

October 16, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success [CMS–1701–P]

The Patient-Centered Primary Care Collaborative (PCPCC) appreciates this opportunity to provide comment on the Administration’s new direction for the Shared Savings Program by establishing pathways to success. PCPCC applauds the Department of Health and Human Services for demonstrating its commitment to the future of the Medicare Shared Savings Program (MSSP) by making bold changes to ensure there is a clear path to risk-based accountable care. We are, however, concerned by estimates that far fewer organizations would choose to join or remain in the MSSP program. We encourage CMS to balance its effort to incentivize accountable care organizations (ACOs) to move more quickly to risk with the need to maintain a healthy pool of ACOs moving along the risk continuum.

PCPCC Background and Vision for Primary Care

Founded in 2006, PCPCC is a not-for-profit multi-stakeholder membership organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the Patient-Centered Medical Home (PCMH). Representing a broad group of public and private organizations – including payers, healthcare clinicians and other providers, leading corporations and patient and consumer advocacy groups – the PCPCC’s mission is to unify and engage diverse stakeholders in promoting policies and sharing best practices that support growth of high-performing primary care to achieve the “Quadruple Aim”: better care, better health, lower costs, and greater joy for clinicians and staff in delivery of care.

In 2017, PCPCC published the [Shared Principles of Primary Care](#) – identifying an ideal vision of primary care that builds upon advanced primary care concepts such as the PCMH. These Shared Principles were developed by stakeholders representing all aspects of healthcare and nearly 300 organizations have signed on in support of them. They are designed to move the United States toward a vibrant future of person-centered, team-based, community aligned primary care that will drive better health, better care, and lower costs. They also put an emphasis on all stakeholders stewarding precious healthcare resources. It is important that any effort to empower primary care take note of the consensus principles and seek to achieve the vision they represent.

Advanced Primary Care is the Foundation for Successful ACOs

Empowered primary care, as exemplified by the PCMH model and demonstrations such as Comprehensive Primary Care Plus (CPC+), create a team-based care structure and incent the population-based delivery approach that forms the foundation of successful ACOs. Key elements within the Shared Principles of Primary Care – such as an emphasis on health promotion and prevention, increased access to first-contact care, and partnering with patients to manage chronic conditions facilitate the focus on high-value care that is necessary for strong ACO outcomes. These interventions can reduce emergency department use and unnecessary hospitalizations and align incentives across the medical neighborhood to support outcomes in ACOs.

PCPCC remains strongly committed to accountable care and appreciates efforts by CMS to strengthen the program and move more participants to risk-bearing models. We continue to believe there is a path forward for continued efforts to align a variety of CMS programs designed to encourage high-value care and consumer satisfaction – including both PCMHs and ACOs. Many program rules and restrictions, quality measures, and reporting requirements could be better aligned to simplify participation for clinicians and better align incentives across programs.

Advanced Primary Care and the ACO Program

Recent research conducted by the PCPCC¹ demonstrates the importance of PMCH to ACOs achieving success. In a first-ever study of its kind, PCPCCs 2018 Evidence Report examined the interaction between these two models through both qualitative and quantitative methods. The quantitative research showed that:

- Medicare ACOs with a higher proportion of PCMH primary care physicians were more likely to generate savings – MSSP participants with more PCMHs showed greater average savings of up to 1.9 percent (see study for methodology/important caveats). These results, for ACOs with more PCMH PCP share, are notable given that the overall savings for all MSSP ACOs in the study sample is 0.6 percent.
- Medicare ACOs with a higher proportion of PCMH primary care physicians had higher clinical quality scores related to preventative screenings and services as well as chronic management (both diabetic and coronary artery disease composites).

The research qualitatively showed that strong foundation of advanced primary care as embodied in the PCMH is critical to the success of care delivery reforms focused on keeping people healthy and preventing illness, managing chronic conditions to reduce hospitalizations and ER visits, better meeting patient needs and preferences, and reducing costs, among other goals.

¹ <https://www.pcpcc.org/resource/evidence2018>

With 10 percent of the US population in ACOs and growing, and more than 20 percent of primary care physicians practicing in PCMHs, these findings have widespread applicability for public and private policymakers as these programs continue to evolve. PCPCC is pleased to see recognition of this primary care impact from CMS and encourages further effort to promote accountable care models based on a strong, advanced primary care foundation. More specifically, PCPCC encourages CMS to build on this evidence to drive more MSSP success by having ACOs report the percentage of primary care practices that have PCMH Recognition and incentivizing a rising percentage of advanced primary care practices. This would both strengthen the MSSP program and build on Congressional intent in the Medicare Access & CHIP Reauthorization Act.

Clinician-Led Alternative Payment Models

PCPCC applauds CMS attempts to make the ACO program more accessible for low-revenue and inexperienced ACOs but encourages it to further consider glide-track options. The transition to value-based payment must be a system-wide transformation. For this to be successful, there must be more opportunities and more accessible opportunities for practices and organizations to begin moving along the path to outcome-based payment. A narrow program that accelerates progress for some, but leaves many behind, will not meet our national ambitions to transform to a high-value, outcome-based healthcare delivery system. Specifically – additional and highly accessible alternative payment paths are needed for groups of clinicians who need time to gradually expand and experiment with risk-based payment in the Merit-Based Incentive Payment Program (MIPS) before moving into more complex ACO programs.

PCPCC notes that the proposed rule does not mention Comprehensive Primary Care Plus (CPC+) practices participating in ACOs. We believe that the CPC+ model is empowering practices to begin the transition to risk through care management fees and performance-based incentives. As noted by our research mentioned above, these types of transformations are foundational to achieving success in accountable care models. CMS should ensure that care management fees do not harm ACOs that are transforming primary care practices to encourage primary care investment and coordination with ACOs, until those costs are fully incorporated into the baseline and therefore the benchmark.

Specific Responses to CMS Proposals

Voluntary and Beneficiary Opt-In Alignment Methodology

PCPCC strongly believes that the foundational elements of a strong healthcare system, as espoused by Barbara Starfield, include first Contact accessibility, Coordination, Comprehensiveness, and Continuity.² Recognizing the importance of relationship-based care, we strongly support voluntary alignment which allows patients to select their providers and

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3133574/>

maintain a strong primary care relationship. We are pleased to see CMS expand the number of qualified clinicians that the patient can select as a primary clinician, as this supports a strong, continuous relationship between the patient and their provider.

While better engaging consumers in their care is an important goal, PCPCC does not believe the opt-in methodology provides adequate additional benefit to merit the added complexity that the opt-in process would create. We also believe that the focus on a consumer-clinician relationship in voluntary alignment to be a better attribution tool than the consumer selecting an ACO directly. PCPCC has concerns about the provider behavior that might be incented by a defined ACO “opt-in” period – such as “cherry picking” or “lemon-dropping.” Instead, CMS should allow the voluntary alignment methodology to permit greater direction from the consumer, when appropriate.

Beneficiary Engagement

PCPCC believes that the opportunity to provide incentive payments to beneficiaries would be a strong tool to help consumers be more engaged and active participants in the delivery of their care. Strong safeguards would be required, however, to ensure that incentives are not abused to alter the composition of the patient panel through cherry picking” or “lemon-dropping.” PCPCC encourages CMS to allow these sorts of incentives at the specific point of care, rather than as an ACO-wide incentive. This would encourage behavior among active participants and help prevent incentives from being used as a recruitment tool.

High and Low Revenue ACOs/Experienced and Inexperienced ACOs and the Ramp-Up to Risk

As noted above, PCPCC believes clinician-led ACOs, often “low-revenue,” have significant potential to transform the healthcare system. We appreciate efforts by the administration to reduce administrative burden and allow greater access to shared savings for these organizations. A New England Journal of Medicine article by Harvard Medical School researchers recently found that, “ACOs that are physician groups have stronger incentives to lower spending than hospital-integrated ACOs ... After 3 years of the MSSP, participation in shared-savings contracts by physician groups was associated with savings for Medicare that grew over the study period, whereas hospital-integrated ACOs did not produce savings (on average) during the same period.”³ We believe that the move two-sided risk will help hospitals ACOs better align incentives and improve performance.

As noted, we are concerned by projections that many ACOs would leave the program, and fewer would choose to enter it. Ideally, we would like to see provisions for low-revenue ACOs spur much greater interest and participation in the ACO program among organizations that CMS would define as low-revenue and inexperienced. We encourage CMS to prioritize the entrance of new participants into the MSSP program as it implements these concepts.

³ <https://www.nejm.org/doi/full/10.1056/NEJMsa1803388>

PCPCC is strongly supportive of the additional flexibility in the ACO program, and supportive of five-year agreements – which would provide needed stability and transition time for ACOs. We are concerned, however, that two years may not be enough time for a new ACO to transition to a model that includes risk. Similarly, we believe that CMS must provide adequate notice to participants as well as clear and deliberate timelines for any transition. Implementing significant changes mid-year is likely an unnecessary complication for participants.

While not perfectly analogous, we believe that PCPCC research on PCMH practice transformation can help inform this decision – as practice transformation is a key tool to success in accountable care. Our 2017 analysis revealed that the longer a practice had been transformed, and the higher the risk of the patient pool in terms of comorbid conditions, the more significant the positive effect of practice transformation, especially in terms of cost savings. “The peer-reviewed findings ... supported this claim in that a majority of the studies that looked at four years or more of data had positive results, whereas many studies looking at two years of data or less had missed or non-significant results.” Overall, the data suggests that the longer a practice has been transformed, the more positive its impact on quality, cost and utilization.⁴ CMS may want to take this research into account when considering a faster ramp-up approach for ACOs to accept risk.

Addressing Critical Behavioral Health Needs

CMS seeks comments on further developing the program’s quality measure set in response to the agency’s Meaningful Measures Initiative as well as to support ACOs in addressing opioid utilization. While PCPCC supports the administration’s focus on opioid utilization, we believe quality measurement and incentives for accountable care organizations should be tied to broader patient outcomes. PCPCC believes that CMS has an opportunity to leverage Meaningful Measure 12 – the Prevention, Treatment, and Management of Mental Health, which seeks to Promote Effective Prevention and Treatment of Chronic Disease. This measure, which encourages effective integration with primary care through diagnosis, prevention and treatment of depression and effective management of mental disorders (e.g., schizophrenia, bipolar disorder), and dementia (e.g., Alzheimer’s disease), has a huge potential to be transformative. A broader measure, that leverages continuous, relationship-based care in the primary care setting will be better able to sustain positive patient outcomes over time (including challenges with opioid abuse when relevant).

PCPCC is also pleased to see the recent CMS Quality Payment Program quality funding announcement for measure development – including the development of mental health and substance use measures under the leadership of the American Psychiatric Association. Particularly important are the development of patient experience outcome measures.

⁴ <https://www.pcpcc.org/resource/impact-primary-care-practice-transformation-cost-quality-and-utilization>

Conclusion

Our multisector members look forward to working with you to support new and continued models that will drive higher-value care and improved patient outcomes. Please contact Christopher Adamec, Director of Policy at cadamec@pcpcc.org or 202-640-1212 with any questions.

Sincerely,

A handwritten signature in black ink that reads "Ann C. Greiner". The signature is written in a cursive style with a large initial "A" and a long, sweeping underline.

Ann Greiner
President & CEO