PREMIER TRANSFORMING HEALTHCARE TOGETHER®

September 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1770–P
Submitted electronically to: http://www.regulations.gov

Re: Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts

Dear Administrator Brooks-LaSure:

On behalf of the Premier healthcare alliance serving approximately 4,400 hospitals and health systems and approximately 250,000 Continuum of Care and other providers, we appreciate the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) CY 2023 Physician Fee Schedule (PFS). Premier maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our hospitals and health systems, their employed physicians and independent physicians aligned with them. Premier runs the largest population health collaborative in the country, the Population Health Management Collaborative, which has worked with well over 200 accountable care organizations (ACOs) and is currently comprised of more than 70 ACOs.

In the CY 2023 PFS, CMS proposes several notable changes to the Medicare Shared Savings Program (MSSP), as well as to the Quality Payment Program (QPP) and physician payments, generally**. As discussed in greater detail below, Premier:**

- **Applauds CMS for taking action to improve the sustainability of the MSSP and to attract new ACO participants**, including providing additional options for risk, modifications to its benchmarking and risk adjustment methodologies, offering new opportunities for upfront investments, and establishing alternatives for achieving shared savings. We provide several recommendations on how CMS can further improve on these policies, including eliminating the high-low revenue distinction and providing a more gradual transition to new MSSP quality reporting requirements.

- **Urges CMS to work with Congress to adopt broader telehealth reforms and recommends that CMS expand telehealth flexibilities in alternative payment models (APMs).**

- **Supports CMS' continued commitment to advancing behavioral health and its proposals aimed at improving access, quality and equity of these services for Medicare beneficiaries.**

- **Encourages CMS to work with Congress to extend the expiring Advanced APM Incentive Payments.**

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Healthcare providers continue to face significant financial pressures during these unprecedented times. Additionally, providers face several looming payment cuts, including expiration of the 3 percent increase in physician payments in 2022, as well as the potential for an additional 4 percent sequester because of statutory PAYGO. Additionally, as discussed in greater detail below, the 5 percent Advanced APM Incentive Payment is set to expire with the 2022 performance period if Congress does not act. As CMS looks to finalize these proposals, **we strongly urge them to prioritize policies that reduce burden and costs for providers.** CMS should also aim to craft policies that support tech-enabled healthcare, which will ultimately reduce burden for both providers and CMS.

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

As part of the CY 2023 PFS rule, CMS proposes several policy changes to the Medicare Shared Savings Program (MSSP) which are aimed at attracting new ACO participants, sustaining participation of existing ACOs, and advancing health equity. We applaud CMS for taking action to not only support growth in the MSSP but also to address several well-known issues in the program that have made it challenging for ACOs to continue participation. As addressed in more detail below, Premier:

- Supports CMS' proposals to smooth the transition to two-sided risk by giving ACOs additional time in one-sided risk tracks and allowing all ACOs to remain at BASIC Level E;
- Strongly urges CMS to eliminate the high-low revenue distinction across all MSSP policies;
- Recommends key revisions to CMS' proposal for Advanced Investment Payment, including expanding eligibility to ensure safety net providers are included and to maximize efforts to advance health equity;
- Strongly urges CMS to establish a more adequate transition to new electronic clinical quality measures (eCQMs) / Merit-based Incentive Payment System (MIPS) CQM reporting requirements, including ensuring requirements are consistent with CMS' digital quality measurement strategy and piloting requirements prior to broad adoption;
- Recommends CMS revise eligibility for its proposed health equity adjustment and reconsider its design to incentivize social determinants of heath (SDOH) data collection;
- Supports CMS' broader goals of adopting an administratively-set benchmark, but strongly urges CMS to work with stakeholders to refine methodologies before broader adoption, including evaluating impacts of the pandemic on healthcare utilization and trends; and
- Supports proposed changes to risk adjustment methodology, but continues to urge CMS to increase the risk score caps to 5 percent and apply a symmetrical cap on decrease in risk scores.

We address these and other policies in more detail in our comments below.

Smoothing the Transition to Performance-Based Risk in ACOs

In 2018, CMS redesigned the participation options under MSSP to more rapidly transition to two-sided risk. Under these changes, eligible ACOs could begin under a one-sided risk track for two years (BASIC track Levels A and B) and would advance to a two-sided track that included incrementally higher levels of risk and reward (Levels C, D, and E) during the remaining three years of the ACO's first agreement period. CMS limited an ACO's ability to participate in the BASIC track, requiring all ACOs to eventually transition to participation in the ENHANCED track of the program.

CMS did allow for greater flexibility for certain ACOs depending on whether they were considered high- or low-revenue. Specifically, high revenue ACOs are limited to a single agreement period under the BASIC track prior to transitioning to participation under the ENHANCED track, while low-revenue ACOs are generally limited to two agreement periods under the BASIC track.

Last fall, CMS rolled out its Innovation Center strategy refresh which set CMS' strategic objectives for advancing health system transformation and achieving equitable outcomes through high-quality, person-centered care. One of CMS' primary goals is to get all Medicare fee-for-service (FFS) beneficiaries into a care relationship that is accountable for quality and total cost of care by 2030.

To support these goals, CMS now believes it would be more prudent to provide ACOs greater flexibility to join the program under one-sided risk and remain in the program under lower levels of performance-based risk. Specifically, CMS proposes to allow ACOs more time under a one-sided risk level and more flexibility in transitioning to higher levels of risk and potential reward by modifying the participation options available under the MSSP. Under CMS' proposed transition policy:

- Currently participating ACOs, or ACOs that begin an agreement period in CY 2023 at Level A or Level B, may elect to maintain their participation at Level A or Level B for the remainder of their current agreement period.
- Inexperienced ACOs that are beginning their first agreement period on or after Jan. 1, 2024 at Level A may elect to remain in Level A for all subsequent performance years of the agreement period.
- ACOs that elect to remain in Level A or B for the entirety of their first agreement period would be eligible to enter into subsequent agreement periods (on or after Jan. 1, 2024) under the BASIC track glide path, allowing for up to seven years under one-sided risk over the course of two agreement periods.
- The ENHANCED track would be optional for all ACOs, regardless of experience or revenue status.

We support CMS' proposal to smooth the transition to two-sided risk for all ACOs. As CMS states in the rule, this policy will provide ACOs with additional options for participation – both encouraging more ACOs to join the MSSP, while increasing the potential that ACOs remain in the program.

We also applaud CMS for not limiting this policy based on whether an ACO is high- or low-revenue. As CMS notes, considering whether an ACO is high- or low-revenue may disincentivize certain providers from forming ACOs or joining existing ACOs. Relatedly, as we discuss in greater detail below, **we strongly recommend that CMS eliminate the high-low revenue distinction.**

Finally, as noted below, we continue to recommend that CMS utilize MSSP as an innovation platform. As part of this, CMS should establish a track that would allow ACOs to elect full risk, allowing participants the option to be eligible for 100 percent shared savings and losses, similar to the Next Generation ACO (NGACO) model and the ACO REACH model full-risk track.

Eliminate High-Low Revenue Distinction

Under *Pathways to Success*, CMS began distinguishing between high- and low-revenue ACOs as a means of differentiating ACOs by type of provider (e.g., hospital-led vs. physician-led ACOs). This policy is built on the dual-premise that: 1) physician-owned ACOs (low-revenue) perform better than hospital-led (high-revenue) ones and 2) that low-revenue ACOs have less ability to control expenditures for beneficiaries.

CMS has continued to state its belief that low-revenue ACOs outperform high-revenue ACOs, noting in the proposed rule that low-revenue ACOs have historically had better financial performance than high-revenue ACOs. However, a recent Premier analysis found that differences between high-revenue and low-revenue ACOs may be driven by other factors beyond ACO composition. Findings include:

- **Low-revenue ACOs have more flexibility in selecting providers in certain locations, meaning they may be better able to reduce spending and achieve savings targets.** Our analysis found that high- and low-revenue ACOs operate in distinctly different geographies, with high-revenue ACOs providing care to more beneficiaries and operating in more diverse areas. This suggests that high-revenue ACOs (i.e., hospital-led) may have less flexibility to select providers who are operating in more favorable areas.
- **High-revenue ACOs serve higher cost beneficiaries attributed through specialists.** Our analysis found that high-revenue ACOs receive a significantly higher proportion of attributed lives through specialist attribution. Even after accounting for risk, beneficiaries that are attributed through specialists appear to have higher costs than others in a given region when compared to beneficiaries that are attributed through primary care providers.
- **No significant differences in performance could be found once adjustments accounted for differences in attribution and geography.** Prior to accounting for risk and geographic normalization, our analysis found that low-revenue ACOs appear to outperform high-revenue ACOs by 3-4 percent, similar to CMS' findings. However, once applying a more refined comparison of the regional efficiency of high- and low-revenue ACOs, we found that difference in performance shrinks to 1-2 percent. Furthermore, after controlling for ACO churn by including only ACOs that have participated for three or more years, we found there is no significant difference between high- versus low-revenue ACO performance.

These findings demonstrate that other factors outside an ACO's control, such as geographic location or attribution, are more significant factors that explain differences in ACO financial performance. Continuing to distinguish ACO participants as high- versus low-revenue creates an unlevel playing field that disadvantages hospital-led ACOs relative to their physician-led counterparts.

The high-low revenue distinction was initially adopted as part of CMS' larger package of proposals aimed at moving ACOs more quickly to risk. As noted above, CMS is now focused on increasing and broadening participation. While we applaud CMS for not distinguishing between high- and low-revenue ACOs as part of its risk progression proposal, we are concerned that CMS continues to state its belief that low-revenue ACOs outperform high-revenue ACOs and has put forward policies that would continue this distinction.

Premier continues to strongly urge CMS to eliminate the high-low revenue distinction in MSSP, which is flawed and creates market distortions by advantaging one provider type over another. In fall 2021, CMS set a goal of moving all Medicare beneficiaries into an accountable care relationship by 2030. To achieve this goal, CMS will need to craft ACO policies that do not limit provider participation and encourage ACOs to enter into less attractive markets. The best way to drive high-quality care for patients is to create incentives that drive all providers to collaborate and innovate to deliver high-quality, cost-effective healthcare. Unfortunately, the high-low revenue distinction has discouraged partnership with certain types of providers, such as hospitals and specialists. Eliminating the high-low revenue distinction will ensure that high performers are encouraged to participate in models regardless of provider type and will allow providers to more effectively collaborate in ways that best meet the needs of their population.

Increasing Participation in Accountable Care Models in Underserved Communities by Providing an Option for Advance Investment Payments to Certain ACOs

CMS proposes to allow certain new ACOs to receive upfront shared savings, known as Advanced Investment Payments (AIPs). This funding is intended to assist ACOs in covering the upfront investment costs related to ACO participation. This proposal builds on upfront payments that CMS had previously tested through two Innovation Center models: 1) the Advance Payment (AP) ACO Model, which operated from 2012 to 2015, and 2) the ACO Investment Model (AIM), which operated from 2015 to 2018. Both models operated by prepaying shared savings to ACOs and later recouping those amounts from earned shared savings.

AIP Eligibility. CMS proposes to limit eligibility for AIP funding to new ACOs and ACOs inexperienced with performance-based risk Medicare ACO initiatives. Additionally, ACOs would need to be "low-revenue" as defined as having less than 35 percent of its Medicare A and B FFS revenue through assigned beneficiaries. We support CMS' decision to not limit this opportunity to rural areas or areas with low ACO penetration, as with the prior two models. However, **we are concerned that CMS' proposal is too restrictive and may not achieve CMS' stated goal of reaching providers and suppliers who serve underserved beneficiaries**.

By limiting eligibility to only low-revenue ACOs, many rural providers – including Critical Access Hospitals (CAHs) – which would benefit from this new upfront investment would not qualify as they are often considered high-revenue ACOs. Additionally, as noted in greater detail below and supported by a recent Premier analysis, **Premier continues to strongly urge CMS to eliminate the arbitrary high-low revenue distinction, which is not a true metric of ACOs' performance**. Our analysis found that after accounting for differences in geographic location and beneficiary attribution, there was no significant difference in high-low revenue ACO performance – suggesting that other factors may be driving any differences in financial performance.[1] As a result, **Premier strongly recommends that CMS remove the requirement that ACOs be low revenue to be eligible for the AIP.**

Additionally, consistent with CMS' broader goals of advancing health equity, **CMS should expand eligibility for the AIP to all ACOs to support investments in health equity initiatives**. While many ACOs are interested in developing initiatives to address social determinants of health (SDOH) and to advance health equity, some have struggled to secure the necessary investments to stand up the programs or infrastructure to support these efforts. One of the investment categories for the AIP is to provide care for underserved beneficiaries, including addressing SDOH. Expanding AIP eligibility for all ACOs would be an opportunity for CMS to invest in and support providers in advancing the Administration's health equity goals and would pose limited risk to the Medicare Trust Funds, as AIPs are generally recouped fully from shared savings, while benefiting many more Medicare beneficiaries than the current CMS proposal.

Finally, CMS proposes that the AIP would be available for ACOs that apply to be a part of the MSSP beginning in CY 2024. We are concerned that this may discourage some ACOs from starting their agreement periods in CY 2023. As a result, **we urge CMS to allow ACOs that start in 2023 to apply for the AIP through a special application process,** allowing them to be eligible to receive funding beginning in 2024.

AIP Payment methodology. Under CMS' proposal, eligible ACOs would receive a one-time fixed payment of $250,000 and eight quarterly payments that would vary based on the number of assigned beneficiaries (up to 10,000 beneficiaries) that are either dual eligible or live in an underserved area defined by the Area

[1] [Add link to Premier article]

Deprivation Index (ADI). Quarterly payments per beneficiary would range from $0 to $45, depending on the beneficiary's risk-based score.

CMS also seeks comment on whether it should set quarterly payments at the start of each performance year and not vary them by quarter based on aligned beneficiaries, acknowledging that some ACOs may prefer to have a stable quarterly payment throughout the year that they will know in advance. For other ACOs, an updated quarterly payment may be preferable, especially if the ACO is actively expanding its beneficiary population to include more underserved beneficiaries. Given ACOs will have varying preferences on this policy, we recommend that CMS give ACOs the option to opt into CMS' alternative of setting a fixed quarterly payment at the start of the performance year based on aligned beneficiaries at that time. This approach will allow ACOs to make the decision that best meets the needs of their organization.

Additionally, CMS proposes to set a beneficiary's risk score based on whether they are dual eligible (100 points) or based on the ADI for the census block group where the beneficiary lives (0-100 points based on the ADI national percentile). The ADI is a metric of how disadvantaged a given location may be relative to other locations and does not capture an individual beneficiary's social needs. As a result, a beneficiary could be considered disadvantaged compared to others located in his or her state or surrounding community but may score lower based on a national comparison. As discussed in more detail below, we are also concerned that existing ADI mapping tools (available through Neighborhood Atlas®) are limited and only allow users to look up addresses one at a time. Licensing restrictions would prevent ACOs from partnering with other entities who could assist them in developing more sophisticated tools to allow them to identify their beneficiaries' ADI scores more readily. Given ongoing labor shortages in the healthcare sector, these types of partnerships are more important than ever and will help alleviate provider burden, while allowing providers to focus their time on patient care. Additionally, CMS should aim to adopt policies that support tech-enabled solutions that reduce burden on providers.

Recoupment. CMS proposes to recoup AIP from any shared savings earned by the ACO. Under this proposal, an ACO would not be eligible to receive any shared savings until CMS had recouped the AIP in its entirety. If an ACO does not achieve shared savings during its agreement period or subsequent agreement periods, CMS would not recoup the AIP. However, if the ACO terminates its participation agreement during the agreement period, an ACO would be required to repay all AIPs it received.

We support CMS' proposal to not recoup AIP amounts above the amount of shared savings that the ACO receives during the current or subsequent agreement periods. However, we are concerned that as currently proposed, an ACO would not receive any shared savings until they have fully repaid the AIPs. Many ACOs utilize shared savings to support care coordination and other services that are critical to the operation of the ACO but are not paid for under Medicare. This proposal sets up a scenario whereby an ACO may not receive shared savings for multiple years, which may make it difficult for them to continue certain activities initially funded by AIP payments. As a result, we recommend that CMS revise this proposal to allow ACOs the option for CMS to recoup up to 50 percent of shared savings in a performance period until which time CMS has fully recouped the AIP. If an ACO selects this option and does not fully repay the AIP by the end of the agreement period (and does not move forward with another agreement period), CMS could recoup any outstanding AIP balance up to the amount of shared savings earned over the agreement period.

Amended ACO Quality Reporting and Quality Standard

Over the last couple of years, CMS has finalized several fundamental changes to the MSSP quality performance standard, including sunsetting the Web Interface reporting mechanism in performance year (PY) 2025 and requiring ACOs to report eCQMs or MIPS CQMs. To further incentivize ACOs to transition

to the new reporting requirements prior to 2025, CMS adopted a policy as part of last year's rulemaking that allows an ACO to meet the existing quality performance standard in PY 2023 by:

- Reporting 3 APP eCQMs/MIPS CQMs, meeting completeness and case minimum requirements for each;
- Scoring at or above the 10th percentile on one or more APP outcome measures; and
- Scoring at or above the 30th percentile on one or more of the remaining APP measures.

As part of this year's rule, CMS proposes to extend this incentive through PY 2024. Because the quality performance threshold increases from the 30th to the 40th percentile in PY 2024, under this proposal ACOs would need to score at or above the 40th percentile on one more of the remaining APP measures.

While we have long advocated for allowing ACOs to report measures through reporting mechanisms other than the Web Interface and reducing the number of required measures, Premier has continued to voice concern that this new APP eCQM / MIPS CQM reporting policy places significant burden on providers, especially during a time when they are still actively responding to the COVID-19 pandemic and other cost pressures.

Premier appreciates that CMS has responded to stakeholder concerns by delaying the requirements until CY 2025, but we remain significantly concerned about the readiness of the MSSP ACO community to meet this transition timeline. Therefore, we continue **to recommend that CMS ensure a more gradual transition to these new requirements and continue to collect more data and stakeholder feedback prior to sunsetting the CMS Web Interface and requiring reporting of eCQMs / MIPS CQMs.**

We offer the following recommendations for improving the ACO quality reporting standard:

- **Consider the current limitations of EHRs and burden associated with eCQM reporting;**
- **Recognize ACOs are fundamentally different than clinician and groups;**
- **Consider the unintended consequences of quality policies; and**
- **Digital quality measurement is the goal, but an adequate transition is needed**

We have provided additional information on each of these recommendations below.

Consider the current limitations of EHRs and burden associated with eCQM reporting

In order to report eCQMs, ACOs will be required to aggregate data across multiple tax identification numbers (TINs) and EHR systems. It is critically important to understand that **ACOs vary widely in their electronic data extraction and aggregation capabilities.** Some ACOs have a single EHR that covers the entire organization, but more commonly ACOs have multiple different EHR instances across the organization – in some cases, numbering well over 100 different EHR instances. For ACOs with multiple EHRs, producing eCQMs from those disparate systems requires time, money and effort in changing workflows and acquiring new technology services.

Additionally, **certified EHR technology (CEHRT) standards have not advanced enough to support quality measurement derived from multiple sources.** The interoperability standards aim to ease data sharing across providers; however, these standards are still under development and evolving. As a result, aspects of the ACO quality policies are not feasible in current systems. For example, CEHRT only allows for reporting eCQMs from a single EHR. As a result, combining data from multiple EHRs to produce a single result is not a capability that most ACOs have. Similarly, CMS requires that ACOs submit

deduplicated patient data. However, at this time there is no technical way to deduplicate data when submitting aggregated QRDA III files, since these files do not have patient-level data. Several vendors have indicated that modifications to their EHR systems to support revised MSSP quality reporting requirements will not be available until 2024 at the earliest.

In addition to burden, modifying systems to support or enable eCQM reporting can be a very expensive endeavor for ACOs. According to a 2021 survey by the National Association of Accountable Care Organizations (NAACOS), nearly three-quarters of respondents estimated that the necessary upgrades and operational changes to support eCQM or MIPS CQM quality measurement would cost at least $100,000 – with 14 percent of ACOs estimating costs of more than $1 million. These changes come at a time when providers are facing several looming payment cuts, including expiration of the 3 percent increase in physician payments in 2022, as well as the potential for an additional 4 percent sequester as a result of statutory PAYGO. Additionally, without Congressional action, the 5 percent Advanced APM Incentive Payment, which is available to many ACO clinicians, is set to expire with the 2022 performance period (for 2024 payment year). Given the costs associated with the transition to eCQM reporting and looming payment cuts, some providers and ACOs are considering leaving the MSSP all together.

Recognize ACOs are fundamentally different than clinician and groups

The new reporting requirements will also essentially align the MSSP quality standard with MIPS. This is a fundamentally flawed approach. ACOs reflect coordination of care across the continuum, as compared to MIPS, which reflect point-in-time encounters by individual clinicians and groups. ACOs are a network of aligned providers rather than a specific provider type. While we generally support alignment across CMS programs, the current policies set MIPS as the gold standard, with APMs as the entity that must align with MIPS. This is antithetical to the goal of moving clinicians from volume to value. Rather, **we should create the ideal measurement approach for APMs and align setting- and provider- specific measurement approaches so that providers are encouraged to move to APMs.**

Another significant change to the reporting requirements is that CMS will now require ACOs to report on all patients who meet the measure specifications, rather than just Medicare beneficiaries aligned to the ACO. We understand CMS' intent is to assess the quality of care across all patients and all payers, similar to the approach CMS uses in other quality reporting programs. All-payer measurement is ideal for setting provider-specific measurement as you are holding providers accountable for their entire patient population. ACOs are held accountable for cost for a defined patient population by partnering with providers to innovate and coordinate care. ACOs themselves do not directly provide care. Moreover, the ACO entity does not have the ability or flexibilities to design care interventions for other payers' patients. Requiring ACOs to report on the all-payer population of its participant providers is comparable to requiring a health plan to report on other payers' populations.

Under the new APP-based quality performance standard, ACOs must achieve at least the 30th percentile across all MIPS Quality performance category scores in order to be eligible for shared savings. This threshold increases to the 40th percentile in PY 2024. We believe ACOs will be unfairly disadvantaged when compared against the MIPS quality performance scores. Since MIPS participants can select which measures they report, participants are incentivized to choose measures on which they have historically and are currently performing well. As a result, the MIPS overall quality score tends to skew high, even if individual measures do not.

Currently, CMS publishes the quality measure benchmarks that ACOs must achieve in advance of the upcoming performance year. This information is valuable in informing ACOs' quality improvement activities and helps identify the performance standard they seek to attain. CMS has continued to indicate that it

cannot set benchmarks in advance under the new requirements since they are based on MIPS data for the current performance year. To help mitigate these concerns, as part of last year's rulemaking CMS began providing historical data for the relevant score percentiles to guide ACOs when comparing their anticipated quality scores to the percentiles required for earning shared savings. Since then, CMS has discovered that the historical reference values published during CY 2022 rulemaking were erroneously determined using a weighted rather than unweighted distribution of MIPS Quality performance category scores. As a result, the updated percentiles vary significantly from what was reported last year. **We continue to strongly urge CMS to be more transparent by providing additional information on the methodology and results of this analysis.** As noted in more detail below, errors, such as the one highlighted in the rule, could have significant impacts on ACOs' shared savings, especially in light of CMS' proposal to re-open financial determinations when MIPS errors are discovered.

Consider the unintended consequences of quality policies

Last fall, CMS set a goal of getting all fee-for-service Medicare beneficiaries into a care relationship that is accountable for quality and total cost of care by 2030. As noted elsewhere in our comment letter, CMS is adopting several policies that are aimed at encouraging new providers and ACOs to join MSSP, which will ultimately help CMS achieve its goal.

Given the challenges associated with the new APP-based quality reporting requirements, some ACOs are considering narrowing their participants list, which would ultimately hinder CMS' ability to align all beneficiaries with ACOs. For example, the move to all-payer data quality measurement will now include the total population of patients seen by all providers affiliated with the ACO, including specialists. All-payer measurement could significantly impact ACO performance on certain measures where historically certain ACO clinicians have not performed these assessments or measurements because they are not relevant to or reflective of the clinical care the clinician is furnishing. For example, most orthopedists or ophthalmologists do not screen patients for depression. However, all-payer, APP-based quality reporting could cause their patients to be included in the denominator of this measure and adversely affect the ACO's measure performance score. As a result, some ACOs are considering removing specialists from their ACO.

Additionally, some smaller or independent physician practices would need to make significant investments in their EHR systems in order to successfully report eCQMs under the new requirements. As practices consider the business case for this investment, some are likely to determine that continuing to partner with an ACO is no longer feasible. As noted above, this investment would coincide with significantly decreased payments to physicians (e.g., further decreases in the conversion factor) and the expiration of the Advanced APM Incentive Payments.

Digital quality measurement is the goal, but an adequate transition is needed

CMS has continued to articulate its goal of moving to full digital measurement, with the goal of streamlining CMS' approach to data collection, calculation, and reporting to fully leverage clinical and patient-centered information for measurement, improvement, and learning. Premier appreciates CMS' commitment to advancing digital measurement. We have long been committed to advancing providers' capability to analyze data from multiple sources and to manage the health of their populations.

We believe ACOs quality reporting can be the leaders in advancing digital quality measurement, as ACOs are inherently incented to collect data across the care continuum for their beneficiaries. ACO quality measurement represents an opportunity to understand how we can use existing and novel data sources to accurately assess care across the continuum.

If implemented as currently proposed, the MSSP quality reporting standard would be the only pay-for-performance program that requires reporting of an eCQM measure set. For the past several years CMS has gradually increased the number of eCQMs across all quality reporting programs. In recognition of the challenges associated with reporting eCQMs, CMS has provided notable flexibility in these programs. For clinicians reporting in MIPS, the flexibility is provided by allowing clinicians to select their reporting mechanism and measures. For hospitals, eCQM reporting is limited to the pay-for-reporting programs; eCQMs have not been required in hospital pay-for-performance programs due to the inability to guarantee accuracy of scores for payment purposes. **It is unreasonable to place a more stringent reporting approach on ACOs, that must combine data across settings, while setting-specific quality programs are provided with additional flexibility.** We understand that the policy, as proposed, would give ACOs the option of reporting MIPS CQMs; however, ACOs face the same data aggregation and accuracy challenges with combining data across participant TINs when reporting either eCQMs or MIPS CQMS.

As noted above, adapting workflows, data capture and other operational strategies necessary to monitor and report measures under these new requirements will take time and significant resources. As a result, Premier strongly urges CMS to adopt the following changes to ensure a more gradual transition to the new reporting requirements:

> ***Align with CMS Digital Quality Measurement Strategy.*** As part of this proposed rule, CMS seeks additional input on its transition to digital quality measurement (dQM). CMS notes that it is considering how eCQMs "can be refined or repackaged to fit within the potential future dQM definition," noting that "imitations in data standards, requirements, and technology have limited their interoperability." Given these challenges, **we strongly urge CMS to assess the new MSSP quality reporting requirements as part of its broader enterprise-wide dQM initiative**. As noted above, the transition to the new reporting requirements will require significant time and resources from ACOs. As a result, we are concerned that eCQM reporting requirements could shift midstream as CMS continues to evaluate its broader dQM strategy and impose even more burden and instability on ACos. At a minimum, CMS should articulate how the proposed ACO eCQM reporting requirements fit into CMS' broader goals around dQM, given the limitations around eCQMs already acknowledged by CMS.
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> ***Pilot Reporting Requirements First.*** As noted above, ACOs can be a leader in achieving CMS dQM goals. ACOs are inherently incentivized to collect data cross the care continuum for their beneficiaries. Given the numerous technical barriers to eCQM and MIPS CQM reporting highlighted above, **Premier strongly recommends that CMS recruit ACOs to pilot various approaches.** This would be an opportunity for CMS to evaluate and address many of these technical challenges and to adapt its dQM requirements prior to requiring broad adoption.
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> In particular, we recommend that CMS test dQM sampling approaches and options for limiting the population by patient type. ACOs are large entities with a minimum of 5,000 beneficiaries resulting in millions of patient encounters. The inclusion of all data points is not needed in order to have a clear picture of quality. CMS has precedence for using a sampling approach in other programs—the Medicare Advantage Star Ratings and CAHPS. Additionally, while we continue to recommend that CMS limit ACO reporting to aligned beneficiaries or the Medicare patient population, we recognize that at this time many ACOs do not have the technical capabilities to report on a subset of their population through eCQMs or MIPs CQMs. The QRDA I files do not include information on payer type, so ACOs are unable to segment the populations. We encourage CMS to work with stakeholders to develop alternatives for compiling data and identifying patient subsets.

This would also be an opportunity to further evolve the requirements beyond eCQMs to better fit with CMS goals for digital quality measurement. One of the goals of CMS' dQM strategy is to provide clinicians with real-time feedback, which is not currently feasible through eCQMs. The pilot would also be an opportunity for CMS to explore and develop necessary risk adjustment methodologies, exclusion criteria, and patient stratification.

As noted above, requiring ACOs to report all-payer data is comparable to requiring health plans to report on other payers' populations. Instead of building ACO quality reporting based on the structure used for individual clinicians, we strongly urge CMS to look to how quality reporting is conducted by health plans. For example, CMS should explore adopting a similar framework to digital HEDIS, which combines data from multiple sources, including EHRs, clinical registries or health information exchanges (HIEs), case management systems, and claims data.

In the absence of aligning with the broader dQM strategy and piloting new APP-based reporting requirements, **we strongly recommend that CMS reduce reporting burden and include additional incentives for ACOs reporting under these new APP-based requirements**, including:

- **Lower the data completeness threshold.** Starting with a lower threshold would allow ACOs additional time to adapt their various data systems to extract data from affiliated clinicians. This approach also aligns with how CMS implemented reporting for clinician and group reporting, which began with a data completeness of 40 percent and increased gradually to 70 percent.
- **Retain the 30th percentile quality performance standard.** In PY 2024, the quality standard is scheduled to increase to the 40th percentile. We urge CMS to maintain the quality performance standard threshold at the 30th percentile until ACOs have gained sufficient experience with the new reporting requirements.

Health Equity Adjustment

Consistent with CMS' goals to advance health equity, CMS proposes to adopt a health equity adjustment to an ACO's quality performance score, beginning with PY 2023. Under this proposal, an ACO's eligibility and the amount of the adjustment would be determined by the proportion of assigned beneficiaries that are dually eligible or reside in disadvantaged neighborhoods and would be restricted to ACOs with relatively higher quality performance scores. ACOs would be eligible for up to 10 quality bonus points.

In addition to recognizing the efforts of ACOs that serve large numbers of underserved beneficiaries and their communities, CMS intends for the health equity adjustment to serve as an incentive for ACOs to move more quickly from CMS Web Interface to the new APP reporting mechanism. As a result, CMS proposes to restrict eligibility for the health equity adjustment to ACOs that report all 3 eCQMs/MIPS CQMs of the APP measure set and meet data completeness requirements for each of these all-payer measures. ACOs reporting quality data only through the CMS Web Interface would not be eligible for the adjustment.

CMS proposes to calculate the adjustment based on the ACO's quality performance compared to other ACOs (through the "performance scaler"), as well as the proportion of assigned beneficiaries that are considered underserved ("underserved multiplier"). To determine the performance scaler, CMS would divide ACOs into three groups based on their performance for each of the measures. ACOs would be assigned points based on where they fell within the ranking: with the top-third receiving 4 points per measure, the middle-third receiving 2 points per measure, and the bottom-third receiving 0 points per measure, for up to a total of 24 points. CMS will set the underserved multiplier as the higher of an ACO's assigned beneficiary population that (1) are dually eligible or (2) reside in a census block group with an ADI national percentile rank of 85 or greater. To be eligible to receive the bonus, the ACO must have an

underserved multiplier of at least 20 percent. To set the health equity adjustment, CMS will multiply the performance scalar by the underserved multiplier, capping the adjustment at 10 bonus points. The health equity adjustment would then be applied to the ACO's MIPS Quality performance category score. CMS anticipates that higher health equity-adjusted scores could enable those ACOs to meet the quality performance standard and earn shared savings or have their shared losses reduced, enhancing financially stability, and attracting new provider groups that care for large numbers of underserved beneficiaries.

While we support the health equity adjustment in concept, we have several concerns with the adjustment as proposed.

First, tying eligibility to eCQM or MIPS CQM reporting is a flawed approach and will significantly limit who qualifies for the adjustment. Specifically, some ACOs who would benefit most from the adjustment will be excluded by the APP reporting requirement. As noted above, ACOs continue to face several challenges with adopting the new quality reporting requirements, including the costs and burdens associated with upgrading systems or contracting with vendors or registries. As CMS notes in the rule, few ACOs submitted eCQM or MIPS CQM data last year. Based on the challenges that ACOs continue to face with these requirements, Premier does not anticipate this number will significantly increase in 2023.

We understand that CMS is interested in finding additional ways to incentivize ACOs to adopt APP reporting voluntarily before it becomes mandatory starting with PY 2025. However, tying a health equity adjustment to the types of quality data submitted or the data reporting mechanism seems inappropriate and misguided. One of the goals of this adjustment is to support ACOs that serve a high proportion of underserved beneficiaries. Underserved beneficiaries tend to have higher costs that are not adequately captured in an ACO's historical benchmark due to historical service underutilization. Consequently, ACOs caring for these patients will be seriously challenged to devote sufficient financial resources to invest in the health IT infrastructure necessary for APP reporting in time for mandatory reporting, much less to transition to the APP earlier than what is required. Therefore, it appears likely that few potentially eligible ACOs are likely to qualify for the health-equity adjustment, at least in the early days. **We strongly recommend that CMS remove the requirement that an ACO would need to report eCQMs or MIPS CQMs to be eligible for the health equity adjustment.**

Second, we are concerned that few ACOs will be able to meet the 20 percent threshold required for the underserved multiplier. As proposed, some ACOs would not qualify for the adjustment simply because of where they are located. Dual eligible beneficiary percentages will vary across states depending on nonuniform criteria for Medicaid eligibility. Additionally, since CMS is comparing ACOs to the ADI national percentile rank, some populations who may appear underserved relative to others in their surrounding area or state, may in fact fall below the 85th percentile when compared to other communities nationwide. CMS seeks comment on utilizing Part D Low-Income Subsidy (LIS) data as either a replacement or a supplement for the dual eligibility status and ADI. Given Part D LIS eligibility is uniform nationwide, the metric may provide a more consistent comparison of whether beneficiaries are undeserved. We recommend that CMS share additional data and analysis comparing these data sources and the number of beneficiaries who would qualify under each metric by geographic regions.

CMS must also recognize that some ACOs may have limited data analytics capabilities. As a result, we would encourage CMS to utilize a dataset that is publicly available and that can be used without restrictions. While the Neighborhood Atlas® does have some data lookup tools available on its website, those tools only allow viewers to look up individual addresses one at a time. While users can download full datasets of the ADI data, data use is limited for non-profit education, research and public health purposes. As a result, ACOs would be unable to partner with other organizations to digest and format this data in a way that would allow them to easily identify which of their beneficiaries would meet the 85th national

percentile. Given ongoing labor shortages in the healthcare sector, these types of partnerships are more important than ever and will help alleviate provider burden, while allowing providers to focus their time on patient care.

As discussed in greater detail below, one of the challenges with shifting payments and incentivizes to address health disparities is the lack of available standardized data on social determinants of health (SDOH) at the individual patient level. **We strongly encourage CMS to reconsider the design of the health equity adjustment to support capture of SDOH data in a standardized format until data is more consistently captured and can be used to adjust payments and/or stratify quality measurement.** For example, CMS could set the health equity adjustment bonus points based on the percentage of SDOH and/or demographic data that ACOs report on their aligned beneficiaries. Over time, CMS could consider evolving this adjustment to address other challenges with SDOH data collection, with the goal of eventually setting the adjustment based on patient-level SDOH data. This data would also be valuable in adjusting ACO benchmarks, as discussed in greater detail below.

Request for Information (RFI): Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health Measures and Future Measure Development

CMS seeks comment on the future inclusion of two new measures into the APP measure set if they are first adopted into the MIPS measure inventory: Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health. These measures were recently adopted into the Hospital Inpatient Quality Reporting (IQR) Program, beginning with voluntary reporting for the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period (FY 2026 payment determination) and for subsequent years. CMS also proposes adoption of the Screening for Social Drivers of Health into the MIPS measure inventory starting in PY 2023.

The Screening for Social Drivers of Health measure is intended to promote adoption of screening for health-related social needs (HRSNs) by hospitals across five domains: food security, housing instability, transportation needs, utility difficulties, and interpersonal safety. The Screen Positive Rate for Social Drivers of Health is a companion measure to the proposed Screening for Social Drivers of Health measure and is intended to identify high-risk individuals who could benefit from connection to community-based services relevant to their HRSNs.

While we are supportive of CMS expanding screening for social drivers of health, we have a number of concerns with adopting these two measures into the MSSP measure set. Unlike the Hospital IQR Program, both MIPS and MSSP quality reporting are pay-for-performance program where providers are held accountable for their level of performance. However, unlike under MIPS where clinicians can select which quality measures they report and are scored on, ACOs would be required to report and would be scored on any and all HRSN screening measures that are adopted into the MSSP measure set. Additionally, the Screen Positive Rate will vary depending on the ACO's community and the patients aligned to the ACO and as such will capture many factors outside of the ACO's control. We also are reluctant to support adding two screening measures into the MSSP without more information about how CMS would use the measure results. For example, it is unclear if CMS will score ACOs at a measure-level or program-wide level or if it would be based on screening rates or attestation.

Finally, as we noted in our comments regarding adoption of these two measures into the Hospital IQR Program, CMS should explore modifying these measures to assess how providers are closing the screening loop by addressing the needs identified in the screening. **We urge CMS to continue to work with stakeholders to explore more meaningful health equity quality measures.** As part of this, CMS

should use the Measure Applications Partnership (MAP) to provide input, as the statutory intent of the MAP is to evaluate quality measures to ensure the measures appropriately fit a program.

Alternative Quality Performance Standard

Currently, MSSP ACOs must meet a set threshold of quality performance – known as the quality performance standard – in order to be eligible to receive shared savings. ACOs that meet the quality performance standard are eligible for the maximum shared savings associated with their tracks and levels. An ACO that does not achieve the quality performance standard is not eligible for any shared savings.

Given the recent changes to the quality reporting program and the quality performance standard (as discussed above), CMS proposes to revise its MSSP quality performance standard to eliminate this "all or nothing" scoring structure and add an additional option for ACOs that may not achieve the quality performance standard, beginning with CY 2023. Under the proposed alternative standard, an ACO would be eligible for a scaled portion of shared savings if it achieved a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least 1 of 4 outcome measures under the APP measure set. Under this proposal, scaled shared savings would be calculated by multiplying the ACO's health-equity adjusted quality score by the maximum shared savings rate for the ACO's track and level.

Additionally, for ACOs that owe shared losses, CMS uses the quality performance standard to determine the amount of losses the ACO owes. Currently, an ACO that does not achieve the quality performance standard will be fully liable for shared losses determined by its track and level. Under CMS' proposal, ACOs that achieve the alternative quality performance standard would be eligible for scaled shared losses.

Premier supports adoption of the alternative quality performance standard. As CMS notes, this policy will provide ACOs with additional opportunities to qualify for shared savings, as well as mitigate potential shared losses. These policies are particularly important as CMS transitions to its mandatory APP reporting mechanism requirement.

Modification to the Benchmarking Methodology

CMS proposes several modifications to its benchmarking methodology which are aimed at reducing the effect of an ACO's performance on its historical benchmarks and increase options for ACOs caring for high-risk populations. Specifically, CMS proposes to

- Modify the methodology for updating the historical benchmark to incorporate a prospective, external factor
- Incorporate a prior savings adjustment in historical benchmarks for renewing and re-entering ACOs
- Reduce the impact of the negative regional adjustment

CMS believes that these proposed modifications serve as "steppingstones" to a longer-term approach to the benchmarking methodology and are designed to be consistent with potentially adopting and administratively setting benchmarks in the future, as it explores in a related RFI. We respond to each of these proposals below.

All of these proposals would be effective for agreement periods beginning on or after January 1, 2024. We understand that CMS proposes this effective date to ensure ACOs have sufficient time to assess their options before entering into agreement periods, given the final rule will not be out until November 2022. Additionally, it is unlikely that CMS would be able to implement these methodologies in advance of 2024.

However, many ACOs in existing agreement periods would benefit from these policies and having the option may help to encourage continued participation by mitigating the impacts of past performance sooner. Additionally, we are concerned that some ACOs which may have been interested in entering the program in 2023 may look to defer their entry to 2024 in order to benefit from these policies.

As a result, **we strongly urge CMS to allow ACOs in existing agreement periods or agreement periods beginning in 2023 to opt into these new benchmarking methodologies beginning in CY 2024.**

Incorporating a Prospective, External Factor in Growth Rates Used to Update the Historical Benchmark

CMS proposes to incorporate a prospectively projected administrative growth factor – referred as the Accountable Care Prospective Trend (ACPT) - into a three-way blend with national and regional growth rates to update an ACO's historical benchmark for each performance year. ACPT would be projected by the CMS Office of the Actuary (OACT) and would be based on a modified version of the existing FFS United States Per Capita Cost (USPCC) growth trend projections used annually for establishing Medicare Advantage rates. A similar approach is utilized under CMS' Innovation Center Model, ACO REACH. CMS would set the ACPT at the start of an ACO's agreement period and the factor would remain unchanged throughout the five-year agreement period.

CMS believes that incorporating this prospective trend in the update to the benchmark would insulate a portion of the annual update from cost efficiencies resulting from an ACO's historical performance, as well as address the impact of increasing market penetration by ACOs in a regional service area on the existing blended national-regional growth factor.

To protect ACOs from larger shared losses, CMS proposes a guardrail to reduce the impact of the ACPT if unforeseen circumstances occur during an ACO's agreement period. Specifically, if an ACO has shared losses under the proposed three-way blend methodology, CMS would recalculate the ACO's updated benchmark using the national-regional blended factor (two-way blend). If the ACO generates savings using the two-way blend (but not in the three-way blend), the ACO would neither be responsible for shared losses nor eligible for shared savings.

We support CMS' proposal in concept, as a prospective trend factor will improve the predictability of benchmarks. Currently, ACOs can experience large swings in their estimated benchmark over the performance period, as the CMS OACT updates its projections. ACOs utilize a calculator developed by CMS – commonly referred to as the OACT calculator – to project their OACT adjustment and overall financial performance throughout the year. As with any tools of this type, the calculator's predictive ability should improve throughout the year as more actual data becomes available. However, even after the release of the fourth quarter expenditure and utilization reports, the trend factors used in the calculator – especially the regional component – have varied significantly from what is ultimately used during final reconciliation. In some cases, the trends can vary by more than 50 percent from the calculator to reconciliation, potentially causing some ACOs to overpredict shared savings or to owe higher shared losses than expected. Moving to an administratively-set trend factor would allow ACOs to better predict their benchmarks and assess their financial performance throughout the year.

However, at this time, there is limited information to assess how the ACPT would be calculated. Additionally, the COVID-19 pandemic had a significant impact on healthcare utilization and how patients interact with the healthcare system. It is too early to tell how healthcare utilization and delivery will change as we come out of the COVID-19 public health emergency. Accurately projecting trend factors may be particularly challenging over the next several years.

As a result, **we would encourage CMS to evaluate the impacts of the pandemic on healthcare utilization and work with stakeholders to develop a methodology that sufficiently addresses these concerns. Given the uncertainty around healthcare costs moving forward, we recommend that CMS initially adopt a one-year administrative trend factor.** This would allow CMS time to evaluate and to refine its methodology without locking ACOs into a five-year trend factor that may significantly under- or overpredict spending growth and changes in utilization over the agreement period. CMS could consider gradually lengthening the amount of time over which the trend factor is applied as it comes to refine its methodology.

Finally, CMS proposes that it would have sole discretion to adjust the weight of the ACPT if unforeseen circumstances warranted adjustments, such as a recession or pandemic. At a minimum, CMS should define "unforeseen circumstances" and the criteria it would use to evaluate whether an adjustment is necessary.

Adjusting ACO Benchmarks to Account for Prior Savings

For renewing or re-entering ACOs, CMS proposes to adjust the ACO's benchmark for prior savings it achieved under the MSSP. CMS believes that this adjustment will help mitigate concerns stakeholders have raised regarding the ratcheting effect that occurs as an ACO's benchmark is rebased and incorporates past efficiencies achieved by the ACO under the program. CMS would adjust an ACO's benchmark based on the higher of either the prior savings adjustment or the ACO's positive regional adjustment. It would also use a prior savings adjustment to offset negative regional adjustments for ACOs that are higher spending compared to their regional service area.

To calculate prior savings, CMS will use savings achieved in the three performance years preceding the new agreement period. CMS will calculate prior savings adjustment as equal to the lesser of 50 percent of the ACO's prorated positive average per capita prior savings or 5 percent of national per capita FFS expenditures for assignable beneficiaries.

Premier agrees that CMS' proposal to adjust benchmarks for prior savings will help to mitigate concerns regarding the ratcheting effect. We encourage CMS to expand the policy to include savings achieved under the Next Generation ACO model, Global/Professional Direct Contracting model, as well as the new ACO REACH model, and any future ACO or ACO-like models.

Additionally, we encourage CMS to explore setting this policy at the TIN level, rather than at the individual ACO-level. This would help to capture any changes that may occur as participants move from one ACO to another across agreement periods. Compared to 2018, the number of ACOs participating in MSSP has decreased while the number of covered beneficiaries has remained consistent. This indicates that there continues to be aggregation and growth of existing ACOs, which is a trend Premier has also seen while working with our member ACOs. By not applying the previous savings adjustment at the TIN level, participants, and potentially any ACO that they join, could be negatively impacted due to movement between ACOs. We believe that the spirit of this proposal is to capture previous savings generated while participating in MSSP. Calculating savings at the ACO level would fail to capture the full scope of previous utilization reductions and savings achieved.

Reducing the Impact of the Negative Regional Adjustment

CMS proposes two policy changes designed to limit the impact of negative regional adjustments on an ACO's historical benchmarks and further incentivize participation of ACOs serving high cost beneficiaries:

1. Reduce the cap on negative regional adjustments from -5 percent of national per capita expenditures for Parts A and B services in BY3 for assignable beneficiaries to -1.5 percent.
2. After applying the cap, apply an offset to the negative regional adjustment based on the ACO's proportion of assigned dual eligible beneficiaries and average HCC risk score. Under this proposal the higher an ACO's proportion of dual eligible beneficiaries or the higher its risk score, the larger the offset factor would be and the larger the reduction to the overall negative regional adjustment.

Premier supports this policy and agrees with CMS' assessment that this policy will help mitigate the impact of negative regional adjustments, especially for ACOs that serve a high proportion of underserved and high-cost beneficiaries. We encourage CMS to further evaluate whether additional changes may be necessary for ACOs that include a significant proportion of high-needs beneficiaries or beneficiaries that are aligned through specialists as compared to their surrounding region. As noted above, a recent Premier analysis found that even after accounting for risk, beneficiaries that are attributed through specialists appear to have higher costs than others in a given region when compared to beneficiaries that are attributed through primary care providers. CMS should consider lowering the cap amount based on the share of the ACO's population that is attributed through Step 2 attribution.

Incorporating an Administrative Benchmarking Approach into the Shared Savings Program

Under the current MSSP benchmarking methodology, CMS uses historical expenditures from an ACO's assigned beneficiaries, as well as factors based on national and regional FFS expenditures. This has raised concerns that over time ACOs are competing against themselves and creates a race to the bottom. CMS is seeking comment on alternative approaches to its benchmarking methodology as part of its effort to improve the sustainability of the MSSP. In particular, CMS is interested in exploring how to calculate ACO historical benchmarks using administratively set benchmarks that are decoupled from ongoing actual fee-for-service spending.

In particular, CMS notes there are two ways that using historical fee-for-service spending may lead to lower benchmarks:

- First, use of historical expenditures puts downward pressure on an individual ACO's benchmark as a result of spending reductions it achieved on its historical benchmark expenditures, regional adjustment, and update factor. This issue can occur when CMS resets an ACO's benchmark at the start of each agreement period based on historical expenditures from the prior agreement period.
- Second, the use of historical expenditures can place downward pressure on benchmarks due to program-wide spending reductions across all ACOs. This second issue will become more pronounced as CMS looks to expand the MSSP program.

Premier has long advocated for modifications to the benchmarking methodology to ensure ACOs are not penalized for efficiencies gained through their MSSP participation and is supportive in concept of moving towards an administratively-set benchmark. However, as noted above, this RFI comes at a time when our entire healthcare system is continuing to assess what the impact of the COVID-19 pandemic will have on healthcare utilization and service delivery moving forward. This will likely require significant changes to existing actuarial and predictive models. **We strongly urge CMS to engage with stakeholders over the next several years to evaluate appropriate methodologies for setting an administratively-set benchmark.**

Additionally, as CMS continues to evaluate longer term changes to the benchmarking methodology, we would recommend that CMS consider other modifications both in the short-term and as part of its longer-term strategy.

Currently, CMS incorporates regional expenditures into the benchmark calculation to mitigate the "race to the bottom" approach that results when a benchmark is based solely on an ACO's historical experience. However, an ACO's assigned population is included in the regional reference population. For ACOs with a large penetration in the region, this may have the unintended consequence of continuing to set the benchmark solely based on an ACO's historical performance, thus perpetuating the race to the bottom.

CMS had previously sought comment on removing an ACO's population from the regional reference population. We continue to encourage CMS to explore and provide stakeholders more information on the potential impact of removing ACO beneficiaries from the regional reference population, especially for ACOs with large portions of specialist participants. Under MSSP, beneficiaries are assigned to an ACO based on the plurality of primary care services. Advanced practice providers operating in specialists' offices are classified as primary care providers for purposes of attribution. Beneficiaries who are attributed through these providers may have higher costs as a result of a high-cost episodes of care for which they are seeing the specialist, such as cancer or a cardiac event. We are concerned that ACOs with a large proportion of specialists may have a patient population that is very different (i.e., historically more costly) than the remaining region.

CMS should also consider other sustainable approaches to benchmarking. For example, to address concerns over the impact of ACO-assigned beneficiaries on the regional trend factor, CMS should modify the region it uses for setting the trend factor so that no more than 50 percent of the region's assignable beneficiaries are assigned to that ACO. By increasing the regional population, CMS will help to mitigate the impact of past performance on the calculation of the regional trend and adjustment factors, while ensuring that CMS still maintains a large enough population to accurately calculate the factors.

CMS should also explore ways to further stratify benchmarking based on patient risk factors. The current benchmarking and risk adjustment methodologies favor patients who are attributed based on primary care services. As a result, benchmarks are often artificially lower for certain high-cost patient populations, which can disincentivize inclusion of specialists in ACOs. For example, in recent years we have seen a rapid increase in Part B drug costs for oncology patients. These increased costs are not sufficiently accounted for in existing benchmarking or risk adjustment methodologies, resulting in losses for ACOs who may serve a large oncology population. To better account for these high-cost patients, CMS should further stratify its current benchmarking approach to set separate benchmarks for patients with certain high-cost chronic conditions or treatments.

Reopening Initial Determinations of ACO Financial Performance

CMS generally releases reconciliation reports in August for the prior performance year that include determinations of whether ACOs have met the quality performance standard and are eligible for shared savings or responsible for shared losses. This timeline does not align with the MIPS targeted review process. As a result of timeline mismatch, CMS may not discover MIPS feedback errors that affect ACO performance results until after an ACO's initial financial determination has been made and the ACO has received shared savings or CMS has recouped shared losses.

In the proposed rule, CMS discusses that it is considering an approach by which it would reopen ACO financial determinations for good cause. Under this approach, CMS would set thresholds for error magnitude or number of ACOs affected that could trigger reopening. Upon learning of a MIPS quality score

error, CMS would exercise its reopening discretion to correct errors affecting shared savings eligibility determination or shared savings or loss amounts. Any corrections -- either updates to shared savings or losses – would be made during the following year.

We are concerned that this policy could add a new layer of uncertainty to ACOs on whether the financial reconciliation could significantly be altered as a result of errors that are outside their control. We are also concerned that this could result in CMS clawing back shared savings from ACOs who may have already paid out gainsharing to participant providers or used shared savings to invest in care delivery transformation.

We strongly recommend that CMS not proceed with this policy for PY 2023. It is not possible to properly assess the value and impact of this proposed policy as described in the rule. For example, any threshold criteria (e.g., amount of payment error, number of ACOs affected) used to determine errors meriting reopening need to be fully stipulated by CMS. Potential thresholds should also be accompanied by data from CMS that state the number of ACOs that would be impacted and the amounts involved. The error correction process for MIPS under the QPP has not gone smoothly and we strongly oppose importing that process into ACO reconciliation at this time. **If CMS persists in pursuing this policy, at a minimum, CMS should hold ACOs harmless and only reopen financial reconciliations under situations where an ACO would benefit.**

The MIPS-MSSP timeline mismatch issue above also exemplifies the ongoing concerns we have about imposing MIPS program standards and policies on ACO quality measurement. **We reiterate that MIPS is a fundamentally flawed program and does not support the desired transition from volume to value.** This issue of unaligned timelines highlights yet one more challenge with the reporting requirements. ACOs should not be penalized for errors that are discovered in MIPS after their initial financial reconciliation is calculated. At a minimum, **CMS should hold ACOs harmless and only reopen financial reconciliations under situations where an ACO would benefit**. Additionally, we continue to request that CMS provide additional information on the calculation of scores.

Request for Comment on Addressing Health Equity Through Benchmarking

Reducing disparities in care and achieving health equity across communities requires a holistic approach to care, shifting the incentives in our health system from sickness-based to wellness-based. When providers are responsible for total cost of care for their patients, such as through ACOs, and have flexibility to address SDOH, providers will be proactive in addressing inequity and disparities. However, addressing the underlying social and economic inequities as well as systemic barriers and biases that drive disparities in care requires (1) data collection and monitoring of key outcomes and health equity measures and (2) shifting the payment system to account for a more comprehensive set of services that address disparities.

We applaud CMS' recognition that current benchmarking methodologies may undervalue the healthcare needs of underserved beneficiaries given historically low healthcare utilization by these populations. However, one of the major challenges to adjusting payments and benchmarks to address disparities in care is the lack of standardized sociodemographic data at the patient-level. As a result, some models – such as the ACO REACH model – are relying on proxies for identifying undeserved beneficiaries, such as duals status or ADI, which may not fully identify undeserved beneficiaries.

Health systems are currently capturing SDOH data, but the information is not easily translatable for CMS purposes. For example, despite an available framework for mapping the more than 900 race ethnicity codes provided by the CDC to the OMB, race and ethnicity codes captured in the EHR cannot be consistently mapped. This is a result of lack of use of standard taxonomies—in part by the EHRs and in

part by the providers to allow the category selections to align with how their populations would like to report information. Similarly, there are an abundance of tools to screen for SDOH with underlying definitions for certain social risk factors (e.g., food insecurity) varying significantly even when the same tool is used by different providers.

We urge CMS to focus on improving data collection and standardization prior to making significant reforms to its benchmarking methodology to address health equity. Standardization is vital to providers' success in driving towards health equity, as it will foster the development and sharing of best practices within and among clinical settings, health systems, and delivery system designs. The Agency for Healthcare Research and Quality (AHRQ) has found that one of the biggest barriers most health systems face in improving quality and reducing disparities within their own walls is systematically identifying the populations they serve, addressing the needs of these populations, and monitoring improvements over time. AHRQ further found that the principal challenges in obtaining race, ethnicity, and language data for use in quality improvement assessments include a lack of standardization and understanding of why the data are being collected.

It is vital that CMS also invest in educating both patients and providers about the importance of collecting SDOH information, the evidence for how it affects care, and existing privacy requirements under HIPAA that safeguard information patients share with their providers. CMS should also consider advancing standards that clearly indicate the dates and times associated with data collection, as certain sociodemographic factors (e.g., homelessness) are subject to change.

As part of its broader goals around advancing health equity, CMS has identified several efforts across Medicare that would require use and collection of socio-demographic data, including for stratifying quality measurement or payment adjustments. We ask that CMS make a concerted effort to advance standards for the collection of socio-demographic information, using existing tools such as the United States Core Data for Interoperability (USCDI), Z-codes, HL7 and Fast Healthcare Interoperability Resources (FHIR) standards. This coordinated approach requires significant input from providers across the continuum, vendors, payers, and suppliers. As a result, **we recommend that CMS convene a dedicated Task Force or Expert Panel of stakeholders to support advancing standards and collection of socio-demographic factors.** The Task Force or Expert Panel should include, at a minimum, representation from acute and nonacute providers, vendors and suppliers, beneficiaries and plans.

Improving the Risk Adjustment Methodology to Better Account for Medically Complex, High-Cost Beneficiaries

CMS uses prospective HCC risk scores to adjust an ACO's historical benchmark at the time of reconciliation to account for changes in severity and case mix of its assigned population between BY3 and the performance year. Increases in risk scores are capped at 3 percent for the agreement period – which is commonly referred to as the "3 percent cap." Currently, CMS applies the cap separately across the four Medicare enrollment types used for setting benchmarks.

CMS proposes two changes to how it applies its risk adjustment methodology. First, CMS will account for changes in the demographic risk score for the ACO's beneficiary population from BY 3 to the performance year prior to applying the 3 percent cap. Second, CMS will apply the 3 percent cap in aggregate across the four Medicare enrollment types, which will allow the risk score for individual enrollment types to increase by more than 3 percent, so long as the ACO does not hit the cap in aggregate.

Premier supports CMS' proposals to account for demographic risk scores prior to applying the cap, as well as capping risk score growth in aggregate. This policy will help to ensure that ACOs are not

penalized for large swings in their population that may contribute to higher risk scores outside of changes in HCC risk scores. In particular, this policy will be beneficial for ACOs that may look to expand their aligned population to include more high-needs or underserved populations.

Premier also continues to **strongly urge CMS to increase the risk score cap to 5 percent and to apply a symmetrical cap on decrease in risk score.** Increasing the cap to 5 percent will better account for changes in risk score over the agreement period. The current methodology of normalizing risk adjustment in a region can penalize ACOs who have been coding accurately and who maintain the same level of risk over their agreement period. Under this scenario, an ACO could see a decrease in their risk score if others in their region increase their coding intensity. This issue is further exacerbated for ACOs that include a large number of specialists, since they have less opportunities to increase their risk score. CMS has previously indicated that it is hesitant to introduce a cap on decreases in risk score because it is concerned it could create a gaming opportunity for ACOs. We believe this concern can be mitigated if CMS uses its other tools available for monitoring for potential gaming, such as continuing to monitor changes in voluntary alignment of beneficiaries and its primary care provider.

Additionally, we continue to urge CMS to standardize the risk adjustment methodology it uses across all Medicare programs and models. With different approaches, providers have different incentives which lead to inconsistent practices. For example, MSSP ACOs have the opportunity to improve their benchmark by up to 3 percent over the course of their agreement period with more accurate coding documentation. In Medicare Advantage, there is no limit to risk score increases or decreases. Clinicians are the primary source of coding documentation and are incented to maximize coding as part of their negotiations with payers. At the same time, clinicians must negotiate their risk-based arrangements with payers to maximize a share of risk adjustment. At a minimum, CMS should align the methodology used in MSSP Enhanced with Medicare Advantage.

Finally, we encourage CMS to continue to explore reforms to its risk adjustment methodology across all Medicare programs and models by:

- ***Updating HCC Model to use ICD-10 codes.*** The current methodology is based on ICD-9 codes, which have been largely phased out under the Medicare payment systems in favor of the ICD-10 code set. ICD-10 codes allow for multiple clinical concepts, offering more specificity than ICD-9. In the past, CMS has expressed concerns that coding has not stabilized. However, the health industry has been using ICD-10 codes for more than six years and the risk adjustment model needs to be updated to reflect the new code set. CMS should work with stakeholders to explore ways to incentivize more accurate ICD-10 coding.
- ***Refining HCC Diagnoses*.** Data integrity and the refinement of the HCC models is dependent on the data quality and the reporting of the most specific, accurate diagnosis information. To further incentivize accurate coding, CMS should remove certain unspecified codes that should have specificity. For example, diabetes with unspecified complications, unspecified heart failure, and unspecified peripheral vascular diseases are diagnoses that lack specificity but are still assigned as an HCC category, even though complications can vary significantly
- ***Incorporating Social Determinants of Health.*** SDOH are widely recognized as important predictors in clinical care. Incorporating SDOH disease interactions would provide a mechanism to encourage the collection of SDOH without incentivizing coding intensity for financial improvement. We believe SHOH should be used as a disease interaction methodology to appropriately capture the impact of SDOH on patient severity reporting. Just as the American Medical Association (AMA) has recognized the importance of SDOH in the medical decision-making component used in the assignment of evaluation and management code level methodology, a SDOH component should be factored into the HCC severity calculations.

Increased Opportunities for Low Revenue ACOs to Share in Savings

In order for an ACO to receive shared savings it must meet a minimum savings rate (MSR). The purpose of the MSR is to ensure that the observed savings are the result of ACO activities to improve the quality and efficiency of care delivery, and not the result of normal year-to-year variations in beneficiary expenditures.

CMS proposes a new opportunity for low-revenue ACOs to receive partial shared savings if they do not meet the MSR. The proposed policy would be applicable for low-revenue ACOs that enter an agreement period in the BASIC track beginning on or after January 1, 2024 and have at least 5,000 assigned beneficiaries at time of reconciliation. Under this proposal, qualifying ACOs that meet the quality performance standard but do not meet the MSR would be eligible to receive half of the maximum shared rate for their given track. For ACOs that do not meet the quality performance standard but do meet the proposed alternative standard would be eligible to received scaled shared savings.

As noted above, we continue to urge CMS to eliminate the high-low revenue distinction in MSSP. **Premier strongly recommends that CMS not limit this policy to just low-revenue ACOs.** As CMS notes, a higher MSR can discourage ACOs from participating in the program. This is true for all ACOs, not just those that are low-revenue. For some ACOs, the difference between whether they qualify for shared savings is just a fraction of a percent. This can be discouraging for participants and ultimately result in some ACOs choosing to exit the program.

As a result, we would encourage CMS to adopt a policy that would allow for scaled shared savings depending on how close they were to achieving the MSR. CMS could set a lower alternative MSR threshold and a sliding scale for achieving savings. Under this policy, if an ACO achieved the lower threshold it would be eligible for a portion of shared savings, which would be determined based on where the ACO falls between the lower alternative MSR and the MSR. While we encourage CMS to adopt this for all ACOs, at a minimum, we encourage CMS to adopt this policy for ACOs in their first agreement period, regardless of revenue status. It can take ACOs multiple years before they are able to achieve the level of savings necessary to reach the MSR. This would reward ACOs for their continued high performance and continue to encourage their participation in the program.

Requirements for ACO Marketing Materials

As part of its efforts to reduce administrative burden on ACOs, CMS proposes to eliminate the requirement that ACOs submit marketing materials to CMS for review and approval prior to dissemination. ACO materials will still be required to utilize CMS template language (if available), be non-discriminatory, comply with regulations regarding beneficiary incentives, and not be materially inaccurate or misleading. CMS retains its authority to request ACOs submit marketing materials for review by the agency at any time and will continue to issue written notices to ACOs if materials are disapproved.

Premier supports CMS' proposal to eliminate the requirement that ACOs submit marketing material for advance review. As CMS indicates in the rule, less than 1 percent of marketing material submissions submitted to CMS in 2021 were denied. This proposal will help to reduce burden on ACOs.

Beneficiary Notification Requirements

CMS proposes to reduce the frequency of required beneficiary notifications from a minimum of once per performance year to once per agreement period. Additionally, CMS proposes that at either the beneficiary's next primary care service visit with an ACO professional or no later than 180 days after the beneficiary

notice was provided, the ACO must give the beneficiary a meaningful opportunity to engage with an ACO representative and to ask questions. This follow-up communication opportunity, which is not a billable service, may be delivered verbally or in writing. The ACO must track and document the follow-up engagement and make documentation available to CMS upon request.

Finally, CMS proposes to clarify that ACOs must post beneficiary notification signage in all facilities where ACO participants furnish services, whether or not primary care services are furnished on site. The signage must inform beneficiaries of the availability of standardized written notices about the ACO and its participants, the beneficiary's right to opt out of data-sharing, and the option to designate an ACO provider through the voluntary assignment process.

Premier has long advocated for reducing the frequency of required notification to beneficiaries to once per agreement period. As we have noted previously, requiring ACOs to notify beneficiaries annually when there have been no programmatic changes can cause unnecessary confusion and burden on patients and creates significant burden for ACOs.

We are concerned that CMS is replacing the annual notification requirement with a new requirement that ACOs provide beneficiaries with an opportunity engage with an ACO representative. While we appreciate that CMS drafted the requirement in such a way to provide ACOs with flexibility, we are concerned that the proposal is vague and lacks clarity around what ACOs must do to meet the requirement, such as documentation of the follow-up visit. We are also concerned that this new requirement will place additional burden on ACOs while potentially creating confusion and anxiety for beneficiaries who might assume that the new encounter is occurring because of changes being made to their ACOs.

We understand that CMS desires to improve beneficiaries' understanding of ACOs and value-based care, but we do not think the proposed mandatory follow-up encounter will achieve this goal. Instead, we encourage CMS to work with stakeholders, including beneficiary advocates and caregivers, to develop a notification process that adds value to the patient-ACO relationship by clearly informing beneficiaries about the role of ACOs and the beneficiaries' rights without placing new or significant burden on the ACOs.

Finally, we are concerned about CMS' requirement that signage be posted in all facilities, including non-primary care facilities. Some ACOs partner with specialists whose practices may include sites where no ACO-aligned beneficiaries are seen. Requiring ACO-related signage at such sites inevitably will create confusion for patients seen there and thereby impose burden on the specialists who must take time during the clinical encounter to explain the intent of the irrelevant signage. The burden could adversely affect the relationship between an ACO and its specialist partners and jeopardize the availability of needed specialty expertise to the ACO's aligned beneficiaries. **We encourage CMS to modify the policy to clarify that signage is required in all facilities where ACO-aligned beneficiaries receive care.**

Ongoing Considerations about Impacts of the COVID-19 PHE

CMS notes that while ACOs saw sharp declines in spending in 2020 due to the COVID-19 pandemic, spending rebounded in 2021. As a result, CMS believes using a historical benchmark that is an average across a base period including both 2020 and 2021 represents "a reasonable basis from which to update ACO spending targets going forward." Additionally, CMS believes that the current trends and update factors will sufficiently address and mitigate impacts on benchmark year expenditures and that the proposed ACPT would further mitigate any potential adverse effects. Accordingly, CMS does not propose any additional changes to the MSSP financial methodology to address impacts from the pandemic but seeks comment on these assumptions and other impacts from the COVID-19 PHE.

One area that CMS' analysis overlooks is the impact of the PHE on beneficiary risk scores, which are a vital component to ACO performance, as well as CMS' ability to monitor the program. CMS relies on a prospective CMS-HCC scoring system, where the diagnoses captured in one year are used to adjust the expenditure targets during the following year. For example, diagnoses captured during office visits in 2020 would impact 2021 expenditure targets.

To control for risk score growth in the MSSP, CMS uses a retrospective adjustment to renormalize risk scores by beneficiary type around an average HCC of 1.0. Additionally, as discussed in more detail above, CMS currently limits increases in risk scores over the course of the agreement period to 3 percent above the average risk score in Base Year 3.

Premier is concerned that the COVID-19 PHE may have a negative impact on risk scores for ACOs that started or renewed in 2022 (or "2022 starters"), as well as those in the years immediately following. With the decrease in service utilization in CY 2020, we also saw a marked decrease in encounters and opportunities, such as an annual wellness visits, to properly capture diagnosis codes and perform routine diagnostics. As noted above, this would negatively impact risk scores used for 2021, or Base Year 3 for 2022 starters. Premier estimates that 2021 national risk scores could decrease by an estimated 4-7 percent prior to renormalization.

While the renormalization process will, on a national basis, keep existing ACOs whole, we are concerned that for 2022 starters there may be a potential disconnect between their risk scores and expenses. As beneficiaries return to a normal routine of office visits and diagnostics, and as the acuity of the population returns to a normal HCC distribution, risk scores should rise at an accelerated rate across all beneficiaries. However, 2022 starters will have their risk score growth capped at 3 percent based on 2021 expenditures (Base Year 3), which is likely too low given the challenges highlighted above. To address this issue, **Premier recommends raising the cap for new or renewing 2022 starters to at least the difference between the 2020 and 2021 renormalization rates, plus 3 percent. We also recommend that CMS continue to monitor and work with stakeholders to address the impacts of the COVID-19 PHE on MSSP.**

MSSP Innovation

In the proposed rule, CMS mentions its larger ACO strategy of using the Innovation Center to test new payment and service delivery models on the MSSP "chassis" in order to "better harmonize policies across Medicare ACO initiatives and enable [CMS] to scale any findings." **Premier strongly supports CMS' strategy of utilizing MSSP as an innovation platform and for harmonizing policies across initiatives and scaling best practices.** As we have previously noted, ACOs participating in MSSP should not have to leave this permanent program to take on more advanced risk or to utilize new flexibilities or enhancements being tested under other models. CMS should test new incentives or flexibilities under its Innovation Center authority, as it has done previously under the ACO Investment Model and Track 1+.

As part of this, **we urge CMS to provide ACOs with additional tools to drive care innovation,** including:

- **Establishing an opportunity for participants to elect 100 percent risk.** Under this track, participants would be eligible for 100% shared savings/losses. Similar to Next Generation ACO (NGACO) or the Direct Contracting/ACO REACH full-risk track, CMS could apply a discount to guarantee Medicare savings.

- **Providing a glide path to capitation.** Premier has long advocated for a model which allows an ACO to establish primary care capitation and bundled payments within the ACO. CMS should

provide MSSP participants a similar option which would allow them to reduce a certain percentage of FFS payments in exchange for receiving a prospective population-based payment. CMS has employed similar methodologies in Direct Contracting/ACO REACH and NGACO, such as through the All-Inclusive Population-Based Payment (AIPBP).

- **Testing new options for alignment.** To achieve CMS' goal of getting all Medicare beneficiaries into a care relationship accountable for quality and total cost of care, we must think beyond primary care attribution approaches. Voluntary alignment is beneficial but is still limited to beneficiaries with an ongoing relationship with a primary care provider. CMS should consider testing new approaches for aligning beneficiaries, such as through other types of non-primary care providers (e.g., specialists) or based on the ACO's affiliation with Medicaid Managed Care Organizations (MCOs). CMS should also explore geography-based alignment. CMS sought to include a similar alignment methodology in the Direct Contracting Geographic Model. However, this model was problematic as it created overlap challenges with providers currently participating in APMs.

- **Establishing additional benchmark options based on patient population and clinical need,** especially for complex patient populations. To drive innovation in care, providers need adequate budgets to meet the care needs of various populations. CMS has recognized the need to modify benchmarking approaches to meet the needs of certain populations through other models, such as the Primary Care First Seriously Ill Population and the Direct Contracting High Needs track. We urge CMS to consider additional benchmarking approaches for certain high-needs or high-cost Medicare populations. This approach will be critical as CMS seeks to align additional beneficiaries with APMs. Unassignable beneficiaries typically have not received primary care services and are frequent emergency department users. As a result, current benchmarking and risk adjustment approaches, which are based on historical claims, are unlikely to capture the costs of these patients.

- **Offering enhanced waivers or benefits.** CMS should expand the types of waivers and enhancements available under MSSP to match those that are offered under the NGACO and Direct Contracting. For example, CMS should improve the MSSP Beneficiary Incentive Program to match flexibilities granted under the NGACO model. CMS should also look to adopt flexibilities granted under the COVID-19 PHE, such as hospital at home model and additional telehealth flexibilities

TELEHEALTH AND OTHER SERVICES INVOLVING COMMUNICATION TECHNOLOGIES

Telehealth has been an essential tool for providers in addressing the healthcare needs of patients during the COVID-19 public health emergency (PHE). **We appreciate the flexibilities that CMS has provided and urge CMS to continue to expand Medicare coverage and payment of all types of virtual services involving communications technologies including telehealth, online visits, and audio visits.** We also urge CMS to expand telehealth flexibilities granted under the PHE to APMs, which we discuss in greater detail below.

As part of CY 2021 rulemaking, CMS adopted a new category of telehealth services (Category 3), which allow services to be added on a temporary basis while CMS continues to develop and assess the clinical evidence base to support permanent adoption. Category 3 services will remain on the telehealth list through CY 2023. As part of this year's rule, CMS proposes to add 53 services to the telehealth list on a Category 3 basis.

CMS also proposes several policies to implement provisions of the Consolidated Appropriations Act of 2022 (CAA of 2022) which are intended to extend certain telehealth flexibilities for 151 days following conclusion of the COVID-19 PHE, including:

- Allow telehealth services to be furnished in any geographic area and any originating site, including a beneficiary's home
- Allow certain services to be furnished as audio-only
- Allow physical therapists, occupational therapists, speech-language pathologists and audiologists to furnish telehealth services
- Allow continued payment for telehealth services furnished by FQHCs and RHCs

Premier supports adoption of additional Category 3 services and CMS' proposals to extend certain telehealth flexibilities post-PHE, consistent with statute. Both policies provide additional time for data collection and analysis to demonstrate clinical benefit in support of broader and more permanent adoption.

Premier continues to believe that telehealth services offer the ability to enhance medical management between patients and providers, enable remote monitoring, and greatly improve communication and education between primary and specialty care providers. Ultimately, we recognize that CMS has limited statutory authority to expand telehealth services following conclusion of the PHE. **We continue to urge CMS to work with Congress to adopt broader telehealth reforms.**

Additionally, Premier strongly recommends that CMS expand telehealth flexibilities in APMs. Specifically, the following waivers should be implemented without burdensome documentation requirements:

- **Expanded set of services.** As noted above, CMS established a new category of telehealth services (Category 3), which provides CMS with the opportunity to build the evidence base for permanent inclusion. This policy will conclude in CY 2023. The current telehealth waivers limit APMs to services available on the existing telehealth lists. CMS should view APMs as an opportunity to test expansion of telehealth services by creating a list of covered telehealth services specifically for APMs. This would allow APMs to retain the full list of services provided during the PHE while CMS builds the evidence base needed for broader adoption.

- **Originating Site Restrictions**: Several current CMS APMs include waivers that allow APM participants to furnish telehealth services outside of rural areas and to beneficiaries in their home. These waivers greatly expand the utility of telehealth for both patients and providers but have been challenging to implement due to burdensome documentation requirements. CMS should develop uniform language for these waivers that can be incorporated into the design of future models. Additionally, CMS should look to minimize the administrative burden of implementing a telehealth waiver.

- **Frequency limits.** As part of the PHE, CMS waived frequency limits on certain services furnished via telehealth: subsequent hospital care, subsequent nursing facility care, and critical care consultation services. Under a fee-for-service construct, these limits may help ensure patients receive proper in-person care and that bad actors do not abuse billing for these services. These protections are inherent to APMs, however, which are already incented to provide care in the most appropriate setting to ensure the best outcomes.

- **Established patient requirements**. Several of the virtual and telehealth services require that a patient receive in-person services from a practitioner within a certain time period in order to be eligible for services to be delivered remotely. Under the PHE, CMS waived many of these requirements to allow practitioners to furnish virtual and telehealth services to both established and new patients. For APMs where beneficiaries voluntarily align or are prospectively assigned, this requirement would limit beneficiary access to receiving telehealth from all of the APM's participant providers. For example, there may be instances where a provider, such as a specialist, could furnish appropriate care to a patient who may be new to the specialist but has already received in-person care from another provider within the APM.

- **Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) ability to furnish services.** While RHCs and FQHCs can serve as a site where patients can receive telehealth services ("originating site"), statute has restricted them from serving as the site where practitioners can furnish telehealth services ("distant site"). During the PHE, Congress enacted legislation which allows RHCs and FQHCs to serve as distant sites[2]. RHCs and FQHCs are a critical source of care for many patients in underserved communities. Expanding this flexibility would improve access and continuity of care for patients who rely on RHC or FQHC services. In the absence of Congressional action, we urge CMS to allow for RHCs and FQHCs that are participating in APMs to serve as distant sites for telehealth services.

PHE Flexibilities for Direct Supervision Requirements

Certain Medicare regulations impose more restrictive supervision requirements than existing state scope of practice laws which hinder healthcare professionals from practicing to the full extent of their licenses. During the COVID-19 PHE, CMS has enacted several key flexibilities around supervision and scope of practice which have been essential in ensuring access to healthcare for the Medicare population and has greatly improved the efficient of care delivered during the PHE. One of these key flexibilities has been the ability of healthcare professionals to meet supervision requirements through the use of audio/visual real-time communications technology. Under this policy, a supervising professional can meet the direct supervision requirements for diagnostic tests, physicians' services and some hospital outpatient services by being immediately available through a virtual presence using real-time audio/video technology. CMS seeks comment on whether to make this flexibility permanent.

Premier urges CMS to permanently adopt its policy to allow practitioners to meet direct supervision requirements through a virtual presence. At a minimum, we would encourage CMS to extend the policies allowed during the COVID-19 PHE for a sufficient number of years to collect robust data on patient outcomes and satisfaction and access to care for Medicare beneficiaries, especially in rural areas and in communities with shortages of healthcare personnel.

BEHAVIORAL HEALTH

Earlier this year, CMS released a comprehensive Behavioral Health Strategy, which includes goals to strengthen quality and equity, improve access to mental health and substance use disorder services, ensure effective pain management and enact data-driven system change. To support the goal of expanding access to mental healthcare, CMS proposes in this rule to allow licensed professional counselors (LPCs)

[2] Under the Consolidated Appropriations Act, 2022, this flexibility will stay in place for an additional 151 days following conclusion of PHE.

and licensed marriage and family therapists (LMFTs) to furnish behavioral health services under general rather than direct supervision, and to create new coding and payment for behavioral health integration billed by clinical psychologists (CPs) and clinical social workers (CSWs). CMS also proposes to continue PHE-era flexibilities to allow initiation of buprenorphine treatment via audio-video or audio-only communication without an initial in-person evaluation. Additionally, CMS advances its goal of ensuring effective pain treatment and management through the proposed creation of chronic pain treatment and management bundled payments.

Premier applauds CMS' continued commitment to improving access, quality and equity in behavioral healthcare for Medicare beneficiaries. We strongly support CMS' proposal to amend the direct supervision requirements under the "incident to" regulations to allow LPCs and LMFTs the flexibility to practice under general supervision. Premier also supports CMS' proposal to create new billing options for CPs and CSWs providing General Behavioral Health Integration. We urge CMS to engage with stakeholders to identify potential additional codes to qualify as eligible initiating visit codes within the scope of clinical psychologists' practice to maximize access to coordinated care.

Premier also supports CMS' focus on improving access to prevention and treatment services for substance use disorders through proposals to 1) create new G-codes for bundled monthly chronic pain management (CPM) services, and 2) continue to allow intake appointments for buprenorphine treatment to be provided via telehealth. We recommend that CMS add the CPM codes to the Medicare Telehealth Services list to expand access to care, as pain assessment, treatment and management are critically needed among Medicare beneficiaries who are homebound by their chronic pain.

SPLIT (OR SHARED) E/M VISITS

A split (or shared) visit refers to an E/M visit that is performed by both a physician and a non-physician practitioner (NPP) who are in the same group. Billing for split visits vary based on the setting in which the service is furnished. For visits in the non-facility setting (e.g., office), the physician is permitted to bill for the split visit if the visit meets the conditions for services furnished "incident to" a physician's professional service. For visits furnished in the facility setting (e.g., hospital), CMS' longstanding split billing policy allows a physician to bill for the split E/M visit only if the physician performed the substantive portion of the visit.

As part of last year's rulemaking, CMS adopted a policy whereby the physician or NPP who performs the substantive portion of the E/M visit in the facility setting would be permitted to bill for the visit. CMS defined the "substantive portion" as more than half of total time spent performing the visit. Based on stakeholder input, CMS finalized a phased-in approach which delayed the requirements until CY 2023. CMS now proposes to further delay the requirements until CY 2024 to give providers additional time to become accustomed to the new coding and payment changes proposed for Other E/M visits, as well as to give CMS more time to evaluate the policy.

We continue to have concerns that CMS' proposal to define "substantive portion" based on time will create a significant administrative burden on care teams and may ultimately discourage team-based care. Defining "substantive" as the majority of time assumes that all minutes dedicated to a visit are of equal weight and substance. However, there might be instances where a physician or NPP may have done the bulk of an assessment or exam with the patient but may have taken less time than the other practitioner. For example, a NPP may need to spend additional time with a patient he or she has not seen before in order to obtain the patient's medical history. Conversely, the physician may already have an established relationship with the patient and is able to furnish the physical exam or counseling in less time.

Premier recommends that CMS provide an alternative method for determining substantive portion of the split visit based on either history of present illness, physical exam, or MDM that is consistent with prior guidance.[3] If a physician furnishes one of these key components of the E/M visit, he or she should be considered to have performed the substantive portion of the visit and chose the appropriate E/M service. We also ask that CMS clarify how this policy should be applied when E/M services are furnished via telehealth.

QUALITY PAYMENT PROGRAM

Traditional Merit-Based Incentive Payment System (MIPS)

Quality Performance Category

For performance years 2024 and 2025 / payment years 2026 and 2027, CMS proposes to increase the data completeness threshold for quality measures from 70 percent to 75 percent and to amend the definition of high priority measure to include health equity measures beginning with performance year 2023.

Premier opposes increasing the data completeness threshold for quality measure reporting at this time. Office practice patterns and workflows have not yet fully recovered from disruptions related to the COVID-19 PHE and significant staff shortages are ongoing. Comprehensive overhaul of E/M service documentation and coding requirements is just being completed. Additionally, physician reimbursement is being seriously threatened by sequential years of zero percent annual fee schedule updates and a decreasing conversion factor. Increasing clinician reporting burden at this time would be far from supportive of the physician community in such challenging times.

Additionally, Premier is concerned that CMS appears to be contemplating further increases to the completion threshold over the next several years. **Premier strongly encourages CMS to work with stakeholders and quality measurement experts to set the ultimate target completeness threshold and the timeline for achieving that threshold**. Expectations of reaching 100 percent data completeness are unrealistic as there will always be some operational and process challenges in a complicated reporting program like MIPS. It is also unclear whether the same completeness threshold is appropriate for all measure types and all measure categories.

Finally, Premier applauds CMS for its ongoing agency-wide attention to advancing health equity. Conceptually, we support amending the definition of "high priority measure" to include health equity-related quality measures. We recommend that CMS clarify what criteria must be met for a measure to be considered a health equity-related measure and consider reinstituting the expired bonus structure that was associated with high priority measures.

RFI: MIPS Quality Performance Category Health Equity

CMS seeks input on the future inclusion of additional health equity measures in the MIPS Quality performance category, including the Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health measures recently finalized for use in the Hospital IQR Program. As we note in greater detail above, we have a number of concerns regarding adoption of the Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health into the APP measure set.

[3] CSG, "Split/Shared Visits," March 22, 2021, https://www.cgsmedicare.com/partb/pubs/news/2021/03/cope21142.html

Premier supports carefully crafted health equity measures for future inclusion in the MIPS Quality performance category measure inventory and urges CMS to work with stakeholders to continue to explore meaningful health equity measures for inclusion. Premier encourages CMS to consider the following key principles as it evaluates new health equity measures:

- Measures should be actionable.
- Risk adjustment should be included wherever appropriate to account for factors outside of clinician control.
- Exclusions may be necessary for clinicians practicing in small, rural or other resource-limited settings.
- Measure reliability and validity are enhanced by the consistent use of validated, standardized data collection tools.
- While clinicians should be encouraged to collect social risk factor information from their patients, those clinicians should not be penalized for patient refusal to provide that information.
- Selection of self-reported patient characteristics for stratified analyses and reporting of measure data should be driven by the purpose of the measure and intended use of the data.
- Characteristics should have standardized definitions that are compatible with CEHRT.
- Substantial experience should be gained with health equity-related measures before making their reporting mandatory for clinicians (e.g., in the foundational layer of MVPs) or used in pay-for-performance programs.

Improvement Activities (IAs) Performance Category

CMS proposes the addition of four new IAs, all of which address the agency's Priorities for Reducing Disparities in Health[4]:

- Use Security Labeling Services Available in Certified Health Information Technology (IT) for Electronic Health Record (EHR) Data to Facilitate Data Segmentation; (IA_AHE_XX)
- Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients (IA_AHE_XX)
- Create and Implement a Language Access Plan (IA_EPA_XX)
- COVID-19 Vaccine Promotion for Practice Staff (IA_ERP_XX)

Premier supports the addition of IAs as proposed. These changes, combined with those finalized during the CY 2022 rulemaking cycle, now ensure that clinicians have multiple options for taking actions that will assess and improve the equity-awareness level of their practices. The Data Segmentation activity will also leverage 2015 Edition Cures Update CEHRT to protect patient privacy while gathering interoperable information that facilitates holistic patient care.

Promoting Interoperability Performance Category

e-Prescribing Objective: Mandatory Reporting Query of Prescription Drug Monitoring Program

After several years of optional reporting under the e-Prescribing Objective, CMS proposes to require reporting of the Query of Prescription Drug Monitoring Program (PDMP) measure beginning with performance year 2023. CMS believes that PDMPs are now sufficiently accessible and integrated into health IT systems to allow reporting by clinicians without undue efforts. The mandatory measure would be

[4] The priorities are described in the CMS Framework for Health Equity at https://sss.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/framework-for-health-equity.

expanded to include Schedules III and IV controlled substances (in addition to Schedule II). Exclusions would be available for clinicians who write fewer than 100 permissible prescriptions during the reporting period and those who cannot report on this measure in accordance with applicable laws. The PDMP query must occur before electronic transmission of the associated controlled substance prescription. CMS hopes to transition the measure from its current Yes/No response to a scored numerator/denominator-based configuration in the future.

Premier is generally supportive of measures addressing opioid use in ambulatory settings. We support measure expansion to include Schedule III and IV controlled substances. **However, we strongly recommend that Query of PDMP measure reporting remain optional until ongoing challenges are addressed.** CMS needs to address residual inconsistencies across state PDMPs and to work with states to resolve the barriers to data access by clinicians that are presented by heterogeneous state licensing requirements. For example, the state of Missouri PDMP remains untested and RxCheck remains in the prototype testing stage. If CMS wants to promote routine electronic queries of PDMPs, it should work with the Office of the National Coordinator for Health Information Technology (ONC) to support development of data and interoperability standards that would enable this type of electronic exchange. CMS should work with ONC to include data elements within the USCDI and functionality within CEHRT to enable better monitoring and reporting of opioid-related care, treatment, and outcomes. Additionally, given the ongoing criticality of addressing issues regarding opioid use, we once again urge CMS and ONC to identify and prioritize the need for revised or new CEHRT criteria as well as the potential need for development, adoption and support for additional data, interoperability and transmission standards.

Health Information Exchange (HIE) Objective: Measure Addition and Scoring Modification

CMS proposes to add a new measure – Enabling Exchange under TEFCA (Trusted Exchange Framework and Common Agreement) – to the HIE Objective beginning with performance year CY 2023. The new measure would serve as a third alternative by which clinicians could satisfy the HIE Objective requirements (i.e., in addition to either reporting the HIE Bi-Directional Exchange measure or the pair of referral loop support measures – sending and receiving/reconciling). Credit for the proposed measure would be awarded when a clinician attests to 1) participating as a TEFCA Framework Agreement signatory, and 2) under the Framework Agreement is using the functions of CEHRT, in production, to support bidirectional exchange of patient information. Additionally, CMS proposes to change the total points available under this objective from the current 40 points to 30 points. The 10 points would be transferred to the e-Prescribing Objective's Query PDMP measure, as that measure is proposed to change from optional, bonus-point reporting to required beginning with CY 2023 reporting.

Premier appreciates efforts by CMS to encourage use of interoperable health IT and to increase Promoting Interoperability Program reporting flexibility for clinicians. Premier remains cautiously optimistic that TEFCA, once fully implemented, will help achieve nationwide interoperability as envisioned by the ONC Interoperability Roadmap and the 21st Century Cures Act. However, progress towards TEFCA implementation is slow and incremental and much remains to be accomplished to operationalize TEFCA. We caution CMS about offering new measures such as Enabling Exchange under TEFCA before additional TEFCA milestones are confirmed and achieved.

Public Health and Clinical Data Exchange Objective: Mandatory Measure Addition, Active Engagement Revisions, and Scoring Modifications

For the Public Health and Clinical Data Exchange objective, CMS proposes to incent clinicians to reach a higher level of active engagement more quickly in reporting measures under this objective by revising the current level options beginning with performance year 2023. Clinicians would only be allowed to remain at the revised Option 1 Level – Pre-production and Validation – for a single EHR reporting period before

moving to the Option 2 Level – Validated Data Production. CMS further proposes that a clinician would be required to submit an engagement option level for each of the measures it reports whether mandatory or optional. A clinician would be permitted to remain at revised Option Level 1 for one additional year if the clinician switches between one or more clinical data registries or public health agencies. **Premier supports the proposed changes to the active engagement level requirements as part of a renewed commitment to public health reporting throughout the healthcare delivery system triggered by the COVID-19 PHE.**

CMS also proposes to adjust scoring of the Public Health and Clinical Data Exchange Objective beginning with the CY 2023 EHR reporting period to further emphasize the significance of public health data exchange by clinicians with clinical registries and public health agencies. The points available for reporting mandatory measures under this objective would increase from 10 points currently to 25 points; awarding of points requires reporting for all of the mandatory measures. The added 15 points would come from reducing the points associated with the Provide Patients Electronic Access to Their Healthcare Information measure under the Provider to Patient Exchange Objective from the current 40 points to 25 points. This scoring change combined with that proposed under the HIE Objective would result in the following PIP point distribution: 20 points for the e-Prescribing Objective, 30 points for the HIE Objective, 25 points for the Provider to Patient Exchange Objective, and 25 points for the Public Health and Clinical Data Exchange Objective. **The COVID-19 PHE has clearly demonstrated the importance of smooth flow of information between clinicians and public health agencies, and Premier supports the proposed higher value for the Public Health and Clinical Data Exchange Objective.**

MIPS Value Pathways (MVPs)

CMS introduced the MVP concept during the CY 2020 PFS rulemaking cycle and views MVP reporting as the "future state of MIPS" and a bridge for clinicians from traditional FFS care delivery to APM participation. For performance year 2023/payment year 2025, CMS proposes additional policies to support MVP implementation, including establishing processes for gathering public input about submissions for new and revised candidate MVPs. Several proposals address subgroup reporting, including setting a requirement that each subgroup provide a narrative description of its composition at the time of subgroup registration each year. This narrative would be made publicly available through a CMS website.

Premier supports the addition of formal opportunities for public comment regarding new and revised candidate MVPs which will help enhance the transparency of the MVP development process. However, **we are concerned about the proposed requirement for subgroup submission of a narrative self-description.** CMS intends that multispecialty groups will restructure themselves into multiple subgroups for MVP reporting. For large multispecialty groups the number of subgroups could be quite large (e.g., 50 or greater) and the aggregate number of narratives required under this proposal could be substantial and create considerable provider burden. The value-add offered by the narrative is unclear. If it is meant to inform beneficiaries, there is no evidence that beneficiaries or their representatives were involved in decision making about the narrative. As a result, Premier does not support CMS' proposal to require subgroups to submit an annual narrative about their composition. At a minimum, CMS should provide template language or check-box forms that can be completed and returned electronically. Additionally, CMS should only require groups to submit a narrative annually if the description materially changes.

Premier appreciates that CMS is not proposing a specific date under which it would sunset Traditional MIPS and mandate MVP reporting. We continue to support the potential for MVPs to serve as a bridge for some clinicians to begin their transition from FFS to APMs. **CMS should not sunset Traditional MIPS reporting and mandate reporting through MVPs until sufficient MVPs are available and applicable to at least 90 percent of clinicians.**

RFI: MVP and APM Participant Reporting

CMS seeks feedback on ways to better align clinician experience between MVPs and APMs so that MVP reporting serves as a bridge to APM participation. CMS plans to prioritize approaches that enhance information available to patients by using specialty-specific performance measurement that minimize complexity wherever possible.

Premier views MVP reporting as a potential step towards APM participation for some clinicians. This transition will be inherently limited by the large numbers of clinicians that are exempt from MIPS reporting and that presumably will also be exempt from mandatory MVP reporting. Further, the optimal relationship between MVPs and APMs remains unclear. We urge CMS to design MVPs so that providers are prepared and better incented to adopt APMs. Requiring MVPs to include a population health measure and incorporating health equity measures over time is a step towards encouraging movement into APMs. However, every aspect of MVPs should be designed to encourage the movement to APMs, including measure scoring and weights, multispecialty group/subgroup reporting composition and reporting exceptions. APM measures should be translated for use in MVPs rather than the converse, and we reiterate our previously expressed objection to forcing APM measures into a MIPS format as is being done in the Shared Savings Program – this is misalignment and counterproductive to moving from volume-to-value. Alignment will be served by developing MVPs that center on quality improvement, efficient resource use, patient outcomes, and technology to improve care for specific patient populations or conditions.

APM Performance Pathway (APP)

The APP was finalized during CY 2021 PFS rulemaking as a MIPS reporting and scoring option for MIPS eligible clinicians participating in a MIPS APM. In the context of MVP subgroup reporting, CMS proposes to disallow subgroup reporting through the APP to avoid confusion with MVP subgroup reporting. Additionally, CMS had never intended to allow subgroup reporting as part of the design of the APP. However, CMS seeks input on an alternative that would allow subgroup reporting through the APP as some MIPS APM clinicians with shared characteristics (e.g., team-based care, shared EHRs) might wish to use this reporting mechanism. CMS asks commenters to indicate a preference to allow or disallow APP subgroup reporting based on balancing reporting flexibility with administrative burden, since CMS would need to adapt certain subgroup policies to APP subgroup reporting (e.g., subgroup registration and self-description).

In general, **Premier supports reporting flexibility wherever feasible as long as provider burden is minimal.** However, we are unsure what burden other than subgroup registration would be imposed on MIPS APM clinicians if they were allowed to report through the APP as subgroups. Participation in MIPS APMs is intended to have reduced burden compared to other MIPS reporting mechanisms. We encourage CMS to provide more detail on what policies and processes would be required to implement APP subgroup reporting and how reporting through the APP would benefit MIPS APM clinicians versus their current reporting options.

Advanced APM Incentive Program

The defining criteria for an Advanced APM are set in statute (sections 1833(z)(3)(C) and (D) of the Social Security Act) and described further in regulation at §414.1415(a) through (c). Statute requires that payments made to providers through an Advanced APM must be contingent on provider performance on prespecified quality measures. Regulations require that (1) at least one of the required quality measures be an outcome measure and (2) one must appear in the finalized MIPS measure inventory, be endorsed by a consensus-based entity, or be determined by CMS to be evidence-based, reliable and valid. CMS proposes regulation text language changes to clarify that a single measure may satisfy both of these

stipulations. **Premier supports the administrative simplification represented by the clarifying language changes as proposed.**

CMS also proposes to permanently set the Advanced APM generally applicable nominal risk standard at 8 percent. **Premier supports this change, noting that the standard previously has been set at 8 percent on a temporary basis and periodically renewed at that level several times since the QPP's inception.**

Finally, CMS proposes to modify the Advanced APM 50-clinician limit provision of the medical home model risk-bearing standard to apply at the APM Entity level rather than at the parent organization level. **Premier supports this change.**

RFI: Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs

In its 2022 Medicare payment final rules, CMS articulated its goal of moving to fully digital measurement across its quality enterprise by 2025. As part of this goal, CMS aims to streamline the approach to data collection, calculation and reporting to fully leverage clinical and patient-centered information for measurement, improvement and learning. In this proposed rule, CMS seeks input on initiatives for continuing to advance towards digital quality measurement and the use of FHIR® in the QPP, focusing on questions of digital quality measurement dQM definition, data standardization and approaches to reporting electronic clinical quality measures eCQMs based on FHIR standards.

Premier appreciates CMS' ongoing commitment to transition to digital quality measurement. We have long been committed to advancing providers' digital capabilities to analyze data from multiple sources and to manage the health of their populations. Below we offer comments on next steps in moving to digital quality measurement based on our experience with supporting providers in their use of advanced data analytics and quality reporting.

> ***Definitions.*** CMS updates its dQM definition: *quality measures, organized as self-contained measure specifications and code packages, that use one or more sources of health information that is captured and can be transmitted electronically via interoperable systems.*
>
> **Premier supports this revised definition and appreciates that CMS is considering data sources beyond EHRs.** As part of this discussion, CMS indicates that given the ongoing challenges of eCQM reporting, the agency is considering how best eCQMs will fit within a digital quality framework. We have previously shared with CMS our concerns about the largely dysfunctional current state of eCQM reporting within the hospital inpatient reporting programs, and we therefore recommend that CMS proceed deliberately and cautiously regarding adaptations of eCQMs to dQMs and permissible data sources for dQMs.
>
> ***Data Standards and FHIR eCQM Reporting.*** CMS states that standardization is necessary across implementation guides and value sets to facilitate interoperability and continues to emphasize the potential role to be played during information exchange by FHIR-enabled application programming interfaces (APIs). CMS also reports continuing to test conversion of existing eCQMs for use with FHIR-based resources and indicates plans to develop a unified CMS FHIR receiving system.
>
> **Premier strongly believes that a holistic approach is needed to data standards whereby standards intentionally are developed and adopted for use across care settings.** While the current number of common data elements across inpatient, outpatient and post-acute care are

quite limited, they could easily serve as a familiar starting point for patient assessment across the care continuum.

We also believe that it is likely, but not certain, that FHIR resources will make measure development and maintenance easier over time. However, we note that testing of FHIR-enabled measures by developers is in its early stages. Sufficient dQM measure testing and evaluation by multi-stakeholder groups such as HITAC and NQF will be essential prior to wide-spread adoption.

Premier notes that a key component to implementing FHIR-based eCQMs is the adoption of bulk FHIR transactions to simplify and speed data transmission. Without bulk FHIR transaction availability, providers will not be able to support FHIR-based data exchange. We further note that the FHIR standards are not yet broad enough to support all potential use cases as much of the data captured in the EHRs does not map to a consensus standard. Similarly, FHIR is only used by EHRs and has limited application to other digital data sources, such as HIEs. Open APIs and rapid expansion of the FHIR standard are needed to achieve functional dQM reporting. Premier strongly urges CMS to work with ONC to accelerate the adoption and consistent implementation of data and interoperability standards so that provider data collection and reporting requirements are seamlessly enabled by health information technology.

RFI: Potential Transition to Individual QP Determinations Only

Clinicians who have a certain percentage of payments or patients through the advanced APM are considered Qualifying APM Participants (QPs). CMS currently makes that determination at the APM entity level based on the collective performance of clinicians on an APM's Participant List. As a result, QP status is awarded either to all or none of an APM entity's clinicians.

CMS seeks input on whether it should modify this approach and instead make QP determinations at the individual clinician level. CMS notes that it is considering this option as part of its efforts to encourage more specialist participation in APMs. Stakeholders have noted concerns that the current QP methodology might be discouraging APMs from including certain clinicians, such as specialists. For example, inclusion of specialists in an APM may lower the percentage of total patients or payments that flow through the APM because the specialist may not contribute alignment to the APM and typically has a higher proportion of patients outside the APM.

Premier has continued to highlight challenges with the QP threshold methodology and the impact it may have on inclusion of specialists. However, **we caution CMS in finalizing its proposal to solely calculate QP status at the individual clinician level, as this may create undue burden on providers and APMs and may not achieve CMS' intended purpose**. As noted above, specialists do not attribute significant alignment to APMs. As a result, many specialists would not achieve QP status at the individual level, despite their active engagement with an APM. Additionally, transitioning to individual QP determinations may create administrative burden on APMs as they rearrange participation lists based on who meets QP thresholds.

We instead encourage CMS to explore other policies to improve specialist integration into APMs:

- **Test new types of beneficiary attribution.** Existing attribution methodologies focus on plurality of primary care services, which can result in a low volume of patients being aligned to the ACO through the specialists. As a result, many specialists may not find it worthwhile to engage with the APM. CMS should test other forms of attribution or alignment, such as voluntary alignment through specialists or other providers.

- **Modify risk adjustment and benchmarking methodologies to better account for complex and high-needs populations.** Inclusion of specialists can often result in higher cost patients with complex medical needs being aligned to the APM. As discussed previously, there are several challenges with existing risk adjustment methodologies, which may result in these higher costs not being sufficiently accounted for in an APM's benchmark or target price. As a result, APM entities may be discouraged from including specialists. As noted above, we provide several recommendations for improving the risk adjustment methodology for MSSP. Many of these same recommendations could be applied to and should be considered for other APMs.
- **Modify QP Threshold Calculation.** As noted above, inclusions of specialists in an APM may lower the percentage of total patients or payments flowing through the APM because specialists do not contribute alignment to the APM and typically have a high proportion of their patients outside of an APM. CMS should consider other approaches for determining the QP thresholds, such as setting thresholds by specialty type.

RFI: QPP Incentives Beginning in Performance Year 2023

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established an incentive for clinicians to participate in advanced APMs through the establishment of a 5 percent bonus (commonly referred to as the MACRA bonus). This bonus has been critical to clinicians in covering the investment costs of moving to new payment models, as well as overcoming the revenue advantages of FFS volume-based payments. CY 2022 is the final performance year and CY 2024 is the final payment year for the MACRA bonus. Under current statute, there are no incentives for QPs in CY 2025. Starting in payment year 2026, QPs will be eligible for a higher PFS annual conversion factor (0.75 percent) compared to non-QPs (0.25 percent). Finally, the threshold for qualifying as a QP will increase beginning in performance year 2023 / payment year 2025.

In the proposed rule, CMS acknowledges several challenges with the upcoming expiration of the MACRA bonuses and rising QP thresholds:

- CMS anticipates that the rising QP threshold will result in a lower number of clinicians qualifying for QP status.
- Since MIPS eligible clinicians are eligible for a maximum payment adjustment of up to 9 percent, the QP conversion factor is not expected to equate the anticipated maximum positive payment adjustment under MIPS until after CY 2038. As a result, remaining in FFS may be more appealing for some clinicians.

Premier shares CMS' concern that the expiration of the MACRA bonuses, coupled with the QPP incentive structure, may not be adequate to encourage providers to move to APMs. In fact, we are deeply concerned that this will result in incentives shifting back to FFS. As noted above, the MACRA bonus has been a crucial tool for clinicians in offsetting the costs associated with shifting to APM participation, such as investing in workflow improvements, digital health tools, care coordinators, data analytics and quality measurement system. For example, on average ACOs spend between $1-2 million per year on these types of advanced care delivery tools. The MACRA bonus has also helped APMs expand services beyond traditional FFS, such as funding wellness programs, reducing cost sharing for beneficiaries and improving patient care coordination.

Premier has continued to call on Congress to extend the MACRA bonus by six years, along with granting CMS the authority to set thresholds based on current APM adoption. **We encourage CMS to work with Congress to support an extension of the MACRA bonus and these additional flexibilities.** We also

encourage CMS to explore its Innovation Center authority and whether it could allocate funding to continue making payments to participants operating in Advanced APMs, pending an extension of the bonus.

REQUIRING MANUFACTURERS OF CERTAIN SINGLE-DOSE CONTAINER OR SINGLE-USE PACKAGE DRUGS TO PROVIDE REFUNDS WITH RESPECT TO DISCARDED AMOUNTS

Beginning January 1, 2023, Part B drug manufacturers are required to refund discarded drug amounts exceeding 10 percent of total charges for the drug in a given calendar quarter. CMS proposes to use the JW modifier to determine the refund amount due for a discarded drug.

The JW modifier has been required on Medicare claims since CY 2017 to identify the amount of a drug that was discarded and eligible for payment. However, CMS expresses concern that this modifier is often omitted on claims. CMS believes this may be because there is currently a lack of incentive to bill accurately since CMS will pay up to the full amount of the labelled dose. To address this issue, CMS is proposing to establish a new modifier (JZ), which would be used to attest that the physician did not discard any drugs being billed from a single-use vial.

Under this proposed policy, a provider would bill Medicare for the amount of drug administered on one line of the claim and the amount discarded with the JW on another line of the claim. Units administered and units discarded would total to the labeled dose on the vial. Alternatively, the provider may administer the full amount of the drug included in the single-use vial and bill one line with the JZ modifier attesting the entire vial was administered and no amount is being billed for discarded drugs.

Premier urges CMS to not proceed with the JZ modifier and instead determine appropriate incentives to encourage appropriate physician documentation with the existing JW modifier. It is also essential for CMS to determine mechanisms for decreasing provider burden associated with documentation. In speaking with our members, we learned that a primary reason providers are not currently using the JW modifier is because the undue burden it creates in documentation does not overcome the potential rebate. Implementing a new modifier, without addressing the misaligned incentives, only adds to provider burden in an environment where staffing shortages are dictating a need to reduce burden, not increase it.

MEDICARE PROVIDER AND SUPPLIER ENROLLMENT AND CONDITIONS OF DMEPOS PAYMENT

Premier appreciates CMS' efforts to enhance the enrollment process to help confirm that providers and suppliers meet all Medicare requirements. We support the broader provider enrollment and revalidation documentation requirements and processes detailed in Section I of the proposed rule that should result in additional financial fraud, waste, and abuse protections for all provider types. However, the CMS proposal to revise Skilled Nursing Facility (SNF) enrollment is misguided and will have downstream consequences for providers and the patients they serve. CMS proposes to move initially enrolling SNFs from the current limited-risk screening category under § 424.518 to the high-level of categorical screening. Under the proposal, revalidated SNFs would be subject to moderate risk-level screening.

Premier shares the concerns of CMS and many other stakeholders regarding the fiscal instability of SNFs resulting from the combined effects of the COVID-19 public health emergency (PHE) and the Patient

Driven Payment Model (PDPM) that was implemented in FY 2019, just months before the PHE began. Given the historic nature of the ongoing COVID-19 PHE and its disproportionate fiscal effects on SNFs, adding new layers of burdensome oversight at this juncture would only exacerbate the ongoing challenges SNF providers are facing. A significant contributing factor to the fiscal strain on SNFs is the unstable labor market. Premier firmly believes increased labor costs are not transitory. Long before the pandemic, many staff were in short supply and growing closer to retirement age. For example, according to pre-pandemic research published in 2018, healthcare was projected to be short more than one million nurses by 2020 as a result of nurse retirements, an aging U.S. population and a stagnant talent pipeline.[5] Since that time, the pandemic has only exacerbated matters, with more than 500,0000 nurse retirements expected in 2022.[6] As talent shortages become more severe, providers are paying more to attract and retain scarce staff.

Additionally, SNFs are already subject to both state and federal on-site surveys to verify capabilities to provide SNF services prior to opening, on a regular basis, and at any time due to a complaint. The CMS proposal would add another entity to conduct an on-site survey prior to enrollment and at revalidation, which is redundant and unnecessary. Further, as justification for the proposed changes, CMS cites multiple reports and documented instances of patient abuse and neglect in SNFs. However, the statutory authority of these provider enrollment regulations pertains to financial fraud, waste, and abuse – not patient care.

Therefore, Premier urges CMS to not finalize its proposal to change the provider enrollment category for SNFs from limited-risk screening category under § 424.518 to the high-level of categorical screening.

ELECTRONIC PRESCRIBING FOR CONTROLLED SUBSTANCES FOR A COVERED PART D DRUG UNDER A PRESCRIPTION DRUG PLAN OR AN MA-PD PLAN

Premier has long been supportive of moving to electronic transmission of prescription information because of the many benefits it offers over written prescriptions. The SUPPORT for Patients and Communities Act (P.L. 115-271) required such systems be implemented beginning January 1, 2021. In previous rulemaking, CMS delayed implementation and requirements until January 1, 2023. CMS describes this delay as necessary to recognize the unique challenges that prescribers are facing during the COVID-19 PHE. Additionally, CMS established a January 1, 2025 compliance timeline for prescriptions written for beneficiaries in a long-term care facility (LTCF).

Premier appreciates CMS providing flexibility for providers who are struggling with the challenges of the PHE and the difficulties they are facing implementing new systems or upgrades. In previous comments, Premier also commended CMS for recognizing that some LTC settings/services in rural communities do not have sufficient capabilities to support the National Council for Prescription Drug Programs (NCPDP) SCRIPT 2017071 standard. In the time since CMS finalized the decision to extend the compliance timeline for LTFCs to January 1, 2025, NCPDP has released a new SCRIPT 2022011 standard. Premier supports the adoption of the new SCRIPT 2022011 standard.

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[5] Zhang, Ziaoming, et al., "United States Registered Nurse Workforce Report Card and Shortage Forecast: A Revisit," American Journal of Medical Quality, 2018, Vol. 33(3) 229–236, https://edsource.org/wp-content/uploads/2019/02/Zhang-Daniel-Pforsich-Lin-2017-United-StatesRegistered-Nurse-Workforce-Report-Card-and-Shortage-Forecast_-A-Revisit.pdf

[6] American Nurses Association, "Nurses in the Workforce," https://www.nursingworld.org/practicepolicy/workforce/

Further, as we discuss technology improvements for providers, we urge CMS to enhance its efforts to develop standards and measures for data exchange and sharing across all care settings, including long-term and post-acute care (LTPAC). Ensuring interoperability across electronic health record (EHR) systems and settings of care can unlock barriers to data sharing and care coordination between health systems, physician group practices, independent physicians, as well as LTC and PAC settings. Many LTPAC providers rely on paper-based transmission of information and are not using EHRs or are using EHRs that are not designed for interoperability. CMS must address this barrier to truly support efforts to standardize patient data, improve care quality, and reduce costs across the continuum.

CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the CY 2023 PFS Proposed Rule. If you have any questions regarding our comments or need more information, please contact Melissa Medeiros, Senior Director of Policy, at melissa_medeiros@premierinc.com or (202) 879-4107.

Sincerely,

Soumi Saha, PharmD, JD
Senior Vice President, Government Affairs
Premier healthcare alliance

Appendix: PINC AI™ Analysis: Hospital-Led ACOs Perform as Well as Physician-Led Models

September 06, 2022

PINC AI™ Analysis: Hospital-Led ACOs Perform as Well as Physician-Led Models

Population Health | Advocacy | Blog

Key takeaways:

- CMS policy forces ACOs that include hospitals as formal network members, known as high-revenue, to assume greater levels of performance-based risk in the MSSP because they assume that low-revenue, physician-only ACOs are better able to achieve savings targets.
- PINC AI™ analysis shows the differences between high-revenue and low-revenue ACOs has more to do with cherry picking locations and attribution methodology than with real performance.

- Continuing to distinguish ACO participants as high- versus low-revenue creates an unlevel playing field that disadvantages ACOs that include hospitals relative to their physician-led counterparts.

The Medicare Shared Savings Program (MSSP) was established under the 2010 Affordable Care Act as a means of making care more efficient and controlling costs within a traditional fee-for-service payment system. Accountable care organizations (ACOs) are designed to reward providers for furnishing high-value care through various incentives, including shared savings.

Over time, the program has evolved to align with the Centers for Medicare and Medicaid Services' (CMS') priorities. In 2018, CMS finalized a program overhaul of the MSSP under its *Pathways to Success* reforms. A primary intent of *Pathways* was to adjust incentives to ensure that lower-performing ACOs would move into risk-bearing tracks and avoid "parking" in an upside only track indefinitely.

One of the notable policies that CMS adopted within *Pathways* is a distinction between low-revenue and high-revenue ACOs. The distinction is determined based on the amount of fee-for-service (FFS) revenue paid to ACO participants as a percent of total FFS expenditures for attributed beneficiaries, regardless of site of care. Most ACOs that include a hospital as a formal network meeting via listing on their participation list are classified as high revenue, while ACOs that only include physicians - especially those that only include primary care physicians - are often generally classified as low revenue.

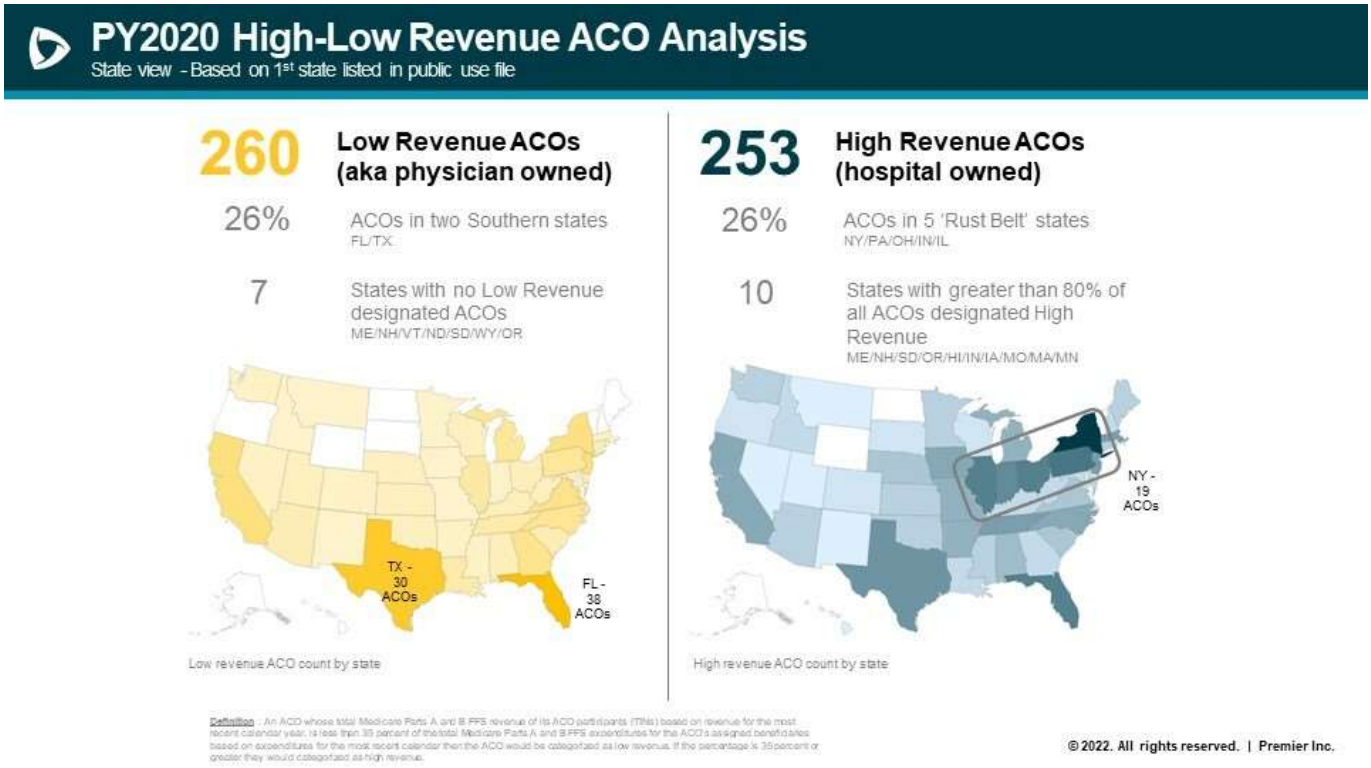
This policy is built on the dual-premise that: 1) physician-comprised ACOs (low revenue) perform better in reducing expenditures than ACOs who include a hospital-(high revenue) and 2) that that low-revenue ACOs lack the resources and capital to take on risk more quickly.[1]

Under *Pathways*, CMS requires high-revenue ACOs to progress to risk at a much faster clip than low-revenue counterparts. High-revenue ACOs determined to be inexperienced with performance-based Medicare ACO initiatives may participate in the BASIC (upside-only, shared savings) track for a single agreement period. Those determined to be experienced with such initiatives are restricted to participating in the ENHANCED (greatest risk-sharing) track, with a limited one-time exception for BASIC track participants.

PINC AI™ consultants have more than 12 years' practical experience helping create successful operating models for ACOs across the revenue spectrum. Based on their on-the-ground experiences, neither of CMS' assumptions about high- versus low-revenue ACO performance hold true. To test that belief, PINC AI™ partnered with Milliman to conduct data-driven research to test the dual-premises – around revenue and physician versus hospital leadership – on which the high-low revenue distinction is based.

Finding #1: Low-revenue ACOs are better able to cherry pick locations to ensure they reduce spending and achieve savings targets.

The analysis found that high- and low-revenue ACOs operate in distinctly different geographies. An assessment of the 2020 program showed 26 percent of physician-led ACOs operate in just two states, Florida and Texas.



These states have dramatically higher benchmarks than ACOs in other regions (see table below). This is important because higher benchmarks mean there is much more opportunity to achieve savings through better coordinated care.

Similarly, there are no low-revenue ACOs in seven states (Maine, New Hampshire, Vermont, North Dakota, South Dakota, Oregon). These states tend to have some of the lowest Medicare spending in the nation, which in turn drives down the CMS benchmarks and the room for improvement to demonstrate strong savings.

In contrast, high-revenue ACOs provide care to more beneficiaries and operate in more diverse areas. The analysis found that high-revenue ACOs operate in 2,337 counties, versus 1,546 counties for their low-revenue counterparts. As opposed to concentrating in high-cost states, high-revenue ACOs tended to cluster in five Rust Belt states (New Jersey, Pennsylvania, Ohio, Indiana, Illinois) with more moderate benchmarks.

2 States w/ 26% of Low Revenue ACOs

State	ACO 2019 Enrollment	Aggregate Updated Benchmark ($Ms)	Avg. Per Beneficiary	% of Nt'l Avg
TX	418,541	$ 5,378	$ 12,850	108%
FL	339,971	$ 4,347	$ 12,787	107%
Average	**758,512**	**$ 9,726**	**$ 12,822**	**108%**

5 States w/ 26% of High Revenue ACOs

State	ACO 2019 Enrollment	Aggregate Updated Benchmark ($Ms)	Avg. Per Beneficiary	% of Nt'l Avg
IL	245,031	$ 2,922	$ 11,925	100%
OH	235,708	$ 2,620	$ 11,117	93%
NJ	191,682	$ 2,473	$ 12,903	108%
PA	105,270	$ 1,331	$ 12,647	106%
IN	30,728	$ 329	$ 10,716	90%
Average	**808,419**	**$ 9,676**	**$ 11,970**	**100%**
All Other States	**2,520,897**	**$ 29,339**	**$ 11,638**	**98%**
United States	**4,087,828**	**$ 48,741**	**$ 11,924**	**100%**

Source: CMS Performance Year Financial and Quality Results for 2019[2]

Overall, the analysis strongly suggests that observed differences in cost efficiency in aggregate between high- and low-revenue ACOs may be due (in whole or in part) to selection bias.

Low-revenue ACOs should not get credit for better performance and distinct advantages over others if differences in savings are due to little more than location choice. In fact, this creates a perverse incentive that could have the unintended consequence of leaving low-spending states out of the movement to value-based care.

Finding #2: High-revenue ACOs have higher cost beneficiaries attributed through specialists.

In the MSSP, CMS uses a two-step methodology for assigning beneficiaries to ACOs. Under Step 1, beneficiaries are attributed to the caregiver providing the most primary care services, inclusive of primary care physicians or non-physician practitioners (NPP), such as a nurse practitioner, physician assistant or clinical nurse specialist. If a beneficiary is not assigned through Step 1, they are assigned based on the specialist physician providing the bulk of medical services (known as Step 2 assignment).

In the MSSP, medical oncology, neurology and cardiology are among the specialties eligible for Step 2 assignment. However, some specialty NPPs are eligible for attribution in Step 1, regardless of the practice type.[3] As a result, it is possible for even non-attribution-eligible specialties to drive attribution to an ACO through NPPs.

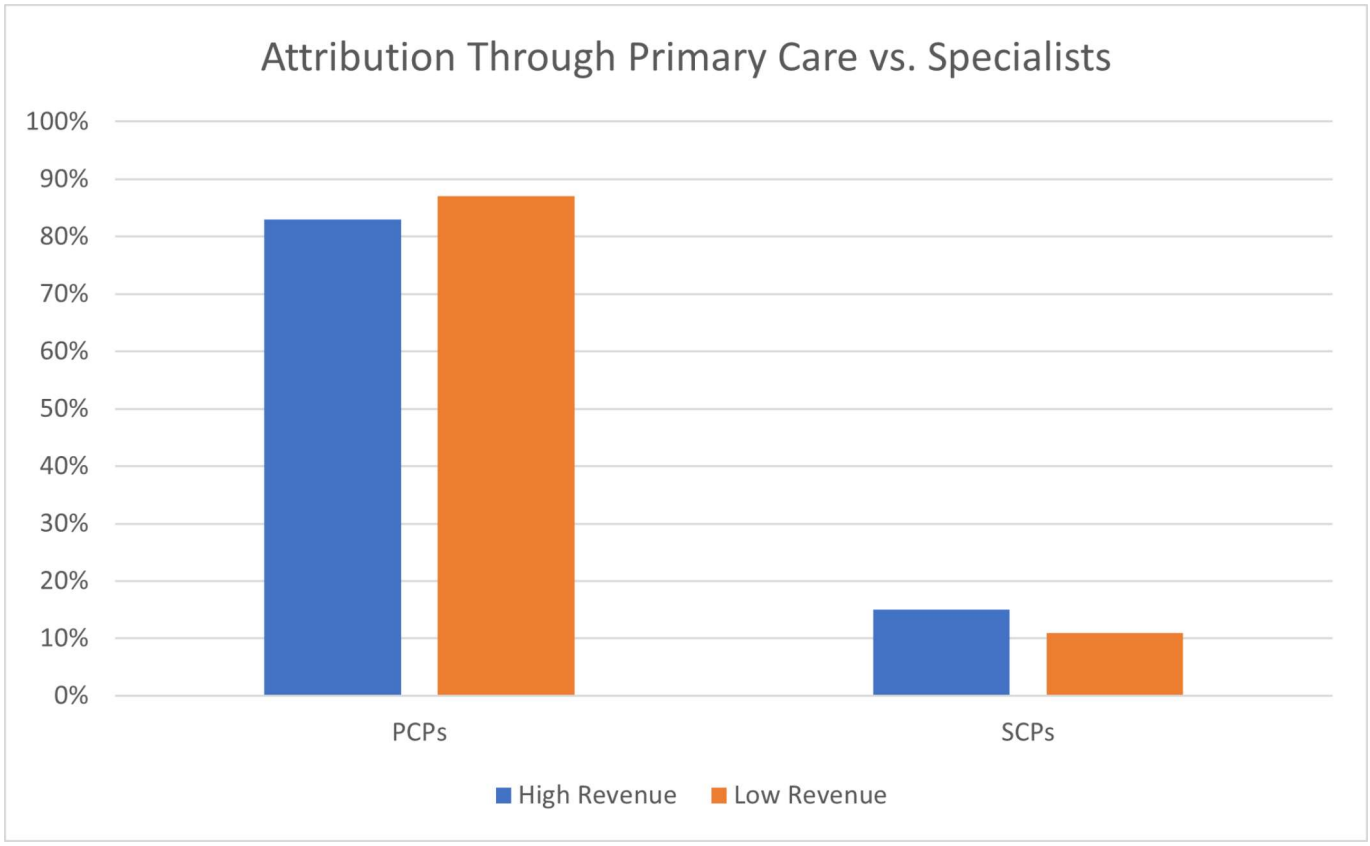
Specialty physicians typically provide care for higher cost and sicker patents than primary care physicians. Because risk adjustment models underpredict the costs for higher acuity patients,[4] ACOs that receive a higher proportion of beneficiaries attributed through specialists are at a distinct disadvantage – they must provide more and more intense services to these beneficiaries, which drives up total costs and limits the ACOs' abilities to achieve the savings that the MSSP rewards. This creates a disincentive for ACOs that have large number of specialists and for specialist participation in general.

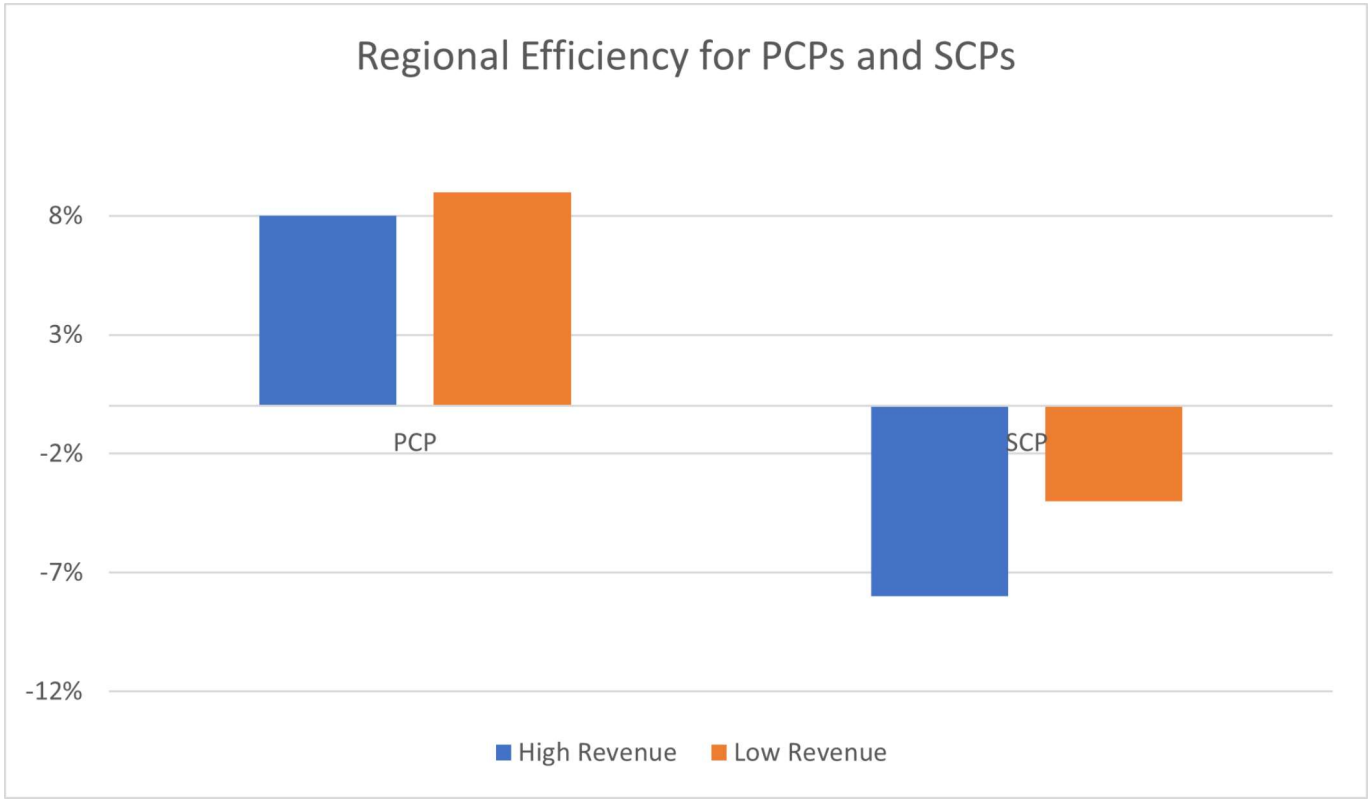
To give a specific example, consider a recently diagnosed cancer patient. The beneficiary will be attributed to an ACO through the patient's oncology specialist while the patient is undergoing active treatment; but this will happen before the risk coding has "caught up" to the expense. In other words, since benchmarks would be set *before* the cancer diagnoses were captured, the benchmark would not reflect the intensity of needed services in the current performance year. Exacerbating the issue, the specialist is likely to lose attribution for the patient the following year once treatment has finished and the patient resumes routine care from his or her primary care physician. As a result, under the MSSP, it is likely that a specialist's panel risk scores will never accurately reflect the cost of caring for those beneficiaries.

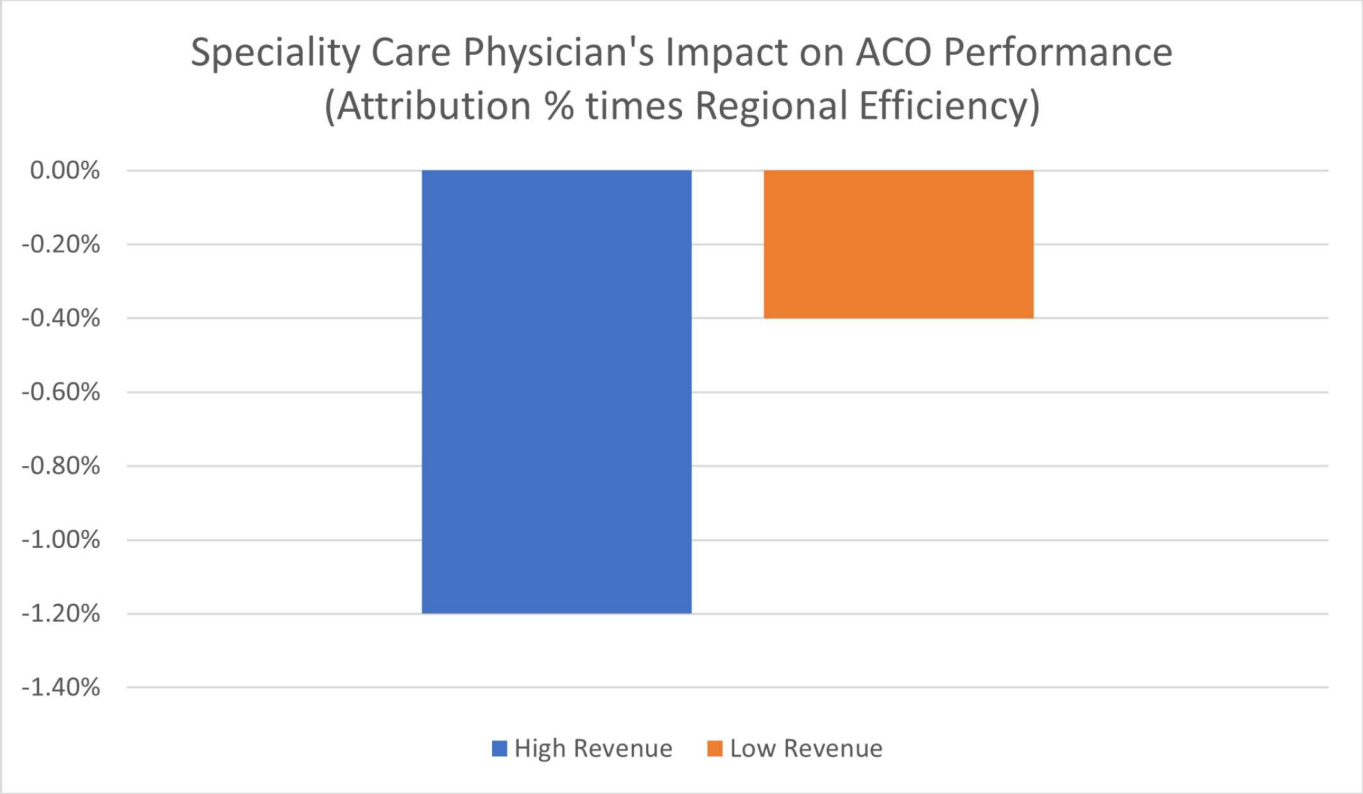
These factors impact both the performance year and the setting of the historical benchmark. As part of the process to determine the benchmark, the average expenditure for the ACO population is compared to the risk-adjusted cost for Medicare beneficiaries in the region. A portion of the difference in cost for those populations is applied to the ACO's benchmark, with ACOs that are higher cost than the region having the expenditure target lowered. This approach rewards ACOs that have historically lowered the cost for their beneficiaries. However, it has a perverse impact on specialist involvement.

Again, using an oncologist as an example, imagine the ACO is in a region of 20,000 Medicare beneficiaries and that 10,000 are attributed to the ACO. If there are 80 beneficiaries under active treatment for common cancers, that would be a rate of 40 per 10,000 population. However, if the oncologist is in an ACO, there is a chance that all 80 of those beneficiaries are attributed, which would create a rate of 80 per 10,000. As a result, even after risk adjustment, that ACO will likely have a negative adjustment applied to its benchmark.

This phenomenon disproportionately affects the high-revenue ACOs. The analysis found that high-revenue ACOs receive a higher proportion of lives through specialist attribution. Across the board, between 4-6 percent more beneficiaries assigned to high-revenue ACOs come in through specialists. While this may seem to be a small percentage, these specialists resulted in costs that are 11-16 percent higher overall than their primary care counterparts. Across a large swath of covered lives, these differentials can add up to meaningful cost differences.


Attribution Through Primary Care vs. Specialists
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
PCPs
SCPs
High Revenue
Low Revenue


Regional Efficiency for PCPs and SCPs
8%
3%
-2%
-7%
-12%
PCP
SCP
High Revenue
Low Revenue



Source: PINC AI™ and Milliman analysis. Charts above represent all beneficiary types for 2019 ACOs that had at least 4 years of MSSP participation as of 2019.

Even after accounting for risk, beneficiaries attributed through specialists have higher costs than others in a given region when compared to beneficiaries aligned through primary care providers.

It is unfair to punish high-revenue ACOs for specialist attribution or to create disincentives for providers to include specialists in value-based care. If anything, CMS needs to find more mechanisms to include specialists in the overall movement to value and total cost of care models.

Finding #3: No significant differences in performance could be found once adjustments accounted for differences in attribution and geography.

Prior to accounting for risk and geographic normalization, low-revenue ACOs appear to outperform high-revenue ACOs by 3-4 percent, based on data from recent years. However, after applying a more refined comparison of the regional efficiency of high- and low-revenue ACOs in this cohort, that number shrinks to 1-2 percent. Once accounting for the higher churn rate of low-revenue ACOs by isolating ACOs that have three or more years of participation, there was no significant difference in performance between high- versus low-revenue ACOs.

These findings suggest that additional adjustments must be made to account for differences in geographic regions and attribution when comparing the performance of high- and low-revenue ACOs.

Continuing to distinguish ACO participants as high- versus low-revenue creates an unlevel playing field that disadvantages hospital-led ACOs relative to their physician-led counterparts.

CMS exposes high-revenue ACOs to significantly greater levels of risk and limits their capacity to earn shared savings within the MSSP. This, in turn, has driven some health system ACOs to re-evaluate

participation in the program.

In fall 2021, CMS set a goal[5] of moving all Medicare beneficiaries into an accountable care relationship by 2030. To achieve this goal, CMS will need to craft ACO policies that do not limit provider participation and encourage ACOs to enter less attractive markets.

More must be done to ensure all providers have the same opportunities to succeed under value-based care. Hospitals and health systems are, and should remain, indispensable ACO participants and leaders. Hospital-led ACOs have significantly contributed to the success of the MSSP program:

- High-revenue ACOs cover more lives than low-revenue ACOs, coordinating care for more than 60 percent of all MSSP beneficiaries.
- High-revenue ACOs operate in more geographies: 2,337 counties, versus 1,546 counties for low-revenue ACOs, as noted above.
- Including hospitals in the ACO mix effectively balances access to primary care with increased focus on beneficiaries who require more. By definition, ACOs that include hospitals as formal network members cover a greater proportion of more ill (and more costly) lives. Incenting an equitable mix is a holistic approach to include a greater number of providers across the spectrum, while ensuring that the ACO model reaches patients who are sicker and more care intensive.

CMS recently proposed several notable changes to the MSSP, which are focused on attracting new providers into the program, improving the sustainability of the MSSP for existing ACOs and increasing the program's reach to underserved populations. While these proposals would align the risk tracks for low- and high-revenue ACOs, CMS continues to assert that low-revenue ACOs perform better than high-revenue ACOs. This belief translates into proposed policies that are limited to low-revenue ACOs only, including upfront investment payments and additional opportunities to earn shared savings.

As policymakers debate future changes to the MSSP – including recent proposals under the CY2023 Physician Fee Schedule – discussions should not be clouded by dubious correlations between size and performance or by inclusion of hospitals as formal participants. Eliminating the high-low revenue and physician-hospital distinctions to re-level the playing field for all program participants should be a priority.

Additionally, we continue to urge CMS to work with stakeholders to modify its risk-adjustment methodology and benchmarking approach to better account for the costs of beneficiaries, especially those with complex and high-cost medical needs. As part of that, CMS should:

- Stratify its current benchmarking approach – which is based on Medicare enrollment status – to set separate benchmarks for patients with certain high-cost chronic conditions or treatments.
- Standardize its risk adjustment methodology across all Medicare programs and models. At a minimum, CMS should align the methodology used in MSSP Enhanced

with Medicare Advantage.

- Increase its risk score cap to 5 percent to better account for changes in risk score over the agreement period.

METHODOLOGY

Data Sources:

The authors used 2016-2019 claims within the Medicare 100 percent Research Identifiable Files (RIF) data set, for beneficiaries enrolled in Medicare Fee for Service (FFS) Parts A and B. These files contain all Medicare Parts A and B paid claims generated by all Medicare FFS beneficiaries. Information in the files includes diagnosis codes, procedure codes, diagnosis-related group (DRG) codes, site-of-service information, national drug codes (NDC) and beneficiary information (including age, eligibility status, low-income status and an indicator for health maintenance organization (HMO) enrollment). The CMS data was relied upon without audit or verification. Publicly available information was used to flag each ACO as high or low revenue.

Analytical Process:

As a first step – given that the RIF data set provides yearly enrollment information for each ACO -- all beneficiaries who were attributed to an MSSP ACO in each of 2016, 2017, 2018 or 2019, were identified.

A necessary second step in the analysis was to normalize the relative cost of these beneficiaries for risk and geography. To achieve this, the authors divided observed per-beneficiary-per-year (PBPY) spending by observed "hierarchical condition category" (CMS-HCC) risk score for each ACO cohort's attributed lives; and compared this risk-adjusted PBPY to the regional risk-normalized PBPY – calculated as the ACO-beneficiary weighted average PBPY across all counties the ACO pulled lives from the Medicare 100 percent data.

The resulting "Regional Efficiency" allowed comparison of the cost of high- and low-revenue ACOs in aggregate, normalized for risk and geographic difference. This metric is also relevant to observe model performance between these cohorts, as the MSSP uses a similar calculation to increase/decrease an ACO's historical benchmark.

Sources Cited:

1. https://www.cms.gov/newsroom/fact-sheets/final-rule-creates-pathways-success-medicare-shared-savings-program

2. https://data.cms.gov/medicare-...; Includes 4 high cost / special needs ACOs with average beneficiary cost over $20,000

3. Medicare Shared Savings Program SHARED SAVINGS AND LOSSES AND ASSIGNMENT METHODOLOGY, January 2022 Version 10, Appendix C, Tables 9 and 10, https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-and-losses-and-assignment-methodology-specifications.pdf-1

4. MedPac Report to the Congress: Medicare and the Health Care Delivery System | June 2014 Chap 2, Pg 22 https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun14_ch02.pdf

5. https://innovation.cms.gov/str...

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