

Bridging to Value With Codes That Promote Care Management

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The optimal approach for transitioning toward value-based payment and care remains unclear for many clinicians and health care organizations. Although a common goal may be to successfully assume financial accountability under value-based payment models that emphasize quality and costs rather than volume of care, success in these reforms can require substantial infrastructure investments, clinician engagement, and the ability to absorb financial losses. Many clinicians and groups may need more incremental steps to practice transformation.¹

Certain fee-for-service billing codes that emphasize care management—in particular, those related to transitional care management (TCM) and chronic care management (CCM)—may provide a solution. A key feature of value-based payment models is an overarching emphasis on improving quality and reducing unwarranted expenditures through care management (eg, reducing readmissions after hospital discharge, improving referrals between primary and specialty care to manage chronic disease). Therefore, billing codes that promote coordination and management can encourage care delivery changes that align with those needed to succeed in value-based payment models.

Strategically, effective billing codes can serve as guides to help organizations identify how to invest in specific care delivery functions, rather than “boiling the ocean” in search of solutions. Financially, organizations can engage in care management activities and build competencies for succeeding in value-based payment reforms while receiving predictable reimbursements. However, the effectiveness of these codes depends on the degree to which they are adopted, as well as whether the associated activities move organizations toward care delivery structures and processes needed to succeed in a value-based payment environment. In this article, we highlight these dynamics using TCM and CCM billing codes implemented by CMS, a leader in the nationwide shift from volume-based fee-for-service toward value-based payment and care delivery.

Codes as Bridges to Value-Based Payment

CMS implemented TCM codes in 2013 in an effort to improve care management and optimize health outcomes during the

ABSTRACT

Transitional care management (TCM) and chronic care management (CCM) fee-for-service billing codes can serve as bridges to help organizations build care management capabilities and effectively transition from volume- to value-based care. TCM codes encourage providers to build capabilities for managing hospital discharge transitions. CCM codes encourage physician and nonphysician staff to build capabilities for longitudinally managing patients with multiple chronic conditions. Implementation challenges include achieving return on investment in health information technology and securing stakeholder commitment and engagement. Nonetheless, policy makers have reinforced their commitment to these codes, offering an encouraging signal for organizations seeking more gradual ways to build competencies and bridge toward value-based payment and care delivery.

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potentially vulnerable period following hospital discharge. TCM reimburses clinicians and their organizations for delivering a combination of non-face-to-face communication and in-person care to patients within 7 or 14 calendar days following hospital discharge. In 2015, CMS implemented CCM codes to encourage clinicians to longitudinally manage the care of patients with multiple chronic diseases—individuals who often suffer from care fragmentation while incurring the majority of all Medicare expenditures.² CCM codes reimburse physicians and other clinical staff for care coordination and chronic disease management outside traditional office visits.

For clinicians and health care organizations, TCM and CCM represent potential bridges to value-based payment arrangements. TCM promotes hospital follow-up by incentivizing clinicians to proactively identify and contact patients who are discharged from the hospital. This often requires a change in practice and clinician workflows—from developing connections and communication channels with hospitals to assigning support staff to reach out to patients in a timely manner. The process of delivering TCM services also prompts outpatient clinicians to review discharge information, medication changes, and recommended follow-up laboratory tests and imaging. These codes have yielded promising results thus far, with early evidence showing that patients receiving TCM after discharge have fewer readmissions, lower health care expenditures, and lower mortality.³

Similarly, CCM supports care management capabilities by reimbursing physician and nonphysician staff (eg, nurses, medical assistants) for collaboratively delivering non-visit-based care to patients with multiple chronic conditions. CCM emphasizes the development of patient care plans that incorporate disease self-management and care coordination across specialties (eg, dietitian or endocrinologist referrals for patients with diabetes)—factors that can reduce the impact of care fragmentation and improve disease management. CCM has been shown to reduce health care expenditures among Medicare beneficiaries, likely through decreased use of inpatient hospital and postacute care services,⁴ while achieving substantial additional revenue for practices.⁵

TCM and CCM codes encourage capabilities that are important for delivering value-based care. For instance, TCM codes can encourage providers to create discharge and care transitions capabilities that are vital to success in value-based programs, such as bundled payments and accountable care organizations.^{6,7} CCM codes encourage team-based care and long-term disease management, particularly among individuals with multiple chronic diseases—an emphasis that is aligned with Medicare's population and primary care value-based payment models, such as Comprehensive Primary Care Plus and forthcoming direct contracting models.

TAKEAWAY POINTS

For many health care organizations, it remains unclear how to build care management capabilities that enable smooth transitions to value-based payment and care. Transitional care management (TCM) and chronic care management (CCM) billing codes can serve as bridges for this purpose.

- ▶ TCM codes encourage providers to build capabilities for managing hospital discharge transitions that are emphasized in value-based programs, such as bundled payments.
- ▶ CCM codes encourage providers to build capabilities for longitudinally managing patients with multiple chronic conditions, which align with capabilities needed in value-based programs, such as accountable care organizations.
- ▶ Providers must address several challenges to successfully implement these codes.

Challenges in Implementing TCM and CCM

Despite these successes, uptake of TCM and CCM codes has been modest to date,⁸ possibly due to implementation barriers. First, clinicians and groups must be able to justify the requisite investments (eg, staff, information technology, workflow changes) against reimbursement for TCM and CCM activities. For instance, organizations considering CCM can face obstacles acquiring new electronic health record functionality necessary to support documentation, time tracking, and billing of TCM and CCM.⁹ Securing commitment and engagement from organizational leaders, physicians, and nonphysician staff poses an additional challenge. Moreover, recouping the investment in staff time to deliver these services may require that practices be large enough to deliver care coordination services to a sufficient number of patients. For example, at least 131 Medicare patients in the initial iteration of CCM are needed to recoup staff salary and overhead costs,⁵ making the financial value proposition less appealing to smaller practices. From the patient perspective, the inability to afford repeated co-payments can serve as a barrier to accessing these services.⁹

Second, TCM and CCM codes involve site-of-service requirements that may fail to maximize organizations' ability to use them to coordinate care. For example, TCM can be furnished only to individuals being discharged to community settings, an important limitation given the frequency with which patients are discharged to postacute care facilities, such as skilled nursing facilities. Third, TCM is limited by allowing only 1 payment per patient per hospitalization, an element that may be particularly challenging for complex patients with long hospitalizations. Finally, although the coordination work involved in TCM and CCM may span multiple clinicians or groups (eg, discussions between hospital and primary care teams, coordination between primary care and subspecialty clinicians), the ability to use financial incentives to engage different clinicians is limited by the fact that TCM and CCM payments are made to only 1 entity.

The Path Forward

CMS has reinforced its commitment to these codes, in part by addressing both reimbursement and patient population issues in

the 2020 Medicare Physician Fee Schedule.¹⁰ For example, the agency increased reimbursement amounts for TCM services and allowed these codes to be billed concurrently with CCM, hospice care, home care with care plan oversight, and other services that benefit from provider-to-provider communication during transitions. In addition, CMS introduced a new add-on code to reimburse clinicians for additional time spent on noncomplex CCM and broadened the reimbursement criteria for complex CCM to include disease monitoring without substantial revisions in patient care plans. Finally, the agency implemented new Principal Care Management codes in 2020 to support care management for patients with a single high-risk disease or complex chronic condition.

Other policy changes will be needed to support providers using TCM and CCM to transition to value-based payment. For TCM, refinements that would retain the emphasis on transitions of care while better shifting organizations into an era of value-focused, episode-based payment models may include allowing multiple points of patient contact extended over a 90-day period following discharge and enabling access to TCM services for all patients being discharged from the hospital, including those who transition to postacute care facilities prior to discharge home. For CCM, greater latitude in the frequency that add-on codes can be reported per calendar month would better reflect the time and resources required to manage patients longitudinally across different diseases with varying complexity. Moreover, efforts to increase patient engagement in CCM services could focus on removing out-of-pocket cost barriers. Finally, as uptake of and policy focus on both TCM and CCM gain attention, large-scale evaluations are needed to assess the impact of TCM and CCM services on clinical, quality, and cost outcomes, as well as to elucidate facilitators and barriers to the uptake and use of these codes.

Although these fee-for-service codes neither substitute for nor replace value-based reforms, they nonetheless emphasize the importance of care management activities. Both TCM and CCM services ultimately encourage organizations to adopt broader accountability for patients across the care continuum. Therefore, together with early evidence supporting the success of these codes, emerging policy changes offer an encouraging signal for organizations that

are seeking more gradual ways to build competencies and bridge toward value-based payment and care delivery. ■

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