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June 25, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1694–P
P.O. Box 8011
Baltimore, MD 21244–1850

RE: CMS–1694–P – Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims; published at Federal Register, Vol. 83, No. 88, May 7, 2018.

Submitted electronically via www.regulations.gov

Dear Ms. Verma,

UnityPoint Health ("UPH") appreciates this opportunity to provide feedback on the 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 home care services 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.

UPH appreciates the time and effort of CMS in developing and proposing this rule and respectfully offers the following comments.

PROPOSED CHANGES TO MEDICARE SEVERITY DIAGNOSTIC-RELATED GROUP (MS-DRG CLASSIFICATIONS AND RELATIVE WEIGHTS

In relation to the MS–DRG Documentation and Coding Adjustment for FY 2019, CMS is proposing to make an adjustment of +0.5 percent to the standardized amount to account for changes in MS–DRG documentation and coding that do not reflect real changes in case-mix.

Comment: While we agree that MACRA provides for a +0.5 percent adjustment in FY 2019, we are concerned that this amount does not restore a 0.7 percent adjustment omitted for FY 2018 and ultimately still owing for FY 2019. As stated in the preamble of this rule (page 20170), "section 414 of the MACRA replaced the single positive adjustment we intended to make in FY 2018 *once the recoupment required by section 631 of the ATRA [American Taxpayer Relief Act (Pub. L. 112-240)] was complete* with a 0.5 percent positive adjustment to the standardized amount of Medicare payments to acute care hospitals for FYs 2018 through 2023." It is our contention that the recoupment, required by ATRA for the adjustment to be budget neutral, was never complete.

As background, ATRA authorized CMS to impose negative adjustments totaling $11 billion for FY 2014-2017. However, CMS was required to offset these negative adjustments via a single positive adjustment in FY 2018. Even though MACRA altered the restoration process by replacing the single positive adjustment with a series of incremental positive adjustments between FY 2018-2023, CMS was never authorized to impose a permanent negative adjustment beyond FY 2017. By retaining the 0.7% adjustment, CMS has misinterpreted the adjustment directives issued by Congress. Our position is further supported by passage of the 21st Century Cures Act (Pub. L. 114-255), which assumed that the "baseline" for the negative adjustments imposed between FY 2014-2017 remained static at 3.2%. When Congress altered the positive adjustment for FY 2018 from 0.5% to 0.4588%, it recognized that 0.2412% would not be restored. Since Congress did not likewise update the "baseline" to reflect CMS' revised total negative adjustment of 3.9%, Congress assumed that the 0.7% adjustment would be returned as part of the restoration process. **In light of the clear Congressional intent supporting the restoration of the 0.7% adjustment, we urge CMS to reverse its FY 2018 position and restore the 0.7% adjustment for both FY 2018 and FY 2019.**

OTHER PROPOSED CHANGES IN THE IPPS FOR OPERATING SYSTEM

Among the numerous changes for CY 2019, CMS is proposing an expansion of the post-acute care transfer policy for discharges to hospice care and the continuance of the low-volume hospital payment adjustment policy.

Comment: To conform to statutory changes resulting from the Bipartisan Budget Act of 2018, CMS is expanding the MS–DRGs subject to the post-acute care transfer policy and special payment policy to include discharges to hospice care by a hospice program as a qualified discharge, effective for discharges occurring on or after October 1, 2018. Specifically, Patient Discharge Status code of 50 (Discharged / Transferred to Hospice—Routine or Continuous Home Care) or 51 (Discharged / Transferred to Hospice, General Inpatient Care or Inpatient Respite) will be subject to payment as a transfer case. CMS estimates that this statutory expansion to the post-acute care transfer policy will reduce Medicare payments under the IPPS by approximately $240 million in FY 2019 and up to $540 million annually by FY 2028. While we understand that this is a statutory change, **we question the efficacy of including hospice within the post-acute care transfer policy in terms of patient choice and quality of life at end of life**. Reimbursement policies that appear to dissuade transfers to hospice and potentially result in hospice election delays should not be enacted. Forty percent of patients electing hospice services from our affiliated hospice agency have a MLOS of less than 7 days. Hospice value shows a greater cost savings for LOS at even 7-15 days by reducing ICU deaths, emergency room visits and unnecessary hospitalizations. It is unclear how CMS considered hospice cost benefits within its analysis and what factors influenced an estimate that

almost doubles IPPS cost savings by 2028. Aside from a purely cost analysis, this policy seems to disregard the potential ramifications of inserting reimbursement considerations within medical decisions of appropriate placement and patient needs and/or preferences. For hospice elections, this decision is compounded by patient choices that highly value quality of life considerations in which curative care is no longer desired. We believe that reimbursement policy should encourage hospice placement and error on the side of early transfers to hospice when appropriate. We are pleased that Congress has directed MedPAC to monitor this transfer case policy.

Another proposed revision related to statutory changes enacted by the Bipartisan Budget Act of 2018 is the extension of the low-volume hospital payment adjustment policy. In particular, the definition of a low-volume hospital and the methodology for calculating the payment adjustment were modified for FYs 2019 through 2022. Prior changes to the definition and adjustment calculation were also extended through FY 2018. This policy is a crucial payment lifeline to promote acute care access in remote and isolated areas. **We support the low-volume adjustment policy as recently revised.** UPH has three affiliated hospitals in Iowa that meet this definition, and this funding has enabled doors to remain open in those communities.

QUALITY DATA REPORTING REQUIREMENTS

For the Hospital Inpatient Quality Reporting (IQR) Program, CMS is proposing to streamline measures by revising measures evaluation criteria, eliminating certain measures, and removing measurement redundancies. CMS is implementing a holistic approach to evaluating the Hospital IQR Program's current measures in the context of the measures used in the other IPPS quality programs (the Hospital Readmissions Reduction Program, the HAC Reduction Program, and the Hospital VBP Program).

Comment: For the Hospital IQR Program, CMS is proposing to adopt an eighth factor for measurement removal, to remove 18 previously adopted measures that are "topped out", no longer relevant, or where the burden of data collection outweighs the measure's ability to contribute to improved quality of care, and to de-duplicate 21 measures that exist in other hospital quality programs. **We are extremely supportive of the Meaningful Measures initiative and its goals align with prior UnityPoint Health comment letters on the need to simplify and streamline quality measures.** As for the addition of Factor 8 for measure removal (costs associated with a measure outweigh the benefit of its continued use in the program), we say "thank you" and believe its omission was an oversight. In this round, CMS has targeted low hanging fruits and we are grateful for the regulatory relief.

In addition, we would suggest that CMS examine regulatory relief that includes the mechanics of data collection and submission. This is touched upon by CMS in the preamble related to "Potential Future Development and Adoption of eCQMs Generally." One area which has created duplicative/unnecessary reporting burden for our integrated health system is QualityNet access. QualityNet houses reports to monitor performance under various CMS quality programs including the Inpatient and Outpatient Quality Reporting, Value Based Purchasing Program, HAC Reduction Program, and Hospital Readmission Reduction Program. UPH regularly uses QualityNet reports, such as (1) Overall Hospital Star Rating Hospital Specific Reports, (2) Hospital Value-Based Purchasing (VBP) Percentage Payment Summary Report (PPSR); (3) Hospital-Acquired Condition Reduction Program Hospital Specific Reports; (4) Medicare Spending per Beneficiary Hospital Specific Reports; (5) Public Reporting Preview Reports; and (6) Hospital Readmission Reduction Program Hospital Specific Reports. While each UPH hospital can access these

reports through the QualityNet secure file exchange, our centralized UPH analytics personnel **with** approved QualityNet Healthcare System level access **cannot** receive these same reports. This requires duplicative steps by our centralized analytics team to request these reports from each hospital, which is both unnecessary and time consuming and defeats any efficiency efforts to centralize reporting functions. **We encourage CMS to instruct QualityNet to permit system level secure file exchange access for integrated health systems.**

A second area of regulatory relief relates to timely and specific notice by CMS of measurement tools. UPH is not unique in our desire to be proactive in monitoring performance for CMS quality programs; however, when CMS changes software versions and measurement weightings with little to no notice, it is difficult to be proactive. For example, CMS has just released the proposed software version to be used for the FY2019 HAC program, but the time period is in the past (October 1, 2015 - June 30, 2017), so we lose the ability to proactively monitor our own performance. Timely notice of applicable software versions also relates to individual measures, such as the Patient Safety and Adverse Events Composite (PSI-90) and the Hospital-Wide All-Cause Unplanned Readmission Measure (HWR). The most recent SAS software available for PSI-90 cannot be used to monitor current performance because the code is not meant to be used for discharges after the third quarter of 2016 and it uses different diagnosis codes based on discharge date. In addition, cases that had been previously excluded are reintroduced to the numerator, causing large variability in the data. **We encourage CMS to be more timely in its notice of software versions and to examine the timeliness of the underlying data being captured.** Specifically, CMS should strive to:

- Release software earlier, before data is scheduled to going public;
- Communicate individual indicators and weighting that will be included in a composite; and
- Timely communicate when to expect new software and what changes to expect.

It is these details which define measurement success and are required to promote initiatives focused on continual health care improvement.

SUPPORTING DOCUMENTATION FOR SUBMISSION OF A MEDICARE COST REPORT

CMS is proposing revisions to the supporting documentation required for an acceptable Medicare cost report submission.

Comment: **We applaud these changes** by CMS to reduce regulatory burdens on administrative functions.

PUBLIC LIST OF HOSPTIAL STANDARD CHARGES VIA THE INTERNET

E*ffective January 1, 2019, in accordance with section 2718(e) of the Public Health Service Act, CMS is updating guidelines to require hospitals to make available a list of their current standard charges via the internet in a machine readable format and to update this information at least annually, or more often as appropriate.*

Comment: We want to recognize the overall effort of CMS to target regulatory relief within this proposed rule. Meaningful pricing for consumers is another area that could benefit from clear direction as well as regulatory relief. Foremost, UPH supports efforts to provide consumers with greater transparency for pricing and improved data access. Currently, UPH participates in state hospital association efforts in our various jurisdictions to make pricing information available to consumers. We have links on each UPH hospital website to these resources. While the current state of these websites

may not fully conform to the updated guidelines, they have been a starting point for price transparency. In addition, these state websites contain information for multiple hospitals and force some consistency and ease for consumer comparisons. Second, to be meaningful, transparency efforts need to be comprehensive (include both hospital and physician measures for quality, cost, and patient satisfaction) and not solely target hospital pricing. Part A transparency will not prevent surprises from Part B billing. As currently structured, the physician component adds another pricing and quality layer, which quickly becomes more complex for services or procedures that have multiple physicians – surgeon, radiologist, pathologist, anesthesiologist, hospitalist, and/or primary care. Transparency for hospital pricing would benefit from clear regulatory expectations. Third, we are encouraged that CMS is seeking further information to pinpoint what is meaningful data for consumers. At issue is whether the information being requested and its public availability will be understandable and useful to consumers. If not, then hospitals are being requested to divert resources from health care delivery to public reporting that at best may be disregarded by consumers or at worst may confuse and misinform consumers. Misinform relates to pricing that only involves hospital stays and procedures and is based on charges.

While we support meaningful price transparency, the public reporting of ill-defined "standard charges" starting January 1, 2019, without understanding its value simply imposes more burden without known benefit. And without further definition, hospitals also cannot fully quantify resources required to accumulate and maintain this data. Given the breadth of the topics for which CMS seeks further information / clarification, **we would encourage CMS to delay implementation for at least one year to review feedback and either establish a stakeholder advisory group or conduct a voluntary demonstration on this topic.** It is important that public information be accurate and meaningful and we believe this mandate should not proceed until this can be accomplished with confidence.

PHYSICIAN CERTIFICATION AND RECERTIFICATION OF CLAIMS

CMS is proposing revisions to prevent denials when the order does not include the precise location of the supplemental information within the medical record.

Comment: **UPH enthusiastically supports this change**, which prioritizes patient care over burdensome documentation.

REQUEST FOR FUTURE RELIEF FOR EMERGENCY CARE BARRIERS

Emergency Medical Treatment and Active Labor Act (EMTALA) was passed by the US Congress in 1986 as part of the Consolidated Omnibus Reconciliation Act (COBRA) to address the problem of "patient dumping." EMTALA regulations are not revisited within this proposed rule.

Comment: EMTALA was passed into law more than 30 years ago at a time when the practice of medicine was much different in terms of staffing, technology and use of advanced practice providers. Hospitals, particularly Critical Access Hospitals (CAHs) and those located in rural areas, continually grapple with physician shortages. This is particularly true for Emergency Departments, and hospitals have increasingly turned to advanced practice providers for an onsite presence in providing emergency care. While EMTALA permits emergency care to be provided by advanced practice providers within the scope of the license as determined by the states, the EMTALA statute and corresponding regulations supersede state licensure with respect to certifying patient transfers. In particular, EMTALA requires consultation between an Advanced Registered Nurse Practitioner (ARNP) and a doctor of medicine or osteopathy to certify the

transfer of a patient. We would request that this provision be reconsidered to respect state licensure and scope of practice laws.

Iowa, in addition to several other states, allow for independent practice by an ARNP (655 – 7.1 IAC). The Iowa Board of Nursing outlines an ARNP's scope and practice to include healthcare services to Iowans of all ages in primary and/or ambulatory, acute, and long-term settings. The ARNP practices within their scope of practice based upon their educational background and the standards and guidelines established by their national certifying body (i.e. American Nurses Credentialing Center, American Academy of Nurse Practitioners). In Iowa, an ARNP may practice independently. However, an ARNP may have a collaborative agreement with a physician or physicians if their practice so warrants, but this agreement is not a requirement of the Iowa Board of Nursing.

The EMTALA consultation requirement for patient transfers requires collaboration in each case regardless of ARNP knowledge and experience. This requirement does not allow independent practice, imposes an undue delay in providing care, and has financial implications for hospitals that are already operating on thin margins. A natural delay is created when any provider is required to consult with another provider; therefore, potentially delaying critical treatment which is one of the core principles EMTALA is based upon. Iowa hospitals utilizing ARNPs in Emergency Departments are also faced with paying an additional provider specially for on-call services to the ARNP. **We would request that CMS work with Congress to remove this requirement from statute and regulation.** In the meantime, and if possible, we would request that CMS consider implementing a demonstration to test the waiver of this requirement for CAHs or rural hospitals with 100 or fewer beds that are located within a HPSA to enable ARNPs to practice at top of licensure. This waiver would be similar in nature to the nonenforcement instruction issued by CMS for physician supervision requirements in CAHs and small rural hospitals. We appreciate your consideration of this request for additional relief.

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

Sincerely,

Sabra Rosener
Vice President / Government Relations Officer