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Developing the Right Approaches to Chronic Care in Medicare

by Jane Horvath and Robert Berenson, MD

Effective chronic care for people with complex and multiple chronic conditions requires the involvement of physicians and coordination among multiple treating physicians. Approaches to chronic care management have become common in private sector health plans, however, Medicare is just beginning to explore both the implications of chronic illness and approaches to chronic illness care. The recent Medicare Modernization Act provides for testing a private sector vendor approach to chronic illness care. However, the approach is likely to be of limited benefit to a significant portion of beneficiaries who have complex chronic care needs. Medicare has an important opportunity to develop truly new and effective approaches to chronic care that take into account the different nature of the senior population relative to the working age population for whom the current private sector approaches are designed.

INTRODUCTION

Americans are living longer than ever, in part due to new medical treatments and technologies, and better prevention and healthier lifestyles. However, people are living longer with chronic diseases -- diseases such as heart disease, diabetes and even some cancers. Often, diseases that used to be fatal early on, can now be effectively managed for years. And as we live longer, more of us live with multiple and complex chronic conditions that require a high degree of medical management and monitoring over time and a new commitment to encouraging patient self-management.

Policymakers are just beginning to realize the implications for Medicare of living longer with chronic illness, particularly living with multiple chronic diseases.[1] In general, about 20% of beneficiaries have five or more chronic conditions and account for over two-thirds of Medicare spending. Beneficiaries with five or more conditions see about 14 different physicians in a year and have almost 40 office visits.[2] The chances of an otherwise unnecessary hospitalization-- for conditions that can and should be managed effectively on an outpatient basis-- increases from about 1% for a beneficiary with just one condition to about 13% for a beneficiary with five conditions and again to about 27% for a person with eight chronic conditions.[3] It seems then that beneficiaries with multiple chronic conditions have unattended complications despite their high health care utilization. It also appears that the number of chronic conditions has more influence on health care spending than age does in the Medicare population.[4]

WHAT THE LAW DOES

Section 721 of the Medicare Modernization Act (MMA) provides for a new Chronic Care Improvement (CCI) program within the traditional Medicare program; the law also requires a new emphasis on chronic illness management within the Medicare Advantage program. The CCI program is essentially a vendor-operated, disease management program targeting beneficiaries with chronic obstructive pulmonary disease, congestive heart failure, and diabetes mellitus, and other conditions that the Secretary may specify. CCI is to be tested for three years after which the Secretary will evaluate the program for financial outcomes (program savings), clinical quality (hospital readmission rates and adherence to clinical guidelines), and beneficiary satisfaction.

In general, a CCI vendor must guide beneficiaries in managing their health. Every beneficiary enrolled with a vendor is to have a care plan that is to include disease self-management education, physician education and collaboration with physicians and other providers to enhance communication of relevant clinical information. Care plans can also include use of monitoring devices to facilitate transmission of clinical indicators. CCI vendors are to have a tracking system to follow each beneficiary across settings and track outcomes in each setting.

CONCERNS

Physicians Not Actively Involved. The CCI program and traditional disease management vendor

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programs do not address a core reality -- that beneficiaries' personal physicians mostly are responsible for their care and not health plans or disease management vendors. Policymakers need to address how to engage the front lines of health care utilization and quality – doctors and other health care professionals. In order to be successful, effective case management/disease management needs the active involvement of the physician.[5] This CCI initiative is quite removed from the physician even though the legislation calls for an individual's care plan to include physician education and collaboration.[6]

Consistent with the overall philosophy of the MMA, the law's approach to addressing the growing need for improved care for those with chronic health conditions is a corporate one, focused on providing contracts to third party vendors, rather than enabling professionals to better serve their patients. Medicare has an important opportunity to lead the restructuring of how physicians organize and deliver health services, as called for by the Institute of Medicine in their seminal Quality Chasm Report.[7] Instead, the MMA would have Medicare merely follow private sector approaches that may not be well suited to the Medicare population.

Working-Age Population Model. Disease management developed in the context of managed care plans that served the employer sponsored market. Therefore, disease management has generally applied to a working age population with a much lower prevalence of medical complexity and multiple comorbidities. For instance, only seven percent of elderly Medicare beneficiaries with diabetes have just that disease while fully 37% of beneficiaries with diabetes have four or more additional conditions. In contrast, among the non-elderly with diabetes, 22% have only diabetes and about 19% have four or more additional conditions.[8] A further example is found in Medicaid. Even though disease management vendor programs have become popular in Medicaid,[9] people who are concurrently eligible for Medicare are almost always excluded, so vendors have not gained experience with medically complex elderly populations through this contracting approach either.

Disease management can bring important benefits to relatively healthy individuals, particularly in terms of secondary prevention. It is also proper that CCI programs are required to identify and address enrollee comorbidities. However, these programs have not generally been designed to successfully address the needs of medically complex patients, whose needs go well beyond learning disease self management techniques and who have multiple professionals affecting the care and treatments of their different conditions. It will be challenging for disease management companies and related vendors to develop the necessary linkages with physicians, especially because the law provides no new reason for physicians to engage with them. Creating effective relationships with treating physicians is further complicated by the probability that these management companies will be operating across great distances from a central location with no particular connection to the communities in which they will operate.

Medicare disease management will be beneficial to a certain segment of beneficiaries, and it would certainly be part of a comprehensive strategy. But it is not a sufficient response to the needs of a growing segment of the Medicare population -- medically complex individuals whose needs drive program spending.

Interaction with New Drug Benefit. In administering the MMA, the Centers for Medicare and Medicaid Services (CMS) also must pay special attention to the potential that Part D stand-alone drug plans, which are required to have a medication therapy management program, would work at cross purposes with Chronic Care Improvement disease management programs, with the former focused on reducing unnecessary prescription drug expenditures and the latter attempting to improve compliance with prescribed drug regimen.

IMPROVEMENTS

Focus on Physicians. While CCI is likely to be helpful to younger, healthier Medicare beneficiaries, CCI will not assist the 20% of the program beneficiaries with five or more conditions on whose behalf over two-thirds of program expenditures are made. Instead of the corporate, vendor-oriented approach as embodied in the bill, it is time to return to basics and think about interventions and incentives that target the professionals who directly care for these medically complex individuals. The successful example of the Prospective Payment System for paying hospitals, which produced greater hospital efficiency and corresponding reductions in Medicare program costs, suggests that basic payment policy can be a catalyst for modifying provider behavior. In this case, physicians should be paid and supported for taking responsibility for assertively coordinating the care for patients with complex chronic conditions. Part of that coordination activity might involve interacting with nurses and others from disease management vendors.

One such model has appeared in slightly different forms in Medicare legislation in the past two sessions of Congress, but ultimately lost out to the

corporate approach.[10] This model, the complex clinical care payment model, would place responsibility and accountability for clinical care coordination of medically complex individuals with physicians (and their staffs acting under their direction). Participating physicians would agree to coordinate clinical care, would consult with other treating providers as necessary and would receive a monthly administrative payment for the extra time and attention involved. The model could be expanded in a number of ways. For example, physicians could be required to have, on staff or under contract, a case management function to make referrals to community resources that could address the supportive service needs of these patients.

CMS has a demonstration design that incorporates one approach to changing the nature of physician practice -- the physician group practice demonstration. However, it is limited to large, group practices that have at least 200 full-time physicians and this demonstration addresses spending for all beneficiaries cared for by the group. Physicians would receive bonus payments to the extent that spending is below established targets. This demonstration is on the right track, but it does not target the population with multiple chronic conditions, and the size of the physician group will limit the extent to which the model can be replicated if it proves successful.

CMS has numerous other demonstrations to test care management/disease management models. However, all of them have design issues that will likely limit their success for medically complex individuals. Several of the projects target specific diseases, rather than specifically targeting beneficiaries with multiple conditions. And the demonstration models typically ignore addressing the crucial role of the treating physician in care management.

An example of a model that incorporates the clinical care management focus and which could be adapted for Medicare is a program in Georgia – the SOURCE program – for medically complex Supplemental Security Income eligibles. In this program, local entities (case management agencies, hospitals, aging agencies) provide enhanced care management and recruit physicians to work in tandem with the case managers. The physicians generally receive monthly per client administrative payments, agree to provide clinical care coordination and agree to work closely with the client's case manager who brings supportive services to the mix in support of better medical outcomes. These are all small area efforts, where local agencies have the capability to develop relationships with doctors in the community and call attention to medical issues that might otherwise go unnoticed and where aggressive case management tracks beneficiary use of services – including other physicians and services that the primary care physician might not otherwise have known about.

Medicare has considerable ability to lead the necessary restructuring of the practice of medicine and re-orient care to chronic care management. The MMA tilts far too much in the direction of a corporate, vendor solution for aspects of the program that would be served better by involving those who actually deliver health care on the front lines – physicians in their own medical practices.

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[1] Among a number of recent policy documents that examine the issue of chronic conditions and Medicare, is Eichner, June and Blumenthal, David, eds. *Medicare in the 21st Century: Building a Better Chronic Care System.* National Academy of Social Insurance. Washington DC. January 2003.

[2] Partnership for Solutions, *Medicare: Cost and Prevalence of Chronic Conditions.* Johns Hopkins University, Baltimore MD. July 2002.

[3] Wolff J. et al. *Archives of Internal Medicine*, November 11, 2002.

[4] Berenson R, Horvath J, *Clinical Characteristics of Medicare Beneficiaries and Implications for Medicare Reforms.* Prepared for the Center for Medicare Advocacy, March 2002. Accessed February 2004, www.partnershipforsolutions.org/DMS/files/MedBeneficiaries2-03.pdf. It is also true that the presence of chronic conditions is associated with age, however, costs and utilization are similar for beneficiaries with multiple chronic conditions regardless of age.

[5] Chen, A , Brown, R; et al. *Best Practices in Coordinated Care*. Prepared for the Health Care Financing Administration. Mathematica Policy Research, Princeton NJ. March 2000. Accessed February 2004 at www.mathematica-mpr.com/pdfs/bestsum.pdf

[6] Physician collaboration is one of the generally accepted defining criteria for disease management programs; however, the extent of that collaboration is highly variable.

[7] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* National Academy of Sciences. Washington, D.C. March 2001

[8] Partnership for Solutions, unpublished data from the 2000 Medical Expenditure Panel Survey conducted by the Agency for Healthcare Research and Quality. Johns Hopkins University, Baltimore, MD. Data for heart diseases are similar. 19% of the non-elderly with heart disease have only heart disease, while only 8% of the elderly with heart disease have only heart disease, while 37% have 4 or more additional conditions, compared to 24% of the non-elderly.

[9] As of July 2003, 23 States had some form of disease management (DM) program in the Medicaid fee-for-service system. Source: DMNOW.org website accessed November 2003.

[10] Most recently, the complex clinical care payment concept was included as a demonstration in the Senate version of the Medicare reform legislation, S. 1, in June 2003, Section 443. The provision set new participation standards for physicians willing to participate including conducting a range of care coordination activities that linked medical and supportive services oriented to the beneficiary and family caregivers.