August 15, 2013

The Honorable Max Baucus
Chairman
Senate Finance Committee
Washington, D.C. 20510

The Honorable Dave Camp
Chairman
House Ways and Means Committee
Washington, D.C. 20515

The Honorable Orrin Hatch
Ranking Member
Senate Finance Committee
Washington, D.C. 20510

The Honorable Sander Levin
Ranking Member
House Ways and Means Committee
Washington, D.C. 20515

Dear Chairman Baucus, Ranking Member Hatch, Chairman Camp, and Ranking Member Levin:

We thank you for the opportunity to provide input on the Medicare post-acute care (PAC) policy reforms that are being considered by your Committees. The National Transitions of Care Coalition (NTOCC) shares your commitment to ensuring that Medicare beneficiaries receive the right PAC, in the right setting, at the right time and believes that as policymakers and health care providers strive to improve health care quality and patient safety, that there should be a focus on care transitions, especially for those beneficiaries transitioning from the hospital to post-acute care.

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.

NTOCC was particularly encouraged to learn that one of your stated goals is to focus on "improving patient quality of care and improving care transitions." As you are 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 transitions from one care setting to another 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 breakdowns create serious patient safety, quality of care, and health outcome concerns.

The problems resulting from poor transitions also lead to significant financial burdens for patients, payers, and taxpayers. For instance, unnecessary hospital readmissions are often a result of errors and poor communication made in transitioning patients. Nearly one in five Medicare patients discharged from a hospital—approximately 2.6 million seniors—is

readmitted within 30 days, at a cost of over $26 billion every year, with an estimated $12 billion spent on preventable readmissions.[i] 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.[ii] In fact, several evidence-based models focused on improving care coordination have reduced 30-day readmission rates by 20-40 percent.[iii] Recently in January, the Journal of the American Medical Association (JAMA) published numerous studies and articles around the theme of hospital readmissions and care coordination, and several of those studies suggest that systems focused specifically on transitions of care can improve hospital readmissions dramatically.[iv]

Payment Reforms

NTOCC strongly supports several of the current Centers for Medicare & Medicaid Services (CMS) demonstration programs and other payment proposals that are focused on addressing gaps in transitions, particularly for patient populations that are at high risk for a poor transition. We believe that these programs could provide the Committees with valuable insight into effective programs for managing care transitions.

This includes the Community Based Care Transitions Program (CCTP) (created by Section 3026 of the Affordable Care Act), which provides funding to test models for improving care transitions for high risk Medicare patients by using services to more effectively manage patients' transitions. With 102 sites participating in the demonstration across the country, the program will provide care transition services to nearly 700,000 Medicare beneficiaries in 40 states over the next 5 years. NTOCC is hopeful that the data from the CCTP will demonstrate the impact that effective transitions can have on patient outcomes and costs, and we believe that it could be instructive for the Committees as they considers policies to reform the PAC system.

Unfortunately, in March 2013, the Senate Continuing Resolution stripped $200 million from the $500 million that had been appropriated for the duration of the CCTP. NTOCC strongly opposed this cut, and we urge policymakers going forward to protect funding for the CCTP, which is an incubator for innovative ideas in care transitions that can drive cost-effective improvements in how clinicians provide care. Other delivery reforms, such as the Medicare Shared Savings Program, have prioritized key activities, including team-based care, shared decision making, and development of a care plan, all of which are essential to effective care transitions. Both the CCTP and the Medicare Shared Savings Program incentivize a team of clinicians to provide the highest quality care while striving to eliminate unnecessary costs through the possibility of sharing in any Medicare savings that result from the successful efforts of the program. Integral to that success is improved care transitions from acute care to PAC.

In conjunction with these payment reform demonstrations, CMS has issued several payment proposals to encourage better care transitions within the fee-for-service system. In the Final Physician Fee Schedule Rule for Calendar Year 2013, CMS finalized a new payment for primary care physicians to furnish non-face-to-face "Transitional Care Management" (TCM) services to help a patient transition back to the community following a discharge from a hospital or nursing facility. NTOCC strongly supported the addition of these codes as 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.

In addition, in the Proposed Physician Fee Physician Schedule Rule for Calendar Year 2014, CMS further complemented the TCM codes by proposing to pay physicians a new fee, beginning in 2015, for managing Medicare patients with two or more chronic conditions apart from face-to-face office visits. Under the CMS proposal, payments would be made for the development and revision of care plans, and could include monitoring of patients' medical and functional needs, subject to the patient having an annual, in-person wellness visit. NTOCC strongly supports this proposal, given that many providers in the physician community state that the care management included in the Evaluation and Management (E/M) service codes for many complex chronic care patients is not adequate to capture the typical non-face-to-face care management work that is involved in caring for these beneficiaries.

NTOCC supports the many provisions in the Affordable Care Act (ACA) that are aimed at promoting care coordination and effective transitions, but believes that more can be done, and we encourage both the House Ways & Means and the Senate Finance Committees to consider more fundamental payment changes that target care transitions. One option would be MedPAC's recommendation from its June 2012 Report to Congress which 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."[v]

With that in mind, last year, Congressmen Earl Blumenauer (D-OR) and Thomas Petri (R-WI) introduced the Medicare Transitional Care Act (H.R. 6413), which would provide Medicare beneficiaries that are at highest risk for hospital readmissions access to evidence-based transitional care services provided by an eligible transitional care entity, such as a hospital or skilled nursing facility. Payment for these services would be linked to performance metrics to ensure that interventions result in improved outcomes, which will ultimately lead to reductions in Medicare spending. NTOCC strongly supports this bill.

The transitional services defined in the bill align with NTOCC's "Seven Essential Intervention Categories" which highlight the essential care transition interventions identified from a cross-walk of the various well-respected models of care, such as the Care Transitions Intervention, Transitional Care Model, Guided Care Model, Project Re-Engineered Discharge and Better Outcomes for Older Adults through Safe Transitions, and Rush University Medical Center's Enhanced Discharge Planning Program, all of which have demonstrated improvements in both health outcomes and reduction in costs to the health care system. The legislation would foster the use of these and other evidence-based transitions of care models.

We encourage the Committees to consider similar care transitions-focused proposals going forward which will build on the progress made in the ACA, address the current gaps in care coordination, improve patient outcomes, and reduce unnecessary health related expenses for both beneficiaries and Medicare.

Quality Measures

NTOCC strongly supports the integrated care and team-based care models that many of the CMS demonstration programs are testing. Furthermore, in order to promote shared accountability throughout the transition and among the care team, NTOCC strongly recommends implementing process measures that are aligned between both the provider (or facility) sending the patient and the provider (or facility) receiving the patient to ensure that key information received has been acted upon.

Additionally, NTOCC is encouraged by the focus on quality measures in payment programs which reward activities that seek to address some of the challenges that occur during transitions, such as the communication of clear and accurate information between providers, patients, and family caregivers.

For example, last year, CMS issued the Hospital Inpatient Quality Reporting Program final rule, which incorporated the "3-Item Care Transitions Measure" (CTM-3) into the existing Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. CTM-3, which was developed by an NTOCC Advisors Council member, identifies the key care indicators that are critical to improving transitions and reducing avoidable hospital readmissions: patients who understand self-care in the post hospital setting, medication management, and having patient's preferences incorporated into the care plan.[vi] This measure will help hospitals and providers assess whether they are adequately preparing patients to leave the hospital and identify areas for improvement. Most importantly, it requires hospitals to adopt a patient-centered approach to transitional care. NTOCC strongly supports the inclusion of this measure for patients in the hospital, and encourages policymakers to promulgate the measure in other care settings.

NTOCC believes that quality measures play a very important role in delivery reform. However, it is important that CMS work with pertinent stakeholders to ensure that there is a coordinated effort to reduce any financial or administrative burden that any new quality measures or requirements would pose on healthcare providers. The demands on primary care physicians and hospitals are likely to significantly increase as the ACA is implemented and almost 30 million individuals will become newly insured. Therefore, NTOCC encourages CMS to seek a balance between additional quality requirements on providers and what is necessary to encourage broader use of best practices and strategies for effective care transitions.

Barriers to Post-Acute Care

In the Ways & Means Committee Hearing on the Medicare Post-Acute Care System held in June, 2013, NTOCC appreciated Congressman Jim McDermott's (D-WA) attention to a very important issue regarding beneficiary access to the Medicare Skilled Nursing Facility (SNF) benefit. As you may know, 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 are disqualified from accessing the SNF benefit and face greater financial liability when transitioning to skilled nursing care. 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 which can increase the risk for a readmission and negatively impact patient outcomes. NTOCC is concerned that this trend will continue as the current readmission penalties may continue to incentivize outpatient classification over inpatient status.

Recently, Congressmen Joe Courtney (D-CT) and Tom Latham (R-IA), and Senator Sherrod Brown (D-OH) introduced The Improving Access to Medicare Coverage Act of 2013 (H.R. 1179 and S. 569), which would ensure that time spent in observation status be counted towards meeting the three-day prior inpatient stay threshold to qualify for Medicare SNF coverage. We encourage the Committee Chairmen to consider this important bill in your deliberations, which would improve transitions for those beneficiaries that need SNF follow-up care and remove financial burdens to these services for seniors and family caregivers who can least afford it.

NTOCC shares the Committees' goals of "improving patient quality of care and improving care transitions, while rationalizing payment systems and improving program efficiency" and is encouraged by the deliberative and inclusive approach being taken on this important topic. NTOCC appreciates the opportunity to submit these comments and looks forward to working with both Committees to improve patient outcomes and strengthen our health care delivery system.

Sincerely,

Cheri Lattimer
Executive Director

[i] The Community Based Care Transitions Program: The Centers for Medicare & Medicaid Innovation. Web. Centerhttp://innovation.cms.gov/initiatives/CCTP/

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

[iii] 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

[iv] Journal of the American Medical Association. Vol. 309.4 (2013): Print. http://jama.jamanetwork.com/issue.aspx?journalid=67&issueid=926266&direction=P

[v] 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

[vi] Coleman, Eric, MD, MPH. "3 item Care Transitions Measure- FAQ." The Care Transitions Program. The Care Transitions Program, 12 June 2012. Web. 13 Jun 2012. http://www.caretransitions.org/documents/CTM_FAQs.pdf