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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): Direct Provider Contracting Models Request for Information

Submitted electronically via DPC@cms.hhs.gov

Dear Ms. Verma,

UnityPoint Health (UPH) appreciates the opportunity to provide comments regarding the Direct Provider Contracting Models Request for Information. 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 CMS 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 (UAC) is the ACO affiliated with UPH and has value-based contracts with multiple payers, including Medicare. UAC is the largest ACO participating in the Next Generation ACO Model with roughly 83,000 beneficiaries attributed to this program and has received first-year savings. Historically, UAC has providers that have participated in the Medicare Shared Savings Program (MSSP) as well as providers from the Trinity Pioneer ACO, which was the most rural ACO and achieved two years of savings.

It is from our ACO experience that we respectfully offer the following input.

In general, UPH is supportive of new payment and service delivery models that advance providers from volume to value. With the passage of MACRA, there is an urgency for CMS and the Innovation Center to develop more Advanced Alternative Payment Models (A-APMs). As these models are considered and developed, we are encouraged that CMS is seeking stakeholder input and that this Request For Information (RFI) is specifically exploring options for direct provider contracting. We also are pleased that the RFI recognizes that the CMS already offers some robust A-APMs that fit into a DPC model, such as ACOs, CPC+ and BPCI. If new DPC models are developed, we urge the Innovation Center to establish a clear 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 risk is increased, so should the opportunity for demonstration payment incentives and regulatory and operational flexibilities. We ask CMS 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.

PROVIDER/STATE PARTICIPATION

1. *How can a DPC model be designed to attract a wide variety of practices, including small, independent practices, and/or physicians? Specifically, is it feasible or desirable for practices to be able to participate independently or, instead, through a convening organization such as an ACO, physician network, or other arrangement?*

The most effective approach to facilitate greater participation by a wide variety of practices is to reduce and eventually eliminate the MIPS exemptions. MIPS has extensively excluded many rural providers through the rulemaking process and there is little incentive for these providers to aspire to A-APM participation. Additionally, the MACRA framework should simplify incentives with bonuses and small fee schedule increases generated in all APM frameworks (including MSSP Track 1). Focal to program success and sustainability, we encourage CMS to systematically bridge proportional risk to greater incentives. Instead of penalties, providers electing to not participate in APMs should not obtain a fee increase. To fund this measure, we propose the reallocation of the MIPS exceptional performance bonus dollars to be utilized within the context of this framework.

There is also substantial and comprehensive risk and resources required to participate as an A-APM, which significantly effects clinician engagement and participation. Tax incentives may serve 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 the form of 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 A-APM model. Distributed incentive earnings should not be considered as a loan and should not require physicians to match funds.

BENEFICIARY PARTICIPATION

8. *The Medicare program, specifically Medicare Part B, has certain beneficiary cost-sharing requirements, including Part B premiums, a Part B deductible, and 20 percent coinsurance for most Part B services once the deductible is met. Are these types of incentives necessary to test a DPC initiative?*

We agree that consumer participation in demonstration models may currently be acting as a barrier for physicians participating in A-APMs. To further entice beneficiary participation, we support the institution of direct financial benefits to beneficiaries. Maintaining a voluntary program mindset, the utilization of shared savings models enables payers and providers to share benefits; beneficiary incentives could take the form of wellness performance benefits, not just copayment waivers. We believe that these incentives should be tied to risk-bearing models and we encourage CMS to take a comprehensive look across all A-APM models and demonstrations to make these tools available in a standardized fashion.

GENERAL MODEL DESIGN

14. *Should quality performance of DPC-participating practices be determined and benchmarked in a different way under a potential DPC model?*

CMS has made measuring quality performance too complex, and each model varies. Instead of creating additional performance measures, we believe that any future models should strive to require streamlined quality data measurement under common domains and with a focus on outcomes, particularly when payment is tied to quality/value. We do not agree with the current and ever-expanding MIPS measurement approach that silos measurement within provider specialty, as we believe this dilutes any emphasis on population health and total cost of care.

15. *Are there other direct contracting arrangements in the commercial sector and/or with Medicare Advantage plans that CMS should consider testing in FFS Medicare and/or Medicaid?*

Medicare Advantage (MA) provides an important option for Medicare beneficiaries to access coordinated care and greater benefits. We support efforts to encourage provider-based MA plans with added flexibility to innovate and achieve better outcomes. The more MA governance is infused with providers and its payment structure can be divorced from Fee-For-Service limitations, the better MA plans will be able to drive innovation, better quality and outcomes, and lower costs. One such option would be a demonstration that enables high-value ACOs with third-party administration (TPA) capabilities to compete with MA plans. We believe this option has tremendous potential to achieve the greatest savings, highest quality and best patient experience as providers will be equipped with an aligned economic incentive to control costs and provide quality care with top patient experience.

As for Medicaid, we support 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. For providers that are ready to assume more risk (either two-sided risk based on Fee-For-Service or global capitation), we urge CMS to consider 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 Managed Care Organization (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.

EXISITING ACO INITIATIVES

21. *How can we strengthen such initiatives to potentially attract more physician practices and/or enable a greater proportion of practices to accept two-sided financial risk? What additional waivers would be necessary? Are there refinements and/or additional provisions that CMS should consider adding to existing initiatives?*

Greater Participation: To attract more providers and encourage two-sided financial risk, we recommend that CMS strengthen the current testing environment by providing certainty for those participating in demonstrations and that these demonstrations continue to include phased entry options.

UPH believes engagement amongst the early adoption community should be further explored. It is through the successes of these early adopters that others will be encouraged to follow. It also accelerates change as developed and tested by providers. That said, the uncertain future of models developed by the Innovation Center deters potential eligible clinician populations from transitioning to the A-APM framework. To correct the gray area encompassing A-APM participation, UPH strongly recommends that CMS 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.

Further, 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 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.

In recognition that participation in value-based care is a continuum, we urge CMS when possible to continue the use of payment tracks within demonstrations to promote a glide path to capitated payment, such as that available under MSSP or the Next Generation ACO model.

Additional Waivers: We strongly encourage CMS to act within its power to institute Stark Law exceptions for providers within a population-based risk-bearing A-APM model. We cannot understate the impact of this expanded waiver authority to expedite the process for providers looking to join A-APMs and increase clinician and patient responsiveness.

Program Refinements: We suggest that CMS develop more opportunities or tracks with global payments and associated flexibilities as well as strengthen data sharing in support of population health objectives and total cost of care.

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 CMS to continue offering global payment models that correspond to heightened regulatory flexibility. The goal with global payments is to free 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.

As for data sharing, we 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 to assess 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."

We also request that CMS 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, CMS could then choose to expand this data sharing beyond down-side risk ACOs.

We appreciate the opportunity to provide input on this Request For Information. 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,

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Vice President, Government & External Affairs