



UnityPoint Health

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October 16, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5524-P
P.O. Box 8013
Baltimore, MD 21244-8050

RE: **CMS-5524-P** - Medicare Program; Cancellation of Advancing Care Coordination through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Model; published in Vol. 82, No. 158 Federal Register 39310-39333 (Thursday, August 17, 2017).

Submitted electronically via <http://www.regulations.gov>

Dear Ms. Verma:

UnityPoint Health (UPH) is pleased to provide input in response to the Centers for Medicare & Medicaid Services' (CMS) proposed rule regarding mandatory episodic payment models. 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 6.2 million patient visits.

As an integrated healthcare system, UPH believes that patient-centered care is best supported by a value-based payment structure that enables healthcare providers to focus on population health instead of volume-based episodic care. UPH's commitment to population health and value-based care is evidenced by our status as an early adopter of an Accountable Care Organization framework, within the Pioneer ACO Model, the Medicare Shared Savings Model, and the Next Generation ACO Model. We also have regional participation in CMS Innovation Center Medicare models, including the Bundled Payments for Care Improvement (BPCI) Initiative and the Medicare Care Choices Model.

In terms of the mandatory bundle demonstrations, UPH had acute care hospitals in 5 of the initially selected MSAs. As a result of this Proposed Rule, all UPH hospitals are no longer mandated to participate.

TABLE 1. UnityPoint Health Affiliates in Impacted EPM and Cardiac Rehab Models

| MSA | MSA Title | UnityPoint Health Affiliates (legal names) | Comprehensive Care for Joint Replacement Model (CJR) | Surgical Hip and Femur Fracture Treatment (SHFFT) | Acute Myocardial Infarction (AMI) | Coronary Artery Bypass Graft (CABG) | Cardiac Rehabilitation Incentive Payment Model (CR) |
|-------|-------------------------------------|--|--|---|-----------------------------------|-------------------------------------|---|
| 16300 | Cedar Rapids, IA | St. Luke's Methodist Hospital | No | No | Yes | Yes | No |
| 19340 | Davenport-Moline-Rock Island, IA-IL | Trinity Medical Center | No | No | No | No | Yes |
| 19780 | Des Moines-West Des Moines, IA | Central Iowa Hospital Corporation | No | No | Yes | Yes | No |
| 47940 | Waterloo-Cedar Falls, IA | Allen Memorial Hospital Corporation | No | No | Yes | Yes | Yes |
| 31540 | Madison, WI | Meriter Hospital, Inc. | Yes | Yes | Yes | Yes | Yes |

Table 1 lists the hospitals across 3 states (Illinois, Iowa and Wisconsin) that were impacted by the former iteration of this rule.

We respectfully offer the following comments to this Proposed Rule.

CANCELLATION OF EPMs

CMS has proposed to cancel the Episode Payment Models (EPMs) and the Cardiac Rehabilitation (CR) incentive payment model. In addition, several changes are proposed to the Comprehensive Care for Joint Replacement (CJR) model, including a narrowed geographic scope, broaden clinician participation eligibility, and the inclusion of a MACRA-eligible track.

Comment: UPH supports the cancellation of these mandatory models. While UPH believes that CMMI has the authority to administer mandatory demonstrations, we believe that the timing of these mandatory demonstrations was premature and that the overlap provisions were not aligned to encourage or sustain risk-bearing population health Advanced Alternative Payment Models (AAPMs).

Models were Not Ready for Prime Time: These demonstrations were premature for several reasons. First, these mandatory bundles were proposed without the benefit of a thorough analysis of episodic payment demonstrations. When the first proposed rule (CMS-5519-P) was published on August 2, 2016, CJR, the first mandatory bundle, had just started on April 1, 2016, and the second year BCPI report had not been released. Despite this, CMS-5519-P proposed new EPMs and changes to CJR during its second quarter of operations to harmonize with EPMs. At that time, UPH questioned the

expansion of mandatory bundles when CJR rules were being revised.¹ We noted that frequent revisions diminish provider confidence in payment reform initiatives and our preference that CMS concentrate on prioritizing the voluntary BPCI rules. Second, these demonstrations were proposed and finalized without sufficient operational framework to allow timely and successful implementation by selected hospitals. Unlike the pre-work that occurred in 2012 prior to BPCI implementation, CMS did not supply “rules of the game” well in advance of implementation for providers to prepare and revise workflows and patient processes. Particularly with mandatory demonstrations, CMS must promote a timely dialogue with providers. In this case, technical assistance opportunities were lacking, the Medicare data sharing process had not begun, no referenced templates in such areas as beneficiary notice were published or distributed, and waiver guidelines were not provided. This seeming lack of operational urgency from CMS under estimated provider time, effort and expense required for staff training as well as for alignment of EHR systems, financial and quality reporting, and other infrastructure to meet EPM and incentive program protocols. The devil is in the details, and any mandatory projects should strive to provide as much operational detail as possible prior to implementation, including during the Proposed Rule stage.

Overlap Rules did not Encourage Population Health: Of utmost importance to our organization and the primary reason for our support of the EPM cancellation is the continued haphazard consideration of program overlap among CMS and CMMI initiatives. As mentioned, UPH through UnityPoint Health Accountable Care is a Next Generation ACO Model Participant and an early adopter of CMMI and CMS ACO models. We are extremely frustrated that, with each new APM, overlap rules permit episodic payments to erode population health payments. **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.** The overlap rules in proposed EPMs were the poster child for creating population health disincentives and would have imposed additional and necessary burdens on early adopters of Medicare risk-bearing ACO models.

- Proposed EPM Overlap Rule Implications: The proposed EPMs excluded Next Generation ACO and MSSP Track 3 beneficiaries and removed Next Generation ACOs and MSSP Track 3 ACOs from the definition of an EPM Collaborator. **At the crux of this issue is that Next Generation ACOs do not treat Next Generation ACO beneficiaries differently from other Medicare beneficiaries.** Of the Medicare beneficiaries served by UPH in 2016 for Cardiac EPM DRGs, Next Generation ACO attribution varied between 32-55%; meaning that the majority (a combined 57%) were outside the Next Generation ACO contract. This exclusion penalizes Next Generation ACOs by requiring bifurcated infrastructure systems for targeted EPM DRGs – two sets of beneficiary notices, programming tracking and reporting, operational processes, and waivers for Medicare beneficiaries. In addition, the proposed Next Generation ACO beneficiary exclusion creates potential confusion for beneficiaries. This exclusion separates Next Generation ACO beneficiaries from non-Next Generation ACO or EPM beneficiaries and may lead beneficiaries to question the

¹ UPH comment letter to CMS-5519-P submitted on October 3, 2016 via www.regulations.gov, tracking number 11kk00--88ss99ff--88zzjb.

relative benefits received under each initiative for which they had little say in participating (i.e. Next Generation ACO beneficiaries just recently obtained a voluntarily alignment process). Finally, a Next Generation ACO should have been included as an eligible EPM collaborator representing its Next Generation ACO Participant providers/suppliers in the context of another CMS reimbursement contract, like ACOs in Track 1 or 2 of the Medicare Shared Savings Program. By excluding risk-bearing ACOs from this definition, it requires individual Next Generation ACO providers to independently contract for financial arrangements, when the Next Generation ACO infrastructure is ideally set up to manage these arrangements.

- Overlap Challenges Among Existing APMs: The EPM overlap rules are just one illustration of the larger issue and its detraction from population health innovation. In one of our geographic regions, there are five operating CMS and CMMI sponsored payment models – Next Generation ACO, Medicare Shared Savings Program Track 3, Oncology Care Model, Comprehensive ESRD Care Model, and Bundled Payments for Care Improvement. These programs have differing rules related to attribution, financial implications, operational waivers, beneficiary notice, and other requirements. For our Next Generation ACO, which is responsible for overall population health for its attributed beneficiaries, this requires our staff to become experts in these other payment reform programs to understand how our beneficiaries are impacted and when we are no longer responsible for managing certain aspects of their health outcomes.

Current rules do not prioritize population health programs over episodic care programs – BPCI, OCM, and CERSDCM 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. This allows programs still based on FFS reimbursement to erode the financial modeling of population health programs. It also allows new episodic programs and their providers to skim off infrastructure investments made by population health programs for their beneficiaries – for instance, physician practices are utilizing EHR software at acute care facilities to meet reporting and other program requirements. Current rules do not require notice of attribution among programs nor inter-program care coordination – there is no proactive outreach to Next Generation ACOs when episodic care models receive attribution. When a beneficiary is attributed to multiple payment reform initiatives, current CMS and CMMI required notices do not adequately address overlap and create confusion. In alignment with incentivizing movement to value and risk-bearing arrangements, **it would seem more logical to leave attribution with total population health models, such as the Next Generation, then to shift extra administrative burden to, and remove revenue from, population health AAPMs.**

- Comprehensive Overlap Framework is Needed: CMS and CMMI should encourage and incentivize population health service delivery over episodic service delivery. Instead overlap has been an afterthought in the rush to release new AAPMs. Without a clear programmatic hierarchy that rewards the transition from volume to value, providers will be hesitant to bear greater risk and move to population health models. We would suggest that CMS use the existing payment model classification framework (Figure A)² refined by the Health Care Payment Learning & Action

² Alternative Payment Models Framework and Progress Tracking Work Group, “Alternative Payment Model (APM) Framework: Final White Paper,” published on January 12, 2016.

FIGURE A. Alternative Payment Model Framework



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. Presently, this service delivery prioritization does not exist, and CMMI simply categorizes its innovation models into categories: Accountable care; Episode-based payment initiatives; Primary care transformation; Initiatives focused on the Medicaid and CHIP population; Initiatives focused on the Medicare-Medicaid enrollees; Initiatives to accelerate the development and testing of new payment and service delivery models; and Initiatives to speed the adoption of best practices. Moving forward, **it would be extremely helpful for all new AAPMs to be placed in a service delivery hierarchy so that providers understand the scope of their risk-bearing obligations and the inter-relationship among CMS and CMMI programs.** As CMS develops this comprehensive framework, it should involve initial stakeholder input from existing AAPM Participants and then be subject to a public comment process.

- **Overlap Principles:** When developing future overlap rules, we offer the following suggestions:
 - **Risk-bearing population health models should take precedence over episodic care models for attribution and financial modeling.** Population health models with prospective attribute are particularly disadvantaged when population health programming, care coordination efforts, and financial modeling are undercut through the “partial” transfer of beneficiaries for episodic care. Instead, contracting with episodic care providers should be at the discretion of the population health model participant (such as an ACO) to allow the ACO service delivery flexibility.
 - **Population health models should take precedence over Fee-For-Service models for attribution and financial modeling.** This appropriately incentivizes transition to value and risk-bearing. Fee-For-Service models still ultimately reward service volume and may inappropriately incent hospitalizations or high-cost placements. The population health model participant should not be allowed to manage care for their population with minimal carve-outs, particularly carve-outs for Fee-For-Service models.
 - **Risk-bearing population health model participants should be allowed to opt out of participation in mandatory model demonstrations.** CMS should reward providers that voluntarily choose to accept risk. By granting population health models participants the

discretion to opt out, these model participants can innovate based on the needs and priorities of their beneficiaries and control the flow of funds within their service delivery model.

- **CMS develop a mandatory decision support tool that encompasses all payment reform models to assign attribution and financial modeling.** We urge CMS to develop a tool to clarify the pecking order for beneficiary attribution and financial implications (i.e. order in which models receives payment). We would also suggest that, upon the release of each new model, CMS and/or CMMI incorporate the model into the decision support tool.

Cardiac Rehabilitation (CR) incentive payment model: CMS has also proposed the cancellation of this incentive program. Should this incentive model resurface as a voluntary opportunity, UPH wants to reiterate our belief that CMS missed the largest opportunity to incentivize beneficiary behavior change – this model prohibited the use of incentive payments for the waiver of copayments. According to our providers, **the ability and/or desire of beneficiaries to make copayments is the largest stumbling block for beneficiaries to continue cardiac rehabilitation services.** While some beneficiaries will benefit from transportation incentives, transportation incentives are worthless if the beneficiary cannot afford service copayments. Assuming there is a \$20 copay, beneficiaries would have to expend \$220 out of pocket to reach the 12-session threshold. If 36 sessions were to occur, this would require \$720 in copayments. This is simply unaffordable for many beneficiaries when you add other cardiac medical expenses related to office visits and medications, let alone for beneficiaries who require more intensive post-acute services such as nursing home stays or home health visits. To make this model truly meaningful, we recommend that this incentive payment should enable providers more choice as to services/costs that would be reimbursable, including the waiver of copayments.

DATA SHARING

Similar to other proposed payment reform models, CMS had proposed to share upon request both raw claims-level data and claims summary data with EPM Participants.

Comment: UnityPoint Health does 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. In addition, we would like to encourage CMS to advance the following concepts:

- **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.”
- **Access to All-Payer administrative claims data.**

Overall, the cancellation of this mandatory demonstration allows our AAPM (i.e., Next Generation ACO Participant) to continue its strategic investment in population health initiatives based on our populations/communities, instead of in an effort to comply with conflicting CMS mandates. On behalf of

our patients and their families and caregivers, UnityPoint Health appreciates the opportunity to provide input and looks forward to participating in shaping future alternative payment models. To discuss UPH comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Executive Director of Regulatory Affairs, at cathy.simmons@unitypoint.org or 319-361-2336.

Sincerely,



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