January 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Improvements to the Medicare Shared Savings Program

Dear Administrator Brooks-LaSure:

The National Association of ACOs (NAACOS) appreciates the opportunity to provide our recommendations on changes to the Medicare Shared Savings Program (MSSP) that will help support the goal of all Medicare patients in an accountable care relationship responsible for total cost of care and quality by 2030. NAACOS represents more than 400 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of physicians, health systems and other provider organizations across the nation to improve quality of care for patients and reduce health care costs. NAACOS members serve over 8 million beneficiaries in Medicare value-based payment models, including the MSSP and the ACO Realizing Equity, Access, and Community Health (REACH) Model, among other alternative payment models (APMs). Additionally, our members engage in value-based payment arrangements across other payers, including Medicaid and Medicare Advantage.

As CMS begins considering changes for the CY 2025 Medicare Physician Fee Schedule, CMS must consider approaches that will maintain and expand existing ACOs. While new growth is also essential, we are concerned that the current environment could lead to a retreat from the model. All MSSP policies must recognize the broader competitive landscape—fee-for-service (FFS) remains a strong financial alternative and Medicare Advantage (MA) offers stronger opportunities to provide enhanced beneficiary services. The MSSP must compete to have stronger financial incentives than FFS and comparable flexibilities to MA. Specifically, we request that CMS:

1. **Recognize the fiscal realities of remaining in APMs.** ACOs and other APMs remain a voluntary option for providers. Accordingly, ACOs must compete with one another and the broader FFS environment to attract and retain providers. To date, FFS remains the more predictable revenue stream with volume as the primary lever for control. Long-term stability and predictability are needed in ACO benchmark approaches to ensure providers remain in the model. In the absence of advanced APM incentives, the potential for achieving shared savings is the sole opportunity to increase revenue for providers in the APM. Beyond provider retention, ACO revenue opportunities have a direct impact on patient care as ACOs reinvest shared savings into patient

benefits such as care management, transportation, and enhanced services. These benefits are comparable to enhanced services and benefits provided in Medicare Advantage, ensuring that traditional Medicare remains a strong option for beneficiaries. To ensure that ACOs remain a fiscally strong option for providers and patients, CMS should:

- ***Correct the Benchmark Ratchet.*** The majority of MSSP participants will soon enter new contract agreements and have their benchmarks rebased and lowered due to achieving savings during the current contract cycle. While CMS has adopted policies to reduce the impact of the ratchet (i.e., prior savings adjustment, ACPT) these policies do not go far enough and many ACOs may face deep reductions to their benchmarks.

2. **Leverage its authority to create strong nonfinancial incentives.** With financial incentives as the root of many APMs, nonfinancial incentives offer additional opportunity to release providers from the constraints of FFS and develop new innovative approaches. Congress recognized this inherent need by exempting clinicians in APMs from the quality reporting approaches for clinicians in FFS (i.e., MIPS). In recent years we have seen a retreat from this intent. To immediately create stronger nonfinancial incentives, CMS should:
    - ***Improve Quality Requirements.*** To achieve the 2030 goal, CMS should set accountable care relationships as the gold standard, with MIPS or other FFS quality programs supporting the movement to population health.
    - ***Improve Beneficiary Notifications.*** Addressing the duplicative, complex, and burdensome requirements can help foster better relationships between patients and their physicians while also helping beneficiaries understand the goals of an ACO.
3. **Support next generation innovation.** With over $18.5 billion in savings achieved, MSSP has successfully lowered costs and provided better services to beneficiaries. Despite this success, the program structure has largely remained the same. Long-term participants need additional avenues to continue to innovate within the program. The Innovation Center has tested several approaches that should be incorporated into MSSP, CMS should:
    - ***Offer Primary Care Hybrid Payment.*** ACOs seek pathways for increasing payment to primary care. Additionally, the MSSP must leverage approaches that shift the underlying payment mechanism from FFS.
    - ***Offer "Enhanced Plus."*** ACOs seek options for approaches for achieving higher reward through higher risk.

<u>Correct the Benchmark Ratchet</u>

NAACOS has long advocated for fair and accurate financial benchmarks that create achievable spending targets for ACOs to generate shared savings. CMS must balance creating program policies that generate savings to Medicare while retaining participants in a voluntary model. **NAACOS implores CMS to consider changes to mitigate benchmark ratchets that occur when rebasing.**

We believe the ratchet effect threatens future participation in ACOs, particularly for long-term ACO participants. For example, one ACO who began in MSSP in 2012 is approaching its fifth agreement and yet another ratcheting of its historic benchmark. The ACO's spending is now 25 percent below that of its region, which should be hailed as a policy success. Instead, the ACO's savings will become smaller (since savings opportunities will shrink with its benchmark) and the cost of running its care management programs will exceed shared savings. When this happens, their local health system, which continues to operate in FFS only, will have more revenue to attract the ACO's clinicians. ACO participation is voluntary, and CMS must recognize the broader financial realities when developing benchmark policies.

It will be critical for CMS to consider variations in regional spending when addressing the ratchet. Regional variation in spending is inherent in FFS, and as such, needs to be considered when setting and addressing ACO benchmarks, including addressing the ratchet and setting an administrative growth rate in benchmarks. This was borne out earlier this year in ACO REACH and changes to the Medicare hospital wage index. Because of changes to the wage index, ACOs in some regions would see large increases in hospital spending through no fault of their own. As CMS looks to solve the ratchet effect, the size of the ratchet depends on several factors, including how efficient the ACO is relative to its region, how efficient the region is, and the amount of savings generated in the ACO's prior agreement period. ACOs in more efficient regions need a higher prior savings adjustment to offset the lack of help provided by the regional adjustment. Relatedly, NAACOS continues to urge CMS to fix the "rural glitch," where CMS counts an ACO's own beneficiaries in the regional benchmarking calculations, effectively penalizing ACOs for lowering the cost of their assigned populations.

Increase the Amount of the Prior Savings Adjustment

A prior savings adjustment is needed to help curtail the ratchet effect. For new agreement periods starting next year, CMS will calculate ACO savings generated in the prior three years and add some of those savings back into ACO benchmarks. However, that add back is capped at 50 percent of savings generated, which cannot exceed 5 percent of national FFS spending, the same cap applied to an ACO's positive regional adjustment. The add back is also limited to the three years prior to the start of the new agreement period. NAACOS continues to feel this is not enough to help ACOs who have generated billions in savings for Medicare. Below are changes we'd like to see to the prior savings adjustment.

- **Increase the prior savings adjustment while also recognizing regional efficiency.** NAACOS suggests a revised approach that creates a hybrid with the current regional adjustment. CMS would continue to weigh the regional adjustment at 50 percent for ACOs that are lower spending compared to their region. CMS would also add back 100 percent of ACOs' prior savings achieved ABOVE the ACO's regional adjustment, which we call "incremental savings."
    - Current: Prior Savings Adjustment = Average per capita gross savings from the last 3 years X 50%
    - Recommendation: Prior Savings Adjustment = (Average per capita positive regional adjustment X 50%) PLUS (Average per capita gross savings from the last 3 years minus average per capita positive regional adjustment) X 100%
- **Allow the savings potential to increase beyond 5 percent.** Under current policy, the 5 percent cap on the regional and prior savings adjustments effectively limits ACO activities, including care management programs. ACO savings are achieved through non-billable services such as care coordination services that are not or cannot be billed. The more ACOs invest in these services the greater a wedge it creates between the true costs and its historic benchmark. Five percent is inadequate to support the work of ACOs, especially in the face of physician payment cuts, and incent providers to move away from FFS. CMS's current 5 percent cap is effectively a cap on ACO savings. MSSP's statutory requirements say ACOs should promote patient-centeredness, evidence-based medicine, and patient engagement. With little opportunity for savings, CMS is limiting ACOs' ability to meet Congress's goals.

As guiding principles for its work, CMS should continue to recognize the importance of the regional adjustment. Despite its criticism, the regional adjustment plays a critical role in aiding already low-cost providers in all regions of the country. Doing away with it would remove incentives for efficient providers from operating in shared savings arrangements. For example, a total removal of the regional adjustment strips new ACOs of any opportunity to create savings. It is also difficult to track the

movement of ACO participants in and out of individual ACOs, so keeping the regional adjustment is a way to capture practices that move. Furthermore, a prior savings adjustment should be designed in a way to incentivize continuous improvement. Some ACOs have been in the MSSP for more than a decade and have achieved tremendous savings. If CMS wants to see them remain in the program and have them continue to provide high-quality care, it must not penalize providers who are more successful and recognize that future adjustments to the ratchet provide incentives to generate additional savings.

The above recommendations would achieve several policy goals, including better addressing the ratchet, retaining regional adjustments, and incenting continuous improvement over time. As it is currently constructed, the prior savings adjustment helps very few ACOs since CMS gives ACOs the higher of either the regional adjustment or the prior savings adjustment.

Additionally, CMS should consider:

- Risk adjusting any caps to make it a more accurate reflection of the complexity of the patient population.
- Accounting for savings generated beyond the previous three years to help ACOs who have generated savings. Some ACOs have been in MSSP for more than a decade and have millions in savings not captured by a shorter, three-year look back period.
- Avoid penalizing ACOs in their prior savings adjustment if their spending is higher than that of their region. This would penalize providers who serve high-cost patients.
- Counting savings generated by REACH ACOs to be eligible for a prior savings adjustment should they enter or reenter into MSSP. The current regulation is unclear, but allowing REACH ACOs to be eligible would meet the overall intent of the policy.

Improve the Accountable Care Prospective Trend

Also starting in new agreement periods starting next year, CMS will incorporate a new Accountable Care Prospective Trend (ACPT). The ACPT will be a third of the update to ACO benchmarks, along with the existing two-way, national-regional blend. NAACOS had previously asked CMS to pause the ACPT's implementation and supports it replacing the national portion of the current national-regional blend, which CMS recently sought comment on.

As CMS considers its next steps on administrative benchmarks, it must prioritize one factor: Base the administrative trend on an ACO's region. A single, national trend can never be reflective of everyone's individual experience across the nation. ACOs should not be punished if they operate in regions with spending growth above that of national inflation.

There are ways to improve the ACPT:

- Use the ACPT as the national component of the current two-way trend adjustment, rather than observed national FFS spending. This creates a benchmark that is based less on national spending and more on regional spending, which is a policy NAACOS has long advocated for.
- If CMS continues to calculate the ACPT at a national level, CMS should consider ways to make it reflective of regional differences in spending, for example, by including a geographic adjustment factor.
- Remove ACO-assigned beneficiaries from the regional comparison group, negating the effect of ACOs' savings on the regional trend. This would still allow CMS to move toward its goal of an administratively set benchmark while minimizing the unintended consequences of harming nearly a third of ACOs.

CMS should create additional guardrails to protect ACOs who would see lower benchmarks because of the ACPT. These include:

- Setting ACOs' trend update at the higher of the proposed three-way trend adjustment or the current two-way trend adjustment.
- Basing the ACPT on regional spending, rather than national. Because there is significant variation in regional spending growth, the use of a national trend will benefit ACOs in regions with slower spending growth and reduce benchmarks for ACOs in regions with higher spending growth.
- As an alternative option, allow the annual update factor to continue being based on the regional trend rate to avoid annual "shocks" when the regional and national trend rates diverge; and tie the overall trend rate to the ACPT over the five-year agreement period, this longer period should reduce the overall divergence.
- Using a three-year projection of the ACPT, which is the current projection used in the USPCC. It would be difficult to project five years out, and reserving the right to make mid-agreement period adjustments simply introduces uncertainty.

CMS should explore additional questions when pondering further incorporation of administrative benchmarks.

1) **How much of a "wedge" does CMS find it acceptable to create?** The wedge is the slice of spending growth between that of ACOs and that of Medicare spending. Under current policy, it is effectively 5 percent, the size of the cap on the regional and prior savings adjustments. That is too small to drive innovation, particularly in a world where provider organizations can achieve much greater revenue in Medicare Advantage.
2) **How big of a skew in the trend would trigger the need for a guardrail?** NAACOS calls for stronger guardrail policies above, and CMS includes some under the current ACPT policy. CMS needs to consider how big of a difference between expected trend and actual trend would trigger additional policies to ensure ACOs are not unfairly penalized.

It's important to remember that any move to administrative benchmarks won't solve this problem of benchmarks starting off at unachievably low levels because of ratcheting due to rebasing. This ratchet does not just cap savings, it caps investments in beneficiaries, and it caps how much an ACO can truly transition away from FFS and towards value.

<u>Improve Quality Requirements</u>

eCQMs, MIPS CQMs and Medicare CQMs

ACOs have a desire to see more digital measurement approaches incorporated into quality reporting. An efficient, technology-enabled future where data can be shared bi-directionally to better inform patient care is the future state many in the health care industry want to achieve. Digital measurement should allow for seamless quality reporting that reduces burden and provides real time performance data that can be used to improve patient care. This efficient, technology-enabled quality reporting is a future state ACOs strive toward.

As CMS attempts to move the MSSP closer to this future state of interoperability through the required use of eCQMs, the agency must address the unintended consequences and implications for ACOs, the clinicians in those ACOs and the patients they serve. We are pleased to see CMS finalize an interim reporting option that begins to address many of the unintended consequences of moving to eCQM reporting for ACOs that NAACOS has raised. CMS notes Medicare CQM reporting is intended to be a

temporary, transitional reporting option. We are concerned that when this option is eliminated the same challenges will persist for ACOs. The report all-payer eCQMs/MIPS CQMs approach remains flawed. We continue to have concerns with the quality and validity of the data and increased costs associated this approach. CMS should not move forward without proof-of-concept of both technical feasibility and the impact of the shift to all-payer measurement for ACOs. CMS must also consider future digital quality measurement (dQM) goals and how this policy works to further that goal. ACOs should not have to invest in developing processes now that will need to be replaced in the near future.

We urge CMS to:

- Allow the Medicare CQM option to continue until CMS has tested technical capabilities and the impact of the shift to all-payer measurement and dQMs for ACOs through a pilot, or until digital quality measurement and reporting is feasible for all ACOs;
- Pilot eCQMs and dQMs for a subset of ACOs to identify key challenges and unintended consequences that need to be resolved before moving forward on a program-wide basis. CMS should provide incentives for ACOs to do this testing, such as providing pay-for-reporting status for quality measures, upfront funding, adjustments to financial benchmarks, or an increased savings rate to help offset the high costs for doing this work;
- Create Electronic Health Record (EHR) certification criteria that supports ACOs in what they are required to achieve for electronic clinical quality and digital quality measurement. Certified EHR Technology (CEHRT) requirements do not standardize the capture and reporting of individual eCQM data elements across vendor systems and not all CEHRT vendors will implement every eCQM required for ACO reporting unless it is made a requirement for CEHRT;
- Allow for alternative data completeness standards for ACOs reporting eCQMs or MIPS CQMs, or allow for exceptions/exclusions that acknowledge the difficulty of aggregating data across ACO participants; and
- Identify an alternative pathway to transmit data in a standardized way to enable successful patient matching, such as use of a national patient identifier or revisions to QRDA I formats.

Aligning ACO Measures with the Universal Foundation Measure Set

ACOs support efforts to align quality measures across payers, contracts, and payment models. However, CMS must ensure measures that have not been tested are optional as the agency moves forward with efforts to adjust measure sets to align with the new Universal Foundation measures. As CMS considers changes to the MSSP measure set to align with the Universal Foundation, the following issues must be addressed:

- CMS must first test measures before making them required and scored measures for ACOs.
- CMS should avoid making any mandatory changes during the timeframe they are also asking ACOs to transition to new reporting methods. ACOs are currently devoting large amounts of time and resources to making operational and Information Technology changes to implement the measures currently required for eCQMs, MIPS CQMs and Medicare CQMs. Adding new mandatory measures to this list at the same time ACOs are required to fully transition to these new reporting methods will add significant burden and impede their ability to succeed.
- Ensure there is not significant growth in the number of measures ACOs must report. CMS started the MSSP with over 30 quality measures, and over time reduced the measure set to reduce burdens associated with reporting. This should continue to be a focus for CMS.

Incorporating MIPS Value Pathways (MVPs) in MSSP

Many of the specialty measures used in the MIPS program are not oriented toward value-based care and therefore would have very little utility and add significant burden, complexity, and confusion. This is another example of the misalignment that takes place when the MSSP or other value models are combined with a FFS-focused program such as MIPS. **NAACOS opposes the mandatory use of MVPs in ACOs.** Instead, CMS should allow ACOs to continue to identify the best ways to engage specialists in value arrangements.

MSSP Claims Based Quality Measures

MSSP ACOs are measured on certain claims-based quality metrics, however CMS provides little performance data to support ACOs in improvement efforts. Previously CMS shared quarterly performance information on the claims-based measures with ACOs. **We urge CMS to reinstate the quarterly claims-based quality information and reports**. Absent this information, ACOs have tried to project their own performance but cannot make accurate assessments given the lack of information around risk adjustment and other measure details.

Promoting Interoperability and CEHRT Requirements for ACOs

NAACOS is disappointed CMS is moving forward with a requirement to align CEHRT requirements for MSSP ACOs with MIPS. NAACOS strongly opposes this policy which will add significant burden to ACOs and further disincentivize participation in APMs and Advanced APMs, we urge CMS to reconsider this policy. By requiring all ACOs' eligible clinicians to report Promoting Interoperability, regardless of track or qualifying APM participant (QP) status, CMS is creating yet another disincentive for ACOs to participate in an Advanced APM and obtain QP status at a time when the financial incentives in place for this participation are expiring. CMS notes their intention with this policy is to reduce burdens for ACOs, however the result is the opposite. Instead, CMS is now creating a new reporting obligation for ACOs who participate in an Advanced APM and obtain QP status. Lastly, QPs are statutorily excluded from the MIPS program and this policy subjects QPs to MIPS, as Promoting Interoperability is the only reporting obligation ACOs have in the program.

CMS's one year delay in the requirement's enforcement is insufficient as ACOs will still struggle to comply with this change. CMS must ensure ACOs have the opportunity to recruit small practices who are not currently on CEHRT which advances value-based care and supports CMS's stated goal of having all patients in an accountable care relationship by 2030. ACOs can provide resources and assistance for transitioning to CEHRT, however this can take time. The current 75 percent attestation approach allowed ACOs to bring these practices into value arrangements. Should CMS move forward with this policy, it will stifle growth in ACOs and take CMS further from their goal of having all patients in an accountable care relationship by 2030. Many ACOs are now faced with the difficult decision of needing to drop small, independent practices from their participation. CMS must signal a change in this policy prior to the September deadline to add or drop ACO participants to avoid losing participation from this critical group of clinicians in value models.

We also have several implementation questions and concerns for this requirement. We are concerned with CMS's recommendation that ACOs report PI at the APM Entity level. This is not possible unless the ACO is a single TIN comprised of a single EHR product. CMS also notes that ACOs will be responsible for checking the individual eligibility of clinicians across their ACO at multiple times in the performance year to determine who must report. This is simply not feasible, and CMS should instead provide ACOs with a list of clinicians they are expected to report on. Importantly, CMS must also clarify that the small practice exception is applicable to small practices in the ACO either as an automatic exclusion or an exception. CMS must also clarify how clinicians in an ACO are expected to apply for hardship exceptions,

and who would receive the notifications regarding approval status for those applications. Finally, CMS must clearly outline the audit expectations and responsibilities, for example, would the ACO be responsible for complying with audit requests, or would this fall on the practice. These questions demonstrate the complexity and burden that is being introduced with the addition of this requirement.

Improve Beneficiary Notifications

NAACOS continues to advocate for more sensible and effective approaches to beneficiary communications in MSSP. In previous feedback to the agency, we detailed concerns with the requirements as currently written and highlight key challenges ACOs face in implementing and complying with these requirements. Through conversations with ACO members and consumer advocacy organizations, we have summarized four overarching issues with the beneficiary notification requirements[1]:

1. ACOs lack access to information needed to identify the denominator of beneficiaries to which they are required to provide the notice and follow-up.
2. The timing requirements of the initial notice and follow-up are impractical and make it effectively impossible to be fully in compliance.
3. Lack of appropriate guidance from CMS and contradictory information provided by ACO coordinators have caused significant confusion among ACOs about how to comply with the requirements.
4. These requirements have caused confusion and frustration for Medicare beneficiaries, in direct contrast with the intention of the requirements.

NAACOS has also recommended changes to the "Medicare & You" handbook, which CMS provides annually to each Medicare household, to include information on MSSP and the agency's accountable care goals. Effectively communicating with and educating beneficiaries about accountable care will be essential to achieving the 2030 goal. NAACOS will continue to engage with CMS and other stakeholders, including patients and consumer advocates, to improve beneficiary communications as they are critical to expanding the reach of accountable care and to the success of patient engagement activities. We plan to convene a group of ACO leaders and consumer advocates to develop commonsense solutions to these challenges and we look forward to sharing the resulting recommendations with CMS.

Primary Care Hybrid Payment

More flexible payment mechanisms can support care delivery transformation, strengthen primary care, and increase participation in ACO initiatives. Specifically, the National Academies of Sciences, Engineering, and Medicine (NASEM) recommends shifting primary care payment toward hybrid models that include prospective population-based payment in addition to a per-visit payment.

A primary care hybrid payment option in MSSP could also advance CMS's goal of having all traditional Medicare beneficiaries in a care relationship with accountability for quality and total cost of care by 2030. There is broad multistakeholder support for a hybrid payment option within MSSP, including primary care clinicians, ACOs, consumer organizations, health plans and others. NAACOS and others have called on CMS to implement an option to provide prospective payment for primary care within

[1] Additional detail on each of these four areas can be found on pages 21-23 of NAACOS comments on the 2024 Medicare Physician Fee Schedule Proposed Rule.

MSSP and outlined payment approaches that accommodate the differing needs and capabilities of various primary care practice types.

NAACOS appreciates CMS's collaboration with our members and other stakeholders on the development of a hybrid payment option for MSSP and we were pleased to see CMS reference such an option in a blog post and in the proposed 2024 Medicare Physician Fee Schedule rule. To make this option feasible and attractive for as many ACOs as possible, CMS should:

- Allow select TINs in an ACO to participate, rather than requiring participation of all TINs in the ACO. This ensures that 1) the option is fully voluntary for both the ACOs and all participating practices and 2) one practice in an ACO that does not wish to participate would not have veto power over the participation of other practices in the ACO.
- Provide sufficient data and technical assistance to the ACOs and the primary care practices participating in this option to support management and administration of population-based payments.
- Ensure the amount of the hybrid payment is greater than historical FFS payments and sufficient to fund advanced primary care and population health initiatives (e.g., chronic disease management, behavioral health integration, addressing social needs, etc.).
- Establish appropriate guardrails that balance the need for transparency and accountability while minimizing administrative burden.

Many ACOs and primary care practices lack the necessary infrastructure and resources to manage population-based payments. To enable broad participation in this option, additional data, tools, and technical assistance should be provided, at the ACO-level and at the practice-level. REACH ACOs participating in the Primary Care Capitation (PCC) payment mechanism receive beneficiary alignment data, claims data, risk adjustment data, aggregated payment data, aggregated benchmark data, and quality performance scoring data from CMS throughout the performance year. ACOs participating in a primary care hybrid payment model within MSSP should similarly be provided timely, actionable data to support practices in operationalizing payment and care delivery changes. More granular data would help primary care practices electing this option to better understand and implement payment changes. For example, aggregated payment and benchmark data provided in ACO REACH should be provided at the practice-level or beneficiary-level. Reports at the ACO-level do not enable individual primary care practices to assess and track their performance on financial targets. Primary care practices should be empowered with data that are relevant to them to drive sustainable payment transformation.

ACOs looking to elect this option are formed by or in partnership with primary care practices who wish to change their payment flow and increase investment in advanced primary care. CMS should leverage existing MSSP requirements to ensure transparency and accountability for all parties, such as:

1. Requiring participation agreement amendments that detail payment arrangements negotiated and agreed to by the practices and the ACOs.
2. Expanding ACOs' existing public reporting requirements to report how the hybrid payment funds are used, similar to spend plans used in other models (e.g., advance investment payments).

We look forward to our continued collaboration with CMS on this proposal and encourage the agency to work expeditiously to implement primary care hybrid payment in MSSP as soon as feasible.

Offer "Enhanced Plus" Opportunity for Higher Risk and Reward

NAACOS has advocated for CMS to offer a higher-risk track in MSSP than the current Enhanced track, which we've called "Enhanced Plus." This would serve the dual purpose of (1) encouraging ACOs to take on higher levels of risk, which would in turn produce higher savings, drive innovation, and improve patient care overall; and (2) providing REACH ACOs with an offramp from the model that is set to expire at the end of 2026 and better leverage MSSP as an innovation platform. We were pleased to see CMS seek comment on the concept in the 2024 Medicare Physician Fee Schedule proposed rule. Our concept for "Enhanced Plus" will provide more flexibility and innovation that allow providers to deliver optimal patient care in ways that best suit them and their populations. We offer a summary of our thinking below.

Risk Sharing

CMS should offer a choice between a full-risk option with a manageable discount or a shared savings rate of 85 percent or 90 percent. CMS needs to acknowledge that the financial incentives under Enhanced are attractive with its 75 percent shared savings rate and a 40 percent shared loss rate. In a full-risk model with either a 2 percent or 3 percent discount, ACOs would have to generate savings of 8 percent or 12 percent, respectively, to earn savings equivalent to what they would earn in Enhanced.

There is precedence as ACO REACH offers two levels of risk and Next Gen offered options for percent shared savings (80 or 100), variable discounts, and caps on savings and loss rates between 5 percent and 15 percent. These options provide a tradeoff between how much ACOs could pay back to the Medicare trust fund or reinvest in incentives or patient care.

As an alternative to a shared savings rate, CMS must be creative in setting a discount. One option is to set the discount to max out at half of the average shared savings earned for all of MSSP. For example, MSSP averaged 5 percent savings in one year, the discount would top out at 2.5 percent for the next year. This would incentivize high performance and continuous savings without punishing ACOs who generate greater savings. It's imperative CMS provide certainty and simplicity and allow ACOs to know their spending targets at the start of a performance year.

Non-Financial Incentives

It will be critical for CMS to also consider non-financial incentives to entice participation in a full-risk model given the relative attractiveness of the current Enhanced track. Few ACOs can generate the levels of savings needed to make a full-risk model with a discount more attractive. The answer lies in waivers and other non-financial incentives, which we spell out below.

- **Population-based payments**—As we note above, we would like MSSP to include prospective population-based payments for primary care. Enhanced Plus should allow options for population-based payments. This would allow ACOs to enter negotiated payment arrangements with specialists and preferred providers, which is a concept not present today in MSSP.
- **NPI-level participation** – Innovation Center models have been very attractive for ACOs comprised of large health system and multispecialty practices because of their ability to include individual participants rather than the full-TIN model participation of MSSP. While we work to address issues that make it challenging for some providers (e.g., specialists, rural, etc.) to participate, an Enhanced Plus track should allow TIN/NPI participation to allow ACOs to better select participants.
- **Addressing high needs patients—**CMS should install a high-needs track with MSSP which includes successful elements of REACH, such as favorable benchmarking policies, more appropriate quality measures, use of concurrent risk adjustment, and lower beneficiary

alignment minimums. The REACH High Needs ACOs have been very successful and expanded ACO access to more vulnerable populations. Within MSSP, CMS should allow an ACO to participate in both a high needs and other ACO tracks in the same market.

- **More waivers and flexibilities** – Waivers available today in MSSP have become increasingly stale and burdensome. In contrast, Innovation Center models offer much better ways to meet patient needs. Enhanced Plus should offer more advanced waivers, including the post discharge home visit waiver, care management home visit waiver, tailored Part B cost sharing support, and others being tested under ACO REACH. ACOs should have maximum flexibility to determine how to implement the benefits. Additionally, MSSP would be wise to allow greater flexibility in how waivers are implemented, which is greater in Innovation Center models. That lack of flexibility is one reason why waivers aren't used as greatly in MSSP. Specifically, CMS should
    - Create a process to accept public nominations for waivers in MSSP, similar to the process by which the public could annually request additions to the Medicare telehealth services list.
    - Waive Medicare's requirement that limits AWVs to once every 365 days. Instead, it should allow ACOS to provide one visit a calendar year to encourage the care coordination and care management that comes with AWVs.
    - Create enhanced patient benefits through the use of waivers that allow patient cost-sharing support.
- **Better access to data** – Managing populations requires access to data to understand your patients, their health, their needs and where they're seeking care. Enhanced Plus should provide access to better beneficiary-level data. This includes data dashboards that existed under the Next Generation ACO model, these were well used and provided a better view of data nationally to make better comparisons.
- **Paper-based voluntary alignment** – ACO REACH's paper-based voluntary alignment has been well utilized and helps ACOs better engage patients. We recommend it be deployed in MSSP to better engage patients. Additionally, CMS should consider speeding up the timeline for aligning beneficiaries through voluntary alignment; perhaps considering a monthly update as currently it can take several months between when a beneficiary voluntarily aligns before they show up on an ACO's patient roster.

Conclusion

Thank you for the opportunity to provide feedback on ways to improve MSSP and increase ACO participation. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement on this model. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
NAACOS