January 22, 2016

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, DC 20510

Dear Senators Isakson and Warner:

The National Transitions of Care Coalition (NTOCC) appreciates the opportunity to comment on the Senate Finance Chronic Care Working Group's document that outlines policy options for improving the care and treatment and treatment of Medicare beneficiaries living with multiple chronic conditions.

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 patient-designated 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 caregivers.

NTOCC appreciates the Working Group's dedication to improving the lives of individuals who are living with chronic conditions and applauds the Working Group for recognizing the importance of transitional care as part of the solution. As the Working Group develops legislation around the policy options presented, NTOCC encourages the Working Group to consider the following suggestions:

NTOCC Supports the CCM Co-Payment Waiver and Proposed High-Severity CCM Code

NTOCC supports the Chronic Care Working Group's proposals to waive the co-payment associated with the current chronic care management (CCM) code and to establish a permanent, high-severity CCM code to reimburse clinicians for coordinating care for beneficiaries living with multiple complex conditions.

Patients living with multiple chronic conditions face significant challenges when moving from one care setting to another within our nation's fragmented health care system. Poor communication during transitions can lead to confusion about a patient's condition, duplicative tests, inconsistent patient monitoring, medication errors, delays in diagnosis and lack of follow through on referrals.

The CCM code ensures patients benefit from a provider's thoughtful attention to strategizing how to best implement their care plan. However, the co-payment associated with the code

inhibits its utilization. According to data released by the Centers for Medicare & Medicaid Services, approximately 35 million Americans are eligible to receive care coordination services, but the agency only received 100,000 requests for reimbursement in 2015. Providers fail to use the code for a number of reasons, including they find it difficult to explain to patients there is a co-payment for a previously "free" service, and the administrative and resource costs to meet the requirements for payment are equal to, and in some cases exceed, any reimbursement for CMS for the service.

The establishment of a high-severity CCM code would ensure providers managing patients who would benefit most from care coordination are adequately reimbursed for any additional costs associated with that patient's care. We encourage the committee to consider the unique challenges of a chronic care code and encourage this code to be classified as needing no coinsurance as well.

NTOCC Applauds the Working Group for Recognizing the Importance of Addressing Behavioral Health

NTOCC strongly supports the Working Group's proposal to improve care for patients living with chronic diseases and behavioral health disorders. Patients living with chronic conditions have been found to have higher rates of major depression compared with other primary care patients.[1] The association between the two can be attributed to depression expediting the chronic disease which, in turn, exacerbates symptoms of depression. It is estimated that up to one-third of individuals with a serious medical condition experience symptoms of depression.[2] Policies that address the behavioral and physical health of a patient and involve all types of providers are essential to effective chronic care management.

NTOCC is happy to assist the committee in developing these policy proposals and wanted to include the following two options as starting points. NTOCC encourages the Working Group to look into creating better parity between mental health care and physical health care, both in access to care and in payment of services. We also encourage the Working Group to look for ways to improve the care coordination between mental and physical health providers. For individuals with a serious medical condition combined with depression, providers need to be able to view the patient as a whole and not segmented into mental and physical health.

NTOCC Supports the Authorization of a Medication Adherence Study

NTOCC also supports the Working Group's proposal to authorize a study that will improve medication adherence. Medication errors often lead to poor health outcomes for patients and avoidable hospital readmissions. In fact, on discharge from the hospital, 30% of patients have at least one medication discrepancy and an estimated 66% of medication errors occur upon admission, during a transfer, or on discharge of a patient. We encourage the Working Group to ensure the study analyzes medications reconciliation at every stage of a patient's transition. NTOCC believes such a study has the potential to identify barriers to medication reconciliation

[1] Katon W. Epidemiology and treatment of depression in patients with chronic medical illness. *Dialogues in Clinical Neuroscience*. 2011; 12(1): 7-23. Available here: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181964/.

[2] Dailey S, Gill C, Karl S Barrio Minton C. DSM-5 Learning Companion for Counselors. Alexandria, VA: American Counseling Association; 2014

and also patient and caregiver education about the necessity of their medicine. Both of these are great ways to improve transitions.

NTOCC Encourages the Working Group to Develop Strong Quality Measures for Transitional Care

NTOCC is supportive of the development of quality measures for care transitions that will improve health outcomes for patients living with chronic conditions. Strong quality measures are important to patients and consumers, particularly as a patient transitions from one care setting to another, because it shows how our health system is performing and the steps it is taking to improve care for patients over time. We encourage the Working Group to view us as a resource as it develops any measures related to transitional care.

NTOCC Urges the Committee to Address IT Interoperability Issues

NTOCC believes the capacity for health information technology to improve communication and information sharing will help improve the quality of care for chronic care patients in care transitions. In order for telehealth technology to be most effective throughout the system, it incorporate several elements, including standardized processes, mandatory performance measures, and established accountability for these processes among the health care providers coordinating a patient's care.

NTOCC believes that interoperability among the various technology systems—such as the administrative systems, medical record systems, diagnostic tools, transcription, and security, and others—is critical for effective transitions of care.

NTOCC appreciates the opportunity to submit these comments and looks forward to continuing to serve as a resource to the Chronic Care Working Group to improve patient outcomes and strengthen our health care delivery system. Please contact NTOCC's policy director, Jessica Layson Davis, with any questions or comments at jdavis@vennstrategies.com.

Sincerely,

Cheri Lattimer
Executive Director