September 11, 2023
Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1784-P: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

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), CY 2024 Physician Fee Schedule notice of proposed rulemaking (CMS-1784-P) ("Proposed Rule").

The Task Force is a consortium that supports 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.

The Task Force is dedicated to advancing the adoption of value-based care models as a lever to accelerate the transition to a sustainable, cost efficient, consumer focused health care delivery system. Consequently, our comments on this NPRM focus primarily on policy proposals impacting the Medicare Shared Savings Program and the Quality Payment Program rather than the proposed changes to the broader fee schedule impacting fee-for-service. With that said, we have raised the importance of stabilizing fee-for-service payments for certain

segments of the health care system as part of a broader strategy to enable the transition to value based care.

Specifically, HCTTF believes that robust primary care is the backbone of most effective value-based payment models and, given the importance of team-based care and care coordination to improving quality and controlling costs, adequate funding is needed to support physicians in the short-term to allow them to invest in the infrastructure and staffing necessary to transition into value-based models. **We strongly encourage CMS to consider this factor when making changes to the fee schedule to ensure that Medicare payment rates for physicians are sufficient to stabilize the existing primary care workforce while continuing to drive a long-term shift to greater uptake of value-based care.** A short-term strategy for supporting providers is vital for the system overall and critical to attracting and retaining physicians in value-based payment models that operate on a fee-for-service chassis (like the Medicare Shared Savings Program).

We appreciate the opportunity to provide input on the following topics and questions:

- *II.E(27): Services Addressing Health Related Social Needs*
- *III.G: Medicare Shared Savings Program*
- *IV: Updates to the Quality Payment Program*

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I. Services Addressing Health Related Social Needs (Section II.E(27))

A. General Comments

HCTTF broadly supports CMS efforts to better account for and fund Community Health Integration (CHI) efforts designed to impact the social determinants of health. The Task Force has long recognized the importance of CHI services as a key component to successful efforts to improve population health. Many of our members have integrated community health workers, care navigators, and peer support specialists into their care teams and view them as critical to effective value-based care. Medicare coverage for CHI services has the potential to create new opportunities for patients to access vital services, increase access to existing services, reduce disparities in care, and increase workforce capacity.

B. Services Addressing Health-Related Social Needs (Community Health Integration services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services)

In the Proposed Rule, CMS notes the need to better recognize, through coding and payment policies, when members of an interdisciplinary team, including community health workers (CHWs), are involved in treatment of Medicare beneficiaries. To this end, CMS proposes to pay separately for CHI, Social Determinants of Health Risk Assessment, and Principal Illness Navigation services to account for resources when clinicians involve CHWs, care navigators, and

peer support specialists in furnishing medically necessary care. **The Task Force supports this proposal.**

CMS seeks comments on the most effective way to track initiating events for CHI services. CMS has proposed requiring an E/M visit from the billing practitioner as a trigger event to qualify for CHI services. The Task Force has three recommendations in response to this proposal:

1. **We urge CMS to allow additional professional services other than an E/M visit to qualify as the prerequisite initiating visit for CHI services (including the Annual Wellness Visits).** Patients that are most likely to benefit from CHI services are often those with the least stable access to a usual source of care. Consequently, these patients often enter the health care system through emergency department visits and hospitalization rather than a primary care provider. Creating a pathway for emergency department and hospital level providers to connect these patients to CHI services will help address some of the common barriers that impact access to care (transportation/housing/food insecurity) and increase the odds that patients will develop a usual source of care thus improving preventative and chronic condition management.
2. **We encourage CMS to allow more than one individual to bill for these services in a given month,** CMS proposes to limit billing for CHI services to a single provider in a given month. This proposal is misaligned with the way that patients, especially those with multiple needs, navigate the health care system. Patients seeing multiple providers often require varying types of CHI support (e.g., clinical integration, assistance with financial programs, nutrition support, housing program assistance). We recommend CMS modify the proposed definitions for these codes to allow multiple providers to deliver these services during a defined period.
3. **We recommend CMS allow for CHI services to be delivered in increments of less than 60 minutes to better align service delivery to individual patient needs.** For example, established patients or those with less complex CHI needs may only require 30 minutes of CHI services, while new patients with more complex social needs may require a lengthy intake session in addition to 30 minutes of services weekly for several months.

CMS also requested feedback on training requirements for those providing CHI services. The Task Force appreciates the need for clear standards to protect patients and ensure high quality care. Through our work on other areas, including efforts to improve maternity care, we have heard from CHWs and doulas about the challenges BIPOC communities have in accessing individual level accreditation programs and the negative impact this has on equity in the workforce. **To address these concerns, CMS should consider program-level accreditation rather than or in addition to individual level certification for programs employing**

CHWs/billing CHI codes. A number of state Medicaid agencies have begun implementing program-level accreditation for organizations that employ CHWs. The Community Based Workforce Alliance and National Committee for Quality Assurance have developed recommendations for program-level standards in partnership with CHWs. The Task Force believes these existing resources should inform Medicare policy in the interests of multi-payer alignment**. Furthermore, we recommend CMS allow navigators to qualify for reimbursement based on their training for the specific services they are rendering, rather than requiring cross-training for all types of navigator services.** For example, financial navigators should not be required to have the same training as clinical care or community support focused navigators who assist patients with education and social support services.

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. In particular, we appreciate that CMS is proposing to take action to address longstanding MSSP participant concerns with the Continuous Quality Measure reporting requirements and regional update factors to the ACO benchmarking methodology. The Task Force is also encouraged to see CMS exploring the potential for a higher risk track in MSSP and opportunities for ACO and community-based organization alignment. We look forward to continuing to engage with CMS to further refine and strengthen MSSP. **Our detailed feedback on the Proposed Rule's specific provisions is provided below.**

B. Quality Reporting and Performance Requirement Revisions

- **Proposal for MSSP ACOs to Report Medicare CQMs:** For performance year 2024 and subsequent performance years, CMS is proposing to create a Medicare Clinical Quality Measure (CQMs) reporting option for MSSP ACOs as a temporary alternative to the all-payer CQM reporting requirements. The goal of this proposal is to allow ACOs to report digitally on their Medicare patients without being penalized for serving other patients, while also reducing barriers to digital measurement to allow MSSP to align with the Universal Foundation for adults in 2025. Under the Proposed rule, ACOs would continue to have the option to report quality data through the CMS Web Interface, eCQMs, and/or MIPS CQMs collection types in performance year 2024. Starting in 2025, ACOs would be required to report eCQMs, MIPs CQMs or the Medicare CQMs (if finalized).

  The Task Force supports the proposal to allow ACOs the option to report Medicare CQMs for only their assignable Medicare population starting in 2024. As we and other organizations have noted in past comments, MSSP ACOs have long been concerned about the logistical challenges and accuracy of reporting all-payer CQMs. While appreciative that CMS proposes the Medicare CQMs as a transitional

policy, we are concerned that the proposal does not address the underlying challenges with eCQM / MIPS CQM reporting. **We continue to urge CMS to align its MSSP quality policy with the CMS digital quality measurement strategy and to first pilot the MSSP quality requirements prior to requiring broader adoption. Additionally, HCTTF recommends that CMS make the Medicare CQM reporting option permanent until digital quality measurement and reporting is feasible for all ACOs.**

Furthermore, HCTTF members have questions about how the assignable Medicare population reporting requirements will apply to ACOs that have elected prospective vs. retrospective alignment. ACOs, especially those operating under prospective assignment with retrospective reconciliation, may not have the data necessary to determine their assignable populations due to factors like claims run-out. **We request that CMS (1) clarify in the final rule if Medicare CQM reporting applies to the assigned or the assignable population and, (2) work with stakeholders to come up with a process to ensure ACOs know/can report on their eligible patients (example: limit reporting requirements to beneficiaries that are aligned at both the beginning and the end of the performance period).**

- **Proposal to Align CEHRT Requirements for MSSP ACOs with MIPS:** CMS is proposing to remove MSSP's CEHRT threshold requirements beginning performance year 2024. CMS is also proposing to add a new requirement that all MIPS eligible clinicians, Qualifying APM Participants (QPs), and Partial QPs participating in the ACO, regardless of track, are to report the MIPS Promoting Interoperability (PI) performance category measures and requirements for performance years beginning on or after January 1, 2024. CMS also proposes sunsetting the CEHRT certification requirement in MSSP and requiring that ACOs publicly report the number of MIPS eligible clinicians, QPs and Partial QPs participating in the ACO that earn a MIPS performance category score for the PI performance category.

  The Task Force recognizes that the intent of this proposal is to reduce variation in reporting requirements, however, **HCTTF opposes this proposal and strongly encourages CMS to reconsider this policy change**. When the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was enacted, one of the often-touted benefits of APM participation for providers was the potential to alleviate aspects of the administrative reporting burden under MIPS. **Aligning ACO reporting to the MIPS PI requirements will create additional reporting burdens for ACOs and undercuts a primary benefit of APM participation for individual providers, thus weakening the incentive to participate in the program.**

- **<u>Proposal to Modify the Equity Adjustment Underserved Multiplier:</u>** CMS proposes to modify the calculation of both the proportion of assigned dually eligible beneficiaries, and the proportion of assigned Part-D low-income subsidy beneficiaries, to focus on the number of beneficiaries (rather than person-years) when calculating the proportion of underserved ACO's assigned beneficiaries. CMS is also proposing to revise the health equity adjustment multiplier by removing beneficiaries without an Area Deprivation Index (ADI) ranking (rather than assigning them a zero) from both the numerator and denominator of the underserved beneficiary calculation.

  The Task Force supports these changes and appreciates the ongoing efforts by CMS to develop methodologies that incentivize a focus on health equity within APMs. With that said, we also recognize that using the national level ADI calculation may fail to fully recognize underserved beneficiaries from higher income states and high-cost communities. This issue is evident when comparing the national level and state level ADI heat-maps for a given state and observing how beneficiaries that are underserved in relation to others within their state may not qualify as underserved nationally.

  We urge CMS to consider strategies to better account for state and local variation when measuring equity issues. CMMI recently announced that it will be revising the health equity benchmark adjustment for the ACO-REACH model by incorporating two new variables: the State-based Area Deprivation Index (ADI) and Low-Income Subsidy (LIS) status. CMMI will weigh all variables equally: (1/3 weight) National-Based ADI + (1/3 weight) State Based ADI + (1/3 weight) Dual Medicare-Medicaid status/LIS status. **The Task Force recommends that CMS implement a similar change to the MSSP health equity adjustment methodology to balance national and state level variations in equity.**
- **<u>Proposal to Use Historical Data to Establish the 40th Percentile MIPS Quality Performance Category Score:</u>** CMS proposes to use historical submission-level MIPS Quality performance category scores to calculate the 40th percentile MIPS Quality performance category score. Under this methodology, CMS would use a rolling three-performance year average with a lag of one performance year. For example, the 40th percentile MIPS Quality performance category score, used for the quality performance standard for performance year 2024, would be based on averaging the 40th percentile MIPS Quality performance category scores from performance years 2020 through 2022. This proposal's goal is to allow CMS to provide ACOs with the MSSP quality performance standard they must meet in order to share in savings at the maximum sharing rate prior to the start of the performance year.

  The Task Force supports this proposal. In our response to the 2022 physician fee schedule proposed rule, we highlighted our members' concerns with the lack of

information on the level of quality performance that would enable an ACO to be eligible to share in savings. We called on CMS to provide prospective information on both the quality score that would qualify an ACO for savings and the methodology used to calculate the benchmarks. We appreciate that CMS is taking action to address this issue.

C. *Beneficiary Assignment Revisions*

- **Proposal to Add a Third Step to the Stepwise Assignment Methodology Used to Assign Beneficiaries to ACOs:** CMS proposes a revision to the two-step beneficiary assignment methodology for MSSP to include a new step three, which would utilize a proposed expanded window for assignment. This expanded window would be a 24-month period that would include the current 12-month assignment window and the preceding 12 months to identify additional beneficiaries for assignment. This proposal would update the "Expanded Window for Assignment" starting in 2025 to 24 months rather than the current 12 months for beneficiaries not previously eligible for assignment under the current pre-step eligibility methodology. CMS is proposing this change to better account for beneficiaries who receive primary care from nurse practitioners, physician assistants and clinical nurse specialists during the 12-month assignment window and who received at least one primary care service from a physician in the preceding 12 months.

  HCTTF supports the intent of this proposal and agrees with the need to capture data more accurately on assignable ACO beneficiaries. That said, our members are concerned that a longer 24-month assignment window could result in CMS assigning beneficiaries to an ACO that do not have a primary relationship with providers in the ACO, nor are adequately captured in the ACO's benchmark. Specifically, our members raised the concern that beneficiaries with complex conditions that are being managed by a specialist – but where primary contact is with a PA/NP – may be linked to an ACO despite the fact that the bulk of their care is being managed by an outside specialist. **We request CMS provide clarification on any guardrails CMS intends to implement to address this concern and/or proposed strategies to ensure that beneficiary assignment to an ACO aligns with an active care relationship.**

  Furthermore, we recommend CMS take steps to directly address the challenges with non-physician practitioner attribution to ACOs. This could be accomplished by incorporating specialty designation codes for NPPs in the Provider Enrollment, Chain, and Ownership System (PECOS). CMS could gather this information by modifying the existing Medicare enrollment application field used for physicians. CMS should also allow ACOs to use TIN-NPI level participant selection as opposed to full-TIN participation. This would allow ACOs greater control to select high

performing specialists and NPPs for participation and/or exclude specialty-focused NPPs from driving assignment.

- **Expanded CPT/HCPCS Codes:** CMS proposes to add several CPT/HCPCS codes to the list of qualifying primary care for ACO assignment. Proposed codes cover: smoking cessation counseling, remote physiologic monitoring, cervical cancer screening, office-based opioid use disorder services, complex evaluation & management services, community health integration services, principal illness navigation services, social determents of health risk assessment, caregiver behavioral health management training, and caregiver training services.

  HCTTF generally supports CMS efforts to ensure that patients with a primary care relationship are appropriately assigned to an ACO. With that said, our members have raised concerns that the scope of the proposed codes may result in inappropriate assignment. Task Force members note that these services may be offered by a wide range of providers and include services that are commonly offered in a time limited fashion. Consequently, there is a risk that assignment using some of these codes may not accurately represent an ongoing care relationship. **The Task Force urges CMS to monitor for unintended consequences and adjust the policy moving forward as needed or adopt changes to its risk adjustment and benchmarking methodologies to better account for these populations.**

D. Benchmarking Methodology Revisions

- **Proposal to Mitigate the Impact of the Negative Regional Adjustment on the Benchmark to Encourage Participation by ACOs Caring for Medically Complex, High-Cost Beneficiaries:** In the 2023 PFS final rule, CMS reduced the cap on negative adjustments from 5 percent to 1.5 percent of national per capita Part A & B spending and further reduced negative adjustments as the proportion of dually eligible beneficiaries or average prospective HCC risk score of an ACO increased. In this Proposed Rule, CMS proposes to eliminate the negative regional adjustment totally. As a result, ACOs that would face a negative overall adjustment to their benchmark based on the methodology adopted in the CY 2023 PFS final rule would benefit, as they would now receive no downward adjustment. **HCTTF supports this proposed policy change and appreciates CMS taking action to further support ACOs caring for complex and high-cost patients.** We also encourage CMS to continue to evaluate and address the ratchet effect for regionally efficient ACOs. While we support the proposed MSSP policy changes and hope they are successful in bringing more inefficient ACOs into the program, this policy may increase the rate at which a given region becomes more efficient. This could exacerbate the impact of

the ratchet effect for ACOs that are already efficient and competing against a region getting more efficient at a faster pace.

E. Proposals to Improve ACO Risk Adjustment and Alignment

- **Proposal to Cap Regional Service Area Risk Score Growth for Symmetry with ACO Risk Score Cap:** CMS is proposing to modify the calculation of the regional component of the three-way blended benchmark update factor (weighted one-third accountable care prospective trend (ACPT), and two-thirds national-regional blend). Under this approach CMS would cap prospective HCC risk score growth in an ACO's regional service area between benchmark year three and the performance year and also account for an ACO's aggregate market share. This cap on regional risk score growth would apply independently of the cap on an ACO's own prospective HCC risk score growth. This means that this proposed cap on prospective HCC risk score growth in an ACO's regional service area would be applied whether or not the ACO's prospective risk score growth was capped.

  CMS notes that the regional risk score growth cap would increase the regional component of the update factor for ACOs in regions with aggregate regional prospective HCC risk score growth above the cap while not affecting ACOs in regions with aggregate regional prospective HCC risk score growth below the cap. Furthermore, CMS notes that this proposal would maintain a disincentive against coding intensity for ACOs with high market share by adjusting the regional risk score growth cap based on ACO market share.

  The Task Force supports this policy proposal. In our response to the 2023 PFS NPRM proposal to implement the ACPT methodology, we noted that establishing a national ACO specific spending trend factor to the existing MSSP benchmarking methodology did not adequately account for regional variation in spending growth. We encouraged CMS to: (1) replace the current national trend factor with the ACPT trend factor, and (2) remove an ACO's beneficiaries from the regional trend calculation. While this proposal varies from our prior recommendations, we appreciate that CMS intends to make methodology changes that substantively address our underlying concerns with the balance of national and regional trends in MSSP ACO benchmarks.

- **Proposal to Update How Benchmarks are Risk Adjusted:** In the 2024 Medicare Advantage Capitation Rates and Part C and Part D Payment Policy rule, CMS finalized the transition to a revised CMS-HCC risk adjustment model Version 28 (V28). V28 made several changes to the types of codes included and weighting of codes in the HCC calculation. It was unclear how the transition to V28 from the current HCC Version 24 (V24) would be managed for MSSP ACOs. In this Proposed Rule, CMS

proposes to apply the same CMS-HCC risk adjustment model used in the performance year for all benchmark years, when calculating prospective HCC risk scores to risk adjust benchmarks for agreement periods beginning on January 1, 2024, and in subsequent years.

This three-year phase-in would align with what is being done in Medicare Advantage and will result in risk adjustment that is weighted at 67 percent of the current 2020 CMS-HCC risk adjustment model and 33 percent of the CMS-HCC risk adjustment model for performance year (PY) 2024. ACOs in an existing agreement period would continue to have the current methodology for calculating benchmark year and performance year prospective HCC risk scores using different CMS-HCC risk adjustment model(s) applied. These ACOs are expected to experience smaller adverse impacts as a result of the phase-in of V28 and our existing approach to renormalize prospective HCC risk scores by Medicare enrollment type, among other factors.

The Task Force appreciates the additional clarity CMS is offering on this policy change. When CMS announced V28, we noted the potential impact of the HCC changes on ACOs and called for the uniform application of risk adjustment methodologies to both the baseline and performance periods of ACOs. **We support the changes CMS is proposing to make to HCC coding for ACOs signing new agreements on or after 1/1/2024. With that said, to create an even playing field, the Task Force strongly encourages CMS to apply this policy uniformly across all ACOs – not only those with new agreements in 2024.**

F. Advanced Inventive Payment Program Revisions

CMS is proposing several changes to the Advanced Incentive Payment (AIP) program to address potential implementation challenges ahead of the program start date on 1/1/2024. CMS proposes to:

- Allow ACOs to advance to two-sided model levels within the BASIC track's glide path, beginning in performance year three of the agreement period in which they receive advance investment payments.
- Only recoup advance investment payments from the shared savings of an ACO that wishes to renew early to continue its participation in the Shared Savings Program, instead of directly recouping the payments from the ACO.
- Require ACOs to report spend plan updates and actual spend information to CMS in addition to publicly reporting such information.
- Modify the termination policies to specify that CMS would immediately terminate advance investment payments to an ACO for future quarters if the ACO voluntarily terminates from MSSP.
- Codify that ACOs receiving advance investment payments may seek reconsideration review of all payment calculations.

The Task Force supports these policy changes to the AIP program. Specifically, we appreciate that CMS is focused on both creating better onramps for providers to participate in ACOs as well as allowing sufficient flexibility for ACOs to adopt greater risk arrangements at their own pace. **With that said, we reiterate our comment from the CY2023 PFS rulemaking calling on CMS to remove the requirement that an ACO be considered low-revenue to participate in the AIP program.** As noted in our earlier comments, the high/low revenue distinction limits the reach of the AIP by barring many ACOs who would most benefit from participation (e.g., many ACOs that include rural providers, FQHCs, and CAHs).

G. Request for Information on Future MSSP Policies

The Proposed Rule includes a number of Requests for Information which seek input on potential policy changes for future MSSP rulemaking. The Task Force appreciates the opportunity to engage with CMS on the future of MSSP and offers the following recommendations on the topic areas highlighted by CMS:

TOPIC: Incorporating a higher risk track than the ENHANCED track:

HCTTF members have consistently called for opportunities to accept greater levels of risk within MSSP. As the only permanent ACO option currently available in the Medicare program, MSSP offers the greatest opportunity for achieving scalable and sustainable value-based payment models in Original Medicare. Consequently, we believe it is essential that CMS both create greater onramps for model participation, as occurred in the 2023 PFS rulemaking, and focus on creating opportunities for ongoing growth for experienced ACOs.

A new MSSP advanced risk track should prioritize encouraging experienced ACOs to shift away from the FFS payment chassis by offering three things: **(1) greater ACO opportunity for reward and accountability for risks based on costs and quality, (2) additional financial flexibilities to support ACO investment in care reforms and encourage a focus on improving health equity, and (3) expanded benefit enhancements to allow ACOs flexibility in how they manage their patient population.** CMS has repeatedly tested some of these concepts in earlier CMMI ACO and primary care models and has continued to incorporate these concepts into models like ACO-REACH. Specifically, we encourage CMS to incorporate the following into MSSP:

1. **Greater Risk/Reward Opportunities**: CMS should create the option for MSSP advanced risk tracks above the existing ENHANCED Track that offers ACO the option of:
    - **Increased Shared Savings (once minimum savings rate and quality standards are met or exceeded)**: First dollar savings at a rate of at least 85% not to exceed 20% of updated benchmark.
    - **Increased Shared Losses (once medical loss ratio and quality standards are met or exceeded)**: First dollar losses at a rate based on quality

performance, with minimum shared loss rate of 55% and maximum of 75%, not to exceed 15% of updated benchmark.

2. **Additional Financial Flexibilities:** Allow MSSP ACOs accepting two-sided risk the option to receive:
    - **Monthly primary care capitation** payments equal to 100% of their historical primary care spending. This would provide important cash flow opportunities for ACOs looking to make proactive investments in primary care capacity to better manage patient care.
    - **Total cost of care capitation** payments similar to the global track in ACO REACH. A total cost of care capitation option would support ACOs interested in better engaging specialists, a previously stated CMS goal, through mechanisms such as shadow bundles.
    - **Population Based Payment** option similar to what was available under the Next Generation ACO model that would allow ACOs to negotiate fee schedule reductions with specific providers in exchange for the flexibility of a prospective population adjusted payment.

3. **Expanded Benefit Enhancements:** CMS should leverage MSSP as a platform for innovation by expanding the availability of benefit enhancements used in other models, to experienced MSSP ACOs. Enhancements should include:
    - **Improved Beneficiary Affordability:** Implement lessons from value-based insurance design into MSSP by:
        - Covering patient copays and deductibles for visits to ACO providers in advanced risk models.
        - Offering Part B premium rebates tied to tight usage of an ACO's affiliated network.
        - Create a framework for Medicare ACO supplemental plan offerings with lower cost-sharing for care delivered through the ACO.
        - Other opportunities for CMS to offer direct incentives to beneficiaries in MSSP ACOs such as Part A premium waivers.

TOPIC: Modifying the amount of the prior savings adjustment through changes to the 50% scaling factor used in determining the adjustment, as well as considerations for potential modifications to the positive regional adjustment to reduce the possibility of inflating the benchmark

HCTTF supports CMS modifying the prior savings adjustment methodology to better reflect the savings achieved by an ACO during the three years prior to the start of the current agreement period. This change in methodology would more accurately account for the shared savings achieved by an ACO in prior agreement periods and reduces the impact of the ratchet

effect on ACO benchmarks. The Task Force also encourages CMS to adjust the methodology to account for savings achieved under past and future total cost of care models (including the Next Generation ACO model, ACO REACH, and any future TCOC ACO models).

TOPIC: Potential refinements to the ACPT and the three-way blended benchmark update factor, such as (i) replacing the national component of the two-way blend with the ACPT, and (ii) scaling the weight given to the ACPT in a two-way blend for each ACO based on the collective market share of multiple ACOs within the ACO's regional service area

During the 2023 PFS rulemaking, HCTTF expressed support for the policy goals behind the ACPT proposal. We appreciated that CMS was working to address the downward ratchet effect on benchmarks based on historical spending that threatens to make benchmarking strategies untenable in the long term through the ACPT. We also appreciated the insight CMS offered on the potential for the use of administratively set benchmarks. With that said, Task Force members raised concerns about the impact of the ACPT on the balance of national vs. regional trends in the MSSP benchmark calculation and called on CMS to adjust the ACPT methodology to increase regional trend considerations.

To address this issue, we recommend that CMS replace the current national trend factor with the ACPT trend factor. 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. **We also encourage CMS to evaluate removing an ACO's beneficiaries from the regional trend calculation and provide data on the impact of this change to stakeholders.** HCTTF believes that removing ACO beneficiaries from the calculation would be the most direct approach to address the rural glitch issue. With that said, we recognize that this may have a negative impact on the benchmarks of ACOs with large numbers of specialists that care for the majority of complex patients in a given region. We encourage CMS to consider combining risk adjustment methodologies with the removal of an ACO's beneficiaries from trend calculations with the policy goal of minimizing the potential for penalizing an ACO for: (1) improving the efficiency and reducing the cost of care for the patients they serve in their region, and (2) accepting TCOC responsibility for complex, high risk, and high-cost patients in their region.

TOPIC: Approaches to promote ACO and Community Based Organizations collaboration

HCTTF fully supports CMS efforts to promote alignment between ACOs (and other APMs) and Community Based Organizations (CBOs). A central goal of ACO models is to drive fundamental improvements in population health, yet the tools necessary to accomplish this often exist outside of clinical care settings. Clinical care accounts for a small proportion of the average individual's overall health. Factors including food access/nutrition, housing,

transportation, employment, environmental exposures, stress, and genetics all combine to drive the bulk of health outcomes of most people. Many communities have established CBOs that specifically address these needs, yet they often lack the resources to fully meet the demand for services. In order for ACOs to maximize their potential to impact population health, it is imperative that CMS identify pathways for ACOs to effectively partner with CBOs.

To accomplish this the Task Force recommends that CMS work along three distinct but interrelated areas:

1. **Improving SDOH Data Collection:**

Understanding the SDOH needs of a patient population is critical for enabling effective partnerships and referrals to CBOs. To accomplish this, ACOs require access to accurate demographic data beyond race and ethnicity. Thus, we recommend CMS consider developing a broader strategy for collecting SDOH data that aligns with existing national initiatives in this space, leverages technology available across multiple settings, and limits additional data collection burden on providers. Specifically, CMS could align with the Gravity Project and United States Core Data for Interoperability (USCDI) who are establishing coding and documentation standards in this space. Furthermore, CMS could work with EHR vendors to advance the adoption of USCDI Version 3, which includes categories of data elements that capture health status (including health concerns, functional status, disability status, and mental function), demographics (including race, ethnicity, tribal affiliation, sexual orientation, gender identity and preferred language), and problems (including SDOH concerns) so these data can be appropriately requested via the APIs from EHRs

CMS should also invest in ensuring ACOs and providers can effectively use the data that is collected to make care decisions. In prior comments, HCTTF cited the example of the Epic Social Determinants of Health (SDOH) Wheel, a graphic that represents ten domains: financial resource strain, transportation needs, alcohol use, depression, intimate partner violence, social connections, physical activity, tobacco use, stress, and food insecurity. Patients' responses to demographics and medical history questions turn the panels in the wheel graphic green (low risk), yellow (moderate risk), or red (high risk), allowing providers to identify the social needs of patients more effectively.

2. **Incorporate Equity Adjustments into Payment Methodologies**

Current benchmarking and risk adjustment strategies rely on historical claims data to inform decisions about appropriate funding levels. Consequently, these approaches are insufficient to accurately capture the resource needs of underserved patient populations that, by definition, have not received the level of resources necessary to achieve equitable care. HCTTF appreciates that CMS has recognized this issue and is exploring options for equity adjustments that will ensure benchmarks are appropriately set to account for the needs of underserved patients. We encourage CMS to continue refining equity adjustment methodologies like those

seen in ACO REACH with an emphasis on creating clear incentives to focus on underserved populations and the financial flexibilities to dedicate funding to addressing SDOH needs.

As we note earlier in this comment letter, using the national level ADI calculation may fail to fully recognize underserved beneficiaries from higher income states and high-cost communities. We urge CMS to consider strategies to better account for state and local variation when measuring equity issues such as the revised health equity benchmark adjustment for the ACO-REACH model. We also encourage CMS to focus on additive adjustments that increase resources for underserved communities without creating a zero-sum situation for those serving better resourced communities. While we recognize the CMS interest in balancing investments and limiting spending, these strategies contribute to a broader perception that equity investments will result in poorer service for those that are currently doing well, thus making it harder to sustain support.

3. Support Efforts to Streamline Partnerships with CBOs

Finally, HCTTF encourages CMS to focus on supporting efforts to simplify and streamline partnership and contracting efforts between ACOs, providers, and CBOs. There are a number of payer and provider led efforts in this area such as the Partnership to Align Social Care, that are working to develop well defined value propositions, clear contracting guidance, and examples of working relationships for payers and CBOs. CMS could accelerate these efforts in a variety of ways including:

- Leveraging CMMI models to directly fund and evaluate partnership efforts,
- Issuing guidance on the acceptable methods/approaches for ACOs to partner with CBOs, and
- Coordinating with other federal agencies that fund work in areas such as housing, nutrition, transportation, and education to develop policies for funding that better align with the needs of the people receiving these services.

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

H. QP Determinations and the APM Incentives

CMS proposes to end entity level QP determinations and make all QP determinations at the individual level beginning with the QP Performance Period for CY 2024. CMS believes this proposed methodology would ensure that those eligible clinicians who individually meet a QP threshold would receive QP status and its commensurate financial and other benefits. Additionally, CMS believes that this policy change would remove the incentive for APM Entities to exclude certain types of eligible clinicians from their Participation Lists because the success or failure of the APM Entity's eligible clinicians to reach QP status no longer would be calculated at the entity level.

While HCTTF appreciates the concerns raised by CMS we oppose this proposal as a strategy to address them. The transition to individual determinations will create large

downstream burdens for APM entities that are responsible for calculating QP status on behalf of their providers. **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 continue to allow APM entities the flexibility to opt into QP determinations at the entity level rather than the individual level.**

I. QPP Payment Amount and Patient Count Methods

CMS is proposing to modify the definition of "attribution-eligible beneficiary" to include a beneficiary who has a minimum of one claim for a covered professional service furnished by an eligible clinician who is on the Participation List for the APM Entity (rather than the current definition that states "one claim for E/M services"). CMS states that this policy change is intended to reduce the complexity of CMS calculations and allow for the development of novel patient attribution methodologies for VBC models**. The Task Force supports this proposal and believes that this is a sensible policy change that will allow CMS to respond to ongoing innovations in the payment model space.**

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

Sincerely,

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