UnityPoint Accountable Care

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October 2, 2020

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1734–P
P.O. Box 8016
Baltimore, MD 21244–8016

RE: CMS-1734-P: Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA–PD Plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy published in Vol. 85, No. 159 Federal Register 50074-50665 on August 17, 2020.

Submitted electronically via www.regulations.gov

Dear Administrator Verma:

UnityPoint Accountable Care (UAC) appreciates the opportunity to provide comments in response to the Physician Fee Schedule CY 2021 proposed rule. UAC is the Accountable Care Organization (ACO) affiliated with UnityPoint Health (UPH), a Midwest integrated health care system, and has value-based contracts with multiple payers, including Medicare. In fact, UAC is one of the largest Next Generation ACO with nearly 5,000 providers (about half of which are independents) and about 100,000 attributed beneficiaries in Iowa and Illinois. UAC is very committed to our value-based mission. Prior to the Next Generation ACO model, we participated in both the Pioneer ACO model and Medicare Shared Savings Program (MSSP) since 2012.

UAC is limiting our comments to the proposed revision of the Qualifying APM (Alternative Payment Model) Participant Threshold Score calculation.

QUALIFYING APM PARTICIPANT (QP) THRESHOLD SCORE CALCULATION

CMS is proposing that beneficiaries who have been prospectively attributed to an Alternative Payment Model (APM) Entity for a QP Performance Period will be excluded from the attribution-eligible beneficiary count for any other APM Entity that is participating in an APM where that beneficiary would be ineligible to be added to the APM Entity's attributed beneficiary list. The effect of this proposed policy is to remove such prospectively attributed beneficiaries from the denominators when calculating Threshold Scores for APM Entities or individual eligible clinicians in Advanced APMs that align beneficiaries retrospectively, thereby preventing dilution of the Threshold Score for the APM Entity or individual eligible clinician in an Advanced APM that uses retrospective attribution.

Comment: **UAC supports this revision and respectfully requests that it be expanded to include all Advanced APMs – both APMs with prospective and retrospective attribution.** While the regulatory text would suggest that this denominator fix applies to any other APM entity where the beneficiary would be ineligible to be added to their attribution list, the preamble appears to limit the plain language to Advanced APMs with retrospective attribution. The limitation is arbitrary and not within the plain language of the regulation proposed in subsection (1)(i) of 42 CFR §414.1435. This change is particularly important and urgent for Advanced APMs and their Participant Providers who have been and continue to be committed to value-based care. As the MACRA Thresholds continue to increase in performance year 2021, Advanced APMs should not be penalized by a flawed Threshold Score calculation. We wholeheartedly agree with CMS's characterization that the current calculation dilutes the Threshold Score. By removing beneficiaries who are already attributed to another Advanced APM and are therefore ineligible to be attribution eligible for other Advanced APMs, we believe this "right sizes" the Threshold Score denominator (i.e. the universe of Fee For Service eligible beneficiaries). We are confused, however, as to why CMS would choose to limit this calculation change to Advanced APMs with retrospective attribution. Threshold Scores are diluted for all Advanced APMs, including Advanced APMs with prospective attribution.

UAC participates in the Next Generation ACO Model, which uses prospective attribution. In the absence of any Threshold Score calculation fix (today's circumstance), beneficiaries who are attributed to our ACO are also included in the universe of attributable beneficiaries for all other ACOs in our service area and vice versa. UAC has overlapping ACOs in our service areas. Using the State of Iowa as an example, there are MSSP ACOs with prospective attribution: Genesis Accountable Care Organization, LLC; MercyOne ACO V; MercyOne ACO IV; Caravan Health ACO 20 LLC; MercyOne ACO III; Nebraska Health Network, LLC; Mercycare Accountable Care Organization, LLC; MercyOne ACO I; Mayo Clinic Community ACO, LLC; and Alegent Health Partners, LLC. None of these MSSP ACOs nor UAC would receive relief under the Threshold Score proposal. However, Iowa also has MSSP ACOs with retrospective attribution - Prairie Vista

Care Organization; MPG Health Collaborative LLC; Caravan Health ACO 41 LLC; Heartland Health ACO Inc; and Think ACO, LLC. These ACOs would benefit from this proposal, without any justification as to why or how these ACOs should receive differential treatment. Bottom line is that all ACOs with overlapping service areas will have beneficiaries in their pool of attribution-eligible beneficiaries who would never be able to assigned to their ACO.

For UAC, this flawed calculation has had real implications for our ACO network under the Next Generation ACO Model. This is particularly impactful to specialists with no ACO attribution but who contribute to care coordination, quality outcomes and quite frankly overall cost management efforts. In the first 2020 Quality Payment Program (QPP) snapshot, the UAC patient count snapshot was 51%. For our nearly 5000 providers in the Next Generation ACO – more than half of which are independents and over 40% are specialists, this snapshot meets the threshold (35%) for 2020. That said, *we have no confidence due to lack of transparency from CMS/HHS in snapshot calculations that UAC will meet this threshold in 2021 and the pandemic just heightens this concern as service delivery and care patterns have been atypical this year and will likely affect attribution*. Due to the risk associated to our entire network of not making the initial snapshot in 2021, UAC made the tough decision to remove specialists without attribution (up to 35% of our network providers) from Participant Provider status and transfer them to Preferred Provider status when we submitted our 2021 Participant List due on September 4, 2020. UAC's governance structure responsible for that decision includes providers that represent those impacted specialists. **Specifically, of our 4959 UAC providers, 1649 were moved to Preferred Provider status.** This tightening of the Participant List impacts some specialists who have been Participant Providers and in at risk arrangements with UAC since 2012. As Preferred Providers, providers will be subject to Merit-based Incentive Payment System (MIPS) reporting and lose the 5% Advanced APM bonus on Part B revenue. For many of these specialists, CMS has no Advanced APM models for which they may otherwise participate and, if models exist, they are episodic rather than focusing on holistic care.

In addition, we respectfully request that CMS consider holding the MACRA threshold for patient count at the 2020 level (35%) due the COVID pandemic. Under the Public Health Emergency (PHE), HHS/CMS has been granted to authority to institute regulatory flexibilities. In reference to the patient count threshold, the statute reads "*the secretary may base the determination of whether an eligible professional is a qualifying APM participant…by using counts of patients in lieu of using payments and using the same or similar percentage criteria…as the Secretary determines appropriate.*" In conjunction with the PHE, CMS has ample authority to maintain the threshold, particularly given that Threshold Scores will be dependent upon beneficiary attribution reflecting periods when patient volume was intentionally depressed due to concerns with maintaining patient and provider safety and preserving levels

of personal protective equipment (PPE).

Finally, should CMS act to revise the Threshold Score calculation and/or maintain the MACRA threshold, we would request an additional flexibility – provide that CMS and its Innovation Center (CMMI) reopen Participant List submission timeframes for the limited purpose of restoring Participant Provider status to impacted non-attribution providers. As indicated above, the Next Generation ACO required its list to be submitted on September 4th. The decision of UAC to move non-attribution specialists from Participant Provider status to Preferred Provider status was made based on the flawed calculation and the rising threshold. If these requirements are changed, UAC would like to opportunity to restore non-attribution providers on Preferred Provider status to Participant Provider status. UAC would not have transferred non-attribution providers to preferred status but for the QPP regulations in place at the time. Although the regulatory framework does not list these transferred providers as attribution eligible, it is a misnomer to suggest that they do not provide value to beneficiaries, their overall health care outcomes and quality of life as well as meaningful contributions to our ACO and its mission to provide holistic and coordinated care.

We are pleased to provide comments on this proposal. To discuss our comments or for additional information, please contact Cathy Simmons, Government and External Affairs at cathy.simmons@unitypoint.org or 319-361-2336.

Sincerely,

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