caresync

2818 Cypress Ridge Blvd, Ste 150
Wesley Chapel, FL 33544

January 26, 2016

The Honorable Orrin Hatch
Chairman, Committee on Finance
United States Senate
104 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
107 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, D.C. 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

CareSync would like to commend the Senate Finance Committee's Chronic Care Working Group for their leadership, vision, and efforts toward significantly improving the care for patients that suffer from chronic illnesses in America.

CareSync has been advancing care coordination by combining technology and services to give providers, patients, and caregivers a better healthcare experience since 2011. Since the inception of CPT Code 99490 for Chronic Care Management reimbursement, CareSync has added more than 400 physician partners that care for more than 400,000 Medicare patients with chronic conditions.

CareSync is one of the largest Chronic Care Management provider in the U.S. because we adhere to the following beliefs:

- The patient is the only constant in healthcare;
- Merit or value based payment models cannot meaningfully happen until the interoperability of healthcare data becomes a reality;
- The overwhelming portion of Medicare patients' clinical data is still on paper; and
- The only way to currently build a longitudinal record of a patient is to, at the patient's direction, obtain all of their records from all of their providers.

CareSync is dedicated to improving patient outcomes. Our extensive data has revealed that:

- 64% of CareSync members avoided duplicate tests.
- 65% of CareSync members were more engaged and less likely to be behind.
- 1/3 of CareSync members found a significant error in their medical records.
- 84% CareSync helped members remember to follow-up on care plan directives after appointments.

It is our goal at CareSync to support the initiatives that improve or create Chronic Care Management (CCM) policies, to improve the quality of care patients receive, to advance patient engagement and satisfaction, and to replace the high costs of

healthcare with cost effective and efficient care coordination. We hope that the following information and recommendations are meaningful to the Chronic Care Working Group, as well as meaningful to the adoption of physicians in the healthcare industry that will help us all drive the development of innovative products and services to better manage Medicare beneficiaries with multiple chronic conditions.

REDUCING THE DARK SPACE IN HEALTHCARE

Unfortunately, it is difficult to accurately determine the appropriate level of care or even measure the improvement in outcomes without a comprehensive patient-centric baseline for each patient. If providers had access to a comprehensive, longitudinal record of the patient's journey through healthcare, the level of care and patient outcomes would be far more accurate, and the patients would be more engaged because they were equipped with meaningful data about their health.

Due to the fact that CCM focuses first on the creation of a patient-centric care plan and does not explicitly require the creation of a baseline, it is typically four to six months into a patient's enrollment in CCM until any sort of patient-specific baseline of historical episodes are created. CareSync would like to recommend that future public policies expressly recognize the importance of a patient's comprehensive history in healthcare. Such policies will significantly enhance the creation and effectiveness of merit and value based payment structures.

IMPROVING CHRONIC CARE MANAGEMENT

The Manual Component to Creating Patient-Centric Care Plans

The byproduct of the current structure is that it takes several months of enrollment in CCM before a patient's healthcare history is created. CareSync provided non-face-to-face care coordination prior to CCM that began with the creation of a comprehensive patient record and as a result, can compare the effectiveness of that model to CCM. Based upon this experience, CareSync can attest that while CCM has been effective in addressing gaps in care, the behavioral change and care team collaboration was significantly greater within the model that began first with the creation of a patient's comprehensive health history.

The creation of CCM was a step forward in the effort to have interoperable, patient-centric, and comprehensive care plans. CareSync believes that the spirit of the CCM code requires the collection and aggregation of all of a patient's records from all of their providers. As a result, CareSync spends a significant amount of time requesting, processing, and transcribing patient records during the first three months of a patient's enrollment in CCM. The most effective care plan is one that will show a complete history of the patient's disease(s). CareSync spends a great amount of time creating the longitudinal view of the chronic conditions and the treatments prescribed to manage them.

The Confusion About the Patient's Financial Responsibility

A major benefit of the CCM program is that it was designed to help primary care physicians coordinate care and health records in order to provide comprehensive patient-centric care. Unfortunately the patient benefit and the value that it builds is small at the onset; as records begin to be gathered from previous doctor visits and hospital stays. It then increases in value each month as patient health records are added, until those records are completely up to date. Therefore, based on the perceived value of CCM at month one, patient engagement and satisfaction is significantly low. Co-payments then become a deterrent and a barrier to entry into the program though patients still want to own their records.

The confusion over patient financial responsibility is astronomically greater within Medicare Advantage plans because there is no consistency with the plan and benefit design. Some Medicare Advantage plans are reimbursing akin to Medicare. Others require as much as a 20%-30% coinsurance from the patient. In one case a Medicare Advantage plan paid $42.70 but then charged the patient a $40 co-payment, leaving the reimbursement to be only $2.70. Another issue we found is that Medicare Advantage plans are predominantly and consistently treating CCM as a Code 11 office visit in which there is a regularly elevated copay on the patient that also deters patient adoption into the program.

In addition, providers are billing CCM to Medicare Advantage plans at their chosen inflated rate, often by 100%-150% in order to cover the physician's cost to provide CCM services to their patients. With this said, the Medicare Advantage plans that are currently not recognizing or simply not covering the CPT code 99490 at all; therefore, denying all claims submitted for CCM services. At that point the inflated amount is then billed directly to the patient, further deterring patients from participating in CCM programs and causing most to opt-out/un-enroll in CCM services.

These are actual examples of experiences our members have had with their insurance carriers that are not covering CCM (99490) and/or applying it towards patient's co-payments, coinsurance or to their calendar year deductible for 2015. The names of the carriers and identifying information has not been included as our only purpose for providing these examples is to demonstrate the inconsistencies in coverage.

1. 9/24/2015 denied claim;
    a. Remit Remark "Benefits are not provided for services, etc." $150.00 billed; $0 paid.
2. 8/28/2015 denied claim;
    a. Remit Remarks "The benefit for this service is included in the payment/allowance for another service/procedure etc.". "The impact of prior payer(s) adjudication including payment and/or adjustments." $55.00 Billed; $17.61 Allowable; $37.39 Adjustments.

In addition to the specific examples above, we have seen the following occur throughout the country.

1. Plans pay 34.05, applying a $40 co-pay to all claims and after the adjustments are made, little or no reimbursement is made to providers.
2. Plans reimbursement amount is $30; GHI applies $30 to co-pay.

Often patients don't see the value of CCM until they have been enrolled for several months.
At month three, patients start to see their full health record and receive value from the program. At month six, patients are fully engaged and patient satisfaction is higher as a result of getting much more than a call inquiring about their health status. The copay will continue to be a challenge for any Medicare patient without a secondary or supplemental insurance unless CCM considers incorporating the creation of the patient's comprehensive healthcare history.

Without consistency among Medicare Advantage plans there is great confusion. In addition, there is low enrollment among patients who need CCM services in order to maintain compliance with a care plan as well as avoid unnecessary Emergency Room readmissions. CareSync would like to recommend that future public policies remove the current patient co-pay responsibility, believing this to be a serious barrier to adoption by Medicare patients that need it the most.

Realistic Time Needed to Fulfill the Chronic Care Management Requirements

CMS has made clear that CCM is both a time and scope code with equally clear and relevant requirements that are to be performed each month to compliantly bill for CCM. Having performed CCM on over 20,000 patients in the last year, we can assure this committee that completing the requirements relevant to each patient cannot be done in 20 minutes. CareSync spends a great amount of time each month creating an extensive summary of the patient's chronic conditions and the treatments prescribed to manage them in their care plans. CareSync would like to recommend that future public policies seek to increase the amount of reimbursement of CCM by 50% based solely on the time and effort that it takes to perform the requirements.

HIGH-SEVERITY CHRONIC CARE MANAGEMENT

CareSync applauds the committee's consideration of a high-severity chronic care management to accommodate for more complex patients. We would welcome an opportunity to serve as a resource, share our data, and help in any way we can to determine the appropriate threshold of factors for the elevated code. There is no doubt that there are chronic Medicare patients who require an elevated level of care to identify and treat gaps in their healthcare. We praise your efforts to ensure the provision of the appropriate level of care, which if provided effectively will significantly reduce healthcare costs while simultaneously improving patient outcomes.

As described above, the commencement of CCM starting with a comprehensive patient-centric healthcare history will significantly help identify which patients require an elevated level of care. In doing so, removing the current patient co-pay responsibility would help to eliminate the barrier to adoption of the program. If CMS were to increase the CCM reimbursement amount by 50% based on the time it takes to perform the requirements, it would align with the amount of time it truly takes to provide chronic care management to patients. Finally, we feel that additional codes for patients who are suffering from four or more chronic conditions, and require a significant amount of additional time to coordinate their care across multiple providers each month, is a step in the right direction. We feel that these suggestions further support the goals of this committee and those of CMS; to reduce costs and ensure that the appropriate level of care is provided to each patient.

As one of the largest providers of CCM, CareSync thanks you for the opportunity to provide feedback from our experience over the past year. We welcome the opportunity to be a resource for the Chronic Care Working Group's CCM initiatives.

Sincerely,

Travis Bond, CEO