January 27, 2025

Jeff Wu
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–4208–P
Submitted electronically to: http://www.regulations.gov

RE: Contract Year 2026 Policy and Technical Changes to the Medicare Advantage and Part D Programs Proposed Rule

Dear Acting Administrator Wu:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the Contract Year (CY) 2026 Medicare Advantage (MA) Program Proposed Rule. NAACOS is a member-led and member-owned nonprofit of more than 500 ACOs and value-based care (VBC) entities in Medicare, Medicaid, and commercial insurance working on behalf of physicians, health systems, and other providers across the nation to improve quality of care for patients and reduce health care cost. NAACOS represents more than 9.5 million beneficiary lives through Medicare's population health-focused payment and delivery models, such as the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model, along with other alternative payment models (APMs). Beyond Medicare, our members participate in accountable care arrangements across payers, including Medicaid and Medicare Advantage programs. Our comments below reflect the concerns of our members and our shared goals of driving accountable care in Medicare Advantage by enabling providers to innovate care.

NAACOS is pleased that the proposed rule includes several changes aimed at enhancing transparency in MA, improving access to care, updating key data needs, and adding important payment information. Through risk-bearing arrangements, providers are accountable for costs and outcomes of Medicare Advantage enrollees. Beyond the provisions in the proposed rule, we recommend that CMS explore additional levers to drive accountable care in MA and support providers. CMS should:

- Encourage plans to give providers real-time access to data in standardized formats to better enable accountable care arrangements across payers.
- Collect data on VBC arrangements in MA; CMS should explore creating a Star Rating measure that assesses plans on availability and adoption of VBC contracts.

Medical Loss Ratio (MLR) Reporting

CMS is proposing to update MLR reporting with the goal of improving the accuracy and comparability of MLRs across plan contracts, providing additional information on payment and vertical integration, and expanding data collection on provider payment arrangements.

Currently, incentives and bonuses made to providers are included in the MLR numerator regardless of whether they are tied to clinical or quality outcomes. CMS proposes to require clinical and quality standards for provider incentives and bonus arrangements in the MA MLR numerator with the goal of aligning bonus payments with care outcomes. While we are generally supportive of aligning bonus payments with care outcomes, there may be unintended consequences of this policy.

First, we are concerned that the policy may deter plans from generating more VBC risk contracts due to the administrative burden associated with reporting additional information and the nature of incentives in VBC risk contracts. Provider financial incentives in risk arrangements are designed based on both quality outcomes and financial performance, with varying approaches for combining these two elements. In some contracts, providers must pass a quality floor before receiving any financial incentives, some incentives are scaled based on quality performance, while others have separate performance pools for quality and financial performance. Ultimately, these incentives are returned to providers to redesign care processes and improve patient care. Providers in VBC risk arrangements rely on these incentives, and it is imperative that we preserve meaningful incentives and not further deter growth of accountable care in MA. **Prior to finalizing this policy, we ask that CMS collect data to understand provider incentives in MA risk arrangements.** We continue to encourage CMS to collect more data on the implementation of risk arrangements across MA, with the structure of provider incentives being a critical input to inform future MA policy.

Second, we are concerned with the requirement for clearly defined, objectively measurable, and well-documented clinical and quality improvement measures. While this may be feasible in some areas of care (e.g., primary care), there is a dearth of standardized quality metrics that meaningfully apply to all types of care. For example, a risk arrangement for certain specialties may not have available measures, requiring novel approaches for assessing outcomes. The proposed rule mentions the purpose of the MLR requirement is to create incentives for MA organizations to reduce administrative costs. Consequently, we are concerned that the impact of this proposal may further drive the proliferation of quality measure sets that vary across payers, contracts, and models – presenting challenges to each VBC provider as each contract's variation in measures and data reporting requirements adds compounding administrative burden and infrastructure costs. **We reiterate the need to understand MA plan approaches for designing incentives in risk arrangements prior to finalizing changes to MLR requirements. CMS should require plans to report more information on provider incentives to inform future rulemaking.** Additionally, CMS should continue work with the Core Quality Measures Collaborative (CQMC) to help ensure aligned measures across the continuum.

Another major challenge for many providers in risk-bearing MA contracts is access to payment information in digestible and standardized data formats. **NAACOS supports CMS collecting broader payment arrangement data because this gives VBC providers information to inform contract negotiations and design of accountable care models.** By collecting data from MA plans on VBC arrangements and how they are structured, CMS can better support providers invested in participating in, succeeding in, and sustaining VBC contracts in MA.

To improve access to this information, CMS should:

- Ensure that the MLR reporting on detailed provider payment arrangements includes information on VBC contracts that each MA plan offers and implements. This includes percentage of

patients, payments, and providers in VBC arrangements. Where possible, we support alignment with the existing Health Care Payment Learning and Action Network (HCPLAN) VBC definitions and categories. This data should be publicly available and provide valuable feedback on how MA plans are engaging in VBC across geographies, types of contracts, and types of providers.

- As we note above, CMS should consider constructing a measure of VBC adoption and incorporate into Star Ratings over time to help promote greater adoption of VBC arrangements in MA.
- Ensure reporting requirements are in standard file formats for providers to easily ingest data collected from various plans. CMS should convene a technical expert panel (TEP) of payers, providers, and other stakeholders on MLR reporting to ensure definitions are clear and the collected information will be meaningful to all parties.

Coverage of Anti-Obesity Medications

CMS proposes to reinterpret the statute to include treatment of obesity as a covered condition for anti-obesity medications. Under current policy, anti-obesity medications are only covered in Part D if they are being used to treat medically accepted indications such as Type 2 diabetes or established cardiac conditions.

The proposed changes imply that any patient prescribed and taking 2+ doses of the anti-obesity medications are added to the diabetes medication adherence quality measure denominator. This may be inaccurate because this will place patients who do not have a diagnosis of diabetes in the denominator. CMS needs to correct this error such that these patients are kept out of the measure denominator and that the measure should only include individuals taking the medications for diabetes as their primary diagnosis. If left uncorrected, both providers and plans will have lower quality scores due to lack of adherence for patients without diabetes.

Finally, CMS should include these medications within their Part D data collection and transparency efforts. MA plans will be developing strategies, determining formulary coverage, and underwriting key assumptions for pricing such as utilization rates, medication adherence, outcomes, and costs. VBC providers, whether or not they take Part D risk, will be impacted by the rising costs and utilization of these drugs in their accountable care arrangements.

Prior Authorization (PA) and Utilization Management (UM)

CMS proposes to change the definition of internal coverage criteria and requirements for public posting to clarify when MA plans can apply UM and ensure plans are making beneficiaries aware of appeal rights. CMS also proposes collecting detailed data from plan-level appeals that will provide more information on UM and PA practices, including requiring plans to ensure artificial intelligence (AI) algorithms and tools do not impede any advancements of equity or discriminate on any health status factors.

Streamlining and aligning PA processes across payers is necessary to ease administrative burden for all providers. **NAACOS supports CMS's proposal to collect data, make information public, and build in guardrails.** Transparency in this process and creating standards for reporting will contribute to better care coordination and understanding of network access.

For the requirement to collect detailed data on initial coverage decisions and plan-level appeals, we ask CMS to require MA plans to report all services (at the procedural level) that require PA along with the indicated rates of denial, including:

- Total number of denials, successful overturn of denials to approvals, and any payment information,
- Total number of denials that stayed denied and received no payments for rendered services, and
- Timing of decision processes from denials and approvals, appeals and overturn, and decisions leading to payment.

Provider Directories

CMS proposes enhancements to information included in consumer tools and directories to add more clarity and real-time data on provider selection, particularly those that are in/out-of-network. Specifically, CMS proposes to require MA plans to make provider directory data available on the Medicare Plan Finder (MPF) with attestations of accuracy, consistency, and updated provider changes. CMS also emphasizes requiring MA plans to meet quality checks, data requirements, and compliance to enhance transparency.

NAACOS supports these proposed enhancements because they add more clarity and real-time data on provider availability, particularly those providers that are in/out-of-network. For providers who have committed to managing risk through advanced primary care and population health management, more transparent data can help design and implement innovative approaches for payment models. To make these files more accessible and usable to providers, we ask that CMS require plans to report accurate and timely MA network data, particularly on network adequacy and in/out-of-network providers, in standardized file formats that are easily accessible, updated, and digestible for providers.

Supplemental Benefits

CMS proposes to address misleading marketing practices by expanding marketing definitions so that MA plans are required to seek approvals on marketing of supplemental benefits. While we support expanding marketing definitions to include communications about supplemental benefits, we ask CMS to closely monitor this requirement. Many providers in accountable care relationships in MA are delegated the responsibility of providing information about supplemental benefits. We want to ensure the change in marketing requirements does not create undue burden for providers or hinder this type of innovative arrangement that leads to better patient outcomes.

Additionally, CMS proposes requirements for the use of flex/debit cards, specifying how and when debit cards can be used as well as additional disclosures to increase transparency. CMS also proposes to prohibit MA plans from marketing the dollar value of the supplemental benefit. **NAACOS supports these changes that provide more transparency into supplemental benefits. Further, we would like CMS to examine if it's always appropriate to categorize debit card and other supplemental expenses as medical expenses.** For example, certain supplemental benefits expenses (e.g., transportation, gym memberships, etc.) may be better categorized in the administrative portion of the MLR calculation as they are non-clinical expenditures. For providers in risk-bearing arrangements, when these expenditures

are considered medical expenses, the provider is held accountable for spending without any insight or influence to manage these services or costs for their patients.

In prior rules, CMS required MA plans to report information on supplemental benefits in encounter data. This requirement along with the proposed updates will make additional data available to providers and stakeholders in order to understand supplemental benefit use and value. **CMS should work to ensure MA plans share information with providers on supplemental benefits available to patients in real time, at the point of care, and in a standardized manner**. This will allow providers to incorporate these services into their care plans, to better serve their patients, and to prevent any duplicative interventions. Furthermore, increased coordination of benefits usage and costs better supports providers in communicating accurate and updated information to their patients about their care options and allows enrollees to make more informed decisions.

Part D

CMS clarifies and reminds plans that formularies should have broad access to lower cost drugs, particularly providing beneficiaries access to generics, biosimilars, and other lower-cost and medically appropriate drugs. CMS is also taking steps to promote transparency around Part D data such as pharmacy network contracts.

NAACOS supports CMS's efforts to promote transparency in Part D data, providing greater insights for providers that are taking risk on Part D. Specifically, CMS should require MA plans to integrate pharmacy data into MA encounter data including claims, real-time pharmacy benefit data, and dispensing information. Better integration of Part D data will help providers keep track of medication adherence in a more accurate and timely manner. Transparency in this area will also help to standardize benefits that are currently varied across plans; this variation makes this increasing cost element more difficult to manage. As part of price transparency in Part D spend, CMS should also include rebate details that current data sets do not include because this data helps providers understand actual cost information when rebates are applied.

CMS should continue to monitor how the proposed rule and Inflation Reduction Act (IRA) are implemented by MA plans, particularly changes impacting those VBC providers that take Part D risk but have no control over or comprehensive information on drug prices and what is being prescribed outside their purview (e.g., specialty care drugs).

Behavioral Health (BH)

CMS proposes to increase access to behavioral health care by aligning patient cost-sharing with that of traditional Medicare, decreasing coinsurance from 30-50% to 20% for mental health, psychiatric, substance abuse, and partial acute/intensive outpatient services. CMS also proposes zero cost-sharing for opioid treatment programs.

Given many VBC providers and entities take on risk and are accountable for quality and total cost of care, they are motivated to provide coordinated and integrated behavioral health in their care management strategies. **Accordingly, NAACOS supports CMS's proposal to increase access to behavioral health providers because waiving/reducing cost-sharing for high value services help to**

improve patients' access to mental health, psychiatric, substance abuse, and intensive BH services. CMS should also seek input from other stakeholders that hold risk for BH services to ensure the proposed changes are not overly restrictive.

Conclusion

Thank you for the opportunity to provide feedback on CY 2026 MA Proposed Rule. 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 thank CMS for continuing to emphasize data and process transparency, particularly in the areas of marketing and communications, high-cost drugs, supplemental benefits, MLR reporting, and prior authorization. We look forward to our continued engagement on our shared goals to further the transition to value and accountable care within MA. 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