NATIONAL HEALTH POLICY
FORUM

FORUM SESSION

Coordinating Chronic Care:

Will New Incentives Spur Primary Care-Specialist Collaboration?

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All can agree: care that is coordinated among clinicians and settings is better care. The patient is less likely to be confused, to receive duplicative tests or dangerous drug interactions, or to be readmitted to a hospital. Agreement is less spontaneous when it comes to creating, measuring, rewarding, and propagating care coordination. Some observers suggest that successful coordination requires the infrastructure supplied by an integrated delivery system or an accountable care organization. Others look to a building-block approach that will gradually draw in medical practices of various configurations. Many in both camps look to the patient-centered medical home (PCMH) model as a promising vehicle for facilitating coordination.

Coordinated, team-based care is one of the defining characteristics of the PCMH model, and one that appeals to many patients. A survey released in March by the John A. Hartford Foundation revealed that, among older Americans, relatively few patients receive such care but more would like to have it.[1] Those who have experience with team-based care in a medical home like it and believe that it improves their health status. However, the PCMH concept of the team does not necessarily extend beyond the borders of the primary care practice, which has given rise to talk of the need for a medical "neighborhood."

A momentum to reward care coordination has been manifest in the last year. The Centers for Medicare & Medicaid Services (CMS) included in its newest physician fee schedule a provision that would allow qualifying physicians to bill Medicare for non-face-to-face care in the delivery of complex chronic care management services.[2] (This is a follow-on to an already introduced payment code for care coordination upon a patient's discharge from the hospital.) H.R. 4015, the SGR Repeal and Medicare Provider

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Payment Modernization Act (not enacted), contained language establishing at least one payment code for coordinating care for individuals with chronic care needs. In the private sector, NCQA (National Committee for Quality Assurance) has instituted a new recognition program for the patient-centered specialty practice, which focuses on coordination and sharing information among primary care clinicians and specialists.[3]

If there are to be new billing codes and other reward programs, concern arises about which patients and providers will qualify and how patients will designate the provider to be paid. Medicare proposals focus on complex chronic care management for beneficiaries with two or more chronic conditions; the NCQA program does not make this specification. NCQA is also inclusive in terms of the specialty practices eligible to apply for recognition. The unsuccessful SGR bill would have limited payment to professionals practicing in a PCMH or comparable specialty practice recognized by an organization in turn recognized by the Secretary for this purpose, or providers who meet comparable qualifications established by the Secretary. CMS has stated its intent to develop standards "for furnishing chronic care management services to ensure that the physicians and practitioners who bill for these services have the capability to provide them."[4]

Frequently cited barriers to effective care coordination are time and money. Primary care physicians (PCPs) in particular are pushed to see many patients quickly and they may restrict their "interaction" with a specialist to simply referring a patient to be seen. Neither PCPs nor specialists are typically paid extra for taking on additional analysis and communication chores that do not take place in the context of a face-to-face appointment with the patient. An additional barrier may be lack of or incompatible health information technology (HIT).

A less obvious but potentially critical barrier may be the absence of a trust relationship between two clinicians. Opportunities for developing relationships with specialists on the basis of consultation around hospital care have diminished with the substitution of hospitalists for PCPs in the delivery of inpatient care. Nevertheless, if a PCP and a specialist are to co-manage a patient's health, at least for a period of time, they must find ways to ensure that each has the other's trust and respect. Even then, questions are sure to arise about how mutual responsibilities and service delivery to a patient will be reflected in a reimbursement formula.

This Forum session considered the reasoning that is leading toward reimbursement for non-face-to-face care management and the chal-

lenges of implementing such reimbursement policy. It looked at how well efforts to bring primary and specialty care together at the practice level have succeeded, and what processes and infrastructure may be created to help physicians adjust to practice redesign.

SPEAKERS

Andrew Bindman, MD, senior advisor to the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services as well as a professor at the University of California, San Francisco, School of Medicine, discussed the evolution in CMS's thinking about paying for non-face-to-face chronic care services and the concept of advanced primary care. NCQA President **Margaret O'Kane, MHA**, described her organization's new patient-centered specialty practice recognition program, which focuses on coordinating care and sharing information between primary care clinicians and specialists. **Randall Curnow, MD, MBA**, vice president of medical affairs at Mercy Health Physicians in Cincinnati, Ohio, spoke from the primary care perspective about his efforts in two health systems to promote integrated, patient-centered care and to measure performance on these dimensions. **Karen Joynt, MD, MPH**, a practicing cardiologist who is also on the faculty of the Harvard School of Public Health spoke as a specialist about the challenges to meaningful co-management of patient care.

KEY QUESTIONS

- What inducement or leverage can primary care physicians, being paid to coordinate care as part of a patient-centered medical home arrangement, use to persuade specialists to be part of a medical neighborhood?
- How do primary and specialty physicians determine their relative responsibilities with respect to a patient? If additional compensation is involved for care coordination, who determines how that is apportioned?
- Are care coordination fees and recognition sufficient to drive practice change? What more will it take to achieve truly patient-centered delivery?
- How will care coordination agreements or arrangements be evaluated? How will CMS or other payers know whether they are getting the value they seek?

• What say should a patient have in who will be his or her chief care coordinator? What procedures should be in place to safeguard a patient's ability to change this designation over time or in the face of new diagnoses?

ENDNOTES

1. The John A. Hartford Foundation, "Public Poll: 'On Your Team: What Older Adults Think About Team Care and Medical Home Services," March 21, 2014, www.jhartfound.org/learning-center/public-poll-on-your-team-how-older-adults-view-team-care-and-the-medical-home/.
2. Federal Register, 78, no. 237, December 10, 2013, "Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Final Rule," www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28696.pdf; see page 17714 and following.
3. For more information, see the NCQA web site at https://www.ncqa.org/Programs/Recognition/PatientCenteredSpecialtyPracticePCSP.aspx.
4. "Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Final Rule," p. 74415.