AMERICA'S PHYSICIAN GROUPS

September 12, 2025

Mehmet Oz, MD, MBA
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted via https://www.regulations.gov/document/CMS-2025-0304-0009

**Re: 2026 Physician Fee Schedule and Medicare Shared Savings Program Proposed Rule [CMS-1832-P]**

Dear Administrator Oz:

America's Physician Groups (APG) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) 2025 Proposed Rule for the Medicare Physician Fee Schedule and Medicare Shared Savings Program. We welcome the agency's openness to stakeholder input and its ongoing commitment to improving health care for all Americans.

Below, APG will first provide (I) a brief description of our organization, followed by (II) a summary of CMS's proposed rule, (III) a summary of APG's recommendations, (IV) our fuller comments and recommendations. Together they reflect the voice of APG's membership and the commitment to working with the agency to ensure that all Americans have consistently accessible, high-quality, equitable, person-centered health care.

## I. About America's Physician Groups

APG is a national association representing approximately 340 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models and capitated and delegated relationships with health plans in Medicare Advantage (MA). APG members collectively employ or contract with approximately 260,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for approximately 90 million patients, including an estimated 1 in 4 Americans and 1 in 3 Medicare Advantage enrollees.

APG's motto, "Taking Responsibility for America's Health," underscores our physician groups' preference for being in risk-based, accountable, and responsible relationships with all payers, including MA health plans, rather than being paid by plans on a fee-for-service basis. Delegation of risk from

payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide.

## II. CMS Proposed Rule

In the proposed rule, CMS proposes policy changes to the Physician Fee Schedule (PFS), the Medicare Shared Savings Program (MSSP), and the Quality Payment Program (QPP). CMS also proposes a new specialist model, new reimbursement policies for drugs eligible for reimbursement under Medicare Part B, and submits various Request for Information (RFI). These steps align with CMS' strategy to create a health care system that results in better quality, efficiency, empowerment, and innovation for all Medicare beneficiaries.

## III. Summary of APG's Recommendations

### A. Recommendations Related to Physician Fee Schedule

- **APG appreciates the increase to the 2026 physician fee schedule conversion factor of more than 3 percent and urges Congress and CMS to make additional increases in future years' updates to reverse the erosion in physician payment over multiple years.**

- **APG strongly recommends that CMS finalize the proposal to reclassify skin substitutes as incident-to supplies and set payment rates uniformly across different outpatient settings at the highest average for the FDA's three categories of skin substitutes.**

- **APG recommends that CMS finalize the proposal to streamline the process that permits Medicare to pay for telehealth services by removing the provisional category of telehealth services.**

- **APG recommends that CMS finalize the proposal to permanently remove frequency limits for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.**

- **APG recommends that CMS finalize the proposal to permanently adopt a definition of "direct supervision" that permits the practitioner to provide supervision through real-time audio and visual interactive telecommunications.**

- **APG recommends that CMS finalize the proposal to integrate behavioral health into advanced primary care management (APCM) with the creation of three new add-on codes for behavioral health integration (BHI) and psychiatric collaborative care model (CoCM).**

- **APG recommends that CMS finalize the proposal to test a fully online, asynchronous option for delivering Medicare Diabetes Prevention Program (MDPP) care.**

**B. Recommendations Related to MSSP**

- **APG recommends that CMS finalize the proposal to permit risk-inexperienced MSSP ACOs to participate under a one-sided model for only up to five performance years under the ACO's first agreement period in the BASIC track's glide path.**

- **APG recommends that CMS allow 60 days for ACOs to notify the agency about updates in their certified ACO participant list with (1) a TIN newly enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS) with no prior Medicare billing claims history, and to do so (2) for an ACO participant that experiences a CHOW during the performance year and outside of the annual change request cycle.**

- **APG recommends that CMS finalize the proposal to allow a SNF affiliate undergoing a change of ownership (CHOW) resulting in a new TIN to be added to the list of SNFs participating in the three-day waiver. Doing so would allow a seamless continuation of care pathways.**

- **APG recommends that CMS modify the proposal to allow MSSP ACOs entering a new agreement period to have fewer than 5,000 assigned beneficiaries by permitting this leniency in each of the three benchmark years if the ACO participates in the BASIC track and face potential – but not automatic – savings and losses at a lower amount.**

- **APG recommends that CMS finalize the proposal to expand the definition of "primary care services" for purposes of beneficiary assignment to MSSP ACOs to include new behavioral health integration and psychiatric collaborative care management add-on services.**

- **APG recommends that CMS retain the use of code G1036 Administration of a standard, evidence-based social determinants of health risk assessment tool in the definition of primary care services used for purposes of assignment to MSSP ACOs with a name change to better reflect the characteristics captured by this tool.**

- **APG recommends that CMS finalize the proposal to revise the definition of a beneficiary eligible for Medicare clinical quality measures (CQMs) to those with a primary care service from selected clinicians, including primary care providers, designated specialists, physician assistants, nurse practitioners, and clinical nurse specialists.**

- **APG recommends that CMS align the breast cancer screening and colorectal cancer screening between measure sets by excluding any requirements to document discussions.**

- **APG recommends that CMS continue to allow MSSP ACOs to report Medicare CQMs until 2032 to allow smaller rural practices time to prepare to report digital**

**measures.**

- **APG recommends that, if CMS removes the Health Equity Adjustment applied to an ACO's quality score, the agency increases the maximum adjustment available from the complex organization adjustment to 10 points.**

- **APG recommends that CMS not automatically terminate any ACO contract based on failure to meet quality standards, but rather decide on a case-by-case basis the best option based on individual ACO circumstances.**

- **APG recommends that CMS finalize the proposal to add cyberattacks, including the introduction of ransomware and malware, as qualifying events for "extreme and uncontrollable circumstances" (EUC) and encourages CMS to take an expansive view of what constitutes a cyberattack when determining EUC applications.**

- **APG recommends that CMS finalize the proposal to rename the health equity benchmark adjustment (HEBA) to the "population adjustment" to better reflect the methodology underlying the calculation of the adjustment.**

**C. Recommendations Related Quality Payment Program (QPP)**

- **APG recommends that CMS finalize the proposal to add a determination of all eligible clinicians in Advanced APMs for Qualifying APM Participant (QP) status at the individual level, in addition to determinations at the APM Entity level.**

**D. Recommendations Related to Ambulatory Specialty Model (ASM)**

- **APG supports CMS's proposal to test an Ambulatory Specialty Model (ASM) but recommends that the agency to explore other options for integrating specialists into these existing efforts and employing MVPs for the measurement of their performance.**

## IV. APG's Detailed Comments and Recommendations

### A. Physician Fee Schedule

#### i. Physician Fee Schedule Payment Update

Beginning in 2026, there will be two separate conversion factors for Qualifying APM Participants (QPs) and non-QP clinicians. The update to the qualifying APM conversion factor (which applies to PFS payments for QPs) for CY 2026 is 0.75 percent while the update to the nonqualifying APM conversion factor (which applies to PFS payments for all other clinicians) for CY 2026 is 0.25 percent. The change to

the PFS conversion factors for CY 2026 includes these updates as required by statute, a one-year increase of +2.50 percent for CY 2026 stipulated by statute, and an estimated 0.55 percent adjustment necessary to account for proposed changes in work RVUs. Thus, the CY 2026 qualifying APM conversion factor represents a projected increase of $1.24 (3.8%) from the current conversion factor of $32.35, for a total of $33.59. Similarly, the CY 2026 nonqualifying APM conversion factor represents a projected increase of $1.07 (3.3%) from the current conversion factor of $32.35, for a total of $33.42.

APG commends the efforts of Congress and CMS to increase the conversion factor but is concerned that additional increases will be necessary to reverse years of minimal or no increases. Inflation-driven increases to rent and labor costs place considerable financial strain on providers. While APG understands that there is data lag inherent in CMS's collection of information about input costs, we urge CMS to continue seeking more timely information about practice expenses for its RVU updates. Providers do not experience a data lag; practice expenses are incurred as outlays are made, regardless of whether RVUs are updated in a timely way.

- **APG appreciates the increase to the 2026 physician fee schedule conversion factor of more than 3 percent and urges Congress and CMS to make additional increases in future years' updates to reverse the erosion in physician payment over multiple years.**

### ii. Determination of Relative Value Units (RVUs) and Geographic Practice Cost Indices (GCPIs)

CMS proposes modifications to certain RVUs and GPCIs used to calculate PFS payment rates. Starting in 2026 and applying to Work RVUs, CMS proposes applying a productivity adjustment of minus 2.5 percent for services that are expected to become more efficient over time.

CMS has also proposed changes to the calculation of practice expense RVUs. The agency recognizes that providers in office-based settings face greater costs compared to providers in facility settings and proposes a methodological change that reflects this fact.

CMS also added further refinement for malpractice (MP) RVUs, clarifying that certain specialties require imputed data on premiums. Statute requires CMS to periodically review and update GCPIs and provide updates. CMS provides these required updates in Addendum D and E of the proposed rule.

APG members are confused about CMS's rationale for which specialties would receive conversion factor increases and decreases (see Table 1). Although APG understands that CMS is statutorily required to make any PFS changes on a budget neutral basis, the agency's proposed changes do not seem to align with the goal of restraining cost growth for specialties and services that are expected to become more efficient over time while allocating more resources to those that are time based. APG members are particularly concerned about the 1 percent cut to the conversion factor for physical therapy (PT) and occupational therapy (OT), interventions that are vital to the health and wellness of Medicare enrollees and are an effective tool for lowering downstream costs. Yet because of low reimbursement rates, providers are already reporting difficulties in finding practitioners who will accept Medicare or other insurance. CMS's proposed 2026 rates for PT and OT services thus risk increasing the severity of provider shortages.

**Table 1. CY 2026 PFS Estimated Impact on Total Allowed Charges by Specialty**

| (A) Specialty | (B) Total: Non-Facility/Facility | (C) Allowed Charges (mil) | (D) Impact of Work RVU Changes | (E) Impact of PE RVU Changes | (F) Impact of MP RVU Changes | (G) Combined Impact |
|---|---|---|---|---|---|---|
| ALLERGY/IMMUNOLOGY | *TOTAL* | $212 | 0% | 7% | 0% | 7% |
| | *Non-Facility* | $204 | 0% | 8% | 0% | 8% |
| | *Facility* | $8 | 0% | -11% | 0% | -11% |
| ANESTHESIOLOGY | *TOTAL* | $1,595 | 0% | -1% | 0% | -1% |
| | *Non-Facility* | $310 | 0% | 7% | 0% | 7% |
| | *Facility* | $1,285 | 0% | -3% | 0% | -3% |
| AUDIOLOGIST | *TOTAL* | $75 | 0% | 0% | 0% | -1% |
| | *Non-Facility* | $72 | 0% | 0% | 0% | 0% |
| | *Facility* | $3 | 0% | -13% | 0% | -14% |
| CARDIAC SURGERY | *TOTAL* | $150 | -1% | -3% | 0% | -3% |
| | *Non-Facility* | $27 | 0% | 6% | 0% | 6% |
| | *Facility* | $124 | -1% | -5% | 0% | -5% |
| CARDIOLOGY | *TOTAL* | $5,995 | 0% | 1% | 0% | 1% |
| | *Non-Facility* | $3,747 | 0% | 5% | 0% | 5% |
| | *Facility* | $2,248 | -1% | -6% | 0% | -7% |
| CHIROPRACTIC | *TOTAL* | $626 | -1% | -1% | 0% | -2% |
| | *Non-Facility* | $624 | -1% | -1% | 0% | -2% |
| | *Facility* | $2 | -1% | -15% | 0% | -17% |
| CLINICAL PSYCHOLOGIST | *TOTAL* | $727 | 3% | 2% | -1% | 3% |
| | *Non-Facility* | $589 | 3% | 3% | -1% | 5% |
| | *Facility* | $138 | 3% | -5% | -1% | -3% |
| CLINICAL SOCIAL WORKER | *TOTAL* | $1,011 | 4% | 2% | -1% | 4% |
| | *Non-Facility* | $871 | 4% | 3% | -1% | 6% |
| | *Facility* | $140 | 4% | -5% | -1% | -2% |
| COLON AND RECTAL SURGERY | *TOTAL* | $146 | -1% | -2% | 0% | -2% |
| | *Non-Facility* | $53 | 0% | 7% | 0% | 7% |
| | *Facility* | $93 | -1% | -7% | 0% | -7% |
| CRITICAL CARE | *TOTAL* | $336 | 0% | -5% | 0% | -4% |
| | *Non-Facility* | $54 | 0% | 7% | 0% | 7% |
| | *Facility* | $281 | 0% | -7% | 1% | -7% |
| DERMATOLOGY | *TOTAL* | $3,898 | 0% | -1% | 0% | -2% |
| | *Non-Facility* | $3,757 | 0% | -1% | 0% | -1% |
| | *Facility* | $142 | -1% | -13% | 0% | -14% |
| DIAGNOSTIC TESTING FACILITY | *TOTAL* | $913 | 0% | 0% | 0% | 0% |
| | *Non-Facility* | $911 | 0% | 0% | 0% | 0% |
| | *Facility* | $2 | -1% | 0% | 1% | -1% |
| EMERGENCY MEDICINE | *TOTAL* | $2,408 | 0% | -3% | 1% | -1% |
| | *Non-Facility* | $217 | 0% | 7% | 0% | 7% |
| | *Facility* | $2,191 | 0% | -4% | 1% | -2% |
| ENDOCRINOLOGY | *TOTAL* | $526 | 0% | 2% | 0% | 3% |
| | *Non-Facility* | $425 | 0% | 6% | 0% | 6% |
| | *Facility* | $101 | 0% | -11% | 0% | -10% |
| FAMILY PRACTICE | *TOTAL* | $5,426 | 0% | 3% | 0% | 3% |
| | *Non-Facility* | $4,367 | 0% | 6% | 0% | 6% |
| | *Facility* | $1,059 | 0% | -9% | 0% | -9% |
| GASTROENTEROLOGY | *TOTAL* | $1,391 | 0% | -3% | 0% | -4% |
| | *Non-Facility* | $504 | 0% | 6% | 0% | 6% |
| | *Facility* | $887 | -1% | -9% | 0% | -10% |
| GENERAL PRACTICE | *TOTAL* | $372 | 0% | 3% | 0% | 3% |
| | *Non-Facility* | $298 | 0% | 5% | 0% | 6% |
| | *Facility* | $73 | 0% | -8% | 0% | -7% |
| GENERAL SURGERY | *TOTAL* | $1,524 | 0% | -3% | 0% | -3% |
| | *Non-Facility* | $447 | 0% | 6% | 0% | 6% |
| | *Facility* | $1,078 | -1% | -7% | 0% | -7% |
| | *TOTAL* | $199 | 1% | 1% | 0% | 1% |

| (A) Specialty | (B) Total: Non-Facility/Facility | (C) Allowed Charges (mil) | (D) Impact of Work RVU Changes | (E) Impact of PE RVU Changes | (F) Impact of MP RVU Changes | (G) Combined Impact |
|---|---|---|---|---|---|---|
| GERIATRICS | *Non-Facility* | $127 | 1% | 7% | 0% | 8% |
| | *Facility* | $72 | 0% | -10% | 0% | -9% |
| HAND SURGERY | *TOTAL* | $260 | 0% | 0% | 0% | -1% |
| | *Non-Facility* | $141 | 0% | 5% | 0% | 5% |
| | *Facility* | $119 | -1% | -7% | 0% | -7% |
| HEMATOLOGY/ONCOLOGY | *TOTAL* | $1,537 | 0% | 0% | 0% | 0% |
| | *Non-Facility* | $984 | 0% | 6% | 0% | 6% |
| | *Facility* | $552 | 0% | -11% | 0% | -11% |
| INDEPENDENT LABORATORY | *TOTAL* | $545 | 0% | -1% | 0% | -1% |
| | *Non-Facility* | $531 | 0% | -1% | 0% | -1% |
| | *Facility* | $14 | -1% | -1% | 0% | -3% |
| INFECTIOUS DISEASE | *TOTAL* | $537 | 0% | -7% | 0% | -6% |
| | *Non-Facility* | $85 | 0% | 7% | 0% | 7% |
| | *Facility* | $452 | 0% | -10% | 0% | -9% |
| INTERNAL MEDICINE | *TOTAL* | $9,378 | 0% | -2% | 0% | -1% |
| | *Non-Facility* | $4,649 | 0% | 6% | 0% | 6% |
| | *Facility* | $4,729 | 0% | -9% | 0% | -8% |
| INTERVENTIONAL PAIN MGMT | *TOTAL* | $825 | 0% | 3% | 0% | 3% |
| | *Non-Facility* | $645 | 0% | 7% | 0% | 6% |
| | *Facility* | $180 | -1% | -8% | 0% | -9% |
| INTERVENTIONAL RADIOLOGY | *TOTAL* | $437 | -1% | 2% | 0% | 2% |
| | *Non-Facility* | $259 | 0% | 7% | 0% | 7% |
| | *Facility* | $178 | -2% | -6% | 1% | -7% |
| MULTISPECIALTY CLINIC/OTHER PHYS | *TOTAL* | $155 | 0% | -2% | 0% | -2% |
| | *Non-Facility* | $77 | 0% | 5% | 0% | 5% |
| | *Facility* | $78 | 0% | -9% | 0% | -9% |
| NEPHROLOGY | *TOTAL* | $1,623 | 0% | 0% | 0% | 1% |
| | *Non-Facility* | $971 | 1% | 6% | 0% | 7% |
| | *Facility* | $653 | 0% | -9% | 0% | -9% |
| NEUROLOGY | *TOTAL* | $1,312 | 0% | 1% | 0% | 1% |
| | *Non-Facility* | $833 | 0% | 6% | 0% | 6% |
| | *Facility* | $480 | 0% | -9% | 0% | -9% |
| NEUROSURGERY | *TOTAL* | $682 | -1% | -4% | 0% | -5% |
| | *Non-Facility* | $115 | 0% | 6% | 0% | 6% |
| | *Facility* | $567 | -1% | -6% | 0% | -7% |
| NUCLEAR MEDICINE | *TOTAL* | $47 | -1% | 0% | 0% | -1% |
| | *Non-Facility* | $21 | 0% | 2% | 0% | 1% |
| | *Facility* | $27 | -1% | -2% | 0% | -3% |
| NURSE ANES / ANES ASST | *TOTAL* | $1,060 | 0% | -2% | 0% | -1% |
| | *Non-Facility* | $20 | 0% | 9% | 0% | 10% |
| | *Facility* | $1,040 | 0% | -2% | 0% | -1% |
| NURSE PRACTITIONER | *TOTAL* | $7,704 | 0% | 0% | 0% | 1% |
| | *Non-Facility* | $5,074 | 0% | 5% | 0% | 5% |
| | *Facility* | $2,630 | 0% | -9% | 0% | -9% |
| OBSTETRICS/GYNECOLOGY | *TOTAL* | $540 | 0% | -1% | 0% | -1% |
| | *Non-Facility* | $369 | 0% | 4% | 0% | 4% |
| | *Facility* | $171 | -1% | -10% | 1% | -10% |
| OPHTHALMOLOGY | *TOTAL* | $4,444 | 0% | -1% | 0% | -2% |
| | *Non-Facility* | $3,143 | 0% | 3% | 0% | 3% |
| | *Facility* | $1,301 | -1% | -12% | 0% | -13% |
| OPTOMETRY | *TOTAL* | $1,356 | 0% | 2% | 0% | 2% |
| | *Non-Facility* | $1,293 | 0% | 3% | 0% | 3% |
| | *Facility* | $62 | 0% | -13% | 0% | -13% |
| ORAL/MAXILLOFACIAL SURGERY | *TOTAL* | $44 | 0% | 1% | 0% | 0% |
| | *Non-Facility* | $33 | 0% | 4% | 0% | 4% |
| | *Facility* | $11 | -1% | -10% | 0% | -11% |
| ORTHOPEDIC SURGERY | *TOTAL* | $3,271 | 0% | -2% | 0% | -3% |
| | *Non-Facility* | $1,446 | 0% | 5% | 0% | 5% |

| (A) Specialty | (B) Total: Non-Facility/Facility | (C) Allowed Charges (mil) | (D) Impact of Work RVU Changes | (E) Impact of PE RVU Changes | (F) Impact of MP RVU Changes | (G) Combined Impact |
|---|---|---|---|---|---|---|
| | *Facility* | $1,825 | -1% | -8% | 0% | -9% |
| OTHER | *TOTAL* | $54 | 0% | 0% | 0% | 0% |
| | *Non-Facility* | $43 | 0% | 3% | 0% | 3% |
| | *Facility* | $11 | 0% | -9% | 0% | -9% |
| OTOLARNGOLOGY | *TOTAL* | $1,124 | 0% | 0% | 0% | 0% |
| | *Non-Facility* | $892 | 0% | 3% | 0% | 3% |
| | *Facility* | $232 | -1% | -11% | 0% | -12% |
| PATHOLOGY | *TOTAL* | $1,169 | -1% | -1% | 0% | -2% |
| | *Non-Facility* | $620 | -1% | -1% | 0% | -2% |
| | *Facility* | $549 | -1% | -2% | 0% | -3% |
| PEDIATRICS | *TOTAL* | $53 | 0% | 2% | 0% | 2% |
| | *Non-Facility* | $35 | 0% | 6% | 0% | 7% |
| | *Facility* | $19 | 0% | -8% | 0% | -7% |
| PHYSICAL MEDICINE | *TOTAL* | $1,136 | 0% | -2% | 0% | -2% |
| | *Non-Facility* | $540 | 0% | 6% | 0% | 6% |
| | *Facility* | $596 | 0% | -9% | 0% | -9% |
| PHYSICAL/OCCUPATIONAL THERAPY | *TOTAL* | $6,183 | 0% | -1% | 0% | -1% |
| | *Non-Facility* | $6,183 | 0% | -1% | 0% | -1% |
| | *Facility* | $0 | -1% | -6% | 0% | -7% |
| PHYSICIAN ASSISTANT | *TOTAL* | $3,926 | 0% | 0% | 0% | 1% |
| | *Non-Facility* | $2,716 | 0% | 4% | 0% | 4% |
| | *Facility* | $1,211 | 0% | -8% | 0% | -8% |
| PLASTIC SURGERY | *TOTAL* | $286 | -1% | -3% | 0% | -4% |
| | *Non-Facility* | $127 | 0% | 4% | 0% | 4% |
| | *Facility* | $159 | -1% | -9% | 0% | -10% |
| PODIATRY | *TOTAL* | $1,858 | 0% | 2% | 0% | 2% |
| | *Non-Facility* | $1,648 | 0% | 3% | 0% | 3% |
| | *Facility* | $209 | 0% | -8% | 0% | -9% |
| PORTABLE **X**-RAY SUPPLIER | *TOTAL* | $79 | 0% | -1% | 0% | -1% |
| | *Non-Facility* | $76 | 0% | -1% | 0% | -1% |
| | *Facility* | $3 | -1% | -1% | 0% | -2% |
| PSYCHIATRY | *TOTAL* | $825 | 1% | 0% | 0% | 0% |
| | *Non-Facility* | $499 | 1% | 6% | 0% | 6% |
| | *Facility* | $326 | 1% | -9% | 0% | -9% |
| PULMONARY DISEASE | *TOTAL* | $1,227 | 0% | -2% | 0% | -1% |
| | *Non-Facility* | $536 | 0% | 7% | 0% | 7% |
| | *Facility* | $691 | 0% | -8% | 0% | -8% |
| RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS | *TOTAL* | $1,502 | -1% | -1% | 0% | -1% |
| | *Non-Facility* | $1,006 | 0% | -1% | 0% | -1% |
| | *Facility* | $496 | -1% | -1% | 0% | -2% |
| RADIOLOGY | *TOTAL* | $4,492 | -1% | -1% | 0% | -2% |
| | *Non-Facility* | $1,964 | 0% | 1% | 0% | 1% |
| | *Facility* | $2,528 | -2% | -2% | 1% | -3% |
| RHEUMATOLOGY | *TOTAL* | $523 | 0% | 4% | 0% | 4% |
| | *Non-Facility* | $469 | 0% | 6% | 0% | 6% |
| | *Facility* | $54 | 0% | -12% | 0% | -12% |
| THORACIC SURGERY | *TOTAL* | $288 | -1% | -3% | 0% | -3% |
| | *Non-Facility* | $55 | 0% | 8% | 0% | 8% |
| | *Facility* | $233 | -1% | -5% | 0% | -5% |
| UROLOGY | *TOTAL* | $1,600 | 0% | 1% | 0% | 0% |
| | *Non-Facility* | $1,123 | 0% | 5% | 0% | 5% |
| | *Facility* | $477 | -1% | -9% | 0% | -10% |
| VASCULAR SURGERY | *TOTAL* | $929 | 0% | 5% | 0% | 5% |
| | *Non-Facility* | $656 | 0% | 9% | 0% | 9% |
| | *Facility* | $273 | 0% | -6% | 1% | -6% |
| **TOTAL** | ***TOTAL*** | **$90,545** | **0%** | **0%** | **0%** | **0%** |
| | *Non-Facility* | $57,482 | 0% | 4% | 0% | 4% |
| | *Facility* | $33,064 | 0% | -7% | 0% | -7% |

* Column G may not equal the sum of columns D, E, and F due to rounding.

APG member organizations are also confused about the 1 percent decrease in internal medicine payment rates while a 3 percent increase is proposed for general practice. Internal medicine and general practice do not seem to be distinct enough specialties to justify a difference in conversion factor updates.

### iii. Skin Substitute Payment

CMS acknowledges the significant increase in Medicare Part B spending on skin substitutes over the last few years, rising from $256 million in 2019 to more than $10 billion in 2024. CMS currently treats skin substitutes as biological products for the purposes of Medicare payment, which can reach as high as $2,000 per square inch. CMS proposes to pay for skin substitutes as "incident-to supplies," a change that is expected to reduce spending on these products by nearly 90 percent. "Incident-to supplies" refers to supplies that are furnished as an integral, although incidental, part of the physician's professional services during diagnosis or treatment of an injury or illness.

CMS proposes that skin substitutes be paid uniformly across different outpatient settings as a stated "primary policy objective" to ensure a consistent payment approach across physician offices and hospital outpatient departments. CMS proposes a single payment set at the highest average for the FDA's three categories of skin substitutes, resulting in an initial payment rate of about $125.38 per square centimeter. CMS also noted that the proposed policy is designed to "limit some of the current profiteering practices occurring in this industry."

APG applauds CMS's efforts to protect taxpayer and Medicare patients from waste, fraud, and abuse and strongly supports the agency's proposed modifications to the skin substitute payment. APG members take responsibility for the quality and total cost of care for the patients whom they serve, and the rapid increase in skin substitute spending has had a significant impact on many organizations' expenses. Reclassifying skin substitutes as incident-to-supplies is a smart solution that will save taxpayer money while placing skin substitutes in a reimbursement category that is more closely aligned with FDA regulation of skin substitutes.

- **APG strongly recommends that CMS finalize the proposal to reclassify skin substitutes as incident-to supplies and set payment rates uniformly across different outpatient settings at the highest average for the FDA's three categories of skin substitutes.**

### iv. Payment for Telehealth Services

CMS proposes several changes to telehealth rules for 2025 and subsequent years, as follows:

- Streamlining the process that permits Medicare to pay for telehealth services by removing the provisional category of telehealth services.
- Permanently removing frequency limits for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.
- Permanently adopting a definition of "direct supervision" that permits the practitioner to provide supervision through real-time audio and visual interactive telecommunications.
- Transitioning back to pre-pandemic policies that require teaching physicians to maintain

a physical presence during critical portions of resident-furnished services for services provided within MSAs.

APG supports CMS's proposed telehealth changes and encourages the agency to seek additional opportunities to offer telehealth flexibilities to accountable care participants. Accountable care relationships in which physicians take responsibility for the quality and cost of care for the patients whom they serve address any concerns about telehealth potentially harming quality or increasing costs. In value-based care arrangements, the decision of whether to make use of telehealth is most appropriately made by the patient and physician together for each encounter.

- **APG recommends that CMS finalize the proposal to streamline the process that permits Medicare to pay for telehealth services by removing the provisional category of telehealth services.**

- **APG recommends that CMS finalize the proposal to permanently remove frequency limits for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.**

- **APG recommends that CMS finalize the proposal to permanently adopt a definition of "direct supervision" that permits the practitioner to provide supervision through real-time audio and visual interactive telecommunications.**

### v. Enhanced Care Management Proposals

In the 2025 PFS, CMS created a set of HCC codes to better describe advanced primary care management (APCM) services broadly, to provide more stability in payment and coding for practitioners in the context of continued evolution in advanced primary care, and to provide the agency with a mechanism for continued and intentional improvements to advanced primary care.

Specifically, CMS established three new G-codes that describe a set of care management services and communication technology-based services (CTBS) furnished under a broader application of advanced primary care services. The codes include the following:

- G0556 – APCM for patients with up to one chronic condition
- G0557 – APCM for patients with multiple chronic conditions
- G0558 – APCM for qualified Medicare beneficiaries (QMBs) with multiple chronic conditions

Beginning in 2026, CMS proposes to integrate behavioral health into APCM with add-on codes for behavioral health integration (BHI) and psychiatric collaborative care model (CoCM). The integration will occur through the establishment of three new G-codes to be billed as add-on services when the APCM base code is reported by the same practitioner in the same month. The codes are as follows:

- GPCM1: Initial psychiatric collaborative care management, with a proposed work RVU of 1.88
- GPCM2: Subsequent psychiatric collaborative care management, with a proposed work RVU on 2.05

- GPCM3: Care management services for behavioral health conditions, with a proposed work RVU of .93

CMS also proposes that physicians and other practitioners who furnish APCM services be able to provide BHI and CoCM without needing to document the time spent performing these services to "help facilitate a more holistic, team-based approach to care coordination and reduce burden." CMS proposes an optional odd-on code for APCM services that removes the time-based requirements of the existing BHI and CoCM codes.

APG supports CMS's efforts to integrate behavioral health care with advanced primary care and allow clinicians who furnish these services to bill for them without time-based requirements.

- **APG recommends that CMS finalize the proposal to integrate behavioral health into advanced primary care management (APCM) with the creation of three new add-on codes for behavioral health integration (BHI) and psychiatric collaborative care model (CoCM).**

**vi. Evaluation and Management Visits**

CMS proposes changes to the Medicare Diabetes Prevention Program (MDPP). CMS will test coverage of a fully online, asynchronous option for delivering MDPP care until December 31, 2029. CMS clarifies that, since organizations are required to submit a separate application for each delivery mode used, providers are required to obtain an online organization code prior to delivering online MDPP sessions. The requirement for live, online interactions with a coach remains in place.

APG supports CMS's proposal to add flexibility to the MDPP by testing a fully online, asynchronous option for delivering MDPP care. This commonsense proposal builds on the success of the more limited online option available in the existing MDPP.

- **APG recommends that CMS finalize the proposal to test a fully online, asynchronous option for delivering Medicare Diabetes Prevention Program (MDPP) care.**

**B. Medicare Shared Savings Program (MSSP)**

**i. Limiting Participation in One-Sided Risk**

CMS proposes to modify the requirements for determining an ACO's eligibility for MSSP participation options, applicable for agreement periods beginning on or after January 1, 2027. Under the proposed approach, an ACO identified as inexperienced with performance-based risk Medicare ACO initiatives would be able to participate in MSSP under a one-sided model for up to five performance years under the ACO's first agreement period in the BASIC track's glide path (if eligible), instead of a maximum of seven performance years spanning two agreement periods in the BASIC track's glide path, as currently allowed.

CMS would also require ACOs inexperienced with performance-based risk Medicare ACO initiatives to progress more rapidly to higher levels of risk and potential reward. These ACOs would need to operate under a two-sided model by their second or subsequent agreement period, through participation in Level E of the BASIC track for all performance years of the agreement period, or in the

ENHANCED track (subject to the proposed exception prohibiting ACOs with fewer than 5,000 assigned beneficiaries in certain benchmark years from participating in the ENHANCED track).

CMS would maintain an approach similar to existing requirements for determining the participation options for an ACO determined to be experienced with performance-based risk Medicare ACO initiatives. That is, for agreement periods beginning on or after January 1, 2027, if an ACO is determined to be experienced with performance-based risk Medicare ACO initiatives, the ACO may enter either the BASIC track Level E for all performance years of the agreement period, or the ENHANCED track (subject to the proposed exception prohibiting ACOs with fewer than 5,000 assigned beneficiaries in certain benchmark years from participating in the ENHANCED track)

CMS notes that this change aims to strike a balance between policies that support MSSP's growth through allowing participation in one-sided models and policies that encourage greater participation in performance-based risk.

APG strongly believes that, while organizations inexperienced with risk should begin in one-sided models, optimal performance in terms of quality and costs only result when organizations are fully at risk in two-sided models.

- **APG recommends that CMS finalize the proposal to permit risk-inexperienced MSSP ACOs to participate under a one-sided model for only up to five performance years under the ACO's first agreement period in the BASIC track's glide path.**

**ii. Change of Ownership Scenarios (CHOW) Modifications**

To be eligible to participate in MSSP, an ACO must maintain, update, and submit to CMS an accurate and complete ACO participant list. The ACO participant list identifies each ACO participating organization by its Medicare-enrolled Taxpayer Identification Number (TIN) and legal business name.

Currently, during a specified timeline and within the annual MSSP change request cycle, ACOs are able to add an entity to their previously certified ACO participant list according to the form and manner specified by CMS. To provide flexibility for ACOs and to support ACOs' participation in MSSP, CMS proposes to (1) require ACOs to update their certified ACO participant list with a TIN newly enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS) with no prior Medicare billing claims history, and to do so (2) for an ACO participant that experiences a change of ownership (CHOW) during the performance year and outside of the annual change request cycle. Similarly, CMS proposes to require ACOs to report changes that occur during the performance year to the ACO's SNF affiliate list if a SNF affiliate undergoes a CHOW resulting in a new TIN. These proposals would ensure that an ACO participant or SNF affiliate that goes through a CHOW and remains the exact same entity with a new TIN can continue participating in the Shared Savings Program without interruption.

APG thanks CMS for allowing modification to occur to the ACO participant list when a participant initiates a CHOW for a Medicare enrolled TIN. We note that the time of notification to the agency is restrictive and may be challenging for the ACO to update such information in 30 days. It would be difficult for the ACO to be notified and then pass this information along to CMS. As such, APG believes it would be in the best interest of MSSP ACOs and CMS to allow 60 days for notification to the agency. Doing so would ensure that any potential changes or modifications that CMS may require could

be made within a certain period without disruption to the ACO.

- **APG recommends that CMS allow 60 days for ACOs to notify the agency about updates in their certified ACO participant list with (1) a TIN newly enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS) with no prior Medicare billing claims history, and to do so (2) for an ACO participant that experiences a CHOW during the performance year and outside of the annual change request cycle.**

- **APG recommends that CMS finalize the proposal to allow a SNF affiliate undergoing a change of ownership (CHOW) resulting in a new TIN to be added to the list of SNFs participating in the three-day waiver. Doing so would allow a seamless continuation of care pathways.**

### iii. Eligibility Requirement Modifications

Under current MSSP regulations, CMS "deems" an ACO to have initially satisfied the statutory requirement to have at least 5,000 assigned Medicare FFS beneficiaries if 5,000 or more beneficiaries are historically assigned to the ACO participants in each of the three historical benchmark years. This regulatory provision was established to align with the statutory requirement and to ensure CMS is able to reliably and accurately assess ACO financial and quality performance.

Since the inception of the program, CMS has gained additional experience with the requirement for an ACO to have 5,000 beneficiaries assigned in each benchmark year. This experience shows that CMS can both retain the financial integrity of benchmark calculations and ensure CMS can reliably and accurately assess ACO financial and quality performance while allowing for ACOs that have fewer than 5,000 beneficiaries assigned in their benchmark years to enter MSSP, if the agency implements additional safeguards that protect ACOs and the Medicare Trust Funds.

CMS proposes that, as an eligibility requirement for MSSP, ACOs applying to enter a new agreement period beginning on or after January 1, 2027, must have at least 5,000 assigned beneficiaries in benchmark year (BY) 3, but may have fewer than 5,000 assigned beneficiaries in BY1, BY2, or both. To establish safeguards to protect the Medicare Trust Funds and ACOs from the potential greater variation in expenditures caused by the reduction in the size of the ACO's assigned beneficiary population in benchmark years, CMS proposes to (1) require that an ACO applying to enter a new agreement period that has fewer than 5,000 assigned beneficiaries in BY1, BY2, or both, may only enter the BASIC track; and (2) cap shared savings and shared losses at a lesser amount if an ACO, at any time during the agreement period, has fewer than 5,000 assigned beneficiaries in any of the three BYs. CMS also proposes to exclude ACOs that fall below 5,000 assigned beneficiaries in any benchmark year from being eligible to leverage existing policies that provide certain low revenue ACOs participating in the BASIC track with increased opportunities to share in savings.

APG supports the proposed changes since they add additional flexibility for smaller groups, allowing them to get involved in MSSP sooner than they might be able to otherwise. APG encourages CMS to consider a benchmark to allow for ACOs that may fall below the 5,000-beneficiary minimum in each year. CMS should also consider a six-month grace period to allow for the ACO to be able to reach the 5,000 minimum.

Additionally, APG believes that CMS should not restrict other options available to all ACOs that cannot meet the minimum threshold. Specifically, CMS should still allow for prepaid shared savings for those low revenue ACOs. The inability to meet the minimum 5,000 threshold should not automatically result in punitive changes for these ACOs that may not be as well resourced as others.

- **APG recommends that CMS modify the proposal to allow MSSP ACOs entering a new agreement period to have fewer than 5,000 assigned beneficiaries by permitting this leniency in each of the three benchmark years if the ACO participates in the BASIC track and face potential – but not automatic – savings and losses at a lower amount.**

**iv. Redefine "Primary Care Services"**

Under its claims-based assignment methodology, CMS assigns Medicare FFS beneficiaries to MSSP ACOs based on their use of "primary care services" as defined in the program's regulations. CMS proposes to revise the definition of primary care services used for purposes of beneficiary assignment under MSSP to align with payment policy proposals under the Medicare PFS.

CMS proposes to include new behavioral health integration and psychiatric collaborative care management add-on services for the purposes of determining beneficiary assignment for the performance year starting on January 1, 2026, and in subsequent performance years, when these services are furnished with advanced primary care management services. Additionally, CMS proposes to not include G1036 Administration of a standard, evidence-based social determinants of health risk assessment tool in the definition of primary care services used for purposes of assignment, beginning January 1, 2026, and in subsequent years.

APG supports CMS's proposal to expand the definition of "primary care services" to include new behavioral health integration and psychiatric collaborative care management add-on services for purposes of beneficiary assignment to MSSP ACOs This proposal will align the beneficiary assignment methodology with the inclusion of these services in primary care services paid for under the Medicare PFS when they are provided in conjunction with advanced primary care management services.

APG understands that CMS is reviewing and revising the agency's approach as it relates to certain aspects of social determinants of health. APG believes that the benefits of providers accessing non-medical risk for their patient populations is important to ensure holistic health. From a population health perspective, it is important to treat "whole persons" since certain non-health related factors can directly affect their health. Therefore, APG encourages CMS to consider keeping this code with a nomenclature change such as similar ones that it is undertaking throughout the rule. APG suggests terms that would better reflect the characteristics captured by this tool, such as "Upstream Drivers of Health" or "Non-Medical Drivers of Health" to ensure that ACOs continue to capture this vital information.

- **APG recommends that CMS finalize the proposal to expand the definition of "primary care services" for purposes of beneficiary assignment to MSSP ACOs to include new behavioral health integration and psychiatric collaborative care management add-on services.**

- **APG recommends that CMS retain the use of code G1036 Administration of a standard, evidence-based social determinants of health risk assessment tool in the definition of**

**primary care services used for purposes of assignment to MSSP ACOs with a name change to better reflect the characteristics captured by this tool.**

### v. Revise the Definition of a "Beneficiary Eligible for Medicare CQMs"

CMS proposes to revise the definition of a beneficiary eligible for Medicare clinical quality measures (CQMs) for performance year 2025 and subsequent performance years. The agency would require 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; who has one of the specialty designations included in § 425.402(c); or who is a physician assistant, nurse practitioner, or clinical nurse specialist.[1]

CMS believes that the proposal to revise the definition of a beneficiary eligible for Medicare CQMs would reduce ACOs' burden in the patient matching necessary to report Medicare CQMs. The agency believes that the list of beneficiaries eligible for Medicare CQMs would then have greater overlap with the list of beneficiaries that are assignable to an ACO. CMS notes that the proposed definitional change is expected to increase the list of assignable beneficiaries by an average of 85 percent for most ACOs.

APG support CMS's proposal to revise the definition of a beneficiary eligible for Medicare clinical quality measures (CQMs) to those with a primary care service from selected clinicians, including primary care providers, designated specialists, physician assistants, nurse practitioners, and clinical nurse specialists.

- **APG recommends that CMS finalize the proposal to revise the definition of a beneficiary eligible for Medicare clinical quality measures (CQMs) to those with a primary care service from selected clinicians, including primary care providers, designated specialists, physician assistants, nurse practitioners, and clinical nurse specialists.**

### vi. Promote Alignment with CMS' Quality Programs

CMS provides an update to the agency's ongoing work to standardize and better align quality reporting measures via the Universal Foundation measures. The measure set currently consists of six measures and will incrementally grow over performance years 2025 through 2028 to comprise ten measures (Table 2).

For performance year 2025 and subsequent performance years, MSSP ACOs are required to report the Alternative Payment Model (APM) Performance Pathway (APP) Plus Quality Measure Set ("APP Plus") for MSSP ACOs, including the removal of Quality ID: 487 Screening for Social Drivers of Health.

Table 1 below displays the list of the quality measures to be included in the APP Plus quality

[1] Specialist included in § 425.402(c) include cardiology, osteopathic manipulative medicine, neurology, obstetrics/gynecology, sports medicine, physical medicine and rehabilitation, psychiatry, geriatric psychiatry, pulmonary disease, nephrology, endocrinology, multispecialty clinic or group practice, addiction medicine, hematology, hematology/oncology, preventive medicine, neuropsychiatry, medical oncology, gynecology/oncology.

measure set for MSSP ACOs as finalized in the CY 2025 PFS final rule and with the proposed removal of Quality ID: 487 Screening for Social Drivers of Health from the APP Plus quality measure set.

**Table 2: Measures Included in the APP Plus Quality Measure Set for MSSP ACOs Starting in 2028 or the Performance Year That is a Year After the ECQM Specification Becomes Available, Whichever is Later**

| Quality # | Measure Title | Collection Type | Submitter Type | Meaningful Measures 2.0 Area | Measure Type |
|---|---|---|---|---|---|
| 321 | CAHPS for MIPS | CAHPS for MIPS Survey | Third Party Intermediary | Person-Centered Care | Patient Engagement/Experience |
| 479 | Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups | Administrative Claims | N/A | Affordability and Efficiency | Outcome^ |
| 484 | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | Administrative Claims | N/A | Affordability and Efficiency | Outcome^ |
| 001 | Diabetes: Glycemic Status Assessment Greater Than 9% | eCQM/Medicare CQM | APM Entity/Third Party Intermediary | Chronic Conditions | Intermediate Outcome^ |
| 134 | Preventive Care and Screening: Screening for Depression and Follow-up Plan | eCQM/Medicare CQM | APM Entity/Third Party Intermediary | Behavioral Health | Process |
| 236 | Controlling High Blood Pressure | eCQM/Medicare CQM | APM Entity/Third Party Intermediary | Chronic Conditions | Intermediate Outcome^ |
| 112 | Breast Cancer Screening | eCQM/Medicare CQM | APM Entity/Third Party Intermediary | Wellness and Prevention | Process |
| 113 | Colorectal Cancer Screening | eCQM/Medicare CQM | APM Entity/Third Party Intermediary | Wellness and Prevention | Process |
| 305 | Initiation and Engagement of Substance Use Disorder Treatment | eCQM/Medicare CQM | APM Entity/Third Party Intermediary | Behavioral Health | Process |
| 493 | Adult Immunization Status | eCQM/Medicare CQM | APM Entity/Third Party Intermediary | Wellness and Prevention | Process |

^ Indicates this is an outcome measure for purposes of qualifying for the eCQM reporting incentive and the alternative quality performance standard.

APG members have concerns that CMS' proposals would create a disparity between eCQMs, MIPS CQMs, and Medicare CQMs measures. Specifically, APG members have expressed confusion as to why two measures – for discussing breast cancer screening and colorectal cancer screening – are planned to be added to MIPS CQMs and Medicare CQMs but not to eCQMs.

APG members strongly emphasize that while clinically appropriate, the measures will be challenging for ACOs to track and integrate into their electronic health record (EHR) systems, especially given the required start date of next year. These changes would require EHRs to make accommodations for the discussion component, in which otherwise ACOs would need to check for the discussion component manually. In addition, ACOs are still adjusting to the MIPS CQMs, eCQMs, and Medicare CQMs.

- **APG recommends that CMS align the breast cancer screening and colorectal cancer screening between measure sets by excluding any requirements to document discussions.**

APG members are also concerned about CMS's push towards all payer/all patients MIPS CQMs and eCQMs. The concerns are focused on (1) the additional workload for practices and (2) the strong reluctance of commercial patients to give their information to CMS. While members understand and support CMS efforts to obtain more information about patients covered under CMS programs, the requirement to for a Medicare program to include non-Medicare patient information is an overreach and is inappropriate. APG members have been reporting that providers are uncomfortable with providing commercial patient information to CMS, fearing that is a violation of patient privacy and trust.

- **APG recommends that CMS continue to allow MSSP ACOs to report Medicare CQMs until 2032 to allow smaller rural practices time to prepare to report digital measures.**

### vii. Remove and Revise the Health Equity Adjustment Applied to an ACO's Quality Score

CMS proposes to remove the health equity adjustment applied to an ACO's quality score beginning in performance year 2025. CMS believes that the application of the Complex Organization Adjustment and the extension of the electronic Clinical Quality Measure (eCQM)/MIPS CQM reporting incentive, as finalized in prior rules, have made it unnecessary to continue applying the health equity adjustment to an ACO's quality score.

The Complex Organization Adjustment upwardly adjusts an ACO's MIPS Quality performance category score when an ACO reports quality data via eCQMs. The eCQM/MIPS CQM reporting incentive supports ACOs in meeting the quality performance standard and in sharing in the maximum shared savings allowable by track. CMS notes that these policies underscore the agency's commitment to all payer/all patient quality measure reporting. CMS believes that the proposal to remove the health equity adjustment would deduplicate scoring factors and further simplify MSSP quality scoring methodology.

CMS notes that only 13 of 71 ACOs received the health equity adjustment in performance year 2023 ACO quality results. CMS also observes that all ACOs that received the health equity adjustment bonus points also met the criteria for the eCQM/MIPS CQM demonstrates the duplicative nature of the health equity adjustment and the eCQM/MIPS CQM reporting incentive.

Additionally, to reflect the data accurately that are used to calculate the health equity adjustment in performance years 2023 and 2024, CMS proposes to revise the terminology used to describe this adjustment and other related terms in MSSP regulations.

Current rules allow for a health equity adjustment of up to ten points for ACO quality scores. In the 2025 physician fee schedule final rule, CMS established the complex organization adjustments for eCQMs to account for the organizational complexities faced by Virtual Groups and APM Entities, including MSSP ACOs, when reporting eCQMs. A Virtual Group and an APM Entity would receive one measure achievement point for each submitted eCQM that meets the case minimum and data completeness requirements. Each reported eCQM may not score more than 10 measure achievement points and the total achievement points (numerator) may not exceed the total available measure achievement points (denominator) for the quality performance category.

The Complex Organization Adjustment for a Virtual Group or APM Entity may not exceed 10 percent of the total available measure achievement points in the quality performance category. The adjustment would be added for each measure submitted at the individual measure level. CMS has noted that the agency "will revisit and end this adjustment as uptake of FHIR [Application Programming Interface] API increases, requirements surrounding the use of FHIR API are established, or other barriers posed by organizational complexity are otherwise reduced."

APG disagrees with CMS' assumption that the complex organizational adjustment will cover the up to ten bonus points eliminated as part of the removal of the health equity adjustment since the complex organization adjustment is only four points. APG believes that, if CMS is going to remove the health equity adjustment, it should be replaced by a metric that offers a similar impact that health equity had on an ACO's quality score.

- **APG recommends that, if CMS removes the Health Equity Adjustment applied to an ACO's quality score, the agency increases the maximum adjustment available from the complex organization adjustment to 10 points.**

### viii. Revise Quality Reporting Monitoring Provisions

CMS proposes to modify the MSSP quality reporting monitoring requirements because the agency inadvertently did not modify the program's monitoring policies when CMS established the alternative quality performance standard through earlier rulemaking. In addition to existing policy – under which CMS monitors whether ACOs meet the quality performance standard – CMS would also monitor whether ACOs meet the alternative quality performance standard for performance years beginning on or after January 1, 2026.

CMS also proposes to extend the specific actions that the agency may take if an ACO fails to meet the quality performance standard. Such actions would apply if an ACO fails to meet the quality performance standard or the alternative quality performance standard, including immediately terminating the ACO's participation agreement. If the proposal is finalized, and an ACO fails to meet both standards, CMS will take one of the following actions: (1) provide a warning notice to the ACO; (2) request a corrective action plan from the ACO; or (3) place the ACO on a special monitoring plan.

An ACO's agreement will be terminated if the ACO (1) fails to meet both quality standards for two consecutive plan years within an agreement period; or (2) fails to meet both quality standards for any three performance years within an agreement period. CMS clarifies that these criteria do not apply to ACOs that fail both quality standards for two consecutive performance years across two agreement periods (i.e. the last performance year of the previous agreement period and the first performance year of the new agreement period).

APG understands CMS' desire to see ACOs meet quality standards but believes that the agency's proposed policy is the equivalent of having the "perfect be the enemy of the good." APG's members object to severity of automatic removal from the program, especially during a time when ACOs are still adjusting to new reporting methodologies. Members believe that notices and corrective action plans are legitimate tools for CMS to use, but they also believe that the agency should be more lenient and focus more on seeking improvement and not looking for reasons to evict participants from the program. Members also express fear that the standards will inadvertently deter ACOs from adding practices that work in lower-income or more Medicaid-reliant areas.

- **APG recommends that CMS not automatically terminate any ACO contract based on failure to meet quality standards, but rather decide on a case-by-case basis the best option based on individual ACO circumstances.**

### ix. Expand Extreme and Uncontrollable Circumstances Policies Used to Determine ACO Quality and Financial Performance

Current statute permits ACOs to request reweighting performance categories if they encounter "extreme and uncontrollable circumstances" (EUC) outside of their control, such as the result of natural disasters. Starting with performance year 2025, CMS proposes expanding EUC eligibility to ACOs affected by cyberattacks, including ransomware and malware. CMS notes that statute prevents retroactive regulatory changes except when failure to do so would be "contrary to the public interest." CMS notes that ACOs' heavy reliance on digital infrastructure and third-party vendors make them increasingly vulnerable to cyberattacks that can disrupt patient care.

APG strongly supports CMS' proposal to add cyberattacks, including ransomware and malware as qualifying events for EUC and encourages CMS to take an expansive view of what constitutes a cyberattack when determining EUC applications.

- **APG recommends that CMS finalize the proposal to add cyberattacks, including the introduction of ransomware and malware, as qualifying events for "extreme and uncontrollable circumstances" (EUC) and encourages CMS to take an expansive view of what constitutes a cyberattack when determining EUC applications.**

### x. Rename the Health Equity Benchmark Adjustment

CMS also proposes renaming the "health equity benchmark adjustment" (HEBA) to the "population adjustment," starting with performance year 2025. CMS notes that the policy encourages MSSP participation from ACOs that would have not considered entering the program otherwise, adding that "45 percent of ACOs receiving HEBA would not have qualified for the prior savings adjustment or positive regional adjustments." CMS believes that renaming HEBA to "population adjustment" will more

accurately reflect the adjustment's nature, which accounts for the proportion of the ACO's assigned beneficiaries who are enrolled in Medicare Part D LIS or dually eligible for Medicare and Medicaid.

APG supports CMS's proposal to rename the HEBA to the "population adjustment." Since this calculation includes ACO's assigned beneficiaries that are enrolled in the Medicare Part D Low Income Subsidy or who are dually eligible for Medicare and Medicaid, it better reflects the methodology underlying the calculation of the benchmark.

- **APG recommends that CMS finalize the proposal to rename the health equity benchmark adjustment (HEBA) to the "population adjustment" to better reflect the methodology underlying the calculation of the adjustment.**

## C. Quality Payment Program (QPP)

### i. Alternative Payment Model (APM) Changes

CMS proposes to add a determination of all eligible clinicians in Advanced APMs for Qualifying APM Participant (QP) status at the individual level, in addition to determinations at the APM Entity level. As part of the effort to simplify this process, CMS proposes to use Covered Professional Services as the set of services used for QP determinations.

Under current policy, CMS generally makes QP determinations at the APM Entity level. There are limited exceptions in which CMS will perform this calculation for an individual clinician. CMS generally uses Evaluation and Management services to determine which beneficiaries are included in QP determinations. CMS proposes to add an individual QP determination calculation for all clinicians participating in an Advanced APM to determinations at the APM entity level. CMS also proposes to create a uniform calculation methodology by expanding to all Covered Professional Services the types of services that the agency includes in the QP calculations from a set of Evaluation and Management services.

APG strongly supports the addition of the individual clinician level for the calculation of the qualifying status. Currently the calculation is only made at the entity level and thus may disadvantage clinicians that participate in other risk-based models. The proposed change would enable them to qualify for QP status and receive the conversion factor addition to their fee schedule if their entity doesn't otherwise qualify.

- **APG recommends that CMS finalize the proposal to add a determination of all eligible clinicians in Advanced APMs for Qualifying APM Participant (QP) status at the individual level, in addition to determinations at the APM Entity level.**

## D. Ambulatory Specialty Model (ASM)

CMS proposes testing the Ambulatory Specialty Model (ASM), a new alternative payment model operating under the authority of the Center for Medicate and Medicaid Innovation (CMMI). The model

would run from January 1, 2027 to December 31, 2033 and would be mandatory for specialists who meet criteria in selected geographic markets and treat Medicare beneficiaries with heart failure and lower back pain. Specialists would be required to report a select set of clinically relevant measures and activities that assess quality, cost, interoperability, and care coordination practices. Clinician performance would be assessed at the individual level relative to peers who are also ASM participants with a similar specialty treating the same chronic condition. About one quarter of core-based statistical areas and metro division would be selected for participation. The risk level would increase from 9 percent to 12 percent as the model progresses (Table 3).

**Table 3: ASM Risk Levels for Each Performance Year**

| ASM Performance Year | ASM Payment Year | ASM Risk Level |
|---|---|---|
| 2027 | 2029 | 9 percent |
| 2028 | 2030 | 9 percent |
| 2029 | 2031 | 10 percent |
| 2030 | 2032 | 11 percent |
| 2031 | 2033 | 12 percent |

APG welcomes the creation of a new, mandatory Ambulatory Specialty Model under the CMS Innovation Center focused on specialty care for beneficiaries with heart failure and low back pain. If not well managed, these conditions can lead to avoidable hospitalization and generate substantial provision of low-value care. A mandatory model for these conditions along the lines of others that have been tested in the past is overdue.

At the same time, APG members have expressed reservations about the ASM's mandatory status, especially in combination with downside risk. Members also expressed a desire for greater caution from CMS to ensure that specialist models are appropriately integrated with total cost of care models. APG members also worry about the inadvertent incentives that specialists may face to provide unnecessary and expensive bundled services, since physician groups, not specialists, will be the risk-bearing entities.

APG shares CMS's support for the goals of coordination of primary and specialty care and providing incentives for specialists to participate in value-based care arrangements. APG also agrees that the MVPs used in the ASM model would offer advantages to MIPS performance measurement. Widespread adoption of value by specialists has remained frustratingly elusive, so APG applauds CMS's efforts to make progress toward this goal.

However, it is unclear from the description of the proposed approach for the ASM that it would be able to overcome existing obstacles and provide an effective incentive for specialists to move toward value-based care arrangements. As suggested by CMS, mandatory participation may be necessary to ensure sufficient participation in the model.

APG's greatest concern with the proposed model is that it will not sufficiently encourage greater coordination between primary care and specialty care, and in fact will divert specialists from participating in existing value-based care approaches such as MSSP and ACO REACH. Given that these models and programs are the main means of achieving CMS's goal of having all traditional Medicare beneficiaries and most Medicaid beneficiaries in an accountable relationship by 2030, APG encourages CMS to explore further options for integrating specialists into these existing efforts and employing MVPs for the measurement of their performance. APG looks forward to providing more detailed recommendations in response to future proposed rulemaking.

- **APG supports CMS's proposal to test an Ambulatory Specialty Model (ASM) but recommends that the agency to explore other options for integrating specialists into these existing efforts and employing MVPs for the measurement of their performance.**

**E. Requests for Information**

CMS released various requests for information (RFIs) indicating potential future strategies for

the future of Medicare. The RFI most pertinent to APG members is "Towards Digital Quality Measurement in CMS Quality Programs", which is the RFI addressing the use of Fast Healthcare Interoperability Resources (FHIR)-based electronic clinical quality measures (eCQMs) in quality reporting and payment programs. CMS requested feedback on the following questions:

- What additional concerns, if any, should CMS take into consideration when developing FHIR-based reporting requirements for systems receiving quality data?

APG members have expressed strong concerns that providers will be caught between conflicting obligations from state and local laws versus federal requirements to protect patient's medical privacy – particularly CMS's proposed requirements to submit FHIR-based eCQMs in a push for more data to inform sounder decision making. APG's physician member organizations are worried that conforming to FHIR requirements will inadvertently cause them to violate data protection law meant to protect Americans against government intrusion into their intimate medical details.

## V. Conclusion

APG thanks CMS for the agency's commitment to ensuring that the Medicare program continues to address stakeholder concerns and meet the needs of all beneficiaries. APG looks forward to working with CMS as the proposals in this proposed rule are refined and finalized.

Sincerely,

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