October 3, 2016

Andrew Slavitt, Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-5519-P  
P.O. Box 8013  
Baltimore, MD 21244-1850

RE: CMS-5519-P - Medicare Program; Advancing Care Coordination through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR); Federal Register Vol. 81, No. 148, p. 50794 (August 2, 2016).

Submitted electronically via www.regulations.gov

Dear Mr. Slavitt:

UnityPoint Health (UPH) is pleased to provide input in response to the Centers for Medicare & Medicaid Services’ (CMS) proposed rule relating to episode payment models. 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, 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. Since 2014, two UHP senior affiliates, UnityPoint Health – Meriter and UnityPoint Health – Methodist | Proctor, have been participating in the CMMI Bundled Payments for Care Improvement Initiative Model 2.

As an integrated healthcare system, UPH believes that patient-centered care is best supported by a value-based payment structure that enables healthcare providers to focus on population health instead of volume-based episodic care. We appreciate the time and effort spent by CMS in developing these payment models. We respectfully offer the following comments to the proposed regulatory framework.

**CMMI AUTHORITY TO TEST INNOVATION**

Under the Affordable Care Act (ACA), CMMI was established to “test innovative payment and service
delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to” Fee-for-Service Medicare beneficiaries, Medicaid enrollees, or Medicare-Medicaid beneficiaries. (ACA, Section 1115A) On September 28, 2016, 179 U.S. Representatives signed a letter to CMS to challenge CMMI’s use of mandatory demonstrations with a request that the agency “cease all current and future planned mandatory initiatives under CMMI.” Cited as examples of this transgression were episodes of care contained within this proposal – the Comprehensive Care for Joint Replacement Model (CJR) and the “Cardiac Models” (CABG and AMI) within the Advancing Care Coordination through Episode Payment Models (EPMs).

While we do not completely agree with the timing and technical issues related to these bundles, we believe that the ACA granted CMMI definite authority to proceed with mandatory initiatives under its expansion of models authority. The ACA provision reads:

(c) Taking into account the evaluation under subsection (b)(4), the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested under subsection (b) or a demonstration project under section 1866C, to the extent determined appropriate by the Secretary, if—
(1) the Secretary determines that such expansion is expected to—
(A) reduce spending under applicable title without reducing the quality of care; or
(B) improve the quality of care and reduce spending; and
(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under applicable titles.

This provision allows CMMI to disseminate best practices, including nationwide implementation, of models that balance cost and quality concerns and have been certified by the CMS Chief Actuary. This provision was put in place to expedite rulemaking and implementation for promising and innovative ideas. As CMS works to implement the aggressive timeframe enacted by the bi-partisan MACRA legislation and offer options for provider reimbursement and enhanced service delivery, we need to demonstrate restraint when curbing authority intended to support healthcare innovation.

**GENERAL EPM PROVISIONS**

The major purpose of this proposed rule is to create and test three new episode payment models (EPMs). The proposed mandatory EPMs are acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and surgical hip/femur fracture treatment excluding lower extremity joint replacement (SHFFT). This proposal will test whether an EPM for AMI, CABG, and SHFFT episodes of care will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. The following comments relate to provisions that ride across the proposed EPMs.

**Mandatory MSA Participation:**
Except for low-volume MSAs, CMS will randomly select MSAs for participation in the proposed AMI and CABG EPMs ("cardiac bundles"). Participating regions will be identified in the Final Rule, which may not be published until either December 2016 or January 2017. The SHFFT EPM will be implemented in MSAs already participating in the CJR program. All proposed EPMs will start July 2017.

- **Comment:** While we applaud CMS for attempting to establish a common EPM framework, the short timeframe for implementation is less than desirable and is causing anxiety for our providers and our service delivery partners. We respectfully request that this program be delayed until at least January 2018 to allow for adequate preparation in the targeted yet diverse DRGs. In the future, we ask that CMS specifically identify participating service areas or MSAs in the proposed rules, instead of the final rule process. The failure to identify regions at this stage does not enable stakeholders to specifically address or question those selected regions as well as to obtain the targeted engagement and input of selected providers in the rulemaking process.

We are also generally concerned with the rapid-fire timing of new proposed EPMs and the diversity of the bundles being proposed. CJR, the first mandatory bundle, just started April 1, 2016, and the second year BCPI report has not been released. While only in its second quarter of operation, CMS is proposing changes to CJR to harmonize with EPMs. We question the expansion of bundles when rules are being revised so early in the process. Frequent revisions without first analyzing current projects erodes provider confidence in payment reform initiatives. With MACRA in the mix, we would have preferred CMS to have concentrated on revising the BCPI rules and further encourage voluntary bundles first. We are not convinced that the objectives of this initiative could not be accomplished through the next iteration of the BPCI or another voluntary opportunity.

**Program Overlap – Next Generation ACO Partial Exclusion:**

This Model provides guidance as to overlap with various Medicare payment reform models. In particular, Next Generation ACO beneficiaries are excluded from EPM attribution. Additionally, Next Generation ACOs are not included within the definition of EPM Collaborator and ACO is defined as MSSP ACOs.

- **Comment:** UPH operates an affiliated ACO, UnityPoint Health Partners (UPHP). UPHP is one of 18 Next Generation ACOs. We are disappointed and confused by the proposed partial exclusion and its implications.

  First, the exclusion of Next Generation beneficiaries assumes that Next Generation beneficiaries receive all care in network and do not travel. Although this exclusion is easier to understand when seeking in-network care, it becomes more difficult when the beneficiary is on a vacation and receiving out of network care. Out-of-network care may be more likely for these episodes which are more emergent and less elective than a knee replacement procedure. For instance, assume Mr. Smith goes to Washington (within an EPM MSA) and has an AMI-PCI episode. How will the Washington hospital know that they are a Next Generation beneficiary and to be excluded? Who is responsible should the Washington hospital evoke EPM waivers that were not authorized by the Next Generation ACO? Aside from reiterating that Next Generation beneficiaries are excluded, it is difficult to determine how this will work from a practical standpoint and we encourage CMS to investigate the ramifications of this provision with Next Generation ACOs prior to its enactment.

  Second, ACOs are defined as MSSP ACOs which exclude Next Generation ACOs by omission. In addition, the definition of EPM Collaborator specifically excludes Next Generation ACOs. This term is
used to identify eligible entities that may participate in financial arrangements with the EPM Participant or downstream agreements related to the EPM episode. This means that Next Generation ACOs cannot take part in financial arrangements for EPM episodes. There is not a similar preclusion for Track II or Track III MSSP ACOs. Effectively, this forecloses the Next Generation ACO from acting on behalf of its providers to enter into financial arrangements with EPM Participants (Anchor Hospitals) for beneficiaries outside the Next Generation ACO. In our case, UHP represents providers across the care continuum, including home health agencies and independent providers. While these providers are not excluded from the EPM episodes, their ACO is excluded, which collectively represents them in network contracting. Without the ACO, these providers must act as independent agents in EPM participation.

We request a complete exemption for Next Generation ACO Participants. These Anchor Hospitals and their providers and suppliers are already performing the work required of the bundle and the dual administration would be difficult. We also believe that this exemption would create an incentive for providers to join Next Generation ACOs and participate in population health on a larger scale.

**Episode Initiator:**
Hospitals are proposed as the episode initiator and the bearer of the financial risk for these episodes of care. The selection of hospitals to be financially responsible is premised on CMS’ belief that hospitals are more likely to have resources to appropriately coordinate and manage care throughout the episode, and that key model attributes are currently performed by hospital staff, such as discharge planning and post-acute care recommendations for recovery, key dimensions of high quality and efficient care for the episode.

- **Comment:** For the proposed EPMs, UPH agrees that the episode initiator should be the hospital instead of physician group practices. This is consistent with the episode being triggered by admission to an acute care hospital stay.

  In terms of financial responsibility, we urge CMS to develop a set framework to guide decisions in this area. We understand a preference to have one entity financially responsible for project performance. While hospitals are a common thread in the proposed episodes, selected hospitals are not voluntarily participating in the proposed EPMs nor do anchor hospitals possess similar infrastructure or capacity to bear risk. During the care episode, ideal care and successful care coordination involve multiple providers across the care continuum and hospitals for the most part have the greatest percentage of sunk costs. As CMS contemplates additional bundles, we request CMS to review the appropriateness of a hospital-centric focus - “we believe hospitals would have significant opportunity to redesign care and improve quality of care furnished during the applicable episode” (page 50799) – for episodes spanning inpatient and outpatient settings.

**Episode Definition:**
The EPMs cover a “90-day post-discharge” episode. These episodes begin with admission to an acute care hospital for an identified MS–DRG and end 90 days after the date of discharge from the hospital. The 90-day post-discharge episode would include the procedure or clinical condition, accompanying inpatient stay, and other Medicare Part A or Part B services, include hospitalizations, post-acute care and provider services.
• **Comment:** We agree that a 90-day period is appropriate, although most costs are incurred during the first 30 days. As CMS contemplates additional bundles, we urge CMS to analyze this timeframe and develop a set framework to guide decisions in this area. While we generally agree with the list of EPM “included services,” we urge the removal of both inpatient psychiatric facility (IPF) services and hospice services as not being related to or resulting from the EPM procedure or clinical condition. The exclusion of both services would be consistent with their treatment under the BPCI model.

**Performance Years, Retrospective Episode Payment and Two-Sided Risk Model:**
The EPMs are proposed to begin July 1, 2017, for a five-year period. Under this proposal, all providers and suppliers caring for Medicare beneficiaries in EPM episodes would continue to bill and be paid as usual under the applicable Medicare payment system. After the completion of an EPM performance year, the potential for hospitals to receive reconciliation payments or to be responsible for repayment is calculated retrospectively. CMS proposes to establish a two-sided risk model for hospitals with responsibility for repayment of excess episode spending to begin in the second quarter of performance year 2.

• **Comment:** UPH supports the application of retrospective episode payment methodology. While CMS proposes to begin downside risk repayment during performance year 2, we respectfully request to delay this repayment obligation for excess episode spending until performance year 3. To conform to MACRA, we would suggest that downside risk not be implemented for partial years, but rather full performance years.

**Episode Benchmarks and Price Setting Methodology:**
CMS proposes to calculate and communicate episode target prices to each EPM Participant prior to the performance period. Features of the price setting methodology incorporate 3-year historic payment data sets, benchmark trending, transition of hospital-specific to regional pricing, and a discount factor. The proposal is silent regarding any hospital case-mix risk adjustments to reflect disparities in beneficiaries’ medical complexity. Similarly, this case-mix adjustment is also omitted in the CJR.

• **Comment:** The importance of providing defined targets prior the performance period cannot be understated and UPH supports this approach. Without preset targets, it is difficult to plan and forecast financial outcomes. Likewise, we support the use of national targets and trending of historical data to set and update the target price. This feature promotes and recognizes high quality service delivery and seeks to eliminate regional variation. To further promote and recognize quality, we generally support pricing that uses larger data sets. As presently proposed, pricing transitions from a blend of primarily provider-specific pricing to completely regional pricing. This transitional methodology may motivate poor performers during the startup; however, good performers with efficient process and decreased spending have much less wiggle room for improvement. To incentivize high-value programming, we request that CMS provide an option to EPM Participants to permit them to immediately jump to either national or regional pricing instead of hospital-specific pricing.

We are alarmed that CMS again omitted the use of Hierarchical Condition Category (CMS-HCC) risk scores to capture a beneficiary’s medical complexity and acuity. In a recent Health Affairs article, researchers calculated the net difference in CJR reconciliation payments with and without risk adjustment using data from 2011-2013 and reported that reconciliation payments were reduced by $827 per episode for each standard-deviation increase in a hospital’s patient complexity. (Ellimoottil,
et al, Health Affairs, 2016) We urge CMS to include risk adjustment methodology to correct this issue. In the absence of this correction, this project runs the risk of having providers cherry picking beneficiaries.

Quality Measures:
In this Model, quality performance standards are tied to the ability to earn a reconciliation payment if actual episode spending is less than the target price. Each proposed EPM specifies between 2 and 4 quality measures.

- **Comment:** The HCAHPS Survey (NQF #0166) is common to all proposed EPMs. We question the use of this patient experience measure as it applies to a sample of all adult hospital inpatient admits and is not restricted to the service lines or MS-DRGs targeted by the proposed EPMs. This measure does not reflect quality for targeted episodes of care and we are skeptical that these measures will meet quality requirements for Advanced APMs.

  For the SHFFT model, CMS recognizes that none of the proposed measures specifically target the care of SHFFT model beneficiaries. Aside from the HCAHPS measure, this also includes the Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550) (Hip/Knee Complications); and Voluntary Total Hip Arthroplasty (THA) / Total Knee Arthroplasty (TKA) Patient-Reported Outcome (PRO) and Limited Risk Variable data submission (Patient-reported outcomes and limited risk variable data following elective primary THA/TKA). Again we are believe this does not adequately tie quality to performance and are skeptical that these measures will enable the SHFFT model to meet quality requirements to qualify as an Advanced APM.

  In the AMI EPM, an “Excess Days in Acute Care after Hospitalization for AMI” is proposed. Under the CMS Quality Measure Development Plan, measures must either be endorsed by a consensus-based entity such as NQF or they must undergo a rigorous evidence-based review. While the AMI Excess Day measure is non-endorsed by a consensus-based entity, the proposed rule indicates that its adoption in the Hospital Inpatient Quality Reporting Program qualifies as an “existing quality measure”. We question whether this quality program is in fact included within this definition and it is unclear what evidence-based review has occurred.

Limit or Adjust Hospital Financial Responsibility:
To limit a hospital’s overall repayment responsibility for the raw NPRA contribution to the repayment amount, CJR includes a 10% stop-loss limit in performance year 3 and a 20% limit in performance years 4 and 5.

- **Comment:** We would request that the stop-loss limit be set at 10% of all performance years and, should risk-bearing be expanded to all episode providers, that the stop-loss limit be applied to all entities bearing risk.

Financial Arrangements:
The proposed EPMs use a retrospective episode payment model. Medicare FFS payments for services included in an episode of care would continue to be made to all providers and suppliers under the existing payment systems, and episode payment would be based on later reconciliation of episode actual spending
under those Medicare payment systems to the episode target price. Further EPM Participants (Anchor Hospitals) can enter into complimentary financial arrangements with providers and suppliers caring for beneficiaries in EPM episodes. EPM Participants may offer targeted beneficiary incentives similar to other CMS programs. The proposed EPMs must comply with fraud and abuse laws.

- **Comment:** We support the ability to provide beneficiary incentives tied to quality, but believe these will be underutilized until bundled payment quality and financial targets are clear and providers become more experienced with this environment and their capacity to meet outcomes. We also encourage CMS to consider the waiver of any coinsurance and/or deductibles related to relevant follow-up care across providers and settings during the bundled episode of care.

In terms of the need for fraud and abuse waivers, we urge CMS and OIG to specifically address the application of waivers to the proposed EPMs. Since the enactment of the physician self-referral law in 1989 and the original enactment of the Anti-Kickback statute in 1972, the delivery of health care services and the payment for those services – among all payers, both government and private - has changed dramatically. By intent and design, Stark physician self-referral law (“Stark”) separates entities that are furnishing designated health services from physicians who are providing care to Medicare beneficiaries. Advanced APMs face the challenge of trying to achieve system-wide clinical and financial integration to lower costs and improve health access and outcomes, while simultaneously complying with Stark, Anti-Kickback, and other laws and regulations that create care silos. There are many activities and relationships that are necessary to achieve successful clinical and financial integration that remain prohibited outside of specific payment models. Healthcare providers need flexibility, in the context of appropriate fraud and abuse safeguards, to collaborate and manage care in ways that would otherwise be prohibited – exactly the policy intent of MACRA.

While the ACA legislated a pathway for regulatory waivers to be developed and applied to its risk-based models, no such legislative language was included in MACRA. Strictly construed, MSSP waivers are only applicable to MSSP healthcare providers. In addition, MSSP waivers do not expressly apply to commercial business or Medicaid programs and have not been established in a manner that provides adequate assurance that the waivers will continue. This lack of clarity has limited their efficacy as providers do not have the assurance needed to venture into innovative payment models, take financial risk or invest in alternative delivery methods. This state of uncertainty is being exacerbated as MACRA and CMS value-based payment goals encourage the development of new risk-based payment models.

One specific approach to accommodate innovative payment models is the creation of a new exception to the compensation arrangement provisions of the Stark Law. This waiver would allow risk-bearing models to experiment with innovative non-fee-for-service payment methodologies that will encourage coordination of care, elimination of unnecessary and duplicative services, enhance patient satisfaction and preserve healthcare quality indicators. This exception would expressly apply to all qualifying lines of business and payment arrangements, as healthcare providers do not use separate care processes for different patient populations or payment plans. The proposed waiver includes:

- Amending the §1877(e) compensation arrangements exception to add a new provision for innovative payment methodologies that promote and advance accountability for quality, cost/risk, care coordination, patient experience and outcomes.
Meeting pre-existing Stark and anti-kickback statutes for ACO and other risk sharing arrangements, which safeguards include written agreements, transparency, and provider accountability, as well as prohibitions on double billing or shifting costs to federal healthcare payers.

Under current interpretations, Stark arguably prohibits even commercial payers from entering into innovative arrangements with hospitals and physicians to promote quality, care coordination and cost reduction. This new exception would be instrumental in helping physicians, hospitals and other healthcare providers participating in the risk-bearing models to succeed under MACRA.

**Waivers of Medicare Program Rules:**
The EPM models contain waivers to support provider and supplier efforts to increase quality and decrease episode spending. The proposed waivers are post-discharge home visits, billing and payment for telehealth services, SNF 3-day rule, and waivers of Medicare program rules to allow reconciliation payment or recoupment actions. These waivers are similar to other CMS program waivers. For the CR Incentive Payment Model, a new waiver is proposed to allow proposed CR services to be supplied to EPM beneficiaries during an AMI or CABG episode.

- **Comment:** UPH enthusiastically supports these programmatic waivers as tested by CMMI ACOs (Next Generation ACOs and Pioneer Model ACOs) and disseminated to other CMS programs. These waivers not only reduce costs but have been key in enhancing beneficiary satisfaction.

**Data Sharing:**
CMS proposes to share upon request both raw claims-level data and claims summary data with EPM Participants. Specifically, beneficiary-level claims data will be provided for the historical 3-year period used to calculate the episode benchmark and quality-adjusted target prices and, upon request, ongoing quarterly beneficiary-identifiable claims data will be provided. For enable the review of regional pricing, CMS proposes to provide aggregate regional data.

- **Comment:** Instead of relying on EPM Participant requests for ongoing data sharing, UPH requests that CMS provide all data automatically to EMP Participants. Based on our BPCI Model experience, claims data has been utilized to monitor trends and pinpoint areas where care practice improvement are appropriate as well as to assess the cost drivers during the acute and post-acute periods of the episode.

**PROPOSED EPMs - AMI and CABG MODELS**
The 90-day cardiac episodes covered for the AMI Model are AMI MS-DRGs (280-282) and those Percutaneous Coronary Intervention (PCI) MS-DRGs (246-251) representing Inpatient Prospective Payment System admissions for AMI that are treated with PCIs; and for the CABG Model are CABG MS-DRGs (231-236). These five-year bundled payment pilots will be mandated in 98 randomly selected metropolitan statistical areas (“MSAs”) to be announced in the Final Rule publication. Eligible MSAs include the UPH geographic regions of Cedar Rapids (IA), Des Moines (IA), Madison (WI), Peoria (IL), Quad Cities (IA/IL), Sioux City (IA) and Waterloo (IA).

- **Comment:** The uncertainty surrounding the participating MSAs and speed to implementation
upon publication of the Final Rule are causing anxiety for our providers. In addition, the episodes of care chosen for the “Cardiac Bundle” represent very diverse treatment paths – medical management and surgical interventions. Post-Acute Care and Outpatient services typically represent less than one-fifth of total cost of care for Cardiac Bundles compared to nearly one-half in SHFFT episodes. This diversity makes standardized workflows more difficult and opportunities for savings less.

An additional complexity derives from UPHP’s participation in the Next Generation ACO. Next Generation beneficiaries are excluded and Next Generation ACOs cannot be EPM Collaborators to share risk or gain; however, the Next Generation exclusions do not impact Next Generation provider or suppliers for services provided in the EPM to non-Next Generation Beneficiaries. This will require knowledge and tracking within two separate reporting systems, which is an unfortunate burden to place of early adopters/innovators as represented by providers within the Next Generation ACO.

**PROPOSED EPMs - SURGICAL HIP/FEMUR FRACTURE TREATMENT (“SHFFT”) MODEL**

The five-year SHFFT model includes 90-day episodes (MS-DRGs 480–482) and would be mandated in the 67 MSAs that were selected for the CJR model, which is a mandatory bundle for lower extremity joint replacement (MS-DRGs 469 and 470). Meriter-UnityPoint Health, located in South Central Wisconsin, is the only UPH senior affiliate located in a CJR MSA but was exempted from the CJR model due to Meriter’s participation in the BPCI Initiative Model 2 for lower joint replacements.

- **Comment:** As stated earlier, we have a basic concern related to the eligibility of the quality measures to qualify for Advanced APM status. Unlike the knee replacement bundles which are primarily elective, the SHFFT represent more emergent care with patients whose health status is more complex. Within our sole CJR-eligible MSA region, Meriter-UnityPoint Health participates in the BPCI for MS-DRGs 469 and 470. Under the proposal, Meriter would be tapped for the SHFFT model, for which they do not participate in the BPCI. This will create a 6-month timeframe in which Meriter will operate under both the BPCI and the SHFFT. For this reason, we ask that CMS carefully consider the interplay between voluntary and mandatory bundles in the future.

Again, an additional complexity derives from UPHP’s participation in the Next Generation ACO. Next Generation beneficiaries are excluded and Next Generation ACOs cannot be EPM Collaborators to share risk or gain; however, the Next Generation exclusions do not impact Next Generation provider or suppliers for services provided in the EPM to non-Next Generation Beneficiaries. This will require knowledge and tracking within two separate reporting systems, which is an unfortunate burden to place of early adopters/innovators as represented by providers within the Next Generation ACO.

**CARDIAC REHABILITATION (CR) INCENTIVE PAYMENT MODEL**

This proposed model is a financial incentive to hospitals based on the utilization of CR services by beneficiaries hospitalized for a heart attack or bypass surgery. This five-year incentive payment model would be offered to hospitals in 90 MSAs to be announced in the Final Rule publication. Of the 90 MSAs, half would be from selected mandatory Cardiac Bundles and the remainder would be from those areas
outside the mandatory cardiac EPM MSAs. This two-tiered retrospective payment model would pay (1) $25 per CR service for each of the first 11 services paid by Medicare during the episode and (2) $175 per service paid by Medicare during the episode after the first 11 services.

- **Comment**: We are generally supportive of this model. Consistent with our comments throughout, we request that CMS waive copayments for these services. Also, because it is likely that we may have more than one MSA participating in the Cardiac Bundles, we would request that all MSAs selected for these bundles be able to access this incentive. This will promote consistent workflows within our organization and also provide consistent messaging to eligible beneficiaries.

**FUTURE MEDICARE EPMs**

**Refinements to the Voluntary BPCI Model in 2018**

The purpose is to enable providers to potentially meet criteria for Advanced APMs under MACRA. Critically, these models will require use of CEHRT and tie payment to quality performance. After the final BPCI performance year in 2018, current BPCI Model 2 participants with EPM bundles within EPM MSAs will transition to the proposed EPM models.

- **Comment**: We encourage CMS to release these proposed rules as soon as possible in 2018 so that existing participants can provide input and adequately prepare for implementation. While we assume that CMS will reopen this voluntary initiative to allow others providers to participate and to perhaps include other DRGs, we believe that this should be recurring opportunity to accommodate increasing interest in Advanced APMs over time. We also suggest that CMS consider bundle variations beyond setting (current Models 1-4). Such variation may offer providers choice related to alternative episode timeframes, benchmark and trending standards, and different risk corridors.

We appreciate the opportunity to provide comments to the proposed rule. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President and Government Relations Officer, Government & External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

Sabra Rosener
VP, Government & External Affairs