

NHPF Forum Session
Meeting Announcement



**Medicare and Chronic Conditions:
Breaking Down Barriers to Better Care**

A DISCUSSION FEATURING:

David Blumenthal, M.D.
Chair
Study Panel on Medicare and
Chronic Care in the 21st
Century
National Academy of Social
Insurance
and
Director
Institute for Health Policy
Massachusetts General
Hospital/Partners HealthCare

Robert A. Berenson, M.D.
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WITH COMMENTS FROM:

Stuart Guterman
Director
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Information
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and Human Services

Terri Shaw
Professional Staff Member
(Minority)
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Joel White
Professional Staff Member
(Majority)
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

**Wednesday,
March 26, 2003**

11:45 am–12:15 pm — *Lunch*
12:15–2:15 pm — *Discussion*

Hyatt Regency Capitol Hill
400 New Jersey Avenue, NW
Ticonderoga Room

To register:

Please call Tiombe Diggs at
202/872-1392 as soon as
possible. Space is limited.

**For additional information
on this topic:**

*Medicare in the 21st Century:
Building a Better Chronic Care
System*, National Academy of
Social Insurance — available
at <http://www.nasi.org>.



Medicare and Chronic Conditions: Breaking Down Barriers to Better Care

The Medicare population has changed since the program was enacted in 1965. Due to advances in medical science and technology, aged beneficiaries now live longer than previous generations, but they also have an increased likelihood of living with one or more chronic conditions. And enrollment of nonelderly individuals with disabilities is rising rapidly, increasing 18.6 percent between 1995 and 1999.¹

Chronic conditions are pervasive among the Medicare population. Nearly 80 percent of Medicare beneficiaries have at least one of the following chronic conditions: stroke, diabetes, emphysema, heart disease, hypertension, arthritis, osteoporosis, broken hip, Parkinson's disease, and urinary incontinence. Almost 63 percent of beneficiaries have two or more conditions; of this group, almost one-third have five or more chronic conditions.²

Yet the Medicare program is not designed to meet these beneficiaries' needs. Good chronic care has been characterized as continuous, multidisciplinary, accessible, coordinated, and patient-centered.³ But Medicare beneficiaries with chronic conditions typically receive fragmented health care from multiple providers and multiple sites of care.⁴ The costs to the program are substantial. There is a strong pattern of increasing utilization as the number of conditions increases. A recent analysis using 1999 Medicare claims data showed that almost 32 percent of Medicare beneficiaries have four or more chronic conditions and drive almost 79 percent of program spending.⁵

SESSION OVERVIEW

This meeting will consider Medicare beneficiaries with chronic conditions, focusing on their prevalence, cost, utilization patterns, needs, and preferences. It will address the significant financial, statutory, and regulatory barriers to chronic care facing the Medicare program and its providers. Discussants will weigh recommendations developed by a panel of experts for building a better chronic care system. They will also discuss various options and demonstration projects being pursued by members of Congress and the Centers for Medicare and Medicaid Services.

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NHPF is a nonpartisan education and information exchange for federal health policymakers.

Geared toward acute, episodic care, the basic structure of Medicare coverage and payment policy makes the program resistant to change. Medicare rewards high-tech providers and treatments, when people with major chronic illnesses actually want and need education, emotional support, care coordination, and follow-up.⁶ Original Medicare's fee-for-service reimbursement is based on payment to individual providers, with particular emphasis on physicians. Reimbursement is most frequently tied to discrete services such as office visits and procedures. These policies discourage a team approach to care and provide little incentive to keep beneficiaries well.

Medicare statute and policies do not support coverage for many benefits and services vital to those with chronic conditions, such as outpatient prescription drugs, sensory aids, or custodial care. Medicare payments are prohibited for services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."⁷ Medicare providers and contractors often interpret this provision to mean that they may deny care when the beneficiary's condition is stable or when maintenance services are needed, which creates problems for those with chronic conditions.⁸ For example, rehabilitative services often are not covered when their goal is to maintain or slow the deterioration of function. Home health services covered by Medicare are limited to beneficiaries who are "homebound" and in need of "skilled" services on an "intermittent basis." Coverage policy on durable medical equipment requires that the equipment be used primarily in the home, so that access is limited for those who prefer to be more independent. Patient-support services such as family education and phone calls or e-mails between office visits generally are not reimbursed at all.

To address these problems and consider potential solutions, the National Academy on Social Insurance (NASI) convened an independent, bipartisan panel of experts. The study panel recently released its report, *Medicare in the 21st Century: Building a Better Chronic Care System*, (available at <http://www.nasi.org>). The report provides an overview of Medicare and chronic conditions, reviews past initiatives to improve care for people with chronic conditions, and lays out recommendations for change.⁹

The panel set a new vision for Medicare to improve care and financing for those with chronic conditions and then proposed recommendations to move toward that vision. Recommendations include the following:

- Provide beneficiaries with financial protection from chronic conditions (for example, add an annual cap on out-of-pocket expenditures for covered services).
- Support the continuum of care beyond those services presently covered by Medicare (for example, add prescription drug coverage, relax the homebound requirement, cover durable medical

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equipment with the specific intent of maintaining and restoring function).

- Promote new models of care (for example, use graduate medical education funding to support chronic care training, risk adjust evaluation and management codes).
- Strengthen the role of the Centers for Medicare and Medicaid Services (CMS) as a purchaser of care (for example, designate Medicare Partnerships for Quality Service demonstration [formerly called Centers of Excellence] for select chronic conditions).
- Support enhanced information systems (for example, foster electronic systems that track beneficiaries across multiple providers and care settings).
- Implement and support funding for research and demonstration projects (for example, redefine budget neutrality for the purpose of approving proposed demonstrations).

SPEAKERS AND DISCUSSANTS

As Congress and the Bush administration begin to explore ways to improve beneficiary care in traditional Medicare, the NASI recommendations lay the groundwork for fruitful discussion. **Robert Berenson, M.D.**, will begin by presenting the clinical characteristics of Medicare beneficiaries and the barriers to chronic care management in Medicare. Berenson is an independent consultant who works primarily with organizations such as AcademyHealth, the Center for Studying Health System Change, the Urban Institute, and the National Health Policy Forum. Previously, he was director of the Center for Health Plans and Providers within the Health Care Financing Administration (now known as CMS) in the Clinton administration.

David Blumenthal, M.D., M.P.P., served as chair of NASI's Study Panel on Medicare and Chronic Care in the 21st Century. He will describe the panel's vision for Medicare to improve care and financing for beneficiaries with chronic conditions and present recommendations to move toward that vision. Blumenthal is director, Institute for Health Policy, and physician at the Massachusetts General Hospital/Partners HealthCare system in Boston.

These presentations will be followed by responses from three distinguished speakers:

Stuart Guterman is the director of the Office of Research, Development, and Information at CMS. He will discuss a series of disease management demonstrations being undertaken by CMS (for more information, see <http://www.hhs.gov/news/press/2003pres/20030227.html>).

Joel White is a professional staff member of the House Ways and Means Subcommittee on Health, chaired by Rep. Nancy Johnson

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(R-Conn.). He will discuss Johnson's priorities regarding chronic disease management in the Medicare program.

Terri Shaw is a professional staff member for Rep. Pete Stark (D-Calif.), ranking member of the House Ways and Means Subcommittee on Health. She will discuss Stark's priorities regarding coordinated care benefits in the Medicare program.

KEY QUESTIONS

The discussion will center on the following questions:

- What is the general prevalence and cost of chronic conditions? What are the utilization patterns of Medicare beneficiaries with multiple chronic conditions?
- What are the chief legal and administrative constraints to providing better chronic care in Medicare? How do these barriers differ between fee-for-service and Medicare+Choice?
- Of the NASI panel's recommendations, which could be implemented immediately and which would take longer? Which would require congressional action? What resistance might exist in the provider community?
- What are the cost implications of these recommendations? What are the political implications?
- Which of these recommendations will be tested by the disease management demonstrations being undertaken by CMS?
- How might these recommendations be incorporated into broader Medicare reform?

ENDNOTES

1. Sandra M. Foote and Christopher Hogan, "Disability Profile and Health Care Costs of Medicare Beneficiaries under Age 65," *Health Affairs*, 20, no. 6: 242.
2. Robert A. Berenson and Jane Horvath, "The Clinical Characteristics of Medicare Beneficiaries and Implications for Medicare Reform," prepared for the Center for Medicare Advocacy, Inc., Conference on Medicare Coordinated Care, Washington, D.C., March 2002, 5; accessed March 3, 2003, at <http://www.partnershipforsolutions.org/DMS/files/MedBeneficiaries2-03.pdf>.
3. June Eichner and David Blumenthal, eds., *Medicare in the 21st Century: Building a Better Chronic Care System* (Washington, D.C.: National Academy of Social Insurance, January 2003), 11; accessed February 27, 2003, at http://www.nasi.org/usr_doc/Chronic_Care_Report.pdf.
4. Stuart Guterman, Centers for Medicare and Medicaid Services, testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, February 25, 2003, 1; accessed March 3, 2003, at <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=94>.
5. Robert A. Berenson and Jane Horvath, "Confronting the Barriers to Chronic Care Management in Medicare," *Health Affairs*, "Web Exclusive," January 22, 2003, W3-38; accessed February 28, 2003, at <http://www.healthaffairs.org/WebExclusives/2202Berenson.pdf>.

6. Ed Wagner, M.D., Group Health Cooperative, testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, February 25, 2003, 2-3; accessed March 3, 2003, at <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=96>.
7. 42 U.S.C. §§1395y(a)(9),(10),(12).
8. Vicki Gottlich, "Medical Necessity Determinations in the Medicare Program: Are the Interests of Beneficiaries with Chronic Conditions Being Met?" prepared for Partnership for Solutions: Better Lives for People with Chronic Conditions, Baltimore, Maryland, January 2003, 3, 6; accessed March 5, 2003, at <http://www.partnershipforsolutions.org/DMS/files/MedNec1202.pdf>.
9. Eichner and Blumenthal, *Medicare*, v-vii.