

# **Beyond Talk: A Working Session on Regulatory Reform Improving Care for People with Chronic Conditions**

## **Executive Report**

**National Chronic Care Consortium  
8100 26<sup>th</sup> Avenue South, Suite 120  
Bloomington, Minnesota 55425  
952-858-8999**

**April 16, 2002**

On March 11-13, 2002, the National Chronic Care Consortium, in collaboration with the Centers for Medicare and Medicaid Services, The Robert Wood Johnson Foundation Medicare/Medicaid Integration Program, Health Policy Alternatives, Inc., and the National Family Caregivers Association, held a Working Session on Regulatory Reform. Senior staff from the Institute of Medicine, the U.S. Department of Health and Human Services—Office of the Assistant Secretary for Planning and Evaluation, and AARP were active participants. This report contains highlights of the meeting. The recommendations contained in this report may not fully reflect the opinion of all collaborators or participants. The report is intended to stimulate thinking, create focus, and build energy for legislative and regulatory changes that would help create market forces that are more responsive to people with chronic conditions. We will refine our advocacy agenda based on responses to this working document. Comments on this report should be sent to Richard J. Bringewatt, President and CEO, National Chronic Care Consortium at [rbringewatt@ncccconline.org](mailto:rbringewatt@ncccconline.org) or (952) 858-8999.

# **Beyond Talk: A Working Session on Regulatory Reform Improving Care for People with Chronic Conditions**

## **Executive Summary**

Federal and state regulatory and policy staff, chronic care providers, consumer advocates, researchers, and national healthcare policy center representatives came together in a collaborative spirit over two and a half days to discuss barriers to better quality care for chronically ill and disabled Americans. There was general consensus that:

- Major regulatory barriers exist to providing proper chronic illness care.
- Most regulatory problems are rooted in an antiquated acute care policy structure that is imbedded in the Medicare program.
- Most operational problems relate to inappropriate benefit structures and perverse financial incentives.
- Several short-term regulatory fixes may be possible, but the most important changes will require time, successful political process, and additional resources.

These general observations are rooted in an understanding that traditional Medicare requirements are incompatible with the nature of chronic conditions. Chronic conditions are:

- Multidimensional—yet current policy is medically oriented
- Interdependent—yet current policy is highly fragmented
- Ongoing—yet current policy is driven by short-term acute episodes
- Disabling—yet current policy is focused primarily on disease
- Interpersonal—yet current policy minimizes the role of consumers

It is the conviction of the National Chronic Care Consortium that to fix the problem we must:

1. Empower patients and families to maintain their health and manage their care when needed.
2. Improve access to needed services and coordinate care across time, place, and profession.
3. Advance clinical effectiveness, with greater emphasis given to preventing disease and disability progression and the ongoing management of late-stage and comorbid conditions.
4. Strengthen the management infrastructure, using integrated information system technology.
5. Improve financial performance through improved payment methods and financial incentives.

The following are offered as priority, next-stage health policy and structural reform initiatives.

### **Policy Reform**

1. Use demonstration authority to expedite risk adjustment for specialized M+C plans.
2. Eliminate inequities in traditional Medicare reimbursement for serving beneficiaries with medically complex conditions (e.g., clinical care management fee for principal beneficiary physicians, episode of care payment, and specialized geriatric clinic demonstration).
3. Establish continuity of care as a consumer right.
4. Establish care coordination as a Medicare benefit, with activities crossing settings and extending over time, including medication management as part of coordinated care plans.

### **Structural Reform**

1. Designate a senior CMS executive to provide oversight for all policy for persons dually eligible for Medicare and Medicaid. Establish an ongoing federal-state policy group, including plan and provider representation, to simplify compliance and optimize cumulative cost and quality outcomes for people dually eligible for Medicare and Medicaid.
2. Develop new oversight capabilities, including chronic care quality and system performance measures, compatible conditions of participation among programs serving the same Medicare beneficiary, and certification methods to improve/promote continuity of care.
3. Provide incentives to integrate information systems and apply “smart card” technology.

## Background

On March 11-13, 2002, 140 health policy, health plan, and healthcare provider leaders in chronic illness care met to identify regulatory barriers to serving people with chronic conditions and to explore options for problem resolution.

The National Chronic Care Consortium, in collaboration with the Centers for Medicare and Medicaid Services (CMS), The Robert Wood Johnson Foundation Medicare/Medicaid Integration Program, and Health Policy Alternatives, Inc., sponsored this invitational Working Session on Regulatory Reform.

Participants included primary, acute, and long-term care leaders; physicians, nurses, social workers, and other health care specialists; and healthcare system and health plan executives. Participants represented the spectrum of organizational arrangements, traditional and managed care financing, U.S. markets, and national demonstration programs, including PACE, Social HMO, and EverCare. Thomas Scully, CMS Administrator; Bobby Jindal, Health and Human Services Assistant Secretary for Planning and Evaluation; and Reed Tuckson, M.D., United Health Group, gave keynote addresses. Staff leadership from all major CMS divisions and the U.S. Department of Health and Human Services Regulatory Reform Initiative, as well as executives from state Medicaid programs serving the dually eligible, the Institute of Medicine, AARP, the Alzheimer's Association, and the National Family Caregivers Association actively participated.

Working Session participants gave special focus to 12 issues:

- Patient assessment and care planning across settings
- Physician reimbursement for chronic illness care services
- Continuity of care under HIPAA
- Multi-medication management
- Financial barriers under Medicare fee-for-service
- Financial barriers under Medicare+Choice financing
- Streamlining certification and licensure for continuum providers
- Standardizing quality and cost reporting under Medicare and Medicaid
- Simplifying health plan enrollment under Medicare and Medicaid
- Involving physicians and changing physician behavior (Medicare/Medicaid beneficiaries)
- Open access versus closed networks: maximizing quality outcomes (Medicare/Medicaid beneficiaries)
- Consumer benefits of continuity of care (Medicare/Medicaid beneficiaries)

Participants were charged with looking through the eyes of people with chronic conditions and their family caregivers to:

- Identify the most onerous problems in providing care for the chronically ill under Medicare and Medicaid financing.
- Recommend short-term regulatory changes to improve care outcomes.
- Identify other longer-term policy solutions to chronic illness care.

All participants received background material in advance of the meeting to help sharpen the focus of discussion and expedite the process of deliberation. This material included *A Guide to Regulatory Reform for People with Chronic Conditions* and two issue briefs, *Patient Assessment and Care Planning for the Chronically Ill* and *Physician Reimbursement Issues*. Health Policy Alternatives, Inc., in collaboration with the National Chronic Care Consortium prepared these materials with financial support provided by AARP.

The purpose of this report is not simply to highlight the major recommendations of the Working Session. It is also to stimulate thinking, create focus, and build energy for changing market forces to be more responsive to people with chronic conditions. We will use responses to this report to further refine our advocacy agenda.

### General Observations

- *Meeting participants agreed that MAJOR regulatory barriers exist to providing proper chronic illness care. People with chronic conditions are the largest, highest-cost, and fastest-growing service group in healthcare, yet Medicare regulations are fundamentally inconsistent with the nature of chronic illness. In 1999 nearly two-thirds of Medicare beneficiaries had two or more chronic conditions, and accounted for over 95 percent of Medicare expenditures.<sup>1</sup> It is common for people with chronic conditions to have multiple, interrelated problems, yet Medicare focuses almost exclusively on a person's medical condition, one condition at a time. The primary concern of most Medicare beneficiaries is maintaining their ability to carry out normal activities of daily living, yet Medicare is focused almost exclusively on treating a biological disorder. People with chronic conditions are heavily dependent upon collaboration among care providers who serve them. Annually, the average Medicare beneficiary has 15 physician visits to almost seven different physicians; those with five or more chronic conditions average 37 office visits a year and see nearly 14 different physicians.<sup>2</sup> Yet Medicare contains multiple disincentives for providers to work together. A chronic condition is frequently rooted in circumstances that occurred years prior to a diagnosis and frequently will continue in some form for life, yet Medicare virtually ignores historical or future cost and quality considerations. It supports a crisis intervention approach rather than seeking to prevent, delay, or minimize disability progression. Most Medicare beneficiaries want to control their own approach to care as much as possible, yet Medicare contains incentives for providers to take charge, offering care in institutional settings with little regard for patient and family preferences.*
- *Most regulatory problems are rooted in an antiquated acute care policy structure imbedded in the Medicare program. The Medicare program was established primarily to provide older people with medical insurance to help them cover hospital, physician, and other related acute care costs. Medicaid was established primarily to help defray the cost of healthcare for the poor. They were seen as separate and distinct programs. Yet nearly a third of Medicare and a third of Medicaid expenditures are for providing healthcare for the same people.<sup>3</sup> Rules and regulations are written using a policy structure that is out of date and out of touch with twenty-first century reality. The Medicare program alone has 22 separate provider certification categories. Each has its own set of requirements, even though many of these providers serve the same people, frequently at the same time or in sequence to one another. Today Medicare and Medicaid have less to do with financing insurable events and more to do with the ongoing management of care. There is a fundamental discontinuity between the programs' defining principles and the needs of today's beneficiaries.*
- *Most operational problems are primarily related to inappropriate benefit structures and perverse financial incentives that are rooted in statute. While most plans and providers assume that regulations are their primary nemesis, most "regulatory" problems have their roots in*

---

<sup>1</sup> Gerard Anderson. Presentation at the 13<sup>th</sup> Annual Conference of the National Academy of Social Insurance, Session IV, January 25, 2001, Washington, D.C.

<sup>2</sup> Partnership for Solutions, 2002.

<sup>3</sup> HealthCare Finance Administration. *A Profile of Dually Eligible Beneficiaries*, conference papers from National Policy Forum, May 6, 1997.

Medicare and Medicaid law. Financing structures overvalue the role of institutions and medical specialists and undervalue the role of nutrition and prevention and the use of clinic, home, and community services. Quick, short-term regulatory fixes can produce important, but marginal change; it will not resolve the fundamental problems of chronic illness care. Any effort designed to improve care for people with chronic conditions must change benefit structures and financial methods and incentives within Medicare and Medicaid law. Budget limitations and other competing priorities create a major impediment to fundamental reform, yet the barriers to effective chronic illness care will not be removed without changing market forces to target and serve people with chronic conditions as a matter of priority. This requires legislative change.

- *Several short-term regulatory fixes may be possible, but most changes will require additional resources. Policy, plan, and provider leaders share many concerns about the antiquated nature of federal regulations. Several regulatory changes could be made with minimal effort. Many will require significant investment of time and effort. Effective reform will require an overall plan, focused on producing short-term, mid-term, and long-term results.*
- *Meeting participants were frustrated by powers of the status quo but eager to see change. There are multiple forces at work to maintain current operating structures. The prevailing industry wisdom is to fine-tune what currently exists and leave fundamental change for a later time. Yet there was a general sense among Working Session participants that incremental reform was not in the best interest of Medicare and Medicaid beneficiaries or the general public. Participants were eager to see something done to fundamentally change the nature of how we finance, administer, and deliver care to people with chronic conditions.*

## Major Recommendations

Over 100 specific recommendations were made as part of the discussion and comments at the regulatory reform meeting. While they are not all directly related to the regulation of healthcare, all have important implications for improving the regulation of care for people with chronic conditions. What follows is a subset of those recommendations—those that are most likely to: (a) empower patients and families, (b) improve service access and care coordination, (c) advance clinical effectiveness, (d) strengthen the management infrastructure, (e) improve financial incentives, and (d) modify regulatory oversight.

Some of these recommendations are focused on changing a specific regulation to improve care outcomes. Many of them will require a change in statute. Most will require additional resources to implement. We will review these recommendations with policy, plan, and provider leaders and establish an advocacy agenda based upon their perceived feasibility, resource limitations, and a sense of what can produce the greatest benefit over the long term. Implementation will also require active leadership and/or participation by CMS and/or congressional staff.

### Empowering Patients and Families

1. *Establish continuity of care as a consumer right. Identify and standardize a set of conditions of participation requirements that are common across Medicare provider categories and that are seen as important to ensuring continuity of care for people with chronic conditions, e.g., intake, assessment, care planning, and discharge procedures and quality assurance. Thus, there would be a new set of conditions of participation for continuity of care across setting, with waivers for portions of existing requirements that reinforce fragmented care management activity. Under this right, beneficiaries who needed and wanted continuity of care could exercise their right to have all physicians and providers who serve them, either at*

the same time or in sequence to one another, work together using a common set of continuity of care protocols.

2. *Establish a consumer checklist for continuity of care.* Define a set of quality measures that consumers can use to monitor provider continuity of care behavior. The following are offered as examples for consideration: (a) a common medical record among all physicians who see them, (b) methods for multi-medication management, (c) structures to eliminate the need for patients to give the same information every time they see a different provider within a network, (d) assurance that all providers who care for them know, or will know in a timely way, their treatment preferences, and (e) assistance in making a smooth transition between hospital, nursing home, home health, clinic, and other care settings. This checklist should be made available to all Medicare beneficiaries.
3. *Establish a patient's right to participate in care planning.* Establish as a care planning requirement the right for Medicare beneficiaries to participate in all care planning decisions, including the right to sign off on treatment plans prior to authorization.
4. *Establish a consumer-directed care benefit.* Establish benefits and alternative payment methods for consumer-directed care.

### **Improving Service Access and Care Coordination**

1. *Modify E and M coding to recognize physician consultation time spent with family caregivers (without beneficiary).* Physicians frequently need to talk with family members in the diagnosis and treatment of people with chronic conditions. The current evaluation and management (E and M) coding structure does not recognize reimbursement for time spent with family members unless more than 50 percent of a visit is dedicated to coordination related activity, and it does not recognize time spent with a family member without a patient present. E and M codes should enable physicians to be compensated for time spent with family members, with or without the patient present. This is especially important to address when the beneficiary has dementia or cognitive impairment.
2. *Establish a medical care coordinator payment.* A physician should be designated to coordinate all medical care provided for a defined episode of care or medically complex condition whenever a Medicare beneficiary requires services from multiple physicians or other Medicare providers. The designated physician should receive compensation to ensure that medical care provided is complementary to an overall treatment plan.
3. *Establish a Medicare coordinated care benefit.* This voluntary benefit should compensate an interdisciplinary team to coordinate the full array of medical and social services required by any Medicare beneficiary to optimize health and well-being. Initially, the benefit should be restricted to a sub-set of the Medicare population that has multiple chronic conditions and/or a late-stage chronic condition and where there is a high correlation with the use of multiple services. This benefit may be provided by any organization that meets provider certification requirements for the defined benefit. Certification requirements should include development of a comprehensive assessment and care plan, involvement of an interdisciplinary team, monitoring of services in accordance with an overall plan of care, and use of non-institutional services according to patient/client preferences.

### **Advancing Clinical Effectiveness**

1. *Establish an E and M code for risk screening.* The purpose of this code would be to encourage physicians to conduct an initial risk screen for symptoms evidencing a high correlation with hospitalization, nursing home placement, rapid disease and/or disability progression, multiple medication use, or involvement of multiple Medicare services. The screening instrument should be designed to activate specific interventions that will prevent, delay, or minimize disease and disability progression.

2. *Eliminate the three-day prior hospitalization rule. Specific provisions would be made for physicians to directly admit a patient to a nursing home or other care facility without a three-day prior hospitalization whenever there is evidence that such authorization could produce equal or better results at equal or reduced costs.*
3. *Compensate healthcare professionals for specialized geriatric training. Medicare should offer a differentiated payment to all healthcare professionals who have received a geriatric certification.*
4. *Establish specialized geriatric clinics. Use national demonstration authority to develop prototype outpatient clinics specializing in geriatric care. Establish these clinics through integrated health systems and pay them a capitated payment to manage all Medicare services for beneficiaries who are frail and/or have medically complex chronic conditions.*
5. *Create a national warehouse or clearinghouse of best practice information and material in chronic illness care. Use this resource to identify and disseminate operational information and materials that have demonstrated evidence of producing the best outcomes in care of people with chronic conditions.*

### **Strengthening Management Infrastructure**

1. *Apply “smart card” technology. While smart card technology has been available for some time, its application to chronic care has not been fully utilized. It could allow consumers to be in control of their records and provide a simple and cost effective means for sharing information with multiple providers. It might be useful to begin with the application of smart card technology through a pharmacy benefit, particularly for those with medication management requirements.*
2. *Establish training programs, financial incentives, and certification methods to improve/promote team management. Effective care of people with chronic conditions requires team management. This does not mean that all members of a team must work in the same place, but all physicians and care providers who serve the same person must work together around a common plan of care if cumulative cost and quality objectives are to be realized. Medicare funding should be made available to support team training and/or education for Medicare certified healthcare professionals.*
3. *Develop system quality measures. Chronic conditions are seldom addressed by a single provider, yet virtually all performance measures focus on specific, discrete interventions or the performance of system components, e.g., hospitals and nursing homes. Without replacing these intervention or provider-based measures, it is important to develop indicators that measure the performance of providers, as a collective, relative to their ability to achieve quality and costs outcomes for chronic conditions that require multi-provider involvement. It is the only way we will begin to understand what combination of care is most cost effective in serving people with chronic conditions over time.*

### **Improving Financial Incentives**

1. *Modify co-pays and deductible policy to produce incentives for improving care outcomes for people with chronic conditions. All co-pay and deductible policies should be analyzed in terms of their bias toward use of specific services and their relative cost benefit for achieving long-term quality and cost outcomes. Co-pay and deductible policy should be modified with the intent of producing the best results possible.*
2. *Establish differentiated payment for serving frail/complex beneficiaries. Traditional Medicare financing and M+C financing contain disincentives for serving people who are frail and/or have medically complex conditions. All traditional and M+C payment structures should provide incentives for targeting and improve the care for high-cost, complex care patients.*
3. *Establish a clinical care management fee. The traditional Medicare payment structure undervalues the activities of physicians who serve a high percentage of Medicare*

beneficiaries who are frail or have medically complex conditions. This has serious implications for attracting physicians to address Medicare's most costly and complex problems. Physicians who specialize in care of people with complex care needs should receive a clinical care management fee for each patient who has a diagnosis that is highly correlated with complex care management needs, e.g., those with five or more chronic conditions or those with a complex cluster of diseases, such as CHF, COPD, diabetes, and hypertension. Physicians who receive a clinical care management fee should demonstrate special skills and capabilities in serving medically complex Medicare beneficiaries.

4. *Create episode of care payments.* People experiencing a hip fracture, stroke, or other acute episode of a chronic condition are required to receive care from multiple providers in a fairly short period. Currently, each provider has an incentive to optimize reimbursement under separate reimbursement structures, without regard for cumulative cost and care effect. CMS should make a single payment to a clinic or care management team that meets predefined qualifications to purchase and manage ALL related Medicare benefits provided for a defined group of Medicare beneficiaries. The clinic or care management team should be authorized to use whatever services or combinations of care it chooses as long as the total cost does not exceed the usual cost of care under traditional Medicare financing. This payment method should begin under demonstration funding but with the purpose of implementing the use of episodic care payment methods as soon as systems are established that evidence improved cost and care outcomes in relation to usual care methods.
5. *Use demonstration authority to expedite change to full risk adjustment for specialized M+C plans.* Health plans that specialize in care of people with chronic conditions cannot wait until 2007 to fully implement a risk adjustment payment methodology. Current adverse incentives imbedded in the existing payment methods will drive them out of business. CMS should use its demonstration authority to expedite implementation of risk adjustment with plans that are ready, willing, and able to implement a risk adjustment methodology sooner. It should immediately move toward testing the feasibility of a common approach to risk-adjusted capitation for specialized M+C plans that primarily or exclusively serve frail, medically-complex beneficiaries and that meet certain capability standards. This should complement, not substitute for, an evaluation of the newly announced "selected significant conditions" risk-adjustment model to determine whether this model can be modified to pay appropriately for frail and high-risk beneficiaries or whether a new payment methodology altogether is needed. It also should consider adopting the MedPAC recommendation of moving M+C base rates up to 100 percent of fee-for-service but only for plans that serve a disproportionate share of frail since these are the plans being underpaid.

### **Modifying Regulatory Oversight**

1. *Standardize Medicare conditions of participation in relation to chronic illness care.* CMS should immediately begin to review provider participation requirements to identify any inconsistencies in approach used among the existing 22 provider categories. It should determine which provider categories are used by a significant number of Medicare beneficiaries, either at the same time or in sequence to one another. It should move to standardize and/or consolidate requirements as soon as possible to eliminate unnecessary differences and/or duplications and facilitate collaboration and integration of activities.
2. *Designate a senior CMS executive to provide oversight for all policy for persons dually eligible for Medicare and Medicaid.* Establish an ongoing federal-state policy-making structure to simplify compliance for plans and providers serving people who are dually eligible for Medicare and Medicaid beneficiaries and to optimize cumulative cost and quality outcomes. This process should involve participation from CMS, state Medicaid agencies, and plans and providers with special capabilities in serving people who are dually eligible for Medicare and Medicaid. This would refine requirements to create such things as a single enrollment process for beneficiaries of Medicare and Medicaid, remove some restrictions on marketing to dually eligible

beneficiaries, and streamline reporting requirements. To ensure coordination of Medicare and Medicaid policy, the federal budget process should be integrated in the scoring of Medicare and Medicaid expenditures and savings. Any material changes in coverage or financing policies for one program that could result in cost-shifting to the other should also be factored into the scoring process.

3. *Review all chronic care demonstration cost and quality mechanisms and standardize data elements, tools, and reports.* PACE, Social HMOs, EverCare, and other federally designated programs and or demonstration initiatives targeted at improving care for the chronically ill have separate and distinct programs. While many of the existing distinctions are necessary to address different policy interests, it is important to standardize tools and measures used by these programs to facilitate appropriate comparison of their relative cost benefits. It is important to encourage development of state-of-the-art interventions in chronic illness care, regardless of the structure under which care is provided.

### **From Talk to Action**

The Consortium invites those who share our vision and values to comment on these recommendations. We ask you to help us refine our advocacy agenda. Join us or let us join you to improve care for people with chronic conditions.

E-mail your comments to Rich Bringewatt at [rbringewatt@nccconline.org](mailto:rbringewatt@nccconline.org) or call him at (952) 858-8999. We want to use our available resources in the most effective way we can.