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Deputy Administrator and Director Adam Boehler
Center for Medicare and Medicaid Innovation
Department of Health and Human Services
Baltimore, Maryland 21244

RE: Request for Information on Direct Contracting—Geographic Population-Based Payment Model Option

Submitted electronically via DPC@cms.hhs.gov

Dear Deputy Administrator and Director Boehler,

UnityPoint Health ("UPH") appreciates this opportunity to provide comment on this Request for Information (RFI). The Center for Medicare and Medicaid Innovation (CMMI) is soliciting comment on the Direct Contracting - Geographic Population-Based Payment (PBP) model option. Specific feedback is sought on criteria for selecting Direct Contracting Entities (DCEs), including feedback on the proposed criteria under consideration; selection criteria for target regions; the types of entities that might be interested in participating as DCEs in the Geographic PBP model option; potential conflicts of interest that might arise and how they might be resolved; beneficiary protection considerations; payment methodology parameters; and general model design questions.

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 as an early ACO adopter 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 appreciates the time and effort of CMMI in developing this concept and respectfully offers the following overall comments related to program design as well as responses to select issues posed by CMMI.

GENERAL COMMENTS

As an early-adopter of Medicare risk-bearing ACO models, UPH has made significant contributions to health care delivery transformation. The Geographic PBP model ("this model") should be developed as the final stage for successful MSSP Tracks 2 or 3 (or Basic Track, level E, or Enhanced Track under Pathways to Success) or Next Generation ACO entities in managing the risk of an assigned beneficiary population. To take this step, we suggest that ACOs should be enabled to forge new partnerships with Medicare Advantage (MA) plans that are not currently authorized through current demonstration authority. The following recommendations build upon the general structure set forth by CMMI in the RFI to make the program one in which eligible ACOs and Medicare Advantage plans could partner in a manner that would bring the most benefit to Medicare beneficiaries, the Medicare program and providers.

1. **DCE Eligibility and Selection:** As proposed, applicants "may be a healthcare organization consisting of a direct or affiliated network of healthcare providers, a health plan, or other type of organization that has formal partnerships or other contractual relationships with Medicare-enrolled providers or suppliers in the target region."

   Comment: First, we highly recommend that this model include a preference for a co-application by an experienced "Medicare ACO" and another healthcare organization. This preference recognizes this model as the final state for "Medicare ACOs" and a continuation of the unique experience and knowledge gained by organizations in high-performing, risk-bearing "Medicare ACOs". A co-application would underscore the aligned economic interests of both providers of direct patient care services and MA plans that have developed expertise in the administration of the Medicare benefits. We believe a co-applicant process would also incorporate ACO learnings that emphasize shared decision-making between beneficiaries and their providers. Second, while we applaud CMMI for suggesting a flexible definition of a Direct Contracting Entity (DCE) that may include MA plans, we encourage CMS to limit MA plan participation to DCEs that are co-applicants with experienced "Medicare ACOs". Given that MA plans can already participate in CMMI MA demonstrations for Value-Based Insurance Design (VBID) and MA Qualifying Payment Arrangement Incentive (MAQI) and there is a separate CMMI health plan innovation initiative under development, we believe that MA plans have ample opportunity to innovate outside this primary care Fee-For-Service (FFS) transformation model.

   For purposes of eligibility, we would propose the following definitions:

   - "Medicare ACOs" reference the ACOs under Tracks 2 and 3 of the Medicare Shared Savings Program (or Basic Track, level E, or Enhanced Track under Pathways to Success) or the Next Generation ACO (NGACO) program. *For 2018, there were 51 NGACO; 38 MSSP Track 3; and 8 MSSP Track 2. These ACOs offer a broad pool of potential DCE applicants to provide a valid and reliable cohort for model testing.*

- "MA plans" mean MA organizations at the individual plan or segment level that have or are entering into an integrated/collaborative arrangement with a "Medicare ACO". Examples of integrated/collaborative arrangements may include provider-sponsored health plans such as joint ventures or formal partnerships or other collaborative arrangements between "Medicare ACOs" and MA plans that share governance, substantial economic risk and integrate providers/suppliers into health plan processes related to network design, provider contracting, quality and care coordination in order to drive innovation, improve quality and outcomes, and lower costs.

2. **Selection of Geographic Regions:** CMS expects to "limit participation to four target regions" in the first performance year. As proposed, target region "means a CMS-approved geographic area that forms the basis for determining which beneficiaries are aligned to a DCE through a geographic alignment methodology. CMS intends to allow an applicant to propose a target region for CMS approval, subject to certain requirements." In addition, CMS will "select one or more DCEs per target region, favoring target regions with at least two DCEs to encourage competition."

   Comment: We have suggestions related to the number of target regions, the definition of target regions and the concept of competition as it relates to DCEs and preferences for the selection of target regions.

   - Number of target regions: ***We do not believe initial year participation should be limited.*** Instead, CMMI should consider the quality of each application when considering how many regions may participate in the first performance year. If qualified DCE applicants exceed four geographic regions, CMS should allow participation from all qualified DCEs to gather information about the success of this model across as many geographic regions and patient populations as possible. As providers seek to move to value-based arrangements, we believe that limiting participation in a top-tier opportunity would have a potential chilling effect on providers willing to serve as innovators and transition to value-based arrangements.

   - Target region definition: ***For "Medicare ACO" applicants/co-applicants, target region should be defined by the Medicare beneficiaries that were assigned to the ACO during its most recent performance year, rather than by a county or zip code methodology.*** This definition would prioritize beneficiary choice. Unlike MA, "Medicare ACOs" have established individual patient relationships that are not restricted by arbitrary time and distance network adequacy rules and have a chilling effect on MA spread in rural areas and ultimately limit beneficiary choice. Since this model is intended as a final state for "Medicare ACOs," the target region should respect continuity of care delivery and include all "Medicare ACO" aligned beneficiaries.

   - Target region and DCE competition: ***We do not believe that preference for first-year participation should be given to regions with multiple DCE applicants.*** Such a preference too narrowly defines competition and naturally defaults DCE participation to urban areas with high volumes of Medicare beneficiaries and providers. It also erroneously presumes that DCE applicants will propose target regions that are identical or with significant overlap. Alternatively, if the model is to retain a competition preference, CMMI should expand competition beyond DCEs and recognize other CMS/CMMI FFS risk-bearing models within

targeted regions as competition, including other MSSP Track 1+ and other CMMI demonstration models, such as Primary Care First and the Direct Contracting Professional and Direct Contracting Global models. ***In addition, we strongly believe it would be a disservice for this model to target regions with low penetration of advanced alternative payment models (A-APMs).*** As mentioned previously, organizations who have been successful in "Medicare ACOs" and other risk-based contracts have unparalleled experience managing value and care coordination for Medicare beneficiaries and should be encouraged to participate in this model.

As this is an effort to move from a volume-based FFS-delivery system, DCE competition (with an expanded definition) should be but one factor in selecting target regions. Regardless of DCE competition, we think there is merit for testing this model in geographic areas with high FFS penetration or low adoption rates for MA plans. Many of these areas are rural in nature and suffer from shortages in healthcare professionals. In these regions, we recommend that CMMI disregard the preference for competition and instead allow applicants to demonstrate other factors to encourage FFS transformation – high FFS market penetration, rural geographies, concentration of complex or high acuity beneficiaries, and/or other factors.

3. **Comparison Groups:** It is proposed that CMMI would "construct a comparison group from areas outside of the payment model option's target regions."

   Comment: We disagree with the need for comparison groups from outside the model's targeted regions. Foremost, it would be challenging to find other "like" geographies with the health status, acuity, social determinants of health and healthcare utilization patterns of a given population in a target region. Given this challenge, the validity of the comparison would likely be contested without getting to the merits of the model itself. Alternatively, ***we would recommend that this model employ pre-post methodology for evaluation purposes***, as used in the Pioneer ACO Model and the NGACO Model. We would also recommend that the evaluation of this model include a component that compares results in rural and urban geographies and ultimately to those beneficiaries.

4. **Attribution and Alignment Methodology**: It is proposed that each DCE would be at "full risk for the total cost of care (TCOC) for Medicare FFS beneficiaries" in the target region. If there are multiple DCEs in a region, CMMI is "considering either randomly aligning beneficiaries in the target region to one of the DCEs or allowing beneficiaries in the target region to voluntarily align themselves to a specific DCE."

   Comment: For "Medicare ACOs" applicants/co-applicants, the attribution methodology should align with the ACO's most recent performance year. ***We oppose random alignment of beneficiaries to a DCE.*** Random assignment does not recognize established relationships between beneficiaries and providers, respect beneficiary choice, or eliminate the need to risk adjust (since resulting populations would not be homogenous). ***We cannot emphasize enough that aligned beneficiaries in this model should be restricted to those who have an established care relationship with the DCE.*** Along those lines, we would encourage greater flexibility within the voluntary alignment option to enable DCEs to proactively market to non-aligned beneficiaries about the benefits of this model.

5. **Benchmark and Trend:** As proposed, a "DCE's TCOC accountability would be calculated based on the historical Medicare Parts A and B per capita spending in the target region". The model's benchmark would be determined for geographically aligned beneficiaries during a baseline period; trended forward to the performance year; adjusted by a geographic factor; and discounted to achieve savings targets.

   Comment: This proposal lacks sufficient detail to enable DCEs to determine whether this model will be financially sustainable, and CMMI should prioritize the release of a detailed methodology with accompanying technical assistance opportunities in advance of the Request for Applications (RFA) release. Areas requiring more information include:

   - *Per capita spending* – ***This model should factor in adjustments for the aligned population.*** At a minimum, this model should use differentiated rate cell methodology – aged/disabled, ESRD, and duals. Ideally, we would suggest that this model integrate any factors in the rate cell methodology that would materially impact individual costs, such as age groups, gender, etc. This spending should also break out Part B drugs. The more detailed the spend analysis, the better DCEs will be equipped to appropriately target spending based on differentiated population needs. Alternatively, risk adjustments could take these demographic factors into account.

   - *Trends* – ***This model should include prospective annual trends, and not simply rely on fixed benchmarks based on FFS costs.*** This would include trends attributable to population-based costs, such as "age in" populations, the aging of the benchmarked populations and associated Part B costs for each rate cell. The trend methodology should mirror the rate cell/risk adjustment methodology. The trends should also incorporate unit-cost changes that Medicare imposes in their fee schedule. If benchmarks are to be used for a 5-year contract period, there needs to be a mechanism to reassess the accuracy of the benchmark or to permit DCEs to timely exit contracts.

   - *Discount* – While we support value propositions, ***the proposed "across-the-board" 3-5% minimum savings target for all DCEs is not reasonable.*** For "Medicare ACOs" applicants/co-applicants, these early-adopter, risk-bearing ACOs have already been in Medicare contracts with diminishing return savings over the course of multiple years and, in some cases, nearly a decade. To hold these "Medicare ACOs" DCEs to the same percentage of savings disregards past savings as well as their potential to substantively contribute to program content and overall value. We encourage CMMI to consider a more reasonable discount for "Medicare ACO" applicants/co-applicants of 0.5% savings annually. Alternatively, the discount could be phased in over the course of the contract.

   - *Quality Adjustment* – Similar to MA, ACOs should get rewarded for quality performance. This model should enable ACOs to offset some of the proposed discount by exceeding quality measures. We would envision the range of the quality adjustment to about 2%.

6. **Administrative Costs and Capitated Medical Risk:** As proposed, "DCEs would be paid on a capitated basis with the option for the DCE to contract with healthcare providers and pay these providers directly for any services used by aligned beneficiaries in the target region."

Comment: This model envisions an option whereby DCEs could provide claims processing and other administrative functions. The proposal does not detail funding for these administrative functions. ***We recommend that DCE applicants that are "Medicare ACOs" co-applying with a MA plan have the option to bid for the administrative service functions of managing the Medicare benefit for the assigned patient population in addition to the TCOC capitated payment.*** We suggest that the co-applicant would present a bid to the agency in the same manner as MA plans do under the current Part C system.

7. **Open Network:** It is proposed that Medicare FFS beneficiaries aligned to DCEs participating would "retain all of their Original Medicare benefits, including freedom of choice of any Medicare provider/supplier, even if the provider/supplier does not have an arrangement with the DCE."

   Comment: ***We believe that this model should disrupt the concept of network to promote quality access through beneficiary and provider incentives.*** We agree that beneficiaries should have choice. We also believe that DCEs should be able to influence choice through tiered referral practices that emphasis quality, care coordination and efficiency. Without engaging beneficiaries in discussions of quality and cost, DCEs will be hampered in taking accountability for TCOC. To sustainably achieve open networks from the provider perspective, the goal is to have broad networks and this model should encourage network participation as a means for providers to transition to value. Specifically, this model should establish a "Medicare ACO" exception to open networks. This exception would allow "Medicare ACOs", who co-apply with a MA plan, to have a closed network as a continuation of their risk-bearing ACO work in the event they can demonstrate network adequacy standards. For "Medicare ACOs" in rural areas, this model should allow DCEs to meet network adequacy through alternative means, such as telehealth, centers of excellence, and time-and-distance exceptions for provider shortages. A fallback option would be for this model to institute a reduction in FFS payment for each provider/supplier in a targeted region that declines to participate in this model's transition to value. This concept is similar to the payment offset under the Merit-based Incentive Payment System, which in part encourages Quality Payment Program participation through a reduction Part B reimbursement.

8. **Overlap:** As proposed, this model does not address its interaction with other CMS or CMMI initiatives. One of the proposed selection criteria is "The strength of the applicant's strategy for leveraging current CMS models or programs and existing and/or planned delivery system transformation efforts within the target region to support DC success."

   Comment: ***We are extremely concerned with the lack of direction on model overlap, which is a strong disincentive for providers to take heightened risk for total populations.*** This model should include a hierarchical approach to CMS / Innovation Center model overlap, in which precedence is given to population health risk-bearing entities and DCEs should be at the top. DCEs need to be assured that they will have a steady beneficiary population to test this model. As CMMI continues to release new Advanced APM models, many overlap rules fail to recognize the totality of population health

programming and instead incentivize siloed, episodic care (whether procedures or condition-based) based upon Fee-For-Service constructs over total population health programming. With the advent of a new round of mandatory bundles and ESRD programming forthcoming, this issue needs resolution. It is also unclear how Primary Care First alignment as well as other Direct Contracting models will be factored in and whether the co-existence of other models with this model is sustainable.

9. **Part D Data Sharing:** As proposed, this model does not include accountability for Part D drug costs or the ability of DCEs to obtain Part D drug cost data for its aligned population. The RFI does, however, seek input on whether benchmarks should include accountability for Part D drug costs.

   Comment: Given the importance of coordination of pharmacy care and medication therapy management, we support access by DCEs to Part D claims data for aligned beneficiaries regardless of whether Part D drug costs are included in the benchmark. Drug information would enhance the DCE's ability to manage and coordinate patient care. This data would provide insight into prescribing patterns, use of Generics, and patient refills and missed refills. With the opioid crisis, the data would also enhance the DCE's ability to clinically manage this emergency. Although not currently included within this model's benchmark, we would support an option to include Part D drugs costs under certain circumstances. If a "Medicare ACO" is a co-applicant with a MA plan, the resulting DCE could offer a Part D benefit under the same terms as that benefit is offered under its current MA Plan offering.

10. **Waivers and Beneficiary Enhancements:** As proposed, this model does not address its treatment of fraud and abuse waivers or beneficiary enhancements.

    Comment: While the ACA legislated a pathway for regulatory waivers to be developed and applied to its risk-based models, the model description does not reference these protections. Since these waivers have proven instrumental in other CMMI demonstrations to enable clinical and financial integration to lower costs and improve health access and outcomes, we urge that this model include an explicit statement about included fraud and abuse safeguards. Additionally, this model should maintain all benefit enhancements that have been provided in "Medicare ACO" models and should enable future enhancements to be developed and expanded to meet further beneficiary needs and to allow for increased financial incentives for beneficiaries. This may include the ability to waive Medicare copayments and deductibles for beneficiaries who stay within the DCE's preferred provider network.

OTHER MODEL CONSIDERATIONS

In addition to the key model parameters listed above, the RFI posed other questions / issues.

Inclusion of Rural Geographies: It is imperative that this model be tested in rural geographies alongside urban geographies. One in five Medicare beneficiaries reside in rural areas. The rural population itself generally is older, more medically complex, and less affluent – all of which impact outcomes and opportunities for care coordination. Despite these opportunities, most CMS and CMMI payment reform

initiatives and value-based models have targeted urban areas. In addition, the penetration of MA plans in rural areas lags behind their adoption in urban geographies. For instance, 30% of NGACO beneficiaries attributed to UnityPoint Accountable Care reside in counties that do not meet network adequacy standards. We believe that this primary care focused model could increase healthcare options to beneficiaries in areas previously unserved or underserved by MA plans and for which FFS health care delivery systems are more prevalent. As an ACO with a largely rural footprint who has been successful under both the Pioneer ACO Model and NGACO, we believe that the NGACO Model offers safeguards to preserve access and quality for beneficiaries in rural areas that could be used in this model. What we hope this model will demonstrate is the needed financial and service delivery flexibility to assure access to high quality care, including the recognition that the cost of access differs in geographies with distance barriers and gaps in community wrap-around services. Again, we would urge CMMI to include a rural versus urban component to the evaluation of this model.

Social Determinants of Health: We do believe that this model has great potential for addressing beneficiary needs related to social determinants of health (such as food, housing, and transportation). For more specific feedback, we would refer CMMI to our comment letter dated November 16, 2018 in response to "*RFI: IMPACT Act Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors*". Two areas to note are that:

- Flexibility for local solutions: Community networks and resources vary greatly and are not subject to one-size-fits-all solutions. Although this model may incorporate social determinants of health strategies, regulatory discretion should avoid being too prescriptive and/or mandating particular tools or community partners.

- Funding streams: It is undisputable that social determinants of health impact health outcomes and quality of life. This should not assume that DCEs under this model should become financially accountable for delivering these services.

We are pleased to provide input on this RFI and its impact on our integrated health system and the individuals and communities we serve. 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,

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