March 4, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: (CMS-2022-0021) Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Administrator Brooks-LaSure:

The National Association of ACOs (NAACOS) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, as published on February 2, 2022. NAACOS is the largest association of ACOs and Direct Contracting Entities (DCEs) representing more than 12 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. Certain proposals in the Advance Notice have the potential to broadly impact Medicare programs and the overall shift to value-based care.

Value-based Care Measurement

NAACOS is very supportive of CMS's proposal to develop a measure to assess the use of value-based contracts in MA and supports the agency's efforts to encourage MA plans to enter into value-based contracts with providers as long as those contracts are fairly negotiated between providers and payers. Assessing how MA organizations are engaging in value-based care is important for understanding the broader transition to value and would provide valuable information on how to incentivize provider participation in value-based care. This could also help incentivize MA plans to work with ACOs and expand access to the high-quality, cost-effective care they provide.

NAACOS requests that CMS encourage MA plans to work with ACOs, who have been at the leading edge of value-based care work. Incentivizing work with ACOs would both spur the country's broader shift to value and better align payers' efforts in value-based care work.

There should also be a strong focus on aligning 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 such a measure and what information would be most valuable to include.

Risk Adjustment

NAACOS is very concerned about the growing imbalance in risk adjustment policies between MA and various ACO programs that operate within traditional Medicare. CMS estimates that risk scores in MA will increase by an average of 3.5 percent in 2023. Risk adjustment policies in MSSP, by comparison, can only increase by 3 percent over a five-year agreement period. ACOs in the Next Generation ACO Model saw their risk scores fall in 2020 as ambulatory services fell across fee-for-service Medicare. Meanwhile, CMS proposes in this regulation to withhold 2020 risk scores from the 2023 normalization factor CMS uses in MA, which would avoid a drop in the 2023 normalization factor. These policies create an inherently uneven playing field for providers operating in alternative payment models (APMs) within traditional Medicare.

There are numerous polices in GPDC, such as use of a Coding Intensity Factor and a DCE-level +/3 percent risk score cap, designed to limit risk score growth. **NAACOS urges CMS to align risk adjustment policies across all of its programs, including traditional Medicare and MA to avoid arbitrage and profit seeking based solely on risk scores**. In the March 2021, the Medicare Payment Advisory Commission reported that higher diagnosis coding intensity resulted in MA risk scores that were more than 9 percent higher than scores for similar fee-for-service beneficiaries.[1] In contrast, traditional Medicare's accountable care programs including MSSP, NextGen, GPDC, and REACH have multiple controls in place used to limit risk score increases.

As NAACOS detailed in our comments to the proposed 2022 Medicare Physician Fee Schedule, there are refinements to be made in the MSSP risk adjustment policies to create fairer, more equitable financial methodologies for ACOs.[2] NAACOS has repeatedly urged CMS to apply a risk adjustment cap of no less than 5 percent and a downward cap no greater than -5 percent for an ACO's five-year MSSP agreement period. Using MSSP PY 2017 results, 87 percent of ACOs would have had at least one enrollment type trigger the +/-3 percent cap when looking at the 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 it is 85 percent, and the third performance year 92 percent.

Additionally, CMS should align the use of a risk adjustment cap for the ACO and its region, applying a consistent capping policy to both. The inconsistency of capping one and not the other harms ACOs and is patently unfair. For example, if an ACO's risk score goes up 6 percent and the region's risk score also increases 6 percent, the ACO's benchmark is reduced by a devastating 3 percent even though it simply matched its region. Current policy is also driving inequity. Beneficiaries who are in the disabled and the aged-dual categories are, in most combinations, more than twice as likely to be above the cap as those who are in the aged non-dual category.

Risk Adjustment

In Section G, CMS solicits feedback on potential enhancements to the current CMS-hierarchical condition category (HCC) risk adjustment model in order to address impacts of social determinants of health (SDOH) on beneficiary health status. NAACOS supports efforts to incorporate social risk factors (SRFs) into risk adjustment to better reflect the additional costs associated with achieving equitable health outcomes for patients experiencing negative SDOH or health-related social needs (HRSNs). Policies to account for

[1] https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch12_sec.pdf
[2] https://www.naacos.com/naacos-proposed-2022-mpfs-comments

social risk in payment must be carefully designed and implemented in order 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 for that investment and, given the complexity of overlapping and intersecting SRFs affecting patients and the lack of SRF data for patients who have been historically disenfranchised and may lack access to health care, has the potential to unfairly penalize the most at-risk underserved populations.[3]

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.[4] Such area-based indices should be used in combination with individual-level data on social need when available in order to better account for within-community differences.[5] 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.

Health Equity

Stratified Reporting

NAACOS applauds CMS's work to stratify quality measures by certain SRFs to identify gaps in quality performance within contracts. CMS currently stratifies a set of clinical care measures by race, ethnicity, gender, rural/urban status, low-income status (LIS), dual-eligibility status, disability status, and age group, and additionally stratifies a small set of patient experience measures by race, ethnicity, and gender for Part C. This is an important step in the effort to close health equity gaps and we encourage CMS to stratify quality measures for providers in other programs such as APMs. NAACOS recommends CMS explore other variables for stratification such as language spoken at home, LGBTQ identity, and education level, to determine what combination of variables provides the most actionable data and is representative of diverse populations' experiences.

Health Equity Index

CMS notes the agency is developing a health equity index as a methodological enhancement to the Star Ratings that summarizes contract performance among those with SRFs across multiple measures into a single score. While NAACOS is supportive of the goal to incentivize plan sponsors to reduce disparities through care improvements and evidence-based interventions for higher-risk beneficiaries, it is concerning that CMS notes that current available data to use for the index include only disability and LIS/DE. There is mixed evidence on these variables as effective indicators for health equity, with recent evidence that dual eligibility is an insufficient proxy for social risk, obscuring important SRFs affecting duals disparately.[6,7] Given state-by-state differences in Medicaid eligibility criteria, you cannot accurately compare dual-eligible beneficiaries nationally.[8] It is clear that a more nuanced approach is needed to adequately account for social risk.

[3] https://www.healthaffairs.org/do/10.1377/forefront.20210726.546811/full/
[4] https://www.healthaffairs.org/do/10.1377/forefront.20210526.933567/full/
[5] https://www.healthaffairs.org/do/10.1377/forefront.20210913.764162/full/
[6] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766930
[7] https://journals.lww.com/md-journal/fulltext/2020/09180/dual_eligible_patients_are_not_the_same__how.68.aspx
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7864213/

Before developing a health equity index, CMS should explore other variables to include and pursue strategies to improve data collection on important demographic factors that contribute to health disparities such as race, ethnicity, language, and gender identity. These strategies should include communication and education efforts to build trust with beneficiaries, as many may be hesitant to report this data because of the history of healthcare discrimination against racial/ethnic minorities and women.[9] NAACOS also urges CMS to collaborate with stakeholders to create data collection and reporting processes that result in accurate and actionable data without placing undue burden on providers.

Measure of Contracts' Assessment of Beneficiary Needs

NAACOS supports the efforts of CMS to increase standardized screening for HRSNs and SRFs, and we recommend developing positive incentives for providers to conduct these screenings effectively and efficiently. In order to meet diverse practice and provider needs, there is a need for flexibility in choosing which screening tool to use, as long as it meets basic standards. CMS should work to publish guidelines to help providers choose the right screening tool, as well as educational materials to train providers on how to ask screening questions in a manner that encourages honest and accurate responses from patients, and how to communicate to patients how the information will be used. We encourage the agency to avoid implementing overly burdensome requirements or too many measures, which would limit uptake and contribute to provider burnout. It is also important to consider the broader health system and collaborate with other payers to ensure cross-payer alignment that will support an overall shift to a more equitable health system.

Screening and Referral to Services for Social Needs

As referenced above, NAACOS encourages CMS consider proper incentives, reasonable flexibility, and cross-payer alignment when developing social risk screening requirements. Incorporating referral to intervention adds another layer of complexity and CMS should recognize the additional time and resources required to develop relationships with social services and community-based organizations (CBOs), as well as the costs associated with the information technology infrastructure necessary for a closed-loop referral system. Many CBOs are underfunded and may not be able to handle the additional capacity to meet the increased demand generated by these referrals. CMS should solicit detailed feedback from CBOs, small and/or rural providers, and other relevant stakeholders in order to understand these challenges before considering this type of measure.

Conclusion

We appreciate the opportunity to comment on these proposals. NAACOS looks forward to working with CMS to develop and implement policies that advance the shift to value-based care and drive health equity improvements. Should you have any questions about our comments, please contact David Pittman, senior policy advisor at NAACOS, at dpittman@naacos.com.

[9] https://www.shvs.org/exploring-strategies-to-fill-gaps-in-medicaid-race-ethnicity-and-language-data/