September 6, 2022
Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1770-P: Medicare CY Payment Policies Under the Physician Fee Schedule; and Medicare Shared Savings Program Requirements

Dear Administrator Brooks-LaSure:

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS), Medicare Payment Policies Under the Physician Fee Schedule and Medicare Shared Savings Program Requirements (CMS-1770-P) ("Proposed Rule").

The Task Force is a consortium of private sector stakeholders that support accelerating the pace of transforming the delivery system into one that better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver better health and better care at reduced costs. We 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 CMS and other public and private stakeholders, can increase the momentum of delivery system transformation. We appreciate the opportunity to provide input on the following topics and questions:

- *II.D: Payment for Medicare Telehealth Services Under Section 1834(m) of the Act*
- *III.G: Medicare Shared Savings Program*
- *IV: Updates to the Quality Payment Program*

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## I. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (Section II.D)

The Task Force supports progressive policies related to telehealth services as a way of providing effective and efficient person-centered, value-based care. Undoubtedly, telehealth services helped to keep Medicare beneficiaries in touch with health care professionals during COVID-19, which showed how telehealth can enhance patient care and help reduce health disparities. The pandemic-related telehealth waivers are providing important learnings to inform policymakers about how best to modernize current telehealth policies to meet the opportunities and demands of the 21st century. The Proposed Rule contains several proposals related to the provision of telehealth services to which the Task Force responds below.

**The Task Force continues to support the Category 3 services designation and supports CMS's proposal to maintain that list until the end of 2023,** or longer if the public health emergency (PHE) extends well into 2023**.** The opportunity to continue to evaluate Category 3 services for permanent status on the Category 1 or Category 2 lists is important to better advance access to virtual care where appropriate. **Similarly, we support the addition of services to the Category 3 list as proposed in Table 8**.

**The Task Force does not support CMS's proposal to end coverage and payment for audio-only evaluation and management services after the 151-day post-PHE extension period.** CMS states its belief that the governing statute infers that a telehealth encounter be so analogous to in-person care that the telehealth service is essentially a substitute for a face-to-face encounter. Accordingly, CMS's perspective is that a telehealth service should be both an audio and video communication as to make it a "face-to-face" encounter. We disagree with this position and believes it may have a discriminatory impact for beneficiaries who lack adequate technology or the ability or desire to connect by video.

While the ability to visually see a patient may be beneficial, it should not be dispositive of coverage and/or payment of telehealth services. We believe applying a mandatory video connection is an arbitrary requirement; reaching a patient by audio-only means is still better than not connecting with the patient at all. **Therefore, we urge CMS to revisit this proposal and extend coverage and payment for audio-only evaluation and management services beyond the post-PHE extension period.** Additionally, we urge CMS to engage with stakeholders to identify effective strategies for gathering data on the reasons Medicare beneficiaries are or are not utilizing telehealth services (both with and without video). Gaining insights into telehealth utilization is critical for informing future policy decisions.

**The Task Force continues to be concerned with the in-person visit requirements for mental health telehealth services.** Requiring an in-person encounter for mental health services every six months is arbitrary and could contribute to health disparities for those with limitations in being able to travel to appointments for a variety of legitimate reasons, many of which the Task Force outlined in its CY 2022 MPFS comment letter. Providing mental health services through telehealth allows individuals to choose a provider that aligns with their cultural views. The in-person visit requirement will likely limit individuals' ability to choose a mental health care provider who can provide culturally congruent care depending on which provider is next available for an in-person mental health appointment. **Given the impact of COVID-19 and other**

**current events on mental well-being, we urge CMS to pursue flexible policies that promote access to necessary mental health services.**

If eliminating the six-month in person requirement for mental health telehealth services is not feasible, **the Task Force offers the following recommendations:**

- **Delay enforcement of the in-person requirement and announce a period of non-enforcement for one-to-two years to provide Medicare beneficiaries the broadest possible access to mental telehealth services.** By doing so, CMS could reduce the burden for providers, and barriers for patients, to receive mental health telehealth services beyond the PHE.
- **Allow the in-person visit to be furnished by any provider in the selected practice and/or ACO**, including a primary care provider or a provider of the same specialty or subspecialty.
- **Waive or exempt the in-person visit requirement for beneficiaries who are unable to travel, reside in a rural area, or who have a provider who is not located within a reasonable travel distance.** Specialist access is a significant concern in many communities; creating these flexibilities will help eliminate barriers to access, ensure beneficiaries are not denied treatment due to provider shortages related to the in-person visit requirement, and can accelerate the move toward integrated, coordinated care

The Task Force understands that the direct supervision waiver tied to the PHE will likely end during 2023. Many services critical to providing person-centered, value-based care are subject to general supervision, so this waiver expiration will have limited impact on care coordination and related services. **However, there are two value-based care categories of services for which the Task Force urges CMS to change the level of required physician supervision from direct to general: (1) Advanced Care Planning codes; and (2) Annual Wellness Visits codes**. Task Force members believe these services can be provided by effectively by appropriate non-physician practitioners without the direct supervision of a physician.

## II. Medicare Shared Savings Program (Section III.G)

### A. *General Comments*

The Task Force broadly supports the steps CMS is taking through this Proposed Rule to address several of the challenges participants in the Medicare Shared Savings Program (MSSP) have raised over the years. We applaud the emphasis this rule places on providing upfront financial support for inexperienced ACOs, creating smoother glidepaths for ACOs transitioning to performance-based risk, and developing benchmarking and risk adjustment methodologies intended to sustain long-term participation in the program. Many of these changes are consistent in spirit with recommendations for improving MSSP that HCTTF submitted to CMS in the fall of 2021.

The Task Force has a few general recommendations for improving MSSP and strengthening the opportunities presented in the Proposed Rule:

- **Allow existing ACOs the opportunity to opt into the new policies created under this Proposed Rule**. Several of the key proposals intended to encourage greater MSSP participation are limited to ACOs starting in 2024. While we appreciate that CMS is attempting to avoid impacting the 2023 application cycle already underway, limiting opportunities to only new or renewing ACOs will create a two-tiered system within MSSP that may disadvantage current ACO participants. CMS should offer ACOs the option to modify their existing contracts to align with the new policies being proposed rather than requiring existing ACOs to wait until the end of their agreements in 2025 or later.
- **Major changes to ACO benchmarks such as the package of reforms in this proposed rule should undergo an interim period for testing and refinement before full implementation**. These are complex policies that take time for ACOs to understand and model in advance of agreement periods and performance years to inform their participation decisions. Whenever possible, CMS should take a "do no harm" approach and apply the "better of" new versus existing methodologies to ACO benchmarks during the testing period. CMS should also provide an open forum for stakeholder feedback, learning and continuous improvement.
- **Discontinue the use of the low/high revenue ACO distinction in the MSSP program**. In previous letters, the Task Force has noted that the high/low revenue distinction CMS applies to MSSP ACOs creates unnecessary complexity within the program and does not effectively achieve the broader policy goals of CMS. Several of the Proposed Rule's policies are intended to increase MSSP participation among providers working in underserved communities, yet also limit participation to low-revenue ACOs. Many safety-net providers – Critical Access Hospitals (CAHs), Rural Health Centers (RHCs), and Federally Qualified Health Centers (FQHCs) – would be classified as high-revenue ACOs and thus prohibited from benefitting from the very policies intended to increase their participation in MSSP. We strongly encourage CMS to end the use of the high/low revenue distinction.
- **Leverage MSSP as a platform for ACO innovation by aligning with and testing concepts developed by the Center for Medicare and Medicaid Innovation (CMMI or the Innovation Center).** The Task Force has previously called for CMS to streamline its APM portfolio and simplify participation for providers. As the largest permanent ACO program in the market, CMS should leverage MSSP as a platform for further innovation and refinement 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 sustainable participation options to fall back on in the event a CMMI model fails or simply ends as scheduled. Implementing CMMI ACO models under MSSP would simplify the model portfolio by aligning all ACO participation options to a single application timeline with a predictable update schedule. The permanence of the program also creates a natural comparison group for CMMI model evaluations allowing for faster, more efficient, and more robust impact analyses. We encourage CMS to explore opportunities to further test, evaluate, and refine the ACO program by testing new model concepts within MSSP using CMMI authority. The Task Force previously submitted a letter to CMS that discusses this issue in greater detail.

- **Improve the evaluation and certification process for CMMI models to strengthen innovation and align with evolving CMS priorities.** The Task Force previously submitted detailed comments to CMS on the need to revisit the CMMI model evaluation and certification process. We believe that CMMI has done an admirable job working to meet its evaluation mandate given the complexity of the models under review and the ever-changing health care market. That said, evaluators face numerous challenges that have made it difficult to fully quantify the impacts of models and translate evaluation findings into broader policy actions. These challenges will only get more difficult as CMS makes progress on the goal of fully expanding accountable care to all Medicare FFS beneficiaries by 2030.

  The model certification process presents distinct but related challenges for CMS efforts to drive health care transformation. Since Congress did not define the level of evidence or degree of certainty needed for certification in the statute, CMS was tasked with interpreting the statutory language and establishing a standard for the level of evidence necessary for certifying a model. According to CMS officials, the resulting certification standard adopted by CMS is 95 percent or greater certainty of savings. Several interested parties, including academic researchers and model participants, have noted that this is a very high bar that is likely causing CMS to miss out on opportunities to expand models that would drive systemic health system changes and long-term savings to the Medicare Trust Fund.

  We encourage CMS to make strengthening CMMI evaluations and reviewing the model certification process a top priority. We believe that the size and scale of MSSP provide an opportunity for CMS to use the program as an anchor evaluation. Testing CMMI models within MSSP would reduce the cost and complexity of model design while providing a natural comparison group of non-participating MSSP ACOs for evaluation. As a permanent program, MSSP could be used to expand promising concepts from models that don't meet the criteria for full expansion.

**Our detailed remarks on the Proposed Rule's specific provisions are provided below.**

*B. Providing an Option for Advance Investment Payments to Certain ACOs*

The Task Force has previously highlighted the positive impacts of the CMS Innovation Center's ACO Investment Model (AIM) and called on CMS to expand the model or offer similar funding options as a permanent part of MSSP. We applaud and support the proposal to build on the AIM model with the creation of the ACO Investment Program (AIP). We believe offering ACOs up-front $250,000 lump sum payments and quarterly per-beneficiary payments for a two-year period will provide ACOs with much needed cash-flow to support the transformation efforts necessary to succeed in MSSP. We also strongly support the CMS proposals to allow funds to be spent over the full five-year agreement period and to forgive the repayment requirement if an ACO does not achieve shared savings during its first or subsequent agreement periods.

While supportive of the overall concept of the AIP, we have several recommendations to improve the program.

- **Expand AIP access to all ACOs regardless of revenue status:** We recommend CMS expand ACO access to AIPs by removing the high/low revenue ACO distinction as an AIP eligibility criteria. As noted above, the high/low revenue distinctions create an unnecessary layer of complexity in the MSSP program and will result in unintended consequences when used to set eligibility and payment policies for ACOs. In this case, the exclusion of high revenue ACOs from eligibility for the AIP program will preclude many key safety-net providers such as FQHCs, RHCs, and CAHs from participation. Given the broader policy goal driving the AIP – expanding ACO access in underserved communities – we believe that CMS should remove the revenue distinction and make the program broadly available to all ACOs. If CMS is unwilling to end the use of revenue distinctions, we encourage CMS to create a process to exempt FQHCs, RHCs, CAHs, and other safety net providers from the policy to ensure they have access to AIP funds.
- **Allow existing ACOs to apply for AIP funds:** We encourage CMS to allow existing ACOs to apply for AIP funding once the program is available. In the Proposed Rule, CMS notes that AIP funding will only be available to ACOs starting participation in or after 2024. We recognize that this program will take time to implement and that an earlier start date could interfere with the 2023 MSSP ACO application cycle. However, limiting AIP funding to ACOs entering in 2024 may discourage potential 2023 ACOs from joining MSSP and bars existing inexperienced ACOs from benefitting from these policies. Thus, we recommend that CMS establish a process for inexperienced MSSP ACOs that joined prior to 2024 to apply for AIP funds. Such a process could include shortening the period that funds would be used and repaid to align with the ACOs remaining agreement period, extending the period to carry over into a second agreement period, or allowing ACOs to end their current agreement period early and enter a new five-year agreement that aligns with the planned AIP timeline.
- **Evaluate the impact of using national, state, and regional variation on health equity adjustment strategies:** The Task Force supports the efforts that CMS has made to account for health equity in the design of APMs. In the Proposed Rule, CMS outlines a plan to use Medicare-Medicaid dual eligibility status and Area Deprivation Index (ADI) rankings to set per-beneficiary-per-quarter payment amounts for ACOs. We believe that this is a positive step in the right direction to guide resources towards improving care and outcomes in underserved communities. We specifically support the decision to implement a graduated payment scale when reviewing ADI scores and view it as an improvement over the positive and negative adjustment approach employed in the ACO-REACH model. That said, there are two issues we recommend CMS consider before finalizing this policy.

    1. **CMS should evaluate the impact of state level Medicaid policy on dual eligibility status.** While dual eligibility status is a reasonable marker for identifying low-income Medicare beneficiaries generally, it is not a consistent measure of economic distress across states. Medicaid eligibility varies by state and several states have not expanded Medicaid up to 138 percent of the federal poverty level as allowed under the Affordable Care Act. Consequently, the average dual eligible beneficiary in a state without expanded Medicaid eligibility likely has a much higher degree of economic insecurity compared to

a dual eligible beneficiary from a state with expanded eligibility. We encourage CMS to evaluate the impacts of this variation on the AIP program and consider whether another – more uniform – measure of economic insecurity should be used to target AIP funds to ACOs.

2. **CMS should model the impacts of using the state level rather than national ADI rankings to determine payments to ACOs**. While the national ADI approach is a useful measure of absolute socioeconomic disadvantage across the country, it does not reflect important variations in relative disadvantage at the regional level. While CMS has a clear mandate to narrow disparities in health equity at the national level, the impacts of relative disadvantage within states and communities also plays an important role in driving disparities in health equity. **While a CMS strategy for advancing health equity should direct resources to underserved areas at the national level, we believe such a strategy should also recognize and support communities that are disadvantaged relative to others within their state.**

CMS also requested feedback on using the Health Professional Shortage Area (HPSA) designation for primary care in place of the ADI ranking for identifying underserved populations. While living in a HPSA is an important factor impacting Medicare beneficiaries' access to care and health status, it is only one of many socioeconomic factors impacting health. **Consequently, we believe that it is appropriate for CMS to use more comprehensive measures of disadvantage (such as the ADI) in the effort to incorporate health equity as a consideration in APM designs.**

*C. Smoothing the Transition to Performance-Based Risk*

HCTTF is on record calling for the need for greater support and more on-ramp opportunities for providers interested in ACO participation and see this proposal as a welcome step in that direction. We applaud the move by CMS to implement policies that smooth the transition to two-sided risk arrangements especially considering the recent plateau in the growth of new ACOs joining MSSP.

**The Task Force supports the proposal to allow inexperienced ACOs to participate in upside only risk (Level A) for up to 7 years (5 years of the first agreement period and the first 2 years of a second agreement period) before continuing on the Basic track glide path.** We also appreciate that the proposal would extend the option to allow existing inexperienced ACOs in tracks A and B to modify the remainder of their agreement to remain in in upside-only risk. We believe this same flexibility should be applied to other MSSP programs in this Proposed Rule such as the AIP. This approach would remove an incentive for providers that would otherwise join MSSP in 2023 to delay participation until 2024 or later.

The Task Force continues to believe there is value in providers advancing into two-sided risk arrangements as they gain experience with APMs. **Consequently, we do not support a policy of a 12-year upside only risk option.** Generally, we agree with the CMS assessment that a maximum of 7 years under a upside only risk arrangement represents an appropriate balance between the goals of onboarding new providers into APMs and moving the broader health care system into performance-based risk arrangements. The proposed 7-year upside-only risk option should be sufficient for providers to gain this experience and do not believe the potential 12-

year upside-only risk option for inexperienced low-revenue ACOs offered by CMS will be necessary.

**The Task Force supports the proposal to make the Enhanced track optional for all MSSP ACOs and allow ACOs to remain in Track E permanently.** Offering ACOs the ability to remain in a lower risk arrangement rather than advancing to MSSP Enhanced is an important flexibility that will likely help to retain the participation of ACOs and grow the MSSP program. We especially appreciate that CMS has made this option available to all ACOs regardless of their revenue status or level of experience**. To ensure that this policy shift is having the desired impact of increasing MSSP participation, we recommend that CMS monitor the program to track the number of ACO participating in and beneficiaries served under each of the six tracks.** Additionally, CMS should evaluate MSSP at the Track levels to identify impacts on the cost and quality of care received by Medicare beneficiaries and ensure that the extended upside-only risk option is not negatively impacting performance in either area.

**We also reiterate our call for CMS to create another full-risk track option for advanced ACOs.** In prior letters to CMS, the Task Force has called for a full-risk option that includes a capitated payment model as well as other improvements to the long-term sustainability of MSSP. In addition to the HCTTF, several other MSSP interested parties and MedPAC have recommended the creation of a full-risk MSSP track. While HCTTF supports the strong effort to create better on-ramps into MSSP in this Proposed Rule, we believe the program also needs greater opportunities for advanced ACOs. The strong interest in the Next Generation ACO and ACO-REACH models demonstrate that ACOs are willing and able to take on full-risk arrangements, yet CMS lacks a permanent full-risk offering. **We strongly encourage CMS to support the continued advancement of ACOs by offering a permanent full-risk track option.**

*D. Increased Shared Savings Opportunities for Low-Revenue ACOs*

**The Task Force supports the proposal to allow MSSP ACOs in the Basic Track that meet quality standards but do not meet minimum savings rate (MSR) requirements to receive a 50 percent of the shared savings they would be eligible for had they met the MSR.** We believe that the allowing ACOs to receive a reduced shared savings rate (20 percent in Tracks A/B and 25 percent in Tracks C/D/E) represent a reasonable approach to balancing the goal of encouraging ACOs to meet the MSR with the reality that it takes time for ACOs to successfully implement the care delivery reforms that drive savings. This policy proposal offers some additional financial support for ACOs to remain in the program while maintaining incentives to further improve their performance and earn the full shared savings rate for which they would otherwise be eligible. **While supportive of this proposal, we strongly encourage CMS to eliminate the high/low revenue distinction and expand this opportunity to all ACOs regardless of their revenue status**. As noted earlier in this letter, many safety net providers that would most benefit from this opportunity – including RHCs, CAHs, and FQHCs – would likely be designated as high-revenue ACOs.

*E. Accountable Care Prospective Trend Addition to Benchmark Methodology*

**The Task Force supports the broader concept underpinning the Accountable Care Prospective Trend (ACPT) proposal; however, we have specific recommendations to improve the implementation of this benchmarking change.** HCTTF appreciates that the Proposed Rule clearly notes the challenges of the existing MSSP benchmarking methodology. The downward

ratchet effect of benchmarks based on historical spending combined with the long-term impacts of rebasing and the goal of having all Medicare fee-for-service beneficiaries in an accountable care arrangement by 2030 make current benchmarking strategies untenable. We believe the proposal to recognize the broader impact of ACOs on Medicare spending via the ACPT is a positive short-term step to ameliorating some of these issues while CMS works to refine its administrative benchmarking strategy. We also support the concept of using the ACPT approach as an opportunity to refine and phase in an administrative trend component to MSSP benchmarking over time.

That said, our members have highlighted some specific concerns with the APCT methodology.

- Many HCTTF members are current MSSP participants and are experienced in using CMS Office of the Actuary provided data to estimate benchmark ranges. These members have found that prior CMS efforts to project health care trends have been inconsistent, resulting in large swings in benchmarks outside of CMS estimates. Given the limited information available in the Proposed Rule to fully model the ACPT and the ongoing shifts in health care trends as a result of the COVID-19 pandemic, it is difficult to provide detailed feedback on the proposed methodology. **Consequently, we recommend that CMS pilot the ACPT with a short-term trend – one to two years rather than five – while it evaluates the impacts of the pandemic on health care spending and service utilization. We also strongly encourage CMS to continue engaging with MSSP ACOs to identify issues with the transition to the new methodology and address concerns.** During the pilot period, we recommend flexible options for ACOs and a "do no harm" approach to benchmark adjustments (e.g., apply the "better of" new vs. old methodology whenever possible for ACOs regardless of whether they generate shared savings or losses for the performance year).
- **The proposal to add the ACPT methodology establishing a national ACO specific spending trend factor to the existing MSSP benchmarking methodology does not adequately account for regional variation in spending growth.** While the ACPT trend factor is an improvement in that it is ACO specific, the proposed approach for incorporating it into the MSSP benchmark methodology would further amplify the impact of national spending trends on MSSP ACO benchmarks and create new challenges for ACOs. ACO spending rates, market share, and impact on non-ACO spending and practice patterns vary across the country. As CMS discusses in the Proposed Rule's Administrative Benchmarking Request for Information, an Administrative benchmarking strategy will need to account for existing regional variation and incorporate a clear strategy for benchmark convergence across ACOs in a given region. A review of county-level Medicare spending growth shows that some regions have consistently trended above or below the national average for several consecutive years. By further diluting the impact of regional trends in the benchmarking methodology, CMS creates the potential for arbitrarily excessive losses among ACOs operating in low-growth regions and windfall gains among ACOs operating in high-growth regions.

  We appreciate the CMS proposal to institute a guardrail strategy to protect ACOs from experiencing losses greater than what they would have seen under the two-way

blend benchmarking methodology**. We urge CMS to consider an alternative strategy to the proposed three-way blend. Specifically, we recommend that CMS evaluate the impacts of continuing to use a two-factor benchmarking methodology but: (1) replace the current national trend factor with the ACPT trend factor, and (2) remove an ACOs beneficiaries from the regional trend calculation.** Under this approach, CMS would continue to weight the regional trend factor by the ACOs market share and thus combine the benefits of a prospective national ACO-specific trend with a more accurate assessment of regional spending changes. This approach would also directly address the "rural glitch" issue on which HCTTF has previously commented whereby ACOs that represent a majority of their markets are penalized for their efforts to control costs. This approach would represent a reasonable transition state while CMS develops a fully Administrative benchmark methodology. If CMS chooses to continue with the proposed methodology, we urge CMS to ensure that the guardrail strategy appropriately buffers ACOs against excessive losses and curbs windfall gains.

- **The proposed ACPT methodology would only be available to ACOs with agreement period starting on or after 2024.** We understand CMS's desire to avoid changes to existing ACO agreements and the ongoing 2023 application cycle, however, we believe limiting this policy to new agreement periods could place existing ACOs at a disadvantage relative to others in the program. **We urge CMS to allow existing ACOs the opportunity to opt into the new benchmarking methodology.** This could be done by allowing existing ACOs to modify their current agreements or creating a streamlined process for ACOs to renew agreements early to align with the new benchmarking methodology.

*F. Request for Information on MSSP Administrative Benchmarking Strategy*

The Task Force supports the general concept of administrative benchmarking as a promising solution to creating a sustainable benchmarking methodology for ACOs. Since the passage of the Affordable Care Act, we have seen APMs take on an increasing role in the health care marketplace and identified several challenges with existing benchmarking strategies. These challenges have been well documented and thoroughly discussed in research papers and commentaries by HCTTF, CMS, MedPAC, and several other experts and groups. At the core of these issues is the fact that current benchmarking approaches – based on historical spending and regional/national trends with periodic rebasing – penalize ACOs for their individual success containing costs and their collective impact on the health care market by ratcheting benchmarks downward over time. To date, many ACOs have sustained their participation by working to be more efficient than their fee-for-service counterparts and hoping to remain below regional or national spending trends. This strategy will become increasingly untenable as CMS moves toward the goal of having all Medicare fee-for-service beneficiaries aligned to a provider accountable for cost and quality by 2030.

A well designed and effectively implemented Administrative benchmarking strategy has the potential to address these issues and support a fairer, more sustainable, and more equitable health care system. To accomplish this CMS should consider the following points:

- **CMS should clearly define the goals of an administrative benchmark strategy.** To date, ACO benchmarking strategies have primarily focused on reducing spending relative to fee-for-service. As CMS notes in this RFI, the growth of ACO market share makes fee-

for-service spending an unsustainable comparator for measuring success. That Task Force believes that now, a decade into the operation of MSSP, it is time for CMS to clearly signal a shift the broader policy goal of ACO benchmarking. **Specifically, we believe the CMS Administrative benchmarking strategy for MSSP should prioritize: (1) predictable and sustainable health care spending growth rates for the Medicare trust fund, (2) sustainable reimbursement rates for providers that incentivize investment in efficiently delivering high quality care, and (3) increasing investment in underserved communities to improve health equity.** Furthermore, achieving these goals will require buy in from providers responsible for delivering care. **We believe that transparency is foundational to achieving broad support for this effort and strongly urge CMS to make the details of any administrative benchmarking methodology public so that all interested parties can review, fully understand, and provide informed feedback on the planned future direction of Medicare payment strategies.** Accomplishing these goals may require CMS to take a long view as ACO spending increases relative to fee-for-service in the short term to increase provider participation. However, we believe that the long-term ability to set predictable spending growth targets and use payment policy to promote efficiency, equity, and quality are worthwhile tradeoffs.

- **Administrative benchmarks should allow for regional variation.** While there is a well-developed body of research examining unjustified small area variations in health care costs, overall differences in regional health care costs are often due to justifiable factors including the health status of patient populations, the cost of physical infrastructure, and hiring. A national (or excessively large regional) Administrative benchmark would unduly benefit or harm providers in high and low-cost regions by failing to account for reasonable variations in health care spending. This said, it is a reasonable policy goal for CMS to pursue a reduction in spending variation within a given region. We encourage CMS to consider leveraging existing county level benchmarking strategies used in programs like Medicare Advantage to ensure benchmarking sufficiently accounts for current regional variation. During a convergence phase these county areas could be aggregated into large regions to promote alignment across ACOs. Policy on the ultimate size of the benchmarking regions and the timeline for the convergence phase region should be established through ongoing dialogue and feedback from ACOs and other interested parties.
- **The benchmarking transition period should meet ACOs where they are with a focus on balancing continuous improvement with spending normalization.** During the initial years of the convergence phase, the Task Force believes the primary goal of CMS should be maximizing provider participation in ACOs. To achieve this, we believe the approach discussed by CMS of basing the benchmarks of high cost ACOs on the ACOs historical spending and gradually aligning spend to the administrative benchmark for the region is a reasonable approach.
- **Benchmarking methodology should be aligned with goals of improving health equity.** The Task Force is encouraged to see the emphasis CMS has placed on incorporating benchmarking as part of its broader health equity strategy. We encourage CMS to use this convergence period to increase investments in underserved communities. This could be done by building on the experience CMS has gained using indices such as the ADI to

weight additional per beneficiary payments to providers. We also recommend CMS evaluate the difference between average spending among underserved communities compared to well-resourced communities to establish a measure of reasonable costs for appropriate care. This measure could then serve as a target floor for spending rates in underserved communities to promote greater investment and provider attention. After the convergence phase, we would encourage CMS to continue the use of a health equity index strategy to weight payments to ACOs. That said, we encourage CMS to revisit this issue with ACOs and other interested parties to revisit strategies for continuing to promote health equity through benchmarking given the amount of time we expect the convergence phase to take.

Regarding the RFI approaches to addressing health inequities via the MSSP benchmark methodology to incentivize ACOs to serve historically underserved communities, the Task Force recommends CMS invest significantly in standardizing the collection and sharing of Social Drivers of Health (SDOH) data. Any adjustments to the benchmarking methodology will be reliant on valid, standardized data that accurately reflects the populations for which these proposals are seeking to improve health and health equity.

*G. Adjusting ACO Benchmarks for Prior Savings*

The Task Force has consistently highlighted the need to recognize and account for the prior efforts of ACOs – and all APM participants – to generate savings when negotiating new model agreements. The failure to recognize and account for these efforts is one of the primary barriers to the long-term sustainability of provider participation in MSSP and other CMS payment models. We appreciate the proposal to adjust an ACO's benchmark based on the higher of either the prior savings adjustment or the ACO's positive regional adjustment. We also appreciate the proposal to allow ACOs to use a prior savings adjustment to offset negative regional adjustments when an ACOs spending is higher than their regional service area. These policy changes are positive steps that will help to reduce the negative impacts of the ratchet effect on ACOs.

**While generally supportive of the goals of these policies, we believe the current proposal should be adjusted to maximize the impact on ACOs.** The intent of this policy is to boost incentives for high-performing ACOs – especially in low-cost regions – to remain in MSSP by reducing the ratchet effect. Yet, the proposal to apply the higher of either: (1) the positive regional adjustment, or (2) a prior savings adjustment equal to the lesser of 50 percent of an ACOs prior savings capped at five percent of national FFS spending for assignable beneficiaries. This means that the majority of low-cost ACOs would not experience a meaningful benefit from this policy change. **We recommend that CMS recognize the efforts of these ACOs by applying the actual average savings rate over the previous three years as the upward adjustment factor for new agreement periods.**

Furthermore, many MSSP ACOs participated in other CMS APMs prior to joining MSSP. Experience with other models is often a key steppingstone to participation in Advanced APMs and should also be included when considering an ACOs prior savings. **We encourage CMS to expand the policy to include savings achieved by an ACO from participation in the Next Generation ACO model, ACO-REACH, and future CMS or CMMI ACO models.**

*H. Limiting Negative Regional Adjustment Impacts on ACOs*

**The Task Force supports CMS's proposal to reduce the cap on negative adjustments from 5 percent to 1.5 percent of national per capita Part A & B spending and further decrease negative adjustments as the proportion of dually eligible beneficiaries or average prospective HCC risk score increases.** This policy aligns with the broader goal of increasing ACO participation rates by creating an incentive for ACOs that are high-cost relative to their regions to join MSSP and maintain participation.

*I. Increasing Positive ACO Risk Adjustment Cap*

The Task Force appreciates the CMS efforts to improve the MSSP risk adjustment methodology. The current three percent flat cap approach to risk adjustment places ACOs serving disabled and dual eligible Medicare beneficiaries at a disadvantage as these populations are much more likely to hit the risk score cap compared to the aged non-dual population. The CMS proposal to modify the current three percent HCC risk score cap to account for demographic changes before applying the three percent cap is a positive step. We support the proposal to calculate and apply the risk score cap to the aggregate score across an ACO's aligned patient population rather that at the level of Medicare enrollment type. Applying a cap at the level of the enrollment type creates a perverse incentive to avoid patients from high-risk enrollment categories in favor of patients from enrollment categories that are less likely to be subject to the cap.

However, there are additional changes CMS should make to advance the stated goal of supporting ACOs with small panel sizes or high proportions of dually eligible/ESRD/complex patients. Specifically, we recommend that CMS:

- **Increase the base risk score cap to five percent to more appropriately compensate ACOs treating a large proportion of high-risk and complex patients.** ACO providers have a clear incentive to identify, treat, and attempt to prevent chronic conditions to both improve quality and control costs. The current risk adjustment cap creates a disincentive for treating underserved communities that CMS should address if it is to be successful in meeting the goal of increasing ACO coverage in these areas. By definition, patients in underserved communities have not had appropriate access to high quality care. It is reasonable to expect that as ACO coverage increases in traditionally underserved communities, ACO providers will identify and document a wide range of previously underreported health needs. A static cap on risk score growth penalizes both inappropriately intensive coding as well as appropriate – even desirable – efforts to accurately document the burden of disease in a community. If CMS intends to retain a static cap on risk score growth, we recommend that the cap amount be increased to reduce the negative impact on providers that are appropriately identifying and documenting patient needs. We recommend that the cap be increased to 5 percent, consistent with the proposal in the Value in Health Care Act.
- **Allow the risk adjustment cap to align with broader regional risk score growth trends within an ACOs region when those trends exceed five percent.** A flat percentage cap will always disadvantage ACOs in regions where risk score growth exceeds the cap. While CMS may wish to limit the potential for risk score gaming, a flat cap approach created a perverse incentive for providers to avoid complex patients and further exacerbates the challenge of improving care in underserved communities.

*J. Extending eCQM Incentives*

As stated in prior letters, the Task Force is directionally supportive of the proposed changes to MSSP's quality performance standard and reporting requirements but remains concerned about the implementation timeline. **The Task Force supports CMS' proposal to extend the current incentives for reporting eCQMs through 2024 in alignment with the web interface reporting option.** Providing ACOs with an additional year of incentives is a much-needed support as ACOs attempt to meet the technical requirements needed for eCQM reporting. That said, we feel compelled to stress that this transition is logistically challenging and requires large investments of both funds and time to accomplish, especially for larger health care systems and provider organizations operating across multiple electronic medical records.

CMS should take active steps to support this transition, identify best practices for transitioning to eCQM reporting and pilot strategies for collecting the demographic data necessary to support health equity. In the Proposed Rule, CMS seeks feedback on a digital quality measurement (dQM) strategy. **We recommend CMS ensure that the eCQM reporting requirements for MSSP align with the broader dQM strategy once finalized. We recommend CMS allow ACOs to continue reporting using the web interface until resources and solutions are widely available to allow EHRs to meet the eCQM and interoperability requirements, which will take longer than the current timeline allows.**

**Finally, we encourage CMS to recruit a cohort of ACOs to pilot the transition to eCQMs.** A pilot program would allow CMS to get an accurate assessment of the resources required to implement eCQMs, identify common barriers to transition, test strategies for improving reporting on other priority issues such as beneficiary demographics.

*K. MSSP Sliding Scale Approach to Determining Shared Savings for ACOs in Basic or Enhanced Tracks*

CMS proposes to return to a previous policy which applies a sliding scale methodology to determine the amount of shared savings an ACO can receive. This proposal, if finalized, would remove the "all-or-nothing" savings adjustment that was implemented in the final CY 2021 Physician Fee Schedule rule. The current proposal is designed to address multiple concerns: (1) the challenges of transitioning from reporting via the CMS Web Interface to required reporting of eCQMs/MIPS CQMs; (2) how small differences in the distribution of ACOs MIPS Quality performance category scores may result in a large difference in the number of ACOs that fail to meet the quality performance standard; and, (3) the need to adjust the quality performance score based on an ACO's patient population as reflected in the health equity adjustment (discussed in the next section below).

**The Task Force supports the sliding scale methodology proposal, and of its application to ACOs in both the Basic and Enhanced tracks.** Removing the risk of an "all-or-nothing" qualification standard is critically important to supporting providers, particularly those furnishing care in underserved areas to patients with high unmet healthcare needs. The sliding scale policy is more supportive of attracting new providers to the ACO program and to helping CMS meet its goal of having all Medicare Part A and B beneficiaries in accountable care relationships by 2030.

*L. MSSP Health Equity Adjustment for ACOs that Report All-Payer eCQMs/MIPS CQMs, and Are High Performing on Quality, and Serve a High Proportion of Underserved Beneficiaries*

CMS' sliding scale methodology to determine shared savings (described in Section III.G.4.b.2-5) uses a health equity adjustment data point (described in more detail below). This adjustment is designed to upwardly change quality performance scores for ACOs that both serve a high proportion of underserved individuals and achieve high quality performance. As performance reporting moves from the CMS Web Interface to eCQM/MIPS CQM reporting and de facto includes all-payer data, this adjustment will help ensure that those providers serving a higher proportion of low-income patients who are dually eligible for Medicare and Medicaid, and/or provide services in geographic locations with ADI scores of 85 or above, are not inadvertently penalized for their performance. CMS notes that it also wants to proactively avoid situations in which ACOs sidestep underserved populations due to the transition to all-payer eCQMs. The health equity adjustment will add a maximum of ten points to an ACO's MIPS Quality performance score but does not change current policy for how that score is calculated.

The Task Force supports the rationale for creating a health equity adjustment. We believe this is a needed strategy to address the ongoing challenge of risk adjustment in an environment in which risk is calculated based on age and gender and not on various factors that have been identified as being more correlated with driving desirable health outcomes and quality performance. However, we have concerns with the methodology as described in the Proposed Rule.

Consistent with our other comments on this Proposed Rule, we believe that tying eligibility to eCQM or MIPS CQM reporting is a flawed approach and will significantly limit who qualifies for the adjustment. ACOs who would benefit most from the adjustment will be excluded by the APM Performance Pathway (APP) reporting requirement, since ACOs continue to face challenges – due to financial constraints – in implementing upgraded systems, contracting with vendors or registries, and training staff to use this new process for data submission. Given these challenges, it is unrealistic to believe that a significant number of ACOs will participate in eCQM or MIPS CPM reporting in 2023.

We understand that CMS is interested in finding additional ways to incentivize ACOs to adopt APP reporting voluntarily before it becomes mandatory starting with PY 2025. However, tying a health equity adjustment to the types of quality data submitted or the data reporting mechanism seems inappropriate and misguided. One of the goals of this adjustment is to support ACOs that serve a high proportion of underserved beneficiaries. Underserved beneficiaries tend to have higher costs that are not adequately captured in an ACO's benchmark due to historical service underutilization. Consequently, ACOs caring for these patients will be seriously challenged to devote sufficient financial resources to invest in the health IT infrastructure necessary for APP reporting in time for mandatory reporting, much less to transition to the APP earlier than what is required. Therefore, it appears likely that few potentially eligible ACOs are likely to qualify for the health-equity adjustment, at least in the early days. **We strongly recommend that CMS remove the requirement that an ACO would need to report eCQMs or MIPS CQMs to be eligible for the health equity adjustment.**

We are also concerned that few ACOs will be able to meet the 20 percent threshold required for the underserved multiplier. As proposed, some ACOs would not qualify for the adjustment simply because of where they are located. Dual eligible beneficiary percentages will vary across states depending on nonuniform criteria for Medicaid eligibility. Additionally, since

CMS is comparing ACOs to the ADI national percentile rank, some populations who may appear underserved relative to others in their surrounding area or state, may in fact fall below the 85th percentile when compared to other communities nationwide. CMS seeks comment on utilizing Part D Low-Income Subsidy (LIS) data as either a replacement or a supplement for the dual eligibility status and ADI. Given Part D LIS eligibility is uniform nationwide, the metric may provide a more consistent comparison of whether beneficiaries are undeserved. We recommend that CMS share additional data and analysis comparing these data sources and the number of beneficiaries who would qualify under each metric by geographic regions.

CMS should also recognize that some ACOs may have limited data analytics capabilities. As a result, we encourage CMS to utilize a dataset that is publicly available and that can be used without restrictions. While the Neighborhood Atlas® does have some data lookup tools available on its website, those tools only allow viewers to access individual addresses one at a time. While users can download full datasets of the ADI data, data use is limited for non-profit education, research, and public health purposes. As a result, ACOs would be unable to partner with other organizations to digest and format this data in a way that would allow them to easily identify which of their beneficiaries would meet the 85th national percentile. Given ongoing labor shortages in the health care sector, these types of partnerships are more important than ever and will help alleviate provider burden, while allowing providers to focus their time on patient care.

**The Task Force strongly urges CMS to consider redesigning the health equity adjustment.** One way to do so, which would address both the concerns listed above, and address the need for improvements in Social Drivers of Health (SDOH) data collection, would be for CMS to tie the health equity adjustment to the percentage of SDOH and/or demographic data that ACOs report on their aligned beneficiaries. Over time, CMS could consider evolving this adjustment to address other challenges with SDOH data collection, with the goal of eventually setting the adjustment based on patient-level SDOH data. This data would also be valuable in adjusting ACO benchmarks, as discussed in greater detail below.

*M. Calculating County FFS Expenditures to Reflect Differences in Prospective Assignment and Preliminary Prospective Assignment with Retrospective Reconciliation*

HCTTF members have concerns with the CMS proposal update the preliminary prospective assignment methodology to address what CMS had framed as a bias in favor of prospective assignment ACOs. We recognize the merits of aligning the benchmark and trending methodologies to be "all prospective" or "all retrospective," based on the ACOs selected approach. However, our members have noted that the proposed methodology for addressing a potential bias favoring ACOs using prospective assignment could widen a structural advantage for retrospective assignment. This would create an incentive for ACOs to switch to retrospective assignment solely due to this policy change; adding operational burden and cost and limiting ACOs ability to effective targeting of clinical interventions within a population of patients known in advance.

**We recommend that CMS and stakeholders take more time to thoroughly study how individual ACOs fare under both assignment methodologies, under both current policy and the Proposed Rule, before finalizing any changes.** Specifically, we recommend that CMS:

- Establish a two-year pilot of the new assignment methodology.
- Offer ACO transparency by making the final settlement results available to all ACOs (using both prospective and retrospective assignment) reporting how the ACO would perform under retrospective assignment, the current prospective assignment methodology, and under the proposed prospective assignment methodology.
- Create a level playing field by applying waiver flexibilities equally across all MSSP ACOs regardless of their assignment methodology.

## III. Updates to the Quality Payment Program (Section IV)

### *A. Screening for Social Drivers of Health Proposed Measure*

CMS proposes to implement a new measure of screening for social drivers of health to the MIPs program. This proposed measure would assess the percentage of patients (18 or older) seen in a physician practice or health system and are screened for: (1) food insecurity, (2) housing instability, (3) transportation problems, (4) utility difficulties, and (5) interpersonal safety.

**The Task Force supports adding this measure into MIPS and strongly suggests that CMS use this measures as a way to collect SDOH data, as per the RFI in Section IV.(d).** In addition to serving multiple purposes across this Proposed Rule, these measures also align with the proposal in the CY 2023 Medicare Advantage Proposed Rule that would require all Special Needs Plans (SNPs) to complete health risk assessments of enrollees, including questions on housing stability, food insecurity and access to transportation. It would also create alignment with the recently finalized Inpatient Quality Reporting Program (IQR) rules for FY 2023, in which this measure will now be included for all inpatient hospital programs.

One caveat to the Task Force's support is to note that a positive screen for interpersonal safety may require providers to connect the patient to law enforcement within a certain amount of time. One Task Force provider member suggests that this domain be considered for a separate measure, to allow providers to understand the impact of positive screens on resources. In addition, we recommend CMS share with providers lessons learned from the Accountable Health Communities model on best practices related to this domain (*e.g.*, are there times when it is appropriate not to ask or revisit this question; ethical dilemmas around mandated reporting; licensing considerations for screeners ascertaining this information; and times when self-reporting may differ from observations).

**Regardless of the screening tool or measure, we strongly urge CMS to develop recommendations on how to best educate patients and providers on the importance of collecting social needs data.**

### *B. Request for Information on MIPS Quality Performance Category and Advancing Health Equity*

CMS seeks input on a several questions related to developing measures related to the following three topic areas:

1. Patients' health equity needs
2. Assessing the rate of providers' collection of patient-reported social risk data

3. Patient-reported data on receipt of language services and clinician/patient communication

The Task Force offers the following input:

- **Measuring Patient's Health Equity Needs:** The Task Force recommends CMS develop two companion measures to be partnered with the proposed *Screening for SDOH Measure* discussed above. The first is a measure of how many patients screen positive for any of the five SDOH categories. The "positive screen" measure was finalized in the FY 2023 Inpatient Prospective Payment System rule and should be coupled with this screening measure if that is to be implemented for MIPs. In addition, we recommend CMS develop a measure that quantifies the rate at which providers are acting upon information learned during screening and addressing the identified needs. While screening for social drivers of health is an important step forward, the patient is not best served until steps are taken to support follow-up and referral for needed services.

  The Measure Applications Partnership's Health Equity and Rural Health work groups expressed similar concerns during their December 2021 meeting. By creating accountability for providers in helping their patients connect to needed services and supports, this will de facto translate the data from these measures into actionable information. The design of this measure should account for the fact that providers do not have full control as to which follow-up services are sought and provided. The measure should also incorporate a way to account for the availability of services (or lack thereof) in a community to address social needs. Finally, on the "closing the loop" issue, given that efforts to connect patients to services outside of the clinical environment often are not reimbursable, we recommend CMS provide resources so that providers can properly invest to achieve positive outcomes in this area.

- **Assessing the Collection of Self-Reported Patient Characteristics***:* CMS requests feedback on the feasibility of a measure that quantifies providers' rates of collecting patient self-reported data. The Task Force supports the concept of creating accountability for the collection of patient-level self-reported data. However, the Task Force also notes that many payers and providers are making strides in patient-level data collection; thus in addition to quantifying data collection, CMS should address the need for data exchange between payers and providers. Any individual patient is asked for these data points multiple times, and in multiple settings, along their care-seeking journey. Simply quantifying how often each provider or payer collects these data may not provide a full picture of whether or not the system is improving in this area. Any measure developed within this concept should include a variable that reflects interoperability and data sharing infrastructure.

  **In addition to creating an accountability measure, the Task Force recommends CMS seek to identify and scale best practices in patient-level self-reported data collection and offer providers assistance in implementing these practices.** Examples include:

  - MedStar Health, MD/VA: MedStar Health created a standardized eight-question screening tool that was validated by the National Academy of Medicine and invested in significant staff training that included role playing,

motivational interviewing, and listening skills, to help promote its successful use with patients. MedStar also embedded the screening tool into its EHR, which allows care team members to find and make referrals to appropriate community-based organizations.

- Mt. Sinai, New York City: Using tools via Press Ganey, Mt. Sinai is working towards 95 percent data completion rate of self-reported person-level data for their underserved populations. They are achieving this via strategies that include patient education, staff education and training, and making important updates to their data collection forms that collect perceptions of race and ethnicity.

The Task Force also offers the following feedback to CMS' questions related to this potential measure:

1. *Which self-reported patient characteristics, including but not limited to those listed above, are important to collect in a standardized format to facilitate future use in quality measures, such as stratification? Which characteristics would you consider lower priority for CMS to collect for use in quality measurement*? All of the self-reported patient characteristics listed in the Proposed Rule are of equal priority for collection. However, the Task Force suggests that these characteristics be organized into two categories: (1) demographic characteristics, which include race, ethnicity, preferred language, gender identity, sexual orientation, disability status, income, education, and employment; to this group we urge adding veteran status and disability status as well; and (2) determinants of health, including food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety.
2. *Are there certain characteristics that are important to collect together to more meaningfully categorize patient populations (for example, examining the intersection of race and gender identity)*? Intersectionality is present across multiple demographic variables, which is why it is important to equally prioritize the collection of all characteristics.

- **Receipt of Language Services and Patient-Clinician Communication:** CMS is considering developing a measure that assesses the receipt of appropriate language services and/or the extent of clinician-patient communication. Recognizing how critical it is that patients can clearly communicate their concerns, feelings, and preferences to their clinicians, most health care providers have worked to provide interpretation services based on the language needs of their patients' community. However, in many cases, these services are offered by telephone or video teleconference. For patients who are hearing and/or otherwise cognitively impaired, audio/video translation services may satisfy the letter, but not the spirit, of the policy. Patients with multiple and complex conditions may have particularly significant difficulties understanding their diagnoses and treatment choices.

Thus, any measure related to the receipt of language services should include questions related not just to whether services were available in the individual's language, but also whether the information was communicated in a way that allowed the patient to

fully understand the information; how much time the interpreter spent explaining a given situation; and whether the patient had consistent access to the same interpreter, who could provide ongoing support without having to "re-learn" the patient during each conversation.

For all three categories of measure topics, the Task Force recommends that any health equity measures can and should be designed to be useable and feasible for use regardless of provider practice size or location. Understanding patients' needs and gaps in their non-clinical supports should be information available to all providers. Finally, the Task Force fully supports standardizing coding that allows for interoperability and sharing of data, but also recommends CMS integrate these standards into the measure design in such a way that allows providers to use existing screening tools to collect and submit data. This flexibility helps reduce provider burden and cost, particularly when it comes to any requirements to implement new screening tools.

Finally, CMS requests feedback on whether it would be beneficial to stratify either outcome or process measures by patient demographics and/or stratify these measures by identified social needs, such as food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety.

Earlier this year, the Task Force offered full support to CMS' proposal to stratify quality measures in the Inpatient Prospective Payment System, as well as other quality programs, by patient demographics. Stratification by race, ethnicity, language, and other demographic variables holds the key to helping identify where the most significant gaps in care delivery and outcomes lie. The Task Force remains supportive but recommends that measure stratification – whether by social drivers of health or patient demographics – be used for internal quality improvement and, in certain cases as described in our IPPS comments, for public reporting. Stratification allows decisionmakers to set a baseline and identify if their efforts are "moving the needle." However, tying payment or risk to stratification could have a detrimental effect, particularly on providers who care for the most underserved and vulnerable patients.

Stratifying measures by social drivers can be a valuable tool for CMS and providers to be able to identify where to invest resources to address health inequities, where to direct high-level CMS policy and resources, and opportunities for efficient community partnerships. That being said, there are several steps needed in order to move to stratification by social drivers. We recommend CMS work with stakeholders and put potential stratifications through a public input process like the National Quality Forum-endorsement process to better understand which stratifications would be robust enough to maintain scientific acceptability. Unlike stratification by race, ethnicity, and language variables, it is highly likely that patients may fall into multiple SDOH categories. This makes not only for a robustness of data challenge, but also a methodological challenge in terms of not overcounting the extent to which drivers of health are affecting patient care and outcomes.

*C. APM Entity Reporting on Promoting Interoperability*

In the Proposed Rule, CMS details the option for APM entities to report the Promoting Interoperability performance category at the APM Entity level. Task Force members recognize the critical importance of interoperable data systems to realizing efficient and effective person-centered, value-based care, which allows care teams to coordinate effectively across affiliated

and unaffiliated providers. The Task Force believes that CMS should balance program reporting goals with the need for APM Entity flexibility to align reporting requirements with operational needs. **We support this proposal, which would provide greater flexibility in how providers can report on their performance in this category and help enhance overall usage of interoperable systems**.

*D. Request for Information on the Proposed Transition to Individual QP Determination*

The Proposed Rule requests information on a transition to individual QP determinations rather than the current APM Entity level determinations. The Task Force is encouraged to see that CMS is considering creative strategies to leverage policy to encourage specialist engagement in APMs. We broadly support policy changes that align the goals of expanding APM participation while maximizing the number of providers achieving QP status. We agree with CMS that the QP determination policy has the potential to drive greater specialist engagement. The current entity level determination has had the unintended consequence of discouraging some APM participants from including specialist practices out of concern that their participation could jeopardize their organizations overall QP status. Conversely, there are specialists that would not qualify as QPs individually but currently quality and receive the five percent APM Incentive Payment simply by being associated with a larger APM entity.

A shift to individual level QP determinations may negatively impact some providers ability to qualify for the Advanced APM bonus as some specialists individually will not be able to achieve QP status. As HCTTF raised in an earlier letter to CMS on APM alignment, if CMS wants to improve specialist engagement it is critical for CMS both to create new APM opportunities for specialists to engage in and enable existing APMs the flexibility to engage specialists within existing models. **To this end, we encourage CMS to allow TIN NPI selection in MSSP to allow ACOs to target specific specialists for participation as opposed to an entire practice. We also recommend that CMS extend APM entities the flexibility to opt into QP determinations at the entity level rather than the individual level.** This would give APM entities the ability to select the QP determination strategy that best aligns with their organizations capabilities and strategy for advancing provider engagement and reduce provider burden associated with moving away from a reporting approach they favor and have already implemented. CMS could support Advanced APM participants by providing tools to enable them to calculate both their entity level and individual level scores.

E. *Generally Applicable Nominal Amount Standard*

In 2017, CMS set the "nominal amount" standard for determining when an APM qualifies as an Advanced APM at 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities. This threshold was set to expire in 2024 and CMS is proposing to permanently establish the eight percent revenue-based nominal amount standard for the applicable QP Performance Period, beginning with the 2023 QP Performance Period.

**The Task Force supports permanently establishing the eight percent nominal risk standard when determining APMs that qualify as an Advanced APM.** While there is little value in making it harder for entities to qualify as an Advanced APM, the Task Force would be in support of keeping the standard as is or lowering it.

F. *Request for Information Regarding the Transition from APM Incentive Payments to the Enhanced PFS Conversion Factor Update for QPs*

CMS seeks input about addressing the payment incentive gap for qualifying providers participating in Advanced APMs. Through performance year 2022, qualifying providers are eligible to receive a five percent Advanced APM bonus, which will be paid in the 2024 payment year. Beginning in 2026, Qualifying APM participants will receive a 0.75 increase to their MPFS annual payment update. Under current law, there is no financial incentive for Qualifying APM Participants in Advanced APMs in CY 2025.

Currently, the Task Force's main legislative priority is to extend the five percent APm Incentive Payment for at least two years. If that goal is achieved, this new policy would address the 2025 gap year in Advanced APM payment incentives. We believe it is appropriate to extend the five percent bonus payment because the uptake of advance value models has not gone as fast as Congress anticipated. This strong financial incentive should remain in place to attract new providers to participate in Advanced APMs and reward those that continue to move forward in their journeys. We urge CMS to support industry efforts to legislatively extend the APM Incentive Payment to keep up the momentum of value transformation.

It is unclear whether the Administration has the authority to provide financial incentives akin to the APM Incentive Payments without a Congressionally authorized extension. **We urge the CMS Innovation Center to consider whether it could allocate dollars from its authorized funds to continue to make payments to participants operating in Advanced APMs.**

G. *Request for Information on the MIPS Quality Performance and Equity*

**As noted above, the Task Force supports implementation of both measures.** In addition to serving multiple purposes across this Proposed Rule, these measures align efforts to increase and improve screening in both Medicare Advantage, and in the inpatient hospital setting.

We note that screening positive for interpersonal safety may require providers to connect the patient to law enforcement within a certain amount of time. One Task Force provider member suggests that this domain be considered for a separate measure, to allow providers to understand the impact of positive screens on resources. In addition, we recommend CMS provide MSSP participants with lessons learned from the Accountable Health Communities model on best practices related to this domain (e.g., are there times when it is appropriate to not ask or revisit this question; ethical dilemmas around mandated reporting; licensing considerations for screeners ascertaining this information; and times when self-reporting may differ from observations).

**The Task Force supports the direction of the *Positive Rate for Social Drivers of Health* measure as it is important for providers to not only screen patients for drivers of health but to track the rate of positive screens, as these indicate where unaddressed social needs lie.** Our members suggest that the data from this measure are best suited for internal quality improvement in the context of understanding the needs of a given ACO's patients. There are concerns about the potential use of this measure for performance-based payment policy.

We believe CMS should work with the measure developer to develop and test a composite measure that provides data on the rate at which providers refer positive-screened patients to other organizations and whether follow up services are being provided. The design of this measure should account for the fact that providers do not have full control as to which

follow-up services are sought and provided. The measure should also incorporate in its design a way to account for the availability of services in a community to address social needs. Finally, on the "closing the loop" issue, given that efforts to connect patients to services outside of the clinical environment are often not reimbursable, we recommend CMS provide resources so that providers can achieve positive outcomes in this area. Regardless of the screening tool or measure, **we urge CMS to consider developing recommendations on how to best educate patients and providers on the importance of collecting social needs data.**

*H. Request for Information on MIPS Value Pathway (MVP) and APM Participant Reporting*

CMS requests feedback on how it can use MIPS Value Pathways (MVPs) to obtain more meaningful performance data from both primary care and specialty clinicians, and drive improvements for APP reporters and APM participants. In the Task Force's CY 2022 Physician Fee Schedule comments, our support for the underlying concept behind the MVPs continues, and we see the value in a mechanism that has the potential to create a streamlined glidepath for providers to participate in MIPs and Advanced APMs. However, we have concerns that the case for sunsetting traditional MIPS is still unclear, and that the lack of alternative payment models for physicians – particularly primary care providers – to transition into will create logistical challenges for this effort.

Our members note that primary care providers and family physicians report significant frustration with MIPS participation due in part to the costly and administratively burdensome reporting process. QPP participation data shows that MIPS has failed to help physicians transition into APMs. As currently finalized in the CY 2022 Physician Fee Schedule rule, we are concerned that MVPs will not meaningfully address these ongoing issues.

To address these concerns, we recommend the following:

- Eliminate category-based scoring in MVPs and adopt a multi-category scoring approach. Requiring separate attestation and reporting across the four categories is unnecessarily burdensome and does not reflect the work done to improve quality and patient outcomes.
- Further, this evaluation is occurring within a fee-for-service based system that does not provide the stability and flexibility offered by prospective payments. The use of TPCC and similar measures in MVPs will serve as a deterrent to participation in MVPs and in APMs in the future.
- Encourage sub-group reporting and the integration of specialty care measures into the MVP and other value-based programs. In addition, do not restrict sub-group participation population to specialty providers. Primary care practices may have different specialties that report to the MVP; restricting sub-group participation conflicts with the goal of aligning practices participation in Advanced APMs.

***

The Task Force appreciates the opportunity to respond to the MPFS Proposed Rule. Please contact HCTTF Senior Director Joshua Traylor (Joshua.Traylor@hcttf.org) with questions about the letter or requests for additional information.

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