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November 29, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Brooks-LaSure:

In the 2024 Physician Fee Schedule (PFS) final rule, the Centers for Medicare & Medicaid Services (CMS) approved a proposal to shift to a revised CMS-HCC risk adjustment model for the Medicare Shared Savings Program (MSSP). AMGA reiterates its comments submitted in response to the proposed rule and once again expresses serious concerns about this decision. Importantly, we emphasize the rule's potentially deleterious financial impact on providers, as well as MSSP's pivotal role in the shift to value-based care. We caution that frequent and substantial rule changes erode provider confidence, hindering the success of the MSSP and impeding progress toward value-based care.

Founded in 1950, AMGA is a trade association leading the transformation of healthcare in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high-performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality, high-value care. More than 177,000 physicians practice in our member organizations, delivering care to more than one in three Americans. Our members are also leaders in value-based care delivery, focusing on improving patient outcomes while driving down overall healthcare costs.

AMGA is pleased to offer comments on the HCC risk adjustment model as finalized in the CY 2024 PFS Final Rule for your consideration. Specifically, our comments address the following concerns:

1. **Financial Ramifications of the Blended Risk Score Transition:** AMGA expresses deep concern about the potential financial repercussions for ACOs in performance year (PY) 2024, stemming from the transition to a blended risk score incorporating the 2024 CMS-HCC risk adjustment model (V28). The complex decision-making process for ACOs with existing agreement periods highlights the administrative burden and potential negative impact on shared savings payments, emphasizing the need for clear and consistent rules in value-based care models.

2. **Discrepancies in ACO Payment System and Threats to Value-Based Model Goals:** AMGA raises concerns about ACOs defaulting to the existing benchmarking strategy, as opposed to the finalized change, emphasizing the need for uniformity in risk adjustment methods. Using different HCC models to risk score benchmark years and performance years makes realistic comparisons difficult if not impossible, potentially eroding trust in the effectiveness of the MSSP.

Our detailed comments are below.

1. **Financial Ramifications of the Blended Risk Score Transition**

The transition to a blended risk score in PY 2024, with 33% based on the V28, raises serious financial concerns for ACOs with existing agreement periods. CMS estimates that, when applying the same risk adjustment model used in the performance year for all benchmark years, using V28 in PY 2021 would have increased combined shared savings payments by roughly 2% for ACOs. However, using the current benchmarking technique, the same scenario would have resulted in an 11% payment reduction.¹ While AMGA recognizes the 11% reduction was calculated using entirely V28 risk scores, we maintain our concern that applying the blended benchmarking technique to all ACOs with existing agreement periods will have a negative financial impact.

For ACOs with agreement periods starting before January 1, 2024, the decision to adopt the new benchmarking methodology requires a thorough evaluation to assess potential benefits, considering CMS' indication that the proposed methodology could reduce benchmarks for at least 25% of ACOs in existing agreement periods. If advantageous, ACOs must weigh whether the benefit justifies an early renewal for a new agreement period starting on January 1, 2025. The complexity of this decision highlights the administrative burden imposed by frequent changes to program rules, potentially resulting in reduced payments for ACOs adversely affected by benchmarking changes. In these cases, the reduction in shared savings payments is not a reflection of performance but stems from a shift in model parameters. Likewise, ACOs with patient populations weighted less heavily under V28 than under V24 face financial losses through no fault of their own.

AMGA acknowledges the inevitability of winners and losers in every model but emphasizes that these outcomes should be determined by clear rules established at the participants' entry into the program, not by changes occurring after the necessary investments have been made.

2. **Discrepancies in ACO Payment System and Threats to Value-Based Model Goals:**

AMGA is also concerned that ACOs with existing agreement periods will default to using the current benchmarking strategy, as opposed to the finalized change. CMS justifies this decision by stating that "the Shared Savings Programs' longstanding approach is to maintain a consistent benchmarking methodology for the duration of an ACO's agreement period because methodological changes can have varying impacts on ACO's benchmarks and performance."² Yet these ACOs will be subject to a new HCC model over the same period. Regardless of the specific model employed, maintaining uniformity in risk adjustment is essential for accurate comparisons

¹ Page 1155 of the unpublished rule.

² Page 1167 of the unpublished rule.

and fair evaluations. Any deviations from this uniformity may lead to unjustified fluctuations in ACO shared savings payments, diminishing trust in the program's effectiveness.

AMGA objects to finalizing a proposal that introduces such discrepancies into the ACO payment system. The model design should, to the greatest extent possible, evaluate and reflect an ACO's efforts and outcomes.

AMGA remains steadfast in its support of the MSSP and CMS' efforts to transition Medicare to a value-based model by 2030. Our chief concern lies in the potential hindrance posed by this rule, as it may increase the complexity of participation in the model and diminish the likelihood of CMS and providers achieving the ambitious goal of having 100% of Medicare beneficiaries in a value-based model by 2030.³

We appreciate your consideration of our comments. Please contact Darryl M. Drevna, senior director of regulatory affairs, at ddrevna@amga.org or 703.838.0033 ext. 339, with any questions or concerns.

Sincerely,

A handwritten signature in cursive script that reads "Jerry Penso".

Jerry Penso, MD, MBA
President and Chief Executive Officer, AMGA

³ <https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper>