September 4, 2012

Acting Administrator Marilyn Tavenner
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1590-P
P.O. Box 8011,
Baltimore, MD 21244–1850

Re: CMS–1590–P CMS Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule; payments for Part B drugs; and other Medicare Part B payment policies

Dear Ms. Tavenner,

We thank you for the opportunity to comment on CMS' Proposed Physician Fee Schedule Rule (CMS-1590-P) for calendar year 2013.

The National Transitions of Care Coalition (NTOCC) believes that the improvement of transitions, or hand-offs, between care settings is integral to meeting CMS' "three part aim" of better care, better health, and lower costs. NTOCC strongly supports provisions in the proposed 2013 Medicare Physician Fee Schedule that incentivize care coordination, specifically the proposal to explicitly pay for post-discharge transitional care management services for beneficiaries. NTOCC agrees that "successful efforts to improve hospital discharge care management and care transitions could improve quality of care while simultaneously decreasing costs."[i]

As you are well aware, patients—particularly the elderly and individuals with chronic or serious illnesses—face significant challenges when moving from one care setting to another within our fragmented health care system. Poor communication during these transitions can lead to confusion about the patient's condition and appropriate care, duplicative tests, inconsistent patient monitoring, medication errors, delays in diagnosis and lack of follow through on referrals. These failures create serious patient safety, quality of care, and health outcome concerns.

NTOCC agrees that primary care physicians play a vital role in the ongoing management of patients' post-hospital discharge care, especially for more vulnerable populations with chronic conditions who are at high risk for readmission. NTOCC strongly supports the proposal to create a HCPCS G-code that specifically describes post-discharge transitional care management services furnished by community physician or qualified non-physician practitioner. This will ensure that services that are already being provided by health care providers are appropriately captured and compensated, as well as encourage providers to offer transitional services that have been proven to improve health outcomes and beneficiary experience of care and reduce health care expenditures.

The proposed rule is an important step forward toward improving the coordination of care during times of transition, and NTOCC offers the following comments to enhance the proposed rule.

Post-Discharge Transitional Care Management

NTOCC supports the defined post-discharge services outlined in the proposed rule as they align with NTOCC's "Seven Essential Intervention Categories" that are found in many evidence-based care interventions such as: the Care Transitions Intervention; Transitional Care Model; Guided Care Model; Project Re-Engineered Discharge; Home Based Primary Care Model; Geriatric Resources for Assessment and Care of Elders; Rush University Medical Center's Enhanced Discharge Planning Program; and Better Outcomes for Older Adults through Safe Transitions- all of which have demonstrated improvements in both health outcomes and reduction in costs to the health care system.

In particular, NTOCC strongly supports CMS' provisions to include in the post-discharge services "an assessment of the patient's health status…and psychosocial needs following discharge", and subsequently "addressing the patient's medical and psychosocial issues, and medication reconciliation and management."[ii] People with multiple chronic medical and mental health conditions are among the highest-risk patients most prone to harm from inadequate transitions. NTOCC encourages CMS to continue to work towards incentivizing a more integrated care system which will ensure that primary care providers can coordinate appropriate follow-up care with behavioral health professionals and collaborate with these providers in executing the care plan. NTOCC applauds CMS for the inclusion of these services, and encourages the agency to include them in the final rule.

As CMS considers additional requirements under the proposed rule, NTOCC urges the agency to ensure they are not overly burdensome or create a disincentive to bill under the post-discharge transitional care service code. Approximately, 78 percent of primary care practices in the United States have five or fewer physicians supported by medical assistant and receptionists.[iii] With these small practices in mind, NTOCC reminds the Agency that reimbursement is not the only barrier that may discourage providers to offer and bill for these services. As indicated in the proposed rule, CMS has modeled the proposal in part on the way CMS "currently pays physicians for the non face-to face care plan oversight services furnished for patients under care of home health agencies or hospices."[iv] However, several studies indicate few primary care physicians in these small practices bill for the home health oversight codes that offer greater reimbursement for communicating with home health professionals primarily due to the perceived burden of documentation.[v,vi] Billing and paperwork requirements can be challenging for small practices and can also raise new liability concerns. Furthermore, the demands on primary care physicians are likely to significantly increase as the Affordable Care Act is implemented, as more individuals will seek preventative care due to requirements that insurance companies must cover these services and almost 30 million individuals will become newly insured. Therefore, NTOCC encourages CMS to seek a balance between additional requirements on providers and what is necessary to encourage broader use of best practices and strategies for follow-up care after discharge.

To date, there has been a significant amount of attention on the timing for the face-to-face encounter following a hospital discharge. While NTOCC does not have a position on the appropriate time frame for a follow-up visit, we would like to highlight that some experts have indicated that a greater emphasis should be placed on the content of 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.[vii] This tool can be used by physicians, who are under strict time constraints, as a guide to conduct substantive visits in an efficient manner and ensure effective communication.

In addition, NTOCC supports CMS' collaboration with the American Medical Association Chronic Care Coordination Workgroup (C3W), in which the RVS Update Committee (RUC) recently updated the telephone services codes for both physicians and qualified non-physician health care professionals (CPT Codes 99441-99443 and 98966-98969) and recommended these codes, which represent a wide range of essential transitional care communication assessment and management services, receive full reimbursement as a covered service under Medicare. Many of NTOCC's member organizations submitted comments in support of full reimbursement for these codes when they were first proposed in 2007. NTOCC encourages CMS to continue to work with AMA on refining these codes and to implement them.

Qualified Non-physician Practitioner

As referenced previously, engagement of the community and primary care physicians following discharge from a hospital, skilled nursing facility (SNF), or community mental health center (CMHC) is integral to ensuring the beneficiary receives the appropriate follow-up care. Given the current challenges facing primary care physicians, we feel that it is important that the final rule ensures that qualified care transition professionals, including case managers, nurses, pharmacists and social workers, are eligible to provide the transitional care services.

NTOCC believes that the post-discharge process should be a collaborative one that engages the beneficiary, family caregivers, and the entire care team. Case managers, nurses, pharmacists, social workers and other medical providers play an integral role assisting with patient communication and information transfers. Furthermore, they can aid patients by providing support, advocacy, medication adherence assessment, motivational intervention, resource coordination, enhanced patient self-management, and care planning. Given the limited size of primary care practices across the United States, NTOCC believes it is important that a broad range of qualified health professionals be eligible to perform the transitional care services defined in the proposed rule. While we understand the statutory limitations that CMS has in terms of expanding billing codes under this proposed rule to other licensed health practitioners, NTOCC believes that in order to effectively address the care transition challenges in the health care system CMS must seek to establish a payment system that promotes and supports team-based care.

Hospital and SNF Discharge Services

NTOCC agrees that the activities described in the current hospital discharge codes (CPT codes 99238 and 99239), and nursing facility discharge services (CPT codes 99315 and 99316) capture many of the services that are critical to achieving successful transitions and avoid hospital readmissions. However, it is clear that gaps in care exist given that almost 20 percent of Medicare patients must be readmitted within 30 days of their original release and those readmissions cost Medicare more than $17 billion a year.[viii] Few patients have the tools to effectively navigate the healthcare system after discharge from a hospital and studies have shown

that direct communication between hospitals and primary care physicians occurs only 20 percent of the time.[ix] In fact, the Medicare Payment Advisory Commission (MedPAC) concluded in its 2009 Report to Congress that a large proportion of re-hospitalizations could be prevented by improving the discharge planning process and coordinating care after discharge.[x] Transitions from the emergency room, of which a large percentage result in discharges from the hospital, are a particularly vulnerable time for patients. NTOCC believes that CMS must also ensure that emergency medicine medical providers, such as physicians, have the resources to engage in planning and coordination with primary care offices to ensure a safe and effective transition for these patients. Finally, nearly one in five Americans lack adequate access to a primary care or community physician, which creates significant challenges to relying solely on primary care physicians for ensuring appropriate follow-up care.[xi] According to the American Association of Medical Colleges, this will continue to be a problem in the future as projections indicate a shortage of 45,000 primary care physicians by 2020.[xii]

Given these gaps in care, the proposed rule solicits comment on the "best ways to ensure that all activities of the discharge day management codes for hospital and nursing facility discharge, including the care coordination activities, are understood and furnished by the physicians or qualified non-physician practitioners who bill for these services." To that end, NTOCC has created a number of tools to help providers improve care transitions. For example, NTOCC's guidebook *Improving on Transitions of Care: How to Implement and Evaluate a Plan* was created to provide institutions and their staff with basic concepts of care evaluation and implement processes to improve discharge activities. NTOCC has also created free web-based transitions of care evaluation software for institutions to track their quality improvement efforts. These and other tools for providers and consumers can be found at www.ntocc.org.

Finally, MedPAC identified in its June 2012 Report to Congress the delays in systematic delivery changes and lack of financial incentives to coordinate care, and specifically highlighted that "given the evidence on transitional care to date, an established payment could be made to a care manager who would work with the beneficiaries during their hospitalization and as they move to the community or other setting."[xiii] While not in the purview of this proposed rule, NTOCC believes that a transitional care payment, such as the one detailed by MedPAC, would address the current communication and transition failures in our health care system and go a long way towards improving patient outcomes and reducing unnecessary health related expenses.

We appreciate this opportunity to submit comments. Please feel free to contact Lindsay Punzenberger, NTOCC's Policy Director, at 202-466-4721 or lpunzenberger@vennstrategies.com.

Sincerely,

Cheri Lattimer
Executive Director

[i] Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face to Face Encounters; Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Quality Improvement Organization Regulations; Proposed Rules, Fed. Reg, Vol. 77, No. 146. (July 30, 2012). Web. www.gpo.gov/fdsys/pkg/FR-2012-07-30/pdf/2012-16814.pdf

[ii] Physician Fee Schedule Proposed Rule (July 30, 2012), ibid.

[iii] Bodenheimer, T., H. Pham. "Primary Care: Current Problems and Proposed Solutions." Health Affairs (Millwood) 2010; 29(5): 799-805.

[iv] Physician Fee Schedule Proposed Rule (July 30, 2012), ibid.

[v] Department of Health and Human Services Office of the Inspector General, Report: The Physician's Role in Medicare Home Health. Dec 2001. Web. http://oig.hhs.gov/oei/reports/oei-02-00-00620.pdf

[vi] Bay State Visiting Nurse Association & Hospice, "Many Physicians Not Billing for Work They Are Already Doing". Springfield, MA. Web. http://baystatehealth.com/StaticFiles/Baystate/Services/Baystate%20VNAH/01%202010%20Physician%20Reimbursement.pdf

vi 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

[viii] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates, Proposed Rule, Fed. Reg, Vol. 77, No. 92. 28110-28039 (May 11, 2012). Web. http://www.gpo.gov/fdsys/pkg/FR-2012-05-11/html/2012-9985.htm

[ix] Erickson, S. "The Patient Centered Medical Home (PCMH): Overview of the Model and Movement Part II," American College of Physicians, July 2010.

[x] Medicare Payment Advisory Commission. Report to Congress: Improving Incentives in the Medicare Program. June 2009. Web. http://www.medpac.gov/documents/jun09_entirereport.pdf

[xi] Cullen, Esme, and Usha Ranji. "Background Brief: Primary Care Shortage."KaiserEDU.org, April, 2011. Web. 16 Aug 2012. Web. http://www.kaiseredu.org/Issue-Modules/Primary-Care-Shortage/Background-Brief.aspx

[xii] Center for Workforce Studies, Association of American Medical Colleges American."Recent Studies and Reports on Physician Shortages in the US". August, 2011. Web. https://www.aamc.org/download/100598/data/recentworkforcestudiesnov09.pdf/

[xiii] Medicare Payment Advisory Commission. Report to Congress: Medicare and the Health Care Delivery System. June 2012. Web. http://www.medpac.gov/documents/Jun12_EntireReport.pdf