



UnityPoint Health

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October 28, 2016

Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: Request for Information on State Innovation Model Concepts

Submitted electronically via SIM.RFI@cms.hhs.gov

Dear Mr. Slavitt:

UnityPoint Health (UPH) is pleased to provide input in response to the Centers for Medicare & Medicaid Services' (CMS) request for information on the State Innovation Model. 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. Through our affiliated ACO, UPH has partnered with CMS from the inception of Medicare ACO programming. Trinity Pioneer ACO, representing a rural eight-county service area in central northwest Iowa, started in the CMMI Pioneer Model ACO program in 2012. The Trinity Pioneer ACO achieved two years of savings through program innovation and coordination. In July 2012, UnityPoint Health Partners, representing the majority of our remaining service area regions, began its participation in the MSSP ACO model. Since January 2016, we combined our Medicare ACO efforts under UnityPoint Health Partners to participate in the first cohort of the Next Generation ACO (NGACO). Our NGACO providers care for more than 73,000 NGACO beneficiaries, and we are the largest ACO in the NGACO program.

As an integrated healthcare system and a NGACO, 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 this effort by CMS to seek stakeholder input in how to best develop the SIM in support of multipayer payment models. We respectfully offer the following provider perspective.

[MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS](#)

UPH highly supports multi-payer strategies in which **states align with existing Medicare models**, instead of encouraging state-specific new payer models. As a large integrated health system with providers and facilities in three states, this national approach promotes alignment of healthcare delivery priorities, common minimum quality standards, and regulatory consistency. For providers serving in communities on state borders, this larger focus will assist them to concentrate on patient care holistically rather than meeting multiple and competing state-driven healthcare goals related to value-based arrangements.

Value-Based Payment Models

As the largest NGACO within the first cohort, UPH would be thrilled to have the opportunity to engage in multipayer initiatives that support present Advanced APM models and encourage sustainable delivery and payment reforms. We advocate for a Value Based Payment (VBP) system that is designed in a manner that aligns with the structure and goals of CMS on VBP and enhances the ability of providers to meet the requirements of the MACRA payment terms. We encourage greater input by providers in the SIM. Our concern lies with embedding too much flexibility in SIM to States and their commercial health plan partners, which effectively establish through regulation siloed standards of care delivery. We recommend that CMS establish basic constructs for SIM grantees that encourage holistic care and streamlined regulations and incent participation by providers in risk-based VBP programs. UPH recommends that the SIM be reconfigured to include the following:

1. Different Types of VBP Options

While providers assuming risk is a fundamental part of VBP, providers are at different levels of maturity in regard to capabilities and networks. SIM grantees, including Managed Care Organization (MCO) subcontractors, and VBP contractors (i.e. providers) should be able to select different levels of defined VBP arrangements. Types of VBP arrangements supported by SIM funds should include, at a minimum:

(a) Total cost of care for the general population

In this model, the State Medicaid agency (or its MCOs) enters into a VBP arrangement with the Provider (ACO or Group) which considers total PMPM (per member per month) expenditure for the total attributed population (Global Capitation), and overall outcomes of care (potentially avoidable ED visits, hospital admissions, and the underlying VBP quality metrics). There are significant opportunities to reduce costs and improve quality by expanding total cost of care contracting. This model would be a good avenue for many providers to meet MACRA risk-bearing requirements.

(b) Bundles of care

In this model, the State Medicaid agency (or its MCOs) contracts for specific, patient-focused bundles of care (such as maternity care episodes or stroke). Here, the cost of a patient's office visits, tests, treatments and hospitalizations associated with a specific illness, medical event, or condition are all rolled or "bundled" into a single, episode-based total cost for the episode. Because variations in utilization and potentially avoidable complications are linked to the specific episodes, this model has shown much promise in stimulating patient-focused, integrated care delivery teams to substantially increase the value of care delivered from a wide range of conditions. This model is a good avenue for specialists to become engaged in Medicaid VBP

contracting and can assist physicians in qualifying for bonus payments under MACRA, if designed in alignment with Medicare.

(c) Total care for special needs subpopulations

For some specific subpopulations, severe co-morbidity or disability may require highly specific and costly care needs, so that the majority (or even all) of the care costs are included in the full-year-of-care bundles.

2. Differing Levels of Risk Providers Could Assume to Qualify as a VBP

Providers are at different places in regard to the amount of financial risk they are ready or able to take in regard to the Medicaid population. To be an Advanced APM, CMS requires nominal risk-bearing arrangements, which are not reflected in our current SIM supported contracts. Therefore, the SIM should accommodate differing levels of risk that include, at minimum, the following:

(a) Level 0 FFS with bonus

FFS with bonus and/or withhold based on quality scores is not considered to be a sufficient move away from traditional fee-for-service incentives to be counted as value based payment. Such payment does not align with Medicare's risk bearing requirements. Some States continue to reimburse preventative services on a FFS basis because it is positive to incent volume in such areas.

(b) Level 1 FFS with upside-only

Under this model, shared savings are achieved when quality outcome scores are sufficient. This Level consists of 'upside only' shared savings arrangements. Here, the capitation and bundled payments exist only virtually. When the accrued fee-for-service payments for the integrated care service are lower than the virtual PMPM capitation or bundle budget, the MCO can share the savings with the parties in the contract ('retrospective reconciliation'). Potential provider losses are not shared and providers are not 'at risk'.

(c) Level 2 FFS with risk sharing, upside and downside risk

Under this model, shared savings are available when total cost of care is under the benchmark and quality outcome scores are sufficient and downside risk is reduced when total cost of care is over the benchmark and quality outcome scores are high.

(d) Level 3 Global capitation (with outcome-based component)

Capitation arrangements for all or portions of populations with a quality component would consist of 'upside and downside' risk-sharing arrangements. To reduce unwarranted insurance risk for providers, stop loss, risk corridors and/or other risk-mitigation strategies could be authorized.

3. Innovator Program for Providers Ready to Assume More Risk

A voluntary Innovator Program, similar to that created in New York,¹ should be an option for VBP Providers/ACOs prepared for participation in Level 2 and 3 value-based arrangements by Year 2019. In the State of New York, General Population and Subpopulation value-based arrangements are rewarded by receiving up to 95% of the total dollars which have been traditionally paid from the State to MCOs. The

¹ See *New Roadmap, Annual Update, June 2016, Appendix IX, page 84*

Innovator Program is intended to encourage and reward early adoption of VBP arrangements, supporting those groups who have made investments in moving towards population health management.

Specifically, the Innovator Program rewards providers with up to 95% of premium pass-through for total risk arrangements as the prime Program benefit. The pass-through percentage is determined by analyzing the amount of the risk and administrative tasks taken on by the providers: more delegation results in higher percentage of premium (between 90% and 95%). The providers are required to pass a strict set of criteria to be deemed an ‘innovator’ and once they have reached Innovator status, all MCOs are required to participate in these arrangements. We would recommend that the specifics of an Innovator Program should be outlined in the VBP contract. Administrative functions that can be fully or partially delegated, as well as those that cannot be delegated, are displayed below.²

Optimum			
#	MCO Administrative Functions*	MCO	Provider
1	Utilization Review (UR)		
2	Utilization and Care Management (UM)		
3	Drug Utilization Reviews (DUR)		
4	Appeals and Grievances		
5	Quality		
6	Claims Administration		
7	Member/Customer Service		
8	Network Management		
9	Risk Adjustment & Reinsurance		
10	Disease Management		
11	Provider Services Helpdesk		
12	Provider Relations		
13	Credentialing		
14	Data Sharing		
15	Member Enrollment/Advertising		
16	Fraud, Waste and Abuse		
17	Legal		
18	Compliance		

Legend	
	Sole Responsibility
	Shared Responsibility
	Can't be delegated

In the New York model, to be eligible for 90% premium pass-through, functions 1, 2 and 10, listed in the table above, must be fully delegated to the provider, while at least half of the tasks listed as “shared” should be partially delegated. To be eligible for the 95% premium, tasks 1, 2, 6, 10 and 13 must be fully

² *Id.*

delegated to the provider, while all the other tasks should be delegated to the maximum amount possible. Percentages may be set between 90 and 95% depending on the exact delegation of tasks negotiated.

4. A Medicaid Quality Program That Aligns With and Qualifies for Medicare Programming

UPH has participated in value-based contracts with Medicare, Medicaid and commercial payers. Through various contracts, UPH collects, monitors and reports on over 200 quality measures. Streamlining quality measures and reporting requirements across multiple payers would reduce administrative burdens on providers and allow efforts to more appropriately focus on patient care.

Beginning in 2019, MACRA allows an All-Payer Threshold Option to achieve a Qualified Provider status under an Advanced APM. We encourage CMS to require that SIM grantees utilize quality measures that comport with the quality framework set forth in the CMS Quality Measure Development Plan (MDP) in support of MACRA. Of note, within the MDP, Advanced APMS are provided considerable deference so that Advanced APM reporting remains focused on innovative programming and Merit-based Incentive Payment System (MIPS) reporting requirements should align but not increase Advanced APM reporting domain requirements. In support of MACRA, we would suggest that SIM grantees not only follow MACRA quality guidelines but provide similar reporting deference to Advanced APMS participating in SIM projects.

We also discourage SIM grantees from developing/adopting their own VBP quality reporting constructs without consideration to, and preference for, Medicare quality measures, when applicable. In particular, if a State Medicaid agency, or their contractors, choose to measure a condition or outcome within a current Medicare program, they should use the same measure – for instance, the Medicare ACO quality measures should be used by Medicaid for similar conditions or outcomes (understanding that age parameters for Medicaid may need to adjusted). We are concerned that the SIM project in Iowa has chosen to adopt a VBP composite measurement tool (i.e. Value Index Score developed by 3M) that was developed for one health plan in Iowa based on a commercial population. Providers have raised numerous concerns related to this tool.³ The SIM project gives undue legitimacy to this tool. Its fit with the MDP

³ Concerns identified by a cross selection of UPC physicians and UPH ACO directors as of 9/16 include:

(i)Measurement Selection – We question the use of some of the underlying VIS measures.

(ii)Measures Are Divergent from Similar Evidence-Based ACO Measures - We have established workflows to address NQF metrics outside the VIS.

(iii)Measurement Selection Lacked Meaningful Provider Input – While 3M offers that the VIS tool is based on a tremendous amount of actuarial work, we do not know the extent to which Iowa providers were engaged in this development process. Wellmark Blue Cross Blue Shield cites to provider focus groups and IME references the SIM planning process to show provider engagement in tool development. We are unaware of any significant changes that have been incorporated into the measures themselves as a result of these efforts.

(iv)Non-Transparent Scores and “Black Box” Calculations - These scores cannot be replicated by providers. While 3M provides a list (The 3MSM Value Index Score (VIS): Measurement and Evidence (March 2015) of measures identifying denominators and numerators, it is unclear how all measures are weighted in their respective quality domains. Of particular concern are the efficiency and tertiary prevention domains, in which not only the weighting is known but the underlying measures are confusing.

deserves scrutiny as it related to quality domains and underlying measures, which do not fit evidence-based parameters in MDP. More importantly, it is questionable whether this tool is adequate for use with the Medicaid Population. The VIS tool was developed for a commercial population, which is generally healthier and exhibit fewer social determinants of health than Medicaid population. We are unaware of any other Medicaid program which utilizes the VIS tool. Among populations lacking adequate measures are the pediatric population (given the percentage of Iowa children covered by Medicaid) as well as patients presenting with behavioral health diagnoses.

5. A VBP Steering Committee and Clinical Advisory Group

The goals of the SIM Grant, as well as programming within many States and their respective Medicaid agencies, are to improve population health and individual health outcomes and to reward high value care delivery. These goals will not be obtained without reforming the Medicaid payment system. The selection of the VBP arrangements and the selection of accompanying quality measures need to be closely aligned. A new payment system cannot be designed without involving the healthcare delivery systems that care for the Medicaid beneficiaries. It has been our experience that healthcare delivery systems have limited or no representation on meaningful SIM steering committees, particularly in decision making bodies surrounding VBP.

We propose that the SIM require the creation of a Value Based Steering Committee to establish and monitor VBP options, risk levels, and innovation efforts. At a minimum, providers with experience in risk based VBPs should be on the Steering Committee. Further, CMS should require the establishment of a Clinical Advisory Group (CAG) to validate proposed bundle or subpopulation definition and corresponding analysis, and decide upon a set of quality measures for each arrangement. Members to the CAG should be nominated through recommendations from VBP Steering Committee members, other State agencies, professional groups and associations. Specific consideration should be given to the composition of the CAG to ensure that it not only represented geographic diversity (urban and rural), but also the total spectrum of care as it relates to the specific condition/subpopulation discussed.

6. Modify MCO Contracts, If Any, with State Medicaid Agencies to Meet Requirements

It has been our experience that SIM expectations have not been clearly defined in MCO contracts. Through updates to the Medicaid Managed Care Model Contracts, the SIM should require State Medicaid Agencies to add the VBP terms and requirements of the VBP system into the MCO contracts to stimulate their

(v) Targets Are Not Meaningful – In the past, IME has provided the VIS results (as percentages) without set targets other than general improvement. Without specific performance expectations, targets are meaningless. Although the VIS 2.0 will provide a point system rather than a percentage system, this change does not address the lack of specific performance targets to gauge the magnitude of IME performance expectations in these areas. If goal is to quality measure is to support the Triple Aim, the most direct method to use evidence-based measures with associated scores, set a target, incentivize progress, and encourage high quality for each ACO.

(vi) Reports Are Too Complex – VIS reports are cumbersome at best, require an extraordinary amount of time commitment from clinic support staff and leadership to interpret, and for the most part do not contain actionable items.

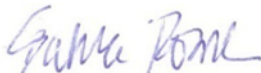
adoption of VBP arrangements. This requirement will set consistent parameters for providers when negotiating VBP arrangements with MCOs.

Access to Data

We implore CMS to mandate that SIM grantees and their commercial payers share full claims data feeds to allow providers to manage risk and their patient population. This data is needed to assess total cost of care. To be most effective, the monthly raw claims data feed must be timely and complete. The Medicare ACO claims data feed is a good starting point for SIM grantees and subcontractors to emulate. Currently data feeds from our State Medicaid agencies, as well as from commercial health plans, are typically provided on a quarterly, not monthly basis, and then the feed is less than complete (devoid of cost information) and often is delayed an additional 2-3 months to provide “mature” data. In addition, the roll-up reports create unneeded complexity and create further delay in their production as well as provider interpretation. As a NGACO, we have advanced analytics and predictive modeling tools and can factor in completion percentages and trends. The delay in Medicaid and commercial data and their incomplete nature hinders a provider’s ability act on data, making gap reports virtually inconsequential. While we understand that not all providers have advanced analytics capabilities, we strongly believe that providers should have the option to request monthly data feeds. Ideally, this data feed should resemble the CMS data feed or be placed in an All-Payers Database that uploads to a common data framework. We would advocate that SIM projects include timely, complete data sharing requirements and that providers be solicited for ongoing input.

We appreciate the opportunity to provide input on the SIM. 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