CAPSULE COMMENTARIES

Capsule Commentary on O'Malley et al., Providers' Experiences with Chronic Care Management (CCM) Services and Fees: A Qualitative Research Study

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This qualitative study by O'Malley et al. explores the current state of chronic care management (CCM) in a variety of practice settings.[1] The investigators conducted semi-structured interviews of providers who bill the Centers for Medicare and Medicaid Services (CMS) for CCM, those who do not, and professional society representatives in order to elucidate the perceived facilitating factors, barriers, successes, and failures of the federal payment policy for the important disease management work done outside of office visits. Their findings reveal critical limitations in the CCM payment policy, even after the 2017 amendments.[2]

For context, we know that CCM, done right, can decrease hospitalization and ED visits over time, with an estimated $101-per-participant reduction in Medicare spending.[3] We also know that proper implementation of CCM, like anything else, takes time and money. Reimbursement for CCM by CMS is a step in the right direction, but uptake in the early years of the policy is incredibly low, with fewer than 5% of all eligible providers billing CCM. This study sheds light on *why*.

The study findings are limited by the small number of non-billing providers interviewed, but the results highlight the limitations of the CCM policy itself. Documentation burdens and active billing (as opposed to per-member/per-month payments used in patient-centered medical home models) create barriers to entry for providers. Worse, patient eligibility restrictions and coinsurance payments are barriers for patients. We know from the 40-year old RAND health insurance experiment that patient cost sharing leads to decreased utilization of even highly effective services,[4] and cost sharing was indeed highlighted as a barrier for those without supplemental coverage. One in seven Medicare beneficiaries have no supplemental coverage,[5] and they are disproportionately black, poor, and disabled. Not only is the coinsurance ineffective at achieving the goal, but it contributes to health inequity.

Taken together, these findings suggest that further improvements in the CCM payment policy that reduce barriers to uptake and ensure best practices have the potential to reduce costly utilization, improve outcomes, and save money, the holy grail of healthcare value.

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Compliance with Ethical Standards:

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