



UnityPoint Clinic

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September 6, 2022

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-1770-P: Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts, published in Vol. 87, No. 145 Federal Register 45860-46843 on July 29, 2022.

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 more than 430 physician clinics, 39 hospitals in urban and rural communities, and 14 home health agencies throughout our 9 regions, UnityPoint Health provides care throughout Iowa, central Illinois, and southern Wisconsin. On an annual basis, UnityPoint Health hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 7.8 million patient visits.

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 Center for Medicare and Medicaid Innovation's Global and Professional Direct Contracting Model, which serves more than 100,000 beneficiaries and includes providers that have participated in the Next Generation ACO Model, the Medicare Shared Savings Program (MSSP), and the Pioneer ACO Model.

UnityPoint Clinic respectfully offers the following comments to the proposed regulatory framework.

REVISIONS TO PAYMENT POLICIES

CMS proposes a 2023 physician conversion factor of \$33.0775, a decrease of 4.42% from the 2022 CF of \$34.6062.

Comment: A consistent decrease to the physician conversion factor over the last several years has continued to suppress the ability of providers in providing high quality care in a financially sustainable way. Many health care professionals are in a financial recovery from the COVID-19 pandemic. Additional inflationary pressures and exponential increases to health care labor and supply costs, coupled with a reduced conversion factor, threaten access to vital services provided to Medicare beneficiaries and Medicaid members. **UnityPoint Clinic strongly requests CMS adequately increase the physician conversion factor to reflect the current financial landscape of health care.**

TELEHEALTH SERVICES

CMS proposes to extend coverage for the services added on an interim basis, but not yet given Category 3 status, through 151 days post-PHE. Additionally, CMS proposes to (1) add more than 50 codes to the Category 3 status, (2) create three new HCPCS codes under Category 1, (3) delay the in-person requirements for mental health telehealth services until the 152nd day after the PHE ends, and (4) increase the telehealth originating site facility fee from \$27.59 to \$28.61.

Comment: UnityPoint Clinic appreciates the extension of telehealth flexibility. Like most providers, UnityPoint Clinic heavily increased adoption of telehealth during the COVID-19 pandemic to safely provide care to vulnerable populations and communities. As outlined below, **UnityPoint Clinic requests CMS make permanent telehealth flexibilities under the current PHE.**

Make Permanent Telehealth Flexibilities

- 1) **Permanent waiver of originating site requirements** to allow care in the home and urban areas to be a covered, billable service. 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.
- 2) **Reimbursement for inpatient encounters (CPT 99218 - 99223, 99231 – 99236, 99238 - 99239) 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 history and physical must be performed twice by providers on the same team.
- 3) **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.

Mental Health Services

UnityPoint Clinic is pleased to see CMS delay the in-person requirements for mental health visits and continues to advocate for permanency of this flexibility. During the pandemic, 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 Emergency Departments (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.

BEHAVIORAL HEALTH VALUATION OF CODES

CMS proposes to allow licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs) to bill Medicare under general supervision as well as create a new code (GBHI1) for general behavioral health integration services to be performed by clinical psychologists (CPs) and clinical social workers (CSWs).

Comment: UnityPoint Clinic is pleased to see CMS allow LPCs and LMFTs to bill Medicare under general supervision. This will provide significant improvement for Medicare beneficiaries. UnityPoint Clinic continues to advocate for Congress to allow LPCs and LMFTs to be independently credentialed by Medicare as they are by Medicaid. Additionally, UnityPoint Clinic supports the use of GBHI1 for general behavioral health integration services to be performed by CPs and CSWs. Billing recognized by Medicare will be key for Medicaid and commercial payors to also begin billing, which will result in consistent administration of services and reimbursement and ease management by health care providers.

RURAL HEALTH CLINICS (RHC) & FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

CMS proposes to add the new chronic pain management and behavioral health integration services to the RHC and FQHC specific general care management HCPCS code, G0511. Additionally, CMS clarifies that a 12-consecutive month cost report should be used to establish a specified provider-based RHC's payment limit per visit.

Comment:

Tele-Mental Health Services: UnityPoint Clinic supports the use of G0511 for chronic pain management and behavioral health integration services. Similar to concerns already outlined above, it will be key for Medicaid and commercial payors to also begin billing for these services so that administration and reimbursement are consistent and more easily managed by health care providers.

Limit Per Visit: UnityPoint Clinic supports the methodology used to establish a specific provider-based RHC payment limit per visit. RHCs enable access to fundamental preventative and maintenance care for rural beneficiaries, and adequate reimbursement will assist with keeping clinic doors open.

ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES

CMS finalizes its proposal to require prescribers to electronically prescribe at least 70% of their Schedule II, III, IV, and V controlled substances that are Part D drugs with exceptions as well as to limit CMS compliance actions during the 2023 calendar year.

Comment: UnityPoint Clinic supports finalizing both the electronic prescribing and compliance

proposals. At present, EPCS by UnityPoint Clinic providers ranges from 90%-97%. This deviation from 100% is due to extraordinary circumstances, such as emergencies or disasters, and a variety of information technology issues, including internet down time, cybersecurity breaches, program malfunctions, and loss of power. However, in recent years with more security (namely, two-factor authorization), electronic prescribing has become a standard practice. Overall, EPCS supports getting medication to beneficiaries both timely and efficiently.

CLINICAL LAB FEE SCHEDULE (CLFS)

CMS proposes changes to data reporting and certain reimbursement. For the data reporting period of January 1, 2023, through March 31, 2023, the data collection period is January 1, 2019, through June 30, 2019. The \$3 specimen collection fee is continued for specimens collected on behalf of a home health agency or skilled nursing facility.

Comment: As proposed, the Protecting Access to Medicare Act of 2014 (PAMA) reporting period does not reflect current payment activity; however, adjusting the data collection period to January 1, 2022, through June 30, 2022, reflects COVID-19 pandemic data. **UnityPoint Clinic requests that CMS delay reporting until the year following the end of the COVID-19 PHE.** This delay will allow a more accurate view of PAMA data collection and will reflect the current laboratory and health care landscape.

UnityPoint Clinic is pleased to see the continuation of reimbursement for collecting specimens from homebound patients. Our labs provide rapid test results on a daily basis in order to triage health conditions and inform providers of any necessary changes to treatment regimens. Reimbursement often limits the access radius by which a laboratory can break even in providing services. Consideration of travel time in the reimbursement schedule, particularly in rural areas, helps promote greater access. Overall, we appreciate the ability to be reimbursed for specimen collection.

COLORECTAL CANCER SCREENING

CMS proposes to reduce the minimum age to 45 years for payment of certain colorectal cancer screening tests. CMS also proposes to expand colorectal cancer screening tests to include a follow-up screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result.

Comment: **UnityPoint Clinic supports expanding the minimum age to 45 years** as it aligns with the United States Preventive Services Taskforce (USPSTF) recommendations. **UnityPoint Clinic agrees colorectal cancer screening tests should include a follow-up screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive.** This policy buttresses adherence efforts in preventative care and will shore up frequently voiced beneficiary grievances around unexpected bills for diagnostic testing confused as covered under a screening test benefit.

PREVENTIVE VACCINE ADMINISTRATION

CMS proposes refinements for preventive vaccine administration under the Medicare Part B vaccine benefit. Specifically, CMS proposes to annually update the payment amount and to adjust for the geographic locality. Additionally, CMS proposes to continue the additional payment for at-home

COVID-19 vaccinations for CY 2023.

Comment: UnityPoint Clinic supports these proposals; however, we encourage CMS to review the current payment for all Medicare Part B covered vaccines (*flu, pneumococcal, HepB, COVID-19, etc.*) to ensure the administration payment rate of approximately \$30 accurately reflects current health care labor and supply costs.

Additionally, **UnityPoint Clinic strongly encourages CMS to include other CDC recommended vaccines for this age group, such as Tdap and Shingles, within Medicare Part B coverage.**

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 encompasses four focus areas as well as a request for information (RFI) on administratively set benchmarks.

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. In 2022, we serve more than 103,000 beneficiaries through over 6,000 providers in the GPDC Model. Unlike many other ACOs, 54% of providers are independent and we embrace and include specialists (presently 33% in this contract) – the specialist percentage is limited and has been reduced for this contract to conform with MACRA thresholds. In the first five performance years of the Next Generation ACO Model, UnityPoint Accountable Care achieved quality scores above 90 out of 100 and achieved savings for the Medicare program. In addition to our extensive CMMI portfolio, we have participated in the MSSP and intend to move into this model for the entirety our Medicare ACO arrangements in 2023.

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

1. Quality Performance Standard and Reporting

- *Scaled Approach for Shared Savings and Losses:* CMS proposes to reinstate a sliding scale approach for determining shared savings and shared losses.

Comment: UnityPoint Accountable Care supports the reinstatement of a proration methodology.

- *Electronic Clinical Quality Measures (eCQMs) / Merit-based Incentive Payment (MIPS) CQMs:* CMS proposes to extend the incentive for reporting eCQMs/MIPS CQMs through performance year 2024 and to begin full reporting of the measures in performance year 2025.

Comment: UnityPoint Accountable Care applauds CMS for extending the incentive for eCQMs/MIPS CQMs reporting. As a large ACO with an expansive provider network of more

than 6,000 providers that includes primary care and specialists, as well as both employed and independent providers, UnityPoint Accountable Care works across 60+ electronic medical record (EMR) systems to capture and report quality data. The additional time to build and validate reporting infrastructure and processes for our complex network is appreciated. Additionally, we reiterate our concerns about the eCQM all-payer approach. Evaluating quality performance based on all-payer data ties savings to performance for patients that the ACO does not actively manage and exacerbates exponentially interoperability challenges related to data capture and reporting across tens of EMRs. For ACOs that include independents, this all-payer approach is costly, creates undue burden, and disincentivizes participation in MSSP and other CMS value-base initiatives.

- *Health Equity Adjustment: CMS proposes a health equity adjustment of up to 10 bonus points to an ACO's MIPS quality performance category score when reporting all-payer eCQMs/MIPS CQMs. CMS proposes to use the area deprivation index (ADI) score and Medicare and Medicaid dually eligible status to assess underserved populations.*

Comment: UnityPoint Accountable Care supports the continued emphasis on health equity and the establishment of a health equity adjustment. We agree with the Value Based Care Coalition suggestion that the definition of underserved communities should include consideration of both national and state percentiles if the Area Deprivation Index (ADI) is used.

We believe that ACOs are uniquely positioned to serve as a hub for population health coordination and innovation. To assist with speed to implementation, UnityPoint Accountable Care encourages CMS to consider providing a prospective payment to ACOs in advance of the performance year to target care to underserved populations in order to build the processes and necessary infrastructure. At the discretion of the ACO, funds could potentially be used to develop and/or implement patient assessment tools that incorporate social drivers of health needs and refer patients to community resources; use technology platforms to cohort/segment patients by demographics, identified care and social drivers of health needs, and appropriate levels of care and provider types; strengthen community engagement efforts to provide wrap around services; and appropriately scale existing outreach and care delivery programs to serve hard-to-reach patient populations.

- *Request for Information (RFI) – Social Drivers of Health Measures (SDOH): CMS is seeking feedback on two future eCQM measures in the alternative payment model (APM) performance pathway (APP) measure set: (1) Screening for Social Drivers of Health and (2) Screen Positive Rate for Social Drivers of Health.*

UnityPoint Clinic supports identifying SDOHs and removing barriers to equitable care, but encourages CMS to consider operational issues – timing and scope – prior to implementation. Organizations will need time to develop systems and processes for receiving and providing the required information, which often includes software and technical vendor builds and associated costs. To achieve positive results, community services and partnerships will need to be established or reestablished to remove barriers and leverage resources, and these ultimately relationships take time. From a clinical and human perspective, SDOH

screenings often include sensitive subjects, and it will be important that these screenings are completed in an appropriate setting and where identified gaps can be effectively addressed. Given the time and response to implement this measure, **CMS needs to carefully direct which settings should prioritize implementation first.**

2. Benchmarking Methodology

- *Prospective Trend: CMS proposes to incorporate a prospectively projected administrative growth factor, the accountable care prospective trend (ACPT), into a three-way blend with national and regional growth rates to update an ACO's historical benchmark for each performance year. CMS also proposes a "guardrail" to provide protection for ACOs from larger shared losses.*

Comment: UnityPoint Accountable Care generally supports approaches that mitigate unforeseen impacts experienced from the national/regional blend. In theory, the three-way blend allows benchmarks to grow higher than actual spending growth rates. That said, there are many unknowns with this prospective trend proposal that potentially impact ACO financial stability and predictability, and ACOs are on the financial hook for this untested modeling. To help mitigate unforeseen impacts of this new blend, UnityPoint Health requests that CMS provide greater detail and transparency on the national, regional, and ACPT calculations as well as the definition of region. We are pleased that CMS has proposed guardrails as a safety net mechanism in support of maintaining ACOs and their providers in value contracts. As ACOs are at financial risk, these guardrails should be triggered to support shared savings and mitigation of losses for at-risk ACOs. As such, if there are savings under the three-way blend, CMS should not force ACOs with savings to switch to a less advantageous two-way blend. On the other hand, if the three-way blend adversely impacts ACOs, the two-way blend should be permitted if losses are mitigated.

- *Adjusting ACO Benchmarks for Prior Savings: CMS proposes a prior savings adjustment to be applied in the benchmarks of renewing ACOs and re-entering ACOs, if reconciled in one or more performance years during a three-year period preceding the renewal/re-entry agreement.*

Comment: UnityPoint Accountable Care supports this proposal and urges CMS to define historical savings as including participation in Centers for Medicaid and Medicare Services ACO models, such as Global and Professional Direct Contracting, Next Generation ACO, and the Pioneer ACO. The "ratcheting effect" is a concern particularly for ACOs that are early adopters of shared savings models and already operate in lower spend regions of the country. For example, UnityPoint Accountable Care has been driving down costs in Iowa with savings to Medicare since our inception in 2012. The rate at which cost of care can be further driven down year after year becomes marginal. In general, we support strategies that enable experienced ACOs to drive down cost of care while providing financial opportunities for continued participation in the future.

- *Reducing Negative Regional Adjustments: CMS proposes to (1) reduce the cap from negative 5% of national per capita expenditures for Parts A and B services to negative 1.5%, and (2) gradually decrease the negative regional adjustment amount as an ACO's proportion of dual*

eligible beneficiaries increases or its weighted-average prospective Hierarchical Condition Category (HCC) risk score increases.

Comment: UnityPoint Accountable Care supports proposals to limit the impact of negative regional adjustments for ACOs with high-cost populations. These policy changes will help ACOs serving high-cost beneficiaries receive a heightened benchmark after the regional adjustment and will further incentivize program participation among these ACOs. We are pleased that CMS intends to tailor adjustments based on the specific population served, including HHC scores or dual eligible percentage, and recommend that CMS utilize the methodology which best advantages ACOs serving those acute, complex, and/or vulnerable populations.

- *Impact of the COVID-19 Pandemic.* CMS states that historical benchmarks averaged across a base period including both 2020 and 2021 would appear to represent a reasonable basis for updating ACO spending targets.

Comment: The inclusion of calendar years within the eye of the pandemic storm is problematic, and UnityPoint Accountable Care opposes their inclusion within baseline calculations.

- *Alternative Benchmarking Policies:* CMS seeks comment on alternative benchmarking policies related to regional expenditure calculations.

Comment: UnityPoint Accountable Care is extremely pleased that CMS is revisiting this issue. In last year's PFS comment letter, UnityPoint Accountable Care expressed concerns with CMS calculating regional Fee-For-Service (FFS) expenditures using a population of assignable beneficiaries that includes the ACO's own assigned beneficiaries. This policy results in benchmarks that are lower for ACOs with high market penetration and is referred to as the rural glitch, given its disproportionate negative impact on benchmarks in rural service areas. **We wholeheartedly support Alternative 1, the exclusion of an ACO's own beneficiaries and associated expenditures from the historical benchmark calculation.** Ultimately ACOs should not be penalized through lower benchmarks that reflect their own success in managing populations and reducing expenditures, but benchmarks should reflect populations and associated FFS expenditures that are managed by other providers or are altogether unmanaged.

3. Calculating County Fee-For-Service Expenditures

- *Change to assignment window:* For ACOs selecting prospective assignment, CMS would use an offset assignment window (for example, October through September preceding the calendar year), and for ACOs selecting preliminary prospective assignment with retrospective reconciliation, CMS would continue to use calendar year assignment window.

Comment: UnityPoint Accountable Care requests more information on the underlying cause of the higher historical benchmarks for the prospective assignment methodology as described in the narrative. Should the assignment window be offset, UnityPoint Accountable Care requests that CMS consider revising its policy for annual wellness visits (AWVs) to transition to calendar year basis instead of a "365 + 1 day" window of time.

4. Risk Adjustment Methodology

- *Capping Risk Score Growth: CMS proposes to modify the 3% cap on risk score growth. Specifically, the ACO's aggregate prospective Hierarchical Condition Category (HCC) risk score would be subject to a cap equal to the ACO's aggregate growth in demographic risk scores between benchmark year 3 and the performance year plus 3 percentage points.*

Comment: This cap is being revised in part to guard against coding initiatives and theoretically enables some growth for complex patients. **UnityPoint Accountable Care cautiously supports** but has concerns that this may introduce more complexity and less financial certainty.

5. Reducing Administrative Burden

- *Marketing Materials Review: CMS proposes to no longer require review of marketing materials by CMS prior to use, effective on and after performance years 2023.*

Comment: **UnityPoint Accountable Care generally supports eliminating the universal submission of mostly templated marketing materials for CMS approval.** This process was burdensome and added unnecessary delay to tight communication timeframes. UnityPoint Accountable Care requests that CMS permit ACOs to use their own templates for marketing materials, including the beneficiary notification letter, which is the approach used for Medicare Advantage plans. The templated letters as written are confusing to beneficiaries, who often mistake the letters for fraudulent communications related to the Medicare program and their benefits.

- *Beneficiary Notifications: CMS proposes to reduce the minimum frequency of beneficiary notices from annually to once per agreement period and seeks comment on requiring a follow-up communication to promote beneficiary comprehensive of the standardized written notice.*

Comment: Overall, UnityPoint Accountable Care agrees with the concept of providing beneficiary notification materials and supports notification frequency at once per agreement period. That said, tying mailings to an event or data certain (such as a primary care office visit) as pulled from the electronic medical record may not fit each beneficiary's situation, adds to the potential for beneficiary confusion, and creates undue monitoring and administrative complexities. **UnityPoint Accountable Care recommends that CMS simply require the once-per-agreement-period notification and enable ACOs with the flexibility to determine specific timing per notification policies.** As for the proposal to add a follow-up mailing at the 180-day post-visit mark, this simply adds nothing of substance, creates more administrative complexity, and has the potential to further beneficiary confusion. **We urge CMS to reconsider and not require this duplicative follow-up notification.**

- *SNF 3-day Rule Waiver Application: CMS proposes to streamline the application by removing certain narratives. For performance years on and after January 1, 2024, CMS proposed to accept attestations in lieu of relevant plan submissions.*

Comment: **UnityPoint Accountable Care supports this proposal and appreciates the reduction in administrative burden.**

6. Request for Information: Administratively Set Benchmarks

CMS seeks comment on an alternative approach to calculating ACO historical benchmarks utilizing administratively set benchmarks decoupled from ongoing observed Fee-For-Service spending.

Comment: As referenced in our comments to “Adjusting ACO Benchmarks for Prior Savings” above, the ratcheting effect is a real concern for long-standing ACOs as well as for ACOs in rural areas. UnityPoint Accountable Care is one of those impacted ACOs. We appreciate that CMS is exploring this issue and developing an approach. In our review, the narrative raises more questions than it answers. **We highly recommend that CMS engage interested stakeholders, including those ACOs heavily impacted by the ratcheting effect, as you further consider options and potential solutions.** Some initial feedback includes:

- ACOs should be rewarded on their Per Member Per Month/utilization levels, not simply trend. High-performing ACOs will likely compare unfavorably to lower-performing (high-baseline) ACOs if reviewed solely on year-to-year trends due to reduced opportunity to impact cost.
- CMS could consider embedding a financial variable within the benchmark to reflect the disproportionate cost of rural populations. Simply put, the cost of access is greater in rural areas. The provision of care in rural areas is often more intense, difficult, and challenging to manage the cost of care and outreach to rural populations. This financial accounting in the benchmark could be based on HHS' rural definition presented as a variable within the benchmark to account for the disproportionate share of ACO's rural population similar to how the ACO REACH model accounts for the health equity adjustment. This approach would address the financial challenges versus solely the quality challenges associated with ACOs desiring to better care for and to outreach to populations in rural communities while managing financial challenges.
- CMS should further explain the rationale underlying the adjustment of prior savings – specifically the difference between ACOs with lower spend versus higher spend. It is unclear why an ACO that has higher spend would be entitled to a full prior shared savings rate versus an ACO that was able to achieve lower spend than the region would only achieve 50 percent positive regional adjustment.

UnityPoint Accountable Care would be interested in participating in further discussion on how to address the ratcheting effect and implementation of an administratively set benchmark.

RURAL EMERGENCY HOSPITAL (REH)

Congress enacted the Rural Emergency Hospital designation in the Consolidated Appropriations Act (CAA) of 2021 (Pub. L. 116–260), which was signed into law on December 27, 2020. CMS proposes underlying regulations in various CY 2023 Medicare proposed rules – Rural Emergency Hospital Conditions of Participation and CY 2023 Outpatient Prospective Payment System. Within the Medicare Shared Savings Program, CMS proposes to include REH within beneficiary attribution calculations.

Comment: UnityPoint Clinic appreciates the efforts of Congress to recognize this new rural hospital designation. This designation preserves essential health care services in rural communities as an

alternative to shuttering facilities and requiring rural residents to travel further for emergency and outpatient services. We appreciate that CMS is monitoring the development of REH payment policy in relation to ACO beneficiary assignment. As Critical Access Hospitals (CAH) or small rural acute care hospitals convert to a REH designation, it is our understanding that CMS will permit new REHs to enroll in Medicare through the 855A “change of information” process. **We similarly encourage a streamlined and seamless process for continued participation in the Medicare Shared Savings Program so conversions are recognized in real time and ACO Participants in an Advanced Alternative Payment Model do not lose Qualified Participant (QP) status.**

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 (FFS) to advanced alternative payment models (APMs). Two pivotal provisions are scheduled to sunset – the Qualifying APM Participant (QP) thresholds and the 5 percent 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-percent 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: 12 proposed pathways for MIPS Value Pathways (MVP); Prescription Drug Monitoring Program (PDMP) measures; optional Trusted Exchange Framework and Common Agreement (TEFA) measures; and scoring updates in the Promoting Interoperability objective measures. CMS also seeks feedback on several requests for information (RFIs).

Comment:

MIPS Value Pathways (MVP): UnityPoint Clinic has not changed our position from the last two years and do not support the MVP proposal in concept. Instead, we believe CMS should target its work efforts on providing more Alternative Payment Model (APM) options. Enhancing MIPS and potentially making it more attractive does not necessarily assist in the overall transition to value-based services and population health, but it does divert resources and rewards from providers who have been early adopters of care delivery innovation.

The current updates to the MVP Guiding Principles illustrate the increased reporting burden for multi-specialty organizations, such as UnityPoint Clinic and our parent organization, UnityPoint Health. Together we have roughly 60 specialty fields. Requiring measure sets for each specialty could result in

upwards of 400 different eQMs for reporting purposes, given the request to submit seven measures per MVP. Although there are currently only 199 measures in the eQm library, providers are struggling to keep up and do not have the resources to support the ever-changing eQMs data set. We implore CMS to decide whether it is seeking measurement in support of population health or volume based and episodic care. **We do not support the approach to institute a data set tailored to every specialty and subspecialty in lieu of population health focused measures.**

Promoting Interoperability – Schedule II Opioids and Schedule III & IV Drugs: While UnityPoint Clinic understands the benefits of monitoring schedule drug classes, the proposal lacks clarity around query specifications and poses a swift implementation timeline for providers. Among our concerns are:

- Inadequate development time - This proposal does not allow vendors/software the ability to build and test capabilities in distinguishing new and various schedule drug reporting.
- Applicable clinicians - The ability to prescribe schedule drugs is not in scope for all eligible clinician provider types (e.g., Speech Therapy, Physical Therapy, Occupational Therapy, Audiology, etc.).
- Exclusion requirements - While the exclusion applies for providers who write less than 100 scripts at an individual level, this measure still requires these provider types to have access to query and search PDMPs.
- Cost - In some states, this access is through a contracted access license and requires a fee-based subscription.
- State readiness - Some states may not have the ability to send and received new data in such a short turnaround time to implementation. As a multi-state clinical enterprise, UnityPoint Clinic has experienced state variation in Prescription Drug Monitoring Program (PDMP) measure build and data submission.

Until there is standardization of the PDMP build across states and systems and clarity in reporting specification, we oppose these performance measures. As proposed, these are particularly problematic for multi-state clinical practices to operationalize.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey: We continue to have concerns about the CAHPS for MIPS survey methodology. Foremost, this survey is very subjective – based on the beneficiary’s perception of their health and experiences over time and with multiple physician groups and other services. Other concerns include: (1) sample size of 860 is the same regardless of actual ACO size and sampled beneficiaries do not represent the full population ACOs serve; (2) surveys are administered once annually with results usually received midway through the performance year; (3) survey data is not actionable and is received back aggregated at the ACO level, which is problematic for ACO with hundreds of TINs trying understanding where opportunities for improvements reside.

Trusted Exchange Framework and Common Agreement (TEFCA): **UnityPoint Clinic supports the TEFCA proposal.** By connecting to a network that connects to a Quality Health Information Network (QHIN)

or directly to QHIN, we can share health information in the same manner as described in the attestation statements previously finalized for the health information exchange (HIE) bi-directional exchange measure.

Promoting Interoperability (PI) Objective Measures Scoring Updates: **UnityPoint Clinic supports the scoring methodology for the performance period in CY 2023.** We do have concerns with the proposal to reweight provider types in the PI objective measure, as reweighting would not apply to entities who report as a group.

RFI – Patient Access to Health Information: CMS has requested additional information on the usefulness of allowing patients the ability to add information into their electronic health records in alignment with promoting patient access and utilization. **UnityPoint Clinic encourages all patients to be familiar with and utilized their electronic health record information. However, allowing patients to add information without clinical validation and review should not be unfettered and could result in false health information potentially being utilized by both patients and providers.** For example, a patient might state they no longer have a hypertension diagnosis as they have been able to manage normal blood pressure by taking medication. This statement does not clinically equate to removal of a hypertension diagnosis. UnityPoint Clinic recommends that any information added by patients be screened or contain a note to identify the source.

CMS also requests feedback on a potential future measure around patient access. Due to disparities across application programming interfaces (API) and Fast Healthcare Interoperability Resources (FHIR) technology versions, we do not believe the benefit outweighs the burden in adding a patient access measure at this time. By adding a new measure, this not only triggers data collection and submission but also implies that providers would be assessing outcomes based on the use of technology by their patients. If a provider is being measured on their patient's access of their medical records, their focus to increase a measure score would be to promote use of the tool and educate about the tool, which diverts time away from traditional clinical care. This would take away from true patient care and push focus onto technological support during visits, putting an unrealistic burden on providers in promoting and educating on technology with patients. In the future, patient access to update records may be fitting if appropriate checks and balances are put into place; however, at this point, it presents more burden to patients and providers.

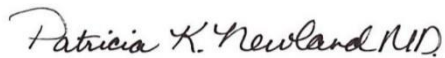
RFI – Digital Quality Measures (dQMs): Similar to UnityPoint Health's comments submitted on FY2023 IPPS proposal¹, **UnityPoint Clinic urges CMS to require standardization with all health care providers and vendors before fully implementing measures.** Our major concerns lie within the variation of FHIR versions, lack of version requirements, and variation in industry timelines. With multiple versions of FHIR and no version requirements, this puts limitations on a provider's ability to connect to certain application interfaces. There is no consistency in who is required to have FHIR, how to submit data, and when to submit data. This becomes a large challenge for providers who attempt to submit utilizing these vendors and payors. Additionally, expanded measures will require extra time to build out functionality and reporting. The more data required to be sent through FHIR, the more timelines will

¹ https://govaffairs.unitypoint.org/wp-content/uploads/IPPS-FY-2023_UnityPoint_Health_-6.17.22.pdf

need to be extended for organizational readiness, including validation of processes for each measure. **UnityPoint Clinic recommends that CMS take organizational readiness into consideration when determining final timelines for FHIR.**

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.

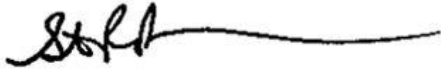
Sincerely,



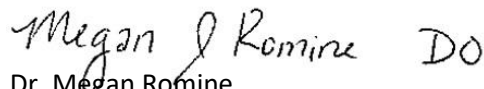
Dr. Patricia Newland
President & CEO
UnityPoint Clinic



Dr. Dan Allan
Chief Medical Officer
UnityPoint Clinic



Steve Palmersheim
Chief Financial Officer
UnityPoint Clinic & UnityPoint Accountable Care



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



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