

Patient-Centered Payment for Care of Chronic Conditions

The Need to Improve Payment for Care of Chronic Conditions

The majority of adults in the United States have a chronic condition such as arthritis, asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart disease, or kidney disease, and many children also have chronic conditions. Healthcare spending is much higher for patients who have chronic diseases, but a significant portion of that spending pays for unnecessary services, unnecessarily-expensive services, and treatment of complications that result from inadequate care.

Although many chronic conditions can be managed effectively by a primary care practice if the practice is paid adequately to do so, some patients will need support from a specialist for diagnosis, development of a care plan, and/or treatment and care management. This is particularly true for patients who have difficult-to-diagnose symptoms and severe, complex, or uncommon conditions.

In order for all patients to receive the most effective care, specialists who diagnose and treat chronic conditions need to receive adequate and appropriate payments for their services. However, standard fee-for-service payment systems fail to pay adequately for all of the services that patients need. Current value-based payment systems (such as performance-based payments, shared savings programs, and population-based payment) fail to correct the problems with fee-for-service payments, and they can financially penalize physician practices and other providers that serve complex and high-need patients.

Patient-Centered Payment for Care of Chronic Conditions

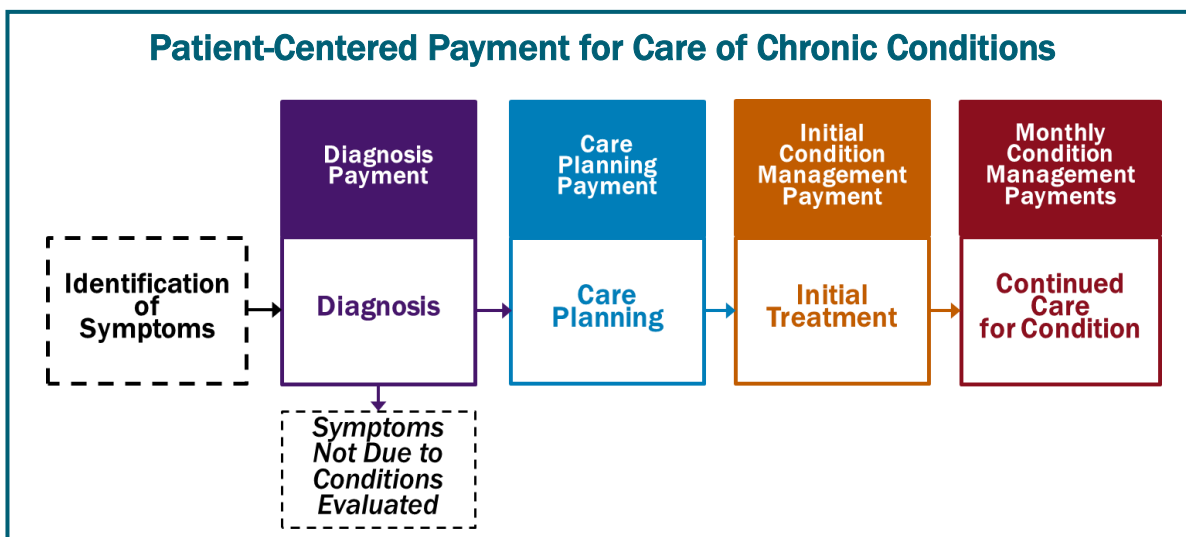
In a *patient-centered* payment system:

- A patient with a chronic condition should be able to receive the services that will best address their specific needs.
- A patient with a chronic condition should be assured of receiving appropriate, evidence-based care.
- The payment amounts should be adequate to cover the cost of delivering services in a high-quality manner to patients with chronic conditions.
- A patient with a chronic condition should be able to select which physician practice or provider will deliver care for the condition based on the quality and cost of the services they will receive.

Although every chronic condition is different, the care patients need for most chronic conditions can be divided into four distinct phases, each of which has a significant impact on the outcomes patients experience and the cost of the care they receive:

- (1) Diagnosis,
- (2) Care planning,
- (3) Initial treatment, and
- (4) Continued care for the condition.

Some patients will be able to receive adequate services in each phase from their primary care practice. Other patients will need services from a specialty care provider in one, some, or all of the phases. The only way to ensure that each patient can get appropriate specialty services for their specific needs, and the only way to ensure that each specialist is paid appropriately for the services they provide, is to create separate payments specifically designed to support each phase of care.



A. Categories of Payment

1. Payment for Diagnosis

Adequate time and sufficient expertise are required to collect the information about the patient that is needed for accurate diagnosis, while avoiding unnecessary testing and misdiagnosis. Although there are thousands of different billing codes and associated fees that are used to pay physicians for performing specific procedures and tests, there are no billing codes or fees specifically designed to pay a physician to determine the cause of a patient's symptoms or to determine whether a patient has a specific chronic disease. In a *patient-centered* approach to payment, a specialist should receive a **Diagnosis Payment** that is specifically designed to support an accurate evaluation of the patient's symptoms, regardless of how many visits the patient makes with the physician.

If a patient has a combination of symptoms and other characteristics that require more time to evaluate correctly, the amount of the Diagnosis Payment will have to be higher so the physician making the diagnostic determination can allocate adequate time. The Diagnosis Payment should be stratified into three different levels based on the complexity of decision-making as determined by the number of potential diagnoses, the amount and complexity of diagnostic data to be analyzed, and the patient's comorbidities:

- **Low Complexity Diagnosis Payment**
- **Moderate Complexity Diagnosis Payment**
- **High Complexity Diagnosis Payment**

Many unnecessary referrals from primary care practices to specialists could be avoided if the primary care physician could receive assistance from a specialist in making a diagnosis and/or determining whether a referral is appropriate. A **Diagnostic Assistance Payment** should also be created to enable the specialist to provide this assistance.

2. Payment for Care Planning

There are typically multiple approaches to treating and managing a chronic condition. The choices and the tradeoffs evolve continuously as new therapies are created and as new evidence emerges about the relative effects of treatments. The expertise of a specialist will often be needed to identify the best alternatives, to educate the patient about the choices, and to assist the patient in deciding which to pursue.

The physician who prepares the care plan may be different from the physician who diagnoses the condition and/or the physician who will actually manage the patient's care on an ongoing basis. In a *patient-centered* payment system, a **Care Planning Payment** is needed that is specifically designed to support this phase of care. More time will be needed to carry out an effective care planning process for some patients than others, so the Care Planning Payment should be stratified into three different levels based on the complexity of the planning, and an additional payment should be available for complex patients who require an extensive amount of time to

understand and select an approach to treatment and care that will work for them:

- **Low Complexity Care Planning Payment**
- **Moderate Complexity Care Planning Payment**
- **High Complexity Care Planning Payment**
- **Payment for Additional Time Required by Patient in Care Planning**

As in the case of diagnosis, rather than referring the patient to a specialist for the full care planning process, a primary care physician may be able to prepare an appropriate care plan if they receive assistance from a specialist. A **Care Planning Assistance Payment** should be created to enable the specialist to provide this assistance.

3. Payment for Condition Management

Development of a care plan will trigger the beginning of what will often be a lifetime of activities needed to manage the chronic disease, including both treatments and lifestyle changes designed to reduce the severity of symptoms caused by the chronic condition, to prevent exacerbations of the condition and associated complications, and ideally to slow the progression of the disease.

The most appropriate way to pay for these services is through a monthly **Condition Management Payment** for each patient that gives the physician practice flexibility to assist each patient in the way that will be most effective and efficient for that patient. A monthly payment also encourages preventing exacerbations and avoiding treatment complications, since the fewer problems the patient has, the less time the practice will need to spend addressing such problems. The monthly payment would only be for chronic condition *management*, not for any specific drugs, procedures, or tests the patient needs as part of their care plan; these other services should be paid for through service-specific fees.

Patients should have the ability to choose which physician practice will help them in managing their chronic condition. Some patients will want or need their primary care practice to do this. Other patients will want or need to have a specialist practice do so, even if they continue to receive wellness care and occasional acute care from the primary care practice. In a patient-centered payment system, **the patient should explicitly enroll to receive services from the physician practice the patient wants to provide their care**, and then that practice would bill for and receive the monthly payments.

The Condition Management Payments will need to be higher for those patients who will require more time from the physician practice that is providing condition management services:

- A higher **Initial Condition Management Payment** should be paid during at least the first month of care in order to support the additional time needed to provide education and assistance to the patient in implementing the care plan and to make any revisions to the care plan based on: (1) whether the patient experiences any problems in implementing the care plan, and (2) whether the care succeeds in improving the patient's health.

- After the initial treatment period, higher monthly Condition Management Payments should be paid for the following types of patients because of the additional time a physician practice will need to spend on their care:

- ◆ **Condition Management Payment for a Complex Patient**, i.e., a patient who has a combination of health conditions or other characteristics (often referred to as “social determinants of health”) that make the patient more susceptible to serious exacerbations or complications.
- ◆ **Condition Management Payment for Complex Treatment**, i.e., a patient who needs to receive medications that can have dangerous side effects, multiple treatments that must be carefully sequenced or timed, or treatments that are difficult to use correctly.

4. Payment for Administration of Medications

Although most patients with a chronic disease will use oral medications to treat the condition, some patients will need to have their medications injected or infused by a physician or a nurse. The physician practice has to purchase an inventory of the drugs it expects to be using, and Medicare and health insurance plans pay the practice for the drugs after they are administered to individual patients. The “ASP+x%” methodology payers typically use to pay for the drugs can result in significant financial losses for physician practices, and this can make it difficult for the practices to provide patients with the most appropriate medications.

The ASP+x% methodology should be replaced with a new **Practice-Administered Drug Cost (PADC) Payment** that has three components:

- (1) **Payment for Drug Acquisition Cost;**
- (2) **Payment for Wastage/Breakage Losses; and**
- (3) **Monthly Payment for Costs of Pharmacy Operations.**

B. Accountability for Quality and Utilization of Services

Payments that are designed specifically to support the types of care patients need are necessary but not sufficient to assure that a patient will receive appropriate and high-quality care. A *patient-centered* payment system also needs effective mechanisms for ensuring that each patient receives the most appropriate services for their specific condition, that the patient does not receive inappropriate or unnecessary services, and that services are delivered in the most effective way possible.

1. Delivery of Evidence-Based Services

The best way to ensure that each patient receives appropriate services is for the physician practice receiving a Diagnosis Payment, Care Planning Payment, or Condition Management Payment to deliver services (or develop a plan for services) consistent with an evidence-based *Clinical Practice Guideline (CPG)* or a *Clinical Pathway* that is appropriate for the patient’s condition and characteristics. A Clinical Practice Guideline assembles all of the available evidence regarding how to diagnose and manage the chronic condition, with consideration for the

tradeoffs between accuracy, safety, and cost of various approaches. A “Clinical Pathway” is a set of guidelines that recommend the use of a specific approach when the evidence is unclear or where multiple options have equivalent benefit but different costs. CPGs and Pathways must be free of influence by commercial firms.

Under Patient-Centered Payment for Care of Chronic Conditions, use of an evidence-based Clinical Practice Guideline or Pathway would be required in order for the physician to bill and be paid for services:

- If the physician practice bills a payer or patient for a Diagnosis Payment or a Care Planning Payment, the physician would need to attest that they had utilized an appropriate Clinical Practice Guideline or Pathway in determining the diagnosis or developing the care plan. The physician could deviate from the guidelines if necessary for patient-specific reasons, but the practice would only submit the bill if the reasons for deviation are documented in the patient’s clinical record.
- If the physician practice bills a payer or patient for a Care Planning Payment, it would also attest that it had engaged in a shared decision-making process with the patient (unless there were documented reasons as to why this was not feasible) and that it had prepared a written care plan and provided a copy to the patient.
- If the physician practice bills a payer or patient for a Condition Management Payment, the physician would need to attest that (1) the practice had delivered or ordered all evidence-based services defined in an appropriate Clinical Practice Guideline or Pathway to the patient during the month, and (2) the practice had *not* delivered or ordered any services that are not recommended by the Guidelines or Pathway. The physician could deviate from the guidelines if necessary for patient-specific reasons, but the practice would only submit the bill if the physician attests that the deviation was necessary and the reasons for deviation are documented in the patient’s clinical record.

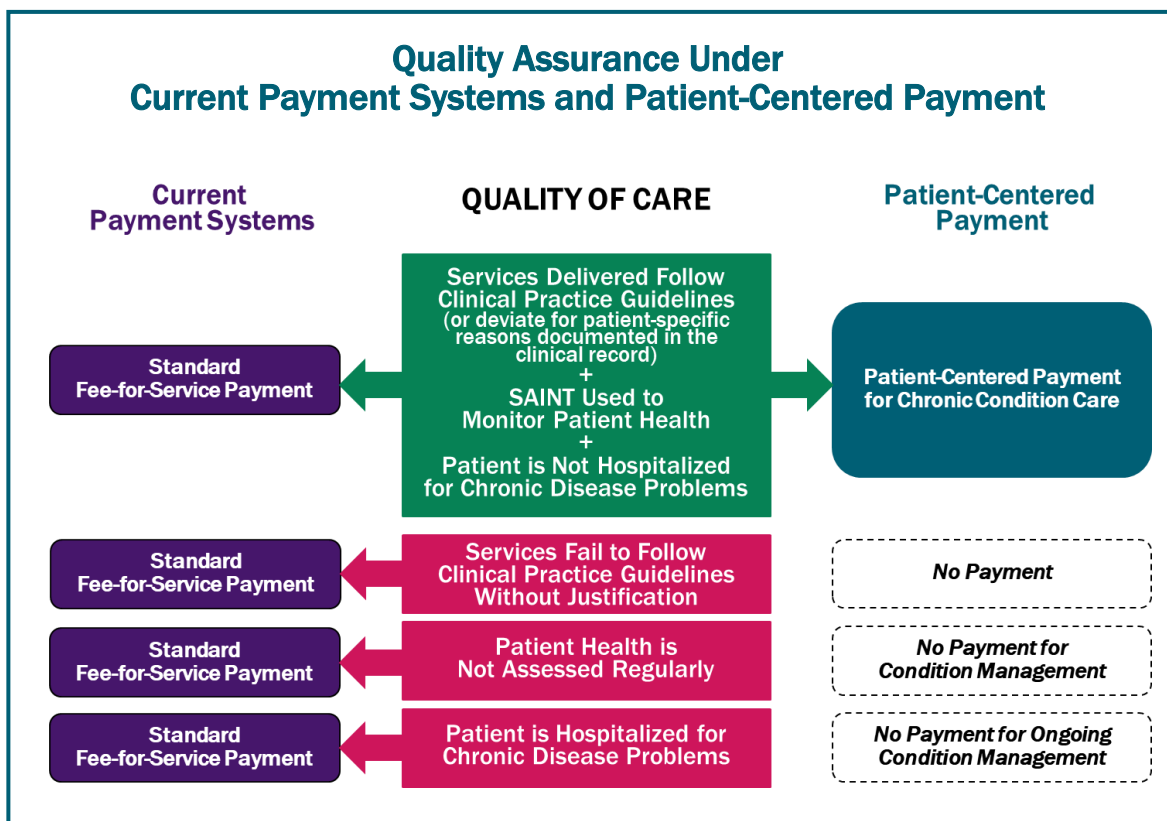
2. Monitoring Patient Health

In addition to delivering evidence-based services to the patient, a physician practice that is delivering condition management services should proactively monitor the patient’s condition to identify any problems the patient is experiencing and to assess the outcomes of the services delivered. In order for a physician practice to bill and be paid for Condition Management Payments, the practice would need to attest that it uses a *Standardized Assessment, Information, and Networking Technology (SAINT)* to help it monitor the patient’s chronic conditions. A SAINT (such as www.HowsYourHealth.org) provides a systematic way for a patient to provide the physician practice with actionable information about any physical and/or emotional problems the patient is having and whether the services the practice is providing to the patient are addressing the issues that are of most concern to the patient.

3. Outcome-Based Payment

Finally, a physician practice should not receive a Condition Management Payment during any month in which the patient has to be hospitalized for an exacerbation or complication of their chronic condition. This would not

Quality Assurance Under Current Payment Systems and Patient-Centered Payment



apply to the Initial Condition Management Payments, since a patient could have disease exacerbations requiring hospitalization until the physician practice is able to find a treatment and care plan that will work effectively for the patient.

C. Adequacy of Payment

The third essential characteristic of a *patient-centered* payment system is that the payment amounts are adequate to cover the cost of delivering services in a high-quality manner. No matter what *method* is used to pay for diagnosis, care planning, or treatment, if the payment *amount* is not sufficient to cover the time and cost involved in delivering high-quality care, the patient may fail to receive an accurate diagnosis, may receive unnecessary or unnecessarily-expensive services, or may experience avoidable problems. Consequently, the payment amounts should be based on what it costs to deliver high-quality care, not based on the fees paid in the past, the amount of savings that has been produced, or an arbitrary percentage of total spending.

In each phase of care, the Patient-Centered Payment should be higher for patients with greater needs. The higher payments would support the additional time that the physician practice would need to spend with these patients. In addition, the Diagnosis Payments and Initial Condition Management Payments would be much higher than the monthly Condition Management Payments, reflecting the significant amount of time needed to complete these phases with an accurate diagnosis and an effective care plan.

The attached table shows the amounts of payment that are estimated to be adequate to support high-quality care of chronic conditions in both small and large physician practices. These amounts would be paid instead of current fees for Evaluation & Management Services (E/M) office visits, Principal Care Management, and Chronic Care Management.

D. Patient Access and Choice

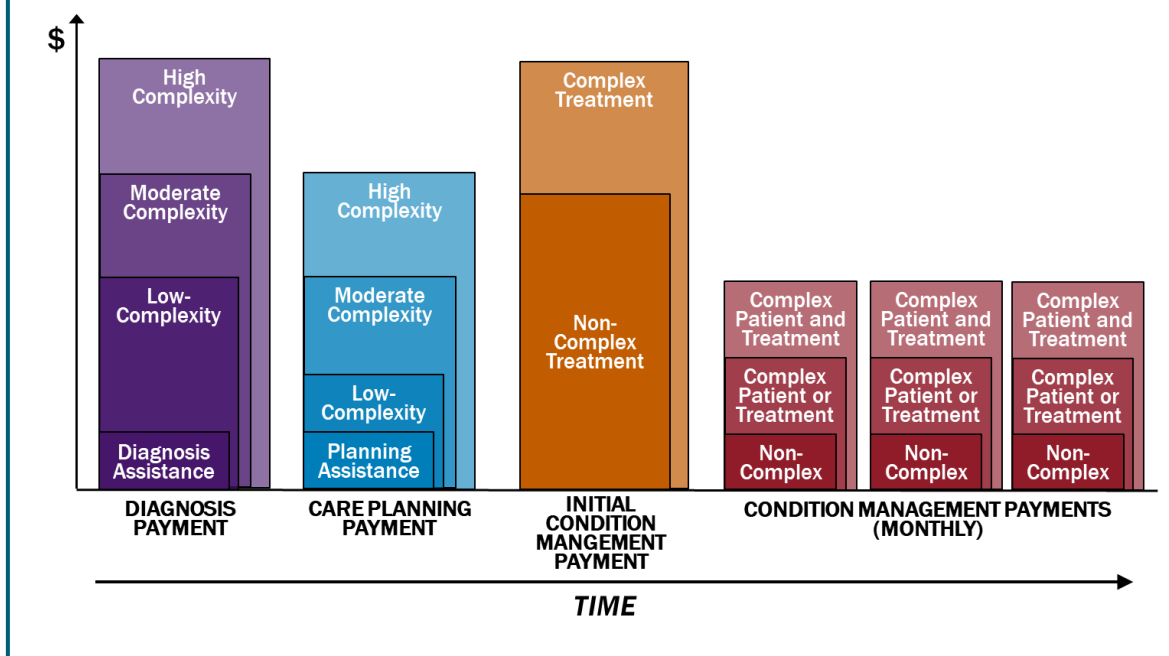
A patient with a chronic condition should be able to select which physician practice or provider will deliver the best care for their condition based on the quality and cost of the services they will receive. Payer-defined narrow networks and cost-sharing requirements (i.e., co-payments, co-insurance, and deductibles) that prevent this need to be eliminated in order to have a truly *patient-centered* payment system.

1. Cost-Sharing for Diagnosis Payments

In order to ensure a patient can receive diagnostic services from the physician(s) best able to diagnose their symptoms accurately and safely, patient cost-sharing for Diagnosis Payments should meet the following criteria:

- The cost-sharing should be lower for an initial evaluation of symptoms by a primary care physician rather than a specialist.
- There should be no cost-sharing for a diagnostic assistance payment to a specialist who assists the primary care physician in making a diagnosis or determining whether a specialist referral should be made.

Relative Magnitude of Individual Payments Under Patient-Centered Payment



- There should be no cost-sharing for a visit to a specialist if the patient has visited a primary care physician (or a different specialist) who was unable to make a diagnosis.
- There should be low cost-sharing for a visit with a specialist if a primary care physician has made a diagnosis but the patient wants a second opinion.
- The cost-sharing amounts should be higher for subsequent specialist evaluations of the same symptoms after a diagnosis has already been made by one specialist.
- The dollar amount of cost-sharing for the patient should be the same regardless of the level of Diagnosis Payment paid to the specialist.

2. Cost Sharing for Care Planning Payments

A patient who has been newly diagnosed with a chronic condition should have a physician practice with appropriate expertise develop an evidence-based care plan for that condition. Requiring a patient to pay cost-sharing for this service could discourage them from obtaining such a care plan and result in them receiving inadequate or inappropriate treatment for their condition. Consequently, once the patient has been diagnosed with a chronic condition, there should be no cost-sharing required for the development of a care plan by either their primary care practice or a specialist practice.

3. Cost Sharing for Condition Management Payments

There should be no co-payments or co-insurance for the monthly Condition Management Payments, nor should they be subject to a deductible. The goal of these services is to prevent chronic condition exacerbations from occurring, and since the savings to the health insurance plan from not having to pay for hospital treatment of exacerbations will likely exceed the cost of the monthly condition management services, it would be undesirable to create cost barriers that could discourage patients from enrolling to receive these services.

Costs and Benefits of Patient-Centered Payment

Spending on the services delivered by physician practices would likely increase under Patient-Centered Payment for Care of Chronic Conditions, particularly for patients who have complex conditions and who face social barriers in maintaining and improving their health, since current payments do a particularly poor job of supporting the services they need. However, the reductions in avoidable spending that will occur when patients receive more accurate diagnoses, evidence-based treatment, and better prevention and management of exacerbations and complications of treatment have the potential to offset these increases and reduce *total spending* for payers.

The fact that a reduction in total spending is likely does *not* mean that a physician practice's eligibility to receive Patient-Centered Payment should be *contingent* on a decrease in total spending occurring. Payment models that make payments explicitly or implicitly contingent on whether there is a reduction in total healthcare spending, such as shared savings programs, can create perverse incentives to undertreat patients in ways that produce short-term savings but result in higher spending in the long run.

Better care for patients with chronic conditions can also have a beneficial impact on worker productivity. Higher worker productivity has a direct economic benefit for employers that can offset higher amounts spent to support high-quality chronic condition care for their employees and families.

Implementing Patient-Centered Payment

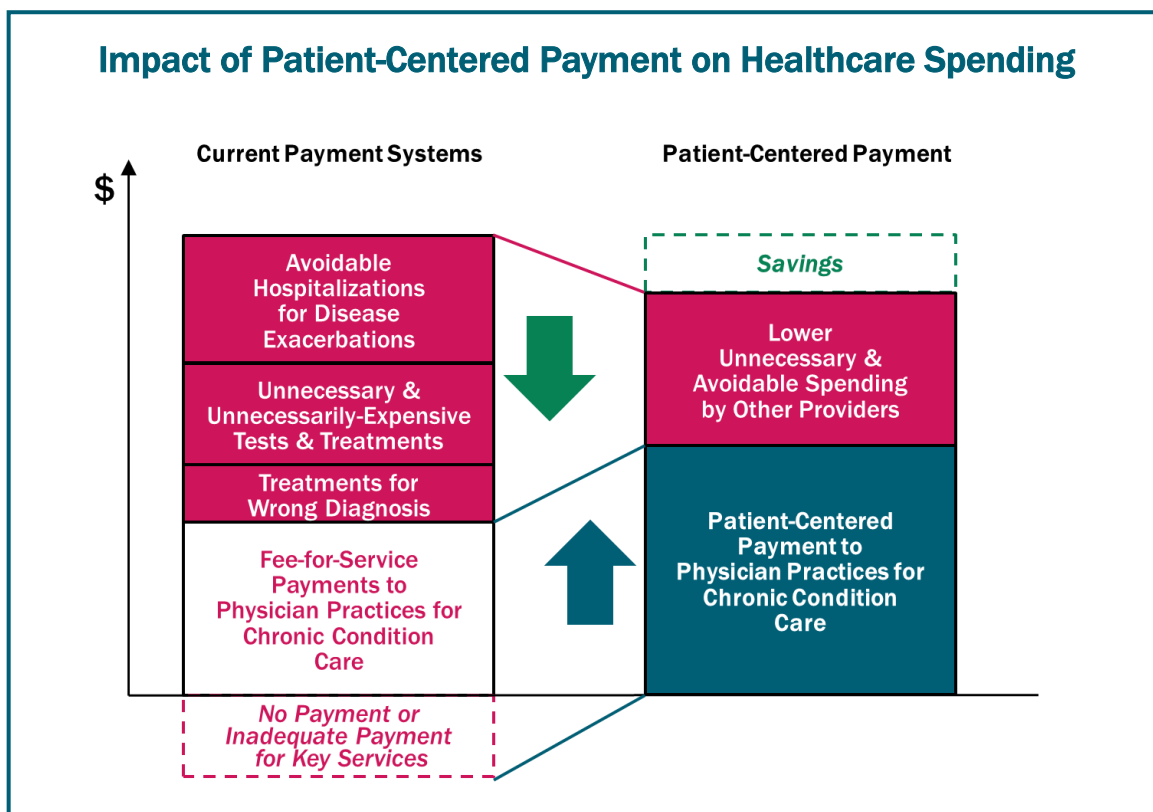
Patient-Centered Payment for Care of Chronic Conditions can be easily operationalized for patients with insurance by creating new billing codes for each of the new payments, as shown in the attached table. Ideally, these codes should be part of the standard set of CPT (Current Procedural Terminology) codes that describe the services physicians deliver. Adequate payment amounts then have to be assigned to each of these CPT codes.

In order to ensure that every person who has a chronic condition has the ability to receive high-quality care for that condition regardless of what type of insurance they have, every payer – every commercial insurance plan, every Medicare Advantage plan, every Medicaid Managed Care Organization, every state Medicaid agency, and Original (fee-for-service) Medicare – will need to make all of the payments under Patient-Centered Payment for Care of Chronic Conditions *available* to any physician practice providing services to the patients insured by that payer so that all patients with a chronic condition have the opportunity to receive high-quality care.

Additional Details

Additional details on all aspects of the patient-centered approach to payment are available in the [full report on Patient-Centered Payment for Care of Chronic Conditions](#) which can be downloaded at:

https://chqpr.org/downloads/Chronic_Condition_Care_Payment.pdf.



Payment Categories and Estimated Payment Amounts in Patient-Centered Payment for Care of Chronic Conditions

Type of Service	Billing Code	Payment Category	Frequency of Payment	Accountability for Quality	Estimated Amount of Payment
Diagnosis	XX040	Diagnosis Assistance	Once per patient	Follow evidence-based guidelines for diagnosis and testing	\$37
	XX041	Low Complexity Diagnosis			\$146
	XX042	Moderate Complexity Diagnosis			\$218
	XX043	High Complexity Diagnosis			\$291
Care Planning	XX050	Care Planning Assistance	Once per patient	Use evidence-based guidelines for treatment and management to design the care plan	\$37
	XX051	Low Complexity Care Planning			\$75
	XX052	Moderate Complexity Care Planning			\$145
	XX053	High Complexity Care Planning			\$214
	XX054	Additional Care Planning Time	Each extra 30 minutes of clinical staff time	\$31	
Chronic Condition Treatment and Management	XX030	Initial Condition Management	Monthly for 1-3 months	Follow evidence-based guidelines for treatment and management and monitor patient needs	\$206
	XX031	Condition Management (Non-Complex Condition and Treatment)	Monthly (except months when patient is hospitalized)		\$40
	XX032	Condition Management for Complex Chronic Condition			\$94
Chronic Condition Treatment and Management (Complex Treatment)	XX034	Initial Condition Management (with Complex Treatment)	Monthly for 1-3 months	Follow evidence-based guidelines for treatment and management and monitor patient needs	\$290
	XX035	Condition Management (with Complex Treatment)	Monthly (except months when patient is hospitalized)		\$94
	XX036	Condition Management for Complex Chronic Condition (with Complex Treatment)			\$133
Injected or Infused Medications	JXXX0	Practice-Administered Drug Cost Payment - Payment for Drug Acquisition Cost	When drug is administered	Follow evidence-based guidelines for choosing medications	Acquisition cost of drug
	JXXX1	Practice-Administered Drug Cost Payment - Payment for Wastage/Breakage Losses			~1% of drug acquisition cost
	XX060	Practice-Administered Drug Cost Payment - Payment for Pharmacy Operations Costs	Monthly	Meet standards for operation of specialty pharmacy	Based on pharmacy operation cost
Test or Other Procedure	Varies	Standard CPT code for procedure or test	When procedure or test is performed		Payment based on cost of procedure or test