UnityPoint Health

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October 16, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1701–P
P.O. Box 8013
Baltimore, MD 21244–1813

RE: CMS–1701–P – Medicare Program: Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success; published at Federal Register, Vol. 83, No. 160, August 17, 2018.

*Submitted electronically via* www.regulations.gov

Dear Ms. Verma,

UnityPoint Health ("UPH") appreciates the time and effort of CMS in the development of the Pathways to Success proposed rule, which streamlines the Medicare Shared Savings Program. UPH is one of the nation's most integrated healthcare systems. Through more than 30,000 employees and our relationships with more than 290 physician clinics, 38 hospitals in metropolitan and rural communities and 15 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. As such, we are committed to the Accountable Care Organization (ACO) model and believe it has resulted in better care for our beneficiaries and a more flexible service delivery model for our providers. UAC has submitted a separate comment letter on the substance of CMS-1701-P.

**The purpose of this letter is to reiterate UPH's interest in the evolution of ACOs beyond the ENHANCED track. We envision this new state as a model that combines features of both ACOs and Medicare Advantage (MA). As a result, we have developed a new framework that we are calling the "MA Plus" model.** Key features include:

- Eligibility limited to provider integrated MA plans, which require collaboration with a Medicare ACO and meaningful provider representation on the plan's governing body.
- Attribution-based enrollment of beneficiaries related to their alignment with Medicare ACOs is utilized with affirmative election to remain in Fee-For-Service Medicare.
- Network adequacy requirements will allow alternative high-quality standards for tele-health and Center of Excellence designations.
- The MA program will serve as the chassis – current MA payment rates and regulatory structure, except as to enrollment methodology and as otherwise defined in the proposal.
- Tailored beneficiary communication strategy and outreach related to plan benefits, cost and enrollment process will be implemented. Marketing to non-attributed ACO beneficiaries is prohibited.
- ACO risk scores for enrolled members will be utilized for the MA Plus plan in initial years.
- Quality performance will be measured under the MA star measurement and rating system, with initial plans deemed as 3-star plans unless heightened ACO quality performance merits a 4-star rating.
- Regulatory flexibility and applicable fraud and abuse waivers will apply to enable benefit enhancements and other practice flexibility.
- A-APM status will be available for this Model – MA Plus plans will complete the All Payer Combination Option application and MA Plus revenue and patient count will be considered as part of the "Medicare Only" threshold needed to maintain A-APM status under MACRA.

We have attached an Executive Summary and Comparison Table. We also have a more detailed MA Plus proposal, which we can provide upon request.

We appreciate this opportunity to propose a newly envisioned future state for ACOs and enhanced care delivery for beneficiaries. To discuss the MA Plus proposal or future state of Medicare ACOs, please contact Sabra Rosener, Vice President, Government and External Affairs at sabra.rosener@unitypoint.org or 515-205-1206. We look forward to working with you.

Sincerely,

Sabra Rosener
VP, Government & External Affairs
UnityPoint Health

# Executive Summary: Medicare Advantage (MA) Plus Proposal

The MA Plus Model is a proposal submitted to the CMS Innovation Center that is designed to be the future of Medicare service delivery. Built upon the popular MA chassis, this provider integrated model seeks to promote the delivery of high-quality care to Medicare beneficiaries and promote economic efficiency in the Medicare Program. The Model respects the provider-patient relationship, offers a superior beneficiary experience as designed by providers and their patients, and removes barriers to delivering care that is high-quality, convenient, requested and timely.

## Need

Medicare costs are a growing percentage of the federal budget. Congress and regulators have mandated that the healthcare industry move to value and increasingly tie payment to quality and health outcomes. Providers are overwhelmed with increasing healthcare regulations and desire to move to a stable payment environment. Seniors in rural areas and elsewhere want affordable access to healthcare and fear reductions in coverage.

## Solution

The Medicare Advantage program is an increasingly popular option for seniors and has shown promise in curbing costs, quality outcomes and offering supplemental benefits desired by seniors. Medicare ACO models have succeeded in offering a differentiated patient experience through enhanced provider engagement and testing benefit enhancements and programmatic waivers. By further enabling MA with ACO best practices, the MA Plus Model will enhance healthcare access, provide high-quality care and offer fiscal relief to the Medicare program. The Model prioritizes choice in healthcare, encourages marketplace competition and assists the government by lessening its role in healthcare administration.

The MA Plus Model is proposed as a five-year pilot. Model features include:

- Eligibility limited to provider integrated MA plans, which require collaboration with a Medicare ACO and meaningful provider representation on the plan's governing body.
- Attribution-based enrollment of beneficiaries related to their alignment with Medicare ACOs is utilized with affirmative election to remain in Fee-For-Service Medicare.
- Network adequacy requirements will allow alternative high-quality standards for tele-health and Center of Excellence designations.
- The MA program will serve as the chassis – current MA payment rates and regulatory structure, except as to enrollment methodology and as otherwise defined in the proposal.
- Tailored beneficiary communication strategy and outreach related to plan benefits, cost and enrollment process will be implemented. Marketing to non-attributed ACO beneficiaries is prohibited.
- ACO risk scores for enrolled members will be utilized for the MA Plus plan in initial years.

- Quality performance will be measured under the MA star measurement and rating system, with initial plans deemed as 3-star plans unless heightened ACO quality performance merits a 4-star rating.
- Regulatory flexibility and applicable fraud and abuse waivers will apply to enable benefit enhancements and other practice flexibility.
- A-APM status will be available for this Model – MA Plus plans will complete the All Payer Combination Option application and MA Plus revenue and patient count will be considered as part of the "Medicare Only" threshold needed to maintain A-APM status under MACRA.

For affiliated ACOs, this Model proposes protections to address concerns that could stem from a reduction in beneficiary count as a result of attribution-based enrollment in the MA Plus plan. These protections include waivers of minimum beneficiary count requirements; recalculations of the minimum savings rate; rebasing the benchmark; partial forgiveness of advance payment model obligations; recalculation of population based payment; ability to switch to lesser MSSP program tracks; and ability to withdraw from the ACO program.

## Hypotheses

Under the auspices of the CMS Innovation Center, the Model proposes to test the following hypotheses:

- Heightened levels of beneficiary satisfaction are associated with the MA Plus Model;
- Attribution-based enrollment into the MA Plus Model is an accepted process for beneficiaries to transition from Fee-For-Service Medicare;
- The MA Plus Model is a preferred avenue for providers to enter into risk-based contracts, and transition to value-based payment; and
- Alternative mechanisms to achieve network adequacy for the MA Plus Model promote enhanced healthcare access and increase the adoption of MA plans in rural areas.

## Timeline

CMS is requested to consider this proposal for a 5-year pilot period under the CMS Innovation Center. As proposed, the pilot period will start January 1, 2020 and will conclude on December 31, 2024. Applications for participation will be accepted on an annual basis.

# Attachment 1: MA Plus Model – Comparison with ACOs and MA

| Issue | ACO | MA Plus | MA |
|---|---|---|---|
| **1. Organization Participation** | Eligible ACOs as defined in section 1899(b) of the Social Security Act and implementing regulations | Collaborative opportunity between Medicare ACOs & Medicare Advantage Organizations | Health Plans |
| **2. Beneficiaries** | | | |
| *a.* ***Alignment*** | Annual utilization based attribution (prospective and retrospective)<br>• May be supplemented through voluntary alignment | Annual attribution-based enrollment with beneficiary opt-out process during Annual Election Period, based on ACO's prospective alignment<br>• Guaranteed Issue Rights to Prior Medicare Supplement, if any<br>• Medicare Supplement Coverage Cancellation | Annual Election Period and Open Enrollment Period.<br><br>Special Enrollment Periods based on beneficiary circumstances |
| *b.* ***Duals*** | Included in Attribution | May be included in bid | Varies with bid and D-SNP restrictions |
| **3. Coverage** | | | |
| *a.* ***Basis*** | Medicare Parts A & B | Medicare Parts A, B & C | Medicare Part C |
| *b.* ***Additions*** | • Benefits to beneficiaries: 3-Day SNF Waiver<br>• Post Discharge Home Visits<br>• Telehealth Originating Site<br>• Cost Sharing Support for Part B<br>• Chronic Disease Mgmt. Reward<br>• Care Mgmt. Home Visits | • Authorize all existing ACO benefit enhancements<br>• Combine MA uniformity and supplemental benefit flexibilities with ACO best practices – Examples:<br>o Provision of telehealth equipment to beneficiaries with chronic diseases at reduced or no cost<br>o Reduced cost sharing for high-value services, such as eye exams for diabetics<br>o Reduced cost sharing for enrollees participating in disease management, such as cardiac rehab<br>o Transportation to follow-up appointments for certain medical diagnoses at no cost | • Limitations on beneficiary out-of-pocket expenses<br>• Supplemental Benefits<br>• Uniformity flexibility |
| *c.* ***Prior authorization*** | Very limited (DME; home health, etc.) | Testing to include lesser use of prior authorization | Common practice for referrals - specialists, drugs, etc. |
| *d.* ***Across state lines*** | Allowed – Freedom of Choice | HMO, HMO-POS and local PPO<br>• PPO allows<br>• Beneficiary cost sharing varies | Restricted in HMO policies |
| *e.* ***Part D*** | n/a | Available | Available |
| **4. Communications / Marketing** | | | |
| *a.* ***Providers*** | ACO Web Page must list ACO Participants | MA Provider Directory | MA Provider Directory |

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| Issue | ACO | MA Plus | MA |
|---|---|---|---|
| b. ***Beneficiaries*** | 42 C.F.R. §425.312 requires certain notices to beneficiaries of participation in an ACO | "File and Use" default for:<br>• Beneficiary Notice of Attribution-based Enrollment with Opt-Out<br><br>Restrictions on direct marketing to non-aligned beneficiaries | File and Use (5-day wait)<br>• Enrollment Packets<br>• ID Cards<br>• Member Services Call Center<br>• Member Newsletter (if benefit / cost sharing info)<br>CMS review (45 days)<br>• Member Services OEV Letter and Scripts<br>• Website |
| **5. Providers** | | | |
| a. ***Beneficiary freedom of choice*** | Yes | HMO, HMO-POS, or PPO | Defined provider network |
| b. ***Service Area*** | No minimum network requirements | Flexibilities to MA time and distance requirements<br>• Telehealth exceptions for all geographies<br>• Time/distance exceptions to account for Centers of Excellence (COE) | Network adequacy time and distance requirements at county level<br>• Allow exception request process |
| c. ***Provider Involvement in governance*** | Participating Providers Required to make up 75% of Governing Board | Network providers required to have meaningful representation on Health Plan Governing Board | Not required |
| **6. Reimbursement** | | | |
| a. ***Method*** | FFS | Capitated PMPM | Capitated PMPM or fee schedule |
| b. ***Benchmark calculation*** | Based on CMS calculations and Baseline Year Data | Bid process | Bid Process |
| c. ***Risk adjustment*** | • Used for benchmarking in MSSP<br>• Limited in NGACO to ±3% over a contract period | Ongoing, unlimited but subject to normalization | Ongoing, unlimited but subject to normalization |
| d. ***AAPM bonus*** | • Certain ACOs have received A-APM status as a result of meeting the requirements at 42 C.F.R. §414.1415<br>• 5% of Part B revenues and paid directly to Part B Tax IDs | • A-APM status via All Payer Combination application<br>• MA Plus A-APM revenue and patient count to be included in Medicare Only thresholds<br>• 5% of all Part B and MA Plus Model revenue to be paid directly to Part B Tax IDs | • Provider or Payer may apply to be A-APM through the All Payer Combination Option<br>• Participation may be included in determination of whether provider meets A-APM requirements |
| e. ***Quality bonus*** | • NGACO – prior to 2019, total quality score impacts the benchmark discount rate<br>• Other MSSP ACOs – quality score impacts the percentage of shared savings | • Star rating – Initial two years to be assigned based upon attainment of predetermined level of ACO quality performance and thereafter default to | • Plans may receive bonus based on star rating<br>• New MA plans are defaulted to 3-star rating |

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| Issue | ACO | MA Plus | MA |
|---|---|---|---|
| | | standard star performance scoring | |
| *f.* ***Provider incentives*** | Shared savings/losses from ACO to providers | Shared savings/losses from plan to ACO Participants via A-APM-compliant risk-sharing arrangement | Related party restrictions from MA plan to provider |
| ***7.*** **Quality** | | | |
| *a.* ***Measures*** | 31 ACO measures with reasonable impact on shared savings/losses<br>• Patient/Caregiver Experience (8)<br>• Care Coordination/Patient Safety (10)<br>• Clinical Care for At-Risk Population (5)<br>• Preventive Health (8) | Existing star measures will serve as quality indicators with potential to incorporate ACO measures within stars construct in MA Plus performance year 3 | 33 star measures<br>• Managing Chronic (Long Term) Conditions (13)<br>• Member Experience with Health Plan (6)<br>• Member Complaints and Changes in the Health Plan's Performance (4)<br>• Health Plan Customer Service (3)<br>• Staying Healthy Screenings, Tests and Vaccines (7) |
| *b.* ***Reporting*** | Via GPRO by ACO | MA Plus Plan to report on all MA star measures via HPMS | Via HPMS by MA plan |
| *c.* ***QPP*** | • Certain ACOs have received A-APM status as a result of meeting the requirements at 42 C.F.R. §414.1415<br>• Qualified Provider (QP) for revenue and patients (i.e. on CMS list) | • A-APM status via All Payer Combination Option application<br>• MA Plus A-APM revenue and patient count to be included in Medicare Only thresholds | • A-APM status via All Payer Combination Option application |
| ***8.*** **Compliance** | | | |
| *a.* ***Program Requirements*** | • Compliance Plan and Compliance Officer required | • Compliance Plan and Compliance Officer required<br>• Follow MA requirements | • Compliance Plan and Compliance Officer required<br>• Compliance audits<br>• First Tier, Downstream, and Related Entities (FDR) requirements<br>• Compliance trainings |
| *b.* ***Fraud and Abuse Waivers*** | • Participation waiver<br>• Patient engagement incentive waiver | Permit VBID waivers and supplement with ACO-type waivers as needed | VBID waivers for uniformity and accessibility of benefits, uniform cost-sharing, and communications, disclosures and marketing |
| **9. ACO Protections for MA Plus Participation** | | | |
| *a.* ***Minimum Beneficiary Count*** | NGACO: 10,000 minimum (7,500 minimum in rural areas)<br>MSSP: 5,000 minimum | No penalty for falling below minimum beneficiary count in ACO for duration of Model | n/a |
| *b.* ***Minimum Saving Rate*** | Applicable to MSSP and based on the ACO's attributed | Provide extra downside protection via lower asymmetrical corridor for | n/a |

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| Issue | ACO | MA Plus | MA |
|---|---|---|---|
| | population; For Tracks 1+, 2 and 3, symmetrical MSR/MLR is required | shared savings/losses for duration of Model | |
| c. ***Benchmark Rebasing*** | Methodology varies between MSSP and NGACO | Recalculate benchmark based on aligned ACO beneficiaries after enrollment in MA Plus Plan is finalized | n/a |
| d. ***Advance Payment Model*** | Upfront or monthly payment for infrastructure investments for MSSP Participants to be repaid to CMS | Recalculate repayment amount based on beneficiaries remaining within ACO and forgive amount attributed to lives enrolled in MA Plus Plan | n/a |
| e. ***Population Based Payment (PBP)*** | Percentage reduction to base FFS monthly payments for NGACO PY-aligned beneficiaries | Recalibrate monthly payments based on aligned beneficiaries and utilization after enrollment in MA Plus Plan is finalized | n/a |
| f. ***Program Track Switch*** | Tracks 1+, 2 and 3 prohibited from switching to Track 1 | Allow ACO to switch to lower risk track for duration of Model | n/a |
| g. ***Option to Withdraw*** | Exiting ACOs must complete the CMS settlement | Allow ACO no-penalty withdrawal on an annual basis following the Open Enrollment Period and ACO alignment is finalized | n/a |
| **10. Bid / Application Process** | | | |
| a. **Requirements** | ACO application process<br>• NGACO: 3-year demonstration with 2-year extension. Closed after third cohort for CY2018<br>• MSSP: 3-year contract with possibility of renewal under 42 C.F.R. §425.224<br>• Applications are open annually | Use MA bid structure<br>• Open bid outside standard timeframe in first year to adjust for Star supplemental scoring and enhanced benefits opportunities<br><br>Five-year demonstration starting January 1, 2019 | MA annual bid structure |