July 12, 2024

The Honorable Sheldon Whitehouse
530 Hart Senate Office Building
Washington, DC 20510

The Honorable Bill Cassidy, MD
455 Dirksen Senate Office Building
Washington, DC 20510

RE**:** Medicare Primary Care Payment RFI

Dear Senator Whitehouse and Senator Cassidy:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to your request for information on the Pay PCPs Act (S. 4338). NAACOS is a member-led and member-owned nonprofit of more than 470 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health systems and physician provider organizations across the nation to improve quality of care for patients and reduce health care costs. NAACOS represents over 9.1 million beneficiary lives through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model, among other alternative payment models (APMs).

NAACOS appreciates your leadership in seeking solutions to improve Medicare's primary care payment system. Our comments and recommendations reflect the shared goal of our members to advance solutions that strengthen primary care and create new opportunities for growth in value-based payment models.

Hybrid Primary Care Payments in Total Cost of Care Models

NAACOS supports expanding hybrid primary care payments to more clinicians in Medicare's total cost of care models where providers are held accountable for costs and quality. This includes building on the success of hybrid primary care payments in ACO REACH by expanding this approach to MSSP and any future Center for Medicare and Medicaid Innovation (CMMI) total cost of care model. Medicare's existing payment system does not adequately adjust physician payments to account for rising costs. Annual cuts to physician payments also jeopardize beneficiary access to care and prevent clinicians from investing in resources to support patient care. Medicare also underinvests in primary care which results in physician practices having limited funding or tools to proactively manage patient care, leading to fragmentation of care with higher costs.

APMs have allowed physicians and other clinicians to change care delivery and improve care coordination while reducing costs. Given the focus on outcomes and prevention, APMs encourage more investment of resources into primary care. This includes expanded primary care teams, enhanced care coordination, and providing primary care practices data and analytics tools. While APM adoption has seen steady growth in recent years, it is essential to give additional flexibility and tools to innovate care. It's clear that more flexible payment mechanisms are needed to support care delivery transformation, strengthen primary care, and increase participation in value models like ACOs. Shifting to prospective payments provides primary care practices with stable and predictable cash flow needed to transform care delivery and provide comprehensive, team-based care.

As the largest APM in Medicare, the MSSP is well-positioned to drive primary care payment innovation for the nearly 11 million beneficiaries in ACOs. Unfortunately, the recently announced ACO Primary Care Flex Model is a time-limited model that will be restricted to a narrow subset of MSSP ACOs for a single application window. Given the wealth of evidence supporting hybrid primary care payment approaches tied to several of CMMI's value models, this payment option should be made available to all MSSP ACOs as a permanent feature of the program. **Expanding hybrid primary care payments in MSSP will serve as another strong incentive to encourage more provider participation.**

Eliminating Medicare's Arbitrary Revenue Distinction

CMS has a policy that differentiates between "high revenue" and "low revenue" ACOs; the ACO PC Flex Model is limited to low revenue ACOs. As a result of this arbitrary policy, 222 of the currently participating ACOs will be ineligible to participate in the PC Flex Model's new hybrid primary care payments. Moreover, this policy excludes many of the providers the model is intended to support, including 67 percent of primary care physicians, 69 percent of non-physician practitioners, 87 percent of rural health clinics, and 25 percent of federally qualified health centers in MSSP. **Eliminating this policy would allow lawmakers to direct CMS to immediately expand hybrid primary care payments across the MSSP. Expanding hybrid payments in the MSSP would be significant given that the program includes 608,000 providers caring for nearly half of beneficiaries in traditional Medicare.**

<u>Challenges with Expanding Beyond Total Cost of Care Models</u>

While NAACOS supports expanding hybrid primary care payments to more providers, expansion beyond total cost of care models has several challenges that are addressed in the design of APMs and ACOs.

Beneficiary Attribution

Beneficiaries in traditional Medicare have no requirement or incentive to select a primary care provider (PCP) and may receive primary care services from several providers, making it difficult to accurately attribute a beneficiary to their primary clinician. Unlike the rest of traditional Medicare, MSSP employs a claims-based assignment methodology to attribute beneficiaries to ACOs based on their use of primary care services. ACO professionals agree to take on accountability for their assigned patient population as part of participation in MSSP.

Access, Quality, and Cost

More flexible payment systems can foster innovation and team-based care, but without an accountability framework, capitated payments can limit patients' access to primary care or increase referrals to specialists.[1] When provided a monthly, per beneficiary payment, PCPs have a greater incentive to refer patients to other physicians for minor procedures and ancillary services, as these increase practice expenses without generating additional revenue under a capitated model. It can also incentivize PCPs to take on a larger patient panel, increasing wait times for appointments. These unintended consequences increase health care costs and decrease patient experience and quality of care. In a total cost of care model, providers are held accountable for the quality and total cost of care for their patient population. This encourages ACOs to focus on increased access to preventive services and evidence-based protocols. ACOs are incentivized to provide patients with the right care at the right time and in the most appropriate and cost-effective setting. This built-in accountability for cost and quality eliminates any inadvertent incentives for primary care practices to stint or divert care.

Encourage Growth in Value Models

As previously mentioned, expanding hybrid primary care payments in total cost of care arrangements will serve as an incentive for more clinicians to join APMs. **The continued growth of CMMI's ACO REACH Model, even in the absence of a new application cycle, is proof that hybrid payment options bring more providers into total cost of care models.** Although APM participation has increased in recent years, there are several factors limiting growth and putting pressure on the growth of programs, including: expiring and diminishing incentive payments, growing financial pressures on ACOs due to lower benchmarks, and increasing alignment of APM program requirements to fee-for-service (FFS). Expanding hybrid payments and aligning them to total cost of care models will serve as a strong incentive given many of the challenges associated with the current FFS system. It will provide clinicians with more predictable funding to address some of the underlying financial difficulties facing primary care providers while ensuring that they are being held accountable for the outcomes and overall costs of their assigned beneficiaries.

Conclusion

Thank you for the opportunity to provide feedback on your primary care payment legislation. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement on improving physician payment. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,

Clif Gaus, Sc.D.
President and CEO, NAACOS

[1] https://www.urban.org/sites/default/files/2016/06/13/02_primary_care_capitation_2.pdf