

**National Coalition on Care Coordination (N3C) Response:  
“Transforming the Health Care Delivery System: Proposals to Improve Patient  
Care and Reduce Health Care Costs”**

*The undersigned members of the National Coalition on Care Coordination (N3C) submit the following comments.*

Chairman Baucus, Ranking Member Grassley, and Members of the Committee:

We would like to commend you for your work to make comprehensive health care reform a reality and for your support for initiatives that realize improved quality and savings through care coordination.

The New York Academy of Medicine and the American Society on Aging formed the National Coalition on Care Coordination (N3C) in March 2008. N3C is a national, non-profit membership coalition of consumer, aging, social service, health care, family caregiver, and professional organizations dedicated to improving the quality of care for individuals of all ages through support for care coordination. N3C’s primary goals are to promote better coordination of health and social services for older adults with multiple chronic conditions, to deepen the knowledge of care coordination models in the health and social sectors, to analyze delivery and financing options, and to advocate for evidence-based policy recommendations on how care coordination can help transform our health care system. N3C believes that care coordination should be an essential part of health care reform to improve the quality of life for America’s aging population and their caregivers, while more efficiently using health care and social support resources.

N3C defines care coordination as a *client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which a care coordinator manages and monitors an individual’s needs, goals, and preferences based on a comprehensive care plan.*

In March 2009, the N3C released “The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illness”, authored by Randall Brown, Ph.D., of Mathematica Policy Research. Dr. Brown synthesized the evidence on cost-effective care coordination interventions and their essential components and presented recommendations for care coordination policies in health care reform that can be supported by the currently available evidence base. The paper draws heavily on Chad Boulton’s (2008) recent comprehensive survey of the literature, supplemented with findings from several recent Medicare demonstration evaluations, especially findings from the Medicare Coordinated Care Demonstration (Peikes et al. 2009).

**Primary Care**

**Payment for Transitional Care Activities**

Based on our research review noted above, the N3C enthusiastically supports your focus on providing payment for transitional care activities. Transitional care interventions in which patients are first engaged while in the hospital and then followed intensively over the 4-6 weeks after discharge to ensure they understand how to adhere to post-discharge instructions for medication and self-care management, recognize symptoms that signify potential complications requiring immediate attention, and make and keep follow-up appointments with their primary care physicians are one of three types of care

coordination interventions which have conclusively demonstrated effectiveness in reducing hospitalizations for Medicare beneficiaries with multiple chronic conditions.

We support your plan to allow care coordination to take place both within a physician practice as well as through a community care manager in communication with the physician. *N3C believes, however, it is important to expand the range of professionals with whom the physician may contract and who may be recognized for payment purposes with respect to transitional care services, including discharge planning.* As written, the proposal focuses only on reimbursement for physicians. Moreover, it does not recognize the role of social workers and others who are essential to transitional care. *N3C believes that care coordination must be interdisciplinary in order to meet the complex needs of patients with the major chronic diseases you specify.* Other professionals, in addition to physicians, should receive reimbursement for their services in this regard if ordered by a physician. Many of these professionals can greatly augment the knowledge of community-based resources that will benefit the patient and prevent rehospitalization. Further we urge you to ensure that legislative language recognizes the need to include family caregivers as potential recipients of appropriate qualified services, such as support of patient self-management. This is essential to improving care and reducing costs for high risk patients, particularly those with cognitive or other functional limitations.

Effective discharge planning and its implementation are central to ensuring follow-up across all care settings. Medicare's existing hospital discharge planning law (42 U.S.C. §1395x (ee)) and related Medicare Conditions of Participation (42 C.F.R. §482.43) should be given appropriate attention and importance by hospital administrators, clinicians, and patient services personnel.

We believe that the care management activities performed should be comprehensive and should be initiated as soon as possible after discharge. Any payments for transitional care activities should be linked to reporting and performance on patient-centered measures of quality and patients' experience of care.

Because care coordination would benefit other Medicare beneficiaries with multiple chronic conditions, the N3C supports expanding payment for transitional care activities to other beneficiaries with multiple chronic conditions. Expanding services to this high-risk group will maximize cost-savings by enabling them to live more independently and avoid further disability and future hospitalizations.

## **Chronic Care Management**

### **CMS Chronic Care Management Innovation Center**

N3C supports your proposal to establish the CMS Chronic Care Management Innovation Center to test care coordination models. We believe the focus of the CMIC should be improvements in access and quality of care for the highest risk, most vulnerable beneficiaries, particularly those with multiple chronic conditions. While much has been learned about which interventions are effective, much remains to be learned. In combination with implementing those elements of care coordination for which there is solid evidence noted above, a streamlined process for continuing research is essential.

N3C would encourage you to add beneficiaries with multiple chronic conditions at risk of progressive disability to the list of potential target patient populations appropriate for care management interventions.

In addition to the key patient-centered criteria you have identified, *it is also essential that the criteria include respecting patient needs and preferences in all care coordination activities, particularly care planning and self-management coaching*; therefore we encourage you to include the following additional criteria for models for initial testing:

- Connecting the patient and family caregiver to community-based support services;
- Ensuring that the care team has ready access to patients' up-to-date medical histories at the point of care;
- Planning, managing, and tracking patient care transitions;
- Identifying and accommodating the needs of patients with physical or cognitive limitations, language or cultural differences or other issues that could impede access to care;
- Assessing the capacity and needs of family caregivers;
- Ensuring the availability of care during evening and weekend hours;
- Frequently collecting survey data on patient and caregiver experience of care and using the data to improve care;
- Incorporating patient decision tools into care decision-making;
- Continually assessing and improving quality, health outcomes, and functional status of patients, as well as engaging in relevant public reporting programs;
- Collecting race, ethnicity, primary language and gender data, and using that data to eliminate health disparities.

*We recommend that the proposed CMIC advisory board have strong representation from consumer and family caregiver groups as well as health services experts. As models are developed and tested, it is essential that beneficiaries and their families are included as team members in fashioning programs and services to be tested.*

## **Hospital Readmissions and Bundling**

### **Hospital Readmissions and Post-Acute Bundling Policy**

The N3C also endorses the Committee's proposal to reduce avoidable and preventable hospital readmissions by encouraging greater care coordination among acute hospital and post-acute providers. We agree that one of the factors which contribute to the fragmentation and gaps in our current system is the lack of incentives to coordinate care.

*We believe that the development of patient protection rules to ensure that patients receive appropriate post-acute care and that access to care is maintained, as noted in the proposal, is essential.*

## **Moving from Fee-for-Service to Payment for Accountable Care**

### **Medicare Shared Savings Program (i.e. Accountable Care Organizations)**

The N3C recommends that the criteria for participation in the Medicare Shared Savings Program should include use of an interdisciplinary team with the skills necessary to meet the needs of the patient. The benefits of involvement of other professionals such as social workers and nurses, working closely with

the physician, in coordinating care have been demonstrated through the successful Medicare Coordinated Care Demonstration programs. The successful programs relied on registered nurses to deliver the bulk of their intervention, with each patient assigned to a particular nurse coordinator to create rapport and preserve continuity with both the patient and the primary care physician. For some patients, social workers were also essential members of the interdisciplinary team because of the assistance they provided with assessing eligibility for and arranging services such as home delivered meals, transportation, emergency response systems, advanced care planning, and coordination with home health agencies. *A key component in preventing complications and hospitalization, and thus reducing costs, for patients with multiple chronic conditions is connecting them with long term care services and community supports. Doing this often requires the skills of professionals other than physicians.*

### **Pay for Chronic Care Management**

Incentives should not put plans at an advantage over Traditional Medicare to provide care coordination. The majority of Medicare Advantage plans are already coordinated care plans, and should be providing chronic care coordination. We support the goal of ensuring that all Medicare patients with multiple chronic illnesses have access to appropriate care coordination and management. However, we also want to ensure that since Medicare Advantage plans rates are based on traditional Medicare (whose providers may receive additional payments for care coordination under your proposals), plans are not given additional payments when they have already been reflected in their base payments.

Thank you again for your consideration of these comments and recommendations. Please do not hesitate to call on us as a resource as you continue to tackle the issue of health care reform.

Sincerely,



Patricia Volland, MSW, MBA  
Senior Vice President and Director, Social Work Leadership Institute  
New York Academy of Medicine  
Co-Chair, National Coalition on Care Coordination (N3C)  
1216 Fifth Avenue, New York, NY 10029  
Email: [pvolland@NYAM.org](mailto:pvolland@NYAM.org)  
Tel. (202) 822-7207



Robyn L. Golden, MA, LCSW  
Director of Older Adult Programs  
Rush University Medical Center  
Co-Chair, National Coalition on Care Coordination (N3C)  
710 South Paulina Street, Suite 422  
Chicago, IL 60612-3814

Email: [Robyn L Golden@rush.edu](mailto:Robyn.L.Golden@rush.edu)  
Tel. 312-942-4436

NATIONAL COALITION ON CARE COORDINATION (N3C) ORGANIZATIONS SIGNING ON:

Alzheimer's Association  
American Society on Aging  
Case Management Society of America  
Center for Medicare Advocacy  
Connecticut Community Care  
Gerontological Society of America  
Hudson Health Plan  
Institute for Healthcare Innovation, College of Nursing, University of Illinois at Chicago  
Matz, Blancato and Associates  
National Alliance for Caregiving  
National Council on Aging  
National Transitions of Care Coalition  
New York Academy of Medicine  
Partners in Care Foundation  
Rush University Medical Center  
SeniorBridge Family of Companies