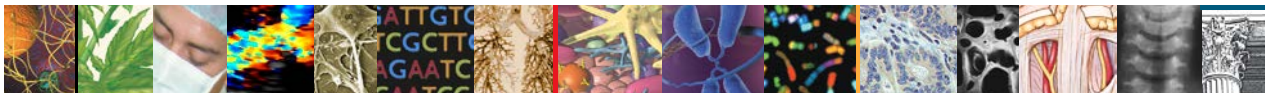

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Perspective

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Medicare's Chronic Care Management Payment — Payment Reform for Primary Care

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Many efforts to reform U.S. health care delivery focus on creating a high-performing primary care system that improves value through increased emphasis on access, prevention, and care coordination. Reformers recognize that the fee-for-service system, which restricts payments for primary care to office-based visits, is poorly designed to support the core activities of primary care, which involve substantial time outside office visits for tasks such as care coordination, patient communication, medication refills, and care provided electronically or by telephone.[1]

But this system is about to change. In 2015, the Centers for Medicare and Medicaid Services (CMS) will introduce a non–visit-based payment for chronic care management (CCM) — the most important broadly applicable change it has made to primary care payment to date.[2] Practices caring for beneficiaries with two or more chronic conditions that are expected to last at least 12 months and that confer a significant risk of death, decompensation, or functional decline (a category that includes more than two thirds of Medicare beneficiaries) can receive a monthly fee of approximately $40 per beneficiary. A physician caring for 200 qualifying patients could see additional revenue of roughly $100,000 annually.

To bill for this fee, practices are required to use a certified electronic health record (EHR), offer round-the-clock access to staff who have access to the EHR, maintain a designated practitioner for each patient, and coordinate care through transitions to and from the hospital, specialists, or other providers (see box). The most substantial additional requirement involves collaboration with the patient on creating and maintaining a comprehensive care plan that includes elements such as a list of health issues, medication-management instructions, and a record of involved social and community services, though the exact specifications for such plans haven't been released. Practices must obtain patients' consent at least annually to serve as their chronic care provider, and a practice team

Requirements for Billing for Chronic Care Management (CCM) Services and Elements Included in the Required Comprehensive Care Plan.*

Scope of services required to bill Medicare for CCM services

24/7 Access to CCM services

Continuity of care with a designated team member with whom patient can get successive routine appointments

Creation of a comprehensive patient-centered care plan based on physical, mental, cognitive, psychosocial, functional, and environmental assessments and an inventory of resources and supports; creation of document assuring provision of care congruent with patient's choices and values

Management of chronic conditions, including system-based approaches to ensure timely receipt of all recommended preventive care services, medication reconciliation with review of adherence and potential interactions, oversight of patient self-management of medications, and systematic assessment of the patient's medical, functional, and psychosocial needs

Management of care transitions between and among health care providers and settings

Coordination with home- and community-based clinical service providers as appropriate to support beneficiary's psychosocial needs and functional deficits

Enhanced opportunities for beneficiary and caregivers to communicate with practitioner regarding beneficiary's care by telephone, secure messaging, Internet, or other asynchronous methods

Other requirements

Informing beneficiary about availability of CCM services and obtaining a written agreement to receive the services, including authorization for electronic communication of medical information with other treating providers

Documentation in the medical record that all CCM services were explained and offered to the beneficiary, and noting of beneficiary's decision to accept or decline services

Provision to beneficiary of written or electronic copy of the care plan, documented in electronic health record

Informing beneficiary of the right to stop CCM services at any time and of the effect on CCM services of a revocation of the agreement

Informing beneficiary that only one practitioner can furnish and be paid for these services during a given calendar month

Elements typically included in comprehensive care plan

Problem list, expected outcome and prognosis, measurable treatment goals, symptom management plan, planned interventions, medication management plan, list of community and social services ordered, plan for directing and coordinating outside services, identification of persons responsible for each intervention, requirements for periodic review and revision of care plan

* Data are from the Centers for Medicare and Medicaid Services.

member must spend at least 20 minutes per month performing non–visit-based care coordination activities for each patient.

The CCM payment's structure and requirements are similar to those of patient-centered medical home (PCMH) initiatives, which generally offer an additional per-member-per-month sum to primary care practices for providing enhanced services.[3] The $40 monthly CCM payment is substantially more than most PCMH initiatives offer but is available only for patients with two or more chronic diseases. Practices need not be formally recognized as PCMHs to receive the payment and so can avoid a costly, time-consuming process.

There will be several important challenges in implementing the policy. First, beneficiaries will face 20% coinsurance for CCM under Medicare Part B. Those without supplemental insurance will have to pay this charge — about $100 per year — out of pocket, and poor patients may not be able to afford the extra expense. Others may refuse to pay for services they previously received free of charge, which could affect their relationships with their providers. For instance, if practices bill for CCM for all qualifying beneficiaries, how will they treat patients who refuse to consent? If practices are already providing care coordination services for Medicare patients, they may continue to do so regardless of whether all patients agree to pay — a choice that raises questions of equity. More important, some practices may instead refuse to continue caring for patients who don't consent to the payment. Monitoring such behavior will be crucial, and practices will need well-formulated plans for addressing these issues.

Second, smaller practices with limited resources may have trouble meeting the substantial requirements for receiving the extra payments and could therefore be rendered ineligible. For instance, small rural practices have been slower to adopt EHRs, which could prevent them from participating. Practices without such advanced capabilities — and their patients — may be the ones that could benefit most from these additional payments.

Third, it's unclear how care plans will be implemented, since current guidelines lack crucial details regarding required features. Current EHRs have no dedicated function for care plans, and it's unclear where in the EHR such plans will reside. Care managers often use separate electronic systems that may not be compatible with clinicians' EHRs, and information from such systems will probably need to be integrated into care plans. The CCM payment could spur EHR developers to create new functions for implementing care plans, but that will take time.

Fourth, the new policy is not restricted to typical primary care specialties, though specialists may not want to take on the requisite coordination responsibilities. Although specialists are often the principal providers for patients with conditions within their specialty, they typically provide less comprehensive primary care than generalists do.[4] Moreover, if multiple physicians bill for this service, conflicts may arise over who will be a patient's "primary physician" for purposes of CCM payments, since Medicare will reimburse only one provider per patient each month. Patients may be barraged by requests to certify practices as their primary provider and may feel pressured to certify providers who might otherwise refuse to see them. Rules for adjudicating such conflicts have not been shared publicly. Overall, it's unclear how CMS plans to audit CCM billing, including the requirement for performing at least 20 minutes of care management activities monthly.

Finally, although the payment will provide additional resources to a desperate primary care system, it may not achieve the practice transformation envisioned in PCMH initiatives. Since the CCM payment provides no incentives for improving quality or reducing total costs, some practices may bill for CCM but continue to fill clinicians' schedules to maximize volume-based revenue without investing in medical-home infrastructure. Also, since the payment is relatively broadly targeted, it may result in increased costs without the associated gains in quality or reductions in service use that might be achievable with payments targeted at the sickest patients. And as studies of medical-home initiatives have shown, it is difficult to transform practice.[5] Such initiatives have tried to mitigate the challenges, in part by including multiple payers in a particular region so that practices receive non–visit-based payments for the majority of their patients. They also facilitate practice transformation through learning collaboratives, data sharing, and assistance with cultural change — none of which will be available with the CCM payment.

Medicare is pursuing a multifaceted strategy to promote more coordinated, higher-value primary care. The CCM fee expands this strategy to all primary care practices serving Medicare beneficiaries. It thus represents a critical step forward in recognizing that the essential features of primary care — continuity, whole-person focus, comprehensiveness, serving as patients' first contact for new health issues, and coordination — are not optimally supported by the fee-for-service model. The CCM payment will support practices that have invested in PCMH infrastructure but are struggling to maintain it without additional non–visit-based sources of revenue and may encourage traditional practices to adopt advanced primary care functions.

The CCM payment will probably evolve over time. Future iterations could provide incentives for adopting additional PCMH capabilities, incorporate incentives for cost reduction, or target practices participating in broader payment-reform experiments such as accountable care organization programs. The policy could also represent a first step toward broader reform whereby an increasing proportion of Medicare's primary care reimbursement would come in the form of fixed monthly payments.

Medicare's CCM payment reflects an investment in primary care that may contribute to the development of a value-oriented health system, though questions remain about how the policy will affect the poorest patients and which practices will receive these payments.

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