A Special Opportunity for your Comments to Make a Difference

Encourage CMS Work on Hospital Discharge and Care Coordination!

Opportunity: The Center for Medicare and Medicaid Services recently issued proposed changes to the Medicare Physician Fee Schedule ("physicians" here includes all practitioners paid by Medicare - MDs, NPs, SWs, etc). The proposed rule provides a unique opportunity to encourage CMS to work toward coordinated care for Medicare beneficiaries. CMS is seeking comments on whether physician activities should seek to ensure effective care coordination surrounding a hospital discharge, including whether hospital discharge care coordination services are appropriately valued. Getting comments to encourage CMS to undertake regulatory and developmental work on continuity and standards would greatly help very sick people who must move around in the health care system.

Background: On July 1, 2011, the Centers for Medicare and Medicaid Services issued proposed changes to the Medicare Physician Fee Schedule and will publish a final rule by November 1, 2011, effective for physicians and nonphysician services furnished during calendar year (CY) 2012. Along with the annual process to set billing rules, which is not our concern here, CMS asked for comments on the following concepts associated with hospital discharge of Medicare beneficiaries:

1) Key physician activities associated with effective care coordination between the treating physician in the hospital and the beneficiary's primary physician in the community;
2) The extent to which the existing clinical vignettes for the hospital discharge and office visit codes appropriately incorporate hospital discharge care coordination activities;
3) Whether the relative values assigned to these services under the physician fee schedule appropriately reflect the resources involved in performing hospital discharge care coordination;
4) Ways to ensure recognition of physician time and complexity of physician work as well as the associated practice expenses; and
5) Any other suggested changes to improve care coordination -- with an emphasis on the beneficiary's transition from the hospital to the community.

Our current "system" often fails to meet the needs of frail elders and their caregivers because hospital discharge is often rushed and responsibility is fragmented, with little communication among settings and providers. CMS is not proposing any changes at this time, but if the comments are compelling, changes will be proposed through future notice and rulemaking. CMS could also issue contracts to develop measures and test innovations.

Key Concepts for Consideration:

1. *Developing or modifying a comprehensive care plan at the time of hospital discharge has become more complicated than it was when the payment vignettes were set out.* Specifically:
    a. The "Intra Service" should now include these added elements: i) educating the next care team about complicated regimens; ii) meshing the discharge care plan with what was in place before hospitalization; iii) negotiating the new plan of care – including at least, frank discussion of likely course of illness, examination of services available, assessment of available caregivers, and incorporation of personal and family preferences and values; iv) documenting the new plan of care well; v) training patient and caregivers in essential skills; and vi) assuring appropriate follow-up (by patient, family, physicians, next care team, and social services)

   b. The "Pre-Service" component now needs to call upon physicians to participate in area-wide standard setting as to the processes of transition to the next setting of care, including meeting standards for transition of responsibility and for information transfer.
2. *A key missing element is feedback from the receiving provider to the discharging provider*.
   a. The physician who assumes responsibility for the patient, if it is not the same physician as in the hospital, should have an increase in RVU (payment) for the first visit, which requires understanding, implementing, and perhaps modifying the plan of care; establishing a plan for monitoring progress and responding to adverse situations; educating patient and caregivers; and responding to changes since discharge.
   b. The physician who assumes responsibility for the patient, if it is not the same physician as in the hospital, should have an incentive to report the adequacy of the transition, providing a feedback loop to the hospital physician. We should learn how to measure discharge process quality and improve it. Reports of substantial inadequacies could eventually be linked to a reduction in the payment for the discharge day for the hospital physician or used in Hospital Compare as a monitor of the overall quality of the hospital's discharge process.
3. *Medicare beneficiaries usually need a primary care practitioner visit quickly after discharge.*
   a. The first post-hospital visit should have the payment increase mentioned above only if it occurs within two weeks (a limit which could be refined with data). Recognizing the added value of timely follow-up is a critical addition to the hospital discharge process.
   b. The adequacy and implementation of the plan for follow-up should be evaluated as part of the survey and certification process in hospitals.
4. *Medicare beneficiaries with complex care needs must have a negotiated, comprehensive, appropriate plan of care that is realistic, understood, implemented, and documented.* Therefore:
   a. CMS should learn how to evaluate the quality and continuity of the plan of care as part of value-based purchasing and survey & certification.
   b. A uniform assessment tool needs to be part of all required reporting (MDS, OASIS, etc) and uniform elements must be part of certified electronic records, in order to develop ways to measure care plan quality and continuity as very sick people move in the care system.

Again – the important thing is to encourage CMS to get into this field and work on continuity and care planning, at least for high-risk beneficiaries. Please write your own comment or be in touch if you want to recycle and modify ours. Eldercare@altarum.org We will also post a blog at www.medicaring.org

Comments Due: The public access link for the rule is at:

http://www.regulations.gov/#!documentDetail;D=CMS-2011-0131-0002

Section K. "Hospital Discharge Care Coordination" begins on page 510. Comments are due by August 30, 2011 and should be sent via the Federal eRulemaking Portal at http://www.regulations.gov (refer to file code CMS-1524-P); or by mail to CMS, Department of Health and Human Services, Attention: CMS-1524-P, P.O. Box 8013, Baltimore, MD 21244-8013. CMS will respond to all comments in a final rule scheduled to be issued by Nov. 1, 2011.