difficulty, and most plans are reducing the generosity of the prescription drug benefits, both to reduce costs and to avoid adverse selection. (Achman and Gold, Berenson)

In addition to a benefit package that does not support provision of care to chronically ill, the traditional Medicare program has very limited flexibility to influence the nature of the health care physicians and other health professionals actually provide. As part of the political deal to achieve passage of Medicare, Section 1801 of the original Medicare statute established that "Nothing in this title shall be construed to authorize any federal officer or employee to exercise any control over the practice of medicine or the manner in which medical services are provided." Section 1802 provided guarantee of beneficiary freedom of choice—in current parlance, Medicare was to be an "any willing provider" program.

Although, in some areas, the federal government was authorized to exert some regulatory authority, e.g., Conditions of Participation for Part A providers, enforcement of the False Claims Act, the traditional program remains a passive payer, precluded from using even basic managed care tools to try to influence the delivery system to improve the care provided to beneficiaries. Thus, for example, the agency administering Medicare cannot designate certain "centers of excellence" for the provision of chronic disease and provide these particular institutions additional payment and greater flexibility in how services are provided.

Rather, as a general proposition, the program rules must be applied uniformly on a national basis. Exemplary performance cannot be rewarded, while poor performance is tolerated. Although particular, innovative professionals would provide additional care coordination services in a highly competent manner that would improve quality efficiently, under current rules all professionals with the correct license would be eligible for additional payments, whether or not they modified the acute care orientation of their practice styles (Wagner et al.) or actually attempted to implement the principles of chronic care management. Given these constraints, policy makers are naturally reluctant to provide a set of additional services that constitute state-of-the-art care for chronically ill.

Another barrier that stands in the way of supporting care for chronically ill beneficiaries the program orientation to provider interests, that has resulted in "turning the program from one that provides a legal entitlement to beneficiaries to one that provides de facto political entitlement to providers." (Vladek) There are a number of manifestations of this provider orientation. Improved, often prospective, administered pricing systems have been implemented for most providers, but, these provider-specific payment systems typically have paid providers based on their historical costs regardless of patient benefit. Thus, for example, the same ambulatory surgical procedure is paid three different rates, depending upon whether it is performed in a hospital outpatient department, an ambulatory surgical center, or a physician's office. Another manifestation of the provider orientation is the siloed nature of clinical practice. "These different payment structures...create strong incentives for providers to focus inward on their own activities and function in self-serving ways, regardless of the cumulative effect on

costs across settings or on the overall quality of care received by a patient with multiple providers." (Bringewatt)

Capitated prepayment as a payment alternative

At the same time, by many measures, the population served has chronic conditions, which presents both a cost and quality challenge. The General Accounting Office analysis of Medicare FFS data from California in 1991, demonstrated that about half (52 percent) of beneficiaries had at least one of five chronic conditions—hypertension, diabetes mellitus, congestive heart failure, ischemic heart disease, and chronic obstructive pulmonary disease. (GAO, 1997) A recent analysis by the Partnership for Solutions at Johns Hopkins showed that about 78 percent of seniors have at least one chronic disease, and almost 63% have two or more.[7] (Berenson and Horvath) In 1996, 12 percent of all Medicare beneficiaries accounted for 75 percent of all Medicare fee for service program payments. Many of these high cost beneficiaries are chronically ill, and much of the Medicare expenditures for their care are for repeated hospitalizations. (Federal Register) The program is geared to paying for these hospitalizations, as acute events, but not for activities that might reduce the need for hospitalization.

---

[7] Among the list of chronic conditions are those that are real but do not have current clinical manifestations, e.g., "disorders of lipid metabolism," or are usually easily managed with low cost prescription drugs or other interventions, e.g., "hypothyroidism." Nevertheless, virtually all of these conditions are treated with often-expensive medication that needs monitoring, and most produce symptoms that benefit from medical interventions.

A potential way of this dilemma, of course, is to alter the fee for service, indemnity construct of the program, by altering payment incentives, the locus of financial risk, and the highly centralized policy making orientation of the program. Writing nearly 40 years ago, Arrow himself recognized the alternative of prepayment for services, then practiced in “closed-panel practice...which bind the patient to a particular group of physicians,” (Arrow) the prepaid group practices, such as Kaiser-Permanente and Group Health Cooperative of Puget Sound.

Even in 1965, Medicare recognized prepaid group practice plans as a different kind of entity for which a different kind of payment method was necessary. (Zaraboso) In 1965, prepaid plans were accommodated by permitting them to be paid on a reasonable cost basis for services, such as physician services that otherwise would be paid on a reasonable charge basis. Over time, the program modified how prepaid group practices, renamed health maintenance organizations (HMOs) in the Social Security Amendments of 1972, were to be paid. (The Tax Equity and Fiscal Responsibility Act of 1982). Under TEFRA, contracting HMOs would be paid 95 percent of the adjusted average per capita costs (AAPCC), with the rates calculated at the county level, with separate rates for the disabled and elderly and adjustment factors for age, sex, institutional status and Medicaid status. The cost contracting option continued to be available to HMOs, and organizations could continue to be paid under the group practice prepayment option. Nevertheless, the major expansion in managed care options were in the risk-contracting program.

The Balanced Budget Act of 1997's Medicare+Choice (M+C) Program—Part C of Medicare—made a number of changes in the way contracting risk plans were paid and called

development of a payment risk adjustment method based on health status, not based just on demographic factors. Under both TEFRA and BBA, contracting health plans were required to provide the statutory Medicare Part A and Part B benefits and had to follow traditional Medicare's coverage decisions. But, importantly, the policies and procedures they adopt to manage the delivery of health care did not have to emulate the traditional Medicare program and its dependence on fee for service payment and indemnity insurance principles.

The logic of capitation as a platform for launching innovations in the care for those with chronic disease is compelling. "In a capitated environment, organizations bearing financial risk have strong financial incentives to identify their high-risk members early and to provide them with special care designed to optimize their health and avert health-related crises. They have longer-range incentives to promote continued good health among older enrollees who are not chronically ill." (Boult, 1999)

When working properly, often within a capitated environment, Wagner has described a chronic care improvement model that, in contrast to typical medical practice, emphasizes early identification of patients at risk through specialized assessment tools, greater attention to treatment planning that provides a schedule of tasks and delineation of roles, evidence-based clinical management, greater attention to techniques that promote patient self-monitoring, and sustained, proactive follow-up. (Wagner)

Carrying out this model requires important delivery system changes, including clinical information systems that facilitate patient identification, care planning, reminders and feedback;

self-management interventions that often rely on expanded responsibilities for nurses in education and support to patients; delivery system redesign that modifies traditional practice roles and office systems and promotes more of a team orientation to care; and decision support aides of various kinds. (Wagner, Cassel, et al.)

Unfortunately, so far, the performance of managed care in delivery system re-engineering has been much less than hoped for numerous reasons related to how health care markets have developed (Berenson, 1998), with the result that the quality of care provided by HMOs to patients with chronic disease is similar to the care provided in the fee for service sector. Although a few studies, including an often cited one by Ware and colleagues, have found that HMO patients with chronic illness had somewhat worse outcomes than those in FFS, (Ware) comprehensive literature reviews by Miller and Luft comparing HMO and FFS performance, which was updated earlier this year, consistently find little difference in performance, even when studies are stratified by categories, such as prevention, chronic care, heart disease, etc. (Miller and Luft) Indeed, Jencks et al. from HCFA found that interstate variations on 24 quality measures in the Medicare FFS program, which included measures of chronic disease management, were far greater than the minor variations found in studies comparing HMO and FFS performance. (Jencks et al.)

A discussion of why prepaid, capitated programs have not achieved better quality outcomes for patients with chronic disease is beyond the scope of this paper. A major factor has been the nature of HMO expansion, beginning in the mid 1980s. To avoid the “bricks and

mortar" costs associated with group and staff model HMOs, insurers were able to take advantage of oversupply of physicians and hospital beds in many metropolitan areas to obtain price discounts from providers and expand rapidly in the form of independent practice association-type HMO. This has satisfied purchasers' desires for broad choice of provider, but has reduced the promise offered by integrated care models. In the West, where there was greater development of capitated medical groups, there has been particular instability in integrated care delivery models. Medical groups are retrenching, physician practice management firms are declaring bankruptcy, and physician-hospital organizations are dissolving or breaking up into their component parts. (Robinson)

For the most part, the recent difficulties of the Medicare+Choice program parallels the experience that HMOs have had in their commercial and other public purchaser markets. A crucial difference is that in commercial markets health plans are able to pass on their double-digit inflationary costs directly to the purchaser, whereas in Medicare the main purchaser's contribution, which comes out of the Part A and Part B trust funds, is fixed according to administrative formula, exposing the beneficiary to the full amount of cost increases, in the form of reduced benefits and increased out of pocket spending. (Berenson) For various reasons many HMOs have chosen to withdraw from the M+C program, affecting more than 2.2 million beneficiaries between December 1998 and January 2002.

The absence of health status based risk adjustment is a problem in any purchasing model that requires individual choice of multiple health plan options, the Medicare+Choice model.

When payments are adjusted only for demographic variables, health plans understandably have no choice but to try to attract healthier than average enrollees within the demographic categories. Although overt cherry picking through discriminatory marketing and other practices is prohibited, risk contracting health plans are able to attract a healthier than average population of Medicare beneficiaries. (GAO, 2000) From the government's financial viewpoint, the ability of plans to risk select results in substantial overpayment to plans for provision of the statutory Medicare benefits. (GAO, 2000)

Similarly, from the health plan's viewpoint, the absence of health status-based risk adjustment has a chilling effect on innovation in provision of care to chronically ill. Although there are numerous examples of innovative programs targeted to care for chronically ill older persons, (Boult, 1998, HMO Workgroup) in the absence of risk status based risk adjustment, there is a disincentive for HMOs to actively promote these programs and market them to eligible Medicare beneficiaries.

As noted earlier, the BBA required implementation of a new risk adjustment system. Currently, CMS is using a risk adjuster based on diagnoses recorded during inpatient hospitalizations. Most agree that an inpatient based risk adjuster, although more accurate than the demographic risk adjuster that has been used since the mid-1980s, potentially has perverse incentives on development of innovative ambulatory based programs for care of the chronically ill, which might substantially reduce the frequency of hospitalization.

Unfortunately, there is no consensus on how to proceed to adopt a risk adjuster that records diagnosis from ambulatory care sites in addition to the hospital. Last year, HCFA

announced an implementation schedule for a comprehensive risk adjuster. Despite concerns expressed by health plans about administrative burden associated with collecting encounter data from physicians' offices and hospital outpatient departments, Congress, in the Medicare, Medicaid and SCHIP Benefit Improvement and Protection Act of 2000, called for full phase-in of health status-based risk adjustment by 2007. However, earlier this year, responding to the plans' concerns and worried about another round of plan pull-outs, CMS Administrator Scully postponed collection of ambulatory encounter data and recently said that he might do so again if he is unable to find a new risk adjustment approach. On March 29, 2002, CMS described a modified risk adjustment approach and resumption of data collection from plans. The modified approach requires a smaller number of diagnoses from ambulatory settings than the previous comprehensive risk adjuster required in an attempt to balance reporting burden and predictive precision. (CMS website)

Given the current instability in the M+C program and the uncertainty of adoption of health status-based risk adjusted payment, a broad-based, capitated prepayment approach to introducing innovation in the care of chronically ill Medicare beneficiaries is in doubt. The TEFRA program and then the M+C program was thought to be a way of reducing program expenditures, while providing a way for beneficiaries to obtain additional benefits, particularly in reduced cost-sharing and prescription drugs. Because of the absence of good risk adjustment, the M+C program is a net financial loser for Medicare. Although beneficiaries did receive substantial additional benefits, those benefits are now being substantially reduced by the health plans

remaining in the program. (Achman and Gold)

Perhaps the basic purpose of contracting with private managed care entities needs to be reexamined. The traditional program does a good job of administering benefits and paying claims, with administrative costs less than 2 percent. What the traditional program, locked into fee for service, indemnity insurance principles and procedures cannot do well is influence the delivery system to adopt more patient-centered, team oriented approaches to delivering care, particularly to those with one or more chronic diseases. Contracting with private plans could be the prime vehicle for care for those with chronic diseases but to accomplish this purpose would require an overhaul of the current regulatory regime and payment methodologies that govern the M+C program. (Berenson) There is little prospect for this kind of overhaul in the foreseeable future.

Capitated demonstrations targeted to the frail elderly/dual eligible

In addition to risk-contracting, a number of care coordination demonstrations involving capitation payment have taken place in Medicare. These programs have focused on a particular subgroup of frail elderly beneficiaries who are nursing home residents or candidates for nursing home placement, and, as such, they represent programs focused on dually eligible Medicare and Medicaid beneficiaries.

The dually eligible population is comprised of diverse subgroups including: physically

disabled non-elderly; cognitively impaired, non-elderly SSI recipients; frail elderly Medicare beneficiaries who "spend-down" through high medical costs their income and assets to become Medicaid eligible, and elderly Medicare beneficiaries who are low-income, but not necessarily frail. (Clark and Hulbert)

According to a recent analysis of a 1997 sample of the Medicare Current Beneficiary Survey (MCBS), (Murray and Shatto) twenty-four percent of dually eligible live in nursing homes, compared to 2 percent of non-dually eligible Medicare beneficiaries. Fifty-five percent of dually eligible self-report being in fair or poor health, compared to twenty-five percent of non-dually eligible. Dually eligible are more likely to suffer from certain diseases and chronic conditions—diabetes 22% to 15%, Alzheimer's 12% to 3%, incontinence 34% to 18%.

Total Medicare payments in 1993 for dually eligible was $6110, about twice as high as payments for non-dually eligible Medicare beneficiaries, with payments higher for each of five service categories. Although the absolute dollar amount difference was greatest for inpatient hospital care, it is not surprising that the largest relative differences between the two groups of beneficiaries were for skilled nursing and home health/hospice services. (Liu et al.)

Liu et al found that the vast majority of the higher Medicare costs of the dually eligible beneficiaries relative to non-dually eligible are attributable to demographic, health, and disability characteristics, such as those identified above. The remaining difference presents a reference amount for cost savings that might be achieved through innovations in service delivery and better coordination between Medicare and Medicaid financing of acute and long term care services, particularly addressing current incentives for cost-shifting between the two programs. (Liu et al.)

Accordingly, a number of demonstrations have focused on service delivery and coordination for the frail elderly, dually eligible population.

The goal of EverCare is to reduce hospitalizations and emergency room visits by nursing home residents by providing more care outpatient care in nursing homes and by better coordinating care. The program assigns a physician and geriatric nurse practitioner to each patient in the nursing home. The demonstration sites, currently operated at six sites, are at risk for all Medicare covered services.

The Program of All-Inclusive Care for the Elderly (PACE) seeks to reduce frail elders' use of hospital and nursing home services by providing adult day care services coordinated by multi disciplinary teams of physicians, nurses and social workers. PACE sites assume financial risk for the acute and long-term care services of dually eligible Medicare and Medicaid beneficiaries who are nursing home eligible but continue to reside in the community.

Similarly, the Social HMO (S/HMO) demonstrations were targeted to Medicare beneficiaries who were nursing home certifiable. The goal of the S/HMO I program, which began in 1985 and still is ongoing in three sites, was to improve care coordination and achieve savings through provision of additional benefits, including prescription drugs and transportation, and limited long-term care benefits. Sites receive a capitated payment, modified from the standard AAPCC methodology, as well as either a Medicaid capitation for dual eligibles or a premium from non-Medicaid eligible participants.

S/HMO II was an expanded program with more of a geriatric care focus. The S/HMO II

program involves care protocols for common health problems among the elderly and employs an interdisciplinary approach to case management, again focused on elderly who are disabled, who need long-term care services, or who are at special risk for developing chronic conditions. Because of a requirement to develop management information systems to facilitate patient assessments and promote information flow, only one site is operational at this time.

The evaluations of the capitated demonstrations targeted to caring for the frail elderly have been mixed, with only the PACE model now incorporated as a standard M+C option with unique payment features. Although these demonstrations have shown promise, and PACE has become a mainstream, non-demonstration program, they currently affect very few beneficiaries, raising the issue of generalizability to much of the Medicare population, even to the frail elderly for whom these programs were designed. Further, these programs focus on the particular needs of beneficiaries with functional limitations and who are nursing home eligible, raising the issue of applicability to most of the nearly 80 percent of beneficiaries with chronic conditions, most of whom remain in the community.

Reform within fee for service Medicare

Although capitation approaches would seem to offer the proper platform for new models of care delivery for patients with chronic disease and the frail elderly, for the foreseeable future, it appears that efforts to improve care must focus on changes to the traditional FFS program. As emphasized earlier, the foundations of Medicare are rooted in indemnity insurance, where the

payer is a passive claims payer.

That formulation oversimplifies the current situation somewhat. Over time, mostly to deal with escalating program outlays, Congress has modified payment approaches to better reward provider efficiency, i.e., payments have evolved from retrospective cost or charge reimbursement to either prospective payments or retrospective payments constrained by expenditure limitations. There have also been attempts to assure basic attention to quality, not only through Conditions of Participation for Part A providers, but also in support for Peer Review Organizations and requirements for providers to conduct periodic patient appraisals suing designated assessment instruments, e.g., OASIS for home health agencies.

Yet, for the most part, the FFS program has no authority to be a value-based purchaser, i.e., it cannot use purchasing tools to try to achieve specific cost or quality outcomes on behalf of the beneficiaries it serves. (For a full discussion of the limitations in the current FFS program see two NASI publications, Medicare: Preparing for the Challenges of the 21st Century and From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare.) With limited exceptions, e.g., local coverage policies, its policies are national in scope and must treat all similar providers the same, by adhering to rules that are subject to specific "notice and comment" procedures.

A relevant example for this discussion is the resource-based relative value scale (RBRVS), used as the basis for physician reimbursement. Part B payment traditionally was

typically based upon "reasonable charges." In COBRA '85 and OBRA '89 provided for development of a national fee schedule based on a relative value scale to replace the reasonable charge payment approach, effective January 1, 1992. With the nearly ten year phase-in recently completed, RBRVS assigns, for each particular service or procedure values of work, practice expense, and malpractice expense component, which together should reflect the relative input costs associated with provision of each of the many thousands of services and procedures for which physicians are reimbursed by Medicare. Thus, each service has a specific number of relative value units (RVUs) associated with it. The RVUs are adjusted by a Geographic Adjustment Factor to reflect local costs of doing business and then multiplied by a national conversion factor, itself subject to complicated calculation, to determine the "allowed charge" under the fee schedule.

One of the explicit goals of the RBRVS-based fee schedule was to shift payment incentives from provision of procedures to provision of evaluation and management services and to limit the inflationary bias inherent in paying based on reasonable charges.[8] In fact, although some believe that the fee schedule still disproportionately rewards surgeons and other proceduralists (Bringewatt), in the past decade there has been a major shift in relative payments for procedures and evaluation and management services over the past decade.

For example, the national payment for a Coronary Artery Bypass Graft (CABG), with

---

[8] One of the unfortunate but unavoidable results of no longer recognizing reasonable charges in a move to a fee schedule is that services and costs that support a team- oriented approach to patients with chronic disease and that vary by practice can no longer be recognized for payment.

three veins, CPT-4 code 33512, was $2225.25 in 1992 and a virtually identical $2216.67 in 2001, whereas the national payment for the most common office visit, 99213, has increased by two thirds, from $31 in 1992 to $50.50 in 2001. (Terry Kay, personal communication) Put another way, in 1992 it took 72 mid-level office visits to generate the same reimbursement as a single three vein CABG, whereas in 2001 it takes only 44 visits. That is significant redistribution, although some argue not enough, and consistent with the legislative mandate to base payment on resource costs, and not on considerations of value for the beneficiary population.

Although relative payments for physician services have been shifted in a desired direction, CMS lacks authority to do many things that might specifically improve reimbursement for practitioners targeting the problems of patients with chronic illness. For example, by law, it must pay all physicians the same amount for the same service; it can't pay differentially based either on specialty or performance. By long established convention and contract, CMS uses the Current Procedural Terminology (CPT) coding system of the American Medical Association for virtually all physician services, despite code definition problems. Finally, grounded in the statutorily based RBRVS methodology, CMS cannot modify payment rates to try to achieve specific policy goals, such as increasing the volume of home visits by physicians.

Incremental changes within the current Medicare coverage and payment structure

Before speculating on how certain additional services that might help in the management

of patients with chronic diseases would be considered, it is important to understand the established procedures CMS has for deciding whether the service will be covered and paid for. (Lewin) First, the agency decides if the proposed service fits into a statutorily established benefit category. For example, Medicare does not cover outpatient pharmaceuticals and preventive tests regardless of their diagnostic and therapeutic benefit, unless specifically authorized in legislation.

Second, assuming the first requirement is met, CMS and its contractors then determine if the service is "reasonable and necessary" for the diagnosis or treatment of illness or injury. To this point, explicit criteria for this decision do not exist, despite the agency's attempt to establish criteria through rule making, first in 1989 and then in 2000. The proposed rules published for comment in 1989 were withdrawn and never published in final. Last year, HCFA published a notice of intent to issue a proposed rule that laid out criteria for covering a proposed new service. Under this formulation, a proposed product or service would be covered if it 1) falls within a Medicare benefit category, 2) can demonstrate medical benefit based on evidence of effectiveness and 3) provides added value to the Medicare population. The agency thus far has not responded to comments on this notice, which, as in the 1989 notice, introduced notions of cost effectiveness in coverage policy.

For now, CMS is trying to establish a more open, transparent, and timely process, for making National Coverage Decisions (NCDs) for new services and emphasizing the need for evidence of medical effectiveness to support new coverage applications. NCDs are binding on

carriers and fiscal intermediaries (FIs) and thus establishing national policy. Nevertheless, most coverage decisions are made by the local carriers and FIs on a case-by case basis as a function of claims processing. Sometimes, local carriers and FIS undertake a formal process to create a specific local medical review policy (LMRP), which is precedent, but only in the area of the local contractor. The merits of local vs. national coverage decisions are beyond the scope of this discussion but, in general, NCDs are made for decisions with broader policy and payment implications and where there is a sufficient basis on which to make informed decisions. It should also be pointed out that coverage decisions are able limit coverage to specific subpopulations of Medicare beneficiaries based on clinical characteristics. For example, a recent NCD for PET scans limited coverage to specific clinical indications.

Third, once a proposed service is found reasonable and necessary, it must be given an appropriate code. The codes serve as the basis for determining payment for services both in episode based payment systems, such as diagnosis related groups for inpatients, and based on fee schedules and allowed charges, such as outpatient hospitals and physicians. Under HIPAA requirements, HCFA ratified two standard code sets for this purpose: The International Classification of Diseases, Ninth Revision, Clinical Modification Coding System (ICD-9-CM) and the HCFA Common Procedural Coding System (HCPCS), Levels I, II, III. HCPCS Level I is CPT. Neither code set is under the direct control of CMS. The processes for obtaining new codes or revising older codes are straightforward, but may be time-consuming. Occasionally, CMS and the AMA CPT Editorial Panel may not agree on the wording of a code description, as noted

above.

Finally, once a service is coded, it is eligible for payment, whether under episode-based payments, e.g. hospitals and home health agencies, or under fee schedules, which are used for physician services, clinical laboratory services, and durable medical supplies. As noted, for the most part payment amounts are determined through national formulas that pay all providers in the same category uniformly.

One other issue is relevant before considering new services for chronically ill beneficiaries. The Medicare statute is very specific about which "providers" and "suppliers" are eligible to be paid under the program and under what circumstances.[9] Professionals and other non-physician personnel not specifically recognized as eligible to receive program payments might be recognized if they provided services "incident to" a physician's service. But the "incident to" provision is very narrow: "services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bill." (Section 1861 (s)(2)(A))

Given precise statutory language and the described process for coverage and payment, I reviewed with an experienced, senior CMS official how the agency would likely consider recommended services that the traditional Medicare program might cover. This analysis is in no

[9] Technically, physicians are considered suppliers to the Medicare program

way definitive, but is meant to identify the relevant barriers to program inclusion.

1. Comprehensive geriatric assessment (CGA). It is usually conducted by a team including a physician, and a nurse and social worker (Boult, 1998) so the "incident to" provision is raised. If performed on all beneficiaries as a "screening" tool, it might be viewed as preventive service and, therefore, would not fit into a benefit category. The agency would likely view the diagnostic process as a proposed new service, thus subjecting to an evidence-based determination of whether it is "reasonable and necessary." Apparently, the literature is mixed, with one appraisal concluding that CGA, although helpful in diagnosis, does not improve patients' outcomes. (Boult, 1998) Given the importance of the intervention and the presence of a body of evidence, the agency might choose to make a National Coverage Decision, which might determine a subpopulation for which the CGA is appropriate, thereby also removing the concern that comprehensive geriatric assessment is a screening intervention. Of course, the service could be mandated legislatively for whichever population Congress decided on.

2. Patient education to promote self-management and care coordination services. For the most part, there are CPT codes that describe these services, but currently the agency generally takes the position that these services are included as pre-work and post-work components that are defined in evaluation and management codes. Nevertheless, it is clear that payment for visits where patient education, care coordination through phone calls, etc. are not separately reimbursable items provides no incentive to change the nature of physician-patient interactions that are based in face-to-face encounters. There is some precedent for individual coverage of

these types of activities, e.g., diabetes education, radiation therapy planning. The major concerns about broad expansion to cover these activities are those described earlier, namely, moral hazard, program integrity, and costs. Proposals to limit the payment for some or all of these services to subpopulations that meet specific criteria based on evidence might be better received and considered as part of the coverage decision process.

3. Transportation services. There is currently no benefit category in which transportation falls and therefore the service cannot be paid for today. Transportation services would have to be legislated.

4. Multi disciplinary team meetings to review and plan. There would be concern that the statute only contemplated reimbursement for services provided to a patient, not services about a patient. There would also be issues about what personnel are eligible for reimbursement, again raising the applicability of "incident to" provision.

Major Initiatives in the FFS Program

NASI, the Bipartisan Commission for Medicare Reform, The Clinton Administration, and

the Senate Finance Committee last year all have discussed more fundamental change to the traditional, FFS program, generally referred to as "Medicare modernization." Many of the modernization proposals involve providing additional benefits, e.g., prescription drugs; contracting reform; competitive bidding for certain services; Medicare governance, etc. In the area of care for patients for chronic care, there were proposals to grant new legislative authority to the agency to establish case management/care coordination programs, disease management programs, and provider/physician collaborations, i.e., a form of bundled hospital/physician payment.

These approaches would represent fundamental departures for the Medicare program, mostly because they involve significantly new payment approaches. There are many versions of the proposals. Some envision case management as modeled after Primary Care Case Management programs in Medicaid and some HMOs where a designated primary care physician either is paid a case management fee or receives a higher reimbursement schedule to be the patient's care coordinator.

Most of these models do not involve primary care capitation payments for services currently paid fee for service under the physician fee schedule, although it should be noted that the traditional Medicare program pays ESRD facilities and renal physicians a monthly capitation payment. Other case manager/care coordination proposals would designate non-physicians, usually nurses, as care coordinators. Some suggest that local agencies, such as Area Agencies on Aging and health departments might play a role in organizing the care coordination services, in addition to provider groups. (Fox)

Based on the apparent success of targeted disease management programs for specific conditions, such as congestive heart failure (CHF), diabetes and asthma, there is interest in direct contracting with disease management firms to help manage care. Even here, there are variations in models. Most commercial disease management programs favor a "bypass" strategy with regard to the patient's usual practice team, creating a new caregiver and team. (Wagner) Other programs, usually located in group and staff HMOs, with stronger links to practices than in network models, favor the "enhancement" model of working with the usual care team.

In demonstrations, HCFA has had some experience with these new approaches to chronic care management. In 1990, OBRA mandated the provision of case management services to Medicare beneficiaries with high-cost illness. The demonstrations were conducted for two years ending in November 1995. The three demonstrations were a CHF focused program administered by a large insurer, a CHF and COPD program administered by a PRO, and a program targeting eight diagnostic groups administered by a tertiary-care teaching hospital. All sites included patient assessments, coordination of care, self-care education, psychological supports, and informal caregivers.

One important finding was the lack of interest in participation by beneficiaries, in many cases because of resistance by involved physicians, especially in the program sponsored by the PRO. In summary, these case management demonstrations found no significant effects on costs, health outcomes, or levels of self-care (Schore et al.)

The BBA required HCFA to evaluate best practices in the private sector for methods of

coordinated care, and then, based, on the findings of the study, design demonstrations to evaluate models of care coordination for beneficiaries with chronic illness. Importantly, a requirement of the demonstrations is that Medicare expenditures should not exceed what would have been spent in the absence of the demonstration.

Mathematica Policy Research won the award to review best practices. MPR identified two main types of coordinated care programs, case management and disease management, and developed a conceptual framework applicable to these delivery models. (Chen, Federal Register) The Best Practices Review pointed out that patients amenable to the two interventions differ in important ways. Case management programs serve a more select group of frail, disabled patients, at risk for recurrent, costly, recurrent adverse medical events.[10] Disease management programs target persons who tend to have a specific condition, although they must be able to address common comorbidities. Corresponding to the different populations, case management programs tend to individualize care, relying heavily ion the judgment of the case manager. In contrast, disease management programs tend to be highly structured and emphasize the use of structured protocols and clinical guidelines.

Another differentiating factor in efficacy of case management programs is whether the programs build on generic, unstructured case management or clinically sophisticated case management, whether directed at a specific disease or to the frail, with functional limitations.

---

[10] Terminology in this area is very confusing. This form of case management, often carried out by nurses, needs to be distinguished from primary care case management, which refers to a physician, usually a primary care physician, who usually acts as a gatekeeper, responsible for approving referrals.

According to Wagner, (Wagner, personal communication) the literature demonstrates that generic case management proved ineffective at reducing costs or altering the utilization patterns in rigorous trials whereas clinically sophisticated case management performed by nurses with specialized training in geriatrics was effective. (Ferguson and Weinburger, Gagnon, Leveille, Rich, Stuck)

Based on the MPR Report, HCFA issued a Solicitation for Proposals for the Coordinated Care Demonstration in July 2000 and recently made 15 awards. Combined with two awards made last year for a BBA-mandated case management demonstration, the agency effectively will oversee 17 demonstrations of various case management and disease management demonstrations.

The public comments on the July 2000 notice are important for consideration of how Medicare can best promote improved care for chronic illness. There were many comments on the difficulties of providing care management services under the current Medicare fee-for-service payment system. Almost all respondents suggested some sort of risk bearing system in which providers would be paid a fixed fee per enrollee and would share in any savings to the Medicare system. Some also suggested that reimbursement be linked to patient outcomes.

Accordingly, HCFA chose to use a monthly all-inclusive rate to pay for the proposed coordinated care services, which might include coordination with community-based services, transportation, medications, non-covered home visits, and equipment. Statutory Medicare services will be reimbursed as usual.

The Medicare, Medicaid and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA) set up an additional demonstration program testing disease management programs for beneficiaries with advanced-stage congestive heart failure, diabetes, and coronary heart disease. CMS recently solicited applications under this program, which could result in three awards covering up to 30,000 beneficiaries at a time. Prescription drugs would be covered under these demonstrations and the demonstrations would be required to meet strict budget neutrality requirements.

Opportunities for Incremental Improvements in the FFS Program

While waiting for results of the major coordinated care demonstrations and considering reorienting the Medicare+Choice program to rewarding plans who manage beneficiaries with a high burden of chronic illness, there may opportunities to make modest changes in the current, indemnity-oriented Medicare program. As noted earlier, over 75 percent of beneficiaries have one or more chronic disease. However, 20 percent of the Medicare population has five or more chronic conditions and this cohort represents 66 percent of Medicare spending.

Some have called for a range of new services to be available to beneficiaries who have a certain number of limitations in Activities of Daily Living (ADLs). Although ADLs do reflect beneficiary functional status, basing eligibility on ADLs would have certain drawbacks. First is the fact that ADLs are typically measures of the need for personal assistance, i.e., measures of

the need for long-term care. However, Medicare does not provide long-term care services, but rather medical services. It would be difficult for a program with an acute/subacute care statutory basis to adopt and implement a long-term care eligibility standard.

Second, consistent with the need to assure equitable access to covered benefits, eligibility should not be predicated on an assessment conducted by specialists, in this case, geriatricians, or institutions that are not generally and widely available. Rather, eligibility should be determined by easily accessible physicians who may well lack specialized expertise. The general physician would not be able to assess or authorize services based on ADLs and might be less able to document clearly a decision that would withstand review.

Rather than using ADLs, we would recommend considering eligibility for additional benefits based on clinical status, as is done in the current program. For purposes of discussion, beneficiaries with five or more serious chronic conditions could be the target group. It might well be that further analysis would permit creation of a subset of chronic conditions, which are associated with higher costs and with provision of services by many professionals, would become the conditions that determine eligibility for additional payment or services.[11] Consistent with planned implementation of health status based risk adjustment in the M+C program, physicians would be expected to identify patient diagnoses through assessment and documentation, within their scopes of practice.

A clinical condition based approach could more readily predict the numbers of eligible and better anticipate program costs than one based on measures of functional status. For beneficiaries who qualify based on the presence of the requisite number of serious conditions, higher payments for office-based care would be made. This enhanced payment could be billed by any and all unique physicians who see the patient for each office visit. The higher payment would more generously compensate physicians for the greater amount of time they and their

---

[11] Whereas the average beneficiary has about 15 physician visits annually and sees 6.4 unique physicians in a year, beneficiaries with five or more chronic conditions have about 37 physician visits annually and see 13.8 unique physicians in a year. (See Berenson and Horvath)

staffs need to care for patients with serious chronic conditions and to coordinate with other treating physicians and other professionals who are caring for the patient.[12]

Unlike a broad based payment available to all physicians, a more targeted and intensive approach might be a clinical case management model whereby a treating physician accepts added responsibility to coordinate the clinical care provided by all treating physicians. In the managed care environment, this approach has received the pejorative appellation of a "gatekeeper," because of the emphasis on requiring the designated physician to approve all referrals to specialists and for many ancillary tests and procedures, although it should be noted that 12 European countries require patients to see a designated physician—a gatekeeper—who functions as the defined point of entry to secondary care. (Saltman and Figueras)

As noted earlier, many Medicaid programs have a similar mechanism, now called the Primary Care Case Manager (PCCM) model. In Medicaid, a beneficiary selects or is otherwise assigned to a primary care doctor who acts as a care coordinator and primary care provider. The model has changed somewhat since it was first implemented in Medicaid and in some cases the

[12]A more straightforward approach would be to permit physicians to apply to a modifier to evaluation and management codes for patients who required more time than average because of the burden of decision-making and coordination requirements that patients actually presented with. Theoretically, the modifier could be used to reflect a range of issues that can produce a more complex visit or consultation, e.g., language difficulties. Proceeding with a broadly applicable modifier would naturally raise program integrity concerns that the modifier would be applied much too broadly and inconsistently by different physicians. The current controversy over documentation guidelines for evaluation and management services points to the need to reduce room for varying interpretations of CPT codes that are used for Medicare payment.

care management aspect has been weakened over time, but it may still have relevance for needs in the Medicare program. Physicians in this role are paid in one of two ways: a monthly per head management fee which is separate and apart from billing for specific services rendered, or a monthly capitation to the physician for a range of primary care services and the care coordination activities.

A number of design issues would have to be considered in applying a PCCM-type approach to Medicare. Whereas these programs are typically required in managed care and in Medicaid applications, the strong Medicare tradition would be to make it voluntary for the beneficiary, perhaps in exchange for reduction of some cost-sharing obligations or discount off of the part B premium. Although the desirability of having a single physician coordinate care might be relevant for all Medicare beneficiaries and might be promoted in program guidance and educational materials, specific reductions in cost-sharing or premium requirements might be limited to those with a certain number of chronic conditions, as discussed above.

For the clinical case manager to have any meaningful ability to reduce unnecessary services, as well as reduce the likelihood of errors that result from care provided by too many, non-communicating professionals, any Medicare PCCM-type program should require the designated clinical case manager to have prior authorization authority. However, in contrast to the manner in which many gatekeeper programs in managed care plans work, a Medicare program could be designed to permit much more flexibility for case manager decision-making.

For example, whereas most gatekeeper programs strictly limit the number and time duration of specialist visits, a Medicare clinical case manager might be allowed to selectively designate certain chronic problems for ongoing care from a specialist, without the need for recurring authorizations. For example, a case manager could recognize that a patient with glaucoma needs ongoing care from an ophthalmologist, without additional authorizations.

For their part, physicians could participate to the extent that they agreed to follow certain administrative procedures to track and monitor all aspects of a beneficiary's care, act as a referral, receive and coordinate clinical reports from others involved in the patient's care, maintain a robust medical record and be available to provide greater consultation time surrounding a qualified beneficiary's care. An outstanding issue is whether specialists who agree to these requirements should be designated as the case managing physician for Medicare beneficiaries, given the prevalence of certain chronic conditions that are commonly cared for by specialists, e.g., cardiologists. Inserting yet another physician into the mix of specialists already caring for a beneficiary with multiple chronic conditions may not be warranted if one of the specialists is willing and able to carry out the coordination functions this model requires.

A logical payment approach for Medicare would be a monthly capitation fee for care management services, in addition to standard fee for service reimbursements for discrete physician services that are reimbursed under the Medicare fee schedule. An alternative would be to bundle standard primary care services into a much larger monthly capitation amount. As

alluded to above, capitation provides greater flexibility than fee for service payment and may be more conducive to implementing delivery system innovation, along the lines of the Chronic Care Model outlined above. However, primary care capitation can have untoward incentives to skimp on care and, depending upon whether capitated physicians are at risk for referrals and hospitalizations, actually may have an incentive for inappropriate referrals.

One approach would be to pay a monthly capitation care management fee to designated physicians while maintaining fee for service reimbursement for discrete physician services for physicians practicing in solo and small group practice, while encouraging the expanded capitation option for physicians practicing in large, multispecialty group practices that have the administrative infrastructure and financial wherewithal to manage larger capitation amounts. Under either payment structure, the model would require some sort of provider designation such that participants would have to meet certain standards for care, quality, and administrative capabilities, a form of conditions of participation or eligibility criteria that has generally not been applied to physicians.

Beyond administrative structures that can facilitate greater coordination of clinical care, it may be appropriate specifically to consider benefit design that can facilitate greater clinical care coordination and management. One such approach would be a modified, home visit type of benefit. The current home health benefit is for people in need of extended home nursing and

personal care services and who meet a technical definition of "homebound." The current 60-day episode of care payment reflects the extended nature of the benefit.

There may be need, however, for another type of benefit that is not as extensive or intensive as the current home health benefit. Although current rules require direct physician supervision of ancillary personnel seeing Medicare patients, such direct supervision is not practical in some circumstances. Physicians have said it would be helpful to clinical care if they could authorize their office nurses or physician assistants to periodically conduct home visits to check on patients. This benefit, then, would be limited in scope to infrequent medical monitoring when a patient is not able to come to the office due to temporary or otherwise acute health conditions but allows the physician more direct knowledge of health status and functioning than a service delivered through a separate agency.

Limitations might need to be placed on the benefit, perhaps by allowing a limited number of visits per beneficiary times per year, by defining the qualifications of practitioners who might make such home visits, and by restricting services, perhaps to medical assessment, medical monitoring, and medication management. Further, the visits might be limited to follow-up associated with acute exacerbations of chronic conditions, or to periods when a patient's treatments have been altered due to a change in health status.

This benefit is not intended to replace the home health benefit but rather is intended to be a limited tool by which physicians can better coordinate care. The benefit needs to be crafted in

such a way that it provides a useful tool for greater clinical care coordination and so that it does not spawn a new cottage industry. In addition, payment for any such benefit would need to recognize differential costs and efficiencies between rural and urban areas. Although the coordinated care and disease management demonstrations correctly are designed to implement broad-based coordination, it is likely that information gained in the demonstrations would assist in crafting specific specifications for this narrow expansion permitted home visits.

Summary

The paper attempts to show that there is a current mismatch between the chronic care related needs of the majority of Medicare beneficiaries and the historical structure of the Medicare program that is grounded in a model of indemnity insurance. Although the more innovative changes in the program would involve moving toward organizational accountability for caring for beneficiaries with chronic conditions, through capitated payments—either for all covered services or for the services specifically related to care coordination activities—such changes will depend upon results of demonstrations, some of which have recently been initiated. In the meantime, there may be an opportunity to make incremental changes within the structure of the current program that would better recognize the needs of beneficiaries with multiple chronic conditions.

REFERENCES

Achman L and Gold M. "Medicare + Choice 1999–2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums," Mathematica Policy Research, Inc., Feb 2002.

Arrow KJ, "Uncertainty and the Welfare Economics of Medical Care," The American Economic Review, vol. LIII, (5) 941–973, December 1963.

Ball RM, "What Medicare's Architects had in Mind," Health Affairs, vol.14 (4) 62–72, Winter 1995.

Berenson, RA, "Bringing Collaboration into the Market Paradigm," Health Affairs, vol. 17 (6), 128–137, Nov/Dec 1998.

Berenson RA, "Medicare+Choice: Doubling or Disappearing?" Health Affairs, Web Exclusive, W65–W82, November 28, 2001.

Berenson, RA and Horvath J, "The Clinical Characteristics of Medicare Beneficiaries and Implications for Medicare Reform," paper presented at Medicare Coordinated Care Conference, sponsored by the Center For Medicare Advocacy, Inc. Washington, DC, March 21, 22, 2002.

Boult C, Boult L, and Pacala JT, "Systems of Care for Older Populations of the Future," Journal of the American Geriatric Society, vol 46 (4), 499–505, 1998

Boult C, Kane RL, Pacala JT, and Wagner EH, "Innovative Healthcare for Chronically Ill Older Persons: Results of a National Survey," The American Journal of Managed Care, vol 5(9), 1163–1172, September 1999.

Bringewatt RJ, "Concept Paper—Modernizing Medicare for People with Chronic Conditions" available from the National Chronic Care Consortium.

Cassel CK, Besdine RW, and Siegel LC, "Restructuring Medicare for the Next Century: What Will Beneficiaries Really Need?" Health Affairs, vol 18 (1), 118–131, Jan/Feb 1999.

Centers for Medicare and Medicaid Services (CMS) website at www.HCFA.gov/Medicare/

rskadjdate.htm assessed April 2, 2002

Chen A, Brown R, Archibold N, et al. "Best Practices in Coordinated Care," Report provided to the Health Care Financing Administration, Contract # HCFA 500-95-0048 (04), submitted by Mathematica Policy Research, Inc., project director Randall S. Brown, March 22, 2000.

Clark WD and Hulbert MM, "Research Issues: Dually Eligible Medicare and Medicaid Beneficiaries, Challenges and Opportunities," Health Care Financing Review, vol 20 (2), 1–10, Winter 1998.

Federal Register, "Medicare Program; Solicitation for Proposals for the Medicare Coordinated Care Demonstration," vol. 65, no. 146, 46466–46473, July 28, 2000.

Ferguson JA and Weinberger M. "Case Management Programs in Primary Care," J Gen Intern Med., vol 13 (2), 123–126, 1998.

Fox PD, "The Medicare Fee-For-Service: Applying Managed Care Techniques," in Medicare: Preparing for the Challenges of the 21st Century, Reischauer RD, Butler, S, Lave, JR editors.

Gagnon AJ, Schein C, McVey L, and Bergman H. "Randomized Controlled Trial of Nurse Case Management of Frail Older People," J. Am Geriatr Soc. Vol 47 (9), 1118–1124.

Gold M, "Medicare+Choice: An Interim Report Card," Health Affairs, vol 20 (4), 120–138, July–August 2001.

HMO Workgroup on Care Management, "Improving the Care of Older Adults with Common Geriatric Conditions," AAHP Foundation, Washington, DC, February 2002.

Iglehart JK, "The Centers for Medicare and Medicaid Services," N. Engl. J. Med. vol 345 (26), 1920–1924, 2001

Jencks SF, Cuerdon T, Burden DR et al, "Quality of Medical Care Delivered to Medicare Beneficiaries," JAMA vol 284 (13): 1670–1676, Oct 4, 2000.

Kay, Terry, CMS, head of physician reimbursement branch, personal communication, December 20, 2001.

Leveille SG, Wagner EH, Davis C et al. “Preventing Disability and Managing Chronic Illness in Frail Older Adults: A Randomized Trial of a Community-based Partnership with Primary Care,” J Am Geriatr Soc. vol 46 (10), 1191–1198, 1998

the Lewin Group, Report 2: The Medicare Payment Process and Patient Access to Technology, 2nd in a Series of Reports Prepared by the Lewin Group for Advamed, Copyright 2000 by the Advanced Medical Technology Association

Liu K, Long SK and Aragon C, “Does Health Status Explain Higher Medicare Costs of Medicaid Enrollees?” Health Care Financing Review, vol 20(2) 39–54.Winter 1998

Mental Health: A Report of the Surgeon General. Rockville, Md.: Department of health and Human Services, 1999.

Miller RH and Luft HS, “HMO Plan Performance Update: An Analysis of Recently Published Literature (1997–2000).” Prepared for the Council on the Economic Impact of Health System Change, 8th Princeton Conference: The Future of Managed Care, May 2001.

Murray LA and Shatto AE, “Dually Eligible Medicare Beneficiaries,” Health Care Financing Review vol 20(20) 131–140. Winter 1998

Myers RJ, “Why Medicare Part A and Part B, as Well as Medicaid?” Health Care Financing Review, vol 22 (1), 53–54, Fall 2000.

Rich MW, “Heart Failure Disease Management Programs: Efficacy and Limitations,” Am J Med. Vol 110 (5), 410–412, 1998.

Robinson JC, “The End of Managed Care,” JAMA vol 285 (20) 2622–2628, May 23/30, 2001.

Saltman RB and Figueras J. “Chapter 6. Delivering Services Efficiently,” in European Health Care Reform: Analysis of Current Strategies WHO Regional Publications, European Series, No. 72, World Health Organization Regional Office for Europe, Copenhagen, 1997.

Schore J, Brown B and Cheh V “Case Management for High-cost Medicare Beneficiaries,” Health Care Financing Review, vol 20 (4), 87–101, Summer, 1999.

Stuck AE, Aronow HU, Steiner, et al. A Trial of Annual In-home Comprehensive Geriatric Assessments for Elderly People Living in the Community," N Engl J Med., vol 333 (18), 1184–1189, 1995

US General Accounting Office 1997 (incomplete)

US general Accounting Office (GAO) "Medicare+Choice: Payments Exceed Cos of Benefits in Fee-For-Service, Adding Billions to Spending. Wash DC: GAO; Aug 2000, Pub No: GAO/HEHS-00-161.

Vladek BC, "The Political Economy of Medicare," Health Affairs, vol 18 (1), 22–36, Jan/Feb 1999.

Wagner EH, Austin BT, Von Korff M,. "Organizing Care for Patients with Chronic Illness," Milbank Quarterly, vol 74 (4), 511–544, 1996.

Wagner EH, "Care of Older People with Chronic Illness" in New Ways to Care for Older People, Building Systems Based on Evidence, edited by Calkins E, Boult C, Wagner, EH, and Pacala, JT, Springer Publishing Company, (incomplete)

Wagner EH, personal communication, November 1, 2001.

Ware JE, Bayliss MS, Rogers WH, et al., "Differences in 4 Year Health Outcomes for Elderly and Poor Chronically Ill Patients Treated in HMO and Fee-for-Service Systems," JAMA 276, 1039–1047, 1996

Zarabozo C, "Milestones in Medicare Managed Care," Health Care Financing Review, vol 22 (1), 61–68, Fall 2000.