PREMIER TRANSFORMING HEALTHCARE TOGETHER®

August 31, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1784–P

Submitted electronically to: http://www.regulations.gov

Re: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program (CMS–1784–P)

Dear Administrator Brooks-LaSure:

Premier Inc. appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the calendar year (CY) 2024 Physician Fee Schedule (PFS) proposed rule, which was published in the Aug. 7, 2023 *Federal Register*.

In our detailed comments below, Premier urges CMS to:

- Establish a more adequate transition to the new Medicare Shared Savings Program (MSSP) quality reporting requirements, including ensuring requirements are consistent with CMS' digital quality measurement strategy, developing accountable care organization (ACO)-specific measures and piloting requirements prior to broad adoption;
- Revise eligibility to make the MSSP health equity adjustment available to all ACOs regardless of their selected quality reporting mechanism;
- Not finalize its proposal to align MSSP with the Merit-Based Incentive Payment System (MIPS) by requiring clinicians participating in an ACO, regardless of track, to meet and report the MIPS Promoting Interoperability (PI) performance category requirements;
- Adopt its proposal to modify MSSP risk adjustment methodology to ensure that both benchmark and performance years reflect the transition to the new risk adjustment model for ACOs starting new agreement periods in 2024, as well as to allow ACOs that started an agreement period prior to 2024 the option to transition to the new risk adjustment model sooner;
- Utilize MSSP as an innovation platform and scale best practices, including incorporating a higher risk track within MSSP and testing a primary care capitation option;
- Eliminate the arbitrary high-low revenue distinction in MSSP;
- Finalize proposals to add new billing codes for caregiver training and services associated with social determinants of health, while considering additional ways to better align data collection requirements and reimbursement across Medicare payment systems;
- Finalize proposed telehealth flexibilities and continue to expand Medicare coverage and payment of all types of virtual services involving communications technologies including telehealth, online visits and audio visits;

13034 Ballantyne Corporate Place
Charlotte, NC 28277
T 704.357.0022
F 704.357.6611

444 North Capitol Street, N.W.
Suite 625, Washington, DC 20001
T 202.393.0860
F 202.393.6499

PREMIERINC.COM

- Finalize behavioral health payment proposals and continue to examine whether additional behavioral health provider types could appropriately provide Medicare benefits to beneficiaries, further expanding access and alleviating critical workforce shortages;
- Finalize a split/shared visit policy that provides an alternative method for determining substantive portion of the visit based on either history of present illness, physical exam or other criteria consistent with prior guidance;
- Work with third-party technology vendors and Congress to help operationalize the Appropriate Use Criteria program and ensure compliance with statutory requirements; and
- Adopt a revised policy to calculate Qualifying APM Participant (QP) determinations at both the APM entity and individual clinician level and award QP status based on the higher score.

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,400 hospitals and approximately 250,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data gleaned from nearly half of U.S. hospital discharges, 812 million hospital outpatient and clinic encounters, and 131 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,460 manufacturers to source the highest quality and most cost-effective products and services. Premier's work is closely aligned with healthcare providers, who drive the product and service contracting decisions using a data driven approach to remove biases in product sourcing and contracting and assure access to the highest quality products. Premier runs the largest population health collaborative in the country, the Population Health Management Collaborative, which has worked with well over 200 ACOs and is currently comprised of more than 70 ACOs.

A Malcolm Baldrige National Quality Award recipient, Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. MEDICARE SHARED SAVINGS PROGRAM (MSSP)

QUALITY PERFORMANCE STANDARD AND REPORTING REQUIREMENTS

Background

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 electronic clinical quality measures (eCQMs) or MIPS clinical quality measures (CQMs) under the new Alternative Payment Model (APM) Performance Pathway (APP). While Premier has 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 and costs on ACOs during a time when providers already face significant financial pressures. As discussed in greater detail below, ***Premier continues to strongly urge CMS to work with stakeholders to align the new reporting***

requirements with CMS' broader digital quality measurement strategy and to pilot the new requirements prior to requiring broad ACO adoption.

Proposals and Recommendations

As part of this year's rule, CMS proposes to establish a new temporary collection type option – Medicare CQMs – to aid ACOs with the transition to eCQM / MIPS CQM reporting under the APP. CMS believes the proposed policy will address stakeholder concerns by only requiring reporting on the ACO's Medicare fee-for-service population (versus all payer/all patient eligible population, as required under the eCQM or MIPS CQM reporting options). The policy is intended to be transitional and provide ACOs with time to build the required infrastructure to report broader eligible populations. CMS proposes to add as Medicare CQMs the three eCQMs/MIPS CQMs under the APP: (1) Diabetes: Hemoglobin A1c Poor Control; (2) Preventive Care; and (3) Screening: Screening for Depression and Follow-Up Plan, and Controlling High Blood Pressure.

Under the proposal, which would be effective beginning with PY 2024, ACOs would aggregate patient data for eligible beneficiaries across all ACO participants and match the aggregated patient data with each Medicare CQM specification to identify the eligible population for each measure. CMS notes it will provide ACOs upon request with a list of beneficiaries who are eligible for Medicare CQMs prior to the start of the quality data submission period. However, due to claims runout, the list may not be complete and ACOs would still need to ensure that they include all beneficiaries who meet the applicable Medicare CQM specification and the definition of a beneficiary eligible for Medicare CQMs for reporting. CMS also proposes data completeness thresholds for Medicare CQMs which mirror the requirements for MIPS reporting.

Premier appreciates that CMS is proposing to add an additional reporting option for ACOs to aid with the transition to all payer/all patient reporting with eCQM / MIPS CQM, which is partially responsive to stakeholder concerns, such as, focusing quality measurement on the population that the ACO manages. However, ***Premier has significant concerns that the proposed policies do not ultimately address the underlying challenges with eCQM / MIPS CQM reporting under the APP***, as are detailed below. As a result, ***Premier continues 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.*** As discussed in greater detail below, Premier strongly urges CMS to work with stakeholders to develop and test ACO-specific measures that align with its broader digital quality strategy.

Below we provide additional information on these recommendations, as well as highlight the ongoing challenges with eCQM / MIPS CQM reporting under the APP.

Consider the current limitations of electronic health records (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 significant investment in time, money and effort in changing workflows and acquiring new technology services, all of which would be better served focusing on patient care.

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 Quality Reporting Document Architecture (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. Even if these systems are available next year, ACOs will need time to adopt and test these changes.

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. Additionally, without Congressional action, the Advanced APM Incentive Payment, which is available to many ACO clinicians, is set to expire with the 2023 performance period (for 2025 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 clinicians 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 Premier generally supports 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, ***CMS 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. Premier understands 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. The ACO also lacks access to data on patients outside the ACO entity, which can further complicate the ability of the ACO to coordinate care effectively. 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.

Consider the unintended consequences of quality policies. In 2021, 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. Last fall, CMS followed up on this goal by releasing a strategy for increasing specialist engagement and integration into value-based care models, such as MSSP.

Given the challenges associated with the new APP-based quality reporting requirements, some ACOs are considering narrowing their participants list, including removing specialists. This will ultimately hinder CMS' ability to align all beneficiaries with ACOs and increase specialist engagement. 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 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 as we have long been committed to advancing providers' capability to analyze data from multiple sources and to manage the health of their populations.

Premier believes ACOs 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.

With the transition to these new reporting requirements, 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 available across all quality reporting programs. However, in recognition of the challenges associated with reporting eCQMs, CMS has provided notable flexibility in these programs, such as allowing clinicians to select their measures (as under MIPS) or limiting the measures to pay-for-reporting programs. ***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.***

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.** Over the last couple of years, CMS has sought input on its transition to digital quality measurement (dQM). As part of this, CMS has noted that it is considering how eCQMs "can be refined or repackaged to fit within the potential future dQM definition," noting that "limitations in data standards, requirements, and technology have limited their interoperability." Given these challenges, ***Premier strongly urges 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, Premier is 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.

- **Pilot reporting requirements First.** 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.

  In particular, Premier recommends 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 to have a clear picture of quality. CMS has precedence for using a sampling approach in other programs - the Medicare Advantage (MA) Star Ratings and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Additionally, while Premier continues 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. Premier encourages 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.

  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, Premier strongly urges 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.

Clarity proposed adoption of Medicare CQMs. Finally, ***Premier urges CMS to provide greater clarity around its implementation of the proposed Medicare CQMs*.** In particular, CMS must clarify if ACOs will be responsible for reporting on their *assigned* beneficiary population or the *assignable* beneficiary population. ACOs will generally know which beneficiaries were assigned to them by the time of the quality data submission period. However, depending on an ACO's selected assignment methodology, they may not be fully aware of their full assignable population. For example, ACOs that have selected prospective assignment with retrospective reconciliation, both their assignable and assigned population will be based on services furnished during the performance year. As a result, their list of beneficiaries will evolve and will be ultimately reconciled after the performance year.

As noted above, CMS will make a list of beneficiaries who are eligible for Medicare CQMs prior to the start of the quality data submission period; however, this list may be incomplete due to claims run out and it is ultimately the responsibility of the ACO to report on all eligible beneficiaries. For some ACOs, especially those under prospective assignment with retrospective reconciliation, there may be no way of knowing which beneficiaries would have been a part of their assignable population. As a result, ***Premier strongly urges CMS to limit reporting under Medicare CQMs to the ACO's assigned population, not the assignable populatio*n.** At a minimum, CMS must clarify which beneficiaries the ACO will be responsible for reporting

on and work with stakeholders to develop a methodology to assist ACOs in ensuring they report on eligible patients.

Finally, CMS proposes data completeness thresholds for reporting. However, CMS is also requiring ACOs to report on all eligible beneficiaries. Premier urges CMS to clarify the interaction of the data completeness thresholds and the requirement that ACOs report on all eligible beneficiaries.

HEALTH EQUITY ADJUSTMENT

Background

Consistent with CMS' goals to advance health equity, CMS adopted as part of the CY 2023 PFS a health equity adjustment to an ACO's quality performance score. Under this policy, beginning with PY 2023, qualifying ACOs are eligible for up to 10 bonus points on the ACO's MIPS quality performance category score if they achieve high performance scores on quality measures and serve a high proportion of underserved beneficiaries. To be eligible, ACOs report all three eCQMs/MIPS CQMs of the APP measure set and meet data completeness requirements for each of the APP measures.

CMS calculates 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 divides ACOs into three groups based on their performance for each of the six APP measures. ACOs are assigned points based on where they fall within the ranking: with the top-third receiving four points per measure, the middle-third receiving two points per measure, and the bottom-third receiving 0 points per measure, for up to a total of 24 points.

CMS sets the underserved multiplier as the higher of an ACO's assigned beneficiary population that are (1) dually eligible; (2) enrolled in Medicare Part D low-income subsidy (LIS); or (3) reside in a census block group with an area deprivation index (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 multiplies 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 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.

Proposals and Recommendations

As part of this year's rule, CMS proposes a couple modifications to the health equity adjustment:

- Revise eligibility for the adjustment to include ACOs that report Medicare CQMs, beginning with PY 2024
- Revise the underserved multiplier calculation to remove beneficiaries without a numeric national percentile rank available for ADI, beginning with PY 2023. CMS believes this approach is more equitable than imputing a score for beneficiaries without an ADI rank. Since the underserved multiplier only counts beneficiaries with an ADI of at least the 85th percentile in the numerator, imputing a score for beneficiaries (such as at the 50th percentile as done under other programs)

would penalize ACOs by counting those beneficiaries in the denominator of the ratio but not in the numerator.

- Modify the calculation of the proportion of assigned beneficiaries who are dually eligible or enrolled in Medicare Part D LIS to include those with partial year dual eligibility or LIS enrollment, beginning with PY 2024. Under this proposal, the underserved multiplier would use the number of assigned beneficiaries with any months dually eligible or enrolled in LIS divided by the total number of assigned beneficiaries.

Premier supports the proposed revisions to the health equity adjustment*.** In particular, the proposals to revise how the underserved multiplier is calculated should improve the efficacy of the multiplier in capturing the proportion of the ACO's population that is considered underserved. ***Premier continues to urge CMS to consider additional changes to the health equity adjustment, including:

- **Revise eligibility requirements to make adjustment available to all ACOs**. 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 due to 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. Premier understands 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***. Premier strongly recommends that CMS remove the requirement that an ACO would need to report eCQMs or MIPS CQMs to be eligible for the health equity adjustment.*** This will ensure that ACOs that serve a high proportion of historically underserved beneficiaries are rewarded for furnishing high-quality care and are not limited simply based on their ability to report through eCQMs or MIPs CQMs.

- **Explore additional revisions to the underserved multiplier, including additional data sources.** As currently constructed, 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 that 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. ***Premier continues to encourage CMS to explore adopting additional or new data sources as they become available that are more reflective of whether a patient is considered underserved***. Premier also encourages CMS to evaluate whether recent changes it made to the ACO REACH model to improve identification of underserved beneficiaries, including adoption of the state-based ADI, would improve the accuracy of the MSSP Health Equity Adjustment.

- **Revise adjustment to support capture of SDOH data in standardized format.** 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. ***Premier continues to encourage CMS to explore modifications to 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.

USE HISTORICAL DATA TO ESTABLISH THE 40TH PERCENTILE MIPS QUALITY PERFORMANCE CATEGORY SCORE

Background

To be eligible to share in savings at the maximum rate under its track, an ACO must achieve a health equity adjusted quality performance score that is equal to or greater than the 40th percentile across all MIPS quality performance category scores. In the past stakeholders, including Premier, have expressed concern that ACOs do not have advance information to determine what quality performance score they must achieve in order to satisfy the quality performance standard.

Proposals and Recommendations

CMS proposes to establish the 40th percentile MIPS quality performance category score by using a three-year average of historical data, beginning for PY 2024. Specifically, for a given performance year, CMS would average the 40th percentile scores from three consecutive prior performance years with one lag year. For example, PY 2024 would be based on the average of MIPS performance category scores from PYs 2020-2022. Under the proposal, CMS would provide ACOs with this threshold prior to the start of the performance year.

Premier supports adoption of this policy to use historical data to determine the 40th percentile threshold and applauds CMS for its responsiveness to concerns previously raised that ACOs do not currently have advance information on the quality threshold required for earning shared savings. Basing the threshold on historical data will provide transparency around the threshold calculation and make the threshold available to ACOs before the performance year begins. Premier agrees that MIPS policies and methodologies change, affecting how a historical benchmark measure may be representative of and comparable to circumstances affecting the MIPS quality performance category score for the performance year involved. Therefore, Premier also supports the agency's use of a three-year historical average rather than a single year of historical data as this should smooth out and minimize the effects of changes in policies and methodologies.

MSSP SCORING POLICY FOR EXCLUDED APP MEASURES

Background

With the adoption of the APP measures as part of the CY 2021 PFS, CMS aligned the MSSP quality performance scoring methodology with the MIPS. As a result, currently if an ACO submits a quality measure that has had significant changes, total available achievement points are reduced by 10 points. Significant change is defined as changes to a measure that are beyond the control of the clinician and may result in patient harm or misleading results, including changes to codes, clinical guidelines or measure specifications. Additionally, for each MIPS measure that is submitted and impacted by significant changes, performance is based on nine consecutive months of data from the performance year.

Based on this measure exclusion policy, the eCQM versions of both the Preventive Care and Screening: Screening for Depression and Follow-up Plan measure and the Controlling High Blood Pressure measure were excluded from the MIPS measure achievement points and total available measure achievement points in PY 2022. If an ACO reported on one or both measures, its total measure achievement and total available achievement points were each reduced by 10 or 20 points (if reporting both measures). However, these ACOs were still required to report all six measures under the APP even though the MIPS Quality performance category score was based on only the non-excluded measures in the APP measure set.

Proposals and Recommendations

CMS proposes a scoring policy to apply in cases when an ACO reports all required measures under the APP, meets the data completeness requirement for all such measures and receives a MIPS quality performance category score that was calculated using reduced total available measure achievement points because of one or more APP measure exclusions. Specifically, beginning with PY 2024, under such circumstances, in order to determine if the ACO meets the quality performance standard required to share in savings at the maximum rate under its track, CMS would apply a floor to the ACO's quality performance score, which would be the higher of either the ACO's health equity adjusted quality score or the equivalent of the 40th percentile MIPS quality performance category score.

Premier strongly supports adoption of the policy which will generally ensure ACOs are not negatively impacted when an APP measure is excluded. Unlike MIPS clinicians, ACOs are not provided the opportunity to choose which measure they report under the APP, and it is outside of their control whether measures are excluded. Premier agrees that the proposed policy is a fairer approach that would result in a quality performance category score that is better reflective of actual performance rather than skewing the score for an ACO, which is still required to report on the APP measure set even when such set contains excluded measures.

ALIGN CEHRT REQUIREMENTS FOR MSSP ACOS WITH MIPS

Background

MSSP ACOs are currently required to certify at the end of each performance year use of certified EHR technology (CEHRT) by their participating clinicians. These requirements differ depending on if an ACO is in a track of MSSP that meets the financial risk standards to be considered an Advanced APM. For ACOs that are in a track that does not meet the financial risk standard, the ACO must certify that at least 50 percent of the eligible clinicians participating in the ACO use CEHRT. For ACOs that are in a track that does meet the financial risk standards to be an Advanced APM, the ACO must certify that at least 75 percent of eligible clinicians participating in the ACO use CEHRT, which is the threshold established under the Quality Payment Program (QPP).

Proposals and Recommendations

In an effort to further align MIPS and the MSSP, CMS proposes that MIPS eligible clinicians, qualifying APM participants (QPs) and Partial QPs participating in an ACO, regardless of track, would be required to meet and report the MIPS Promoting Interoperability (PI) performance category requirements. Under this policy, CMS would sunset the current MSSP requirements at the end of PY 2023 and would instead require reporting of the MIPS PI performance category measures (and scoring) either at the individual, group or virtual group level or by the ACO as an APM entity, beginning with PY 2024. CMS also seeks comment on an alternative policy of requiring ACOs to report on the PI performance category at the APM entity level.

Premier strongly opposes this proposal for multiple reasons, including the excess burden it places on ACOs and clinicians, the policy's contradiction to the statutory exemption from MIPS as a key incentive for clinicians to participate in Advanced APMs and the failure of the policy to recognize the key distinctions between ACOs and individual clinicians or groups.

First, this proposed policy would introduce additional burden to ACOs (or individual clinicians), which are already overburdened and facing upcoming changes which will impact their stability, including the expiration of Advanced APM Incentive Payments at the end of CY 2023. In addition, according to statute, QPs in an Advanced APM are exempt from MIPS, which is a valuable incentive for clinicians to join an Advanced APM. Removing this incentive and requiring these clinicians to meet MIPS PI requirements would be counter to CMS' overall stated goal for all Medicare fee-for-service beneficiaries to be part of care relationships with accountability for quality and total costs by 2030. Encouraging participation in the MSSP and in Advanced APMs is central to achieving that goal.

While Premier appreciates the goal of ensuring compliance with CEHRT criteria, Premier strongly believes that the underlying premise of aligning MSSP with MIPS is fundamentally flawed. As we note above, it fails to recognize the unique role of ACOs as compared to clinicians. Most notably, ACOs are a network of aligned providers that furnish coordinated care across the care continuum. MIPS measures quality on the basis of point-in-time encounters by individual clinicians and groups. Aligning the MSSP with MIPS for the sake of alignment is superfluous to the ultimate goal of moving from volume to value. If the ultimate goal is to incentivize care relationships with accountability for quality and costs, CMS should prioritize establishing policies designed for ACOs and the MSSP specifically, instead of forcing ACOs to align with requirements that are not structured around their unique composition and frameworks. These policies should be focused on their characteristics and challenges to minimize burden so that clinicians are incentivized to move to APMs, as well as continue their participation in APMs.

Further, if CMS goes forward with this policy, additional clarification is needed on how this policy would specifically impact the ACO and clinicians if individual clinicians within the ACO do not meet the MIPS PI reporting requirements.

Finally, CMS specifically inquires about an alternative option to require the ACO to report on the PI performance category at the APM entity level (and not have the options for MIPS eligible clinicians, QPs and partial QPs to report at the individual, group or virtual group level). ***Premier does not support this alternative approach which would further remove options and flexibilities for complying with a proposal that would already be burdensome.*** As described, there are various compositions of ACOs and each variation has its own challenges with satisfying CEHRT requirements. For example, some ACOs include many EHR systems. ACOs are already facing extreme costs to align the systems with evolving CEHRT standards. For ACOs that are already based on PI reporting on a clinician or group level, forcing further restructuring and changes to enable PI reporting at the APM entity level would be imposing excess additional burden unnecessarily.

MIPS VALUE PATHWAY (MVP) REPORTING FOR SPECIALISTS IN SHARED SAVINGS PROGRAM ACOS

Background and Request for Information

CMS introduced the MIPS Value Pathway (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 fee-for-service care delivery to APM participation. In this year's rule, CMS notes that it believes encouraging specialists to report on MVPs could lead to increased specialty engagement in the MSSP. As a result, CMS seeks input

on scoring incentives that could be applied to an ACO's quality performance score when specialists participating in the ACO report quality MVPs. Under this policy, specialists that participate in the ACO would need to report MVPs and the ACO would need to report all measures in the APP measure set, meet the data completeness requirement and receive a MIPS quality performance category score to be eligible for the bonus points.

Additionally, last spring, CMS unveiled the Universal Foundation as part of its broader CMS National Quality Strategy and goals to align quality measurement across programs. CMS notes that it intends to propose future policies aligning the APP measure set for MSSP with the quality measures under the Universal Foundation, beginning in PY 2025. As a result, CMS also seeks feedback on aligning quality measures in the Adult Universal Foundation with measures under the MSSP.

Recommendations

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. ***Premier continues to 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 Premier reiterates our previously expressed objection to forcing APM measures into a MIPS format as is being done in the MSSP, which is misaligned 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.

Finally, while Premier is supportive of aligning measures across quality programs under the Universal Foundation, Premier cautions CMS from making changes to the APP measure set at this time. As noted above, ACOs face a number of operational challenges with implementing eCQMs / MIPS CQMs. Modifying the measure set at this time will only serve to increase the level of burden and complexity that ACOs face in adopting these new changes to meet the PY 2025 implementation deadline. Additionally, Premier continues to urge CMS to work with stakeholders to develop the ideal measure set for ACOs. As discussed in greater detail above, quality measurement for ACOs should recognize the unique role that ACOs play in coordinating care across the continuum. As a result, Premier urges CMS to explore adopting best practices from how quality reporting is conducted by health plans.

MODIFICATIONS TO BENEFICIARY ASSIGNMENT

Background

Beneficiaries are generally assigned to an ACO based on whether they have received the plurality of their primary care services from certain eligible providers participating in the ACO (or ACO professional). To determine an ACO's assigned population, CMS uses a step-wise assignment methodology (or "2-step claims-based process").

As a "pre-step," CMS identifies beneficiaries who had at least one primary care service furnished by an ACO professional who is either a primary care physician (PCP) or a physician with a qualifying specialty

designation (or specialty designation physicians).[1] Under step 1, a beneficiary eligible for assignment who satisfies the pre-step requirement is assigned to an ACO based on the plurality of allowed charges for primary care services furnished during the assignment window by a PCP, nurse practitioner (NP), Physician Assistant (PA) or Certified Nurse Specialist (CNS) in the ACO. Under step 2, of the remaining eligible beneficiaries who satisfy the pre-step but who were not assigned under Step 1, a beneficiary is assigned to the ACO if the plurality of allowed charges for primary care services were furnished by a specialty designation physician in the ACO during the assignment window.

The timing of the assignment window varies depending on the type of assignment the ACO has selected. For ACOs that select prospective assignment, the assignment window is the 12-month period ending Sept. 30 prior to the performance year. For ACOs that select preliminary prospective assignment with retrospective reconciliation, the assignment window is a 12-month during the performance year.

Proposals and Recommendations

CMS proposes, beginning with PY 2025, to add a third step to its beneficiary assignment process, which would expand the period it uses to identify additional beneficiaries for assignment to include the current 12-month assignment window and an additional 12-months preceding the current window. The new step 3 would identify Medicare fee-for-service beneficiaries not previously eligible for assignment under the current pre-step. Under the proposal, CMS would identify additional beneficiaries who (i) received at least one primary care service with an ACO professional who is a NP, PA or CNS during the 12-month assignment window; and (ii) who received at least one primary care service with an ACO professional who is a PCP or specialty designation physician during the 24-month expanded window.

Premier is generally supportive of expanding the process for ACO assignment to capture additional beneficiaries, in alignment with CMS' expressed goal of furthering Medicare FFS beneficiary participation in an accountable care relationship. However, Premier is concerned that the proposed changes to the beneficiary assignment process may potentially result in higher cost and more complex patients being assigned to the ACO whose costs are not adequately captured in the ACO's benchmark. The simulations described in the preamble of the proposed rule demonstrated that the proposed policies added a larger share of beneficiaries with disabled Medicare enrollment type, beneficiaries who resided in areas with higher-than-average ADI national percentile rank, and beneficiaries who had a larger share with any months of Part D LIS enrollment. The analysis also found that the added population included beneficiaries with a lower average Hierarchical Condition Category (HCC) risk score, lower total per capita spending, higher mortality and higher hospice utilization than beneficiaries assignable under current policy. It is not clear, however, from CMS analyses whether the newly assigned higher and complex cost patients disproportionally impact certain ACOs. ***Before implementing the proposed policies, Premier recommends that CMS provides additional analyses and clarifications around the impact of these changes.***

Along those lines, Premier urges CMS to adopt additional complementary policies to mitigate any potential negative impacts to an ACO. Such additional policies may include modifying risk adjustment and benchmarking methodologies to better account for complex and high-needs patients included in the expanded assigned population of the ACO. Potentially, transition policies may be considered to smooth the effects of adding the expanded population for the initial performance years of the proposed policy. At a

[1] CMS specifies in regulation (§ 425.402(c)) the primary specialty designations that are eligible for MSSP assignment which include (1) Cardiology, (2) Osteopathic manipulative medicine, (3) Neurology, (4) Obstetrics/gynecology, (5) Sports medicine, (6) Physical medicine and rehabilitation, (7) Psychiatry, (8) Geriatric psychiatry, (9) Pulmonary disease, (10) Nephrology, (11) Endocrinology, (12) Multispecialty clinic or group practice, (13) Addiction medicine, (14) Hematology, (15) Hematology/oncology, (16) Preventive medicine, (17) Neuropsychiatry, (18) Medical oncology, (19) Gynecology/oncology.

minimum, CMS should monitor for unintended consequences and have an outlined plan for addressing unintended consequences in a timely and responsive manner.

REVISIONS TO THE DEFINITION OF PRIMARY CARE SERVICES USED IN MSSP BENEFICIARY ASSIGNMENT

Background

CMS maintains a list of HCPCS/CPT codes that are used to identify primary care services for purposes of assigning beneficiaries to ACOs.

Proposals and Recommendations

CMS proposes to amend the definition of primary care services used in the assignment methodology to include several additional codes that are either being adopted as new codes under the PFS or that CMS now recognizes as preventive services and should be included in the primary care definition. This includes new codes related to health equity, such as community health integration services, principal illness navigation services and SDOH risk assessment, which are discussed in more detail below.

Premier is generally supportive of continuing to align the primary care service definition used in the MSSP with updates to codes under the PFS*.** Premier also recognizes the importance of capturing information on, and screening for, SDOH and is supportive of efforts to expand available codes to address SDOH. Premier also recognizes that expanding the primary care service definition used in the assignment methodology will correspondingly have the potential for expanding the scope of beneficiaries who are assignable to an ACO. ***Premier urges CMS to continue to monitor the impact of expanding the definition of primary care services to include the additional PFS codes on beneficiary assignment. This includes identifying any patterns in population types and characteristics that may be captured by the additional codes and determining the combined effect that the additions to the definition may have alongside the proposed changes for the expanded ACO assignment process discussed above. Premier also encourages CMS to respond to any identified unintended consequences and consider changes to mitigate any such unintended consequences in a timely manner.

MODIFICATION TO THE BENCHMARKING METHODOLOGY

As part of last year's rulemaking, CMS finalized several modifications to its benchmarking methodology which were generally aimed at reducing the effect of an ACO's performance on its historical benchmarks and increasing options for ACOs caring for high-risk populations. As part of this year's rule, CMS is proposing several modifications to those policies, as well as making updates to how benchmarks are risk adjusted to address recent changes to the CMS-HCC risk adjustment model.

Cap Regional Service Area Risk Score Growth for Symmetry with ACO risk Score Cap

Background

As part of the CY 2023 PFS, CMS finalized its proposal to modify how it updates an ACO's historical benchmark between Benchmark Year (BY) 3 and the performance year to include a prospectively set trend factor, known as the Accountable Care Prospective Trend (ACPT). Under this policy, CMS uses a three-way blend calculated as a weighted average of the existing two-way blend of national and regional growth rates determined after the end of each performance year and the ACPT, which is a fixed projected growth rate

determined at the beginning of the ACO's agreement period. This policy is intended to address concerns that use of historical benchmarks may result in ACOs competing against their past success. Additionally, the policy helps to address the impact of increasing market penetration by ACOs in a regional service area on the existing blended national-regional growth factor.

Additionally, 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 BY 3 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."

As part of last year's rulemaking, CMS made two changes to how it applies its risk adjustment methodology. First, CMS now accounts 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 now applies 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. In general, these policies are beneficial for ACOs that may look to expand their aligned population to include more high-needs or underserved populations.

Stakeholders have expressed concern that the current cap on ACO risk score growth does not account for risk score growth in an ACO's regional service area. As a result, high prospective HCC risk score growth in an ACO's regional service area can decrease the regional update factor, resulting in a lower benchmark for ACOs in that region.

Proposals and Recommendations

CMS proposes to incorporate a regional risk score growth cap when updating the historical benchmark between BY 3 and the performance year. Under this proposal, CMS would use a similar methodology as it adopted for individual ACO risk score growth. CMS believes the policy will strengthen incentives for ACOs to enter or continue to operate in regions with high-risk score growth and care for high-risk beneficiaries.

Premier is generally supportive of CMS' proposal to cap regional service area risk score growth and encourages CMS to continue to monitor the impact of the policy to ensure there are no unintended consequences and consider changes to mitigate these consequences in a timely manner.

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 that have been coding accurately and that 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. Premier believes 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, Premier continues 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.

Mitigate Impact of Negative Regional Adjustment on Benchmark

Background

As part of last year's rulemaking, CMS adopted two policy changes designed to limit the impact of negative regional adjustments on an ACO's historical benchmarks and to further incentivize participation of ACOs serving high cost beneficiaries. Under the finalized policy, CMS:

1. Reduced the cap on negative regional adjustments from -5 percent of national per capita expenditures for Parts A and B services in BY 3 for assignable beneficiaries to -1.5 percent.
2. After applying the cap, applied 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 policy, the higher an ACO's proportion of dual eligible beneficiaries or the higher its risk score, the larger the offset factor will be and the larger the reduction to the overall negative regional adjustment.

Proposals and Recommendations

As part of this year's rulemaking, CMS is interested in revisiting this policy to further mitigate the impact of the negative regional adjustment for ACOs with high-cost populations. Specifically, CMS proposes to modify the policy so that:

- If the ACO's regional adjustment amount is positive, the ACO would receive a regional adjustment, according to the approach finalized last year.
- If the ACO's regional adjustment amount is negative, the ACO would receive no regional adjustment to its benchmark for any enrollment type. If the ACO is eligible for a prior savings adjustment (as detailed below), it would receive the prior savings adjustment as its final adjustment without any offsetting reduction for the negative regional adjustment.

CMS believes that these policy changes will further encourage continued participation among high-cost ACOs that serve medically complex beneficiaries by eliminating the potential of a lower benchmark due to an overall negative regional adjustment. It also believes that eliminating overall negative regional adjustments could further incentivize greater participation among ACOs whose ACO participants have historically been less efficient compared to others in their region. Under this proposed policy, no ACO will be made worse off financially.

Premier supports CMS' proposal to further modify the methodology it uses to limit the impact of negative regional adjustments. As CMS notes, this policy will largely benefit ACOs that serve a high proportion of underserved and high-cost beneficiaries. Premier encourages 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 in more detail below, a 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.

Modify the Prior Savings Adjustment

Background

An ACO's benchmark is reset at the start of each agreement period using the most recent 3 years of historical Medicare Parts A and B expenditures for beneficiaries assigned to the ACO. Stakeholders have raised concerns that rebasing creates a ratcheting effect that incorporates past efficiencies achieved by the ACO, resulting in the ACO competing against its past success. To address these concerns, CMS finalized a policy as part of last year's rulemaking to adjust the ACO's benchmark for prior savings it achieved under the MSSP. Under the policy, CMS adjusts an ACO's benchmark based on the higher of either the prior savings adjustment or the ACO's positive regional adjustment. It also uses a prior savings adjustment to offset negative regional adjustments for ACOs that are higher spending compared to their regional service area, as noted above.

To calculate prior savings, CMS uses savings achieved in the three performance years preceding the new agreement period. CMS calculates 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.

Proposals and Recommendations

CMS proposes refinements to the prior savings adjustment calculation to address circumstances where the amount of savings or losses used in the calculation are changed retroactively to address compliance actions or as the result of issuance of a revised initial determination.

Premier is generally supportive of these refinements and continues to encourage CMS to expand its prior savings adjustment 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, Premier encourages 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.

Revisions to Risk Adjustment of Benchmarks

Background

When setting and updating ACO benchmarks, CMS makes certain adjustments to account for the severity/case mix of and certain demographic factors for an ACO's assigned population. Specifically, CMS uses prospective HCC risk scores and demographic risk scores (as applicable) to perform this risk adjustment. Last spring, CMS finalized a transition to a revised CMS-HCC risk adjustment model through its Announcement of 2024 MA Capitation Rates and Part C and Part D Payment Policies. Among other changes, the revised 2024 CMS-HCC risk adjustment model, Version 28 (V28) accounts for the transition from ICD-9 to ICD-10 to improve its predictive accuracy and incorporates several technical updates over the current 2020 CMS-HCC risk adjustment model, Version 24 (V24). Of note, the revised V28 model includes additional

constraints and removes several HCCs aimed at reducing the impact on risk score variation in coding between MA and fee-for-service.

Under the transition to the V28 model, MA risk scores for 2024 will be calculated as a blend of 67 percent of the risk scores calculated under the V24 model, and 33 percent of the risk scores calculated with the V28 model. CMS expects that for 2025, MA risk scores will be calculated using a blend of 33 percent of the risk scores calculated with V24 model and 67 percent of the risk scores calculated with V28 model, and for 2026, 100 percent of risk scores will be calculated with the V28 model.

Proposals and Recommendations

In light of these recent changes to the CMS-HCC risk adjustment model under MA, CMS proposes updates to the MSSP risk adjustment methodology. Under its proposal, for agreement periods beginning CY 2024 and in subsequent years, CMS would apply the new CMS-HCC risk adjustment methodology for the CY corresponding to the PY in calculating risk scores for Medicare FFS beneficiaries for each BY of the agreement period. As a result, all benchmark years and performance years would reflect the transition to the new risk adjustment model. For agreement periods beginning before CY 2024, CMS would codify its current practice of applying the CMS-HCC risk adjustment methodology. Under this policy, risk ratios used to adjust expenditures would have numerators and denominators calculated using different underlying CMS-HCC risk adjustment methodologies.

Premier supports modifying the risk adjustment methodology to ensure that both benchmark years and performance years reflect the transition to the new risk adjustment model, which will help ensure uniformity in the calculation. Premier also agrees that CMS should maintain consistency by applying the same CMS-HCC risk adjustment model used in the MA program in MSSP. Adoption of this new risk adjustment model will help prevent distortion to the ACO's historical benchmark resulting from model changes and ensure that the model adequately accounts for differences in ACO beneficiary populations, particularly among high-risk beneficiaries.

Premier strongly encourages CMS to give ACOs that had agreement periods that started before CY 2024 the option to transition to this new risk adjustment methodology sooner. This will help ensure that ACOs that serve a high-risk beneficiary population are not disadvantaged solely because of a less precise risk adjustment model being used in the shared savings calculations. Given the timing of the rulemaking process, these ACOs did not have sufficient time to assess this methodology and select an early renewal if this methodology change was in the best interest of their organization.

MODIFICATIONS TO ADVANCE INVESTMENT PAYMENT POLICIES

Background

As part of last year's rulemaking, CMS finalized a new policy to allow certain new ACOs to receive upfront shared savings, known as Advanced Investment Payments (AIPs), beginning with agreement periods beginning on or after Jan. 1, 2024. This funding is intended to assist ACOs in covering the upfront investment costs related to ACO participation. The policy 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.

Under the policy, eligible ACOs receive a one-time fixed payment of $250,000 and eight quarterly payments that 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 ADI. Quarterly payments per beneficiary range from $0 to $45, depending on the beneficiary's risk-based score. The AIP is recouped from any shared savings earned by the ACO.

As finalized last year, AIPs are limited 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.

Proposals and Recommendations

CMS proposes several refinements to the AIP policies to better prepare for initial implementation in CY 2024, including:

- Allowing ACOs to transition to two-sided risk under the BASIC track's glide path beginning in PY3 of the ACO's agreement period;
- Allowing an ACO to early renew its participation agreement at the end of PY2 or later;
- Permitting CMS to terminate AIPs for future quarters if ACO terminates participation and does not immediately enter new agreement period;
- Requiring ACOs to publicly report its use of AIPs for each PY in form and manner specified by CMS; and
- Permitting ACOs to request reconsideration review for all AIP calculations (not just instances where no payments are distributed).

Premier is generally supportive of the refinements that CMS is making to the AIP policies, which will grant eligible ACOs greater flexibility around their participation, such as advancing to higher risk tracks earlier and expanding their options for early renewal. Premier also appreciates the additional clarifications that these proposed policies offer around adoption of the AIP.

However, Premier continues to urge CMS to reconsider the eligibility requirements for the AIP. In particular, ***Premier continues to strongly urge CMS to eliminate the arbitrary high-low revenue distinction, which is not a true metric of ACOs' performance***. As we have noted previously, Premier is concerned that limiting the AIP to low-revenue ACOs only 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, 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.[2] 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, ***Premier continues to urge CMS to 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 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

[2] https://premierinc.com/newsroom/blog/pinc-ai-analysis-hospital-led-acos-perform-as-well-as-physician-led-models

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.

SEEKING COMMENTS ON POTENTIAL FUTURE DEVELOPMENTS TO MSSP POLICIES

Background

As noted above, CMS adopted several policy changes as part of last year's rulemaking which were intended to support its vision of having all Medicare fee-for-service beneficiaries in a relationship with a provider who is accountable for total cost and quality of care by 2030. In the rule, CMS noted 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."

CMS has continued to receive significant input from stakeholders regarding opportunities to increase participation in MSSP and other ACO initiatives. This includes identifying ways to strengthen primary care in MSSP, such as through primary care capitation, as well as offering opportunities for a higher risk track in MSSP. To help support future development of MSSP policies, CMS seeks input on several topics as detailed below.

Request for Information and Recommendations

Premier strongly supports CMS' strategy of utilizing MSSP as an innovation platform and for harmonizing policies across initiatives and scaling best practices. As Premier has 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. As a result, Premier appreciates CMS seeking input on policies to further advance the MSSP and encourage greater ACO and provider participation. Below we provide recommendations in response to CMS' comment solicitation, as well as additional policies that CMS should consider adopting into the MSSP.

Incorporating a Higher Risk Track than the ENHANCED Track. CMS is considering adoption of a higher risk MSSP track under which the shared savings/loss rate would be somewhere between 80 to 100 percent (which is higher than that currently offered under the ENHANCED track). This track would potentially build on the experiences of the Next Generation ACO (NGACO) and ACO REACH Models and provide more potential upside for reward in the program. CMS expresses concern that ACOs in a higher risk track could have an increased incentive to avoid high-cost beneficiaries, and notes that it would consider whether the program's existing approach to expenditure truncation and capping shared savings and shared losses would be sufficient in curbing incentives for ACOs to engage in beneficiary selection in light of the higher potential risk and reward.

CMS seeks input on the policies and model design elements that could be implemented so that a higher risk track would not increase MSSP program expenditure, as well as ways to protect ACOs serving high-risk beneficiaries from expenditure outliers and reduce incentives for ACOs to avoid high-risk beneficiaries. Finally, CMS seeks input on the impact that higher sharing rates could have on care delivery redesign, specialty integration and ACO investment in healthcare providers and practices.

Premier strongly supports adoption of a higher risk track within MSSP, which is an opportunity to build on the lessons learned from the Next Generation ACO and ACO REACH models. The Next Generation ACO Model, in particular, had offered participants the opportunity to elect for full financial risk in exchange for additional flexibilities and incentives that are not available in MSSP. As we had noted previously, Premier was disappointed that the Administration did not extend this model following its conclusion in 2021. At that

time, we had strongly urged CMS to re-evaluate the model for expansion and consider other options for model permanence, such as a higher risk track in MSSP. With its conclusion, participants were faced with the choice of moving into MSSP (and taking on lower financial risk) or moving to the Direct Contracting model, where they would be required to take on capitation, a function that many ACOs have not taken on previously and did not have the resources to deploy. Premier encourages CMS to look to the design of the Next Generation ACO model when adopting a higher risk track within MSSP.

Premier also disagrees with CMS' assertion that ACOs in higher risk tracks have an increased incentive to avoid high-cost beneficiaries. Under the ACO REACH Model, CMS has put in place certain requirements and monitoring activities to reduce the potential for cherry-picking of patients and mitigate the potential of "bad actors" using the model to shift patients to other types of arrangements, such as Medicare Advantage. If CMS is concerned about the potential of the higher risk track incentivizing avoidance of high-cost patients, Premier would encourage CMS to evaluate the applicability of some of the safeguards and policies in place under the ACO REACH model.

Increasing the Amount of the Prior Savings Adjustment. As noted above, CMS established a prior savings adjustment that it will apply when establishing the benchmark for eligible ACOs entering an agreement period beginning on Jan. 1, 2024. The adjustment will account for savings generated by the ACO in prior agreement periods and is intended to address concerns that rebasing of benchmarks based on historical performance results in a ratcheting effect and ACOs competing against their past success. Under the policy, CMS applies a 50 percent scaling factor to the pro-rated positive average per capita prior savings. Stakeholders have continued to urge CMS to consider a higher scaling factor that more closely matches the maximum shared savings rate from an ACO's prior agreement period.

CMS seeks comment on potential changes to the scaling factor used in determining the prior savings adjustment, such as using an average of the ACO's shared savings rates from the three years prior to the start of its agreement period, increasing to 75 percent of shared savings achieved if the ACO participated in the ENHANCED track in the three years prior to the start of the agreement period, or using another value corresponding to the maximum shared savings rate the ACO was eligible to earn in the three years prior to the start of the agreement period.

Premier supports modifying the prior savings adjustment methodology to align the amount of prior savings accounted for in the calculation with what the ACO achieved in the three years prior to the start of the agreement period. This will more accurately reflect and account for shared savings achieved in prior agreement periods and further mitigate the ratchetting effect. As noted in more detail above, Premier also encourages CMS to expand its policy to include savings achieved under past and future total cost of care models, such as the Next Generation ACO model, Direct Contracting, ACO REACH model and any future ACO or ACO-like models.

Expanding the ACPT Over Time and Addressing Overall Market-wide Ratchet Effects. As noted above, CMS recently adopted a prospectively projected administrative growth factor (referred to as the ACPT) into a three-way blend with national and regional growth rates to update an ACO's historical benchmark for each performance year, beginning with agreement periods starting on or after Jan. 1, 2024. CMS believes that incorporating this prospective trend will insulate a portion of the annual update from cost efficiencies resulting from an ACO's historical performance (i.e., address the ratchetting effect), 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.

The ACPT is projected by the CMS Office of the Actuary (OACT) and is based on a modified version of the existing fee-for-service 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 will set the ACPT at the start of an ACO's agreement period and the factor would remain unchanged throughout the five-year agreement period.

To protect ACOs from larger shared losses, CMS finalized 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 will 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.

Since finalizing these policies, CMS has continued to receive stakeholder feedback on the ACPT, including concerns that the three-way blend effectively increases the proportion of the benchmark update that is based upon national trends and may not adequately account for geographic variation in spending growth. CMS seeks comment on potential modifications to the ACPT including, replacing the national component of the two-way national-regional blend and scaling the weight hat CMS gives to the two-way blend based on the ACOs collective market share of multiple ACOs within the ACO's regional service area.

Premier has long advocated for modifications to the MSSP 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. As we highlighted in our comments last year, Premier supports adoption of the prospective trend factor in concept as it 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. Moving to an administratively-set trend factor would allow ACOs to better predict their benchmarks and assess their financial performance throughout the year.

However, Premier continues to have concerns around there being limited time to assess the impact of the ACPT, especially at a time when our entire healthcare system is continuing to evaluate the impact of the COVID-19 pandemic on healthcare utilization and service delivery moving forward. This will likely require significant changes to existing actuarial and predictive models and make projecting trend factors particularly challenging over the next several years. ***Premier strongly urges CMS to engage with stakeholders over the next several years to evaluate appropriate methodologies for setting an administratively-set benchmark.*** As part of that, Premier recommends that CMS evaluate the accuracy of its ACPT projections against actual spending prior to making any changes to the three-way blend, such as by replacing the national component of the two-way national-regional blend.

Additionally, as CMS continues to evaluate longer term changes to the benchmarking methodology, Premier 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. ***Premier continues 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. Premier is

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 that 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.

Promoting ACO and Community Based Organizations (CBOs) Collaboration. Finally, CMS seeks comment on ways to improve and incentivize collaboration between ACOs and Community Based Organizations (CBOs) to address unmet health-related social needs. ***Premier appreciates CMS' ongoing commitment to addressing health equity and for the agency seeking input on ways to further strengthen partnerships between ACOs and CBOs.*** 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.

Premier applauds CMS' ongoing recognition for the need to create incentives to help advance health equity. However, one of the major challenges to adjusting benchmarks or better targeting incentives is the lack of standardized sociodemographic data at the patient-level. As a result, some models are relying on proxies for identifying undeserved beneficiaries, such as duals status or ADI, which may not fully identify undeserved beneficiaries.

To further advance efforts to address health equity, Premier recommends that CMS focus on:

- ***Standardization of SDOH Data.*** Premier continues to urge CMS to focus on improving data collection and standardization, which 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.[3] AHRQ further found that the principal challenges in obtaining race, ethnicity and language data for use in quality improvement

[3] https://www.ahrq.gov/research/findings/final-reports/iomracereport/index.html

assessments include a lack of standardization and understanding of why the data are being collected.

To help foster better data collection and standardization, CMS should adopt incentives, such as quality program bonuses, to help incentivize standardized data collection, as is discussed in greater detail above**.** Additionally, CMS should 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. Finally, Premier encourages CMS to evaluate the standards that hospitals and other entities already have in place to advance health equity. This creates opportunities for CMS to build on and create synergies where possible on existing efforts as CMS and other federal partners work towards a national standard.

- ***Adjust financial methodologies to address health equity.*** As noted above, Premier appreciates CMS' recognition that current financial methodologies may need to be modified to ensure benchmarks are appropriately set to account for the needs of undeserved patients. To that end, Premier recommends that CMS ensure the appropriate flexibilities and payments are in place for ACOs to strengthen their focus on addressing health equity, such as paying for services that address SDOH. CMS should consider allowing ACOs to opt into receiving payment for enhanced services that would allow ACOs to better partner with CBOs in providing innovative wrap-around services aimed at addressing SDOH and advancing health equity. CMS has adopted similar policies in other Innovation Center models. For example, under the Oncology Care Model (OCM), participants received a monthly fee for delivering enhanced services. This allowed participants to create triage clinics, hydration stations and hire financial counselors.

  Finally, Premier continues to urge CMS to consider ways to modify MSSP benchmarks to better account for historical underutilization of services**.** CMS has started to do this with certain Innovation Center models, such as ACO REACH. However, under ACO REACH, CMS offsets those increases by reducing benchmarks for lower risk patients. Premier strongly urges CMS to ensure any modifications it makes to benchmarks to account for underutilization is done as additional payments and not offset through reductions elsewhere in the model. Reducing benchmarks for other beneficiaries introduces new inaccuracies into the payment methodology and potential introduces new inequities.

Additional MSSP Innovations. As noted above, Premier appreciates CMS' interest in utilizing MSSP as an innovation platform and for harmonizing policies across initiatives and scaling best practices. To that end, Premier recommends that CMS adopt the following policies:

- ***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 fee-for-service 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 by 2030, we must think beyond primary care attribution approaches. 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). Additionally, MSSP ACOs currently can only voluntarily align beneficiaries through Medicare.gov. CMS should provide

ACOs with additional options to voluntarily align beneficiaries, such as through paper-based forms or their own websites, which has the potential to increase beneficiaries' engagement in MSSP and help improve policy alignment across total cost of care initiatives.

- ***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 High Needs Population track under ACO REACH. Premier urges 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 ACO REACH. 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.

ELIMINATE HIGH-LOW REVENUE DISTINCTION

Background

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.

Recommendations

CMS has continued to state its belief that low-revenue ACOs outperform high-revenue ACOs, highlighting 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*****.** Premier's 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*****.** Premier's 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, Premier's 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, Premier 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, Premier 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.

***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*.** To achieve its goal of getting all beneficiaries into an accountable care relationship by 2030, 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.

BENEFICIARY NOTIFICATION REQUIREMENTS

Background

CMS modified its beneficiary notification requirements as part of last year's making to add in a new requirement that ACOs give beneficiaries a meaningful opportunity to engage with an ACO representative and to ask questions following the initial notification. This follow-up communication must occur no later than the earlier of the beneficiary's next primary care service visit or 180 days from the date the standardized initial notice was provided. 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.

Recommendations

As we have previously noted, ***Premier is concerned that the new requirements for follow-up communication places 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*.** Additionally, while Premier appreciates that CMS drafted the requirements in such a way to provide ACOs with flexibility, this has created a lot of confusion for ACOs around how to comply with the requirements – from how the communication must occur to the documentation that ACOs must maintain. Additionally, it is difficult for ACOs to design processes to ensure compliance with the timing of the notification,

which requires the follow-up communication to occur at the earlier of the beneficiary's next primary care visit or 180 days after the initial communication. Since ACOs often do not have real-time insight into when a primary care visit occurs, some ACOs are considering requiring the follow-up communication to occur at every primary care visit to ensure compliance with the requirement. This introduces additional burden on ACO professionals, as well as increases potential confusion for beneficiaries.

Premier understands that CMS desires to improve beneficiaries' understanding of ACOs and value-based care, but we do not think follow-up encounter achieves this goal. Instead, ***Premier continues to 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.*** At a minimum, CMS should modify the requirement to allow for the communication to occur anytime within the 180-days following the initial communication. This will ensure ACOs have the flexibility to conduct the follow-up in a way that is most meaningful for their patients and to allow them to establish straightforward protocols to comply with the requirements.

340B IMPACTS ON MSSP

Background

Starting in CY 2018, CMS adopted a policy to pay hospitals for separately payable, non-pass-through drugs (other than vaccines and those furnished by rural sole community hospitals, inpatient prospective payment system (IPPS) exempt cancer hospitals, and children's hospitals) purchased through the 340B program at the average sales price (ASP)-22.5 percent, rather than ASP+6 percent. This policy was subject to ongoing litigation, with the Supreme Court ultimately ruling in June 2022 that the Secretary does not have the authority to vary payment rates for drugs and biologicals among groups of hospitals in the absence of having conducted a survey of hospitals' acquisition costs. The Supreme Court remanded the case back to lower courts to effectuate a remedy.

In September 2022, the District Court vacated CMS' 340B reimbursement rate for the remainder of 2022. In response to this order, CMS changed its payment systems to make payment at ASP+6 percent for claims with a date of service after Sept. 27, 2022. Additionally, some of CMS' Medicare payment contractors allowed for reprocessing of all 2022 claims at the revised ASP+6 percent rate. As part of last year's OPPS rule, CMS finalized a return to paying for 340B-acquired drugs at ASP+6 percent, starting in CY 2023.

In January 2023, the District Court issued a remand to CMS giving it the opportunity to determine the proper remedy for addressing the reduced payment amounts that 340B hospitals received for 2018 through 2022. This past July, CMS released a proposed rule outlining its remedy for reversing its 340B-acquired drug payment policy. Under the proposed remedy affected 340B providers would receive a one-time lump sum payment to offset the decrease in 340B payments they received from 2018 to 2022. CMS estimates that $9 billion is owed to approximately 1,600 affected 340B-covered entity hospitals. Additionally, in order to maintain budget neutrality, CMS proposes to reduce the OPPS conversion factor by 0.5 percent, starting in CY 2025. The reduction would be in place until CMS recoups approximately $7.8 billion in payments, which it estimates will take 16 years.

Recommendations

As detailed in Premier's response to the 340B Remedy Proposed Rule, Premier supports CMS' proposal to make a lump sum payment to 340B hospitals for the amounts they are owed based on the difference between ASP-22.5 percent and ASP+6 percent; however, Premier strongly opposes CMS' proposal to prospectively

recoup the budget neutrality adjustment it applied to all non-drug items and services between 2018 to 2022. This policy is both inconsistent with the law and CMS' longstanding past precedent regarding application of budget neutrality adjustments. Additional details on these policies and Premier's comments are available here.

This change in payment policy may also have a negative impact on ACOs that include 340B eligible hospitals and whose benchmarks are based on historical spending from 2018-2022. For these ACOs, their benchmark would have been based on 340B spending set at ASP-22.5 percent, while any 340B spending that were to occur during its performance periods, starting in CY 2023, would be paid at ASP+6 percent. As a result, when reconciling performance year expenditures against benchmarks, these ACOs may appear to have significantly higher 340B expenditures even if there was no change in drug utilization. Additionally, as noted above, many Medicare contractors reprocessed all 2022 340B claims at the ASP+6 percent, which will also impact ACO expenditures in PY 2022.

Historically, CMS has addressed underlying fee-for-service changes from the baseline period to performance year through regional or national trend adjustments to the MSSP benchmark. Premier is concerned that this standard approach may not adequately address the differences in payment, particularly for ACOs with high 340B spend, given 340B eligibility and spending will vary significantly across ACOs. As a result, addressing these changes through regional or national trends may actually result in ACOs with no to minimal 340B spend benefiting from the policy change, as compared to ACOs with high 340B spend not being made whole.

Premier urges CMS to address this policy in a way that holds ACOs harmless from these underlying fee-for-service changes. In other value-based care models, CMS has achieved this by either ensuring the same payment methodology and rate is used when comparing spend in the baseline period to the performance period or by removing these costs completely when calculating reconciliation payments.

III. PROPOSED NEW MEDICARE BILLING CODES

Background and Proposals

Add-on code for visit complexity. During CY 2021 rulemaking, CMS established a new add-on code for complex patients, G2211, that could be reported with office and outpatient (O/O) evaluation and management (E/M) codes. The primary policy goal of G2211 was to increase payments to primary care physicians and to reimburse them more appropriately for the care they provide to highly complex patients as part of ongoing care. At the time, CMS estimated that implementing G2211 would increase PFS spending by $3.3 billion, requiring a corresponding 3.0 percent cut to the CY 2021 PFS conversion factor to ensure budget neutrality. Given the significant projected impact, Congress imposed a moratorium on Medicare payment for G2211 before Jan. 1, 2024 in the Consolidated Appropriations Act of 2021. As a result, although the O/O E/M visit complexity add-on code can be reported, it is currently assigned a bundled payment status indicator. For 2024, CMS proposes to implement the new G2211 code and decreases its prior utilization assumption from 90 percent to 38 percent; however, CMS does note that approximately 90 percent of the -2.17 percent budget neutrality adjustment to the PFS for 2024 is attributable to CMS' estimated impacts from G2211.

Payment for caregiver training services. In the 2023 PFS proposed rule, CMS sought comment about establishing payment for caregiver training services (CPT codes 96202, 96203, 9X015-9X017). After consideration of comments and review of payment policies for patient-centered care involving care coordination and team-based care, CMS believes Caregiving Training Services could be reasonable and necessary to treat the patient's illness or injury. For 2024, CMS proposes to allow payment for Behavioral management/modification training for guardians/caregivers of patients with a mental or physical health

diagnosis (CPT codes 96202 & 96203) and Caregiver training in strategies and techniques to facilitate the patient's functional performance (CPT codes 9X015-9X017) based on an established therapy plan.

Services addressing health-related social needs. For 2024, CMS proposes to create new provider billing mechanisms for three types of social need-related services: Community Health Integration (CHI), Principal Illness Navigation (PIN) and Social Determinants of Health (SDOH) Risk Assessments. Specifically, CMS proposes to create two new G codes describing CHI services performed by certified or trained auxiliary personal, which may include a Community Health Worker, incident to the professional services and under the general supervision of the billing practitioner. CMS also proposes PIN services parallel to the proposed CHI services, but focused on patients with a serious, high-risk illness who may not have SDOH needs. Finally, CMS proposes a HCPCS code for the work involved administering an evidence-based SDOH risk assessment when medically reasonable and necessary in relation to an E/M visit to inform the diagnosis and treatment plan.

Recommendations

Premier supports CMS' proposals to include additional billing codes under the PFS that compensate providers for the work they already do to best serve those with complex medical needs and SDOH concerns and their caregivers. Additionally, Premier recommends that CMS consider ways to better align data collection requirements and reimbursement across Medicare payment systems.

For example, hospital staff may conduct social risk screening during a patient's inpatient stay as part of the Inpatient Quality Reporting program and receive no additional reimbursement to fulfill this requirement. Yet, the same patient may be screened by a provider in an outpatient setting who would be able to bill under the PFS for the new SDOH Risk Assessment code, if finalized as proposed. Premier believes it is critical that important social risk factor data is captured as efficiently as possible by the right provider in the right setting. CMS should consider whether requiring any additional data collection without adequately adjusting reimbursement is equivalent to an unfunded mandate.

IV. TELEHEALTH AND OTHER SERVICES INVOLVING COMMUNICATION TECHNOLOGIES

Background and Proposals

CMS proposes a number of clarifications and revisions to the process for making changes to the Medicare Telehealth Services List. During the public health emergency (PHE), CMS initiated a process to add services to the list on a temporary basis under Category 3 status. With the end of the PHE in May 2023, CMS proposes to replace the current Category 1-3 status with permanent or provisional status. CMS would assign "permanent" status to any service when the service elements map to a service on the telehealth list that has a permanent status. CMS would assign "provisional" status to a service that does not map to a service with permanent status, but there is some evidence of clinical benefit analogous to the clinical benefit of the in-person service when the service is provided via telehealth by an eligible Medicare telehealth physician or practitioner.

In addition, CMS proposes to continue to allow real-time audio and visual communications to satisfy direct supervision requirements for presence and "immediate availability" of the supervising practitioner. CMS seeks feedback on whether this flexibility should be made permanent, including whether this should be allowed only for a subset of services.

Recommendations

Telehealth has been an essential tool for providers in addressing the healthcare needs of patients during the COVID-19 PHE. ***Premier appreciates the flexibilities that CMS has provided and urges 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*.** As such, Premier urges CMS to finalize its "immediate availability" proposal described above and to not limit this flexibility to a particular subset of services unless there is an evidence-based safety or efficacy concern. Hospitals and health systems are currently making strategic workforce development and staffing decisions to deal with ongoing labor shortages. Offering permanency for this flexibility would allow longer-term strategic planning.

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, Premier recognizes that CMS has limited statutory authority to expand telehealth services following conclusion of the current Congressional expansion which is set to expire in December 2024. Therefore, ***Premier continues to urge CMS to work with Congress to adopt broader telehealth reforms.***

V. BEHAVIORAL HEALTH

Background

CMS previously 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 behavioral healthcare, CMS proposes several regulatory changes to covered Medicare benefits and billing requirements, including the following:

- Establishing Medicare Part B coverage for services billed by marriage and family therapists (MFTs) and mental health counselors (MHCs), as required by the Consolidated Appropriations Act of 2023;
- Allowing addiction counselors to enroll as MHCs;
- Establishing new HCPCS codes for psychotherapy for crisis services that are furnished in an applicable site of service, including the home or a mobile unit (required by CAA, 2023);
- Allowing clinical social workers, MFTs and MHCs to bill for Health Behavior Assessment and Intervention Services; and
- Amending the hospice Conditions of Participation to allow social workers, MFTs and MHCs to serve on hospice interdisciplinary groups.

Recommendations

Premier applauds CMS' continued commitment to improving access, quality and equity in behavioral healthcare for Medicare beneficiaries. Premier encourages CMS to continue to examine whether additional behavioral health provider types could appropriately provide Medicare benefits to beneficiaries as well, further expanding access and alleviating critical workforce shortages.

VI. SPLIT (OR SHARED E/M VISITS)

Background

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.

In previous 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. In last year's rulemaking (for CY 2023), CMS further delayed 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 collect data to evaluate the impacts of the policy.

CMS now proposes to again delay implementation of its new definition of "substantive portion," which determines which provider is eligible to bill for the visit. Rather than only basing "substantive portion" on which provider spends more than half of the total visit time with the patient (as previously finalized), CMS proposes to continue to define "substantive portion" as ***either*** based on history, or exam, or medical decision making, ***or*** more than half of total time.

Recommendations

Premier supports CMS' proposed delay in moving to the previously finalized definition (i.e., only based on half of the total visit time). Premier recommends that CMS publicly commit to not moving forward with a revised definition until the AMA CPT Editorial Panel has finished revising certain aspects of shared or split visits, which will likely impact CMS' policy.

Premier continues 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 in which a physician or NPP has performed the bulk of an assessment or exam with the patient but spent 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.

Ultimately, 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.[4] 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. Premier also asks that CMS clarify how this policy should be applied when E/M services are furnished via telehealth.

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

VII. APPROPRIATE USE CRITERIA (AUC) FOR ADVANCED DIAGNOSTIC IMAGING SERVICES

Background and Proposals

Section 218(b) of the Protecting Access to Medicare Act (PAMA) directs CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. AUC are a set of individual criteria that link a specific clinical condition or presentation, one or more services and an assessment of the appropriateness of the service(s). Evidence-based AUC for imaging can assist clinicians in selecting the imaging study that is most likely to improve health outcomes for patients based on their individual context. AUC are integrated into the clinical workflow via clinical decision support modules (CDSMs).

In this rulemaking, CMS proposes to pause implementation of the AUC program for re-evaluation, and to rescind the current AUC regulations at §414.94. CMS notes that the agency feels it has exhausted all reasonable options for fully operationalizing the AUC program consistent with the statutory provisions requiring real-time claims-based reporting to collect information on AUC consultation for advanced diagnostic imaging services. Further, CMS states that it expects the program reevaluation to be difficult and time-consuming and thus does not propose a timeframe for recommencing implementation.

At the root of CMS' implementation pause is the fact that the agency's existing Medicare claims processing system is technologically incapable of executing real-time claims processing in a way that complies with the highly prescriptive statutory requirements for the AUC program. In order to implement the program in accordance with current law, the Medicare claims processing system must fully automate the process for distinguishing which advanced diagnostic imaging claims are subject to the AUC program requirement to report AUC consultation information as prescribed by section 1834(q)(4)(B) of the Act. In the proposed rule, CMS discusses the practical complexity of the AUC when an advanced diagnostic imaging service is furnished in two settings and only one of the settings is an applicable setting, which is not an uncommon clinical scenario. CMS also discusses risks from the implementation of the AUC program related to data integrity and accuracy, beneficiary access and potential beneficiary financial liability for advanced diagnostic imaging services. CMS concludes it has not identified any practical way to move the AUC program forward beyond the educational and operations testing period.

CMS does specifically note that clinical decision support tools can still be beneficial in assisting with clinical decision making. The agency highly encourages continued use of these tools, and notes that other Medicare programs such as the Quality Payment Program (QPP) advance some of the same quality- and efficiency-focused goals as the AUC program is intended to address.

Recommendations

Premier recognizes the significant challenges that CMS faces with operationalizing the real-time claims processing aspect of the AUC program. Premier also agrees that the significant risks that such technical challenges pose - to data integrity and accuracy, to beneficiary financial liabilities and to access to care - warrant taking a different approach rather than relying on admittedly unreliable, antiquated claims processing systems. ***Premier notes that there is no apparent statutory provision precluding CMS from seeking proposals from the private sector to develop a claims processing system that actually does what the statute requires, which the agency may later incorporate into its rulemaking as a proposal subject to public comment. Therefore, Premier encourages CMS to explore the possibility of contracting with a third-party to help operationalize the program and ensure compliance with statutory requirements***.
Premier encourages CMS to work with Congress to advance legislation to enable implementation of a Medicare payment model for advanced diagnostic imaging based on the use of AUC embedded in CDSMs.

CMS acknowledges in this rule that its proposed implementation pause results in forfeited savings to Medicare from the use of AUCs driving the right patients to the right clinical solutions. Additionally, as CMS notes, clinical decision support tools offer extraordinary value in advancing the quality, safety, efficiency and safety of healthcare. Premier and many of our member hospitals and health systems are already voluntarily leveraging CDSM-powered AUC workflows and will continue to do so. However, Premier is concerned that an indefinite pause on a national-scale program leveraging CDSM technology will have a chilling effect on future innovation. Developers and vendors are unlikely to invest the research and development resources needed to unleash the potential of CDSMs in healthcare given the precedent of sudden course-reversal that CMS proposes to set through this rulemaking. Furthermore, future proposals from CMS that involve investments in technology may be stifled as entities question whether CMS will truly move forward with implementation or abandon its own policy down the road. Given that adoption of technology will be necessary as healthcare continues to evolve and transform, ***Premier strongly urges CMS to not abandon the AUC program and set the precedent that it can reverse course after entities have made significant time and monetary investments to comply.*** Entities should not be punished for proactively implementing statutory and regulatory requirements in advance of enforcement deadlines. Finally, abandonment of the AUC program at this juncture may subject CMS to legal action.

Additionally, Premier recommends that any legislative "fix" to the AUC program should unlock additional value for providers who invest in CDSM technology. To date, providers who have invested in CDSM technology to implement the AUC program requirements have had a compelling compliance reason for doing so. Knowing that the AUC program may promote more widespread adoption of CDSM technology, Premier recommends that CMS consider other opportunities to leverage CDSMs in federal policymaking, such as designing a demonstration model within the Medicare Advantage program that leverages CDSMs to reduce administrative burden and patient wait times associated with prior authorizations. Premier further recommends that CMS engage stakeholders in developing any legislative "fix" that includes AUC and CDSM technology organizations, impacted providers, and entities who have already implemented AUC and CDSM technologies.

VIII. QUALITY PAYMENT PROGRAM – QP DETERMINATIONS AND THE APM INCENTIVE

Background

Clinicians who have a certain percentage of payments or patients through an 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.

Proposals and Recommendations

CMS is proposing to modify this approach and instead make QP determinations at the individual clinician level. Stakeholders have noted concerns that the current QP methodology might discourage 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. CMS believes that making the QP determination at the individual clinician level will address these concerns.

Premier strongly opposes solely calculating QP status at the individual clinician level, as this may create undue burden on providers and APMs and may not achieve CMS' intended purpose. 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.

Premier instead encourages CMS to calculate QP determinations at both at the APM entity and individual clinician level and award QP status based on the higher score. Premier also encourages 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, Premier provides 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.

IX. CONCLUSION

In closing, Premier appreciates the opportunity to submit these comments on the CY 2024 PFS proposed rule. If you have any questions regarding our comments or need more information, please contact Mason Ingram, Director of Payer Policy, at mason_ingram@premierinc.com or 334.318.5016.

Sincerely,

Soumi Saha, PharmD, JD
Senior Vice President of Government Affairs
Premier Inc.