May 9, 2024

Liz Fowler, PhD, JD
Deputy Administrator and Director
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Woodlawn, MD 21244

Meena Seshamani, MD, PhD
Deputy Administrator and Director
Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Woodlawn, MD 21244

Dear Deputy Administrator Fowler and Deputy Administrator Seshamani:

On behalf of the Primary Care Collaborative (PCC) and PCC's Better Health – NOW campaign (BHN), we write to express our appreciation for the ACO Primary Care Flex Model, particularly your process to gather diverse input on model design attributes and the speed in which your teams developed the model. Below we offer suggestions to ensure successful implementation of this important model.

PCC is a nonprofit, nonpartisan multi-stakeholder coalition of 70 organizational Executive Members ranging from clinicians and patient advocates to employer groups and health plans. PCC's members share a commitment to an equitable, high value health care system with primary care at its base: care that emphasizes comprehensiveness, longitudinal relationships, and "upstream" drivers for a better patient experience and better health outcomes. (See the Shared Principles of Primary Care). In March 2022, PCC launched the Better Health – NOW (BHN) campaign to realize bold policy change rooted in a simple principle: We need strong primary care in every community to achieve better health for all.

By providing a new hybrid payment option to certain Medicare Shared Savings Program (MSSP) primary care practices, the ACO Primary Care Flex Model represents a substantive step to strengthen primary care for beneficiaries and builds on the success of MSSP. We are pleased to see the model information released to date supports three principles Better Health—NOW participants have previously communicated:

- The option must result in increased investment in primary care.
- The option must be available rapidly and in all geographies.
- Implementing this option will create additional value for Medicare and for beneficiaries.

We particularly appreciate your efforts to craft transparency and spending guardrails aimed at ensuring funds intended to strengthen primary care do, in fact, reach primary care practices where that investment can support improved care.

PCC and our Better Health – NOW campaign partners look forward to continuing our work with you to ensure eligible primary care practices and ACOs are aware of the opportunity to participate. After consultation with our member organizations, we have identified areas for clarification and opportunities to strengthen the model during implementation, discussed below.

Engaging Stakeholders and Promoting Equity

Establishing pathways to enhanced, prospective population-based payment is central to remedying the ongoing underinvestment in primary care and associated workforce challenges. We appreciate the robust stakeholder-agency dialogue that helped shape this model, and we believe it facilitated the model's timely development and release. We particularly commend the Center for Medicare's Performance-Based Payment Models Group and the CMS Innovation Center's Seamless Care Models Group for their assiduous efforts to incorporate the perspectives of PCC and its diverse member organizations.

During model implementation, we encourage CMS to continue its commitment to dialogue with front-line clinicians and beneficiary advocates, as well as eligible ACOs. The Innovation Center should consider identifying a regular group of front-line clinicians and patients that could provide periodic, real-time feedback on the model. Additionally, to better communicate the model's potential to improve patient access and care, the Innovation Center should consider developing a patient journey map, like those developed for other recent models.

We thank the Innovation Center for designating disparity reduction in primary care access and outcomes as a model objective. While we await the Request for Applications, we are encouraged by the agency's intent to design an equity-promoting payment methodology and enable participation by eligible FQHCs.

Equitable outcomes often depend on equitable voice. Research from Community Catalyst, has found that "When preferences were ignored, older adults were more likely to forgo medical care and report lower satisfaction with their care."[1]

Governance is central to achieving equity. Current ACO rules require that ACO participants and beneficiaries be included in the governing board of each ACO. **The Innovation Center should identify and disseminate best practices for robust engagement of front-line clinicians, patients and community voices in ACO governance, to ensure alignment between ACO PC Flex ACOs and MSSP overall.**

Ensuring Beneficiary Affordability

The success of the ACO Primary Care Flex model hinges on increasing beneficiary engagement and utilization of whole-person primary care services – before adverse health outcomes or avoidable acute care or specialty expenses occur. For this reason, appropriate relief from beneficiary cost sharing barriers is essential to achieve the

[1] Community Catalyst. (2022). Person-Centered Care: Why Taking Individuals' Care Preferences into Account Matters. Retrieved from https://www.communitycatalyst.org/wp-content/uploads/2023/09/Person-Centered-Care-Report-Why-it-Matters.pdf

model's objectives with respect to outcomes, spending and equity. Thus, PCC and our Better Health – NOW Campaign partners have consistently encouraged CMS to explore opportunities for cost sharing relief under this model – particularly for those services included in the population-based payment components. The current Beneficiary Incentive Program (BIP) in MSSP lacks flexibility to tailor the program to the needs of an ACO's population, making it extremely costly and burdensome to implement, and preventing uptake. We note that the Innovation Center has tested tailored cost-sharing relief as part of other models such as ACO REACH, and similar approaches could be considered for possible adoption in ACO PC Flex.

We hope that additional cost-sharing relief will be announced in the RfA. However, if as previously indicated, CMS has concerns about its authority to do so, we would request that CMS work with the HHS Office of General Counsel to clarify for stakeholders the precise statutory, regulatory or interpretative barriers. Additionally, we would invite the Administration to work with the Better Health – NOW Campaign in our efforts to remove such barriers.

Supporting Whole Person, Integrated Primary Care

The twin epidemics of poor mental well-being and addiction are afflicting families and communities across the country, and primary care practices increasingly address these challenges in the course of patient care.[2] Evidence-based models of mental health integration, including the Collaborative Care Model and Primary Care-Behavioral Health have proven successful in meeting these challenges– even in rural and underserved locales.[3] [4] However, they have yet to achieve sufficient scale.

At the same time, the impact of social drivers of health on the health of Medicare beneficiaries has been increasingly recognized, leading CMS to establish payment for community health integration and social needs assessment services.

Given the impact of behavioral health and unmet social needs on overall Medicare beneficiary outcomes, the CMS Innovation Center has a responsibility to support ACOs and practices in wider implementation of integrated, whole-person care. However, based on the information released to date, this model's details have yet to include additional model features to explicitly strengthen behavioral health and social care integration. To better integrate behavioral health and social care, we recommend the following steps:

- **Beginning in Performance Year 1, CMS should track utilization of and expenditures on behavioral health integration services and recently**

---

[2] Rotenstein, L. S., Edwards, S. T., & Landon, B. E. (2023). Adult primary care physician visits increasingly address mental health concerns. *Health Affairs*, *42*(2), 163–171. https://doi.org/10.1377/hlthaff.2022.00705

[3] Blackmore, M. A., Patel, U. B., Stein, D., Carleton, K. E., Ricketts, S. M., Ansari, A. M., & Chung, H. (2022). Collaborative care for low-income patients from racial-ethnic minority groups in primary care: Engagement and clinical outcomes. *Psychiatric Services*, *73*(8), 842–848. https://doi.org/10.1176/appi.ps.202000924

[4] Powers, D. M., Bowen, D. J., Arao, R. F., Vredevoogd, M., Russo, J., Grover, T., & Unützer, J. (2020). Rural clinics implementing collaborative care for low-income patients can achieve comparable or better depression outcomes. *Families, Systems, & Health*, *38*(3), 242–254. https://doi.org/10.1037/fsh0000522

established social care integration services, as part of ACO participants' spend plan and associated reporting. This will provide a chance to assess implementation of service capabilities and beneficiary utilizationat the ACO and practice levels and across the model.

- **In years 2-5, the Innovation Center should offer additional enhancements to the prospective, population-based payment components of the model for those practices that routinely furnish such services.** We commend to your attention to MassHealth's Section 1115 Medicaid Waiver, which provides tiered primary care payment, within an ACO structure, based on certain behavioral and social care integration capacities.

Maximizing Participation

ACO leaders have shared with PCC that certain features could limit the model's reach and impact. **Specifically, model participation is limited to new MSSP ACO contracts and requires the use of prospective assignment. We ask that CMS reconsider these requirements.**

Reduction in the number of ACOs, practices or assigned beneficiaries could limit the size of the intervention group and delay assessment of the model's impacts. We are concerned that reduced participation could delay the date at which successful features could be incorporated elsewhere in Medicare. Most importantly, these limitations could deny the model's enhanced resources and care improvements for potentially interested primary care practices and their patients.

At a minimum, we encourage CMS to consider an additional application period, to give existing ACOs an opportunity to fully weigh the benefits of the model and plan for the adjustments necessary to shift from retrospective assignment to prospective assignment.

The ACO PC Flex model is a step forward for Medicare beneficiary health and well-being as well as for those in primary care who are their partners in health. PCC and our Better Health – NOW campaign value CMS' commitment to dialogue and appreciate this opportunity to share our perspectives on how to strengthen the model during implementation. If our team can answer any questions regarding this letter or would like to discuss these comments further, please contact PCC's Director of Policy, Larry McNeely at lmcneely@thepcc.org.

Sincerely,

Ann Greiner
President & CEO
Primary Care Collaborative