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September 11, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1676–P
P.O. Box 8016
Baltimore, MD 21244–8013

RE: CMS–1676–P – Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program; published in Federal Register (Vol. 82, No. 139), July 21, 2017

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 2018 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 Partners is the ACO affiliated with UPH and has value-based contracts with multiple payers, including Medicare. UnityPoint Health Partners 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.

OFF-CAMPUS PROVIDER BASED DEPARTMENT REIMBURSEMENT

In the CY2017 Ambulatory Surgical Center / Hospital Outpatient Prospective Payment System (OPPS) interim final rule, CMS finalized that it would establish payment policies under the PFS for 2017 by scaling the OPPS payment rates by 50%. In this rule, CMS proposes to set payment rates for services provided at non-excepted off-campus provider-based departments at 25% of the OPPS payment rate for 2018.

- ***Comment***: **UPH opposes this further reduction in payment rates for non-excepted off-campus provider-based departments and urges CMS to maintain the 50% rate until data**

becomes available and a thorough analysis can be performed. In terms of process, we are extremely concerned that the agency would recommend significant reductions without the benefit of data and time to analyze the current payment methodology and without having addressed previous stakeholder comments and concerns. It is disappointing that the agency would forward a recommendation that is an admittedly "imprecise adjustment . . . [that] may overestimate PFS non-facility payment relative to OPPS payments." We do not believe that outpatient departments of hospitals should bear financial responsibility for imprecise adjustments by CMS, which blatantly disregard site neutrality principles. In terms of policy impact, we are appalled at the seeming lack of understanding or appreciation by CMS on how this reimbursement policy effects access to care. Should hospitals be penalized through higher reimbursement rates for services provided through outpatient departments, this will adversely impact vulnerable communities lacking other sources of health care. Because CMS does not have data to "more precisely account for any differential between these two update factors," we believe it is premature for CMS to adjust this rate for 2018.

POTENTIALLY MISVALUED CODES

CMS has revisited numerous billing codes that have been potentially misvalued. In this process, CMS is proposing revisions as well as seeking comments on factors associated with the valuation process.

- ***Comment***: In our review, we offer input related to the following:
  - Bronchial Aspiration of Tracheobronchial Tree (CPT Codes 31645): For CY 2018, CMS is proposing the RUC-recommended work RVU of 2.88 for CPT code 31645, which is a reduction from the current RVU of 2.91. While CMS recognizes that this procedure should be valued higher than the RVU for the base procedure for this family of codes (CPT code 31622 - Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed), CMS is seeking comment on whether the work of moderate sedation was inadvertently included in the development of the recommended work RVU. We do not believe this to be the case and support the original RVU of 2.91. CTP code 31645 is predominantly used in the ICU for patients who have mucous plugging of the central airway causing atelectasis/collapse of lung or lobes of the lung. This code is also utilized for diagnostic purposes when obtaining specimens for culture or cytology. The former can be quite complicated and long while in comparison the latter is usually a quicker, less-involved procedure although can involve high-risk patients who are critically ill with severely compromised lung function. **We urge CMS to revisit the RVU associated with this code and, at a minimum, retain the current RVU of 2.91.**
  - Pulmonary Diagnostic Tests (CPT Codes 94621): CMS is proposing the RUC-recommended work RVUs of 1.42 for CPT code 94621. In addition, CMS is refining to refine the clinical labor time for the ''Provide preservice education/obtain consent'' activity from 10 minutes to 5 minutes, which is the current time assigned for this task. While CMS agrees that CPT code 94621 requires additional time above the standard for this clinical labor activity, CMS is questioning whether double the current time would be typical for this procedure. **We do not support the reduction in educational time for code 94621 from 10 minutes to 5 minutes.**

This code is related to a complex process that requires active participation by the patient. Limited education could create a medical legal risk and result in poorer test quality with skewed results. We encourage CMS to retain the current 10-minute education time for CPT code 94621.

- Continuous Glucose Monitoring (CPT Code 95251): For CY 2018, CMS is proposing the RUC-recommended work RVU of 0.70 for CPT code 95251; but is specifically seeking comment on whether the 2 minutes of physician preservice time is necessary. **We encourage CMS to maintain the 2-minute preservice time allotment.** Although we agree that the 2-minute time allotment may not be needed by physicians for preparation time, we do believe that this time is appropriate for outreach/education (i.e. introduce both the concept of continuous monitoring and the staff person that will be placing the monitor as well as responding to patient questions or concerns).

NEW CARE COORDINATION SERVICES AND PAYMENT FOR RURAL HEALTH CLINICS (RHCS) AND FEDERALLY-QUALIFIED HEALTH CENTERS (FQHCS)

For RHCs and FQHCs, CMS is proposing to adopt CPT codes for CY 2018 for reporting several care management services currently reported using Medicare G-codes. CMS is proposing to create General Care Management code GCCC1 for RHCs and FQHCs, with the payment amount set at the average of the 3 national non-facility PFS payment rates for the CCM and general BHI codes and updated annually based on the PFS amounts. In addition, CMS is proposing to create a psychiatric CoCM code for RHCs and FQHCs, GCCC2, with the payment amount set at the average of the 2 national non-facility PFS payment rates for CoCM codes, to be updated annually based on the PFS amounts.

- ***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.

  To encourage greater use of these codes, **we urge CMS to eliminate the co-payment and deductible for these services in all sites of service.** Despite the overall merits of these services, their nature as non-face-to-face billable services creates beneficiary confusion and patient dis-satisfaction when patients receive these bills. This patient dissatisfaction results in a reluctance from providers to order these services. Even without a co-payment or deductible, care coordination services will raise revenue through cost savings to CMS attributable to the avoidance and reduction in preventable readmissions or transfers to higher care levels. We believe these services should be provided without a beneficiary charge.

MEDICARE TELEHEALTH SERVICES

CMS is proposing that telehealth service reimbursement be extended to (1) counseling visit to discuss need for lung cancer screening using low dose computed tomography – HCPCS code G0296; (2) psychotherapy sessions for crisis – CPT codes 99497 and 99498; (3) interactive complexity

telehealth add on– CPT code 90785; (4) administration of patient-focused health risk assessment instrument telehealth add on – CPT code 96160; (5) administration of caregiver-focused health risk assessment instrument telehealth add on – CPT code 96161; and (6) comprehensive assessment of and care planning for patients requiring chronic care management services telehealth add on – HCPCS code G0506. In addition, CMS is proposing to eliminate the required use of the GT modifier on professional claims

- ***Comment***: Telehealth is a vital service delivery modality that enables access to services for beneficiaries with distance barriers and provider shortages. **We applaud the continued expansion of the list of telehealth services eligible for reimbursement**. While the services targeted for this year's expansion impact a relatively small proportion of Medicare beneficiaries, a telehealth service delivery option recognizes its importance for high-risk individuals in accessing care. 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. We encourage CMS to consider eliminating the requirement that the "originating site" for telehealth services must be located in a rural HPSA or a county outside of a MSA. 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).

  In terms of eliminating the GT modifier, we are concerned that this change may potentially create confusion and will result in additional provider costs. Presently, many providers are still trying to understand the basics of telehealth billing and completing IT infrastructure investments in the build/structure and changes in their EMRs to accommodate this service modality. Is this change needed or just a preference? Any changes in coding impact EMR builds, whether these changes are substantive or simply "clean up" in nature. Although we agree that the existence of the POS code and GT modifier does seem redundant, the removal of the GT modifier may imply that there are substantive changes aside from the intent to streamline coding. For our organization, this will require that we revisit the logic in our EMR system to remove the GT modifier for CMS-1500, which has EMR cost implications as well as associated training related to this change. **We request that CMS not revise this GT modifier code at this time.**

  CMS has also provided a list of Submitted Requests To Add Services to the List of Telehealth Services for CY 2018. One of the addition requests relates to CPT code 99444 – Online E/M by physician/QHP: CPT Code. Presently CMS has assigned this code a non-covered status, which has had this status since its creation for CY 2008 (CY 2016, CY 2014, and CY 2008). This non-coverage status prevents reimbursement for claims with CPT code 99444. **We believe that CMS inappropriately disregarded the RUC recommendations to associate a RVU with CPT code 99444 in 2008. Accordingly, we urge CMS to apply RVU amounts to this code to permit Medicare reimbursement for this service.**

  As background, in its initial non-coverage decision, CMS in 72 FR 66371 (2008) stated:

  > *CPT code 99444, Online evaluation and management service provided by a physician to an established patient, guardian or health care provider not*

> *originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network, the HCPAC recommended 0.25 work RVUs for CPT code 98966; 0.50 work RVUs for CPT code 98967; 0.75 work RVUs for CPT code 98968; carrier pricing for CPT code 98969; and the RUC recommended 0.25 work RVUs for CPT code 99441; 0.50 work RVUs for CPT code 99442; 0.75 work RVUs for CPT code 99443; and carrier pricing for CPT code 99444. We are assigning a status indicator of ''N'' (Non-covered service) to these services because: (1) These services are non-face-to-face; and (2) the code descriptor includes language that recognizes the provision of services to parties other than the beneficiary and for whom Medicare does not provide coverage (for example, guardian).*

The above should be reconsidered because this service and its billing code was not intended to be a substitute for a face-to-face encounter and subject to the telehealth restrictions. Given the plain language of the CPT description, an online evaluation and management service would never be able to be delivered in person, nor is that the intent. As a stand-alone service, this service does not rely on the RVU of an underlying in-person encounter (as this could already be accomplished through a GT modifier) and the RUC appropriately recommended separate and distinct values for this service. In our opinion, by placing a non-coverage value on this code, CMS has incorrectly interpreted this service as a substitute for in-person services as opposed to a distinct service that can stand alone. As such, this primary service should not be subject to the telehealth list and should be reimbursed based on its assigned RVU. We encourage CMS to revisit this code as well as codes in this family to recognize their status as primary, stand-alone services delivered through a technology-based platform.

APPROPRIATE USE CRITERIA (AUC) FOR ADVANCED DIAGNOSTIC IMAGING SERVICES

CMS is proposing to further delay until January 1, 2019 a requirement that physicians ordering advanced imaging services consult appropriate use criteria. Under this proposal, ordering professionals must begin consulting specified applicable AUC through qualified clinical decision support mechanisms (CDSMs) for applicable imaging services ordered on and after January 1, 2019, and furnishing professionals must begin reporting AUC consultation information on Medicare claims for advanced diagnostic imaging services for which payment is made under an applicable payment system and ordered on or after January 1, 2019.

- ***Comment***: We support the further implementation delay until January 1, 2019. Based upon our experience evaluating the CDSM marketplace as well as selecting and implementing a CDSM within an EMR order entry workflow throughout our enterprise – inpatient, outpatient, and emergency department settings; a transition to CDSM must be done deliberately and thoughtfully. We reiterate at a high level our comments made last year which recommend that (1) a structured indication be entered into a qualified CDSM for every advanced imaging examination, whether an AUC exists or not; (2) CMS establish minimum qualified CDSM functional requirements; and (3) Priority Clinical Areas (PCAs) be used solely as a measurement tool, but not as a limiting set of indications for CDSM use. These recommendations are detailed in our comments (ID: CMS-2016-0116-5763 on www.regulations.gov).

DIABETES PREVENTION PROGRAM (DPP) MODEL

CMS is proposing to implement a pre-diabetes outreach program based upon a CMMI Health Care Innovation Award Round 1 demonstration project. The program is scheduled to begin on January 1, 2019. This is the second opportunity through the rule-making process for stakeholders to provide comment. For this comment period, CMS is proposing additional policies necessary for suppliers to begin providing MDPP services nationally in 2018, including the MDPP payment structure, as well as additional supplier enrollment requirements and supplier compliance standards. For an entity to be eligible to enroll in Medicare as an MDPP supplier, they must achieve CMS interim preliminary recognition, CDC preliminary recognition (if established), or CDC full recognition.

- ***Comment***: Given the pervasiveness of diabetes and pre-diabetes, we generally support efforts aimed at diabetes prevention and management. However, **we believe that mandating the proposed demonstration pilot project by April 1, 2018 is premature**. We still have concerns that CMS has not provided adequate financial information to realistically inform stakeholders (see UPH 2017 comments). CMS has not clarified how a grant project with a three-year award of $11,885,134 and an estimated savings of $4,273,807 has been factored into the success of this program. These figures suggest that there are upfront costs associated with implementation that need to be better understood by providers aside from projected long-term Medicare savings. Red flags are also raised by the fact that:
    - Certified Diabetic Educators (CDEs) are not expedited and/or receive special recognition in the path to become DPP suppliers. This seems to be misaligned and creates silos when furthering diabetes outreach to Medicare beneficiaries;
    - The program structure, class frequency and duration lacks flexibility. While we do not doubt that stringent compliance will yield improved outcomes, a design that does not allow flexibility in delivery will not allow greatest impact. We suggest that CMS create an exception process to allow for further experimental in this program and to promote better outcomes; and
    - The mandate of this program beyond Medicare Part B to Medicare Advantage and PACE plans unduly restricts these plan providers. If pre-diabetes education is now considered a core benefit, we encourage CMS to allow these programs to seek waivers of the DPP upon a showing of alternative pre-diabetes outreach that may better fit their service delivery model.

MEDICARE SHARED SAVINGS PROGRAM – PAYMENT TREATMENT MADE UNDER A DEMONSTRATION, PILOT, OR TIME LIMITED PROGRAM

CMS is proposing to include only final individually beneficiary identifiable payments made under a demonstration, pilot or time limited program in financial calculations related to establishing and updating benchmarks and determining performance year expenditures under the Shared Savings Program.

- Comment: UPH participates in the Next Generation ACO through its accountable care entity, UnityPoint Health Accountable Care. Although we currently have no affiliated members participating in the Medicare Shared Savings Program, we participated in that program from

2012 through 2015. Overlap treatment by CMS of multiple demonstrations, pilots or time-limited programs has long been a recurring concern for UPH. When organizations have committed to bear risk for health care populations, there is a finite opportunity for those organizations to reduce costs while maintaining access and quality. CMS and CMMI should work together to establish a hierarchy for these overlapping programs, so that demonstrations involving overall population health (i.e. ACOs) do not have their population health strategies and financial opportunities continually eroded as new demonstrations with limited/targeted impacts (i.e. care episodes) are brought forward. We anticipate that, with the desire by establish more Advanced Alternative Payment Models under MACRA, more overlap issues will occur and create disincentives for organizations to pursue total population health initiatives as opposed to episodic care programming. **We urge CMS and CMMI to work together, in collaboration with stakeholders, to formalize an overlap hierarchy which appropriately promotes transition by providers to a population health framework and to enter into risk-bearing relationships.**

EMERGENCY DEPARTMENT VISITS COMMENT SOLICITATION

CMS is seeking comment from stakeholders on whether emergency department visits are undervalued due to increasing heterogeneity of the settings under which emergency department visits are furnished and changes to the patient population. At issue is whether CPT codes 99281–99385 (Emergency department visits for the evaluation and management of a patient) should be reviewed under the misvalued code initiative.

- ***Comment***: UPH applauds this effort to revisit emergency department coding. In particular, we urge CMS to consider heightened reimbursement levels for behavioral health patients evaluated in the emergency department. It is typical that these patients receive services in specially equipped rooms and staff have received special/extra training for this population. At one of our hospitals, our emergency department has a separate unit for behavioral health patients. Aside from behavioral health, emergency departments are differentiated in their capacity to treat stroke patients and reimbursement should be structured to reflect such specialized training and associated infrastructure investments.

OPIOID ADDICTION POLICY AND REIMBURSEMENT

The rule creates new codes and higher payments to recognized drug delivery implants utilized by physicians in addressing opioid addiction. For CY 2018, CMS is proposing to make separate payment for the insertion, removal, and removal with reinsertion of Buprenorphine subdermal implants using HCPCS G codes.

- ***Comment***: Given the national emergency that was declared surrounding the opioid crisis, **we support efforts by CMS to encourage reimbursement and flexible service delivery in this area**.

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

Sincerely,

Sabra Rosener, J.D.
Vice President / Government Relations Officer