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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 Accountable Care (UAC) appreciates this opportunity to provide feedback on the proposed rule. UnityPoint Accountable Care is the ACO affiliated with UnityPoint Health (UPH), one of the nation's most integrated healthcare systems. Through more than 30,000 employees and 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) has value-based contracts with multiple payers, including Medicare. UAC is a current Next Generation ACO, and we include providers that have participated in the Medicare Shared Savings Program (MSSP) as well as providers from the Pioneer ACO Model.

UAC appreciates the time and effort of CMS in developing and proposing this rule and respectfully offers the following comments.

GENERAL COMMENTS

As an early adopter of ACO models, UAC has and is participating in Medicare ACO models as a glide path to assuming greater risk while enhancing overall population health. UAC is one of the largest ACO participating in the Next Generation ACO Model with roughly 80,000 beneficiaries attributed to this

program and has received first-year shared savings with performance results pending for the second year. Historically, UAC has providers that have participated in the MSSP as well as providers from the Trinity Pioneer ACO, which was the most rural ACO and achieved two years of shared savings. In our opinion, Medicare ACO models have succeeded in offering a differentiated patient experience through enhanced provider engagement and testing benefit enhancements and programmatic waivers. We also agree that a transition to value-based care necessitates participation by all providers in two-sided risk arrangements and applaud efforts by CMS to examine geographies, provider types and settings as well as beneficiary engagement to encourage further ACO model penetration. While we support the Pathway to Success proposal as an initial step to streamline ACO thought and resources, we believe that more work is needed to make ACO Model costs sustainable and predictable, to foster regulatory flexibility that encourages further care delivery innovation, and to promote ACO service delivery in rural areas and across provider settings. We would also like to see differentiation between BASIC Track Level E and the ENHANCED track beyond heightened risk. These differences should include expanded regulatory relief, beneficiary enhancements and waivers, and beneficiary engagement tools. We would also encourage CMS to more closely link ACO performance and regulatory standards to those applicable to Medicare Advantage (MA).

REDESIGNING PARTICIPATION OPTIONS TO TRANSITION TO PERFORMANCE-BASED RISK

CMS is proposing to restructure the MSSP to include a BASIC and ENHANCED track and create a glide path to risk. Among the proposed changes are lengthened agreement periods, annual participation elections, participation options based on Medicare revenue and ACO experience, and participation requirements targeting two-sided models.

- ***Comment***: We generally support the renaming and streamlining of Medicare's framework for ACOs. In particular, we support:
  - Longer 5-year agreement periods. We agree that this will add stability for potential participants making investments in this program.
  - Initial 18-month timeframe for start-up activities and performance. This allows any new ACO participant, regardless of track and level, the ability to acclimate to the new program, including its administrative requirements and the receipt of more performance/claims data. Although CMS has proposed to implement this 18-month timeframe for 2019 only, we would support this initial performance period for future years as well.
  - Prospective attribution throughout the Pathways to Success framework. When we participated in the MSSP, our retrospective attribution churn rate was approximately 25% per quarter and undermined efforts at targeted care coordination and quality improvement initiatives. To avoid this churn, we believe that it is imperative for ACOs to have a durable perception of their target population.
  - Transition to risk. We back the transition from upside-only risk to two-sided risk within the initial agreement period and agree that CMS should look at ACO experience to determine participation eligibility. We believe that all ACOs should be able to assume downside risk within performance periods four or five and that, while experienced ACOs should not be able to revert to one-sided models, CMS should consider some flexibility for experienced ACOs with small attributed

populations (less than 5,000) to permit their initial participation to include BASIC Track, Levels C or D at the option of the ACO.

- Advanced Alternative Payment Model (Advanced APM) status. We agree that Advanced APM status should be limited to BASIC track, Level E and ENHANCED track participants. We believe this status is an incentive in itself for transitioning to heightened models of payment risk.

Given our experience with Medicare ACO models and the factors that influenced our participation, we believe that the Pathway to Success proposal could be strengthened to better encourage providers' transition to value. Although we believe that ACOs must transition to risk, there is a learning curve associated with successful population health strategies and implementation. Key areas for your reconsideration are:

- Minimum Savings Rate (MSR). Using CMS performance data, the National Association of ACOs found that in 2017 60% of MSSP ACOs generated savings for Medicare and 34% of MSSP ACOs earned shared savings.[1] The gap in these figures (i.e. 26%) is attributable to ACOs whose savings did not meet the MSR threshold. For ACOs in BASIC track Level A and Level B, MSR is set according to the number of assigned beneficiaries with a floor of 2.0 for 60,000+ beneficiaries. In subsequent years, lower MSR/MLR (Minimum Savings Rate / Minimum Loss Rate) corridors may be established by the ACO. Although we understand economies of scale, we are concerned that small ACOs are immediately disincentivized to participate.
- Shared savings rate. Rates are proposed at 25% for BASIC track, Levels A and B; 30% for BASIC track, Level C; 40% for BASIC track, Level D; 50% for BASIC track, Level E; and 75% for ENHANCED track. This is a drastic departure from current law, in which MSSP Track 1 participants are eligible to receive a 50% savings rate. We question the appetite of new providers to participate when potential rewards are limited to 25% as well as of some experienced ACOs to continue at lower rates. We support the National Association of ACOs recommendation that rates be revised to 50% for BASIC track, Levels A and B; 55% for BASIC track, Levels C and D; and 60% for BASIC track, Level E.
- Early termination for ACOs with "poor financial" performance. This is defined as ACO expenditures for the assigned beneficiary population that exceed the ACO updated benchmark by an amount equal to or exceeding either the ACOs negative MSR under a one-sided model or the ACOs MLR under a two-sided model after two performance years. We believe that this provision overemphasizes cost savings without taking into account other performance indicators, that risk corridors disadvantage rural providers, and that two years is not sufficient duration. We request that CMS revisit the early termination provision and its intended use.

Lastly, while we support participation distinctions based on ACO experience, we are opposed to the eligibility distinction based on Medicare FFS revenue (i.e. low-revenue ACOs versus high-revenue ACOs). CMS rationalizes this distinction by stating:

> *. . . our policies would recognize the relationship between the ACO's degree of control over total Medicare Parts A and B FFS expenditures for its assigned*

[1] NAACOs, More Medicare Accountable Care Organizations (ACOs) Achieve Quality and Cost Goals in 2017: Medicare Shared Savings Program (MSSP) ACOs Improve Quality and Save Medicare Money While Preserving Beneficiary Choice of Providers," August 20, 2018, access at https://www.naacos.com/press-release--more-medicare-acos-achieve-quality-and-cost-goals-in-2017

> *beneficiaries and its readiness to accept higher or lower degrees of performance-based risk. . . . By basing participation options on the ACO's degree of control over total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries, low revenue ACOs, which tend to be smaller and have less capital, would be able to continue in the program longer under lower levels of risk; whereas high revenue ACOs, which tend to include institutional providers and are typically larger and better capitalized, would be required to move more quickly to higher levels of performance-based risk in the ENHANCED track, because they should be able to exert more influence, direction, and coordination over the full continuum of care.*[2]

The inclusion of a "low-revenue" model is CMS's recognition that ACO models and other value-based arrangements have low adoption rates in rural areas and small physician practices. We were surprised that CMS did not take a more targeted approach – offering incentives for rural providers within the proposed framework, including lower levels of MSR, higher rates for shared savings, or differentiated rules that invoke involuntary termination. That said, we do appreciate this affirmative attempt by CMS to include rural providers and beneficiaries rather than using a MIPS-like approach, which has been to exclude/excuse rural providers from participation. However, we do not believe that rural and small providers fit squarely within the low-revenue category. In fact, we believe this revenue-based distinction establishes a dichotomy that will lead to unintended and even contrary results for rural providers, small providers, and many ACOs with mixed FFS and cost-based revenue (including both urban and rural provider/suppliers).

To illustrate our point, we suggest that CMS examine healthcare delivery in some Midwest / Plains states (such as Iowa, Kansas, Nebraska, South Dakota, North Dakota). The penetration of Medicare ACOs and MA plans in these states is low to moderate and the population base is relatively small. To accelerate the adoption of value-based care in rural America, CMS must encourage regional care delivery (regardless of provider status as low- or high-revenue), structure reimbursement to recognize cost of care versus access to care (instead of cost-based reimbursement), and streamline regulations to enable providers and beneficiaries to compare ACO services and MA plans.

- Regional care delivery. Contrary to the definition of "low revenue", rural healthcare delivery cannot exist in isolation. The low- and high-revenue distinction does not portray ideal care in rural areas and its reliance on urban specialists and hospitals. In reality, most "rural" ACOs would be more accurately characterized as mixed-revenue – for example, Midwest providers do not practice in isolation, they have relationships with urban hospitals and specialists, and they are challenged with an eroding commercial payer base and tight operating margins. Many urban hospitals have relationships with rural providers and vice versa. Hospital-based ACOs are not homogenous and we believe that the ACOs composition should be considered when determine its eligibility glidepath. We would also refute generalizations that ACOs encourage consolidation and reduce competition and choice for Medicare FFS beneficiaries. This assertion fails to distinguish between provider ownership and collaborative arrangements and does not account for provider motivation. In UAC, approximately half of our providers are independent and choose to enter into an ACO contract to obtain support services that they cannot afford and to offer a

[2] Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success, CMS-1701-P, 83(160) Fed Reg 41786, at page 41788

collaborative platform to reduce fees for their beneficiaries. Other drivers of participation in the ACO include avoidance of MIPS reporting, the Advanced APM bonus and economies of scale (i.e. caseload size for risk bearing). We do not believe that a low-revenue distinction will result in an influx of participation by small and/or rural ACOs.

- Restructuring rural reimbursement to differentiate access from care. Cost-based reimbursement is the elephant in the room and is at odds with principles of value-based care. First, cost-based reimbursement has inverse incentives; namely, reduced utilization actually increases cost. For example, if we reduced the average daily census in a Critical Access Hospital (CAH) by half from 10 to 5, the cost will be readjusted against those five patients through the cost report and interim rate setting process. Basically what cost $100 in year one is now $200 in year two's rate, because fixed cost and core staffing expense remain static and there's virtually no opportunity to lower variable expense. Over time, CAHs always receive their costs. The same holds true for physicians in Rural Health Clinics (RHCs). They receive an All Inclusive Rate payment, which is capped in a RHC and unable to be flexed. Second, CAH cost reports include hospital services like depreciation and administrative costs, but do not include investments in community-based services. The ACO must incur these investments as "costs" against its benchmark. Third, ACO performance periods do not sync with CAH operations, which have a fiscal rate adjustment in July.

  Despite the proposed cap adjustments, we believe that more must be done. By separating the "cost of access" from the "cost of care," reimbursement incentives and high-value care could and should be aligned in rural areas. The "cost of care" concept is the equivalent of traditional medical care and could be reimbursed through Medicare Fee For Service rate schedules. Like all healthcare facilities, we believe that small/rural hospitals should be held accountable for reducing the cost of care while maintaining quality standards. A value-based payment program could be implemented for cost of care services with the potential to be rewarded through a shared savings or other quality program. "Cost of access" refers to services that maintain/improve access for beneficiaries in rural areas that are proven to lower the total cost of care. These items should be encouraged. Examples of access costs include care coordination teams, palliative care, telehealth, homecare, hospice, eVisits, and urgent care clinics. These cost items could be reimbursed using an incremental rate founded on cost-based reimbursement and proposed adjustments could be made via cost reports or similar mechanisms. As envisioned, an add-on earned for rural access could be applied to any value-based program. It would allow rural providers and facilities to participate in value-based programs for their "cost of care" component, while still receiving proportional cost-based reimbursement to promote "cost of access" infrastructure.
- Streamline ACO and MA regulations to promote comparisons. Despite efforts by this rule to condense and more narrowly define ACO tracks, the future of ACOs remains unclear. We believe there has been a missed opportunity to more clearly defined ACOs as a service delivery alternative and compare its advantages and disadvantages to traditional FFS and MA alternatives. In this rule as well as future rulemaking, we urge CMS to include discussion of how ACO and MA regulations can be similarly constructed and to be intentional about regulatory differences. This would not only streamline provider compliance but also enhance public perception and beneficiary understanding. For example, we would suggest that the Meaningful Measures initiative provide

guidance on how quality measures and reporting could be more similar, including the use of common definitions and the potential for Star ratings.

FEE-FOR-SERVICE BENEFIT ENHANCEMENTS

CMS is proposing to offer telehealth and 3-day SNF waivers to two-sided ACOs, regardless of the beneficiary attribution methodology. The telehealth waiver not only eliminates the geographic restriction for originating site but allows the originating site to include a beneficiary's home.

- ***Comment***: UAC has been on the frontlines of developing both benefit enhancements proposed by this rule. Our utilization of these waivers has historically exceeded their use by other Medicare ACO participants. We firmly believe that benefit enhancements are a powerful tool to enhance patient care and provider engagement and we fully support their use by risk-bearing ACOs. We agree with CMS that ACOs that bear financial risk have a heightened incentive to restrain wasteful spending and mitigates the likelihood of over-utilization of healthcare services. Benefit enhancements remove barriers to care and allow providers to determine the best means of delivering care and providing access to care for their patients. These tools are foundational for value-based care and we would suggest that as ACOs accept more risk, they should be afforded greater access to benefit enhancements. In future rulemaking, we would encourage CMS to consider additional benefit enhancements that would be available under the ENHANCED track.

  In terms the proposed 3-day waiver, we would raise issue with the CMS assumption related to how rural areas may "control unnecessary costs." As a reminder, UAC is located in Iowa and central Illinois, in largely rural geographies. While we concur that there are fewer SNFs located in rural areas, the current FFS payment differential between SNFs and CAH swing-bed services may assist with access to care but will not necessarily reduce costs. CAH swing-bed services are reimbursed at 101 percent of "reasonable cost", while SNF services are currently paid at predetermined daily rates under the SNF Prospective Payment System. The OIG found that CAH reimbursement equated to almost four times the SNF reimbursement.[3] We urge CMS to revisit how to incorporate and encourage cost-based services and facilities to transition to value.

PROVIDING TOOLS TO STRENGTHEN BENEFICIARY ENGAGEMENT

CMS is proposing that two-sided ACOs, regardless of the beneficiary attribution methodology, establish a beneficiary incentive program. The incentive payment would be paid to each assigned beneficiary for each qualifying service received. In addition, CMS is proposing to reinstate a beneficiary notification requirement and enable an opt-in based assignment methodology. This point of care notification would include information on voluntary alignment, ACO providers/suppliers participation in the Shared Savings Program and opting out of data sharing.

- ***Comment***: We support removing restrictions on two-sided ACOs that limit tools to promote beneficiary engagement and instituting practices to empower patients and caregivers with

[3] OIG, "Medicare Could Have Saved Billions at Critical Access Hospitals if Swing-Bed Services were Reimbursed Using the Skilled Nursing Facility Prospective Payment System Rates", March 2015, accessed at https://oig.hhs.gov/oas/reports/region5/51200046.pdf

information and incentives to inform high-value care decisions. This includes the ability to offer beneficiary incentive programs. Along with this support, we urge CMS to carefully monitor these programs to identify future opportunities to improve beneficiary engagement rates and enhance meaningful outcomes. Although this is a good start, we believe that the proposal should allow more targeted and tiered benefits to specific ACO populations or subpopulations. We would also call out that ACOs are proposed to fully fund the costs associated with operating a beneficiary incentive program, including the cost of any incentive payments. This funding assumes a stable and predictable payment mechanism, which has not been demonstrated under MSSP financial models, and may result in the availability of this incentive to fewer beneficiaries than anticipated.

CMS is proposing that ACOs must notify beneficiaries at the point of care about voluntary alignment, its participating in the MSSP and the opportunity to decline claims data sharing. This notice is to occur during a beneficiary's first primary care visit and is in addition to current posting requirements and the availability of written notices upon request. We request that CMS reconsider the notice means and timing as we believe any point of care notice at the physician offices is difficult to train and operationalize. In our experience, a point of care notice that is unrelated to the issue at hand creates room for error, becomes one of multiple point-of-care communications, and lends to beneficiary confusion, rather than clarity. Instead, we would recommend that CMS institute an annual beneficiary notification that includes an ACO response line. In addition, since MSSP retired a similar notice procedure in the past due in part to beneficiary confusion and provider burden, we would suggest that CMS use a different and more user-friendly format for this notice and perform an evaluation of this form and process during its initial rollout.

BENCHMARKING METHODOLOGY REFINEMENTS

CMS is proposing to revise the risk adjustment methodology for adjusting the historical benchmark as well as to use regional factors when establishing and resetting benchmarks. In particular, CMS is proposing to reduce the maximum weight used in calculating the regional adjustment from 70 percent to 50 percent and to cap the regional adjustment amount using a flat dollar amount equal to 5 percent of national Medicare FFS per capita expenditures. CMS will use the CMS–HCC prospective risk scores to adjust the historical benchmark for changes in severity and case mix for all assigned beneficiaries, subject to a symmetrical cap of positive or negative 3 percent for the agreement period. In calculating the regional trend and update factors, CMS will use a blend of regional and national growth rates based on Medicare FFS expenditures with increasing weight placed on the national component of the blend as the ACO's penetration in its regional service area increases.

- ***Comment***: Consistent with our past commentary, we believe that the benchmark methodology of shared savings is flawed, in that shared savings models will not produce long-term savings. The MSSP program is structured to give a bonus to high-cost providers who reduce spending, not reward cost-efficient providers who enter the program and keep costs down. An analysis of 2015 performance showed just how powerful the benchmark is: ACOs who generated savings not only had higher benchmarks, but also had higher per-capita spending than those ACOs who surpassed their

benchmarks.[4] Although CMS is trying to address this by altering the regional benchmarking blend, we are not convinced that this proposal goes far enough, particularly for beneficiaries in rural areas and environments with cost-based reimbursement. We would recommend that CMS engage rural stakeholders to further explore benchmark methodology that accurately reflects cost of care versus cost of access. If this divide can be bridged, ACOs will become a viable service delivery platform option for rural beneficiaries.

Also, we cannot overstate the importance of accurate risk coding and CMS should encourage and not penalize the accurate and detailed documentation of health status information. It should also be noted that accurate coding is a direct result of ongoing CMS initiatives and policies that have encouraged EHR use and standards across healthcare providers and settings. We support the ±3 percent symmetrical cap for ACOs in the BASIC track to encourage population health strategies beyond improved risk coding. For ACOs in the ENHANCED track, we would suggest that CMS consider a benchmarking methodology akin to that used in the MA program.

UPDATING PROGRAM POLICIES

CMS is proposing to revise the voluntary alignment process, the definition of primary care services for beneficiary assignment and the quality and interoperability measures. CMS is also soliciting input to better encourage ACOs to coordinate pharmacy care.

- ***Comment***: To conform policy with section 50331 of the Bipartisan Budget Act of 2018, CMS will assign a beneficiary to an ACO based upon their selection of any ACO professional, regardless of specialty, as their primary clinician. While we agree that beneficiary choice is a preferable assignment method to claims-based attribution, we are concerned that this voluntary alignment will remain for the duration of the entire agreement period and any subsequent agreement periods under the MSSP. At issue are proceduralists or episodic care specialists. For example, a beneficiary may voluntary align to an oncologist during a cancer episode, but no longer require care from that provider once the cancer is in remission. It would seem that CMS may want to consider an annual election process for beneficiaries to voluntarily align.

  UnityPoint Health has been supportive of the Meaningful Measures initiative and applauds CMS's efforts to streamline data collection and reporting. We provided specific comments on the current ACO measure set during the rulemaking process for the CY 2019 Physician Fee Schedule,[5] which included an overall reduction in the number of quality measures and a transition to outcome-based measures. We agree with the current proposal to replace ACO-11 (Use of Certified EHR Technology) with an attestation related to CEHRT use – Next Generation ACOs have used this attestation approach successfully. Additionally, we are pleased to learn that CMS is considering an opioid use measure. For the resulting measure, we encourage CMS to institute first as a reporting only measure before ramping up to a pay-for-performance measure to iron out any reporting inconsistencies and to allow

[4] Bielamowicz, L. ACOs Still Aren't Saving Money for Medicare. April 5, 2018. https://gisthealthcare.com/acos-still-arent-saving-money-medicare/

[5] UnityPoint Health comment letter for CY 2019 Physician Fee Schedule; See "PFS_2019_UPH_9-19-18" at Regulations.gov tracking number 1k2-95ck-wei9

ACOs to incorporate within our medication therapy management regimes or similar decision support tools.

As for the coordination of pharmacy care for ACO beneficiaries, we would request that CMS consider sharing Part D data for lives attributed to ENHANCED track ACOs and that Part D Plans be encouraged to work in collaboration with beneficiaries and ENHANCED track ACOs to address medication therapy management. Drug information would enhance an ACO'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 an ACO's ability to clinically manage this emergency. We believe this powerful data itself would serve as an incentive for providers to transition to advanced risk-bearing models in the ENHANCED track. Upon piloting Part D data access in the ENHANCED track, CMS could then choose to expand this data sharing to down-side risk ACOs in the BASIC track, Levels C, D and E.

We are pleased to provide comments to the proposed regulations and their impact on our patients and integrated healthcare system. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President, UPH Government and External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

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UnityPoint Accountable Care

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