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July 2, 2019

Assistant Secretary David J. Kautter
Tax Policy, Department of the Treasury

Administrator Seema Verma
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–9936–NC2
P.O. Box 8013
Baltimore, MD 21244–1850

RE: CMS–9936–NC2 - Request for Information Regarding State Relief and Empowerment Waivers; published at Vol. 84, No. 86 Federal Register 19000-19003 on May 3, 2019.

Submitted electronically via http://www.regulations.gov

Dear Assistant Secretary Kautter and Administrator Verma,

UnityPoint Health ("UPH") appreciates this opportunity to provide comment on this request for information regarding state relief and empowerment waivers. UPH is one of the nation's most integrated healthcare systems. Through more than 32,000 employees and our relationships with more than 310 physician clinics, 39 hospitals in metropolitan and rural communities and 19 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, central Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 6.2 million patient visits.

In addition, UPH is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. UnityPoint Accountable Care (UAC) is the ACO affiliated with UPH and has value-based contracts with multiple payers, including Medicare. UAC is a current Next Generation ACO, and it contains providers that have participated in the Medicare Shared Savings Program (MSSP) as well as providers from the Pioneer ACO Model. UnityPoint Health also participates in a Medicare Advantage provider-sponsored health plan through HealthPartners UnityPoint Health.

UPH respectfully offers the following comments.

SOLICITATION OF PUBLIC COMMENTS

To solicit ideas and spur additional thinking and innovation as states consider developing section 1332 waiver plans, the Treasury and CMS are seeking comments on ideas for other innovative waiver concepts. Responses to this RFI may be considered in the development of future waiver concepts. Suggestions should meet the section 1332 guardrails, may incorporate the entire range of 1332 waivable requirements, and may potentially be used alone or in combination with other waiver concepts, state proposals or policy changes. There is interest in suggestions that could advance some or all of the principles outlined in the October 2018 guidance and within the Background section of this RFI. Descriptions of how states might align these flexibilities under section 1332 with other flexibilities under federal law, including regulatory flexibility, section 1115 Medicaid waivers as well as state law are encouraged.

Comment: ***We have been both frustrated and disappointed with how the 1332 Waiver process has been operationalized by CMS and its Innovation Center.*** Our organization has been personally involved in three instances with the State of Iowa where this process should have offered relief, but ***the 1332 Waiver process created barriers and ultimately limited patient choice***. While envisioned as a mechanism to promote health care access, the 1332 Waiver process has become bogged down with administrative paperwork and processes that make it unavailable as a vehicle to respond to real-time problems. Through the Innovation Center, CMS has defaulted to a demonstration process that does not promote nimbleness or innovation. The result is a the very structured and drawn-out process that focuses on implementation perfection over outcomes and operational flexibility. Failed opportunities to support access and innovation in Iowa are listed below:

- *Iowa Stopgap Measure* (2017): This is the only Iowa proposal that was formally submitted through the 1332 Waiver process. As background, Iowa experienced a mass exodus of insurers from the individual health insurance marketplace – nine carriers left Iowa's marketplace between 2014 and 2017. Over 72,000 Iowans relied on purchasing health insurance through the federal marketplace and, without immediate and long-term relief, it was projected that one insurer would remain to cover all 99 counties with estimated premium rate increases of 56% or higher. As a result, 18,000 to 22,000 Iowans would likely lose health insurance.

  On August 21, 2017, the State of Iowa submitted a 1332 Waiver Application to propose a short-term solution to Iowa's "immediate collapsing market." The State had been in weekly conversations with CMS since June of that year. Key provisions of the proposal were: (1) a single, standard plan available to every eligible Iowa consumer from each participating carrier; (2) flat, per-member-per-month credits based on age and income, and (3) a reinsurance program to support high-cost claimants. Although the State acknowledged that current 1332 Waiver "timing requirements alone prohibit any meaningful relief and are ill-suited to deal with this emergency," it believed that President Trump's Executive Order 13765 authorized needed flexibility within the 1332 Waiver process to support innovative and timely proposals. Among the flexibilities requested in the *Iowa Stopgap Measure* were:

  - Expedited approval timeframe – Section 42 U.S.C. §18052(d) allows the Secretary 180 days to make an application determination. This timeframe begins after CMS determines that the application is complete. Given the timing of the submission relative to the November 1 open enrollment date, an expedited review process was necessary.

- Refundable credit reallocation – Section 26 U.S.C. § 36B provides a refundable credit for coverage under a quality health plan. As proposed, federal funding would be reallocated to per-member per-month premium credits to lower standard plan premiums, a reinsurance pool to offset the high cost claimants and administrative costs.
- Single standard plan to be available off-Exchange – Section 42 U.S.C.§18022(d) describes levels of coverage (bronze, silver, gold or platinum) provided by qualified health plans. The proposal was intended to allow carriers to offer only a single plan at the silver tier level.
- Cost-sharing reductions funds – Section 42 U.S.C. §18071 provides for reduced cost-sharing for individuals enrolling in qualified health plans. As the standard plan under the *Iowa Stopgap Measure* would be available only in an off-Exchange, the carriers were not required to offer any of the cost-sharing plan levels. While this provision was moot under this proposal, the State requested use of these funds to further support the per-member per-month premium credit program and reinsurance program.

The State of Iowa subsequently withdrew its application with the statement that "Section 1332 Waivers are not designed to fix collapsing individual health insurance markets." ***With CMS approval 12 days prior to open enrollment, there was simply not enough time to implement this solution.*** In addition, this process is not ideal to facilitate short-term or transitional solutions.

- *HealthCare Direct* proposal (2017): UnityPoint Health worked with the University of Iowa Health Care to craft a "non-insurance" short-term solution. This option sought funding from the State of Iowa (using a combination of State and Federal funds) and the authority to continue to offer basic healthcare services via an accountable care organization (ACO) delivery system to individuals without an Exchange coverage option for 2018. This option could have been used in combination with, or as alternative to, the *Iowa Stopgap Measure* above.

  As proposed to the State of Iowa, this program would have allowed individuals to enroll in a temporary state-run program called *HealthCare Direct*. Federal funds and member contributions would have been pooled to pay eligible providers for defined health care services. The concept would have offered basic primary care and acute care services to a general-risk pool of individuals while a more permanent solution would have been developed by the federal and state governments and the market. In addition to the general-risk pool, a high-risk pool would have been established for extremely high-cost individuals. The existing Health Insurance Plan of Iowa (HIPIOWA), housing a high-risk health insurance pool since 1986, would have been modified to administer *HealthCare Direct*. As proposed, funding sources would have included federal tax credit subsidies and federal cost share reduction funds; the remainder to come from Innovation funding from CMS ($43 million in State Innovation Model grant funding repurposed or other Innovation funds available through the agency) or the Patient and State Stability Fund[1] ($115 billion over 9 years to be distributed among states had legislation been enacted).

[1] Section 132, American Health Care Act of 2017 (AHCA). The AHCA failed to pass the 115th Congress.

After preliminary discussions with the State and CMS, this proposal was not deemed appropriate for a 1332 Waiver process. ***While potential funding sources had been identified, it was not clear that this proposal would fit within the 1332 Waiver budget neutrality provisions. In addition, the lack of an expedited timeframe and the stringent application process also put this proposal at operational risk*** as it ideally needed approval within a 60-day timeframe***.***

- Medicaid managed care alternative (2019) – On March 29, 2019, the Iowa Department of Human Services (DHS) received notice that UnitedHealthcare (UHC) would leave the Iowa Health Link program effective July 1, 2019. This again limits choice to two MCOs for Iowans. This announcement was compounded by the fact that July 1 was also the date when (1) a new Medicaid managed care organization, Centene/Iowa Total Care, was scheduled to start providing coverage in Iowa, and (2) the State was transitioning to a passive MCO enrollment process among the MCOs. We believe that this market exit is further proof that managed care has not been the panacea in Iowa. Since its adoption in April 2016[2], cost savings have not met original predictions and, more importantly, two MCOs have terminated contracts early causing disruption to continuity of care for vulnerable Iowans. Due to MCO volatility, a provider-based alternative from organizations with long-standing commitments in Iowa appeared to be a needed option.

  As the largest integrated health system within the State of Iowa, UnityPoint Health brought forth a proposal to the State and our Congressional delegation whereby the State could recognize arrangements with provider organizations to directly deliver value-based care. Specifically, the proposal involved use of an experienced URAC-accredited organization in Iowa to provide claims payment, medical and behavioral health utilization/case management, compliance and appeals and denials services for assigned Iowa Medicaid lives. An implementation plan with a July 1 start date was presented at the beginning of April. Over the course of three years, it was proposed that underlying payment would transition from a per-member per-month fee, to partial capitation and then to full risk. This proposal would also align with directives in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for States to encourage Advanced Alternative Payment Models.

  We believe that this payment demonstration would have been an appropriate test case under a 1332 Waiver application. ***After preliminary discussions with the Innovation Center, speed to enactment was again an issue*** – the proposal could not be approved in time for a July 1 start date.

The above examples illustrate some short-comings of the 1332 Waiver process. ***We urge CMS to institute an expedited 1332 Waiver process.*** This includes a fast track application as well as a shortened review process. ***Although CMS mandates a demonstration-like process, we would recommend a more flexible procedure that solicits and rewards innovative solutions to emergent problems.*** The 1332 Waiver process should equip States with the ability to "test and fail" in pursuit of a tailored solutions, rather than pilots that must attest to actuarial certainty. Shorter project timeframes of two or three years should also

[2] The managed care delivery system in Iowa is authorized through the §1915(b) High Quality Healthcare Initiative Waiver, effective April 1, 2016.

be considered to enable short-term and transitional tests of change. ***We also believe CMS too narrowly construes budget neutrality.*** It is unrealistic to require innovations devoid of upfront investments and we would implore a more flexible interpretation of this concept.

We are pleased to provide input on this request for information and its impact on our integrated health system and the individuals and communities we serve. ***As structured, we believe that the 1332 Waiver process is a missed opportunity.*** To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President, Government & External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

Sabra Rosener, JD
VP, Government & External Affairs