March 6, 2023

Hon. Chiquita Brooks-LaSure
CMS Administrator
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Hon. Meena Seshamani
CMS Deputy Administrator for the Center for Medicare
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-2023-0010-0001 - Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Administrator Brooks-LaSure and Deputy Administrator Seshamani:

Oak Street Health appreciates the opportunity to offer comments to the Centers for Medicare and Medicaid Services (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. We applaud and share CMS' goals of:

1. Advancing health equity
2. Moving as many beneficiaries as possible to accountable arrangements by 2023; and
3. Ensuring the financial state of Medicare Advantage (MA) is appropriate and sound.

In order to analyze the proposed risk adjustment changes in the Advance Notice, our primary care health centers offer a powerful lens because we run the same care model, in every location, in 21 states, focusing on communities with underserved patient demographic compositions. In these populations, we have demonstrated success both delivering high quality care but also saving taxpayer dollars.

- In 2020, we were the 4th highest saver of 513 Accountable Care Organizations participating in the Medicare Shared Savings Program (MSSP), achieving a savings rate of 16.86% compared to 4% on average for the participating organizations.

- In 2021, during the first year of the Centers for Medicare and Medicaid Innovation (CMMI) Global and Professional Direct Contracting Model (now called ACO REACH), we achieved the highest net savings in the model, a rate nearly 12 times greater than the net savings rate for the GPDC model as a whole; we also achieved a 100% quality rating.

Throughout this comment letter, we provide:

- ✓ Specific, clinical analysis
- ✓ Limited, targeted requests and;
- ✓ Productive recommendations about how to make the proposed changes even more impactful.

With that in mind - given our achievements caring for some of the most underserved communities in the nation - we are compelled to share that our analysis of the proposed v28 CMS-HCC model demonstrates a transfer of MA resources away from underserved communities and towards higher income, healthier areas. Below are data for our own patients, not the entire MA system.

- For our patients who are both full benefit dually eligible and Black or African American, we see a $480 per member per year reduction in risk-adjusted payments compared to the change in payment we see for Oak Street Health patients who are non-duals and White.

- For all of our patients who are full benefit dually eligible, we see a $240 per member per year reduction in risk adjusted payments compared to the change in payment we see in our patients who are non-duals and White.

We believe there are **relatively small adjustments in the proposed changes** that can preserve CMS' objectives regarding program integrity and sustainability while augmenting the health equity goals of the Biden/Harris administration. These include:

1. Increasing demographic coefficients for dually eligible beneficiaries
2. Further increasing coefficients for certain chronic illnesses overall and for dually eligible beneficiaries specifically
3. Expanding frailty adjustment to all dually eligible beneficiaries, not just those in FIDE D-SNPS
4. Revisiting a limited number of removed codes in the proposed v28 CMS-HCC model and reintroducing a clinically relevant subset
5. Adding new codes into the proposed v28 CMS-HCC model capturing diagnoses that are inordinately prevalent in underserved communities

To ensure the changes above are cost neutral to the original proposal, we recommend lower proposed increases to demographic coefficients for non-dual beneficiaries to offset increases from the above changes.

As CMS thinks about the future of the proposals laid out in the Advance Notice, we request the agency delay establishing new risk adjustment policy until 2025. We believe this is necessary in order for CMS to perform additional analysis, receive stakeholder feedback and develop limited changes to this proposal that will move even closer to CMS' objectives. As

an implementer and champion of health equity, we welcome the opportunity to partner with CMS to ensure we are working together towards a more equitable Medicare program.

Background: Oak Street Health

Oak Street Health is a national network of value-based primary care centers for adults on Medicare; our structure is fundamentally based upon taking on the financial risk of our patients and delivering for them in the form of positive health outcomes.

- Founded in 2012, we currently provide care in 21 states to 224,000 Americans. Oak Street Health's mission is to, "rebuild health care as it should be," by reducing costs, improving outcomes and providing high-quality care.

- We accomplish this by being personal, evidence-based, equitable and accountable.

- We are reimbursed through a fully capitated value-based model, which allows us the flexibility to focus on those services that have the greatest impact on keeping people healthy.

Our results versus Medicare benchmarks include:

✓ 51% reduction in hospital admissions
✓ 42% reduction in 30-day readmission rates
✓ 51% reduction in emergency department visits

To achieve these results, we invest substantially in support for behavioral health, food and housing needs and have intentionally rebuilt the entire primary care model.

- In fact, our financial model depends upon those under our care becoming and staying healthy, both physically and mentally.

- That is why we dedicate time daily for our providers to serve their patients who do not have a visit scheduled that day; the difference in the Oak Street Health model is that rather than wait for a need to arise, our providers proactively reach out to their patients who may need support.

- It is also why each of our facilities has an active community room with social and educational events for patients and the community.

Background: By the Numbers, The Underserved Communities We Care For

Oak Street Health enters into capitated arrangements with MA plans in which we take on the entire financial risk and provide total cost of care for our patients. Therefore, when thinking about how we developed our comments - and the expertise we bring to bear - we believe it is critical to note the following defining characteristics of Oak Street Health:

- ✓ 42% of the Medicare beneficiaries we care for are dually eligible for both Medicare and Medicaid.
- ✓ 98% of our primary care health centers across the country are located in communities where the average income is 300% of the Federal Poverty Level or below.
- ✓ More than 50% of our patients identify as Black or African American; Latino or Hispanic; or Indigenous Americans.
- ✓ 77% of our primary care health centers are located in medically underserved (MUA) or health professional shortage areas (HPSA).
- ✓ An additional 22% of our primary care health centers are located fewer than three miles from an MUA or HPSA.

We support these communities by ensuring our workforce looks like those we care for:

- ✓ 55% of our healthcare providers identify as people of color (compared to 45% overall in US healthcare).
- ✓ 71% of our employees overall identify as people of color (compared to 38% of the healthcare workforce nationwide).
- ✓ 58% of our staff is managed by a supervisor who is a woman (compared to 40% in the United States).

Our Comments Regarding the Advance Notice as Proposed, Risk Adjustment

Oak Street Health is a value-based primary care health provider. For the vast majority of the Medicare beneficiaries we serve, we are responsible for their total cost of care. As is well known, this structure - and moving as much of the Medicare population as possible towards it by 2030 - is a significant priority for CMS. Naturally, we share that priority and want value-based care to thrive.

At Oak Street Health, our patients engage in longitudinal care founded upon relationships of trust with our providers who are focused on capturing the entirety of our patients' condition burden to support their overall care needs and deploy appropriate care interventions. **It is our internal policy that only our providers capture diagnoses via face-to-face visits with substantiation for each condition**.

Our team has analyzed the diagnoses undergoing change in the proposed model, specifically we examined:

- Angina Pectoris
- Chronic Heart Failure
- Chronic Kidney Disease
- Coagulation Defects
- Depression
- Diabetes
- Disorders of Immunity
- Endocrine and Metabolic Disorders
- Protein-Calorie Malnutrition
- Rheumatoid Arthritis
- Substance Use Disorders
- Vascular Disease

We largely agree with and are supportive of the rationale for the removal of many of the diagnoses from the v28 CMS-HCC model based upon the increased support brought to the primary conditions and more advanced stages of disease. However, these diagnoses are disproportionately found in people of color and dually eligible beneficiaries. When the elimination of these codes is offset by increases in demographic coefficients at a disproportionate rate for non-duals, the net result is a reduction of resources for people of color and dually eligible beneficiaries and an increase in resources for healthy patients.

Praise for v28 CMS HCC Model

We appreciate the diligence CMS is bringing as it updates the HCC model to reflect the latest coding patterns from 2019 and efforts to better align to the conditions that are most correlated with total cost of care.

We recognize the disease coefficient for a subset of primary conditions and more advanced stages of disease are increased, even as milder stages are eliminated. In particular, we are pleased to see an increase in resources for the following key conditions correlated with higher cost of care in our population; this new clinical investment is sorely needed as we see the following patterns for these specific conditions:

- Chronic kidney disease (CKD):
    - Our patients with CKD diagnosis have 32% higher hospital admissions than our average population.
    - Our full benefit dually eligible patients with CKD have 68% higher hospital admission rates than our average population.

- Dementia
    - Our patients with dementia diagnosis have a 28% higher hospital admission rate than our average population.

- Cancer
    - Our patients with cancer have a 70% higher hospital admission rate than our average population.

- Rheumatoid arthritis
    - Our patients with rheumatoid arthritis have a 20% higher hospital admission rate than our average population.

We understand CMS is focusing on eliminating the secondary conditions and increasing the weight given to primary conditions which drive complications.

- We understand the removal of secondary hyperparathyroidism of renal origin from Endocrine and Metabolic Disorders and the increased disease coefficient for CKD, which is the primary risk factor for this secondary condition.

- Similarly, we acknowledge the removal of coagulation defects in light of the increase in disease coefficient for atrial fibrillation by almost 9%, as atrial fibrillation is the primary underlying condition for this secondary complication.

Achieving Augmented Health Equity in the v28 CMS-HCC Model

We believe there are multiple options for small adjustments in the proposed v28 CMS-HCC Model that preserve both program integrity goals and sustainability without reducing resources for the chronically ill and those patients in need of greater attention.

Below, we offer options contingent upon revisiting both the **demographic coefficient changes** and the **disease coefficient changes** to avoid moving resources away from underserved beneficiaries and towards higher income, less diverse populations. **We are supportive of the elimination of codes shown to be subject to abuse, but not at the expense of populations in underserved communities.**

Our recommendations include:

1. Increasing the demographic coefficient for dually eligible beneficiaries
2. Further increasing disease coefficients for certain chronic conditions overall and for dually eligible beneficiaries
3. Revisiting a targeted number of eliminated codes and reintroducing a clinically relevant subset of diagnoses
4. Adding new codes into risk adjustment that are inordinately prevalent in underserved communities

Oak Street Health suggests these proposals as a menu of ideas for CMS to consider as a means to address health equity via the Advance Notice while still achieving the other goals set out by the agency. We believe ideas across the proposals can be combined and only a subset of them need to be utilized to optimize the health equity impacts of the proposals.

***Proposal 1*: Increase the demographic coefficient for dual eligibles**

Under the proposed v28 CMS-HCC risk adjustment model, we see increases in the demographic coefficients for non-duals that are more advantageous than the changes for dually eligibles.

Key Concern: Among Medicare fee-for-service beneficiaries aged 65 years or older, dually eligible beneficiaries have higher annual all-cause mortality, all-cause hospitalizations, and hospitalization-related mortality compared with non-duals. Between 2004 and 2017, these differences did not decrease.

When we compare the changes in demographic coefficients for non-duals and dually eligible beneficiaries from the v24 CMS-HCC model to the v28 CMS-HCC model, we see stark increases in non-duals either at rates higher than - or at the expense of - dually eligibles.

- For example, community non-dual, aged beneficiaries who are male and 80-84 years old experience an increase of 0.015 in the demographic coefficient, which corresponds to about $144 in additional resources per member per year; meanwhile, full benefit dually eligible, aged beneficiaries experience a decrease of 0.014, resulting in a decrease of $134 in resources per member per year. Please see the below chart:

CMS-HCC Model Demographic Coefficients for Continuing Enrollees

Change in Demographic Coefficient by Community Group from v24 to v28

Color coding based on the magnitude of change (negative red, positive green)

	Change in Demographic Coefficient from v24 to v28		Change in Revenue from v24 to v28 (Per Member Per Year)	
	Community, NonDual, Aged	Community, FBDual, Aged	Community, NonDual, Aged	Community, NonDual, Disabled
Female				
65-69 Years	0.007	-0.006	$67	-$58
70-74 Years	0.009	-0.013	$86	-$125
75-79 Years	0.014	0.003	$134	$29
80-84 Years	-0.004	-0.051	-$38	-$490
85-89 Years	-0.017	-0.09	-$163	-$864
90-94 Years	-0.046	-0.118	-$442	-$1,133
95 Years or Over	-0.045	-0.164	-$432	-$1,574
Male				
65-69 Years	0.024	0.037	$230	$355
70-74 Years	0.002	0.026	$19	$250
75-79 Years	0.029	0.004	$278	$38
80-84 Years	0.015	-0.014	$144	-$134
85-89 Years	-0.022	-0.093	-$211	-$893
90-94 Years	-0.041	-0.149	-$394	-$1,430
95 Years or Over	-0.09	-0.209	-$864	-$2,006

***Our Recommendation*:** We recommend CMS not reduce the demographic coefficient for dually eligibles, especially for full benefit dually eligible beneficiaries, and instead shift any necessary decreases in the demographic coefficients to non-duals.

***Proposal 2*: Further increase disease coefficients for certain chronic illnesses overall and for dually eligibles**

Under the proposed model, we see 39 HCCs where the disease coefficient for dually eligibles is lower than for non-duals. In addition, in the changes from the v24 CMS-HCC Model to the v28 CMS-HCC model, we see 39 conditions where the disease coefficients for non-duals increase at

higher rates - and sometimes at the expense of - the change in the disease coefficients for dually eligibles.

Key Concern: We are concerned there are 39 conditions with higher disease coefficients for non-duals than for full benefit dually eligible beneficiaries.

For example, Rheumatoid Arthritis conditions are weighted at 0.617 for community non-dual aged, compared to 0.439 for community full benefit dually eligible beneficiaries. Non-duals with rheumatoid arthritis receive $1,709 more in resources per member per year than full benefit dually eligible beneficiaries to care for their needs.

Disease Cofficients

Comparison of the Disease Coefficients in v28 for NonDuals vs Full Benefit Duals

		Community, NonDual, Aged	Community, FBDual, Aged	NonDuals vs Duals	
v28 HCC	HCC Description	HCC RAF	HCC RAF	NonDual - FBDual HCC RAF	Revenue Impact (Per Member Per Year)
49	Specified Lysosomal Storage Disorders	9.256	2.833	6.423	$61,661
195	Myasthenia Gravis with (Acute) Exacerbation	2.909	2.153	0.756	$7,258
193	Chronic Inflammatory Demyelinating Polyneuritis and Multifocal Motor Neuropathy	1.692	0.957	0.735	$7,056
191	Quadriplegic Cerebral Palsy	0.855	0.393	0.462	$4,435
276	Lung Transplant Status/Complications	2.531	2.21	0.321	$3,082
192	Cerebral Palsy, Except Quadriplegic	0.314		0.314	$3,014
17	Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic	4.209	3.896	0.313	$3,005
68	Cholangitis and Obstruction of Bile Duct Without Gallstones	0.388	0.085	0.303	$2,909
114	Common Variable and Combined Immunodeficiencies	2.262	2.016	0.246	$2,362
19	Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers	1.798	1.563	0.235	$2,256
300	Exudative Macular Degeneration	0.596	0.37	0.226	$2,170
279	Severe Persistent Asthma	0.818	0.594	0.224	$2,150
93	Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders	0.617	0.439	0.178	$1,709
115	Specified Immunodeficiencies and White Blood Cell Disorders	0.565	0.438	0.127	$1,219
62	Liver Transplant Status/Complications	0.376	0.261	0.115	$1,104
200	Friedreich and Other Hereditary Ataxias; Huntington Disease	0.279	0.165	0.114	$1,094
109	Acquired Hemolytic, Aplastic, and Sideroblastic Anemias	1.144	1.048	0.096	$922
50	Amyloidosis, Porphyria, and Other Specified Metabolic Disorders	0.648	0.555	0.093	$893
65	Chronic Hepatitis	0.185	0.101	0.084	$806
181	Paraplegia	0.942	0.859	0.083	$797
182	Spinal Cord Disorders/Injuries	0.478	0.402	0.076	$730
283	Empyema, Lung Abscess	0.204	0.131	0.073	$701
18	Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid	2.341	2.277	0.064	$614
80	Crohn's Disease (Regional Enteritis)	0.55	0.49	0.06	$576
180	Quadriplegia	1.125	1.068	0.057	$547
197	Muscular Dystrophy	0.426	0.369	0.057	$547
81	Ulcerative Colitis	0.244	0.201	0.043	$413
108	Sickle Cell Disorders, Except Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia Major	0.146	0.103	0.043	$413
94	Systemic Lupus Erythematosus and Other Specified Systemic Connective Tissue Disorders	0.268	0.237	0.031	$298
254	Monoplegia, Other Paralytic Syndromes	0.321	0.292	0.029	$278
278	Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis	0.818	0.791	0.027	$259
21	Lymphoma and Other Cancers	0.671	0.654	0.017	$163
227	Cardiomyopathy/Myocarditis	0.189	0.173	0.016	$154
196	Myasthenia Gravis without (Acute) Exacerbation and Other Myoneural Disorders	0.516	0.503	0.013	$125
298	Severe Diabetic Eye Disease, Retinal Vein Occlusion, and Vitreous Hemorrhage	0.336	0.323	0.013	$125
201	Seizure Disorders and Convulsions	0.245	0.233	0.012	$115
328	Chronic Kidney Disease, Moderate (Stage 3B)	0.127	0.116	0.011	$106
329	Chronic Kidney Disease, Moderate (Stage 3, Except 3B)	0.127	0.116	0.011	$106
154	Bipolar Disorders without Psychosis	0.351	0.349	0.002	$19

In addition, when comparing the change in disease coefficients from the v24 CMS-HCC model to the v28 CMS-HCC model, non-duals with Rheumatoid Arthritis experience an increase of 0.196 compared to full benefit dually eligibles who experience an increase of 0.068 in HCC RAF. Non-duals gain $1,229 in resources per member per year more than full benefit dually eligible beneficiaries with the change to the v28 CMS-HCC model.

Change in Disease Coefficients

Change in Disease Coefficients from v24 to v28 for NonDuals vs Ful Benefit Duals

		Community, NonDual, Aged	Community, FBDual, Aged	v28-v24 Change in HCC RAF between NonDual and FB Dual	Revenue Impact (Per Member Per Year)
v28 HCC	*HCC Description*	*v28-v24 Change in HCC RAF*	*v28-v24 Change in HCC RAF*		
195	Myasthenia Gravis with (Acute) Exacerbation	2.437	1.746	0.691	$6,634
212	Respiratory Arrest	0.016	-0.329	0.345	$3,312
17	Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic	1.55	1.33	0.22	$2,112
283	Empyema, Lung Abscess	0.074	-0.127	0.201	$1,930
198	Multiple Sclerosis	0.224	0.049	0.175	$1,680
1	HIV/AIDS	-0.034	-0.198	0.164	$1,574
264	Vascular Disease with Complications	0.072	-0.067	0.139	$1,334
136	Alcohol Use with Psychotic Complications	0.095	-0.036	0.131	$1,258
137	Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	0.095	-0.036	0.131	$1,258
138	Drug Use Disorder, Mild, Uncomplicated, Except Cannabis	0.094	-0.036	0.13	$1,248
93	Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders	0.196	0.068	0.128	$1,229
182	Spinal Cord Disorders/Injuries	-0.003	-0.13	0.127	$1,219
381	Pressure Ulcer of Skin with Full Thickness Skin Loss	0.006	-0.092	0.098	$941
63	Chronic Liver Failure/End-Stage Liver Disorders	0.08	-0.009	0.089	$854
152	Psychosis, Except Schizophrenia	0.091	0.009	0.082	$787
211	Respirator Dependence/Tracheostomy Status/Complications	-0.121	-0.202	0.081	$778
409	Amputation Status, Lower Limb/Amputation Complications	0.079	0.004	0.075	$720
298	Severe Diabetic Eye Disease, Retinal Vein Occlusion, and Vitreous Hemorrhage	0.114	0.052	0.062	$595
21	Lymphoma and Other Cancers	-0.004	-0.063	0.059	$566
254	Monoplegia, Other Paralytic Syndromes	-0.01	-0.053	0.043	$413
201	Seizure Disorders and Convulsions	0.025	-0.004	0.029	$278
80	Crohn's Disease (Regional Enteritis)	0.242	0.215	0.027	$259
282	Aspiration and Specified Bacterial Pneumonias	-0.077	-0.103	0.026	$250
92	Bone/Joint/Muscle/Severe Soft Tissue Infections/Necrosis	0.078	0.053	0.025	$240
280	Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders	-0.016	-0.04	0.024	$230
229	Unstable Angina and Other Acute Ischemic Heart Disease	0.045	0.023	0.022	$211
64	Cirrhosis of Liver	0.084	0.064	0.02	$192
48	Morbid Obesity	-0.064	-0.083	0.019	$182
112	Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions	0.258	0.239	0.019	$182
36	Diabetes with Severe Acute Complications	-0.136	-0.154	0.018	$173
37	Diabetes with Chronic Complications	-0.136	-0.154	0.018	$173
382	Pressure Ulcer of Skin with Partial Thickness Skin Loss	0.182	0.166	0.016	$154
248	Intracranial Hemorrhage	0.009	-0.003	0.012	$115
249	Ischemic or Unspecified Stroke	0.009	-0.003	0.012	$115
126	Dementia, Moderate	-0.005	-0.015	0.01	$96
127	Dementia, Mild or Unspecified	-0.005	-0.015	0.01	$96
238	Specified Heart Arrhythmias	0.031	0.023	0.008	$77
213	Cardio-Respiratory Failure and Shock	0.088	0.081	0.007	$67
300	Exudative Macular Degeneration	0.075	0.072	0.003	$29

***Our Recommendations*:**

1) Calibrate the v28 CMS-HCC model to ensure sufficient resources to support the care of full benefit dually eligible beneficiaries by ensuring the disease coefficient is the same or greater for the 39 conditions where full benefit dually eligible beneficiaries are currently disadvantaged.

2) Increase the disease coefficients for full benefit dually eligible beneficiaries for the 39 conditions where dually eligibles experience unfavorable rate of change from the v24 CMS-HCC model to the v28 CMS-HCC model relative to non-duals.

***Proposal 3:* Revisit a targeted number of eliminated codes and reintroduce a clinically relevant subset of diagnoses**

Given the clinical impacts of these conditions for the overall cost of care, we request CMS consider the following five specific areas:

1. **Vascular Disease**: Continue to keep **Atherosclerosis with Claudication** in the HCC model.
2. **Depression**: Continue to keep **Mild Depression** in the HCC model and include **Post-Traumatic Stress Disorder (PTSD)** in the HCC model
3. **Protein Calorie Malnutrition**: Continue to keep **Moderate** and **Severe** Protein Calorie Malnutrition in the HCC model.
4. **Angina Pectoris**: Continue to keep Angina Pectoris in the HCC model.
5. **Diabetes with Complications**: Increase the constrained disease coefficient factor for full benefit dually eligible beneficiaries.

Vascular Disease

We are supportive of the removal of Atherosclerosis of the Aorta for Vascular Disease; we do not see immediate impact on admissions or total cost of care for our population. However, we are concerned Atherosclerosis with Claudication is no longer a risk-adjusting diagnosis in the v28 CMS-HCC model.

- *Impact on clinical outcomes:*
    - Diagnosing and treating arterial vascular disease during the symptomatic phase – known as claudication – and prior to rest pain is critical to provide important interventions such as dietary, smoking cessation, exercise counseling, and medication management.
    - This can reduce the need for invasive procedures or amputation.

- *Request of CMS:*
    - We recommend the continued inclusion of **atherosclerosis with claudication** in the v28 CMS-HCC model.

Depression

Major Depressive Disorder (MDD) is a highly prevalent condition amongst the populations we serve. Among other causes, exposure to violent crime and domestic violence in the home can be more prevalent in underserved communities.

- *Impact on clinical outcomes:*
    - Our patients with mild MDD have 15% higher hospital admissions than our average population. Our full benefit dually eligible patients with mild MDD have 31% higher hospital admission than our average population.
    - Our patients with moderate MDD have 32% higher hospital admission rates than our average population. Our full benefit dually eligible patients with moderate MDD have 62% higher hospital admission rates than our average population.

- *Impact of HCC model changes:*
    - For our full benefit dually eligible patients, we see a $48 per member per year further reduction in risk adjusted payments in addition to the decline in payments we see in our patients who are non-duals.

- *Implications for health equity:*
    - Even mild MDD can have a negative effect on treatment and medication adherence within chronic disease management. By eliminating resources for the upstream MDD disease management, we suspect we could see a longitudinal increase in acute hospitalizations due to conditions such as Heart Failure and Chronic Obstructive Pulmonary Disease (COPD).
    - In addition to eliminating mild depression, the v28 CMS-HCC model does not include PTSD. As a result, value-based providers may lack adequate up front funding to manage these downstream consequences of trauma.We know many patients with PTSD have comorbid MDD and with this proposed cut to MDD, we could see a further negative impact on resources for this large traumatized group.

- *Request of CMS:*
    - Keep mild depression codes in the HCC model
    - Introduce PTSD into the v28 CMS-HCC model

Protein Calorie Malnutrition

In older adults, malnutrition impacts physical function and length of stay for surgical hospitalizations. Causes of malnutrition such as poverty, social isolation, depression and dementia are common in our patients. Significantly, the cost to restore the health of these individuals is also higher in future years and significantly impinges upon the ability of these Americans to age at home.

- *Impact on clinical outcomes:*

    - Our patients with PCM diagnosis have a 101% higher hospital admission rate than our average population.
    - Our full benefit dually eligible patients with PCM diagnosis have 122% higher hospital admission rates than our average population.
    - Most concerning, our patients who are both full benefit dually eligible and either Black or African American or Hispanic or Latino have a 138% higher hospital admission rate than our average population.

- *Impact of HCC model changes:*
    - Our full benefit dually eligible patients will experience $125 per year <u>further</u> reduction in risk adjusted resources in addition to the decline in payment we see in our patients who are non-duals.

- *Implications for health equity:*
    - Without addressing the increased impact to total cost of care required to support patients who are malnourished as they encounter escalated health interventions in the following year, the ability to cover the costs for proactive care will be at risk as malnutrition is associated with increased mortality.

- *Request of CMS:*
    - Keep **<u>moderate</u>** and **<u>severe</u>** PCM in the HCC model
    - Orient providers around **<u>validated instruments</u>** for making this diagnosis. At Oak Street Health, we use the most recent consensus diagnostic criteria as defined by the Global Leadership Initiative on Malnutrition (GLIM).

<u>Angina Pectoris</u>

Early identification of coronary disease has been proven to both save lives and reduce costs. Angina typically presents as pain or discomfort in the chest. While symptoms of angina are commonly experienced as pain, they may also present as Anginal Equivalents with symptoms including shortness of breath, nausea, jaw pain and stomach discomfort. Research has shown Anginal Equivalents are more commonly experienced in women than in men. The proposed removal of the angina-related codes would eliminate the means of appropriately accounting for these risks.

- *Impact on clinical outcomes:*
    - Our patients with Angina Pectoris have 61% higher hospital admission rates than our average population.
    - Our full benefit dually eligible patients with Angina Pectoris have 98% higher hospital admission rates than our average population.
        - Our patients who are both full benefit dually eligible and Black or African American have 115% higher hospital admission rates than our average population.

- *Impact of HCC model changes:*
    - Our full benefit dually eligible patients experience $29 per year further reduction in risk adjusted resources in addition to the decline in payment we see in our patients who are non-duals.

- *Implications for health equity:*
    - Even after an invasive procedure (percutaneous revascularization) to treat angina, women and Black or African American patients experience higher hospitalization rates than white patients. Due to this, Black or African American patients and women with coronary artery disease are burdened with increased healthcare costs, worsening an existing racial and gender-based disparity.
        - We believe elimination of risk adjustment for angina and the corresponding codes will exacerbate these disparities and constrain the investments in prevention we and others are making to **end this health inequity**.

- *Request of CMS:*
    - Keep **Angina Pectoris** in the v28 CMS-HCC Model

Diabetes with Complications

While we understand the goals of addressing discretionary coding practices by constraining all diabetes disease coefficients, we are concerned about the pullback in resources for fully dual eligible beneficiaries.

- *Impact on clinical outcomes:*
    - In our population, the vast majority of patients with diabetes have diabetes with complications.
    - Our full benefit dually eligible patients with diabetes have 38% higher hospital admission rates than our average population.
    - Our patients who are both full benefit dually eligible and Black or African American have 44% higher hospital admission rates than our average population.

- *Impact of HCC model changes:*
    - Our full benefit dually eligible patients experience $29 per year further reduction in risk adjusted resources in addition to the decline in resources we see in our patients who are non-duals.

- *Implications for health equity:*
    - Patients with diabetes are two to three times more likely to develop depression than patients without diabetes, however only 25-50% of diabetics with depression are diagnosed and treated.

    - Patients with diabetes and depression show poorer glycemic control, decreased physical activity, higher obesity, and potentially more diabetes end-organ complications and impaired function.
    - In our population, 40**%** of our patients with diabetes also have depression.
    - Patients with both diabetes and mild depression have 42% higher hospital admission rates than our average population
        - Patients who have both diabetes and moderate depression have hospitalization rates that are 63% higher than our average population.
        - In our value-based, at-risk and total cost of care model, managing care and supporting health outcomes for these patients requires significant investment in ongoing diabetes management education and support.
    - Moreover, diabetes continues to be one of the most expensive medical conditions in the United States.
        - According to the Centers for Disease Control and Prevention (CDC) and American Diabetes Association (ADA), the costs of this care grew 26% between 2012 and 2017, the last time the measure was completed.
        - Additionally, for most patients, the cost of diabetes care is actually felt up to five years before the diagnosis.
        - The comorbidity of these conditions put patients at high risk of hospitalization as our admissions data shows.

- *Request of CMS:*
    - Increase the constrained disease coefficient factor for full benefit dually eligible beneficiaries in the v28 CMS-HCC model to closer to the disease coefficient for diabetes with complications for full benefit dually eligible beneficiaries in the v24 CMS-HCC model.

Proposal 4: **Add new codes into risk adjustment that are inordinately prevalent in underserved communities**

Several condition categories are not part of the CMS model today, yet we see impact on total cost of care from them in the underserved communities we serve. We recommend CMS consider the inclusion of these new categories into the model:

- Post Traumatic Stress Disorder (PTSD)
- Hypertension, which is also a key condition in MA STARS for blood pressure control and medication adherence measures

There are likely additional new codes that could be added to increase accuracy of the risk adjustment model and augment the health equity objectives of the proposed changes in the Advance Notice.

Additionally, as noted above, these proposals are meant to be a menu of ideas for CMS to consider as a means to address health equity within the proposals of the Advance Notice while still achieving the objectives of the agency. We are not advocating for increased funding to

Medicare Advantage compared to what is contained in the Advance Notice and believe increases from the proposals above can be offset with a decrease to the increases in demographic coefficients for non-dual patients in the proposal.

Given the scale of the changes CMS is proposing for the risk adjustment model, including reordering and renumbering, we ask CMS to delay establishing new risk adjustment policy until at least 2025 payment dates and engage in stakeholder collaboration as a new risk adjustment model is developed.

Most critically, this additional time will enable CMS to fully consider targeted changes to ensure the v28 CMS-HCC model truly advances CMS' health equity goals. As we emerge from the COVID-19 public health emergency combined with a time of tremendous healthcare workforce challenges, the additional nine months after the final rate notice will enable organizations to invest in the systems, provider training, organizational change management and technology infrastructure necessary to adhere to these new coding requirements.

Our Comments Regarding the Advance Notice as Proposed, Universal Foundation Quality Measures

Potential New Measure Concepts and Methodological Enhancements for Future Years
Health Equity (Part C and D)

Oak Street Health is extremely pleased CMS has proposed the establishment of a Health Equity Index with a corresponding reward factor to be included in the MA STARS measures. As a network of primary care providers mostly caring for long ignored and underserved communities, we tremendously appreciate and strenuously support CMS' proposal to reward MA plans that are high performers in serving populations with greater needs and specific social risk factors. We believe this new measure creates an increased incentive for plans to work with providers dedicated to underserved communities and, in particular, likely will neutralize the reluctance of plans to contract with providers serving patient populations consisting of a large percentage of beneficiaries dually eligible for both Medicare and Medicaid.

In previous Oak Street Health comments to CMS, notably last winter's response to the Medicare Advantage and Part D Advance Notice, and our submission to last summer's Request for Information regarding Medicare Advantage and the recent Part C and D proposed rule, we offered consistent feedback about how both Medicare Advantage STARS ratings and risk adjustment can be structured to account for the social complexity of Medicare beneficiaries. In December, a new report by the National Quality Forum, funded in part by CMS, was published showing which social risk factors should be included in risk adjustment and how linking them to payment would bolster care in places long without it. We also want to point out the National Quality Forum's important work. In addition, as CMS works towards its goal of ensuring by 2030 that as many Medicare beneficiaries are in accountable relationships as possible, we continue to encourage the agency to implement initiatives and promulgate regulations incentivizing full

risk taking by plans and providers, particularly in primary care. **The more financial risk both plans and providers take, the less expensive care in America will become.**

With respect to the proposed STARS Health Equity Index, again, we are certainly tremendously supportive. With that in mind, while the current proposal rewards MA plans that are high performers around social risk factors - and we believe we are well positioned as a solution to not only partner with plans to do well on this new measure but also to help CMS meet its health equity goals via this new reward - we also suggest making adjustments that could more directly impact providers caring for a high number of beneficiaries dually eligible for both Medicare and Medicaid. Further refinements to this measure and other opportunities could include:

- Adjusting STAR ratings to account for social risk factors by setting different cut points for plans with higher levels of beneficiaries dually eligible for both Medicare and Medicaid.

- Developing an adjustment to STARS cut points which is based on census tract data rather than at the national level.

- Ensuring additional resources - including any payments derived via a Health Equity Index reward factor - flow through to providers serving a higher proportion of beneficiaries dually eligible for both Medicare and Medicaid. These additional resources can be utilized by providers for additional investment in care coordination and social work programs to help patients overcome health disparities. We appreciate that the statutory non-interference clause presents challenges for a regulatory approach to this recommendation. However, we encourage CMS to consider approaches to rewarding plans that channel any new funding toward providers focused on traditionally underserved populations.

    - As Oak Street Health looks at this new proposed numerical award within STARS, we believe there are two ways to ensure those who directly deliver care - healthcare providers, particularly in primary care - are included in rewarding the critical investment CMS is encouraging by proposing this measure.

        - The first is risk-adjusting CMS thresholds to account for high numbers of dual eligible beneficiaries. A patient's overall health and likelihood of completing a preventative screening or staying medication adherent can be impacted by SDOH factors and risk adjustment thresholds at the measure level would account for this.
        - The second is to establish policies ensuring funds earned from the health equity reward are directly allocated to patient care, specifically towards assisting beneficiaries with overcoming any myriad of social barriers which often stand in the way of positive health outcomes. Again, recognizing the limitations of the non-interference clause, we encourage CMS to identify policies promoting investments in primary care for underserved populations. Linking this reward and ensuring payment flows

directly to primary care providers so they can reinvest it back into social support for these populations would likely be the most simple way to achieve this goal.

- CMS should leverage either the Social Vulnerability Index (SVI) or the Social Deprivation Index (SDI) to account for social complexity in the risk adjustment methodology for Medicare Advantage payments.

    - The SVI includes many social factors which overlap with the social determinants of health, including income, poverty, unemployment, education, race, ethnicity and disability status. Leveraging the SVI can help streamline collection of SDOH data while better tracking patient social and healthcare needs.
    - Similar to the SVI, the SDI can be used to identify areas impacted by SDOH and create more specificity at the neighborhood and local levels.

Cross-Cutting: Sexual Orientation and Gender Identity for HEDIS Measures (Part C)
Oak Street Health is supportive of this proposal.

Cross-Cutting: Identifying Chronic Conditions in HEDIS Measures (Part C)
Oak Street Health is supportive of the new, simpler methodology to identify chronic conditions and patients eligible for Stars measures.

Blood Pressure Control Measures (Part C)
Oak Street Health is supportive of the approach to take an average of blood pressure readings over time, providing it means we can still capture remote blood pressure readings taken with remote monitoring equipment. White Coat Hypertension occurs in 15-30% of patients with an elevated office blood pressure. Patient reported Blood Pressure also emphasizes the importance of patient self monitoring in achieving Blood Pressure Control.

Kidney Health (Part C)
Oak Street Health supports the approach of measuring kidney health management related to person-centered outcomes, shared decision making, and preparedness for kidney failure. There are four measures which we consider to serve as key differentiators in kidney care performance. These measures can also be impacted through primary care support. Below, we offer additional details regarding our views on specific measures.

1. Percent of Patients Engaged with a Nephrologist: Patients with late stage kidney disease and kidney failure require direct nephrologist oversight to ensure their kidney care needs are managed appropriately. This measure indicates PCP ability to appropriately refer to nephrologists and motivate patients to complete their clinically necessary touchpoints.

2. Percent of Patients on a Home Modality: Patients who treat on home modalities (vs. in-center dialysis) experience improvements in clinical outcomes and quality of life. This measure indicates PCP ability to educate patients about the benefits of home modalities

(i.e. Peritoneal Dialysis or Home Hemodialysis), motivate them to discuss these options with their nephrologists, and support them through the process to prepare for home modalities.

3. Percent of Patients with Permanent Access in Place: Patients with a fistula or graft (vs. a central venous catheter) experience improved clinical outcomes and fewer hospital admissions that often relate to blood stream infections or fluid overload. This measure indicates PCP ability to educate patients about the benefits of using a permanent access, motivate them to discuss this subject with their nephrologist, and support them through the access placement process.

4. Percent of Patients Transplant Listed: Successful kidney transplants often involve a superior quality of life and life expectancy compared to dialysis as an alternative treatment method. This measure indicates PCP ability to refer patients to a transplant center for evaluation and subsequently receive placement on the national waiting list, pending their candidacy.

Social Connection Screening and Intervention (Part C)
Broadening the Mental Health Conditions Assessed by (HOS) (Part C)
Measuring Access to Mental Health Care on HOS (Part C)
Addressing Unmet Health-Related Social Needs on HOS (Part C)

The Health Outcomes Survey (HOS) is a key CMS program enabling MA health plans to understand patient-reported outcomes and identify opportunities for quality improvement. Oak Street Health is generally supportive of the goal to enhance the HOS survey to broaden mental health assessments and address needs. However, we do worry about the declining response rates to the survey. Over the last five years, the HOS survey response rates continue to decline from 43% in Cohort 20 Baseline (N=545,210) to 31.2% in Cohort 24 Baseline (N=910,581). This represents a 27.4% decrease in patients completing the survey while the sample size has increased 67%. The HOS 3.0 survey is lengthy in the current state and contains 62 questions, including demographic information. We encourage CMS to consider that including additional data points to the survey will increase the respondent burden and potentially disincentivize patients from completing the survey. With that in mind, Oak Street Health proposes CMS strategically focus on the access to mental health care gap that exists nationwide. As such, of the three proposed survey enhancements, “Broadening the Mental Health Conditions Assessed”, “Measuring Access to Mental Health Care”, and “Addressing Unmet Health-Related Social Needs”, we support prioritizing the “Measuring Access to Mental Health Care” component over the other two. We support prioritizing this element first as it will help health plans better understand the current access to mental health care issues that exist in their networks and encourage partnership to address these gaps. As access to mental health care becomes more readily available, enhancing the HOS survey to broaden the assessment of needs is the next logical step as patients will have resources available to address their mental health and health-related social needs.

Conclusion

We appreciate the opportunity to offer comments to the 2024 Advance Notice. Oak Street Health stands ready to work with CMS to ensure the agency reaches its goals around health equity, value-based care and ensuring the financial state of MA is appropriate and sound. If you would like to speak in greater detail about our response, please contact our Vice President and Head of Government Affairs, Andrew Schwab at andrew.schwab@oakstreethealth.com.

Sincerely,

Ali Khan, MD, MPP, FACP
Chief Medical Officer for Value Based Care Strategy