Medicare and Chronic Conditions: Breaking Down Barriers to Better Care

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What is a chronic condition?

- A chronic illness, functional limitation, or cognitive/mental impairment;
- Limits what a person can do;
- Requires ongoing care.
Chronic conditions are prevalent among Medicare beneficiaries

Many beneficiaries have functional limitations

<table>
<thead>
<tr>
<th>Activity Level</th>
<th>Aged (%)</th>
<th>Disabled (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IADLs only</td>
<td>12%</td>
<td>31%</td>
</tr>
<tr>
<td>1 ADL</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>2 ADLs</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>3+ADLs</td>
<td>8%</td>
<td>8%</td>
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</tbody>
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One-third of beneficiaries have a serious chronic condition

Source: One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems (Moon and Storeygard, 2001).
Spending is concentrated on beneficiaries with multiple chronic conditions

- Beneficiaries with 5+ chronic conditions account for 66% of Medicare spending
- Beneficiaries with chronic conditions account for 95% of Medicare spending
Beneficiaries with chronic conditions have significant out-of-pocket expenditures

- Out-of-pocket spending increases with each additional chronic condition
- In 1996, $1,492 annually for those with 3+ chronic conditions and no supplemental coverage
Beneficiaries with multiple conditions are high utilizers of physician services.

Note: Data for Aged 65+ beneficiaries.
Beneficiaries with multiple chronic conditions fill the most prescriptions.

Source: MEPS, 1996 (Berenson and Horvath, 2002).
A Chronic Care Delivery Model

• Pioneered by Wagner and associates at Group Health Cooperative of Puget Sound and The MacColl Institute

• Offers a multidimensional approach to a complex problem

• Identifies 6 essential elements: community resources, health care organization, self-management support, delivery system redesign, decision support, clinical information systems
Delivery System Redesign

• Specialized assessment tools to identify patients at risk
• Multi-professional team responsibility and delineation of roles
• Active promotion of patient self-management
• Proactive follow-up/communication, outside of the anachronistic office visit
Barriers to Implementing the Model in Most of Medicare

- The nature of medical education and the resultant professional culture and orientation of clinical practices
- Traditional Medicare is based in traditional indemnity insurance
- Major benefit limitations and restrictions in the Medicare statute
Professional Issues

• Hard to influence by public policy
• Based on an orientation to identifying and caring for acute illnesses and injuries, not chronic conditions
  – “find it and fix it” – solve, rather than manage, problems
  – “the tyranny of the urgent”
  – failure to find the unusual and the life-threatening is worse than overlooking the common and considering quality of life
Professional Issues (cont.)

• Oriented to those who present for care, rather than to populations who inhabit their chronic conditions
• Little division of labor – M.D. as captain of the ship
• Underuse of information management and decision support tools
• Resistance to change, even in the face of demonstrable failures
Demonstrable Failures

- Cited in Grumbach and Bodenheimer JAMA, Aug 22, 2002
- 73% of high BP patients not adequately treated
- 40,000 diabetics had amputations that might have been prevented
- 75% of those with depression receive suboptimal care after seeing an M.D.
- THESE DEFICIENCIES ARE COMPOUNDED WHEN THERE ARE MULTIPLE CONDITIONS
Specific Structural and Organizational Deficiencies

• Residency training takes place in hospitals
• Severe shortage of geriatricians
• Guidelines (even when followed) usually ignore co-morbidities
• Disease management and primary/principal care are not well coordinated
• Lack of integrated care orientation (also fostered by siloed payment systems)
Medicare Statute Based on Indemnity Insurance of the ’60s

- Kenneth Arrow in 1963: for people with chronic illness, “insurance in the strict sense is probably pointless.”
- Why? Moral hazard
- Yet, 80% of beneficiaries have one or more chronic condition and 20% have 5 or more and account for two thirds of program spending.
Example of the Problem: Should Medicare Pay for E-mails?

• Why not phone calls, while you’re asking?
• In a fee for service payment system, there are a number of concerns:
  – Relatively high transaction costs relative the value of the underlying service
  – Substantial program integrity concerns
  – “Nuclear force” moral hazard
Capitation Is Better Suited Than FFS to Support the Model

• While there is a prototype, it would be modified to reflect available local resources, skill mix, culture, leadership

• Capitation shifts determination of nature and mix of services to provider, away from necessarily inflexible reimbursement rules
  - Thus, physicians and other professionals, not policy makers, figure out how to deal with “e-mail fatigue”
Capitation vs. FFS (cont.)

• Siloed reimbursement to providers compromises the “business case” for quality in chronic care management
• But capitation has become a four letter word
• And the M+C program penalizes plans (and contracted providers) for attracting patients with chronic conditions. The potential of M+C is not being achieved.
Problems in How Traditional Medicare Pays for MD Services

• N.B. -- many Medicare payment systems have evolved from FFS to prepayment for episodes of care – physician payment is the main exception
• Payment is for discrete services
• Somewhat fails to account for complexity
• Pays based on resources expended, whether serve a useful purpose or not
• And doesn’t pay differentially for quality
Medicare Benefits Need to Be Improved and Upgraded

- Outpt. prescription drugs are not covered
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- Combined impact of premiums, deductibles, and unlimited cost-sharing
- Important quality of life/functional support benefits are excluded
Medicare Benefit Deficiencies (cont.)

- Sensory loss support devices not covered (eyeglasses, hearing aids)
- DME and home health limitations, e.g., the “homebound” definition
- Interpretation that rehabilitation services require prognosis of improvement, and not maintenance or slowed deterioration