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VIEWPOINT

Medicare Payment for Chronic Care Delivered in a Patient-Centered Medical Home

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Each July, the Centers for Medicare & Medicaid Services (CMS) publishes in the *Federal Register* its proposals for updating the Medicare physician fee schedule for the upcoming calendar year.¹ The rule applies to the approximately 37 million beneficiaries in the fee-for-service program. Following a 60-day public comment period, the CMS finalizes the rule and typically implements it the following January. Although these rules cover a wide range of services, included within the document issued this past July is a little-noticed discussion of Medicare's intent to make a substantial change in its payment policy. If the rule is finalized as proposed, for the first time physicians would be able to bill Medicare for the non-face-to-face delivery of complex chronic care management services provided by a practice that has the capability to furnish these services.

The CMS's proposal for complex chronic care management is consistent with the principles initially described in pediatrics,² in family medicine, and more recently promoted by a multispecialty working group of the American Medical Association for providing comprehensive patient-centered primary care.³ At the heart of this approach is the requirement for a practitioner to establish a care plan for patients with chronic care needs. The care plan is based on a physical, mental, cognitive, psychosocial, and functional and environmental (re)assessment of the patient and on an inventory of resources and supports available to the patient. The plan typically includes a problem list, the patient's expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community and social services ordered, an assessment of how the services of agencies and specialists unconnected to the practice will be coordinated, identification of the individuals responsible for each intervention, and requirements for periodic review and, when applicable, revision.

Additional key components of complex chronic care management services include (1) the provision of 24-hour-a-day, 7-day-a-week access to clinical staff to address the patient's acute care needs supported by clinicians' access to the patient's full electronic medical record even when the office is closed; (2) continuity of care over time with a designated practitioner or member of the care team; (3) management of care transitions such as follow-up after an emergency department visit or a discharge from a hospital or skilled nursing facility; (4) coordination with home and community-based clinical service providers to support a patient's psychosocial needs and functional deficits; and (5) enhanced opportunities for patients to communicate with a clinical member of the care team regarding their care not only by telephone but also through the

use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

Some physicians who wish to provide these services may need to make additional investments in technology, staff training, and the development of systematic protocols. The CMS is in the process of establishing standards for the capabilities that would be required to bill for complex chronic care management services and is evaluating whether any of the organizations that accredit patient-centered medical homes apply standards that meet or exceed those the CMS is considering. The potential standards the CMS is considering are that the practice (1) uses an electronic health record for patient care that meets the most current standards for meaningful use, (2) employs advanced practice registered nurses or physician assistants to help deliver complex chronic care management services, and (3) has written protocols for staff that describe the methods and expected "norms" for furnishing each component of complex chronic care management services. The CMS is proposing to implement its complex chronic care management services policy in 2015 so that it has sufficient time to develop and obtain public input on the standards necessary to demonstrate the capability to provide these services.

The CMS intends to limit payment for complex chronic care management services to those Medicare beneficiaries who have 2 or more chronic conditions. These individuals are at increased risk of costly emergency department visits, hospitalizations, and utilization of postacute care services,⁴ all of which the CMS hopes to reduce through the investment in complex chronic care management services.

The CMS has not indicated in the proposed rule how much it will pay for complex long-term care management services, but it has proposed that an eligible practitioner could bill Medicare for non-face-to-face delivery of these services when they reach at least an hour's duration during a 90-day period. This would include time spent by a clinical staff member furnishing aspects of these services to address a patient's complex chronic care need outside of the practice's normal business hours. Because changes in Medicare's physician payment system are required to be budget neutral, complex chronic care management service payments will not increase the total aggregate payments to physicians, but rather they will be offset by corresponding reductions in payments for all other physician billing codes.

The CMS is proposing that before a physician can bill for these services, the physician must inform the eligible beneficiary about the availability of the services from the practitioner and obtain the patient's consent to receive them. This process would include an annual

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discussion with the patient about what complex chronic care management services are and that cost sharing (20% co-payment) applies to these services even when they are not delivered face-to-face in the practice. The CMS has asked for comment on the appropriate amount to pay for the proposed chronic care management service. The CMS is aware that, to be successful, physicians would need to be willing to provide the new services and Medicare beneficiaries would need to be willing to receive them.

The CMS is proposing that this discussion would ordinarily occur as a part of a beneficiary's annual wellness visit when a practitioner would be expected to systematically capture information that is essential for the development of a care plan. A beneficiary is limited to 1 annual wellness visit per year, and the beneficiary's selection of a practitioner for this service provides a valuable indicator of whom the beneficiary is choosing to provide complex chronic care services. A physician of any specialty would be eligible to deliver and bill Medicare for complex chronic care management services, provided that the practice meets the established standards. However, the CMS suggests it is sound payment policy and in the patient's interest for the beneficiary to select one practitioner to coordinate chronic care services. The proposed rule provides a mechanism for a beneficiary to revoke his or her consent for complex chronic care management services at any point during the year and to change the practitioner chosen to deliver these services.

Through its Centers for Medicare & Medicaid Innovation, the CMS is conducting demonstrations designed to improve payment for and encourage long-term investment in care management services. These initiatives include the Multi-Payer Advanced Primary Care demonstration, the Federal Qualified Health Centers Demonstration, and the Comprehensive Primary Care initiative.⁵ The CMS expects that the proposed fee schedule payment changes will not

disrupt its ability to evaluate these demonstrations and anticipates that payment for complex chronic care management services through the fee schedule will help practitioners prepare for additional changes in payment policy that could evolve from these demonstrations. Payment for complex chronic care management services delivered through qualified physician practices may also support the development and enhance the performance of accountable care organizations, which have been found to be better able to improve quality and lower costs for Medicare beneficiaries when they are oriented toward primary care.⁶ Given the increasing interest and experience in the patient-centered medical home model of care, the CMS's proposal is likely to generate a substantial number of public comments. Proponents of this model of care may be pleased that Medicare is recognizing the value of non-face-to-face chronic care management services through proposed payment policy changes that rely on structural changes in a practice as well as documented delivery of complex chronic care management services. Some may feel that it is unnecessary to limit the delivery of complex chronic care management services to physicians meeting particular standards or practicing in a patient-centered medical home or that the requirement to document the delivery of non-face-to-face services is too burdensome. However, given the novelty of the proposed payment approach under the physician fee schedule, the CMS's policy direction attempts to increase efficiency and value while at the same time striving to ensure that practitioners have the capability of delivering chronic care management services and protecting against the risk of fraudulent billing. Assuming these concerns can be resolved, the bigger test is whether patients will value these services enough to pay extra for them, and if investing in chronic care management services will achieve the goal of higher quality at lower overall cost.

ARTICLE INFORMATION

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Additional Information: The public comment period on this proposed rule ends at 5 PM eastern standard time on September 6, 2013. Comments may be submitted referring to the file code CMS-1600-P by mail, in person, or electronically at <http://www.regulations.gov>. Additional details regarding the address for mailing or delivering comments can be found in the notice posted in the *Federal Register*.¹

Correction: This article was corrected on August 9, 2013, for errors in reference 1.

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