COMMUNITY HEALTH PROVIDER ALLIANCE
LEADERS IN INTEGRATED PRIMARY CARE

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1701-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via https://www.regulations.gov/comment?D=CMS-2018-0101-0001

**Re: CMS-1701-P, Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success**

Dear Administrator Verma,

On behalf of our community's Accountable Care Organization, Community Health Provider Alliance (CHPA), we would like to take this opportunity to express the interest federally qualified health centers (referred to here as FQHCs, or "health centers") have in the Medicare Shared Savings Program (MSSP).

Our ACO is a not-for-profit community-based organization comprised solely of FQHCs in Colorado. Our health centers are non-profit, community-directed providers that serve as the primary medical home for 790,000 patients in our state, including more than 1 in 7 Coloradoans.

We welcome the opportunity to respond to CMS' Pathways to Success NPRM. While we believe the proposed rule includes important steps toward increased success, there are several areas where we raise caution and seek clarification. In summary, our comments will focus on the following areas:

- Health centers are important partners in accountable care arrangements, producing cost savings for the system and enhanced quality of care for beneficiaries and look forward to continuing this work together.
- CMS should invest in a more gradual pathway to increased levels of financial risk for low-revenue provider-led accountable care organizations (ACOs), with consideration made to those ACOs comprised solely of FQHCs.
- Many FQHCs, because they provide care to some of the most underserved communities in the country, require additional investment to prepare for two-sided risk arrangements.
- Increased flexibility in the ability to provide telehealth services will support health centers participating in the Pathways to Success Program.
- A more appropriate benchmarking process will support participating health centers in delivering the best care for the vulnerable populations they serve.
- CMS should be mindful of inadvertently causing "cherry-picking" of patients by allowing ACOs to provide beneficiary incentives.

We are in opposition to a few key aspects of the recent proposed Pathways to Success rule, in particular the agency's proposal to cut ACOs shared savings rates below 50 percent, reduce the time in a shared savings-only model from six to two years, and application of a +/- 3 percent risk adjustment cap across an extended agreement period.

These proposed changes will harm patients and providers by limiting improvements in savings and quality ACOs provide, while slowing progress made in transitioning to value-base payments. Our ACO has made a significant investment in funding the operations to support the MSSP, and a reduction in potential savings will greatly impact our ability to reinvest in our care models/teams and will significantly limit our ability to generate enough capital to meet the repayment mechanism requirements. As a non-profit, low revenue ACO, our ACO may be forced out of the MSSP because we will lack the capital required for the repayment mechanism. Our initial intention was to build up that capital over the course of 6 years under the current system, but that timeline is drastically reduced with the proposed changes.

We appreciate CMS' recognition of the additional time many provider-led ACOs may need to transition to higher levels of two-sided risk by allowing provider-led ACOs to cycle through the "BASIC" track for two agreement periods. However, this still only allows provider-led ACOs two years without taking on financial risk. Due to the pace of data sharing and the imperative to transform care models, we recommend CMS allow provider-led ACOs an even more gradual pathway to two-sided risk. Specifically, we suggest CMS allow provider-led ACOs a minimum of three years in the "BASIC" track in an upside-only arrangement.

While we support incorporating regional expenditures in the benchmark established for an ACO's first agreement, we are concerned that the two proposed policies to limit the magnitude of the adjustment undermines the policy goals. As CMS has recognized, the incorporation of regional expenditures provides an ACO with a benchmark that is more reflective of FFS spending in the ACO's region than a benchmark based solely on the ACO's own historical expenditures. This approach creates stronger financial incentives for ACOs that have been successful in reducing expenditures to remain in the program, thus improving program sustainability. It also allows CMS to better capture the cost experience in the ACO's region, the health status and socio-economic dynamics of the regional population, and location-specific Medicare payments when compared to using national FFS expenditures.

We disagree that higher weights for the regional adjustment results in potential windfall gains to lower-cost ACOs. Those gains are not windfalls but compensate lower-cost ACOs for the work invested in practices to reduce the overall costs of care for Medicare beneficiaries. In fact, a lower-cost ACO composed of FQHCs may have higher expenditures for primary care due to the Prospective Payment System (PPS) methodology as compared to regional expenditures for primary care services that are generally reimbursed under the Medicare fee schedule. The risk adjustment benchmarking cap uniquely will harm our non-profit FQHC-based ACO. In the past, our coding processes were fairly rudimentary which is evidenced by our unusually low risk adjustment scores and unusually low benchmarks given the patient population we serve. Our network's understanding of risk adjustment is relatively new, but we've implemented coding improvement efforts to more accurately reflect the acuity of our patients and to better capture HCC codes annually. The proposed limit of +/-3% would mitigate our efforts to improve in these crucial areas which impact our ability to be successful in the MSSP.

On the other hand, we support a number of proposals in the rule and encourage CMS to finalize its proposals to: 1) move to five-year agreement periods; 2) reduce burdens related to quality reporting; 3)

expand the use of waivers for telehealth and skilled nursing facility stays; and 4) provide flexibility with choosing assignment methodology regardless of risk model.

The proposed provisions related to allowing ACOs to provide and be reimbursed for telehealth services, will help health centers continue to meet the unique needs of their communities in the most cost-efficient ways. However, while the preamble to the proposed rule outlines the process for which a provider can be reimbursed for his or her telehealth work, it is not clear how this new provision will impact health centers. Health centers are currently limited to serving as originating sites only and are not able to provide or be reimbursed as a distant site in Medicare. The preamble and proposed rule make reference to "physicians and providers" using the ACO's TIN, however it is not clear if this provision will allow health centers to fully participate in the telehealth provisions. We encourage CMS to clarify the language in the proposed rule in order to clearly allow health centers to provide this valuable service through their work in an ACO.

FQHCs are unique in that they are both required by federal law and committed to serving everyone that seeks care and must serve communities most in need of care. They turn no patient away, regardless of income, insurance status, risk, or complexity. This open-door policy is a defining feature of the health center mission of providing quality, affordable access to care to all who need it. Additionally, beneficiaries' freedom of choice is an important way for practices and payers, including Medicare, to gauge practice effectiveness and the demand for access to health care services in specific communities. Should CMS decide to allow ACOs to incentivize beneficiaries, it should implement safeguards to ensure that higher-revenue ACOs do not inadvertently attract healthier patients, potentially skewing quality metrics and leaving sicker patients with fewer options.

Thank you again for your work on behalf of patients and providers to advance value-based payment. We appreciate your interest in sustaining the success of Medicare ACOs and creating an environment where providers are encouraged to enter into value-based payment arrangements and help patients receive high-quality, coordinate care.

Sincerely,

Kerry Cogan
Chief Executive Officer
Community Health Provider Alliance (CHPA)