August 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC
Submitted electronically to: http://www.regulations.gov

Re: Medicare Program; Request for Information on Medicare (CMS-4203-NC)

Dear Administrator Brooks-LaSure:

On behalf of the Premier healthcare alliance serving approximately 4,400 hospitals and health systems and approximately 250,000 Continuum of Care and other providers, we appreciate the opportunity to submit comments on the Center for Medicare & Medicaid Services (CMS) Request for Information (RFI) on Medicare Advantage (MA). With integrated data and analytics, collaboratives, supply chain solutions, and consulting and other services, Premier enables better care and outcomes at a lower cost. Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Premier runs the largest population health collaboratives in the country, the Population Health Management Collaborative, which has worked with hundreds of organizations in Medicare alternative payment models (APMs) and value-based arrangements with MA organizations and other insurers. Our comments primarily reflect the concerns of our hospitals and health systems, their employed physicians and independent physicians aligned with them.

Premier strongly supports CMS' Vision for Medicare and appreciates the opportunity to engage with CMS on developing data-driven policy change in the MA program. Below we offer responses to the RFI and highlight opportunities to continue to strengthen the quality and sustainability of the MA program for plans, providers, and Medicare beneficiaries. In our comments, Premier asks CMS to consider the following:

- Leveraging value-based care models and unleashing data to reduce disparities in care;
- Streamlining prior authorization in MA to reduce provider burden and ensure access to medically necessary care;
- Improving access to telehealth and allowing diagnoses captured through audio-only telehealth visits to count toward risk adjustment methodologies across Medicare payment models;
- Creating new incentives to encourage MA plans to enter value-based contracting arrangements with providers;
- Collecting and analyzing data on MA plans' value-based payment model requirements to promote greater alignment;
- Improving alignment of program requirements and flexibilities across MA and accountable care organizations;
- Strengthening oversight of medical loss ratio compliance;
- Preparing rural providers to succeed under APMs, including in MA as managed care penetration increases, to preserve access to care; and
- Ensuring accurate and sustainable risk adjustment models across Medicare programs.

Advancing Health Equity

CMS solicits comments on a number of issues related to addressing health equity among MA beneficiaries. Premier is committed to advancing high quality, cost-effective, equitable healthcare. We have demonstrated this commitment by:

- *Advancing the movement to value-based care*. When providers are responsible for total cost of care for their patients and have flexibility to address social determinants of health (SDOH), providers will be proactive in addressing equity and disparities.
- *Unleashing data*. Unfettered access to claims and clinical data is necessary to understand where patients are in their community, how they interact with the healthcare system, and what gaps are exacerbating health conditions.
- *Leveraging data insights and shared learnings to implement strategies to rapidly improve health equity*. Premier is proud to be working with this administration to improve the health and wellbeing of mothers and infants through the Maternal Morbidity and Mortality Data and Analysis Initiative. We are working to scale a collaborative of more than 220 diverse hospitals representing every state. The collaborative will use standardized data to assess the efficacy of evidence-based interventions on maternal-infant morbidity and mortality with overarching considerations on health equity including disparities and SDOH. Premier has committed to raising the bar on quality, safety, and cost of care for mothers and babies across the U.S., aligning with CMS' Maternity Care Action Plan.

Having clear, comprehensive and compelling person-level data is crucial to identifying gaps in outcomes and the interventions that best address them. Value-based care provides the incentives to implement the right interventions at the right time for the right populations. Premier appreciates the opportunity to provide feedback on this significant priority, and our specific policy recommendations are detailed below.

Advancing health equity through value-based care

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 and have flexibility to address SDOH, providers will be proactive in addressing inequity and disparities.** APMs are designed to make providers accountable for the cost and quality of care for a defined patient population. This incents providers to be proactive in identifying and managing the care of their accountable populations. Shifting the payment system also creates opportunity to address a more comprehensive set of services that address SDOH, as providers are empowered to use the right resources for the right populations to improve outcomes. CMS can make meaningful progress towards advancing health equity in the MA program by incentivizing MA organizations to partner with providers in value-based arrangements.

While traditional Medicare APMs have paved the way for the movement to value in Medicare, a significant amount of MA payment remains in fee-for-service contracts between plans and providers. These volume-driven contracts do not allow providers the resource flexibility to capture SDOH data in patient encounters and coordinate care across a resource team to address social risk factors. To empower providers to transform care we must move away from fee-for-service and ensure all payment systems are built on value. We include specific policy recommendations for incenting MA plans to enter value-based arrangements under the "**Driving Innovation to Promote Person-Centered Care**" section below.

Advancing health equity through unleashing data

Addressing the underlying social and economic inequities and the 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. In order to appropriately address disparities across MA beneficiaries, CMS should consider the following:

- *Social risk factors and demographic data collection*. Regardless of the dataset used to measure quality in MA, patient-reported data is the gold standard for capturing social risk factors. Health systems are on the ground capturing sociodemographic data in patient encounters, but this information is not easily translatable for CMS purposes. For example, despite an available

framework for mapping the more than 900 race and ethnicity codes provided by the Centers for Disease Control and Prevention (CDC), race and ethnicity codes captured in the electronic health record (EHR) cannot be consistently mapped. This is due to a lack of standard taxonomies within and across EHRs. Similarly, while there is an abundance of tools to screen for SDOH, underlying definitions for certain social risk factors (e.g., food insecurity) vary significantly, even when the same tool is used by different providers. It is critical that CMS work to improve and streamline SDOH data collection so that providers and plans collect the data once, collect it correctly, and make it immediately available for providers.

We ask that CMS make a concerted effort to advance standards for the collection of sociodemographic information, using existing tools such as the United States Core Data for Interoperability (USCDI), Z-codes, HL7 and Fast Healthcare Interoperability Resources (FHIR) standards. CMS needs a coordinated approach for using sociodemographic data for numerous purposes including payment and quality in the MA program and beyond. This coordinated approach requires significant input from providers across the continuum, vendors, MA plans, and suppliers. **We recommend that CMS convene a dedicated Task Force or Expert Panel of stakeholders to support advancing standards and collection of sociodemographic factors.** The Task Force or Expert Panel should include, at a minimum, representation from MA plans, acute and nonacute providers, vendors and suppliers, and beneficiaries. **Including the provider voice in this discussion is critical, as it ensures CMS is aware of what flexibilities may be needed in the selection and implementation of screening and other data collection tools.** It is vital that CMS also invest in educating both patients and providers about the importance of collecting SDOH information, the evidence for how it affects care, and existing privacy requirements under HIPAA that safeguard information patients share with their providers. CMS should also consider advancing standards that clearly indicate the dates and times associated with data collection, as certain sociodemographic factors (e.g., homelessness) are subject to change.

- *Data sharing between health plans and providers.* Healthcare providers are the frontline of patient care and patient experiences and are most appropriately situated to address health disparities in their patient populations and communities. The Agency for Healthcare Research and Quality (AHRQ) has found that one of the biggest barriers most health systems face in improving quality and reducing disparities within their own walls is systematically identifying the populations they serve, addressing the needs of these populations, and monitoring improvements over time. AHRQ further found that the principal challenges in obtaining race, ethnicity, and language data for use in quality improvement assessments include a lack of standardization and understanding of why the data are being collected.

  Data sharing remains a high-priority challenge for providers in both fee-for-service contracts and value-based arrangements with MA organizations. In a recent Premier survey, 80 percent of provider respondents said they do not have access to timely and/or comprehensive data on their patients, even in risk-based arrangements where such data is critical to providing high-quality patient care. Specifically, providers note that the data they receive from payers often reflects only a portion of the care received by beneficiaries in the value-based arrangements. Further, faced with significant lag times for receiving data, hospitals and clinicians have already invested significant amounts of their own resources to create infrastructure to reduce delays. **CMS should evaluate the timeliness and comprehensiveness of data that MA plans are sharing with providers, with a particular focus on unleashing any SDOH data to which MA plans have access but frontline health workers do not.** As payers and providers each seek to implement innovative models for addressing SDOH, equal access to data is necessary to level the playing field and enable multi-pronged approaches to advancing health equity.

Expanding Access: Coverage and Care

Unlike traditional Medicare, MA plans limit Medicare beneficiaries' access to healthcare by only covering items and services that are furnished by in-network providers and suppliers, and by stipulating that beneficiaries and providers meet certain utilization management requirements. Our recommendations for improving access to coverage and care in the MA program are included below.

Prior authorization in MA

The Department of Health and Human Services' Office of Inspector General (OIG) recently raised concerns about MA plans' misaligned incentives to deny beneficiary access to services and deny payments to providers in an attempt to increase profits. Among other findings, OIG determined that 13 percent of denied MA prior authorization requests met Medicare coverage rules – beneficiaries would have clear medical justification for receiving the services had they been enrolled in Traditional Medicare. Additionally, among the payment denials that OIG reviewed, 18 percent met Medicare coverage rules *and* MA plans' billing rules, and **were the result of human error**. CMS' own annual audits of MA organizations have highlighted widespread and persistent problems related to inappropriate denials of services and payment, resulting in diminished access to care for beneficiaries and insufficient reimbursement for providers.

The MA prior authorization process is burdensome to providers, delays necessary care, and is disconnected from the clinical workflow. According to a recent American Medical Association survey, 93 percent of physicians reported care delays associated with prior authorization, and 82 percent reported that prior authorization led to treatment abandonment. Medicare beneficiaries cannot wait for Congressional action to require electronic prior authorization in MA. Transitioning to fully electronic prior authorization transactions would save the healthcare industry $437 million annually, and would reduce the time from providers' submitting a request to receiving a health plan's decision by 69 percent. **It is imperative that absent immediate statutory imperative, CMS should leverage its demonstration authorities to require MA plans to utilize electronic prior authorization platforms to ensure beneficiary access to medically necessary care. CMS should also conduct an evaluation of MA plans' patterns of denying prior authorization requests to determine whether plans are inappropriately using prior authorization requirements as another pathway for denials, and whether it is truly appropriate for plans to fully deny payment when providers render services but fail to complete the authorization process due to urgency in the patient's care.** Additionally, health plans frequently apply prior authorization to services for which there is a clear clinical pathway and for which the overwhelming number of requests are authorized. In these instances, the potential care delays and administrative costs associated with prior authorization simply cannot be justified. **CMS should investigate these practices and hold MA plans accountable for unnecessarily denying care and payment.** CMS must improve transparency by requiring that health plans make prior authorization requirements available to both providers and beneficiaries upfront. We recommend that plans also be required to deliver prior authorization responses within 72 calendar hours for standard, non-urgent services and within 24 calendar hours for urgent services.

Using clinical decision support mechanisms (CDSMs) to improve the prior authorization process

The current practice of using health plan or vendor staff review prior authorization requests means that real-time decision-making will not be possible for a significant portion of these requests, and human errors are rampant. An opportunity to improve this process exists specifically within the area of advanced imaging to truly enable real-time decisions by utilizing the CDSMs and appropriate use criteria (AUC) established in the Protecting Access to Medicare Act (PAMA) of 2014. CDSMs used in the AUC program are certified by CMS based on the use of valid, evidence-based measures. They are implemented by providers and thereby allow providers to choose a single set of clinical criteria for all patients for which the CDSM is utilized. If CDSMs were allowed as an option to perform medical necessity review for MA patients, providers would have both instant, transparent access to the criteria on which their imaging

orders are being evaluated as well as the ability to use the same criteria for all MA patients, which would reduce variation in standard of care. **Premier urges CMS to leverage its demonstration authorities to test requiring MA plans to approve prior authorization requests for advanced imaging that demonstrate 1) adherence to appropriate use criteria made by a qualified CDSM, and 2) an identifier of the qualified CDSM that issued the AUC adherence determination.**

Improving access to telehealth

Telehealth provides an important tool that providers and payers may use to expand access to care for Medicare beneficiaries. Telehealth benefits are more widely utilized in MA than in Traditional Medicare – a recent HHS OIG report found that 49 percent of MA beneficiaries used telehealth during the first year of the COVID-19 pandemic, compared to 38 percent of those enrolled in Medicare fee-for-service. By CMS' analysis, nearly one-third of beneficiaries that received a telemedicine service did so by using audio-only telephone technology. However, MA plans are prohibited from counting diagnoses captured through audio-only telehealth visits towards beneficiary scores for risk adjustment. This reduces the available resources for plans and providers in risk-sharing arrangements who utilize audio-only telehealth to manage care. It also creates access issues for beneficiaries who are physically unable to attend an in-person office visit and lack adequate resources, including access to broadband in rural communities, to use audio-video technology. **CMS should allow MA plans to count diagnoses captured through audio-only telehealth services toward risk score for risk adjustment payments.** We believe CMS should afford consistent flexibility across all Medicare programs, and **we urge CMS to allow audio-only telehealth diagnoses to be included in risk adjustment methodologies across Medicare payment models, including ACOs.**

Driving Innovation to Promote Person-Centered Care

The flexibility around Medicare's capitated payments to MA plans is one lever that spurs the adoption of innovations that can potentially improve outcomes and reduce costs. Importantly, this capitation is paired with the Star Ratings program's quality and patient satisfaction measures as guard rails to limit stinting on healthcare services. Proof of concept for the importance of these MA design features was illustrated in a study investigating the effects of capitation on clinical practice transformation, which saw a decrease in hospital-based services, an increase in officed-based care, and a 6 percent improvement in survival rates.[1] Yet, it is not the CMS capitated payments to MA plans alone that create a value-based care system. The ability to innovate and design payment arrangements for MA provider networks that target success on value-based care goals is key to a MA plan's success in delivering person-centered, value-based care.

In our comments on the CY 2023 Advance Notice, Premier applauded CMS for expressing interest in developing a measure to capture engagement in value-based arrangements among MA organizations. We continue to encourage CMS to explore tying MA organizations' participation in value-based arrangements to plan quality measures and payment. The Health Care Payment Learning and Action Network (LAN) oversees a survey of commercial insurers each year to track their progress in alternate payment arrangements with providers based on the payment model categories associated with the LAN's widely accepted APM Framework. For data related to CY 2020, MA plans reported having 58 percent of their provider payment arrangements in categories 3 and 4 of the LAN APM Framework, which includes one- and two-sided shared savings arrangements as well as a variety of population-based arrangements. While this is meaningful progress, a significant amount of Medicare payment in MA remains in fee-for-service models.

[1] Mandal AK, Tagomori GK, Felix R v., Howell SC. Value-based contracting innovated Medicare advantage healthcare delivery and improved survival. *The American Journal of Managed Care*. 2017;23(2): e41-e49. https://europepmc.org/article/med/28245661

Encouraging MA plans to offer value-based arrangements

Premier strongly recommends that CMS continue to pursue a Star Ratings measure that incents MA plans to come to the negotiating table with providers to enter into value-based arrangements. Further, we recommend that CMS structure said measure(s) to align with how providers are assessed for earning advanced APM, or Medicare Access and CHIP Reauthorization Act (MACRA), bonus payments. The advanced APM bonus assesses the percent of patients or payments in a value-based arrangement that bears more than nominal risk. CMS should create a more level playing field by holding MA plans to the same evaluation metrics. CMS should also collect the measure data in a format that could be easily used for the provider determination of the advanced APM bonus, reducing overall administrative burden.

Currently, CMS incentivizes provider engagement with MA plans' risk-based contracts by offering the Other-Payer Advanced APM pathway for eligible clinicians to become Qualifying Alternative Payment Model Participants (QPs) in the Medicare Quality Payment Program. However, a Premier survey found that **87 percent of provider respondents met APM bonus thresholds through Medicare fee-for-service (FFS) APMs alone**. Uptake of Other-Payer Advanced APMs is limited because MA plans lack the incentives to come to the table with providers in the movement to value. It is imperative that CMS focus its policy levers on driving all payers to offer APMs.

Premier recommends that CMS develop additional incentives to encourage health plans to shift their contracting to value-based arrangements and APMs, with a focus on improved patient outcomes for the most vulnerable populations. We believe CMS should explore the following incentives:

- Introducing new measure(s) of the volume of payments/patients/providers in value-based arrangements in the Star Ratings program.
- Offering plans additional flexibilities through the Value-Based Insurance Design (VBID) model in exchange for engaging more deeply with providers in value-based care.
- Leveraging Section 402 demonstration authority to test incentives for increasing value-based arrangements in the MA bid and payment processes. For example, tying quality bonus payment percentages or rebate percentages to the percentage of patients or payments MA plans have in value-based arrangements.

Tying managed care incentives to provider adoption of APMs, including leveraging the bid process to reward value to the fullest extent allowable administratively, is key to fostering new provider-payer partnerships that will ultimately drive innovation and care transformation.

Alignment across MA plans' value-based arrangements

Premier commends CMS' recent Health Affairs blog that cites alignment of requirements for value-based payment arrangements as a critical priority. The administrative burden that providers face participating in the fragmented, misaligned payer APM environment detracts from providers' focus on furnishing high-quality care. Hospitals and health systems are currently faced with overwhelming labor costs and are continuing to recover from the disruption of the COVID-19 pandemic. Unnecessarily expending FTEs and other resources to bridge different health plan requirements is untenable.

CMS has admitted to having limited insight into the types and quality of value-based arrangements between plans and healthcare providers in MA. In addition to aligning MA with value-based efforts in Traditional Medicare, **it is imperative that CMS begin collecting and analyzing data from MA plans on their value-based arrangements**. Key data points necessary to drive alignment include:

- *Clinical areas or episodes of care.* There is a lack of alignment across MA plan arrangements in defining service components and other characteristics of bundled payments or episodes of care.
- *Quality measurement.* This includes quality measures, performance thresholds, and timelines and mode(s) for reporting.

- *Financial models and incentives.* This includes the level or amount of payment at risk and the overall payment structure.
- *Technology requirements*. There are a variety of requirements around technology platforms and capabilities across MA plans' value-based arrangements, some of which require significant investment from providers to purchase and utilize. Streamlining these requirements helps providers maximize their available resources to improve patient care and outcomes.

MA plans frequently tailor models to meet specific needs associated with certain geographies (e.g., rural providers). **CMS should include such variation in its data collection, analyzing health plans' approaches to identify best practices for tailoring models to suit the needs of different patient populations, provider types and geographies.** Using the data collected, Premier urges CMS to set consistent, appropriate standards for Other Payer APMs, while continuing to allow flexibility for MA plans to meet the needs of their contracted providers. **Further, we encourage CMS to invest in more granular evaluation strategies for the benefit design and payment models that plans test through the Value-Based Insurance Design (VBID) model in order to identify and publicize the components of these models tests that work, and those that do not.**

Alignment between MA and accountable care organizations (ACOs)

In the MA program, the benchmark formula and other factors increase Medicare payments to many MA plans above their bid amounts. Part of the savings is used by the plans to enhance benefits, which increases enrollment. The savings created under MA are real, but only a small share is used to offset federal costs. In contrast, the Medicare Shared Savings Program (MSSP) collectively saved Medicare $1.66 billion in 2021. CMS should improve policy alignment between ACOs and MA plans to ensure that ACOs do not face a competitive disadvantage that undermines their value to preserving and strengthening the Medicare program.

As MA penetration increases, beneficiary alignment becomes more difficult for ACOs, which face a dwindling risk pool of eligible Medicare beneficiaries. In order to be successful in the MA program, plans must aggressively market their products to eligible beneficiaries, who must then elect to enroll. Beneficiaries are not simultaneously presented with the option to select an ACO to which to align, which would provide an opportunity to equitably compare their health insurance coverage choices. **CMS should analyze differences in beneficiary steering to elect MA versus align with an ACO in Traditional Medicare to ensure that plans do not engage in "cherry picking" tactics that result in ACOs caring for only the most vulnerable, high-cost Medicare patient populations.**

Improving beneficiary outreach and communications

We encourage CMS to be more flexible in its regulatory oversight requirements of communication and education activities between providers and MA beneficiaries, allowing more proactive outreach regarding plan options, especially as we view this communication through a health equity lens. CMS could consider testing such flexibilities among a narrow subset of providers and patient populations and monitoring to ensure that patient education does not give way to inappropriate marketing practices. In addition, we encourage the agency to be more timely in its response to MA providers on these issues before open enrollment begins. Increased flexibility is needed to ensure providers have maximum opportunities to educate our patients to better inform their healthcare decision making.

Supporting Affordability and Sustainability

The current payment methodology of the MA program creates an uneven power and financial dynamic between MA plans and providers. Despite unprecedentedly high annual payment updates in the MA program, studies have shown that MA plans generally reimburse providers at rates below Traditional

Medicare.[2] Coupled with the additional resources that providers must allocate to processing prior authorizations, appealing improper denials and managing slower cashflow, plans' reimbursements woefully underfund the true cost of providing care. If CMS maintains that Traditional Medicare reimbursement rates are the most appropriate fee-for-service rates for items and services supported by available data, then the agency must take stronger action to incent plans to pay providers no less than Traditional Medicare rates. **This includes monitoring and enforcing all existing statutory and regulatory payer price transparency requirements that would lend greater visibility to MA plans' fee-for-service payment rates, empowering providers and patients to seek the best price for care.**

Strengthening medical loss ratio oversight

Medical loss ratio (MLR) requirements for MA plans attempt to constrain plan profiteering by mandating that the difference between revenues and medical costs cannot exceed 15 percent of total revenues. However, there are no restrictions to prevent parent companies of MA plans from boosting profits by funneling MA dollars through related businesses that are not subject to MLR regulations. In fact, the largest MA payers all have vertically-integrated businesses including pharmacy benefit managers (PBMs) and retail pharmacies, post-acute providers, physician practices, and health services subsidiaries providing data analytics and other products. This creates perverse incentives to move MA earnings outside the reach of federal regulations.

As a taxpayer-funded health benefits program, Medicare should not be a major profit driver for private health insurance companies. **Premier recommends that CMS implement, monitor and enforce more stringent MLR requirements for MA plans that take into account the movement of federal funding through payer-owned healthcare providers and health services companies.**

Preserving access to care in rural areas

There is significant variation in MA penetration across different geographies, with rural areas generally having a lower proportion of MA beneficiaries and a higher proportion of beneficiaries in Traditional Medicare compared to urban areas. We appreciate CMS recognizing the specific needs of rural hospitals and health systems in Traditional Medicare through offering cost-based payment for Critical Access Hospitals (CAHs) and Rural Health Clinics (RHCs). Cost-based payment preserves access to care for rural beneficiaries by adequately funding costly rural hospital operations. As MA penetration increases nationwide, rural providers face the challenge of negotiating in-network payment rates, which may not sufficiently cover the cost of care, with private health plans. When CMS implemented prospective Medicare fee-for-service payments for hospitals and moved away from cost-based payment in the 1980s, rural hospital finances were disproportionately affected.[3] From 1988-1988, 140 rural hospitals closed, most of which had fewer than 50 beds. One-third of the smallest rural hospitals that closed faced the highest negative margins on Medicare patients.

CMS must urgently act to ensure that rural Medicare beneficiaries maintain access to care as MA penetration increases. **Premier recommends that CMS engage with rural providers to develop and recruit participants for innovative Medicare payment models that emphasize improving quality, access and sustainability in rural communities.** Incenting rural providers to join APMs is crucial to not only equipping them to succeed under MA, but to CMS achieving the agency's goal of moving all Medicare and a majority of Medicaid beneficiaries into an accountable care relationship by 2030. Specifically, Premier recommends that CMS take the following actions:

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[2] Trish E, Ginsburg P, Gascue L, Joyce G. Physician reimbursement in Medicare Advantage compared with Traditional Medicare and commercial health insurance. *JAMA Internal Medicine*. 2017 Sep; 177(9): 1287–1295. Published online 2017 Sep 5.

[3] United States Government Accountability Office. *Rural Hospitals: Factors That Affect Risk of Closure*. GAO Report HRD-90-134 (June 1990)

- *Adopt more sustainable financial methodologies for rural providers.* This includes lowering the minimum savings rate or reducing discounts applied under the models for rural ACOs, adjusting benchmarks to account for historical underutilization of services and modifying benchmarks to hold rural ACOs harmless for cost increases that are driven by the underlying cost-based payment system.
- *Provide new opportunities for upfront funding.* CMS recently proposed a new upfront funding opportunity for low-revenue ACOs new to the Medicare Shared Savings Program and inexperienced with other ACO initiatives. Many rural providers use single tax identification numbers (TINs) for their CAH and provider groups and will be unable to qualify as low-revenue by CMS' existing standards.
- *Create a glide path to risk.* CMS should develop a value-based purchasing program for CAHs that are not currently participating in APMs to put them on a path to value-based care. CMS should also allow rural ACOs at least two years to progress to the next risk level, with the option to progress faster.
- *Modify risk adjustment approaches.* Rural providers often have lower patient risk scores, but higher rates of comorbid conditions and chronic disease among their patient populations. To address this challenge, CMS should incentivize more accurate coding capture practices by counting diagnoses captured via telehealth for risk adjustment, incorporating SDOH into the risk adjustment methodology, and removing or setting a higher score cap for beneficiaries aligned through rural providers.

<u>Ensuring accurate and sustainable risk adjustment models</u>

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 MA, 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, but 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 MA.

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

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

management code level methodology, a SDOH component should be factored into the HCC severity calculations.

In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the Medicare Request for Information. If you have any questions regarding our comments or need more information, please contact Mason Ingram, Director of Payment Policy, at Mason_Ingram@premierinc.com or 334.318.5016.

Sincerely,

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Premier healthcare alliance