UnityPoint Health

Government & External Affairs
1776 West Lakes Parkway, Suite 400
West Des Moines, IA 50266
www.unitypoint.org

September 16, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–5527–P
P.O. Box 8013
Baltimore, MD 21244–1850

RE: CMS–5527–P – Medicare Program; Specialty Care Models To Improve Quality of Care and Reduce Expenditures; published in Vol. 84, No. 138 Federal Register 34478-34595 on July 19, 2019.

Submitted electronically via www.regulations.gov

Dear Administrator Verma:

UnityPoint Health ("UPH") appreciates the opportunity to provide comments in response to the Centers for Medicare & Medicaid Services' (CMS) proposed rule to establish two mandatory specialty care models. Through more than 32,000 employees, our relationships with more than 310 physician clinics, 39 hospitals in metropolitan and rural communities and 19 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, western 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.

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. UPH's commitment to population health and value-based care is evidenced by our status as an early adopter of an Accountable Care Organization (ACO) framework. UnityPoint Health 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 as well as providers from the Pioneer ACO Model. UPH also has had regional participation in other Centers for Medicare and Medicaid Innovation (CMMI) Medicare models, including the Bundled Payments for Care Improvement (BPCI) Initiative and the Medicare Care Choices Model. Our home health agency, UnityPoint at Home, is licensed and practices in the one of the nine states that is mandatorily participating in the Innovation Center's Home Health Value-Based Purchasing Model (HHVBP).

UnityPoint Health respectfully offers the following comments to the proposed regulatory framework.

GENERAL PROVISIONS

CMS is proposing that both new mandatory models be subject to certain beneficiary protections and common requirements, including provisions related to model evaluation, audits and record retention, monitoring and compliance, remedial action, limitations on review and rights in data and intellectual property.

Comment:

Mandatory Models: **UPH agrees that the CMMI has the authority to proceed with mandatory initiatives under its Expansion of Models authority**.[1] We appreciate CMS's efforts to move from volume to value and recognize the importance of agency discretion to facilitate change. While we do not always agree with the timing and technical issues of CMMI models, we believe that the discretion to make models mandatory is necessary in order to disseminate best practices, including nationwide implementation, of models that balance cost and quality concerns and to instill timely flexibility and adjustments within an otherwise rigid payment construct. Additionally, we urge CMS to continue the formal rule-making process for the release of mandatory models, so that stakeholders can participate in the development of model parameters.

Selected Geographic Regions: In this proposed rule, CMS indicates that each model will use a random sampling methodology to select model participants. The actual geographic regions subject to these models have not been identified in this proposed rule. In the past, CMS has rationalized, in part, the nondisclosure of regions during this rule-making phase as necessary to assure that CMS receives stakeholder input from the entire nation, instead of just those selected regions. We understand this rationale; however, this timing disadvantages providers, in that mandatory models often have aggressive implementation timeframes and when geographic regions are "revealed" in the final rule, there is often less than 90 days until go live. This is the case with both proposed Specialty Care Models, which are set for implementation on January 1, 2020. **We would request that CMS always allow at least a 90-day period prior to implementation, and perhaps more time dependent upon the model, to facilitate operational success and beneficiary satisfaction**. These initiatives require additional beneficiary notice, workflow revisions and, in many cases, external support to incorporate infrastructure / software changes. Until a final rule is released, it is not practical or efficient for providers to prepare to operationalize these models.

Overlap Treatment: With the increasing speed at which new APMs are released, **we continue to be concerned that the lack of a strict overlap structure undermines the financial integrity of early adopters in high-risk Advanced APM models**. In the absence of an established overlap framework that incorporates both CMS and CMMI value-based programming, CMS is effectively creating a disincentive for providers to voluntarily bear heightened risk for a total population. Now as CMS is encouraging providers to enter into Direct Contracting models, providers are not equipped with enough information to evaluate the potential effect of specialty and other episodic models on global payments and total cost of care. When provider organizations commit to bear risk for the health care

[1] 42 USC 1315A(c)

of populations, there is a finite opportunity for those organizations to reduce costs while maintaining access and quality. For instance, when an ACO is in a market, new episodic models and their providers have been permitted to piggy back off ACO infrastructure investments, are not required to provide notice of attribution among programs nor inter-program care coordination, and impose narrow 60- or 90-day treatment timeframes that are misaligned to holistic care. Without an overall framework, at-risk providers must review each model to determine impact on population health strategies and financial opportunities and many times, as with these Specialty Care Models, the rules are unclear.

To address this entanglement, **we encourage a hierarchical approach to CMS / CMMI model overlap**, in which precedence is given to population health risk-bearing entities. **We would suggest that CMS use the existing payment model classification framework refined by the Health Care Payment Learning & Action Network (LAN) as a basis for its overlap policy**. Within this framework for payment models, CMS should offer a hierarchy of the various delivery models. For example, if a bundled payment were being proposed in a geographic area in which there is a prevalent ACO, the ACO should drive patient attribution and performance goals to incorporate specialty care within the patient's care plan. As for reimbursement, these payments would be included within the ACO financial framework and, for ACOs under a capitated model, the ACO could convert the bundles into sub-capitation arrangements. Such approach would prioritize holistic patient care, engage specialists, leverage ACO infrastructure investments, and provide model certainty for ACOs and high performing networks as they consider and participate in innovative payment approaches.

When developing an overlap framework, we offer the following suggestions:

- **Risk-bearing population health models should take precedence over episodic care models for attribution and financial modeling**. Population health models with prospective attribution are particularly disadvantaged when population health programming, care coordination efforts, and financial modeling are undercut through the "partial" transfer of beneficiaries for episodic care. Instead, contracting with episodic care providers should be at the discretion of the population health model participant (such as an ACO) to allow the ACO service delivery flexibility.
- **Population health models should take precedence over Fee-For-Service models for attribution and financial modeling**. This appropriately incentivizes transition to value and risk-bearing. Fee-For-Service models still ultimately reward service volume and may inappropriately incent hospitalizations or high-cost placements. The population health model participant should not be allowed to manage care for their population with minimal carve-outs, particularly carve-outs for Fee-For-Service models.
- **Risk-bearing population health model participants should be allowed to opt out of participation in mandatory model demonstrations**. CMS should reward providers that voluntarily choose to accept risk. By granting population health models participants the discretion to opt out, these model participants can innovate based on the needs and priorities of their beneficiaries and control the flow of funds within their service delivery model.
- **CMS should develop a mandatory decision support tool that encompasses all payment reform models to assign attribution and financial modeling**. We urge CMS to develop a tool to clarify the pecking order for beneficiary attribution and financial implications (i.e. order in which models receives payment). We would also suggest that, upon the release of each new model,

CMS and/or CMMI incorporate each model into the decision support tool.

RADIATION ONCOLOGY (RO) MODEL

The mandatory RO Model would test prospective site-neutral, episode-based payments for specified professional and technical radiotherapy (RT) services furnished during a 90-day episode to Medicare fee-for-service (FFS) beneficiaries diagnosed with certain cancer types. Specific to the RO Model, the model is proposed for five performance years starting either January 1, 2020 or April 1, 2020. Proposed participants include Hospital Outpatient Provider Departments (HOPDs), physician group participants and freestanding radiation therapy centers. The proposed pricing methodology includes withholds related to incomplete episodes, quality, and beneficiary experience. This model is intended to meet qualifications for an Advanced APM and would require four quality measures and collection of a CAHPS survey.

Comment: Without regard to overlap magnitude (both beneficiaries and provider/suppliers), the RO Model in principle and reality overlaps populations attributed to, and participating in, global models. **As a Next Generation ACO Participant, our ACO is impacted as this not only affects financial modeling and benchmarks, but it impacts our strategy in establishing an ACO provider network and our overall population health care strategy**. For providers subject to this overlap, this implicates additional quality reporting and payment parameters outside those under the Next Generation ACO. We would recommend that CMS develop an overlap framework as suggested in our *Overlap Treatment* narrative.

In general, this is a site-neutral payment model associated with specific quality measures. The concept of site neutrality is an attempt to "fix" inequities in the Fee-For-Service payment structure. Consistent with prior input to CMS, **UPH has general concerns related to how this concept fits with access to care and within the constructs of two-sided risk models**.

In general, we question CMS's role in site of service delivery decisions for organizations engaged in two-sided risk models. While the intent of site neutral policies is to allow healthcare decisions to focus on delivery instead of payment, we do not believe that this can be effectively accomplished under Fee-For-Service parameters. Site neutrality is based on the assumption that this payment structure will curb excess use; however, access to care in the Midwest and in rural areas is primarily driven by geography and efficiencies and not cost. We would recommend that CMS encourage value-based programs and allow providers through shared decision-making with their patients to determine appropriate and convenient delivery options.

We also believe that there are unintended consequences to "resetting the table" in this fashion. Namely, this approach fails to recognize that independent (free-standing) and for-profit entities will strategize to cherry pick certain lower-acuity patients to increase their operating margins and erode already fragile provider-based department operating margins for Midwest providers. Without developing a holistic payment approach that takes into consider all payments, fee schedules will continue to drive healthcare builds and infrastructure. We wholeheartedly urge CMS to focus on population health objectives and the path to value within this and all Medicare payment regulations and to promote regulatory and payment flexibility for providers who engage in financial risk.

ESRD TREATMENT CHOICES (ETC) MODEL

The mandatory ETC Model would test the effectiveness of adjusting certain Medicare payments to ESRD facilities and Managing Clinicians to encourage greater utilization of home dialysis and kidney transplantation. In particular, the model proposes to adjust payments for home dialysis claims with claim-through dates from January 1, 2020, through December 31, 2022 through a Home Dialysis Payment Adjustment (HDPA), and to assess the rates of home dialysis and kidney transplant among beneficiaries attributed to ETC Participants during the period beginning January 1, 2020, and ending June 30, 2025, with a Performance Payment Adjustment (PPA) based on those rates applying to claims for dialysis and dialysis-related services with claim-through dates beginning January 1, 2021, and ending June 30, 2026. This model does not qualify as an Advanced APM and requires two quality measures - the Standardized Mortality Ratio and the Standardized Hospitalization Ratio.

Comment: Generally, **UPH is supportive of movement to home dialysis, methodology that supports peritoneal dialysis and involves a more graduated approach to hemodialysis, accelerated pathways to kidney transplantation and an overall emphasis on patients making informed choices, rather than decisions based on provider convenience**. While we are pleased that CMS recognizes that this model needs to be tested in rural areas, we would encourage CMS to assure payment equity for treating rural patients that takes into account geographic distance from dialysis facilities.

For our attributed Next Generation ACO beneficiaries, less than 1% have an ESRD diagnosis and these beneficiaries are highly concentrated but dispersed around 10 cities with dialysis facilities. For our ACO, the relative overlap potential (both beneficiaries and provider/suppliers) between models will be small. **While we anticipate that our Next Generation ACO will benefit from reduced costs under the ETC Model, we are still concerned with the lack of details in the proposed rule related to overlap treatment**, including additional work effort or reporting that this may entail. Although the ETC Model does not include quality measures for clinicians at this point, if providers are included within a total cost of care Advanced APM, we would encourage CMS to consider exempting them from ETC Model reporting. We would reiterate our recommendation that CMS develop an overlap framework as suggested in our *Overlap Treatment* narrative.

We are pleased to provide comments to the proposed regulations and their impact on our integrated healthcare system. 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 and External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

Sabra Rosener, JD
VP, Government & External Affairs
UnityPoint Health