

Transitional Care Management: Why Bother?

Think of it as a way to help your patients, potentially save the system money, and help your bottom line all at the same time.

Transitional care management (TCM) is a hot topic. In this issue you will find an article coauthored by Jacqueline Bloink and myself on the new TCM codes. As you will see in the article, TCM codes will likely become the most lucrative codes that you commonly bill. By providing TCM in the fashion required by these codes, you will not only be doing well by yourself but also doing well by your patients and the health care system as a whole. Or at least that is how the Centers for Medicare & Medicaid Services (CMS) hopes it will turn out.

By its own estimate, CMS will spend \$1.34 billion in 2013 on these codes, generating a 4 percent increase in

percent, 18.1 percent, and 15.3 percent respectively.³

Currently only 44 percent of patients are seen by *any* physician within 14 days of discharge.¹ A small study by Misky et al in 2010 showed that, at a tertiary care hospital, patients saw their primary care provider for follow-up within 30 days only 49 percent of the time. Those patients who saw their primary care provider had a 3 percent 30-day readmission rate, while those that didn't had a 21 percent readmission rate.⁴

CMS isn't putting all its eggs in the TCM basket. In October 2012, CMS began financially penalizing hospitals that have high readmission rates for patients with CHF, acute MI, and pneumonia. CMS is also hoping that the Medicare Shared Savings Program (ACOs) will reduce readmissions and that its patient-centered medical home pilots will bear fruit as well.⁵

It seems obvious that providing better transitions of

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payments to family physicians and a 3 percent increase for internists. This is based on the assumption that TCM will be billed for roughly 6.7 million discharges out of an anticipated 10 million and that 75 percent of those will use the lower rate code.^{1,2} Whether or not you agree with this generous assumption, CMS is clearly prepared to spend a bucket-load of money on this.

But why? I'd like to say it is because CMS finally recognizes all the uncompensated care coordination work that family physicians do and has decided to right an old wrong. But really it isn't about us. It is about reducing the hospital readmission rate.

For many years we've been hearing that the readmission rate for Medicare patients is nearly 20 percent and that readmissions cost \$26 billion annually, with \$17 billion being preventable. The most recent research suggests it isn't *that* bad. However, it is still bad. A February 2013 study analyzed 2010 Medicare data from the Dartmouth Atlas Project. That study shows that the 30-day medical readmission rate in 2010 was 15.9 percent, the surgical readmission rate was 12.4 percent, and disease-specific readmission rates for congestive heart failure (CHF), acute myocardial infarction (MI), and pneumonia were 21.1

percent, 18.1 percent, and 15.3 percent respectively.³ care will help reduce readmissions. I certainly hope that is true. Let's see if we can prove it so.



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2. Ross M. CMS places \$1 billion bet on transitional care management. Bridging Business & Healthcare blog. Knoxville, Tenn: Pershing Yoakley & Associates. Nov. 27, 2012. <http://healthcareblog.pyapc.com/2012/11/articles/healthcare-reform/cms-places-1-billion-bet-on-transitional-care-management>.

3. *The Revolving Door: A Report on U.S. Hospital Readmissions*. Princeton, NJ: Robert Wood Johnson Foundation; Feb. 11, 2013. <http://www.dartmouthatlas.org/pages/readmissions2013>.

4. Misky GJ, Wald HL, Coleman EA. Post-hospitalization transitions: examining the effects of timing of primary care provider follow-up. *J Hosp Med.* 2010;5(7):392-397.

5. Health policy brief: improving care transitions. *Health Aff.* Sept. 13, 2012. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=76.