UnityPoint Health

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April 19, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5519-IFC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS-5519-IFC - Medicare Program; Advancing Care Coordination through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model; Delay of Effective Date; published Vol. 82, No. 53 Federal Register 14464-14466 (Tuesday, March 21, 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) Interim Final 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 5.6 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.

For the payment reform initiatives contemplated in this Interim Final Rule, UPH has acute care hospitals

in 5 of the selected MSAs. Our impacted hospitals are identified in Table 1 and cover 3 states – Illinois,

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

Iowa and Wisconsin. In addition, please note that the Madison, Wisconsin region has been selected for all bundles as well as the Cardiac Rehabilitation Incentive Payment Model, which places a significant burden on this region and its providers.

We respectfully offer the following comments to this Interim Final Rule.

DELAYED IMPLEMENTATION START DATE

CMS has proposed to delay the implementation date from July 1, 2017 to October 1, 2017. UPH wholeheartedly supports the delay in start date until October 1. As of the filing of these comments, CMS has held only one Technical Assistance webinar, which was a broad overview lacking specific operational details. In addition, CMS has not begun the Medicare data sharing process, published/distributed any referenced templates in such areas as beneficiary notice, or provided waiver guidelines. UPH cannot overemphasize the fact that these "rules of the game" are needed well in advance of implementation for providers to prepare and revise workflows and patient processes. Not only will provider and staff training be needed, but EHR systems, financial and quality reporting, and other infrastructure must be revised to align with EPM and incentive program protocols. Based on the same rationale, UPH would also support a delay in implementation until January 1, 2018. The more lead time for planning and preparation as well as opportunities to engage in stakeholder technical assistance forums, the more likely the provider community will be able to respond and perform to CMS expectations. Presently, we do not have adequate details regarding CMS program expectations, which makes program preparations difficult at best.

IMPACT OF DELAYED START DATE ON OPERATIONS

Performance Period: Given the proposal to shorten the first performance period from six months to three months, CMS is seeking input regarding the appropriate length for the first performance period. UPH believes that performance years need to be longer than three months and ideally should reflect at least a 12-month period. A longer duration is preferred so that performance outcomes have time to produce meaningful results and trends and first-year timeframes are comparable to subsequent performance years throughout the initiative. From that perspective, UPH supports either (1) combining the October-December 2017 period with the second full performance year to create a 15-month first performance year or (2) requesting that the delay be extended until January 1, 2018 and have that 12-month period be the first performance year. In either case, we would advocate that the project terminates after December 31, 2021 (performance year 4) and not be extended an additional year.

Downside Risk: Although CMS has not specifically sought comment on the impact of delayed implementation on downside risk, we believe that downside should continue to occur no sooner than performance year 3. Whether the first performance year is 15 or 12 months, UPH encourages that mandatory downside risk be delayed until 2020 (new performance year 3). This progression to downside risk will enable providers to obtain reports and financial reconciliation for at least one full performance year prior to entering downside risk on a mandatory basis. As an early adopter of other CMS Innovation Center initiatives, we have found great benefit to a two-year period for trial performance (without downside risk) to work with CMS to remove any kinks from the process. While we urge a delay in mandatory downside risk until 2020, we would support earlier timeframes for voluntary downside risk bearing for those entities wishing to qualify as an Advanced APM under the Quality Payment Program.

Data Sharing: Despite any delay in the start date, UPH would like to reiterate our desire to receive Medicare claims data in support of this initiative as soon as possible. This IFC review period should not be used to further delay the sharing of claims data. Ideally, we would prefer receiving this dataset at least three months prior to the project implementation start date. If we receive relatively clean data and have reports prebuilt, just uploading and scrubbing the data will take a minimum of 30 days before the data becomes actionable and is in a format that may be presented to our providers and supporting teams in finance and process excellence.

EPM / CJR OPERATIONAL IMPERATIVES

Next Generation ACO Overlap: As a Next Generation ACO (NGACO) Participant, UPH urges CMS to reconsider its exclusion of NGACO beneficiaries from this model as well as the exclusion of a NGACO from the definition of EPM Collaborator. The current exclusions create additional burdens for NGACOs, who have agreed to bear heightened risk for a defined Medicare beneficiary population. *At the crux of this issue is that NGACOs do not treat NGACO beneficiaries differently from other Medicare beneficiaries.* Of the Medicare beneficiaries served by UPH in 2016 for Cardiac EPM DRGs, NGACO attribution varied between 32-55%; meaning that the majority (a combined 57%) were outside the NGACO contract. This exclusion penalizes NGACOs by requiring bifurcated infrastructure systems for targeted EPM DRGs – two sets of beneficiary notices, programing tracking and reporting, operational processes, and waivers for Medicare beneficiaries. In addition, the proposed NGACO beneficiary exclusion creates potential

confusion for beneficiaries. This exclusion separates NGACO beneficiaries from non-NGACO or EPM beneficiaries and may lead beneficiaries to question the relative benefits received under each initiative for which they had little say in participating (i.e. NGACO beneficiaries just recently obtained a voluntarily alignment process). Finally, a NGACO should be included as an eligible EPM collaborator representing its NGACO Participant providers/suppliers in the context of another CMS reimbursement contract, like ACOs in Track 1 or 2 of the Medicare Shared Savings Program.

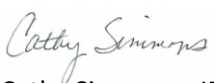
Hospitals as Risk Bearers: UPH reiterates its support of hospitals as the risk-bearing entity for these EPMs. The cost of the targeted DRGs largely involve acute care expense, both the initial stay and subsequent avoidable readmissions, and are initiated with the inpatient admission, which make hospitals the most appropriate entity to bear risk. As CMS further reviews this Interim Final Rule, we would encourage that the hospitals remain as risk bearers. While there may be some bundled arrangements where other providers are responsible for a larger percentage of the Medicare cost and may be appropriate to assume financial risk, the bundles at hand do not seem to represent those DRGs or conditions.

CARDIAC REHABILITATION INCENTIVE PAYMENT MODEL IMPERATIVES

The premise being tested in this model is that better outcomes result when beneficiaries have at least 12 cardiac rehabilitation sessions. In support of this premise, UPH believes that CMS has missed the largest opportunity to incentivize beneficiary behavior change – this model prohibits the use of incentive payments for the waiver of copayments. The ability and/or desire of beneficiaries to make copayments is the largest stumbling block for patients 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 will have had 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, this incentive payment should enable providers more choice as to services/costs that would be reimbursable, including the waiver of copayments.

On behalf of our patients and their families and caregivers, UnityPoint Health appreciates the opportunity to provide input related to this Interim Final Rule. UnityPoint Health 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,



Cathy Simmons, JD, MPP
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