



UnityPoint Health

Government & External Affairs
1776 West Lakes Parkway, Suite 400
West Des Moines, IA 50266
www.unitypoint.org

September 10, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-1693-P – Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability ; published in Federal Register (Vol. 83, No. 145), July 27, 2018

Submitted electronically via www.regulations.gov

Dear Ms. Verma:

UnityPoint Health (“UPH”) appreciates the opportunity to provide comments in response to the Centers for Medicare & Medicaid Services’ (CMS) proposed rule for the 2019 Physician Fee Schedule and Part B reimbursement. Through more than 30,000 employees, 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, western 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. UnityPoint Health Accountable Care (UAC) is the ACO affiliated with UPH and has value-based contracts with multiple payers, including Medicare. UAC is a current Next Generation ACO, and it contains providers that have participated in the Medicare Shared Savings Program as well as providers from the Pioneer ACO Model.

UnityPoint Health respectfully offers the following comments to the proposed regulatory framework.

EVALUATION & MANAGEMENT (E/M) VISITS

CMS is proposing a number of coding and payment changes with the intent of reducing administrative burden and improving payment accuracy. Proposed changes will be addressed individually in our comments.

- **Comment:** CMS proposes an overall implementation date of January 1, 2019 for all proposed E/M changes. Should any of these proposal become final, we support the January 1, 2019 date for removal of redundant documentation; however, we would request that CMS consider delaying until

January 1, 2020, other proposed changes to allow for more modeling and feedback that will ensure seamless implementation.

Eliminating Extra Documentation Requirements for Home Visits: CMS is proposing to remove the requirement that the medical record must document the medical necessity of furnishing the visit in the home rather than in the office. We want to thank CMS for this proposal to reduce administrative burden and enable more beneficiaries to access home health services. From a provider standpoint, this proposal does reduce unnecessary physician documentation. This is a great first step and ***we support implementation starting January 1, 2019.*** Along the same rationale, we request that CMS consider:

- Eliminating the requirement for the Home Health face-to-face encounter for certification/recertification for post-acute or skilled discharges. In situations in which a home health referral is made as part of a post-acute or skilled nursing facility discharge, a mandatory face-to-face encounter for purposes of certification is not necessary and a waste of physician time and associated costs. We would recommend that CMS permit these certifications to be claims based and to rely upon the medical record of the patient to determine need.
- Recognizing efficient patient home health transitions between traditional Medicare and Medicare Advantage. Presently, when a home health beneficiary switches between Fee-for-Service Medicare and Medicare Advantage, the HHA must re-establish the beneficiary'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 CMS simply enable home health eligibility to continue regardless of Medicare payment source.

Eliminating Prohibition on Billing Same-Day Visits by Practitioners of the Same Group and Specialty: ***We support implementation on January 1, 2019.*** This proposal recognizes the value of follow up of patients who need additional evaluation by the same, as well as different necessary specialties, as dictated by the patient's situation. We would suggest that this proposed rule be limited to care outside of global care diagnosis—new medical complications or diagnosis or underlying medical condition that need addressed not related to a primary procedure (surgery). While we do not foresee any unintended consequences, we do anticipate that this will greatly simplify billing activities.

Removing Redundancy in E/M Visit Documentation: Under this proposal, practitioners would no longer be required to re-enter information in the medical record regarding the chief complaint and history that are already entered by ancillary staff or the beneficiary. ***We support a January 1, 2019 implementation date for this provision.*** This would be a great win for patient satisfaction and working at top of license with support staff by eliminating repeated questions and re-entry of information. In terms of expanded application to medical decision-making or for new patients, we would fully support CMS's continued exploration and encourage expanded adoption as these would promote the full value of an EHR. To realize this, CMS should continue to encourage safe and efficient sharing of data across all settings of care.

Providing Choices in Documentation—Medical Decision-Making (MDM), Time or Current Framework: CMS is proposing three choices to document an E/M visit. The proposed E/M payment rates would apply regardless of the selected documentation approach and the existing CPT coding structure would remain. ***In concept, we support the recognition of time, medical decision making***

and additional codes reflecting prolonged time ordered or performed by providers in coordination of care for patients. The impact of a complete unhooking of payments related to EM codes would lift significantly the burden of documentation on practitioners; however, ***due to the multiplicity of coding options to use under the proposed change framework and in the face of other payers not providing similar options, we anticipate that this will lead to provider confusion (multiple different documentation requirements) and negate a large part of the intended value of the change. We request that CMS delay implementation for one year*** to allow our organization and providers across the country to fully digest the rules, make workflow changes, revise EHRs as needed and institute training.

CMS has requested input on several implementation questions. In general, these questions and our responses imply that this proposed framework requires more thought and stakeholder input and would support a one-year delay in implementation.

- MDM guidelines: We believe these guidelines would need to be changed in subsequent years. The value of MDM, patient education and coordination of care across the care continuum would become the basis for payment models. This transition would involve partnering with Medicare Advantage health plans and commercial payers in a meaningful dialogue to move in the same direction as these payment models have played off each other for years.
- Use of time as a framework for documentation: We believe this framework should also be linked to the MDM grid and documentation of complexity of care coordination and patient risk score. We would encourage CMS to transition over a 2- or 3-year period to this model to match the work being done now in value based contracting. Specifically related to the issue of unit of time fulfilled when reaching the mid-point of the total time, we would encourage CMS to consider using the podiatry framework provided for time for other ambulatory medical E/M services.
- Add-on codes: While there are always costs associated with coding and billing changes, we support the additional codes for prolonged E/M visit services.
- Use of other E/M documentation systems, such as the Marshfield tool: We believe this is worthy of more exploration by CMS. In reference to the Marshfield tool, we believe it is simpler to use.
- Whether proposed choices alleviate documentation burdens and better reflect medical practice: In principle they do. Our pause is in details and the operational impact on offices and groups around compensation modeling and managing this in face of other payment models that are disparate.
- Impact of proposed choices on clinical workflows, EHR templated, and other aspects of practitioner work: Fully implemented this proposed rule would completely change the workflows, templated note format and use of the EHR as a data aggregator and repository to be referenced for medical decision making after performing needed history and physical examination for the medicals condition present. While there are long-term benefits, there are real and potentially significant short-term costs related to development, training and implementation.

Minimizing Documentation Requirements by Simplifying Payment Amounts: CMS is proposing to pay a single rate for level 2 through 5 E/M rates. This proposal includes valuation exceptions related to (1) separately identifiable E/M visits furnished in conjunction with a 0-day global procedure, (2) primary care E/M visits for continuous patient care, and (3) certain types of specialist

E/M visits, including those with inherent visit complexity. This is a major change. In its current form, **we cannot support a January 1, 2019 start date** as there are too many unanswered questions and it is unclear the extent to which CMS has involved stakeholders in vetting the considered alternatives. Our specific concerns include:

- Accounting for E/M Resource Overlap between Stand-Alone Visits and Global Periods: We do not believe this reflects the value to the patient or the provider, as lack of payment for same day procedures with E/M code does not recognize the clinical need and value, the convenience to the patient, and the overall efficiency of the care. **We would recommend that CMS focus less on a devaluation and/or clarity around diagnosis codes and instead target the need for independent history and examination.**
- Proposed HCPCS G-code Add-ons to Recognize Additional Relative Resources for Certain Kinds of Visits: We applaud CMS in recognizing the great value these bring to primary care provider work and patient outcomes. This exemplifies the movement toward recognizing value via the time for coordinating care for better outcomes instead of focusing on sheer service volume. **Although we are extremely supportive, we do not believe that this policy adequately addresses the deficiencies in CPT coding for E/M services.** In our review of how the proposed rule impacts primary care (less so family medicine) and primarily cognitive specialties, we still have concerns despite proposed rules and code changes.
- Proposed HCPCS G-Code for Prolonged Services: **We support** this initial step.
In terms of the alternatives considered, we are intrigued by both (more limited single payment rate and use of patient relationship modifiers) and, without further detail and analysis, we do not believe that they should be eliminated from consideration. As for a single payment rate that includes combined E/M visit levels 2 through 4, we would support further exploration as this appears to be a simpler and better approach than that which is proposed. We do agree that this analysis should include a minimum of three or perhaps four levels to better streamline documentation. As for patient relationship modifiers, this is promising. Again we would suggest that CMS explore and recommend how this could be phased in over at least a two-year period to allow for expanded dialogue and successful implementation.

NONEXCEPTED OFF-CAMPUS PROVIDER-BASED DEPARTMENTS

For CY 2019, CMS is proposing to maintain the current PFS relativity adjuster Relatively Adjuster at 40 percent.

- **Comment**: UPH opposed this reduction in payment rates for non-excepted off-campus provider-based departments (PBDs) when first instituted for CY 2018¹. For CY 2019, CMS is proposing to continue the use of a single scaling factor “until we identify a workable alternative mechanism that would improve payment accuracy.” **We are disappointed that this imprecise methodology continues to be used** and that CMS has recommended its expansion to other services and PBDs within the CY 2019 OP/ASC proposed rule (CMS–1695–P)². UPH intends to submit a comment

¹ See PFS_2018_UPC_9-11-17 at Regulations.gov tracking number 1k1-8ym0-6v25

² 83(147) Fed Reg 37046-37240 published on July 31, 2018 – *Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging*

letter related to the excepted status of off-campus PBDs and the excepted status of items and services during the public notice and comment period for CMS–1695–P.

COMMUNICATION TECHNOLOGY-BASED SERVICES

CMS is proposing to modernize Medicare payment by expanding telehealth reimbursement for specific services. In particular, CMS is proposing to reimburse (1) virtual check-ins (HCPCS code GVC11); remote evaluation of pre-recorded patient information (HCPCS code GRAS1), including store-and-forward technology; (3) interprofessional internet consultation (CPT codes 994X6, 994X0, 99446, 99447, 99448, and 99449); (4) Prolonged preventive service(s) (HCPCS codes G0513 and G0514); and (5) Expanded access to home dialysis therapy and expanded use of telehealth for individuals with stroke.

- ***Comment:*** We applaud these efforts. Overall these telehealth proposals are steps in the right direction for the advancement of telehealth and utilization of generally available consumer and provider technologies to deliver improved/enhanced care. Telehealth is a vital service delivery modality that enables access to services for patients with distance or transportation barriers, mobility issues and/or provider shortages. Although many patients in our service reside in a rural or underserved area, there is a substantial number of patients living in metropolitan areas that have access barriers to health care services. Before addressing the proposed rules, we would like to reiterate our continued position relative to telehealth expansion. ***We recognize CMS does not have authority to modify the Social Security Act; however we strongly encourage CMS to advocate for eliminating the geographic restrictions imposed on originating sites by Section 1834(m) (the requirement that the “originating site” for telehealth services must be located in a rural Health Provider Shortage Area or a county outside of a Metropolitan Statistical Area).*** This geographic limitation draws arbitrary service eligibility lines, which do not necessarily correlate to patient barriers to care but do restrict service delivery options and preferences and hamper population health initiatives. ***At a minimum, we recommend that CMS tie the removal of this rural limitation to providers participating in risk-bearing arrangements*** (i.e. participation in an Advanced Alternative Payment Model under the Quality Payment Program). CMS could also consider expanding originating services generally to include patient homes, schools, long term care hospitals, hospice centers, and employer work sites.

Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code GVC11): We support this expansion and encourage flexibility in this arena. In particular, ***we would recommend including real-time (synchronous) and store-and-forward (asynchronous) audio and video platforms, although we believe that audio-only telephone interactions are not equivalent to interactions that are enhanced with video or other kinds of data transmission.*** That said, we believe that providers can determine when the audio-only platform may be appropriate to assess whether the patient’s condition necessitates an office visit and that CMS should not include a bright-line exclusion here.

We would also request that CMS revisit the window of time and/or circumstances in which this

service should be bundled. As proposed, this service is separately billable if it is “not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.” We are uncertain how these timeframes were derived and, without evidence of fraud or abuse, CMS should enable latitude and not impose restrictions. We are also concerned that “related E/M service” and “or soonest available appointment” are unclear and would serve as a disincentive for these services to be provided. Instead we would suggest that CMS bundle virtual check-in services provided on the same day and within 3 days pre-visit and 24 hours post-visit for the same patient diagnosis.

CMS has requested input on several implementation questions. In terms of consent, we believe that consent would be implied by a patient through their access to a technology-based platform and that CMS should not require verbal consent to be noted in the medical record for each service. For future frequency limitations related to the same provider and patient, we believe it is premature for CMS to consider frequency limits, which without evidence of fraud and abuse are arbitrary at best. Overall, frequency limitations would create confusion and hesitation with providers that could prevent utilization and adoption of the service. In addition, we believe that potential overutilization of virtual check-ins would be mitigated by Medicare’s requirements for the visit to be reasonable and medically necessary/appropriate.

Remote evaluation of pre-recorded patient information (HCPCS code GRAS1): We support this telehealth expansion. We would also support the use of this modality for new encounters to aid timely evaluations for patients. Similar to virtual check-ins, we would request that CMS revisit the window of time in which services are bundled. Like virtual check-ins, this service is separately billable if it is “not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.” Again we are uncertain how these timeframes were established and the same unclear terms are used. In addition we do not believe that current timeframes will have the intended result. An example of unintended results could be a dermatology E/M visit for a patient presenting with a rash. Then two days later, there is a change in the rash and the patient wants to know if they need to come in to the clinic or if the change is not concerning/requiring an in-person visit. The patient takes a picture and sends it to the provider via a patient portal. We do believe this remote evaluation would be separately billable. We encourage CMS to consider bundling the remote evaluation of pre-recorded patient information provided on the same day and within 3 days pre-visit and 24 hours post-visit for the same patient diagnosis. We also recommend that new patients be included under this service. Allowing such coverage for new patients would increase access to specialty services by providers being able to triage more appropriately and improve outcomes in a time-sensitive manner.

Interprofessional internet consultation (CPT codes 994X6, 994X0, 99446, 99447, 99448, and 99449): We support these additions. The primary benefit is for the patient, and the practitioner is compensated for providing reimbursable services (i.e. being recognized for the time and expertise needed to provide the services). We believe that these consultative services are separately identifiable and comport with the current practice of medicine and need for timely care. This modality of interprofessional consultation recognizes that is not efficient or practical for patients to directly seek these services via separate in-person consults from specialists nor it is desirable for

specialists to not be reimbursed for consults to primary care providers when delivered via the internet. In fact, we would opine that the use of provider-to-provider consults may potentially save avoidable Medicare costs resulting from a more appropriate use of specialty E/M visits. This modality is also conducive to EHR documentation.

While we support these additions, we would also reiterate our previous position that telephone visits are not equivalent to video or other patient care data transmissions. We request that CMS clarify whether “interprofessional internet service” encompasses real-time video, a store-and-forward visit, or simply a patient-provider message via a patient portal. We have case uses for all these situations and would urge CMS to similarly interpret these codes as reimbursing these modalities.

In terms of potential program integrity issues, we believe that the potential is not greater than with other practice modalities. Assuming that interprofessional internet consults would be subject to the Medicare “medically appropriate” guidelines, we do not favor any additional limitations. As for advanced consent, we believe that CMS should require the same as the level of consent that is required for in-person care for separate reimbursement to apply. As CMS continues to encourage transition to value through two-sided risk ACO and MA vehicles, CMS should continue to provide implementation flexibility to enable such organizations to innovate in service delivery outside traditional Fee-for-Service billing constraints.

Prolonged preventive service(s) (HCPCS codes G0513 and G0514): We support these new codes. In addition, we would request that CMS consider establishing codes related to patient education, pharmacy management services, dietary and counseling services.

Expanded use of telehealth for individuals with stroke: We are extremely supportive of this provision as authorized under the Bipartisan Budget Act of 2018. We believe that CMS’s proposed billing modifier and the mobile stroke unit definition are appropriate. UPH currently uses mobile stroke units and reimbursement of this service by CMS will encourage further improvement in our ability to timely evaluate strokes, to enable timely treatment, and to improve patient outcomes and quality of life. For future rulemaking, we would suggest that CMS consider Skilled Nursing Facilities and Long Term Care Hospitals as appropriate originating sites for telehealth services furnished for the diagnosis, evaluation, or treatment of symptoms of an acute stroke.

COMMUNICATION TECHNOLOGY-BASED SERVICES IN RURAL HEALTH CLINICS (RHCS) AND FEDERALLY-QUALIFIED HEALTH CENTERS (FQHCS)

For CY 2019, CMS is proposing payment for RHCs and FQHCS for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit.

- ***Comment: We enthusiastically encourage this billing expansion for RHCs and FQHCS.*** UPH has more than 30 associated stand-alone RHCs located throughout Iowa and Illinois. In these rural areas, the residents are primarily elderly with a high prevalence of multiple chronic conditions and other socioeconomic risks. RHCs provide needed safety net access and enable Medicare beneficiaries to remain in their communities. This proposed rule promotes access the healthcare services through service delivery flexibility and enables greater use of these services for vulnerable populations. Since this provision is almost verbatim with the proposed virtual check-in and remote evaluation of pre-

recorded patient information, ***we would suggest CMS consider our recommendations related to the bundled timeframe as well as to language revisions to clarify terminology.***

APPROPRIATE USE CRITERIA (AUC) FOR ADVANCED DIAGNOSTIC IMAGING SERVICES

For CY 2019, CMS is proposing to expand applicable settings, revise consultation requirement to include auxiliary personnel, clarify reporting requirements across claim types and by both the furnishing professional and furnishing facility, revise significant hardship exceptions, and solicit feedback regarding the identification of outliers.

- ***Comment:*** We appreciate the opportunity to provide input as AUC is being further refined.
 - ***Definition of applicable settings:*** We support the addition of independent diagnostic testing facilities (IDTF) to this definition. ***We believe this definition should also include provider based services*** (PBS), including a situation, for example, in which orthopedic physicians have a MRI in their own office.
 - ***Consultation requirement:*** ***We support*** the revision to include auxiliary professionals as this is necessary due to workload and workflow constraints.
 - ***Reporting:*** ***We support a comprehensive approach of reporting on all claims.*** For claims-based reporting, we would prefer reporting based on an UCI reporting system, which would hopefully be accounted for by vendors and avoid the burden and potential confusion from G-codes and modifiers. In the alternative, we would suggest the continued use of the DSN number, which would also avoid additional modifiers or G-Codes.
 - ***Hardship exceptions:*** ***We support*** the hardships as listed; however, would caution against creating too many exceptions and undermining the purpose of the program.
 - ***Outlier identification:*** We realize that CMS is still developing the process to identify outlier ordering professionals. If outliers are identified based upon utilization data (by decile over a period of time), it is likely that “n” sizes may be quite low for individual providers. If this approach is used by instead utilization is aggregated at the TIN level, it is possible that individual outliers will negatively impact all TIN providers and could place significant burdens on large organizations. On the other hand, if outliers are identified using appropriateness scores, this could be potentially subject to “gaming” by providers. Since there does not appear to be an ideal solution, ***we would urge CMS to work with stakeholders as they continue to work on this issue.***

MEDICARE CLINICAL LABORATORY FEE SCHEDULE

CMS is proposing to revisit the definition of applicable laboratory.

- ***Comment:*** UPH supports the objective is to obtain as much applicable information as possible from the broadest possible representation of the laboratory market on which to base CLFS payment amounts without imposing undue burden on those entities. With that in mind, ***we recommend retaining the current low expenditure threshold*** as the proposed increase or decrease does not appear to substantially impact the number of laboratories reporting. As for other approaches to defining applicable laboratory, we do not believe there is compelling advantages to either proposed alternative and would not support these approaches at this time.

CY 2019 UPDATES TO THE QUALITY PAYMENT PROGRAM (QPP)

CMS is proposing numerous changes to the QPP, which consists of two participation pathways – the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs), including the All-Payer Combination Option to qualify as an Advanced APM. CMS is also proposing waivers of MIPS requirements as part of the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration.

- **Comment:** UAC is a Participant in the Next Generation ACO, which qualifies its provider / suppliers as an Advanced APM. In addition, UPH has some providers outside UAC that qualify for and must report under MIPS. It is from both perspectives that we would like to address select provisions of the proposed QPP update. Upfront, ***we would suggest that CMS consider moving the QPP proposed rules to a notice and comment period earlier in the calendar year.*** By placing within the annual Physician Fee Schedule update, it is unlikely that the final rule will be released before November leaving only 2 months to operationalize changes. We would suggest that the QPP update occur during a timeframe that is more aligned to the annual Inpatient Prospective Payment System update (proposed rule in the spring and final rule in the summer).

MIPS Program: The timing of the expanded definition of eligible clinician is problematic. Beginning with the 2021 payment year (or the 2019 performance year), an expanded definitions of eligible clinician is proposed to include physical therapists, occupational therapists, clinical social workers and clinical psychologists. Alternatively, if quality measures proposed for removal are not finalized, beginning with the 2021 payment year (or the 2019 performance year), the definition of eligible clinician would be further expanded to include qualified speech-language pathologists, qualified audiologists, certified nurse-midwives, and registered dietitians or nutrition professionals, provided that each applicable eligible clinician type would have at least 6 MIPS quality measures available to them. ***We urge CMS to consider delaying the effective date of this expanded definition for one year or alternatively exempting these expanded clinicians from MIPS reporting if they are associated with a TIN that appeared on the 2019 Next Generation ACO participant list.*** Foremost, it should be noted that just because MIPS quality measures are available, this should not be equated to mean that vendors have constructed software packages for these clinicians. For instance, of all MIPS measures, EPIC has roughly 60 eCQMs and the selected measures focus on family practice, primary care and orthopedics. Any targeted measures for the expanded group of eligible clinicians will likely need to be manually extracted in the first year. In general, the expanded group will require quality workflows and re-education and training to be successful under MIPS reporting. For Next Generation ACO Participants, the anticipated publication date of this Final Rule does not allow adequate time to enable these clinician types to be included on a Next Generation ACO provider list and, without accommodate, all these clinicians would be subject to MIPS reporting.

For performance year 2018, MIPS had extensively excluded many rural providers through the rule making process and left little incentive for these providers to aspire to A-APM participation. In this proposed rule, CMS has expanded the low-volume threshold by establishing a third criteria (minimum number of covered professional services) and effectively enabled more clinicians to be exempt from MIPS requirements. ***We are concerned that further broadening the low-volume threshold does little to encourage these providers to transition to value and increasingly penalizes those remaining in MIPS as the pool of eligible clinicians continues to shrink.***

CMS requested comment on the new measure, Health Information Exchange Across the Care Continuum under the Health Information Exchange objective. We believe that this measure is premature and does not account for the variation in EHR adoption across sites of care. While hospitals may have a high EHR adoption rate, this cannot be assumed for long term care facilities and post-acute care providers such as skilled nursing facilities, home health, and behavioral health settings. We do not believe that eligible clinicians should be penalized if they collaborate with sites that do not have reciprocal EHR capabilities. ***We believe that the Health Information Exchange Across the Care Continuum needs further work and do not support as proposed.***

In terms of QPP reporting, we want to share some successes and challenges. We appreciate that CMS has a dedicated call desk and want to complement the overall timeliness of its responses. We usually receive responses, including escalating issues, within 1 to 2 working days with an outside response time of 4 days. ***While response times have been outstanding, the quality of the QPP call desk responses could be improved.*** We often receive conflicting information from different call desk staff, the canned replies are many times not responsive to the initial question, and call summaries often characterize the initial question incorrectly. As for the Enterprise Identity Data Management (EIDM) system, we were pleased to see the definitional changes within the proposed rule. ***We would request that CMS provide further clarification and education on the various EIDM roles so organizations can understand what is needed for submitting data, running reports, and approving access.*** We would also request that CMS institute notifications or user/submitter communications when there are system downtimes or errors.

Advanced APMs: We support the CMS proposals to increase CEHRT usage, require evidenced-based quality and outcomes measures, and continue the heightened financial risk bearing standard. We believe that these proposals are foundational as entities move to value.

Perhaps the biggest impediment to Advanced APM status and growth is an issue that CMS choose not to address – Advanced APM participation thresholds. ***We reiterate our past position that Advanced APM participation thresholds for Medicare-only revenue or patient count should be eliminated altogether or kept at 2017 and 2018 performance year levels.*** The Proposed Rule maintains the MACRA thresholds which progressively increase the revenue percentage for QPs within Advanced APMs from 25% to 50% (starting in 2019) to 75% (starting in 2021) and the patient counts from 20% to 35% to 50%. We are concerned with the graduated schedule of heightened thresholds. In particular, these thresholds:

- Discourage future Advanced APM participation from clinicians struggling to meet current thresholds.
- Jeopardize clinicians that have already achieved Advanced APM status.
- Disfavor rural providers, as the limited number of rural patients makes thresholds more difficult to achieve than in urban areas. In rural areas, ACOs may participate in every available risk arrangement but still fall short on the number of covered lives.

In addition, the thresholds incorrectly assume that accelerated growth in value-based arrangements is achievable over a very short term. The thresholds fail to adequately consider:

- Levels of risk arrangements outside Part B Medicare, which are often insufficient in Advanced APM local markets
- Inherent attribution limits. There are a limited number of primary care providers (PCPs) or PCP-like specialists that are not employed by competitive health systems or, as the only major

specialist group in the community, are willing to align directly with one health system versus another health system.

- Diminishing return constructs within Advanced APMS. The objective is to deploy programs and resources to lower the overall costs while maintaining access and quality. As a result, there is a decrease in overall revenue from value-based arrangements.

As participation in Advanced APMs increases, we urge CMS to re-evaluate these thresholds to encourage greater migration to value-based arrangements. Instead of MACRA thresholds, Advanced APM status should rely on the underlying eligibility requirements for those Advanced APM demonstrations or programs appearing on the QPP website list. If thresholds are not eliminated, we would suggest that revenue threshold remain constant at the 25% revenue or 20% patient count Medicare-only thresholds with one caveat – Medicare-only should also recognize MA revenue or patient count as needed for MA relationships that share “more than nominal risk” with clinicians.

All-Payer Combination Option: Despite changes offered, we continue to believe that the proposed determination process is highly complex and resource intensive and will not achieve its intended purpose. Aligned with our recommendation to eliminate all thresholds or freeze current Medicare-only participation thresholds, ***we would suggest that the All-Payer Combination Model should be eliminated or the recognition of Other Payer Advanced APMs should be limited to CMS programs and/or initiatives.*** As mentioned in our Advanced APM response above, we are supportive of MA revenue and patients being applied to the Medicare-only thresholds for MA plans that meet Advanced APM requirements.

Among our specific concerns,

- Burden for data and submission has shifted to an untested and burdensome eligible clinician-initiated process. It has been our observation that although CMS has established a payer-initiated process under the QPP, participation by payers has been lackluster. In states with single dominate payers, the ability of providers to participate is held hostage.
- TIN reporting option, while helpful, still requires an aggregation of data that is controlled by payers.
- ACOs are not recognized in the eligible clinician-initiated process, only individual NPIs or TINs. To put in perspective, UAC has more than 5,000 eligible clinicians and 150 provider/supplier TINS. This approach is flawed, as the ACO and not eligible clinicians are the contracted party in many value-based arrangements. Direct reporting by clinician TINs and NPIs negates an advantage of the ACO structure and streamlined reporting and hinders the ability of the ACO to monitor and assist its provider network in the QP determination process.

Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration: The MAQI Demonstration proposes waivers that will exempt clinicians from MIPS reporting requirements and payment adjustment for a given year if they participate to a sufficient degree in Qualifying Payment Arrangements with Medicare Advantage Organizations. ***UPH supports including clinician participation in certain Medicare Advantage (MA) value-based arrangements within the “Medicare-only” QPP thresholds and outside the thresholds of the All-Payer Combination Option.*** If CMS would recognize this approach, we do not believe that this Demonstration would be necessary. We would urge CMS to consider paths that recognize QP status

for clinicians participating in Medicare value-based arrangements, rather than merely exempting them from burdensome MIPs reporting requirements. These clinicians have already made a commitment to value through high-risk arrangements and should be rewarded. Aside from these policy concerns, we laid out concerns related to the proposed MAQI information collection in our response to CMS-10673³. We believe that this process could be streamlined.

MEDICARE SHARED SAVINGS PROGRAM (MSSP) QUALITY MEASURES

CMS is proposing to reduce the total number of measures in the MSSP quality measure set from 31 to 24 and focus the measure set on more outcome-based measures including patient experience of care.

- **Comment:** UPH participates in the Next Generation ACO through UAC, which uses the MSSP measure set. Although generally supportive of the changes, we have some comments, requests for clarification as well as additional items for consideration.

New Web Interface measure: **We support** the addition of *ACO-47 (NQF #0101) Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls* to fill the existing gap in following up on positive fall screenings.

Removed Web Interface metrics: **We support** the removal of all six measures. For ACO-12 (NQF #0097) Medication Reconciliation Post-Discharge, we support removal based on its burdensome manual extraction; however, should there be a way to reduce this burden in the future, we believe this is generally a good measure that promotes best practice. For ACO-15 (NQF #0043) Pneumonia Vaccination Status for Older Adults, we agree that this should be removed due to no longer meeting clinical guidelines but we would encourage CMS to reinstate a successor measure once it is endorsed. From a patient care perspective, this can have great impact the populations we serve. **For future consideration, we request that CMS remove ACO-40 (NQF #0710) Depression Remission at Twelve Months.** Most groups receive very small denominator counts because of the restrictive criteria for the denominator criteria and required use of the PHQ-9 tool. UAC has never had more than 10 patients in this metric. CMS has proposed to remove Use of Imaging Studies for low denominator counts which makes the metric not valuable, so we would suggest that the same rational be applied to ACO-40.

New CAHPS measures: **We support** the adding both proposed measures as they promote a positive experience for our patients.

Convert CAHPS measures to Pay-for-Performance: CMS seeks comment on potentially converting the Health and Functional Status SSM (ACO-7) to pay-for-performance from pay-for-reporting in the future. **We are opposed to this conversion at this time.** This measure is very subjective (being based on the patients perception of their health) and is not necessarily anything that providers can influence. Our opposition relates to concerns with the CAHPS survey methodology: (1) Sample size of 860 is the same regardless of actual ACO size; (2) sampled patients do not represent the full population we serve (when comparing our own CG-CAHPS data comparing Next Generation patients to non-Next Generation patients, Next Generation patients consistently score us higher in almost every domain); and (3) providers cannot influence response rates (while we have a low response

³ UPH letter to Medicare Program; Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

rate and high number of surveys returned for bad addresses, we aren't able to supplement with more accurate contact information in effort to reach more of the sampled patients). We would recommend keeping the status of ACO-7 as reporting only while CMS works through changes in how the data is collected over time. When these issues are resolved, we would support CMS efforts to reintroduce this measure with pay-for-performance status.

Removed claims metrics: *We support* the removal of the four measures and appreciate that CMS will be providing ACOs quarterly data on Skilled Nursing Facility 30-Day All-Cause Readmission, All-Cause Unplanned Admissions for Patients with Diabetes, and All-Cause Unplanned Admission for Patients with Heart Failure.

Other requests: As we look to plan for and implement the proposed changes, we request guidance on the following: (1) On page 35878, the proposed rule references Table 26 by stating "Care Coordination / Patient Safety – 5 measures, including the double-weighted EHR measure." For purposed of the Next Generation ACO model, is ACO-11 double weighted or does this weighting only apply to ACOs within the MSSP?; and (2) 2018 changes to Web Interface submission requirements for Next Generation ACO quality reporting. Without notice, CMS changed the reporting format from an xml format to an Excel format. The new Excel file template was provided, including 146 columns to capture data for all measures in one spreadsheet and drop down lists to help ensure only valid data was submitted in each cell. While this format might be helpful for an organization that manually abstracts their data into the spreadsheet, it was and is very burdensome for organizations that have automated this process to pull directly from their EHR. UAC had been required to use the xml format since its participation in the Pioneer ACO Model in 2012. We would request that CMS consider reinstating the xml format for early adopters and also suggest that in the future CMS work with stakeholders as it considers "upgrading" reporting systems to consider timing and impact.

PHYSICIAN SELF-REFERRAL LAW

CMS is proposing revisions to the Stark Law intended to reflect changes from Bipartisan Budget Act of 2018 pertaining to the writing and signature requirements in certain compensation arrangement exceptions.

- **Comment:** Of the two alternative approaches offered by CMS, *we prefer the second alternative – to delete §411.353(g) in its entirety and codify a new special rule on compensation arrangements at §411.354(e).* We recommend this alternative because we believe that this more directly accomplishes Congressional intent and an entirely new exception will not be embedded in an existing exception subject to past rulings and interpretations.

While UPH is supportive of reform efforts that include clarification of substantive terms and technical corrections as offered in this proposed rule, we believe more clear, directional change is needed in the Stark Law to recognize the shift from a fee-for-service system to one in which the providers undertake the financial risk of healthcare delivery. As healthcare providers continue to assume more risk and transition toward value-based payments, removing the impediments created by the Stark Law has become more clearly necessary for the Medicare Program to better control the rise in medical costs as well as the provider community's willingness to accept the role of legal and financial risk taker. Physicians who seek to participate in Alternative Payment Models ("APMs")

or waiver covered ACO arrangements need to **know** their efforts will not result in possible violations of the Stark Law. In response to CMS-1720-NC, the recent Request for Information Regarding the Physician Self-Referral Law, UPH offered **a dedicated Stark Law exception that addressed innovative value-based payment models that establish networks involving designated health services entities and referring physicians to assume financial risk and provide high-value services.**⁴ In addition we offered companion language that included harmonizing language to provide clarity within existing Stark Law exceptions for value-based arrangements.⁵

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,



Dan Allen, MD
Chief Medical Officer
UnityPoint Clinic



Sabra Rosener, JD
VP, Government & External Affairs
UnityPoint Health

⁴ StarkRFI_UPH_08-24-18.pdf submitted via Regulations.gov at comment tracking number: 1k2-9515-eahs; See Appendix A: New Value Based Arrangements Exception

⁵ StarkRFI_UPH_08-24-18.pdf submitted via Regulations.gov at comment tracking number: 1k2-9515-eahs; See Appendix B: Other Modifications to Existing Exceptions