NATIONAL ASSOCIATION OF Community Health Centers

Main Office
7501 Wisconsin Ave.
Suite 1100W
Bethesda, MD 20814
301.347.0400 Tel
301.347.0459 Fax

Division of Public Policy and Research
1400 Eye Street, NW
Suite 910
Washington, DC 20005
202.296.3800 Tel
202.296.3526 FAX

October 16, 2018

Center for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1701-P
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted electronically via www.regulations.gov

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

Dear Administrator Verma:

On behalf of the National Association of Community Health Centers (NACHC), we would like to take this opportunity the express the interest federally qualified health centers (referred to here as FQHCs, or "health centers") have in the Medicare Shared Savings Program (MSSP).

NACHC is the national membership organization for federally qualified health centers (FQHCs or "health centers"). With over 1,400 organizations and more than 11,000 sites nationwide, health centers are non-profit, community-directed providers that serve as the primary medical home for over 28 million patients, including 1 in 6 Medicaid beneficiaries. Health centers serve as the largest primary care network in the country providing comprehensive services in all 50 states and U.S. Territories. For more detail on health centers, please see Attachment A.

NACHC welcomes the opportunity to respond to CMS' Pathways to Success NPRM. While NACHC believes the proposed rule includes important steps toward increased success, there are also 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 provider-led accountable care organizations (ACOs).
- 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.

Health centers are important partners in accountable care arrangements, producing cost savings for the system and enhanced quality of care for beneficiaries.

Today, health centers across the country, in both rural and urban settings, participate in a variety of value-based and accountable care initiatives. Health centers pride themselves on the high quality of care that they deliver. Studies show that health centers are leaders in primary care and consistently perform better on a wide range of ambulatory care quality measures than private physicians, exceeding Medicaid managed care organization high performance benchmark scores in areas including diabetes control, blood pressure control, and PAP tests.[1,2] They do this while achieving significant cost savings – nearly $24 billion annually to the health care system.[3]

Additionally, health centers are on the leading edge of primary care practice transformation and innovation. Over 70 percent of health centers are nationally recognized patient center medical homes. Many are working toward integrated models of care, taking a patient-centered approach to providing behavioral health and substance use disorder services. In 2017 alone, health centers provided almost 11 million visits for mental health and substance abuse services. Health centers are also meaningfully leveraging technology as part of their practice transformation efforts with nearly 100 percent of the total health centers utilizing an electronic health record (EHR) system, and 57 percent of health centers across the country using telehealth or are in the process of implementing a telehealth program.

CMS should invest in a more gradual pathway to increased levels of financial risk for provider-led accountable care organizations (ACOs).

Many health centers are actively engaging in value-based and accountable care initiatives, outlined further in Attachment B. Health center participation in these models – ranging from ACOs to multi-payer initiatives – have demonstrated cost-savings and high-quality outcomes. In fact, a review of the 2014 MSSP performance year found that 44 percent of provider-led ACOs that included at least one FQHC achieved shared savings compared to just 28 percent of all ACOs. Furthermore, health centers often participate in provider-led ACOs, and these ACOs in both upside-only and two-sided risk arrangements saved more money in performance year 2017 than ACOs in only two-sided risk arrangements ($0.182 billion versus $0.033 billion, a difference of nearly $150 million).[4] Clearly, health centers' record of cost-efficient, high quality and comprehensive care health centers provide makes them powerful drivers of cost savings in accountable care arrangements.

---

[1] Goldman, LE et al. Federally Qualified Health Centers and Private Practice Performance on Ambulatory Care Measures. American Journal of Preventive Medicine. (2012). 43(2):142-149. | Fontil et al. Management of Hypertension in Primary Care Safety-Net Clinics in the United States: A Comparison of Community Health Centers and Private Physicians' Offices. Health Services Research. (April 2017). 52:2.

[2] Shin P, Sharac J, Rosenbaum S, Paradise J. Quality of care in community health centers and factors associated with performance. Kaiser Commission on Medicaid and the Uninsured Report #8447 (June 2013).

[3] Ku L,et al. Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform. Geiger Gibson/RCHN Community Health Foundation Collaborative at the George Washington University. Policy Research Brief No. 19. (June 2010).

[4] Source: CMS analysis. Data for performance year 2016. A negative net impact means program savings; a positive net impact means program costs.

As health centers often operate on razor thin margins, it can be challenging for them to take on a two-sided risk arrangement and, most especially, the high level of financial risk proposed in the Pathways to Success "Enhanced" track. An investment of time and resources is required to adapt new models of care and develop new financial relationships with other providers. For many health centers, the two years CMS proposes to allow for that investment through upside-only, shared savings arrangements is not sufficient. The claims data from Medicare often arrives months after the fact, but this data is vital to health centers, which must adjust their care model to produce the highest quality outcomes and bend the cost curve. NACHC appreciates 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, NACHC recommends CMS allow provider-led ACOs an even more gradual pathway to two-sided risk. Specifically, NACHC recommends CMS allow provider-led ACOs a minimum of three years in the "Basic" track in an upside-only arrangement.

Because health centers provide care to some of the most underserved communities in the country, they often require additional investment to prepare for two-sided risk arrangements.

Health centers provide services to some of the most underserved and vulnerable populations in the country including a disproportionate share of the country's most economically disadvantaged – 71 percent of health center patients live at or below 100 percent of the federal poverty line. Health centers participating in shared savings arrangements have been able to leverage those dollars to continue transforming care for their patients – expanding needed services, investing in telehealth infrastructure, hiring providers despite serious workforce shortages, and opening new access points in areas of need. All of these activities are essential to ensure that health centers operating in two-sided risk arrangements are able to successfully maintain and even enhance the quality of care they provide. As such, NACHC recommends that for provider-led ACOs, CMS increase the shared savings rate in years 1 and 2, the upside-only years of the "Basic" track, to at least 35 percent. This would enable health centers, who provide care in some of the most underserved communities in the country, to best prepare for a two-sided risk arrangement in subsequent years of the "Basic" track and in the "Enhanced" track.

Increased flexibility in the ability to provide telehealth services will support health centers participating in the Pathways to Success Program.

The key to health centers' success in care transformation and cost-effectiveness is the unique health center model. This includes a commitment to serve all individuals who come through their doors regardless of their ability to pay, the provision of a broad array of primary and preventative services under one roof, and a patient-controlled Boards of Directors that ensure accountability to the community.

At the same time, health centers are often at the forefront of technology advances, with 57 percent of health centers either currently using telehealth or in the process of implementing a

telehealth program. The proposed provisions related to increased provider flexibility, in particular 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. NACHC encourages 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.

A more appropriate benchmarking process will support participating health centers in delivering the best care for the vulnerable populations that they serve.

Under current policies applicable to establishing the benchmark for ACOs beginning a second or subsequent agreement period in 2017 and later years, CMS replaces the national trend factor with regional trend factors, using a phased approach to adjust the rebased benchmark to reflect a percentage of the difference between the ACO's historical expenditures and FFS expenditures in the ACO's regional service area, depending on whether the ACO is found to have lower or higher spending compared to its regional service area. Ultimately a weight of 70 percent will be applied in calculating the regional adjustment for all ACOs beginning no later than the third agreement period in which the ACO's benchmark is rebased using this methodology, unless the Secretary determines that a lower weight should be applied.

The proposed rule would incorporate regional expenditures, including the regional adjustment and regional trend and update factors, in the benchmark established for an ACO's first agreement period. However, the proposed rule applies two policies to limit the magnitude of the adjustment: (1) reducing the weight that is applied to the adjustment from a maximum of 70 percent to a maximum of 50 percent and (2) imposing an absolute dollar limit on the adjustment. The reason for those limitations is due to concern that, as the higher weights for the regional adjustment are phased in over time, the benchmarks for low-spending ACOs may become overly inflated to the point where these organizations need to do little to maintain or change their practices to generate savings, resulting in potential windfall gains to lower-cost ACOs.

While NACHC supports incorporating regional expenditures in the benchmark established for an ACO's first agreement, NACHC is 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.

NACHC disagrees 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. Accordingly, NACHC encourages CMS to reconsider limiting the magnitude of the regional adjustment through an absolute dollar limit and in its place consider increasing the maximum weight applied to adjustments to 75 percent.

CMS should be mindful of inadvertently causing "cherry-picking" of patients by allowing ACOs to provide beneficiary incentives.

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.

We also encourage CMS to take appropriate measures to ensure that there are no anti-kickback or physician self-referral laws violated through this beneficiary incentive process.

In closing, NACHC appreciates the opportunity to submit comments on this important rule, and both our staff and our member health centers would be happy to provide any further information that would be helpful.

Sincerely,

Jana Eubank
Vice President, Public Policy & Research
National Association of Community Health Centers

NATIONAL ASSOCIATION OF Community Health Centers

Attachment A:

OVERVIEW OF FEDERALLY QUALIFIED HEALTH CENTERS

For over 50 years, health centers have provided access to quality and affordable primary and preventive healthcare services to millions of uninsured and medically underserved people nationwide, regardless of their ability to pay. At present there are almost 1,400 health centers with more than 11,000 sites. Together, they serve ***over 28 million patients***, including 8.4 million children and more than 1 in 6 Medicaid beneficiaries.

Health centers provide care to all individuals, regardless of their ability to pay. All health centers provide a full range of primary and preventive services, as well as services that enable patients to access health care appropriately (e.g., translation, health education, transportation). A growing number of Health Centers also provide dental, behavioral health, pharmacy, and other important supplemental services.

To be approved by the Federal government as a Health Center, an organization must meet requirements outlined in Section 330 of the Public Health Service Act. These requirements include, but are not limited to:

- Serve a federally-designated medically underserved area or a medically underserved population. Some Health Centers serve an entire community, while other target specific populations, such as persons experiencing homelessness or migrant farmworkers.
- Offer services to all persons, regardless of the person's ability to pay.
- Charge no more than a nominal fee to patients whose incomes are at or below the Federal Poverty Level (FPL).
- Charge persons whose incomes are between 101% and 200% FPL based on a sliding fee scale.
- Be governed by a board of directors, of whom a majority of members must be patients of the health center.

Most Section 330 health centers receive Federal grants from the Bureau of Primary Health Care (BPHC) within HRSA. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing care to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients who are not indigent or who have insurance, whether public or private, are expected to pay for the services rendered. In 2017, on average, the insurance status of Health Center patients is as follows:

- 49% are Medicaid recipients
- 23% are uninsured
- 18% are privately insured
- 9% are Medicare recipients

No two health centers are identical, but they all share one common purpose: to provide primary health care services that are coordinated, culturally and linguistically competent, and community-directed, to uninsured and medically underserved people.

NATIONAL ASSOCIATION OF Community Health Centers

Attachment B:

EXAMPLES OF HEALTH CENTERS ENGAGING IN PAYMENT AND DELIVERY REFORM INITIATIVES

Health centers nationwide are successfully engaging in a variety value-based initiatives in both Medicare and Medicaid. Examples of such statewide and regional initiatives are provided below. In addition these larger initiatives, individual health centers also hold value-based agreements with payers including Medicaid managed care organizations.

Health Homes

Health centers in 14 states have been active participants in Health Homes programs implemented in their states.

In **Missouri**, the Primary Care Association (which represents FQHCs) and the state Medicaid agency collaboratively designed a State Plan Amendment to implement Section 2703 of the ACA. The PCA monitors progress, provides solutions to implementation challenges, and provides quality coaching and population health tools and data analytics to improve performance. This Health Homes initiative is improving care coordination and service integration for individuals with chronic conditions while improving quality and reducing costs.

Multi-Payer Initiatives

Health centers have been engaged in the current Multi-Payer Advanced Primary Care Practice demonstrations hosted by the Center for Medicare and Medicaid Innovation. Health centers are also participating in other state-based multi-payer initiatives.

In **Ohio** the Department of Medicaid, in conjunction with the Office of Health Transformation, received the State Innovation Model grant to launch the Ohio Comprehensive Primary Care (CPC), an investment in primary care infrastructure intended to support improved population health outcomes. CPC is a patient-centered medical home program, which is a team-based care delivery model led by primary care practices that comprehensively manage patients' health needs. Currently 20 Ohio FQHC networks are participating in the first cohort, accounting for 57 of the 92 participating sites. This initiative will deliver a coordinated, comprehensive model that will improve the health of patients while aligning the method of payment to incentivize positive health outcomes.

Integrated Networks (ACOs, IPAs)

Health centers across the country are actively involved in accountable care organizations participating in the **Medicare Shared Savings Program** (MSSP). These value-based partnerships are enabling health centers to be rewarded for the valuable primary and preventative care they provide and their long history of working with both clinical and non-clinical partners to deliver coordinated, cost-effective care. In performance year 2014, RTI's evaluation of the MSSP found that among participating ACOs that included at least one FQHC (with no hospital), 44% achieved shared savings compared to 28% of all ACOs.

In **Kentucky**, the Primary Care Association (which represents FQHCs) formed an independent practice association (IPA) with FQHCs and rural health clinics (RHCs) in the state in 2011. The IPA focuses on building the support structure to enable participating FQHCs and RHCs to manage costs and improve the quality of care provided to patients. The IPA has established value-based contracts with Medicaid managed care, Medicare advantage, and commercial health plans. Additionally, several of the Kentucky FQHCs and RHCs have also worked with the PCA to form a MSSP ACO, which is showing positive trends.

In **Minnesota**, ten FQHCs have formed a safety-net accountable care organization, Federally Qualified Health Center Urban Health Network (FUHN), as part of the state's Medicaid Integrated Health Partnership program. To date, FUHN has saved Minnesota and federal taxpayers over $16 million. These savings are a result of robust care coordination services and data analytics that reduced emergency department use by 20%. These results were achieved with the underlying FQHC PPS structure in place. Moreover, the state Medicaid agency recently recommended updating the FQHC PPS rates to recognize their investments in value-based care.

In **Vermont**, seven FQHCs formed an accountable care organization, Community Health Accountable Care (CHAC). CHAC entered into shared savings arrangements with Medicare, Vermont Medicaid, and Blue Cross and Blue Shield of Vermont in 2014. In its first year as an ACO, CHAC saved Vermont $7.8 million in Medicaid health care costs and received $3.35 million through the shared savings program agreement. Since its inception, CHAC's network has grown to include 10 FQHCs, 4 rural health clinics, 7 hospitals, 14 mental health and specialized services designated agencies, and 9 certified home health agencies. The FQHCs continue to be actively engaged in the payment and delivery reform efforts in the state as Vermont looks to transition to an all-payer ACO model.