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From the Editor
The Medicare Paradox

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From the Editor

The Medicare Paradox

The Medicare program administered through the Centers for Medicare and Medicaid Services (CMS) spends nearly one billion dollars a day on healthcare, the bulk of it for inpatient hospitalizations for acute events. By the year 2010, an additional 77 million baby boomers are expected to become Medicare eligible. According to the Congressional Budget Office,¹ nearly half of Medicare patients suffer from three or more chronic conditions.

"Thus, Medicare is geared toward paying for hospitalizations as acute events but not for activities that might reduce the need for hospitalization, many of which are correlated to chronic conditions."² Hence, the Medicare paradox. The Medicare program is, in reality, a program serving people with chronic conditions, typically multiple chronic conditions for whom traditional indemnity insurance principals and coverage are not appropriate and whose health status presents a challenge for both cost and quality of care.² What then are the roots of this Medicare paradox, and what current tools and techniques exist to possibly modernize Medicare and alleviate this problem?

Since its enactment nearly 40 years ago, the traditional program remains as a "passive payer," precluded from using even basic managed care tools to try to induce the delivery system to improve beneficiaries' care. For example, Medicare cannot designate certain "Centers of Excellence" for the provision of chronic disease care and provide these particular institutions with additional payment and greater flexibility in how services are provided.

In addition, the program rules of Medicare must be uniformly applied across the country. Exemplary performance cannot be rewarded, while poor performance is tolerated. Can you think of any other major national program costing hundreds of billions of dollars with similar rules and regulations? Finally, work by Jencks and colleagues over a sustained period of time,^{3,4} has shown dramatic differences in the quality of care delivered across the United States within the Medicare system. More recently,⁵ others have demonstrated that a good part of the utilization of resources under Medicare is probably of little benefit. While it would be difficult to tackle all of these issues simultaneously, how might the chronic care improvement model be adopted by Medicare, and what statutory and structural changes would facilitate that adoption?

The chronic care improvement model, generally attributed to Dr. Ed Wagner⁶ at the Group Health Cooperative of Puget Sound, 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. Berenson² notes that implementing this model within Medicare 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, and delivery system redesign that modifies traditional practice roles

and promotes a team orientation to care. Regrettably, virtually all of these services would not be covered or reimbursed under the current Medicare statutory authority. Specifically, multiple disciplinary team conferences to review and plan for care 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 that are based in statute limit innovative approaches to the care of beneficiaries with chronic conditions. Once again, the paradox raises its sinister visage.

It was, in part, because of this paradox that Congresswoman Nancy L. Johnson (R-Connecticut) convened a briefing on Capitol Hill earlier this past spring. Representative Johnson is Chairwoman of the House Ways and Means Health Subcommittee and a long proponent of Medicare reform. She is currently serving her 11th term in the House.

The briefing focused on one aspect of the paradox of Medicare, namely, care for persons with chronic illnesses. I concur with Representative Johnson in that through the introduction of disease management tools, we might be able to go a long way toward reversing the Medicare paradox and, thereby, improve care for persons with chronic illnesses and save money for the Medicare program. I had the privilege of participating in this briefing along with the leadership of the National Committee on Quality Assurance (NCQA), the Disease Management Association of America (DMAA), and key physician leaders from several prominent managed care companies. Collectively, we reinforced the view that the Wagner chronic care model makes sense, and we must find ways to implement aspects of that vision for Medicare beneficiaries with multiple chronic conditions. There are a number of tools and techniques that are a part of this overarching strategy.

One technique might be to expand the use of capitation as a platform for launching innovations in chronic care. "In a capitated environment, where organizations bear financial risk, it makes sense for them to identify high-risk members early and to provide them with special care designed to optimize their health and avert health-related crises."² Yet, given our current political climate, it seems unlikely that Medicare will wholeheartedly embrace widespread capitation-like programs.

The briefing panel urged Representative Johnson to support the expansion of various demonstration projects currently underway to evaluate the impact of disease management in the Medicare program. According to the DMAA, disease management "is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant in supporting the physician/patient relationship and their plan of care. Disease management emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies."⁷ Finally, disease management explicitly calls for an evaluation of the clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health. Indeed, at the hearings, the DMAA submitted a comprehensive outline with recommendations for Medicare direct contracting for disease management. Some may interpret this as self-serving, but those individuals surely don't appreciate the power of better chronic care management.

In addition to expanding the current demonstration projects and calling for specific statutory amendments, other panelists echoed the work of Berenson and urged Representative Johnson to press for increased payment for office visits for specific

Medicare providers. For example, for certain beneficiaries who qualify based on the presence of a requisite number of serious conditions, payments for office-based care might 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 staff need to care for patients with serious chronic conditions and to coordinate with other professionals caring for the same patient."²

I had the privilege of discussing with Representative Johnson the need for disease management tools and techniques as part of any contemplated Medicare drug benefit. Specifically, I would look for patient compliance programs and patient-centered education programs, both basic to any disease management effort and critical for improved pharmaceutical utilization. Imagine a Medicare drug benefit without the tools of disease management -- to me, it would be knuckleheaded!⁸

I am proud of the work of the DMAA, the NCQA, Representative Nancy Johnson, and our Office of Health Policy. The Medicare paradox can't be solved overnight, but these aforementioned incremental changes could go a long way toward improving the coordination of care for persons with multiple chronic conditions. As usual, I am interested in your views. You can reach me at my email address, david.nash@jefferson.edu. You can learn more about the DMAA at their website, www.DMAA.org, and the capitated disease management demonstration projects at www.CMS.gov.

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