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Confronting The Barriers To Chronic Care Management In Medicare

A proposal to make some changes to Medicare's existing structure, while we await the results of a new round of demonstrations.

by Robert A. Berenson and Jane Horvath

ABSTRACT: This paper examines the ability of the current Medicare program—both traditional fee-for-service and risk-based contracting—to address the needs of beneficiaries with chronic conditions, who represent almost 80 percent of program enrollment. Grounded in indemnity insurance principles, including concerns about "moral hazard," the traditional Medicare program faces difficulty evolving to support of a chronic care model of health care practice. Although capitation may be the most desirable platform to support provision of care to beneficiaries with chronic conditions, the current structural limitations and problems faced in the Medicare+Choice program limit capitation's use at this time.

Nobel laureate Kenneth Arrow's 1963 article, "Uncertainty and the Welfare Economics of Medical Care," is often cited to make the case that the special nature of medical care makes markets for it different from more typical competitive markets.[1] Special characteristics of these markets include the existence of uncertainty in the incidence of disease and in the efficacy of treatment, as well as the asymmetry of information between buyer (the patient) and seller (the physician).[2]

Less well remembered is a section of Arrow's paper entitled "The Theory of Ideal Insurance." Here he emphasizes the core importance in insurance of the concept of "moral hazard": "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."[3] When the insured person wishes the event to occur and can affect its occurrence, there is moral hazard. Arrow emphasized that the value of insurance increases as the uncertainty of the risk being insured against rises. This is the reason, he explains, for putting greater emphasis on insurance against hospitalization and surgery than against other forms of medical care.

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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." In essence, he was relying on the moral hazard argument that patients with chronic illness desire to use health services and that physicians and others want to provide the care to them, thereby undermining the function and actuarial soundness of insurance.

Medicare was enacted less than two years after Arrow's article was published, and adhering to the prevailing principles of insurance was important to the political debate at the time. Indeed, the Johnson administration's King-Anderson bill provided only for inpatient hospital services. Along the legislative path to enactment, there were proposals to include physician services but to limit coverage to those services provided by hospital staff—for example, for inpatient surgery.[4] At the last minute, Wilbur Mills, chairman of the House Ways and Means Committee, added voluntary Part B coverage for physician services. Medicare provides more complete coverage for more uncertain risk—hospital care through Part A—than for more known risk—physician services through Part B. For the most part, outpatient drugs are not included at all.[5]

In statute and operations, the traditional Medicare fee-for-service (FFS) program reflected indemnity insurance coverage and benefit principles. There was no explicit commitment to preventing disease or maintaining the health of people with chronic illness. However, the program—then as now—strays from Arrow's concepts of insurance in the strict sense: It is a risk pool segmented from the general population and one where the prevalence of chronic conditions is quite high.

Despite some loosening of strict insurance principles through small changes in benefits and attempts to move the program to risk-based capitation, Medicare is not well positioned to improve service delivery for patients with chronic conditions precisely because of its roots in indemnity insurance. Yet the Medicare program is in reality a program serving people with chronic conditions—typically, multiple chronic conditions—for whom traditional indemnity insurance principles and coverage are not appropriate and whose health status presents a challenge for both cost and quality of care. A recent analysis using 1999 Medicare claims data showed that about 78 percent of Medicare beneficiaries have at least one chronic disease; almost 32 percent have four or more, and they drive almost 79 percent of program spending.[6] Among elderly Medicare beneficiaries (not the younger disabled), Jennifer Wolff and colleagues found that the more chronic conditions a patient has, the greater the likelihood of hospitalization for an ambula-

tory care–sensitive event.[7] Medicare is geared toward paying for these hospitalizations as acute events but not for activities that might reduce the need for hospitalization, many of which are correlated to chronic conditions.

In contrast to today's Medicare program, with its acute care orientation, a Medicare chronic care model would use payment and coverage tools to deliver an integrated array of services across settings designed to prevent, or delay, declines in functional and health status. When an acute episode of illness does occur, the chronic care model would work to return the patient to the highest possible level of functioning. But for the most part, Medicare is precluded from applying the coverage, payment, and delivery system policy tools some private health plans and provider groups now use to manage care more rationally and effectively for special populations with ongoing care needs.

Moral Hazard Concerns Persist

To illustrate the difficulties a traditional insurer like Medicare has in transforming its policies and procedures to support the delivery of care to patients with chronic conditions, consider what might at first appear to be a straightforward decision to reimburse physicians and other professionals for telephone and e-mail communications with patients. In chronic disease care management models, phone calls have been viewed as essential to high-quality and efficient care.[8]

Unfortunately, from the viewpoint of an indemnity payer, coverage and payment for telephone calls and e-mail raise a series of troubling issues. For both provider and payer, 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 telephone and e-mail communications would be daunting and certainly more intrusive even than the much-criticized oversight requirements for relatively straightforward office visits.[9]

But most importantly, paying for routine phone calls and e-mail communications 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 a person's physical presence, such as office visits, patients typically experience "time costs," inconvenience, discomfort, and other unpleasant effects, which act as a natural brake on excessive utilization. Not so for phone calls and e-mail messages from the comfort of home.[10]

From the practitioner's point of view, "excessive" patient-generated phone calls and e-mail messages to the professional team caring for patients' chronic diseases would probably be desirable, consistent with the importance of promoting pa-

tient "self-management" responsibility and skills.[11] When, as now, telephone and e-mail communication is not reimbursed, conscientious physicians who increase the amount of such contacts will surely suffer financially. In a very real sense, then, the FFS payment restrictions on reimbursement for nonvisit contacts freezes innovation in how clinical care is practiced. Yet, from the indemnity payer's point of view, the financial exposure could be disastrous, or, in a context where there are spending limits, such as in the Medicare payment system for physicians, spending could shift among physicians in politically unsustainable ways.[12]

Benefit Limitations For Chronic Care

Beyond issues of moral hazard and the indemnity nature of Medicare, another limitation the program is that it still lacks coverage for most prescription drugs. Even though there are certain statutory and regulatory loopholes that permit limited, albeit important, coverage for certain drugs that are used for specific chronic diseases because the drugs are not self-administered and are provided "incident to" a physician service, prescription drugs that are the staples of chronic disease management are effectively not covered. The 1999 surgeon general's report on 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.[13]

Many beneficiaries obtain reasonable drug coverage through supplemental coverage particularly retiree health benefits and enrollment in Medicare+Choice (M+C) managed care plans.[14] However, retiree health programs are being sharply scaled back. M+C is experiencing difficulty, and most plans are reducing the generosity of drug benefits, to reduce costs and to avoid adverse selection.[15]

Although much of the debate about Medicare prescription drugs involves concerns about the cost of such a benefit expansion, prescription drugs are discrete, clearly identifiable services for which beneficiaries will face substantial out-of-pocket costs. Prescription drug coverage has become commonplace in commercial products based in indemnity insurance; it is the kind of benefit that Medicare, relying on intermediaries—in this case, pharmacy benefit managers (PBMs)—is accustomed to providing. The challenges raised by expanding Medicare benefits to include prescription drugs are substantively different from those that accompany new, improved forms of care delivery to patients with multiple chronic conditions.

The Chronic Care Improvement Model

Edward 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.[16]

Implementing this model would require important delivery system changes, including greater reliance on clinical information systems; patient self-management interventions that rely on expanded responsibilities for nurses in education and patient support; delivery system redesign that modifies traditional practice roles and promotes a team orientation to care; and various decision-support aids.

Most of these services would not be covered or reimbursed under current statutory authority. The Centers for Medicare and Medicaid Services (CMS) has procedures for deciding whether a service will be covered and therefore reimbursed.[17] The agency first decides if the proposed service fits into a statutorily established benefit category. For example, Medicare does not cover self-administered outpatient drugs or preventive tests, regardless of their diagnostic and therapeutic benefit, because there is no basis for these benefit categories in legislation. If there is an appropriate benefit category for a new service, then the CMS and its contractors must determine whether the service is "reasonable and necessary" to diagnose or treat an illness or injury. Explicit criteria for this decision do not yet exist, despite the CMS's attempt to establish criteria through rule making, first in 1989 and then in 1999.[18]

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 (DRGs) for inpatient care, and based on fee schedules and allowed charges, such as those for paying hospital outpatient departments and physicians. Finally, once a service is coded, it is eligible for payment, whether under episode-based payments (for example, hospitals and home health agencies) or under fee schedules, which are used for physician services, clinical laboratory services, and durable medical supplies.

The Medicare statute is very specific about which "providers" and "suppliers" are eligible to be paid and under what circumstances.[19] Non- physician personnel not specifically recognized as eligible to receive Medicare 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)].

The CMS's elaborate, statute-based review of new procedures would make the kind of services in Wagner's chronic care model difficult to support, without major legislative change. For example, patient education to promote self-management is not a covered benefit, except in very limited circumstances, such as diabetes education. More generally, the "incident to" provisions might restrict the kinds of activities for which nonphysicians could be reimbursed. Similarly, multi-

"Reliance on FFS reimbursement for services limits delivery system innovations that are available outside Medicare."

disciplinary team conferences to review and plan would likely face a concern that the statute only contemplated reimbursement for services provided to patients, not services about patients. In short, the rules governing benefits and payments in Medicare, based in statute, limit innovative approaches to the care of beneficiaries with chronic conditions.

A statutory change to the traditional FFS program to support the chronic care model, while desirable, should not be undertaken lightly. Even seemingly small changes in Medicare have great fiscal impact and tend to affect other payers and medical practice. Payment per service generally requires fairly precise service standardization—that is, an expectation that the content of the service provided by thousands of professionals who bill Medicare is comparable. To this point, the content of multidisciplinary team conferences and patient education, the application of information technology, and other innovations are not standardized. Indeed, it may turn out that different health care organizations, with different cultures, will (and should) adopt different approaches to adapting the chronic care model to their own circumstances, thereby making FFS reimbursement for the components inappropriate.

Inability To Influence The Delivery System

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 the federal government was authorized to exert some regulatory authority in some areas (for example, 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 induce the delivery system to improve beneficiaries' care. Thus, for example, the agency administering Medicare cannot designate certain "centers of excellence" for the provision of chronic disease care and provide these particular institutions additional payment and greater flexibility in how services are provided.[20]

Rather, as a general proposition, the program rules must be applied uniformly across the country. Exemplary performance cannot be rewarded, while poor performance is tolerated. This general program constraint naturally makes policy-

makers reluctant to provide a new set of services that constitute state-of-the-art care for chronically ill people when those services would require a change in clinical practice to improve clinical coordination and ongoing care management. 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 actually attempted to implement the principles of chronic care management.

Another barrier in the way of supporting care for chronically ill beneficiaries is the program's predominant orientation toward providers' interests. 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 pay providers based on their historical costs, regardless of patient benefit. Thus, for example, three different rates are paid for the same ambulatory surgical procedure, depending upon whether it is performed in a hospital outpatient department, an ambulatory surgical center, or a physician's office.

Reliance on FFS reimbursement for services limits delivery system innovations that are available outside Medicare. Even the prospective payment systems discussed above may not improve the delivery of chronic care, in that, as in the straight FFS payments these new systems replaced, the silo nature of clinical practice is still reinforced: "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."[21]

Capitated Prepayment As An Alternative

The logic of capitation as a platform for launching innovations in chronic care 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."[22]

Advocates of market reform built on managed competition principles had envisioned delivery systems that integrated the insurance function with the delivery of care and were recognized as clearly identifiable health care delivery organizations with distinctive characteristics that differentiated them from other competitors in the market for enrollees who had free choice of all health plans. Although not all of these competing organizations would actually engage in mutually exclusive contracting between health plan and provider groups, as in the Kaiser Permanente model, there nevertheless was an expectation that health plans and provider groups of all shapes and sizes would get together in special relationships.

In a system of health plans contracting with one or at most a few provider organizations, capitation to the provider organization would then be a logical method of payment, under which an actual or virtual multispecialty physician group would be able to redesign care to better serve patients with chronic conditions, unconstrained by the inevitable limitations of FFS reimbursement. As we all know, markets did not proceed as many had envisioned. Instead of engaging physicians in special relationships, most health plans wound up essentially contracting with all available physicians and hospitals, more or less reverting back to the status of claims-paying insurance companies. The result is that the quality of care provided to patients with chronic disease by health maintenance organizations (HMOs) is similar to that provided in the FFS sector.[23]

Assuming that performance could improve, to pursue private-plan contracting as a prime vehicle for better chronic care would still require an overhaul of the current regulatory regime and payment methodologies that govern M+C.[24] Given the current instability in the M+C program and the uncertainty of adoption of health status–based risk-adjusted payment, a private health plan–based, capitated approach to introducing innovation in the care of chronically ill Medicare beneficiaries is in doubt.

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 evaluations of these demonstrations have been mixed, with only the Program of All-Inclusive Care for the Elderly (PACE) now incorporated as a standard M+C option with unique payment features. Although these demonstrations have shown promise, and PACE has moved out of demonstration status, they affect very few beneficiaries, which raises the issue of how generalizable they are to much of the Medicare population, even to the frail elderly for whom they were designed. Further, these programs focus on the needs of beneficiaries who have functional limitations and are eligible for nursing home care, which raises the issue of applicability to most of the nearly 80 percent of beneficiaries with chronic conditions, most of whom reside in the community.

Chronic Care Experimentation In Traditional 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, despite its serious limitations. Medicare's roots in indemnity insurance limit the program's ability to be an agent for change in the delivery of health care, although attempts have been made in the traditional program to spur such delivery system change.

The CMS lacks the authority to do many things that might improve reimbursement for practitioners who target 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 on specialty or performance. By long-established convention and contract, the 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 resource-based relative value scale (RBRVS) methodology, the CMS cannot modify payment rates to try to achieve specific policy goals, such as increasing the volume of home visits by physicians.

The National Academy of Social Insurance, the National Bipartisan Commission on the Future of Medicare, recent administrations, and relevant House and Senate committees 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, such as prescription drugs; contracting reform; competitive bidding for certain services; and Medicare governance changes, among others. Regarding chronic care, there were proposals to grant the CMS new legislative authority to establish case management or care coordination programs, disease management programs, and provider-physician collaborations—that is, a form of bundled hospital/physician payment.

These approaches would represent basic departures for the Medicare program, mostly because they involve completely new payment approaches. The proposals come in many varieties. Some envision case management as modeled after primary care case management (PCCM) programs in Medicaid and some HMOs, in which 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 now paid for under the physician fee schedule, although the traditional Medicare program pays end-stage renal disease (ESRD) facilities and renal physicians a monthly capitation payment, not FFS. Other case manager or care coordination proposals would designate nonphysicians, 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 coordination of care, in addition to provider groups.[25] Based on the apparent success of private-sector 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 in Medicare.

Experiences With Chronic Care Demonstrations

In demonstrations, the CMS has had some experience with these new approaches to chronic care management. In 1990 Congress mandated the provision of case management services to Medicare beneficiaries with high-cost illness. The

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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 chronic obstructive pulmonary disease (COPD) program administered by a peer review organization (PRO), and a program targeting eight diagnostic groups administered by a tertiary care teaching hospital. All sites included patient assessments, coordination of care, patient self-management, caregiver education, and psychological supports.

One important finding was beneficiaries' lack of interest in participating, in many cases because of resistance by physicians involved, especially in the program sponsored by the PRO. In summary, these case management demonstrations found no notable effects on costs, health outcomes, or levels of self-care.[26]

The Balanced Budget Act (BBA) of 1997 required the CMS (then 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, Medicare spending under the demonstrations was not to exceed what would have been spent without their presence.

Mathematica Policy Research (MPR) conducted the review and evaluation for the CMS and identified two main types of coordinated care programs—case management and disease management—and developed a conceptual framework applicable to these delivery models.[27] This MPR review found 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, adverse medical events.[28] Disease management programs target people who tend to have a specific condition, although the programs must be able to address common comorbidities. Corresponding to the different populations, case management programs tend to individualize care, relying heavily on 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 the efficacy of case management programs is whether the programs build on generic, unstructured case management or clinically sophisticated case management, regardless of whether directed at a specific disease or to frail people with functional limitations. According to Wagner, 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.[29]

Based on the MPR report, the CMS issued a Solicitation for Proposals for the

Coordinated Care Demonstration in July 2000 and recently made fifteen awards. Combined with two awards made last year for a BBA-mandated case management demonstration, the CMS effectively will oversee seventeen demonstrations of various case management and disease management demonstrations.

The July 2000 notice solicited formal public comment on the contents of the notice and demonstration design. These comments are important for consideration of how Medicare can best promote improved care for chronic illness. Many comments referred to the difficulties of providing care management services under the current Medicare FFS 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 Medicare. Some also suggested that reimbursement be linked to patient outcomes.

Accordingly, the CMS 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, noncovered home visits, and equipment. Statutory Medicare services will be reimbursed as usual.

Lastly, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 set up additional demonstration programs testing disease management programs for beneficiaries with advanced-stage CHF, diabetes, and coronary heart disease. The 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 FFS Medicare

While waiting for results of the major coordinated care demonstrations and considering a reorientation of M+C to reward plans that manage the care of beneficiaries with a high burden of chronic illness, there may opportunities to make modest changes in the current, indemnity-oriented Medicare program.

A fifth of beneficiaries have five or more chronic conditions and account for nearly two-thirds of Medicare spending. Beneficiaries with multiple chronic conditions have very high service use; this indicates that clinical care coordination may be lacking. For example, beneficiaries with five or more conditions fill an average of forty-nine prescriptions in a year, have an average of thirty-seven physician visits, see fourteen different or unique physicians in a year, and log more than 7,000 inpatient days per 1,000 people.[30] Although service use is high, their care is not coordinated across providers and settings, for all of the reasons discussed earlier. We need to think about incremental ways to improve care coordination for medically complex beneficiaries in the absence of benefit expansion or other program reforms.

Beneficiaries with five or more serious chronic conditions could be the initial

"Capitation provides greater flexibility than FFS payment does and may be more conducive to implementing system innovation."

target group for any incremental policy change. Further analysis could permit the creation of a subset of chronic conditions, associated with higher costs and with provision of services by many professionals, that would be used as "qualifying conditions" to determine eligibility for additional payment or services. Consistent with planned implementation of health status–based risk adjustment in M+C, physicians would be expected to identify patient diagnoses through assessment and documentation, within their scopes of practice.

■ **Increased payment for office visits.** For beneficiaries who qualify based on the presence of the requisite number of serious conditions, payments for office-based care would be higher. This increased payment could be billed by any and all unique physicians who see the patient for each office visit. The higher payment would compensate physicians more generously for the greater amount of time they and their staffs need to care for patients with serious chronic conditions and to coordinate with other professionals caring for the same patient.[31]

■ **Clinical care management.** Unlike a broad-based payment available to all physicians, a more targeted and intensive approach might be a clinical care management model, whereby one treating physician accepts the added responsibility to coordinate the clinical care provided by all treating physicians in return for an administrative payment.[32] 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 twelve European countries require patients to see a designated physician—a gatekeeper—who functions as the defined point of entry to secondary care).[33]

As noted earlier, many Medicaid programs have a similar mechanism, now called the PCCM model. A Medicaid beneficiary selects or is otherwise assigned to a primary care physician, who acts as a care coordinator and primary care provider. Physicians in this role are paid in one of two ways: a monthly per person management fee, which is separate and apart from billing for specific services rendered, or a monthly capitation payment to the physician for a range of primary care services and care coordination activities.

Applying the PCCM model to Medicare. A number of design issues would have to be considered in applying a PCCM-type approach to Medicare. Whereas enrollment in these programs is 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 people with a certain number of chronic conditions, as discussed above.

For the clinical care manager to have any meaningful ability to reduce unnecessary services, as well as to reduce the likelihood of errors that result from care provided by too many noncommunicating professionals, any Medicare PCCM-type program should require the designated clinical care 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 care managers' decision making. For example, a Medicare clinical care manager might be allowed to selectively designate certain chronic problems, such as glaucoma, for ongoing care from a specialist (in this case, an ophthalmologist), without the need for recurring authorizations.

For their part, physicians could participate as clinical care managers 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 agent, receive and coordinate clinical reports from others involved in the patient's care, maintain a robust medical record, be available to provide greater consultation time surrounding a qualified beneficiary's care, and have appropriate staff and administrative capabilities to do so. An outstanding issue is whether specialists who agree to these requirements should be designated as the care managing physician for Medicare beneficiaries, given the prevalence of certain chronic conditions that are commonly cared for by specialists, such as cardiologists. Precluding specialist participation and inserting yet another physician (a generalist care manager) to act as the clinical care coordinator 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.

Supportive services. This model could be expanded to facilitate leveraging non–Medicare covered supportive services for the benefit of patients needing such services. To that end, the administrative payment could go to providers willing to have staff knowledgeable about the availability of other resources in the community, and how to get access to those resources, make referrals or coordinate access to those services. These supportive services can be very important to successful medical treatment and can improve quality of life.

Payment options. A logical payment approach for Medicare would be a monthly fee for care management services, in addition to standard FFS reimbursements for discrete physician services covered under the Medicare fee schedule. This approach does not require changes to the physician fee schedule and does not inherently induce greater service use to gain access to the clinical care coordination services. An alternative would be to bundle standard primary care services into a much larger monthly capitation amount. As discussed earlier, capitation provides greater flexibility than FFS payment does and may be more conducive to imple-

menting delivery system innovation, along the lines of the chronic care model. 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, might actually provide an incentive for inappropriate referrals.

Both payment options could be employed for maximum reach and effect. There could be a monthly capitation care management fee paid to designated physicians while maintaining FFS reimbursement for discrete services by 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, so 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. Depending on how the criteria are structured, the requirements, coupled with new payments, could promote greater use of Web-based medical communication and documentation systems.

■ **A new home visit benefit.** Beyond administrative structures, it also may be appropriate to consider benefit design that can facilitate greater clinical care coordination and management. One such approach would be a modified home visit 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 sixty-day episode-of-care payment reflects the benefit's extended nature.

There may be need 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. A modified benefit would promote the chronic care approach if physicians 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 because of temporary or otherwise acute health conditions, but it would allow the physician to have more direct knowledge of a patient's health status and functioning than would be possible if the service were delivered through a separate agency.

The benefit might need some limitations, perhaps by allowing a limited number of visits per beneficiary 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 because of a change in health status.

This benefit is not intended to replace the current home health benefit but

rather is intended to be a limited tool by which physicians can better coordinate care. The benefit must be crafted so that it provides a useful tool for greater clinical care coordination and 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 specifications for this narrow expansion of permitted home visits.

In this paper we have attempted to show that there is a mismatch between the chronic care needs of the majority of Medicare beneficiaries and Medicare's historical grounding in an indemnity insurance model. Although the more innovative proposed changes to 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 begun only recently. In the meantime, there may be an opportunity to make incremental, yet important, changes to the current traditional program that would better recognize the needs of beneficiaries with multiple chronic conditions.

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NOTES

1. K.J. Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review* 50, no. 5 (1963): 941–973.
2. The *Journal of Health Policy, Politics and Law* dedicated an entire issue (October 2001) to a reconsideration of this seminal article.
3. The term *moral hazard* is often misconstrued to imply personal blame or lack of appropriate morality. No such connotation is intended.
4. R.J. Myers, "Why Medicare Part A and Part B, as Well as Medicaid?" *Health Care Financing Review* 22, no. 1 (2000): 53–54.
5. R.M. Ball, "What Medicare's Architects Had in Mind," *Health Affairs* (Winter 1995): 62–72. Reportedly, a main reason prescription drugs were not included was the relatively high transaction costs associated with submitting claims for then inexpensive pharmaceuticals. The same issue pertains to consideration today of direct reimbursement for telephone calls and e-mail.
6. R.A. Berenson and J. Horvath, "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, Washington, D.C., 21–22 March 2002). Among the list of chronic conditions are those that are real but do not have current clinical manifestations, such as disorders of lipid metabolism, or are usually easily managed with low-cost prescription drugs or other interventions, such as hypothyroidism. Nevertheless, virtually all of these conditions are treated with often costly medications that need monitoring, and most produce symptoms that benefit from medical interventions.
7. J. Wolff, B. Starfield, and G. Anderson, "Prevalence, Expenditures, and Complications of Multiple Chronic

Conditions in the Elderly," *Archives of Internal Medicine* (11 November 2002): 2269–2276.

8. E.H. Wagner, B.T. Austin, and M. Von Korff, "Organizing Care for Patients with Chronic Illness," *Milbank Quarterly* 74, no. 4 (1996): 511–544.
9. J.K. Iglehart, "The Centers for Medicare and Medicaid Services," *New England Journal of Medicine* 345, no. 26 (2001): 1920–1924. A complicating issue would be the collection of the 20 percent coinsurance that is required under Part B payment rules. If this were required, patients would have to be billed for cents. If it were waived because the administrative costs of collection would be too great, any potential deterrent effect of coinsurance on utilization would disappear.
10. Arthur Garson, dean of academic operations, Baylor College of Medicine, at the workshop, "Creating a Vision: The Academic Health Center of the Future," sponsored by the Commonwealth Fund, 25 October 2001, described the phenomenon of physicians experiencing "e-mail fatigue" caused by the increasing onslaught of e-mail from motivated patients.
11. E.H. Wagner, "Care of Older People with Chronic Illness," in *New Ways to Care for Older People, Building Systems Based on Evidence,* ed. E. Calkins et al. (New York: Springer Publishing Company, 1999).
12. The most straightforward and practical way to compensate physicians and their staffs for engaging in nonvisit-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.
13. U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, Md.: U.S. Public Health Service, 1999).
14. Henry J. Kaiser Foundation, "Medicare and Prescription Drugs: A Chartpack," 12 June 2002, www.kff.org/content/2002/6048 (2 January 2003).
15. L. Achman and M. Gold, "Medicare+Choice 1999–2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums" (Washington: Mathematica Policy Research, February 2002).
16. Wagner, "Care of Older People."
17. Lewin Group, "Report 2: The Medicare Payment Process and Patient Access to Technology," No. 2 in a Series of Reports Prepared by the Lewin Group for Advamed (Falls Church, Va.: Advanced Medical Technology Association, 2000).
18. The proposed rules published for comment in 1989 were withdrawn and never published in final form. Another set of proposed rules was issued in 1999 but never finalized. In 2000 the CMS (then 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 CMS thus far has not responded to comments on this notice, which, as in the 1989 notice, introduced notions of cost-effectiveness in coverage policy.
19. Technically, physicians are considered suppliers to the Medicare program.
20. Beginning in 1987 the CMS took regulatory action through a series of national coverage decisions pertaining to transplant procedures (heart, liver, and lung) that limited medically necessary transplant services to those performed in facilities meeting certain requirements, a type of center of excellence. See Centers for Medicare and Medicaid Services, "Medicare Coverage Policy, NCDs, Transplant Centers: Re-evaluation of Criteria for Medicare Approval (#CAG-0061N)," 26 July 2002, www.cms.hhs.gov/coverage/8b3-aa4.asp (2 January 2003).
21. R.J. Bringewatt, "Concept Paper—Modernizing Medicare for People with Chronic Conditions" (Unpublished paper, National Chronic Care Consortium, Minneapolis, August 2001).
22. C. Boult et al., "Innovative Healthcare for Chronically Ill Older Persons: Results of a National Survey," *American Journal of Managed Care* 5, no. 9 (1999): 1163–1172.
23. A few studies, including an oft-cited one by John Ware and colleagues, have found that HMO patients with chronic illness had somewhat worse outcomes than those in FFS have had. See J.E. Ware et al., "Differences in Four-Year Health Outcomes for Elderly and Poor Chronically Ill Patients Treated in HMO and Fee-for-Service Systems," *Journal of the American Medical Association* 276, no. 13 (1996): 1039–1047. However, a comprehensive literature review by Robert Miller and Hal Luft comparing HMO and FFS performance, which was updated in 2002, consistently finds little difference in performance, even when studies are stratified by categories, such as prevention, chronic care, heart disease, and so on. See R.H. Miller and H.S. Luft, "HMO Plan Performance Update: An Analysis of the Literature, 1997–2000," *Health Affairs* (July/Aug 2002): 63–86. Indeed, Stephen Jencks and colleagues found that interstate variations on twenty-four qual-

ity 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. See S.F. Jencks et al., “Quality of Medical Care Delivered to Medicare Beneficiaries,” *Journal of the American Medical Association* 284, no. 13 (2000): 1670–1676.

24. R.A. Berenson, “Medicare+Choice: Doubling or Disappearing?” 28 November 2001, www.healthaffairs.org/WebExclusives/Berenson_Web_Excl_112801.htm (2 January 2003).
25. P.D. Fox, “The Medicare Fee-for-Service System: Opportunities for Applying Managed Care Techniques,” in *Medicare: Preparing for the Challenges of the Twenty-first Century,* ed. R.D. Reischauer, S. Butler, and J.R. Lave (Washington: National Academy of Social Insurance, 1998).
26. J. Schore, B. Brown, and V. Cheh, “Case Management for High-Cost Medicare Beneficiaries,” *Health Care Financing Review* 20, no. 4 (1999): 87–101.
27. A. Chen et al., “Best Practices in Coordinated Care,” Report to the Health Care Financing Administration, Contract no. HCFA 500-95-0048 (04) (Washington: Mathematica Policy Research, 22 March 2002); and “Medicare Program; Solicitation for Proposals for the Medicare Coordinated Care Demonstration,” *Federal Register* 65, no. 146 (2000): 46466–46473.
28. 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.
29. Edward Wagner, Center for Health Studies, Group Health Cooperative of Puget Sound, personal communication, 1 November 2001; J.A. Ferguson and M. Weinberger, “Case Management Programs in Primary Care,” *Journal of General Internal Medicine* 13, no. 2 (1998): 123–126; A.J. Gagnon et al., “Randomized Controlled Trial of Nurse Case Management of Frail Older People,” *Journal of the American Geriatrics Society* 47, no. 9 (1999): 1118–1124; S.G. Leveille et al., “Preventing Disability and Managing Chronic Illness in Frail Older Adults: A Randomized Trial of a Community-Based Partnership with Primary Care,” *Journal of the American Geriatrics Society* 46, no. 10 (1998): 1191–1198; M.W. Rich, “Heart Failure Disease Management Programs: Efficacy and Limitations,” *American Journal of Medicine* 110, no. 5 (1998): 410–412; and A.E. Stuck et al., “A Trial of Annual In-Home Comprehensive Geriatric Assessments for Elderly People Living in the Community,” *New England Journal of Medicine* 333, no. 18 (1995): 1184–1189.
30. Berenson and Horvath, “The Clinical Characteristics of Medicare Beneficiaries.”
31. 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, such as language difficulties. Proceeding with a broadly applicable modifier, however, would raise serious program integrity concerns that the modifier would be applied much too broadly and inconsistently by different physicians and would deflect from the objective of recognizing the unique coordination and patient education activities associated with patients who have multiple chronic conditions.
32. A clinical care management fee would avoid several of the problems that arise in adding a new service or benefit, as discussed earlier. First, this administrative payment would be outside the benefit structure. It would apply to clinical management on behalf of a specific group of beneficiaries. Standardization of service across providers is less of an issue in that this payment is an average to compensate for a range of fairly well known activities. The monthly payment is structured to acknowledge that the amount of activity needed on behalf of individual patients will vary over time. Creating a clinical care management fee would involve provider designation, which, while politically thorny, builds on the precedent of organ transplant center designation in Medicare.
33. R.B. Saltman and J. Figueras, “Delivering Services Efficiently,” in *European Health Care Reform: Analysis of Current Strategies WHO Regional Publications,* European Series no. 72 (Copenhagen: World Health Organization Regional Office for Europe, 1997).