caravanhealth

September 10, 2018

Submitted Electronically

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

Re: Comments on CMS-1693-P; CY2019 Quality Payment Program Proposed Rule

Dear Administrator Verma:

Caravan Health appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule (PFS) and Quality Payment Program (QPP) performance year 2019 proposed rule. Caravan Health supports more than 250 health systems operating in Accountable Care Organizations and other payment models across the country, with a particular focus on rural areas. Our clients provide care for approximately one million Medicare beneficiaries each year. Our comments related to specific aspects of the proposed rule are below.

- ***The Proposed Restructure of Evaluation & Management Billing Will Harm the Most Vulnerable Patients and Their Providers***

While we appreciate CMS's effort to reduce the administrative burden on providers, we believe CMS has unnecessarily conflated payment with documentation. The five levels of payment currently in use are necessary to distinguish between the intensity of services patients of varying complexity require. The proposed system of add-ons is overly simplistic and hence insufficient to recognize this variation. CMS notes that its proposed change is budget neutral; but fails to observe that it will in fact redistribute money from those that treat the most challenging patients to providers that regularly work with more moderately complex patients. This diversion of money will incentivize providers to avoid complex patients that have the highest need for services.

In turning E&M billing into an urgent care approach, CMS is discouraging and undervaluing providers that regularly treat the highest complexity patients. At minimum we suggest at least three levels are needed to adequately capture the variation, however, we remain unconvinced that this is an appropriate solution.

While CMS's proposed attempt to reduce documentation is appreciated; in practice, providers must maintain high levels of documentation in order to ensure proper treatment, care coordination, and to succeed under new models of value-based payment. Given CMS's interest in encouraging value-based payment models, we find it confusing that CMS would simultaneously promote policies that may harm the ability of providers to manage patient care. Rather than collapsing E&M codes, we

recommend that CMS update its 1995/1997 guidelines that distinguish between the five levels of visit in order to provide clear guidance regarding audit expectations, with time spent on patient care as the primary differentiator between different intensity of service and payment.

- ***Carve Out -25 Modifier Dual Visits that Include an Annual Wellness Visit (AWV)***

As part of its proposal to simplify E&M billing, CMS also proposes to reduce payment for dual services provided with a -25 modifier by fifty percent. Caravan Health urges CMS to explicitly carve out Annual Wellness Visits (AWVs) from this policy, as failure to do so will make it more difficult for patients to access and providers to offer this essential service.

Caravan has seen in its work with ACO Participants the strong relationship between AWVs and cost and quality improvements. As AWVs represent additional work for providers, many adopt work flows that leverage other E&M visits by patients. The convenience to the patient allows providers to conduct more Annual Wellness Visits and in turn better track and manage the care of their patient population. Because of the comprehensive nature of the Annual Wellness Visit, we do not believe it is appropriate for CMS to apply a payment reduction, even when furnished on the same day as another service.

- ***CMS Should Clarify the Purpose of the Virtual Check-In***

Caravan Health is encouraged by CMS's proposal for a new code to reimburse providers for virtually "checking in" with their patients. However, we request that CMS clarify the purpose and use case of the virtual check-in so providers may better assess when this tool is appropriate for use. For example, CMS notes the virtual check-in should generally be patient-driven, but is this a requirement? What circumstance might justify a virtual check-in that is provider-initiated yet billable? Does CMS intend the virtual check-in to serve as a type of triage? We request that CMS clarify the intent of this new code so providers feel comfortable incorporating it into their practice.

Additionally, we strongly recommend that CMS eliminate the patient co-payment requirement from the virtual check-in. As a service that is meant to be patient-driven, it seems likely that many patients will be caught off guard by the later billing of a co-payment for a five minute call to their provider. Further, the collection of such a nominal amount, only a couple dollars per patient, is a poor use of provider time and serves only to irritate patients and create friction in the patient-provider relationship. Providers will not take advantage of this service if it requires them to subsequently bill each patient for a trivial amount of money, as it costs more with respect to postage and staff time than the amount to be collected.

Finally, we encourage CMS to consider the virtual check-in as an opportunity for non-physician qualified health care professionals to maximize their scope of practice. We request that CMS clarify that virtual check-in services may be provided by qualified health care professionals acting under the direction of a physician.

- ***Shared Savings Program Quality Measure Set***

Caravan Health appreciates CMS's continued refinement of the Shared Savings Program quality measure set. We offer the following for consideration regarding specific measures.

- ***CARE-1: Medication Reconciliation Post-Discharge***. We understand the reason for CMS's removal of medication reconciliation and agree that this measure, as currently configured should be retired. We urge CMS to continue to keep medication reconciliation in mind however and search for a meaningful way to hold providers accountable for this important activity.

- ***CARE-2: Falls: Screening for Future Fall Risk*** and ***ACO-47: Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls***. Caravan Health agrees with CMS's proposal to remove fall screen from the Shared Savings Program quality list. We support the switch to ACO-47 which will include enhanced assessment and better serve patients at risk of falls.

- ***DM-7: Diabetes: Eye Exam***. We disagree with CMS's decision to remove DM-7 from the quality measure set. Diabetic eye exams are a much-needed service, particularly for the Medicare population. We urge CMS to maintain this as an active measure to ensure providers remain incentivized to review for potential diabetic complications.

- ***PREV-8: Pneumonia Vaccination Status for Older Adults***. We urge CMS to reconsider removal of PREV-8. Caravan Health has seen in data from its ACOs a real decrease in instances of pneumonia and pneumonia-related deaths correlation to improved scores in vaccination. This is a measure that truly saves lives and the value of which is borne out via CMS's own data.

- ***CMS Proposes Too Many Changes to the Promoting Interoperability Category, Too Quickly***

Caravan Health is extremely concerned that in the proposed rule CMS outlines significant changes to the Promoting Interoperability category with little to no advance warning to providers. We urge CMS to consider steps to build to the proposed structure over a period of two to three years.

First and foremost, CMS proposes to eliminate the option for providers to report using 2014 edition certified electronic health record technology (CEHRT). While Caravan is aware that CMS has been promising a switch to exclusive use of 2015 edition CEHRT, extensions in the past year have made CMS's timing for this change ambiguous. The transition to a 2015 CEHRT represents a huge capital expense and can be upwards of a two-year process for providers to implement. Knowing this, we believe CMS should establish the deadline for 2015 CEHRT with at least a full year of advance notice. We recommend that CMS finalize that beginning in calendar year 2020, Promoting Interoperability will only allow for reporting with 2015 edition CEHRT. For calendar year 2019, we encourage CMS to allow use of the 2014 edition transitional measures one final time. This approach would be most consistent with CMS's desire to give industry as much time to adjust as possible to major technological and code set changes such as the transition to ICD-10 in 2015.

Additionally, CMS proposes to alter the structure of the Promoting Interoperability category with respect to measures and scoring. Caravan is concerned that CMS has not thought through the significance of shifting the category from a maximum total of 155 points in 2018 (notably not including the 10 point bonus for reporting with 2015 CEHRT) to 110 possible points in 2019. The strict reduction in opportunities to score, in conjunction with retooled measures and an increasing maximum penalty of seven percent, threatens to catch many providers by surprise, resulting in potential penalties and loss of revenue. We recommend that CMS phase in the 110 point maximum by either providing more bonus opportunities or maintaining a modest level of base measure scoring. In the example below, we demonstrate how draconian the proposed change can be for a provider that could expect to earn full marks in 2018 relative to their scoring under the 2019

proposed model. As seen below, identical performance could yield up to a 47 percentage point decline for the Promoting Interoperability domain and a 11 percentage point difference for the overall MIPS score as a result of the proposed changes. For MIPS APMs the differential increases to negative thirteen percent.

2018 Measure	2019 Measure	Reported	Scoring 2018	Scoring 2019
Security Risk Analysis		yes	--	--
E-Prescribing		90%	--	9
	Bonus: Query of Prescription Drug Monitoring Program	yes		5
	Bonus: Verify Opioid Treatment Agreement	yes		5
Send a Summary of Care	Support Electronic Referral Loops by Sending Health Information	20%	2	4
Request / Accept a Summary of Care	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20%	2	4
Clinical Information Reconciliation		20%	2	
Provide Patient Access	Provide Patients Electronic Access to Their Health Information	50%	5	20
Patient-Specific Education		20%	2	
View, Download, Transmit		20%	2	
Secure Messaging		20%	2	
Patient-Generated Health Data		20%	2	
Immunization Registry Reporting		yes	10	10
Electronic Case Reporting		yes	5	
Public Health Registry Reporting		yes		
Clinical Data Registry Reporting		yes		
Syndromic Surveillance Reporting		yes		
Report Improvement Activities w/ CEHRT		yes	10	
Report Using 2015 Edition CEHRT		yes	10	
PROMOTING INTEROPERABILITY CATEGORY SCORE			**104**	**57**
CONTRIBUTION TO TOTAL MIPS SCORE (standard MIPS methodology)			**25%**	**14%**
CONTRIBUTION TO TOTAL MIPS SCORE (MIPS APM)			**30%**	**17%**

With respect to the specific measure changes proposed, Caravan suggests that CMS assign more weight for reporting to registries that facilitate health information exchange. Not only does this align with the health information exchange objective, but it offers providers a feasible and fair way to succeed in this objective area when they lack health care partners able to engage in health exchange. This is a particular challenge in rural communities where the majority of referral partners are not able to send or receive health information, thwarting the attempts of practices to send summaries of care. Providers should not be punished for the lacking capability of their referral partners.

To facilitate health exchange further, Caravan suggests that CMS publish a national registry of direct addresses. If CMS is going to mandate provider-to-provider health exchange, then it must assist practices by at least making this information available.

Finally, Caravan requests clarification regarding CMS's new proposed opioid measures. We are unclear on CEHRT readiness for these measures, specifically whether they will be added to the 2015 CEHRT specifications. CMS seems optimistic that these measures can be incorporated on a timeline of months despite no prior indication. If these measures are not currently included in the 2015 CEHRT functional requirements, then small providers will be disproportionately disadvantaged. With so few bonus points and opportunities for a strong score, we are concerned that the available bonus measures may not even be an option for small and rural providers with few

resources. As such, CMS has effectively created a skewed scoring system that rewards large, wealthy provider groups and penalizes the small.

Finally, while Caravan appreciates that CMS is endeavoring to increase flexibility by allowing ACO Participants to report Promoting Interoperability by group (TIN) or by individual clinician (NPI), we urge CMS to maintain the current requirement for TIN-level reporting. The larger an ACO, the more it is to manage the reporting of each of the ACO Participants and to ensure that no ACO partner will be penalized for the failure of another to report. Opening reporting up to individual clinicians within the ACO will significantly increase the difficulty of this exercise.

If CMS wishes to maintain the flexibility for individual reporting by clinicians billing under an ACO Participant TIN, we encourage CMS to adopt a strategy similar to quality reporting, whereby the individual score is used only in the absence of group reporting. This will simplify the management of ACOs and prevent confusion that may result in failure to report and subsequent MIPS penalties.

*

Thank you again for the opportunity to provide comment. If you have any questions or wish to discuss any of our comments further, we would be happy to assist.

Sincerely,

LeeAnn Hastings
Policy & Compliance Officer
Caravan Health