



UnityPoint Health

February 6, 2015

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1461-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS-1461-P - Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Proposed Rule (Vol. 79, No. 235), December 8, 2014

Submitted electronically via www.regulations.gov

Dear Ms. Tavenner:

UnityPoint Health (“UPH”) is pleased to provide the following comments in response to the Centers for Medicare & Medicaid Services’ (CMS) Medicare Shared Savings Program (MSSP) proposed rule for calendar year 2016. UPH is one of the nation’s most integrated healthcare systems. Through more than 28,000 employees and our relationships with more than 290 physician clinics, 32 hospitals in metropolitan and rural communities and home care services throughout our 9 regions, UPH provides care throughout Iowa, Illinois and Wisconsin. On an annual basis, UPH hospitals, clinics and home health provides a full range of coordinated care to patients and families through more than 4.5 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 Health Partners is our clinically integrated delivery system, which holds value-based contracts for more than 300,000 covered lives, including beneficiaries attributed under the Medicare Shared Savings Program since July 2012. In our central northwest region, Trinity Pioneer ACO is one of two predominantly rural ACOs participating in the CMMI Pioneer ACO Model Program.

As an integrated healthcare system, we believe that patient-centered care is best supported by a value-based payment structure that enables healthcare providers to focus on population health instead of episodic care. The Medicare Shared Savings Program is one of several CMS initiatives that encourage the transformation of health care to a value-based care delivery system. We respectfully offer the following comments to the proposed MSSP regulatory framework.

ACO ELIGIBILITY

- Managing Changes to ACO Providers / Suppliers: While we generally agree with the proposed

changes related to the management of ACO Providers / Suppliers within the ACO, we recommend that CMS reconsider a couple items. First, we recognize that CMS uses PECOS as the source of truth to identify the Medicare-enrolled individuals and entities that are affiliated with the ACO participant's TIN list. Since individual practitioners are charged with PECOS registration and updates, this requirement places upon the ACO an administrative burden over which it has no control. We would suggest that CMS revise the PECOS file to indicate whether individual practitioners are affiliated with an ACO, and that the ACO be enabled to populate and update this information. Second, the proposed rule defines "significant changes" to the ACO which require additional reporting to CMS. One such "significant change" is "when the number or identity of ACO participants . . . changes by 50 percent or more during an agreement period."¹ This requirement would disproportionately target small (and often rural) ACOs, comprised of a small number of ACO participants. It also disproportionately targets the addition of small independent practitioners. We would recommend that this definition of "significant change" relate to the number of beneficiaries attributed versus the number of ACO Participants.

- **Required Process to Coordinate Care:** CMS proposes three new eligibility requirements related to the use of health information exchange technologies in care coordination. Under the proposed rule, an ACO needs to describe the following in its application: (1) improving care coordination for beneficiaries; (2) partnering with long-term and post-acute care providers; and (3) milestones or performance targets for assessing implementation progress. We are in support of these additional requirements and recommend that post-acute strategy include strategies addressing palliative care.

- **Transition of Pioneer Program to MSSP:** We are supportive of a condensed application process for Pioneer ACOs. In addition, we request CMS to also consider a distinct, full application process for Pioneer ACOs upon request. The intent of the full application process would be to provide complete program information so that CMS would re-examine the risk of the former Pioneer ACO after one year in the MSSP. While Pioneer ACOs were selected for participation in the Pioneer ACO Program based on their "experience operating as ACOs or in similar arrangements," we do not agree that former Pioneer ACOs are automatically able to accept more down-side risk and this review process would prevent them from being punished from past performance (i.e. take into account prior efforts at driving down utilization). Since shared savings are subject to diminishing returns and eventually plateau or reach "floor," the first year evaluation would assist in this assessment and provide an accurate and more detailed picture of beneficiaries served by the ACO.

PROVISION OF AGGREGATE AND BENEFICIARY IDENTIFIABLE DATA

- **Aggregate Data Reports & Limited Identifiable Data:** The proposed MSSP rule sets forth additional information to be provided within the minimum dataset. These dataset categories are (1) demographic information, (2) health status information, (3) Medicare utilization rates, and (4) expenditure information. We support CMS's proposed additional data categories, including enrollment status, PCP and dates of service.² As part of the demographic data (category 1), we propose that CMS include the home address with zip code within the beneficiary identifiable data and the beneficiary assignment lists. The latter would promote the timely distribution of beneficiary notification letters – the lack of member address and attributed PCPs have resulted in an average notification time lag of 75-90 days (compared to 45-60 days for our Pioneer ACO). In terms of health status information (category 2), we propose that expanded data include HCC score for each assigned beneficiary. Lastly, for Medicare utilization rates (category 3), we request the inclusion of claim and claim line data as well as referring and ordering physician data fields.

¹ 79 Fed. Reg. 72773 (Dec. 8, 2014)

² 79 Fed. Reg. 72785-6 (Dec. 8, 2014)

- Aggregate Data Reports: As a participant in the Pioneer ACO, our organization has seen the benefit of certain standard reports through that program that enhance our ability to meet the Triple Aim. These reports enhance the ability of ACOs to project PMPM in real time by providing detailed utilization and total cost information as well as quality performance measures. We propose that the following Pioneer ACO summary reports also be provided to MSSP ACO organizations:

- Table 6-1: Monthly Expenditure Report
- Table 6-2: Monthly Claims Lag Report
- Pioneer ACO Baseline/Benchmark Report
- ACO Quality Performance Report

ASSIGNMENT OF MEDICARE FFS BENEFICIARIES

- Definition of Primary Care Services: In our comments to the Physician Fee Schedule (CMS-1612-P) for CY2015, UPH is on record as being supportive of payment for non-face-to-face care coordination represented by the Chronic Care Management (CCM) and Transitional Care Management (TCM) services. Both services rely on team-based care and function as an extension of the patient's medical home, including palliative care. The proposed MSSP rule revises the definition of primary care services to include both CCM and TCM billing codes, which subsequently impacts beneficiary assignment related to these services. As an extension to the medical home, we wholeheartedly support this definitional change.

CMS also seeks input on implications of retaining SNF services (CPT codes 99304 to 99318) within the primary care services definition and ultimately ACO beneficiary attribution. Within the community healthcare continuum, SNFs are important post-acute care facilities and often do not share common EHRs with other ACO participants nor common quality measures sought with other ACO Participants. UPH supports the inclusion of SNF services, recognizing that this would be limited to ACO Participant SNFs. Given our general support, we vigorously disagree with CMS' decision to add the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) to the general quality performance measure set used to evaluate the quality of the care furnished by ACOs. Our objection centers primarily on the fact that ACOs generally have no operational control over non-ACO Participant SNFs and there is not incentive for such SNFs to build ACO infrastructure. We respectfully ask CMS to reconsider this position to include the SNFRM within the quality performance measure set or to at least limit this measure to SNFs who are ACO Participants.

- Physician Specialties and Non-Physician Practitioners in Assignment: Currently, beneficiary assignment is a two-step process. The second step occurs when the beneficiary receives no primary care services from any primary care physician. This step is based on primary care services from either specialist physicians or certain non-physician practitioners. The proposed MSSP rule revises both steps. First, non-physician practitioners (physician assistants, nurse practitioners, and certified nurse specialists) are included within step 1 of the attribution process. This proposed revision more appropriately ties attribution to how primary care services are delivered, particularly in rural areas – Rural Health Clinics (RHCs) are required to have at least 50% of their services delivered by Nurse Practitioners / Physician Assistants and are not required to have a primary care physician. We support this step 1 change to reflect the nature of how primary care services are delivered. We do note, however, that some non-physician practitioners also exclusively provide non-primary care or specialty services. For instance in our Pioneer ACO, a significant number of beneficiaries were assigned to our Dermatology nurse practitioner and our Gastroenterology nurse practitioner. In that case, the Pioneer program allowed our ACO to remove those providers from attribution methodology. Both of these specialties are proposed to be excluded from attribution in the proposed MSSP rule and we would support a similar exclusion of non-physician ACO

professionals by the ACO.

Second, certain identified specialties are excluded from step 2 of the attribution process. We applaud CMS for attempting to refine specialist attribution to assure a focus on primary care services. Specifically, the proposed rule (section 425.402) identifies a list of 20 primary specialty designations to be included within step 2. We question whether some designations should be included, and despite their use of E&M billing codes, we do not believe that these specialists would anticipate that these designations would be equated to the management of primary care services. We request that CMS consider removing the following specialty designations from step 2 attribution: Allergy/Immunization; Gastroenterology; Neurology; Sports Medicine; Physical Medicine and Rehab; Infectious Disease; Endocrine; and Rheumatology. Additionally, the specialty designation of Multispecialty Clinic or Group Practice should likewise not be included within step 2 or beneficiary assignment, as this generic code designation represents a multitude of specialists – some of which are recommended to be included and excluded from this attribution process.

SHARED SAVINGS AND LOSSES

- Track 3: We commend CMS for their addition of Track 3 methodology. This Track provides another risk-bearing option for ACOs who are looking to transition to other risk-bearing and payment arrangements based on Triple Aim objectives. By offering several risk-bearing tracks, this enables ACOs to match their ACO infrastructure and maturity to the appropriate regulatory framework. We encourage CMS to continue to work with ACOs as the proposed Track 3 and other tracks are developed. To support ACOs to accept increased risk as they gain experience and comfort with alternative payment and program initiatives, we would suggest that CMS consider allowing all ACOs (regardless of track) the ability to up-risk annually during the agreement period.

- Prospective Assignment: Presently, this proposed assignment methodology is limited to Track 3 participants. As we have opined in the past, we support this methodology as an important means to support the Triple Aim. While retroactive attribution uses actual performance year data to identify beneficiaries cared for by an ACO and shared savings calculations will represent only those beneficiaries, it does not provide real-time certainty for planning and implementing population health strategies and services. The need to have an identified population to provide services and test innovations cannot be understated. The quarterly churn of beneficiaries under the present attribution does not enable ACOs to wrap services around an identified population. Also, we respectfully disagree with the implication by CMS that targeting coordinated care for an assigned beneficiary subset is somehow inappropriate. CMS stated:

We continue to believe that the current Shared Savings Program assignment methodology offers strong incentives for health system redesign to impact the care for all FFS beneficiaries that receive care from ACO professionals. As a result, we believe the assignment methodology currently used for the Shared Savings Program limits the potential for gaming and reduces the motivation to target beneficiaries for avoidance.³

The vision of UPH is to provide the “best care for every patient, every time” – whether that care is being provided to MSSP beneficiaries, all Medicare beneficiaries, Medicare enrollees, or other patients. While we wholeheartedly agree that MSSP is intended to change the care experience for all beneficiaries, this goal is the “end game” and not the charge of the individual contractors. The MSSP agreement relates only to services for attributed beneficiaries. The sustainability of the MSSP lies in beneficiary engagement, programming/service innovation, and continued provider participation. As ACOs develop, infrastructure constraints often prevent innovation from being disseminated system-wide. ACOs should be encouraged

³ 79 Fed. Reg. 72809 (Dec. 8, 2014)

to pilot innovative programming on a subset of beneficiaries to determine efficacy prior to full-scale implementation – the MSSP population should be that subset. If MSSP beneficiaries are getting no added benefit, why should they participate? It is short-sighted for CMS to suggest that all Medicare beneficiaries must receive equal treatment. Our participation in the MSSP is intended to demonstrate a high-quality service delivery structure that crosses all payor platforms, it needs the tools to target programming to enable innovation, test delivery strategies, and thoughtfully disseminate successes. A prospective attribution model will enable us to activate beneficiaries and partner with them in achieving high-quality care and enhance quality of life.

- Risk Adjustment: Under the MSSP, CMS adjusts Medicare expenditure amounts using the CMS–HCC model as “it more accurately predicts health care expenditures . . . [and] accounts for variation in case complexity and severity”.⁴ Using this methodology, CMS is authorized to risk adjust downward but not upward.⁵ CMS remains concerned that ACOs “are not encouraged to modify their coding practices in order to increase the likelihood of earning shared savings; rather, shared savings should result from actual reductions in Medicare expenditures for assigned beneficiaries.”⁶ The proposed rule extends this risk adjustment methodology to include all risk-bearing tracks (Tracks 1 & 2). By not authorizing upward adjustments or rebasing of risk scores for newly aligned beneficiaries (particularly those who have “aged in” and do not have a Medicare claims history), the rule perpetuates a health status without supporting individual data and does not account for a greater illness burden over time that accompanies the aging process. If an ACO charged with population health management is taking on the risk for an increased health burden, we believe that there needs to be a risk adjustment credit. The failure to rebase risk undermines the Triple Aim – it emphasizes a financial / cost model over a quality care model. Further, as beneficiary conditions are better understood and care collaborations between providers better manage multi-occurring conditions, ACOs are unfairly measured despite improving oversight, diagnosis and management of beneficiaries with co-morbid conditions. CMS should encourage the use of correct and compliance coding in support of the Triple Aim. Improved coding is not necessarily about “gaming” the system but making sure that ACOs are capturing the best information to facilitate care coordination across providers and specialties. Instead of disallowing upward risk adjustment, we believe CMS should regulate this process through audits. We respectfully recommend that CMS enable risk score adjustments to be made both downward and upward for all participating ACOs.
- Methods to Encourage ACO Participation in Performance-Based Risk Arrangements:
 - Payment and Program Waivers – Generally: CMS has proposed several categories of payment and program waivers to be applied only to Track 3 participants. Due to the potential benefit to beneficiaries, CMS should consider extending these waivers for both risk-bearing Tracks 2 and 3. Through our involvement with the Pioneer ACO, we have gained valuable experience with several of these waivers, and there is evidence to demonstrate that they are positively impacting population health outcomes for organizations willing to bear risk.
 - Payment and Program Waivers: SNF 3-Day Rule: This waiver is a “ticket to entry” for top performing ACOs. We support this waiver for Tracks 2 and 3, which addresses a situation that has caused dilemmas for ED providers. This waiver enables ACOs to partner with SNF who are engaged in standardized quality processes and motivated to implement common criteria for care

⁴ 76 Fed. Reg. 67917 (Nov. 2, 2011)

⁵ 42 CFR 425.604 & 45.606

⁶ 79 Fed. Reg. 72813 (Dec. 8, 2014)

management platform across counties and facilities. As referenced under our comments to the definition of primary care services, we highly recommend that the addition of the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) to the quality performance measure set be limited to SNFs who are ACO Participants. Without this limitation, ACOs have no leverage to control or impact this measure. Lastly, our ACO home health agency is closely aligned with external agencies, such as county public health agencies. For Tracks 2 and 3, we would request that CMS extend the 3-day rule waiver to these external, partner agencies.

- Payment and Program Waivers: Telehealth Services: We applaud the waiver for telehealth services for Tracks 2 and 3, which would support our service delivery model and enable Triple Aim objectives. First, our healthcare system serves a largely rural area and telehealth reduces transportation barriers particularly to medical specialists not only for assessment but also interventions. Second, mental health HPSAs are prevalent throughout our service area and telehealth alternatives for mental health assessment and interventions enable behavioral health professionals to serve patients more efficiently. Third, this waiver has the potential to explore the best means to encourage care coordination services and to align with quality measures.
- Payment and Program Waivers: Homebound Requirement: While we are supportive of this concept for Tracks 2 and 3, we have concerns with the waiver as proposed. Specifically, this waiver would only apply to health home agencies that are ACO participants or ACO provider/suppliers. We understand the importance of engaging home health agencies that are highly motivated to implement common ACO goals and objectives. For our organization, this requirement creates an issue as our integrated home health agency is an ACO Participant in the Pioneer ACO, which was in existence prior to the MSSP. We request that CMS develop an exception process to enable our non-ACO Participant home health agency to take advantage of this waiver. Also, the waiver requires a CMS quality rating of three or more stars (CMS 5-Star Quality Rating System as reported on the Home Health Compare website). Since there are no similar quality parameters set for other potential ACO Participants, we urge CMS to remove this requirement and let ACOs self-select partnering home health agencies.
- Payment and Program Waivers: Post-Acute Care Referrals: This waiver supports community-based services and palliative care. By aligning these services, this is an effective means to promote the Triple Aim across the care continuum. We support this waiver for Tracks 2 and 3.
- Payment and Program Waivers: Other Payment Rules: We would urge CMS to establish a timely process through which ACOs may request other individual waivers based on data and program results. As this process is being developed, the Pioneer ACO program should serve as a model for lessons learned and best practices. We would support this waiver process for Tracks 2 and 3.
- Other Options: We offer other suggestions to encourage ACO participation in performance-based arrangements.
 - FFS Reimbursement Alternatives: To incentivize providers to participate, we propose that MSSP ACO Providers / Suppliers should have an increased reimbursement rate. Specifically, we encourage CMS to link provider payment increases to ACO participation (whether provider participation is as a member or a contractor). For traditional Medicare FFS providers, payment schedules would not increase. For ACO Provider / Suppliers, payment increases would be in addition to any shared savings potential.

- Beneficiary Attestation and Incentives: ACOs would benefit from the ability to actively engage beneficiaries earlier in the process. While the MSSP retains beneficiary freedom of choice in selecting healthcare providers, the attribution of beneficiaries based on a plurality of prior claims does not actively promote Day 1 engagement or provide any incentive for beneficiaries to be accountable for a usual, appropriate source of care. We propose that ACOs have an active attribution method as well as financial incentives for beneficiaries. Specifically, we encourage CMS to require beneficiaries to enroll in ACOs and provide that beneficiaries would be eligible for lower co-payments for in-network care and reduced premiums if their ACO meets cost and quality requirements. Beneficiaries would receive access to highly coordinated care and be rewarded through cost savings for their participation in high-value ACOs.

- Other Value-Based Payment Methods: Underlying the MSSP is the Fee-For-Service (FFS) payment methodology, which is involved with claims submission and cost analysis. At its core, FFS promotes volume-based care. As an ACO, we believe that patient-centered care is best supported by a value-based payment structure that enables healthcare providers to focus on population health instead of episodic care. We encourage CMS to work with ACOs to continue to develop new payment structures that transition away from FFS, such as episode of care payments or fixed per-beneficiary payments.

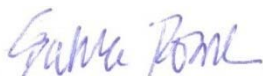
- Rural Engagement and Critical Access Hospital Reimbursement: The current cost based payment structure for critical access entities provides a supporting mechanism for rural communities to have **access** to local healthcare services. As we continue to move into value based payment mechanisms, efforts to achieve Triple Aim objectives has multiple implications:
 1. Care coordination activities to support patients in keeping them safe in their medical home can impact critical access volumes.
 2. The current cost-based payment structure makes it difficult to bend the cost curve for these patients. Ex. Cost of skilled care in a critical access bed in a cost-based structure versus a care facility bed is significantly higher.
 3. Care coordination codes designed to promote coordination at the provider level are not reimbursable under current Rural Health Clinic rules. Thus, ACOs in predominantly rural areas are unfairly weighted in both cost and FFS.

For the MSSP, ACOs have been hesitant to include Critical Access Hospitals as ACO Participants due to their cost-based reimbursement – when CAH utilization is driven down, CAHs can simply request an adjustment their reimbursement to increase their cost base. To encourage greater participation by CAHs within ACOs, we urge that reimbursement methodology must be changed. Particularly, we request CMS to consider separating the **cost of providing care** from the **cost of providing access** to Medicare beneficiaries, and reward rural programs for reducing the cost of care, while maintaining or increasing, the reimbursement for access to care. For the MSSP, costs for CAHs could be set cost-based reimbursement at an amount lower than 101% with the higher potential to share in savings if aligned quality measures are met and savings is achieved. More particularly, CAH reimbursement would be comprised of “Medical Care” and “Beneficiary Access”, with the Medicare FFS rates considered the cost of “Medical Care” and the incremental rate due to cost-based reimbursement considered the cost of “Beneficiary Access.” Potential shared savings would then be computed on the “Medical Care” portion of the payment rate.

- Establishing, Updating, and Resetting the Benchmark: CMS is seeking input on alternative benchmarking methodology.
 - Equal Weighting of Baseline Years – This alternative proposes to weigh the three benchmark years equally, ascribing a weight of one-third to each benchmark year. We respectfully disagree with this recommendation. While we believe this change would have minimal impact to ACOs if there is a stable population and costs, it would not reflect the most current inflationary costs. We support the current rule (60% in benchmark year 1; 30% in benchmark year 2; and 10% in benchmark year 3).
 - Account for Shared Savings or Losses in Prior Period – This alternative proposes that benchmarks be reset to account for shared savings earned in its prior agreement period. We support this methodological change, as it controls the gap between benchmark and actual expenses.
 - Use of Regional Factor which Holds Historical Costs Constant – As an alternative to the current national factor rule, the trend in regional costs would be calculated using an approach based on the PGP demonstration and the historical costs benchmark would be constant relative to the region. We support this approach, provided that the comparison group being large enough and similar to the ACO. For instance, a state/region that is heavily fee for service should not be compared to a state/region that is heavily managed care. If a regional analysis is performed, the ACO should be permitted to comment on the proposed comparison region prior to implementation.

We appreciate the opportunity to provide comments to the proposed rules for calendar year 2016 and their impact on our integrated healthcare system and affiliated ACOs. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President and Government Relations Officer, Public Policy and Government Payors at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,



Sabra Rosener
Vice President / Government Relations Officer
Public Policy and Government Payors
UnityPoint Health
1776 West Lakes Parkway, Suite 400
West Des Moines, IA 50266
sabra.rosener@unitypoint.org
unitypoint.org