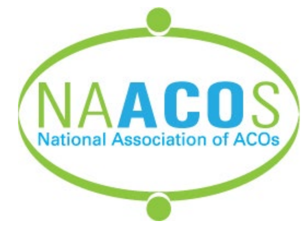


Critical Policy Updates for 2024

Bootcamp 2024

2024 Priorities

- Secure extension of Advanced APM Incentives
    - Inclusion of AAPM incentive extension in Congressional package
- Achieve consensus on future legislation (MACRA 2.0, CMMI reform)
    - Develop future legislative approaches that address MACRA and CMMI reform
    - Draft legislation that is supported by other associations.
    - Identify House and Senate champions to introduce legislation in next Congress
- Increase Congressional Champions
    - Hold Educational Hill Briefings for Congressional staff.
    - Focused attention on appropriations outreach to begin building champions for future legislative efforts.

2024 Priorities

- Publicly promote the importance of VBC
  - Targeted expansion of PR and communications strategies
  - Leverage ACO coalition and Alliance for Value-Based Patient Care to expand NAACOS partnerships
  - Establish new ACO Excellence Award to promote awareness of ACOs and value
- Demonstrate impact of value for patients
  - Partner with patient advocacy groups to engage in joint advocacy and increase public understanding of the benefits of ACOs
  - Support ACOs in optimizing patient engagement approaches
- Adoption of NAACOS recommendations for MSSP and REACH

2024 Priorities

- Build broader support for NAACOS quality recommendations
  - Engage broader coalition on transition to eCQM/dQM issues
  - Develop Congressional champions who will weigh in with Administration
  - Continued participation in quality measurement enterprise activities to ensure ACO voice is represented
- Monitor and evaluate impact of payment policies and other CMMI models (GUIDE, AHEAD, bundled payments, etc.)
  - Monitor and educate members on other provider Medicare payment changes.
- Support members in advancing payment arrangements with other payers
  - Future of value playbook with AHIP and AMA
  - Medicare Advantage arrangements ALC

ACO REACH

- The model generated $870 million in gross savings and $484 million in net savings in 2022
  - Represents a 3% savings rate for the 99 participants
  - Gross savings increased more than 7 times between 2021 and 2022, driven by growth in participation
- REACH is currently due to sunset at the end of 2026
- NAACOS and CMMI are thinking about what is next
- More information on updates that took effect in 2024 are available in this NAACOS resource
- Still faces some political backlash

Other CMMI Models

Guiding an Improved Dementia Experience (GUIDE) Model

- Voluntary, nation-wide model to support patients with dementia and their caregivers
- 8-year model starting on July 1, 2024
- Overlap with ACO models allowed

States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model

- A state-based, population health model
- Targets all-payer and Medicare FFS growth by a statewide or sub-state entity
- Opportunities include global hospital budgets and primary care programs

Making Care Primary (MCP) Model

- The latest advanced primary care model set to launch 1/1/24
- 10.5-year, multi-payer model in 8 participating states
- 3 progressive tracks w/ more advanced care delivery and payment changes
- ACO overlap not permitted

Innovation in Behavioral Health (IBH) Model

- State-based model, led by state Medicaid Agencies
- Seeks to bridge the gap between behavioral and physical health
- NOFO will be released spring 2024

Enhanced Plus

- NAACOS continues to advocate for a higher/full-risk track in MSSP
- With ACO REACH scheduled to sunset at the end of 2026, Enhanced Plus would provide an on-ramp to MSSP
- Features of Enhanced Plus:
  - Choice between 85-90 percent shared savings rate or full-risk options with a discount
  - NPI-level participation
  - Regional-only benchmarking
  - Options for population-based payments and advanced payment
  - More waivers and flexibilities
  - Better access to data
  - Paper-based voluntary alignment

Primary Care Hybrid Payment

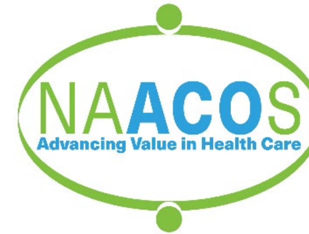
- NAACOS is advocating for a voluntary population-based payment option for primary care within MSSP
  - NAACOS & the Primary Care Collaborative led a sign on letter to CMS and convened a meeting with CMS to propose the option and two payment approaches
  - CMS subsequently held listening sessions on this topic with ACOs, primary care clinicians, & consumer advocates
- Key considerations for CMS:
  1. Guardrails to ensure practice-level payment changes
     - TIN-level participation agreement outlining payment arrangement
     - Spend plan with public reporting
  2. Additional supports needed for small/rural/safety net practices
  3. Increasing investment in primary care within constraints of ACO benchmarks

Rural and Safety Net

NAACOS convened a group of members serving rural and underserved communities to craft recommendations for how CMS can lower barriers for safety-net providers to participate in APMs:

- Consider a global budget or prospective population-based payment
- Lower discounts or minimum savings rate for rural providers in risk-bearing models
- Increase risk caps for rural populations or beneficiaries without historical access to care
- Account for social risk leveraging existing tools
- Waive the current one-visit, one-service requirement for FQHCs and RHCs.
- Remove face-to-face billing requirements for certain services like AWVs
- Develop unique attribution steps for safety-net providers in ACOs
- Pilot test quality reporting approaches for ACOs and other APMs
- Offer waivers that address the needs of safety-net providers

ALLIANCE FOR VALUE-BASED+ PATIENT CARE

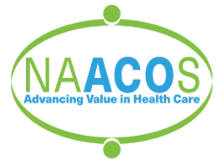


Launched in 2022 to better leverage strategic communications and support the advocacy of value-based care:

valuebasedcare.org

X and LinkedIn

How to Get Involved



Policy Committee

Government Relations Advocacy Call

Monthly discussion focused on Congressional activity for member GR teams

Advocacy and Learning Collaboratives

Quarterly discussion groups focused on advocacy and shared learning
ACO REACH; Patient Engagement; Rural and Underserved; Benchmarks; MA Risk Arrangements

Workgroups

Time-limited groups focused on advocacy or shared learning for a specific content area

- Specialty Engagement

Quality Committee

eCQM Implementation Workgroup

CMS Clinical Code Expansion

CMS has made several changes in recent years that impact clinical care in FFS payment

- **Evaluation and Management**—several updates to E/M coding and payment; changes to split visits; recent implementation of complexity add-on G2211 to support comprehensive primary care
- **Care management**—new CCM codes added in 2022; concurrent CCM/TCM billing for FQHCs and RHCs; chronic pain management treatment services added 2023; new codes for principal illness navigation, community health integration, caregiver training added for 2024
- **Telehealth**—expanded telehealth for mental health services; SDOH risk assessments added to telehealth services; PHE-related telehealth policies in effect through 2024
- **Remote monitoring**—new codes added in 2022 and 2023

CMS Clinical Code Expansion

- While these changes in FFS payment are positive for comprehensive, coordinated care, CMS has not made much progress innovating clinical care in value-based care models.
- NAACOS is advocating for changes in MSSP to enhance ability to improve clinical care:
  - More advanced waivers that have been tested in CMMI models
    - Care management and post-discharge home visits
    - Chronic Disease Management rewards program
    - Hospital at Home
  - Telehealth as a non-financial incentive for all ACOs
  - Changes to the Beneficiary Incentive Program (BIP) to enable ACOs to appropriately tailor to their populations' needs

MSSP Quality Req's

- 2021 & 2022 Medicare PFS Rules made significant changes to the way ACOs are evaluated on quality for purposes of MSSP – creating the new APM Performance Pathway (APP) quality structure
- APP was designed to align quality measurement and scoring in MSSP with the Merit-Based Incentive Payment System (MIPS)
- This will require ACOs to move to electronic clinical quality measure (eCQM) or MIPS CQM reporting for PY 2025 (data reported in early 2026)

Challenges

- Key challenges for ACOs moving to digital measures:
  - Data aggregation across disparate EHRs
  - Patient de-duplication
  - Costs (internal and vendor support)
  - Impact on quality scores due to all payer evaluation
  - Impact on ACOs with high proportions of specialists
- CMS is moving ACOs to eCQMs (QRDA I/III) or MIPS CQMs– at the same time CMS and ONC are focused on FHIR for the future

Medicare CQMs

- **NAACOS advocacy resulted in a new reporting option for ACOs –Medicare CQMs starting in 2024**
  - Reporting MIPS CQM measures on Medicare FFS patients meeting ACO assignment criteria
  - New CMS Medicare CQM checklist resource

Medicare CQM Patient =

- Meets the criteria for a beneficiary to be assigned to an ACO; and
  - Had at least one claim w/ a DOS during the measurement period 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 PA, NP or CNS
- A Medicare FFS beneficiary who is voluntarily aligned to the ACO

Medicare CQMs

- **CMS will provide ACOs with a quarterly list of beneficiaries eligible for Medicare CQMs in the Quarterly Informational Report Packages**
  - List will be cumulative and updated quarterly to reflect the most recent quarter's data
  - 4th quarter list of beneficiaries will include encounters w DOS 1/1-12/31 of the performance year – delivered typically in Feb.
  - List will include age, diagnosis, encounter and exclusion flags (to extent info is avail through claims and administrative systems) – flags meant to assist and do not replace the need to evaluate patients for the denominator criteria

- **Medicare CQMs can be submitted by the ACO or a third-party intermediary**
  - Allows for use of multiple data sources (like MIPS CQMs) to compile numerator and denominator
  - CMS created identifiers that reflect the quality number followed by "SSP" which must be included in submission files (001SSP, 134SSP, 236SSP)

Medicare CQMs

NAACOS
National Association of ACOs

Benchmarks

- For PY 2024 and 2025 CMS will score Medicare CQMs using performance period benchmarks since they will lack any historical data. In PY 2026, transitions to using historical benchmarks

Data Completeness

- For PY 2024, 2025, 2026 = 75% (CMS did not finalize increase in data completeness thresholds for MIPS)
- CMS resource

Availability

- CMS expects that the sunsetting of Medicare CQMs may be paced w the uptake of FHIR API technology, but this will be assessed on industry readiness and CMS requirements – intended to be a time limited, transitional reporting option

NAACOS Advocacy

- **NAACOS advocacy calling on CMS to continue all reporting options until feasibility for eCQMs and dQMs have been tested**
- **Other advocacy:**
  - Quality Committee
  - Policy Committee
  - eCQM Implementation Group
- **Resources:**
  - NAACOS quality webpage
  - New NAACOS Resources – reporting and scoring req's
  - QPP Resource Center

Aligning CEHRT Req’s w MIPS

- **For PY 2025 and subsequent years**, unless otherwise excluded, an ACO participant, ACO provider/supplier, and ACO professional that is a MIPS eligible clinician, Qualifying APM Participant (QP) or Partial Qualifying APM Participant (Partial QP), regardless of track, must:

1. Report the MIPS Promoting Interoperability (PI) performance category measures and requirements to MIPS according to 42 CFR part 414, subpart O, at the individual, group, virtual group, or APM entity level
2. Earn a MIPS performance category score for the MIPS PI performance category

- **Advocacy resulted in a one-year delay – NAACOS will continue to push for the removal of this burdensome requirement**

Aligning CEHRT Req's w MIPS

- An ACO participant, ACO provider/supplier or ACO professional that is excluded from PI requirements does not need to report. Examples of exclusions include:
  - Low volume threshold
  - Do not meet MIPS eligible clinician definition
  - Qualify for reweighting of the PI category to zero as set forth at § 414.1380(c)(2) – clinical social worker, clinical psychologist, PT, OT, SLP, audiologist, registered dietitian
- See Table 31 in final 2024 MPFS rule for examples

Aligning CEHRT Req's w MIPS

- If an ACO fails to meet these requirements, CMS may take remedial action before termination for noncompliance (warning notice, corrective action plan, or special monitoring plan)
- CMS notes participant agreements must allow the ACO to take remedial action against the ACO participant, including imposition of a corrective action plan, denial of incentive payments and termination of the ACO participation agreement detailed at §425.116(a)(7)
- ACOs must also publicly report total number of ACO participants, ACO providers/suppliers and ACO professionals that are MIPS eligible clinicians, QPs or Partial QPs that earn a MIPS PI score

Information Blocking

- Cures Act prescribes penalties for information blocking
  - Health IT developers, health information networks and health information exchanges face Civil Monetary Penalties (CMPs) up to $1M per violation
  - Healthcare providers will have “appropriate disincentives” – just proposed (comments closed 1/2/24)

Background

- **Information blocking is a practice that:**

1. Except as required by law or covered by an exception in subpart B or subpart C of this part, is likely to interfere with access, exchange, or use of electronic health information; and
2. If conducted by a health IT developer of certified health IT, health information network, or health information exchange, such developer, network, or exchange knows, or should know, that such practice is likely to interfere with access, exchange, or use of electronic health information; or
3. If conducted by a health care provider, such provider knows that such practice is unreasonable and is likely to interfere with access, exchange, or use of electronic health information.

Background

- NAACOS resource outlines the 8 exceptions finalized and key definitions
  - Preventing harm, privacy, security, infeasibility, health IT performance, content/manner, fees, licensing
  - ONC fact sheet
- Given the broad nature of the definition, NAACOS is advocating for more clear guidance & education on what constitutes info blocking

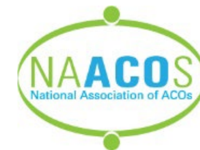
Proposed Rule

- Disincentives for hospitals and clinicians
  - Eligible hospital or CAH would not be a Meaningful EHR User for the Medicare Promoting Interoperability Program – loss of 75 percent of the annual market basket increase for hospitals
  - CAHs payment would be reduced to 100% of reasonable costs (not 101%)
  - An eligible clinician or group would not be a meaningful user of CEHRT under the MIPS Promoting Interoperability performance category for the applicable PY (accounts for a portion of the overall MIPS score)

Proposed Rule

- **Disincentives for ACOs**
  - A healthcare provider would be deemed ineligible to participate in MSSP for a period of at least one year if found to have committed info blocking
  - Can remove from ACO or prevent from joining an ACO
- CMS would screen ACOs, ACO participants and ACO providers/suppliers for an OIG determination of info blocking and deny the addition of such providers to an ACO's participant list for a period of at least one year

Proposed Rule



- **Disincentives for ACOs**
  - If ACO reapplies in a subsequent year, CMS will review whether OIG had any subsequent determinations of info blocking, and if corrections and safeguards had been put in place to prevent reoccurrence – as part of the application process
  - CMS will notify an ACO if one of its participants, providers or suppliers committed info blocking so the ACO can take remedial action (remove from ACO)
  - **Because MSSP is a full TIN program – need clarification from CMS regarding how this will work**

NAACOS Comments

- **NAACOS comments raised concerns with approach to prohibit participation in the MSSP as a disincentive and stressed that this approach penalizes patients by blocking participation in value models aimed at improving patient care**
- Other key recommendations:
  - Don’t apply penalties that prohibit participation in value-based care models. Instead, CMS should look to ACOs as partners in advancing interoperability and assisting in identifying and remediating cases of information blocking.
  - Apply a Corrective Action Plan rather than imposing financial penalties.
  - Focus first on establishing a joint CMS-ONC educational campaign to increase awareness among health care providers in regard to what constitutes information blocking.
  - Avoid double penalizing health care providers found to have committed information blocking.
  - Clearly outline the appeals rights of ACOs and the clinicians in an ACO, which should be aligned with those afforded to health IT developers and vendors.

Prior Auth Final Rule

- Final rule sets requirements for MA plans, Medicaid and CHIP FFS and managed care programs and Exchange Qualified Health Plans to improve the electronic exchange of health information and prior authorization processes.
  - Final rule
  - Fact sheet
- Rule establishes requirements for payers to streamline the prior authorization process beginning in 2026 requiring prior auth decisions to be sent within 72 hours for expedited requests and 7 calendar days for standard requests (some exceptions for Exchange plans).
- Requires payers to implement HL7 FHIR Prior Auth application programming interface (API) which can be used to facilitate a more efficient electronic prior auth exchange (enforcement effective Jan. 2027).
  - Medicare FFS has already implemented an electronic prior auth API

Discussion and Questions

NAACOS
National Association of ACOs