

November 20, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Centers for Medicare & Medicaid Services (CMS): Innovation Center New Direction Request for Information

Submitted electronically via CMMI_NewDirection@cms.hhs.gov

Dear Ms. Verma,

UnityPoint Health (UPH) appreciates the opportunity to provide comments on the Request for Information (RFI) regarding the CMS Innovation Center (Innovation Center). UPH is one of the nation's most integrated healthcare systems. Through more than 30,000 employees, our relationships with more than 290 physician clinics, 38 hospitals in the 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 provide a full range of coordinated care to patients and families through more than 6.2 million patient visits. In addition, UPH is actively engaged in numerous initiatives which support population health and value-based care.

UPH is an early adopter of innovative value-based models and has partnered in Innovation Center demonstrations for seven years. UPH participates in Innovation Center contracts under the Bundled Payment for Care Improvement Model 2, the Home Health Value-Based Purchasing Model, and the Medicare Care Choices Model. In addition, UnityPoint Accountable Care (UPAC) is the ACO affiliated with UPH and has value-based contracts with multiple payers, including Medicare. UPAC is the largest ACO participating in the Next Generation ACO Model with roughly 80,000 beneficiaries attributed to this program and has received first-year savings. Historically, UPAC has providers that have participated in the Medicare Shared Savings Program as well as providers from the Trinity Pioneer ACO, which was the most rural ACO and achieved two years of savings.

We appreciate CMS' outreach to stakeholders, including the provider community, as it seeks to build upon the work at the Innovation Center. We respectfully offer the following comments.

INNOVATION CENTER AUTHORITY TO TEST INNOVATION

Prior to addressing the issues raised in this Request for Information, we feel compelled to dispel the believe that “CMMI exceeded statutory authority by issuing broad, compulsory models, like the Part B Drug Payment Model and Episode Payment Model (EPM) models.”¹ ***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).*** Within our ACO, we rank as one of the largest Next Generation ACOs, are one of the most rural ACOs, and have specialists as more than 40% of our participating providers, including behavioral health providers. ***We do not agree that the Innovation Center exceeded its authority and, in fact, believe that this discretion is necessary in order to instill timely flexibility and adjustments within an otherwise rigid payment construct.*** Under the Affordable Care Act (ACA), Congress established the Innovation Center 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.²

While we do not always agree with the timing and technical issues related to Innovation Center initiatives, we believe that Congress granted the Innovation Center definite authority to proceed with mandatory initiatives under its Expansion of Models authority. The statute 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.³

This provision allows the Innovation Center 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

¹ RFI comment letter in response to this RFI dated November 15, 2017, from 113 organizations – the first listed organization is Advocates for Responsible Care (ARxC).

² 42 USC 1315A(a)(1)

³ 42 USC 1315A(c)

and innovative ideas. ***As an early adopter of Innovation Center ACO and other voluntary models, as well as a current participant in the mandatory HHVBP model, we appreciate CMS' efforts to move from volume to value and recognize the importance of agency discretion to facilitate change.*** 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, CMS should demonstrate restraint when curbing authority intended by Congress to support healthcare innovation.

GUIDING PRINCIPLES

As an early adopter, we are invested in the basic tenets of the Innovation Center to reduce costs and improve quality for Medicare and Medicaid beneficiaries. As for the guiding principles, which mark a new chapter for the Innovation Center, we are pleased with the focus and the high bar it sets for ensuring high quality care at a reduced cost.

1) **Choice and competition in the market** – As an organization that operates in three Midwest states, UPH is a firm believer in improving choice for beneficiaries and promoting a competitive marketplace. We hope to work with the Innovation Center to ***improve geographic disparities by increasing access and competition within rural areas.***

2) **Provider Choice and Incentives** – We are supportive of the Innovation Center's efforts to improve provider choice and incentives, especially as it relates to ***reducing unnecessarily burdensome regulations.*** We are pleased with the focus on models with defined control groups or comparison populations, and encourage the Innovation Center to promote data sharing to inform participating entities in strengthening models.

3) **Patient-centered care** – We support the Innovation Center's emphasis on flexibility and empowering beneficiaries to take ownership of their health. We agree that "beneficiaries should be empowered as consumer[s]," and ***recommend that both CMS and the Innovation Center make all APM performance data available to the public as soon as "final" data has been released by the agency after the data review and/or approval period provided to model Participants.*** We want to assure that data released to the public is not only timely but accurate to avoid beneficiary confusion. UPH believes improved data sharing can improve outcomes for beneficiaries while informing participating entities in strengthening models.

4) **Benefit design and price transparency** – UPH supports greater price transparency to ensure cost-effective care and improves outcomes. In this arena, UPH supports the recommendation of The Conference Board (*Adjusting the Prescription: Committee for Economic Development Recommendations for Health Care Reform*) to ***repurpose the ACA's Independent Payment Advisory Board (IPAB) to provide information for the physician-patient relationship.*** This would include data gathering and research to inform both patients and providers in their decision-making process. With the importance of data, a centralized structure for its release and dissemination should be prioritized.

5) **Transparent model design and evaluation** – UPH is encouraged by the Innovation Center’s focus on transparent design and evaluation methods, especially as it relates to collaborations with public stakeholders. The Innovation Center has actively released Requests for Information to stakeholders and the public; however, it would be ***helpful if the Innovation Center would release summaries of feedback that is received from the RFI process.*** These summaries would not need to reflect each commentator, but it would be beneficial to learn response rates and general feedback themes. This information would also aid in understanding the patchwork of national innovation as well as future payment direction. In terms of model design and evaluation, we understand the desire to implement multipayer models; however, we have concerns with commercial payer participation, which leaves out some geographies due to payer reluctance. This effectively omits feedback from providers in those regions and similarly prioritizes feedback from a select group of payers. ***We request that multi-payer models in the public payer arena be afforded the same weight as multi-payer models including private payers.***

6) **Small Scale Testing** – We support Innovation Center efforts to test smaller scale models that may meet requirements for expansion. Under the ACA, Congress established the Innovation Center to test innovative payment and service delivery models. This provision allows the Innovation Center 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 expedites rulemaking and implementation for promising and innovative ideas. ***As a current Participant in several Innovation Center models, including a mandatory model, and with aggressive MACRA timeframes, we strongly support CMS’ authority to test and disseminate new models and discourage undue restraint in this area.***

In addition to the guiding principles, we would like to raise the issue of sustainability as it relates to the various demonstration models. UPH has embraced the Innovation Center’s focus and priorities, which have resulted in improved outcomes at a lower cost across several models that we’ve participated in. We’ve seen firsthand how organizations like UPH can work with CMS and States to become laboratories of innovation – and we remain firmly committed to that effort. However, there are stages in the process that lead to great uncertainty for the provider and/or organization, such as whether a various model will continue. This uncertainty creates a disincentive to participate. We are particularly concerned with other commentators suggest limiting demonstrations to five years.⁴ While we understand that demonstrations should eventually reach conclusion and either migrate to a permanent status, be revised, or be dissolved, we are concerned that a 5-year timeframe does not and should not adequately represent all demonstrations. By inserting such a timeframe, this period may become a de facto timeframe for all projects; instead agency discretion should be utilized in conjunction with stakeholder input to determine appropriate model duration, scope and spread. Generally, the Innovation Center should examine steps to provide certainty for beneficiaries, providers and organizations that are looking at alternative methods of providing high-quality care over the short- and long-term. ***While sustainability may be implied within the***

⁴ Letter referenced in Footnote 1

guiding principles listed above, we believe that it should be elevated to a stand-alone principle and added to this list.

POTENTIAL PAYMENT REFORM MODELS

In response to CMS' search for feedback and guidance, the framework outlined below incorporates and expands upon the Innovation Center's guiding principles to new design models.

EXPANDED OPPORTUNITIES FOR PARTICIPATION IN ADVANCED APMS

Established by the passage of MACRA, APMs were developed with the goal of reforming Medicare's Part B payment method. Coupled with the delivery of high-quality and cost-efficient care, qualified participants have demonstrated an integral role in building upon the lay APM foundation. Currently participating in the Next Generation ACO demonstration, UnityPoint Health is proud to lead by example. A subsidiary of UnityPoint Health, UnityPoint Accountable Care (UPAC) has received more than \$28 million in shared savings from value-based contracting efforts; of which \$10.5 million stem from participation in the Medicare Next Generation ACO Model and \$18.2 million from various commercial payers. The shared savings from the participating in the Medicare Next Generation ACO Model were tied to performance on both quality and cost. The results reflect the continued commitment of UPH to transition away from the traditional Fee-For-Service payment model while building on its track record as a national leader in managing patient populations.

As the nation's largest Next Generation ACO demonstration model with a history of demonstrated savings, UPH firmly believes the delivery of value-based care continues to generate significant progress. **The Innovation Center should establish a hierarchy of demonstrations that provide a stepwise approach for providers to accept various degrees of risk in exchange for heightened levels of Part B compensation under MACRA as well as demonstration payment incentives and regulatory and operational flexibilities. To increase opportunities for eligible clinicians to participate in Advanced APMs (A-APMs) and achieve QP participation threshold, UPH encourages CMS to:**

(1) Simplify incentives; (2) Focus on chronic care management; (3) Support MA participation as a contributory means to achieve QP state; and (4) Encourage models emphasizing rural provider participation; and (5) Promote continued participation in A-APMs by early adopters.

As a step to simplify incentives, ***bonuses and small fee schedule increases should be generated in all APM frameworks, incorporating those participants operating under MSSP Track 1 in which providers have taken on increased investment risk.*** In following this step, providers electing to not participate in APMs should not incur a fee increase. To fund this measure, we propose to reallocate the MIPS exceptional performance bonus dollars to be utilized within the context of this framework. Focal to program success and sustainability, we highlight the systematic integrity of bridging proportional risk to incentives. We ask

the Administration to consider, as program frameworks are proposed, whether there are sufficient benefits in heightened risk-bearing models to maintain an elevated level of commitment or instead whether models with reduced risk will introduce migration of early innovators to lower risk models.

To achieve long-term health objectives established by CMS, ***encouraging chronic care management in demonstrations should be a focal step*** in aligning with the guiding principle of patient-centered care. We support an emphasis in the creation of holistic population health models, as opposed to models limited to specific disease states and their episodes of care. UPH further ***encourages avenues in which rural populations are a focal feature of proposed models***. MIPS has extensively excluded many rural providers through the rule making process and there is little incentive for these providers to aspire to A-APM participation. As a distinguished early adopter, ***UPH believes engagement amongst the early adoption community should be further explored***. When possible, we urge the Innovation Center to continue the use of payment tracks within demonstrations to promote a glide path to capitated payment, such as that available under the Next Generation ACO. We are also encouraged by the joint efforts of the Innovation Center with States to test global payments, including the Maryland All-Payer Model, the Vermont All-Payer ACO Model and the Pennsylvania Rural Health Model. Our concern with all-payer models is that the dissemination potential is limited by a disinterest and general refusal of commercial payers to share claims data, not to mention participation in larger multipayer reform efforts. We recommend that the Innovation Center engage in multiple payer efforts involving public payers (so as not to limit those regions with limited commercial payer interest) and that all demonstrations require timely sharing of summary and raw claims data with providers. Once a public payer model is successful, there will be better success at encouraging private participation; however, this should not be a limiting factor in areas with interested and willing provider groups and State agencies.

As a means of transitioning from Fee-For-Service constructs, global payments promote provider flexibility and capture the removal of restrictive regulations presently afflicting care decisions. ***We strongly encourage the Innovation Center to continue offering global payment models that correspond to heightened regulatory flexibility***. Our goal with global payments is to free our providers from the arbitrary confines of Fee-For-Service reimbursement and, when applied at an ACO level, it enables patient-centered care to prevail and eliminates siloed provider (business unit) targets in favor of enterprise-wide targets. For services outside the ACO, it enables the ACO to contract for those services outside Fee-For-Service constraints and ideally within sub-capitated arrangements that are market based and with willing participants. Theoretically, global payments should simplify regulatory concerns by eliminating Stark and Anti-kickback concerns, medically necessary determinations (similar to the PACE program), burdensome waiver processes, and referral requirements. Within this transition, the Innovation Center should consider a model for Medicare block grant funding directly to A-APM entities, based on the national average per beneficiary. We are concerned that regional performance benchmarks are not as attractive to warrant continued participation by high performers.

To increase responsiveness to eligible clinicians and their patients, as well as potentially expediting the process for providers that seek to join A-APMs, UPH encourages the Administration to consider the following measures:

(1) Prospective Attribution development; (2) Tax incentives; (3) Stark Law exceptions; (4) Expanded Waiver authorities; (5) Statutory recognition of A-APMs; (6) Financial incentives for beneficiaries; (7) All payer database mandate; (8) Clarification of overlapping program rules; (9) Comprehensive healthcare system risk-sharing solutions; and (10) Value payments.

To avoid the churn of retrospective attribution, a durable perception of the target population will be quintessential to the Administration's ability to meaningfully respond to eligible clinicians and their patients. **When participating in MSSP, our retrospective attribution churn rate was approximately 25% per quarter and undermined efforts at targeted care coordination and quality improvement initiatives. It also created confusion for beneficiaries.** The comprehensive risk and resources required to participate as an A-APM significantly effects clinician engagement and participation. **Tax incentives act as a channel to address current participation barriers amongst clinicians and reward those physicians whom have already transitioned to A-APM models.** Incentives could take form as tax-free retained earnings, retained by the physician practices, which could exclusively be utilized as infrastructure development and risk reserve offsets to assist in the transition to an APM model. Distributed incentive earnings should not be considered as a loan and should not require physicians to match funds. We also recognize consumer participation in demonstration models may currently be acting as a barrier for physicians participating in A-APMs. To further entice beneficiary participation, **we recommend the institution of financial benefits to beneficiaries.** Maintaining a voluntary program mindset, the utilization of shared savings models enable payers and providers to share benefits; beneficiary incentives could take form as wellness performance benefits, not copayment waivers.

In furthering the Agency's goal, **we strongly encourage the Administration to act within its power to institute Stark Law exceptions for providers within a population-based risk-bearing A-APM model.** We would further suggest the expansion of waiver authority as an avenue the Administration should explore, which would have positive impacts on the agency's desire to both expedite the process for providers looking to join A-APMs and increase clinician and patient responsiveness.

As with risk, the future of a model deters potential eligible clinician populations from transitioning to the A-APM framework; to correct the gray area encompassing A-APM participation, **UPH strongly recommends the Administration make formal recommendations to statutorily recognize A-APM models upon completion of a demonstration period.** With appropriate modifications, the Next Generation Model ACO (referencing a second iteration of the Pioneer ACO Model) should graduate from the Innovation Center lab into the mainstream healthcare model market, where the model will be able to function similarly to comparable risk-bearing models or provider-owned Medicare Advantage plans.

Current regulatory overlaps have muddled program rule clarity and are increasingly viewed as a disincentive for providers to take heightened risk for total populations. Current overlap rules fail to recognize the totality of population health programming and incentivize siloed, episodic care (whether procedures or condition-based) based upon Fee-For-Service constructs over total population health programming. For instance, Oncology Care Model, Comprehensive ESRD Care Model, and Bundled Payments for Care Improvement (BPCI) beneficiaries are removed from the Next Generation ACO for

purposes for these episodic procedures, yet the Next Generation ACO remains responsible for the overall outcomes and costs of their care. These rules allow new episodic programs and their providers to skim off ACO infrastructure investments, do not require notice of attribution among programs nor inter-program care coordination, and impose a narrow 60- or 90-day treatment timeframe misaligned to holistic care (i.e., a significant number of BPCI episodes, such as congestive heart failure, chronic obstructive pulmonary disease, and diabetes, require lengthy aftercare and are subject to co-morbidities). To address the entanglement, ***we encourage a hierarchical approach to CMS / Innovation Center 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 can 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.

UPH recommends that CMS consider the following measures to capture appropriate data to drive the design of innovation payment models and initiatives to encourage A-APM participation amongst the eligible clinician population:

(1) Streamlined data reporting; (2) Formation of an all payer database; and (3) Integration of Part D data.

As an early adopter of payment innovation and care delivery transformation, perhaps our biggest learning involved working with data and becoming a truly data-driven organization. We cannot understate the importance of EHR and claims data and the ability to synthesize and proactively analyze this data for our patients. We also have come to realize that collecting data for purely reporting purposes is not productive. In terms of data reporting, ***we support the genesis of the CMS Meaningful Measures initiative.*** In our response to the Draft CMS Quality Measure Development Plan⁵, UPH conducted a cursory review of quality measure sets listed in the Table below. Although a year old, this Table still illustrates the point that CMS collects disparate data under differing quality domains. Future models should strive to require streamlined data under common domains, particularly when payment is tied to quality/value.

MA	NGACO	ACO / PCMH Consensus Core*	MIPS**	PQRS
Managing Chronic (Long Term) Conditions (12)	At Risk Population (7)	Cardiovascular Care (4)	Clinical Care	Effective Clinical Care (145)
		Diabetes (5)		
		Behavioral Health (2)		
		Pulmonary (2)		

⁵ UPH letter dated March 1, 2016, and submitted via MACRA-MDP@hsag.com

	Care Coordination / Patient Safety (9)	Care Coordination / Patient Safety (1)	Safety Care Coordination	Patient Safety (43) Communication and Care Coordination (42)
Member Experience with Health Plan (6) Member Complaints and Changes in the Health Plan's Performance (4) Health Plan Customer Service (3)	Patient/Caregiver Experience (8)	Patient Experience (3)	Patient and Caregiver Experience	Person and Caregiver-Centered Experience (16)
Staying Healthy: Screenings, Tests and Vaccines (7)	Preventive Health (9)	Prevention and Wellness (6)	Population Health and Prevention	Community / Population Health (15)
		Utilization & Cost / Overuse (1)	Efficiency and Cost Reduction	Efficiency and Cost Reduction (20)

* Measure counts exclude future areas identified for measure development

**Released Consensus Core Measure Sets for: (A) ACO and PCMH / Primary Care - 22 measures; (B) Cardiovascular - 31 measures; (C) Gastroenterology - 8 measures; (D) HIV - Hep C - 8 measures; (E) Medical Oncology - 14 measures; and (F) OB-GYN - 11 measures

In terms of data sharing, we do not want to miss an opportunity to encourage a more robust system to share claims data. **We are supportive of sharing both raw claims-level data and claims summary data.** We have used claims data to monitor trends and pinpoint areas where care practice improvement is appropriate as well as to assess cost drivers. **This claims data should not be subject in an opt-in process,** but rather should be routinely available and provided, which allows and encourages providers / organizations to access and utilize this information. The untimely receipt of data and any variance from standardized formats has hindered our ability to drive innovation within payment models and measures. We encourage CMS to advance the following concepts within its models:

- **Access to All-Payer administrative claims data.**
- **Access to substance abuse records by treating providers.**
- **Permit the sharing of patient medical information within a clinically integrated care setting.** HIPAA currently restricts the sharing of a patient’s medical information for “health care operations.”

Further, we request that the Administration consider the sharing of Part D data for lives attributed to certain population health entities, namely down-side risk ACOs. 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. We believe this powerful data itself would serve as an incentive for providers to transition to these advanced risk-bearing models. With the opioid crisis, the data would also enhance an ACO’s ability to clinically manage this emergency.

Upon piloting Part D data access, the Innovation Center could then choose to expand this data sharing beyond down-side risk ACOs.

MEDICARE ADVANTAGE INNOVATION MODELS

Medicare Advantage (MA) provides an important option for Medicare beneficiaries to access coordinated care and greater benefits. We support CMS efforts to provide MA plans with flexibility to innovate and achieve better outcomes. The more MA can be divorced from Fee-For-Service limitations, the better they will be able to innovate. We believe there are variety ways CMS can further these goals, such as increasing choice and reducing cost in ways that incentivize both the beneficiary and provider group.

We are encouraged by plans from CMS in implementing the Medicare Advantage Value-Based Insurance Design (VBID) model, which represents how CMS is exploring alternative payment models in the MA program under its existing 1115A authority. To that end, ***we encourage CMS to pursue more models in the MA plan space that go beyond Fee-For-Service and MA for paying for care delivery.*** One such option would be a demonstration that empowers ACOs with third-party administration (TPA) capabilities to compete with MA plans. UPH believes that A-APMs such as Next Generation ACOs are uniquely positioned to step up involvement in the MA space given their experience in support of population health and value-based care.

STATE-BASED AND LOCAL INNOVATION, INCLUDING MEDICAID-FOCUSED MODELS

States play an important role in delivering high-quality care in Medicaid that meet the needs of their residents. Health care providers are vital to those efforts and work with CMS to test models based on state plans and local innovation initiatives. UPH values our Medicaid patients and is highly engaged with our States in assuring that our patients receive high-value care. We have responded in the Innovation Center's Request for Information processes for both the State Innovation Model (SIM) Concepts in October 2016⁶ and the Pediatric Alternative Payment Model Concepts in April 2017⁷. UPH also had representatives participate in the State Planning process for the Iowa SIM grant.

In general, ***we support CMS' interest in providing States with more flexibility and encouraging the use of value-based arrangements.*** The nature of the value-based arrangements can be flexible to reflect different maturity levels related to capabilities and networks, such as bundled or episodic care payments, total cost of care payments for special needs population, and/or total costs of care payments for the general population. Additionally, payment scope can be combined with varying levels of provider risk – Fee-For-Service with bonuses; Fee-For-Service with upside only risk; Fee-For-Service with two-sided risk; and Global capitation. Within these constructs, there are some low hanging fruits; we believe that States

⁶ UPH letter dated October 28, 2016, and submitted via SIM.RFI@cms.hhs.gov

⁷ UPH letter dated April 6, 2017, and submitted via HealthyChildrenandYouth@cms.hhs.gov

should re-envision the use of referral networks, pilot pediatric payment alternatives, and permit ACOs to compete alongside MCOs in the Medicaid space.

For providers that are ready to assume more risk (either two-sided risk based on Fee-For-Service or global capitation), ***the Innovation Center should offer, or encourage States to offer, a voluntary Innovator Program***, similar to that created in New York. The Innovator Program in New York 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. If adopted, we would recommend that the specifics of an Innovator Program should be outlined in any VBP contract.

We also believe the ***Innovation Center should pursue a cross continuum Social Determinants of Health model that combines attributes of, and effectively partners, the Accountable Care Community model and down-side risk ACOs***. The combination of these models would address the heterogenous medical needs of a Medicaid population that is often exacerbated by social determinants of health requiring wrap around and after-care services.

MENTAL AND BEHAVIORAL HEALTH MODELS

The Substance Abuse and Mental Health Services Administration (SAMHSA) developed the Primary and Behavioral Health Care Integration (PBHCI) Program. It provides support to communities to coordinate and integrate primary care services into publicly funded, community-based behavioral health settings. UnityPoint Health - Berryhill Center, a Community Mental Health Center (CMHC) in Fort Dodge, Iowa, is participating in the eighth cohort and this primary care and behavioral health care integration has improved outcomes for our patients. Selected clinical outcomes are:

- Blood Pressure 39.2% of the population has improved with 23.4% no longer at risk against targets;
- Waist circumference was 60.3% outcome improved with 11.0% no longer at risk; and
- Cholesterol – HDL 52.9% improved with 4.3% no longer at risk, LDL 47.7% improved with 9.2% no longer at risk and Tri-glycerides 45.7% outcome improved with 10.0% no longer at risk.

While the SAMHSA grant has focused on care delivery and quality outcomes, it raises issues related to a sustainable payment model. Among our recurring sustainability concerns is the retention of a primary care provider. ***We request that the Innovation Center work with Health Resources and Services Administration and SAMSHA to consider a pilot that enables CMHCs to utilize Federally Qualified Health Center (FQHC) payment mechanisms for the integration of primary care services***. While FQHCs are supported to provide behavioral health services in-house, the same is generally not true for CMHCs. Sustainable payment modeling is vital. We believe that there should be no wrong door for behavioral health services and that patients with Severe Mental Illness (SMI) should be supported in an environment in which they are currently receiving services and have a familiarity and comfort level.

We appreciate the opportunity to provide comments on the “new direction” of the Innovation Center and its impact on our integrated health system and our patients. UnityPoint Health is passionate about our value-based work and its future. We are encouraged by the suggested topics and look forward to continuing our relationship and dialogue with the Innovation Center as the nation moves from healthcare reimbursement volume to holistic value. 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,

A handwritten signature in blue ink that reads "Sabra Rosener".

Sabra Rosener, JD

Vice President, Government and External Affairs