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mission. "We don't know how big a problem it is," said Susan P. Montgomery, DVM, MPH, epidemiology team lead in the CDC's parasitic diseases branch.

Of the 17 Texas blood donors with confirmed Chagas disease in her study, Garcia noted 6 were suspected to have acquired the infection close to home. However, blood donor screening likely detects only a small percentage of local or imported US cases, because those at highest risk are underrepresented among donors, Garcia said.

Furthermore, not all those with confirmed Chagas had traditional risk factors, such as spending time in an endemic country and staying in areas with substandard housing (Garcia MN et al. *Am J Trop Med Hyg.* 2015;92[2]:325-330). The researchers have found locally transmitted cases among

people who live in rural areas or spend substantial amounts of time outdoors.

Garcia explained that local transmission in the United States likely can be traced back to small mammals, such as wood rats, squirrels, possums, and skunks that act as reservoirs for *T cruzi* and serve as a source of constant blood meals for the triatomine bugs with which they tend to cohabitate. These animals then make their homes in substandard human housing and bring the insects with them, leading to human exposure to the parasite.

In line with this mode of local transmission, Garcia and her colleagues found a high prevalence of *T cruzi* infection among triatomine bugs in southwestern Texas. They reported at the ASTMH meeting that three-quarters of the 40 bugs collected from June 2013 to January 2014 were infected.

The insects were predominantly collected near homes in rural areas, and an analysis of the infected insects found that half had recently fed on humans.

Another potentially underappreciated source of local transmission is mother-to-child transmission, which can occur in 1% to 10% of pregnancies in infected women. Montgomery noted 1 confirmed case of *T cruzi* infection in an infant born in Virginia to a mother likely infected in Bolivia (*MMWR Morb Mortal Wkly Rep.* 2012;61[26]:477-479). However, she and Bern estimated that at least 63 and as many as 315 congenital *T cruzi* infections occur each year in the United States (Bern C and Montgomery SP. *Clin Infect Dis.* 2009;49:e52-e54).

"The biggest thing we learned is that people ...can get Chagas even if they haven't left the country," Garcia said. ■

The JAMA Forum

Nudging Medical Practice Change One Regulation at a Time

Andrew B. Bindman, MD

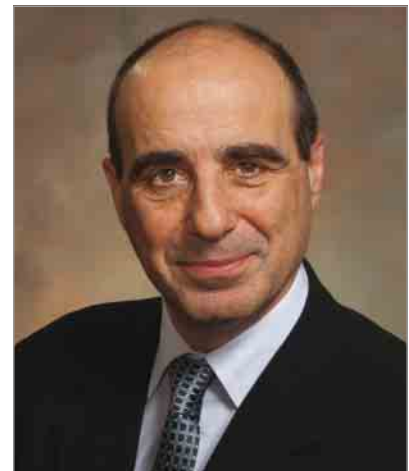
With the arrival of 2015, Medicare has implemented its long-debated chronic care management (CCM) payment policy (<http://bit.ly/1xqSoVr>). The policy represents a victory for the medical community, which has advocated for a means to receive payment for managing patient care that doesn't involve a face-to-face visit, such as coordinating care with other practitioners, communicating with community-based service providers, and responding to emails from patients.

Medicare anticipates that an investment in CCM services could help reduce costs associated with emergency department visits, hospitalizations, and post-acute care in an institution. The new policy also has the potential to provide a significant new source of revenue for primary care practices that care for Medicare patients with multiple chronic conditions.

Eligible practitioners who furnish a minimum of 20 minutes of service to create, monitor, or revise a care plan for a Medicare beneficiary with 2 or more chronic conditions are now able to bill \$42 once per month for these services using a new Current Procedural Terminology (CPT) payment code.

Among other things, a practitioner using this new code for managing chronic conditions must make available a member of the practice care team with access to the beneficiary's electronic health record (EHR), including the care plan, 24 hours per day, 7 days per week. (The EHR system used also must meet certification criteria for the EHR incentive program established by the Office of the National Coordinator for Health Information Technology.) Billing is limited to a specific practitioner designated by a Medicare beneficiary with 2 or more chronic conditions to furnish these services.

Approximately 20 million Medicare fee-for-service beneficiaries who have at least 2 chronic conditions make an office visit within a 1-year period (<http://go.cms.gov/1yj7dgK>). This care is provided by approximately 120 000 physicians who deliver primary care services within the Medicare program, which suggests that, on average, there are approximately 165 Medicare fee-for-service beneficiaries per primary care physician (<http://go.cms.gov/1yBtOUF>). If an individual physician furnished CCM services for all 12 months in a year to all 165 of these eligible Medicare beneficiaries, that would yield



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more than \$80 000 through the new payment code.

Of course, the experience of each physician will vary, depending upon how many eligible Medicare beneficiaries are actually in the practice, the willingness of the beneficiary to designate the primary care physician as the practitioner to furnish the service, and the number of months the physician actually delivers the service throughout the

year. Eligible Medicare beneficiaries also may designate a specialist rather than a primary care-trained physician to furnish CCM services if the specialist's practice is equipped to do so.

It's possible that CCM payments would constitute new income for physicians. But the requirements for delivering CCM, such as round-the-clock availability of clinical practice staff, would likely lead many to invest the payments in personnel (such as a nurse practitioner or other clinical health professionals) or in technology to extend their capacity to actually deliver the service. Physicians practicing as a part of a group would be in a good position to pool these funds to acquire the necessary resources.

The CCM payment policy builds on Medicare's transitional care payment policy from 2 years earlier (<http://bit.ly/17ZsQsH>). Transitional care payments are for practitioners who furnish care management services to Medicare beneficiaries for the 30 days following a discharge from a hospital, skilled nursing facility, or other qualifying institution. Practitioners who deliver this service and complete an office visit with the patient within 14 days of discharge may bill for the visit at a rate that is higher than a routine office visit. Practitioners' use of this code began slowly but it has increased over time.

Promoting Practice Change Through Payment

Both the CCM and transitional care payment policies were implemented through the executive branch's regulatory process; they did not require new legislation to take effect. Legislative action on physician payment policy has been scant since the passage of the Affordable Care Act (ACA). The ACA included a time-limited 10% payment bonus for primary care services furnished to Medicare beneficiaries and a requirement that payment for these services furnished to Medicaid beneficiaries be paid at Medicare payment rates.

However, an ACA-related Medicaid primary care payment bump expired at the end of 2014 and the Medicare bonus incentive is set to expire at the end of this year.

The medical community has tried, without success, to convince Congress to extend these provisions. Now, all but 15 states have reduced their payment rates, some quite dramatically, for Medicaid primary care services (<http://bit.ly/1D5XbQ8>).

The enactment of the CCM payment and the transitional care payment policies demonstrates that even without the support of Congress, it is possible for the Obama Administration to promote practice change through physician payment. These payment policies are regulations that were enacted in the context of current law, which calls for an annual rule-writing process to update the Medicare physician fee schedule.

The ACA also grants significant discretion to the Secretary of the Department of Health and Human Services to test and implement payment reforms that improve quality without increasing costs or maintain quality at a lower cost. The Centers for Medicare & Medicaid Services (CMS) demonstration projects under way to test models of patient-centered medical homes are for the purpose of determining whether the administration can and should take this step.

A Catalyst in Transforming Care?

Although less radical than other high-profile payment reforms, such as accountable care organizations, Medicare payment for CCM services has the potential to be a catalyst in transforming care. It provides a new source of revenue for those practitioners who have already made changes to meet Medicare's requirements for CCM payment. And it also signals to practitioners who have been slower to make a change, most of whom still operate in a fee-for-service environment, that there will be some means to financially support enhanced efforts to

deliver primary care services to patients with multiple chronic conditions. In addition, Medicare's implementation of this policy through a CPT code rather than a Medicare-specific payment code (G code) makes it more likely that other payers will follow Medicare's lead and also begin to reimburse practitioners for CCM services that are not delivered in a face-to-face visit.

There will be questions moving forward, such as whether Medicare's reimbursement for CCM is adequate and if it should be tiered to align with differences in patients' severity of illness. Practitioners delivering primary care services will also want to know how the requirements for payment for CCM services will align with any future plans Medicare might have to provide payment for practitioners delivering services in a patient-centered medical home.

But with the CCM payment policy, Medicare has cracked open the door. A demonstration that CCM results in higher-quality health care and lower overall costs could encourage this or a future administration to use its regulatory power to expand practitioners' ability to be paid for a wider range of health care services that are delivered outside of a face-to-face visit. ■

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