Round Pegs and Square Holes:
Medicare and Chronic Care

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Introduction

It is by now a truism that Medicare's financing and benefit structures, administrative mechanisms, and operational culture fit poorly with the growing burden of chronic disease experienced by Medicare beneficiaries; Medicare has failed to support health care professionals' growing sophistication in treating and managing chronic disease. Like all truisms, this one is at least partially true. But like everything having to do with Medicare and most things having to do with chronic illness, the matter is also complicated. Some of what is seen as a "misfit" between Medicare and chronic care may reflect more fundamental problems in Medicare itself, or in American social policy more broadly. Some of what is assumed about professional consensus may be inaccurate. Some favored solutions may cause more problems than they solve.

This paper seeks to categorize and describe the major problems in Medicare's interaction with chronic illness and to identify a number of short- to medium-range policy issues that offer some prospect for early amelioration. Finally, this paper places the Medicare discussion into the context of changes in chronic care within the broader health care system.

While a complete restructuring of Medicare is probably politically unfeasible in the near future, relatively modest changes in the Physician Fee Schedule, the home health benefit, durable medical equipment (DME) policies, occupational and physical therapy, and the rules for transitioning beneficiaries between providers could be effected with fewer political barriers. These policy changes would immediately help beneficiaries with chronic conditions afford and obtain the services they need. Conversely, if the Medicare benefit package were restructured to give all beneficiaries more of what they need: lower out-of-pocket costs, a complete restructuring

of the Physician Fee Schedule, expanded preventive services, and comprehensive outpatient prescription drug coverage, for starters, then these broad-based reforms would be of particular help to people with chronic conditions.

Evolution

Governments in the United States were in the business of financing care of the chronically ill long before they became involved in financing acute care. Public facilities for the care of the chronically mentally ill date back to the middle of the 19th century; almshouses and poor farms (generally operated by county governments) served, by the early 20th century, mostly the insane, the senescent, and the totally disabled. Inpatient facilities for the treatment of tuberculosis dotted the landscape, and were primarily public. At least through the Second World War, however, very little of what we would today consider active treatment was provided in those facilities. Their function was largely custodial. But for most chronic illnesses at the time, custodial care was about the best anyone could do.[1] In this regard, it's worth remembering that the initial drafting of Medicare legislation roughly coincided, historically, with the earliest trials of anti-tuberculosis and psychotropic drugs.

In other words, when Medicare was enacted, "acute care" might have been generally translated, at least for the lay public and members of Congress, as "care for treatable illnesses," although public perceptions of the actual effectiveness of much acute medical care were probably exaggerated at the time, as they continue to be. It's widely known that the basic Medicare benefit package was largely adopted from the Standard Option of the Federal Employees Health

[1] B.C. Vladeck, *Unloving Care* (New York: Basic Books, 1980).

Benefit Plan, circa 1964. What's almost entirely forgotten is what that *meant* in 1964–65: that the elderly obtained the same degree of access to the miracles of modern medicine that the employed population already largely enjoyed. Those miracles were provided by an acute care system almost entirely distinct from the array of chronic care institutions that were already used primarily by the elderly and were primarily supported by state and local funds. The acute care system was primarily involved in the delivery of curative services, most of which had been developed within the preceding 20 years.

The Social Security Act initially forbade payment of cash benefits to "inmates of public institutions," which meant, at the time, county poorhouses and state mental hospitals, not correctional institutions. That provision was modified in the early 1950s to permit vendor payments (a precursor to Medicaid) to public general hospitals and nursing homes, but the prohibition on payments to state-operated Institutions for Mental Diseases continues to this day. The statute's prohibition of Medicare and Medicaid payments for "custodial" services also still exists.[2]

In short, Medicare was designed **not** to cover services for the care of chronic illness, as those services were understood when Medicare was proposed, debated, and enacted. Since then, our attitudes towards and knowledge of chronic illness have changed. The advances of modern medicine have enabled us to categorize chronic illnesses into those we can cure (e.g. tuberculosis, gastric ulcers); those we can treat with some success with "halfway technologies" (e.g. schizophrenia, arthritis, congestive heart failure); and those chronic diseases that have become much more prevalent as modern medicine has succeeded in treating the infections, heart

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[2] B.C. Vladeck, *Unloving Care* (New York: Basic Books, 1980).

attacks and strokes that used to kill almost everyone who developed them (e.g. emphysema, spinal cord injuries). In a sense, our attitudes and expectations towards chronic illness have become less unlike our attitudes and expectations about acute illnesses: for both, we now feel that we can and should "do something" rather than let illnesses run their natural course. It is useful to remember, however, that while our attitudes toward chronic conditions have evolved, the existence of extensive publicly financed systems for their treatment is not a new phenomenon.

Principles

As medical advances have allowed us to become less fatalistic about the natural history of chronic disease, clinicians have developed some professional opinions and conclusions about how to treat them. While some of the principles of good treatment for chronic conditions mirror principles of good medical care in general, especially the principles of modern geriatric medicine, there are ways in which optimal treatment of chronic conditions differs from treatment of shorter-term, acute illnesses. While every authority has a slightly different list and set of categories, it is not unreasonable to conclude that good chronic care partakes of at least the following seven characteristics[3,4]:

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[3] E.H. Wagner, "Organizing Care for Patients with Chronic Illness," *The Milbank Quarterly* 74, no 4 (1996).

[4] C.K. Cassel, R.W. Besdine, and L.C. Siegel, "Restructuring Medicare For The Next Century: What Will Beneficiaries Need?" *Health Affairs* (January/February 1999): 118–131.

- It is **continuous**; that is, the same health professional, or coherent group of professionals, manages the patient's care over the protracted time periods made necessary by the characteristics of chronic illnesses;
- It is **multidisciplinary**; that is, the effects and complications of serious chronic illnesses—both medical and non-medical—are sufficiently diverse and ramified that no one professional discipline can be expected to adequately address them all; in good chronic care, physicians, nurses, social workers, therapists, nutritionists, and others work together in a highly communicative and mutually supportive way.
- It is **accessible**; that is, patients do not have to devote an inordinate amount of time and energy to obtaining the services they need, when they need them;
- It is **coordinated** and **seamless**; that is, the different professionals and organizations involved in the patient's care work together in an efficient and harmonious manner, in a way that is largely invisible to the patient;
- It **encourages "activation" of patients to be involved in their own care, that** is, the better educated patients are about their problems and issues of self-care, the better off they are likely to be; and
- It **supports patients' families and other caregivers**; that is, chronic illness is something that happens to families, not just individual patients. Conversely, non-professional relatives and friends, in fact provide most care of the chronically ill, including chronically ill Medicare beneficiaries. Good systems of chronic care reinforce such "informal" caregiving, rather than frustrate it.

To anticipate a relatively obviously punch line, Medicare, as it is currently constituted, effectively supports none of these characteristics. Some of the reasons why are described below.

Medicare—Structural Difficulties

To fully and fairly understand the sources of the misfit between Medicare and our contemporary conceptions of good chronic care, it is useful to begin at the most basic level: people with serious chronic illnesses incur significantly more health care costs than people without them, and better access to care generally produces greater expense. On average, Medicare itself (exclusive of supplemental benefit plans, Medicaid, and beneficiary out-of-pocket expenses) now covers barely half of the total health care expenditures of the average beneficiary, and an even smaller proportion of the expenses of a beneficiary with chronic illness. All other things (like beneficiaries' incomes) being equal (which of course they never are, as will be discussed below), then the generic problem of the overall scantiness of the basic Medicare benefit package disproportionately affects beneficiaries with serious chronic problems.[5]

On the current political agenda, the hole in the Medicare benefit package receiving the most attention is Medicare's non-coverage of most outpatient prescription drugs. Ten percent of Medicare beneficiaries account for 39 percent of all beneficiary spending on prescription drugs. The four percent of beneficiaries with the highest outpatient prescription drug expenditures spend more than $6,000 apiece per year on prescription drugs, while the average (mean)

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[5] S. Maxwell, M. Moon, and M. Segal, "Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*"* (Washington, DC: The Urban Institute, December 2000).

beneficiary pays $1,755 per year.[6] It's fair to assume that those high-use beneficiaries are mostly individuals with chronic illnesses. It's also fair to assume, for reasons that will be discussed below, that these high-use beneficiaries are somewhat less likely to have private supplemental coverage to pay for prescription drugs.

Out-of-pocket expenses for prescription drugs is only a subset of beneficiaries' out-of-pocket liabilities. Here, the critical issue is the lack of any sort of cap on beneficiary liabilities, a characteristic that now distinguishes Medicare from almost every other health insurance policy generally available in the United States. Parenthetically, this absence lies at the heart of the increasing expenditures for Medicare beneficiaries borne by Medicaid, a major issue in and of itself that is largely outside the scope of this paper. But again, the simple syllogism holds: the more a beneficiary uses health services, the more her out-of-pocket expenditures are likely to be and the less likely she is to have additional resources to fill that gap.

Out-of-pocket expenses can be especially difficult for Medicare beneficiaries with psychiatric illnesses, because Medicare coverage of mental health services is even more limited than coverage of other medical services. For mental health services, beneficiaries are liable for 50%, rather than 20%, of fees for service; the number of covered services is capped; and coverage of inpatient psychiatric hospitalization has a lifetime limit of 190 days, while general inpatient hospital care has no lifetime limit (there are benefit period limits for general inpatient hospitalization).[7]

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[6] M.E. Gluck and K.W. Hanson, *Medicare Chart Book,* (Menlo Park, California: The Henry J. Kaiser Family Foundation, Fall 2001), figure 55.

[7] Medicare Rights Center, "Medicare Facts and Faces: Getting Affordable Mental Health Care" (New York: Medicare Rights Center, November 2001).

Finally, Medicare, true to its origins, still does not cover services viewed as primarily "custodial," which it interprets as those services designed to assist impaired individuals with activities of daily living in any way not integrally connected to an identifiable acute illness or problem. Medicare's non-coverage of long-term nursing home care is the most widely recognized manifestation of these old conceptual habits. The convoluted lines drawn in Medicare home care between "skilled" services, which Medicare will pay for, and "custodial" services, which Medicare will not pay for, are often even more frustrating and illogical.

Coverage and Income

Because Social Security—and to a lesser extent, Medicare—has been so successful at reducing poverty among this nation's elderly, the general financial circumstances of older and disabled Americans are not well-understood. While it is true that a smaller proportion of the elderly than members of other age groups fall below the federal poverty line in individual or household income, the great bulk of persons 65 and older are concentrated in the income bands just above the poverty level. Thus, while only 10% of persons 65 and older had incomes below the federal poverty level in 1999, fully 27% of beneficiaries 65 and older had incomes between 100% and 200% of the poverty level.[8] The **median** income of an elderly Medicare beneficiary was about $15,000, slightly less than twice the poverty level for an individual.[9]

Beneficiaries with serious chronic health problems are systematically poorer than average. According to Moon and Storeygard, fully 44% of beneficiaries with incomes below the

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[8] Data from Kaiser Family Foundation via personal Email correspondence January 18, 2002.

[9] S. Maxwell, M. Moon, and M. Segal, "Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries," (Washington, DC: The Urban Institute, May 2001).

poverty level had serious physical or cognitive problems, or both, in 1997, while fewer than 23% of beneficiaries with incomes at 200%–400% of poverty, and about 12% of beneficiaries with incomes greater than 400% of poverty had such problems. There is considerable interaction in this data with age, of course; older beneficiaries tend to be both sicker and poorer than average.[10]

The exception to this relationship between age, ill health, and poverty is non-elderly disabled beneficiaries. These beneficiaries are all affected by serious chronic illness, and are generally both poorer and sicker than elderly beneficiaries. Further, disabled beneficiaries are almost twice as likely as elderly beneficiaries to have cognitive problems, generally as the result of either mental illness or mental retardation, for which Medicare coverage of treatment services is even less generous than for treatment of other illnesses.[11] In other words, disabled beneficiaries, who are poorer to begin with, are less likely to have Medicare pay for the services they most need.

In their analysis of data from the Medicare Current Beneficiary Survey, Moon and Storeygard found that Medicare beneficiaries with significant physical problems spend considerably more out of pocket than beneficiaries without such problems, even though Medicare itself is also spending substantially more money on them. Beneficiaries with cognitive impairments only (no serious physical impairments) spend slightly less out-of-pocket than beneficiaries with neither physical nor cognitive impairments. Moon and Storeygard attribute this phenomenon to the greater reliance on family care and impaired access to formal services of

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[10] M. Moon and M. Storeygard, "One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems," (Washington, DC: The Urban Institute, September 2001).

[11] The Henry J. Kaiser Family Foundation, "The Faces of Medicare: Medicare and The Cognitively Impaired," (Menlo Park, CA: Kaiser Family Foundation, 1999).

the cognitively disabled.[12] In general, when a beneficiary has high out-of-pocket health costs, Medicare is probably also spending a lot on this beneficiary. This pattern reflects how Medicare's cost-sharing structure works: when a covered service is received, Medicare generally pays for some of its cost and the beneficiary pays for the rest.

Keeping this structure in mind, some of the problems Medicare beneficiaries with chronic illnesses have with Medicare might be viewed, not as problems with Medicare's coverage policies and practices (after all, all beneficiaries are subject to the same rules), but rather as a problem of inadequate incomes. Chronic illnesses cause problems for all Medicare beneficiaries who develop them, but having a chronic illness and being poor creates a heavily compounded effect. Conversely, while it is hard to imagine that Medicare would ever (or should ever) fully cover every service that a chronically ill person needs, it's clear that even with existing coverage policies, the relatively small number of rich beneficiaries with chronic illnesses are able to obtain the services they need without significant financial hardship.

Medicaid

Disabled Medicare beneficiaries, especially those with psychiatric problems, beneficiaries in need of long-term care, and other low-income beneficiaries with significant chronic illnesses are thus likely to be significantly dependent on Medicaid to fill in the gaps left by Medicare. For some five million Medicare beneficiaries, Medicaid is an indispensable safety net. But it is also a safety net with a lot of holes.

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[12] Moon and Storeygard, "One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems," (New York: The Commonwealth Fund, September 2001).

Any generalization about Medicaid is necessarily suspect, because by design Medicaid varies dramatically from state to state. However, it is true that in many states, historically low levels of reimbursement of providers by Medicaid, combined in some instances with continuing stigmatization of the program and its beneficiaries, have meant that coverage has not always guaranteed access to services. For the dually entitled Medicare/Medicaid beneficiaries, the most glaring example of this problem has been overt discrimination against Medicaid beneficiaries in nursing home admissions, at least by the more prestigious facilities, although access problems have also been severe for dental services, some durable medical equipment, and many medical subspecialists. Since the Balanced Budget Act of 1997 overturned the then-prevailing case law, state Medicaid programs have also been free to pay less than 100% of Medicare deductibles or copayments incurred by dually eligible beneficiaries, thus providing further financial disincentives for providers to accept Medicaid or dually-eligible patients.

The vagaries of Medicaid's eligibility process have historically created enormous impediments to affordable health care for low-income seniors. Again, only a relatively small proportion of Medicare beneficiaries have incomes below the poverty level. A far larger number of disabled beneficiaries and elderly beneficiaries with serious chronic illnesses have out-of-pocket medical expenses, net of Medicare coverage, sufficiently high to render them eligible for Medicaid (in some states, some of the time) under one of the several provisions that permit states to tailor coverage for the "medically needy," or those in need of institutional care, or those who would be in need of institutional care if they were not receiving home and community-based

services.[13] Depending on the particular state and the phases of the political moon, the process of obtaining Medicaid eligibility based on those categories can vary from the relatively routine to almost impossible. Eligibility often requires potential beneficiaries to exhaust almost all their lifetime accumulation of assets, and frequently requires an adversarial investigation of the beneficiary's personal circumstances. Moreover, as a result of its very connectedness to the beneficiary's health status and health care expenditures, such Medicaid eligibility is always time-limited (at least in principle), contingent, and tied to the failure of the beneficiary to get any better.

The perverse effects of such an eligibility system are best illustrated by the extreme case of the primarily younger, disabled people who are capable of obtaining paid employment and eager to do so, but who cannot afford to lose their Medicaid coverage as a result of the increased income employment would provide.[14] More generally, Medicaid eligibility tied to health care utilization seems to work better for providers of service than for potential recipients of those services: only a fraction of moderate-income Medicare beneficiaries with high out-of-pocket medical expenses qualify for Medicaid, but nursing homes and hospitals have the opportunity and the incentive to expedite the eligibility process—although once the patient returns to the community, Medicaid coverage may well expire long before the patients' needs do. Those

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[13] J. O'Keeffe, A.K. Long, K. Liu and M. Kerr, "How Do They Manage? A Case Study of Elderly Persons Functionally Eligible for Medicaid Waiver Services But Not Receiving Them," (Washington, DC: AARP, March 1999).

[14] A. Schneider, V. Strohmeyer and R. Ellberger, "Medicaid Eligibility for Individuals with Disabilities," (Washington, DC: The Henry J Kaiser Family Foundation Kaiser Commission on Medicaid and The Uninsured, May 2000).

beneficiaries who are deterred from seeking or obtaining needed services in the first place never appear in the eligibility or utilization statistics.

The fragility and incompleteness of the Medicaid safety net for low- and moderate-income Medicare beneficiaries is perhaps best reflected in the low, but highly variable, rates of enrollment of those at least theoretically eligible in the Qualified Medicare Beneficiary/Special Low-Income Medicare Beneficiary (QMB/SLMB) programs. QMB and SLMB are designed precisely to address the problem of high out-of-pocket expenditures, but they provide no financial protection for services not covered by Medicare, and in any event enroll only a small fraction of those thought to be eligible.[15] It is quite possible that those who do enroll in QMB/SLMB are disproportionately beneficiaries with significant chronic problems who therefore have atypically high out-of-pocket expenses, since those beneficiaries are presumably the most likely to have sufficient motivation to overcome the many obstacles to enrollment. However, the data on program participation is far too limited to permit drawing that, or any other, conclusion about enrollees' characteristics.[16]

Private Options

For those beneficiaries whose income or assets are too great to permit them to qualify for Medicaid supplementation in the states in which they live, private Medicare supplemental plans (Medigap) would appear to provide an avenue through which they could obtain protection

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[15] Families USA, "Shortchanged: Billions Withheld from Medicare Beneficiaries" (Washington DC: Families USA, July 1998).

[16] Medicare Rights Center, "Medicare Facts and Faces: Making Health Care Affordable for People with Low Incomes" (New York: Medicare Rights Center, November 2000).

against crushing out-of-pocket costs. In truth, that avenue is fully or largely closed off in most states. To begin with, in many states, individual Medigap policies are just not available to disabled beneficiaries. Only fourteen states have laws requiring the sale of Medigap to under-65 disabled beneficiaries under certain circumstances.[17] For elderly beneficiaries, most states permit medical underwriting of Medigap plans purchased after a brief initial eligibility period. Only eleven states have laws that restrict underwriting and/or premium rating practices.[18] And of course, while Medigap policies can offer excellent protection against the costs of deductibles and copayments for Medicare-covered services, most offer no assistance in defraying the costs of services, which Medicare does not cover.

Many health care pundits and policymakers have argued that the best alternative to conventional Medicare coverage for beneficiaries with chronic illness has long been obvious: private managed care plans. During most of the 1990s, private managed care plans routinely offered Medicare beneficiaries effective protection against high out-of-pocket costs, along with at least some coverage of outpatient prescription drugs, generally with no premium expense other than the basic Part B premium. Moreover, the incentives inherent in full-risk capitation offered such plans, at least in principle, considerable motivation to proactively employ cost-effective prevention and early-intervention strategies in their approach to managing chronic illnesses.

For whatever reasons, however, such plans never succeeded in attracting a large number of seriously ill beneficiaries, even when their overall enrollments were growing most rapidly in

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[17] N. Tapay and G. Smolka, "Disabled Medicare Beneficiaries Under Age 65: A Review of State Efforts to Provide Access to Medicare Supplemental Insurance" (Washington, DC: AARP, October 1999).

[18] S. Lutzky, L.M.B. Alecxih, V. Pankaj, S. Laud, and G. Schaab, "Restricting Underwriting and Premium Rating Practices in the Medigap Market," (Washington, DC: The Lewin Group for AARP, 2001).

the mid-90s. According to Moon and Storeygard, while more than one-third of all Medicare beneficiaries had a serious cognitive or physical problem, or both, in 1997, fewer than one-quarter of Medicare HMO enrollees had one or more of these serious health problems.[19] And there have been at least a pair of studies suggesting that not only were HMOs less likely to enroll seriously-ill beneficiaries in the first place, but they were also far more likely to disenroll beneficiaries who became seriously ill after the onset of illness.[20] Again, the actual mechanisms by which this occurred are in some ways less important than the overwhelmingly clear fact that it did.

Whatever the causes behind this disproportionately low enrollment of the chronically ill in Medicare HMOs, the availability of HMOs as a safety valve for Medicare beneficiaries has substantially diminished in the last several years. Many plans have pulled out of Medicare wholly or in part, and most that remain have increased their premiums, cut back on their benefits, or both. As Medicare's relative payment rates to HMOs have decreased to more fully reflect the relatively favorable selection they have enjoyed, the ability of plans to use excess payments to subsidize additional benefits has naturally diminished.

And whatever the causes of the low and diminishing number of chronically ill beneficiaries enrolled in managed care, it turns out that from a clinical perspective (as opposed to a financial perspective), that may not matter terribly much at all. For whatever the logic of economic incentives, there is scant evidence that managed care plans actually did a better job in

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[19] Moon and Storeygard, "One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems," (New York: The Commonwealth Fund, September 2001).

[20] R.O. Morgan, B.A. Virnig, C.A. DeVito and N.A. Persily, "The Medicare-HMO Revolving Door – The Healthy Go In and The Sick Go Out," *New England Journal of Medicine* 337, no.3 (1997): 169–75.

caring for chronically ill beneficiaries than the "traditional" fee-for-service system did, and there is some evidence that they actually did worse.[21] In general, patterns of practice in most Medicare HMOs have been remarkably similar to practice patterns in fee-for-service in the same communities; part of the effect that we have long attributed to the incentives of capitation or the form of physician organization may in fact have been attributable to the geographic difference in geographic practice styles, for instance between California and Minnesota physicians, in general, and Florida and Massachusetts physicians. In many areas, the same physicians are on all or many of the Medicare HMO provider panels. These are the same physicians who treat Medicare fee-for-service patients. It is not surprising, therefore, that practice patterns are not significantly different for Medicare HMO enrollees and beneficiaries in Original Medicare, since the two groups might have had the same physicians.

What 'Acute Care' Means Today

While some of the misfit between Medicare and the needs of chronically ill beneficiaries arises from the basic structure of Medicare insurance coverage, other problems arise from the program's acute care roots and orientation. Some of these problems are quite obvious, while others are subtler. To begin with, there is the famous statutory language which forbids Medicare payments for services which "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member," and which then goes on to specifically forbid payment for "personal comfort items…routine physical

[21] Ware, *et al.* "Differences in 4-year health outcomes for elderly and poor, chronically ill patients treated in HMOs and fee-for-service systems. Results from the Medical Outcomes Study." *JAMA*. 1996 October 2; 276(13): 1039–47.

checkups…eye examinations…hearing aids…custodial care."[22] The process through which Medicare determines which specific services it will pay for and which it won't, and the outcomes of those processes, are notoriously complex, confusing, and often contradictory—and often the subject of considerable reform efforts. Nevertheless, some generalizations about the implications of this language are possible.

First, the statute clearly draws a line between covered "treatment" services, on the one hand, and those that involve "personal comfort" or "custodial care," on the other. In actual clinical practice, of course, those boundaries may be significantly fuzzier, or even in some cases non-existent. Special mattresses or wheelchair seats designed to reduce the risk of decubitus ulcers, for example, can be especially important preventive measures for older patients with a variety of chronic illnesses, but their function is primarily to prevent a disease, which, if the patient is lucky, she doesn't yet have. Medicare carriers may thus be willing to provide such items to beneficiaries only after they have developed actual symptoms—after, in other words, the items could really be of use.

Second, clinicians who care for the chronically ill have contended that the notion of "treatment of illness"[23] has often been interpreted by Medicare contractors to mean active treatment of underlying disease, rather than intervention in the functional consequences of disease. Thus, until recently, many Medicare contractors refused to recognize a primary diagnosis of Alzheimer's Disease—not because it isn't a disease, but because the Carriers did not believe that there is any efficacious treatment for it. Because Carriers didn't believe Alzheimer's

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[22] 42 U.S.C. 1395y Section 1862 (1)(I)(6).

was treatable, Medicare did not pay for services that addressed the effects of the illness on physical or behavioral function.

A more dramatic illustration of the policy convolutions engendered by that statutory language involves Medicare coverage of enteral and parenteral nutrition. Obviously, nutrition is both essential to the health of all Medicare beneficiaries and precisely within the category of services that the law would seem to preclude Medicare from covering. And to the extent that enteral or parenteral feeding supplements basic oral nutrition, Medicare will not pay. But for patients whose digestive systems are sufficiently damaged or dysfunctional to prevent oral nutrition, CMS staff has defined that functional problem as "the functioning of a malformed body member." In other words, parenteral or enteral nutrition is defined as the equivalent of a prosthetic for the beneficiary's digestive system—and thus eligible for coverage while other nutrition services are not.

Finally, the interpretation of "treatment of illness" by Medicare—as with all other major payers—has contributed to Medicare's obsession with reductions in inpatient hospital lengths of stay, despite the fact that at least some patients with serious chronic illnesses might benefit considerably from more carefully-planned and gradually-implemented discharge transition processes than are now generally provided. The continuing pressure on hospitals to decrease length of stay, even when doing so has negative effects on patients' well-being, is particularly peculiar since, for the overwhelming proportion of all inpatient cases, Medicare is financially indifferent to all but the most protracted stays.

Medicare's acute care orientation also goes arm-in-arm with a model of care in which the physician is always the sovereign captain of the team. Thus, Medicare coverage for any home

health services, most rehabilitation and physical therapy, durable medical equipment, and other services and items on which chronically ill beneficiaries may be especially reliant hinges on specific physician orders, even though most practicing physicians are notoriously ignorant in these areas. Effective integrated systems of care for the chronically ill depend both on substantive specialists and real interdisciplinary teams. Most Medicare patients do not have access to the optimal benefits of interdisciplinary teams.

Finally, for some Medicare beneficiaries, the program's acute care orientation leads to further coverage problems. Medicare coverage of hospital inpatient and other Part A services is still tied to the concept of "spell of illness," which is about as acute-care oriented a notion as one can find. But the "spell of illness" concept often significantly compromises the availability of rehabilitative or restorative services for beneficiaries with illnesses the "spell" of which can be expected to be the rest of their lives. And while only about 6,000[24] beneficiaries exhaust their limit on lifetime reserve inpatient hospital days each year, it's safe to assume that most of them are people with chronic medical problems.

Family Affairs

Medicare's basic structure causes difficulty for beneficiaries with serious chronic illnesses in at least one other way: while chronic illness is something that happens to *families*, Medicare provides benefits to *individuals*. Both Medicare and Medicaid are *individual* entitlements (although eligibility for Medicaid often depends on *family* income, creating the whole tangled mess of spousal impoverishment provisions, liens on estates, and asset transfer

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[24] Data from Email correspondence with Richard Foster, CMS, January 14, 2001.

prohibitions), but the problems caused by chronic illness often affect family members as well. Family members, for example, are often the major providers of advice and guidance to beneficiaries about choices of health plans, of providers, and of treatments, but except for spouses or relatives who have sought guardianship or designated payee status, most relatives have no legal standing to participate in such decisions, and Medicare and its contractors generally make no effort to inform or educate them. Even cognitively intact beneficiaries may be overcome by the blizzard of paper frequently associated with chronic illness and high service utilization. The relatives who are left to disentangle the information maze receive no assistance.

Most centrally, Medicare fails to recognize, or even take advantage of, the pervasiveness of family caregivers, even though some modest policy proposals have been advanced in that direction. Assessments and plans of care for home care invariably assume that certain tasks will be performed by informal caregivers, whether the caregivers are capable of and willing to perform these tasks, or not. Every clinician engaged in the care of the frail elderly can recount instances in which services to a patient might have been significantly improved—and total costs to Medicare and often Medicaid reduced—with only modest direct assistance to a caregiver, but such assistance is generally unattainable under current policies.

Indeed, there is certainly some number of instances in which the Medicare-paid service provider acts in a way that makes the work of the informal caregiver even more difficult. Conversely, the training and orientation of most professional in-home caregivers, reinforced both by Medicare rules and state licensure standards, militates against establishment of a true collaboration between formal and informal caregivers, in which information is freely exchanged

and tasks are allocated on the basis of ability to perform or patient preference, rather than coverage and payment rules.

POLICY BARRIERS

The Medicare Physician Fee Schedule

As the previous pages describe, many barriers to more effective care of chronically ill Medicare beneficiaries arise from intrinsic characteristics of the Medicare program itself—its limited benefits, the problems of high out-of-pocket costs, its acute-care and individual orientations. Overcoming those barriers would therefore require fundamental changes in the basic structure of Medicare—changes that may well be highly desirable, but difficult to achieve in the short term, as a practical matter. But other problems with the provision of care to chronically ill Medicare beneficiaries may derive from more narrow, specific, or discretionary characteristics of the Medicare program, all of which could presumably be fixed at least somewhat more readily. In this section, I will identify some—but certainly not all—of those barriers, accounting, I hope, for a good share of those that are most significant, and thus most suitable to go to the top of any short-term policy agenda.

The Medicare Physician Fee Schedule

Mandated by legislation enacted in 1990 and implemented beginning in 1992, the Medicare Physician Fee Schedule has been widely acknowledged as a major improvement in the Medicare system. Based on a Resource-Based Relative Value Scale (RBRVS), the fee schedule was designed to replace an arbitrary and often unfair charge-based system, to provide a more

rational and transparent framework for physician fees, to reallocate at least some spending on physicians' services away from surgery and invasive medical procedures towards "cognitive services," and to support efforts at cost containment. By many accounts, the fee schedule has succeeded along at least some of these dimensions. But it has become a major obstacle to positive change in the provision of care to chronically ill beneficiaries.

The "Achilles' heel" of the Fee Schedule has been the coding and classification of "Evaluation and Management" (E&M) services, which collectively account for almost half of all Medicare-paid physician services. The existing E&M codes fail to adequately reflect the additional complexity and time requirements associated with caring for many chronically-ill patients; they provide little incentive for continuity of care; and they conflate case management with other physician services in a way that often leaves the appearance of minimal or non-existent payment for the case management function. For a variety of complicated reasons, the entire issue of appropriate E&M codes and coding has become a major source of frustration, confusion, and anxiety in the physician community, and perhaps the single most significant source of friction between physicians and CMS. There's growing sentiment, which I share, that we probably need to scrap the entire coding and classification system, and start all over again. In the course of doing that, it might well be possible to address some of the issues specific to chronic care.

As desirable as it may be, replacement of the E&M codes would not solve all the problems with the Medicare Fee Schedule system that affect care of the chronically ill. In particular, it would not address the problem of paying fairly and appropriately when a number of different professionals are involved in managing a case, ideally working in close partnership with

one another. The expansion of direct Medicare payment to some non-physician providers, especially advanced practice nurses and, to a lesser extent, physical therapists, means that some members of the care team can bill separately for services while others can not; similarly, the same service is billed differently depending on whether it is provided by a non-physician in independent practice or someone with the same licensure working for a physician and providing service "incident to" services provided by the physician. And activities that may be essential for the effective maintenance and operations of interdisciplinary teamwork, such as case conferencing, may not be reimbursable at all because they are not considered direct services to beneficiaries.[25, 26]

In capitated managed care plans or in the case of inpatient services, these particular problems presumably should not exist, as the plan or provider can support interdisciplinary teamwork among salaried or partially-salaried employees, and presumably make determinations about the relative cost-effectiveness of various support activities that foster such teamwork. Certainly, some fully (and generously) capitated long-term care demonstration projects, such as PACE or the Urban Medical Group, are often seen as models for such teamwork. But of course a declining proportion of Medicare beneficiaries—and, as discussed above, especially of seriously ill Medicare beneficiaries—are enrolled in capitated plans, and reimbursement of plans is less generous than it was.

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[25] L.I. Iezzoni, "The Demand for Documentation for Medicare Payment," *The New England Journal of Medicine* 341, no.5 (1999): 365–367.

[26] L.I. Iezzoni, "Evaluation and Management Guidelines," *The New England Journal of Medicine* 339, no. 23 (1998): 1697–1698.

A particular subset of this issue of how to support teams within the framework of Medicare's payment system is the question of how to support case management services. That issue has bedeviled Medicare policy makers for years. Again, the Medicare Fee Schedule does identify physician case management of home care patients as a separately billable service, but case management of other patients receiving other services is generally supposed to be incorporated into other payments. And there are many instances, of course, in which physicians are not the optimal case managers. Yet it seems clear that case management is likely to be effective only to the extent that the work of case managers is closely connected to that of the patients' physicians, and involves the power to steer patients away from inappropriate or overly expensive services as well as the power to connect them with the right ones. Here again, some sort of capitation arrangement would appear to offer much better incentives and alternative ways of finding the money to pay for the services people with Medicare need. In that regard, it's hard to know whether the continuing relative paucity of such activities within Medicare managed care plans reflects the extent to which case management may *not* be cost-effective, or merely the effects of professional and organizational inertia.

Home Care

No aspect of Medicare has undergone more turbulence and more change in the last decade than home care, and the nature of those changes lie exactly at the center of the mismatch between Medicare and the needs of the chronically ill. Beginning in the late 1980s, the Medicare home care benefit was transformed from a limited acute care service to a chronic care benefit, with enormous growth in utilization and costs as some of the unmet demand for chronic care

services became met. In keeping with the laws of political motion, however, that action was almost inevitably followed by an equal and opposite reaction, consisting of major investigative initiatives followed by the dramatic budget cuts of the Balanced Budget Act of 1997. After a period of enormous, unprecedented, and at least partially unanticipated shrinkage in the volume of home health services being provided to Medicare beneficiaries (and to a lesser extent in the number of agencies providing such services), the phasing in of BBA home care provisions, combined with some Congressional undoing in 1999 and 2000, appear to have left Medicare home care in an uneasy and unstable equilibrium.

The Medicare home health benefit reflects the acute care model more than the chronic care model for delivering care. Under the law, Medicare beneficiaries are eligible for covered home care when they are "homebound" and need "skilled" services on an "intermittent" basis. The law presumes that beneficiaries who are not homebound can receive the services they need in doctors' offices or other provider settings, and that beneficiaries who need skilled services on a continuous or regular (rather than intermittent) basis should receive these services in institutional facilities.

These statutory limitations reflect Medicare's bias toward covering care according to the acute care model—a series of targeted, staccato, specific clinical interventions on behalf of someone who is temporarily incapacitated, rather than continuous interdisciplinary care. Modern geriatrics, a field that evolved after Medicare was enacted, teaches continuous and interdisciplinary care for chronic and acute conditions, since continuous care can prevent further functional decline in a patient with acute or chronic conditions. The home care statute does not reflect this clinical principle. The home care statute also reflects policymakers' anxiety—well-

founded, it would appear from the evidence about the growth of Medicare home care in the 1990s—that demand for continuous, non-"skilled" services among the frail elderly and disabled might be effectively infinite.

The notion of "homebound" has long proved to be particularly problematic. Given the reality of family and other caregivers and modern assistive technologies, one suspects that the only people who are literally homebound are the occasional morbidly obese bedbound patients one sees on TV, because they have gotten literally too wide to fit through the doorframes and must be extricated from their dwellings by emergency services workers equipped with pickaxes and chainsaws. Even the frailest and most disabled patient leaves home once in a while—certainly for doctors' visits or other medical care that is not offered in the home—and, of utmost political symbolism, to go to church. When the HHS Inspector General focused on home care claims in the mid-90s, however, they found literally hundreds of thousands of Medicare-paid home care visits for which they claimed that the beneficiaries did not meet the homebound criterion. In the more egregious instances, they could demonstrate that the beneficiaries were not homebound because they were never home to be interviewed by investigators. But many of the claims they denied clearly involved beneficiaries who were very ill, and who certainly needed skilled home care services, but who fell on the other side of the rather arbitrary line employed by intermediaries and the IG to adjudicate cases of homeboundedness.[27]

In 1996 and 1997, I personally spent many hours participating in extensive discussions of ways in which the homebound criterion might be made more realistic and more operationally useful, and HCFA staff did literally hundreds of hours of research and analysis. Eventually, we

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[27] B.C. Vladeck, "The Storm Before The Calm Before The Storm," Care *Management Journals* 2, no. 4 (winter 2000): 232–7.

proposed legislative language to tighten and further interpret the concept, which evoked strenuous opposition and resulted, in the final form of the Balanced Budget Act, in a provision calling for a further HHS study of the issue. That study was duly conducted, and resulted in a report that contained no recommendations—the issue still proved too hard.[28]

Of course, the logical solution would thus appear to be to abandon the concept of "homebound" altogether, but in the face of the evidence about potential demand for home care services, policymakers are reluctant to eliminate the criterion until they have something with which to replace it. Finding that something has also proved to be highly elusive.

Another way in which the Medicare home health benefit is a misfit in caring for chronically ill beneficiaries is its continued reliance on physicians to prescribe and oversee the benefit. Physicians usually have little expertise in home care and home care services, and in most instances it is the home care nurse, not the physician, who actually observes the patient in the home setting.[29] As a practical matter, then, most physician involvement in home care is limited to signing forms prepared by discharge planners or home cares nurses. Often, physicians don't even read these forms, let alone understand them. In other cases, the physician doesn't know enough to order or approve legitimately needed home care services, so the beneficiary goes without needed covered services. This poses a particularly serious problem for beneficiaries and the home care agencies serving them when the beneficiaries have been treated as "service" patients in public or teaching hospitals, and as a result frequently don't have regular

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[28] U.S. Department of Health and Human Services. "'Homebound'—A Criterion for Eligibility for Medicare Home Health Care." Report to Congress, April 1999.

[29] "The Physician's Role in Medicare Home Health" (OEI-02-00-00620). (Washington, DC: Department of Health and Human Services Office of Inspector General, 2001).

physicians who know anything about them. In these instances, while someone will sign a home care order in order to permit the patient's discharge, changing the plan of care to account for any change in the patient's condition effectively requires a rehospitalization, since hospitalization is the only way to engage a physician in directing changes.

In a different vein, some of the problems with the development of home care in this country over the last several decades have arisen from the failure of Medicare to pursue a practical and coherent quality improvement strategy. Assuring the quality of home care services is intrinsically difficult, since those services are provided in a decentralized way in essentially private settings. Theory suggests that the best hope of insuring and improving the quality of care under such circumstances is to rely on provider organizations that can develop and maintain powerful corporate cultures revolving around quality and patient service; invest resources in the training and retraining of a staff comprised primarily of long-term, full-time employees; and employ supervisory structures that prepare first-line supervisors to perform effective oversight and reward them when they do so. Instead, the Medicare Conditions of Participation for home care have in effect encouraged the proliferation of extremely small agencies with essentially no supervisory or training resources and a heavy reliance on part-time and contract employees. Quality assurance has focused on the ritual completion of certain forms of paperwork, rather than any actual evaluation of the services provided to clients.

Because it has proved politically impossible to raise the threshold of expectation for home health agencies, CMS has adopted as its long-term strategy for quality improvement the collection and utilization of patient assessment data. This strategy is already beginning to bear fruit in the analogous example of the use of the Minimum Data Set for quality monitoring in

nursing homes, but the MDS example also suggests that it will take many years before all the data CMS and home health care agencies are collecting with the OASIS instrument can be turned into a useful quality improvement/measurement tool. In the interim, there is always the risk that the political process can further delay or even stop the implementation of quality measures.

Other Policy Issues

The mismatch between Medicare and chronic care at the policy level is not confined to the Physician Fee Schedule or home care policy. There are dozens of other problems, lacunae, or holes in program design that cry out to be fixed. In the interests of space, however, only three others will be briefly mentioned here: durable medical equipment, occupational and physical therapy, and transitioning patients.

First, as technologies and professionals' attitudes about chronic illness and functional limitations continue to evolve, more and better devices and equipment come onto the market that at least purport to provide assistance to patients. The political history of Medicare's Durable Medical Equipment (DME) benefit is particularly tawdry and complicated, but it has produced policies with so many peculiarities, internal inconsistencies, and intellectual dead ends that the inability of beneficiaries and their care providers to even figure out what they are entitled to is a major problem. Devices for assisting people who have trouble walking—spanning the technological gamut from more sophisticated walkers to high-powered electric scooters and wheelchairs—have improved and proliferated in the last decade, but Medicare DME policy is still dominated by the requirement that equipment be used primarily in the home. That requirement originated from a legitimate fear that unscrupulous operators of nursing homes and

hospitals would abuse the benefit to equip their facilities, but there certainly should be other ways of policing such abuses. As with home care, Medicare relies on physicians to control DME utilization, and most physicians know very little about the subject. Physicians are required to sign "Certificates of Medical Necessity," a requirement that unnecessarily adds a layer of difficulty and delay to the caregiving process.

Medicare policies towards occupational and physical therapy are even more muddled. OT and PT are covered in inpatient general hospitals and, separately, in outpatient departments, free-standing or "distinct part" specialty rehabilitation hospitals, comprehensive outpatient rehabilitation facilities (CORFs), skilled nursing facilities, hospice (although only to a very limited degree), physicians' offices, in home care, and in individual professional practices when permitted by state law. However, few policies and no standards are applied uniformly across all those settings, in part because different entities administer different programs for Medicare. Although the literature shows considerable overlap in patient characteristics and needs, at least for those with certain diagnoses (e.g., hip fracture) among specialty rehabilitation hospitals, skilled nursing facilities, and home care, Medicare mandates the use of different assessment instruments for each category, while mandating patient assessment but no standardized tools for office-based patients.

The BBA adopted especially onerous limitations on outpatient rehabilitation. Although there has been a significant trend in OT and PT (along with other parts of the health system) from inpatient to outpatient treatment, the BBA tightened the cap on per-visit payments while putting a limit on the number of visits, and changed the methodology for paying CORFs in a way

that effectively put many CORFs out of business.[30,31] Congress has already postponed implementation of those limits several times. No one seemed to be paying very much attention to this aspect of the BBA; rehab providers only appeared on participants' lists of proposals relatively late in the game.

Medicare's failure to enforce regulations about transitioning patients adds to the misfit between Medicare and chronic care. In recent years, researchers have increasingly called attention to the transition of patients among providers—between hospitals and nursing homes or home care agencies, or vice versa, for example—as a particularly problematic and troublesome aspect of chronic care. Bad things often happen to patients in, or as a direct result of, such transitions. Medicare has extensive regulations, contained in facility Conditions of Participation that theoretically govern most such transitions when they affect Medicare patients. However, these regulations seem to be observed almost entirely in the breach, and there is very little evidence of any effort to enforce them. It's no exaggeration, for example, to infer that Medicare patients are discharged from acute hospitals in a manner inconsistent with the prevailing regulations literally hundreds of thousands of times a year, yet I certainly can't remember a single enforcement action based on that regulation. As with the rest of the Medicare program, services provided by different facilities are treated as entirely separate, autonomous phenomena, even when they are provided serially to a single patient, and even when the providers all have common ownership or control.

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[30] B. Gage, "Impact of The BBA on Post-Acute Utilization," *Health Care Financing Review* 20, no.4 (summer 1999): 103–26.

[31] J.B. Klein and A. Sugarman, "The Quake That Rocked Rehabilitation. The Balanced Budget Act of 1997: Business Implications and Survival Strategies," *Rehabilitation Management* 10, no.6 (Oct-Nov 1997): 108–11.

Making Medicare Safe for Chronic Care

With all of these problems in the relationship between Medicare and chronic care, it's still not clear that Medicare policies, in and of themselves, can be characterized fairly as the principal barrier to improving care of the chronically ill elderly. With notable exceptions in specific, localized programs, care of non-Medicare chronically ill people in this country tends not to be so hot, either. The fact is that the problem posed for clinicians and patients alike by the growing number of people surviving with complex chronic illnesses is historically novel, and one to which both biomedical research and medical education have been relatively slow to respond.

Our contemporary fascination with the power of economic incentives in all modes of discourse—if not all modes of life—has complicated this discussion considerably. Implicit in much health policy discussion is the assumption that if one could only design the right payment incentives, then the desired clinical behavior would follow. Not only is this proposition, when put so baldly, demonstrably false, but it tends to work better when there are established norms and expectations in clinical practice towards which one can give clinicians incentives to gravitate. But the history of efforts to *create* new modalities of clinical practice by fiddling with payment mechanisms, in Medicare and elsewhere, is littered with unhappy experiments.

In this regard, the failure of Medicare managed care plans to significantly outperform the fee-for-service system in care of the chronically ill perhaps becomes more understandable. For whatever the economic incentives, practitioners in managed care plans have been no more able than their fee-for-service counterparts to draw on an established body of clinical expertise or even consensus clinical opinion. They, too, have been making it up as they go along.

For more than twenty years, in public policy towards services for the chronically ill, the United States has thus been caught in what I have described elsewhere as a "chicken and egg" dilemma. In the absence of well-tested, widely disseminated models of superior chronic care, policymakers have been reluctant to expand benefits. They have been unwilling to commit additional funds for services they can't already see and evaluate. Yet providers of service, many of whom have ideas about how service delivery might be improved, argue that they are unable to implement such new models of care without adequate reimbursement underpinnings.

In chronic care, this stalemate has been exacerbated by the shared financing responsibilities, especially between Medicare and Medicaid, combined with the anxieties of policymakers who fear that the demand for services, once such services become covered and reimbursable, would grow dramatically. This problem is particularly severe at the boundary between medical and non-medical services, where Medicaid has long provided coverage (for at least some clients) for at least some services that would not qualify as medical care under Medicare's standards. Good chronic care may straddle or obliterate that boundary, but until now there has been no policymaking process that does: the federal Office of Management and Budget continues to insist, for instance, that demonstration projects for dually-eligible, chronically ill Medicare/Medicaid beneficiaries be budget-neutral in both Medicare and Medicaid separately, rather than permitting calculation of a single aggregate federal liability. Projects that might save more federal Medicaid dollars than they cost in increased Medicare dollars have thus not been approved.

The very concept of "budget neutrality" as applied to demonstration projects, along with its evil twin, the "pay as you go" requirements under the Budget Enforcement Act of 1990, have

hoisted much of the advocacy community on its own petard. While it is true that the current, inadequate non-system of care for the chronically ill is wasteful and inefficient in many instances, acknowledging this is a far cry from asserting that improvements in coverage of services for the chronically ill would save money. Given how relatively small a *share* of the costs currently incurred by its chronically ill beneficiaries Medicare is now paying, it's hard to conceive of a more rational system in which beneficiaries would receive substantially better services but the program as a whole would pay less. Nor should this argument be necessary. The assumption that Medicare can only be improved if doing so does not increase the costs of the program is a political assertion, not a logical or economic necessity. And advocates who continue to insist that the benefit expansions they support would reduce total Medicare costs are only impairing their only credibility, and thereby their effectiveness as advocates.

Chronic Care and Medicare Reform

Just as the relationship between Medicare and the needs of its chronically ill beneficiaries can only be understood in the context of the overall shape of the Medicare program, so the subject of improving Medicare for the chronically ill must be considered in the broader context of Medicare's future. So long as Medicare "reform" is a euphemism for reduction in the real value of Medicare benefits, then it is hard to see how any such "reform" could help those beneficiaries most dependent on the program's benefits, and therefore most in need of benefit improvements. To the extent that Medicare's current benefits are deemed economically unsustainable in the future, then the prospects of serious improvements in benefits are obviously

dim, but that depiction is a matter of political choice and relative political influence, not ineluctable economic laws.

Conversely, one would like to be able to at least imagine a reframing of the debate in terms of what the Medicare benefit package should be from the perspective of optimal care of beneficiaries, maximal fit between benefit structures and clinical judgements of necessity and appropriateness, and equity of financial burden. In such a debate, it would quickly become clear that those reforms that would be of greatest use to all beneficiaries—a decent, comprehensive, prescription drug benefit; more effective limits on out-of-pocket liabilities; expanded coverage of preventive services; and a total restructuring of the Physician Fee Schedule—would also be of particular benefit to beneficiaries with significant chronic illness.

Given the current political stalemate over the future of Medicare, which is likely to be broken only by tectonic shifts in the balance of national political forces, far reaching "reform" or reform is unlikely in the foreseeable future. But there are a number of ameliorative steps that could benefit chronically ill beneficiaries without overwhelming increases in cost. This paper has pointed out specific areas in which relatively minor reforms could immediately help people with chronic conditions: the home health and DME benefits, policies towards rehabilitation, the Physician Fee Schedule, and regulations about transitioning patients. In addition, the "chicken and egg" stalemate around the design of systems of comprehensive chronic care could be attacked, if not totally broken down, by a program of systematic experimentation of the kind that was in fact standard practice for Medicare in the 1970s and early 1980s. Given the needs of chronically ill beneficiaries, there is no good reason to delay implementing this agenda.