September 21, 2021

Sent via Electronic Mail

Meena Seshamani, M.D., Ph.D.
Deputy Administrator and Director, Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: Recommendations for Improving the Medicare Shared Savings Program

Dear Dr. Seshamani:

The Health Care Transformation Task Force (HCTTF or Task Force) writes to offer recommendations for strengthening the Medicare Shared Savings Program (SSP), advancing the adoption of Accountable Care Organizations among providers, and increasing the proportion of Medicare beneficiaries covered by accountable care arrangements.

The Task Force is a consortium representing a diverse set of organizations from various segments of the health care industry – including providers, payers, purchasers, and patient advocacy organizations – all committed to adopting payment reforms that promote a competitive and affordable marketplace for value-based health care and allow health care organizations to move from a system that incentivizes volume of services to one that rewards value of care. HCTTF member organizations strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by the Centers for Medicare and Medicaid Services (CMS) and others, can increase the pace of delivery system transformation.

The Task Force fully supports the new value transformation framework for CMMI priorities recently announced by CMS leadership. Our members have built, operated, and participated in many of the CMS- designed alternative payment models (APMs), including both the Next Generation ACO Model and the Medicare Shared Savings Program, and we have advocated for broader adoption of accountable care payment models. CMS has an important opportunity to further refine MSSP in a manner that expands access to APMs for both providers and beneficiaries that have historically been left out of these models. We believe MSSP can be used as a platform to streamline the model portfolio and test new Center for Medicare and Medicaid Innovation (CMMI) model concepts. The comments offered here reflect a desire to support the ongoing efforts of CMS to transform our health care system.

General Comments

ACOs have played a key role in transforming the health care system by creating incentives for providers to deliver higher quality, more cost-efficient care. While CMS has launched several ACO models over the last decade, MSSP is the only permanent accountable care model option currently available to providers. We encourage CMS to leverage MSSP to further advance provider adoption of APMs across the country. CMS can accomplish this by modifying policies that make the program less accessible for new participants, providing additional flexibilities within MSSP to improve program sustainability for existing participants, and using MSSP as a testing platform for future CMMI model concepts.

Improving Accessibility for New Participants

The Task Force believes that broad participation in APMs is critical for building a sustainable health system focused on the quality rather than volume of care. The increasing complexity of new APMs has created a two-tiered system that favors well-resourced providers with capacity to accept risk over providers with fewer resources or prior experience with APMs, essentially leaving behind a whole class of providers and the beneficiaries they serve. We encourage CMS to focus on expanding provider participation in innovative payment models, especially permenent options like MSSP.

One of the primary features of APMs that incentivize initial provider participation is the opportunity to earn increasing shared savings payments in exchange for taking on escalating levels of risk. Changes to MSSP made under Pathways to Success have reduced the opportunity for shared savings and consequently lowered the incentive for new participants to join the model. **We recommend CMS encourage participation in MSSP by increasing the percent of shared savings for participants in Levels A and B to 50 percent, Levels C and D to 55 percent, and Level E to 60 percent.**

Creating Sustainable Risk Options for Existing Participants

We encourage CMS to refine MSSP with a focus on retaining current model participants and creating sustainable pathways to accept higher levels of risk within the program. To this end, CMS should implement the following changes:

Create a Full-Risk Track for Advanced MSSP ACOs. The interest in the Next Generation ACO model demonstrates that there are ACOs willing and able to take on full-risk arrangements, yet CMS lacks a permanent full risk offering. Under the Next Generation model ACOs had the ability to select between 80 percent and 100 percent shared risk arrangement with a cap on savings and losses of 5 to 15 percent of the benchmark amount. Currently, MSSP ACOs are limited to a 75 percent shared risk arrangement (with losses capped at 15 percent of the benchmark) making the MSSP Enhanced Track a step back for Next Generation ACOs. Furthermore, as currently designed, the CMMI Direct Contracting models financial methodology does not represent a viable next step for many of the successful former Next Generation ACOs. We strongly encourage CMS to support the continued advancement of ACOs to full-risk arrangements by offering a permanent full risk option for ACOs.

- **Modify risk adjustment and benchmarking to better reflect the factors MSSP ACOs encounter in the delivery of care, including addressing the social determinants of health and community level factors impacting care.** Experts[1] have raised concerns that the current methodology for risk adjustment within MSSP may inadvertently lead ACOs to avoid certain high-risk populations and the providers who serve them, further exacerbating health inequities. We believe that CMS can use risk adjustment to incentivize and reward providers for delivering high quality care to underserved and historically marginalized communities. To accomplish this, CMS should calculate a separate higher benchmark to apply to beneficiaries with specific high-cost conditions or historical spending that is statistically higher (*e.g.*, two standard deviations) than the overall average of beneficiaries in the model.

  This approach is similar to what CMMI does in the Primary Care First and Direct Contracting high-needs tracks; however, we propose that CMS allow for benchmarks to be blended within a single ACO based on patient-level risk profiles rather than create a separate high-needs track in MSSP. CMS should also raise the risk adjustment cap to five percent to more accurately account for ACOs taking on higher risk populations over time. At the same time, CMS should create a floor so that ACOs without a significant change in population do not have to implement an extensive HCC coding program simply to avoid having their population risk be under-represented when normalized.

- **Eliminate the high and low revenue ACO distinction created under the Pathways for Success program.** The high and low revenue standard is arbitrary and presents an unnecessary complication in determining when an ACO may progress to the highest risk track. Furthermore, it creates a disincentive for ACOs that are voluntarily coordinating to advance APM goals. No ACO should be required to take on more risk than the nominal risk standard set by CMS (*i.e.,* Basic Track- Level E). High performers should be encouraged to participate in this model regardless of provider type.

- **Modify the MSSP benchmarking methodology so participants aren't competing against their own successes in providing better care.** The current MSSP benchmarking methodology uses a blend of regional and historical expenditures to set spending targets. The regional calculation incorporates all beneficiaries in the ACOs' region, including those assigned to the ACO, resulting in ACOs being measured against their own performance. This creates a disincentive for ACOs to fully maximize potential savings because the long-term result will be tougher benchmarks and consequently fewer resources to sustain care delivery changes. To ensure ACOs are not penalized for the savings they achieve for their assigned populations, CMS should remove an ACO's beneficiaries from regional benchmarks to which that ACO is compared.

- **Create a glide path for quality reporting.** ACO quality reporting is a costly and time-consuming endeavor that, while necessary, places a strain on ACO resources. CMS should focus on creating a glide path for practices to build up their reporting

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6394223/

capabilities over time and balance administrative load with the need to gather reliable performance data. We recommend that CMS limit quality reporting to the ACO-aligned beneficiary population and provide a more gradual transition to the use of registries or electronic clinical quality measures (eCQMs) for reporting.

- **Increase flexibility for ACOs to select participating providers by allowing TIN/NPI ACO enrollment.** Currently, MSSP requires ACOs be defined by their Medicare billing Tax Identification Number (TIN). Consequently, ACOs are required to include all providers (identified by their National Provider Identifier (NPI)) regardless of how well they align to the care delivery priorities of the ACO. The Next Generation ACO model allowed ACOs to determine participation using a TIN-NPI combination which enabled them to create more focused high-performing provider networks. We urge CMS to extend the Next Generation ACO Model TIN-NIP participation approach as an option to MSSP participants.

- **Enhance beneficiary awareness of and experience with ACOs.** CMS should prioritize improving beneficiary awareness and experience when selecting and receiving their care from an ACO. Regarding the selection of an ACO, we believe that beneficiaries should be aware of the APMs that impact their care and voluntary ACO alignment is an important aspect of increasing awareness. We recommend that CMS allow paper-based enrollment for beneficiaries in MSSP similar to what CMS is currently allowing for participants in the Direct Contracting model. There should be no "wrong door" for beneficiaries that want to be aligned to an ACO. Allowing paper-based enrollment would create a more convenient pathway for many Medicare beneficiaries compared to online enrollment.

  Additionally, CMS should apply value-based insurance design concepts within MSSP by waiving beneficiary cost sharing for not only preventative care, but also care coordination and case management services delivered by ACOs. Cost sharing waivers are not new for ACO models, but prior CMS waivers have effectively required ACOs to subsidize the cost sharing amount, which created a disincentive for implementing the waiver. CMS should fully cover the cost of co-pay waivers. Effective preventative care, care coordination, and case management are critical to the health of beneficiaries and, when reimbursed under an advanced APM framework, present a minimal risk of unnecessary utilization. Removing financial barriers for beneficiaries and ACOs would increase uptake of these services and improve outcomes.

Leveraging MSSP as a Platform for Innovation

CMS has been clear in its desire to streamline APM portfolio and align with many of the recommendations made in chapter two of the June 2021 MedPAC report. The Task Force fully supports the goals of creating a simpler model portfolio focused on maximizing the impact of APMs and transitioning the health care system away from FFS structures. To this end, predictable and sustainable APM participation options are critical drivers for increasing model participation. As the largest permanent ACO program in the market, CMS should focus energy

on identifying ways to leverage MSSP as a platform for further innovations and refinements in the ACO space. Aligning new ACO concepts developed within CMMI with MSSP would be advantageous for both CMS and model participants. As a permanent program, MSSP offers the benefit of providing ACO participants permanent participation tracks that they can transition to in the event a specific innovation fails. It also would simplify the model portfolio for ACOs by aligning all ACO participation options to a single application timeline with a relatively predictable update schedule. The permanence of the program also created a natural comparison group for CMMI model evaluations allowing for faster, more efficient, and more robust impact analyses.

CMS could consider testing a range of model concepts as variations on the existing MSSP program including:

- **New Payment Arrangements**: A full-risk participation option with a discount, primary care capitation, per member per month funding mechanism for services like care management and behavioral health.
- **Methodologies for Promoting Equity:** Incentivizing a focus on health equity using financial methodologies designed to reward increasing the total number of primary care relationships and outreach to currently unassignable or historically underserved beneficiaries.
- **Improving Beneficiary Affordability:** Improve affordability by testing a waiver of all cost sharing liability for Medicare beneficiaries aligned with an ACO participating in a total cost of care arrangement.
- **Improving Implementation and Operations:** Establishing a defined implementation period for new organizations to build capacity to take on risk as an ACO.
- **Enhanced Waiver Options:** Expanded waivers based on lessons learned from other models such as the Next Generation ACO model waivers for post discharge home visits, care management home visits, and telehealth.
- **Promoting Alignment Across Models and Provider Types:** Integrated specialist models into ACOs by aligning episode-based payments for specific specialties with the financial methodologies used in accountable care arrangements.

The HCTTF is excited about CMS' new vision for the future of value transformation across CMS and is eager to partner with CMS to achieve sustainable change, a goal that requires alignment between the private and public sectors and engagement with payers, providers, purchasers, and patients.

Please contact Joshua Traylor (Joshua.Traylor@hcttf.org | 202.556.0339) with any questions or feedback on this letter.

Sincerely,

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