June 25, 2013

Administrator Marilyn Tavenner
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1599–P
P.O. Box 8011, Baltimore, MD 21244–1850.

Re: CMS Proposed FY2014 Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital Prospective Payment System (LTCH PPS) (CMS–1599–P)

Dear Administrator Tavenner:

We appreciate the opportunity to comment on the proposed FY 2014 Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital Prospective Payment System Payment Rule.

The National Transitions of Care Coalition (NTOCC) is a non-profit organization of leading multidisciplinary health care organizations and stakeholders dedicated to providing solutions that improve the quality of health care through stronger collaboration between providers, patients, and family caregivers. The organization was formed in 2006 to raise awareness about the importance of transitions in improving health care quality, reducing medication errors, and enhancing clinical outcomes among health care professionals, government leaders, patients and family caregivers.

Hospital Readmissions Reduction Program

NTOCC supports CMS' Hospital Readmissions Reduction Program as one strategy to promote improved communication and coordination of patient care following a hospital stay. However, NTOCC has long advocated that in order to successfully reduce avoidable hospital readmissions and improve health outcomes, hospitals need - in addition to accountability measures - specific tools and resources that can drive quality improvements in the management of a patient's transition from post-hospital discharge to their next point of care.

To that end, there are several models of care and interventions aimed at improving the coordination of care between care settings that have demonstrated improved health outcomes and reduced hospital readmissions. One such tool is the *Compendium of Evidence-Based Care Transition Interventions* which provides a user-friendly centralized resource for providers to have access to all currently available evidence-based interventions and tools. NTOCC created the compendium as a tool to assist medical providers and policymakers who are seeking a centralized resource on the most up-to-date research on care transitions. A companion resource to the compendium is *NTOCC's Seven Essential Intervention Categories Guide,* which highlights the essential care transition interventions identified from a cross-walk of the various models of care. These seven care interventions include: medications management; transition

planning; patient and family engagement/education; information transfer; follow-up care; health care provider engagement; and shared accountability across providers.

NTOCC believes that these types of care transition strategies are critical to the success of the Hospital Readmissions Reduction Program, and we are concerned that without employing these proven interventions, the program may create incentives for strategies that lead to reduced readmission rates—such as increasing referrals to emergency care or categorization of patients as outpatients—but would do little to improve the overall quality of care for patients. NTOCC urges CMS to evaluate how hospitals and other entities are reducing readmissions for the designated patient populations and whether the program is successful in promoting the types of strategies that lead to reduced readmissions through improved care transitions.

Admission and Medical Review Criteria for Hospital Inpatient Services

NTOCC appreciates CMS clarifying its policy on the medical necessity of inpatient admissions spanning two midnights or more, and CMS' recognition of the "recent increases in the length of time that Medicare beneficiaries spend as hospital outpatient receiving observation services." This is an important issue particularly for Medicare beneficiaries who are hospitalized under observation status, but not formally admitted as an inpatient, and then need skilled nursing facility (SNF) care.

Under current law, to qualify for the SNF benefit, Medicare requires that a patient must have an inpatient stay of three or more consecutive days. However, hospitals are increasingly classifying patients as "outpatients" despite the fact that they stay for many days and nights and receive the care and medical services as if they were inpatients. These beneficiaries face greater financial liability towards accessing skilled nursing care, and many are forced to forgo care because the costs are too burdensome. This poses a significant barrier for accessing critical follow-up care provided by the SNFs, leading to the possibility of an improper transition from the hospital and increasing the risk for a readmission. NTOCC is concerned that this trend will continue as the current readmission penalties may continue to incentivize outpatient classification over inpatient status.

NTOCC supports CMS providing clarity on when a beneficiary would appropriately qualify for admission as an inpatient, as presumably that would decrease the number of beneficiaries inappropriately held for multiple days under "observation status," effectively precluding them from qualifying for the SNF benefit. While we understand that CMS is constrained by current law, NTOCC would also support further expanding the type of patient classification which would qualify for the SNF benefit to ensure that time spent in observation stay could be counted toward meeting the three-day prior inpatient stay requirement needed to qualify for Medicare SNF coverage. We look forward to working with Congress and CMS on addressing this issue.

Long-Term Care Hospital (LTCH) Quality Reporting: All-Cause Readmission Measure

As you are aware, older adults and other individuals with chronic illness or multiple comorbidities face significant challenges when transitioning from one care setting to another and are at the highest risk for readmissions, adverse drug events, and even death.[i] This is

especially true for those beneficiaries at the end of life. A recent *Journal of the American Medical Association* study found "for Medicare beneficiaries who died over the past decade (from 2000 to 2009), the average number of 'health care transitions' -- i.e. changes in location of care -- in the last 90 days of life increased by 50 percent."[ii]

For these medically complex patients, because of the nature of their comorbidities, it is often hard to pinpoint the exact chronic condition that caused the readmission. In addition, given that this particular Medicare population is relatively small, assigning a disease-specific readmission measure would dilute the sum population in the denominator of the calculation, resulting in a less robust or meaningful measure. Therefore, NTOCC supports CMS' proposed all-cause unplanned readmission measure for 30-days post-discharge from LTCH. However, given the typical condition of patients who enter LTCHs, NTOCC urges CMS to have an appropriate risk adjustment for calculating readmissions for these medically complex beneficiaries.

Inpatient Psychiatric Facility Quality Reporting Program: Follow-Up After Hospitalization for Mental Illness

NTOCC also strongly supports the inclusion of the new process measure for the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) which would assess follow-up care after hospitalization for mental illness. It is critical that we continue to work on better integration of behavioral healthcare services into the broader health care continuum to ensure that continuity of treatment and proper follow-up care is provided as "one in four Americans experiences a mental illness or substance abuse disorder each year, and the majority also has a comorbid physical health condition."[iii] As the Agency has previously noted, it is estimated that "half of first-time psychiatric patients are readmitted within two years of hospital discharge…and appropriate follow up care and management of diseases, such as mental illnesses, are known to reduce the risk of repeated hospitalizations."[iv]

NTOCC believes this measure is an important step forward in promoting quality transitions by ensuring that this particular vulnerable patient population receives a follow-up visit. However, NTOCC would like to highlight that a follow-up visit does not necessarily result in improved outcomes; rather, it is also important to focus on what happens during the post-discharge visit. For example, experts working with the California Health Care Foundation have created a new "Physician Checklist" for providers to use during the post-hospital follow-up visit.[v] This tool can be used by physicians, including mental health practitioners, who are under strict time constraints, as a guide to conduct substantive visits in an efficient manner and ensure effective communication. In future rulemakings, NTOCC urges CMS to consider expanding this measure to include those components of a follow-up visit that have proven successful in both improving outcomes and reducing readmissions.

In addition, while there are varying approaches to collecting data on follow-up care within the 7 and 30 day timeframe to calculate the measure, NTOCC suggests that CMS declare a specific standard of collection so that all entities can record data in a uniform fashion in order to compare outcomes appropriately.

NTOCC appreciates the Agency's attention to these important issues and shares your commitment to improving outcomes for patients as they transition through our health care system. Please consider us as a resource on any of the topics discussed above and thank you for the opportunity to provide these comments. Should you have any questions or need further clarification please contact Jackie Stewart at jstewart@vennstrategies.com.

Sincerely,

Cheri Lattimer
Executive Director

[i] Parekh, Anand, MD. Deputy Assistant Secretary for Health at HHS Blog. "Help for People with Multiple Chronic Conditions." September, 2012. http://www.healthcare.gov/blog/2012/09/hfpwmcc090712.html

[ii] Teno JM, Gozalo PL, Bynum JW, et al. Change in End-of-Life Care for Medicare Beneficiaries: Site of Death, Place of Care, and Health Care Transitions in 2000, 2005, and 2009. JAMA. 2013;309(5):470-477. http://jama.jamanetwork.com/article.aspx?articleid=1568250

[iii] American Hospital association. January 2012. Trend Watch. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CC8QFjAA&url=http%3A%2F%2Fwww.aha.org%2Fresearch%2Freports%2Ftw%2F12jan-tw-behavhealth.pdf&ei=GmS_UYudB-ji4AO3joGwAQ&usg=AFQjCNGm1aGy2-3M_oTvb0N7I66Jz2jEUw&sig2=hLs-kD-ngDbNbh8p72_fhg&bvm=bv.47883778,d.dmg

[iv] CMS Proposed FY2014 Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital Prospective Payment System (LTCH PPS). Proposed Rule, Fed, Reg. Vol 98, No. 91. (CMS–1599–P). http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Proposed-Rule-Home-Page-Items/FY-2014-IPPS-Proposed-Rule-CMS-1599-P-Regulations.html

[v] Coleman, E. "The Post-Hospital Follow-Up Visit: A Physician Checklist to Reduce Readmissions." . California Healthcare Foundation, October, 2010. Web. http://www.chcf.org/publications/2010/10/the-post-hospital-follow-up-visit-a-physician-checklist