WISCONSIN HOSPITAL ASSOCIATION, INC.

September 10, 2018

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

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 Program

Dear Ms. Verma:

On behalf of our more than 135 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed revisions to payment policies under the Physician Fee Schedule (PFS).

WHA was established in 1920 and is a voluntary membership association. We represent all of Wisconsin's hospitals and integrated health systems. Our members include small, mid and large-sized hospitals, including many Critical Access Hospitals and several large academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members. In addition, many of these entities employ or are closely affiliated with physicians and other providers. On behalf of our members, WHA appreciates the opportunity to comment on the proposed rule.

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Evaluation and Management (E&M) Documentation Revisions and Payment Changes.

Because of the highly integrated nature of Wisconsin's health care system, WHA's work extends far beyond the hospital walls. At the direction of our board of directors, to address the interests and concerns of our integrated health system members, WHA has developed a strategic physician agenda. Our comments on the Evaluation and Management (E&M) documentation revisions and payment changes in the proposed rule illustrate how these provisions impact physicians working in our members' health systems.

Documentation changes

WHA strongly supports CMS's proposals to streamline E&M documentation. Reducing physician burnout is a top advocacy priority for WHA. Much of this burnout results from the heavy load of documentation within an EHR that is required for reimbursement, and whenever a requirement can be removed that does not support good patient care, that should be done. Specific rule provisions that accomplish this goal include:

- Removing redundancy in E&M visit documentation, when that information is already in the patient record, and requiring physicians to only be required to focus their documentation on what has change since the last visit or on pertinent items that have not changed. This will speed documentation and make it easier to locate pertinent information within the medical record without having to wade through pages of repetitive information.

- Eliminating extra documentation requirements for home visits. This change acknowledges that whether a visit occurs in home or office is best determined by the practitioner and the patient without applying additional rules. This is especially helpful for patients discharged after hospital stays who often require follow up post-acute care in the home to ensure their recovery is on track.

- Eliminating the prohibition on billing same-day visits by practitioners of the same group and specialty. This change acknowledges that practitioners within the same specialty may provide very different types of services to patients, even though they share the same specialty "title". In addition, it will enhance efficiency of care both for the patient and the practitioners by avoiding the need to return for clinic visits on different days.

- Reducing teaching physician documentation requirements for E&M services. WHA supports the changes in the proposed rule that streamline documentation required of a teaching physician by eliminating duplicative notations made by that physician. We support the provision that the teaching physician's involvement and participation may instead be demonstrated by notes in the medical records made by a physician, resident, or nurse.

CMS also asked commenters to address whether these streamlined documentation provisions should be implemented as of January 1, 2019, or not until January 1, 2020. WHA strongly supports CMS's "Patients over Paperwork" initiative and appreciates CMS's acknowledgement of the burden that documentation places on practitioners. That being said, WHA favors a phase-in period for these documentation changes in 2019 to allow clinicians to acclimate to the changes, with full implementation in 2020 at the earliest.

Consolidating E&M Payment Amounts

WHA strongly opposes CMS's proposal to consolidate the current 5 E&M reimbursement categories into 2 categories. This change will financially disadvantage physicians who see a more complex patient panel. Financial modeling conducted by some of our members anticipates losses in the millions of dollars each year should these changes go into effect. These losses will not be offset by the increases in efficiency that are expected due to the reduction in documentation requirements. While we appreciate the proposed creation of add-on codes to mitigate this impact, this will only serve to negate the efficiencies the rule hopes to achieve with the documentation changes described earlier in this letter. Additionally, the add-on codes will not generate enough revenue to offset the losses that will result from the code consolidation.

Quality Payment Program Changes

This letter also provides comments on the proposed changes to the Quality Payment Program. Wisconsin is home to very high-quality, high performing health systems, many of which rank at the top on national quality measures. WHA has continuously supported these systems by advocating payment initiatives that reward quality, improve patient experience and lower the cost of care. Such payment systems must be thoughtfully implemented, recognize administrative complexities and be highly accurate to drive improvement. These principles guide our comments in this area.

The proposed rule's changes to the Quality Payment Program and generally modest and beneficial. These changes continue a trend established in the CY 2018 updates to the QPP for an incremental, flexible approach to implementation.

Merit-Based Incentive Payment System (MIPS) changes

- Expansion of eligible clinicians. WHA does not object to the proposed inclusion of new categories of eligible clinicians in the quality payment program for CY 2019 (occupational therapists, physical therapists, clinical social workers, and clinical psychologists). However, we do have significant concerns about the relationship of these additional clinicians to the promoting interoperability performance category, and support setting the category weight to zero for the foreseeable future.

- Adding covered professional services to the low-volume threshold. The rule proposes an additional exclusionary category for MIPs: those clinicians who provide 200 or less covered professional services per year under the PFS. WHA supports this change, as it will prevent providers from being penalized by measures that are not meaningful because of the low volume of services provided. The proposed opt-in policy (see below) will permit clinicians who are ready to participate in MIPS even if excluded under these low-volume thresholds

- MIPS opt-in policy: We support the proposed MIPS opt-in policy starting in 2019. The ultimate goal should be broad participation in quality efforts by as many clinicians as possible and allowing opt-in will increase participation in the program by non-mandated clinicians who are ready to participate in MIPS.

- Category weight changes. The rule proposes increasing the cost category weight from 10% to 15%. WHA does not support this increase and urges CMS to maintain the cost category at 10% for at least the 2021 payment year. In our comments on the 2018 updates to the QPP, we supported keeping the scoring of this category at 0% for the 2020 payment year because we did not believe that CMS had the correct mix of cost measures, nor did clinicians have experience with the measures. Nonetheless, CMS set the cost category at 10% in the final rule. We urge maintaining this percentage until clinicians have experience with a correct mix of cost measures.

- New episode measures for MIPS cost category. WHA opposes adding the 8 new episode measures to the MIPS cost category. Measures need to be actionable and meaningful, and the proposed episodes need further vetting. WHA supports endorsement of quality measures by the National Quality Forum before their incorporation into MIPS.

MIPS Meaningful Use Provisions

WHA believes that CMS should structure its rulemaking for the MIPS Advancing Care Information performance category—proposed to be renamed the "Promoting Interoperability ("PI") performance category"—in such a way as to minimize regulatory burdens on physicians and other clinicians participating in MIPS ("MIPS eligible clinicians") and to ensure that any additional EHR investments, additional time spent using EHR technology, or adjustments to workflow that are necessary to avoid Medicare penalties are outweighed by health care cost-savings and improvements in patient outcomes. Reducing EHR task burden on physicians and other providers is especially important as provider time spent using an EHR continues to be significant. In a recent study of family medicine physicians providing care at clinics associated with the University of Wisconsin, researchers found that the average total EHR time per

weekday for a 1.0 clinical FTE was 5.9 hours and that physicians spent 44.2 percent of their total EHR time per day doing clerical tasks.

Similarly, the Trump Administration often has expressed its support for reducing the burden associated with regulatory compliance. For example, on January 30, 2017, the President issued an Executive Order, "Reducing Regulation & Controlling Regulatory Costs," that stated that "it is essential to manage the costs associated with the governmental imposition of private expenditures required to comply with Federal regulations" and that "it is important that for every one new regulation issued, at least two prior regulations be identified for elimination." On March 5, 2018, in remarks to the Federation of American Hospitals, Secretary Alex Azar identified the following as a "key engine for transformation" of health care: "addressing any government burdens that may be getting in the way of integrated, collaborative, and holistic care for the patient, and of structures that may create new value more generally."

The following WHA comments on CMS's proposals for the MIPS PI performance category align with the Administration's stated policy of reducing regulatory burden.

- Finalize 90-day reporting period for the MIPS PI performance category in 2020.
  CMS proposes that the 2020 reporting period for the MIPS PI performance category be any continuous 90-day period within CY 2020. Under current law, the 2018 and 2019 reporting periods for the PI performance category is any continuous 90-day period within the respective calendar year, and CMS has not yet adopted a policy for the 2020 reporting period.

WHA supports this proposal as providing flexibility for MIPS eligible clinicians seeking to demonstrate meaningful use of certified EHR technology. Such flexibility will be especially important as MIPS eligible clinicians make system and workflow adjustments that will be necessary to address other proposed changes to the PI performance category contained in this proposed rule, including new mandatory measures and a new scoring methodology.

- Finalize proposed scoring methodology for the MIPS PI performance category.
  CMS proposes a new scoring methodology for the PI performance category beginning with the 2019 reporting period. A combination of "pass/fail" and performance-based scoring, CMS's proposal contains several elements for MIPS eligible clinicians seeking to avoid a Medicare reimbursement penalty:

    - Each reportable measure would be scored individually based on the MIPS eligible clinician's performance and would be worth up to a specified number of points. The scores for each of the individual measures would be added together to calculate a total score for the PI performance category of up to 100 points. (The MIPS eligible clinician's score on the PI performance category would continue to

account for a fixed percentage—i.e., 25 percent—of the MIPS eligible clinician's final score under MIPS.)

- MIPS eligible clinicians would need to report on all required measures in order to earn any score for the PI performance category; failing to report a required measure or reporting "No" on a measure that must be reported as a "Yes/No" attestation would result in a score of 0 for the PI performance category. Under current law, the scoring methodology for the PI performance category is likewise a combination of "pass/fail" and performance-based scoring; the score for the PI performance category currently is comprised of an "all-or-nothing" "base score" and a performance-based "performance score" that allows the MIPS eligible clinician to gain points for performing at varying levels above the base score requirements.

WHA supports this proposal because it would align the scoring methodology for the MIPS PI performance category with the scoring methodology for the Medicare PI Program. As WHA previously has commented to CMS, including in WHA's comment letter to CMS on the 2019 IPPS proposed rule, CMS should encourage and facilitate greater alignment among the various federal programs that reward or penalize hospitals or providers for meaningfully using certified EHR technology, including the PI performance category of MIPS and the Medicare and Medicaid PI Programs. As CMS acknowledges in this proposed rule, "the distinction between ambulatory and inpatient [certified EHR technology] has diminished and more clinicians are sharing hospitals' [certified EHR technology]," and accordingly, "aligning the requirements between programs would lessen the burden on health care providers."

- Remove certain measures from MIPS PI performance category. Beginning with the 2019 reporting period, CMS proposes removing four measures from the PI performance category: "patient-specific education," "view, download, or transmit," "secure messaging," and "patient-generated health data." These four measures, however, currently are not required to be reported in that they do not factor into a MIPS eligible clinician's base score but rather can be reported to add points to the MIPS eligible clinician's performance score.

WHA supports proposals to reduce EHR task burden on MIPS eligible clinicians by reducing the number of measures that hospitals must report under the MIPS PI performance category. As WHA previously has commented to CMS, many of the measures that are proposed for removal unfairly put the ability of providers to succeed largely outside of providers' control by making success contingent on the actions of others.

- Do not finalize "Query of PDMP" measure for MIPS PI performance category. CMS proposes adding a new measure to the PI performance category: for any electronically prescribed Schedule II opioid, the MIPS eligible clinician would have to use data from certified EHR technology to conduct a query of a prescription drug monitoring program ("PDMP") for prescription drug history. CMS proposes making this

new measure optional for the 2019 reporting period and mandatory beginning with the 2020 reporting period.

WHA recommends not finalizing this premature proposal, which is not supported by any standards or certification criteria. As WHA stated in its comment letter to CMS on the 2019 IPPS proposed rule in the context of the Medicare PI Program, while Wisconsin providers rely on the dispensing data collected by Wisconsin's PDMP to provide efficient and high-quality care, and while the ability to access such data helps to prevent the abuse of opioids and other prescription drugs, Wisconsin providers have encountered significant problems with integrating the PDMP into their EHRs. Because of this lack of widespread integration between PDMPs and certified EHR products, this proposed measure would create significant provider EHR task burden by necessitating manual data entry into the EHR to document completion of the PDMP query and by necessitating manual calculation of the measure. In the proposed rule, CMS even acknowledges these problems with this proposed measure by stating that "PDMP integration is not currently in widespread use for [certified EHR technology]" and that "many MIPS eligible clinicians may require additional time and workflow changes at the point of care before they can meet this measure without experiencing significant burden."

- Do not finalize "Verify Opioid Treatment Agreement" measure for MIPS PI performance category. CMS proposes adding a new measure to the PI performance category: for any electronically prescribed Schedule II opioid, the MIPS eligible clinician would have to "seek[] to identify the existence of a signed opioid treatment agreement" and incorporate such agreement into the patient's EHR. CMS proposes making this new measure optional for the 2019 reporting period and mandatory beginning with the 2020 reporting period.

WHA recommends not finalizing this premature proposal, which is not supported by any standards or certification criteria. As WHA stated in its comment letter to CMS on the 2019 IPPS proposed rule in the context of the Medicare PI Program, the lack of a definition of "opioid treatment agreement" and the lack of a description of what actions the MIPS eligible clinician must take to "seek[] to identify the existence of a signed opioid treatment agreement" likely would cause confusion as to how to attest to this measure and therefore may make it unnecessarily difficult to score highly on this measure. In the proposed rule, CMS even acknowledges that this proposed measure would create non-health-IT-related burdens for providers and that these burdens "could require additional time and changes to existing workflows . . . and manual calculation of the measure."

If CMS does decide to finalize this proposed measure, WHA recommends first amending the measure to focus only on incorporation of the opioid treatment agreement into the patient's EHR. As WHA stated in its comment letter to CMS on the 2019 IPPS proposed rule in the context of the Medicare PI Program, because this proposed measure would require the hospital not only to incorporate opioid treatment agreements into the patient's EHR but also first to take non-health-

IT actions to identify the existence of such agreements, the measure would create additional regulatory burden on providers and does not appear to align with CMS's new stated goals of promoting interoperability and improving patient access to health information.

- Do not finalize additional public health reporting requirement. Beginning with the 2019 reporting period, CMS proposes requiring that MIPS eligible clinicians report on any two available measures from within the "public health and clinical data exchange" objective. Under the proposal, if the MIPS eligible clinician fails to report on any two such measures, he or she will earn a score of 0 points for the PI performance category. Under current law, reporting on measures from within the "public health and clinical data registry reporting" objective is not required because such measures do not factor into a MIPS eligible clinician's base score; instead, if the MIPS eligible clinician reports on merely one such measure, he or she earns 10 performance points that can be added to his or her base score. WHA recommends not finalizing this proposal because it creates additional reporting burdens for MIPS eligible clinicians.

- Finalize lower performance thresholds for pertain measures in Medicaid PI program for physicians. Beginning with the 2019 EHR reporting period for the Medicaid PI Program for physicians and other eligible professionals ("EPs"), CMS proposes lowering the performance threshold for two measures associated with the "coordination of care through patient engagement" objective. Specifically, CMS would establish at 5 percent the performance threshold for the "view, download, or transmit" measure and for the "secure messaging" measure. Under current law, the performance threshold for the "view, download, and transmit" measure is 5 percent for the 2018 EHR reporting period and is scheduled to increase to 10 percent for the 2019 EHR reporting period. Similarly, the performance threshold for the "secure messaging" measure is 5 percent for the 2018 EHR reporting period and is scheduled to increase to 25 percent for the 2019 EHR reporting period.

WHA recommends finalizing this proposal because it makes it easier for physicians to demonstrate meaningful use of certified EHR technology. As WHA has commented previously to CMS, the meaningful use measures for the "patient engagement" objective put the ability of providers to succeed largely outside of providers' control by making success contingent on the actions of others, i.e., patients. WHA is pleased that CMS acknowledges as much in the proposed rule, recognizing that "these two measures are the largest barrier to successfully demonstrating meaningful use."

Advanced Alternative Payment Models (APMs)

- Revenue-based risk standard. In our comments last year, WHA supported CMS's intention to retain the 8% standard for two additional years to give CMS time to evaluate the impact of the revenue-based standard. WHA supports extending the 8% revenue-based risk standard through 2024.

- Qualified participant (QP) determinations. WHA supports the proposed QP determinations made at the individual or Taxpayer Identification level. We requested this flexibility in last year's rulemaking cycle and appreciate its inclusion for CY 2019.

- Increasing use of CEHRT. CMS is proposing to increase the requirement relating to the use of certified electronic health records technology (CEHRT) from 50% of eligible clinicians in each APM entity in 2018 to 75% in 2019. WHA is opposed to this significant increase at this time. If implemented, CMS should provide examples of how it will verify this requirement.

- Physician Technical Advisory Council (PTAC). The PTAC was established under the MACRA to provide a process for stakeholders to analyze and develop new APMs for the QPP. The PTAC has solicited and proposed new models to HHS but none have been accepted and made available for an optional APM. WHA strongly urges CMS to create improved pathways to approved Medicare Part B Advanced APMs with better coordination with the PTAC. At this point, none of the models vetted by the PTAC have become available for providers through the innovation center.

Telehealth Provisions

Many communities in Wisconsin and across the country struggle to retain access to health care services in the context of physician and other health professional shortages and in some cases due to transportation- or distance-based barriers. Health care access barriers that are transportation-based particularly can impact rural communities, where the distance to the nearest hospital or clinic can be significant. Telehealth and related communications technologies can help to address these access issues by allowing patients to receive care locally by connecting to existing providers in other locations. Telehealth can save patients long commutes and allow them to remain in their communities, thereby increasing the accessibility of care while decreasing the amount of time patients need to be away from work and family. Accordingly, WHA believes that CMS should structure its coverage and payment policies for health services delivered via communications technology, including via telehealth, in such a way as to facilitate health care providers' continued adoption and implementation of such technologies to deliver high-quality patient care in an accessible and cost-effective manner.

In the comments that follow, WHA advocates that CMS remove barriers to providers' use of telehealth and related technologies to deliver health care services to Medicare beneficiaries.

- Permit payment for "virtual check-ins". Beginning January 1, 2019, CMS proposes to pay for a newly defined type of physician service furnished using communication technology: virtual check-in appointments. Under CMS's proposal, providers could use a new HCPCS code, GVCI1, to bill for a brief, non-face-to-face check-in with an established patient via communication technology to assess whether the patient's condition necessitates an office visit. CMS would not allow providers to bill for this service if the service originates from a related E/M service provided within the previous seven days or leads to a related E/M service within the subsequent 24 hours "or soonest available appointment." CMS proposes pricing this proposed new service at a rate lower than existing E/M in-person visits. Because the proposed new service is not intended to substitute for an in-person service separately payable under the Physician Fee Schedule, CMS does not consider the proposed new service to be a Medicare telehealth service that is subject to Medicare's payment restrictions for telehealth services related to geography or patient setting. WHA supports this proposal because it expands Medicare beneficiary access to health services delivered via communications technology.

- Permit payment for remote evaluation of pre-recorded patient information. Beginning January 1, 2019, CMS proposes to pay for a newly defined type of physician service furnished using communication technology: remote evaluation of pre-recorded patient information. Under CMS's proposal, providers could use a new HCPCS code, GRAS1, to bill for a provider's remote evaluation of patient-recorded images or videos to assess whether the patient's condition necessitates an office visit. CMS would not allow providers to bill for this service if the service originates from a related E/M service provided within the previous seven days or leads to a related E/M service within the subsequent 24 hours "or soonest available appointment." Because the proposed new service is not intended to substitute for an in-person service separately payable under the Physician Fee Schedule, CMS does not consider the proposed new service to be a Medicare telehealth service that is subject to Medicare's payment restrictions for telehealth services related to geography or patient setting. WHA supports this proposal because it would expand Medicare beneficiary access to health services delivered via communications technology.

- Permit payment for interprofessional internet consultations. Beginning January 1, 2019, CMS proposes to cover six CPT codes that describe provider-to-provider consultations conducted via telephone, internet, or EHR to assist with the diagnosis or management of the patient's problem without the need for the patient's face-to-face contact with the consulting provider: 99446, 99447, 99448, 99449, and 994X0. Because the proposed new services are not intended to substitute for an in-person service separately payable under the Physician Fee Schedule, CMS does not consider the proposed new services to be a

Medicare telehealth services related to geography or patient setting. WHA supports this proposal because it would expand Medicare beneficiary access to health services delivered via communications technology.

- Permit payment for chronic care remote physiologic monitoring. Beginning January 1, 2019, CMS proposes to cover three new CPT codes that describe services that use remote patient monitoring technology to monitor and manage patient care needs, including chronic care management. Because the proposed new services are not intended to substitute for an in-person service separately payable under the Physician Fee Schedule, CMS does not consider the proposed new services to be a Medicare telehealth service that is subject to Medicare's payment restrictions for telehealth services related to geography or patient setting. Currently, CMS already covers CPT code 99091 that similarly describes remote patient monitoring services. WHA supports this proposal because it would expand Medicare beneficiary access to health services delivered via communications technology.

- Cover prolonged preventive services as a Medicare telehealth service. Beginning January 1, 2019, CMS proposes adding two HCPCS codes to the list of Medicare-covered telehealth services: G0513 and G0514, which describe prolonged preventive services in an outpatient setting. WHA supports this proposal because it would expand Medicare beneficiary access to health services delivered via communications technology.

Hospital Conditions of Participation Revisions

- Do not proceed with duplicative rulemaking to revise the hospital Conditions of Participation. CMS states that it is considering future rulemaking to revise the hospital Conditions of Participation ("CoP") and other health and safety standards for other Medicare- and Medicaid-participating providers and suppliers to mandate interoperability and the electronic exchange of health information.

WHA recommends that CMS not proceed with future rulemaking so to revise the hospital CoP or similar other regulations. Any new requirements for interoperability or health information exchange within the hospital CoP would be duplicative with what hospitals already have to report under the Medicare PI Program to avoid receiving Medicare reimbursement penalties. Further, all requirements in the hospital CoP must be met as a condition of receiving Medicare

funding, and unlike CMS's recently finalized requirements for the Medicare PI Program, hospital CoP requirements do not involve "performance-based scoring." Accordingly, by including these requirements in the hospital CoP, CMS would be acting inconsistently with its recent efforts to move the Medicare PI Program incrementally away from a wholly "pass/fail" or "all-or-nothing" approach.

WHA shares the goals of streamlining documentation within the Physician Fee Schedule and appreciate many of the changes proposed. However, we strongly urge CMS to abandon its proposal for consolidation of the E&M codes. We support many of the proposed changes to the QPP to drive toward a meaningful, value-based system and encourage CMS to continue refining the QPP in line with our comments

Thank you for the opportunity to comment on this proposed rule. If you have questions, please contact Andrew Brenton, assistant general counsel, at abrenton@wha.org, or Laura Rose, vice president, policy development, at lrose@wha.org.

Sincerely,

/s/

Eric Borgerding
President and CEO