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

Re: CY 2025 Payment Policies in the Physician Fee Schedule for the Medicare Shared Savings Program

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The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to share recommendations on the Medicare Shared Savings Program (MSSP), in advance of the CY 2025 Physician Fee Schedule (PFS) Proposed Rule. The Task Force believes these recommendations will help the Centers for Medicare & Medicaid Services (CMS) achieve the goal of ensuring all Medicare patients are in accountable care relationships by 2030, by encouraging new accountable care organizations (ACOs) to form, while also helping existing ACOs to thrive as they continue to improve access and quality of care for patients.

The Task Force is a consortium that supports accelerating the pace of delivery system transformation to better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and consumer/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 that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

Our comments focus on (I.) the risk arrangements and benefit enhancements available to MSSP participants, (II.) the risk adjustment to account for prior savings, (III.) the Quality Payment Program requirements for ACOs, (IV.) the collection and use of health equity data, and (V.) other model design elements.

I. Risk Arrangements & Benefit Enhancements

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 Traditional Medicare. Consequently, we believe it is essential that CMS both create greater on-ramps for model participation, as well as 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 fee-for-service (FFS) payments by offering three things: **(1) greater ACO opportunity for reward and accountability for risk based on costs and quality, (2) additional financial flexibilities to support ACO investment in care transformation, primary care, and health equity, and (3) expanded benefit enhancements to allow ACOs flexibility in how they address patient needs.** 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. **Offer Greater Risk / Reward Opportunities**: CMS should create the option for MSSP advanced risk tracks above the existing ENHANCED Track that offers ACOs the option of having greater up- and downside risk, including:
    a. **Increased Shared Savings**: First dollar savings at a rate of at least 85%, not to exceed 20% of an updated benchmark. This applies after the minimum savings rate and quality standards are met or exceeded.
    b. **Increased Shared Losses**: First dollar losses at a rate based on quality performance, with a minimum shared loss rate of 55% and maximum of 75%, not to exceed 15% of an updated benchmark. This applies once the medical loss ratio and quality standards are met or exceeded.

2. **Support Capitated Payments:** Allow MSSP ACOs under two-sided risk the option of:
    a. **Monthly primary care capitation** payments set at 100% of their historical primary care spending. Consider incorporating adjustments based on: (1) health equity, (2) quality of care, and/or (3) increased primary care investment above historic levels. These adjustments would recognize the fact that historical primary care spending reflects an underinvestment in care, particularly for underserved communities, while also rewarding ACOs for improving quality of care for beneficiaries. The primary care capitation would provide important cash flow opportunities for ACOs looking to make proactive investments in primary care capacity to better manage patient care.
    b. **Total cost of care capitation** payments like the global track in ACO REACH. This option would support ACOs interested in better engaging specialists through mechanisms such as shadow bundles, in alignment with the CMMI Strategic Refresh. This would also provide ACO REACH participants with a clear option after the model concludes, creating greater predictability and encouraging the ongoing participation of these ACOs in CMS models.
    c. **Population Based Payments** similar to what was available under the Next Generation ACO model, allowing ACOs to negotiate fee schedule reductions with specific providers in exchange for the flexibility of a prospective population-adjusted payment.

3. **Increase Benefit Enhancements:** CMS should allow ACOs to improve care delivery and beneficiary affordability by expanding the MSSP benefit enhancement to match those in other models. Enhancements available to MSSP ACOs advanced risk tracks should include:
    a. **Beneficiary Affordability:** Implement lessons from value-based insurance design by allowing MSSP ACOs to:
        i. Waive patient copays and deductibles for visits to ACO providers in advanced risk models, similar to the ACO REACH program. This is particularly important for high value services such as primary care and

services to address patients' health-related social needs, such as the Community Health Integration services that became available in 2024.

   ii. Offer Part B premium rebates tied to tight usage of an ACO's affiliated network.
   iii. Create a framework for Medicare ACO supplemental plan offerings, with lower cost-sharing for care delivered through the ACO.
   iv. Offer direct incentives to beneficiaries in MSSP ACOs through various waivers.

b. **Telehealth:** Broaden telehealth waivers to apply regardless of ACO assignment methodology, to provide ACOs a stable telehealth policy environment after the end of COVID-related telehealth policy exceptions. In addition, CMS should engage with stakeholders to identify additional services that can be safely and effectively provided via telehealth, leveraging ACOs to test and refine a modernized telehealth policy. More broadly, CMS should extend access to telehealth to the full extent of its regulatory authority through the physician fee schedule.
c. **Simplify SNF Three-Day Waiver:** Simplify the requirements for the skilled nursing facility (SNF) waiver to make it easier for ACOs to implement, by adopting flexibilities implemented during COVID as permanent waivers. This could include encouraging, but not requiring, ACOs to contract with SNFs.
d. **Home-based services:** Explore adding additional waivers related to home-based services. CMS should adopt the post-discharge and care management home visits waivers in place under the ACO REACH model.

II. Benchmarks

With $8.8 billion in net savings from 2013 to 2022, ACOs have a proven track record for reducing Medicare spending while improving quality of care and access for beneficiaries. While the existing MSSP risk tracks create an on-ramp for new ACOs, especially with the recent addition of the Advance Investment Payment, established ACOs face ongoing challenges to their long-term program participation and ability to invest the resources needed to meaningfully transform patient care. This is due largely to benchmark ratcheting effects – where ACO benchmarks are lowered over time due to their own success in reducing health care costs. There are two separate benchmark effects in play for ACOs, one during the agreement period and the second when a new agreement is signed.

First, within an agreement period, ACOs see benchmark ratcheting due to CMS' inclusion of ACOs' assigned beneficiaries in their regional comparison populations. Thus, as ACOs lower expenditures, the regional comparison is also lowered, impacting ACO benchmarks and savings potential. Acknowledging this challenge, CMS instituted a new five-year prospective cost growth trend factor known as the Accountable Care Prospective Trend (ACPT) based on U.S. per capita cost (USPCC) as one-third of a three-way blended trend incorporating the existing national-regional blend. The ACPT does not fully account for ratcheting within an agreement period, but it does reduce the weight of regional trends. The Task Force and its members will monitor the impact of the ACPT on benchmark ratcheting within ACO agreement periods as it is rolled out with new agreements starting in 2024.

The second major benchmark ratchet occurs when ACOs rebase to new five-year agreement periods. ACO success in lowering costs in the prior period results in benchmarks that are ratcheted down in the new agreement. Acknowledging this second challenge, CMS introduced a new Prior Savings Adjustment (PSA), which is 50% of an ACO's average prior three years of gross savings, capped at 5% of national Medicare fee-for-service expenditures. However, these policies do not go far enough, as many high-performing ACOs will still face deep reductions to their benchmarks in their next contracts. CMS should find ways to balance Medicare savings while retaining current MSSP participants and preserving their ability to significantly invest in care delivery innovation and continuous quality improvement.

HCTTF believes that CMS should adopt a policy that rewards participants for achieving previous savings, while still accounting for regional efficiency. Currently, CMS allows ACOs to receive the higher of their current regional efficiency benchmark adjustment as calculated today (weighted according to the agreement period and capped at 5%) or the Prior Savings Adjustment (50% of three-year average prior gross savings capped at 5% of national Medicare fee-for-service expenditures). For ACO agreements starting in 2024 and beyond, CMS will also no longer apply negative regional adjustments for ACOs with higher costs relative to their regions. The Task Force recommends that CMS adopt the following proposed hybrid methodology for adjusting ACO benchmarks at rebasing:

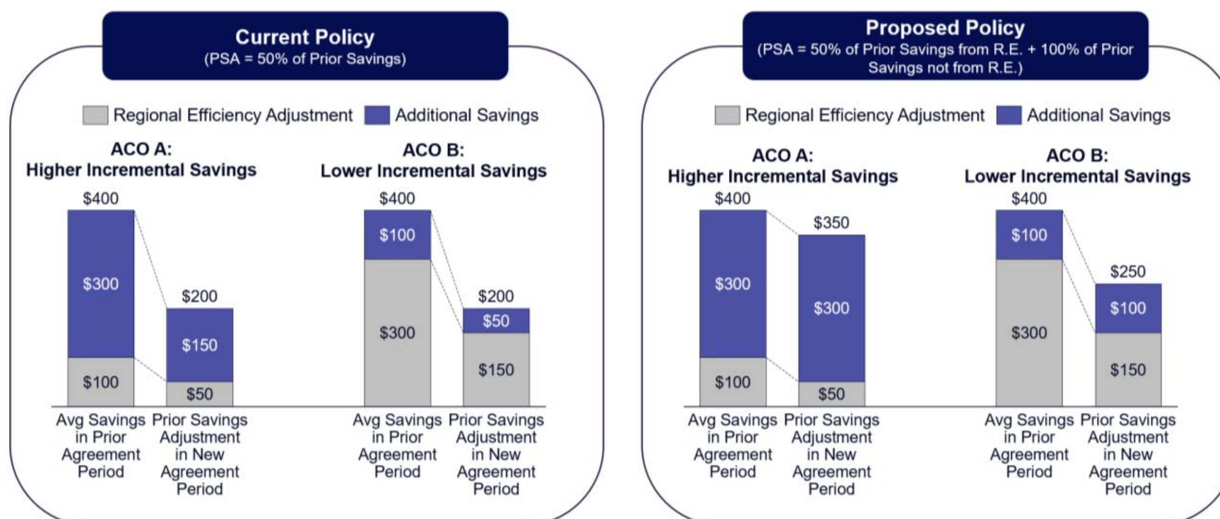
1. **First, apply the ACO's regional efficiency adjustment using the current methodology** (50% for second and subsequent agreement periods for ACOs with lower spending than their regions). ACOs with higher costs relative to their regions would still be protected from negative adjustments.

2. **Second, apply a revised Prior Savings Adjustment (PSA) at 100% of the average gross savings the ACO earned in the prior three years, after deducting the ACO's regional efficiency adjustment.** This ensures that providers receive credit for the previous incremental savings they achieved above the regional efficiency adjustment.

3. **Third, raise or remove the PSA cap (now set at 5% of national FFS spending) and risk-adjust the cap** to ensure the policy does not unintentionally harm ACOs that serve the highest-risk patients.

The purpose of this proposed policy is to mitigate the overall ratchet effect by increasing the PSA, while maintaining strong incentives to drive continuous quality improvement and incremental new savings. This proposal reflects an evolution in HCTTF thinking about how to incorporate PSA and regional adjustments into the MSSP benchmarking methodology, to achieve savings to Medicare while retaining successful participants in a voluntary model and supporting their ability to invest in their patients. The proposal is illustrated in Figure 1, which models the impact of the current policy relative to the proposed policy.

Figure 1: Visualization of the Proposed Prior Savings Adjustment Policy



Source: Evolent, January 2024

III. Quality Payment Program

While the financial incentives described above are a key element of MSSP, one essential non-financial incentive for participants is the reduced reporting burden available to ACOs and other alternative payment model (APM) participants. When the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was enacted, one of the central benefits of APM participation for clinicians was the potential to alleviate the reporting burden under MIPS. In turn, the reduced administrative burden helped APMs as they invested in improving patient care.

However, several recent regulatory actions have increased the reporting burden on ACOs and other APM participants. For example, the forthcoming electronic Clinical Quality Measure (eCQM) reporting requirements are difficult to comply with and do not necessarily produce high-quality data for CMS. As many ACOs have shared with CMS, the eCQM requirements are extremely expensive and major EHR vendors do not have standard processes to support their implementation. The Task Force is concerned that these policy changes will weaken the incentives to participate in MSSP and other APMs. In addition, CMS will require APM participants to meet the Merit-Based Incentive Payment System (MIPS) Promoting Interoperability requirements starting in 2025, to be equivalent to those governing clinicians working under FFS. To address these concerns, the Task Force recommends the following:

1. **CMS should address ACO challenges in reporting accurate eCQM data, by either creating an alternative data completeness standard for ACOs or implementing an exclusion policy that acknowledges the difficulty of aggregating data across ACO participants.** In addition, CMS could consider piloting eCQMs with a subset of ACOs to identify any unintended consequences prior to a broader rollout. 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. The underlying challenges with eCQM / MIPS CQM include reporting across multiple Tax Identification Numbers (TINs) and electronic health

records (EHRs), which result in large data inaccuracies that will skew results. Even organizations with a single EHR may not have seamless reporting. Certified EHR Technology (CEHRT) requirements do not standardize data collection for all eCQM data elements, meaning that the EHR may not support eCQM reporting. Therefore, CMS should adopt alternative policies that meet the goals of encouraging continuous quality improvement, while obtaining accurate, comparable data across ACOs.

2. **CMS should retain the Medicare CQM reporting option until digital quality measurement and reporting is feasible for all ACOs**, rather than requiring the transition to all-payer eCQM reporting. While appreciative that CMS offers the Medicare CQM reporting option as a transitional policy, this approach shares many of the operational challenges described above. In particular, ACOs must make significant investments in standing up the infrastructure and processes to support this reporting option. Therefore, many ACOs are choosing to focus on meeting eCQM reporting requirements, since the Medicare CQM option is not permanent. HCTTF recommends that CMS retain the Medicare CQM reporting option as permanent until the challenges described above have been addressed and digital quality measurement and reporting is feasible for all ACOs. At a minimum, CMS should provide ACOs with at least 2 performance years prior to removing the Medicare CQM reporting option to ensure ACOs have sufficient time to fully transition to eCQM reporting.

3. **CMS should modify the Medicare CQM reporting requirements to only be applicable to an ACO's assigned population, rather than their assignable population.** For ACOs under retrospective alignment, both their assignable and assigned populations will be based on services furnished during the performance year. CMS has indicated that it will provide ACOs with a list of beneficiaries who are eligible for Medicare CQMs prior to the start of the submission period. However, this list may be incomplete due to factors like claims run-out and it is ultimately the ACOs responsibility to report on all eligible beneficiaries. ACOs will generally be aware of their assigned population by the start of the quality submission period. As a result, HCTTF members urge CMS to modify the reporting option to only be applicable to an ACO's assigned population. Additionally, CMS should work with stakeholders to ensure ACOs understand and can report on their assigned patients and should avoid penalizing ACOs who may be unable to identify their full assigned patient population during the initial reporting periods.

4. **CMS should not require ACOs and other APM participants to report on MIPS Promoting Interoperability requirements.** Aligning ACO reporting to those of FFS clinicians will create additional reporting burdens for ACOs and undercuts a primary benefit of APM participation for individual clinicians, thus weakening the incentive to participate in MSSP and other Advanced APMs.

IV. Health Equity

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 most people's overall health. Factors including food, housing, transportation, employment, environmental exposures, stress, and genetics all combine to drive the bulk of health outcomes for 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. 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 develop policies along several distinct but interrelated areas:

1. **Support Standardized Data Collection for Health Equity.** CMS should align with organizations that are establishing coding and documentation standards for health-related social needs (HRSN) data, such as the Gravity Project and United States Core Data for Interoperability (USCDI). Furthermore, CMS should 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 other HRSNs, so these data can be appropriately requested via the APIs from EHRs.

2. **Incorporate Health Equity Data into the Benchmark Methodology.** Current benchmarks rely on historical claims data to set funding levels. Consequently, these approaches do not accurately capture the needs of underserved patient populations that, by definition, have not received the 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:
    a. **Continue refining equity adjustment methodologies**, with an emphasis on creating clear incentives to focus on underserved populations and the financial flexibilities to dedicate funding to addressing HRSNs.
    b. **Consider strategies to better account for state and local variation when measuring equity issues.** As noted in previous letters, the Task Force is concerned that using the national Area Deprivation Index may not fully recognize underserved beneficiaries from higher-income states and communities.
    c. **Focus on upside adjustments that increase resources for underserved communities**, without creating a zero-sum situation for those serving better-resourced communities. While recognizing 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**: CMS should support efforts to streamline partnership and contracting efforts between ACOs, providers, and CBOs. CMS could support existing payer and provider efforts to develop value propositions, clear contracting guidance, and examples of working relationships, such as the Partnership to Align Social Care that is working to strengthen CBO networks operating as part of a community care hub model.[1] CMS could accelerate these efforts by:
    a. **Leveraging CMMI models** to directly fund and evaluate partnerships.
    b. **Issuing guidance** on the best practices for ACOs to partner with CBOs, with incentives to utilize and/or support community-centric approaches, such as community care hubs.
    c. **Coordinating with other federal agencies** that fund work in areas such as housing, nutrition, transportation, and education to develop policies for funding strategies that better align with community-led efforts to meet the needs of the people receiving these services.

V. General Model Design

The Task Force encourages CMS to consider several updates to the MSSP program that would apply to all participating ACOs. We believe the following changes would further improve the program and better attract and retain ACOs:

1. **Support MSSP ACOs that Primarily Serve Institutionalized Beneficiaries.** In eliminating the negative regional adjustment cap, CMS recognized that MSSP's design must account for the fact that medically complex, high-cost beneficiaries are underrepresented in MSSP. This is especially true for Nursing Facility residents who are disproportionately dual-eligible and the ACOs who primarily serve them. The MSSP QPP currently penalizes institutionally-oriented ACOs in at least two ways: (1) by including CAHPS as a quality measure despite institutionalized beneficiaries being exempt from the survey, and (2) by failing to appropriately risk-adjust the claims-based admissions and readmissions measures. For ACOs whose attributed population is greater than 50% comprised of institutionalized beneficiaries, CMS should exclude CAHPS as a quality measure (and proportionally increase the weighting of the other quality measures) and create a separate risk-adjustment methodology for outcomes measures (as is done under the institutional segment in Medicare Advantage).

2. **Eliminate Low/High Revenue ACO Distinctions:** HCTTF continues to call for CMS to remove the revenue distinction for MSSP ACOs, because it limits the reach of the model by barring many ACOs who would most benefit from participation (*e.g.*, ACOs that include rural providers, FQHCs, and CAHs).

[1] Chappel A Cronin K, Kulinski K, et al. "Improving Health and Well-Being Through Community Care Hubs", *Health Affairs Forefront*, November 29, 2022.

3. **Streamline Attribution:** Allow both electronic and paper-based voluntary alignment, to meet patient preferences and address potential access barriers. CMS should also support ACOs with retrospective alignment by informing them of beneficiaries that already prospectively aligned for the applicable performance year. In addition, CMS should offer greater flexibility in rules on how ACOs communicate with beneficiaries, to allow ACOs to better educate patients on the benefits of seeking care from an ACO and how it differs from traditional care options. Additionally, CMS could invest resources in better educating the public on the benefits of ACOs.

4. **Encourage Provider Engagement:** Create additional flexibilities for ACOs to form provider networks and contract with specialists by:
   a. **Allowing ACO participation by specific providers** to help ACOs curate a high-value, highly engaged network of primary care providers and specialists that align to the ACO cost and quality goals. CMS can accomplish this by allowing ACOs to define the specific National Provider Identifiers (NPIs) they work with on TIN-NPI lists.
   b. **Supporting ACOs in engaging high-value specialists** and facilities by engaging in efforts to develop nested bundles, shadow bundles, and other mutually beneficial payment arrangements.

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The Task Force appreciates the opportunity to provide feedback on MSSP improvements in advance of the CY 2025 PFS Proposed Rule. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org) or Senior Director Theresa Dreyer (theresa.dreyer@hcttf.org) with questions related to these comments.

Sincerely,

Eric Fennel
Vice President, Network Strategy and Value-Based Solutions
Aetna, A CVS Health Company

Karen Johnson
Vice President, Practice Advancement
American Academy of Family Physicians

Claire Mulhearn
Chief Communications & Public Affairs Officer
agilon health

Melanie Phelps
Senior Advocacy Advisor,
Health System Transformation
American Heart Association

Sean Cavanaugh
Chief Policy Officer
Aledade, Inc.

Patrick Holland
Chief Financial Officer
Atrius Health

Ashley Yeats, MD
Vice President of Medical Operations
Blue Cross Blue Shield of Massachusetts

Todd Van Tol
Executive Vice President, Health Care Value
Blue Cross Blue Shield of Michigan

Paul Hendley
Management Consultant
Blue Cross Blue Shield of North Carolina

Laura Fox
Director, Payment Innovation
Blue Shield of California

Zak Ramadan-Jradi
Vice President, Network Management
Cambia Health Solutions

Todd Gottula
Founder, President
Clarify Health

Wesley Wolfe
Executive Director, Market and Network Services
Cleveland Clinic

Emily Stewart
Executive Director
Community Catalyst

Amy Kaszak
Executive Vice President of Strategic Initiatives
Curana Health

Mark McClellan, MD, PhD
Director
Duke Margolis Center for Health Policy

Angelica Jewett
Vice President, Value Based Solutions
Elevance Health

Ashley Ridlon
Vice President, Health Policy
Evolent

Sophia Tripoli
Director, Center for Affordable Whole-Person Care
Families USA

Richard Lipeles
Chief Operating Officer
Heritage Provider Network

Andy Marino
Senior Vice President, Plan Networks
Honest Medical Group

David Nace
Chief Medical Officer
Innovaccer

Anthony Barrueta
Senior Vice President, Government Relations
Kaiser Permanente

Ryan Anderson, MD
Interim Vice President, Clinical Care Transformation
MedStar Health

Sinsi Hernández-Cancio
Vice President for Health Justice
National Partnership for Women & Families

Alan Balch
CEO
National Patient Advocate Foundation

Joy Burkhard
Executive Director
Policy Center for Maternal Mental Health

Seth Edwards
Vice President, Population Health and Value-based Care
Premier

Jake Woods
Manager, Accountable Care Models
PSW

Sam Holliday
CEO
Oshi Health

Srin Vishwanath
CEO
OPN Healthcare

Jordan Asher, MD, MS
Executive Vice President, Chief Clinical Officer
Sentara Health

Signify Health

Jim Sinkoff
Deputy Executive Officer and Chief Financial Officer
Sun River Health

Emily Brower
SVP Clinical Integration & Physician Services
Trinity Health

Garon Meikle
Chief Financial Officer
UAW Retiree Medical Benefits Trust

Judy Zerzan-Thul, MD
Chief Medical Officer
Washington State Heath Care Authority

TASK FORCE MEMBERS: Aetna • agilon health • Aledade • American Academy of Family Physicians • American Heart Association • Atrius Health • Blue Cross Blue Shield of Massachusetts • Blue Cross Blue Shield of Michigan • Blue Cross Blue Shield of North Carolina • Blue Shield of California • Cambia Health Solutions • Clarify Health • Cleveland Clinic • Community Catalyst • Curana Health • Elevance Health • Evolent • Families USA • Heritage Provider Network • Honest Medical Group • Innovaccer • Kaiser Permanente • Mark McClellan • MedStar Health • National Partnership for Women & Families • National Patient Advocate Foundation • OPN Healthcare • Oshi Health • Policy Center for Maternal Mental Health • Premier • PSW • Sentara Healthcare • Signify Health • Sun River Health • Trinity Health • Washington State Health Care Authority • UAW Retiree Medical Benefits Trust