NAACOS
Advancing Value in Health Care

Policy Implications

Boot Camp 201 – Clinical Operations

HHS/CMS Senior Leadership Takes Shape

RFK Jr.

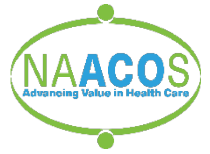
- **Heather Flick,** Chief of Staff
- ***Stefanie Spear***, Principal Deputy Chief of Staff

- **Russel Vought,** OMB Director
- **Theo Merkel,** Domestic Policy Council
- **Dr. Joel M. Zinberg**, National Economic Council

Dr. Oz

- ***Stephanie Carlton*****,** Chief of Staff
- ***Kimberly Brandt*****,** Deputy Administrator, COO
- ***John Brooks*****,** Deputy Administrator, Chief Policy and Regulatory Officer
- **Chris Klomp,** Director of Medicare
- **Alec Aramanda,** Deputy Director of Medicare
- ***Abe Sutton*****,** Director of CMMI
- ***Drew Snyder*****,** Director of Medicaid

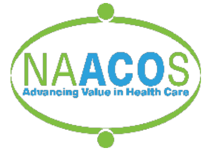
HHS Secretary RFK Jr.



"President Trump has asked me to do three things:

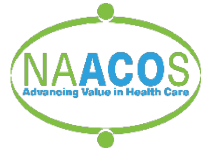
1. Clean up the corruption in our government health agencies.
2. Return those agencies to their rich tradition of gold-standard, evidence-based science.
3. **Make America Healthy Again by ending the chronic disease epidemic.**"

CMS Administrator Mehmet Oz, MD



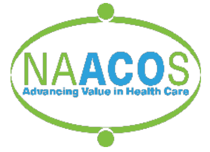
- Proponent of Medicare Advantage (MA) and has expressed concerns about coverage gaps for innovative technologies.
- "A concerning percentage of American hospitals and medical groups [have a] fee-for-service model, which has created dysfunctional and expensive incentives in health-care for decades, also suffocated their cash flow when the pandemic limited lucrative medical procedures…
- We could achieve [our] goals by buying health-care coverage for every American who is not on Medicaid through the Medicare Advantage program, which a third of Medicare beneficiaries already use very successfully." (2020)

Trump Administration: Key Themes



- **Healthcare was not a campaign priority**
- **Robust and free competition**
  - Policies that increase supply of healthcare providers in rural areas
  - Offload risk from the government
- **Patient choice**
  - Control of healthcare dollars with the patient
  - Sustainability and value for beneficiaries
- **Provider autonomy**
  - Avoid irrational reimbursement schemes
  - Reduce regulatory compliance burdens
    - Emphasis for rural
    - End quality measurement complex
    - Move away from restrictive and complicated FFS approaches to VBC approaches
  - Unleash innovation
- **Transparency**
- **Reduce fraud, waste, and abuse**

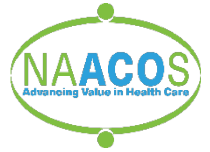
Trump Priorities for VBC



Project 2025 Highlights

- Regulations to reinstate:
  - MCIT: expedited coverage for FDA-designated breakthrough devices
  - RADV
  - MAQI: exempt providers from MIPS for participating in MA VBC arrangements
  - GPDC, currently known as REACH
- Needed statutory changes:
  - VBC: replace FFS with VBC payments; eliminate MSSP; remove barriers to direct primary care; ensure shared savings and reference pricing benefits consumers
  - MA: default option for enrollment, reconfigure risk, remove restrictions on benefits/services; give beneficiaries direct control of dollars
  - Price transparency: codify and strengthen, revisit No Suprises Act
  - Remove restrictions on physician-owned hospitals

Trump Priorities for VBC



Paragon Institute

- Eliminate VBC
  - End MIPS and other pay-for-performance programs; CMS should facilitate reporting and publication of all-payer data that is useful to patients, payers, other third parties
  - Eliminate AAPM incentives, if retained focus on all-payer participation, proportional bonus based on level of adoption
- Enact permanent payment reforms in traditional Medicare such as episode and population-based payments
- Reduce overpayments and reform PFS to incorporate market-based pricing (e.g., MA rates)
- Recent policy brief: Two Pathways for Medicare's Future: MA and ACOs

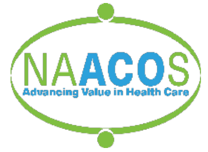
VBC Addresses Trump Priorities

- Focus on health
  - Reduction of chronic illness burden
  - Focus on primary care
  - Focus on nonmedical contributions to health (nutritional, behavioral)
- Robust and Free Competition
  - Groups of providers compete, with insurers as well
  - Pathway for providers to take on risk
  - *MSSP is on-ramp to higher risk models like GPDC, small rural/independent need significant time with lower risk to progress to direct contracting/capitation*
  - All providers should have pathways for managing risk of populations
- Patient Choice
  - Additional choice for healthcare coverage, driven by patient provider selection
  - Patient autonomy with supportive management from ACOs
  - Patients receive enhanced benefits beyond what's covered in Medicare*
- Provider Autonomy
  - Moves away from FFS structure and regulatory burden
  - Tech-enabled healthcare
- ACOs serve a critical role in identification of fraud, waste, and abuse; led the identification of massive catheter fraud

VBC Provider Priorities

- Retain and boost competition through sustainable pathways for APMs
  - Incentives to join value across all lines of business
    - VBC options available across Medicaid and Medicare Advantage
  - Ensure long-term financial viability for VBC
    - Aligned benchmarks across ACOs and MA: more comparable prospective trend approaches
  - Stable physician payment
- Enhance patient choice by allowing patients to choose VBC entities
  - Enhanced beneficiary education on options for DC/ACOs
  - Expanded voluntary alignment, explore alignment with MA
- Provider autonomy
  - Simplify quality measurement: streamlined approach that can be used across payers and uses measures meaningful to patients
  - Create pathways for all providers to participate in VBC arrangements
  - Continue to shift payment arrangements away from FFS; promote payment arrangements within total cost of care (primary care, specialty payments)
  - Expansion of allowable services/benefits for providers at risk: expanded and simplified waivers

NAACOS' Immediate Priorities for VBC Providers

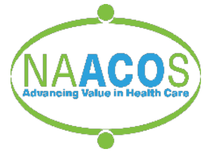


- Competition
  - Extend GPDC until 2030, create a pathway for permanence
  - Direct Primary Care (i.e., ACO PC Flex) available for all risk-bearing MSSP ACOs
  - Direct GAO/ASPE to conduct a report on benchmarks (policies that increase/decrease participation, comparability to MA)
  - Require MA to report on VBC contract availability and adoption
  - Ensure stability in MSSP by adjusting ACPT to reflect actual spending
- Patient Choice
  - Align GPDC and MSSP voluntary alignment, simplify, remove restrictions for homebound patients
  - Eliminate follow-up beneficiary notification
- Provider Autonomy
  - Make all REACH waivers available in MSSP; eliminate waiver burden (simple reporting metrics)
  - Create a process for ACOs to apply for custom waivers
  - Quality: remove PI requirement, retain WI until 2030, test reporting approaches that will benefit payers, patients

Revisiting Past Trump Admin Approaches

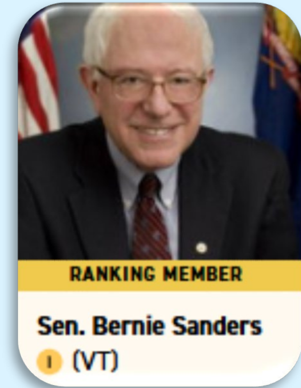
- Geographic Direct Contracting
- Rural Focused Model (CHART)
- Mandatory risk
- Mandatory participation

Senate Committee Leadership



Finance Committee

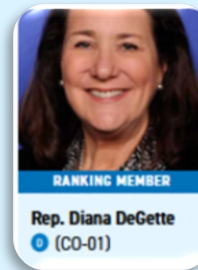
HELP Committee



House Committee Leadership

Energy & Commerce

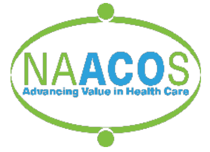
Health Subcommittee



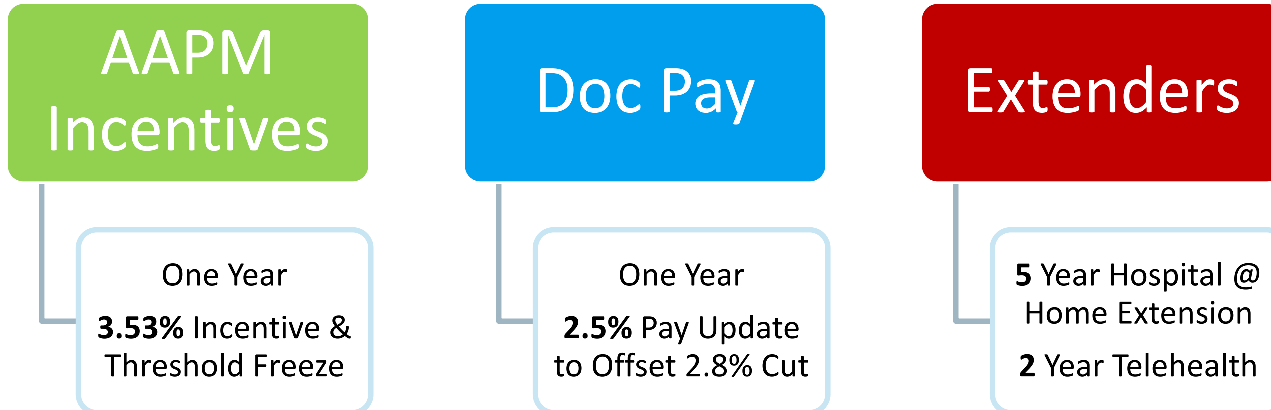
Ways & Means

Health Subcommittee

2024 Health Extenders



- In November, twenty-two of the nation's leading health stakeholder groups sent a letter calling on Congress to extend Medicare's AAPM incentives & stop physician payment cuts.
- Political disagreement stalled progress on bipartisan health agreement that included Medicare extender.
- Congressional leaders are looking for a path forward to address these health priorities in 2025.



Congressional Update

2025 Government Funding Timeline

2025 Short-term Advocacy

- Lawmakers in the House and Senate introduced legislation that would extend the AAPM incentives and address physician payment cuts.
- House Members introduced bill to delay eCQM requirements & pilot test.
- Committees and leadership working to try and identify path forward to address govt funding & Medicare extenders.

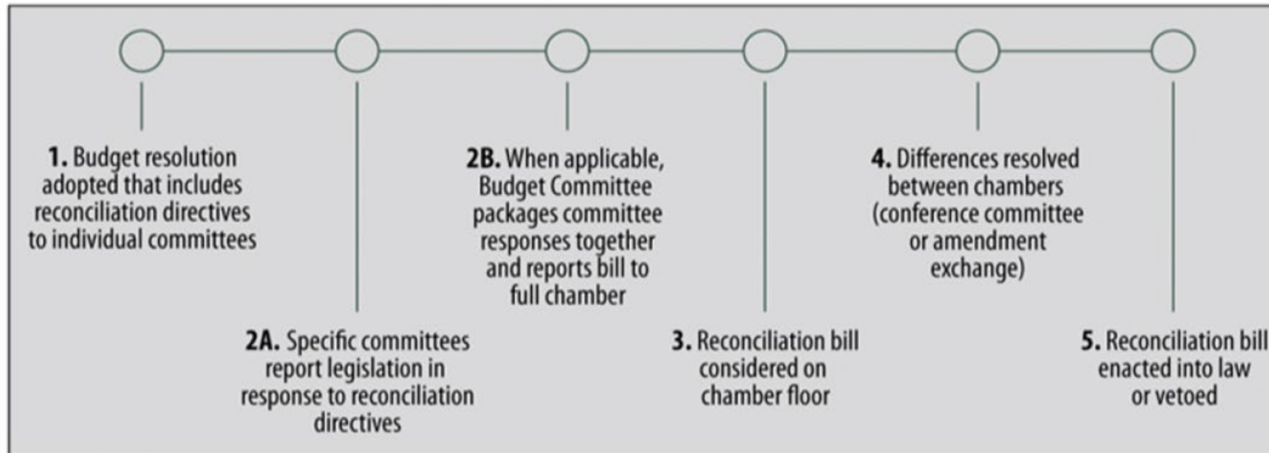
Budget Reconciliation

NAACOS Advancing Value in Health Care

GOP Budget Reconciliation Priorities

- Extension of Tax Cuts and Jobs Act Policy
- Immigration & Energy Funding
- Government Funding Reductions **($2.5 trillion)**
  - **Key Health Cuts On the Menu:** *Site-Neutral; Medicaid Reforms; ACA Changes*

Figure 1. Major Stages of the Reconciliation Process



Source: Congressional Research Service.

Medicare Payment & Reporting Bills

Preserving Patient Access to Accountable Care Act

- Extends Medicare's AAPM incentives @3.53 percent for payment year 2027 and maintains 2024 revenue and patient thresholds for qualifying APM status
  - ***Bill Sponsors:*** Reps. Darin LaHood (R-IL); Neal Dunn (R-FL); Suzan DelBene (D-WA); Kim Schrier (D-WA)

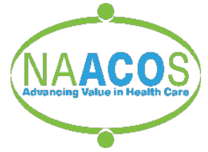
Medicare Patient Access and Practice Stabilization Act

- Stops Medicare's 2.83 percent payment cut for 2025 and provides physicians with a 2 percent payment update for the remainder of 2025 (April 1- Dec 31).
  - ***Bill Sponsors:*** Reps. Greg Murphy (R-NC); Mariannette Miller-Meeks (R-IA); Claudia Tenney (R-NY); Carol Miller (R-WV); John Joyce (R-PA); Jimmy Panetta (D-CA); Kim Schrier (D-WA); Raja Krishnamoorthi (D-IL); Ami Bera (D-CA); Raul Ruiz (D-CA)

Healthcare Efficiency Through Flexibility Act

- Delays mandatory eCQM reporting until 2030 and maintains all reporting options (including Web Interface). Requires CMS to pilot test prior to mandatory eCQM transition for ACOs.
  - ***Bill Sponsors:*** Reps. Vern Buchanan (R-FL); Dan Crenshaw (R-TX); Jimmy Panetta (D-CA)

Medicare Bills Under Development



ACO Assignment

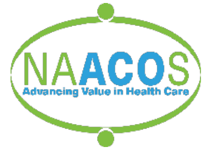
- Rep. Adrian Smith (R-NE), Rep. Suzan DelBene (D-WA), Sen. John Barrasso (R-WY), Sen. Sheldon Whitehouse (D-RI) working to reintroduce bills to expand ACO assignment to more non-physicians.
  - VBC stakeholders have raised challenges with cost concerns regarding specialist NPP attribution.

Hospital Site-Neutral

- Sens. Bill Cassidy (R-LA) and Maggie Hassan (D-NH) introduced a bipartisan legislative framework to reform hospital site-neutral payments.
  1. Establishing Site-Neutral Payments in Off-Campus Hospital Outpatient Departments
  2. Establishing Site-Neutral Payments for Common Outpatient Services
  3. Reinvesting into Hospitals
     - Rural Hospitals (Sole Community; Low Volume; Medicare Dependent)
     - High Needs Hospitals (Core lines of service; payer mix; uncompensated care etc.)
     - Value-Based Reimbursement (Bonus payments for two-side risk APMs)
       - **Option 1:** Receive an increase in reimbursements or higher capitated payment rate (PMPM)
       - **Option 2:** Rural and safety net hospitals would have benchmarks set using baseline spending prior to site-neutral changes and slowly phase out over 2 years as APM moves to risk
- Site neutral payment reforms could save $100-300 of billions over a 10-year budget window.

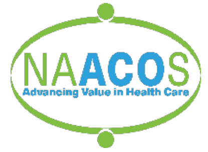
Recent Policies Impacting Clinical Operations

Behavioral Health



- 2025 MPFS rule finalized 10 new codes for behavioral health services, including:
  - Safety planning interventions—*added to definition of PC services in MSSP assignment*
  - Post-discharge phone follow up after ED visit for crisis encounter, to limit suicide risk—*added to definition of PC services in MSSP assignment*
  - Providing digital mental health treatment devices and training patients on their use
  - Interprofessional consultation for practitioners whose scope is limited to mental health diagnosis and treatment
- Primary care hybrid payment RFI included questions on including behavioral health integration services into future advanced primary care payments

Behavioral Health Integration



Ways ACOs can support BHI:

- Registries custom built for the population
  - Leverages central office in a way single practice could not
- EMR builds/upgrades that prompt PCPs to focus more on behavioral health
- Targeted outreach and follow-up for patients that are higher risk
- Data systems and reporting over time
  - Allows ACOs to identify trends and redistribute resources as needed to address community issues
- Referral network platform
  - ACOs can develop relationships with BH provider networks for PCPs to leverage with more moderate/severe BH needs
- Addressing suicidality uncovered through additional screening
  - Centralized crisis line to support PCPs when they have a patient present with suicidality

Challenges reported by ACOs:

- Cultural/Structural—Deciding between centralized vs. practice-level approach
  - Centralization
    - Pro: allows ACO to build larger caseload from multiple practices, justify resources and then build out
    - Con: limited by not being on-site, no warm handoffs; PCPs may be more skeptical/resistant to centralized approach
  - Practice-level
    - Pro: more PCP buy-in; enables warm handoffs
    - Con: caseload required for FTE; difficult to scale
- Financial
  - Upfront funding and appropriate volume needed for embedding within practices
  - Payer alignment: rates are an access barrier for commercial patients; some BHI codes not reimbursed by CMS
- Patient Engagement
  - Acquiring and documenting patient consent for digital tools

Advanced Primary Care Management

- CMS finalized new APCM services, bundle care management and communications technology-based services, began CY2025
  - Added to definition of PC services used in MSSP assignment
- Not time based, no timing restrictions, billable monthly, cannot be billed by the same practitioner for the same patient in a month as CCM, PCM, TCM, interprofessional consult, remote eval of video/image, virtual check-in, e-visits
- Required elements/practice capabilities to bill (attestation-based):
  - (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, (10) performance measurement
  - Providers in MSSP, REACH, MCP, PCF satisfy requirements (2), (9), (10) through participation

Level 1

Patients with zero to one chronic conditions

RVU = 0.25

~ $15

Level 2

Patients with two or more chronic conditions

RVU = 0.77

~ $50

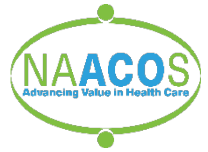
Level 3

Patients with 2+ chronic conditions who are QMBs

RVU = 1.67

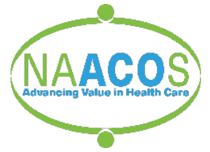
~ $110

Patient Engagement



- Recommendations for improving beneficiary engagement-related policies in ACO programs
- Orientation webinar and educational materials for ACO beneficiary board reps
- Patient and Community Engagement Deep Dive Roundtable

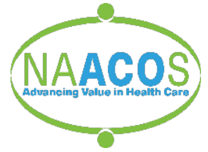
MSSP Quality: APP Plus Measure Set



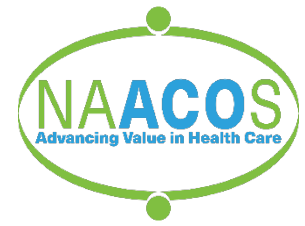
- Goal: Align with the Universal Foundation measure set

Performance Year	Finalized New Measures
PY 2025	Breast Cancer Screening (Quality #12)
PY 2026	Colorectal Cancer Screening (Quality #113)
PY 2027	Initiation and Engagement of Substance Use Disorder Treatment (Quality #305)
PY 2028 or 1 year after the eCQM specification is available	Screening for Social Drivers of Health (Quality #487) Adult Immunization Status (Quality #493)

MSSP Quality: Reporting

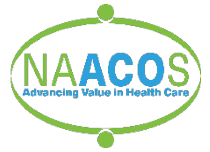


- Sunsets the Web Interface options for MSSP ACOs in PY 2025.
- Extended MIPS CQM reporting option for MSSP ACOs for an additional 2 years (PY 2025 and PY2026).
- Sunsetting of Medicare CQMs will occur no sooner than five years from now.
- Extended the eCQM reporting incentive (a lower quality performance standard) to continue encouraging ACOs to report via eCQMs.
- Extended the MIPS CQM reporting incentive for an additional 2 years (PY 2025 and PY2026).
- Added a Complex Organization Adjustment beginning in PY 2025 for all APM Entities who report eCQMs, which would provide additional points added to an ACO's quality score
- Will score Medicare CQM performance against flat benchmarks for a measure's first 2 performance years.



Recent & Upcoming NAACOS Activities

Community Engagement



- Resource on new HRSN codes in Medicare (in progress)
- Webinar on financial contracts/sustainable funding options for CBO/community care hub (CCH) partnerships (Q1-2)
- Joint resource with P2ASC on value proposition for ACOs/VBC entities contracting with CBOs/CCHs (Q2-3)
- ACO/VBC best practices resource with case study spotlights (Q3-4)
- Exploring opportunities for partnership matching (in partnership with P2ASC)

Deep Dive on Specialty Care Engagement

Key Topics to Address

- Patient Population– defining area of care and patient population (patient cohort, episodic, disease-specific)
- Payment arrangement: cap, sub-cap, withholds, risk adjustment, stand-alone v. fit within TCOC
- Rewards and Incentives
- Variation across LOBs
- Rural and Underserved Populations

Activities

- Pre-conference sessions with providers and payers
- Resource on emerging best practices for specialist engagement
- Broad stakeholder convening on policies to advance specialist adoption of APMs

VBC Playbook Series

AHIP, AMA, and NAACOS established a collaboration to identify principles and voluntary best practices to foster sustainable success in value-based care (VBC). The playbook series is intended to advance the adoption of VBC.

- Playbook of Voluntary Best Practices to Advance Data Sharing—Focused on data sharing, as a fundamental building block of VBC
- Playbook of Voluntary Best Practices for VBC Payment Arrangements—Focused on underlying payment arrangements that seek to align payment with performance on quality, cost, and patient experiences
    - Webinar recording
    - Presentation slides