

111TH CONGRESS
1ST SESSION

H. R. 2773

To amend title XVIII of the Social Security Act to cover transitional care services to improve the quality and cost effectiveness of care under the Medicare Program.

IN THE HOUSE OF REPRESENTATIVES

JUNE 9, 2009

Mr. BLUMENAUER (for himself, Mr. BOUSTANY, Mrs. CAPPES, and Mr. MASSA) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to cover transitional care services to improve the quality and cost effectiveness of care under the Medicare Program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medicare Transitional
5 Care Act of 2009”.

6 **SEC. 2. FINDINGS.**

7 Congress finds the following:

1 (1) More than 20 percent of older Americans
2 suffer from five or more chronic conditions and
3 these older adults typically require health care serv-
4 ices from numerous providers across several care
5 settings each year.

6 (2) Insufficient communication among older
7 adults, family caregivers, and health care providers
8 contributes to poor continuity of care, inadequate
9 management of complex health care needs, and pre-
10 ventable hospital admissions.

11 (3) Research suggests that family caregivers
12 often lack the knowledge, skills, and resources to ef-
13 fectively address the complex needs of older adults
14 coping with multiple coexisting conditions.

15 (4) In 2005, health care services for Medicare
16 beneficiaries with five or more chronic conditions ac-
17 counted for 75 percent of total Medicare spending.
18 The vast majority of these costs were due to high
19 rates of hospital admission and readmission.

20 (5) According to Medicare claims data from
21 2003–2004, almost one fifth (19.6 percent) of the
22 11,855,702 Medicare beneficiaries who had been dis-
23 charged from a hospital were rehospitalized within
24 30 days, and 34.0 percent were rehospitalized within
25 90 days.

1 (6) A New England Journal of Medicine study
2 estimates that the cost to Medicare of unplanned re-
3 hospitalizations in 2004 was \$17.4 billion.

4 (7) The MetLife Caregiving Cost Study dem-
5 onstrates that American businesses lose an esti-
6 mated \$34 billion each year due to employees' need
7 to care for loved ones.

8 (8) The Transitional Care Model, developed by
9 the University of Pennsylvania, is a care manage-
10 ment strategy that identifies patients' health goals,
11 coordinates care throughout acute episodes of illness,
12 develops a streamlined plan of care to prevent future
13 hospitalizations, and prepares the beneficiary and
14 family caregivers to implement this care plan.

15 (9) The major goal of the Transitional Care
16 Model is to interrupt cycles of avoidable hospitaliza-
17 tions and promote longer-term positive health out-
18 comes.

19 (10) The Transitional Care Model has shown
20 through multiple randomized clinical trials to
21 produce significant health outcome improvements,
22 reductions in health care costs among at-risk and
23 chronically ill older adults, and increased patient
24 satisfaction.

1 “(2) INITIAL IMPLEMENTATION.—The Sec-
2 retary shall first implement this section for services
3 furnished on or after January 1, 2010.

4 “(3) GENERAL DEFINITIONS.—In this section:

5 “(A) QUALIFIED TRANSITIONAL CARE EN-
6 TITY.—The term ‘qualified transitional care en-
7 tity’ means—

8 “(i) a hospital or a critical care hos-
9 pital;

10 “(ii) a home health agency;

11 “(iii) a primary care practice;

12 “(iv) a federally qualified health cen-
13 ter; or

14 “(v) another entity approved by the
15 Secretary for purposes of this section.

16 “(B) TRANSITIONAL CARE PERIOD.—The
17 term ‘transitional care period’ means, with re-
18 spect to a qualified individual, the period—

19 “(i) beginning on the date the indi-
20 vidual is admitted to a subsection (d) hos-
21 pital (as defined for purposes of section
22 1886) for inpatient hospital services, or is
23 admitted to a critical care hospital for in-
24 patient critical access hospital services, for

1 which payment may be made under this
2 title; and

3 “(ii) ending on the last day of the 90-
4 day period beginning on the date of the in-
5 dividual’s discharge from such hospital or
6 critical care hospital.

7 “(b) QUALIFIED INDIVIDUALS.—

8 “(1) LIMITING FIRST PHASE OF IMPLEMENTA-
9 TION TO HIGH-RISK INDIVIDUALS.—Except as pro-
10 vided in this subsection, qualified individuals are
11 limited to individuals who—

12 “(A) have been admitted to a subsection
13 (d) hospital (as defined for purposes of section
14 1886) for inpatient hospital services or to a
15 critical care hospital for inpatient critical access
16 hospital services; and

17 “(B) are identified by the Secretary as
18 being at highest risk for readmission or for a
19 poor transition from such a hospital to a post-
20 hospital site of care.

21 The identification under subparagraph (B) shall be
22 based on achieving a minimum hierarchical condition
23 category score (specified by the Secretary) in order
24 to target eligibility for benefits under this section to
25 individuals with multiple chronic conditions and

1 other risk factors, such as cognitive impairment, de-
2 pression, or a history of multiple hospitalizations.

3 “(2) SECOND PHASE OF IMPLEMENTATION.—

4 After submitting to Congress the evaluation under
5 subsection (i)(2) and considering any cost-savings
6 and quality improvements from the prior implemen-
7 tation of this section, the Secretary may expand eli-
8 gibility of qualified individuals to include moderate-
9 risk and lower-risk individuals, as determined in ac-
10 cordance with eligibility criteria specified by the Sec-
11 retary. In expanding eligibility, the Secretary may
12 modify or scale transitional care services to meet the
13 specific needs of moderate- and lower-risk individ-
14 uals.

15 “(3) AVOIDING DUPLICATION OF SERVICES.—

16 The Secretary shall ensure that qualified individuals
17 receiving transitional care services are not receiving
18 duplicative services under this title.

19 “(c) TRANSITIONAL CARE SERVICES DEFINED.—In

20 this section, the term ‘transitional care services’ means
21 services that support a qualified individual during the
22 transitional care period and includes the following:

23 “(1) A comprehensive assessment prior to dis-
24 charge including an assessment of the individual’s
25 physical and mental condition, cognitive and func-

1 tional capacities, medication regimen and adherence,
2 social and environmental needs, and primary care-
3 giver needs and resources.

4 “(2) Development of a comprehensive, evi-
5 denced-based plan of transitional care for the indi-
6 vidual developed with the individual and the individ-
7 ual’s primary caregiver and other health team mem-
8 bers, identifying potential health risks, treatment
9 goals, current therapies, and future services for both
10 the individual and any primary caregiver.

11 “(3) A visit at the care setting within 24 hours
12 after discharge from the hospital or critical access
13 hospital.

14 “(4) Home visits to implement the plan of care.

15 “(5) Implementation of the plan of care, includ-
16 ing—

17 “(A) addressing symptoms;

18 “(B) teaching and promoting self-manage-
19 ment skills for the individual and any primary
20 caregiver;

21 “(C) teaching and counseling the indi-
22 vidual and the individual’s primary caregiver
23 (as appropriate) to assure adherence to medica-
24 tions and other therapies and avoid adverse
25 events;

1 “(D) promoting individual access to pri-
2 mary care and community-based services;

3 “(E) coordinating services provided by
4 other health team members and community
5 caregivers; and

6 “(F) facilitating transitions to palliative or
7 hospice care, where appropriate.

8 “(6) Accompanying the individual to follow-up
9 physician visits, as appropriate.

10 “(7) Providing information and resources about
11 conditions and care.

12 “(8) Educating and assisting the individual and
13 the individual’s primary caregiver to arrange and co-
14 ordinate clinician visits and health care services.

15 “(9) Informing providers of services and sup-
16 pliers of those items and services that have been or-
17 dered for and received by the individual from other
18 providers.

19 “(10) Working with providers of services and
20 suppliers to assure appropriate referrals to special-
21 ists, tests, and other services.

22 “(11) Educating and assisting the individual
23 and the individual’s primary caregiver with arrang-
24 ing and coordinating community resources and sup-
25 port services (such as medical equipment, meals,

1 homemaker services, assistance with daily activities,
2 shopping, and transportation).

3 “(12) Providing to the qualified individual, pri-
4 mary caregiver, and appropriate clinicians and quali-
5 fied transitional care entity providing ongoing care
6 at the conclusion of the transitional care period a
7 written summary that includes the goals established
8 in the plan of care described in paragraph (2),
9 progress in achieving such goals, and remaining
10 treatment needs.

11 “(13) Other services that the Secretary deter-
12 mines are appropriate.

13 The Secretary shall determine and update the services to
14 be included in transitional care services as appropriate,
15 based on the evidence of their effectiveness in reducing
16 hospital readmissions and improving health outcomes.

17 “(d) TRANSITIONAL CARE CLINICIANS.—

18 “(1) IN GENERAL.—In this section, the term
19 ‘transitional care clinician’ means, with respect to a
20 qualified individual, a nurse or other health profes-
21 sional who—

22 “(A) has received specialized training in
23 the clinical care of people with multiple chronic
24 conditions (including medication management)
25 and communication and coordination with mul-

1 tiple providers of services, suppliers, patients,
2 and their primary caregivers;

3 “(B) is supported by an interdisciplinary
4 team in a manner that assures continuity of
5 care throughout a transitional care period and
6 across care settings (including the residences of
7 qualified individuals);

8 “(C) is employed by (or has a contract
9 with) with a qualified transitional care entity
10 for the furnishing of transitional care services;
11 and

12 “(D) meets such participation criteria as
13 the Secretary may specify consistent with this
14 subsection.

15 “(2) PARTICIPATION CRITERIA.—In establishing
16 participation criteria under paragraph (1)(C), the
17 Secretary shall assure that transitional care clini-
18 cians meet relevant experience and training require-
19 ments and have the ability to meet the individual
20 needs of qualified individuals.

21 “(3) ENCOURAGEMENT OF HIT.—The Secretary
22 may provide for an additional payment to encourage
23 transitional care clinicians and qualified transitional
24 care entities to use health information technology in
25 the provision of transitional care services.

1 “(e) PAYMENT.—

2 “(1) IN GENERAL.—The Secretary shall deter-
3 mine the method of payment for transitional care
4 services under this section, including appropriate
5 risk adjustment that reflects the differences in re-
6 sources needed to provide transitional care services
7 to individuals with differing characteristics and cir-
8 cumstances and, when applicable, the performance
9 measures under subsection (f). The payment amount
10 shall be sufficient to ensure the provision of nec-
11 essary transitional care services throughout the tran-
12 sitional care period. The payment shall be structured
13 in a manner to explicitly recognize transitional care
14 as an episode of services that crosses multiple care
15 settings, providers of services, and suppliers. The
16 payment with respect to transitional care services
17 furnished by a transitional care clinician shall be
18 made, notwithstanding any other provision of this
19 title, to the qualified transitional care entity which
20 employs, or has a contract with, the clinician for the
21 furnishing of such services.

22 “(2) NO COST-SHARING.—Notwithstanding sec-
23 tion 1833, there shall be no deductible or cost-shar-
24 ing applicable to payment under this section for
25 transitional care services.

1 “(f) PERFORMANCE MEASURES.—

2 “(1) ACCOUNTABILITY.—

3 “(A) IN GENERAL.—The Secretary shall
4 establish a method whereby qualified transi-
5 tional care entities responsible for furnishing
6 transitional care services would be held account-
7 able for process and outcome performance
8 measures specified by the Secretary from those
9 that have been endorsed by the National Qual-
10 ity Forum.

11 “(B) DEVELOPMENT AND ENDORSEMENT
12 OF PERFORMANCE MEASURE SET.—For pur-
13 poses of carrying out subparagraph (A), the
14 Secretary shall enter into an arrangement—

15 “(i) with the National Quality Forum
16 for the evaluation, endorsement, and rec-
17 ommendation of an appropriate set of per-
18 formance measures for transitional care
19 services and for the identification of gaps
20 in available measures; and

21 “(ii) with the Agency for Healthcare
22 Research and Quality to support measure
23 development, to fill gaps in available meas-
24 ures, and to provide for the ongoing main-

1 tenance of the set of performance meas-
2 ures for transitional care services.

3 “(2) PAY FOR PERFORMANCE.—As soon as
4 practicable after reliable process and outcome per-
5 formance measures have been endorsed and specified
6 under subparagraph (A), the Secretary shall provide
7 that the payment amounts under subsection (e) for
8 transitional care services shall be linked to perform-
9 ance on such measures.

10 “(3) PUBLIC REPORTING.—The Secretary shall
11 establish a mechanism to publicly report on a quali-
12 fying entity’s transitional care performance on such
13 measures, including providing benchmarks to iden-
14 tify high performers and those practices that con-
15 tribute to lower hospital readmission rates.

16 “(4) DISSEMINATION OF INFORMATION ON
17 BEST PRACTICES.—The Secretary shall disseminate
18 information on best practices used by transitional
19 care clinicians and qualifying transitional care enti-
20 ties in furnishing transitional care services for pur-
21 poses of application in other settings, such as in con-
22 ditions of participation under this title, under the
23 Quality Improvement Organization (QIO) Program
24 under part B of title XI, and public-private quality
25 alliances, such as the Hospital Quality Alliance.

1 “(g) NOTIFICATION OF ELIGIBILITY AND COORDINA-
2 TION WITH HOSPITAL DISCHARGE PLANNING.—In estab-
3 lishing standards for discharge planning under section
4 1861(ee)(1), the Secretary shall require each subsection
5 (d) hospital and each critical care hospital—

6 “(1) to identify, as soon as practicable after ad-
7 mission, those patients who are qualified individuals
8 under this section; and

9 “(2) to provide to such patients and their pri-
10 mary caregivers a list of qualified transitional care
11 entities available to arrange for the provision of
12 transitional care services, a list of transitional serv-
13 ices provided under this section, and a notice that
14 the transitional care service benefit is provided to
15 qualified individuals with no deductible or cost-shar-
16 ing.

17 Nothing in this section shall be construed as preventing
18 such a hospital from entering into an agreement with a
19 qualified transitional care entity or a transitional care cli-
20 nician for the furnishing of transitional care services to
21 the hospital’s patients.

22 “(h) PREVENTION OF INAPPROPRIATE STEERING.—
23 The Secretary shall promulgate such regulations as the
24 Secretary deems necessary to address any protections
25 needed, beyond those otherwise provided under law and

1 regulations, to prevent inappropriate steering of qualified
2 individuals to providers of services, suppliers, qualified
3 transitional care entities, or transitional care clinicians,
4 under this section or inappropriate limitations on access
5 to needed transitional care services under this section.

6 “(i) EVALUATION OF BENEFIT.—

7 “(1) IN GENERAL.—The Secretary shall evalu-
8 ate the performance of the transitional care benefit
9 under this section by measuring the following (for
10 those receiving transitional care services and those
11 not receiving such services):

12 “(A) Admission rates to health care facili-
13 ties.

14 “(B) Hospital readmission rates.

15 “(C) Cost of transitional care and all other
16 health care services.

17 “(D) Quality of transitional care experi-
18 ences.

19 “(E) Measures of quality and efficiency.

20 “(F) Beneficiary, primary caregiver, and
21 provider experience.

22 “(G) Health outcomes.

23 “(H) Reductions in expenditures under
24 this title over time.

1 “(2) REPORT.—The Secretary shall submit a
2 report to Congress no later than April 1, 2013, on
3 the performance measures achieved by the transi-
4 tional care benefit in the first 2 years of implemen-
5 tation. After submitting such report, the Secretary
6 may expand the benefit to moderate-risk and lower-
7 risk individuals in accordance with subsection
8 (b)(2).”.

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