September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1807-P
Submitted electronically to: https://www.regulations.gov

RE: CY2025 Medicare Physician Fee Schedule Proposed Rule

Dear Administrator Brooks-LaSure:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the Calendar Year (CY) 2025 Medicare Physician Fee Schedule (MPFS) proposed rule. NAACOS is a member-led and member-owned nonprofit of more than 470 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 represents over 9.1 million beneficiary lives through Medicare's population health-focused payment and delivery 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). Our comments below reflect concerns of our members and our shared goals to advance payment models that enable providers to innovate care.

NAACOS is pleased that many of the physician payment policies and MSSP policies in the proposed rule will enable providers to deliver comprehensive care management and provide enhanced beneficiary care services. Specifically, the policies to create payment for advanced primary care, receive shared savings payments in advance, and provide a health equity benchmark adjustment in MSSP help achieve those goals. Despite these positive changes, we remain concerned that two key policies will seriously hamper participation in MSSP.

First, CMS must cease its march ahead on changes to the MSSP quality reporting mechanisms and the Certified Electronic Health Record Technology requirements (CEHRT). Despite its acknowledgement of the significant challenges with these policies, the steps taken to support the transition are insufficient. The result of these policies is that ACOs have and will continue to remove practices, particularly smaller and independent practices. We fear that when practices leave the model they will not return. While we agree that digital quality measurement is the goal and ACOs are uniquely qualified to assist practices with needed upgrades in technology; these policies are too aggressive and ignore the upcoming changes on the horizon that will require additional investment. NAACOS joins numerous other stakeholders in urging CMS to delay implementation of new quality reporting mechanisms and reverse the policies for meeting CEHRT requirements.

Second, additional work needs to be undertaken to address the long-term financial viability of ACOs. We have long been concerned about the benchmark ratchet which will arbitrarily lower benchmarks when ACOs enter new contract agreements. Almost a third of MSSP ACOs will be entering new contracts next year, with another third entering new contracts in 2027. We know that the policies to reduce the impact of the ratchet (e.g., prior savings adjustment, regional adjustment, accountable care prospective trend (ACPT)) do not go far enough as many ACOs face deep reductions in their benchmark. Several ACOs are now making the decision not to renew their contracts for MSSP. While some are fortunate to join an existing REACH ACO, which offers a stronger benchmark, we are concerned that recent CMS evaluations signal that the model will not be viable for continuing beyond 2026. While we appreciate that CMS is continuing to explore the potential for a higher risk track within MSSP, the request for information (RFI) makes it clear that CMS constraints are likely to result in a model that is not financially viable and unattractive.

After more than a decade of success generating over $22 billion in gross savings to Medicare, we now must face the fact that benchmarks based predominantly on historical spending are failing providers and defining success solely in comparison to a dwindling fee-for-service (FFS) population limits innovative model design. We ask that CMS produce reports and seek multi-stakeholder input on the overall financial goals of APMs, reasonable comparison groups for defining success, and redesigning benchmarks to attract new participants and maintain current participants.

PHYSICIAN PAYMENT

Physician Payment

CMS proposes a CY 2025 Medicare conversion factor (CF) of $32.36, a 2.8 percent decrease from the 2024 CF rate of $33.29. NAACOS is concerned that continual cuts create a disincentive for clinicians to adopt population health models. When physician payment is cut, clinicians face an untenable financial landscape on which to adopt value-based care, which takes investment in staff, extra services, and technology. Additionally, as future ACO benchmarks are set on declining FFS rates, benchmarks may not adequately reflect the costs of providing comprehensive coordinated care. We must ensure that clinicians in FFS receive adequate payment and build additional financial and nonfinancial incentives for clinicians to adopt accountable care.

Other Payment Policies

CMS makes several proposals for physician payment that recognize the evolution of care delivery. NAACOS supports the following changes:

- ***Telehealth.*** We strongly support the proposal to permanently allow interactive telecommunications systems to include two-way, real-time audio-only communication for any telehealth service furnished to a beneficiary in their home if the distant site practitioner is capable of using an interactive telecommunications system, but the patient is not capable of, or does not consent to, the use of video technology. Additionally, we support maintaining certain telehealth policies through 2025 but ask that CMS consider making these polices permanent. This includes use of virtual supervision, allowing providers to use their enrolled practice location instead of home address, and allowing teaching physicians to have a virtual presence for services furnished involving residents in all teaching settings.

- ***Direct Caregiver Training Services.*** NAACOS supports the addition of new codes for training caregivers to assist the patient with specific clinical needs.
- ***Behavioral Health.*** NAACOS appreciates the continued efforts to appropriately recognize and reflect behavioral health care. We support the addition of services for safety planning interventions, post-discharge telephonic follow-up intervention for individuals with suicide risk, digital mental health treatment (DMHT) devices furnished incident to or integral to professional behavioral health services, and interprofessional telephone/Internet/electronic health record (EHR) assessment and management service provided by a mental health practitioner.

Evaluation and Management (E/M)

CMS proposes a payment policy change for the office and outpatient (O/O) E/M visit complexity add-on code G2211, which was finalized for use beginning in CY 2024. The agency proposes to allow payment when the O/O E/M base code is reported by the same practitioner on the same day as an annual wellness visit (AWV), vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting. NAACOS supports this change.

Enhanced Care Management

Advanced Primary Care Management Services
CMS proposes new coding and payment for advanced primary care management (APCM) services for use by practitioners who are the continuing focal point for all needed health care services and responsible for all primary care services for a beneficiary. Citing limited uptake of existing care management codes billable under the MPFS, CMS seeks to strengthen the use of care management code sets and provide more stability in payment and coding. NAACOS supports this overall proposal and appreciates CMS's efforts to better recognize the resources required to deliver advanced primary care and to reduce administrative burden associated with billing for these services. **We encourage CMS to finalize the proposals for APCM services with modifications**, as detailed below.

APCM Services Codes
CMS proposes to establish three new HCPCS codes for APCM services (GPCM1, GPCM2, GPCM3) that bundle existing care management and communications technology-based services (CTBS) codes. The codes describe APCM services furnished per calendar month by a practitioner who intends to be responsible for the patient's primary care services and serve as the focal point for all needed health care services. Unlike other care management services and CTBS, APCM services would not be time-based and would not include timeframe restrictions. NAACOS supports this flexibility, as time-based requirements and associated documentation have contributed to the limited use of existing care management code sets.

CMS proposes that APCM codes would be stratified into three levels based on certain patient characteristics:

- Level 1 (GPCM1): for a patient with one of fewer chronic conditions
- Level 2 (GPCM2): for a patient with two or more chronic conditions
- Level 3 (GPCM3): for a patient that is Qualified Medicare Beneficiary (QMB) with two or more chronic conditions

CMS sought feedback on the three levels and the use of QMB status as an indicator of social risk. NAACOS supports the APCM Level 1 code and appreciates CMS addressing the current gap in coding and

payment for care management services furnished using an advanced primary care model for patients without multiple chronic conditions. We are concerned that the proposed APCM levels only delineate between beneficiaries who have one or fewer versus two or more chronic conditions. NAACOS urges CMS to recognize the additional resources required when furnishing advanced primary care to beneficiaries with greater clinical complexity. Nearly a quarter of Medicare beneficiaries had five or more chronic conditions as of 2016, and these beneficiaries have significantly greater needs and require more care and resources than beneficiaries with fewer chronic conditions.

NAACOS opposes the use of QMB status as the indicator for social risk required for billing Level 3 APCM services. Health care providers cannot readily access a patient's QMB status, and therefore tracking down this information to bill for Level 3 would be administratively burdensome. In other policies, CMS has used a combination of dual eligible status (DES) and enrollment in the Part D low-income subsidy (LIS) as indicators for social risk, we encourage the agency to align its approach for APCM services with these policies.

Required Elements and Practice Capabilities

CMS defines 10 service elements and practice-level capabilities as necessary for the provision of advanced primary care. Under the proposals, CMS would not require practitioners to furnish all elements included in the codes descriptors during each month in which the service is billed, but the billing practitioners must have the ability to furnish each service element as appropriate for a given beneficiary during any given month. NAACOS supports this proposal, which recognizes that patients' needs may vary month-to-month. Table 21 in the proposed rule provides additional details on the required elements and capabilities, which are: (1) consent, (2) initiating visit for new patients, (3) 24/7 access to care and care continuity, (4) comprehensive care management, (5) patient-centered comprehensive care plan, (6) management of care transitions, (7) home and community-based care coordination, (8) enhanced communication opportunities, (9) patient population-level management, and (10) performance measurement.

CMS proposes that providers participating in MSSP, ACO REACH, Primary Care First, or the Making Care Primary Models would be considered to have automatically met requirements (2), (9), and (10) by virtue of their participation in such models. **NAACOS supports this proposal, and we strongly encourage CMS to expand the elements that ACO providers are automatically considered to have satisfied**. Comprehensive care management, patient-centered care planning, and enhanced communications are core competencies of ACOs and therefore ACO providers should be considered to have additionally met elements (4), (5), and (8). This also adds a nonfinancial incentive for providers to join and form ACOs, which would support CMS's 2030 accountable care goals.

NAACOS has concerns with the potential burden associated with documenting the required service elements and practice capabilities in order to bill for APCM services. Many ACOs provide centralized services to ACO beneficiaries, rather than from the individual practice level and it is unclear from the proposed rule whether this would be sufficient. We urge CMS to provide more clarity around how it will determine whether these elements and capabilities have been satisfied and to minimize burden with any documentation requirements.

Concurrent Billing Restrictions

CMS considers certain care management services and CTBS to be duplicative of APCM services, including chronic care management (CCM), principal care management (PCM), transitional care management (TCM), interprofessional consultation, remote evaluation of patient images/videos, virtual check-in, and

e-visits. Details on the proposed duplicative codes can be found in Table 22. CMS proposes that these services could not be billed by the same practitioner or another practitioner within the same practice for the same patient during a given calendar month in which the patient receives APCM services.

NAACOS opposes the restriction on the entire practice billing for duplicative services and we urge CMS to modify this policy such that duplicative services could not be billed by the same practitioner. CMS defines practices at the tax identification number (TIN)-level. Large multispecialty practices and academic medical centers may have hundreds or thousands of physicians of various specialties and multiple practice locations all billing under a single TIN. The policy of excluding entire practices from billing these CTBS and care management services disadvantages providers in large practices and the patients they serve. For example, a patient whose primary care provider (PCP) and cardiologist both practice under the same TIN would not be able to have a virtual check-in with their cardiologist if their PCP is billing for APCM services, but a patient whose PCP and specialists practice under different TINs would be able to receive these appropriate services from their specialists even though their PCP is providing them with APCM services. This would also cause confusion or concern for patients, who may not understand why they cannot continue to receive appropriate CTBS and/or care management services from their specialists while receiving APCM services from their PCP.

Valuation

CMS proposes to use the current valuation and uptake of the codes that make up the APCM bundle to inform valuation of APCM services. CMS assumes that Level 1 APCM services would be equivalent to two billing units of non-complex CCM services over the course of a year. Level 2 APCM services are assumed to be equivalent to five billing units of non-complex CCM and three billing units of add-on codes over the course of a year. CMS proposes to account for underutilization of CCM services by adding a billing unit of complex CCM to the utilization estimate, in total calculating Level 2 APCM services based on five billing units of non-complex CCM, two billing units of non-complex CCM add-on, one billing unit of complex CCM, and one billing unit of complex CCM add-on. For Level 3 APCM services, CMS proposes to use the difference in per person per year spending for dually eligible beneficiaries versus non-dually eligible beneficiaries, which as of 2021 data was 218 percent. Therefore, CMS multiplied the RVUs of APCM Level 2 to arrive at the valuation for Level 3 APCM services. In all, CMS proposes to value APCM services as follows:

- Level 1 (GPCM1): RVU of 0.17 and estimated national payment rate of $10
- Level 2 (GPCM2): RVU of 0.77 and estimated national payment rate of $50
- Level 3 (GPCM3): RVU of 1.67 and estimated national payment rate of $110

NAACOS appreciates CMS's attempt to account for underutilization of CCM services in the valuation of APCM services. However, we are concerned that the proposed valuations do not include other care management services or CTBS that are part of the proposed APCM services. Particularly in the context of the proposed concurrent billing restrictions, the payment rates may be insufficient to justify billing for APCM services rather than its components. For example, the reimbursement for one billing unit of interprofessional consultation is greater than the monthly payment for Level 1 APCM services. This creates a disincentive to bill for APCM services. We encourage CMS to explore changes to the proposed valuations to better reflect the full scope of CTBS and care management services included in APCM services.

Advanced Primary Care Hybrid Payment RFI

CMS is seeking feedback on coding and payment policies for advanced primary care and the potential development of a primary care hybrid payment "bundle" in traditional Medicare. NAACOS appreciates

CMS's attention to this issue in the proposed rule. NAACOS and others have long advocated for primary care hybrid payment to be made available in the MSSP. We note that implementing advanced primary care hybrid payment in the fee schedule would be a massive policy change and the questions CMS seeks feedback on in the RFI cannot be meaningfully addressed in a 60-day comment period. Therefore, we strongly urge CMS not to move forward with policy changes until it has gathered sufficient stakeholder feedback and taken the appropriate time to assess for unintended consequences.

NAACOS supports the expansion of hybrid primary care payment in Medicare's total cost of care models, where providers are held accountable for costs and quality of care. Many providers participating in these models are already engaging in an advanced primary care delivery model and would benefit from payment changes that reflect that model of care.

While we were pleased to see the announcement of the new ACO Primary Care Flex Model, we were disappointed that it will be limited to a narrow subset of ACOs. **Given the wealth of evidence supporting hybrid primary care payment approaches tied to several of CMMI's value models, this payment option should be made available to all MSSP ACOs as a permanent feature of the program**. This would also add a strong incentive to encourage more provider participation in MSSP and further advance CMS's goal to have all Medicare beneficiaries in accountable care models by 2030. Additionally, nesting primary care hybrid payment within total cost of care models alleviates many of the challenges with implementing broadly under the fee schedule. MSSP's existing methodologies to attribute beneficiaries and measure quality performance could be leveraged for hybrid payments, and ACOs' accountability for costs and quality would prevent issues with beneficiary access to care or increasing referrals to specialists.

We thank CMS for its continued focus on primary care and the transition to value, and we encourage the agency to continue dialogue with a wide range of stakeholders to inform its approach.

MEDICARE SHARED SAVINGS PROGRAM

Quality Requirements

New MSSP Quality Measure Set, APP Plus

CMS proposes to change the MSSP quality measure set in 2025 to align with the Universal Foundation, replacing the APM Performance Pathway (APP) measure set with a new APP Plus measure set. The APP Plus measure set will incrementally add measures to the existing measure set over time, adding two measures in 2025, one measure in 2026/2027 and two measures in 2028 totaling 11 measures.

NAACOS appreciates CMS's willingness to prioritize alignment of quality measure sets. Alignment of quality measure sets across payers and programs can result in reduced burdens associated with monitoring, collecting, and reporting quality measure data; this results in more time spent on patient care and improvement activities. However, ACOs have concerns with the timeline CMS has chosen to introduce new measures, aligning these changes with the date CMS will retire both the Web Interface and, as proposed, the Merit-based Incentive Payment System (MIPS) clinical quality measure (CQM) reporting options.

We urge CMS to delay the introduction of any new measures for three years following retirement of Web Interface and MIPS CQM reporting options.

- *Adapting to new measures will require additional investment at a time when ACOs are making a significant investment to change quality measurement approaches.* ACOs have invested significant resources, both time and money, in preparing for the shift from the Web Interface to electronic clinical quality measures (eCQMs) or Medicare CQMs. This work has been focused on the current APP measure set. Adding additional measures in the same year CMS plans to retire Web Interface and MIPS CQMs will create additional burden. We continually highlight the significant investment required to adopt new reporting mechanisms and new measures. Delaying implementation of any new measure will give ACOs the time and resources they need to continue focusing on the current measure set and change in reporting mechanisms.
- *The new measures are not all specified as eCQMs and should have a period of public reporting prior to implementation.* When new eCQMs are introduced, it requires EHRs to build the measure into the platform and providers to adapt workflows to ensure measure performance reflects actual care provided. Moreover, several of the new measures are not specified as eCQMs. Time is required to adjust to new measures; thus, we ask that CMS introduce the measures as pay-for-reporting for at least one year. This was a standard practice in MSSP prior to alignment with MIPS.

Measure Specific Feedback

Hospital Admission Rates for Patients with Multiple Chronic Conditions. When aligning with MIPS specifications, CMS made changes to the denominator for this measure, excluding those that meet qualified APM participant (QP) status. This resulted in many ACOs not being scored on this measure for 2023, thereby placing more emphasis on the remaining measures in the measure set. This is yet another example of why applying the MIPS FFS-focused policies, measures, and scoring methods on APMs does not work. At a minimum, CMS should return to providing pay-for-reporting status (or full credit) for measures that cannot be scored in these cases.

Screening for Social Drivers of Health. NAACOS supports CMS's efforts to improve health inequities and incentivize screenings for social drivers of health (SDOH); however, CMS must recognize the current state of this work and account for the known challenges in the scoring approach. For example, CMS could make this a pay-for-reporting measure as providers work to address challenges associated with screening. NAACOS has provided detailed recommendations on this topic, including more impactful ways CMS could engage with ACOs on this issue. We look forward to working with CMS to address the following challenges that hinder the collection and use of SDOH information:

- Standardization of Data. Providers are using a variety of tools to conduct SDOH screenings which have not proven to be reliable across tools. More work is needed to ensure that varying tools produce the same results, this will enable better data sharing across providers.
- Collection Approaches. Providers are employing many methods to collect SDOH data—as part of patient portals, during in-office visits, and during care manager outreach, among other methods. CMS should support efforts that explore the benefits and challenges of varying approaches to support providers in collection.
- Collection and Sharing Across Multiple Interactions with the Health Care System. CMS is currently requiring collection of this data across multiple setting-specific programs, which could result in duplicative efforts and patients potentially having to share this information numerous times. CMS should explore how this data can be shared across providers.

Finally, this measure is currently only available for one reporting type and we question the feasibility of adding it to the measure set for ACOs if the measure cannot be reported through all reporting mechanisms.

Reporting Options: Retiring Web Interface and MIPS CQMs

CMS proposes to eliminate both the Web Interface and the Merit-Based Incentive Payment System Clinical Quality Measures (MIPS CQM) reporting options for Performance Year (PY) 2025 and subsequent years. NAACOS is disappointed to see CMS move forward with this policy despite numerous calls on the agency to delay the retirement of the Web Interface and make all reporting options available until CMS tests eCQM, MIPS CQM, Medicare CQM and digital quality measure (dQM) reporting.

Abruptly removing the MIPS CQM reporting option will result in even more ACOs left unprepared for this transition. Some ACOs have already invested significant resources in the MIPS CQM reporting option, as CMS provided no indication through previous rulemaking that this option would no longer be available and leaves both ACOs and vendors with very little time to accommodate such a significant change. For those who already invested in vendor support to report MIPS CQMs, much of the time and resources invested in this option were wasted, and ACOs will have only two months to quickly pivot to another option if this change is finalized. Furthermore, making this change in the same year CMS plans to retire the Web Interface requires ACOs to spend significant effort to determine the best reporting approaches. This work ultimately diverts resources away from innovations that directly support patients.

While we appreciate the Medicare CQM option introduced in 2024, we disagree with CMS's assertion that MIPS CQM reporting is similar to Medicare CQM reporting, which would make retirement of the MIPS CQM option seamless. ACOs cannot easily transition between these reporting approaches. First, identifying the Medicare CQM patient population requires significant resources and many ACOs and vendors are still trying to operationalize how to do this work, as the first Medicare CQM patient lists were just shared with ACOs in May. Specifically, the more limited patient population of Medicare CQMs requires ACOs to identify patients meeting the definition of Medicare CQM eligible patient, which is proving to be challenging and time-consuming work. Second, some vendors have told ACOs that they will not support Medicare CQMs or cannot support them for 2025 due to these challenges. While Medicare CQMs begin to address certain scoring concerns by limiting the patient population assessed, there is still significant work associated with reporting in this manner. We point CMS to our previous comments on the challenges associated with reporting Medicare CQMs.

CMS also notes its intention to fully transition to digital quality measurement in CMS quality reporting and value-based purchasing programs, and states they are working to convert current eCQMs to the Fast Healthcare Interoperability Resources (FHIR) standards. The current requirements force ACOs to make investments in infrastructure that will be wasted as ACOs will soon need to transition to the HL7 FHIR standard. The unintended consequences of these policies have a direct impact on patients and providers. ACOs must reinvest shared savings into technology needs, rather than patient care. Additionally, ACOs are removing practices who need more time to adopt new technologies, and these practices tend to be smaller independent practices.

While NAACOS supports CMS's goal of moving toward digital measurement and appreciate efforts to address ongoing concerns, the significant challenges CMS acknowledges in its infographic on this topic and throughout this proposed rule remain. **To ensure the ongoing success of MSSP, we urge CMS to:**

- **Delay sunsetting the Web Interface and MIPS CQM reporting options for three additional years to align with the timeline required in the CMS Interoperability and Prior Authorization Final Rule;**
- **Make the Medicare CQM option permanent until dQM reporting is proven successful; and**
- **Remove new Promoting Interoperability requirements for MSSP ACOs**.

We also reiterate our previous requests for CMS to consider adding exceptions or exclusions for small practices and certain specialties and/or altering data completeness requirements to address these ongoing challenges and allow for ACOs to be successful in reporting eCQMs, MIPS CQMs, and Medicare CQMs. These exceptions and exclusions already apply in the MIPS program for other performance categories and could easily be applied to ACOs reporting eCQMs, MIPS CQMs, and Medicare CQMs. Making these small changes could allow ACOs to maintain small practices and specialty practices that cannot comply with these changes without undue costs and burdens, and therefore are being dropped by ACOs. This is counter to CMS's goals and ACOs' goals to include and engage more specialists in value-based care and to achieve CMS's goal of aligning all Medicare beneficiaries in accountable care relationships by 2030.

Establishing a Complex Organization Adjustment and Extending the eCQM Reporting Incentive
In recognition of the challenges APM entities face in reporting eCQMs, CMS is proposing to establish a Complex Organization Adjustment beginning in PY 2025. An APM entity would receive one measure achievement point for each submitted eCQM that meets the case minimum and data completeness requirements. Each reported eCQM could not score more than 10 total measure achievement points and the total achievement points may not exceed the total available measure achievement points for the quality score. Additionally, CMS proposes to extend the eCQM reporting incentive in recognition of the challenges ACOs still face in reporting, for PY 2025.

NAACOS appreciates CMS's acknowledgement of the challenges ACOs face reporting aggregated eCQM data, particularly when ACOs are comprised of both independent and employed providers operating on different EHRs and instances of EHRs. **However, the addition of a complex organization adjustment and extension of the eCQM reporting incentive are not sufficient to offset the significant challenges ACOs continue to face. CMS should finalize these policies while also maintaining the Web Interface and MIPS CQM reporting options for three additional years**, as stated above.

Bonus points and reporting incentives do not solve the underlying concerns with data validity and reliability when reporting eCQMs at the ACO level. We stress that the underlying eCQM data when reported at the aggregated ACO level does not reflect the quality of care provided by ACOs. Additionally, adding bonus points to compensate for the misaligned policy makes it difficult to assess quality scores. Layering these bonus points onto the score makes it difficult to track and improve quality over time.

Finally, these policies are also only made available for ACOs reporting eCQMs; however, the challenges also exist for those reporting MIPS CQMs and Medicare CQMs as well. A better approach would be to address the underlying concerns NAACOS and ACOs have repeatedly raised. CMS should test these new reporting approaches before moving forward with a program-wide requirement and give time to create meaningful policies that will result in quality scores which reflect the true quality of care provided by ACOs. Should CMS move forward this approach, we urge CMS to provide these incentives and bonus points to ACOs reporting eCQMs, MIPs CQMs, and Medicare CQMs and maintain these incentives until the underlying concerns are addressed. We also urge CMS to clarify that the eCQM reporting incentive

will be provided to ACOs who fully report both the eCQM and Medicare CQM or MIPS CQM measure sets.

Changes to Medicare CQM Benchmarks

CMS proposes to use flat benchmarks when scoring Medicare CQMs, beginning in PY 2025. CMS would use flat benchmarks for an ACO's first two performance periods. CMS makes this change in response to NAACOS' concerns that ACOs would earn lower achievement points for Medicare CQMs due to the comparison group used in establishing these benchmarks being comprised of only other ACOs, which are high performers relative to non-ACO MIPS clinicians which are included in the comparison group when establishing benchmarks for MIPS CQMs and eCQMs. **NAACOS supports this change, which will make Medicare CQM scoring more predictable and is a fairer approach to establishing benchmarks for ACOs.** However, we urge CMS to make this change permanent rather than for two years. We also request that CMS release performance data publicly so ACOs can better understand Medicare CQM performance data.

We also continue to have ongoing concerns regarding the benchmarking methodology for quality measurement in MIPS and urge CMS to consider an alternative approach that allows all ACOs to succeed and does not make arbitrary cutoffs for scoring for minimal differences in performance. The current benchmarks combine performance from individual clinicians, groups, and now ACOs, which can lead to performance differences based on patient volume. For example, one of CMS's criteria for scoring a MIPS participant against a benchmark requires that a case minimum of at least 20 patients or episodes, yet ACO volumes for these measures will be much higher. Review of the benchmarks within a performance period shows differences in the range of performance by collection type, such as between an eCQM and MIPS CQM, which may more accurately reflect a group's ability to capture electronic data rather than true quality. Benchmarks can also shift widely over multiple performance periods, leading us to question whether they truly reflect the quality of care delivered. As a result, we do not believe that the current methodology truly evaluates an ACO's quality of care against a valid comparator and urge CMS to reconsider the current approach.

Request for Information Regarding CAHPS Changes

CMS is seeking comments on adding a web-based survey mode to the current mail/phone protocol for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. In a field test, CMS found adding the web-based survey mode resulted in a 13 percent increase in response rate. **NAACOS supports this change, as improved response rates are beneficial. However, we reiterate ongoing concerns with CAHPS**. ACOs feel the CAHPS survey does not effectively obtain feedback from patients on the care they receive. There are issues with the timing of the surveys, patients conflate experiences with various providers and have difficulty recalling experiences that took place some time ago. Questions are confusing, leading, and can be misinterpreted. Overall, many ACOs report CAHPS performance does not correlate with whether the patient would recommend the provider or provider group to friends and family. Instead, many ACOs are using their own internal surveys that have a much larger sample size and are more meaningful to patients and providers, using the survey data for improvement purposes. We urge CMS to work with stakeholders to devise a better approach to obtaining patient satisfaction data.

Guiding Principles for Patient-Reported Outcome Measures in Federal Models, and Quality Reporting and Payment Programs Request for Information

CMS seeks feedback on guiding principles for Patient-Reported Outcome Measures (PROMs) in federal models. NAACOS has concerns regarding PROMs, which are difficult to administer, and place added

burden and costs on providers and ACOs. We also are concerned with patient survey fatigue, particularly for those with multiple chronic conditions and high needs, who may now find themselves the focus of many surveys across models and programs. We urge CMS to work with stakeholders to devise a better approach to obtaining Patient-Reported Outcome data for APMs.

CEHRT and Promoting Interoperability Requirements Taking Effect in 2025

CMS finalized a requirement that all MSSP participants, regardless of QP status or track, report MIPS Promoting Interoperability (PI) data starting with the 2025 performance year. CMS also increased Advanced APM CEHRT criteria from requiring 75 percent of all eligible clinicians to use CEHRT to all eligible clinicians, starting in 2025. **We remain opposed to the changes in this requirement:**

- Requiring all MSSP ACOs to report PI is counter to the Medicare Access and CHIP Reauthorization Act (MACRA) intent to relieve burden from MIPS for Advanced APMs. Congress clearly established a two-track system that exempts MIPS clinicians who participate in Advanced APMs and meet QP thresholds. Requiring Advanced APM MSSP ACOs to now report PI goes against this intent and is now subjecting these Advanced APM ACOs to MIPS. This will serve as a disincentive to participate in an Advanced APM at a time when financial incentives to participate in these models are dwindling.
- ACOs still lack clarity regarding how these policies will be implemented and to what extent they will impact ACOs' ability to share in savings generated. While we were pleased to see CMS recently issue new frequently asked questions (FAQs) to MSSP ACOs, there are still several significant implementation questions that remain unanswered. This uncertainty is causing ACOs to drop practices from their participant lists, which is counter to CMS's goals to have all patients in an accountable care relationship by 2030.
- Reporting PI does not equate to more meaningful use of CEHRT in an ACO. ACOs by design must be committed to robust information and data sharing practices to be successful in the program, while reporting PI measures and meeting required objectives for this program are extremely burdensome and will serve only as a check the box exercise, not add any value to patients.

We recommend that CMS employ the following approaches to better understand ACOs' use of CEHRT:

- Require ACOs to attest to use of CEHRT. This is the approach previously employed in MSSP and currently used for REACH. CMS should align requirements between similar models (i.e., ACOs) rather than aligning MSSP with MIPS. This would better support clinicians who move between models, and APM entities that participate in both programs. The REACH attestation approach is preferred as it places less burden on providers and does not require providers to report on the meaningless data points collected in PI.
- Leverage data reported to the Office of the National Coordinator for Health IT (ONC) from health IT developers through the new Insights Condition and Maintenance of Certification finalized in the Health Data, Technology and Interoperability (HTI-1) final rule.
- Gradually increase the Advanced APM CEHRT criteria. Expecting 100 percent of clinicians across an ACO to comply with burdensome PI requirements and/or meet CEHRT criteria is not reasonable. If one practice or clinician fails to meet these criteria, it could jeopardize the entire ACO's ability to satisfy program/model requirements; this is unrealistic. At a minimum, CMS should employ practice enforcement discretion to give ACOs more time to work with practices to comply with these new requirements.
- Apply reasonable exceptions including the small practice exception recognized and used in MIPS, as well as exceptions for non-patient facing clinicians, hospital-based clinicians and

Ambulatory Surgical Center (ASC) based clinicians. Recent FAQs implemented exceptions; however, they are not aligned across programs.

Financial Methodology

Establishing a Higher Risk Track Than Enhanced

CMS sought feedback on but did not propose creating a higher risk, higher reward track than the current Enhanced Track in MSSP. CMS believes that a higher risk track could encourage more ACOs to participate in MSSP and encourage them to generate greater savings to Medicare. Importantly, CMS notes that such an option could replace the current Enhanced Track, as the agency worries about self-selection bias. In 2024, Enhanced is the most popular of the MSSP tracks, with 43 percent of MSSP ACOs participating.

CMS's request for information demonstrates the agency's evolution in considering a higher risk track. CMS notes that it must balance creating savings for Medicare and attracting participation in a voluntary program. Accordingly, additional consideration is needed on financial benchmarks and shared savings arrangements. **NAACOS appreciates that CMS is continuing this important work to evolve MSSP. We have long advocated for a higher risk track in the model; however, as noted above we are concerned that CMS's approach for defining actuarial savings may limit model innovation.** Solely relying on a comparison to a dwindling FFS population to determine the costs of policy change is limiting the potential for innovation in the model. CMS should consider methods that compare performance of APMs to Medicare Advantage.

Additionally, NAACOS does not support replacing the existing Enhanced Track with one that offers a fundamentally different financial methodology or shared savings arrangement. Enhanced is a predictable, stable model that offers a fair balance of risk and reward for providers and ACOs. Altering the fundamental structure of Enhanced jeopardizes MSSP participation. CMS also sought input on how an ACO model requiring provider participation or stronger participation incentives might be applied. NAACOS opposes mandating any model that is higher risk than the Advanced APM nominal risk standard. Additionally, any mandatory model should allow for sufficient time in a no-risk track before gradually taking on risk and provide significant support for providers to understand and succeed in the model.

CMS discusses its concerns with selection bias; however, overly emphasizing selection bias ignores real-world considerations. While all providers should have a pathway for participation in APMs, not all providers are capable of, or should, take on increasingly higher risk levels. As we discuss below, providers serving patients in rural communities and underserved patients tend to have less resources and cannot bear significant risk. For these providers, we must consider other approaches, such as maintaining costs and access rather than reducing costs.

Additionally, a higher risk track beyond Enhanced is needed to allow ACOs to continue innovation. ACOs reinvest shared savings into patient care and provider payment. With benchmarks consistently lowering over time, shared savings are reduced and thus care innovation can be reduced. A higher risk track would allow ACOs to maintain or increase their level of investment in patient care and providers. ACO REACH has demonstrated that with the ability to attain higher savings, ACOs are able to increase staffing to support care management, establish initiatives for high-risk patients, alter payment (e.g., capitation) to ease provider burden and provide more consistent cash flow, and negotiate rates with other providers (e.g., specialists). ACOs and providers who have been in the program for years, need additional funds to continue innovating beyond the progress made to date. Rather, than concern about which providers

elect a higher risk track, CMS could consider additional reporting or requirements for how shared savings dollars are used. This will help ensure that cost associated with a higher risk track is directly impacting patients and providers.

NAACOS continues to believe a higher risk track will attract many existing ACOs in MSSP and REACH, and potentially attract new participants. The popularity of the current Enhanced Track (43 percent of MSSP ACOs) and the continued growth of ACO REACH (in the absence of new applications cycles) demonstrates the need for a continual evolution of the model for providers well-suited to bear significant risk. Below we offer recommendations for a higher risk track.

Financial Benchmarks. NAACOS could support many of the various mechanisms that seek to minimize CMS's exposure to paying shared savings. A reasonable cap on the regional adjustment at around 35 percent of the benchmark, a mandatory 0 percent MSR/MLR, and a tapered approach to shared savings where the ACOs take less of a percentage back as gross savings increase are all approaches that could be implemented. Additionally, our members are indifferent to the use of either a reasonable discount or shared savings approach. Creating clear, consistent, predictable benchmarks that are sustainable (i.e., not ratcheted simply for renewing a contract) will ultimately drive the success of any APM.

Health Equity. More consideration needs to be given to health equity adjustments and initiatives. While CMS is deploying several policies to encourage providers to take on populations that have traditionally been underserved, these policies run counter to MSSP's risk adjustment policies. The model employs a 3 percent cap on ACOs' assigned populations' risk scores. However, because that cap is applied to the difference between Benchmark Year (BY) 3 and a performance year, ACOs serving historically underserved patients are easily reaching the 3 percent cap. This provides a disincentive to serve these patients and runs counter to CMS's health equity goals.

Options for capitated payments. While CMS is offering the new PC Flex Model, there's only one opportunity to join and it is limited to low revenue ACOs. Like the ACO REACH Model, Enhanced should have an option for primary care and total care capitation. These valuable tools allow ACOs to encourage participation and drive innovative payment arrangements with downstream that support higher quality care.

Use of Preferred Providers. The use of preferred providers supports CMS goal to encourage more participation with specialists. Preferred providers can participate in certain ACO initiatives but do not drive patient attribution and are not directly accountable for total cost of care or quality reporting. Rather, preferred providers embrace delivery system innovation by helping close referral loops and improving coordination across the continuum. Preferred providers are able to replicate this approach across several ACOs, increasing their overall engagement. Finally, this creates a pathway for ACOs to employ financial arrangements with preferred providers, helping better engage specialists in APMs.

TIN/NPI Attribution. The use of preferred providers should also be paired with the ability to enroll participants at the TIN/NPI level. Innovation Center models have demonstrated that this approach allows more targeted participant rosters that allow ACOs to better understand and control costs. Moreover, this approach avoids penalties (i.e., high revenue designation) for providers that are in multispecialty practices.

Voluntary Alignment. CMS should expand the MSSP voluntary alignment from the MyMedicare.gov approach to paper- and electronic-voluntary alignment, as done in ACO REACH. This has proved to be a

successful approach to ensuring that a higher proportion of clinicians' patients align to the model. While some adaptations and learnings should be applied, this approach could be an incentive for providers to engage in higher risk tracks.

Model Flexibility. Participants should be given access to all of REACH's waivers, particularly the cost-sharing support. The current set of waivers in MSSP today is very limited and has not evolved over time. Instead, ACOs taking on higher risk levels should have more flexibility in approaches for providing care. Specifically, a higher risk track should offer the post discharge home visit waiver, care management home visit waiver, and tailored Part B cost sharing support. We believe CMS should make these flexibilities available in the current Enhanced Track and a higher risk track. CMS should also consider waiving the statutory restrictions on Annual Wellness Visit scheduling, allowing AWVs to be scheduled and provided once a year at any time during that calendar year. The 12-month timeline results in arbitrary barriers to care and is implemented differently at the discretion of the MACs. This has caused confusion, scheduling challenges, and uncompensated care.

Quality. We do not believe that CMS should require a different quality reporting approach for a potential future track. As we note above, we are concerned with the current timelines for transitioning to new reporting mechanisms. Additionally, taking on additional financial risk does not justify assessing providers on patients covered by other insurance. Rather than defining new quality strategies for a higher risk track, CMS should focus on better understanding the impact of flexibilities offered in models. CMS could publicly provide more information that will help drive use, such as simple descriptive statistics and best practices.

Additional Considerations

CMS seeks feedback on increasing participation by healthcare providers and suppliers in the Shared Savings Program and future Innovation Center ACO models. NAACOS has sought to understand how to engage all provider groups in total cost of care models. Below we summarize recommendations previously shared with CMS.

High Needs Patients. Patients with complex chronic conditions or serious illnesses have some of the highest health care costs and some of the greatest opportunities to benefit from the care coordination and wraparound services that ACOs can provide, but MSSP policies were not designed with these populations in mind, which makes it challenging for health care provider organizations that predominantly serve complex and high needs patients to participate and succeed in the program. While CMS does not propose any specific policies for ACOs that predominantly serve high needs beneficiaries, including those with complex chronic conditions and serious illnesses, NAACOS would like to highlight the challenges these ACOs face in MSSP and encourage CMS to explore solutions to address these challenges. Additionally, CMS should explore elements from the High Needs Track of the ACO REACH Model that could be embedded into MSSP. NAACOS has developed recommendations for addressing the needs of complex patients in APM design, and we encourage CMS to explore incorporating these recommendations into MSSP. Highlights of the recommendations are to:

- Design alternative program policies to account for high-cost, high needs beneficiaries who are significantly different from the average traditional Medicare beneficiary.
- Ensure participation criteria do not exclude high needs beneficiaries from benefitting from value-based care models.
- Account for the care settings and care delivery models through which these populations are often receiving care in attribution models.

- Design financial methodologies specifically for these populations to ensure sustainability and predictability for the participating organizations that serve them.

Rural and Underserved Communities. Despite significant participation in MSSP among safety-net providers, barriers exist for them because of the unique way Medicare pays Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Critical Access Hospitals (CAHs). Highlights of our recommendations include:

- Focus on increasing or maintaining access rather than purely reducing costs. Judging ACO performance based on savings achieved compared to their historical spending may not be appropriate for rural populations or lower cost settings.
- Consider a global budget or prospective population-based payment for safety-net providers, which provides needed stable and predictable payment. Provide lower discounts or minimum savings rate for rural providers in risk-bearing models. Remove the high/low revenue designation in the MSSP that penalizes certain ACOs, especially safety-net providers.
- Address unique payment challenges for safety-net providers by, for example, waiving the current one-visit, one-service requirement for FQHCs and RHCs and removing face-to-face billing requirements for certain services like annual wellness visits. ACOs including safety-net providers, or a high proportion of beneficiaries served by safety-net providers could have a distinct set of waivers.

Considerations for Long-Term Care Providers. Modifications also need to be made for long-term and post-acute care (LTPAC) providers, who have been challenged in their ability to meaningfully participate in MSSP. Fewer than 2,000 Skilled Nursing Facilities (SNFs) participate in ACOs, representing less than 10 percent of SNFs nationwide. NAACOS partnered with the American Health Care Association to recommend changes that support engagement of LTPAC providers.

- CMS should reconsider alternative alignment approaches to better capture the stays of short-term SNF patients in the plurality of care in ways that both prevent inappropriate alignment with community-based providers but recognizing the role SNFs play in patient care.
- CMS should add to the common working file (CWF) that ACO a patient is attributed to, pinpointing the specific ACO to which a patient is attributed, streamlining the coordination of care and resources available to patients.
- CMS should use the concurrent risk adjustment model that is being tested in ACO REACH for the SNF/NF population.
- CMS should prioritize a distinct set of quality metrics that are clinically pertinent and meaningful to the SNF/NF population.

Anomalous and Highly Suspect Billing

CMS proposes to exclude all payments associated with CMS-identified significant, anomalous, and highly suspect (SAHS) billings from ACOs' financial calculations in a relevant calendar year, as well as historic benchmarks for affected future agreement periods. Shortly after the start of the calendar year, CMS would decide which, if any, codes from the year prior would trigger an adjustment. This policy would take effect for all ACOs starting in 2024. CMS expects it will use this authority in "rare and extreme cases." CMS gives itself the sole discretion to identify SAHS billing that would warrant adjustments and outlines criteria in the proposed rule that it will consider.

NAACOS supports CMS's efforts to address SAHS billings in ACOs' financial methodology. Unaddressed, SAHS billing can impact ACOs' shared savings and losses, historic benchmarks, assigned beneficiaries,

high-low revenue determinations, among other ACO program factors. NAACOS also supported CMS's previous efforts to hold ACOs harmless from anomalous billing for catheters experienced in 2023. Combined these policies align with NAACOS and other stakeholder recommendations.

We ask that CMS consider the following in implementation of this policy:

- Transparency on enactment of SAHS billing. We agree with the criteria for triggering SAHS policies as they are broad enough to allow the agency to adapt to changing and uncertain needs. However, transparency on when these policies will be enacted is critical. ACOs need insights into circumstances that will meet the criteria. We request that when an ACO requests a consideration for SAHS billing, CMS provide written feedback of why the circumstance does or does not meet the criteria.
- Feedback loop with ACOs. Currently when ACOs notify CMS and the Department of Health and Human Services Office of the Inspector General (HHS OIG) of suspected fraud, there is little to no response. We recognize that fraud investigations by CMS and the HHS OIG can take years; however, ACOs need information to inform their patient communications and make decisions about future participation. We ask CMS to explore additional ways to notify ACOs of potential actions. For example, if CMS is paying some claims into escrow, then it could flag these claims for ACOs in their regular Claim and Claim Line Feeds (CCLFs).
- Accounting for regional instances of SAHS. As stated in the proposed rule, the catheter billing issue is an outlier. It's rare for such SAHS activity to occur on a national basis as it is typically focused regionally, or even at the county level. These regional instances can have a significant impact on an ACOs performance. In implementation of this policy CMS should ensure that ACOs are held harmless for regional and local instances of SAHS.

As we've previously stated, there are opportunities to improve how ACOs report fraud, as well as to better educate ACOs on the processes CMS and the HHS OIG undertake to investigate fraud. We encourage a continued dialogue between ACOs and CMS on ways to improve the reporting process. As the HHS OIG has previously noted, ACOs are excellent sources to uncover potential fraud, waste, and abuse by identifying patterns of unusual billing.

Reopening ACO Payment Determinations

CMS proposes to create a process by which ACOs can request to recalculate payment determinations, including shared savings and losses, to account for improper payments identified beyond MSSP's three-month claims runout. CMS outlines in the proposed rule several considerations that will factor into its decision to grant redetermination requests. CMS recognizes it will be difficult for ACOs if shared savings or losses are recalculated years later. Additionally, CMS indicates that it wants to respect the "administrative finality" of initial determinations. If finalized, the changes would apply to requests made on or after January 1, 2025. In the proposed rule, CMS states it will evaluate previously received reopening requests for performance years prior to January 1, 2025, consistent with existing policy.

NAACOS supports this policy and requests that CMS apply the policy to performance years prior to 2025. We believe this policy could be an opportunity to remove instances of fraud and abuse from ACO performance calculations, since criminal matters are not often resolved until months or years after a performance year's reconciliation. ACOs typically hear about confirmed fraud in their markets years after the performance period ended yet have no recourse for action. In these cases, ACOs are stuck with accountability for patients' total cost of care but have no ability to stop instances of improper payments.

We believe the policy should apply to prior years in recognition of other suspected SAHS. For example, ACOs have noted SAHS billings for skin substitutes, ventilators, diabetic supplies, and collagen dressings in 2023. For skin grafts alone, Medicare payments rose from $1.3 billion to $3.9 billion from 2022 to 2023, according to data from the Institute for Accountable Care, who analyzed Medicare claims from the CMS Virtual Research Data Center. Spending growth is driven by five new high-cost CPT codes. Coverage is determined by Medicare Administrative Contractors and can vary from one jurisdiction to another. As such, ACOs have reported a rapid increase in the use of biological skin substitutes that do not align with clinical need. For example, ACOs have reported skin substitute products used in patients without control of underlying conditions and exceeding recommended treatment minimums, thus leading to continued treatment of wounds that are not improving.

These issues will not be addressed in other rulemaking that's specific for urinary catheters [CMS–1799–P]. ACOs should have the right to have other SAHS issues corrected from performance years prior to 2025. We ask that CMS apply its SAHS policies proposed in rulemaking earlier this summer, as well as reopening determinations once finalized, to skin substitute products.

CMS also requests feedback on the process to request reopening ACO payment determinations. We ask that CMS employ an approach that minimizes burden to the ACO making the request. While ACOs can perform in depth analysis of their data; ACOs lack detailed information on national or regional billing to make comparisons and should not be requested to provide such information as part of the process. We ask that CMS publish subregulatory guidance on the type of information it will request and potential timelines. CMS notes it may need "considerable time" after deciding to reopen an initial determination before it can complete the process. However, it is imperative to complete actions quickly so that ACOs can notify participants and adjust any downstream payments or incentives. Retention of providers in ACOs is dependent on clear communication about financial incentives and timely payment. Finally, we ask that CMS provide detailed responses, outlining why a request is granted or not granted, to reopening payment determination requests.

Health Equity Benchmark Adjustment

CMS proposes to add a Health Equity Benchmark Adjustment (HEBA) that would upwardly adjust benchmarks for ACOs for new agreements in 2025 and beyond. The adjustment would be based on the proportion of assigned beneficiaries who are enrolled in the Medicare Part D low-income subsidy (LIS) or dually eligible for Medicare and Medicaid. ACOs with at least 20 percent of their aligned beneficiaries meeting these criteria would be eligible for the HEBA. Like the regional adjustment and prior savings adjustment, the HEBA cannot exceed 5 percent of national assignable per capita expenditures. Additionally, ACOs will receive the higher of the HEBA, prior savings adjustment or regional adjustment. Accordingly, CMS estimates that while 20 percent of ACOs in 2023 would be eligible to qualify for the HEBA, only 5 percent of ACOs would have an adjustment higher than either their regional or prior savings adjustment. For those ACOs, the HEBA would increase benchmarks by 1.57 percent.

NAACOS supports this policy, but we encourage CMS to identify additional ways to support providers caring for undeserved beneficiaries. As noted above, the benchmark ratchet threatens the overall success of the program. Additionally, developing and implementing initiatives to address SDOH and health inequities requires significant, sustained funding that many providers, particularly small practices and rural providers, do not have. A 1.57 percent increase to the benchmark is insufficient to invest in services to meet patients' nonmedical needs.

Aligning Prospective HCC Risk Score Cap

CMS proposes to make a conforming change to regulation to clarify that it will use ACOs' benchmarks that have been adjusted for prior savings, HEBA, and regional adjustment to align the 3 percent cap on hierarchical condition category (HCC) scores with that of the ACO's region. If finalized, the change would be reflected in reconciled PY 2024 performance calculations. In last year's rule, CMS capped the risk score growth in an ACO's region for agreements beginning in 2024, making the cap on the ACO and its region symmetrical. NAACOS supports this change as it updates benchmarking policies to reflect new policies.

Prepaid Shared Savings Option

CMS proposes to create a new option for ACOs with a history of earned shared savings to elect to receive prepaid shared savings payments. **NAACOS supports this proposal and encourages CMS to finalize this option, with modifications as detailed below.** When CMS established the advance investment payment (AIP) option in the 2023 MPFS rule, NAACOS encouraged CMS to expand eligibility to include more types of ACOs and more provider types, as the AIP option is restricted to certain new, low revenue ACOs. NAACOS is pleased to see CMS propose this prepaid shared savings (PSS) option without restrictions on past participation or revenue designation. **While more timely payment of shared savings will help fund ACO initiatives throughout the performance year, challenges with the benchmark ratchet will likely hinder the impact of this option.** Especially given that ACOs would need to begin a new participation agreement, and therefore experience a benchmark ratchet, to apply for PSS, ACOs' ability to generate shared savings continues to be diminished. We appreciate CMS's efforts to make the program more attractive for experienced ACOs, but underlying issues with MSSP's financial methodologies must be addressed to sustain long-term participation.

Eligibility and Application Procedures

CMS proposes to establish PSS eligibility criteria such that it is only available to ACOs that are well-positioned to use the funds to improve the quality and efficiency of care for assigned beneficiaries while minimizing the risk of an ACO being unable to repay the funds. To apply for PSS, an ACO must be renewing, applying for a new MSSP agreement, participating in a 2-sided risk track, and must have received a shared savings payment for the most recent year prior to the agreement period for which the ACO is applying, and for which CMS has conducted financial reconciliation. Full eligibility details are on page 61871 in the proposed rule.

NAACOS supports the eligibility criteria overall, which ensure ACOs receiving PSS are in good standing and are likely to generate sufficient savings to repay PSS received. However, **we oppose the requirement for ACOs to begin a new agreement period to be eligible to apply for and receive PSS**. Instead, CMS should allow ACOs to submit a change cycle request to apply for and receive PSS for the remainder of the existing agreement period. As mentioned previously, benchmark rebasing and the associated ratchet effect limits ACOs' ability to generate savings, making this requirement a significant drawback. CMS should explore using an addendum to existing agreements rather than requiring ACOs to begin new agreements for this option.

Under these proposals, the application for PSS would be conducted in conjunction with the MSSP application cycle and ACOs would be required to submit supplemental PSS application information, including a spend plan detailing how the ACO intends to use the funds. NAACOS supports the proposal to align the PSS application with the overall MSSP application, which should limit administrative burden. We encourage CMS to publish PSS application guidance in advance of the MSSP application cycle in 2025 to provide ACOs with ample time to prepare.

Allowable and Prohibited Uses

Similar to AIP, CMS proposes to specify how PSS may be used and to place restrictions on the amount of annual PSS funds that can be spent within the categories of allowable uses. Allowable expense categories include staffing, healthcare infrastructure, and direct beneficiary services (DBS). ACOs would be prohibited from using PSS for any expense outside of the allowable uses.

The category of staffing may include hiring, training, and/or education for staff; health care infrastructure may include investments in or improvements to data registries, practice management systems, CEHRT, health IT tools, closed-loop referral tools, or other improvements for either individual ACO providers/ suppliers or for the ACO at large. CMS defines DBS as "in-kind items or services provided to an ACO beneficiary that are not otherwise covered by traditional Medicare but have a reasonable expectation of improving or maintaining the health or overall function of ACO beneficiaries." This could include cost sharing support, meals and nutrition support, housing assistance, transportation, caregiver support services, home visits, home or environmental modifications, vision, hearing, or dental care, and other such services. CMS indicates it will publish subregulatory guidance with more specific information on DBS and allowable uses of PSS. Additional details and examples of allowable and prohibited uses can be found on pages 61873-5 in the proposed rule.

Notably, CMS specifies that ACOs may tailor DBS to certain subgroups of beneficiaries, such as for beneficiaries with a particular condition or with financial need. NAACOS has long advocated for tailored Part B cost sharing support to be made available in MSSP, as the current Beneficiary Incentive Program (BIP) established by Congress is too restrictive and costly for ACOs to implement. This policy will allow ACOs receiving PSS to provide Part B cost sharing support and other DBS in a way that meets beneficiaries' needs and will have the greatest impact.

CMS also proposes to require that ACOs spend at least 50 percent of annual PSS on DBS and that they may spend up to 50 percent on staffing and healthcare infrastructure. While CMS proposes to limit ACOs to spend no more than 50 percent of prepaid shared savings on staffing and infrastructure, CMS notes that if a staff member is hired or directed to provide direct beneficiary services, ACOs may use funds designated for direct beneficiary services to cover the portion of their salary that aligns with the percentage of time the staff member spends providing direct beneficiary services. While we appreciate the flexibility with which CMS is defining DBS, **NAACOS opposes the requirement to spend at least 50 percent of annual PSS on DBS.**

While CMS asserts that successful ACOs "are likely to have already made significant investments in staffing and healthcare infrastructure," this ignores the fact that these require continued investment to maintain and update. For many ACOs, the majority of shared savings dollars are distributed to ACO participants, and this is a major incentive for providers to join and remain in an ACO. ACOs already publicly report and report to CMS how shared savings are spent within the categories: invested in infrastructure, invested in redesigned care processes/resources, and distributed to ACO participants. We encourage CMS to collect more granular data on how shared savings dollars are currently spent before requiring they be allocated to specific purposes. Successful, experienced ACOs should be provided with maximum flexibility to determine how to spend funds to meet the needs of their populations.

Under these proposals, CMS will provide an estimated annual prepaid shared savings amount by multiplying the first quarterly payment by four, for purposes of allocating PSS funds within the allowable uses for an ACO's spend plan. CMS proposes that if an ACO's actual quarterly payments are lower than

the estimated annual amount, the ACO would not be subject to compliance action because it spent more than 50 percent of the actual annual prepaid shared savings amount on staffing and healthcare infrastructure, so long as it did not spend more than 50 percent of the originally estimated annual amount. **NAACOS supports this proposal but urges CMS to go further to provide ACOs the flexibility to determine how best to allocate PSS funds within the allowable uses.**

Calculation of Prepaid Shared Savings

CMS proposes to calculate an ACO's PSS based on the ACO's historical savings and losses from the most recent two performance years that have been financially reconciled. CMS would notify an ACO in writing of the amount of the quarterly payment and the ACO's opportunity to request reconsideration review. ACOs would be provided with these notices with other quarterly reports ACOs receive in December, May, and August, with ACOs receiving notice regarding the first and second quarterly payments in December of the immediately preceding year. NAACOS supports these proposals. **We encourage CMS to provide ACOs with preliminary estimated PSS amounts during the application cycle to inform development of the spend plan.**

The calculation of PSS payments was designed to ensure the option does not result in additional program expenditures. CMS proposes to calculate a given maximum quarterly prepaid shared savings payment as follows:

(1) Calculate the PSS multiplier as the average per capita savings/losses across the performance years that constitute BY1 and BY2.
(2) Pro-rate the PSS multiplier using the ratio of average assigned person years in the performance years that constitute BY1 and BY2 and the average assigned person years in BY1 and BY2, capped at 1.
(3) Adjust the pro-rated PSS multiplier by the shared savings scaling factor (0.5) and the financial risk scaling factor (2/3).
(4) Cap the pro-rated, adjusted PSS multiplier at 5 percent of national per capita FFS expenditures.
(5) Determine the maximum prepaid shared savings payment for the applicable quarter by multiplying 1/4 of the pro-rated, adjusted, capped PSS multiplier by the ACO's assigned beneficiary person years in the latest available assignment list.

Table 37 in the proposed rule provides a detailed example calculation.

NAACOS supports the proposed calculation of the quarterly PSS payments and the use of an ACO's latest available assignment list to reflect changes to the ACO's assigned population during the agreement period.

Duration, Frequency, and Withholding or Termination

ACOs approved to receive PSS would receive quarterly payments for the entirety of the ACO's agreement period unless withheld or terminated, and catch-up payments would not be made in the event payments are withheld or terminated. Under CMS's proposals, an ACO receiving PSS could elect to receive a smaller payment amount than the maximum quarterly payment calculated by CMS, or to elect to have payments withheld and later resumed. NAACOS appreciates this flexibility, particularly for a voluntary option, and we support the proposed frequency and duration of PSS payments.

CMS proposes that it must terminate an ACO's PSS during an agreement period if the ACO fails to maintain an adequate repayment mechanism, fails to meet the quality performance standard or is subject to pre-termination action for avoiding at-risk beneficiaries. CMS notes that immediate

termination of PSS would only occur in cases of serious noncompliance or risk of harm to beneficiaries. Additionally, CMS proposes that it may withhold or terminate an ACO's PSS if:

- The ACO fails to comply with requirements for PSS;
- The ACO meets any of the grounds for ACO termination set forth in § 425.218(b);
- CMS projects the ACO would not earn sufficient shared savings to repay PSS, based on a rolling 12-month window;
- The ACO fails to earn enough shared savings in a performance year to fully repay the PSS payments received during the performance year;
- The ACO falls below 5,000 beneficiaries;
- The ACO fails to spend the majority of PSS received in a performance year; or
- The ACO requests that CMS withhold payments until the ACO is ready for payments to resume.

NAACOS appreciates that CMS would only immediately terminate PSS in cases of noncompliance or risk of harm to beneficiaries. We encourage CMS to provide more clarity around what would trigger CMS concern that an ACO would be unable to fully repay PSS and offer more flexibility to work with ACOs before withholding or terminating payments.

Monitoring Eligibility

CMS proposes to monitor an ACO's use of PSS by comparing the spend plan submitted by the ACO to the actual spending reported by the ACO. CMS may require ACOs to reallocate PSS funds and submit an updated spend plan if it is determined that an ACO has used PSS for prohibited expenses. ACOs would be required to publicly report the spend plan and actual spending through the public reporting webpage, in addition to reporting to CMS. NAACOS supports the use of ACOs' existing public reporting pages for reporting PSS, which should limit administrative burden.

Recoupment

Similar to other advanced shared savings options, CMS proposes to recoup PSS through shared savings earned by the ACO, and CMS expects that most ACOs would fully repay the PSS received each performance year on an annual basis. If an ACO's earned shared savings are insufficient to fully repay PSS received for a performance year, CMS would withhold future PSS payments and carry forward the remaining balance owed to subsequent performance years. NAACOS supports the proposal to recoup PSS through future performance year savings rather than require ACOs to fully repay PSS each performance year. Shared savings earned by an ACO can fluctuate year over year, sometimes due to factors outside the ACO's control, and this policy allows flexibility to account for this.

If an ACO has outstanding PSS owed to CMS after financial reconciliation of the final performance year of the agreement period, the ACO must repay the full outstanding amount to CMS within 90 days of receiving written notice of the amount due. CMS proposes that if an ACO fails to repay any outstanding PSS within this timeframe, CMS would recoup the amount from the ACO's repayment mechanism. We urge CMS to modify this requirement for an ACO that enters a new MSSP agreement immediately after the end of the agreement in which it received PSS, such that any outstanding PSS balance could be carried over into the subsequent agreement period. This would mirror policies for the AIP option and CMS's proposal for ACO's that early renew.

If an ACO or CMS terminates its participation agreement during the agreement in which the ACO received PSS, CMS proposes that the ACO must repay all outstanding PSS received in full. If the ACO terminates its participation agreement in order to early renew, CMS may recover the amount owed by

reducing the amount of any future shared savings earned by the ACO. NAACOS supports these proposals.

Advance Investment Payments

CMS proposes slight modifications to AIP policies to allow ACOs receiving AIP to voluntarily terminate payments while continuing participation in their current MSSP agreement, and to enable CMS to recoup AIP funds when CMS terminates the participation agreement of an ACO receiving AIP. NAACOS supports these proposals, which align with existing AIP policies and provide clarity for participants.

Beneficiary Assignment

Definition of Primary Care Services Used in Assignment
CMS proposes to add several codes, if finalized for coding and payment under the PFS, to the definition of primary care services used to assign beneficiaries to ACOs:

- Safety Planning Interventions (HCPCS code GSPI1)—*add-on code would only be included when the base code is also a primary care service code included in the definition*
- Post-Discharge Telephonic Follow-Up Contacts Intervention (HCPCS code GFCI1)
- Virtual Check-in Service (CPT code 9X091)—*directly replaces G2012, which is currently included in the definition*
- Advanced Primary Care Management Services (HCPCS codes GPCM1, GPCM2, GPCM3)
- Cardiovascular Risk Assessment and Risk Management Services (HCPCS codes GCDRA, GCDRM)
- Interprofessional Consultation Services (CPT codes 99446, 99447, 99448, 99449, 99451, 99452)
- Direct Caregiver Training Services (HCPCS codes GCTD1, GCTD2, GCTD3)
- Individual Behavior Management/Modification Caregiver Training Services (HCPCS codes GCTB1, GCTB2)

NAACOS supports the addition of these codes. These services support the delivery of comprehensive, coordinated, whole-person care and are reflective of other services CMS has used to assign beneficiaries to ACOs. We encourage CMS to finalize the additions as proposed.

Voluntary Alignment
Currently there is an exception to the MSSP statutory requirement that voluntary alignment supersedes any other assignment, for models with claims-based assignment methodologies that do not include primary care services. CMS proposes to expand the current exception to include models which employ a claims-based assignment methodology using both primary care and non-primary care services. **NAACOS opposes this, as we consider it bad policy to weaken voluntary alignment, which CMS upholds as the gold standard for attributing beneficiaries.**

Voluntary alignment in MSSP is flawed, which has limited its use. It is concerning that rather than addressing barriers to using voluntary alignment more broadly in MSSP, CMS is proposing to undermine its precedence further. While we recognize there may be specific instances in which it is appropriate for a condition-specific model to take precedence over MSSP voluntary alignment, such as the Kidney Care Choices Model in which providers are accountable for total cost of care, we believe CMS should do more to strengthen voluntary alignment policies in MSSP. For example, CMS could provide information to beneficiaries on how to select a primary care provider when they enroll in Medicare and explain why this is beneficial to their care. At a minimum, CMS should exercise significant caution when applying

such exceptions to preserve patients' longitudinal primary care relationships and avoid cycling patients in and out of models. We encourage CMS to take a nuanced approach to model overlap policies and prioritize stable participation in the permanent program.

Eligibility Requirements and Application Procedures

Monitoring Compliance with 5,000 Beneficiary Threshold

Current regulations require that CMS terminate the participation agreement of, and deem ineligible for shared savings, any ACO that does not have at least 5,000 assigned beneficiaries by the end of a given performance year. CMS proposes to remove this requirement to give the agency more flexibility to work with ACOs to increase their assigned populations and continue participation in MSSP. CMS notes that this does not change the requirement to have at least 5,000 assigned beneficiaries and ACOs will still be subject to compliance action if their assigned population falls below 5,000. NAACOS strongly supports this change, which offers more flexibility in compliance and supports continued participation in MSSP. We encourage CMS to finalize this change as proposed.

Revising Antitrust Language in Application Procedures

CMS proposes to modify MSSP regulations to remove references to the Antitrust Policy Statement, which was withdrawn by the Department of Justice and Federal Trade Commission in 2023. ACOs would still be required to agree that CMS may share application contents with Antitrust Agencies. NAACOS supports this revision, which provides clarity following the withdrawal of the Antitrust Policy Statement.

Beneficiary Notifications

CMS proposes two minor changes to the beneficiary notification requirements. First, to modify the timing requirements for the follow-up communication requirements such that it must be provided within 180 days of the initial beneficiary notification, rather than the earlier of 180 days or the next primary care service visit. NAACOS supports this change, which we have advocated for since the follow-up requirement was established in the 2023 MPFS rule.

Second, CMS proposes to modify language at § 425.312(a)(2)(iii) to clarify which beneficiaries ACOs operating under preliminary prospective assignment with retrospective reconciliation are required to furnish the beneficiary notice and follow-up to. NAACOS appreciates CMS's attempt to address issues with the beneficiary notification requirements. Unfortunately, this proposal does not resolve the issues with ACOs' ability to identify which beneficiaries must receive the notice within the required timing. Because CMS requires that the notice be provided prior to or at the beneficiary's first primary care service visit with an ACO professional, the only way to be fully in compliance would be to put all of the burden on frontline primary care practices to furnish, document, and track the notifications.

While these proposed changes are a positive step in the right direction, they do not go far enough to resolve the many issues with the beneficiary notification requirements, as outlined in our comments on the 2024 MPFS rule. These requirements present challenges for ACOs, participating providers, and the Medicare beneficiaries they serve. Some patient and consumer advocates have expressed that the notices are not valuable to patients and may exacerbate mistrust in the health care system. To address these shared concerns, NAACOS and the Health Care Transformation Task Force (HCTTF) convened a cross section of our memberships, with ACOs and patient and consumer advocacy organizations represented, to develop joint recommendations for improving beneficiary engagement in ACO programs. **We encourage CMS to implement the recommendations, which promote moving away**

from the current form letter approach to a more tailored beneficiary education and engagement plan, to advance its accountable care goals.

QUALITY PAYMENT PROGRAM

Advanced Alternative Payment Models

QP Determinations

NAACOS supports CMS's decision in the CY 2024 final rule to continue making QP thresholds determinations at the APM entity level. **NAACOS also supports the agency's proposal to broaden the definition of "attribution eligible beneficiary" for QP thresholds determinations.** This proposed change will more accurately reflect eligible clinicians' actual participation in an APM and should help reduce the instances of APM entities having to make decisions about limiting specialist participation in some models. As uptake of APMs continues to underperform original projections, NAACOS feels the agency should use a determination process that will maximize the number of QPs and promote growth in APMs. We also encourage the agency to collect and provide stakeholders with additional data on the impact this definition change has on participation in ACOs and other APMs.

Differential Conversion Factor Impact on Benchmarks

NAACOS remains concerned that the higher differential conversion factor for QPs will make it difficult for ACOs to reduce spending below benchmarks overtime. We encourage CMS to seek stakeholder input to help the agency develop proper safeguards to ensure payment updates for clinicians do not negatively impact their financial performance in their models.

Request for Information: Building Upon the MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care

CMS seeks input on the design of a future ambulatory specialty model that seeks to increase specialist engagement in value-based payment models. This model would leverage the MIPS Value Pathways (MVP) framework for specialists in ambulatory settings. Participants in the model would not receive a MIPS adjustment and instead, a payment adjustment would be based on certain cost and quality data tied to MVPs. CMS notes they are considering mandatory participation in the model, which would begin no earlier than 2026.

NAACOS opposes mandatory MVP participation by specialists to engage specialty providers in value-based care. We have serious concerns with mandating an approach built on the flawed foundation of MIPS. Specialists have raised numerous concerns with the MVPs since inception including that not all specialties have an MVP set and many MVPs rely on measures that do not indicate high quality care or reflect specialty practice. **While we do not support this model concept, we offer considerations on the areas of feedback requested:**

- Participant definition and performance assessment. Clinicians that participate in any other APM should be exempt from a future MVP-based model. Additionally, more experience is needed with the existing voluntary MVPs in MIPS to determine the measures, scoring methodology, and participants that would be best suited for a future model. CMS should publicly release detailed information on MVPs reported to date to better inform this approach.

- Payment methodology. This approach creates major challenges for attribution and small numbers. Many of the specialty cost measures do not have sufficient data to make meaningful conclusions regarding performance. While we agree with the concept of more specific comparisons between clinicians of the same type who are providing similar services to patients, this has not been successfully accomplished in the current MVP approach.
- Health information technology and data sharing. Any approach should aim to reduce provider burden in the models. As noted above, the current PI requirements do not provide meaningful information to providers. CMS should create non-financial incentives in APMs by removing burdensome requirements of MIPS. Additionally, CMS should provide data feeds to participants that are similar to the data provided in other APMs while also working to ensure that providers have appropriate access to substance use information.
- Health equity. We support CMS goals to address health equity and better support clinicians who serve underserved populations. CMS could continue to leverage dual status, Part D low-income subsidy status, and area deprivation index (ADI) as an initial tool to identify providers serving a larger proportion of underserved populations, defining approaches to give those providers enhanced benefits or scoring approaches in the model. CMS should be cautious about expanding collection of SDOH information to specialists, as this information is being collected in a variety of programs and settings. We are concerned that requiring too many points of collection will lead to beneficiary confusion.
- Multi-payer alignment. We believe that this approach will add burden and is not conducive to multi-payer alignment. We know that there currently is a lack of alignment between the MIPS measures and measures used by payers in value arrangements. We encourage CMS to seek input from payers on their arrangements that engage specialties and determine approaches for replicating those arrangements within Medicare.

CMS Should Adopt an Alternative Approach to Engage Specialists in Value Models

Given CMS's goal of having all Medicare beneficiaries in a relationship accountable for quality and cost by 2030, we urge CMS to focus on specialist engagement in total cost of care (TCOC) models. There must be a focus on allowing providers to coordinate care across the continuum of care, working together to achieve optimal patient outcomes. Instead of relying on a FFS program like MIPS, we must design payment models that bolster coordination and partnership across providers. Total cost of care APM entities are accountable for the full continuum of care. With the primary care team or the specialists providing care for a chronic condition as the foundation for coordinating ongoing patient care, the APM entity is able to support patients with referrals to specialists in the community and transitions between hospitalizations, procedures, post-acute care and back to the home. To effectively achieve these goals ACOs and other total cost of care APM entities currently partner with a broad array of specialists**.** In 2021, specialists represented 65 percent of all participants in MSSP ACOs. Additionally, typically one-third of the clinicians receiving the advanced APM incentive payment are specialists. Increasing specialist participation in total cost of care models should be prioritized over developing a payment model based on MVPs.

Below we highlight our previous recommendations for improving specialist engagement in total cost of care APMs:

Share Data on Cost and Quality Performance for Specialists with ACOs. ACOs need more data on specialist cost and quality performance to identify variations in care, partner with specialists to implement evidence-based protocols to help reduce variation, inform referrals to high-value specialists, and create financial incentives that encourage coordination across the care continuum. While we

appreciate the CMS providing data specific to the ACO, it would be more helpful to provide specialist performance data across a broader population. At a minimum, CMS should provide specialist performance data across Medicare. CMS should work to include specialist data across other payers, such as Medicare Advantage, to provide ACOs with a more wholistic and accurate picture of performance in the market. Benchmarks will then allow ACOs to understand how a specialist's data compares to the region and nation.

Leverage Episode-Based Payment Models to Create Standard Definitions for Episode Payments, Ultimately Supporting Nesting Bundles Within ACOs. Specialists are currently engaged with ACOs, Medicare Advantage, and other payers to implement bundled payments. CMS can support this work by developing industry standard definitions for episodes to be used by ACOs and other payers in the way that best suits their organization and regional market. CMS could also support ACOs who wish to voluntarily participate in an episode-based payment model or nest bundles within their ACO by creating and sharing target prices as well as quality performance data for episodes and appropriate risk adjustment for ACOs to use in designing their own nested bundles or specialist payment approaches. These increased data transparency efforts will be critical in helping ACOs to facilitate better communication among primary care clinicians and specialists. Efforts to engage specialists should allow for options from a menu set of more standardized approaches while still allowing for flexibility.

Address Policy and Program Design Elements that Currently are Prohibitive to the Inclusion of Specialists in TCOC Arrangements. There is currently strong specialist participation in TCOC models; however, there is opportunity to ensure there are strong incentives for collaboration among primary care clinicians and specialists. First, CMS should allow ACOs to negotiate contracts with specialists that would shift payment for certain services. This supports the concept of nested bundles and other negotiated payment approaches. The ACO and specialist could agree to reduce all or a portion of FFS claims payment and receive episodic payment from the ACO or share in the ACO savings. CMS employed a similar approach in the Next Generation ACO Model under its population-based payment mechanisms which allowed ACOs to enter negotiated payment arrangements with downstream providers. The provider received a reduction in FFS claims in exchange for other compensation determined by the ACO, based on quality and other utilization and outcome metrics.

Second, CMS should design TCOC program policies that support providing care to high cost, high need, seriously ill populations, and populations without a regular source of primary care. These high need populations are a strong opportunity for ACOs and community specialists to partner to improve care. Currently, certain policies such as risk score caps and ratcheting benchmarks can discourage ACOs from actively seeking inclusion of these beneficiaries. CMS has recognized the need to better address these populations through other initiatives. For example, ACO REACH has a high needs track which provides higher benchmarks for seriously ill populations. Similarly, the Oncology Care Model provided better incentives for caring for oncology patients than are provided to oncology patients in an ACO. Adequately addressing the needs of these populations will create incentives for specialists to join or partner with ACOs. Additionally, CMS should consider non-financial incentives that would encourage specialists to engage in TCOC arrangements, such as a set of ACO waivers that provide more flexibility to specialists in an ACO.

Finally, CMS should consider attribution approaches that would allow a greater portion of a specialists' patient panel to align to an ACO. Currently, specialists who join total cost of care models have only a small proportion of their patient panel in the ACO.

Address current policies that discourage specialist participation in total cost of care models.

- The MSSP quality requirement to move to eCQMs/MIPS CQMs by 2025 inadvertently penalizes ACOs with specialist participants by requiring reporting and assessment of all-payer and all-patient data rather than focusing on ACO assigned patients. As a result, specialists in the ACO are held accountable for primary care measures that are not clinically appropriate. For example, dermatologists in the ACO would be required to assess and do follow-up on depression screenings, which would not be clinically appropriate. Ultimately this would lead to artificially lowering the ACO's quality score and assessing ACOs based on the case-mix of their population and the proportion of specialists in the ACO.
- The high/low revenue distinction in MSSP discourages ACOs from including specialists. ACOs with more participating specialists are likely to have a larger percent of the ACO's revenue for all expenditures of the assigned beneficiaries. Removing the high/low revenue distinction would remove the disincentive to include specialists in the ACO.
- QP threshold policies discourage specialist participation in ACOs.
- New Promoting Interoperability requirements for Advanced APMs disincentivize participation in ACOs.

CONCLUSION

Thank you for the opportunity to provide feedback on the CY2025 MPFS 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 look forward to our continued engagement on policy changes to advance payment models that enable providers to innovate care. 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