UnityPoint Health

June 3, 2019

Administrator Seema Verma
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–9115-P
P.O. Box 8016
Baltimore, MD 21244–8016

> RE: CMS–9115-P - Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally-Facilitated Exchanges and Health Care Providers; published at Vol. 84, No. 42 Federal Register 7610-7680 on March 4, 2019.

> *Submitted electronically via* http://www.regulations.gov

Dear Administrator Verma,

UnityPoint Health ("UPH") appreciates the opportunity to provide comment on this proposed rule related to interoperability. UPH is one of the nation's most integrated healthcare systems. Through more than 32,000 employees and our relationships with more than 310 physician clinics, 39 hospitals in metropolitan and rural communities and 19 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, central Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 6.2 million patient visits.

In addition, UPH is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. UnityPoint 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 (MSSP) as well as providers from the Pioneer ACO Model. UnityPoint Health also participates in a Medicare Advantage provider-sponsored health plan through HealthPartners UnityPoint Health.

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

REVISIONS TO THE CONDITIONS OF PARTICIPATION FOR HOSPITALS AND CRITICAL ACCESS HOSPITALS (CAHs)

For Medicare- and Medicaid-participating hospitals, psychiatric hospitals and CAHs, this proposal would revise Conditions of Participation (CoPs) to require ''Electronic Notifications,'' that would require such hospitals to send electronic patient event notifications of a patient's admission, discharge, and/or transfer to another health care facility or to another community provider. Notifications would be transmitted to licensed and qualified practitioners, other patient care team members, and PAC services providers and suppliers that: (1) Receive the notification for treatment, care coordination, or quality improvement purposes; (2) have an established care relationship with the patient relevant to his or her care; and (3) for whom the hospital has a reasonable certainty of receipt of notifications. Notifications would include minimum patient health information, such as patient name, treating practitioner name, sending institution name, and, if not prohibited by other applicable law, patient diagnosis.

<u>**Comment**</u>: UPH supports the concept that hospitals share admission, discharge and transfer (ADT) data and we have a vendor solution in place that accomplishes this. This is an important tool within our ACO and population health arsenal; however, it is only as good as the data and the number of hospitals who participate. ***While we are supportive and have some recommendations related to the substance of this proposal, we disagree that this requirement needs to be included within the hospital and CAH CoPs.*** First, this requirement seems premature as it only applies to "hospitals which currently possess EHR systems with the technical capacity to generate information for electronic patient event notifications." Second, this requirement subjects a specific ADT solution to CoP certification audits, which seems arbitrary and subjects this intervention to a heightened level of compliance activities. Lastly, we believe its inclusion within CoPs will create a slippery slope for the addition of more specific health information exchange interventions in future years, effectively creating a laundry list of these interventions. As an alternative to CoP inclusion, we would suggest that CMS incentivize hospitals to participate in electronic notifications. CMS could consider some potential penalty/incentive frameworks which may include a new attestation process with associated penalties; revisions to one of the hospital quality programs to include participation as an offset/bonus; or, for those hospitals who choose to participate, affording hospitals some regulatory flexibility, such as expanded use of telehealth.

In terms of the substance of the proposal, we reiterate our support of this concept outside its inclusion within CoPs. ***We would request that CMS consider the following revisions***:

- Inclusion of ACOs within the list of health care provider and suppliers that receive electronic notifications of ADTs;
- Eliminate the "reasonable certainty of receipt" requirement when sending ADT notifications; and
- Add electronic notifications for Emergency Department presentations that do not result in an admission or transfer.

In the preamble, CMS references ongoing work by ONC to develop consensus standards for ADT-based notifications. As a provider who has an operational solution, we appreciate that CMS has not chosen to restrict hospitals from pursuing more advanced content as part of patient notifications, nor to create redundant requirements where hospitals already have a suitable notification system in place. We intend

to monitor future developments as standards are proposed and will offer input during those rulemaking processes.

REQUEST FOR INFORMATION ON ADVANCING INTEROPERABILITY ACROSS THE CARE CONTINUUM

Health IT adoption and interoperability has lagged in care settings that were not part of the EHR Incentive Programs. Comment is sought on (1) specific policy strategies to deliver financial support for technology adoption and use in these settings; (2) measure concepts that assess interoperability, including measure concepts that address Post-Acute Care (PAC), behavioral health, home and community-based services, and other provider settings; (3) potential measure development work and quality improvement efforts focused on assuring individuals receive sufficient needed services across the care continuum and that services are coordinated; (4) whether hospitals and physicians should adopt the capability to collect and electronically exchange a subset of the same PAC standardized patient assessment data elements in their EHRs; and (5) whether to move toward the adoption of PAC standardized data elements through the expansion of the USCDI process, including administrative, development, and implementation burdens.

Comment:

- Financial support for technology adoption and use – As healthcare moves to community-based care, a promising strategy is to strengthen our ability to leverage social service organizations to best utilize expertise and scarce resources. For example, we cannot overstate the importance of post-acute care settings, such as home health agencies, skilled nursing facilities (SNFs) and assisted living centers, as well as community behavioral health facilities and other community providers. When acute care providers make a community handoff, we need to be confident that the individual referred will have a central point of contact and that the point of contact accepts responsibility for that individual. As noted in the preamble, health IT adoption rates are depressed in care settings that were not subject to the EHR Incentive Programs. We also know that as providers try to maintain patients within community settings, it is important that patient records are comprehensive and follow the patient across care settings. To fill these gaps, ***we would suggest that CMS offer an infrastructure loan for non-profit providers with the caveat that they could offset a portion of their loan based on meeting or exceeding quality objectives.*** The quality component would reward PAC entities for providing high-quality care. This solution would also complement larger value-based arrangements like Medicare ACOs – for those ACOs with a 3-day SNF waiver benefit enhancement, a requirement for participation is that these SNFs must have at least a 3-star rating.

- Measure development and quality improvement focused on access to services and care coordination – UPH participated in a statewide initiative in Iowa that developed a roadmap for providing care in place. ***The Iowa Healthcare Innovation and Visioning Roundtable has suggested that Healthy Communities should demonstrate value more broadly through valid and reliable metrics that measure desired outcomes.***[1] These metrics are:
  - o Unnecessary or potentially preventable ED use

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[1] Access report at: https://dhs.iowa.gov/sites/default/files/SIM_Roundtable-HealthyCommunitiesWorkgroupBreakout_06142018.pdf

- o Potentially preventable hospitalizations
- o Cost (e.g. total cost of care)
- o Linkage with appropriate primary behavioral health care
- o Other institutional care
- o Appropriate care and patient outcomes
- o Health improvement
- o Community care

While the above are suggestions, we recognize that there is a proliferation of measure development (as evidenced by the Quality Payment Program) as well as a streamlining effort in the form of the Meaningful Measures Initiative, which encourages outcome-based measures. If any of the above measure concepts gain steam, our preference would be to adopt current measures when possible and to apply them across more care settings.

- EHR capture of PAC standardized patient assessment data elements (SPADEs) – The SPADEs collect function (e.g., self-care and mobility); cognitive function (e.g., express and understand ideas; mental status, such as depression and dementia); special services, treatments and interventions (e.g., need for ventilator, dialysis, chemotherapy, and total parenteral nutrition); medical conditions and co-morbidities (e.g., diabetes, heart failure, and pressure ulcers); impairments (e.g., incontinence; impaired ability to hear, see, or swallow); and other categories. ***In theory, the ability to have the hospital's or physician's EHR collect, capture and exchange segments of this information is powerful. This assumes that the underlying assessment was accurate and properly documented and that the information is a value-added item – clinically meaningful and not cost prohibitive.*** This rule does not describe the cost associated with incorporating SPADEs within the hospital or provider EHR.

  In terms of SPADEs, we would also like to acknowledge CMS' proposed rulemaking to establish a new data collection domain for social determinants of health starting in 2022.[2] Using authority granted under the IMPACT Act, the proposed data elements are race, ethnicity, preferred language, interpreter services, health literacy, transportation, and social isolation. The purpose of the domain is to "inform provider understanding of individual patient risk factors and treatment preferences, facilitate coordinated care and care planning, and improve patient outcomes." It is widely accepted that social determinants of health greatly impact an individual's health and quality of life. As an integrated healthcare system, our goal is to collaborate with community partner organizations to provide the right care, at the right time, without defect or duplication for our patients and their families, and improving reliability in care coordination across the care continuum. The challenge with requiring healthcare providers to collect additional social determinant of health data internally is that

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[2] CMS–1710–P - Medicare Program; Inpatient Rehabilitation Facility (IRF) Prospective Payment System for Federal Fiscal Year 2020 and Updates to the IRF Quality Reporting Program; CMS–1718–P - Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2020; CMS–1716–P - Medicare Program; Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2020 Rates. We would anticipate similar language to be included in the to-be-released proposed rule on Home Health Prospective Payment System.

we don't know the most useful social risk data to collect and collecting a very comprehensive record has come with almost infeasible administrative burden. In terms of collecting these data points, *we would offer that an initial capture of a small set of social risk information could be extracted from the EHR as the result of the annual wellness visit or social history within the E/M documentation.* Per guidance of the American Academy of Family Physicians[3], the Past, Family, Social History component of the CPT code for E/M visits creates an opportunity to record these data points. Below is a table of social risk factors that may already be contained within the EHR and could serve as a starting point. Administrative burden can be reduced when we use current data points and collection tools.

Data Points	When Collected	Notes
Employment	At registration if insurance is on employer plan	
Insurance status	At registration	
Transportation	E/M	"who brought you today?"; "do you have a way to get back home and to pick up the medications I've prescribed?"
Nutrition	Required as part of the BMI discussion	Noted on After Visit Summary
Personal Safety / falls prevention	In falls protocol	
Ability to afford medications		Quality indicator in the CG-CAHPS "stewardship of patient resources"
Housing	Triggered if home safety concerns	Addressed as home safety falls
Physical activity	E/M	
Substance abuse	E/M	Includes tobacco
Mental health	Separate depression screening at visits	
Disabilities	HCC and updated problem list	
Family and community support	Updates if care navigator or coordinator	

ADVANCING INTEROPERABILITY IN INNOVATIVE MODELS

Comments are being sought on general principles for promoting interoperability in innovation model tests under CMMI. These principles are to provide patient access to their own electronic health information; to

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[3] https://www.aafp.org/practice-management/payment/coding/evaluation-management.html

promote trusted health information exchange; and to adopt health IT standards and pilot emerging standards. In addition, CMMI is soliciting feedback on other avenues to further interoperability among model participants and other health care providers as part of the design and testing of innovative payment and service delivery models.

<u>**Comment**</u>: UPH is proud to be an early adopter of innovation and to have partnered in several CMMI initiatives, including the Pioneer ACO Model, the Next Generation ACO Model, Medicare Care Choices Model and the Bundled Payment Care Initiative. ***We are supportive of the proposed principles for CMMI to advance interoperability.*** We believe that technology can improve workflows and remove barriers to care and data itself is a powerful tool to identify patients with high and rising risk and to manage both chronic care and preventive services. As a large integrated health system with a three-state footprint, our service area is largely rural. From that perspective, we are keenly aware that some of our rural colleagues, particularly community organizations, may not have electronic health records. We would encourage CMMI not to exclude those providers if there is a willingness to innovate and they serve areas that have a high concentration of FFS beneficiaries without value-based arrangements. ***For potential innovators in rural and underserved areas, we would suggest CMMI consider additional financial assistance that could be used for upfront infrastructure costs, similar to the ACO Investment Model.***

We are pleased to provide input on this proposed rule and its impact on our integrated health system and the individuals and communities we serve. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President, Government & External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

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