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November 19, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–3346–P
P.O. Box 8010
Baltimore, MD 21244–1810

RE: CMS–3346–P – Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; published at Federal Register, Vol. 83, No. 183, September 20, 2018.

Submitted electronically via www.regulations.gov

Dear Administrator Verma,

UnityPoint Health ("UPH") appreciates this opportunity to provide feedback on this proposed rule. UPH is one of the nation's most integrated healthcare systems. Through more than 30,000 employees and our relationships with more than 290 physician clinics, 38 hospitals in metropolitan and rural communities and 15 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, central Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 6.2 million patient visits. In addition, UPH is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care.

UPH appreciates the time and effort of CMS in developing and proposing this rule to lessen the regulatory burden on providers across care settings. Our feedback not only responds to proposed changes from the Patients Over Paperwork initiative but also includes additional suggestions to remove red tape – documentation and standards – that hamper delivery of care at the right time, right place and right amount to patients. We respectfully offer the following comments which appear in the order raised in the proposed rule.

HOSPICE

CMS is proposing to defer to State licensure, training and competency requirements for hospice aides, better integrate information from the hospice's drug management expert into routine interdisciplinary group meetings, change notice process of policies and procedures to patient / patient representative and family, and change staff orientation requirements for hospices that provide hospice care to residents of a

skilled nursing facility/nursing facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities.

- **Comments:** In addition, we offer the following suggestions for your consideration in this or future rulemaking.
  - **Remove or extend the 5-day Notice of Election** timely filling submission requirement.
  - **Eliminate Part D pre-authorization** for hospice patients in relation to drugs received during hospice care.
  - **Authorize hospice room and board pass-through** for Medicaid patients in nursing facilities, removing Hospice Agencies as an intermediary in the billing process.

HOSPITALS

CMS is proposing to allow multi-hospital systems to have unified and integrated Quality Assessment and Performance Improvement and unified infection control programs its member hospitals, allow States to dictate when an autopsy is indicated in certain instances, permit hospitals to establish a medical staff policy for outpatient pre-surgery/pre-procedure assessments, clarify that psychiatric hospitals use of non-physician practitioners or doctors of medicine/doctors of osteopathy (MD/DOs) to document progress notes, and for swing bed providers, remove references to requirements applicable to long-term care facilities.

- **Comments**: We support the proposed rules. In addition, we offer the following suggestions for your consideration in this or future rulemaking.
  - **Exemption from RAC audits for hospitals in a Medicare two-sided ACO** as an unnecessary expense for ACO Participants who are already trying to limit their Medicare spend.
  - **Eliminate utilization review regulations around intensity of services and qualifying days for Medicare patients after meeting Admission criteria**. Since payment is based on DRGs, the scrutiny and regulations focused on appropriate documentation and coding are sufficient.
  - **Limit validation surveys** performed by CMS after a survey by an accreditation organization, such as the Joint Commission or Det Norske Veritas (DNV), to ensure that the accreditation organization is doing its job. These surveys create additional burdens on providers and should instead target the initial survey documentation to minimize such burden.

HOME HEALTH AGENCIES

CMS is proposing to eliminate the verbal notification of all patient rights, replace a full competency evaluation with a targeted competency evaluation for aides, and expand the timeframe for providing a clinical record copy from next day to four business days.

- **Comments:** While we fully support the expanded timeframe for copies of clinical records, we do have concerns related to the other proposed rules.

  In terms of verbal notification of all patient rights, we believe this is important and is an elevated expectation within the new Conditions of Participation. As such, we support the retention of the verbal notification requirement with a couple caveats. First, we would request that CMS's requirement for notification in the patient's preferred language by the second visit be revised to read "second visit or five business days". For patients with an acute need, such as daily wound care, it has been challenging to get someone to review all rights and responsibilities by the second visit. Second, the provision of financial liability information has been challenging for insured patients. Although the

HHA can inform the patient of HHA charges, those charges may not reflect the actual costs for patients who were hospitalized and met their deductible. We request that CMS revisit the financial liability information that HHAs are responsible for providing.

We also have concerns with the deficiency testing as proposed. With the new Conditions of Participation, if a home health aide is assessed to be deficient in any skill, they must be removed from patient care until they complete the entire competency exam as well as the entire skills checklist. While we do not find value in completing the written exam again, but we do support them needing to have all skills re-evaluated as we are sending aides into patient homes without direct supervision and we all need to be confident in their competency. We would encourage CMS require a list of skills to be re-evaluated and that the list include those skills required to be done on a patient (versus pseudo-patient) per the Conditions of Participation.

In addition, we offer the following suggestions for your consideration in this or future rulemaking.

- **Authorize Nurse Practitioners (NPs) and Physician Assistants (PAs) to sign home care orders**. Presently this is limited to physicians. Particularly in rural areas where NPs and PAs are the primary care workforce, this rule prevents these providers from following their patients. As a result, there are patients that may have never seen the physician that is expected to sign a plan of care for those patients. At the very least, we urge CMS to consider allowing NPs and PAs to give interim orders for medication changes and plan of care updates – this is currently allowed in hospice, but not in home care.
- **Eliminate physician signature/date stamping requirements** for Medicare documentation and orders to permit electronically generated time stamps.
- **Defer to HHAs in a risk-bearing ACO to determine home health eligibility.** Currently, patient eligibility is dependent upon homebound status. This would allow HHAs in two-sided ACOs to determine whether the HHA can provide as appropriate and effective service that meets the current definition of reasonable and necessary.
- **Allow Occupational Therapy to be a qualifying skilled service** to independently meet eligibility requirements for admitting patients into the Medicare program. Like the prior bullet (home health eligibility), the effectiveness of this request could be demonstrated first by HHAs in a risk-bearing ACO.
- **Remove the Face-To-Face encounter requirement for patients with a qualifying inpatient stay**. This aligns to the Patient Driven Groupings Model (PDGM) to be implemented in 2020. Specifically, if the episode would be classified as an institutional referral source, the Face-To-Face encounter requirement would be removed; however, if the episode would be classified as a community referral source, the Face-To-Face encounter requirement would remain.
- **Expand the role of resident physicians.** We would suggest that residents, who are credentialed and licensed physicians as well as PECOS enrolled, should be treated as a physician in their ability to perform and sign Face-To-Face encounters and to otherwise refer, order and certify home care services. To otherwise limit these activities, significantly reduces access to home care for patients who receive their care from teaching institutions (often with a staffing ratio of 12-15 residents per one faculty physician). In this situation, it becomes nearly impossible for a faculty physician to perform necessary Face-To-Face encounters and review home health plans of care for the entire staff of resident physicians.

- **Eliminate the Home Health Review Choice Demonstration (CMS–10599).** UnityPoint at Home has HHAs in Illinois and is subject to this demonstration. We are extremely disappointed that CMS has continued to pursue this overly broad demonstration that equally applies to HHAs regardless of their record of compliance issues. Instead, we encourage CMS to undertake one of the following more narrowly targeted approaches:
  1. Target high-risk counties within high-risk states. For Illinois, this would entail comparing utilization and potential misuse behaviors between Cook and collar counties to the remainder of counties in Illinois.
  2. Allow HHAs that had successful rates during the first iteration of the demonstration (Pre-Claim Review Demonstration for Home Health Services) to be exempt from the Review Choice Demonstration.
  3. Utilize PEPPER reports to identify utilization and billing patterns that indicate high potential for fraud, waste and abuse and implement monitoring programs for these HHAs versus casting a wide net creating unnecessary administrative burden on HHAs with no history or suspicion of inappropriate utilization or billing.
- **Embed flexibility within Electronic Visit Verification (EVV).** We appreciate the delay of EVV until 2020 and would request that CMS adopt a pro-HHA approach by encouraging "open models" in states. This would allow each HHA to choose an individualized solution that meets their needs as well as minimum federal requirements. As an organization that has HHAs in several states, including border communities, it would allow us to choose one solution and minimize compliance efforts.
- **Recognize efficient patient home health transitions between traditional Medicare and Medicare Advantage.** Presently, when a home health patient switches between Fee-for-Service Medicare and Medicare Advantage, the HHA must re-establish the patient's home health eligibility to continue home health services. To avoid gaps in service and reduce HHA administrative and clinical documentation burden, we recommend that home health eligibility should not be re-established – just as it would not be required for two consecutive episodes being billed to the same payer. At a minimum, we would request that a Face-To-Face encounter not be required for a home health patient who is changing between traditional Medicare and Medicare Advantage. The Face-To-Face encounter requirement is targeted because its sole purpose (to establish home care eligibility) is only retriggered due to a payer change, any scheduling delays result in delays in care, and it creates an unnecessary expense to Medicare. Because of the structure of Home Health Prospective Payment System, we would alternatively recommend that the entire home care episode be paid by the payer verified at the beginning of the episode. In the event the patient changes between traditional Medicare and Medicare Advantage, the home care payment source would change at the beginning of the first episode FOLLOWING the change in coverage, but at the start of the month if this falls during an open home care episode.

CRITICAL ACCESS HOSPITALS

CMS is proposing to reduce CAH review of policies and procedures from annual to biennial, eliminate duplicative requirements to disclose the names of people with a CAH financial interest, and for swing bed providers, remove references to requirements applicable to long-term care facilities.

- **Comments:** We support this proposed rule. In addition, we offer the following suggestions for your consideration in this or future rulemaking.
  - **Remove leased space restrictions to allow mixed use** in support of efficient and enhanced healthcare access in rural communities. This policy limits the ability of CAHs to utilize their space on days, or times, when it is not being leased to a visiting provider. As a result, square footage in safety net facilities is not being maximized and CAHs have abandoned opportunities to expand access to additional services which would require more capital investment for underutilized space. This rule contradicts a tenet of the CMS Rural Health Council – "improving access to care for Americans living in rural settings."
  - **Eliminate the 96-hour physician certification**. By requiring physicians to state that every admission is expected to be less than 96 hours, physicians may be forced to transfer patients who could be safely cared for in the CAH but are expected to need more than 96 hours.
  - **Permanently remove the direct supervision requirement** for CAHs, along with small and rural hospitals.
  - **Limit validation surveys** performed by CMS after a survey by an accreditation organization, such as the Joint Commission or Det Norske Veritas (DNV), to ensure that the accreditation organization is doing its job. These surveys create additional burdens on providers and should instead target the initial survey documentation to minimize such burden.
  - **Reconsider elimination or relaxation of the 35-mile rule for cost-based reimbursement of EMS services**. This rule limits the ability of CAHs to cover the costs of EMS units as well as prohibits CAHs from assuming responsibility for EMS when desired.

COMMUNITY MENTAL HEALTH CENTER (§ 485.914(D))

CMS is proposing to limit the minimum 30-day assessment update for only those clients who receive partial hospitalization program services.

- **Comments:** Our organization is affiliated with five CMHCs in Iowa and Illinois. We support this proposed rule.

RURAL HEALTH CLINICS (RHCS) AND FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

CMS is proposing to reduce the review of patient care policies from annually to biennially and to similarly reduce the frequency for the total evaluation of their programs.

- **Comments:** We support this proposed rule. In addition, we offer the following suggestions for your consideration in this or future rulemaking.
  - **Permit reimbursement for certified diabetic educators (CDEs) as a RHC visit**. While dieticians can be included on the cost reports, nurses who are CDEs cannot be included on the cost report.
  - **Authorize reimbursement for same day Annual Wellness Visits and medically necessary E&M visits**. RHCs are only reimbursed under an all-inclusive rate for this date of service in comparison to Medicare B providers being reimbursed for each provider service.
  - **Loosen direct provider supervision rules**. RHCs are restricted to the type of services that can be provided in the absence of a provider being physically present in the office. Simple nurse visits for weights, blood pressure checks, etc. should be able to be provided without direct provider supervision and would be on par with clinics reimbursed under Medicare Part B.

EMERGENCY PREPAREDNESS

CMS is proposing to expand mandatory timeframes for emergency program review, eliminate duplicative documentation requirements within the emergency plan, and provide greater discretion in both training and testing requirements.

- **Comments:** We appreciate that CMS has extended the flexibilities within these proposed rules to Program for the All-Inclusive Care for the Elderly (PACE) Organizations. PACE Organizations are typically smaller community-based organizations that often do not fit well within a one-size-fits-all approach and will benefit from extended timeframes and the ability to tailor these processes to organizational needs.

ADDITIONAL TOPICS FOR REGULATORY RELIEF

As an integrated health system within a largely rural geography, advanced practice healthcare professionals are vital to provide access to high quality healthcare in our communities. We further encourage CMS to consider holistically revisiting CMS regulatory requirements that restrict State scope of practice laws. In addition to items listed under "Home Health Agencies," we urge that your review start with the following:

- For skilled patients with Physical Therapy / Occupational Therapy / Speech Therapy orders, authorize NPs and PAs to sign orders.
- For cardiac and pulmonary rehabilitation, authorize MPs and PAs to sign orders and individualized treatment plans.
- For diabetes education (Medical Nutrition Therapy), authorize MPs and PAs to sign orders without physician co-signature.
- For diabetic shoes, authorize NPs and PAs to sign orders.

We are pleased to provide comments to the proposed regulations and their impact on our patients and integrated healthcare system. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President, Government and External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

Sabra Rosener
VP, Government & External Affairs