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June 16, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: Request for Information; Health Technology Ecosystem; CMS-0042-NC
7500 Security Boulevard
Baltimore, MD 21244

RE: Stellar Health's Comments in Response to the Request for Information on Health Technology Ecosystem

Dear Administrator Oz:

Stellar Health Group, Inc. and Stellar Health ACO, LLC appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services ("CMS") and the Assistant Secretary for Technology Policy ("ASTP")/Office of the National Coordinator for Health Information Technology ("ONC") Request for Information ("RFI") on the Health Technology Ecosystem. Stellar Health is a health care technology company committed to improving value-based care by optimizing patient care, enhancing operational efficiency, and driving better health outcomes through advanced analytics and real-time data. Stellar Health integrates value-based care in providers' day-to-day workflows by providing real-time insights and corresponding real-time incentives for performing value-based care activities. These real-time insights directly and immediately incentivize providers to perform value-based care activities.

As a healthcare technology company working both as an ACO, and in collaboration with ACOs, we share CMS' and ASTP/ONC's commitment to building a data-driven, patient-centered, and equitable healthcare system. Stellar consistently boosts financial performance and clinical quality for health plans and provider networks. With over 30 payor and provider partners, the Stellar Health platform facilitates value-based care activities for over 1 million patient lives through a network of over 17,000 providers. Specifically, our Stellar Health ACO extends its reach to over 65,000 lives, supported by more than 1,000 providers and partnerships with three payors. We commend CMS and ONC for its focus on improving interoperability, transparency, and access to actionable data across the ecosystem. Based on our experience enabling ACOs to manage quality, cost, and risk across multiple value-based contracts, we respectfully offer the following comments regarding improving access to and standardization of data to enhance patient care.

VB-2. How can key themes and technologies such as artificial intelligence, population health analytics, risk stratification, care coordination, usability, quality measurement, and patient engagement be better integrated into APM requirements?

CMS should leverage artificial intelligence in alternative payment models to maximize preventive care and disease prevention efforts. Alternative payment models' effectiveness is currently limited by lack of incentives for preventive care and disease prevention, high administrative burdens for providers, and long delays in receipt of payment incentives when providers achieve performance goals. Integration of artificial intelligence into value-based care can help address these shortfalls. In the private sector, Stellar Health has done so by using artificial intelligence to integrate and extract meaningful insights from payer and provider data. With this knowledge, Stellar Health's technology provides physicians and their staff with real-time insights into patient care needs. To incentivize action and prioritization of targeted patient health priorities, Stellar Health implements dynamic payment incentives for providers that perform these priority tasks, ensuring that patients receive the high-impact, prevention focused services they need. Integrating concrete value-based care actions into a provider's workflow makes it easy for providers to see and execute preventive health activities that can improve patient health and prevent disease. For example, a real-time prompt during an appointment that a patient is overdue for a mammogram can prevent a future breast cancer diagnosis, avoiding very costly treatment and saving lives.

Stellar Health's business model is a tested example of how artificial intelligence can be leveraged to improve value-based care. Implementing such an approach within federal health care programs can improve disease prevention and patient quality of care, reduce provider administrative burden, and reduce avoidable health care utilization.

Question VB-3. What are essential health IT capabilities for value-based care arrangements?

To effectively improve care delivery and quality while reducing costs, value-based care arrangements require ***real-time*** health IT capabilities, including real-time access to claims data and real-time payment. Currently, delays in access to claims data reduce the ability of this data to be clinically or operationally actionable. Further, the data available falls short of being complete enough to use for accurate financial forecasting or population health analytics purposes. While efforts such as the Beneficiary Claims Data API ("BCDA") have attempted to expand data access, these efforts fail to deliver the timeliness necessary to truly better patient care. For our providers, more timely access to claims data would strengthen transitional care management workflows, reduce avoidable hospitalizations, and improve accuracy in calculating shared savings potential. For Stellar Health as a technology company, real-time or near-real-time claims data would enable us to better identify patients appropriate for targeted care interventions and provide them with more precise opportunities for care improvement. For our ACO, accurate and up-to-date claims intelligence is essential to benchmarking costs, flagging outlier utilization, and coordinating care across dispersed provider networks.

Similarly, delays in payment to providers for performing value-based care activities greatly undermine current value-based care efforts. When providers receive value-based care payments 12 to 18 months after a performance year concludes, it is difficult to connect these payments to any identifiable action taken by the provider. If a provider knows what specific activities generate program savings and corresponding incentive payments, they will be motivated to do more of that particular action. Stellar Health has experienced this firsthand. By incentivizing

value-based care activities with financial rewards in amounts providers know ahead of time and receive promptly after service delivery, Stellar has increased provider participation in prevention activities. Additionally, prompt value-based care payments create predictable cash flow for providers throughout a performance year. When providers are promised quantifiable payment incentives for value-based care activities, they can continuously invest in and strategically plan for prevention efforts in a meaningful way.

Question VB-12. What technology standardization would preserve program-specific flexibility while promoting innovation in APM technology implementation?

CMS can reduce the administrative burden on providers and ACOs by standardizing data where possible across vendors. Lack of health care technology standardization requires multiple workflows and reduces the time and resources providers can spend on direct patient care activities. For example, Stellar Health is negatively impacted by a lack of standardization across electronic medical records ("EMRs"). Stellar Health's technology integrates with EMRs to provide healthcare providers with actionable and real-time patient care insights. However, the lack of standardization of EMRs makes it difficult to build scalable integrations, and instead these efforts require duplication for each EMR system. Further, lack of standardization hampers our ability to support consistent reporting across ACO partners.

In addition to EMR standardization, another area where greater standardization is necessary to promote efficiency and innovation is in Admission, Discharge, and Transfer ("ADT") data. ADT data remains the most valuable dataset for real-time clinical insights, supporting continuity of care, particularly during hospital transitions, and informs timely clinical follow-up. The potential of ADT data to inform and improve care delivery is currently limited due to inconsistency across vendors. The lack of standardization of ADT data across vendors makes accessing and using this data difficult and expensive. As such, we urge CMS to standardize ADT data by adopting national standards, particularly around patient matching methodologies and required data elements. This standardization would help frontline teams proactively follow up with patients after discharge, reducing readmissions and improving quality performance. For ACOs, standardization would enable scalable workflows across all participating ACOs and EMRs, rather than forcing custom solutions for each group.

Standardized EMR and ADT data would also improve real-time health IT capabilities. Current claims data by definition is not "real-time," as it must go through the claim submission process. EHR and ADT data, on the other hand, is more immediately available. Greater standardization of EHR and ADT data can lead to more widespread use of these data sources in value-based care, offering more useful insights for quality improvement.

We appreciate ASTP/ONC's support of the use of Qualified Health Information Networks ("QHINs"). QHINs are networks of organizations that enable standardization and data sharing across organizations. We look forward to hearing about expansion opportunities for QHINs and other initiatives that promote interoperability.

Question TD-19. Regarding price transparency implementation: Which workflows would benefit most from functional price transparency? What improvements would be most valuable for patients, providers, or payers, including CMS?

Greater price transparency for participating providers would greatly improve value-based care. It is impossible for a provider to strategically engage in activities that generate savings and improve care without knowledge of what activities generate the value that leads to incentive payments. Transparent incentives will both incentivize providers to engage in preventive care and will allow CMS to target and prioritize interventions that generate value for federal health care programs. For example, if CMS wishes to prioritize a specific population health goal, such as reducing colon cancer, its efforts will be more effective if it can tie interventions that address that goal with a transparent reward for providers who engage in it. It is widely accepted that regular colorectal cancer screening is one of the most powerful tools for preventing colorectal cancer. Increasing screening prevalence to 70 percent for adults between the ages of 50 and 64 could reduce Medicare spending by $14 billion by 2050.[1] If providers know that a defined incentive payment will be provided for conducting a screening, they can plan and engage in the activities that generate savings and receive prompt payment for doing so.

We also respectfully request that CMS develop certification or pricing transparency requirements for EHR vendors as a condition of participation in federal programs. CMS efforts to promote transparency and patient and provider access to EHR data are undermined by harmful EHR vendor practices such as the charging of exorbitant fees and the gating of essential functionalities behind paywalls. EHR vendors exhibit wide variability in both capabilities and cost structures related to quality reporting, eCQM extraction, and patient engagement. Some vendors are charging providers prohibitive fees for access to MIPS or eCQM modules, and even gating essential functionalities like patient portals behind paywalls. This lack of transparency coupled with onerous costs and administrative hurdles result in fewer resources for quality reporting tools or portal functionality. It can also negatively impact provider performance in value-based care and patient experience. For our ACO, uneven technology access creates disparities across our ACO partners, especially in rural and underserved areas. Without CMS intervention, these practices will continue to circumvent the transparency and access goals of CMS initiatives.

VB-13. What improvements to existing criteria and standards would better support value-based care capabilities while reducing provider burden?

CMS can support value-based care capabilities by improving the accuracy and transparency of risk adjustment and by providing guidance on new reporting mechanisms such as "shadow bundles."

Existing risk stratification efforts can be better improved and integrated into advanced payment model requirements through additional efforts to promote transparency and timeliness of risk adjustment. Accurate and transparent risk adjustment is essential to ensure accurate payments to

[1] Health and Economic Benefits of Colorectal Cancer Interventions, CDC (Oct. 16, 2024), https://www.cdc.gov/nccdphp/priorities/colorectal-cancer.html#:~:text=Almost%2089%25%20of%20adults%20diagnosed,by%20%2414%20billion*%20by%202050..

providers and to facilitate improved patient outcomes. We therefore request that CMS provide clearer guidance and transparency around Hierarchical Condition Category ("HCC") scores. For providers, timely and updated access to HCC scores improves confidence in patient prioritization and documentation workflows. For ACOs, delays in risk adjustment inhibit the actionability and meaningfulness of this data. Due to delays, ACOs often must build their own independent models or outsource projections of risk adjustment, adding administrative costs to the organization and a lack of standardization and predictability. Ensuring timely and updated HCC scores would help ACOs ensure compliance and performance forecasting at the organizational level, and advance patient equity by identifying under-coded populations.

CMS can better support value-based care by providing more guidance around "shadow bundles," a new data reporting mechanism that includes episode-based data and reference prices that are currently only provided to ACOs for informational purposes. Shadow bundles hold promise in helping providers and ACOs navigate care provision and contracting. For ACO providers, primary care physicians could use shadow bundle pricing to make more cost-effective care navigation decisions with full visibility. For our ACO, incorporating shadow bundles into performance benchmarks may encourage cross-group learning and more transparent contracting with referral partners. However, without guidance on how to interpret or act upon these reference prices at the provider or vendor level, their utility remains limited, especially in the ambulatory or primary care setting. We encourage CMS to issue guidance on how providers, technology partners, and ACOs can meaningfully apply these bundles in care delivery or incentive design. Recognizing that a majority of professional spend occurs in the specialty realm, better understanding and harnessing this data would help us make better care decisions.

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Thank you for the opportunity to contribute to this RFI. We welcome further dialogue on how vendors like Stellar can support CMS in achieving a more connected, transparent, and equitable health technology ecosystem. If you have any questions regarding this letter, please contact Michael Meng, Chief Executive Officer, at Michael.Meng@stellarhealth.com.

Sincerely,

Michael C. Meng, CEO
Stellar Health