

September 1, 2022

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-1770-P

**RE: Medicare Shared Savings Program Changes in the Physician Fee Schedule Proposed Rule**

Dear Administrator Brooks-LaSure:

On behalf of the undersigned organizations, we applaud you for taking steps to reach the goal of creating a stronger Medicare program by strengthening accountable care models and speeding the movement toward value for all patients. We appreciate that many of the proposed changes in this rule are responsive to recommendations we have made for improving the Medicare Shared Savings Program (MSSP). Ultimately, many of these proposals will help grow participation in accountable care organizations (ACOs) and realize CMS's stated goal to have all Medicare beneficiaries in a relationship with a provider who is responsible for quality and total cost of care. Additionally, these proposals will build on the current financial success of the program, saving Medicare more than \$15 billion and yielding more than \$650 million in shared savings to ACOs. We appreciate that CMS has thoughtfully considered how to improve the program; below we offer recommendations in response to the proposals.

**Consider additional opportunities for ACOs to participate in advanced investment payments.** We applaud CMS for recognizing the significant upfront resources needed to form an ACO and transition to value-based care. We have long advocated for CMS to make upfront payments available to ACOs and commend CMS's proposal to provide advance investment payments (AIPs) in MSSP. To better address health equity and expand access to accountable care for underserved beneficiaries, we urge CMS to expand eligibility for AIPs to all ACOs working to combat health inequities. Historically, beneficiaries in underserved communities have not had adequate access to health care and this significant unmet need has led to financial benchmarks that do not accurately reflect the cost of addressing the complex medical and psycho-social needs of these beneficiaries. We share CMS's commitment to advancing health equity and ensuring access to high-quality, high-value care. By providing adequate funding for all ACOs to address health related social needs and reduce disparities, we can advance our shared goal of achieving equitable health outcomes for all.

**Refocus the high and low revenue distinction to address the characteristics of beneficiaries served by an ACO.** We appreciate and support CMS's proposal to create a more appropriate glidepath to risk, by allowing ACOs up to seven years in upside-only tracks before advancing to risk. Additionally, we strongly support the proposal to make the Enhanced Track optional for all ACOs. Since the implementation of Pathways to Success, which required ACOs to advance to risk more quickly, we have seen a decline in new entrants to the program. A more reasonable glidepath to risk will attract new participants. We are pleased with changes to the glidepath to risk but remain concerned that the policies are set using the

arbitrary high and low revenue distinction. This distinction penalizes some of the types of providers that CMS seeks to include in the program. For example, ACOs with Federally Qualified Health Centers, Rural Health Clinics and safety net hospitals included on the participant list are typically designated as high-revenue ACOs. A primary objective of ACOs is to allow providers across the continuum to collaborate and coordinate care. CMS should eliminate the high and low revenue distinction. Any efforts to offer benefits to a subset of ACOs should be based on the characteristics of beneficiaries served by the ACO.

**Allow existing ACOs to opt-in to new payment approaches.** We appreciate efforts to update MSSP's financial rules to encourage greater ACO participation, attract new participants, and incentivize serving medically complex and low-income populations. Stakeholders have long advocated for fair, accurate, and predictable benchmarking and risk adjustment policies. CMS addresses these concerns by proposing changes to risk adjustment policies, improving regional adjustments, and making it easier for some ACOs to earn shared savings. However, these policies apply only to ACOs with new agreements beginning in 2024. The vast majority of existing ACOs will not have access to these improved policies for several years unless going through the onerous process of early renewal. CMS should allow existing ACOs to opt-in to the new financial methodology approaches by amending current contracts.

**Engage stakeholders in designing benchmarks for the future.** We support the concept of administrative benchmarks and see this as a pathway to ensure adequate reimbursement and address health equity. We appreciate CMS for recognizing the program needs a long-term solution to the benchmarking "ratchet effect" and appreciate efforts to solicit feedback on administrative benchmarks. We recognize that administrative benchmarks are a necessary step to ensure the long-term viability of the program. However, there are inherent challenges in designing administrative benchmarking; for example, accounting for regional variations in spending so that ACOs are not penalized due to their geography. We ask that CMS engage stakeholders throughout development.

**Reconsider the timeline for requiring eCQM quality reporting and limit reporting to ACO population.** We greatly appreciate CMS proposals to remove the current all-or-nothing approach used in determining whether an ACO is eligible for shared savings based on quality performance. The additional lower quality performance standard, which allows ACOs to receive a portion of savings based on quality score, balances the need to provide ACOs with reasonable targets while incenting quality improvement. We are disappointed that CMS did not address the timeline for ACOs to report electronic clinical quality measures (eCQMs), make adjustment to the flawed all payer approach associated with eCQM reporting, or amend the approach to compare ACO performance with clinician performance in MIPS. We urge CMS to reconsider these policies and engage in a pilot program to test and resolve the numerous feasibility challenges and unintended consequences of all-payer and eCQM reporting.

**Support an extension of the Advanced APM bonuses.** We share CMS's concerns that the Quality Payment Program's incentive structure beginning in performance year 2023 does not create adequate incentives for providers to move from fee-for-service to alternative payment models (APMs). This is compounded by the proposed cuts to the conversion factor and the expiration of MACRA's 5 percent Advanced APM incentive payments. Collectively, we have been calling on Congress to extend these payments as ending them now would sharply discourage and disincentivize providers' efforts to engage in APMs. The incentive payments not only help encourage providers to enter risk-based ACO and

Innovation Center models but also provide additional resources that can be used to expand services beyond traditional fee-for-service. We encourage CMS leadership to work with Congressional leaders to support an extension of the 5 percent Advanced APM incentive payments, along with giving CMS the authority to adjust the thresholds to qualify for the incentive payments.

**Utilize MSSP as an innovation platform.** Since the MSSP launched in 2012, ACOs have been instrumental in transforming our health care system through reduced costs and improved quality. As the only permanent total cost of care model, CMS should consider ways to adapt the MSSP to continue to advance value-based care. To date, MSSP ACOs would have to consider leaving this permanent program to take advantage of enhanced flexibilities offered in Innovation Center models. However, the Innovation Center should – as it has twice previously with the ACO Investment Model and Track 1+ – test model innovations within MSSP. We encourage CMS to provide additional flexibilities within MSSP and to test new concepts offered through Innovation Center models within MSSP (e.g., including a voluntary full risk track; testing other payment mechanisms, such as per-member-per month funding; continuation of the flexibilities offered during the COVID-19 public health emergency and flexibilities proven through other models).

We thank you for your leadership in supporting the movement to value-based care and strengthening MSSP.

Sincerely,

America's Essential Hospitals  
American Academy of Family Physicians  
American Medical Association  
AMGA  
Association of American Medical Colleges  
Federation of American Hospitals  
Health Care Transformation Task Force  
Medical Group Management Association  
National Association of ACOs  
National Rural Health Association  
Premier healthcare alliance