NAACOS Analysis of the CY 2026 Proposed Medicare Physician Fee Schedule

Executive Summary

On July 14, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule. It proposes significant changes to payment for skin substitutes but contains minimal changes for the Medicare Shared Savings Program (MSSP).

In this analysis, we provide details on key proposals affecting ACOs. The rule is summarized in several fact sheets provided by CMS: PFS Fact Sheet, MSSP Fact Sheet, Quality Payment Program (QPP) Fact Sheet, and Ambulatory Specialty Model (ASM) Fact Sheet.

Comments to CMS in response to the proposed rule are due on September 12 and may be submitted via regulations.gov. NAACOS is seeking member input on the proposals in this rule, which will help shape our comments. Please share your feedback by emailing us at advocacy@naacos.com. NAACOS will provide draft comments ahead of the deadline. CMS will review comments and issue a final rule later this year; typically, by November 1.

Medicare Physician Payment Proposals

- Implements a Congressionally directed 2.5 percent update to the conversion factor (CF) for 2026.
    - Qualifying APM CF: Increases from $32.35 to $33.59 representing a +3.83 percent increase.
    - Non-qualifying CF: Increases from $32.35 to $33.42 representing a +3.62 percent increase.
- Modifies payment policies for skin substitutes by:
    - Paying for skin substitutes as incident-to supplies,
    - Aligning skin substitute categories with Food and Drug Administration's (FDA) regulatory statuses, and
    - Establishing a single payment rate based on the highest average for the three FDA approval categories of skin substitute products.
- Revises the practice expense methodology.
- Creates behavioral health add-on codes for behavioral health integration and Collaborative Care Model services as an optional addition to Advanced Primary Care Management services.
- Expands payment policies for digital mental health treatment services to cover devices used in the treatment of attention deficit hyperactivity disorder.
- Streamlines the process for adding services to the Telehealth Services List.

Medicare Shared Savings Program Proposals

Eligibility and Participation Options:

- Reduces the maximum amount of time inexperienced ACOs may participate under a one-sided model from 7 years spanning two agreement periods to 5 years in a single agreement period.

- Requires ACOs to report certain changes to the participant list during the performance year when ACO participant TINs or SNF affiliate TINs undergo a change of ownership.
- Amends eligibility requirements to allow participation of ACOs with fewer than 5,000 beneficiaries in Benchmark Year 1, 2, or both.

Benchmarks:

- Renames the Health Equity Benchmark Adjustment as the "population adjustment."

Assignment:

- Adds three new codes to and removes one code from the definition of primary care services used in assignment.

Quality:

- Removes the health equity adjustment applied to an ACO's quality score beginning in performance year 2025 and revises terminology used to describe the adjustment.
- Revises the definition of a "beneficiary eligible for Medicare CQMs" to more closely align with the assignable population.
- Updates the MSSP quality measure set by removing the Screening for Social Drivers of Health measure.
- Expands the survey modes for the CAHPS for MIPS survey to include a web-mail-phone administration protocol beginning in performance year 2027.
- Expands the application of the extreme and uncontrollable circumstances policies for quality and financial performance to ACOs that are affected by a cyberattack beginning in performance year 2025.
- Modifies ACO monitoring and compliance actions to account for the alternative quality performance standard, codifying current practice.

Quality Payment Program Proposals

Advanced APMs:

- Modifies Qualifying APM Participant (QP) determinations by making determinations at both the individual and APM entity level, while also adding "covered professional services" to QP determinations.

MIPS:

- Maintains the MIPS performance threshold of 75 points through the 2028 performance period.
- Modifies measures for the promoting interoperability performance category.
- Creates a new mandatory Ambulatory Specialty Model to hold specialists accountable for the upstream management of chronic conditions, including low back pain and congestive heart failure, with the model set to begin January 1, 2027, and run for 5 performance years.
- Requests feedback on the transition to digital quality measurement, measures related to wellbeing and nutrition, data quality, and other potential changes to the MIPS program.

PHYSICIAN PAYMENT AND POLICY CHANGES

Payment Update

CMS proposes CY 2026 Medicare conversion factor (CF) increases based on a Congressionally directed one-year increase of 2.5 percent, in addition to the differential CF updates directed by the Medicare Access and CHIP Reauthorization Act (MACRA). These payment updates result in a QP CF of $33.59, a 3.83 percent increase from 2025, and a non-QP CF of $33.42, a 3.62 percent increase from 2025. NAACOS will continue its advocacy, in partnership with other stakeholders, to seek long-term improvements to physician payment updates.

Efficiency Adjustment and Practice Expense

In the proposed rule, CMS raises a variety of concerns with the utilization of the American Medical Association (AMA) Relative Value Scale Update Committee ("RUC") for determining physician work Relative Value Units (RVU) values in the Medicare PFS, which CMS indicates tend to benefit specialty practices more than primary care. To address this, for CY 2026, CMS proposes a -2.5 percent "efficiency adjustment" to all physician work RVUs that are not timed-based codes (i.e., excluding time-based codes such as evaluation and management visits from the negative adjustment). This would periodically apply to all procedure-based codes, which include those most commonly billed by surgical specialists, radiology and pathology specialists, and others. The -2.5 percent adjustment is derived from the CMS Actuary's Medicare Economic Index (MEI) productivity adjustment, aggregated over the past five years.

CMS is also proposing changes to the calculation of practice expense (PE) RVUs and raises concerns about:

- Sample sizes, representativeness, completeness of data, and measurement error related to the AMA's 2024 Physician Practice Information (PPI) survey; and
- The degree to which facility PE RVUs accurately reflect indirect PE costs, given the shift to hospital employment of physicians.

Based on these concerns, CMS is proposing to not utilize the 2024 PPI Survey or the Clinical Practice Information (CPI) survey to determine PE values for CY 2026. CMS is also proposing to reduce the portion of facility PE RVU values that are allocated based on physician work RVUs to equal half the amount allocated to non-facility PE RVUs, beginning in 2026. CMS also proposes utilizing Outpatient Prospective Payment System (OPPS) data to determine PE RVUs for certain radiation therapy and remote monitoring services. CMS estimates that the change to facility PE RVU values will result in a 7 percent decrease in total RVU valuation for specialties primarily practicing in facility settings and 4 percent increase in RVU valuation for specialties primarily practicing in non-facility settings.

Combined, the efficiency adjustment and PE policy, are the primary drivers of a +0.55 percent budget neutrality adjustment to the Medicare PFS conversion factor. As a result, CMS estimates that for almost all specialties, the efficiency adjustment would result in payment changes within the range of +1 percent to -1 percent.

Evaluation and Management Visits

CMS proposes a payment policy change for the office/outpatient (O/O) evaluation and management (E/M) visit complexity add-on code G2211. This code was finalized for use beginning in CY 2024. The

agency proposes expanding the visit complexity code by allowing G2211 to be billed as an add-on code with the home or residence E/M visit code family, which will support longitudinal care relationships for home-based primary care practices and their homebound patients.

Telehealth

CMS proposes several changes to the 5-step review process to simplify and expedite the ability of the agency to add and retain services on the Telehealth Services List. CMS proposes to make permanent the current virtual supervision flexibilities for several additional service types. CMS also proposes terminating virtual supervision flexibilities for teaching physicians supervising services of residents at teaching hospitals.

Policies to Improve Care for Chronic Illness, Behavioral Health, and Enhanced Care Management

Updates to Payment for DMHT - Clarifying the Billing Practitioner
CMS clarifies that the billing practitioner who utilizes the three approved HCPCS codes for Digital Mental Health Treatment (DMHT) devices (G0552, G0553, and G0554) does not need to be the same practitioner who made the original patient mental health condition diagnosis.

Additionally, CMS proposes an expansion of payment policies for these HCPCS codes to also make payment for DMHT devices classified as a digital therapy device for attention deficit hyperactivity disorder (ADHD) defined at § 882.5803 and those cleared under section 510(k) of the FD&C Act or granted De Novo authorization by the FDA. CMS indicates that this expansion is important to fully reflect the change of behavioral health disorders treated by FDA-authorized products. CMS recognizes that Medicare fee-for-service (FFS) claims data for these codes have remained low in volume due to the previously finalized condition of payment requiring full FDA approval of devices. Issues with the current direct-to-consumer delivery and payment model may require future changes to the existing contractor-priced status for HCPCS code G0552, but no changes are proposed at this time due to the rapidly evolving technologies and DMHT therapies, and the lack of sufficient information needed to establish national pricing for devices described by HCPCS code G0552.

Request for Information: Payment Policy for Software as a Service
CMS seeks feedback on future payment policy for Software as a Service (SaaS) to accommodate the use of software-based technologies to support clinical decision-making in outpatient and physician office settings. As the data in the PE methodology has aged and more services have begun to include innovative technologies such as artificial intelligence (AI), the costs for these technologies are not well accounted for in the PE methodology. CMS received PPI survey data from AMA that incorporates practice costs associated with SaaS and AI services, but the data reflected the PE per hour associated with a given specialty, rather than insight into the direct costs associated with the use of these technologies.

Several issues noted by CMS include the wide variations in associated costs of clinically similar SaaS technologies, and that research and development (R&D) and software maintenance costs are often not publicly verifiable. Additionally, there are rarely existing medical items or services that can be compared to determine clinical and resource similarities, ultimately resulting in a limited amount of data on these services.

Request for Information: Prevention and Management of Chronic Disease
In alignment with the Trump Administration Executive Order, "Establishing the President's Make America Healthy Again Commission," CMS seeks feedback on the enhancement and support of prevention and chronic disease management. To help ensure Medicare coverage is flexible to support beneficial lifestyle changes, the RFI seeks input on the following topics:

- Self-management of chronic disease and improved physical activity,
- Services to address social isolation and loneliness for people with Medicare, and
- Separate coding and payment for motivational interviewing, intensive lifestyle interventions, medically tailored meals, FDA-cleared digital therapeutics, and partnerships with local aging and disability organizations.

Community Health Integration and Principal Illness Navigation for Behavioral Health
CMS proposes to clarify that in addition to clinical social workers (CSWs), marriage and family therapists (MFTs) and mental health counselors (MHCs) can bill Medicare directly for community health integration (CHI) and principal illness navigation (PIN) services they personally perform for the diagnosis or treatment of mental illness and that these providers can also perform CHI and PIN services as auxiliary personnel under the general supervision of a billing practitioner. CMS further clarifies, in the absence of state-level requirements, when CSWs, MFTs, and MHCs perform these services as auxiliary personnel under general supervision that they meet the certification or training requirements to perform all CHI and PIN services elements.

Additionally, CMS proposes to allow CPT codes for Psychiatric Diagnostic Evaluation and the Health Behavior Assessment and Intervention (HBAI) to serve as initiating visits for CHI services. CMS indicates that these codes are most analogous to the E/M codes that are currently included as initiating visits for CHI services furnished by practitioners in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness.

Services Related to Upstream Drivers of Health
CMS proposes to eliminate coding and payment for the Social Determinants of Health (SDOH) Risk Assessment code (HCPCS code G0136) and remove the code from the Telehealth Services List beginning January 1, 2026. In its rationale, CMS states that the resource costs described by the code are already accounted for in other codes, such as E/M visits. CMS also proposes conforming regulation text updates at 42 CFR 410.15 to revise the definitions of the first and subsequent annual wellness visit to include personalized prevention plan services.

Additionally, CMS proposes revisions to regulation text to replace the term "social determinants of health" with the term "upstream drivers," as the agency believes this terminology is more comprehensive and includes a variety of factors that can impact the health of Medicare beneficiaries.

Integrating Behavioral Health into Advanced Primary Care Management
CMS proposes to create optional add-on codes for advanced primary care management (APCM) services to facilitate the provision of complementary behavioral health services by removing the time-based requirements of existing behavioral health integration (BHI) and psychiatric Collaborative Care Model (CoCM) codes for beneficiaries receiving APCM services. The proposed add-on codes would be considered "designated care management services" and could be provided by auxiliary personnel under the general supervision of the billing practitioner. CMS indicates that removing the time-based requirements will reduce documentation burden on practitioners and requirements for billing, thus improving access to BHI and CoCM services for primary care patients.

- CMS proposes the addition of three add-on codes, GPCM1 (initial psychiatric CoCM services), GPCM2 (subsequent psychiatric CoCM services), and GPCM3 (general BHI services) for APCM services. These codes can be billed when the APCM base code is reported by the same practitioner in the same month for the beneficiary.
- CMS proposes to value the APCM add-on codes using direct crosswalks to the current valuations for initial and subsequent CoCM services and general BHI services (CPT codes 99492, 99493, and 99484).

Request for Information: APCM and Prevention
CMS seeks feedback on several issues to inform future proposals for APCM services:

- Cost sharing arrangements if APCM includes both preventative services and other Part B services,
- Specific preventative services and screening measures to be included in the APCM bundle, with additional codes as needed,
- New prospective monthly APCM payments to MSSP ACOs for application within primary care practices, and
- Payment reconciliation under the ACO benchmark.

NAACOS supported the introduction of APCM services to reduce the burden of documentation associated with time-based care management services and has also encouraged the agency to expand opportunities for hybrid primary care payment options in MSSP. As with other care management services, cost sharing is often a deterrent to obtaining beneficiary consent. We appreciate that CMS is exploring opportunities to expand the use of APCM services by ACO providers and to reduce or waive cost sharing for APCM services to increase uptake.

Payment for Skin Substitutes

Skin substitute procedures are a growing area in wound care that involve preparation of a wound, the use of at least one skin substitute product (typically a human/cellular tissue product), and application of the skin substitute to a wound through suturing. Under current Medicare PFS policy, CMS reimburses community-based physician practices for the cost of the skin substitute product itself by paying for the skin substitute product as if it were a biologic—providing a payment amount equal to the average sales price (ASP) plus 6 percent. However, most skin substitutes are not approved by the FDA as biologics and instead are merely registered as Human Cells, Tissues, and Cellular and Tissue-based Products ("HCT/Ps"). Other skin substitutes are cleared by FDA as devices, through the Pre-Market Approval (PMA) process, or the 510(k) device clearance process.

Medicare Part B spending on skin substitutes has grown rapidly—from $250 million in 2019 to more than $10 billion in 2024, a nearly 40-fold increase, while the number of patients receiving skin substitutes has only doubled. To address this, CMS proposes to shift payment in both the Medicare PFS and the OPPS to a method that provides separate payment for skin substitute products as a supply that is used for a wound care procedure on an incident-to basis, rather than paying based on the skin substitute product's specific ASP. This policy will NOT apply to skin substitutes approved by FDA as biologics. Those classified as biologics will continue to be paid at ASP plus 6 percent.

By shifting to an incident-to supply method of payment, the payment is no longer tied to the individual ASP of the specific skin substitute product. Instead, CMS will establish three categories for skin substitutes:

- Skin substitutes registered with FDA as HCT/Ps,
- Skin substitutes cleared through FDA's 510(k) clearance for devices, and
- Skin substitutes approved under FDA's PMA process for devices.

For 2026, CMS will establish an initial payment rate for all three categories that is equal to the highest volume-weighted average ASP among the three categories, which CMS has indicated will be the volume-weighted average ASP for the HCT/P category. As a result, for 2026, CMS proposes an initial payment rate of $125.38 per square centimeter, compared to current individual ASP payments frequently in excess of $1,000 per square centimeter. In future years, CMS will establish separate payment rates for each of the three categories based on the volume-weighted average ASP for the specific category, utilizing only OPPS data to determine volume.

CMS is limiting the volume-weighting calculation to only OPPS data because until now, OPPS payment for skin substitutes has been packaged into the overall OPPS payment for the wound care procedure—which has incentivized the use of the lowest-cost skin substitute that is clinically effective (whereas CMS believes that volume in PFS has been distorted based on incentives related to ASP pricing/reimbursement). CMS estimates that this payment change will reduce Medicare spending on skin substitutes by $9.4 billion in 2026.

MEDICARE SHARED SAVINGS PROGRAM

Participation Options

Basic Track – Glide Path

CMS proposes changes to the amount of time an inexperienced ACO can remain under a one-sided model. CMS notes that historical trend analyses show that ACOs transitioning to or remaining in two-sided risk levels of the Basic track outperform ACOs remaining in one-sided models of the Basic track. Specifically, CMS proposes that participation in a one-sided model under the Basic track's glide path will be limited to the first agreement period and reduced from 7 to 5 performance years.

- For inexperienced ACOs with agreement periods beginning on or after January 1, 2027, the ACO can enter the Basic track's glide path at Level A and remain under the one-sided model for its first 5-year agreement period. The ACO must then enter its second or subsequent agreement period under Level E of the Basic track or the Enhanced track.
- ACOs currently participating in a first agreement period under the Basic track's glide path (with 2022, 2023, 2024, or 2025 start dates) and ACOs entering a first agreement period with a January 1, 2026, start date, would be ineligible to enter a subsequent agreement period under the Basic track's glide path, with a start date on or after January 1, 2027. Such ACOs continuing their participation for a second or subsequent agreement period would be limited to participation in Level E of the Basic track or the Enhanced track.

Eligibility Requirements

Change in Ownership Reporting

CMS proposes that beginning January 1, 2026, ACOs will be required to amend participant lists when a change in ownership (CHOW) results in a tax identification number (TIN) that is newly enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS) with no prior Medicare billing claims history during the performance year or outside the annual change request cycle. Similar requirements are proposed for an ACO's skilled nursing facility (SNF) affiliate list if a SNF affiliate undergoes a CHOW resulting in a change to the Medicare enrolled TIN. Following CMS approval of an ACO's change request for an affiliated SNF, the ACO is responsible for confirming with the Medicare administrative contractor (MAC) that the change has been fully effectuated.

Without the ability to report an ACO participant TIN's CHOW and effectuate change in an ACO's participant list, a gap in attribution for beneficiaries served by participant may cause the assigned beneficiary count to drop below 5,000 and negatively impact the ability to meet eligibility requirements. NAACOS supports this change.

Eligibility and Related Financial Reconciliation Requirements

CMS proposes to modify ACO eligibility requirements starting January 1, 2027, so that ACOs entering a new agreement period must have at least 5,000 assigned beneficiaries in Benchmark Year (BY) 3, but can have less than 5,000 assigned beneficiaries in BY1, BY2, or both. These ACOs must enter the Basic track and their shared savings and losses will be capped at a lesser amount to reflect ACO program performance versus normal expenditure variation. Such ACOs would be excluded from policies providing increased opportunities for shared savings in the Basic track, such as those for certain low revenue ACOs.

Approximately 2 percent of ACO applicants were historically denied from entering a new agreement due to having fewer than 5,000 assigned beneficiaries in BY1, BY2, or both, while still having more than 5,000 assigned beneficiaries in BY3 and meeting all other program requirements. New, renewing, or re-entering ACOs that have successfully completed the program and were impacted by the previous policies can now continue their program participation. NAACOS supports this change.

Beneficiary Assignment

Definition of Primary Care Services Used in Assignment

CMS proposes the following revisions to the definition of primary care services that it uses to assign beneficiaries to ACOs, effective January 1, 2026:

- Adding codes for Enhanced Care Model Management Services (HCPCS codes GPCM1, GPCM2, GPCM3), if finalized under Medicare FFS payment policy. These codes are proposed to allow for payment when BHI or CoCM services are furnished in conjunction with APCM services. Codes for APCM services (G0556, G0557, and G0558) were added to MSSP assignment beginning in PY2025. Additionally, the new behavioral health add-on codes mirror existing CPT codes 99484, 99492, and 99493, which are already included in the definition of primary care services used in assignment.
- Removing the code for SDOH risk assessment (HCPCS code G0136) from use in assignment, if the proposed deletion of the code is finalized.

Quality

Definition of a "Beneficiary Eligible for Medicare CQMs"
CMS proposes to revise the definition of a "beneficiary eligible for Medicare CQMs" to more closely align with the assignable population, effective January 1, 2025. CMS notes that experience of providing ACOs quarterly Medicare CQM beneficiary lists for PY 2024 highlighted the complexity of the current definition and caused confusion for ACOs. Specifically, differences between the beneficiary information included in the Medicare CQM beneficiary lists and the assignable or assigned beneficiary files ACOs receive created concerns about which beneficiaries ACOs must include in Medicare CQM reporting.

The revised definition, if finalized, would be:
—a beneficiary eligible for Medicare CQMs "had at least one primary care service with a date of service during the applicable performance year from an ACO professional who is a primary care physician or who has one of the specialty designations included at § 425.402(c), or who is a physician assistant, nurse practitioner, or clinical nurse specialist."

This replaces the term "claims" with "primary care services" and replaces "measurement period" with "performance year" to align with terms used in MSSP assignment methodology. This change is intended to reduce ACO burden when patient matching to report Medicare CQMs. Analysis showed that the revised definition would increase the overlap between the Medicare CQM beneficiary lists and the assignable beneficiary lists to 85 percent, on average. CMS is proposing to apply this change retroactively for PY 2025 because it is in the public interest to reduce burden on ACOs and allow them to dedicate greater resources to care coordination and care delivery enhancements. To support ACOs in preparing for this proposed change, CMS will add an additional variable to the quarterly lists ACOs receive to flag each beneficiary who had a primary care service visit beginning with the PY 2025 Quarter 2 list. NAACOS has previously raised with CMS the operational complexity that ACOs encounter when identifying the Medicare CQM beneficiary population. We appreciate that CMS has proposed this change beginning with the 2025 performance year.

Health Equity Adjustment
CMS proposes to remove the health equity adjustment applied to an ACO's quality score beginning in PY 2025. The agency states that it would be "contrary to the public interest" not to apply this change retroactively and that the change aligns with the Administration's priority to streamline regulations.

In its rationale, CMS believes that ACOs that have received health equity adjustment bonus points are likely to also meet the criteria for the eCQM/MIPS CQM reporting incentive. As CMS has previously stated, it believes that increasing the number of quality measures in the APP Plus quality measure set "will afford ACOs expanded opportunities to satisfy the eCQM/MIPS CQM reporting incentive criteria." Additionally, the agency states that the health equity adjustment and the Complex Organization Adjustment (COA) are duplicative because they serve a similar function. NAACOS believes these arguments are flawed because the MIPS CQM reporting incentive is set to end after PY 2026 and the COA only applies for ACOs that are able to report eCQMs, whereas the health equity adjustment bonus points are available for all reporting options and support ACOs based on characteristics of the assigned beneficiary population.

CMS also proposes revising certain regulation terminology to avoid confusion. CMS proposes to apply the term "quality score" consistently to mean an ACO-level quality score and "quality performance score" consistently to mean a measure-level score. Additionally, the agency proposes to replace the phrase "health equity adjustment bonus points" with "population and income adjustment bonus points" in describing the adjustment for PY 2023 and PY 2024 to more accurately reflect the data used to

calculate the adjustment. The agency is not proposing any changes to the methodology currently used to calculate the bonus points or the health equity adjusted quality performance score for PY 2023 and PY 2024.

APP Plus Measure Set

In the CY 2025 PFS rule, CMS changed the required measure set for MSSP ACOs by replacing the APM Performance Pathway (APP) measure set with the new APP Plus measure set, which incrementally adds measures over time to align with the Universal Foundation. For PY 2026, CMS is proposing minor changes to measures included in the APP Plus quality measure set, including:

- Removing *Quality ID: 487 Screening for Social Drivers of Health* from the APP Plus quality measure set, which was set to be added in PY 2028.
- Revising the eCQM specification for *Quality ID: 134 Preventive Care and Screening: Screening for Depression and Follow-up Plan* by updating the guidance for pharmacological interventions and the follow-up plan. This would clarify policies for when two screenings are documented on the same date/time with different results and update the numerator to clarify that pharmacological interventions include prescribed or active depression medications.
- Updating *Quality ID: 112 Breast Cancer Screening* by expanding the age range for the eCQM specification to women 40-74 years of age, which aligns with the MIPS CQM specification, and adding a definition of "reviewed" for all data collection types to clarify what must be documented in the medical record to meet the quality action.
- Updating *Quality ID: 113 Colorectal Cancer Screening* by adding a definition of "reviewed" for all data collection types to clarify what must be documented in the medical record to meet the quality action. In this proposal, CMS mistakenly refers to a mammography report in reference to the screening. NAACOS will clarify with CMS what the updated definition will be for this measure.
- Updating *Quality ID: 484 Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions* to remove the denominator exclusion for patients assigned to clinicians who achieve Qualifying APM Participant (QP) status and therefore do not participate in MIPS.

Table 51 in the proposed rule summarized the measures included in the APP Plus quality measure set for MSSP ACOs beginning in PY 2028, or one year after the eCQM specification becomes available for Quality ID: 493, whichever is later.

CAHPS for MIPS Survey

In the CY 2025 PFS proposed rule, CMS sought feedback on adding a web-based survey mode to the current mail-phone protocol for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which could increase CAHPS response rates by 13 percent. NAACOS responded in support of the change but also continued to raise concerns with using CAHPS surveys to evaluate patient experience.

In this rule, CMS is proposing to add a web-based survey mode beginning in PY 2027. Vendors would be required to administer the CAHPS for MIPS Survey via a web-mail-phone protocol. Additionally, CMS would require CMS-approved survey vendors submit the range of costs of their services, including the cost of adding the web survey mode as part of the overall costs of CAHPS for MIPS Survey administration publicly reported by vendors, beginning with PY 2026.

Request for Information: Toward Digital Quality Measurement in CMS Quality Programs
CMS is seeking input on the transition to digital quality measurement (dQM) as it seeks to fully move to dQM in its quality reporting and value-based payment programs. Specifically, CMS is requesting feedback on its intended approach of moving to the Fast Healthcare Interoperability Resources (FHIR) standard for eCQM reporting before ultimately moving to FHIR-based digital quality measures (dQMs). A similar request for information (RFI) was included in the proposed Inpatient Prospective Payment Systems (IPPS) rule, to which NAACOS responded with our initial thinking.

In this version of the dQM RFI, CMS includes specific questions related to FHIR-based eCQMs for MSSP and the MIPS quality performance category. Questions fall within the following categories:

(1) FHIR-based eCQM conversion progress;
(2) Data standardization for quality measurement and reporting;
(3) The timeline under consideration for FHIR-based eCQM reporting;
(4) Measure development and reporting tools; and
(5) FHIR Reporting and Data Aggregation for ACOs.

CMS states it will consider feedback on this RFI as the agency refines its dQM transition efforts. NAACOS supports the overall goal of transitioning to a dQM approach that leverages interoperable data sources seamlessly integrated at the point of care—reducing administrative burden and enhancing patient care. However, we are concerned that CMS' proposed approach may increase burden and waste valuable time and resources without meaningfully moving the industry closer to the tech-enabled future we want to achieve. NAACOS will provide in-depth comments in response to this RFI and will continue to advocate for CMS to address flawed and burdensome quality reporting requirements for ACOs and provide sensible protections for ACOs during the transition to dQM.

Extreme and Uncontrollable Circumstances Policies

CMS proposes revising the Extreme and Uncontrollable Circumstances (EUC) policies for MSSP ACOs to explicitly address ACOs affected by an EUC due to a cyberattack, including ransomware/malware, effective retroactively beginning in PY 2025. CMS notes that it is in the public interest to apply these policies beginning in PY 2025 because ACOs' reliance on digital infrastructure and third-party vendors makes them increasingly vulnerable to cyberattacks and it would not be in the best interest of an ACO's patient population to disadvantage an ACO from earning shared savings. In its rationale, CMS cites examples of how cyberattacks could impede an ACO's ability to successfully meet the MSSP quality performance standard.

Current MSSP EUC policies are aligned with the Quality Payment Program's (QPP) automatic EUC policy, which accounts for natural disasters and other EUCs that impact an entire region or locale. Due to the nature of cyberattacks, which would not necessarily affect an entire region or locale, CMS believes there is a need to revise the quality and finance EUC policies to account for an ACO affected at the legal entity level through the MIPS EUC Exception application process.

EUC Policy to Determine Quality Performance
CMS proposes that for PY 2025 and subsequent years, if an ACO is affected at the legal entity level by an EUC due to a cyberattack and wants relief from MSSP quality reporting requirements, the ACO must submit a MIPS EUC Exception application to QPP as an APM Entity for the affected performance year. If approved, CMS would then apply the MSSP quality and finance policies at § 425.512(c), 425.605(f), and

425.610(i) to provide relief from quality reporting requirements and mitigate shared losses, if applicable, for the affected performance year.

If an ACO with an approved MIPS EUC Exception application for a cyberattack chooses to report the APP Plus quality measure set, meets data completeness, and receives a MIPS quality performance category score, then CMS would use the higher of the ACO's quality score or the equivalent of the quality performance standard threshold (40th percentile across MIPS quality performance category scores).

EUC Policy to Determine Financial Performance
Under current policies, ACOs that CMS determines have been affected by an EUC will have any shared losses reduced by the proportion of the year, determined by total months, affected by the EUC and the percentage of the ACO's assigned beneficiaries residing in EUC-affected areas. Because the MIPS EUC Exception application does not differentiate geographic area(s) affected, CMS would be unable to determine the percentage of assigned beneficiaries in an EUC-affected area based on an ACO's submission of an EUC Exception application due to cyberattack. Therefore, CMS proposes to apply MSSP finance EUC policies to 100 percent of an ACO's assigned beneficiaries when the ACO has a MIPS EUC Exception for a cyberattack approved by QPP for the affected performance year.

For determining the proportion of the year affected by an EUC due to cyberattack, CMS proposes to use the start and end date included in the MIPS EUC Exception application. CMS also proposes that if an end date is not included in the ACO's MIPS EUC Exception application, then CMS would apply a 90-day default duration for purposes of mitigating shared losses. If the MIPS EUC Exception application has a start date that is less than 90 days before the end of the performance year, CMS proposes that December 31 would be the end date. If an ACO is affected by an EUC that persists over multiple performance years, the ACO would be required to submit a MIPS EUC Exception application for each affected performance year. Section III.F.7.d. of the proposed rule provides example scenarios of how these policies would be applied.

Benchmarking Methodology

Population Adjustment
For PY 2025 and subsequent performance years, CMS proposes the "Health Equity Benchmark Adjustment (HEBA)" will be renamed the "Population Adjustment" and the "HEBA scaler" is renamed to "Scaler," reflecting a new rationale. No changes will be made to the methodology used to calculate the current health equity benchmark. The adjustment is key for investments needed by rural providers and underserved communities as 45 percent of the ACOs receiving the HEBA in 2025 would not have qualified for the prior savings adjustment or positive regional adjustments, resulting in a less favorable benchmark.

QUALITY PAYMENT PROGRAM

Merit Based Incentive Payment System (MIPS)

Promoting Interoperability
CMS proposes updates to the measures included in the promoting interoperability (PI) performance category, effective January 1, 2026, as follows:

- Modifies the Security Risk Analysis measure to include a second component requiring an affirmative attestation of having conducted security risk management;
- Modifies the High Priority Practices Safety Assurance Factors for Electronic Health Record Resilience (SAFER) Guide measure by requiring use of the 2025 SAFER Guides published in January 2025, rather than the 2016 version currently included in the measure;
- Adopts the Public Health Reporting using Trusted Exchange Framework and Common Agreement (TEFCA) measure as an optional bonus measure under the Public Health and Clinical Data Exchange objective.

Additionally, CMS proposes adopting a measure suppression policy to provide flexibility to exclude a measure from scoring or the determination of a meaningful EHR user due to circumstances that impede effective measurement. CMS would determine whether certain circumstances exist to warrant suppression, based on consideration of:

- The nature, breadth, and duration of the circumstance's effects on reporters' ability to fulfill the measure requirement;
- Availability of certified health IT modules to fulfill the measure;
- If the circumstance affects the measure such that calculating the score would lead to misleading or inaccurate results;
- Out-of-date or conflicting technical standards;
- Technical or operational capacity of required partners; or
- Other factors as determined by CMS.

CMS also proposes to suppress the Electronic Care Reporting measure by excluding the measure from scoring for PY 2025 because the Centers for Disease Control and Prevention (CDC) has temporarily paused electronic case reporting registration and onboarding of new health care organizations while establishing a more efficient and automated process. If finalized, eligible clinicians and hospitals would still be required to report the measure, but CMS would exclude it from calculations for scoring purposes.

Requests for Information

CMS included several additional RFIs on the MIPS program, including two RFIs on changes to MIPS Value Pathways (MVPs), three RFIs related to health care data quality and monitoring systems, and an RFI seeking feedback on future use of well-being and nutrition measures in the QPP. Specifically, CMS requests comments on tools and measures that assess overall health and well-being, as well as on the applicability of tools that assess the integration of complementary and integrative health, skill building, and self-care.

Ambulatory Specialty Model

CMS proposes a new mandatory model, Ambulatory Specialty Model (ASM), for specialists treating low back pain (LBP) and congestive heart failure (CHF) in outpatient settings. This model holds specialists accountable for upstream management of patients with Traditional Medicare that fall into the episode definitions.

Model Participation

All specialists who have historically treated at least 20 Medicare FFS patients for CHF or LBP over a 12-month period will be required to participate in the model. An episode is initiated when the provider submits a professional claim for at least two separate services provided to one patient that are clinically

related to the chronic condition assessed. CMS will verify through claims data. Performance will be assessed at the individual physician level and not at the practice level for:

- CHF specialists, including only cardiologists and
- LBP specialists, including anesthesiologists, pain management/interventional pain management, neurosurgeons, orthopedists, and physical medicine and rehab specialists.

MIPS eligible providers that are also ASM participants would be exempt from MIPS reporting requirements for any ASM performance year they are included in the ASM model.

Overlap with Other Models

CMS indicates the model is intentionally designed to overlap with Advanced APMs, total cost of care (TCOC), and other Innovation Center models to increase engagement with specialists, regardless of organizational structure. Accordingly, the model applies to all specialists, regardless of whether specialist is exempt from MIPS reporting due to QP or Partial QP status. CMS indicates that this approach will capture Medicare FFS beneficiaries across entire practice rather than only the subset of population assigned to the ACO.

CMS seeks comment on the proposal to permit overlap between ASM and existing CMS models, including MSSP and other Innovation Center programs. NAACOS will oppose this approach and advocate that QPs/Partial QPs be excluded from the model unless they voluntarily opt-in to the model. ASM is essentially a MIPS Value Pathway. Congress created nonfinancial incentives for clinicians to adopt advanced APMs by excluding QPs/Partial QPs from MIPS. We believe this approach does not meet statutory intent.

Additionally, CMS indicates that the ASM payment methodology allows for overlap with other Innovation Center models by avoiding shared savings payments to participants in more than one shared savings model. However, it is unclear how CMS will implement payment reconciliations to account for financial overlap between models.

Model Eligibility and Timeline

- Approximately one quarter of core-based statistical areas (CBSAs) and metropolitan divisions
- 5 performance years beginning January 1, 2027, to December 31, 2031
- 5 payment years beginning January 1, 2029, to December 31, 2033

Summary of ASM Payment Methodology

ASM participants would continue to bill Medicare under traditional FFS for services rendered to Medicare beneficiaries. The model would use a two-sided risk arrangement, where a participant would be subject to financial upside and downside risk ranging from +/-9 percent to +/-12 percent of Medicare Part B payments annually, as outlined in this table below.

ASM Risk Levels
(Table 44 in Proposed Rule)

ASM Performance Year	ASM Payment Year	ASM Risk Level
2027	2029	9 percent
2028	2030	9 percent
2029	2031	10 percent
2030	2032	11 percent

2031	2033	12 percent

CMS would leverage final scores across four performance years to determine positive/neutral/negative payment adjustments on future Medicare Part B payments for covered services. CMS breaks down the proposed payment methodology to include three main categories as follows:

1. ASM Incentive Pool
   - Defined as a "virtual" incentive pool based on fixed percent of total Medicare Part B covered professional services claims paid to ASM participants
   - Distributed as a scaled payment adjustment
   - Calculated for each ASM cohort (ASM CHF cohort and ASM LBP cohort) for each ASM payment year

2. ASM Payment Adjustment Factor
   - Calculated adjustments to Medicare Part B payments based on a percentage of ASM's final score
   - Assessed performance against only those clinicians treating the same chronic condition
   - ASM participant's performance would not have immediate financial impact but would result in future net payment adjustments determined by the participant's performance

3. ASM Payment Multipliers
   - Calculated numerical value equal to 1 plus the ASM payment adjustment factor (includes outcomes from performance measures)
   - Applied to Medicare Part B covered professional services payments

CMS notes that under MIPS, each MIPS eligible provider's final score is compared against the performance threshold for the respective payment year and against the other MIPS eligible clinicians in the same cohort to determine whether each MIPS eligible provider will receive a positive, negative, or neutral payment adjustment. Scores falling below one-quarter of the performance threshold receive a negative payment adjustment of -9 percent while scores above performance threshold can receive positive payment adjustments up to +9 percent. Depending on the range of scores within a given MIPS performance period, a scaling factor can be applied to positive adjustments to retain budget neutrality.

CMS indicates that adopting similar performance thresholds and payment adjustment approaches for ASM design would be operationally challenging because ASM would be a new Innovation Center model that lacks historical data from the model's first year results to calibrate performance thresholds to actual performance results. CMS is also challenged by the approach that if a larger portion of ASM participants score above the performance threshold, then the positive payment adjustments for those ASM participants who scored higher may be smaller since there would be fewer negative adjustments from ASM participants that scored below the performance threshold. Applying budget neutrality and scaling factor requirements, CMS' calculations of positive MIPS payment adjustments must be offset by CMS' calculations of negative MIPS payment adjustments.

CMS seeks comments on their overall payment approaches for ASM. Specifically, CMS is interested in feedback on the ASM payment method that includes ASM incentive pool, ASM payment adjustment factors, and ASM payment multipliers. They are also seeking comments on the alternative to compare

final scores across all ASM participants together, similar to the MIPS approach to compare performance scores.

ASM Measures

ASM would leverage the MVP framework to target CHF and LBP. Under ASM, participants' performance would be evaluated across four categories with specific weights and measures outlined in the charts below.

1. **Quality**: controlling blood pressure of CHF patients or improving functional status for patients with low back pain
2. **Cost**: reducing unnecessary care, such as avoidable hospitalizations and lower readmissions
3. **Improvement activities**: adhering to clinical care processes and enhancing patient experiences. This also includes increasing care coordination between specialists and primary care providers—such as executing Collaborative Care Agreements and completing Health-Related Social Needs Screenings
4. **Promoting interoperability**: implementing technology that allows specialists to communicate and share data electronically, including sending specialists' summaries to PCPs and reporting to public health agencies and clinical data registries

Weights of Performance Scoring

ASM Performance Category	**Weight or Scoring Adjustment in Final Score**
Quality	50 percent weight
Cost	50 percent weight
Care Improvement Activity	Scoring adjustment of zero, -10, or -20 points
Promoting Interoperability	Scoring adjustment of zero to -10 points

Proposed ASM Measure Sets for the ASM Quality Performance Category
(Table 39 in Proposed Rule)

Domain	**Prevention Category**	**Measure**	**Collection Type(s)**
Heart Failure			
Excess Utilization	Adverse events and acute care utilization	Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with HF (MIPS Q492)	Claims
Evidence-based Care and Outcomes	Reduction of disease progression	HF: Beta-Blocker Therapy for LVSD (MIPS Q008)	eCQM, MIPS CQM
Evidence-based Care and Outcomes	Reduction of disease progression	HF: ACE Inhibitor or ARB or ARNI Therapy for LVSD (MIPS Q005)	eCQM, MIPS CQM
Evidence-based Care and Outcomes	Reduction of disease progression	Controlling High Blood Pressure (MIPS Q236)	eCQM, MIPS CQM

Patient Reported Outcomes and Experience	Function/health status/wellbeing	Functional Status Assessments for Heart Failure (MIPS Q377)	eCQM
Low Back Pain			
Excess Utilization	Risk reduction/absence of disease	MRI Lumbar Spine for LBP (measure in development)	Claims
Evidence-based Care and Outcomes	Adverse events and acute utilization	Use of High-Risk Medications in Older Adults (MIPS Q238)	eCQM, MIPS CQM
Evidence-based Care and Outcomes	Risk reduction/absence of disease	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (MIPS Q134)	eCQM, MIPS CQM
Evidence-based Care and Outcomes	Risk reduction/absence of disease	Preventive Care and Screening: BMI Screening and Follow-Up Plan (MIPS Q128)	eCQM, MIPS CQM
Patient Reported Outcomes and Experience	Function/health status/wellbeing	Functional Status Change for Patients with Low Back Impairments (MIPS Q220)	MIPS CQM

Summary of ASM Promoting Interoperability Measures
(Table 41 in Proposed Rule)

- e-Prescribing
- Query of PDMP
- Option 1:
  - Support Electronic Referral Loops by Sending Health Information
  - Support Electronic Referral Loops by Receiving and Reconciling Health Information
- Option 2: HIE Bi-Directional Exchange
- Option 3: Enabling Exchange under TEFCA
- Provide Patients Electronic Access to Their Health Information
- Report to the following public health or clinical data registries:
  - Immunization Registry Reporting
  - Electronic Case Reporting
- Option to report one of the following public health agency or clinical data registry measures:
  - Public Health Registry Reporting
  - Clinical Data Registry Reporting
  - Syndromic Surveillance Reporting

Advanced Alternative Payment Models

For Payment Year 2026, Qualifying APM Participants (QPs) will begin receiving higher conversion factor updates on their covered professional services. The Medicare Access and CHIP Reauthorization Act (MACRA) established an annual differential conversion factor update which is 0.75 percent for QPs and 0.25 percent for non-QPs. As noted earlier, the proposed rule also implements a Congressionally directed 2.5 percent update to the conversion factor for 2026. As a result, QPs will receive a total

payment update of **3.83 percent** for 2026. Eligible clinicians who attained QP status for PY (performance year) 2024 will also receive a lump-sum payment in 2026 equal to **1.88 percent** of their 2025 covered professional services claims.

AAPM Incentive Payments
Eligibility to earn future AAPM incentive payments for PY 2025 and beyond **expired at the end of 2024**. Securing an extension of the AAPM incentive payments and maintaining attainable thresholds is a **top legislative priority for NAACOS**. NAACOS is advocating for another extension, along with longer-term reforms to Medicare's physician payment system that will **reward and incentivize participation in value-based care models.**

QP Thresholds Increase
Medicare's QP thresholds increased under current law to **75 percent of payments** and **50 percent of patient count** for PY 2025 and beyond. Since thresholds are set by statute, NAACOS is advocating for Congress to lower the thresholds for PY 2025 and 2026.

QP Thresholds Performance Year 2025 and beyond	
Medicare Payment Amount	**Medicare Patient Count**
• QP thresholds increase from 50 percent to 75 percent • Partial QP thresholds increase from 40 percent to 50 percent	• QP thresholds increase from 35 percent to 50 percent • Partial QP thresholds increase from 25 percent to 35 percent

Proposed Changes to QP Determinations
CMS is proposing two changes to reform the QP determination process, both of which were discussed in previous rulemaking cycles.

1. **CMS proposes to make QP determinations at both the individual and APM entity levels.** Beginning in PY 2026, CMS will calculate QP threshold scores at the individual level for each unique NPI associated with an eligible clinician participating in an AAPM, based on services furnished across all TINs to which the clinician has reassigned their billing rights. CMS had previously proposed making QP determinations solely at the individual NPI level but did not finalize those changes due to concerns raised by NAACOS and other stakeholders. NAACOS is pleased to see that the agency is now implementing our recommendation to allow QP determinations at both the individual and APM entity levels.

2. **CMS is re-introducing a proposal that was not previously finalized to broaden the scope of attribution eligibility from E/M services to "covered professional services" for QP determinations.** Currently, the agency uses a methodology that requires at least one claim for an E/M service to determine attribution-eligible beneficiaries. Under the new proposal, any beneficiary who has received a covered professional service from an eligible clinician (defined by NPI) would qualify for attribution.

QP Calculations
When making QP determinations, CMS begins by calculating threshold scores using the payment amount and patient count methodologies. The payment amount method is based on payments for Medicare Part B covered professional services, including certain supplemental service payments. The

patient count method is based on the number of patients. Both methods use the ratio of "attributed beneficiaries" to "attribution-eligible beneficiaries."

Attributed Beneficiaries *(Numerator)*
An attributed beneficiary is a beneficiary attributed to the APM Entity under the terms of the Advanced APM as indicated on the most recent available list of attributed beneficiaries at the time of QP determination.
Attribution-Eligible Beneficiaries *(Denominator)*
An attribution-eligible beneficiary is determined by six criteria: (1) not enrolled in Medicare Advantage; (2) does not have Medicare as a secondary payer; (3) is enrolled in both Medicare Parts A and B; (4) is at least 18 years of age; (5) a United States resident; and (6) has a minimum of one claim for E/M services furnished by an eligible clinician who is in the APM Entity.

CMS projects that these changes will more accurately reflect clinicians' actual participation in AAPMs and will reduce the incentive to limit specialist participation in models. While the agency's proposed changes to the definition of attribution-eligible beneficiaries will allow specialists to contribute more towards QP score determinations, it could also result in a larger increase in the attribution-eligible patient population without an increase in the overall number of attributed beneficiaries. **NAACOS is seeking member input on how these proposed changes to the QP determination process will impact an ACO's ability to meet QP thresholds.**

For the 2026 QP period, CMS estimates that between **375,000 and 482,200** eligible clinicians will become QPs.

Differential Conversion Factor Updates

As referenced above, QPs will be eligible for higher Medicare payment updates beginning in 2026. However, NAACOS remains concerned that, under current law, the higher **0.75 percent** conversion factor update for QPs may make it more difficult for ACOs to reduce spending below benchmarks. This is because ACO benchmarks updated using national and regional spending trends, and since most providers remain in MIPS, those benchmarks will reflect the lower **0.25 percent** payment update.

It's important to note that current AAPM incentive payments are **not included** in the calculation of ACO benchmarks, nor are they counted as expenditures for the ACO. NAACOS is actively engaging with Congress to ensure that appropriate safeguards are established so that payment updates for clinicians do not negatively impact financial performance within their models.