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Medicare's Transitional Care Payment — A Step toward the Medical Home

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Many health care experts believe that primary care is the foundation on which to build a high-performing health care system, with maximized quality and reduced costs.[1] The Affordable Care Act (ACA), in an acknowledgment of primary care's importance, includes a 10% payment bonus for primary care physicians participating in Medicare between 2011 and 2015. This fee-for-service payment incentive does not require primary care physicians to change the way they provide or document their services.

Although 27% of Medicare beneficiaries are now in managed care (Medicare Advantage) arrangements[2] and the Centers for Medicare and Medicaid Services (CMS) is testing other new payment models, fee for service is likely to remain the dominant Medicare payment model for years to come. Not only will it take time to test and implement new models, but even after they're implemented, fee-for-service payment levels will probably be used as benchmarks for allocating risk-sharing payments in accountable care organizations.

With the publication of its 2013 physician-payment rule, however, CMS took an important step in promoting a new method of enhancing payments for primary care services that will encourage a change in the structure and process of delivery.[3] The first step of this transition is CMS's adoption of new Current Procedural Terminology (CPT) codes under which it will provide bundled payments to physicians for managing patients' transition back to the community after discharge from a hospital, rehabilitation facility, or skilled nursing facility. The transitional care payment will provide physicians with enhanced compensation, which will vary with the complexity of the patients' needs, for specified non–face-to-face care-coordination services plus an office visit within 7 to 14 days after a discharge. In time, CMS expects to eliminate the requirement for the physician visit as a part of its plan to promote payment for care-coordination services delivered in advanced primary care practices.

CMS's overall strategy involves improving quality and reducing costs by investing in care coordination that could help reduce hospital-readmission rates. The ACA authorizes payment penalties for hospitals that have high readmission rates for Medicare beneficiaries. Physicians are not subject to these penalties, but the roles they and their staffs play in discharge planning and care coordination after discharge strongly affect the likelihood of readmission. CMS has had a discharge-day management code in place for hospital-based physicians since 1996. The new transitional care code permits a corresponding payment to community-based physicians who accept responsibility for coordinating discharge plans and ensuring that they're reconciled with other ongoing care. For physicians of patients who need highly complex medical decision making after discharge, the new payment will provide approximately $55 beyond the $143 for the office visit for transitional care services during the 30 days after discharge.

The emerging evidence on transitional care emphasizes the importance of several activities in reducing hospital readmissions. The most effective of these — particularly if initiated early and in combination — are structured hospital discharge planning, primary care input into discharge planning, reconciliation of hospital-prescribed medications with previous medications, early assessment of the follow-up needs and resources of patients once they're home, and electronic discharge notifications and structured discharged summaries available for primary care physicians.[4] Under the new payment rule, physicians who bill for the transitional care service will be required to assess the need for each of several specified transitional care services and then provide the indicated services (see box).

Though these services can be performed without a face-to-face office visit, CMS chose to require such a visit, at least for now, for several reasons. First, despite the lack of solid evidence that such visits contribute to reducing readmission rates, the majority of physicians' comments in response to the proposed new payment code emphasized the necessity of a visit. Second, CMS is concerned that without a visit, patients

Non–Face-to-Face Services for Transitional Care Management.

Services provided to patients outside a face-to-face office visit are expected to be a part of transitional care management service unless the practitioner's reasonable assessment of the patient indicates that a particular service is not medically indicated or needed.

Non–face-to-face services provided by clinical staff, under the direction of the physician or other qualified professional, may include:

- Communication (direct contact, telephone, electronic) with the patient, caregiver, or both within 2 business days after discharge;
- Communication with home health agencies and other community services utilized by the patient;
- Education of patient, family, caregiver, or all of the above to support self-management, independent living, and activities of daily living;
- Assessment of and support for adherence to treatment regimen and medication management;
- Identification of available community and health resources;
- Facilitating access to care and services needed by the patient or family.

Non–face-to-face services provided by the physician or other qualified health care provider may include:

- Obtaining and reviewing the discharge information (e.g., discharge summary or continuity-of-care documents);
- Reviewing need for or follow-up on pending diagnostic tests and treatments;
- Interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems;
- Education of patient, family, guardian, or caregiver;
- Establishment or reestablishment of referrals and arranging for needed community resources;
- Assistance in scheduling any required follow-up with community providers and services.

might be confused about why they're charged a copayment for transitional care services. CMS also hopes to mitigate such confusion by requiring physicians who bill for the discharge-day payment to inform patients that they're eligible for the transitional care service and indicate in the medical record which physician the patient has identified to provide the service. Finally, CMS is concerned that introducing a payment code with no visit requirement could increase the likelihood of fraudulent billing, because there would be less opportunity to use patient reports to corroborate whether the service was actually provided.

On the basis of the anticipated number of hospital, rehabilitation, and nursing home discharges per year and the historical distribution of physician visits after these discharges, CMS estimates it will pay $600 million for transitional care services in 2013, with the majority going to primary care physicians. Since Medicare's sustainable-growth-rate formula caps total physician payments, transitional care payments will be offset by reductions in payments for all other physician billing codes. CMS estimates that primary care physicians will receive, on average, a 7% increase in Medicare payments because of the new code.

The adoption of this policy signals CMS's willingness to invest new resources in primary care for activities that offer the promise of higher-quality care and lower overall health care costs.

In addition, CMS included in the new rule a statement of its interest in developing an enhanced level of payment for primary care services delivered by physicians working in advanced primary care practices that have implemented a medical-home model. CMS has not yet adopted a definition of an advanced primary care practice for this purpose, but it has initiated several pilot programs through its Center for Medicare and Medicaid Innovation (CMMI). In the rule, it outlined five potential comprehensive primary care functions, which were adopted as requirements in one CMMI pilot, the Comprehensive Primary Care Initiative. These include provision of risk-stratified care management, provision of access and continuity for a defined patient population, provision of planned care for chronic conditions and preventive care, patient and caregiver engagement, and coordination of care across the medical neighborhood. Once the criteria for advanced primary care are defined, CMS will also need to decide whether it or an accreditation body will determine which physician practices qualify.

The adoption of an enhanced payment for services delivered by an advanced primary care practice would not be limited to physicians trained in traditional primary care specialties, nor would all primary care physicians qualify, or want to qualify, to receive enhanced payment for this higher level of service. However, given the functions physicians would have to perform to meet the

standards of a primary care medical home, this policy approach could help redirect resources toward primary care physicians demonstrating a capacity to provide an enhanced quality of service. Furthermore, the development of a method for identifying physicians whose practices can provide advanced primary care services would alleviate concerns about allowing physicians to bill for non–face-to-face services without an accompanying office visit. Therefore, such a policy, if designed and implemented properly, could increase payment for primary care and permit services to be delivered in more efficient ways.

In adopting the transitional care payment policy, CMS has begun shifting more financial resources toward primary care and opened the door to further increases in primary care payment in return for the greater accountability and efficiency that studies suggest may be attained through a medical-home model.[5] Whether such benefits are best achieved through an enhanced fee-for-service payment is unclear. Using the fee schedule to expand the delivery of advanced primary care services might well benefit the Medicare population, but such payments might also provide an incentive for visits that won't yield the anticipated benefits of higher quality and lower costs. CMS aims to formulate policy on the basis of CMMI studies, but at some point it will need to take the leap to something better. The 2013 physician-payment rule suggests that day is coming soon.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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The 2011 Duty-Hour Requirements — A Survey of Residency Program Directors

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In 2010, the Accreditation Council for Graduate Medical Education (ACGME) released new Common Program Requirements designed to improve patient safety as well as resident education and quality of life.[1] These rules, which went into effect in July 2011 and introduced additional regulations related to duty hours and resident supervision, have already inspired considerable debate. In studies conducted before implementation, program directors and residents expressed mixed feelings about the potential effects of the new standards.[2,3] Although program directors supported the 80-hour workweek, the maximum frequency of in-house call, and mandatory off-duty time, they opposed limiting first-year residents to 16-hour shifts.[2] Residents expressed greater concern than program directors, fearing potential negative effects on quality of care, as well as resident education, experience, and preparedness for senior roles. The quality of life for residents was the only factor that they predicted might improve.[3]

In a national survey conducted between December 2011 and February 2012, residents reported no improvement in education, total number of hours worked, or the amount of rest they were getting. In fact, many participants described the changes as detrimental, with the majority feeling less prepared to take on more-