September 10, 2018

Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, D.C. 20201

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

Dear Ms. Verma:
On behalf of our more than 200 member hospitals and nearly 50 health systems, the Illinois Health and Hospital Association (IHA) is taking this opportunity to submit comments on the proposed rule establishing new policies and payment rates applicable to the Medicare Physicians Fee Schedule (PFS) for Calendar year (CY) 2019. Additionally, we are offering comments on the proposed changes to the Quality Payment Program (QPP) in Year 3 (2019), which are included in the rule. The comments represent concerns of IHA, as well as those raised by members of IHA’s recently-formed Medical Executive Forum (MEF) Quality Payment Program Subcommittee. IHA and its MACRA QPP subcommittee are willing to further discuss these issues with you or your staff, and we are willing to offer any assistance or support you may need as the full impact on professional services payments is rolled out in 2019.

IHA commends the Centers for Medicare & Medicaid Services (CMS) for its thorough development of this rule, and there are several provisions we support. However, IHA and its member hospitals and health systems QPP Subcommittee representatives have strong concerns with the operational aspects of several provisions, and subsequently, present the following for your consideration:

COMMENTS SPECIFIC TO CHANGES APPLICABLE TO THE PHYSICIAN FEE SCHEDULE PORTION OF THE RULE:

PROPOSED CHANGES TO EVALUATION/MANAGEMENT (E & M) CODING: In response to CMS’ request for feedback regarding ways to reduce administrative burdens and improve Evaluation and Management (E/M) visit coding, CMS proposes
changes in the coding of outpatient/office E & M visits. Currently, there are five levels of codes for those visits. CMS is proposing to maintain a separate payment for Level 1 visits, but at the same time, consolidate payments for Level 2-5 visits. This proposal would be effective for services provided to both new and established patients. The result is a significant reduction in payment for the more complex Level 4 or Level 5 visits.

CMS requests comments as to whether or not to delay implementation of this change to CY 2020. IHA strongly recommends that CMS incorporate this delay in the final rule. Our reasons for this recommendation are:

- We are extremely concerned about the financial impact this change will have on payments to specialists, whose services are used for more acute complex patients. When we compare the proposed payments for Levels 4 and 5 to the current payments, we see per-visit reductions ranging from 17 percent to more than 41 percent. While CMS does propose to include “add-on” payments, IHA is concerned that the add-on amounts will not sufficiently reimburse providers for the additional costs incurred in providing complex specialty services.
- While we applaud CMS’ efforts to reduce the administrative billing and coding burdens on providers, we are concerned that any changes in the billing structure will require additional training and education of provider staffs to accurately implement those changes.

IHA support CMS’ proposals to reduce the medical record documentation burdens on providers to only require that providers record that they have reviewed the patient’s medical history and complaints, and, if appropriate, that no changes were noted.

PROPOSED REDUCTION IN PAYMENTS FOR NEW MEDICARE PART B DRUGS: CMS proposes to reduce the percentage payment for “new” Medicare Part B drugs from 106 percent of the Wholesale Acquisition Cost (WAC) to 103 percent. The agency points to increased Medicare program spending on drugs over the past several years, as well as recommendations from the Medicare Payment Advisory Commission (MedPAC), as justifications for its proposal. In addition to requesting a one-year delay in the implementation of this proposal, IHA requests in its final rule, CMS include the data analyses it used to determine that the 3 percent payment reduction is justified.

PROPOSED ADDITIONAL MEDICARE-COVERED, TELEHEALTH SERVICES: CMS proposes to add two additional Prolonged Preventative Services codes to the listing of Medicare covered telehealth services. CMS also proposes to expand the list of originating sites for individuals with End-Stage Renal Disease (ESRD) to include renal dialysis facilities, ESRD patients’ homes and mobile stroke units. IHA supports these additions to the list of Medicare-covered, telehealth services, but recommends that CMS use its authority to facilitate the development of consistent state-to-state regulations concerning telehealth. Doing so would encourage the
implementation and usage of telehealth programs across states, increasing access for rural Medicare beneficiaries.

PROPOSED INCLUSION OF OTHER PART B SERVICE UPDATES IN THE PFS RULE: For purposes of obtaining further clarity of the topics included in the QPP/PFS proposed and final rules, IHA has noted that for the past several years, CMS has included payment change provisions for the following services in those rules:

- Ambulance;
- Telehealth;
- Therapies (i.e., the therapy caps);
- Part B drugs; and
- The Clinical Laboratory Fee Schedule (CLFS).

Members, on occasion, have stated that when researching specific changes to one or several of the above services, the natural tendency is to check the Medicare Outpatient Prospective Payment System (OPPS) proposed or final rules. Given that CMS’ proposed CY 2019 rule now consolidates both the PFS and QPP changes into one rule, further inclusion of additional Part B services in that rule does not seem appropriate. **Therefore, IHA suggests that in future rulemaking (beginning with the CY 2019 final rules, if possible), payment changes for other Part B services (such as those listed above), be included in the OPPS/ASC payment rule.**

COMMENTS SPECIFIC TO THE QUALITY PAYMENT PROGRAM PORTION OF THE RULE:

QPP PROPOSALS WITH WHICH IHA HAS CONCERNS:

- **Errors in the performance reports—Incorrect TINs assigned to Illinois providers:** Upon receiving their individual performance reports, several members mentioned that their reports included individual Tax Identification Numbers (TINs) that were not part of their specialty/practice. For example, some members mentioned that their Illinois practice reports included performance data from clinicians in Indiana. Conversely, it can be surmised that some practice reports for Illinois clinicians were misreported in other states. **IHA suggests that the presence of these additional errors merits an extension of the deadline for submitting “target review” corrections. We would recommend an extension to at least Nov. 1 from the original target review deadline of Oct. 1.**

- **Opportunity to use facility-based, Value-Based Purchasing (VBP) scores for facility-based clinicians:** Last year, IHA was concerned that clinicians practicing in a hospital setting could be penalized in their Quality and Cost domain performance scores because they were treating more complex patients in hospitals. **CMS proposes that eligible clinicians practicing in a hospital setting and meeting the 75 percent volume**
requirement could use the hospital’s Total Composite Score as derived from the its most recent VBP program results. **While the use of the hospital’s composite score would greatly reduce the reporting burden for eligible clinicians (with which IHA agrees), there are concerns with simply transferring a hospital’s VBP Composite Score to its hospital-based clinicians:**

- Hospitals question the methodology for computing their specific, as well as the national, Medicare Spending-Per-Beneficiary (Cost) benchmarks. CMS assures the industry that no additional supporting data is required of hospitals in order to determine the Cost score; those benchmarks and performance marks will be based on submitted claims. For both the hospital’s and the clinician’s Cost category score, no detailed explanation of the methodology for computing the benchmarks is given in the proposed rule.
- The hospital’s VBP score is based upon a prior three-year reporting period. Hospital-based clinicians who have significantly improved the quality and/or the efficiency of their practice will have the impact of those improvements lessened by applying the three-year performance period used in the hospital VBP program, as opposed to the one-year application as applied in the QPP, where the impact of those improvements would be realized sooner.

**IHA supports the linkage of the hospital’s VBP results with the eligible clinicians’ reporting requirements under MIPS, but strongly recommends that CMS allow for adjustments in the hospital’s score, when warranted.**

- **Exclusion of Track 1, Medicare Shared Savings Program (MSSP) APMs:** The current structure of the Medicare Shared Savings Program should be given more consideration under the APM framework; that would permit Track 1 participants to transition to Tracks 2 or 3. Currently, participation in the Medicare Shared Savings Program requires a three-year commitment, effectively precluding Track 1 programs from eligibility as an Advanced Alternative Payment Model (APM). Although the clinicians participating in these Track 1 models are working to achieve CMS’ goals to transform care delivery, under this proposed rule they would receive no recognition for those efforts. **IHA urges CMS to expand the eligibility criteria for Advanced APMs to include Track 1 ACO participants. This would alleviate our concern that providers who are considering participation as APMs must accept significant downside risk to qualify as an Advanced APM.**

- **Publication of national performance benchmarks in the rule:** Simultaneously with the release of the MIPS-eligible clinicians’ performance feedback reports, CMS should make public the benchmarks and thresholds used to calculate the individual performance scores. Knowing how they are being compared will help clinicians improve their performance. For the hospital VBP program, national benchmarks and thresholds are published for three of the four performance domains: Person and Community Engagement (formerly Patients’ Experiences of Care), Clinical Care and Safety of Care.
The information is made available for both the proposed and final rules for the applicable Medicare payment year. **Supporting the recommendation of its MACRA QPP Subcommittee, IHA strongly recommends that the benchmarks used by CMS to evaluate eligible clinicians’ performance be published as part of the PFS/QPP final rule for CY 2019.**

- **Patient care time reduced by administrative and reporting burdens:** Last year, CMS embarked on an initiative, “Patients Over Paperwork,” the objective of which was to relieve clinicians of many of the administrative burdens that take time away from treating their patients. In several proposed rules published by CMS so far this year, the agency has issued “Requests for Information” (RFIs), soliciting comments from industry stakeholders as to how various administrative burdens could be lessened, if not altogether eliminated. On June 25, one RFI specifically addressed how certain requirements in the Physician Self-Referral law (the “Stark Law”) could be amended to allow providers to improve their quality of care, while at the same time, controlling costs. Some provisions of the Stark Law have been mentioned as discouraging the development of Advanced APMs, a cornerstone of the MACRA. **IHA strongly supports any changes that CMS can bring about which reduce administrative tasks and paperwork for clinicians, allowing them more time to tend to their patients. We also encourage the agency to make public those suggestions received from the industry and, to the extent possible, issue responses and a timetable for implementation of those accepted suggestions as soon as possible.**

- **Issues with Health Information Technology (HIT) vendors:** CMS must provide better oversight of the work of certified HIT vendors as their work cannot be validated in some instances. **IHA strongly recommends that CMS provide stricter oversight of Health Information Technology-Electronic Health Record (HIT-EHR) vendors.** Even for those vendors that satisfy CMS’ certification criteria, data that is exchanged among providers is not validated. Comments from members indicate a high level of frustration resolving errors in reports generated by these vendors. The willingness on the part of certain vendors to resolve these problems is lacking.

- **Increase in the weighting of the cost category domain, but no corresponding CMS feedback on how providers can manage the cost category:** For CY 2019 (payment year 2021), CMS proposes to increase the weighting of the Cost domain from 10 percent to 15 percent, despite the fact that no detailed support for the calculation of the Cost domain is given. There is considerable uncertainty concerning the methodology for the calculation of the Cost Efficiency Domain. Individual clinicians’ claims data can be voluminous and clinicians will need guidance as to how the data is interpreted and applied. **Until the data used by CMS to develop the benchmarks for the Cost domain is made available and vetted appropriately by industry stakeholders, IHA recommends no increase in the weighting should be applied in 2019.**
- **Public reporting of data on Physician Compare**: Physician Compare is CMS’ public reporting vehicle for information on physicians enrolled in the Medicare program. It is expected that with PQRS and MIPS reporting systems, Physician Compare will expand public reporting over the next several years. MACRA requires that the following information be made publicly available:
  - The MIPS eligible physician’s composite performance score;
  - The MIPS eligible physician’s performance in each performance category: Quality, Cost, Advancing Care Information, and Clinical Practice Improvement;
  - The names of eligible clinicians participating in Advanced APMs; and
  - Ranges of composite scores for both aggregate and individual category performance.

The law also provides the opportunity for clinicians to review their specific information before it is made available to the public. This is consistent with the review process available to hospitals when their quality performance data is published on Hospital Compare. However, CMS does discuss in the rule that there are potential differences in the quality benchmarks used in the MIPS performance reports and those used in Physician Compare. **To avoid any possible confusion among eligible clinicians whose performance will be publicly available, CMS must ensure consistency in the data reported under both systems (Individual performance reports and Physician Compare).**

As part of our ongoing work in the transforming the delivery of Illinois healthcare, IHA strongly supports publication and transparency of health data which will improve the quality of care provided to Illinois residents. **IHA supports CMS’ proposal to include a review period prior to the publication of the data. However, we recommend that this review period be extended from the current 30 days to at least 60 days.** Taken together, with other information included on this website (e.g., individual physicians’ billed Medicare charges and Part B payments), the amount of information to review is voluminous. Since Physician Compare is a comparatively new reporting system, it is likely that many physicians will be uncomfortable with, or possibly unaware of, its usage. Many may be unfamiliar with the process of submitting corrections or appealing the data. **Therefore, in addition to recommending an extended review period, IHA strongly suggests that CMS conduct multiple education sessions directed toward the purpose, uses and of Physician Compare data, and how such data can be corrected, if necessary.**

- **Limited review time to review performance reports and to implement improvements**: We are concerned about the length of time available to member eligible clinicians to review their performance feedback reports, submit a targeted review request (with necessary documentation) by Oct. 1, and review and respond to the revised performance reports in order to affect meaningful changes in the next reporting period. As mentioned previously, the time period between the issuance of a revised
performance report and the impact on actual payments is very brief (possibly less than two months). However, beyond that, clinicians will have little time to analyze how they can improve their performance in the upcoming reporting period to have a significant impact on their performance for that period. Although the first reporting period ended on March 31, 2018, the first performance reports were not available for review until July, leaving less than six months for analysis, submission of corrections, review of corrected data, and implementation. **Although we previously recommended an extension of the review period to at least Nov. 1, for future years, we strongly encourage CMS to issue the performance feedback reports at least within three months of the close of the reporting period.**

- **Concerns with quality measures for certain services:** Feedback from our behavioral health members indicates concerns with the current quality measures attributed to them. Behavioral health clinicians (psychiatrists, clinical psychologists), while eligible for MIPS, may not have received the direction and attention that has been focused on other specialties. **IHA requests that CMS provide background on the development of its measures for these behavioral health clinicians and solicit input from these providers as to the appropriateness of those measures.**

In addition, we request that CMS provide further clarification on the quality measures attributable to hospitalists and other clinicians (clinical social workers, physical and occupational therapists) who are eligible to participate in MIPS in CY 2019. This group of clinicians would not be familiar with the Quality Payment Program requirements nor would they be familiar with the measures for Promoting Interoperability. **Consequently, IHA strongly suggests that CMS target education efforts specifically to this group, with a focus on the operational processes used by them to ensure that they can access the data on which they need to report.**

To our knowledge, CMS is considering re-weighting the Quality measures for this new group of eligible clinicians because there may be a limited number of reportable measures. **Given that, IHA suggests that CMS consider phasing-in this group after determining that EMRs are including these measures.** Again, because this is new group of eligible clinicians that will be reporting in 2019, IHA is concerned that EMRs may not be set up to do so.

- **Promoting Interoperability:** CMS proposes that to qualify as an Advanced Alternate Payment Model (AAPM), that APM must require that 75 percent of its participating clinicians use Certified Electronic Health Record Technology (CEHRT) to document and communicate clinical care with patients and other healthcare professionals. This percentage represents an increase from the current requirement of 50 percent. As stated above, IHA has heard from members that issues with health information technology vendors have arisen and resolution of those issues is difficult to achieve.
Consequently, IHA recommends that CMS withdraw its proposal to increase the minimum CEHRT participation percentage for AAPMs, and continue with the current percentage until it can attest to the preparedness of these vendors to address issues challenging the accuracy of their data.

CMS proposes to require the 2015 version of the Certified Electronic Health Record Technology for 2019 PI submissions. IHA is concerned that some organizations will not be able to update their system in time to meet the minimum 90-day reporting period in 2019. For example,

- Many smaller practices may encounter issues upgrading their Electronic Medical Record’s products and obtaining 2015 certification (CEHRT) from the Office of the National Coordinator (ONC); therefore, IHA recommends that until all EMR vendors receive their 2015 certification, CMS should retain the hardship application for possible “vendor issues.”
- Although a hardship application for certain small practices is provided in 2018, the proposed rule makes no mention of continuing the hardship exemption in 2019. CMS should continue this hardship until all EMRs have achieved 2015 CEHRT certification. Specifically,
  - For hardship applications for practices participating in an APM, CMS should continue to reweight the practice score so that it does not adversely affect the overall performance score of the entire ACO; and
  - CMS should consider a hardship application in situations where a practice needs additional system upgrades related to interoperability, but lacks funding to purchase those upgrades.

CMS proposes to add two new opioid measures that will be required to be reported in 2020: Query the Prescription Drug Monitoring Database (PDMP) and Verify Opioid Treatment Plan. Both of these measures will require additional time on the part of the clinician to implement:

- For the PDMP measure, the clinician must check for previous opioid prescriptions for a patient, and document this in the Electronic Medical Record (EMR).
- For the Opioid Treatment Plan, the clinician would have to verify if an opioid treatment agreement exists and how it can be presented in the EMR. Because of the additional workflow time required of the clinician, IHA suggests that CMS develop circumstances under which exclusions from reporting these measures would be appropriate. In addition, given the “newness” of these measures, CMS should allow clinicians to “voluntarily” report these measures in CYs 2020 & 2021, with the requirement applicable to CY 2022.

Finally, CMS has proposed that submitting clinical data to one of two distinct public health registries be a required measure in CY 2019. Implementing a registry submission
would require additional costs for a practice to receive an electronic signal from their EMR. In the proposed rule, CMS requests comments on whether or not to eliminate the Public Health Registry requirement in 2022, and whether it is plausible to submit to a registry if there was no “requirement” to do so. If the requirement will be phased out in 2022, it is inefficient for a provider to incur additional EMR costs on a temporary basis, when, in a few years, the requirement to report is eliminated. Therefore, IHA recommends the requirement to submit in 2022 and beyond be rescinded.

QPP PROPOSALS WHICH IHA SUPPORTS:

- **Offering the “Virtual Groups” participation option:** CMS proposes to continue the opportunity for rural and small practices to participate in a “virtual group” in 2019, with no proposed changes to the eligibility criteria. **IHA supports this proposal.**

- **Exemptions from MIPS, with an “Opt-In” clause:** CMS proposes to add an additional threshold in CY 2019 MIPS participation exemptions to include those clinicians who provide no more than 200 covered professional services. This is in addition to the current thresholds of incurring $90,000 in allowable charges, or treating up to 200 Medicare patients. CMS also proposes to offer a MIPS “opt-in” opportunity for those clinicians who meet one or two of the three thresholds for MIPS exemption. **IHA supports this proposal.**

- **Continuation of the bonus points for the treatment of complex patients and for small practices:** CMS proposes to continue the bonus points awarded for those clinicians and/or practices that treat complex patients or that are classified as a “small practice.” The criteria for categorization, as well as the scoring, are unchanged from 2018. **IHA supports this proposal.**

QPP PROPOSALS WHICH IHA SUPPORTS WITH RECOMMENDATIONS:

- **Clarification of application for MIPS-APM eligible clinicians; streamline reporting of measures:** We support CMS’ goals to reduce administrative burden on providers to improve quality and reduce costs. Currently, providers participating in APMs report their performance under specific measures. MIPS-eligible clinicians who are part of an APM are also required to report certain quality measures. **While CMS has taken steps in previous rulemaking to reduce the redundancy of reporting between the APM-participating, institutional provider and its participating clinicians, as the development of new alternative payment models increases, (particularly in the area of population health), IHA encourages CMS to continue its modifications of the measures reporting processes.**

- **Shortening the performance reporting periods:** The minimum performance period for Quality measures is currently 12 months; CMS proposes to maintain this same period for 2019. Comments received from our members suggest that this reporting period is
too long, so IHA recommends that CMS reduce the reporting period (for both the Quality and Cost domains) from 12 months to 90 days, the reporting period currently used for the Improvement Activities and Promoting Interoperability domains. Doing so would standardize the reporting periods across all domains.

- **Sharing Beneficiary Claims Data Attributable to MIPS APMs:** CMS proposes to clarify the requirement for MIPS APMs to assess performance on quality measures and cost utilization. It states that a MIPS APM “...must be designed in such a way that participating APM Entities are incented to reduce costs of care or utilization or both.” However, for participating providers to apply effective ways of reducing costs, the MIPS APM participating clinicians must have access to the listing of Medicare beneficiaries attributed to that entity. To our knowledge, that information is made available to the Accountable Care Organizations (ACOs), but has not been made available to the MIPS eligible clinicians. **Therefore, IHA requests that in the final rule, CMS commits to sharing beneficiary claims data for those patients attributed to MIPS APM clinicians.**

- **Adding bonus points for complex patients:** Last year, IHA strongly urged CMS to incorporate a risk adjustment, including a socioeconomic adjustment, to ensure caring for more complex patients does not result in the assignment of unfair poor performance scores for providers. IHA’s and others’ advocacy efforts stressing the need for such an adjustment in the current Medicare Readmissions Reduction Program resulted in legislation (Section 102 of H.R. 5273-Helping Hospitals Improve Patient Care Act of 2016) requiring CMS to incorporate a methodology for the implementation of this adjustment in its Hospital Readmissions Reduction Program in FFY 2019. Those regulations can be found in CMS’ final FFY 2019 Inpatient Prospective Payment System (IPPS) Medicare payment rule.

Relative to the QPP, CMS proposes to include an adjustment of up to three bonus points to the total Composite score for those clinicians who treat medically-complex patients. While IHA believes that these additional points are justified, CMS fails to include a socioeconomic adjustment for those clinicians who treat dual-eligible (Medicare & Medicaid) patients, although it does request comments on the feasibility of assigning up to five bonus points to clinicians who treat higher percentages of these patients. **IHA strongly recommends that CMS incorporate the five-point, dual-eligible payment adjustment, but at the same time, increase the additional number of points for complex patients from three to five.**

- **Adding bonus points for small practices:** CMS defines a small practice as one consisting of 15 or fewer clinicians, and will add points to the final composite score provided the practice submits data in at least one performance category. **IHA recommends that CMS make this option available to small rural practices as well, but should reduce the**
number of participants to 10, making this consistent with the virtual group requirement discussed above.

OTHER:

• **Effect of sequestration on MIPS payments**: The proposed rule makes no mention of the impact of the 2 percent sequestration reduction on payments under either the MIPS or APM systems. IHA assumes that the reduction will be applied after any incentive or penalty adjustment is made to the fee schedule payment, but requests that CMS confirm this.

• **Establishing different measures for Non-Physician Practitioners (NPPs)**: In evaluating the measures that CMS has incorporated into the QPP, there is confusion as to the applicability to “non-physician practitioners” (e.g., physician assistants, nurse practitioners or clinical nurse specialists). It is not readily apparent from the rules as to what measures were specifically attributed to NPPs. Therefore, IHA requests that in the final rule, CMS includes a table with measures specifically applicable to NPPs, separately categorized if possible.

• **“Seamless” registration and submission of data**: CMS must ensure that eligible clinicians are able to understand and complete the electronic registration process and actually submit the data to the agency. CMS states in the proposed rule that eligible providers receive their performance data in a format that can be reviewed and analyzed. Proper assignment and usage of the individual TIN and the Enterprise Identity Management (EIM) credentials is critical; however, as mentioned above, eligible clinicians’ TINs have been misclassified. So, IHA recommends that CMS continue to conduct periodic educational sessions or webinars, and make its staff available for ongoing questions and consultations. IHA also cautions CMS that the sheer number of eligible providers could result in a cumbersome data file, making the methods of disseminating that data especially important.

Ms. Verma, thank you again for the opportunity to comment. If you or your staff has any questions on the comments, they should be addressed to Thomas Jendro at (630) 276-5516 or tjendro@team-iha.org.

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