September 12, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1832-P
Submitted electronically to: https://www.regulations.gov

RE: CY2026 Medicare Physician Fee Schedule Proposed Rule

Dear Administrator Oz:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the calendar year (CY) 2026 Medicare Physician Fee Schedule (MPFS) proposed rule. NAACOS is a member-led and member-governed 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 more than 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. Our comments below reflect the views of our members and our shared goal of increasing innovation in accountable care.

NAACOS appreciates that CMS has proposed several policies that support accountable care. We strongly support the proposed change to payment for skin substitutes. We believe this policy addresses loopholes that created an environment ripe for abuse and wasteful spending, including bringing new products to market without need or clear clinical benefit. **We encourage CMS to finalize this policy.**

Accountable care empowers patients and providers with tools to focus on prevention, manage chronic conditions, expand access to services not traditionally covered by Medicare, and reduce overall costs. Ultimately, accountable care is a strong vehicle to meet the objectives of Making America Healthy Again. We encourage CMS to bolster the only permanent accountable care program, MSSP, by:

- **Ensuring MSSP has sustainable and predictable financial benchmarking**. We ask that CMS remove the Accountable Care Prospective Trend (ACPT), address the ACO benchmark ratchet, hold ACOs harmless for fraud, waste and abuse, and engage ACOs in conversations to design long-term sustainable benchmarks.
- **Reducing burden by creating a more reasonable pathway to adoption of digital quality measures (dQMs)**. In recent years, CMS has more closely aligned ACO reporting with MIPS, significantly increasing burden and removing incentives. We would like to reverse the increased burden for MSSP participants by retaining all existing reporting approaches while pilot testing dQMs which will better leverage ACOs current use of data and technology.

- **Expanding innovation in MSSP**. The CMS Innovation Center's accountable care models have identified successful approaches for shifting downstream payments (e.g., capitation) and waiving additional regulatory requirements; these tested approaches should be incorporated into MSSP. Specifically, CMS should provide an opportunity for all ACOs to participate in ACO Primary Care Flex, incorporate all Innovation Center waivers into MSSP, simplify required reporting for waivers, and create an approach for ACOs to recommend and test additional waivers across accountable care models. Finally, we appreciate the Innovation Center's efforts in AHEAD states to expand accountable care by geographically attributing patients without a usual source of care. CMS should consider this approach as an option for MSSP ACOs.

PHYSICIAN PAYMENT

Conversion Factor Updates

Overall, NAACOS supports the proposed conversion factor (CF) increases, which include a Congressionally directed one-year increase of 2.5 percent and the differential CF updates directed by the Medicare Access and CHIP Reauthorization Act (MACRA), resulting in payment updates of:

- $33.59 for Qualifying APM Participants (QPs), a 3.83 percent increase from 2025, and
- $33.42 for non-QPs, a 3.62 percent increase from 2025.

However, 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 the models.**

Evaluation and Management

NAACOS strongly supports CMS' proposal to expand payment policy for the office/outpatient (O/O) evaluation and management (E/M) visit complexity add-on code G2211. This code, established beginning January 1, 2024, was designed to recognize the additional resources required for delivering comprehensive, longitudinal care. Primary care providers serving patients who are homebound or who reside in long-term care facilities have not been permitted to bill this add-on, despite caring for some of Medicare's most complex beneficiaries, because it was limited to the O/O E/M code set. By allowing G2211 to be billed with the home and residence-based E/M code set, CMS will increase access to high-quality care for these beneficiaries. NAACOS applauds CMS for taking the steps to correct this gap in payment between office-based and home-based primary care services. **We encourage CMS to finalize this policy as proposed**.

Telehealth

CMS proposes several changes to the five-step review process to simplify and expedite the ability of the agency to add and retain services on the Medicare Telehealth Services List. CMS believes it should focus its review on whether the service can be furnished using an interactive telecommunications system. NAACOS supports CMS' proposal to adjust the review process and eliminate processes that lack clarity or provide difficulty for requestors.

Chronic Illness, Behavioral Health, and Enhanced Care Management

Digital Mental Health Treatment

NAACOS supports CMS proposals to update payment for Digital Mental Health Treatment (DMHT):

- CMS clarifies that while the patient must have a mental health condition diagnosis, the billing practitioner who utilizes the three approved DMHT device HCPCS codes (G0552, G0553, and G0554) does not need to be the same practitioner who made the original patient mental health condition diagnosis.
- 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).

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.

NAACOS applauds CMS' efforts to further enhance prevention and chronic disease management for Medicare beneficiaries. ACOs and providers in value-based care have been at the forefront of innovating care delivery to improve outcomes for beneficiaries. ACOs and other APMs are a well-established vehicle for meeting Administration's goals. NAACOS recommends that CMS leverage ACOs and other APMs to continue building upon care delivery avenues and operations that are only possible in accountable care. ACOs leverage data and technology, integrating claims and clinical data, for population health improvement to enhance clinical outcomes, as outlined in priorities previously shared with the Administration earlier this year.

CMS should continue to sustain ACOs and other APMs while boosting competition through innovative pathways to further increase savings and protect the Medicare trust fund. Specifically, CMS should:

- Define the long-term proposition for providers to participate in total cost of care models by ensuring that providers are not penalized for their prior success in the models and establishing benchmark practices that promote fairness, accuracy, and predictability.
- Shift away from fee-for-service by allowing more options for capitated approaches. At a minimum, primary care capitation helps address cash flow challenges that practices face when implementing new care delivery approaches. Additional options for capitation will help better engage specialists.
- Unleash innovation in the models by reducing the burden of waivers and giving ACOs more flexibility by developing customized waivers.

Community Health Integration and Principal Illness Navigation for Behavioral Health

NAACOS supports CMS' proposals 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 allow CPT codes for Psychiatric Diagnostic Evaluation and the Health Behavior Assessment and Intervention (HBAI) to serve as initiating visits for CHI services.

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 visits (AWV) 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. NAACOS supports these proposals and the continued recognition of upstream drivers of health.

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. NAACOS supports the proposed changes for the additional add-on codes as outlined and believes these changes will aid primary care providers and auxiliary personnel in their roles in delivering collaborative and integrated psychiatric care with enhanced compensation. We believe progress toward hybrid or population-based payments that provide more sustainable payment for primary care providers will ultimately drive higher value health care.

Request for Information: APCM and Prevention

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. CMS now seeks feedback on several issues to inform future proposals for APCM services.

- *Cost sharing*. As with other care management services, cost sharing is often a deterrent to obtaining beneficiary consent. NAACOS supports options for reducing or waiving cost-sharing for beneficiaries.
- *Included/excluded services*. NAACOS recommends that AWVs be paid separately and not incorporated into an APCM bundle.
- *New prospective monthly APCM payments to MSSP ACOs for application within primary care practices.* We conceptually support a prospective monthly APCM payment within MSSP. Current use of APCM services in ACOs is limited because ACOs have historically used shared savings to offer similar approaches and do not see a need to bill for these services. For other ACOs, the implementation costs (e.g., requiring additional staff) can be prohibitive; a prospective monthly payment would provide flexibility to address cash flow/cost concerns. Additionally, CMS should consider simplifying the requirements for ACO Primary Care Flex (PC Flex) within MSSP to allow for broader primary care payments to account for APCM services. PC Flex should be modified to

allow all ACOs to participate and to allow a portion of the practices in an ACO to opt-in to receive hybrid primary care payment.

Payment for Skin Substitutes

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 average sales price (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.

NAACOS strongly supports the proposal to pay for skin substitutes as incident-to supplies as this will help curb fraud, waste, and abuse. Beginning in 2023, ACOs began reporting significantly higher billing for skin substitutes but have had limited ability to proactively address clinical appropriateness. The current payment policy has created loopholes where a manufacturer can bring a new product to market, that is not clinically different from existing products, at a much higher cost. The number of marketed, coded, and paid products in the U.S. has significantly increased. For example, there were 36 products added as part of the quarterly update in the Medicare April 2025 ASP file. The average price of the 36 new products in April was $1,886 per square centimeter. In the July 2025 ASP file, a new skin substitute product was added with a per square centimeter payment rate of $4,770. However, it is unclear whether this price is tied to any breakthroughs in clinical evidence or product efficacy. Moreover, the Office of Inspector General has indicated that there are problems with the ASP reporting from skin substitute manufacturers[1]. **We believe the proposed policy will stop the cycle of introducing higher cost products with no additional clinical value.**

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. **We strongly support the development of single payment rate across all products regardless of their classification and we urge CMS to retain this approach in future years.** We strongly support the use of the hospital outpatient utilization data to inform the development of practice expense RVUs. However, we ask that CMS use the "pooled" payment rate that reflects an average across all products and would establish a rate of $65 per sq. cm. We believe this will more accurately reflect resource costs.

Ambulatory Specialty Model (ASM)

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. CMS indicates the model is intended to hold specialists accountable for the cost and quality of care in the upstream management of Traditional Medicare patients with these chronic conditions. **NAACOS appreciates CMS' continued focus on specialist integration in value-based care, as it is critical to the goal of improving access to high-**

[1] https://oig.hhs.gov/reports/all/2023/some-skin-substitute-manufacturers-did-not-comply-with-new-asp-reporting-requirements/

quality care at lower costs. However, NAACOS is concerned that the ASM would compete with and limit specialists' participation in Advanced APMs.

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. This mandatory model applies to all specialists, regardless of whether specialist is exempt from MIPS reporting due to QP or Partial QP status. CMS seeks comment on the proposal to permit overlap between ASM and existing CMS models, including MSSP and other Innovation Center programs. **NAACOS opposes this approach. All clinicians in an ACO or total cost of care APM should be excluded from ASM.** Requiring specialists in an ACO to participate will exponentially increase administrative burden, create duplicative reporting requirements, and more importantly, unintentionally discourage specialists from remaining in and joining Advanced APM arrangements**. At a minimum, providers that have QP/Partial QP status should be excluded from the model or allowed to voluntarily opt-in to ASM**. Congress created incentives for clinicians to adopt risk arrangements by excluding QPs/Partial QPs from MIPS, including programs like ASM that are built on the MIPS Value Pathways. We believe ASM's mandatory approach does not uphold this statutory intent under MACRA.

Exempting specialists that participate in TCOC APM better focuses their resources on how to best integrate specialty care into the work that the TCOC APM entity is already doing and invested in. Making this change would also encourage more specialists to participate in advanced APM arrangements without undue costs and burdens in creating separate workflows and investing in completely new infrastructure rather than leveraging their existing reporting processes and building from resources already allocated to specialist engagement.

TCOC APM entities are already accountable for the full continuum of care. The focus on allowing providers to coordinate care across the continuum encourages collaboration to achieve optimal patient outcomes. With the primary care team or the specialists providing care for a chronic condition as the foundation for coordinating ongoing patient care, the TCOC 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 optimize TCOC APMs, CMS should consider the following recommendations that will help improve specialist engagement:

- *Share data on cost and quality so that specialists can understand their performance.* TCOC APM entities need more comprehensive and real-time data on specialists' 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 align financial incentives. Providing specialists' performance data across a broader population, at the minimum for Medicare and Medicare Advantage, will empower TCOC APM entities with more comprehensive performance and payment data.
- *Allow contracting with downstream providers.* CMS should create opportunities for ACOs to enter into downstream payment arrangements by providing options for negotiated discounts with providers, nested bundles within TCOC APMs, and capitated agreements. Creating such incentives for specialists to engage with TCOC APMs means allowing QP eligibility to account for downstream risk arrangements, exempting specialists in TCOC APMs from other mandatory models and addressing program rules that necessitate the removal of specialists from ACOs. Models that are designed to offer support and enhance already active and accelerating risk arrangements will align and create much more meaningful incentives than models that compete with existing VBC models and increase administrative burden by duplicating processes.

- *Leverage bundled payments to create standard definitions for episodic payment and supporting nested bundled within TCOC.* 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. Interest in nested bundled payment arrangements within TCOC models has decreased due to challenges with inaccurate target prices. CMS can 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 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.
- *Attribute more specialists in TCOC models.* CMS should consider attribution approaches that would allow a greater portion of a specialists' patient panel to align to a TCOC APM. Specialists who join TCOC APMs would have a clear path to attribute greater proportion of their patient panel to the VBC entity. Refining this specialist attribution approach will help to align TCOC models so that there can be better data sharing, transparency, and mechanisms to share incentives without withholds or risk of curtailed base payments.

ASM design challenges

Below we offer comments on the proposed ASM design. To summarize, CMS should consider the following changes to help increase the overall effectiveness of ASM:

- reconsider the use of redistribution percentage
- collectively pool participant results
- change the model from individual reporting to team/TIN-based reporting
- increase volume thresholds to account for statistical variations
- create safeguards to account for data fluctuations and ensure timely data sharing needed for clinical interventions

Payment methodology

CMS proposes to leverage final scores across four performance categories to determine positive/neutral/negative payment adjustments on future Medicare Part B payments for participating clinicians. Under the model, clinicians could be subject to maximum financial penalties ranging from 9 percent (2027) to 12 percent (2031) of their Medicare Part B payments annually.

CMS is seeking feedback 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.

- *Redistribution percentage:* CMS should adjust the ASM redistribution percentage of 85 percent to 100 percent and allow the payment adjustments of 9 to 12 percent to be based on 100 percent. Otherwise, the proposal for CMS to retain 15 percent of the incentive pool is simply a payment cut to clinicians without any ties to quality and cost performance. This would be unappealing to specialists, especially high performers, that would see this as a penalty and reduce any potential savings opportunities. Additionally, as clinicians improve their care and

reduce expenditures, the incentive pool only gets smaller, which is counterproductive. To account for the 15 percent payment cut, ASM participants may feel compelled to increase their FFS billing instead of focusing on value-based care. This reiterates the need for Advanced APM participants to be exempt from ASM and allowed to accelerate accountable care under their current APM participation. Increased billing will also impact other models' already ratcheting benchmarks where the proposed ASM payment methodology could reflect heightened services and billing, contradicting the collective goal of adding value by increasing quality and decreasing costs.

- *Volume:* CMS should allow ASM participants to pool results together instead of using individual clinician performance, as this will better account for low volume variations and eligibility thresholds. Because ASM proposes to evaluate results based on individual clinician performance, many specialists will see a very small number of patients that meet criteria and trigger the episode. Pooling results would prevent statistical variation due to low volumes, incentivize clinicians to work collaboratively, and prevent performance solely based on statistics over actual outcomes.
- *Model overlap calculations:* CMS should clarify payment reconciliation methodology to account for financial overlap between models. Payment adjustments paid out on a per claim basis (Medicare Part B payments) would have significant impact on TCOC model benchmarks. Specialists who participate and generate savings from APM might be penalized on their TCOC APM results from benchmark adjustments due to Medicare Part B payment adjustments from ASM. Specialists should not be penalized because of a financial reward from a different program, and exempting TCOC APMs would prevent this overlap and competition between models. Additionally, CMS should hold TCOC models harmless from any increased payment adjustments to ASM participants and should not be counted as part of ACO expenditures.
- *Performance and payment years:* ASM, based on this MIPS framework, lacks meaningful incentives because of the two-year lag time between performance and payment years. At minimum, CMS should create safeguards to account for data fluctuations and ensure they are sharing and reporting back more real-time data needed for clinical interventions. Providing this more frequent and real-time data is a necessity for clinical practice transformation. CMS could also consider providing an upfront payment (e.g., operating payment advance or care management fee that would be reconciled) to help practices invest in new processes and infrastructure.

Performance measures

Under ASM, participants' performance would be evaluated across the four categories of quality, cost, improvement activities, and promoting interoperability. Conceptually, we applaud CMS for including specialty care measures, recognizing the need for specific comparisons between specialists of the same type and providing similar services to patients. However, this has not been successfully accomplished in the current MVP design.

Under the proposed MVP framework to target LBP and CHF, specialists have raised concerns that these four categories rely on measures that are not relevant nor indicate high quality care in their respective specialty areas. The MVP approach creates major challenges for attribution, especially difficult under low volume scenarios. Additionally, many of the specialty cost measures are not paired with appropriate quality measures and do not have sufficient data to make meaningful conclusions related to provider performance.

For the CHF cohort, CMS proposes only including cardiologists because they are central to addressing the root cause of CHF. In practice, CHF is a team-based clinical model where multiple care teams across the care continuum are involved in each CHF patient's care, including cardiac surgery, interventional cardiology, allied health providers, post-acute care providers, and advanced PCPs that manage CHF patients longitudinally. Having volume thresholds and performance solely relying on the cardiologist is not an accurate attribution approach, particularly if the cardiologist is already an ACO participant where advanced PCPs also manage CHF patients. Conversely, for the LBP cohort, CMS proposes many providers attributed to LBP which presents the challenge of accurately attributing relevant measures and performance to any one clinician in the cohort, particularly as this cohort is known to have multiple providers, including surgical specialties, as well as physical therapists and chiropractors. With volumes spread across all these clinicians, measuring anything on an individual level would risk inaccuracies to performance and payment year data. **CMS should change the model from individual reporting to team/TIN-based reporting** to address this dynamic and to account for clinicians that have already been reporting as part of a group.

MEDICARE SHARED SAVINGS PROGRAM

Benchmarking Methodology

Accountable Care Prospective Trend (ACPT)

For new and renewing Medicare Shared Savings Program (MSSP) agreements beginning in 2024, CMS applies ACPT in combination with national and regional growth rates. The ACPT is a fixed projected growth rate determined at the beginning of an ACO's agreement period. It accounts for one-third of the trend update. For 2024, ACPT estimated Medicare cost growth to be 4.9 percent. Actual growth was nearly double at 8 percent, which would have arbitrarily lowered ACO benchmarks. **We applaud the Administration for responding to stakeholder concerns by reducing the weight of the ACPT from one-third of the trend update to one-sixth of the trend update.**

For 2025 and beyond, we urge the Administration to remove the ACPT. CMS introduced the ACPT to address benchmark ratchet challenges by allowing benchmarks to increase beyond actual spending growth rates as ACOs slow overall spending growth, and to serve as an initial step towards administratively set benchmarks, which would no longer rely on a fee-for-service population as participation in MA and ACOs increases. While well intentioned, the ACPT is likely to continue to arbitrarily reduce ACO benchmarks. For 2025, second quarter inflation has almost caught up to full year ACPT. Even if inflation slows and matches ACPT's growth rate for the rest of the year, the ACPT would still arbitrarily lower ACO benchmarks.

We ask that CMS focus on addressing the ACO-specific ratchet effect, which occurs when an ACO lowers its expenditure during an agreement period, lowering the baseline historical expenditures at contract renewal. This has greater significance for most current participants. We believe we have more time to continue addressing the program ratchet that occurs with collective success of all ACOs. We ask that CMS increase the prior savings adjustment, allow ACOs to receive regional adjustments and the prior savings adjustment, and explore options to avoid rebasing at contract renewal.

Policies to Protect ACOs from Fraud: Serious Anomalous and Highly Suspect Billing and Reopening ACO Determinations

ACOs continue to be on the front lines identifying and reducing fraud, waste, and abuse. Given their focus on promoting high-quality and efficient care, ACOs are well-positioned to partner with CMS as good stewards of the Medicare program. ACOs regularly analyze Part A, B, and D claims on their assigned patients to find gaps in patients' care, opportunities for clinical interventions, and trends in costs and utilizations in their populations overall. It is through these efforts that ACOs recognize anomalous spending and report suspected fraudulent billing to CMS and the HHS Office of Inspector General (OIG).

It is imperative that ACOs are held harmless for the very fraud, waste, and abuse they diligently work to identify and curb. Fraudulent Medicare spending penalizes ACOs for expenditures outside their control and jeopardizes the continued participation of clinicians, hospitals, and other health care providers. We urge CMS to protect the ACO program through improvements to the SAHS policy, modifications to reopening determinations, and exploring other solutions for specific instances of fraud, waste, and abuse.

Significant, Anomalous and Highly Suspected Billing Policy

In the 2024 Physician Fee Schedule, CMS finalized a policy 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. CMS indicated that it has the sole discretion to identify SAHS billing and would use this authority in "rare and extreme cases." **While we continue to support this policy, we believe it is too limited to address all instances of fraud, waste, and abuse.** For example, a Department of Health and Human Services' Office of Inspector General (OIG) report highlighted a guilty plea for $1.2B in skin substitute fraud[2], yet these expenses are incorporated into ACO financial reconciliation for 2024. It is now incumbent upon the ACO to determine if the fraudulent actor provided services to its ACO aligned beneficiaries and then file a reopening determination. Rather than requiring ACOs to take these steps, CMS should take a more proactive approach for holding ACOs harmless for known fraud. Accordingly, we ask CMS to:

- Apply the policy at the ACO or county level, not just rare/extreme, national cases
- Modify the criteria to identify SAHS to include:
    - Significant increase in a particular billing code compared to historical data;
    - Claims for which CMS payment is paid into escrow;
    - Claims submitted by a provider under indictment or investigation by a Federal agency;
    - Claims from any DMEPOS provider for which CMS has reversed a threshold of the claims for a Performance Year; and
    - Claims for billing codes previously deemed SAHS in prior years.
- Include a materiality threshold of 0.5% of ACOs benchmark and services not provided by ACO participants.

Reopening Determination

In the 2024 Physician Fee Schedule, CMS finalized a policy 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. We continue to support this policy and recommend that ACOs should be able to re-open their settlements from two or three years prior if criminal proceedings are initiated against potentially fraudulent providers, and those providers rendered services to ACO-aligned beneficiaries. A longer "re-opening period" would help account for the timing of

[2] https://oig.hhs.gov/documents/evaluation/10939/OEI-BL-24-00420.pdf

Department of Justice and OIG investigations, which can take multiple years in some cases. We also ask that CMS consider approaches for accounting for known fraud earlier in the process.

Other Policies to Address Increased Spending for Skin Substitutes

Even with improvements to the SAHS policy we should consider other approaches for ensuring that ACOs are held harmless for fraud, waste, and abuse outside of their control. The SAHS policy was a strong solution for catheter fraud that occurred in 2023 and 2024; however, this policy would not be the appropriate policy solution for the increases in payment for skin substitutes. For skin substitutes, there are known areas of true fraud and increased spending due to the payment policy loophole that will be addressed by the proposed policy to change payment. For most ACOs, the trend factor will account for the increased spending on skin substitutes. However, some ACOs' skin substitute billing is higher than trend. These ACOs tend to be smaller or serve more medically complex patients. CMS should ensure that these ACOs are not penalized by the payment schemes associated with skin substitutes or the known areas of fraud. **We recommend that CMS consider applying lower stop loss truncation thresholds in both MSSP and ACO REACH for patients that receive skin substitutes.** This would address concerns about ACOs being over-exposed to fraud that is beyond their control.

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." No changes will be made to the methodology used to calculate the current health equity benchmark. **NACCOS supports this proposal.** The population adjustment accounts for upstream drivers that impact beneficiaries' health outcomes in the MSSP benchmarking methodology, recognizing the additional resources needed to care for rural, vulnerable, and underserved populations. **Additionally, we ask CMS to implement our prior recommendation to add the population adjustment to the regional adjustment and prior savings adjustment.**

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.

NACCOS supports these proposed changes to the glide path, with the caveat that the minimum performance years within a one-sided model is not lowered any further than 5 years. Additionally, we

reiterate the need for additional flexibility for rural, safety net, and small independent providers. These providers face unique challenges when participating in shared savings models. We have previously recommended that CMS consider:

- Modifying existing APMs to better account for safety-net populations (e.g., a set of waivers specific to safety net providers in APMs).
- Developing new ACO tracks/total cost of care models focused solely on rural and underserved populations. An MSSP track just for safety-net providers would be helpful as these providers are challenged by financial benchmarks because their populations have historically lacked access to care or these providers operate under a cost-based reimbursement system that reduces their ability to generate savings.
- Global budgets, prospective population-based payment, or lower discounts or minimum savings rate for providers in risk-bearing models.

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.

NAACOS supports this change, as it allows ACOs to retain attribution when they have mid-year TIN changes. Without the ability to report an ACO participant's TIN, CHOW, and effectuate change in an ACO's participant list, a gap in attribution for beneficiaries served by a participant may cause the assigned beneficiary count to drop below 5,000 and negatively impact the ability to meet eligibility requirements. NAACOS further encourages CMS to ensure reporting requirements are easy to complete, to limit any added burden on providers and staff.

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.

NAACOS supports this change, as 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. NAACOs appreciates the opportunity for new, renewing, or re-entering ACOs that have successfully completed the program and were impacted by the previous policies to be able to continue their program participation.

Beneficiary Assignment

Definition of Primary Care Services Used in Assignment
CMS proposes adding new codes for Enhanced Care Model Management services (HCPCS codes GPCM1, GPCM2, GPCM3), if finalized for coding and payment under the PFS, to the definition of primary care services used to assign beneficiaries to ACOs. These proposed codes would allow for payment when behavioral health integration (BHI) or Collaborative Care Model (CoCM) services are furnished in conjunctions with APCM services. NAACOS supports this change, as codes for APCM services (G0556, G0557, G0558) are already included in the definition and the new behavioral health add-on codes mirror existing CPT codes 99848, 99492, and 99493, which are also included in the definition. 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.

Additionally, CMS proposes removing the code for SDOH Risk Assessment (HCPCS code G0136) from the definition, if finalized for deletion under the PFS. NAACOS supported its addition to the definition given it is an optional component of the AWV, and therefore we support its removal if this change is finalized and it is no longer billable with AWVs.

Quality

Definition of a "Beneficiary Eligible for Medicare CQMs"
NAACOS applauds CMS' proposal to revise the definition of a "beneficiary eligible for Medicare CQMs" to more closely align with the definition of an "assignable beneficiary" under MSSP. We appreciate that, as proposed, this change would go into effect beginning with PY 2025, which should alleviate some of the burden ACOs face in reporting Medicare CQMs for the 2025 performance year. Specifically, CMS proposes the following revised definition:

A beneficiary eligible for Medicare CQMs is either

- *"A Medicare FFS beneficiary (as defined at § 425.20) who—*
    - *Meets the criteria for a beneficiary to be assigned to an ACO described at § 425.401(a); and*
    - *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."*
- *Or, a Medicare FFS beneficiary who is assigned to an ACO via voluntary alignment.*

We thank CMS for being responsive to the challenges that ACOs have reported in identifying which beneficiaries must be included in Medicare CQM reporting. This change should alleviate some of the confusion created by differences in the Medicare CQM beneficiary lists and the assignable beneficiary lists that ACOs receive from CMS. **We encourage CMS to finalize this change as proposed.**

We note that this change does not eliminate the burden associated with identifying the population of beneficiaries for which Medicare CQMs must be reported. We reiterate our past comments that CMS should limit reporting of Medicare CQMs to the patients included on the list issued by CMS to ACOs reporting Medicare CQMs.

Adjustment to ACOs' Quality Scores

NAACOS supports CMS' proposal to rename the "health equity" adjustment bonus points that can be applied to an ACO's quality performance score to the "population and income" adjustment. We agree that this name more accurately represents the policy, which provides the opportunity to upwardly adjust the quality score for ACOs with complex beneficiary populations to reflect the additional challenges of serving these populations. **We encourage CMS to retain the population and income adjustment for PY 2025 and future years, as it aligns with the agency's goals to encourage accountable care providers to take on downside risk for these vulnerable beneficiary populations.** NAACOS strongly opposes CMS' proposal to eliminate the "population and income adjustment" bonus points applied to an ACO's quality score effective PY 2025. **If finalized, this proposal would disproportionately harm ACOs serving dual eligible beneficiaries and other complex populations.** The adjustment provides a critical guardrail for organizations with complex beneficiary populations, including high proportions of dual eligible beneficiaries. Despite providing high quality care, due to high exclusion rates and other measure-related challenges, ACOs serving these populations often have lower quality scores. NAACOS members with higher proportions of beneficiaries dually enrolled in Medicare and Medicaid (duals) and enrolled in the Part D low-income subsidy (LIS) have expressed extreme concern with their ability to meet the quality performance standard threshold absent this adjustment**. This change jeopardizes the shared savings of organizations serving some of the most high-cost and vulnerable Medicare beneficiaries.** This change would also lower the final MIPS scores of ACO providers in MIPS APM tracks of MSSP, therefore lowering their MIPS payment adjustment applied to all Part B services, further increasing the financial harm to these providers.

While CMS argues that other available adjustments, specifically the eCQM/MIPS CQM reporting incentive and the complex organization adjustment (COA), are duplicative with this adjustment; we disagree with this assertion. These adjustments are not uniformly applied across ACOs and vary based on reporting pathways, and importantly, were not designed to serve the same purpose. As the new name suggests, this adjustment is specifically designed to support ACOs with patient populations that experience negative upstream drivers of health due to beneficiary-level demographics (e.g., eligibility for Medicaid), which make it more difficult to achieve performance on the measures included in the MSSP measure set. These ACOs are those comprised of FQHCs, long-term care facilities, and other provider types that face myriad difficulties participating and succeeding in accountable care. The need for a population-based quality adjustment is not due to lower quality care, but due to application of a measure set that was designed for the average traditional Medicare population.

The reporting incentives and COA were implemented to provide financial incentives to transition to all payer/all patient reporting via eCQMs, but reporting eCQMs is still not feasible due to available technology and vendors' abilities to accurately aggregate and deduplicate data across numerous disparate EHRs and other data sources. This transition can be particularly challenging for smaller, less well-resourced organizations. Removing this incentive may result in these organizations losing out on earned shared savings, thus being left with fewer resources to fund the reporting transition. We believe that eliminating an additional possible 10 incentive points will discourage ACOs from undertaking the investment and other hurdles to eCQMs.

CMS acknowledges that the adjustment has not resulted in shared savings payments that would not otherwise have been made. **We believe that removing the adjustment and particularly doing so retroactively when we are already 9 months into the reporting period, would create harm by making it more difficult for ACOs serving high proportions of duals and LIS beneficiaries to remain in MSSP.** This is contrary to CMS' stated policy goals of having more low-income and access challenged

populations served by accountable care models. Additionally, these ACOs tend to contribute some of the highest savings to the Medicare Trust Funds on a per-beneficiary basis. Eliminating the adjustment will drive out precisely those organizations CMS seeks to retain. We believe that renaming the adjustment, as CMS has proposed, achieves clarity without sacrificing policy goals.

NAACOS strongly urges CMS to retain a 'population quality adjustment' across all available reporting pathways on a permanent basis.

APP Plus Measure Set

CMS proposes several changes to the APM Performance Pathway (APP) Plus measure set, effective for PY 2026 and subsequent years. NAACOS is supportive of CMS' proposals to:

- Revise 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, clarifying policies for when two screenings are documented on the same date/time with different results, and updating the numerator to clarify that pharmacological interventions include prescribed or active depression medications.
- Update the *Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions* (MCC) measure to remove the denominator exclusion for patients assigned to clinicians who achieve Qualifying APM Participant (QP) status and therefore do not participate in MIPS; this erroneously excluded ACO providers who are QPs when the MIPS MCC measure replaced the ACO MCC measure.
- Remove the *Screening for Social Drivers of Health* measure from the APP Plus quality measure set, which was set to be added in PY 2028. NAACOS has opposed the addition of any new measures to the MSSP measure set while ACOs undergo a resource and time-intensive quality reporting transition, and along with concerns about the measure's validity and compatibility with digital reporting, we are pleased that this measure will not be added in PY 2028. We look forward to exploring alternative ways for CMS to support providers and ACOs in identifying and addressing beneficiaries' upstream drivers of health.
- Update the *Breast Cancer Screening* (BCS) measure for the eCQM collection type by expanding the age range for the eCQM specification to women 40-74 years of age, which aligns with the MIPS CQM specification. Due to the misalignment in age ranges for the eCQM and MIPS CQM/Medicare CQM collection type, ACOs are facing significant barriers in PY 2025 data collection efforts.

Beyond the misalignment of age ranges for PY 2025, **NAACOS' members have raised additional concerns with the BCS measure.** Participating practices within ACOs report that some EHR vendors, particularly those for small practices or specialties, have not maintained the capability to extract the data needed for the BCS eCQM and there is potential that it will also occur with the Colorectal Cancer Screening (CCS) eCQM. Vendors believe that they do not need to support this since they were removed as individual measure options from MIPS. As a result, practices with these vendors currently cannot extract the data needed. Depending on the number of practices using these vendors, ACOs that opted to report using eCQMs may be forced to select a different reporting option (MIPS CQMs or Medicare CQMs) with increased burden of data collection and cost since practices with these vendors will need to identify other avenues to obtain the data (likely through manual data abstraction).

Even if a vendor can produce the QRDA 1 file, it will only include women aged 50-74 years since the eCQM specification was not updated to reflect the most recent recommendation to screen women aged 40-74 years for PY2025. The MIPS CQM and Medicare CQM, however, were updated, leading to several

specifications for the same clinical concept to include different age ranges and the associated benchmarking across collection types differ. We believe that CMS must avoid situations where specifications are not clearly supported by vendors and specifications and associated benchmarking are not consistent.

Due to these data collection and extraction challenges, ACOs are at risk of not meeting the 75 percent data completeness requirement for the BCS measure and participating practices within the ACO may be required to collect data manually or through other means, adding undue burden and costs. **We urge CMS to communicate the need to support these eCQMs to EHR vendors and in the interim, identify avenues by which ACOs will not have their potential shared savings at risk (e.g., suppress the measure).** We look forward to working with CMS on solutions to address these challenges.

NAACOS opposes CMS' proposals to add definitions for the term "reviewed" in the measure descriptions of the BCS and the CCS measure, for the MIPS CQM and Medicare CQM collection types, to qualify as meeting the quality action. We believe that this change is an expansion beyond the original intent of the measure, which will increase documentation burden without any value added to the patient or provider. In addition, specifications across reporting options should remain aligned and the eCQM specification does not currently include this requirement, nor would we support its addition to this specification in the future. ACOs often work with their participating practices to extract these data from EHRs even when reporting MIPS CQMs or Medicare CQMs and this change will make it even less feasible for them to minimize the data collection burden for practices if they cannot leverage data from the EHRs.

We also believe that this change could lead to a negative unintended consequence of overuse of these procedures since the timeframe for both measures includes data from previous years (for CCS this can be up to 10 years if a patient received a colonoscopy). It is very unlikely that a review and discussion of the findings will be documented in an easily accessible way and as a result, a repeat mammogram or colorectal cancer screening may be ordered to fulfill the measure and not because the patient is due for this screening. We oppose any change to a measure that could encourage overuse of services, particularly a revision that is not directly tied to improving patient care. This is the specific type of overutilization that ACOs are designed to avoid.

We are further concerned that providers may also be compelled to discuss results from previous years, and potentially on a test that was ordered and reviewed by another provider, to enable them to meet the numerator. There is risk that discussing old test results for no reason other than to satisfy a quality measure will lead to patient confusion and unnecessary alarm.

Lastly, we recommend that CMS consider including patient refusal as an exception across the specifications for all reporting options in the future. This addition will acknowledge and reflect that patients have a choice in the medical care that they receive and allow practices to understand screening hesitancy for quality improvement efforts at the point of care.

CAHPS for MIPS Survey

Following the RFI on adding a web-mode to the CAHPS survey in the CY 2025 PFS proposed rule, which CMS indicated could result in a 13 percent increase in response rates, CMS proposes requiring CAHPS survey vendors to administer the surveys via a web-mail-phone protocol beginning in PY 2027. **NAACOS is supportive of CMS' proposal to add a web-based survey mode to the CAHPS for MIPS survey, as increased response rates are beneficial. However, we reiterate ongoing concerns with the use of**

CAHPS to evaluate patient experience of care provided by ACOs. The timing of surveys results in patients conflating experiences with various providers and having difficulty recalling experiences that took place months ago. The survey itself has not been updated and the questions included are confusing, leading, and can be misinterpreted. Overall, many ACOs report that 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 for improvement purposes. These instruments have a much larger sample size and are more meaningful to patients and providers, using the survey data. We urge CMS to work with stakeholders to devise a better approach to obtaining patient satisfaction data.

While we appreciate that CMS includes in this proposal a requirement for survey vendors to report updated prices, including the cost of adding the web-mode beginning in PY 2026, we urge CMS to ensure that survey vendors do not charge practices unreasonable fees for the addition of the web-mode. Administrative burdens and program requirements are increasingly placing financial strain on health care practices without adding meaningful value to their participation in these programs.

Request for Information: Toward Digital Quality Measurement in CMS Quality Programs
NAACOS applauds CMS' vision of shifting its quality reporting programs to a digital quality measure (dQM) framework that supports multiple use cases. Our members seek to move to a quality measurement approach that leverages interoperable data sources that are seamlessly integrated and available at the point of care, increasing efficiency, reducing administrative burden, and empowering patients and providers to make informed care decisions. To achieve our shared vision of a tech-enabled future, we should prioritize FHIR-based dQMs, which allow providers to access data from numerous sources, including EHRs, rather than the incremental approach to FHIR-based electronic clinical quality measures (eCQMs), which are limited in their sole reliance on data from the EHR, followed by FHIR-based dQMs.

Transforming care delivery and improving quality are cornerstones of accountable care. ACOs and providers in accountable care regularly leverage data and technology, integrating claims and clinical data, to enhance clinical outcomes through innovative solutions and population health management. We believe that the data used for quality measurement should be a byproduct of care delivery – data that accurately and comprehensively represents the quality provided by ACOs and their providers – and shifting to FHIR-based dQMs moves us closer to that goal.

We appreciate CMS' acknowledgement in this RFI of the challenges that ACOs currently face with patient matching, deduplicating, and aggregating the quality data required for the eCQM, Merit-based Incentive Payment System (MIPS) CQM, and Medicare CQM reporting options. Current requirements force ACOs to make investments in infrastructure that do not facilitate the shift to the FHIR standard and the current eCQM approach is limited in both data sources and usefulness of the resulting data. Shifting to FHIR-based eCQMs offers opportunities to leverage the same data for more use cases but is still inherently limited because it only allows for data extracted from an EHR. Alternatively, FHIR-based dQMs, which FHIR-based eCQMs are a subset of, would offer the ideal approach for organizations like ACOs that leverage other digital data sources outside of EHRs and must aggregate data across disparate EHR systems and care settings.

NAACOS supports the overall goal of transitioning to a dQM approach that leverages interoperable data sources integrated at the point of care, which will reduce administrative burden and enhance patient care. Our comments below incorporate key considerations to ensure this transition is successful,

drawing on lessons learned from ACOs' experiences with current eCQMs and FHIR. We look forward to collaborating with CMS on solutions that support the future of tech-enabled healthcare.

Industry Readiness for FHIR-based Reporting

Implementing the FHIR standard for quality reporting would allow the same data to be used for multiple purposes, such as sharing data with a public health agency or health information exchange (HIE) or exchanging data with other health care entities to support comprehensive care across the continuum. While we are aligned with CMS' goal to shift to seamless data exchange leveraging the digital sources that are increasingly available, it will require both vendor readiness and additional education and resources for those reporting to understand and implement what is required. ACOs and their associated practices must be knowledgeable of the current and future capabilities and technologies of their EHRs and other sources of digital data. While progress has been made, this shared understanding between providers and vendors is not yet at the level to support an immediate transition to FHIR-based reporting.

Feedback from our ACO members attempting to work with their vendors on FHIR-based solutions highlights that many members of the vendor community are not currently capable of supporting FHIR-based reporting. One ACO states that even after two years of preparation, they continue to identify and address barriers to successfully report eCQMs, and the time needed for small and rural practices to be able to successfully report will likely take longer. The majority of vendors do not support FHIR, and even fewer support Bulk FHIR, which will be necessary for the volume of data reported by ACOs. For example, one ACO partners with more than 30 EHR vendors, yet only one EHR system is currently able to produce data using Bulk FHIR and another ACO reports that they shifted from attempting FHIR implementation to QRDA submissions after three months of unsuccessful attempts to extract the data using the FHIR standard. Of those that currently support FHIR, our members identified significant challenges with the data's validity and current Bulk FHIR technical limitations include system crashes, scheduled processing windows often requiring weeks to extract data, and duplication issues that make real-time reporting impossible. There is significant potential to reduce burden and costs using this standard; however, much work remains to ensure that the industry is ready to assist providers and ACOs in this effort.

It is critical that CMS establish a certification process that enables end-to-end FHIR-based dQM reporting and requires vendors to demonstrate specific core capabilities, including supporting Bulk FHIR. CMS should also undertake real-world testing to ensure that the vendors supporting digital quality measurement can produce the data necessary and that these data are accurate and complete. In addition, patient matching and deduplication remain a significant challenge for vendors and ACOs; CMS should explore solutions to address these challenges, such as a national patient identifier, or minimum criteria and standard elements for patient matching.

We urge CMS to create and release a detailed timeline with milestones indicating when critical steps and activities have been achieved and what factors and deliverables must be met to indicate that the industry is sufficiently ready to move to the next step. For example, this process and timeline could outline when the technical requirements for FHIR-based reporting will be made available, with adequate time for vendors to integrate them into their products, and when these requirements will be incorporated into certification requirements. At the same time, CMS should also build the internal capabilities needed to receive these data through FHIR-based APIs, pilot some of these solutions with vendors and providers, and release guidance and education to assist practices and ACOs in this transition, including for working with their vendors.

Prioritizing Long-Term Solutions

Data must be made available at the point of care to support clinical decision making, patient empowerment, and quality improvement and be easily accessible with little to no manual manipulation for quality measurement. Value-based care organizations have different approaches to facilitate data availability for clinicians, which may be within the EHR or through custom platforms or products that are integrated with the EHR. It is critical that data are stored where they are most appropriate and most useful, which may vary by clinician and practice. The purposes of quality reporting should not dictate where and how data are stored and displayed.

Organizations should not be required to force other data sources into an EHR solely for the purposes of quality reporting. Because we view FHIR eCQMs as a component of FHIR dQMs, entities such as hospitals or practices that may not be ready to use additional digital data sources would still be able to leverage primarily EHR data while others, such as ACOs and health plans, could use additional sources available to them (e.g., administrative claims, labs, HIE data). Broadening to FHIR-based dQMs will provide the flexibilities needed to allow groups to tailor their efforts based on where they are in collecting and reporting digital data and still shift to the optimal standard for data exchange.

Currently, there is wide variation in documentation practices; standardization and alignment will be critical for achieving seamless dQM reporting. CMS must work with measure stewards to ensure that data elements are aligned across their specifications. We are at significant risk of replicating the ongoing challenges of measures and data elements that appear to be captured and represented consistently but are distinctly different and require additional mapping and data collection – all for the same clinical concept and intent. This is especially important for value-based care organizations that enter into risk arrangements with other payers; for one ACO, they are responsible for over 1,300 measures across value-based contracts and such variations in data elements for measures adds significant burden to their quality reporting efforts. Additionally, practices should be afforded sufficient time to adopt new workflows and input data in discrete fields. While smaller practices may be able to change behavior more quickly, larger groups may require longer to implement such changes, and practices should not be expected to backfill information. Therefore, a sufficient runway should include time for providers to adopt workflow changes and capture meaningful data prospectively before FHIR-based dQM reporting is mandatory.

Piloting and Scaling Approaches with ACOs

Value-based care entities develop relationships with practices, hospitals, other care providers, and vendors to support population health. As such, ACOs are uniquely positioned to partner with CMS in piloting and scaling approaches for FHIR-based dQMs. ACOs that are at the forefront of the digital quality transition could be tapped to help identify vendors that are working to implement FHIR capabilities to participate in a pilot. Once capable vendors have been identified, an ACO pilot should focus on measures that align with the “Make America Healthy Again” priorities and draw from multiple data sources and types. For example:

- Measures that support chronic disease management using concrete data elements (e.g., blood pressure control, glycemic status assessment greater than 9 percent for patients with a diagnosis of diabetes).
- Preventive measures that may rely on data from outside the EHR and across settings and providers (e.g., breast cancer screening, adult immunization status).
- Measures with data elements that may be less likely to be captured in discrete fields (e.g., depression screening and follow up) to identify workflow changes needed to support the measures as dQMs.

This approach should include a representative group of ACOs to ensure that organizations with various compositions, sizes, and geographic footprints can succeed in digital quality measurement. CMS should offer incentives for ACOs to participate in a pilot by providing relief from other ACO quality reporting obligations (i.e., achieving the quality performance standard by participating).

Because ACOs integrate data from multiple sources and across the continuum of care, they are arguably the most complex implementation environment for FHIR-based dQMs. By demonstrating success in an ACO pilot, the health care ecosystem will be able to save time and money during this transition as many of the costs and requirements will be identified and possibly resolved. In addition, it would enable CMS to determine what additional certification requirements may be needed and what additional products and solutions should be enabled to facilitate digital quality measurement. Ultimately, we believe that this work will increase the confidence of all health care providers and CMS that FHIR-based dQMs can be successfully implemented in other health care settings.

FHIR Transition Activities for ACOs

Once pilot testing indicates that vendors are ready and certified to support implementation and potential solutions to assist providers in successful FHIR-based dQM reporting are available, CMS should propose a glide path for all ACOs to transition to FHIR-based reporting. This glide path must include appropriate incentives to support ACOs and their participating practices through each step of the transition in a thoughtful way. By using a stepwise approach with initial activities focused on building the required infrastructure, followed by data collection and reporting by practices and ACOs, we believe that all can be successful. As part of this glide path, CMS should also announce the timeline for sunsetting legacy reporting formats, including QRDA, and align these timelines with adoption milestones for FHIR-based dQMs.

When considering what ACOs will need to successfully embark on this transition, CMS should:

1. Focus on transitioning directly to FHIR dQMs rather than the current proposed approach of first moving to FHIR eCQMs and then FHIR dQMs.
2. Continue to support current reporting options, including Medicare CQMs and MIPS CQMs, until all ACOs can successfully report dQMs.
3. Provide appropriate incentives, guidance, and technical assistance for the transition and ensure ACOs will not risk losing shared savings they would have otherwise earned.
4. Maintain the APP Plus set as currently finalized without adding measures until this transition is complete.
5. Create realistic expectations and requirements on adequate sample sizes for quality measurement that account for real-world limitations.

Focus on transitioning directly to FHIR dQMs rather than the current proposed approach of first moving to FHIR eCQMs and then FHIR dQMs. As stated above, NAACOS believes that moving directly to FHIR-based dQMs, instead of first to FHIR-based eCQMs, will reduce the overall cost and burden and facilitate success of this transition.

Continue to support current reporting options, including Medicare CQMs and MIPS CQMs, until all ACOs can successfully report dQMs. Retaining existing reporting options until the pathway to dQMs is established will enable ACOs to focus on the steps needed for that transition rather than expending time and resources to shift to interim reporting approaches. We also believe that supporting Medicare CQM reporting will facilitate ACOs' shift to dQMs.

Provide appropriate incentives for the transition and ensure ACOs will not risk losing shared savings they would have otherwise earned. As ACOs move to dQMs, it will initially be difficult to determine whether the performance scores produced reflect true differences in quality rather than the degree of data completeness and validity, and vendor capabilities. Based on our members' current experiences with existing eCQMs, significant time and resources are required to ensure that the data are captured in discrete fields. It can take several years working with providers and others on documentation practices and workflow to confirm that the data are consistently captured as intended.

CMS should offer sufficient incentives to encourage ACOs to begin the transition to dQMs. During this transition, CMS should adjust the requirements by which quality performance is assessed since ACOs should not have to expend unnecessary resources and funds to support reporting multiple collection types (e.g., Medicare CQMs and dQMs) to minimize the risk of losing earned shared savings. Many of the initial differences in performance scores and associated benchmarking will be due to differences in data sources rather than true variations in the quality of care provided. A lower quality performance standard threshold during this transition will ensure ACOs are not arbitrarily penalized for being early adopters. In addition, measure benchmarks should be set based on the relevant population, statistically appropriate, and stabilized prior to linking quality scores to penalties.

Maintain the APP Plus set as currently finalized without adding measures until this transition is complete. ACOs, their participating practices, and vendors will need sufficient time to implement these new technologies and specifications. During this transition, we urge CMS to maintain the current set of measures as finalized for 2025. Adding additional measures would only increase the data collection burden and costs.

As CMS seeks to align quality measures across programs, future measure sets should be FHIR-enabled and designed for population health. Rather than adopting the individual clinician measures in MIPS, CMS should seek to align measures across programs that are responsible for total cost of care (i.e., aligning ACO and Medicare Advantage quality approaches), which will ultimately reduce administrative burden for accountable care providers.

Create realistic expectations and requirements on adequate sample sizes for quality measurement that account for real-world limitations. Currently, ACOs are required to report on all patients across all payers and achieve 100 percent data completeness when reporting eCQMs. These expectations do not reflect current limitations that ACOs encounter as they attempt to successfully meet the current reporting requirements.

The shift from former ACO quality reporting, which relied on a small, representative sample of ACO-assigned beneficiaries, to current approaches that require all patient/all payer data has exponentially increased the quantity of data that must be submitted. ACOs should be given time to adapt to this dramatic increase in the reporting population that spans far beyond the ACO's assigned beneficiary population.

The 100 percent data completeness expectation for eCQMs does not allow for exceptions when common occurrences prevent ACOs from reporting on 100 percent of the denominator population, for example: practice closure, independent physician retirement, vendor or practice inability to segment data, or issues with vendors not supporting the ACO required measures. In other quality reporting programs, CMS began with much lower data completeness requirements when shifting to all patient/all payer reporting. We know that 100 percent data completeness is not required to assess quality. CMS

should focus on the validity and accuracy of data over the completeness of data submitted, with the goal of incrementally increasing over time. CMS should allow exceptions to account for such circumstances and prevent them from impeding ACOs' quality reporting success, and we urge CMS to implement such exceptions in the current quality reporting pathways. Additionally, CMS should allow ACOs to exclude patients whose records are not able to be accessed, provided a 75 percent overall threshold for eCQMs is met for the ACO. Specifically, CMS could require that 75 percent of patients from ACO participant TINs are reported on.

Extreme and Uncontrollable Circumstances Policies

CMS proposes expanding the Extreme and Uncontrollable Circumstances (EUC) policies for MSSP ACOs to explicitly address scenarios in which an ACO experiences an EUC due to a cyberattack, including ransomware/malware. **NAACOS applauds CMS for these proposals, and we urge CMS to finalize these policies as proposed.** Cyberattacks are becoming increasingly prevalent against health care organizations, and these attacks interfere with ACOs' ability to comply with program requirements such as quality reporting. 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. The unique nature of cyberattacks prompted CMS to revise the MSSP quality and finance EUC policies to account for an ACO affected at the legal entity level through the MIPS EUC Exception application process.

Importantly, CMS proposes to implement these policies retroactively beginning for PY 2025 to protect ACOs that were affected by cyberattacks in 2025 before PY 2025 reporting takes place in early 2026. 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. **We strongly agree with this sentiment and applaud CMS' efforts to safeguard ACOs from risking earned shared savings.**

EUC Policy to Determine Quality Performance

CMS proposes to require that an ACO affected at the legal entity level by an EUC due to cyberattack must submit a MIPS EUC Exception application to QPP as an APM entity. If approved, CMS would provide relief from quality reporting requirements for the relevant performance year. In alignment with MIPS EUC Exception policies, if an ACO with an approved EUC Exception application for a cyberattack chooses to report the APP Plus measure set, meets data completeness, and receives a MIPS quality performance category score, CMS would use the higher of the ACO's actual score or the equivalent of the quality performance standard threshold. **NAACOS supports this proposal, and we encourage CMS to finalize as proposed.** This approach would allow ACOs to attempt to report quality measures for the affected performance year without putting their performance in the program in jeopardy.

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 cyberattacks affect ACOs at the legal entity level rather than in particular geographic areas, CMS could not determine the percentage of ACO-assigned beneficiaries affected by an EUC due to cyberattack. Therefore, CMS proposes to apply MSSP EUC finance policies to 100 percent of an ACO's assigned beneficiaries when the

ACO has an approved MIPS EUC Exception application for a cyberattack. **NAACOS agrees with this proposed approach, and we recommend that CMS finalize this policy as proposed.**

NAACOS also supports CMS' proposed approach to determine the proportion of the performance year affected by the EUC due to cyberattack using the start and end dates provided on the ACO's EUC Exception application or defaulting to a 90-day duration when no end date is included, unless the start date is less than 90 days from the end of the performance year. For an ACO that 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. We encourage CMS to communicate to ACOs affected by an EUC over multiple performance years that they must submit multiple MIPS EUC Exception applications to have relief from quality reporting requirements and mitigation of any shared losses for the duration of the EUC due to cyberattack.

QUALITY PAYMENT PROGRAM

Merit Based Incentive Payment System (MIPS)

Promoting Interoperability

We continue to oppose the changes in the Promoting Interoperability (PI) requirement; applying MIPS requirements to all MSSP ACOs significantly increases burden, which is contrary to the intent of the Medicare Access and CHIP Reauthorization Act (MACRA). Congress clearly established a two-track system and the change to apply this MIPS category to Advanced APM ACOs in MSSP implemented in PY2025 goes against that intent. We are extremely concerned that this change disincentivizes participation in an Advanced APM at a time when financial incentives to participate in these models continue to be reduced.

We are increasingly concerned that ACOs still lack clarity regarding how these policies will be implemented. It is very possible that ACOs will not be able to successfully report PI due to these unanswered questions.

NAACOS recently shared a list of questions generated by our members that remain unresolved and significantly impact their ability to successfully report for the PI category. These questions highlight areas where additional detailed guidance and clarity are needed including:

- How does CMS intend to calculate the final PI score when it is aggregated at the ACO level versus when the ACO reports at the APM entity-level?
- How can ACOs report PI at the APM entity-level when its participants have exclusions and exemptions?
- How do the exemptions that apply to individual clinicians and practices impact an ACO's reporting? For example, are ACOs that are exclusively comprised of federally qualified health centers (FQHCs) exempt from reporting PI and what reporting, if any, is needed?
- What is the MIPS PI hardship exemption process for QPs who have historically not needed to apply for reweighting?

We are now nine months into the reporting period for 2025 with many questions remaining. We do not believe that ACOs have been afforded sufficient time to successfully work with their practices to ensure that all are capturing the required data and able to submit these data accurately and comprehensively.

We also remain extremely concerned that this uncertainty will cause Advanced APM ACOs to drop additional practices from their participant lists, which is counter to CMS' goals to move providers into two-sided risk models and have all patients in accountable care.

We reaffirm our previous statement that 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. 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' care.

Rather than continuing this current approach of applying this category to ACOs and potentially expanding these requirements to put shared savings at risk, we urge CMS to employ the following approaches to better understand ACOs' use of CEHRT:

- Require ACOs to attest to use of CEHRT, which 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 shift 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 Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT (ASTP/ONC) from health IT developers through the new Insights Condition and Maintenance of Certification finalized in the Health Data, Technology and Interoperability (HTI-1 and HTI-2) final rules.
- 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 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.

Advanced Alternative Payment Models

From 2022 to 2023, there was a 20 percent increase in the percentage of clinicians participating in Advanced APMs and a 41 percent increase in those achieving qualifying APM participant (QP) status. While AAPM participation has steadily grown towards half a million clinicians, **NAACOS shares the agency's concerns that the statutory increase in qualifying thresholds will result in a reduction in the overall number of clinicians achieving QP status.** NAACOS is encouraged that CMS is evaluating proposals to improve the QP determination process and recommends that agency leadership engage with Congress to lower the QP thresholds for Performance Year 2025 and 2026 to help the agency maintain the positive growth of AAPM participation.

Changes to QP Determinations

Determinations at the Individual and Entity Levels
NAACOS supports the agency's proposal to maintain the current APM Entity QP determinations and to further expand the QP determination to individual clinicians whose APM Entity may not qualify.

Expand the Definition of Attribution Eligibility for QP Determinations

While the agency's proposed changes to the definition of attribution-eligible beneficiaries will allow specialists to contribute more towards QP score determinations, NAACOS is concerned that this change could have unintended consequences. ACOs are fundamentally designed around primary care, serving as the foundation for patient attribution and care coordination. However, specialists also play an important role in these models. In fact, most ACOs include a diverse mix of physicians across a range of clinical specialties, reflecting the need for integrated, team-based care delivery.

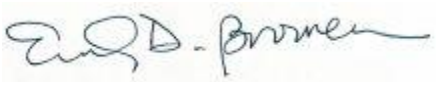
Shifting from E/M services to all professional services will shift the QP determination methodology to include both primary and specialty care. This change could make it more difficult for ACOs with a diverse mix of specialists to meet the increased qualifying thresholds because ACO attribution is based on primary care services. Expanding the number of clinicians and services that account for an ACO's QP determination will result in a larger increase in the attribution-eligible patient population without an increase in the overall number of attributed beneficiaries. A preliminary analysis comparing the QP methodologies highlights that most ACOs would see decreases in their overall QP scores.

Since over 90 percent of clinicians achieve QP status through participation in an ACO, **NAACOS encourages CMS to maintain the current QP attribution approach using E/M services for APM Entity level determinations. If CMS modifies the definition of attribution eligible beneficiaries to include all professional services, this change should apply only to individual-level QP determinations.** This will allow CMS to maintain the current QP determination system for APM Entities, while evaluating the effectiveness of the newly expanded individual level QP determinations. If CMS finalizes changes to the QP determination process, we encourage the agency to closely track and analyze how this policy changes impact the overall number of clinicians qualifying for QP status and provide stakeholders with a detailed analysis in future fee schedules.

CONCLUSION

Thank you for the opportunity to provide feedback on CY 2026 MPFS proposed rule. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health. We look forward to our continued engagement on driving sustainability and innovation in accountable care. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,



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