UnityPoint Health

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April 6, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: Request for Information on Pediatric Alternative Payment Model Concepts

Submitted electronically via HealthyChildrenandYouth@cms.hhs.gov

Dear Ms. Verma:

UnityPoint Health (UPH) is pleased to provide input in response to the Centers for Medicare & Medicaid Services' (CMS) Request for Information relating to Pediatric Alternative Payment Model Concepts. 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 terms of pediatric care, UPH offers a continuum of services from pediatric inpatient services, including a dedicated Children's Hospital, to a variety of pediatric ambulatory services through dedicated primary and specialty clinics as well as home health services. Specifically, Blank Children's Hospital is the flagship of our pediatric acute care services. In operation since 1944, Blank Children's operates a 96-bed pediatric acute care hospital and outpatient clinics, staffed by 94 pediatric primary care and pediatric specialty providers. Medicaid represents almost one-half (47.7%) of Blank charges within the inpatient hospital setting and 65% of charges for the pediatric outpatient clinic population. Many of the children with complex health needs served by the specialty clinics at Blank Children's have private insurance coverage, and Medicaid as secondary coverage. Medicaid is a vital coverage safety net for children in Iowa. Aside from Blank, each UPH region has inpatient pediatric units in our senior acute care hospitals and two regions offer separate pediatric inpatient psychiatric units. UnityPoint Clinic has 16 pediatric clinics that employ 66 pediatric physicians and ARNPs. UnityPoint at Home is our home health agency, which in several regions is the only agency providing home health services to complex pediatric patients. UnityPoint at Home serves approximately 125 medically complex patients with 180 FTEs and another 17 professionals under contract. Due to the chronicity of children in home health, their length of stay is ongoing. For Home Health services, 86% of charges are attributed to Medicaid, with the remainder of charges paid by commercial plans or school districts.

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 framework. We appreciate that CMS is seeking stakeholder input to inform its planning and development of pediatric alternative payment models. With Medicare ACO models first out of the shoot, we believe that there is great opportunity for improved care coordination and holistic service delivery for the pediatric population which comprise nearly half of the Medicaid population, encompassing 30 million children in the United States. We respectfully offer the following comments to this Request for Information.

INTEGRATED PEDIATRIC HEALTHCARE AND HEALTH-RELATED SOCIAL SERVICE DELIVERY MODEL

UPH supports child- and youth-focused care delivery that includes the continuum of healthcare services as well as wrap-around, health-related social services.

An integrated model presents opportunities to address social determinants of health and impact individual and family quality of life by leveraging community resources and other public funding streams. The continuum of services are particularly important in a pediatric setting because children are absolutely dependent on their families and impacted by the family setting; therefore services need to be structured and implemented in the context of the entire family.

While there are always challenges with coordinating among unrelated entities (such as between healthcare organizations and social services agencies), pediatric healthcare organizations themselves have internal challenges which create barriers to care for their clients. The most significant internal barriers include pediatric workforce issues, inadequate reimbursement, and inconsistent health plan service coverage/authorization.

The pediatric workforce shortage is exemplified in the Home Health arena. The Des Moines area is the most populated region in the State of Iowa, yet UnityPoint at Home is the only comprehensive pediatric home health service provider in this area providing intermittent services, in-home therapy, hourly nursing, home medical services, infusion services, and hospice. In this region, UnityPoint at Home has a waiting list of 25 clients, with some placements taking months before services can begin. In many cases, wait list clients are in costly acute care settings pending placement. Even as the only pediatric home health provider in the service area, we cannot recruit enough providers / staff with a pediatric skill set and this shortage is heightened in rural areas – starting only 20 miles outside Des Moines. Because Medicaid reimbursement is relatively low, wages are depressed and not competitive. Any service delivery reform should incorporate support to assure access to adequate healthcare resources, whether through adding healthcare professionals and/or allowing virtual access to professionals.

As a predominantly rural state, Iowa has access and underserved challenges related distance and travel barriers. In general, state Medicaid programs should receive enhanced match rates for rural beneficiaries. To support primary care, we recommend establishing a per-beneficiary payment for each primary care practitioner to compensate in part for ongoing, non-face-to-face care coordination for a panel of patients rather than discrete encounters. To support specialty care, we recommend establishing incentives for telehealth infrastructure. We also recommend instilling flexibility within the 340B Drug Pricing Program

to allow stand-alone Rural Health Center to participate.

OPERATION OF INTEGRATED SERVICE MODEL

Infrastructure Development: To effectively coordinate care, the timely sharing of information/data with community partners is critical. Ideally, this requires the capability to electronically share Social Determinants of Health (SDH) and Health Risk Assessment information. Traditional EHR systems have not included this information and often mechanisms are limited to enable community partners to view and/or edit this information. To customize EHRs and to provide access to external partners is costly, and should be considered and funding supplemented, if these integrated models are to be developed and encouraged.

In Iowa, Public Health has been a leader in collecting and tracking SDH information. We would refer CMS to Webster County Health Department and its customization of Champs EHR as a potential model for SDH collection, tracking and reporting. Without customization, Champs includes fields that track multiple SDHs: Income; Education level; Housing; Living alone status; Language spoken; Translation needs; Race; Ethnicity; Literacy (e.g. reading and comprehension level); Medical home designation; and Pharmacy home designation. Webster County Health Department has further customized Champs to include: Health literacy (e.g. ability to understand health-specific terminology related to diagnoses/conditions); Transportation; Abuse screenings; Parenting assistance; Food access; Utility assistance; and Social support. The Champs EHR permits licensees to individually customize the software, at will and upon need, to track other items and perform reporting functions. It also allows the tracking of referrals to healthcare providers/organizations and other community resources as well as the tracking of referral follow-up. To assure successful collaboration between healthcare providers and community organizations, timely and throughout information sharing is crucial and data sharing/interoperability incentives have not been extended to all healthcare providers or community organizations.

Potential for Improved Outcomes: In our rural state, outcomes are most often improved when opportunities for timely access are increased. To enhance access to specialty care, including behavioral health, we support the use and further expansion of telehealth reimbursement to mitigate provider shortages and distance barriers. To enhance access, Blank has been slowly expanding our telehealth portfolio - child psychology, child development, autism services, nephrology, etc.

Another approach to enhance client access is through a “one-stop shop” concept. We support this concept that permits clients to access multiple services during one visit. In 2015, the Blank Primary Care Clinic launched the Connections in Primary Care model to co-locate Visiting Nurse Services (VNS), the regional Maternal and Child Health agency, and Iowa Legal Aid within the clinic. The VNS Family Outreach Specialist provides home visitation, resource referral, family support, more extensive developmental assessment, and early mental health diagnosis and intervention. In the first two years of implementation, the Connections Program has served 615 children through home visiting, enhanced developmental needs assessments and referral/connection to community resources. The Blank Medical Legal Project, in conjunction with Iowa Legal Aid, addresses legal issues impacting patient health; for instance, a child with asthma living in substandard housing. This co-location model has been very effective in providing immediate access to community-based services. Legal needs impacting patient health typically fall into

five categories: Income/Insurance benefit eligibility denial or coverage denial; Housing issues; Education and employment accommodation issues; Legal status issues; and Personal safety issues. The Blank Medical Legal Project has served 316 families with health harming legal needs in the past two years. The basis of both programs at Blank is to intervene upstream to address the social determinants of health which negatively impact child and family health. Additionally, partnerships with the Children's Community Mental Health Center provider is being explored to create integrated mental health within the primary care clinic and foster care clinic at Blank. Crucial to the concept of co-location or embedded services is that payment methodology must be structured to acknowledge the variety of services that may be provided on the same day, unlike the current episodic-based model.

Accountable Care Organizations: Although UPH does not operate a distinct pediatric ACO, UnityPoint Accountable Care is our affiliated ACO which has contracts with public and private payers. ACOs are defined the same despite any targeted population focus such as pediatrics; they are provider-driven organizations that coordinate efforts of groups of healthcare providers to accept responsibility for the providing high quality and total cost of care for targeted populations. ACOs are both the signatory on payer contracts and the driver of service delivery coordination. Our present ACO structure can accommodate targeting distinct populations, such as children and youth, without creating separate population-specific ACO entities, although clarity would be sought regarding overlap for dual eligibles in our Next Generation ACO. However, pediatric encompassing ACOs should accommodate the services and payment methodologies needed to meet the unique needs of the pediatric population. For example, limiting services for prevention, early identification or early intervention for a young child is counter-productive to the long-term goal of minimizing the impact of treatable, complex health conditions and reducing the dependence on future health care services. Considerations for a free-standing pediatric ACO or an ACO encompassing pediatrics should include recognition that children's costs are often concentrated in the first years of life (unlike adult expenses which occur at the end of life). Special consideration should be given to newborns needing Neonatal Intensive Care services given a pediatric ACO may not be able to impact the child's health pre-delivery if the mother is not served by the ACO. It also should be noted that volume for more intensive and costly pediatric services is much less than it is for adults, therefore pediatric ACO models should accommodate the regional nature of pediatric specialty care. Pediatric health outcomes should be broad, but tailored to children, and measured over a much longer term than adult outcomes (i.e. more than ten years) to reflect the rapid development and milestones achieved early in the life of a child, and a preventive focus across the future impact of adult health. Finally, special attention should be given to the transition from pediatric care to adult care by the ACO to ensure a seamless transition in care. Adolescents and young adults often do not maintain routine, preventive health care services which may have a significant future impact on health outcomes and health care costs.

We also want to clarify the roles of ACOs versus MCOs in response to the questions: "Are states interested in having MCOs be part of an ACO, the ACO itself, or not involved? What responsibilities might MCOs have relative to ACOs and vice versa?" ACOs are healthcare providers responsible to providing services; MCOs are healthcare payers that administer health plans (contracts) – MCOs do not deliver care but offer a variety of covered services under their health plan. In the public arena, MCOs take the place of CMS in claims processing and administration. Where the waters are muddied is that ACOs and MCOs both

promote efficiency and high-value service through care coordination efforts – ACOs engage in care coordination through a provider lens, whereas MCOs engage in care coordination through a health plan lens. It is our belief that providers and not insurers are better positioned to drive care delivery innovation and to streamline care for patients. From an efficiency stand point, it makes more sense to have providers voluntarily agree to be responsible for determining optimal care processes, then having this dictated by multiple health plans (MCOs) with different and changing cost-reduction initiatives requiring different and changing administrative mandates and data reports.

In Iowa, the transition to Medicaid MCOs in 2016 has drastically increased provider administrative burden and also further depleted our health professional workforce shortages as MCOs have hired hundreds of nurses and social workers in support of their individual care coordination and efficiency functions. Since providers and health plans are distinct, we do not believe that these roles should be combined; in fact, we would advocate that for risk-bearing ACOs, that they be exempt from MCO care delivery initiatives. Removing health plan care coordination requirements for two-sided risk ACOs would enable these ACOs to continue to innovate and drive high-quality care without being forced to deviate from their provider-driven care delivery models and would support and encourage provider participation in Advanced Alternative Payment Models in furtherance of MACRA and Quality Payment Program goals.

Other Care Models: We wholeheartedly support the integration of behavioral and physical health in care delivery. Blank Primary Care Clinic and the Regional Child Protection Center are currently exploring partnerships with Orchard Place, a non-profit agency providing residential, outpatient, in-home and care coordination programs for children and youth age 0 to 22 in Des Moines. This partnership is evaluating the Massachusetts Child Psychiatry Access Project (MCPAP) to determine its appropriateness and our ability to replicate in central Iowa. We encourage CMS to consider support pilots that encourage the integration of behavioral health and innovative models which address the child psychiatry shortage in the United States, especially within rural America.

In the same vein, we are also exploring the expansion of a tri-navigational model of care, which we have developed in our rural northwest central Iowa region to address social determinants of health. This vulnerable population model (1) targets (a) children and (b) medically complex persons and/or persons with multi-occurring behavioral health conditions; (2) partners primary care, behavioral health, and public health and (c) has utilized Iowa State Innovation Model funding. This model recognizes that individuals may have different health/social determinant needs, which consequently require different medical homes with distinct supports – public health, primary care, or behavioral health. For high-risk individuals, the primary need often require supports from all three disciplines. Stakeholders include safety net providers, county social services, community funders, and community action agencies; with involvement from key community partners – schools; correctional facilities; law enforcement; area agency on aging; community paramedicine; and faith-based organizations, including the Salvation Army. This rural model has resulted in timely referrals, maximized patient outcomes, and leveraged scarce community resources. As an example, for asthmatic children or children with complex diagnosis, 100% have been referred to the Community Care Coordination (C3) program and received high-risk assessments. Assessments include a health and psycho-social assessment, and, when appropriate, medication reconciliation services. In Webster County, 130 Action Plans have been developed and implemented in coordination

with the school district, public health, and healthcare providers.

INTEGRATED PEDIATRIC SERVICE MODEL PAYMENT AND INCENTIVE ARRANGEMENTS

Perhaps the largest barrier to holistic care delivery is the current reimbursement structure. Although we are supportive of innovative service delivery initiatives and payment alternatives, we are concerned that pediatric care currently operates on a thin operating margin including supplementary philanthropic support. Present Medicaid Fee-For-Service rates are often below cost or break-even at best. Table 1 compares a state's Medicaid physician fees relative to Medicare fees in each state using 2014 data. It should be noted that this comparison does not incorporate Iowa's transition of Medicaid to managed care in April 2016. Since this transition was intended to save $50 million in the first year, we expect comparison rates in Iowa to be significantly reduced. In addition, we anticipate further downward pressure on Medicaid rates nationally if per-capita and/or block funding are implemented by ACA repeal efforts. As a result, we caution CMS against using current Medicaid Fee-For-Service rates as benchmarks for alternative payment models.

Table 1. Medicaid-to-Medicare Fee Index – National and UPH States

Location	All Services	Primary Care	Obstetric Care	Other Services
United States	**0.66**	**0.59**	**0.76**	**0.74**
Illinois	0.62	0.53	0.85	0.70
Iowa	0.82	0.75	0.83	0.98
Wisconsin	0.71	0.58	0.82	0.92

Source: The Henry J. Kaiser Family Foundation, Medicaid-to-Medicare Fee Index, accessed on March 22, 2017 at http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/

While broader service delivery models may enhance care coordination to avoid some duplication, support appropriate level of care determinations, and assist to efficiently leverage existing funding streams, payment models for this population need to reflect long-term benefits and cost-avoidance associated with preventive care as well as overutilization of services. When defining demonstrations, we urge the use broad, risk-stratified populations, instead of disease-specific populations. We also prefer an extended age range to define pediatrics – 0 to 25 and perhaps beyond for individuals with chronic complex conditions. For instance, a primary care pediatrician may have a provider relationship with a developmentally delayed or autistic individual since birth. It would seem arbitrary to force a new primary care relationship when a patient turns 18 or 25 years old.

At-Risk Children: Blank's Connections in Primary Care model is an example of a comprehensive medical home for pediatric primary care that incorporates community partnerships and targets children ages 0 to 5. The targeted clinic includes children experiencing poverty, exposed to childhood adverse events, and of immigrant and minority status and addresses social determinants of health head-on. As a preventive strategy, the challenge is to account for downstream cost-avoidance and quality of life or success factors (such as kindergarten readiness) alongside immediate service costs.

High-Need, High-Risk Children: UnityPoint at Home provides care to complex children and youth, such as

ventilator-dependent children. There are limited subacute beds in Iowa. These children may remain for extended period of time in acute care settings while waiting for a home health slot to open. Once in home health, the challenge is how to appropriately value this service. Beyond simply the home health costs, impact should examine avoidable days in acute care and the impact of inpatient versus home health care on quality of life and family disruption/satisfaction. Additionally, integration of behavioral health as well as other social services in the home setting should be similarly examined.

PEDIATRIC MEASURES

In general, payer contracts require healthcare providers to track and report on a multitude of measures to demonstrate value-based performance. The infrastructure required to support this reporting involves significant investment in technology and equipment, in-house personnel, vendor support, and outreach to providers and staff. At UPH, we track and report more than 150 measures for our six largest value-based contracts, including numerous similar measures with definitional variances requiring distinct collection and reporting rules. These measures include approximately 21 pediatric-specific measures (i.e. identified with age ranges that include below 18 years of age but exclusive of measures for all ages), such as immunization and BMI measures; however, there is not an industry consensus on a recommended pediatric measure set.

UPH requests that CMS avoid the temptation to excessively measure the pediatric population to account for intricacies related to its heterogeneous nature, the large divide between at-risk and high-need, high-risk populations, and the significant portion of relatively healthy children requiring few medical / health services. Instead of endorsing specific measures, we instead offer the following guidelines for their adoption. While UPH understands the need to identify some pediatric-specific measures, we urge CMS to identify only a small number of QPP-compliant measures. These measures would meet processes and guidelines set forth in the CMS Quality Measure Development Plan, use established CMS quality domains, and enable providers to meet MIPS or Advanced APM requirements. For evidence-based pediatric measures, the National Academies of Health, the Health Care Payment and Learning & Action Network (HCP-LAN), and the Pediatric Measures for Accountable Care (PMAC) committee should be consulted. When new measures are identified, they should be examined in light of current CMS measures with a trend towards less reliance on self-reported measures. The administrative burden associated with the collection of self-reported data is significant as providers must extract information either manually or via specially built EHR reports. UPH has consistently made comment to CMS that required measure sets should be streamlined and data sources should be utilized that reduce further administrative burden, particularly for providers in risk-bearing relationships.

Although not specific to pediatrics, UPH also encourages CMS to incorporate mental health status and social determinants of health within its overall population health strategy. We cannot overstate the importance of health risk assessments and appropriate, timely referrals in the promotion of overall health and well-being. We would expect that the CMS assessment and referral strategy would span the age spectrum (pediatric – adult – elderly), although the assessment/screening tools used may be age-specific.

Finally, UPH supports the use of outcomes or long-term goals beyond health status. For example, kindergarten readiness could be used for at-risk children age 0-5. We echo the comments of the Children's

Hospital Association that suggest that selected long-term performance targets, such as various school grade reading levels or graduation rates, should support improvements in adult health and well-being.

COORDINATION OF CMS POPULATION HEALTH INITIATIVES AND ALTERNATIVE PAYMENT MODELS

UnityPoint Health has been actively engaged and an early adopter of alternative payment methodology with both public and private payers. UPH is a current Next Generation ACO Model Participant having joined during the first cohort in 2016. From 2012 through 2015, UPH had regional participation in both the Pioneer ACO Model and the Medicare Shared Saving Model. In addition, UnityPoint Health affiliates are participating in the CMS Bundled Payments for Care Improvement Initiative (model 2), the Mandatory Episode Payment Model and the Medicare Care Choices Model. In terms of Medicaid, UPH has been involved in the Illinois Care Coordination Innovations Project (for Seniors and Persons with Disabilities) and Iowa Medicaid Health Home Program. As CMS considers pediatric payment alternative models, existing models and demonstration projects should be canvassed so as to glean best practices and also streamline processes, data reporting and collection, and other administrative requirements. This will enable providers that are participating in other models to also participate here. CMS should embed service delivery flexibility and defer to provider expertise to develop efficiencies. This should include programmatic waiver authority as well as waivers to the Stark law and certain HIPPA requirements. CMS should create models that permit providers to qualify as an Advanced Alternative Payment Method to capture payment reimbursement advantages under MACRA.

On behalf of our pediatric patients and their families and caregivers, UnityPoint Health appreciates the opportunity to provide input related to this Request for Information. In addition, Blank Children's Hospital is a member of the Children's Hospital Association (CHA). We support the comments submitted by CHA and are committed to participating with the CHA to further strengthen services and supports for the pediatric population. UnityPoint Health looks forward to participating in shaping future alternative payment models and other pediatric-related stakeholder forums. To discuss UPH 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,

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