American Hospital Association™
Advancing Health in America

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Elizabeth Fowler, Ph.D, J.D.
Deputy Administrator and Director
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Dear Dr. Fowler:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) thanks you for holding the Strategy Listening Session for the Center for Medicare and Medicaid Innovation (CMMI) on Nov. 18. We write today to share with you our responses to the following questions that CMMI posed in advance of the session:

1. What is the greatest obstacle to participating in a CMS Innovation Center or other value-based, accountable care model? How do you recommend the CMS Innovation Center alleviate this obstacle?

2. What else could the CMS Innovation Center do to support clinicians and help them be successful in models?

3. How can the Innovation Center better incorporate patient needs and goals into models? How should the impacts of value-based care on patients be measured?

We first want to thank the agency for engaging model participants and other stakeholders with these questions. As our members continue to move toward value, we strongly support CMMI's plans to drive accountable and innovative care, advance health equity and address affordability for patients. We also support your plan to engage in partnerships to achieve system transformation and stand ready to serve as one of your partners to implement alternative payment models (APMs) that best serve patient and provider needs. We hope that our responses to your questions, which we have divided below by topic rather than by question number, are helpful to you as you continue on this journey to improve value-based care for patients and providers.

Lessen the burden of model participation. Hospitals and health systems are at different points on the transition to value, from organizations signing their first APM contract, to those managing hundreds of thousands of beneficiaries across numerous care sites, states and APM programs. But no matter their degree of experience, all hospitals and health systems participating in APMs must transform their delivery structure and financial methodology for the portion of their patient base included in models, while also simultaneously executing their core mission to care for all patients. **For certain providers, the resources required to do this are too great to bear.**

To give themselves a chance of succeeding in APMs, providers are being asked to build APM competencies and infrastructure with neither upfront support to acquire these skills and resources nor with any financial contribution built into their compensation. Specifically, providers are asked to finance all of the APM infrastructure out of presumed savings from changes in care delivery, which could take years to materialize. This is unlike other risk-bearing entities; insurers, for example, receive premiums that are calculated to enable them to spend 15 to 20 percent on administration.

To begin to address this issue, we urge CMMI to balance risk and reward in a way that reflects the significant investments required to launch and maintain APM participation. For example, CMMI could again provide upfront payments to aid certain providers in offsetting the cost of participation in models, including to increase APM participation of providers that serve historically marginalized patients. The agency also could incorporate more glide paths to higher levels of risk so that participants can gain a foothold in APMs before being required to put significant financial resources at risk. Models also should feature risk adjustment methodologies that ensure primary care physicians treating the sickest, most complicated and most historically marginalized patients are not at a disadvantage. In addition, risk adjustment models should take into account patients' social needs and social determinants of health that are beyond clinicians' control but that significantly impact outcomes.

In addition, IT infrastructure is critical to managing the data needed for improving care through APMs. Yet across the industry, the IT infrastructure lags behind in readiness to support APMs. Specifically, the platforms upon which APM programs run are designed for a fee-for-service (FFS) payment system. Thus, participants must dedicate additional resources for APM administrative needs and IT modifications. **CMMI could work to alleviate this issue by incentivizing and assisting IT vendors in making their platforms more functional for APMs. We also recommend CMMI make targeted investments in improving its own IT operations, especially to improve data sharing with providers participating in APMs.** This also could contribute to being able to automate certain elements of participation in APMs, which could alleviate some of the participation burdens providers currently face, as further described below.

CMMI also should make participation easier by reducing regulatory and administrative burdens. For example, we strongly urge CMMI to automate some reporting requirements and streamline the reporting process into a central location. We urge the agency to automate the data it shares with participants, and

select a single document type for doing so. This would allow participants to have one data processing group, rather than multiple disparate teams. It also would be helpful if CMMI created a single channel of interaction with a central CMMI entity. Currently, participants interact on each model through unique channels, requiring different staff to log into different portals to report information to the agency. This results in hospitals and health systems needing to hire multiple teams and divide resources across models.

Finally, we encourage CMMI to offer APM participants relief from regulatory burdens associated with the practice of FFS medicine. For example, CMMI could consider offering model participants relief from utilization management practices, such as prior authorization, and a reduced claims reporting burden to the extent feasible. Models also should waive certain rules and regulations that impede providers' ability to place beneficiaries in the clinical setting that best serves their needs and to coordinate care across settings.

Empower model participants to understand key model features. **Part of the difficulty in participants achieving APM financial viability is understanding their chances of doing so in the first place.** Benchmarking, risk adjustment, reconciliation and associated financial calculations are incredibly complex and differ across models; few providers have the resources to understand them. Even those that do find it burdensome and are expending significant time and money to recreate CMMI's financial methodologies, which can change with little notice during a model performance period. This makes it difficult for providers to make informed decisions about participating in models or set themselves up for success by understanding the targets they are working toward. If it is difficult for providers to model potential financial and clinical outcomes, then it is almost impossible to garner the executive- and clinician-wide support necessary for participation in that APM.

This is especially true for models that are announced just months before launch and for which the agency implements mid-stream model changes. Many of our members have indicated they need one to two years to make all the necessary operational, administrative and clinical adjustments to succeed in models. **We therefore urge CMMI to factor implementation periods into any future APMs and to reduce mid-model changes to the greatest degree possible.**

Another factor that complicates participants' ability to understand model targets and calculations is that financial methodologies, incentives and other logistical aspects of participation differ across models. This makes it extremely challenging to meet administrative requirements of a range of models and for providers to make changes that would allow them to succeed in multiple models. In some instances, a change in one aspect of care could be beneficial in one model and detrimental in another. The many differing model timelines also makes it difficult to participate in different models. CMMI is already aware of these issues, as it has focused some of its strategic refresh on streamlining its model portfolio. **However, we urge the agency to go one step further and work to streamline methodologies across models so that participants**

who have done the work to understand one model can apply that knowledge and understanding to participation in others as well.

Ensure participants have timely, usable data about their attributed populations. The AHA greatly appreciates CMMI's recognition of the importance of targeted, actionable data that is available long before a model begins and at regular intervals during model performance periods. To succeed, model participants need an in-depth understanding of the indicators of patients' health. They also need feedback that is as close to real-time as possible in order to implement changes to care delivery in response to changes in patients' conditions. As detailed above, it also is crucial that data from CMMI is shared with participants in a standardized and consistent manner, with the same data points shared in every model, to the extent feasible and relevant.

The AHA supports CMMI's efforts to meet providers' data needs and stands ready to assist the agency in two-way data sharing for improved patient care and provider experience in models. **In addition to claims data (made available at the individual member claim-line level), we urge the agency to make financial targets and performance data readily available to participants and to summarize it in a standardized, ready-to-use format.** This information is crucial for hospitals and health systems to track and manage their performance in APMs and understand the impact of model performance on patient outcomes.

Support providers' ability to deliver accessible, equitable care to patients. Disparities in health and health care have plagued the U.S. health care system for generations, leaving certain populations – including racial and ethnic minorities, sexual and gender minorities, people with disabilities, and individuals living in rural areas – more likely to experience worse health outcomes, limited access to health care services, and lower quality of care than the general population. We thank CMMI for working toward addressing these disparities in care by embedding health equity into every aspect of its models and increasing its focus on underserved populations.

As part of this work, we urge the agency to ensure that model participants can work in conjunction with the agency to improve health equity. Specifically, we suggest CMMI ensure providers are enabled and incentivized to collect detailed demographic data on preferred language, sexual orientation, gender identity, race, ethnicity, disability status, and any other measures they feel are necessary to capture the true status of the patients they treat. CMMI could help advance these efforts by working with other federal agencies to foster aligned, standardized approaches to collecting, analyzing and exchanging demographic and social risk data. CMMI also should consider supporting the testing of such standards to ensure they are appropriate for broader adoption and implementation. CMMI should help providers do this in a patient-friendly manner that prioritizes patient self-reported data.

Finally, we urge CMMI to improve the care patients receive through APMs by supporting providers' ability to simplify care. Patients want a seamless and straightforward experience in getting the care they need. CMMI could contribute to this

experience by paying for care navigation services and providers, and reimbursing non-medical services such as those provided by social workers.

Again, we thank you for your consideration of our feedback. Please contact me if you have questions, or feel free to have a member of your team contact Shira Hollander, senior associate director of payment policy, at 202-626-2329 or shollander@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development