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Community Health Care Association of New York State www.chcanys.org

COMMUNITY HEALTH CENTER FQHC QUALITY

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:

The Community Health Care Association of New York State (CHCANYS) would like to take this opportunity the express the interest that New York State's federally qualified health centers (referred to here as FQHCs, or "health centers") have in the Medicare Shared Savings Program (MSSP).

CHCANYS is New York State's Primary Care Association for FQHCs. CHCANYS operates as an advocate and voice for health centers across New York State, with over 750 sites serving 2.2 million patients annually. FQHCs are non-profit, community run centers located in medically underserved areas that provide high-quality, cost effective primary care, including behavioral and oral health services, to anyone seeking it, regardless of their insurance status or ability to pay. Each FQHC is governed by a consumer-majority board of directors who seek to identify and prioritize the services most needed by their communities. In short, FQHCs are New York's primary care safety net providers - keeping people well in the community and out of higher cost institutional based settings.

CHCANYS supports comments submitted by the National Association for Community Health Centers (NACHC) and has restated those comments below.

CHCANYS welcomes the opportunity to respond to CMS' Pathways to Success NPRM. While CHACNYS 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 90 percent of health centers in New York State 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. Health centers are also meaningfully leveraging technology as part of their practice transformation efforts with 100 percent of the New York State FQHCs utilizing an electronic health record (EHR) system, many of which are also implementing 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. Health center participation in these models – ranging from ACOs to multi-payer initiatives – have demonstrated cost-savings and high-quality outcomes. In fact, a national 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.

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[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. CHCANYS 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, CHCANYS recommends CMS allow provider-led ACOs an even more gradual pathway to two-sided risk. Specifically, CHCANYS 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.

New York health centers provide services to some of the most underserved and vulnerable populations in the state including a disproportionate share of the state's most economically disadvantaged – 76 percent of health center patients in NYS 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, CHCANYS 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 many 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. CHCANYS 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 CHCANYS supports incorporating regional expenditures in the benchmark established for an ACO's first agreement, CHCANYS 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.

CHCANYS 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, CHCANYS 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, CHCANYS 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,

Rose Duhan

Rose Duhan
President & CEO
Community Health Care Association of New York State