

Medicare's Chronic Care Management Program: Will It Help Primary Care Survive?

In 1927, Francis Weld Peabody declared that “the secret of the care of the patient is in caring for the patient” and acknowledged that “time, sympathy and understanding must be lavishly dispensed” (1). This time commitment is more obvious today, especially for the one third of Medicare patients with 4 or more medical problems (2). Coordination and management of their care are suboptimal, given that Medicare does not pay for time spent on the telephone calls, e-mails, and faxes required. These “out-of-visit services” consume more than 20% of primary care providers' time (3). The need for reimbursement has been recognized for decades (4) but is becoming increasingly urgent with almost universal use of hospitalists and fragmented “silos” of large hospital groups fighting for “market share” and refusing to share electronic health records (EHRs) (5). Transitional care payments and patient-centered medical homes (6) are acknowledgments of the need, but measurable outcomes show limited success (6).

Thus, it is noteworthy that Medicare will now pay \$42 for 20 minutes of “chronic care management” (CCM) (code 99490) per month (2, 7). Some requirements have been published (2, 7), but the documentation is still vague. Few primary care providers will want to participate unless they are convinced that CCM will not cause their practice to lose money.

In this issue, Basu and colleagues (8) provide a comprehensive and rigorous model of cost and revenue projections for CCM using 3 scenarios. Their microsimulation model used national data to simulate different primary care practices, comparing the use of a registered nurse (RN), a licensed practical nurse (LPN), or a physician to provide CCM services. The model recognized opportunity costs (if the physician spent time on office visits instead) and estimated staff costs and overhead. This is probably the most comprehensive analysis of the economic feasibility of CCM that will be available until empirical studies are done.

The authors estimate that 61.7% of Medicare patients would be eligible (386 patients per typical physician). If half enroll, up to 12 additional hours of weekly staff time would be required. Use of nonphysician staff could generate up to \$77 295 of additional profit in the first year (after salaries and benefits for new staff), or \$295 (RN model) to \$326 (LPN model) per patient per year. To break even, a practice would need to enroll 76 patients per full-time equivalent physician if a full-time LPN were used or 131 patients if an RN were used. The greater the involvement of the physician, however, the lower the revenue. If a physician bills for CCM instead of traditional visits, the opportunity costs (3.3 visits per hour at an average of \$83.66, or \$276 vs. \$121 for 3 CCM bills of 20 minutes each) may compel practices to use LPNs or RNs (unless CCM is added to current phy-

sician workload). A “physician-only” model could cause a loss of up to \$12 000 per year. The sensitivity analysis was robust and allowed for various expected issues, including delayed reimbursement; training costs; and geographic, size, and volume differences across practices. The analysis focused solely on staff time rather than responsibilities because Medicare requirements are vague.

Even if assured of additional revenue, many physicians will see significant obstacles to provision of CCM services. Some requirements will require substantial expertise and time to implement and document, including 1) systemic assessment of the medical, functional, and psychosocial needs of patients; 2) identification of measurable treatment goals, congruent with the patient's choices; 3) review of expected outcome and prognosis; 4) management of symptoms; 5) planning of interventions and responsibility for each, with description of how services outside the practice will be directed and coordinated; 6) assessment of potential medication interactions; 7) management of care transitions; and 8) inventory of appropriate patient and community resources and supports and environmental obstacles.

Providers may view the “patient care plan” as another mandate with an audit risk. Despite claims to the contrary (9), there is little empirical evidence that CCM services managed by ancillary staff improve quality, patient satisfaction, or primary care use. Patients may not find such services valuable. Collection of more data will not, by itself, “coordinate care” but may fatten the coffers of EHR and care management companies selling EHR add-ons to automate the process. On the basis of frequently asked questions on its Web site, the Centers for Medicare & Medicaid Services apparently assumes that such companies will be involved (2).

The \$8-per-month CCM copayment may not be covered by insurance because many plans do not cover out-of-visit services. Patients may decline to pay for a service they do not see, believing that they already have their care coordinated. However, they may also be reluctant to prevent their specialists from participating (CCM is not limited to primary care providers), fearing loss of specialty care. None of the 4 practices I contacted in central Connecticut (2 small private practices and 2 large hospital groups, with a total of >500 physicians) plan to participate in CCM, citing the vague requirements and the copayment issue.

Information for CCM will obviously require transfer of data among various EHRs. However, few EHRs currently support sharing outside their system, and the industry has been accused of “information blocking” (5) despite federal requirements for “interoperability,” or easy information transfer. Most physicians believe that

EHRs increase costs, waste time, and have dramatically increased the volume and decreased the quality of clinical information without improving care (10).

These major failings of EHRs do not bode well for the integration of data from multiple sources to make CCM clinically useful. Until available EHR technology fully supports CCM, small practices may believe that it will require expensive data interfaces and that it is duplicative. Consequently, CCM may further widen the gulf between independent internists and large institutional practices if the latter use their larger capital resources to move ahead.

If interoperability were truly effective and primary care providers had easy access to the data across systems required for care coordination, we might not have to hire other providers to do a job that has traditionally been ours alone. Although Basu and colleagues (8) provide convincing evidence that CCM could increase revenue if implemented in certain ways, it is doubtful that it represents "payment reform for primary care" (7), and it may exacerbate an already difficult situation for physicians and patients alike.

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