September 11, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1784–P
P.O. Box 8016
Baltimore, MD 21244–8016

RE: CMS-1770-P: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, published in Vol. 88, No. 150 Federal Register 52262-53197 on August 7, 2023.

Submitted electronically via www.regulations.gov

Dear Administrator Brooks-LaSure:

UnityPoint Clinic appreciates the opportunity to provide comments in response to the Centers for Medicare & Medicaid Services’ (CMS) proposed rule for the 2023 Physician Fee Schedule (PFS). UnityPoint Clinic is comprised of more than 1,180 physicians and advanced practice providers in communities throughout Iowa, Illinois, and Wisconsin. UnityPoint Clinic provides services in family medicine, internal medicine, obstetrics/gynecology, pediatrics, and a wide variety of specialty services, and is the ambulatory arm of UnityPoint Health. UnityPoint Health is one of the nation’s most integrated health care systems. Through more than 32,000 employees and our relationships with 370+ physician clinics, 36 hospitals in urban and rural communities, and 13 home care areas of service throughout our 8 markets, UnityPoint Health provides care throughout Iowa, west-central Illinois, and southern Wisconsin. On an annual basis, UnityPoint Health is responsible for a service area of over 2.3 million people and has generated $344.6 million in community impact.

In addition, UnityPoint Health and UnityPoint Clinic are committed to payment reform and are actively engaged in numerous initiatives that support population health and value-based care. UnityPoint Accountable Care is the accountable care organization (ACO) affiliated with UnityPoint Health and UnityPoint Clinic and has value-based contracts with multiple payers, including Medicare. UnityPoint Accountable Care currently participates in the CMS Medicare Shared Savings Program (MSSP), and it contains providers that have participated in the Center for Medicare and Medicaid Innovation (CMMI) Global and Professional Direct Contracting Model, Next Generation ACO Model, and the Pioneer ACO Model.
UnityPoint Clinic respectfully offers the following comments to the proposed regulatory framework.

## REVISIONS TO PAYMENT POLICIES

### Conversion Factor

**CMS proposes a 2024 physician conversion factor (CF) of $32.7476, a decrease of approximately 3.36% from the 2023 CF of $33.8872 and a further reduction from the 2022 CF of $34.6062.**

**Comment:** According to data from the Medicare Trustees, Medicare physician pay has increased just 9% over the last 22 years, or 0.4% per year on average. This paltry average has not been achieved in the last seven years, and the consistent erosion of the physician CF devalues providers who are the most educated and skilled within the health care workforce. These cuts coexist in a challenging financial backdrop of pandemic recovery, inflationary pressures, and exponential increases to health care labor and supply costs, as well as an escalation in regulatory burdens (e.g., prior authorization, interoperability requirements, and participating in Medicare quality programs such as MIPS). These cuts ultimately threaten access to vital services provided to Medicare beneficiaries and Medicaid members. **UnityPoint Clinic strongly requests CMS adequately increase the physician CF to reflect the current financial landscape of health care.**

### Potentially Misvalued Codes

**CMS comments on potentially misvalued code nominations.**

**Comment:** As a provider clinic organization associated with an integrated health care system, **UnityPoint Clinic appreciates the process for stakeholders to nominate misvalued codes.** But although a process exists, it is difficult for providers outside device makers, trade associations, and specialty society to gather sufficient evidence to demonstrate the totality of impact and, even then, it is an uphill battle. We continue to review these nomination annually, but also want to reiterate the important role of the annual work of CMS in examining the data holistically to identify potentially misvalued codes.

### Services Addressing Health-Related Social Need

**CMS proposes new codes and payment for community health integration services, social determinants of health risk assessment, and principal illness navigation services that are provided by social workers, community health workers, and other auxiliary personnel.**

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1. 2023 ANNUAL REPORT OF THE BOARDS OF TRUSTEES, FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS, accessed at [https://www.cms.gov/oact/tr/2023](https://www.cms.gov/oact/tr/2023) - “Physician payment update amounts are specified for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. These rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large.”
Comment: UnityPoint Clinic applauds the Principal Illness Navigation (PIN) concept but has operational questions that remain unanswered by simply authorizing Medicare reimbursement.

- **How does this additional fee structure fit within the transition to value?** These codes should be available only to providers engaged in Medicare value arrangements, preferably two-sided Medicare risk contracts. Without this tie, this has the potential to drive up total cost of care. Instead, we would suggest that this concept be tested through a CMMI model and/or a MSSP waiver. Providers in these models are committed to value, and many already have strong relationships with community-based organizations.

- **Is this redundant with other Medicare benefits?** In recognition of the benefits of coordinated care delivery, CMS continues to add care management services to the PFS. While we appreciate having tools that are reimbursable to meet beneficiaries where they are, we are concerned with the lack of clarity related to how these services interact and may be billed. Presently, providers may provide Chronic Care Management (CCM) and Remote Patient Monitoring (RPM) services as well as services under a Home Health benefit.

- **Has CMS contemplated implementation costs and additional administrative burden to providers?** CMS indicates that there must be “sufficient clinical integration between the third party and the billing practitioner in order for the services to be fully provided.” First, there will be costs and time associated with integrating this workflow into an electronic medical record. We anticipate that software development and implementation will cost at least $500,000 and that excludes time and effort by our organization to test and train our providers and community-based organizations. Second, this adds yet another administrative / documentation requirement to a visit for which a provider is responsible. Decision support protocols for E/M visits are already lengthy and this will add a community referral and follow-up process. Third, it is unclear what responsibilities / liabilities may be placed on a practitioner’s license through the delegation of a Medicare-reimbursed service to a community-based organization and their unlicensed individuals. Fourth, this new external team member may actually supplant current trained workforce and create workflow inefficiencies.

- **Is there a ready and willing workforce with capacity to perform these functions?** Foremost, health care as an industry is suffering from pervasive workforce shortages. For the positions targeted in this proposal, health care and community-based organizations are competing with retail chains for employees; however, retail chains don’t have the proposed training requirements. Second, shifting PIN care coordination to community-based organizations assumes that community-based organizations have community health workers or peer support counselors able to perform these functions and who are appropriately trained. As a health care organization, we have had challenges recruiting and retaining similar positions – these individuals just don’t exist. In this proposal, CMS is creating another venue to draw workforce away from traditional health care organizations based on specific illness rather than population health needs. Presently, these functions are often performed by other team members with an expertise and training in care coordination and community resources as opposed to being a dedicated community health
worker.

- **Will beneficiary cost sharing associated with services from community-based organizations create confusion?** In general, the uptick in care coordination services has not met expectations when beneficiaries have associated cost sharing. We envision that co-payments for third-party services will run counter to the good intentions for this proposal and further support why this should be piloted in a value-based model.

UnityPoint Clinic and our affiliated ACO, UnityPoint Accountable Care, would welcome the opportunity to work with CMS to further refine this concept. As proposed, UnityPoint Clinic does not believe this PIN concept is mature and ready to operationalize for Traditional Medicare without value-based evidence and parameters.

**Evaluation and Management E/M Visits**

*CMS reaffirms that a new add-on code, G2211, for complex patients will go into effect on January 1, 2024, and proposes to further delay for split (or shared) services using “time only” to determine the “substantive portion” definition in CY 2024.*

**Comment:** UnityPoint Clinic reiterates our long-standing support for split/shared E/M visits to reflect current team-based practice. We agree that the focus should be on time as this will help to build cost-effective teams wrapping care around the patient. That said, UnityPoint Clinic understands that time allotment is a concern for some providers but urges CMS to continue its focus on time alone to determine substantive portion.

UnityPoint Clinic also supports the complex care add-on to appropriately reflect the acuity and multiple underlying chronic conditions of an aging population. We agree with the January 1, 2024 start date.

**Behavioral Health**

*CMS proposes efforts to expand access to and address shortages of behavioral health providers. Specifically, licensed marriage and family therapists (MFTs) and mental health counselors (MHCs), including addiction counselors that meet MHC requirements, may bill Medicare Part B starting January 1, 2024. Revisions are proposed to Behavioral Health Integration codes, Health Behavior Assessment and Intervention codes, and Hospice Conditions of Participation.*

**Comment:** UnityPoint Clinic is pleased that MFTs and MHCs (including addiction counselors) will be independently credentialed by Medicare. We also support the inclusion of these behavioral health professionals within the Hospice Conditions of Participation. As is the case nationally, our three-state service area is riddled with mental health-designated Health Professional Shortage Areas (HPSAs) and wait times for preventive services is growing. Expanding access through additional behavioral health provider categories is welcome. **UnityPoint Clinic also supports the use of licensed professionals to address behavioral health integration and health behavior assessment and intervention.** Expanding access through additional services to meet patient needs is likewise appreciated. To effectively address access issues, CMS must continue to thoughtfully add provider types as well as equip these providers with billing capability. As Medicare often leads coverage that becomes the industry standard, we believe these actions will influence further coverage by commercial payors – ultimately benefiting all patients.
UnityPoint Clinic appreciates that CMS is seeking stakeholder input to further expand access to behavioral health services.

- **Certified Community Behavioral Health Centers (CCBHCs) should be Federally Qualified.** Once behavioral health models or services are authorized, there is a need for stable funding to assure that these models and services can be offered and maintained. Case in point is the CCBHCs. UnityPoint Health drank the Kool-Aid—four of our five affiliated Community Mental Health Centers have received one or more rounds of Substance Abuse and Mental Health Services Administration (SAMHSA) funding. These models enable crisis and mobile services that are well received, but require consistent funding to maintain. Touted as a one-stop shop providing a comprehensive range of mental health and substance use services, this model has been the subject of inconsistent federal funding and aims to have States manage and fund these programs moving forward. It seems ironic that this model would be pushed to States whose poor Medicaid rates dissuade many mental health providers from accepting Medicaid patients altogether. To be successful, we recommend that CCBHCs should be federally funded and managed like Federally Qualified Health Centers, with a core 3-year federal grant and periodic opportunities for supplemental federal funding. Presently, we have former CCBHC grant recipients who are struggling to maintain services under this model once federal funding lapsed.

- **Behavioral Health Patients Awaiting Placement are being Boarded in Emergency Departments (EDs) and Inpatient Units for Lengthy Stays.** The number of behavioral health patients presenting at our EDs is troubling. At one of our small rural hospitals with 40 staffed beds, 3,500+ annual hospital discharges, and 19,500+ annual ED visits, they have noted that:
  - Behavioral health ED visits have grown over time—reaching almost 6% of total ED visits in the last 12 months;
  - Both total behavioral health patients and visits are trending upwards—9% increase since 2019;
  - Behavioral health patients with longer stays are increasing—while an average of 3 behavioral health patients present daily at this small hospital this year, 34% (average of one per day) stay for more than 12 hours;
  - For behavioral health patients with extended ED stays in excess of 24 hours this year:
    - Average length of stay in the ED is 55 hours;
    - 19% of extended stay patients stayed at least 2 days;
    - The longest ED stay was 15 days.

We have similar trends for behavioral health patients housed in inpatient acute beds without medical need but who are awaiting community or post-acute placement. Some have been housed for months, far exceeding any DRG payment.

Ideally, these patients need step-down placement. In the meantime, CMS could consider reimbursing hospitals for days awaiting placement for inpatient stays. For ED stays, CMS could consider the provision of add-on behavioral health services during this visit.

- **Behavioral Health Urgent Care Clinic Models are Clinically Effective but Lack Sustainable Funding**
Mechanisms. During the advent of the COVID-19 pandemic in April 2020, UnityPoint Clinic established a behavioral health urgent care clinic in nine days at a location across the street from one of our hospitals. Not only did this better protect behavioral health patients from the COVID-19 virus as well as free up ED beds for medical patients, but this clinic also provided immediate access to step-down services for patients whose behavioral health concerns did not require an ED visit. In the first two years of operation, 5,580+ visits were provided avoiding ED visits and 95% of patients avoided admissions to an inpatient unit. Roughly 22 patients continue to be seen per day with average appointments lasting 60 minutes. Co-located in the clinic are care coordinators as well as representatives from Community Mental Health Centers serving both adults and children. Despite positive clinical outcomes, this clinic has significant financial losses. When we replicated this clinic in a rural market, it closed within a year due to financial losses. To bolster financial sustainability, CMS should examine reimbursement for team-based care as visits are lengthy and involve multiple team members and disparate funding streams – traditional fee-for-service reimbursement is insufficient forcing the clinic administrators to chase grant-like mechanisms for funding that are often short-term and in small amounts. In this market, 340B savings have been vital to keep these doors open.

Dental Services Inextricably Linked to Specific Covered Services
CMS proposes to codify payment policy for dental services inextricably linked to other covered services used to treat cancer. CMS seeks comment on additional circumstances where evidence supports dental services being integral to the clinical success of covered medical services.

Comment: UnityPoint Clinic agrees that Medicare should cover dental services inextricably linked to other covered services used to treat cancer. In addition, we request that CMS consider covering dental services when linked to significant facial trauma. An example is significant facial trauma resulting from a deer on vehicle auto accident.

TELEHEALTH AND OTHER REMOTE SERVICES
In general, UnityPoint Clinic urges coverage for comprehensive telehealth services on a permanent basis, or care will continue to be inaccessible to beneficiaries who experience barriers to care. UnityPoint Clinic is committed to meeting patients at the right time, with the right care, and the right place – and telehealth is vital to this commitment. CMS must take definitive action and expand telehealth services and billing providers on a permanent basis.

Telehealth Services List
CMS proposes a five-step process for adding, removing, or changing the status of services on the Medicare Telehealth Services List on a permanent basis. During the transition period, CMS proposes to move all codes in Categories 1 and 2 to the “permanent” list and any codes in a “temporary Category 2” or Category 3 to the “provisional” list. For CY 2024, no codes are proposed to be removed; however, list additions are Health and Well-Being Coaching Services as temporary and SDoH Risk Assessment as permanent.

Comment: With the enrollment of new Medicare beneficiaries each year, more Medicare beneficiaries are comfortable with technology to meet their health care needs and actually expect that technology will be used. UnityPoint Clinic generally supports the proposed simplified process for the telehealth service
list and is pleased that no services are proposed for removal in CY 2024. That said, we offer this input:

- **“Optional” Step 5** – This last step addresses those services that meet all other criteria (are separately payable, a face-to-face service, and capable of being furnished using interactive telecommunications) but are not analogous to a service that is already on the permanent list. Step 5 requires a finding of clinical benefit analogous to in-person service. **UnityPoint Clinic encourages CMS to add all services to the permanent list upon a finding of clinical benefit.** If a service can safely and effectively be delivered face-to-face virtually, it seems nonsensical to assign a provisional status just because the service was not covered in the past.

- **Provisional Status** – **UnityPoint Clinic questions the temporary inclusion of services on the Telehealth Services List.** The temporary nature and lack of certainty means that providers are unlikely to use telehealth to provide these services. This status requires providers to continuously stay up to date on a moving target and creates an overall reluctance to commit to a practice change or make needed infrastructure investments. In addition, should provisional status be removed, this exacerbates and does not resolve known access and patient follow up challenges. Unless there is a temporary problem to solve, there is no advantage to provisional status. If there are telehealth services that CMS would like to pilot or test, UnityPoint Clinic would recommend this occur with providers engaged in Medicare value arrangements, preferably two-sided Medicare risk contracts.

- **Notice When Service Removed From the Provisional List** – As providers have shifted care modality based on provisional status (particularly under the PHE and extended flexibilities), some flexibilities have been in place for a significant length of time and will require more operational changes to 'revert' operations back to in-person. **UnityPoint Clinic requests that CMS provide a minimum of 6-months’ notice when services are being removed from the list.**

**Telehealth Reimbursement**

CMS proposes permanent facility rates for certain Place of Service (POS). Specifically, claims billed with POS 02 (Telehealth Provided Other than in Patient’s Home) will continue to be paid at the lower PFS facility rate, and claims billed with POS 10 (Telehealth Provided in Patient’s Home) will be paid at the higher, PFS non-facility rate.

**Comment:** UnityPoint Clinic encourages CMS to adopt reimbursement parity across the board. The location of the patient does not change the investment of provider time/expenses that goes into providing the service. As provider shortages grow and disproportionately impact rural geographies, telehealth is critical to maintain access in rural areas, especially to specialty care. Reimbursement levels definitely impact where care is provided. CMS should continue to evaluate reimbursement data and seek additional feedback to ensure reimbursement rate changes do not have a negative impact on health care access as technology advances.

Other opportunities that would benefit from reimbursement equality include:

1) **Reimbursement parity for inpatient encounters (CPT 99218 - 99223, 99231 – 99236, 99238 – 99239, 99341-99345) via telehealth equal to in-person encounters.** These codes should be reimbursed to reduce duplicative work, improve provider efficiency, and enhance patient
experience. In the absence of a change to enable billing through a telehealth provider, patient histories and physicals must be performed twice by providers on the same team.

2) **Additional eligibility categories for the FCC Rural Health Care Program.** Home Health Agencies serving rural areas should be eligible to participate to promote maintaining rural residents in their homes when possible.

**Extension of Certain Medicare Telehealth Flexibilities**

CMS includes flexibilities authorized by Congress through CY 2024 – continuation of any originating site, audio-only telehealth, and expanded categories of practitioner participation as well as the delay of a prerequisite in-person visit for mental health. CMS continues to evaluate removing frequency limitations, direct supervision requirements, and supervision of residents in teaching settings. Marriage and family therapists and mental health counselors are proposed as telehealth practitioners.

**Comment:** UnityPoint Clinics appreciates that Congress extended telehealth flexibilities through CY 2024 and applauds CMS for acknowledging the urgent and critical need to maintain these flexibilities for patient access to care. Like most providers, UnityPoint Clinic heavily increased adoption of telehealth during the COVID-19 pandemic to safely provide care to vulnerable populations and communities. **UnityPoint Clinic supports a permanent status for these telehealth flexibilities** and shares some outcomes data:

- The federal PHE telehealth waiver of originating site requirements has been transformational in providing access via telehealth services in patient homes and in urban/Metropolitan Statistical Areas. By simply waiving originating site restrictions for the same billable services, **outreach to a more geographically disperse population resulted – from patients residing in 41% of all rural Iowa zip codes in 2019 to patients residing in 90% of all rural Iowa zip codes in 2020 and 2021.**

- Any reinstatement of in-person requirements for mental health visits should include flexibility. The need for behavioral health services has increased over time and behavioral health providers are in short supply. Telehealth is used to manage behavioral health needs in both ED (to reduce boarding times and admissions) and outpatient settings. **For outpatient visits, telehealth correlated to an increase in appointments kept – 75% when telehealth is available, compared to 58% for in-person visits.**

With 35 Rural Health Clinics (RHCs) across Iowa, rural residents have benefited from RHCs serving as a distant site and qualifying for a distant site payment. Annually we provide over 5,000 distant sites visits with 25% of these visits to patients age 70+. For patients surveyed after receiving care through telehealth, 94% rated their overall care experience as “very good.” While RHCs are permanently recognized as distant sites for behavioral health services, this is not the case for general medical telehealth provided after December 31, 2024. **UnityPoint Clinic requests that CMS (1) permanently extend distant site status to RHCs for all telehealth services; (2) reimburse RHCs at their full AIR payment for distant site visits; and (3) treat telehealth visits the same as in-person visits for cost reporting purposes.**

**Remote Monitoring Policies**

CMS clarifies remote physiologic monitoring (RPM) and remote therapeutical monitoring (RTM) policies – specifically, **RPM can only be provided to established patients, RPM and RTM may not be billed together,**
and data collection minimums of at least 16 days in a 30-day period apply. CMS seeks input from stakeholders on current payment policies.

**Comment:** UnityPoint Clinic supports remote monitoring as a means to provide the right care at the right time in the right setting. This has been extremely beneficial for Chronic Care Management (CCM) to our rising-risk and high-risk Medicare beneficiaries to keep them connected with a care team between regular visits. **We request that CMS revisit the 16-day monitoring threshold in a 30-day period.** This frequency is too rigid for many chronic conditions and instead should be based on the clinical scenario and expertise of the provider. Patients with an acute need could benefit from a short period of monitoring to avoid readmission post procedure, while patients with some chronic conditions could effectively be monitored two or three times weekly. Monitoring is different for conditions (diabetes, high blood pressure, congestive heart failure) as well as disease progression. Beneficiary cost associated with monitoring should also be considered – for instance, requiring testing supplies for 16 monitoring events versus 8 monitoring events doubles the beneficiary cost. If parceled on a monthly basis, UnityPoint Clinic would recommend at least 8 times per month as set forth on an individual basis in a care plan.

UnityPoint Clinic also encourages CMS to reconsider concurrent billing for RPM and RTM. Although both services aim to lower the overall cost of health care for these patients, they are in fact two separate services that patients with complex medical conditions may benefit from independently. RPM targets physiologic metrics, while RTM targets therapeutic monitoring, such as adherence to a medication regimen, a physical therapy program, or a cognitive behavioral therapy program. For a diabetic patient, RPM can monitor A1c levels and RTM can monitor medication adherence.

**RURAL HEALTH CLINICS (RHC)**

*CMS proposes to extend telehealth flexibilities through CY 2024, but solicits input on further extensions including direct supervision parameters. Building upon chronic pain management and behavioral health integration services, CMS seeks to expand care management services. Additionally, CMS proposes corresponding changes to Conditions of Certification and the definition of staffing.*

**Comment:** UnityPoint Clinic has 35 RHCs in Iowa, which are vital to providing access to health care for our rural residents. In this rule, there are several provisions that enable telehealth delivery of behavioral health services – behavioral health parity, temporary delay of in-person prerequisites, expansion of behavioral health professionals, supervision requirement for auxiliary personnel, and coverage for intensive outpatient program (IOP) services. **With the shortage of behavioral health professionals, telehealth enables RHCs to more efficiently use staff time as well as deliver care through a mode associated with high patient satisfaction,** and the addition of licensed marriage and family therapists and mental health counselors, including addiction counselors, as credentialed providers is welcomed and will reduce appointment wait times. IOP services have been covered by Medicaid, so we are pleased that Medicare has added this benefit as well.

In terms of general care management, our patients are elderly, and many have several comorbidities. Remote Physiologic Monitoring, Remote Therapeutical Monitoring, and Chronic Care Management services have been well received and reduce travel barriers for beneficiaries. When considering this from a health equity lens, patients cared for by a RHC provider are not able to receive the same services as their
urban counterparts without allowing for this payment methodology for this care delivery modality. **We are concerned about the potential reduction in payment for HCPCS G0511** due to the addition of other more specialized care navigation services and intend to monitor utilization of Chronic Pain Management, general Behavioral Health Integration, Community Health Integration, and Principal Illness Navigation services. We anticipate that these latter services will not be utilized as greatly in the RHC setting, yet these services will negatively impact reimbursement for G0511. We respectfully request that CMS also monitor utilization to help identify any geographic disparities impacting rural residents.

In terms of RHC operations, **UnityPoint Clinic applauds the continuation of direct supervision via the use of two-way audio/video communications technology.** This has been a game changer. While initiated during the PHE, this flexibility has allowed our providers to deliver quality care efficiently to rural Iowans. As workforce challenges exist and are pronounced in some of our rural communities, this enables our RHCs to have a larger community presence, including longer hours or more days. We simply did not and do not have the bodies to maintain these schedules if a physical presence for direct supervision is required. **UnityPoint Clinic wholeheartedly supports the permanency of this flexibility beyond 2024.**

CMS is considering revisions to RHC Conditions for Certification (CfCs) in reference to nurse practitioners (NP). We agree that CMS should remove reference to an obsolete certifying board and instead provide a general reference to these bodies. CMS is next questioning whether the definition of NP should continue to specify that an NP’s certification be in the area of primary care. The comports with the Rural Health Clinic Services Act of 1977 that extended Medicare entitlement and payment for primary services furnished at an RHC by physicians and certain other practitioners (which included NPs). **UnityPoint Clinic supports the continued requirement that NPs be certified in primary care.** As noted by CMS, the primary purpose of training for primary care NPs (e.g. comprehensive, continuous care for patients with most health needs, including chronic conditions) versus acute care NPs (e.g. restorative care, which involves addressing rapidly changing clinical conditions in patients with unstable, chronic, and complex acute and critical conditions) describes the patients being served, with the former being the clientele of RHCs. As workforce is top of mind, we would also suggest that RHCs be allowed to hire non-primary care certified NPs on a provisional short-term basis pending primary care certification. CMS could also grandfather in non-primary care certified NPs at the time of enactment.

As stated in the **Telehealth and Other Remote Services - Extension of Certain Medicare Telehealth Flexibilities** narrative above, UnityPoint Clinic will reiterate our request that **CMS (1) permanently extend distant site status to RHCs for all telehealth services; (2) reimburse RHCs at their full AIR payment for distant site visits; and (3) treat telehealth visits the same as in-person visits for cost reporting purposes.**

**APPROPRIATE USE CRITERIA (AUC) PROGRAM**

**CMS proposes to pause the AUC program indefinitely. The Protecting Access to Medicare Act of 2014, Section 218(b), established the AUC program. Under this program, a practitioner who orders an advanced diagnostic imaging service for a Medicare beneficiary in an applicable setting is required to consult an AUC using a qualified clinical decision support mechanism.**

**Comment: Thank you!** UnityPoint Clinic welcomes this indefinite pause. To operationalize, this program delays care, unnecessarily substitutes individual clinical judgment, and adds administrative burden (as
well as vendor costs). In addition, as providers transition to value, further restraints on advanced diagnostic imaging services are not needed.

### ELECTRONIC PRESCRIBING FOR CONTROLLED SUBSTANCES (EPCS)

For a covered Part D Drug under a Prescription Drug Plan or an MA–PD Plan, CMS streamlines standards for same legal entity, redefines the compliance threshold, and updates exceptions for cases of recognized emergencies and extraordinary circumstances.

**Comment:** UnityPoint Clinic supports finalizing both the electronic prescribing and compliance proposals. In recent years with more security (namely, two-factor authorization), electronic prescribing has become a standard practice, and EPCS supports getting medication to beneficiaries both timely and efficiently. While UnityPoint Clinic greatly exceeds the 70%-compliance threshold, we appreciate the attempt by CMS to recognize exceptions for emergencies and extraordinary circumstances, beyond those “recognized emergencies”. Aside from emergencies or disasters, it has been our experience that a variety of information technology issues, including internet down time, cybersecurity breaches, program malfunctions, and loss of power, comprise the majority of hiccups with e-prescribing and dispensing.

### COVID-19 VACCINE ADMINISTRATION SERVICES

CMS proposes an additional payment for in-home COVID-19 vaccine administration. Specifically, CMS proposes to maintain the in-home additional payment for COVID-19 vaccine administration under the Part B preventive vaccine benefit and also proposes to extend the additional payment to the administration of the other three preventive vaccines included in the Part B preventive vaccine benefit (pneumococcal, influenza, and hepatitis B vaccines) effective January 1, 2024.

**Comment:** UnityPoint Clinic supports these proposals and is pleased that this additional payment amount will be annually updated using the percentage increase in the Medicare Economic Index and adjusted to reflect geographic cost variations. Additionally, UnityPoint Clinic encourages CMS to include other CDC recommended vaccines for this age group within Medicare Part B preventive vaccine benefit.

### ANNUAL WELLNESS VISIT (AWV) ADD-ON

CMS proposes to add a new Social Determinants of Health (SDoH) Risk Assessment as an optional, additional element of the Annual Wellness Visit with an additional payment. Assessment will be paid at 100 percent of the fee schedule amount of the risk assessment and be subject to no beneficiary cost sharing when furnished as part of the same visit with the same date of service as the Annual Wellness Visit.

**Comment:** UnityPoint Clinic is supportive of this add-on element with reimbursement. The proposed new SDoH Risk Assessment is consistent with enhancing patient-centered care and would be a complement to the administration of an AWV. With this new add-on payment, we seek confirmation that the SDoH Risk Assessment add-on to an AWV would not alter the ability of providers to bill separately for a E/M visit for a medically necessary service on the same day and that this does not alter beneficiary cost-sharing responsibilities for that same-day E/M visit.

### MEDICARE SHARED SAVINGS PROGRAM (MSSP)

CMS proposes changes to the MSSP to advance CMS’ overall value-based care strategy of growth, alignment, and equity. The proposal changes quality performance and reporting requirements under the
APM Performance Pathway, refines financial benchmarking methodology, modifies beneficiary assignment, further refines advance investment payments, and eliminates a shared governance exception. CMS also solicits stakeholder input on future policy developments.

Comment: For context, UnityPoint Accountable Care is the accountable care organization (ACO) affiliated with UnityPoint Health and UnityPoint Clinic. UnityPoint Accountable Care has participated in Medicare ACO agreements since 2012 including the Center for Medicare and Medicaid Innovation’s (CMMI) Global and Professional Direct Contracting (GPDC) Model, the Next Generation ACO Model, and the Pioneer ACO Model. During this time, UnityPoint Accountable Care has enjoyed partnering with CMS and CMMI in the testing and developing of value propositions, including benefit enhancements. In 2023, we serve more than 100,000 beneficiaries through over 6,000 providers in the Medicare Shared Savings Program and are participating in the ENHANCED Track.

In addition to the following comments, UnityPoint Accountable Care is a member of the National Association of Accountable Care Organizations (NAACOS) and the Accountable For Health (A4H) Coalition. Both organizations have also submitted comment letters to this proposed rule, to which we contributed content, generally support, and encourage CMS to consider.

Quality Performance Standard and Other Reporting Requirements
The quality performance standard is used to determine whether an ACO is eligible to receive shared savings for a performance year.

Reporting Medicare Clinical Quality Measures (CQMs) – All payor reporting is not feasible at this time, so UnityPoint Accountable Care is pleased that CMS is responding to these concerns and providing an alternative reporting option through Medicare CQMs. UnityPoint Accountable Care supports a Medicare CQM reporting option that is limited to ACO attributed lives identified by the patient list provided by CMS at the beginning of the reporting period. In terms of modality, UnityPoint Accountable Care urges CMS to continue Web Interface reporting beyond 2024 until EHRs, payors, ACOs, and providers are capable of reporting under the new processes. ACOs and providers need clarity, consistency, simplicity, and funding to build the capability for reporting, particularly if the Web Interface is eliminated. Realistically, ACOs will need a two- to three-year transition period to stand up eCQM reporting infrastructure across a broad and diverse network. In many instances, EHR vendor solutions don't exist to meet CMS requirements, which adds more time and expense. This also holds ACOs to an unrealistic standard which their provider network cannot meet.

- Data Completeness Threshold – The proposed 75% and 80% thresholds are not feasible as an initial glidepath, using a new process, and capturing all Medicare FFS attributed beneficiaries. This will be particularly problematic if reporting extends beyond an attributed ACO beneficiary population, and/or the population is not identified at the beginning of the performance year. CMS has already signaled that CMS may not have complete claims data to forward to ACOs prior to the data submission period. UnityPoint Accountable Care requests that CMS reconsider the glidepath, the thresholds, or both.

- APM Performance Pathway (APP) and CAHPS Measure Set – UnityPoint Accountable Care is concerned with the constant changing and/or expansion of measures too quickly without time
to test, assess, and ensure appropriate time for implementation. This is increasingly challenging when reporting models are also changing and this adds time and effort for ACOs and participants in value-based payor models. In general, UnityPoint Accountable Care opposes the reporting on any behavioral health or substance use disorder measures until there is time to transition and we can get full data on these beneficiaries. As measures are added, UnityPoint Accountable Care reiterates the need for specific requirements as well as funding to support.

- **Benchmarks** – CMS proposes scoring benchmarks based on the performance period for the first two years before transitioning to historical benchmarks. Transparency and predictability are important. Today, quality data lags eight to ten months, so ACOs have virtually no opportunity to improve scores based on data. **UnityPoint Accountable Care supports the idea of moving to a three-year historical benchmark with a one-year lag.** Using the historical trend, ACOs should have a more accurate view of where affiliated providers are performing versus where they are experiencing significant swings.

- **Health Equity Adjustment** – UnityPoint Accountable Care generally supports CMS’ focus on health equity; however, these changes and financial implications are occurring too rapidly, and we urge a delay of at least one year. UnityPoint Accountable Care is concerned that the proposed calculation may not account for all components of health equity. Additionally, it is incredibly challenging to measure these efforts in a manner that accurately accounts for the resources, investment, and time across communities needed to advance this work. Funding to support this work is essential. Further time for modeling, analysis, and development for this effort is advised.

**Aligning CEHRT Requirements for Shared Savings Program ACOs with MIPS** – **UnityPoint Accountable Care opposes CMS’ proposal to align CEHRT requirements.** This adds administrative burden as well as a reporting obligation for Advanced APM QPs, who have historically been excluded from the MIPS program, to report Promoting Interoperability in the Quality Payment Program. With workforce challenges and providers exiting health care at record numbers, it is ill-timed to impose additional duties to transition to value and further reduce any incentive for providers to participate in an Advanced APM and obtain QP status.

- **Public Reporting** – CMS proposes to require ACOs to publicly report the number of clinicians that earn a MIPS performance category score for promoting interoperability at the individual, group, virtual group, or APM entity level. **UnityPoint Accountable Care opposes this Promoting Interoperability public reporting requirement** given this detailed data would largely be confusing to Medicare beneficiaries rather than informative. Additionally, these numbers fluctuate frequently, and it would be near impossible to have an accurate count on a routine basis.

**MIPS Value Pathways/Quality Reporting for Specialists** – UnityPoint Accountable Care is interested in strategies to increase specialist engagement. However, having specialists perform extra work is not advisable if you want to expand programming to encourage their participation. CMS is considering bonus points for ACOs with specialists reporting quality MVPs that would be applied after MIPS scoring is complete. An incentive for reporting would help, but UnityPoint Accountable Care does not support making it a requirement. Instead, **CMS should allow specialists (and primary care providers as well) who**
participate in another APM to also be included in an MSSP ACO and qualify for all incentives without additional data reporting other than requirements for ACO and their APM. ACOs need more performance data on specialists. The addition of a payment model or incentive that enables partnership between primary care providers and specialists (such as a care compact) is a more sustainable and proven approach for engaging specialists while continuing to tie care back to the primary care provider. A PMPM should be considered to support this work. Until further development is considered for engaging specialists, UnityPoint Accountable Care believes that specialist engagement needs to be voluntary and maintaining engagement as voluntary is critical.

**Beneficiary Assignment**

Beneficiary “assignment” is the process Medicare uses to determine whether a beneficiary receives a sufficient level of specified primary care services from practitioners in an ACO, indicating that the ACO qualifies as responsible for that beneficiary’s care. Proposed changes are:

**Expanding Window for Assignment and Revising Stepwise Assignment Methodology – UnityPoint Accountable Care urges CMS not to finalize this proposal as ACOs do not have sufficient information to offer informed input.** While UnityPoint Accountable Care generally supports the expanded 24-month assignment window, we are concerned with Step 3 assignment to non-physician practitioners that lack a specialty designation. While UnityPoint Accountable Care appreciates that CMS performed a national simulation², UnityPoint Accountable Care requests that CMS share ACO-specific modeling and analysis of the expanded assignment window and the proposed revisions to the assignment methodology with sufficient time for review prior to signing MSSP contracts for PY 2025. Further CMS analysis could include additional years of data and assess changes to regional factors, per-beneficiary-per-year (PBPY) expenditures, average risk scores, and benchmarks for individual ACOs.

**Revising the Definition of Primary Care Services** – For PY 2024, CMS proposes to revise the definition of primary care services used in MSSP assignment methodology, including several yet-to-be finalized codes/services. Services include smoking and tobacco-use cessation counseling, remote physiologic monitoring, cervical or vaginal screening, office-based opioid use disorder services, complex E/M services add-on, community health integration, principal illness navigation, SDH risk assessment, caregiver behavior management training, and caregiver training services. This is a significant number of changes. Without an appropriate phase-in period and an understanding of how this expanded population will impact care delivery and financial assumptions, UnityPoint Accountable Care opposes the inclusion of this expanded definition of primary care for PY 2024. It is difficult at best for ACOs to be responsible for coordination of care for a population without Claim and Claim Line Feed (CCLF) files. For some ACOs, this newly attributed population may represent a higher risk / acuity with no growth option for the ACO’s risk score to accurately reflect this change resulting from a CMS rule.

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² Nationally, Step 3 assignable beneficiaries included a larger share of beneficiaries with disabled Medicare enrollment type, who resided in areas with slightly higher than average ADI national percentile rank, and had a larger share with any months of part D LIS enrollment. Other characteristics included beneficiaries with a lower average HCC risk score, lower total per capita spending, higher hospice utilization, and higher mortality rate than assignable beneficiaries that would be determined without the proposals. (Source: Table 30)
Benchmark Methodology
As an early ACO adopter of two-sided risk, UnityPoint Accountable Care has consistently been challenged to improve beneficiary access and quality, while being cost efficient. CMS proposes revisions to benchmarking methodology aimed at encouraging sustained participation by ACOs in the program.

Capping ACOs Regional Risk Score Growth – CMS proposes to cap prospective hierarchical condition code (HCC) risk score growth in an ACO’s regional service area between benchmark year (BY) 3 and the PY by applying an adjustment factor to the regional update factor. This regional risk score growth cap would be applied irrespective of any cap on an ACO’s own prospective HCC risk score growth. UnityPoint Accountable Care supports this proposal and urges its application to all MSSP ACOs, including those in existing agreements.

Eliminating the Negative Regional Adjustment – For new agreements starting in 2024, CMS proposes to prevent any ACO from receiving a negative regional adjustment. UnityPoint Accountable Care supports this proposal and urges its application to all MSSP ACOs, including those in existing agreements. While CMS does not propose a change for ACOs with a positive regional adjustment, UnityPoint Accountable Care exists in a market that already has reduced costs within our communities due in part to our long-standing presence. As commonly known, there is effectively a cap on ACO savings under current policies, which does not exist in other Medicare programs, including Medicare Advantage. A race to the bottom should not be the de facto result of these policies and, instead, there should be incentives for continued participation for successful ACOs to maintain participation.

Updating How Benchmarks are Risk Adjusted – For new agreements beginning in 2024, CMS proposes to use the same HCC risk adjustment model for a performance year and the relevant benchmark years. This means that as CMS introduces new risk models, including the forthcoming V28, risk scores would be calculated using a consistent model. UnityPoint Accountable Care supports CMS using a consistent risk model in both the performance and all benchmark years and urges CMS to apply this model to all MSSP ACOs, including those in existing agreements.

Proposed Modifications to Advanced Investment Payments (AIP) Policies
Based on the former ACO Investment Model, CMS finalized a new payment option to provide upfront shared savings payments to certain new ACOs beginning January 1, 2024. CMS proposes additional revisions in advance of the initial implementation year. UnityPoint Accountable Care understands that AIPs are intended to assist new and inexperienced ACOs in one-sided models with upfront financial support to invest in necessary technology and infrastructure. We respectfully request that CMS consider expanding these “loans” or AIPs to all ACOs regardless of performance-based risk level, experience, or high-revenue status. The rate at which MSSP rules and guidance (including performance measures, quality reporting processes, CEHRT requirements, data collection on SDoH risk assessment and health equity, and interoperability standards) change and grow make it extremely challenging for even experienced ACOs to keep pace. To effectively serve attributed beneficiaries, these evolving requirements and programmatic needs puts ACOs in a continuous state of upgrading technology platforms, investing in new technology or technology enhancements, and expending staff and provider time and resources for additional beneficiary outreach targeting vulnerable populations. Every new and updated requirement
posed by CMS has an associated investment dollar. While these requirements are intended to be budget neutral for CMS, they are not budget neutral for ACOs and threaten financial sustainability.

**MSSP Eligibility Requirement – Shared Governance**

CMS proposes to remove the option for ACOs to request an exception to the shared governance requirement that 75% control of an ACO’s governing body must be held by ACO participants. UnityPoint Accountable Care is a provider-led organization, firmly believes this attribute is foundational to the ACO care delivery model, and views this as a distinguishing factor from other Medicare models, such as Medicare Advantage. **UnityPoint Accountable Care supports this proposal and has successfully met this shared governance threshold since our inception in 2012.**

**Potential Future Developments to Shared Savings Program Policies**

CMS seeks input on opportunities to increase participation in ACO initiatives, both MSSP and CMMI Models.

**Higher Risk Track than the ENHANCED Track** - UnityPoint Accountable Care is pleased CMS is considering a higher risk track option within the MSSP. Our enthusiasm is measured if a full risk track contains a 3% discount, which is not more attractive than the ENHANCED Track. To make this higher risk track more attractive to ACOs, CMS could consider the following attributes:

- Benchmarks should emphasize ACO comparisons to region and nation, rather than benchmarking against yourself;
- NPI-level participation versus whole TIN participation to enable flexibility;
- Capitation options;
- More waivers, benefit enhancements, and flexibilities; and
- No discount and a decreased savings rate to below 100% – A 3% discount is a dealbreaker for many ACOs.

**Increasing the Amount of Prior Savings Adjustment** – CMS is seeking comment on potential changes to the 50 percent scaling factor used in determining the prior savings adjustment. **UnityPoint Accountable Care supports either (1) 75% of shared savings achieved or (2) the greater of (a) 5% of national per capita FFS spending in BY3 for assignable beneficiaries or (b) 50% of the pro-rated average per capita savings net of any negative regional adjustments.**

**Expanding the Accountable Care Prospective Trend (ACPT) Over Time and Addressing Overall Market-Wide Ratchet Effects** – CMS seeks input on potential refinements to the ACPT and the three-way blended benchmark update factor. **UnityPoint Accountable Care supports the three-way blend as: 1/3 ACPT weight and 2/3 (ACPT x regional market share) + (regional rate)(1-regional market share) weight. UnityPoint Accountable Care urges CMS to keep ACPT at a national level.**

**Other MSSP Issues:**

**MSSP Reporting** – While CMS does not propose changes to the data being provided to MSSP ACOs, UnityPoint Accountable Care requests that CMS refine its data and reporting approach to better equip ACOs with delivering care to attributed beneficiaries by considering the following:
• **MSSP Quarterly Benchmark Report** – UnityPoint Accountable Care seeks a better way to track performance to benchmark throughout the performance year and drive improvement. UnityPoint Accountable Care encourages CMS to revise the MSSP Quarterly Benchmark Report to include projected and/or year-to-date shared savings levels that include a single dollar amount without requiring template population. CMMI’s GPDC model provided this data to ACO participants in an excel file titled “Q4 REACH.XXXXX.BNMR.PY2022.DXXXXXX.TXXXXXXX,” and it serves as a good example.

• **Attribution/Aligned Lives** – UnityPoint Accountable Care requests that CMS produce an attribution/aligned lives report at the NPI level and, at minimum, provide additional guidance on the CMS attribution process. Specifically, CMS follows a tiered process for attribution. Under Tier 4, CMS provides additional processing logic for attribution exceptions, but the information is limited and does not enable replication or approximate modeling. MSSP ACOs need more transparency and clarity on the attribution logic for exceptions.

• **Additional Member Data** – UnityPoint Accountable Care seeks full and complete data on all of our attributed members to effective coordinate care. ACOs understand that beneficiaries may opt out of data sharing; however, if a beneficiary is not sharing data, then it is extremely difficult for ACOs to manage and track the beneficiary’s care. UnityPoint Accountable Care estimates that this impacts approximately 5% of total claims between monthly claims files and financial settlement reports. **CMS should consider allowing ACOs the opportunity to exclude members from their attribution who opt out of data sharing, and this exclusion process should be conducted annually.**

**Additional Revisions** – While CMS has not proposed changes to the following operational processes and/or requirements, UnityPoint Accountable Care recommends that CMS revisit these operational functions for improved financial performance and care management.

• **Skilled Nursing Facility (SNF) Star Rating Timelines/Processes** – UnityPoint Accountable Care relies on SNFs to improve care, reduce costs, and improve the patient care experience. They are an important provider type in the ACO network. While ACOs support continuous quality checks to ensure SNF providers are capable of meeting minimum care standards, one incident can effectively remove a SNF from participating in any given performance year due to the lengthy process to regain minimum star status. Additionally, the timing of the CMS final star review occurs too late in a performance year so that adverse ratings cannot be corrected before the subsequent performance year. For example, UnityPoint Accountable Care has had SNFs removed from our SNF Affiliate List in the last quarter of the performance year, and those SNFs were unable to participate with the ACO for the entire next year. **UnityPoint Accountable Care encourages CMS to (1) allow SNFs to be added to an Affiliate List on a quarterly basis and (2) reconsider the timing and star rating criteria so SNFs have an opportunity to correct without being a victim of the calendar.**

• **Legacy TINs/PECOS** – UnityPoint Accountable Care has maintained our large and diverse network for nearly a decade during our participation in the Pioneer ACO Model, Next Generation ACO
Model, GPDC Model and MSSP. Recently under MSSP, when a participant changes ownership and subsequently their TIN changes, some UnityPoint Accountable Care participants have been unable to continue to participate in our ACO for the subsequent performance year due to the lengthy and cumbersome PECOS enrollment process. The Next Generation ACO Model and the GPDC Model had efficient processes for identifying Legacy TINs to ensure participants aren’t penalized for changing ownership and are able to participate in the next performance year. **UnityPoint Accountable Care encourages CMS to adopt the GPDC Model process for addressing Legacy TINs within the MSSP Model.**

- **Annual Wellness Visit (AWV) 12-Month Requirement** – FFS Medicare beneficiaries are eligible to receive their AWV every 12 months. AWVs are a great tool for preventive care especially for beneficiaries who are relatively healthy and able to self-manage chronic conditions. While UnityPoint Accountable Care supports an annual AWV appointment, **CMS should consider revising the requirement to enable an AWV to be provided within the calendar year and not requiring beneficiaries to wait exactly 12 months before receiving their next AWV.** Should a beneficiary have their AWV at the end of a performance year, it is extremely challenging to schedule another office visit at the start of the next performance year. This simple but rigid 12-month requirement is enough of a barrier for ACOs and our providers to adequately care for our patients. Under our suggestion, it is true that our ACOs could schedule beneficiary AWVs at the end of a performance year (November-December) and then quickly schedule an AWV at the start of the next performance year (January-February). While this is an extreme and not ideal, the consequences of requiring a beneficiary to wait an entire 12 months makes it difficult to understand the full disease burden of the beneficiary and to adequately manage their care during the performance year. It also reduces patient satisfaction if ACO providers have to wait to schedule an appointment and coordinate their care.

- **Beneficiary Notice Requirements** – While CMS did not propose any changes to beneficiary notification requirements, UnityPoint Accountable Care urges CMS not to finalize the new 180-day follow-up requirement. During the 2023 Performance Year, UnityPoint Accountable Care distributed the 180-day follow-up beneficiary notification. As a result of this notification, we:
  
  o Experienced increased ACO call volumes from beneficiaries. Language in the CMS notification templates did not resonate with beneficiaries and caused confusion and frustration.
  o Were unable to receive clear guidance from CMS on how to comply with the requirements.
  o Lack access to practice-level scheduling data which hampers the ACO’s ability to send notices before the first visit or send follow up notices before the next visit. For new beneficiaries that have not been seen before, it is not feasible for the ACO to get contact information and notify them.

**UnityPoint Accountable Care requests that CMS (1) eliminate the beneficiary notification requirement or (2) send the notification directly to beneficiaries** as CMS has the beneficiary contact information and CMS would likely be perceived as a more legitimate sender.
CONTINUED SUPPORT FOR MACRA INCENTIVES

In 2015, Congress passed the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) intended to accelerate the transition of traditional Medicare from Fee-For-Service to Advanced Alternative Payment Models. Two pivotal provisions are scheduled to sunset – the Qualifying APM Participant (QP) thresholds and the MACRA Medicare Part B payment bonus for Advanced Alternative Payment Model providers.

**Comment:** While we understand that Congressional action is needed for statutory change, it is within the discretion of the Secretary to establish the MACRA patient count threshold. We respectfully request that CMS maintain the patient count threshold at the current 35% threshold. This is particularly important as threshold scores are dependent upon beneficiary attribution reflecting periods when patient volume was depressed due to the public health emergency. In your role in advising Congress, we also implore you to detail the projected impact of the threshold increases as well as bonus expiration on provider participation in the agency’s transition to value and ultimately on the health of the Medicare Trust Fund.

QUALITY PAYMENT PROGRAM (QPP)

CMS proposes a number of revisions to its Quality Payment Program (QPP) including, but not limited to increasing the Merit-Based Incentive Payment System (MIPS) performance threshold; changes to the MIPS dataset resulting in a total of 200 quality measures; establishing five new MIPS Value Pathways (MVPs); refining digital measurement requirements; and revising the calculation of qualifying APM participant (QP) determinations. CMS also seeks feedback through several requests for information.

**Comment:**

Selection of MIPS Quality Measures: CMS is proposing significant changes to the MIPS quality measure set, including: the addition of new measures; updates to specialty sets; removal of existing measures, and substantive changes to existing measures. For the CY 2024 performance period, the proposed measure set contains 200 MIPS quality measures. As it relates to MSSP ACOs, these changes and the financial implications are rapid fire, making it incredibly difficult for ACOs and participating providers to implement changes, adapt practice protocol, monitor, and report. UnityPoint Accountable Care advises that CMS employ a phased approach to changes to quality measures over a three-year phase-out and phase-in process. This will allow CMS, ACOs, and provider organizations to build necessary workflows, documentation protocols, and reporting capabilities as necessary.

QP Determinations and the APM Incentive: The Quality Payment Program provides incentives for clinicians to engage in value-based, patient-centered care under Medicare Part B via MIPS and Advanced APMs.

- **QP Determinations** – CMS is proposing to calculate QP determinations at the individual level for each unique NPI, not at the APM entity level. While CMS believes the change in attribution will streamline QP determinations and help specialists, the change could still result in less specialists participating in ACOs, especially if qualifying thresholds increase as scheduled under current law. NPI reporting also increases burden and additional reporting obligation as APMs will have both QPs and non-QPs in their network. UnityPoint Accountable Care’s network includes many multispecialty providers, which will be impacted and may be disincentivized to participate in value-based care. To encourage participation by specialists and others, CMS could calculate QP...
status by both TIN and NPI and award incentive payment if thresholds are reached under either approach. For this calculation, CMS should maintain the attribution-eligible definition for determinations at the APM level and use the new definition for determinations at the NPI level. Alternatively, CMS could permit MSSP ACOs to select participants by NPI (rather than having to include the entire TIN) to mitigate this challenge altogether.

- **APM Incentive Payment** – Currently, APM incentives are not included in ACO/APM benchmarks. Paying the APM bonus as an increased FFS rate increases ACO’s costs as the APM bonuses are not included in benchmarks. The higher conversion factor update for QPs will make it more difficult for ACOs to achieve lower spending below benchmarks. **UnityPoint Accountable Care** supports extending the APM incentive and delaying the differential conversion factor update to allow additional time for Congress to address the MACRA bonus and reach an agreement to either adjust out of performance year costs or add to the benchmark.

**Request for Feedback – Continuous Performance Improvement and Positive Care Outcomes:** With a desire to modify MIPS policy, CMS seeks suggestions or examples to may include requiring more rigorous performance standards, emphasizing year-to-year improvement in the performance categories, or requiring that MIPS eligible clinicians report on different measures or activities once they have demonstrated consistently high performance on certain measures and activities.

**UnityPoint Accountable Care** urges CMS to structure MIPS to encourage adoption of APMs and provide more non-financial incentives for clinicians who adopt APMs. For APMs to assist CMS in reaching its goal of every Fee-For-Service Medicare beneficiary being in an accountable care relationship by 2030, there needs to be incentives to be in an APM. Additionally, reporting should be easier on both the ACO and the provider participating in an APM. Each year, it becomes increasingly difficult for ACOs to attract participants to join ACO networks and APM models due to the modifications to the MIPS program, resulting in MIPS becoming more attractive to provider organizations. As MIPS becomes more attractive, APM and ACO participation become less attractive. MIPS directly competes with APM/ACO participation and, as this trend continues, ACOs will be forced to make a decision as to whether to continue operating and participating in CMS APM models. This is contrary to the CMS goal.

### 340B DRUG PRICING PROGRAM – ACO BENCHMARK


**Comment:** UnityPoint Health submitted a separate comment letter in response to the remedy proposed in CMS-1793-P resulting from the Supreme Court decision addressing the unlawful CMS reimbursement formula. Although not addressed within the proposed remedy, ACOs are impacted in that benchmark years include underpayments for 340B-acquired drugs, while performance years will now include expenses that reflect the restored 340B-acquired drug payment rate. **We urge CMS to:**

- Develop a 340B remedy that holds ACOs harmless, including those ACOs participating in CMMI models;

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3 Submitted on September 11, 2023 – tracking number lmf-2d7j-f5ns
• Treat the entire lump sum repayment as a non-claims-based expenditure for ACOs in the repayment year; and
• Work with ACO stakeholders when crafting a solution to negate the PMPM 340B-acquired drug spend gap between benchmark and performance years, such as benchmark redeterminations.

We look forward to working with the agency on this important issue.

UnityPoint Clinic is pleased to provide comments on this proposed rule. 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,

Dr. Patricia K. Newland, MD
President
UnityPoint Clinic

Steve Palmersheim
Chief Financial Officer
UnityPoint Clinic & UnityPoint Accountable Care

Dr. Megan J. Romine, DO
Interim Chief Executive Officer & Medical Director
UnityPoint Accountable Care

Cathy Simmons, MPP, JD
Executive Director, Government & External Affairs
UnityPoint Health