July 20, 2022

Lisa Shats
Physician-Focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation (ASPE), Room 415F
PTAC Designated Federal Officer
Office of Health Policy, ASPE
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Request for Input[i] for Population-Based Total Cost of Care (TCOC) Models

This document was sent electronically via email with the subject line "Public Comment – Advocates for Community Health PTAC RFI TCOC" to PTAC@hhs.gov on July 20, 2022. Specific ACH responses and suggestions to questions are in green.

Dear Lisa Shats and the PTAC Committee:

Advocates for Community Health (ACH) appreciates the opportunity to comment on the PTAC's TCOC Models RFI. ACH is a membership organization for federally qualified health centers (FQHCs) who are focused on visionary and innovative policy and advocacy initiatives to effect positive change across the nation's health care system.

Community health centers have been, and will continue to be, vital to achieving health equity in the United States. Over the past few decades, they have served historically marginalized communities and provided comprehensive, culturally competent, integrated care to millions of people. We keep health equity at the core of everything we do. At ACH, we recognize and address social determinants of health as part of our mission for equitable healthcare for all. Ultimately, we seek a nation where we no longer have disparities in health outcomes by race and ethnicity. Therefore, we thank PTAC for centering health equity for TCOC models.

In Summary, we recommend the following suggestions for TCOC Models:

1. Promote culturally and linguistically competent care in TCOC models, particularly to training to providers and increase health literacy to patients.
2. Incentivize the development of FQHCs as community hubs with formal relationships with community-based organizations most able to address the social determinants of health for TCOC models.
3. Consider benchmarks that adjust for dual-eligible beneficiaries and local factors that also consider the dynamic nature of an organization's underlying patient population and need to factor for social investments.

4. Provide transparency for provider and beneficiary overlap rules for attribution with an ideal 12-month historical attribution for a prospective beneficiary list.
5. Allow flexibility with incentives to serve the population at hand, such as allowing flexibility to provide transportation services.
6. Allow money or grants to alleviate infrastructure startup costs, particularly for data analysis and technical assistance needs.
7. Allow carve ins for behavioral health and promote behavioral health integration.
8. Expand eligible providers such as community health workers.
9. Make data accessible and understandable in a timely manner.
10. Consider Medicaid patients, not just Medicare beneficiaries, for value-based care and TCOC models.
11. Limit quality measures but make them count. Add in social determinants of health measures.
    a. Specifically, ACH suggests testing the Health Equity Summary Score (HESS) for FQHCs to see if ideal for TCOC models.
12. Create a FQHC task force to hear the perspective from those that serve the nation's most vulnerable populations, especially for FQHC's ability to handle value-based care.
13. Consider Multi-payers, especially PACE programs, Medicaid plans and managed care organizations for TCOC models.

Specifically, ACH is commenting on the following **Questions to the Public**:

Questions to the Public:

1. The Center for Medicare and Medicaid Innovation (CMMI)'s *Strategy Refresh* includes a goal that all Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and TCOC by 2030. What should these future population- based TCOC models look like?
   CMMI's Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model and Primary Care First (PCF) Models do focus on FQHCs. According to the Uniform Data System[ii], FQHCs serve over 62% of Racial and/or Ethnic Minority Patients or over 16.5 million patients. FQHCs serve almost 1 in 4 patients where their primary language is not English. Therefore, these models should provide culturally competent care, which requires community-based partnerships and buy-in. FQHCs naturally do this. Therefore, we request to be at the table during the design and implementation of models so that our perspective is heard and understood.
2. What type(s) of entity/entities or provider(s) should be accountable for TCOC in population-based TCOC models? Could the accountable entities look like current Accountable Care

Organizations (ACOs) or Medicare Advantage (MA) plans? Could the accountable entities be delivery systems taking on risk, a combination of delivery organizations and payers, or fully integrated systems?

In surveying some of the ACH members, if their FQHC had >10% of their population as dual-eligible, the FQHC also had a Program of All-Inclusive Care for the Elderly (PACE). Therefore, FQHCs should be accountable for TCOC population-based models. However, models must consider FQHC's ability to take on risk and also consider how PACE programs are involved. Our members are interested in TCOC models, but some need assistance, particularly technical assistance for data. Therefore, gliding pathways to risk should be an option for FQHCs. Most FQHCs see mostly Medicaid patients, so a combination of delivery organizations and payers is needed.

We also recommend working with Medicaid Health Plans of America to align best practices for TCOC models.

3. Based on your experience, what are some approaches and best practices for integrating and improving coordination between primary care and specialty care providers within population-based TCOC models?

    1. Has provider participation in population-based TCOC models affected innovation with respect to the integration of primary care and specialty care?
    2. What are some incentives that can help to improve care coordination and provider accountability for TCOC?

ACH suggests incorporating behavioral health into primary care but allowing behavioral health as a carve out. Some of our members state 75% of all their visits involve behavioral health care. The Centers for Medicare and Medicaid Services (CMS) should ensure that FQHCs can actively engage in behavioral health care integration, including through alternative payment arrangements in Medicare and Medicaid that do not require taking on additional risk. Additionally, CMS and other stakeholders can incentivize states to expand optional behavioral health benefits through increased Federal Medical Assistance Percentage (FMAP) or other means. With that said, specific incentives are more about flexibilities. ACH recommends carving in substance use and behavioral health services and waivers so that states permit services to be offered the same day as other encounters. These flexibilities facilitate primary care and behavioral health integration. Additionally, FQHCs should be allowed to address behavioral health interventions to the needs of their communities by supporting telehealth (audio-visual as well as audio only formats), group setting services, and mobile crisis units. Another example of flexibility of behavioral health is the Certified Community Behavioral Health Clinic (CCBHC[iii]) model, which allows 24/7 mobile crisis teams. The CCBHC demonstration is allowed under the Protecting Access to Medicare Act of 2014.

Lastly, similar to the proposed changes Calendar Year 2023 Medicare Shared Savings Program[iv], FQHCs would benefit from one-time fixed payments quarterly payments for the first two years for a 5-year agreement. However, payments should reflect the type of entities and the patient

population. We suggest allowing the upfront payments for FQHCs who serve the most vulnerable populations, particularly those uninsured and on Medicaid.

4. What are some options for evaluating and increasing provider readiness to participate in population-based TCOC models?

a. Are there differences in provider readiness by specialty or other factors?

b. To what extent can provider participation in models with some upside and downside risk help to increase provider readiness to participate in population- based TCOC models? If so, what are some options for improving provider readiness to take on risk?

c. What are some of the provider-level barriers to participating in population-based TCOC models (including barriers for specialists)?
Again, ACH emphasizes allowing a gliding pathway for FQHCs – allowing the option to take on no risk at first to allowing TCOC risk. Having FQHC stakeholders engaged in conversations are needed to assess provider readiness, particularly for those in rural areas. ACH hears the same concerns as other health systems. Barriers include time, staffing, and unpredictability of funding, particularly from 340B. For our providers, we've heard of a "bubble-wrap" concept: there is a need to protect FQHCs, no to muddle the Prospective Payment with any risk payment. We suggest ensuring that capitation models far exceed fee for service.

5. Based on your experience, what kinds of care delivery strategies (e.g., patient-centered medical homes, telehealth, and care coordination; addressing social determinants of health, addressing behavioral health needs, and focusing on seriously ill patients) have been particularly effective for improving quality and reducing TCOC? Why have these strategies been effective? What have been some challenges and opportunities related to these approaches?

a. What are options for incorporating these strategies when developing care delivery models for future population-based TCOC models?

b. What are some best practices for improving the affordability of care for beneficiaries (e.g., copayments, prescription drugs) within population-based models?
From our members, we have heard the following best practices to improve the affordability of care for beneficiaries:

- Care coordination
- Removing and reducing cost-sharing for the beneficiary
- Allowance of different providers, such as licensed marriage counselors, bachelor level social workers, and community health workers
    a. include allowance of coding and inclusion of non-clinical facing roles
- Affordable prescription drugs, particularly insulin
- Focusing on social determinants of health:

a. Transportation services

b. Nutritional services – education and access to healthy foods (see North Carolina's Medicaid Healthy Food Pilot Example[v])

- Allowance for telehealth and telemonitoring, particularly to be furnished in any geographic area and in any originating site setting, including the beneficiary's home, allowing certain services to be furnished via audio-only telecommunications systems, and adjusting in-person visit requirements
- Flexibility for "outside the 4 walls"
- Allowing wraparound services and same day services for multiple encounters

6. Based on your experience, what payment strategies have been particularly effective for supporting efforts to improve quality and reduce TCOC (e.g., shifting risk downstream to providers)? Why have these strategies been effective? What have been some challenges and opportunities related to these approaches?

a. What are the pros and cons of using payment methodologies that rely on a fee- for-service (FFS) architecture with upside and downside risk versus payment methodologies that involve global budgets or capitated payments?
ACH suggests that capitation meets, if not exceeds, the current Prospective Payment Systems. The focus should be prevention and thus social determinants of health. Therefore, a strategy we suggest is a health equity payment. In ACH's CHC Invest campaign[vi], we suggest a very modest $25 per patient per month based off of the Innovation Center's Comprehensive Primary Care Plus (CPC+) Model. CPC+ paid an average of about $25 per Medicare beneficiary per month in 2019, which successfully reduced[vii] outpatient Emergency Department visits and hospitalizations. The suggested amount is conservative compared to CPC+'s successor, the Primary Care First Model, which pays a per-beneficiary per-month population based payment that ranges from $28 to $175[viii] based a practice's overall patient risk group. The Maryland Total Cost of Care (MTCOC) Model also provides a care management payment from $6 to $100[ix] per-beneficiary per-month based on model track and risk adjustment. This model has reduced spending, doubled rates of follow-up after ED or hospital discharge, strengthened case management, support processes to screen patients for social needs, and progressed initial ways for practices to integrate behavioral health care.

7. What are some options for addressing model overlap and incorporating episode-based payments within population-based TCOC models?

a. How might these options vary by differing factors (e.g., ACO ownership type, condition, specialty, type of episode)?

b. What are potential issues related to nesting, carve-outs, and other potential approaches?
The biggest barrier to model overlaps is transparency: clear and timely guidance for model overlaps. For example, some models check overlap at the TIN level, and others work at the NPI/TIN level. With so many models, entities tend to "fight" to enough beneficiaries, which

affects statistical reliability and evaluation of the models. Therefore, we advocate CMS to provide clear overlaps rules in one document for participant providers, preferred providers, and beneficiaries. Additionally, we suggest that models publicly announce accepted applications and contact information as well as windows and clear instructions of adding participants so that if an FQHC would like to participate in an ACO, that partnership is available. ACH also suggests that models clearly define what is considered in each TCOC savings calculations.

8. What specific issues should be considered when applying population-based TCOC models to diverse patient populations and care settings?

a. Are there potential unintended consequences associated with implementing population-based models (for patients, primary care providers, specialty providers, and others)?

b. Are there potential issues related to health equity regarding the implementation of population-based TCOC models?

c. What are the options for increasing the participation of underrepresented and underserved populations in value-based models, including population-based TCOC models?

d. What are the potential implications for safety-net providers and providers who serve historically underserved populations to participate in population-based TCOC models? What are options for identifying these providers and improving their readiness to participate in these models?
Again, ACH suggests further participation and collaboration with FQHCs, particularly those in rural areas. The focus should include delivering culturally and linguistically competent care, which should be a component in all models. We suggest having discussions with ACH and our members to improve their readiness to participate in these models. Additionally, since most of our members serve patients that do not speak English, ACH members can speak to barriers and unintended consequences to those patients.

9. Based on your experience, what are the best performance metrics for evaluating population-based TCOC models, and their impact on the quality and cost of care?

a. What are options for balancing efforts to advance the development and use of patient-centered quality measurements (e.g., patient-reported outcome measures) with the burden associated with collecting the relevant data?

10. Based on your experience, what are different methodologies for developing benchmarks used to determine payment under population-based TCOC models? What are the pros and cons of these approaches? How can approaches for developing benchmarks be improved?

11. Based on your experience, what are different methodologies for risk adjusting measures used to determine payment under population-based TCOC models? What are the pros and cons of these approaches from a beneficiary, physician, or program perspective? Are there any unintended consequences of applying risk adjustment methodologies?
For questions 9-11, ACH suggests limiting quality metrics. Workforce is already an issue, and providers are confused with measures to use. ACH advocates piloting the Health Equity Summary Score (HESS) for FQHCs to see if ideal for TCOC models. Currently, HESS has been tested in the MA population only. Based off our experience, we provide feedback for quality

metrics in general:

ACH advocates that whichever measures are used, data is received in a timely manner and in a digestible way.
Members have identified that following Data Inaccuracy Barriers:

- Lack of SDOH data
- Data lag, especially for claims and integration into EMR
- Internal inconsistency
- Delays contact and relationship building
- Having real information relayed to the Center by MCO, which significantly decrease data inaccuracies
- Lack of master patient index information
    - Can't match claims and data from various sources
    - Lack of staff knowledgeable in analyzing claims data
- Mapping population health platforms to EHRs
- Errors in claims from health plans
- Data errors that affect potential MLR reporting requirements
- Health plans all report different measures – which to use?
- What patient centered measures are used?

Data inaccuracies then affect risk adjust and benchmarks. Therefore, we suggest PTAC considers benchmarks that adjust for dual-eligible beneficiaries and local factors that also consider the dynamic nature of an organization's underlying patient population and need to factor for social investments.

Since benchmarks are based on transient patient populations, ACH suggests a 12-month historical attribution for a prospective beneficiary list.

12. Are there opportunities to improve multi-payer alignment and increase multi-payer participation in population-based TCOC models? What are the most important model design components related to increasing multi-payer alignment (e.g., clinical tools, outcome measures, payment)?
ACH suggests working with Medicaid plans to understand TCOC model needs for FQHCs. For example, depending on the state, most MCOs require FQHCs to screen for social determinants of health. Most of our members use PRAPARE. Therefore, streamlining clinical tools is helpful.

13. What types of services should be included in calculating TCOC in the context of APMs, PFPMs, and population-based TCOC models? To what extent do definitions of TCOC differ across specialties, models, payers, and other factors?

a. Should there be a single definition of TCOC in future population-based TCOC models? Are there considerations regarding why the definition of TCOC should potentially be allowed to differ by certain factors (e.g., payer type)?

b. Are there additional services that should be included in calculations of TCOC for future population-based TCOC models (e.g., prescription drugs, specialty drugs, or non-medical services)? What, if any, issues may exist related to including these additional services in TCOC?

c. Are there current measure specifications that work well? Why or why not?
While Value-Based Care included TCOC models, we suggest having a specific definition for FQHCs and safety providers. Additionally, we suggest community level measure specifications that allow for community participation. This could be measured by number of community assessments. The community already know what they need and how best care should be delivered. Similar to the mission of FQHCs and American College of Physician's (ACP) 7 policy recommendations aimed at achieving greater equity in health care (July 2022)[x], we suggest that savings be invested back into primary care.

14. Are there any other important questions that should be considered related to the development of population-based TCOC models and PFPMs?
ACH suggests that PTAC consider FQHCs and the ACP's 7 policy recommendations. ACH shares similar recommendations with ACP For example, PTAC should consider the following questions:

- What incentives do providers want? What about mid-level clinicians?
- What discussions are occurring across HHS?
- Should there be a RFI regarding the Quality Payment Program? If so, which stakeholders should be involved to help draft questions?
- What claims data technical assistance is available for entities in TCOC?
- For quality measures, particularly for specific conditions, what exclusions to the denominators apply?
- What discussions are occurring with the Office of Minority Health? And what underserved populations may not be considered (disabled, LGBTQIA+, etc.)
- Should primary care providers be part of specialty care models, such as kidney care models?

Again, we appreciate the opportunity to provide feedback for the TCOC RFI. For more information, please feel free to contact me at apearskelly@advocatesforcommunityhealth.org.

Sincerely,

Amanda Kelly
Chief Executive Officer
Advocates for Community Health

[i] https://aspe.hhs.gov/sites/default/files/documents/a5b8fe620a15ea47fbaa7b6ee212647b/TCOC-RFI.pdf
[ii] https://data.hrsa.gov/tools/data-reporting/program-data/national
[iiiiii] https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf
[iviviv] https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-proposed-rule-medicare-shared-savings-program
[v] https://medicaid.ncdhhs.gov/blog/2022/03/15/healthy-opportunities-food-services-available
[vi] https://advocatesforcommunityhealth.org/policy-advocacy/chc-invest/
[vii] https://innovation.cms.gov/data-and-reports/2021/cpc-plus-third-annual-report-findings
[viii] https://innovation.cms.gov/media/document/pcf-py22-payment-meth-vol1
[ix] https://innovation.cms.gov/data-and-reports/2021/md-tcoc-imp-eval-report
[xxx] https://www.acpjournals.org/doi/full/10.7326/M21-4484