COMPLEX CARE ALLIANCE

Payment Models for Patients with Complex Illness and High Needs

Looking Beyond 2026 to Reduce Burden, Drive Savings and Promote Choice and Competition

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Table of Contents

Introduction . . . 3

Why Focus on Patients with Complex Illness and High Needs . . . 3

Future Recommendations . . . 5

Implementation . . . 6

Why Focus on the High Needs Population . . . 6

Current High Needs Policies to Maintain . . . 9

Risk Adjustment . . . 9

Lower Beneficiary Alignment Minimums . . . 10

Differentiated Quality Measurement . . . 10

Primary Care Advanced Payment (Capitation) and Advanced Payment Options . . . 10

Alignment . . . 11

Multiple Risk Options . . . 11

Data Sharing . . . 11

Future High Needs Policy Enhancements . . . 11

Drive Competition Through Patient and Caregiver Choice, Engagement, and Transparency . . . 12

Alignment . . . 12

Benefit Enhancements and Payment Waivers . . . 13

Quality Measurement . . . 14

More Stable and Accurate Benchmarks . . . 15

Increase the Number of High Needs Patients who Can Access Proactive Chronic Care Management . . . 16

Blending Populations and Risk Adjustment . . . 16

Expansion of the High Needs Patient Criteria . . . 17

Support Rural Communities . . . 17

Deepen Medicare-Medicaid Integration . . . 18

Pathways for Implementation . . . 19

Extending High Needs ACO REACH . . . 19

Incorporating into a New Innovation Center ACO Model . . . 19

Building into MSSP . . . 20

Conclusion and Next Steps . . . 20

Partner Organizations Contributing to this Publication . . . 21

Introduction

For years, organizations participating in Medicare's various alternative payment models—including the Medicare Shared Savings Program (MSSP), Pioneer ACO Model, Next Generation ACO Model, Programs of All-Inclusive Care for the Elderly (PACE), and Independence at Home (IAH)—have demonstrated the value of comprehensive, community-based care models tailored to the highest-need beneficiaries. Many of these models have been led by providers and organizations committed to managing care for patients with multiple chronic conditions, functional impairments, and significant social needs—patients who, while making up a relatively small percentage of the Medicare population, account for a disproportionate share of Medicare spending.

The High Needs ACO track, launched under the Global & Professional Direct Contracting Model during the first Trump Administration and continued under the ACO REACH Model, builds on this longstanding legacy. It was explicitly designed to focus on this high-cost, high-need population, drawing from lessons learned in IAH and other pioneering efforts. Roughly 10–15% of Medicare beneficiaries fall into this category, yet they drive 50–60% of total Medicare Parts A and B expenditures due to their complex health needs.

The High Needs ACO Model is already showing positive results: Financial results from 2023 show High Needs ACOs generating $143 million in gross savings and a 13.3% net savings rate, and the second model evaluation report showed gross savings of 3.5% and reduced emergency department visits and hospitalizations. At the same time, the model is reaching some of the most underserved, high need patients in the Medicare population: the average aligned beneficiary has 12 chronic conditions, and over two-thirds of those aligned are dually eligible for Medicare and Medicaid. By definition these patients are some of the sickest and most expensive in the Medicare program. While the High Needs track did not achieve *net* savings in the first evaluation report, we believe that the subsequent substantial growth in beneficiary alignment and policy changes adopted in 2025 are very likely to generate net savings in future years of the program.

The High Needs track, like the ACO REACH model broadly, is scheduled to end after 2026. Given the Administration's interest in helping prevent and treat chronic disease, and the promising early signals that the model is improving outcomes and reducing costs for high need patients, it is critical that CMS (a) consider how to maintain continuity across ACO models for organizations that serve complex patients and (b) plan for how to build successful policies and lessons learned from the High Needs track into future ACO models, which could include a High Needs track in MSSP.

In this paper, we identify key High Needs policies that are working well, plus new or enhanced policies that CMS should consider for a future High Needs model. These new policies are oriented around five key principles:

1. Driving competition through patient and caregiver choice, engagement, and transparency
2. Increasing access to chronic disease prevention and treatment
3. Improving benchmark stability and accuracy
4. Supporting rural communities
5. Deepening Medicare-Medicaid integration

Why Focus on Patients with Complex Illness and High Needs

To make meaningful improvements in cost, quality and access to care, CMS must continue to focus on patients with complex illness. Whereas many complex illness models focus on specific diagnoses, such as end-stage renal disease or cancer, the High Needs track recognizes that patients with "high needs" or advanced illness are heterogeneous in the clinical conditions they may have, but homogenous in their

overall clinical and social needs (which are significantly greater than the average Medicare beneficiary) and total per beneficiary medical spending (which is also significantly greater than the average Medicare beneficiary).[1] Building a definition of High Needs patients that is based around their functional status, clinical, and social needs rather than individual diagnoses supports the delivery of whole-person, person-centered care. The majority of complex patients with high needs are dually eligible for Medicare and Medicaid. Many suffer from cognitive impairment or dementia, and many others suffer from various disabilities. Finally, many of these patients rely on family caregivers for support, making flexibilities that support participant efforts to address caregiver burden and caregiver needs essential for the population. Altogether, these patient population characteristics mean that even small improvements in quality and cost outcomes for the population can have big impacts across the Medicare and Medicaid programs.

In addition, there are a class of providers – e.g., home-based primary care clinicians, palliative care and hospice clinicians, skilled nursing facility (SNF) clinicians, long-term care facilities and others – that specialize in caring for this population. These providers have focused on populations with complex illness and developed specialized models of care. While these models vary somewhat from provider to provider, they have many consistent characteristics, including interdisciplinary care teams, the ability to deliver care in the home and virtually, advance care planning, care management and coordination, greater patient and family engagement, assessment and support for social needs, and 24/7 access. They have developed these models to care for their patients better, even though existing Medicare payment policy is not designed with these patients or care models in mind. While ACOs have been innovating these care models since the advent of the MSSP and Pioneer ACO models, new payment models like the High Needs track in ACO REACH are a unique opportunity to significantly improve outcomes, lower total spending and make meaningful impacts on quality of life for the sickest and frailest beneficiaries in the Medicare and Medicaid programs.

Current High Needs Policies to Maintain

CMS and the High Needs Participants now have nearly four years of experience under the model. CMS should sustain the design elements in the existing High Needs track that are working well and enhance those that aren't. Some design factors that should be sustained in future complex care models include:

- **Benchmark alignment minimums** that make it possible for organizations with under 5,000 patients (the limit in the Medicare Shared Savings Program) to participate.
- **Concurrent risk adjustment**, which more accurately predicts costs for patients with complex illness as they rapidly decline.
- **Differentiated quality and patient experience measures** that are clinically appropriate for a population with complex illness and don't force clinicians to furnish wasteful or inappropriate services.
- **Primary care capitation** and **advanced payment options** that support continual reinvestments in new care models and resources for patients.
- **Multiple alignment opportunities** including signed voluntary alignment and a claims alignment algorithm that does not require a physician visit.
- **Multiple risk options** that enable varying levels of financial accountability and make it easier for new and smaller organizations to participate.
- **Robust and timely reporting and data sharing** across beneficiary alignment, provider participation, claims, compliance, quality, and financial data, among others.
- **Benefit enhancements** that remove obstacles to coordinated care, including the Part B cost sharing waiver and the three-day hospital stay Skilled Nursing Facility waiver.

[1] For ease of reference, we treat references in this paper to "complex," "complex needs", "advanced illness," and "high needs" patient populations as interchangeable unless otherwise specified.

Future Recommendations

In addition, CMS has the opportunity to implement model improvements that would promote important goals such as increasing access to prevention and treatment of chronic disease, increasing competition and patient choice, advancing rural health, and deepening Medicare-Medicaid integration. Recommended policies focus on five key areas of opportunity:

1. **Drive competition through patient and caregiver choice, engagement, and transparency:** CMS should build on successful policies related to voluntary alignment, benefit enhancements, and quality measurement to further empower patients and caregivers. Opportunities include greater flexibility around how and where ACOs can discuss voluntary alignment (including in the patient's home when the ACO provider is the patient's PCP and the home is the site of care), additional benefit enhancement options, and quality measure refinements that allow patients and caregivers to better compare and understand quality outcomes for high needs ACOs.

   Current benefit enhancements and payment waivers suffer from significant administrative burden and complexity. CMS has the opportunity to both reduce the burden of implementing existing benefit enhancements and considerably expand the types of enhancements available, to include incentives that reduce waste and really make patients and caregivers lives better – e.g., reducing cost sharing for Part D drugs, eliminating red tape around obtaining durable medical equipment, and providing a stipend for caregiver respite services. The global risk option minimizes CMS's exposure to risk from less burdensome incentive and waiver options and empowers ACOs to take full accountability for benefit enhancement decisions.

2. **Increase access to prevention and treatment of chronic disease:** Organizations that focus on patients with complex illness have unique care models (home capabilities, much smaller panel sizes, higher frequency of visits) that are designed to improve the management of their patients chronic diseases. CMS could increase the number of beneficiaries who are eligible for high needs care by giving ACOs the option to select high needs participation at the ACO level instead of the individual beneficiary level. Under this "no patient left behind" approach, an ACO that meets a minimum threshold of high needs patients could choose to treat all of its patients as high needs for the purposes of model participation. This would enable beneficiaries with severe chronic disease that don't technically meet the "high needs" clinical criteria to benefit from the same care model, help prevent their disease from deteriorating further and help prevent the onset of more chronic disease.

3. **Improve benchmark stability and accuracy:** CMS should return to exclusively, or at least primarily, using a MA-like regional rate book (modified for high needs) to establish accurate and stable benchmarks for High Needs ACOs. Historical expenditure-based benchmarks are a poor fit for high need ACOs because of the inherent instability in the high needs population. Historical expenditures can quickly become unrepresentative of current experience due to small changes in population, which result from relatively smaller panel sizes, concentration of costs, and high patient turnover tied to mortality. Greater accuracy and stability associated with regional benchmarks would enable the sustained participation of high performers that reduce cost and improve quality and satisfaction. This in turn would provide a dynamic, model-initiated pathway for successful organizations to scale and increase beneficiary access to the care they provide.

4. **Support rural communities:** Rural beneficiaries are less likely to have access to value-based care models than their urban and suburban counterparts. CMS could take a number of steps to increase the number of rural beneficiaries in the model, including CMS-led marketing to high need beneficiaries in rural areas, providing lists of rural beneficiaries who are disconnected from care to high needs ACOs, and revising the health equity benchmark adjustment to increase benchmarks for rural beneficiaries.

5. **Deepen Medicare-Medicaid integration:** The majority of high needs beneficiaries in the current model are dually eligible for Medicare and Medicaid. Many receive Medicaid-funded long-term services and supports (LTSS) to address cognitive and functional impairments. The lack of coordination and integration between Medicaid and Medicare is a long-recognized problem that leads to worse patient experience and worse outcomes. CMS could use several levers to promote greater integration and shared accountability between ACOs and Medicaid risk-bearing entities (including both states and managed care plans), with the goal of more seamless benefit coordination for dually eligible beneficiaries, up to and including full financial integration.

Implementation

There are multiple viable paths CMS could take to ensure continued support for patients with complex needs beyond 2026. From the perspective of providers, patients, and advocates serving this population, the specific model or track is far less important than ensuring the underlying policies remain in place.

CMS has several options for ensuring continuing of high needs policies beyond 2026. These include:

1. Extending the existing High Needs ACO REACH track,
2. Integrating key elements of the model into the Medicare Shared Savings Program (as it did with ACO Primary Care Flex), or
3. Developing a new Innovation Center model specifically tailored to high needs beneficiaries.

Providers caring for this population depend on certain model features—such as appropriate benchmarking, risk adjustment, enhanced benefit flexibilities, and tailored quality measures—to deliver effective, person-centered care. Without a continued policy home for these tools, providers will struggle to sustain the high-touch, longitudinal care that high needs patients require. We urge CMS to act decisively to preserve and build on these policies, regardless of the model chassis used to carry them forward.

Why Focus on the High Needs Population

➜ To make meaningful improvements in cost and quality, CMS must continue to focus on patients with complex illness and High Needs.

There are clear and significant differences between the general Medicare population and those with complex illness and high needs, and it is critical for CMS to treat them differently in model design and payment policy. While there is debate about what qualifies someone as “high needs,” the population generally includes patients with severe and debilitating illness, physical and/or cognitive or mental disabilities, and overall declining health status. The decline in these patients’ health status and their significant health needs render ‘traditional’ payment and care models inappropriate. Typically high needs patients:

- **Have a health status that is substantially different** from the general Medicare population and requires a level of clinical and care management that goes well beyond that of a typical Medicare beneficiary (e.g., high needs practitioners are seeing some patients once a week or more with lower intensity touches and contacts in between);

- **Rapidly decompensate** in a manner that is not fully accounted for in traditional prospective risk adjustment models; and
- **Are homebound, home-limited** or otherwise need care to be brought to them.

While the "high needs" population is definitionally smaller than the non-high needs population, it has an outsized impact on total fee-for-service spending. Recent estimates indicate that patients with high needs represent 10% of the traditional Medicare population but account for 44% of all traditional Medicare spending.[2]

CHART: PY 2022 Direct Contract Evaluation Findings

ACO Track	Percent Racial and Ethnic Minority	Percent Dually Eligible	Average Number of Chronic Conditions
Standard	19%	14%	5.9
High Needs	33%	68%	12.3

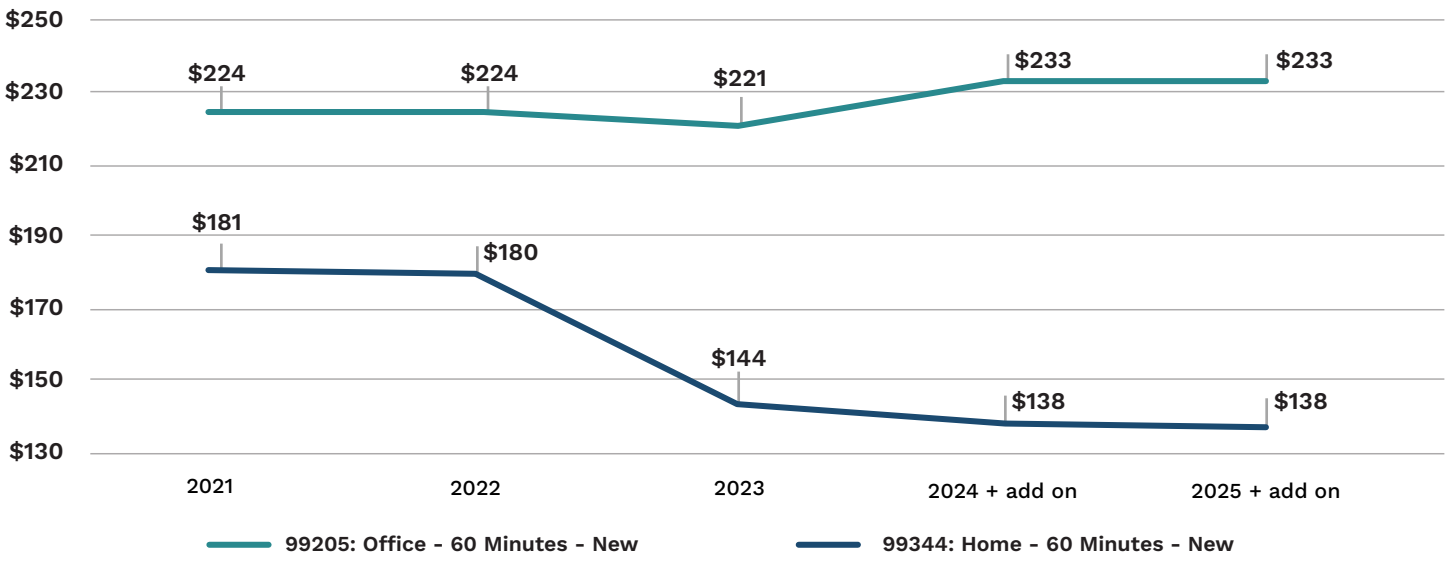
Given the unique needs of this population, there are a class of providers – e.g., home-based primary care clinicians, palliative care and hospice clinicians, skilled nursing facility (SNF) clinicians, long-term care facilities, group practices within MSSP ACOs that serve multiple care settings, and others – that specialize in caring for high needs patients. These providers have focused on populations with complex illness even though existing Medicare payment policy is not designed with these patients, and the care models needed to support them, in mind.

High needs care requires specialized expertise and models of care. While providers that care for average risk populations could develop high needs expertise and care models for the small subset of high needs patients in their population, they rarely have enough high needs patients to justify significant investment or to keep a dedicated high needs resource busy. Instead, high needs providers typically function as specialty providers that receive high needs patients from across a region. Specialized high needs care providers still tend to be smaller, because the subset of the population that they focus on is small and has intensive needs, resulting in smaller provider panel sizes. In addition, because of inadequate fee for service reimbursement, many providers rely on charitable donations or are operated at a loss by larger institutions that view them as a community service, leading to limits on the number of patients they can accept. Many, if not most, high needs care providers are not traditional office-based providers, but rather deliver care to where the beneficiary lives – for example, some organizations have specialized vehicles that are designed to bring some or all of the capabilities of primary care to the home. Because these providers specialize in care for high needs populations, and generally do not treat healthy, average risk individuals, the typical assumption that costs and risk "average out" across a provider's full patient population do not hold true.

High-quality, longitudinal care for high needs patients cannot be sustainable without value-based reimbursement models. Existing fee-for-service payment systems inadequately account for the care that is needed by high needs patients. For example, physician fee schedule rates for home-based evaluation and management services are grossly underpriced relative to office-based services, even though homebound patients are generally more complex.

[2] Lally, Tom, et al. "Prevalence of Independence at Home–Qualifying Beneficiaries in Traditional Medicare, 2014-2021." JAMA Network Open 7.7 (2024): e2421102-e2421102.

CHART: Comparison of Office E&M to Home-based E&M (2021 - 2025)



High needs care is purpose-built for value-based reimbursement models: It is significantly more resource intensive in the short term, but it pays for itself over the long run through better outcomes and avoided utilization. It also adequately compensates interdisciplinary-team-led care coordination and management in a way that FFS cannot. Independence at Home ("IAH") was a predecessor model that helped to refine our understanding of the necessary design features for a high needs value-based model. High Needs REACH is the first ACO-based longitudinal model for this population and drew lessons from IAH.

New payment models like the High Needs track in ACO REACH are a unique opportunity to significantly improve outcomes, lower total spending and make meaningful impacts on health equity for the sickest and frailest beneficiaries in the Medicare and Medicaid programs. And early results from the performance year ("PY") 2022 Direct Contracting Evaluation Report indicate very promising trends in utilization and reductions in total cost of care.

CHART: PY 2022 Direct Contract Evaluation Findings – High Needs Results

Metric	Measure	Impact
Total Gross Spending	Medicare Spending	3.5% reduction
Acute Care Spending	Medicare Spending	6.6% reduction
Outpatient Facility Spending	Medicare Spending	14.4% reduction
ED and Observation Stays	Utilization	5% reduction
Acute Care Hospitalizations	Utilization	6.1% reduction
Acute Care Lengths of Stay	Utilization	7.7% reduction

Current High Needs Policies to Maintain

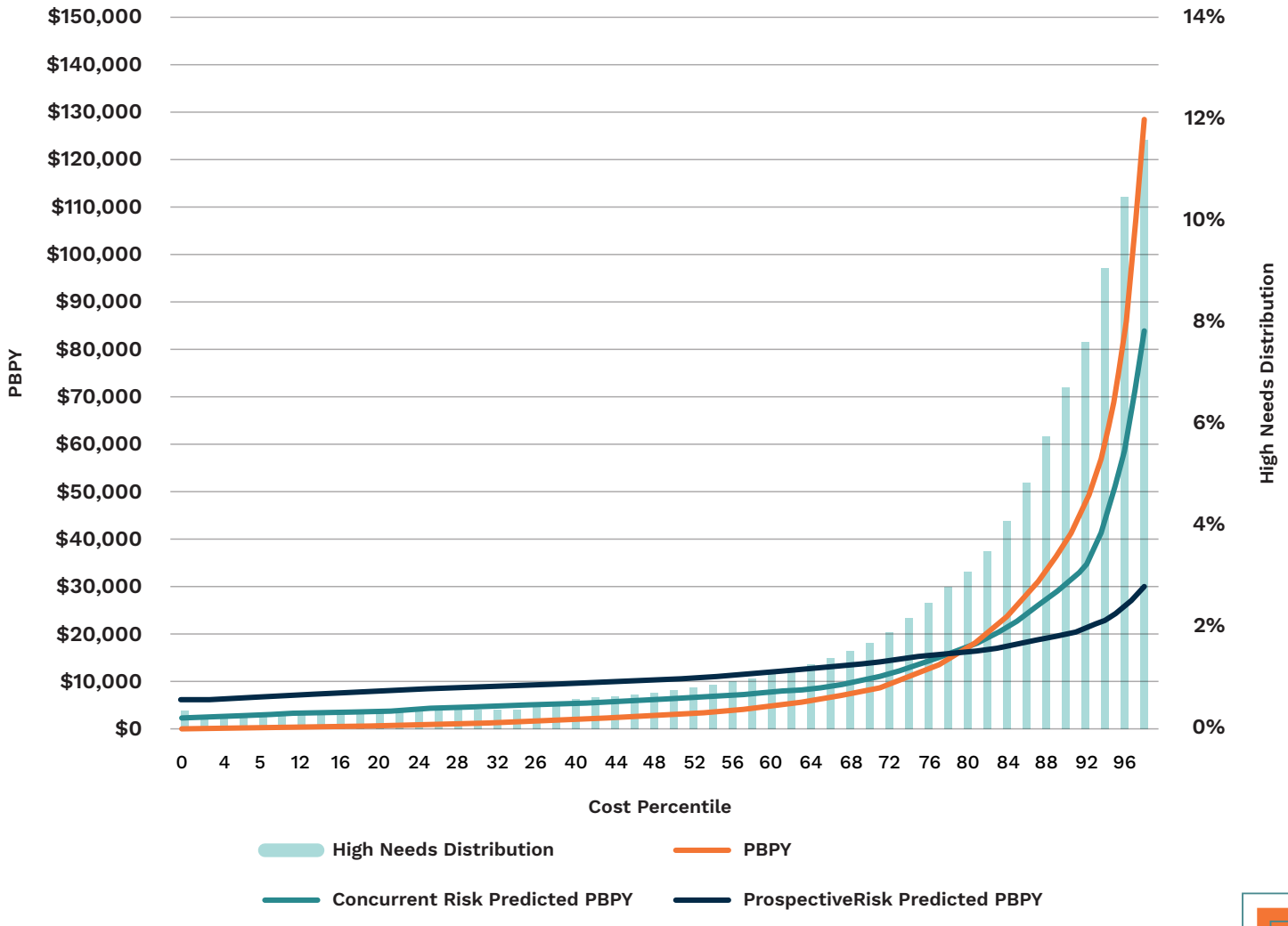
➜ CMS should sustain the model design factors that are working well.

The High Needs Track in ACO REACH was the first longitudinal, risk-based model for complex and seriously ill, high needs patients and was launched in 2021. We now have nearly four years of experience operating under the model and have learned what model design elements are working well. CMS should sustain these policies as it considers future opportunities for patients with complex illness.

Risk Adjustment

Patients with complex illness often decompensate rapidly. It is also well known that the prospective risk adjustment model used in Medicare Advantage, Standard, and New Entrant tracks in REACH and the Medicare Shared Savings Program (MSSP) underpredicts costs for people with complex illness, many of whom die before the ACO's payments can be adjusted to reflect the patient's declining health status. The concurrent risk adjustment model used in the High Needs track of ACO REACH is a much better predictor of costs for seriously ill patients because it adjusts payments to reflect the patient's health status during the performance year (versus waiting to adjust payments the following year as is done with prospective models). The concurrent model also shows less overprediction for the High Needs population along the patient population distribution as demonstrated in the following chart.

CHART: Fee-for-service Population: Concurrent and Prospective Risk Score by PBPY Cost Percentile



As shown in the chart, at the lowest cost percentiles, the concurrent risk adjustment method (orange line) overpredicts actual costs (blue line) less than the prospective risk adjustment method (grey line). At the highest cost percentiles, the concurrent method also underpredicts actual costs less than the prospective method. In other words, the concurrent method is more accurate at both ends of the cost distribution. (Note that points of overprediction at the lower cost end of distribution for the concurrent model are offset by points of underprediction at the higher cost end of the distribution where there is a greater concentration of High Needs beneficiaries – and that overall, the concurrent model tracks the curve of actual costs much better than the prospective model while still providing strong incentives for quality improving cost management).

It is critical for CMS to continue using the concurrent risk adjustment model for this population under all potential policy pathways, including if the Agency were to calculate the regional component of the benchmark separately for High Needs patients. Calculating separate regional rates for the high needs population and continued use of concurrent risk adjustment are mutually reinforcing policies that help ensure that the risk adjustment methodology is not overly dependent on any one component.

The ACO REACH model also includes a cap on an individual ACO's year-over-year risk score growth. CMS has appropriately recognized that high need beneficiaries have more highly variable cost and utilization, and therefore has instituted a higher risk score cap for high needs ACOs than standard ACOs (10% v. 3%). Any future efforts to address risk score growth should recognize and address this difference between high needs and standard patients. We continue to have concerns, however, that instituting a cap with a static reference year could disproportionately affect high needs providers, given the high variability in costs for high needs patients, rapid change in patient condition that often accompanies a patient's being cared for by a high needs provider, and the lack of primary care access that many patients experience before aligning to a high needs provider. We intend to further investigate this issue and provide additional analysis as it is consistent with the common recurring concern that historical experience is often not a representative indicator of current patient population characteristics for provider organizations focused on high needs.

Lower Beneficiary Alignment Minimums

Providers that specialize in care for high needs populations tend to be smaller than providers with an average risk patient population. In the High Needs track of ACO REACH, CMS addressed this fact by creating a beneficiary alignment "glide path" that allowed providers to begin their first year in the model with a minimum of 250 aligned beneficiaries. The beneficiary minimum increases over time, to 1,250 by the final year of the model, but always remains significantly below the 5,000 beneficiary minimum in the Standard track of ACO REACH. In any future High Needs ACO model or track, CMS should continue policies that allow High Needs providers to participate with lower beneficiary alignment minimums.

Differentiated Quality Measurement

It is important for CMS to use quality measures that are tailored to fit the complexity of the patient population and the care model. In the High Needs track of ACO REACH, CMS took a positive first step in this direction – High Needs ACOs are held accountable to the "Days at Home" measure, which is unique to the High Needs track (though for high needs patients residing in long-term care or other institutional settings, this measure could use some refinement). CMS also uses separate quality performance benchmarks (for measures and the CAHPS survey) and separate methods to calculate CAHPS survey results compared with Standard track ACOs. Measuring performance among similar kinds of organizations allows for fair and meaningful comparisons and should be maintained as CMS moves forward.

Primary Care Advanced Payment (Capitation) and Advanced Payment Options

In all tracks of ACO REACH, organizations can reduce their day-to-day claims-based fee-for-service payments in exchange for monthly primary care capitation payments of up to 7% of the risk-adjusted benchmark. This advance payment is important for cash flow purposes and enables high needs

organizations to invest in care management and coordination functions that otherwise would not be possible. The advanced payment option (APO) for non-primary care providers creates an additional opportunity for upfront investment. It also enables ACOs to create downstream reimbursement mechanisms for participant and preferred providers that are based on value and quality.

Alignment

All REACH ACOs can align beneficiaries through claims-based alignment, Medicare dot gov-based voluntary alignment and signed, attestation-based voluntary alignment (SVA). In particular, SVA has improved beneficiary choice, increased overall alignment to the model, and shortened the time for CMS to formally recognize that a beneficiary should be aligned to an ACO. Sustaining an SVA pathway in a future High Needs model or track is important, although we have critical concerns about the ability to discuss voluntary alignment in the beneficiary's home, which are discussed below.

Another important feature of ACO REACH alignment is that the claims-based algorithm does not require a physician service from an ACO physician. Given workforce shortages, the intensive visit frequency associated with high needs models of care, and the high opportunity cost of sending clinicians to patients' homes, many high needs providers rely heavily on advance practice nurses to deliver care. Maintaining a nurse-practitioner-led alignment option reflects the modern practice of medicine and reduces arbitrary barriers to patient alignment.

Multiple Risk Options

All REACH ACOs can select 'professional' or 'global' risk sharing options that enable organizations to choose the level of financial risk they want to take. These options, particularly those with less financial risk, are important for enabling organizations with less experience managing risk to participate.

Data Sharing

ACO REACH provides robust data reporting to participants and has experimented with delivering new types of data such as shadow bundles. We have greatly appreciated the quantity and types of data, the frequency of data, and the supporting guidance for understanding data reports that CMS has provided. CMS has clearly given careful consideration to the types of data that ACOs need to operate in the model, including weekly claims reduction files, SVA response files, and monthly beneficiary alignment files.

Model data sharing has also led to some clear accountable care success stories – ACOs have used this data to uncover a billion-dollar durable medical equipment fraud scheme, as well as waste and abuse related to skin substitute products that according to a recent Department of Justice case resulted in $900 million in unnecessary spending. These are both clear case studies in how organizations can be partners to CMS in rooting out fraudulent spending when they have both tools and accountability for total Medicare costs.

Future High Needs Policy Enhancements

➜ CMS should enhance the existing policies based on learnings from the High Needs track in ACO REACH and in the Medicare Shared Savings Program

These policy enhancements would improve care for patients with complex illness and high needs and further increase the opportunity to lower costs for the Medicare program.

Drive Competition Through Patient and Caregiver Choice, Engagement, and Transparency

CMS has tremendous opportunity to give ACOs new tools to engage patients, empower patients to dictate which providers should be accountable for their care, and deliver quality outcome data that allows patients to make true and accurate comparisons among providers. Putting more decisionmaking power in the hands of consumers, combined with enhanced beneficiary engagement tools and transparency around quality performance, will only increase the incentives for high needs providers to deliver high quality, patient centered care.

Alignment

Voluntary Alignment

SVA has proven to be a powerful tool for aligning high needs patients and growing the number of these patients in accountable care models. Timely alignment is especially important in a high needs model because patients often transition to a high needs provider in the last two to three years of life, when their care needs are more intensive.

CMS could further increase the impact of SVA by allowing monthly SVA. High Needs providers onboard new patients with urgent needs on a daily basis. Having to wait for quarterly SVA delays patient access to important ACO REACH benefit enhancements like Part B cost sharing and the 3-day SNF waiver. Now that CMS has multiple years of experience managing the SVA process, it should be feasible to move to monthly SVA.

Additionally, CMS should explore mechanisms that allow for coordinated transitions of beneficiary alignment between Standard and High Needs ACOs. In practice, many patients begin their care journey in traditional office-based settings but eventually require the more intensive, home-based or longitudinal care delivered by High Needs providers. However, if a patient is prospectively aligned to a Standard ACO—particularly under retrospective or prospective alignment mechanisms—there is currently no pathway for that accountability to transfer to the High Needs provider, even when the patient has clearly transitioned their care.

This misalignment can persist for up to a year or more, during which time the provider responsible for delivering the majority of care is not the one accountable under the ACO model. While such situations may represent a small share of the patient population for Standard ACOs, they represent a substantial proportion for High Needs ACOs. Enabling Standard and High Needs ACOs to partner on a structured protocol—such as through Shared Voluntary Alignment (SVA) updates or a provider-initiated transfer mechanism—would better reflect actual care patterns, honor patient choice, and ensure accountability resides with the provider best positioned to manage the patient's needs.

Finally, existing CMS marketing rules developed many years ago were designed to guard against door-to-door solicitation of beneficiaries. In ACO REACH, these rules have been misapplied to restrict home-based primary care providers from talking about High Needs ACO REACH signed voluntary alignment in the beneficiary's home, even though the beneficiary is home-bound, the provider has an existing (in many cases multi-year) relationship with the patient, and the home is the site of care. This CMS policy decision discriminates against home-based providers serving the high needs population (vs. traditional brick and mortar practices) and negatively impacts both beneficiaries (who can't receive the benefits of ACO REACH) and the size of the high needs population (because voluntary alignment is lower). It also conflicts with express policies that allow Medicare-enrolled providers and suppliers to obtain consent in the home to bill for certain professional services (e.g., chronic care management and the recently proposed advanced primary care services), and policies that encourage voluntary alignment in the home under the GUIDE model. To maintain beneficiary protections from unsolicited contact, CMS could limit signed voluntary alignment in the home to beneficiaries who are established patients of the ACO, with prior primary care services delivered by an ACO clinician.

Claims-based alignment

In MSSP, ACOs have the option to choose between two alignment methodologies: prospective alignment, and prospective alignment with retrospective reconciliation. In contrast, all REACH ACOs are subject to a prospective claims alignment methodology where beneficiaries are aligned at the beginning of the year based on the previous two years of claims history. While a full prospective methodology aims to protect against "lemon dropping" of beneficiaries with high spending during the performance year and to provide greater upfront certainty to ACOs, it has turned out to be a poor fit for the high needs population.

As discussed above, high needs patients typically transition from a traditional primary care provider to a high needs provider once their condition has worsened to the point that they need specialized support for complex care. The combination of the two-year claims alignment look-back period (which is further offset to the performance year) and a single, annual claims alignment opportunity can create a very large time lag between when this transition occurs, and when it is picked up by the claims alignment algorithm. Because patients typically transition to a high needs provider two to three years before end of life, by the time claims alignment catches up, many of these patients have died or are very near to end-of-life; on average, high needs ACOs experience a 20-30% annual mortality rate. Patients are also more likely to experience other transitions in the last two to three years of life that can lead to provider changes, such as moving into a long-term nursing facility or moving to be closer to family.

While signed voluntary alignment and prospective plus alignment can address some of these issues, they are not perfect solutions. Combining the signed voluntary alignment innovation with a prospective alignment with retrospective reconciliation methodology would significantly increase the accuracy and timeliness of ACO alignment for high needs participants. CMS has already recognized the need for methodologies that account for instability and rapid turnover in the high needs population with concurrent risk adjustment; prospective alignment with retrospective reconciliation operates on the same policy principle.

CMS could choose to make prospective alignment with retrospective reconciliation the only alignment option for high needs ACOs, or allow all ACOs to choose as they do in MSSP.

Benefit Enhancements and Payment Waivers

The current benefit enhancements and payment rule waivers in the ACO REACH model provide important tools for engaging patients, reducing barriers to necessary care, and delivering preventive services. However, many of these enhancements have complex and burdensome implementation requirements that limit uptake among model participants. CMS should streamline requirements for existing benefit enhancements to make them easier for ACOs to adopt. There are also additional benefit enhancement and waiver options that would significantly increase the tools available to ACOs for improving patient access to preventive care, preventing exacerbations of chronic conditions, and sharing the benefits of accountable care with aligned beneficiaries.

Allow ACOs to waive Part D cost sharing: Currently ACOs are not allowed to waive cost-sharing for Part D medications, even when (a) those medications are critical for managing an applicable chronic condition and (b) cost sharing for those medications may be prohibitively expensive. This creates disincentives for beneficiaries, especially those of lower socioeconomic status, to obtain and take their medications on time. We regularly hear from patients that struggle to afford the cost-sharing associated with their medications and that this is the biggest barrier to effective chronic disease management and patient compliance.

Reduce DME red tape: Beneficiaries with high needs, and in particularly those that are frail, disabled or otherwise have mobility concerns, tend to use durable medical equipment (DME) more frequently than beneficiaries without high needs. DME is often subject to local and national coverage determinations by the Medicare Administrative Contractors, which can (a) prevent beneficiaries from receiving needed DME, (b) lengthen the time it takes for them to receive DME, and or (c) increase administrative burden on providers

trying to obtain DME for their patients. Given the potential for fraud, these tradeoffs may make sense in a fee-for-service context when the government holds the risk for those payments. However, CMS should create a pathway for ACOs that are accountable for DME spending, that treat a high needs population, and want to bypass LCD and NCD requirements for DME for their aligned beneficiaries. If CMS is concerned about potential fraud, it could establish additional vetting and safeguards for DME vendors that would be eligible to participate in this option, although we are not sure this is needed given that the ACOs hold the financial risk.

Reduce or eliminate a beneficiary's Part B premium and annual deductible: ACOs could be given the same flexibility that Medicare Advantage plans have to reduce or eliminate a beneficiary's Part B premium or annual deductible. This option would allow beneficiaries to realize the direct financial benefits of accountable care and share in savings generated by ACOs, in the same way that Medicare Advantage beneficiaries can receive supplemental benefits when their MA plans submit regionally efficient bids. Currently, ACOs are at a disadvantage to MA plans because they cannot offer this benefit – Part B premium/deductible reductions are a major driver of the movement of beneficiaries from traditional Medicare to MA. Operationally, this benefit enhancement could be accomplished by allowing an ACO to repay the beneficiary or handled administratively by CMS.

Allow ACOs to provide caregiver benefits: Caregivers play an important role in care for many high needs beneficiaries. CMS could provide ACOs with additional tools to engage caregivers and reduce caregiver strain, which in turn can increase the amount of time that a beneficiary is able to remain at home instead of transitioning to a long term nursing facility. ACOs could have the option of providing family caregivers a monthly respite benefit, e.g. through a benefits card up to the monthly respite payment in GUIDE (~$210 / month).

Waive the 6-month prognosis for hospice eligibility: High needs beneficiaries generally transition to a high needs provider in the last two to three years of life. This means that high needs providers are directly upstream of hospice and take responsibility for facilitating the transition to hospice for the majority of their patients. Predicting the timing and trajectory of decline for frail elderly patients can be challenging, as reflected in a nationwide hospice live discharge rate of 18%. At the same time, CMS has heightened scrutiny of long hospice lengths of stay, which has increased the burden of documenting hospice appropriateness, made it harder for some patients to prove eligibility for hospice, and led to an increase in hospices discharging patients alive, which can be disruptive and traumatic for patients and their families. This is another example of a policy that may make sense in fee-for-service, but is unnecessary when a full risk ACO is willing to take accountability for the risk of increased hospice spend in exchange for greater flexibility to match services and supports with individual patient needs.

Quality Measurement

It is important that the high needs track uses a unique quality measure (Days at Home) and performance benchmarks that are designed to account for the clinical circumstances of patients with complex illness. MSSP, on the other hand, includes a set of general measures that may be appropriate for a general health system/ACO but are not purpose-built for organizations treating patients with high needs. In designing a future concept for High Needs beneficiaries, CMS should ensure they are using a measure set for high needs patients that is claims-based (e.g., not chart-review) and that measures what matters most for this population (typically, living at home for as long as possible and avoiding hospitalization and institutionalization). CMS should also continue to judge performance against like-to-like organizations. In MSSP, all ACO types are compared against each other, but in ACO REACH, High Needs ACOs are only benchmarked against other High Needs ACOs. Measuring organizations against other organizations that serve the same general patient population ensures that performance benchmarks and the impact that quality measurement outcomes have on ACO financial performance is credible.

In addition, if CMS wants to continue to use measures that are used for a broader population (e.g., risk-

standardized all cause readmissions) we would encourage CMS to calibrate the measure's risk-adjustment methods for a high-needs specific population. Our understanding is that these measures include risk-adjustment calculations that are calibrated on general Medicare populations which may not be appropriate and could inadvertently penalize organizations serving a high needs population that is home-bound or home limited and seriously ill.

Finally, CMS should explore alternatives to the CAHPS patient experience measure currently used in High Needs ACO REACH. The current survey is more than 60 questions long and asks patients to recall details about their encounters with healthcare providers over the previous 12 months. These characteristics make the survey inaccessible for many high needs beneficiaries, given the very high rates of cognitive impairment and dementia in the high needs population. CMS should experiment with a simplified measure that also allows for response by a caregiver, similar to the quality of life measure that is being piloted in the GUIDE model.

More Stable and Accurate Benchmarks

ACO benchmarks in the Medicare Shared Savings Program ("MSSP") and Standard track in REACH incorporate the ACOs' own historical performance at the start of the model (or agreement period in the case of an MSSP ACO). For High Needs participants, CMS recognized that patient populations would likely be too small and unstable to rely on a participant organization's own historical experience for benchmark purposes. As a result, the Innovation Center chose to use a risk-adjusted regional rate to establish benchmarks for high needs participants in the first four years of the model (2021-2024), which enabled organizations with smaller populations to join. However, beginning in 2025, CMS has moved to a methodology that places much greater weight on ACO's own historical performance.

While historical experience may be incorporated once a High Needs ACO reaches a reasonable patient population size such that historical expenditures are statistically credible, the regional component of the benchmark should account for at least half of the benchmark weight, and preferably more. And the contribution of the regional rate towards the resulting benchmark should not be subject to a ceiling (as it remains in PY25 under CMMI's most recent REACH ACO methodology changes). Because of High Needs practices' smaller patient panel sizes, the significantly higher mortality rates and patient turnover rates inherent to the high needs population, and the concentration of expenditures across a relatively small number of beneficiaries, changes in patient panel composition likely make historical expenditures unrepresentative of the ACO's future patient population. In the case of current High Needs REACH participants, PY 2025 populations may be larger and spread across many new geographies and provider groups relative to the population represented in the baseline years. Localized regional efficiency across a small number of counties and providers is likely not a reliable measure in terms of extrapolation into new regions of the United States.

We recognize that the recommendation to remove the ceiling on the regional blend may raise concerns about the risk of adverse selection–particularly given the recency of discussions over this issue and concerns raised in the PY 2022 GPDC Evaluation, especially with respect to Standard ACOs. As it concerns High Needs, however, we see things differently. Consistent with the discussion above, the relatively smaller patient panel sizes of high-needs-focused organizations, overall greater variability of high needs patient costs, and greater relative changes in year-to-year population mix make it harder to predict costs in a way that promotes selection. For High Needs, the greater risk is an overreliance on historical expenditures that quickly can become unrepresentative of a high needs organization's patient population. The consequence of such overreliance can be to discourage further expansion into underserved communities and foregone cost savings stemming from High Needs ACO model expansion that could have otherwise occurred. Such expansion could take the form of High Needs ACO growth, with new Participating Providers in new geographies, and/or service area expansion among high-needs-care-specialized organizations that are already participating in the model.

Assuming CMS' approach to benchmarking reflects our suggestions, CMS could consider as a guardrail whether to alter the savings corridors to create a more "tiered" approach to savings, with CMS capturing a larger share of the savings as ACOs increase actuarial savings. Today in ACO REACH, these corridors are relatively broad – for example under the Global risk option, ACOs are eligible for first dollar savings (after the 3% to 4% discount is applied) until savings hit 25% of the risk-adjusted benchmark (and are symmetrically 100% liable for any losses before this level).

Additionally, we believe that the regional component of the benchmark could be calibrated to better reflect the High Needs patient population. In the current High Needs track, the regional rates reflect county level expenditures for the average population in the county. Using regional rates or weights reflective of the High Needs population will take some pressure off risk adjustment, which under the current model is the sole mechanism for converting an average population benchmark to a High Needs benchmark. We intend to explore this further – including using actuarial analysis of our claims history in High Needs REACH ACO as well as available Medicare data sources – and will provide a more specific recommendation in a future policy memo to CMS. Similarly, we also plan to explore whether the retrospective trend adjustment ("RTA") is appropriately calibrated for the high needs population, as early analyses indicate that may not be the case.

Increase the Number of High Needs Patients who Can Access Proactive Chronic Care Management

To be eligible for the High Needs ACO track, patients must meet strict clinical eligibility criteria. On its face this requirement makes sense: patients with complex illness should meet a certain clinical threshold to be included in a "high needs" track. However, it also means that participants, even though they specialize in complex, high needs care, inevitably have some patients that do not qualify for the High Needs ACO program: not because these patients do not have significant health care needs and require the same intensive care model as the other patients, but because they don't meet the specific eligibility threshold. This "participation cliff" means that some patients, despite having significant clinical and social needs and receiving care from a High Needs ACO, are left behind, excluded and unable to benefit from the model and stuck in the traditional fee-for-service system. Despite being High Needs ACOs who care for only frail, seriously ill, mobility and cognitively impaired patients, our experience is that only roughly 30-50% of our Medicare patients meet the high needs criteria. This leaves a significant portion of our patients outside of the High Needs ACO. Secondarily, it also makes it more challenging to meet beneficiary alignment minimums.

We believe strongly that there needs to be a "no patient left behind" option available to ACOs, where providers serving patients with complex illness and high needs can opt to treat all of their patients the same, without concerns about accessing and managing different payment and risk arrangements. This approach would significantly increase the overall numbers of patients in accountable care relationships and help practices ensure they can provide all of their patients with the same access to clinical programs and supports made possible through these accountable care relationships. At the same time, greater beneficiary alignment generated by a "no patient left behind" approach could contribute to more stable benchmarks and greater statistical power for evaluations.

To operationalize this policy, we would propose defining a High Needs ACO as any ACO with at least a minimum percentage of aligned beneficiaries who meet clinical high needs eligibility criteria (e.g., 30-35% of their aligned patient population meets eligibility criteria). Such a concentration of high needs patients, who generally make up only 5-10% of the general Medicare population, is strongly indicative of a provider that specializes in caring for high needs patients.

Blending Populations and Risk Adjustment

The concurrent risk adjustment model is critical to accurately predicting the cost of patients with complex illness. To implement the "no patient left behind" policy, it may require CMS to consider how best to blend the "high needs" and "non-high needs" populations together. To achieve this goal, CMS could apply the

concurrent model to the High Needs ACO's entire aligned population, not just those who meet the clinical high needs eligibility criteria. Alternatively, CMS could apply the concurrent model only to the component of the aligned population meeting the High Needs criteria. Subject to further analysis, our recommendation is to apply the concurrent model to the entire population. Applying the concurrent model to both population segments would reflect the overall higher complexity of the patient population and capitalize on the fact that the concurrent model has been shown to produce both less overprediction and less underprediction than the traditional prospective CMS HCC model.

Alternatively, CMS could blend the concurrent model and the prospective model. For example, CMS could create a hybrid model that calculates both prospective and concurrent risk scores for each patient and then determines the weight of each risk score methodology while accounting for any interaction effects in the ACO's overall risk score based on the proportion of high needs beneficiaries in their aligned population. Conceptually, a potentially simple approach supported by precedent would be to create a separate "beneficiary status" for patients with "high needs," consistent with how patients with ESRD or those that are full-benefit dual eligibles are treated under the MSSP methodology and are risk adjusted using a different model than the one used for the aged non-duals standard type population.

Under any option, the point of blending would be to ensure that the model intentionally addresses any interaction effects associated with applying the concurrent model to the patient population meeting the High Needs criteria and the prospective model to those not meeting the criteria. The concept of blending is unnecessary if CMS applies the concurrent risk adjustment model to all beneficiaries.

Expansion of the High Needs Patient Criteria

In conjunction with the "Leave No Patient Behind" recommendation, where organizations would qualify for the high needs model or track, we also recommend broadening the High Needs eligibility criteria. Two main areas for consideration are an expanded definition of frailty, potentially using an open-source, claims-based frailty index; and the occurrence of a moderate to severe dementia diagnosis, using the same severity criteria developed for the GUIDE model.

Support Rural Communities

Historically, beneficiaries in rural communities have been less likely to be aligned to accountable care models than beneficiaries living in urban and suburban areas. Reasons for this include fewer accountable care participants in rural areas, the difficulty of providing economical high quality care in areas with low population density, and lack of awareness of accountable care initiatives. CMS could take several steps to promote greater uptake of a future High Needs track in rural communities.

Upfront investment opportunities targeted to high needs organizations: Under MSSP, smaller organizations and particularly those that serve disadvantaged populations can receive advance payments to support infrastructure. However, MSSP is designed in a way that make these unusable for small organizations serving high needs patients – for example, the 5,000 patient minimum threshold, the need for historical claims experience for benchmark setting purposes, and the prospective risk adjustment model that does not account for high needs populations, etc. Looking to the future, CMS could create similar options for advance payments that create an on-ramp towards more significant financial risk for smaller organizations focused on high needs populations.

CMS-led marketing targeted to rural areas: CMS could take action to proactively increase awareness of high needs ACOs among rural beneficiaries and their caregivers. CMS is already piloting marketing outreach activities in the GUIDE model by sending targeted mailings to Medicare beneficiaries with a dementia diagnosis informing them about available GUIDE programs in their market and how to get in touch. Similarly, CMS could send mailings to patients who meet the high needs eligibility criteria and are not already aligned to an accountable entity, informing them about high needs ACOs in their community and how they can get connected to high needs care.

GUIDE is also piloting sending lists of eligible beneficiaries with a dementia diagnosis to GUIDE participants, so that GUIDE participants can also engage in proactive outreach. CMS had proposed a similar approach under the Seriously Ill Population (SIP) component of Primary Care First, focused on patients who did not appear to have a consistent primary care provider, though it ultimately was not implemented. CMS could revive this strategy for high needs ACOs, identifying rural patients with high needs (and very high spending) who do not appear to be connected to a consistent source of primary care (e.g., no single primary care provider has delivered the majority of their primary care services in the prior 12 months) and allowing high needs ACOs to attempt to proactively engage them. Without proactive engagement (which is a common strategy among Medicare Advantage plans), many high needs patients, particularly in rural communities, may continue to fall through the cracks of the traditional medical system, failing to receive the high-quality, coordinated care that they need.

Revise the health equity benchmark adjustment (HEBA) formula to focus on rurality: In the current ACO REACH model, there is a health equity benchmark adjustment that can increase or a decrease an ACO's benchmark based on the proportion of its aligned population that is dual eligible, eligible for the low-income subsidy, or living in an area with a high Area Deprivation Index (ADI). The current HEBA is small and has not had a material impact on available resources to care for high needs patients. Numerous commenters have also documented issues with the Area Deprivation Index as a measure of health disparities.

Instead, CMS could consider replacing the ADI component of the HEBA with a measure of rurality. Low population density in rural areas is a significant barrier to providing the intensive, high touch, home-based model of care that high needs ACOs deploy. High needs ACOs struggle to achieve economies of scale in rural areas, where the distance between patients is significantly farther than urban and suburban areas. A larger HEBA-like adjustment that incorporates rurality would be a targeted way to address this significant barrier to delivering high needs care in rural communities.

Deepen Medicare-Medicaid Integration

Medicare-Medicaid integration is an important opportunity to improve care delivery for high-needs beneficiaries while reducing costs across both programs. The beneficiaries aligned to the high needs track are disproportionately likely to be dually eligible for Medicare and Medicaid—over two-thirds of aligned beneficiaries in the current high needs track are dual eligibles. This significant overlap creates both an imperative and an opportunity to better integrate these traditionally siloed programs.

Medicaid's coverage of long-term services and supports (LTSS) plays a vital role in enabling beneficiaries to maintain independence and age in place. While LTSS benefits vary by state, they typically include essential services such as personal care assistance, caregiver respite services, and home modification support. These services often prove crucial in helping beneficiaries continue living safely at home rather than requiring institutional care. However, the current fragmentation between Medicare and Medicaid services creates unnecessary barriers to coordinating this care effectively.

Several key policy changes could facilitate enhanced Medicare-Medicaid integration. First, CMS should consider creating a new partnership designation or broadening the definition of "preferred provider" to include entities that bear risk for LTSS spend (potentially including both states and Medicaid managed care plans). This partnership category would help establish clear parameters for data sharing, care coordination, and shared accountability between high needs ACOs and Medicaid risk-bearing entities. ACOs with a Medicaid partner could also have the option to take accountability for both Medicare and Medicaid spend. This integration better align incentives between Medicare and Medicaid risk-bearing entities: shared accountability would allow ACOs to benefit from Medicare-covered activities that generate Medicaid savings, and vice versa. Medicaid partnerships could also create a new alignment pathway—beneficiaries who are covered by a Medicaid risk-bearing entity that partners with a high needs ACO could automatically be aligned to that ACO.

Success in Medicare-Medicaid integration requires careful attention to state-specific variations in Medicaid benefits and existing care delivery systems. ACOs will need clear guidance on data sharing protocols, accountability frameworks, and mechanisms for coordinating with state Medicaid agencies and managed care organizations.

Pathways for Implementation

➜ CMS has multiple options for implementing a new opportunity for improving care for patients with complex conditions. We are agnostic to approach but offer considerations for CMS depending on the path.

CMS has several potential avenues for sustaining and advancing support for beneficiaries with complex needs. While the structural approach may vary, what is most important to the high needs community is not which specific model or track is used, but rather that the foundational policies designed to support high needs care remain in place and continue to evolve. We are not advocating for a single implementation path; instead, we emphasize the importance of maintaining a consistent policy framework that enables organizations to deliver effective, equitable care to complex patient populations.

Each of the following options could serve as a vehicle for continuing this work, provided that the core policy elements described earlier—such as appropriate benchmarking and risk adjustment methodologies, care delivery flexibility, and tailored program requirements—are preserved and adapted as needed.

Extending High Needs ACO REACH

We view the option to extend the existing High Needs model as a bridge to something more permanent rather than a long-term solution. Under an extension, CMS would focus on preserving the core model that is being tested while also having an opportunity to make improvements and increase the number of aligned beneficiaries without jeopardizing but rather strengthening the model evaluation. These changes could include refinements to the benchmark and a shift in policy to allow voluntary alignment in the home. This approach could give CMS additional time if more is needed to produce the full evaluation results prior to developing a new model or folding these concepts into MSSP.

Incorporating into a New Innovation Center ACO Model

Under this approach the CMS Innovation Center would develop a new standalone model test. We believe this approach is justified for several reasons:

- The High Needs track in ACO REACH is the first ACO model test for a high needs population and there are additional concepts (such as those described above) that could be explored to support a pathway to formal model expansion.
- The PY 2022 Direct Contracting Evaluation results included very promising outcomes for the High Needs Track, including reductions in gross spending and utilization across the board.
- The high needs population is responsible for a disproportionate share of health care costs and holds the greatest opportunity for better care and lower spending.
- Recently modified benchmark methodology changes for PY2025 are brand new and entirely untested in practice. It may be unwise to incorporate such policies into a statutory model, such as MSSP, prior to due diligence and model evaluation.

Building into MSSP

There are multiple reasons why many high needs organizations don't participate in MSSP. These include the 5,000 patient threshold, the lack of tailored clinical quality and patient experience measures, and the lack of risk adjustment and benchmarking methodologies that account for high needs patients.

CMS could use the Innovation Center's waiver authority to test a high needs "option" in MSSP similar to the exercise of CMMI's waiver authority to offer the ACO Primary Care Flex Model. Under this option organizations that care for high needs patients could participate in MSSP, select from the multiple risk tracks, but have a set of program expectations that are tailored for high needs organizations consistent with the elements discussed above. These would include:

- **Quality and EHR requirements** that reflect the health status of the population.
- **Lower participation threshold** so organizations with fewer than 5,000 traditional Medicare patients could participate.
- **Different benchmarking methodologies** that account for a smaller, less stable population with high mortality
- **Concurrent risk adjustment** to better reflect the rapid decompensation in health status that is common in the population.

As noted above, we believe one method of incorporating concurrent risk adjustment and a differentiated benchmarking methodology in MSSP would be to treat high needs patients as a new "beneficiary status" consistent with how beneficiaries are subdivided into four categories today: ESRD, aged dual, aged non dual, and disabled. Under this option, beneficiaries that met the high needs criteria would be in their own "high needs status", under which the concurrent risk model would be used to assign their risk score and benchmarks would be calculated and then aggregated up with the risk scores and benchmarks determined for the other statuses. We note that it would also be important to differentiate the risk score caps for these populations as well, continuing that policy from the High Needs track in ACO REACH.

Conclusion and Next Steps

As CMS considers the future of accountable care for patients with complex illness and high needs, it is essential to ensure continuity in the core policy features that enable providers to deliver effective, person-centered care. While CMS has several viable options for implementation—extending the current High Needs track in ACO REACH, integrating key policies into MSSP, or designing a new Innovation Center model—we are agnostic to the specific pathway. What matters most is that CMS sustains and strengthens the foundational policies that support this population.

These include:

- **Concurrent risk adjustment** that accounts for rapid health status changes;
- **Benchmarks that prioritize regional comparability and stability,** calibrated to the high needs population;
- **Lower beneficiary alignment thresholds** to support smaller, specialized providers;
- **Tailored quality measures and patient experience tools** appropriate for serious illness;
- **Flexibility in voluntary alignment**, including the ability to align patients in the home;
- **Benefit enhancements and waivers** that reduce care barriers and support caregivers;

- **Advanced payment and multiple risk options** to support practice transformation;
- **Robust and timely data sharing** to enable proactive care management;
- And **pathways for Medicare-Medicaid integration** to improve coordination for dually eligible individuals.

These policies reflect a model of care that is intensive, often home-based, and highly customized to the needs of a small but high-cost segment of the Medicare population. Importantly, they also create the infrastructure needed to support scaling of specialized high needs care—something that traditional fee-for-service payment structures cannot sustain.

In an era of rapid population aging and rising healthcare spending, expanding access to specialized, community-based care for patients with complex needs must be a strategic priority. The High Needs track in ACO REACH has demonstrated that, with the right tools and incentives, these models can scale—allowing high needs providers to reach more patients and expand into new communities. CMS should consider model scalability and access expansion as core metrics of success in any future model design and evaluation.

We appreciate the opportunity to share these recommendations and look forward to ongoing dialogue with CMS as it develops the next generation of high needs care and payment models. With the right policy infrastructure, CMS can continue to drive meaningful progress on access, quality, and total cost of care for Medicare's most vulnerable beneficiaries.

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