May 12, 2025

Russell T. Vought
Director
U.S. Office of Management and Budget
Submitted electronically to: https://www.regulations.gov/

RE: Request for Information: Deregulation

Dear Director Vought:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the request for information (RFI) on deregulation. NAACOS is a member-led and member-owned nonprofit of nearly 500 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health care providers across the nation to improve quality of care for patients and reduce health care costs. Collectively, our members are accountable for the care of over 9.5 million beneficiaries through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and Direct Contracting/ACO REACH.

Participation in accountable care enables clinicians, health systems, and other providers to implement innovations in care delivery that keep patients healthy, better manage chronic conditions, and eliminate unnecessary care. By design, ACOs and other alternative payment models (APMs) offer financial and nonfinancial incentives for participation. The strongest nonfinancial incentives have been freedom from regulatory burdens of fee-for-service; however, in recent years the Centers for Medicare and Medicaid Services (CMS) began to reinstate some of the regulatory burden on ACOs and other APMs. We strongly support your focus on deregulation and recommend that you reduce regulatory burden in MSSP by:

- Restoring prior benchmark approaches
- Employing a quality reporting approach that leverages data in a streamlined manner
- Eliminating redundant beneficiary communications
- Improving the use of data to support whole-person care
- Standardizing waivers and simplifying implementation requirements to drive innovation

Our detailed recommendations below reflect concerns of our members and our shared goals to advance accountable care and free providers from regulatory burdens.

Restoring Prior Benchmark Approaches

CMS should remove the Accountable Care Prospective Trend (ACPT), which has significantly underestimated Medicare cost growth. While the 2024 ACPT estimated Medicare cost growth to be 4.9 percent, actual growth was nearly double (8 percent). This means that the ACPT will artificially and unfairly reduce ACO benchmarks by 1.03 percent, which, for the average ACO, could reduce revenue earned by 25 percent. Significantly underfunding ACOs will force ACOs to reconsider their approaches

for managing patients, reducing the burden of chronic illness, and providing patients with services that promote wellness but are not typically covered by Medicare. This policy was put in place to address benchmark ratchets, where ACOs are penalized for their prior success. However, this policy inadequately addresses the benchmark ratchet, lacks transparency, and risks inaccurately updating benchmarks when the prospective trend is incorrect.

Quality Reporting Burden

Focus on progression to digital quality rather than interim steps
ACOs have a desire to see more digital measurement approaches incorporated into quality reporting. An efficient, technology-enabled future where data can be shared bi-directionally to better inform patient care is the future state many in the health care industry want to achieve. Digital measurement should allow for seamless quality reporting that reduces burden and provides real-time performance data that can be used to improve patient care. This efficient, technology-enabled quality reporting is a future state ACOs are working to implement.

Unfortunately, CMS's current requirements force ACOs to make investments in infrastructure that will be wasted as ACOs would otherwise be transitioning to the HL7 Fast Healthcare Interoperability Resources (FHIR) standard. The mandatory transition to ACO electronic quality reporting is burdensome and does not move ACOs closer to true digital quality measurement (dQM) that accurately represents quality of care and provides actionable insights for quality improvement. To alleviate these burdens:

- CMS should retain access to all existing ACO reporting options during the transition to dQM, which will require appropriate industry-readiness.
- ACOs should not be required to report on any new measures during the transition to dQM to allow time for electronic health record (EHR) vendors to ensure technical capabilities and workflows are in place.

Do not impose flawed MIPS requirements on APMs
Several aspects of MSSP quality reporting have been revised to align with the Merit-based Incentive Payment System (MIPS). This is counter to the congressional intent of the Medicare Access and CHIP Reauthorization Act (MACRA), which sought to exempt physicians and other clinicians who meaningfully participate in APMs from burdensome MIPS requirements. CMS should remove burdensome requirements that were implemented to align with MIPS:

- *All-patient all-payer reporting.* This requirement 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.
- *Certified Electronic Health Record Technology (CEHRT) attestation.* Recently, CMS required ACOs and its participants to report MIPS Promoting Interoperability (PI), significantly increasing burden, without any added value, and jeopardizing participation in MSSP, particularly for small practices. CMS should revert to the previous approach using a simplified attestation.

Beneficiary Communications and Engagement

Accountable care is built on the foundation of strong patient-provider relationships. Current regulations in the MSSP hamper ACO providers' ability to effectively communicate with beneficiaries about accountable care. Rigid beneficiary notification requirements add cost and burden to ACO participants and have caused confusion and frustration for Medicare beneficiaries, in direct contrast with the intention of the requirements. Revising duplicative, complex, and burdensome requirements will help foster patient-provider relationships while improving beneficiaries' understanding of accountable care. To eliminate unnecessary burden and improve patient engagement with ACOs, CMS should:

- Eliminate the follow-up communication requirement for beneficiary notifications and vastly simplify overall beneficiary notification requirements to alleviate beneficiary confusion. ACOs know their patients best and should have flexibility in how they communicate with patients.
- Create parity between marketing rules for ACOs and Medicare Advantage (MA), which would enable ACOs to create more educational resources for beneficiaries.
- Streamline the approach for voluntary alignment to make it a more useful tool for beneficiary engagement and foster patient choice. This should include aligning the MSSP approach with signed voluntary alignment in REACH and allowing ACO providers to discuss voluntary alignment with homebound patients.

Data and Reporting

Managing populations requires access to data to understand patient health needs and analyze trends in utilization, cost, and quality. More efficient requirements around data exchange and reporting requirements for ACOs would reduce burden and improve integration of care. CMS should:

- Remove current restrictions on substance use disorder (SUD) claims data, which are currently excluded from the Claim and Claim Line Feed (CCLF) files ACOs receive, despite Congress's efforts to align 42 CFR Part 2 with Health Insurance Portability and Accountability Act (HIPAA) through Section 3221 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). This creates barriers to providing coordinated, integrated behavioral health care.
- Make the full Medicare data set available to all APM participants to facilitate accurate benchmarking and provider evaluation.
- Eliminate the ACO public reporting requirement as it is duplicative; instead require ACOs to link to publicly available data from CMS.
- Remove the monthly ACO provider reporting requirement, which does not change CMS provider records and offers no benefit while creating unnecessary burden.

Waivers and Innovation

Waivers offer APM participants unique opportunities to innovate care delivery and create a strong nonfinancial incentive to participate. Waivers available to MSSP ACOs have been limited to-date, hampering potential innovations in the permanent program. Further, arduous documentation and implementation requirements to utilize waivers have hindered their use. To unlock innovation in Medicare's value models, CMS should:

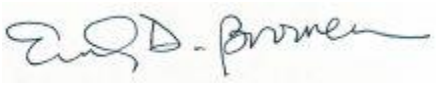
- Implement all Innovation Center waivers in MSSP and allow a process for APM participants to recommend and test new waivers.
- Simplify required reporting for waiver implementation and use.
- Allow ACOs to select subpopulations for which to implement waivers.

- Expand access to primary care capitation in MSSP by simplifying the payment approach from what is in the ACO Primary Care Flex Model and allowing all MSSP ACOs the option to elect primary care capitation and shift the underlying payment mechanism away from fee-for-service.
- More closely align APM waivers with MA flexibilities; for example, by waiving the scheduling restriction on Annual Wellness Visits (AWVs) and instead allowing AWVs to be scheduled once per calendar year.

CONCLUSION

Thank you for the opportunity to provide feedback on eliminating burdensome regulations to improve innovation in value-based care. 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 reducing administrative burden. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,



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