July 1, 2023

The Honorable Bill Cassidy, M.D.
520 Hart Senate Office Building
Washington, DC 20510

The Honorable Thomas R. Carper
513 Hart Senate Office Building
Washington, DC 20510

The Honorable Tim Scott
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Mark R. Warner
703 Hart Senate Office Building
Washington, DC 20510

The Honorable John Cornyn
517 Hart Senate Office Building
Washington DC, 20510

The Honorable Robert Menendez
528 Hart Senate Office Building
Washington DC, 20510

Submitted electronically to: DUALS_Cassidy@cassidy.senate.gov

RE: Request for Feedback on the Dual Eligible Legislation Discussion Draft

Dear Senators:

The National Association of ACOs (NAACOS) appreciates the opportunity to provide feedback in response to the discussion draft legislation on integrated care programs for individuals who are dually eligible for Medicare and Medicaid. NAACOS is a member-led and member-owned nonprofit of more than 400 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health systems and physician provider organizations across the nation to improve quality of care for patients and reduce health care cost. NAACOS members serve over 8 million beneficiaries in Medicare's value-based payment models, including the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model, among other alternative payment models (APMs).

We were pleased to submit comments earlier this year in response to the request for information (RFI) on existing data and improving beneficiary care for dual eligible beneficiaries. We appreciate that a number of our recommendations are addressed in the discussion draft. Our comments reflect the concerns of our members and our shared goals to improve the quality of care and outcomes for dual eligibles while controlling rising costs by increasing coordination and accountability in the health care system.

In our response to the public RFI, NAACOS recommended that Congress:

1. Leverage value-based care models like ACOs as a solution for improving the quality of care while controlling costs for duals.
2. Work with the Centers for Medicare and Medicaid Services (CMS) to increase coordination and alignment between Medicare and Medicaid programs.

3. Direct CMS to develop a fully integrated value-based care ACO model for duals that can be adopted by multiple states.

It is encouraging to see that the discussion draft legislation addresses many of our recommendations by:

1. Directing the Federal Coordinated Health Care Office (FCHCO) within CMS (also known as the Medicare-Medicaid Coordination Office) to develop a fully integrated payment and delivery model for dual eligible individuals.
2. Supporting coordination across states on Medicaid eligibility determinations, plan bidding and reporting deadlines, and enrollment processes, and providing grants to state and local community organizations to support outreach and enrollment.
3. Aligning billing codes under Medicare, Medicaid, and integrated care plans to reduce administrative burden and support adequate payment for providers serving duals.
4. Expanding the Program of All-inclusive Care for the Elderly (PACE) by requiring states to offer PACE, expanding eligibility criteria, and removing restrictions on new PACE organizations and new PACE service areas.

While these provisions indicate positive steps in the right direction, there are key elements of the discussion draft that should be modified to better address the types of arrangements, including ACOs, already serving dual eligible beneficiaries. First, NAACOS recommends eliminating the requirement under Section 302 for Medicare ACOs to have a contract with a state Medicaid agency as a condition of participation in MSSP. Instead, the legislation should direct states to offer contracting opportunities for ACOs and create incentives for ACOs to enter into contracts. Second, we recommend the language in Title I be amended to minimize variability of program models to be published by the FCHCO from which states must select. Excessive state-by-state variation creates significant challenges for health care providers operating in multiple states or serving beneficiaries across state lines. Finally, Congress should ensure true alignment of program elements (e.g., quality measures, risk adjustment model, billing codes, etc.) across the Medicare and Medicaid programs rather than creating separate structures and requirements for duals, which would increase administrative burden for providers and confusion for beneficiaries.

Our detailed comments on specific provisions in the discussion draft legislation are as follows:

<u>Title I—State Integrated Care Programs for Dual Eligible Individuals</u>

Given ACOs' experience delivering high-quality, coordinated care to individuals with complex needs, the language in the legislation should be modified to explicitly include the ACO model as an option for providing integrated care for duals. NAACOS also recommends narrowing the focus of the legislation to fully integrated care plans for full-benefit dual eligible individuals. Variation in Medicaid eligibility across states creates challenges for evaluating and comparing duals populations. Including additional requirements to create "partially integrated" care plans for Medicare Savings Program eligible individuals would increase operational complexity and exacerbate challenges with evaluating program models for duals. At a minimum, programs should begin with a focus on full-benefit duals and ensure effective implementation for that population before expanding to partial-benefit populations.

As mentioned, we recommend including language to minimize variation across the range of program models that the FCHCO is directed to develop in order to reduce administrative burden and confusion for providers operating in multiple states or with beneficiaries across state lines. Many health care provider organizations have practice locations in multiple states or near state borders and, therefore, treat patients that reside and have Medicaid coverage in multiple states. Creating more parameters on

the options that states must choose from, such as having a set of core standard program elements that are consistent across the range of program models, would ease provider burden and support administration and evaluation. Congress should direct the FCHCO to seek stakeholder input on core elements that should be standard across program models and areas that would be more appropriate for state adaptation.

Sec. 2203. Enrollment in Integrated Care Plans
Enrollment processes should give precedence to arrangements where enrollment is defined by primary care alignment. Any passive enrollment should first be informed by ACO assignment, which is tied to beneficiaries' primary care relationships. For beneficiaries without primary care relationships to inform attribution, ACOs should have equal opportunity as other integrated care plan options to be assigned. For any voluntary alignment option, dual eligible beneficiaries should have the option to align to an ACO as long as the ACO has contracted with the state to provide fully integrated benefits for duals. As a principle, enrollment processes should not draw beneficiaries away from existing accountable care relationships.

Sec. 2204. Plan Requirements and Payments
NAACOS recommends amending the comprehensive care plan requirements to apply only to a subset of high-risk patients, rather than to all duals broadly. This would better target care planning resources and engage beneficiaries that truly benefit from a more intensive level of care planning versus those that need more general coordination and navigation support. The health risk assessment could serve as a pre-step to identify which beneficiaries would benefit from a comprehensive care plan. We support the option to provide supplemental benefits, which can better support comprehensive, whole-person care and positive health outcomes. It is important to note that some state Medicaid programs provide generous coverage for supplemental benefits while others may have fewer benefits. Payments to integrated care plans should account for these benefits.

Sec. 102. Conforming Amendments Relating to Federal Coordinated Health Care Office Responsibilities
As previously mentioned, NAACOS recommends limiting the focus to fully integrated care plans for full-benefit duals and exploring ways to expand to partially integrated care programs once the fully integrated care programs have been implemented. Additionally, NAACOS recommends amending the care coordinator requirements to not define explicit staffing ratios for care coordinators. Patient populations will vary and therefore the necessary ratio will vary significantly by organization and region. Requirements should not stipulate explicit staffing ratios, which can create barriers due to workforce shortages. Instead, requirements should include flexibility for offerors of integrated care plans to manage to the population and monitor. We recommend amending the section on quality measures, as creating new measures for duals would increase the quality reporting burden. CMS should be directed to align measures in Medicare and Medicaid programs rather than creating a separate set of quality measures for duals.

Title II—Improving Eligibility Determinations, Enrollment Processes, and Quality of Care for Dual Eligible Individuals

Sec. 201. Development of New Risk Adjustment Payment Model
Overall, we support the development of a new risk adjustment model, which should be designed in a manner such that it can be applied across Medicare and Medicaid programs, including Medicare Advantage (MA) and MA special needs plans, rather than creating a separate model only for integrated care plans. Risk adjustment for duals should be done at the federal level and deployed by the states. Additionally, the new risk adjustment model should have an avenue for incorporating social risk factors.

CMS is leading the way on health equity adjustments and data collection. As this approach is built out, the risk adjustment model should be updated to incorporate these data.

Sec. 211. Review of Hospital Quality Star Rating System

NAACOS supports review of the hospital quality star rating system, and we encourage the development of a measure to assess the use of value-based contracts among hospitals. Assessing how hospitals are engaging in value-based care is important for understanding the broader transition to value and would provide valuable information on how to incentivize broader participation in value-based care. CMS should seek stakeholder input from current value-based care providers on how to structure such a measure and what information would be most valuable to include.

Sec. 212. Requirement for FCHCO and State Medicaid Agencies to Develop Maximum Staffing Ratios for Care Coordinators

As discussed previously, we recommend the legislation avoid explicit staffing ratio requirements, which may inhibit the ability to appropriately manage to the needs of a given population. Instead, this provision should be amended to direct FCHCO to work with the state Medicaid agencies to develop a process for monitoring care coordination and staffing levels.

Title III—Administration

Sec. 301. Alignment of Billing Codes Under Titles XVIII, XIX, and XXII

NAACOS supports this provision, which will reduce administrative burden and ensure more adequate and accurate payments for providers treating duals.

Sec. 302. Requiring Accountable Care Organizations to Have a State Medicaid Agency Contract

NAACOS strongly opposes this provision as currently written, as it creates significant burden for ACOs and fails to address state-level barriers that prevent ACOs from contracting with state Medicaid agencies. Including this as a condition of participation in MSSP would create a barrier to entry, particularly for smaller and rural ACOs that may have less capacity to negotiate such contracts. This section also fails to address complexities for ACOs that operate in multiple states or that have assigned beneficiaries across state lines. This section should be amended such that it directs state Medicaid agencies to offer contracting opportunities for ACOs and create incentives to support ACOs in contracting with states to take accountability for Medicaid. Importantly, accepting accountability for Medicaid beneficiaries must be voluntary, as some ACOs are very small or have little to no experience managing Medicaid costs and benefits.

As mentioned, many states have Medicaid policies that prevent ACOs from taking accountability for duals. For example, some states have a limited number of managed care organizations (MCOs) that they contract with. In order to facilitate MSSP ACOs contracting with states, this section could include language about not limiting the number of ACOs that a state would directly contract with and allowing any ACO that wants to offer fully integrated benefits to duals to contract with the state. ACOs that contract with states to offer fully integrated care plans for duals must have benchmarks inclusive of both Medicare and Medicaid dollars for these beneficiaries. In addition, the FCHCO should be directed to develop guidance for states on such contracts. Guidance should include national standards around core contract elements (e.g., quality assessment, funding for infrastructure development) and appropriate timelines for implementation.

Title IV—PACE

NAACOS supports requiring all states to offer PACE services to eligible individuals, as well as the provisions to expand eligibility criteria for PACE and to remove current restrictions on new PACE providers and new PACE service areas. We recommend defining a clear pathway between ACOs or other integrated care plan offerors and PACE to support providers and patients in navigating PACE enrollment. This could be accomplished by providing incentives for ACOs to screen for PACE eligibility and help eligible beneficiaries get enrolled.

Sec. 405. Cost Outlier Protection for New PACE Providers
An outlier pool would be helpful for new PACE providers, but it must be voluntary. As currently drafted, the budget neutrality provision of this section mandates CMS to cut the Medicare capitation rates of all PACE organizations to cover the costs of the outlier cost reimbursement each year regardless of the appropriations. NAACOS opposes this provision, which would penalize mature PACE organizations by requiring them to fund cost outlier protection from which they could not benefit. Instead, there should be a voluntary option to elect cost outlier protection that is developed by the Office of the Actuary with input from the Center for Medicare and Medicaid Innovation, which has experience developing voluntary outlier protection in its models.

CONCLUSION

Thank you for the opportunity to provide feedback on the dual eligible legislation discussion draft. 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 reforming the system of care for beneficiaries dually eligible for Medicare and Medicaid. 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