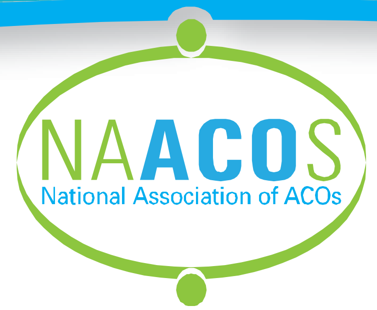

August 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–4203–NC
Submitted electronically to: https://www.regulations.gov/document/CMS-2022-0123-0001

RE: Medicare Program Request for Information

Dear Administrator Brooks-LaSure:

The National Association of ACOs (NAACOS) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) request for information on various aspects of the Medicare Advantage (MA) program. NAACOS is the largest association of ACOs representing more than 13 million beneficiary lives through hundreds of Medicare Shared Savings Program (MSSP), Global and Professional Direct Contracting Model (GPDC), and commercial ACOs. NAACOS is a member-led and member-owned nonprofit that works on behalf of ACOs and DCEs across the nation to improve the quality of Medicare delivery, population health, patient outcomes, and healthcare cost efficiency.

A growing number of Medicare beneficiaries receive their care through the MA program, increasing from a quarter of all beneficiaries a decade ago to 42 percent today. According to current projections, more than half of Medicare will be MA by 2025. MA is and will continue to be a critical lever in CMS's goals to advanced value-based care and make a more affordable, higher quality health system. Specifically, CMS should use its authority to encourage plans to pay its providers for outcomes and quality, rather than traditional volume-based fee-for-service (FFS), or to work with ACOs.

As MA continues to grow, CMS should continue to support ACOs within traditional Medicare and ensure it is a viable alternative to MA. ACOs are designed to reduce Medicare spending and return savings back to the Trust Fund. Additionally, there are benefits to remaining in traditional Medicare, such as the freedom of choice to see any willing provider. ACOs have proven successful in improving access to care, managing whole-person care, and avoiding unnecessary services without blunt tools like prior authorization used in MA. Accordingly, CMS must work to improve alternative payment models (APMs) within traditional Medicare.

Connections Between MA and ACOs

ACO savings are returned directly to the Medicare Trust fund, yet MA has never generated savings to Medicare and is not designed to do so. Recent CMS data show that ACOs have saved Medicare $13.3

billion in gross savings and $4.7 billion in net savings over the last decade. Conversely, the Medicare Payment Advisory Commission (MedPAC) has highlighted that Medicare spends 4 percent more on a beneficiary enrolled in Medicare Advantage compared to those who remain in FFS Medicare. While MA bids fell to a record low of 85 percent of FFS spending in 2022, final benchmarks averaged 108 percent of FFS spending. MedPAC points to uncorrected coding of the intensity of patients' sickness or risk scores (3.6 percent of MA spending) and quality bonuses (3 percent of MA payments). With Medicare spending set to top $1 trillion a year in 2023, this translates into billions of additional dollars spent in MA. This is unsustainable.

ACOs' connection to MA can help address the spending trends. First, when ACOs lower spending across the FFS system, this also lowers payments to MA plans since their payments are based, in part, on FFS spending. Accordingly, thought leaders have encouraged growing ACO participation and increasing provider compensation that is based on outcomes and quality, rather than volume. For example, MedPAC has recommended reforms that would incentivize provider participation in APMs in traditional Medicare. Additionally, the Medicare trustees have suggested placing more emphasis on ACOs as a way to increase the fiscal sustainability of Medicare because of ACOs' ability to avoid low-value services or overly costly new technologies.

Second, CMS should encourage MA plans to enter arrangements with ACOs that incorporate value-based care payment incentives. Unfortunately, most of MA's payments to providers are still rooted in FFS. This doesn't encourage value-based care that we know helps manage chronic illnesses, provides preventive services, and keeps patients healthy. MA should have explicit incentives that will encourage provider-led transformation.

Value-Based Contracting in MA

NAACOS appreciates several questions CMS asks about the connection among ACOs, value-based contracting, and MA plans. We believe the key to fostering overall system transformation is to incentivize provider-driven change. That can be done by simultaneously encouraging MA plans to work with providers in value-based contracts and for providers to work with MA plans by being paid on value-based arrangements. Beyond assessing MA providers on the risk-bearing APM arrangements, CMS should collect information on the percentage of patients, payments, or providers in other value-based arrangements. Below are several ideas NAACOS recommends.

- **Value Based Insurance Design (VBID).** By many standards, VBID has been successful with 34 MA plans and nearly 8 million enrollees participating this year. However, CMS should leverage use of VBID flexibilities to participants' use of value-based payment arrangements with providers.
- **Star Ratings/Measurement.** CMS has the ability to include in the Star Ratings system measures of the number of payment, patients, and/or providers working under value-based payment arrangements for particular plans. NAACOS was very supportive of CMS's proposal earlier this year to develop a measure to assess the use of value-based contracts in MA. Those contracts however should be fairly negotiated between providers and plans. Such a measure would also provide valuable feedback to CMS on how MA plans are engaging in value-based arrangements.
- **Rebate Dollars.** CMS should tie rebate dollars to plans who work with providers practicing within value-based care models, including ACOs.
- **402 Demonstrations.** To date, CMS has mostly leveraged the Innovation Center on which to test payment and delivery system reforms. However, the Affordable Care Act gave CMS the authority to test payment and reimbursement changes. This authority could be leveraged to test value-based payment arrangements in the MA bid and payment process. CMS could, for

example, tie quality bonus payment percentages or rebate percentages to the percentage of patients or payments MA plans have in value-based arrangements.

Reporting Approaches

CMS asks stakeholders about collecting data to better understand MA's work with value-based contracts. NAACOS believes it's critical for CMS to align approaches within MA with the Quality Payment Program. Currently, providers can use Medicare FFS APMs and other payer value-based arrangements to meet the requirements for the advanced APM bonus. However, few providers use the other-payer arrangements to meet the advanced APM bonus. Other payer data is not used because providers face challenges in seeking the necessary information from payers. CMS should collect measure data in a format that could be easily used to for the provider determination of the Advanced APM bonus. This would reduce provider burden and increase use of the "Other Payer" option used in determining Qualifying APM Participant (QP) thresholds.

Parity between ACOs and MA

Recognizing ACO and MA shared goals of improving the quality of care and cost savings to patients, it's imperative to build parity between the two programs. Misaligned incentives are harmful to advancing value as they increase provider burden, create confusion and disincentives for patients, and generate market distortions that favor one entity over another. Below are several opportunities to create parity between ACOs and MA.

Patient Benefits. ACOs should be allowed to provide comparable benefits to patients, such as telehealth visits, transportation benefits, home visits, etc. As ACOs enter value-based arrangements with MA plans, the lack of parity between the two programs increases provider burden. Providers are forced to spend time managing to the various programs rather than managing patient care. For example, if only certain patients are eligible for telehealth visits, then Medicare patients' eligibility must be checked when scheduling visits and determining options for visits.

Quality Measures. There should be a strong focus on aligning quality measures between Medicare ACO programs and MA. Collaborating on quality and equity provides the best outcomes and ensures system-wide change. We recommend CMS work closely with value-based care providers to determine the best ways to structure measurement so that it provides valuable information and helps target interventions across providers.

Marketing Requirements. MA plans and ACOs have differing requirements on how the entity can talk to patients. In MSSP the marketing requirements are much vaguer and more restrictive than MA. For example, ACOs must submit social media messages and marketing materials to CMS for approval. Additionally, the annual beneficiary notification requirement is a burdensome process for ACOs that results in patient confusion. As part of its efforts to promote value, CMS should consider how to align communication requirements across ACOs and MA.

Risk Adjustment. NAACOS continues to be concerned about the imbalance in risk adjustment polices between MA and ACO programs within traditional Medicare. CMS estimates that risk scores in MA will increase by an average of 3.5 percent in 2023. Conversely, risk adjustment policies in MSSP can only increase by 3 percent over a five-year agreement period. Similarly, CMS avoided a drop in MA risk scores for 2023 by not updating the trend years, eliminating the impact of changing use of services and risk

score capture in 2020. Yet, ACOs are seeing risk scores fall – and subsequently their benchmarks along with it – due to decreased opportunity to accurately submit diagnoses in 2020. MedPAC noted in a March 2021 report that higher diagnosis coding intensity resulted in MA risk scores that were more than 9 percent higher than scores for similar FFS beneficiaries. In contrast, accountable care programs in traditional Medicare have multiple controls in place used to limit risk score increases.

These policies create an inherently uneven playing field for providers operating in APMs within traditional Medicare. NAACOS encourages CMS to align risk adjustment policies across all programs to avoid arbitrage and profit seeking based solely on risk scores. There are numerous polices in various ACO programs, such as use of a Coding Intensity Factor, designed to limit risk score growth. Additionally, CMS should:

- Apply risk score policies equally to ACOs and their service regions. Milliman found that 15 percent of MSSP assigned beneficiaries live in counties where the regional risk score exceeds the 3 percent cap. This means that every ACO in those counties will incur losses for every additional at-risk beneficiary aligned to the ACO. We urge CMS to apply the same methodology to the region and the ACO. Not doing so will stifle growth in exactly the areas CMS wants to grow the most.
- Apply a risk adjustment cap of no less than 5 percent and a downward cap no greater than -5 percent in MSSP. NAACOS has found that 87 percent of MSSP ACOs would have had at least one enrollment type trigger the +/-3 percent cap within their first three years of the agreement period. The average percentage capped in the first performance year of the agreement period is 88 percent, in the second performance year is 85 percent, and the third performance year is 92 percent.
- Apply these same caps to a decline in risk scores, i.e., a downward change in risk scores should be capped at 3 percent as well. This would help ACOs who are forced to compete with MA plans for coding adjustments.

Health Equity

Meaningfully addressing health equity requires tailored approaches based on the unique needs of a community. NAACOS believes ACOs and the providers who work within ACOs are best suited to address patients' social needs. ACOs are structured to deliver high-quality care in a cost-effective manner, leveraging health IT and care management infrastructure to provide coordinated, whole-person care. Accordingly, ACOs are uniquely poised to address health inequities and social drivers of health (SDOH). Moreover, clinicians know their patients best, live and work in their communities, and have ties to community-based organizations (CBOs) needed to address social needs. Health plans do not provide direct patient care, thus are one-step removed from the direct patient and community interactions. Accordingly, plans should be incented or required to partner with ACOs and the providers who work within ACOs to advance health equity.

As CMS pursues health equity initiatives across programs, it is critical that the agency define clear standards for collecting sociodemographic and SDOH-related social needs data. Patients' social needs cannot be addressed if social risk factors are not adequately measured, tracked, and reported. These data will be essential in developing targeted interventions that close health equity gaps. Prior to implementing data collection and/or SDOH screening requirements, CMS must standardize SDOH information and collaborate with other payers to ensure comparability across programs and payment mechanisms. Standardization is essential to avoiding an untenable situation where payers have too much information that is neither aligned or structured and providers must navigate duplicative and

conflicting information. CMS also should consider how to share data among, plans, providers and community partners.

NAACOS believes CMS could use positive incentives for providers in MA plans to screen for beneficiaries' health-related social needs (HRSNs) and social risk factors (SRFs). Incentives should be reasonably flexible and allow providers to select the tools that best meet the needs of their practice workflows and patient populations. CMS should also publish standards and guidelines to help providers choose an appropriate screening tool, as well as educational materials to train providers on how to ask screening questions in a culturally competent manner that encourages honest and accurate responses from patients, and to communicate to patients how the information will be used. However, NAACOS encourages CMS to avoid implementing overly burdensome requirements or too many requirements, which would limit uptake and contribute to provider burnout.

CMS needs to consider, but doesn't specifically mention in this RFI, referrals to services for social needs. Many small practices and rural providers lack the resources to develop relationships with social services and CBOs or implement the IT infrastructure necessary for a closed-loop referral system. Additionally, many areas of the country lack sufficient community resources to meet patients' needs. The unfortunate reality is that social services and CBOs in many parts of the country are underfunded and may not have the capacity to meet the needs uncovered by health care providers' screening or be able to accept all referrals. Many providers are hesitant to screen for social needs if they have no way to connect patients with services to meet those needs, and patients may become frustrated if their providers are asking for this information without providing appropriate follow-up. Therefore, CMS should avoid implementing requirements to refer for social needs in situations with inadequate resources. As mentioned above, NAACOS believes ACOs and the providers who work within ACOs are best suited to address patients' social needs. However, consideration must be given to the reality providers face. CMS should work closely with other departments in the federal government, as well as CBOs and social service organizations at the state and local levels, to develop thoughtful solutions to these challenges.

NAACOS supports efforts to incorporate SRFs into risk adjustment to better reflect the additional costs associated with achieving equitable health outcomes for patients experiencing negative SDOH or HRSNs, as stated in our March 2022 response to the MA call letter. Policies to account for social risk in payment must be carefully designed and implemented to avoid unintended consequences that may ultimately exacerbate existing inequities. Findings have shown that adjusting risk scores for individual-level SRFs as a sole strategy to address health inequities would be an inadequate method given the complexity of overlapping and intersecting SRFs and the lack of SRF data for patients who have been historically disenfranchised and may lack access to health care.

Social risk adjustment should be pursued in tandem with other strategies to close health equity gaps, especially given the current lack of robust, self-reported individual-level data on social needs, race and ethnicity, language, and other key factors associated with health disparities. Geographically based measures of social deprivation, such as the Social Vulnerability Index, Area Deprivation Index, and others provide one avenue to align healthcare resources with population needs using existing data. Such area-based indices should be used in combination with individual-level data on social need when available to better account for within-community differences. CMS should also pursue strategies to collect self-reported individual-level SRF data in a standardized way. Before any social risk adjustment methodology is implemented, CMS should seek broad stakeholder feedback, particularly from historically underserved patients and the providers currently working in those areas, to avert any unintended harm.

Data

NAACOS was pleased to see CMS mention data and the exchange of data in the RFI. The ability to share patient information is critical to population health management and care coordination. ACOs and providers who work in ACOs must understand the health and needs of their patients and be able to effectively share information with other care partners. While Medicare has effectively offered data to providers working in APMs, this remains a challenge for providers working with MA plans. Too often providers are fed only partial information about their MA-enrolled patients. CMS should work to create standardized data sets that MA plans share with providers in value-based arrangements. Information could include summaries of patient care, histories of hospitalizations, any known chronic diseases, and prescription drug information, if available. CMS could leverage the plan price transparency requirements to support more comprehensive and standardized information to providers in MA value-arrangements.

NAACOS has given feedback to the Office of the National Coordinator for Health Information Technology (ONC) on the need to better encourage the population-level transfer of health data. To date, much of the focus has been on the sharing of individual patient information or payer-to-payer data exchange. There should be a renewed focus on population-level transfer of data through Application Program Interfaces (APIs). The sharing of MA patient data with providers in value-based care arrangements is a good example of how APIs can be leveraged to inform data exchange for improved population health management. The Trusted Exchange Framework and Common Agreement (TEFCA) is another lever for improved data exchange. If MA plans and ACOs are incentivized or effectively use TEFCA, then it could be a valuable tool for the exchange of patient data between MA plans and ACOs.

Conclusion

Thank you for the opportunity to provide feedback on your future work to improve Medicare Advantage. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement on our shared goals. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
NAACOS