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October 16, 2018

VIA ELECTRONIC SUBMISSION

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1701-P
P.O. Box 8013
Baltimore, Maryland 21244-8013

Dear Administrator Verma:

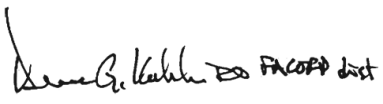
On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) Medicare Shared Savings Program (MSSP) and Accountable Care Organizations (ACOs) Pathways to Success proposed rule.

The ACOFP is the professional organization representing more than 20,000 practicing osteopathic family physicians, residents, and students throughout the United States who are deeply committed to advancing our nation's health care system by improving health care delivery and outcomes and ensuring that patients receive high-quality care.

Overall, as an organization our osteopathic family medicine physicians practice in a variety of settings, including in solo, small, group, rural, Native American Indian healthcare, ACOs, and Advanced Alternative Payment Models (A-APM). Generally, we are supportive of efforts to transition the healthcare system toward value-based care. Value-based care emphasizes wholistic care, wellness, prevention, and avoiding unnecessary resource use, which are at the core of our osteopathic philosophy and training. We also emphasize in our comments the value of primary care in the successful implementation of ACOs and MSSPs. However, we believe there are several barriers to successfully transitioning how health care is delivered and have concerns with several of the proposals in this proposed rule.

Our full comments are detailed on the following pages. Thank you for the opportunity to share these with you. Should you need any additional information or if you have any questions, please feel free to contact Debbie Sarason, Manager, Practice Enhancement and Quality Reporting at (847) 952-5523 or debbies@acofp.org.

Sincerely,



Duane G. Koehler, DO, FACOFP *dist.*
ACOFP President

1. The Value of Primary Care and ACOs

ACOFP has long supported efforts to redesign how care is delivered, especially in terms supporting access to family medicine and primary care services. Our members recognize the importance of value-based care as evidenced by the 40 percent of our members participating in ACOs or Advanced APMs. ACOFP members have firsthand experience of the reality of implementing value-based arrangements, including ACOs, and consistently highlight that ACOs and A-APMs do not sufficiently value the delivery of primary care services and are administratively burdensome for solo, small, and rural area primary care practices.

ACOFP previously has shared with the agency the value of primary care, which is well-documented. Studies have shown that increased access to primary care is more likely to result in preventive services and treatment for medical conditions before they become chronic and costly to treat.[1, 2] Primary care services increase access, improve the quality of care, improve prevention, lead to more appropriate care, and reduce unnecessary or inappropriate specialty care. While this is certainly true under the traditional fee-for-service system, new studies[3] have also shown that primary care is a key contributor to successful ACOs.

For example, the Comprehensive Primary Care (CPC) model provided a capitated payment for non-visit based care management fees, which averaged $17.50 per beneficiary per month. The CPC model resulted in some positive outcomes, including reduced emergency department utilization, fewer hospitalizations, and improved patient satisfaction. Further, Medicare expenditures grew more slowly for CPC participants than for the comparison group.[4] We recognize that there were minimal savings associated with CPC, but highlight that the value of family medicine is in the long-term prevention of chronic conditions and for population health-related measures, which was not taken into account in the program's evaluation. Specifically, the management of chronic diseases and ensuring patients have continued access to preventive services is critical to containing long-term cost growth, which was not reflected sufficiently in CPC.

More recently, in August 2018, the Patient-Centered Primary Care Collaborative (PCPCC) released a report[5] highlighting that a strong foundation of advanced primary care, as embodied in the Patient Centered Medical Home (PCMH), is critical to the success of care delivery reforms. The PCPCC found that ACOs with a higher proportion of PCMH primary care physicians were more likely to generate savings and demonstrated higher quality scores on both process and outcome measures. Specifically, PCPCC concludes that ACOs with a primary care orientation show that: (1) costs generally decreased; and (2) quality outcomes improved. While overall health care utilization results varied, ACOFP believes that utilization related to primary care services is a better use of health care services so long as more expensive, downstream services are avoided while quality outcomes remain the same or

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[1] A. B. Bindman, K. Grumbach, D. Osmond et al., "Primary Care Receipt of Preventive Services," Journal of General Internal Medicine, May 1996 11(5):269–76

[2] L. A. Blewett, P. J. Johnson, B. Lee et al., "When a Usual Source of Care and Usual Provider Matter: Adult Prevention and Screening Services," Journal of General Internal Medicine, Sept. 2008 23(9):1354–60

[3] *See,* Y. Jabbarpour, M. Coffman, A. Habib et al., "Advanced Primary Care: A Key Contributor to Successful ACOs," August 2018. Available at https://www.pcpcc.org/sites/default/files/resources/PCPCC%202018%20Evidence%20Report.pdf.

[4] See, Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report available at https://www.mathematica-mpr.com/our-publications-and-findings/publications/evaluation-of-the-comprehensive-primary-care-initiative-fourth-annual-report.

[5] Y. Jabbarpour, M. Coffman, A. Habib et al., "Advanced Primary Care: A Key Contributor to Successful ACOs," August 2018. Available at https://www.pcpcc.org/sites/default/files/resources/PCPCC%202018%20Evidence%20Report.pdf.

improve. While more research is needed, the PCPCC ultimately recommended that policymakers consider the value of advanced primary care.

ACOFP echoes the findings of these and the numerous other studies that demonstrate the value of increased access to primary care services, especially as they relate to the success of ACOs and potential for cost savings and increased quality. We urge CMS to consider these findings and consider ways to increase access to primary care through ACOs.

2. Proposed Changes to the MSSP and ACOs

ACOFP believes that MSSP and ACO participation is a significant and effective tool to transition our health care delivery system from one that incentivizes the volume of services delivered to the value of those services. Despite their well-documented success, there still remain significant barriers that prevent primary care physicians – especially those in solo, small, or rural area practices – from meaningfully participating in ACOs. Specifically, establishing and participating in ACOs requires a significant upfront investment that is not accounted for in the calculation or availability of shared savings. Such an investment is untenable for solo, small, and rural area primary care practices that operate on continually diminishing margins. These practices do not have the financial reserves or staffing bandwidth to adopt and implement changes to successfully participate in an ACO.

Opportunities

In light of the existing challenges ACOFP members face in meaningfully participating in ACOs, we appreciate the agency's efforts to redesign the MSSP. In this proposed rule, CMS appropriately identifies and proposes key changes that will improve our ability to aid in the transformation of our health care delivery system. Specifically, we appreciate CMS' efforts to increase stability and predictability by extending the ACO agreement period from three to five years. Historically, a three year agreement period has been insufficient in terms of enabling participants to implement reforms to care delivery and workflow. A five-year agreement period is critical to ensuring that ACO participants see the benefits of their investment and effort.

ACOFP also appreciates CMS' steps to implement statutory changes to the MSSP established by the Bipartisan Budget Act of 2018 (BBA) and the 21st Century Cures Act. Specifically, the added regulatory flexibility regarding beneficiary assignment options, expanded use of telehealth, and enabling the provision of beneficiary incentives through a cash equivalent are all efforts that we support. While we recognize that this flexibility is limited by statutory requirements, we appreciate CMS' efforts to provide flexibility within its authority.

Barriers and Challenges

ACOFP is concerned that several of the changes in this proposed rule will exacerbate existing barriers and add challenges to meaningful ACO participation by primary care physicians. As previously noted, there are many existing challenges, some of which the agency seeks to address through this proposed rule. However, challenges remain, including the key deterrents that prevent solo, small, and rural primary care practices from participating in MSSPs. In addition to the upfront costs, the prospect of taking on any risk is especially challenging for these types of practices. CMS' proposals to move ACOs more quickly to mandatory risk-sharing arrangements as well as the proposed reduced shared savings rate make ACO participation more challenging; ACOs will not be able to make the necessary organizational and workflow changes, putting them at a higher risk of failure and ultimately resulting in more departures from the program. Imposing more risk and at an earlier stage will also place

primary care physicians that are new to risk-based sharing arrangements at a significant disadvantage, and they likely will be left behind in the transition to value-based care.

Further, while CMS has proposed alternative beneficiary assignment methodologies, the uncertainty involved with ACO participation as well as the significant data lag continue to pose significant barriers. The opportunity to implement, adapt, refine, and improve care redesign efforts is significantly restricted by the drastic annual increases in financial liability. While we appreciate the flexibility CMS offers for ACO participants to move up to higher risk levels under the Basic Track, we urge similar flexibility for ACO participants to elect to remain in the prior year's risk level. This could be capped to a certain number of performance periods, but would at least provide some protection for participants who may need more time and flexibility to adjust to increasing financial requirements.

As previously stated, we appreciate CMS' efforts to implement the statutory changes in the BBA. While we understand that the BBA limited the availability of these flexibilities to participants in risk-sharing ACOs, we believe it is within CMS' authority to lessen the restrictions and remove certain barriers to participation in risk-sharing arrangements. Specifically, we urge CMS to reconsider its proposals related to the minimum loss rate (MLR) and minimum savings rate (MSR). As physicians look to future ACO years, the prospect of limited upside with increasing downside will continue to force smaller practices to remain in the Merit-based Incentive Payment System, thus derailing the agency's movement toward value-based care.

Further, the reduced shared savings rates for low-risk models and restrictive early termination policies will continue to exclude key ACO participants – primary care physicians. This exclusion will mostly impact primary care physicians, like our members, meaning the availability of the additional regulatory flexibility – much of which is tied to the delivery of primary care services – will not have the intended impact.

3. Recommendations

Overall, we urge CMS to consider and ensure primary care physicians in all settings have an opportunity to meaningfully participate in ACOs and A-APMs. ACOFP believes this will be critical to further improving the quality of care Medicare beneficiaries receive while reducing their costs and costs to the Medicare program.

Based on our outlined concerns and the described value of primary care services, we offer several important recommendations that we believe will advance primary care provider participation in ACOs and help to drive the transition to value-based care arrangements. Specifically, we urge CMS to:

- Use its authority to create alternative pathways, including adjusting MLRs and MSRs, to sufficiently recognize that not all physicians and practices are similarly situated;
- Adjust its proposed mandatory risk and risk increases so that certain qualified ACOs (e.g., rural ACOs) would not be subject to these requirements;
- Provide additional flexibility for certain qualified ACOs such that they can elect to remain at a certain level of risk-sharing;
- Allow ACO participants to terminate without any associated penalties or future restrictions upon demonstrating certain hardships; and
- Remove the risk ratio cap as this would reduce benchmark accuracy in future years, potentially resulting in "cherry-picking" Medicare beneficiaries and reducing access to care.