Improve Patient Access to Chronic Care Management Services

Congress should pass the Chronic Care Management Improvement Act to remove Medicare patient cost-sharing requirements for chronic care management services.

Background

For decades, US health care payment systems have struggled to recognize and value the breadth of work that primary care clinicians furnish as part of their comprehensive, continuous relationships with patients over time. Developing trust with patients, coordinating with specialists, managing multiple chronic conditions, and checking on patients between office visits are all fundamental components of primary care that have, historically, not been formally paid for.

To better support this work, the Centers for Medicare & Medicaid Services (CMS), through Medicare began paying clinicians for non-face-to-face Chronic Care Management (CCM) services in 2015.

Chronic Care Management (CCM): A set of codes related to managing a patient's multiple (2 or more) chronic conditions expected to last at least 12 months, or until the patient's death. Such services include:

- Structured recording of patient health information;
- Maintaining and sharing comprehensive electronic care plans;
- Coordinating across clinicians and settings; and
- Ongoing care management and care transition support.

High-value, low-cost services such as CCM have been consistently shown to improve patient outcomes while saving health care dollars in the long-term. A CMS-commissioned analysis found that ***Medicare spent approximately $95 less per patient per month*** **for beneficiaries receiving CCM services compared to those who did not.** Research has also found that CCM improves clinician efficiency, patient satisfaction, therapy adherence, rates of advance care planning, and reduces hospitalizations and emergency department (ED) visits.

Unfortunately, there remain structural barriers that are impeding utilization of these codes and hindering the intended impact of the investments CMS is trying to make in primary care.

Patient Cost-Sharing

One of the biggest barriers to uptake is the cost to patients. While most preventive care is covered without costs to patients, Medicare is statutorily required to institute a 20 percent patient coinsurance for most services after they've paid their deductible ($283 in 2026). This equals approximately $13 a month for CCM services. While it sounds small, even the smallest cost-sharing requirement can create a significant barrier to care.

Many seniors living on fixed incomes view any additional out-of-pocket costs as untenable. Further, beneficiaries are billed for CCM services outside of office visits, which can be confusing and lead to patients declining these services.

As a result of such barriers, CCM remains significantly underutilized. Only about 4 percent of eligible Medicare beneficiaries currently receive CCM services, despite an estimated 22.5 million beneficiaries qualifying.

Reducing or eliminating cost-sharing for high-value primary care services has consistently been shown to increase utilization of recommended care, improve health outcomes, and lower overall spending.

CCM functions as a preventive service by helping patients manage chronic conditions more effectively, preventing disease progression, and reducing the need for more expensive downstream care.

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Legislative Solution

To address the coinsurance barrier, **Congress should pass the *Chronic Care Management Improvement Act* (H.R. 8261).** This bipartisan legislation is led by Representatives Suzan DelBene (D-WA) and Mike Kelly (R-PA). It would waive this key financial barrier that limits patient access to and uptake of CCM services. By waiving Medicare Part B coinsurance, federal lawmakers can expand access to high-value, low-cost care management services for chronically ill patients, improve health outcomes, and generate savings for the Medicare program over time.

Patient Anecdotes from a 2017 CCM Evaluation Report:

"Other reasons for providing consent included: beneficiaries' trust in the doctor who recommended it, knowing they could withdraw at any time, and feeling that the doctor should be compensated for time spent managing or providing patient care outside of office visits. One patient stated: ***"I don't think he gets paid enough. I thought, "Okay, - if my doc needs a little more money, and I think he does, then that's okay."***

"You're talking to the same person every time. It's somebody that knows my history, knows my medications, knows the doctors I'm seeing, knows what I'm being treated for."

"We think about our health more and what we're doing right or wrong with these phone calls that we're getting every month now. It's a good thing."

However, "though about one in five beneficiaries said they would participate in CCM services whether or not the service was covered by supplemental insurance or Medicaid, *a larger proportion of beneficiaries suggested they would not participate if they had to pay out of pocket.*"