Washington Update

NAACOS Government Affairs Team

Spring 2024

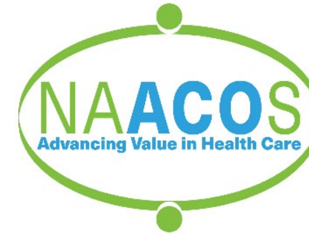
2024 Priorities

- 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

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

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

Landscape of CMMI Models

Total Cost of Care / Global Budget

Model	Status
ACO REACH Model (formerly Direct Contracting)	*Operating through 2026*
Comprehensive Kidney Care Contracting	*Operating through 2026*
CHART Model (community transformation)	*Operating through 2028*
Enhancing Oncology Model	*Operating through June 2028*

State-Based

Model	Status
States AHEAD	*Applications due Mar. & Aug. 2024*
Transforming Maternal Health	*Applications due Summer 2024*
Innovation in Behavioral Health	*Begins Fall 2024*

Primary Care Capitation

Model	Status
Primary Care First	*Operating through 2026*
Kidney Care First	*Operating through 2026*
Making Care Primary	*Begins July 1, 2024*

Episode-Based Payments

Model	Status
BPCI Advanced	*Operating through 2025*
Comprehensive Care for Joint Replacement*	*Operating through 2024*
ESRD Treatment Choices Model*	*Operating through June 2027*
GUIDE (Dementia Care Model)	*Begins July 1, 2024*

RFI on future episode-based payment model design released 07/14/2023

*indicates mandatory model

Medicare Enrollment Trends will Impact Future Accountable Care Approaches

60
50
40
(%) 30
20
10
0

2014 2015 2016 2017 2018 2019 2020 2021 2022

46.57
25.9
17.78
9.75

Medicare ACO
Traditional Medicare (full coverage, non-ACO)
Medicare Advantage
Other (partial coverage)

Source: Medicare Enrollemnt Files,
analyzed by the Institute for Accountable Care

Phase I: Data Sharing

Product: **Playbook** of best and promising practices for overcoming key challenges associated with data sharing for VBC arrangements that persist today, taken directly from the expertise of those participating.

The Future of Sustainable Value-Based Payment:

Voluntary Best Practices to Advance Data Sharing

2023

Advance Action That Accelerates Value

Ensure Strong Financial Incentives to Move to Value

- Benchmarks should reflect the complexity of the patient population and be predictable
- Recognize the up front and ongoing investments (advanced investment payments, prospective-population based payments for primary care)
- Revise the MACRA Incentives to be simpler and more timely

Create Stronger Non-Financial Incentives

- Remove administrative burden and increase flexibility in models

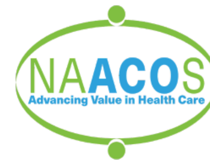
Bolster Benefit to Patients

- Savings generated in models are reinvested in patient care
- Creates opportunity for enhanced/supplemental benefits in traditional Medicare; additional flexibility needed to adjust patient cost sharing

Simplify Quality Measurement

- Thoughtfully move to digital measurement and create pathways for providing more data at the point of care

How to Get Involved



Policy Committee

Government Relations Advocacy Call

Monthly discussion focused on Congressional activity for member GR teams

Advocacy and Learning Coalitions

Groups focused on advocacy and shared learning:
ACO REACH; Patient Engagement; Rural and Underserved; Benchmarks; Medicare Advantage; High Needs Beneficiaries

Workgroups

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

- Specialty Engagement

Quality Committee

eCQM Implementation Workgroup

Congressional Advocacy

What's Happening on Capitol Hill?

APM Extension & Doc Fix– Congress passed a one-year 1.88 percent APM bonus extension for Payment Year 2026 and reduced qualifying thresholds to 50 percent; also offset portion of physician payment cuts.

MACRA Reform– Bipartisan efforts underway in the House and Senate to look at options to reform Medicare payments.

NP Assignment Bill– A bipartisan group of House and Senate members introduced a bill to remove the physician visit requirement for ACO assignment. NAACOS supports expansion but has concerns that as drafted the bill could result in cost increases for some ACOs due to NPPs that practice with specialists.

Medicare/ Medicaid Duals– Bipartisan group of Senators introduced legislation to improve the programs and process for duals. NAACOS has been working with offices and is encouraged that they are committed to improving the bill with input from ACOs.

Primary Care– Senator Whitehouse released a "discussion draft" looking at options to develop a hybrid-payment for primary care and establish a technical advisory committee to address RVUs.

Telehealth & Hospital @ Home– Lawmakers are beginning to discuss options for expending these pandemic era programs before expiration at end of 2024.

Health Care Costs & Transparency– In 2023, House and Senate committees passed legislation to address PBM reform and health care transparency. Disagreements over site-neutrality and PBM reforms disrupted progress; could become an issue again after the 2024 election.

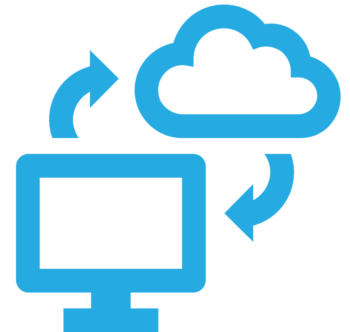
APM Bonus Extension

- NAACOS is pleased that Congress recently passed a short-term APM extension and doc fix, but more work remains.
  - **APMs—** Provides a **1.88 percent** advanced APM incentive payment for Performance Year 2024 (Payment Year 2026) and lowers the APM qualifying thresholds from 75 percent back to 50 percent for this performance year.
    - Still less than current 3.5% bonus but higher % than SFC and E&C originally proposed last year.
    - No phase out of incentives that was included in the House Energy and Commerce bill.
    - Total advanced APM incentive = 2.63% when including 0.75 differential conversion factor.
    - MIPS still has higher financial incentives.
  - **Physician Payment Increase—** Increases the Medicare conversion factor by **1.68 percent** to partially offset the 3.4 percent payment cut that went into effect on January 1, 2024.
- **MACRA 2.0—**We encourage members to review these draft reform concepts and provide our us with feedback at advocacy@naacos.com. (see Appendix)

Congressional Priorities

Reform Medicare Physician Payments to Encourage Movement to Value

Require CMS to Pilot New Digital Quality Requirements Before Final Implementation



Medicare Incentives Favor Status Quo

MACRA's Differential Conversion Factor Updates

One Year
1.88 Percent
Advanced APM
Bonus
Extension

Fee Schedule Update (Percent)

20.00%
15.00%
10.00%
5.00%
0.00%
-5.00%
-10.00%

2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047

Year

CF Update
Advanced APM CF Update
CF Update +CY24 Estimated Max MIPS
Advanced APM CF Update +Incentive

- Beginning in Payment Year 2026 (Performance Year 2024), incentives will favor clinicians who are not participating in advanced APMs and remain in MIPS.
- **Modeling these changes out several years, <u>2032 will be the first year in which incentives again favor clinicians in advanced APMs.</u>**
- Congress needs to reform MACRA and promote solutions for incenting accountable care.

NAACOS 2024 Congressional Priorities

✓ Reform Medicare Physician Payments to Encourage Movement to Value

- Stabilizing Medicare's payment system to account for inflation and ensuring payment adequacy is necessary to help physicians and allow them to continue investing in the infrastructure and staffing necessary to transition into value-based payment models.
- Going forward lawmakers need to:
    - **Develop a new payment system that accounts for inflation in payment updates.**
    - **Ensure that payment updates do not impact a provider's ability to meet financial targets in APM models.**
    - **Maintain stronger financial incentives for physicians that move into APMs.**
    - **Reduce program complexity by ensuring that clinicians in APMs are not required to engage in duplicative quality reporting efforts,**
    - **Emphasize that MIPS should prepare and encourage adoption of APMs.**
    - **Ensure that promising aspects of innovative models have a more predictable pathway for being implemented and becoming permanent.**
        - While updating Medicare's incentive structure will take time, in the short-term, lawmakers should cosponsor and support the **Value in Health Care Act (H.R. 5013/S.3503)**.

✓Require CMS to Pilot New Digital Quality Requirements Before Final Implementation

- Clinicians in APMs should not be required to make investments in new reporting approaches until the data and infrastructure required to report digital quality measures is widely adopted.
- CMS should first pilot test these new digital quality measures for a subset of APMs and ACOs to identify key challenges and unintended consequences that need to be resolved before moving forward on a program-wide basis.
- Congress and CMS should provide incentives to do this testing.

Administration Updates

MSSP Priorities

- Improved beneficiary notification approach
- Reduce burden associated with quality reporting
- Incorporate known innovations in MSSP
  - Hybrid primary care payment ✓
  - Enhanced+

Patient Engagement

NAACOS launched its patient engagement strategy in 2023 which has accomplished:

1. Formation of the Patient Engagement Advocacy & Learning Coalition to convene ACO members for advocacy and shared learning.
2. Update to NAACOS' fact sheet on ACOs & Patients, highlighting patient stories shared by members.
3. Meetings with patient and consumer advocacy organizations to build relationships and align on shared priorities.
4. Survey to gather data about how ACOs use patient board representatives, patient engagement tools and incentives, and what additional resources are needed in this space. Published findings.
5. Release of the new resource *Recruiting & Engaging Patient Representatives: Foundations & Best Practices for ACOs*

Building on this work, NAACOS in partnership with the Health Care Transformation Task Force (HCTTF) convened a group of ACOs, patient and consumer advocacy organizations, and other stakeholders to discuss improvements to ACO program requirements related to patient engagement and develop joint recommendations for driving person-centeredness in ACO program policies.

Person-Centered Care in ACOs

- **Convening focus:** Beneficiary notifications, marketing rules, patient-centeredness criteria, shared governance, voluntary alignment, waivers/incentives to engage beneficiaries in their care.
- **Key discussion themes:**
  - Current program requirements do not achieve shared goals for patient-centeredness and meaningful patient engagement.
  - Need for short-term and long-term recommendations to address underlying issues in the design of program requirements.
  - One of the benefits of ACOs is care that is customized to the patient—communications and engagement efforts should also be customizable to patients' needs and preferences.
  - Short-term: technical fixes to beneficiary notifications, voting rights for MSSP beneficiary board reps, more beneficiary education on ACOs from CMS at Medicare enrollment.
- **Next steps:** Publish a resource outlining challenges with current requirements, immediate improvements, and long-term recommendations for aligning program requirements with a shared vision for the future of patient engagement in value-based care.

ACO Primary Care Flex Model

- CMS announced the ACO PC Flex Model on March 19 to test providing monthly, prospective population-based payments and a one-time advanced shared savings payment to ACOs in MSSP
  - NAACOS and others have been advocating for a hybrid (part-FFS, part-PBP) primary care payment option in MSSP
- Model will run from Jan. 1, 2025 – Dec. 31, 2029

Eligibility: All low-revenue ACOs in MSSP

- Current participants must start a new agreement period
- Cannot also participate in the Advanced Investment Payment (AIP) program
- High-revenue ACOs are excluded
- Approximately 130 ACOs will be selected to participate

Timeline:

- **May 20 – June 17, 2024:** MSSP Application. ACOs should indicate interest in the ACO PC Flex Model
- **Second Quarter 2024:** RFA released
- **August 2024**: ACO PC Flex Model Application
- **Fourth Quarter 2024:** ACO PC Flex Model Signing
- **January 1, 2025**: Model start date

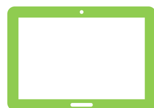
ACO Primary Care Flex Model

- **Advanced Shared Savings Payment:** Participating ACOs will receive upfront Advanced Shared Savings Payment of $250,000
  - May cover costs associated with forming an ACO/administrative costs associated w/ model participation
- **Prospective Primary Care Payment (PPCP):**
  - Monthly, prospective payment that replaces FFS primary care services for all primary care providers, FQHCs, and RHCs.
  - CMS will calculate the payment rate based on average primary care spending in the county plus an enhanced amount based on characteristics of the ACO and its assigned patient population.
  - Providers will submit claims as usual, and Medicare will zero-out the payment.
  - ACOs will distribute the PPCP to their participant primary care providers, FQHCs and RHCs. CMS will require ACOs to publicly report information on the distribution of the PPCP.
  - Since FQHCs and RHCs are not paid FFS, CMS will make a beneficiary-level adjustment to the PPCP for beneficiaries who receive the plurality of primary care services based on allowable charges at FQHCs or RHCs.
- **More information**: Fact sheet, CMS press release, FAQs, Infographic

MSSP Quality Overview

The new APP approach reduced the measure set to 3 clinical quality measures, 2 claims measures and the CAHPS for MIPS survey

When MSSP started there were over 30 quality measures, all reported via Web Interface (sample of ACO patients)



The APP requires reporting via eCQM, MIPS CQM or Medicare CQM and will retire the Web Interface in PY 2025 (data reported in early 2026)

CMS has also prioritized digital quality measurement (dQMs) and has ambitious goals to transition all measures to digital measures at some point in the future

MSSP Quality Overview

2021-2024: ACOs can report either WI, eCQMs, MIPS CQMs or Medicare CQMs or both/all. If you report via multiple types, you will receive the highest of the scores

2022-2024: Policy incentives for those who report eCQMs or MIPS CQMs

2024: Quality Performance Standard Increased from 30th percentile of MIPS quality performance category scores, to the 40th percentile of MIPS quality performance category scores - 77.05 for PY 2024

2025 & subsequent years: All ACOs must report eCQMs, MIPS CQMs or Medicare CQMs

MSSP Quality Updates

- New Medicare CQM reporting type available for PY 2024 - CMS now sharing Medicare CQM quality data with all ACOs via quarterly informational reports
- PY 2023 quality reporting deadline extended to April 15th due to Change Healthcare disruptions
- Looking ahead - CMS looking to align quality measure set with Universal Foundation measure set in future years (2025)
  - Would add composite vaccination measure, Substance Use Disorder treatment measure and SDOH screening measure

2024 APP Quality Measures

eCQM, MIPS CQM, Medicare CQM	Web Interface
Diabetes HbA1c Poor Control (>9%)	Diabetes HbA1c Poor Control (>9%)
Controlling High Blood Pressure	Controlling High Blood Pressure
Screening for Depression and Follow-up Plan	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
CAHPS for MIPS Survey	Screening for Future Fall Risk
Administrative Claims Measures: 1. Hospital wide 30-day, all cause unplanned readmission rate 2. Hospital admission rates for patients with multiple chronic conditions	Influenza Immunization
	Tobacco Use: Screening and Cessation Intervention
	Colorectal Cancer Screening
	Breast Cancer Screening
	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
	Depression Remission at 12 Months
	CAHPS for MIPS Survey
	Administrative Claims Measures: 1. Hospital wide 30-day, all cause unplanned readmission rate 2. Hospital admission rates for patients with multiple chronic conditions

*Measure specifications and benchmarks vary based on reporting method selected; shading indicates outcome/intermediate outcome measure

Enhanced Plus

- NAACOS continues to advocate for a higher/full-risk track in MSSP
  - This is difficult because CMS Actuary says it'll cost money
- 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

CMMI Model Innovations

- Ensure a pathway beyond ACO REACH
- Ensure new models support total cost of care approaches

Post-REACH ACO Ideas

- Benchmarks
  - Testing administrative benchmarks
  - Test novel risk adjustment approaches
  - Build on social risk data collection
  - Other health equity adjustments
- Novel voluntary alignment approaches
- Nested episodic and specialty models
  - High Needs, oncology, kidney care

Expanding ACOs & TCOC models

- NAACOS has a goal to bring more providers into ACO models
- Over the past year we have developed recommendations how existing and future models can include additional types of providers
  - **Safety-net providers** (letter and blog)
  - **Long-term, post-acute care providers** (published a paper in a partnership with the American Health Care Association and National Center for Assisted Living)
  - **Specialists** (letter)
- Key themes address alignment, benchmarks, waivers specific to provider types, and data)

GUIDE & AHEAD Models

GUIDE Model

- Despite its benefits and opportunity to help dementia patients, ACOs have concerns
  - GUIDE payments counting as ACO expenditures
  - Respite care is undervalued
  - High complexity and burden
  - Ripe for bene confusion
- NAACOS is working to address these points and improve the model for ACOs

AHEAD

- ACOs will be accountable for hospital spending on aligned benes
  - Services covered by hospital global budget will be paid from that budget
  - It's unclear in overlap guidance published by CMS what at what rate those hospital services will be paid
- NAACOS is working here to address these points and improve the model for ACOs

Expanding Participation – Rural and Underserved

- Must modify core elements of ACO models to account for safety-net provider challenges
  - Rural and underserved communities are health professional shortage areas
- Judging ACO performance based on savings achieved compared to their historical spending may not be appropriate for these ACOs
  - Limited ability to reduce costs; lower cost settings may be unavailable
- **We need a new paradigm where safety-net-minded APMs focus on increasing or maintaining access rather than purely reducing costs**
  - Models should incentivize improving access over cost reductions

Expanding Participation – Rural and Underserved

Payment Challenges

- Allow care management services to be billed more than once a month
- Waive the current one-visit, one-service requirement for FQHCs and RHCs
- Remove face-to-face billing requirements for certain services like annual wellness visits

Assignment

- Create workarounds for the statutorily required physician-visit
- Multi-year alignment approaches
- Advanced Practice Provider (APP) attribution or removal of physician pre-step in rural communities

Benchmarking

- Consider a global budget or prospective population-based payment approaches
- Adapt risk adjustment policies to not disadvantage sicker populations
- Account for costs that are specific to rural communities (e.g., air ambulance)

Expanding Participation – Post-Acute Care

- Limited ACO participation today by post-acute, long-term care providers
  - Fewer than 2,000 SNFs participate in ACOs, representing less than 10% of SNFs
  - Fewer than 10 percent of ACOs account for nearly three-quarters of SNF participation
  - Nearly 70 percent of ACOs have no SNF participation
- Yet great opportunity remains
  - 40% of inpatient hospital discharges are followed by LTPAC services, totaling nearly 2 million SNF stays per year.
- AHCA/NCAL and NAACOS gathered a roundtable of LTC representatives, ACO leaders, patient advocacy organizations, providers, and health care payers in 2023
- Full details of each recommendation can be found in our White Paper

Expanding Participation – Post-Acute Care

Alignment for Beneficiaries Residing in LTPAC Facilities

- CMS should allow attribution at the facility level, through the facility CMS Certification Number
- Under current policy, patients are attributed to ACOs through clinician-level visits, which are not appropriate for LTPAC patients

Financial Methodology

- CMS should account for the sickness of patients in ways that are more appropriate for LTPAC patients
- Specifically, it should use concurrent risk adjustment

Quality Measurement

- The LTPAC population needs a distinct set of quality metrics that are clinically pertinent and meaningful to their wellbeing.

Data

- CMS should regularly share utilization and cost data
- Technical assistance, particularly for SNFs that are less likely to have robust data infrastructure.

Expanding Participation- Specialists

- Share data on cost and quality performance for specialists with ACOs – resulted in CMS sharing new bundles data w/ MSSP ACOs
- Support total cost of care ACOs with shadow or nested bundled payments for those who elect these arrangements
- Address policy and program design elements that currently are prohibitive to this work

Medicare Advantage

NAACOS launched its Medicare Advantage Advocacy & Learning Coalition April 2, 2024:

1. Formation of the **Medicare Advantage ALC** to convene ACO members for discussing and prioritizing MA topics, sharing best practices, and working on advocacy opportunities
2. Key focus areas include: Quality, Stars, RAF, data/transparency, contracting and payment transparency, supplemental benefits, health equity
3. Examples of Deliverables/Outcomes: content development, live or virtual webinar series/conference/panel discussions delving deeper into various MA topics, sharing best practices, highlighting key positions to advocate for, etc.
4. MA Transparency & Data Collection RFI Letter (CMS released a request for information seeking feedback on how to improve data sharing and transparency in MA)
5. Final Rate Notice: payments from government to MA plans holding still at the 3.7% increase, in addition to STARS and RAF/HCC v28 changes, may have significant pressures on plans which result in downstream impacts on providers reflected in more aggressive payment targets/arrangements meanwhile battling higher cost scenarios in utilization, self-selection, and part D costs.

Health IT Priorities

- Expanding access of data across all lines of business
- Determining member needs in emerging HIT topics such as AI
- Ensuring EMRs and other health IT products support population health efforts
- Education on emerging health IT topics affecting value based care

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

Exec Order on AI

- President Biden issued an executive order on artificial intelligence (AI), requiring HHS to establish an AI Task Force. Will tackle areas such as:
  - Use and maintenance of predictive AI technologies in health care delivery and financing (including quality measurement)
  - Safety and performance monitoring of AI-enabled technologies in health care delivery and financing
  - Advance best practices for AI use in state/local settings
  - Identify AI use cases for reducing administrative burdens in HHS
- Also requires guidance in this area, including how to prevent discrimination within AI and an AI safety program
  - Includes identifying clinical errors in AI technology
  - Establishes a central repository for tracking discrimination or bias

Information Blocking Proposed Rule

- 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 also face penalties – proposed rule released outlining these including some focused on ACO participation
- Information blocking is a practice that is likely to interfere with access, exchange, or use of electronic health information
  - 8 exceptions
- See detalis on reported info blocking on the ONC website
  - 987 reported thus far

Info Blocking Proposed Rule

- 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

Info Blocking Proposed Rule

Claims Counts by Potential Actor

Health Care Provider
CHPL-listed Health IT Developer
Non-Actor
Unknown
Non-CHPL-listed Health IT Developer
HIN/HIE

0 100 200 300 400 500 600 700 800

https://www.healthit.gov/data/quickstats/information-blocking-claims-numbers

Info Blocking Proposed Rule

- Info blocking disincentives for hospitals and clinicians
  - **Hospitals** -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%)
  - **Clinicians** - 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)

Info Blocking 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

Info Blocking 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**

Info Blocking Proposed Rule

- **NAACOS comments: concerned w/ approach prohibiting participation in the MSSP as a disincentive. This 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.

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 – **CMS reports small practice exception does NOT apply to practices in an ACO**

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
- Resources available on NAACOS website

Appendix

MACRA Reform Ideas

Goal: Legislation introduced in next Congress (early 2025)

Key Objectives:

1) **Establish stable physician payment updates**
    - MACRA currently includes a differential conversion factor payment update
    - Physician community is currently pushing for an inflationary payment update
2) **Increase financial incentive to drive more value adoption**
    - Financial incentives for APMs should be stronger than for MIPS
3) **Reduce program complexity**
    - APMs should be goal for all clinicians; quality is inherent in APM model; clinicians in APMs should not be required to engage in quality in the model and in MIPS
    - Emphasize that MIPS approach should prepare and encourage adoption of APMs
    - Streamline qualification and payment of incentives

Reform Options:

- ***Option 1:*** Incentives Based on Medicare Economic Index (MEI)
- ***Option 2:*** Incentives Based on the Status Quo (Differential Conversion Factor w Bonuses)

Option 1: Incentives Based on MEI

Eliminate Differential Conversion Factor & Replace with Medicare Economic Index (MEI)

- **Structure– Option A**
  - 50% MEI update for clinicians not in APMs (aligns with MedPAC payment recs)
  - XX% for clinicians in upside only APMs
  - XX% for clinicians in risk-bearing APMs
- **Structure– Option B**
  - All clinicians receive the same MEI update
  - A percentage of the total annual MEI is put into bonus pool for APMs and advanced APMs
- **Structure– Option C** (*Hybrid Combination*)
  - MEI scaled update for everyone (Option A)
  - MEI bonus pool funds for APMs (Option B)

Incentives Based on MEI: Considerations

Key Benefits

- Simplified structure: all clinicians in an APM receive the same update for that year
- Avoids 2-year lag in incentives & need for thresholds to qualify
- Accounting for higher payments in benchmarks/expenditures is simpler than potential approaches for differential CF

Other Considerations for Discussion

- Demonstrating that all clinicians in APMs are vested in the model
  - Current concern that specialists are not truly participating in APMs
  - Need varying approaches for participant versus preferred providers
    - Participant providers: Receive full incentives for participation
    - Preferred providers: Full incentives dependent on participation across APMs
      - Approach varies based on whether individual or APM entity receives incentive
      - Note: requires changes to MSSP structure
- Incentive Payment to APM Entity or Participating Clinician
  - NAACOS members would prefer to receive incentive payments directly so that they can build incentive structures for clinicians
  - This approach faces significant pushback from Congress. At a minimum, guardrails would be required to demonstrate that clinicians benefit from incentives (required reporting, minimum requirements for what is passed to clinicians)
  - Option 3 creates a hybrid approach. Higher payment to clinicians with bonus pool to the ACO
- Rewarding value adoption in MA or with other payers?

Option 2: Incentives Based on the Status Quo

Maintain Differential Conversion Factor & Establish New Bonus Structure

- Differential CF: safeguards to address differential conversion factor impact on ACO benchmarks
- Bonus: New simplified structure with phase out options
    - Amount: revenue through APM OR set per bene amount; amount must be higher than highest MIPS adjustment
        - Allow APMs to choose AAPM incentives or MIPS Incentives
    - Bonus withhold that goes to APM entity
    - Develop mechanism for potion of APM savings and loss repayments to be invested into the Medicare improvement fund or high-performance bonus pool