AMERICA'S PHYSICIAN GROUPS

September 9, 2024

Chiquita Brooks LaSure
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/commenton/CMS-2024-0256-0045

Re: 2025 Physician Fee Schedule and Medicare Shared Savings Program Proposed Rule (CMS-1807-P)

Dear Administrator Brooks LaSure:

America's Physician Groups (APG) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) 2024 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, and then (IV) our fuller comments and recommendations. Together they reflect the voice of our membership and our commitment to working with the agency to ensure that all Americans have consistently accessible, high-quality, person-centered health care; that health care be equitable; and that the health care system more fully embrace value-based care models in which providers are accountable for both the costs and quality of care.

I. About America's Physician Groups

APG is a national association representing more than 360 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models and Medicare Advantage (MA). APG members collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for roughly 90 million patients, including roughly 30 percent of all Medicare beneficiaries who are enrolled in MA.

Our motto, "Taking Responsibility for America's Health," underscores our members' preference for being in risk-based, accountable, and responsible relationships with all payers, including Medicare and MA health plans, rather than being paid 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; advance health equity; 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 proposes modifications to telehealth rules and the testing of a new specialist model.

Primary care is key to high-quality, whole-person care, and CMS recognizes its value by proposing to adopt new payment mechanisms and CMS Hierarchical Condition Categories (HCC) coding to support new billing alternatives for primary care services. These steps align with the goals articulated in the Department of Health and Human Services' (HHS) Initiative to Strengthen Primary Care. CMS also continues to promote whole-person care in MSSP and to boost the quality of care through multiple changes to the QPP.

III. Summary of APG's Recommendations

A. Recommendations Related to Physician Fee Schedule Proposals

- **APG recommends that CMS finalize the propose advanced primary care management billing codes but consider relaxing some of the required criteria at least temporarily to allow for greater participation.**

- **APG recommends that CMS finalize the telehealth proposals include in the 2025 proposed rule.**

- **APG recommends that CMS seek additional opportunities to offer telehealth flexibilities to accountable care participants.**

- **APG recommends that CMS explore options for integrating specialists into existing value-based care approaches such as MSSP and ACO REACH and employing MVPs for the measurement of their performance, rather than establishing a new Ambulatory Specialty Care Model.**

B. Recommendations Related to MSSP Quality

- **APG recommends that CMS limit the number of new MSSP quality measures added and test new measures before making them required and scored measures for ACOs.**

- **APG strongly recommends that CMS make Medicare Clinical Quality Measures (CQMs) a permanent reporting alternative to all-payer eCQMs.**

- **APG strongly recommends that CMS continue the Web Interface at least through 2026 to allow more time for providers to implement infrastructure for Medicare CQM if needed.**

- **APG recommends that CMS finalize the complex organization adjustment for eCQMs but revisit the anticipated sunsetting of it once FHIR is adopted.**

- **APG recommends that CMS extends the eCQM incentive for the 2025 performance year.**

- **APG recommends that CMS make Medicare CQMs a permanent reporting option.**

- **APG recommends that CMS use flat benchmarks to score ACOs using Medicare CQMs in performance years 2024 and 2025.**

- **APG strongly recommends that CMS remove the requirement that MSSP ACOs fulfill the MIPS Promoting Interoperability (PI) reporting requirements and revert to requiring MSSPs to attest to PI.**

- **APG strongly recommends that CMS provide clear guidance in sufficient time for 2026 participating group decisions and grant leniency to ACOs in 2025 with provider groups that are found not to fulfill the CEHRT requirements, including avoiding all impacts on shared savings and losses.**

C. Recommendations Related to MSSP Beneficiary Assignment, Notification, and Eligibility

- **APG recommends that CMS as considers new disease-specific models, the agency embrace caution in superseding the beneficiary's choice and prioritizing assignment in these models, diverting enrollment and participation from more advanced accountable care options.**

- **APG recommends that CMS finalize the modification to the beneficiary notification requirement to include only the beneficiaries who would qualify under "preliminary prospective assignment with retrospective reconciliation" if the ACO has selected that assignment option.**

- **APG recommends that CMS finalize the modification to the beneficiary follow-up notification requirement to only within 180 days and eliminating "earlier of beneficiary's next primary care service visit."**

- **APG recommends that CMS finalize the proposal to allow ACOs with less than the required 5,000 assigned beneficiaries additional time to fulfill this requirement.**

D. Recommendations Related to MSSP Risk Adjustment

- **APG recommends that CMS permit MSSP ACOs that will have an existing agreement period going into 2024 to opt to have the agency apply the same risk adjustment model to both benchmark and performance years.**

E. Recommendations Related to MSSP Benchmarks and Other Financial Methodology Changes

- **APG recommends that CMS finalize the proposed prepaid shared savings program with modifications to make ACOs eligible, regardless of new or existing agreement, and to grant ACOs the flexibility to determine the best way to spend prepaid shared savings to address beneficiaries' needs.**
- **APG recommends that CMS finalize the proposed significant, anomalous, and highly suspected (SAHS) billing policy and avoids reopening previous years' financial determinations without significant reasons.**

F. Recommendations Related to MSSP Requests for Information (RFI)

- **APG members generally support, but also report mixed reactions, to the possibility of adding a track to MSSP with risk greater than the current ENHANCED track. APG encourages CMS to closely assess the evaluation results from the ACO REACH model to better understand the characteristics of participants that are successful in achieving savings under the Global Risk Option and urges CMS to review these evaluation results with participants as part of a mixed-methods approach to delve into the qualitative lessons to be learned from their experiences.**

G. Recommendations Related to Quality Payment Program (QPP)

- **APG recommends that CMS finalize the modification to the criteria of attribution-eligible beneficiary to include a covered professional service.**
- **APG recommends that CMS finalize the proposal to maintain a 75 percent data completeness requirement for ACO quality measure reporting and encourages the agency to adopt this level as a permanent requirement.**
- **APG recommends that CMS streamline the number of quality measures that physicians are expected to track and report and prioritize outcome and patient-reported measures.**

IV. APG's Detailed Comments and Recommendations

APG members are grateful that CMS's proposals reflect an ongoing willingness to engage with stakeholders and incorporate lessons learned in program refinements. APG also appreciates CMS's clear commitment to improving care for all Medicare beneficiaries, including those adversely affected by social determinants of health and who possess health-related social needs that present challenges for achieving high-quality health and health care outcomes. We also recognize the steps that the agency continues to take to address the crisis in access to primary care.

A. Physician Fee Schedule Proposals

ii. Physician Fee Schedule Payment Update

CMS proposes to reduce the PFS conversion factor by 2.8 percent from $33.29 to $32.36, beginning January 1, 2025. Although APG recognizes that this cut is required by statute, we must note our concern about its deleterious impact on physicians and the patients that they serve, especially for primary care providers and other cognitive-based physicians who are precluded from increasing the volume and intensity of the services they provide when faced with payment rate cuts.

APG will continue to work with Congress to pursue an upward adjustment in physician payment rates in 2025 and future years, and in particular, changes that would benefit primary care. APG thanks CMS for the agency's efforts to improve payment policy for primary care and other more cognitively focused care and encourages the agency to continue to pursue these types of policies.

iii. Advanced Primary Care Management Codes

CMS proposes to establish 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 proposes to establish and pay for 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 (see Table 1).

Table 1. Proposed APCM Bundled Codes and Valuation

Code	Short Descriptor	Crosswalk Codes	CMS Proposed Work RVU	CMS Proposed PE RVU	CMS Proposed MP RVU	CMS Proposed Full RVU	Approximate National Payment Rate
GPCM1	APCM for patients with up to one chronic condition	99490	0.17	0.14	0.01	0.31	$10
GPCM2	APCM for patients with multiple (two or more) chronic conditions	99490, 99439, 99487, 99489	0.77	0.72	0.05	1.54	$50
GPCM3	APCM for QMBs enrollees with multiple chronic conditions	Calculated as a relative increase from GPCM2	1.67	1.57	0.12	3.36	$110

* QMB (Qualified Medicare Beneficiary)

CMS proposes that APCM services would include nearly the same scope of service elements and conditions that the agency established for chronic care management (CCM) and primary care management (PCM) services (including elements of 24/7 access and care continuity, care management and care plan, care coordination, management of care transitions, and enhanced communication). CMS believes this change is appropriate because care management is a key component of care delivery using an advanced primary care model. The proposed phrasing in the code descriptors for APCM services generally tracks the code descriptors for CCM and PCM services, except for references to "time spent" or "minutes" of service.

CMS seeks to ensure that the APCM codes would fully and appropriately capture the care management and CTBS services that are characteristic of the changes in medical practice that characterize advanced primary care, as demonstrated in select CMS Innovation Center models. As CMS does for CCM and PCM services, CMS proposes to require for APCM services that the practitioner provide an initiating visit and obtain beneficiary consent for this care management.

As described in more detail below, CMS proposes to incorporate as elements of APCM services "Management of Care Transitions" and "Enhanced Communications Opportunities." For the "Management of Care Transitions" APCM service element, CMS proposes to specify timely follow-up during care transitions. For the "Enhanced Communications Opportunities" APCM service element, CMS proposes to incorporate access to CTBS services, including remote evaluation of prerecorded patient information and interprofessional telephone/internet/EHR referral service(s), to maintain ongoing communication with the patient, as well as access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and E/M visits (or e-visits).

CMS also proposes to specify for APCM services the practice-level characteristics and capabilities that are inherent in, and necessarily present when, a practitioner is providing covered services using an advanced primary care delivery model. As described in more detail below, included in the service descriptors for GPCM1, GPCM2, and GPCM3, CMS's proposed practice-level capabilities that reflect care delivery using an advanced primary care model are focused on 24/7 access and continuity of care, patient population-level management, and performance measurement. These practice capabilities are indicative of, and necessary to, care delivery using an advanced primary care model. In addition, APCM services, as CMS proposes to define them, could not be fully performed in the absence of these practice capabilities, and in such cases, APCM services should not be billed.

CMS proposes that providers must meet all the following criteria to bill ACPM codes:

- Consent
  - Informing the patient of the availability of APCM services; that only one practitioner can furnish and be paid for these services during a calendar month; of the right to stop services at any time (effective at the end of the calendar month); and that cost sharing may apply (and/or may be covered by supplemental health coverage) [1]
  - Documenting in patient's medical record that consent was obtained
- Initiating Visit for New Patients (separately paid)
  - Initiation would occur during a qualifying visit for new patients
  - An initiating visit is not needed (1) if the beneficiary is not a new patient (has been seen by the practitioner or another practitioner in the same practice within the past three years), or (2) if the beneficiary received another care management service (APCM, CCM, or PCM) within the previous year with the practitioner or another practitioner in the same practice.
- 24/7 Access to Care and Care Continuity
  - Providing 24/7 access for urgent needs to care team/practitioner with real-time access to patient's medical information, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week
  - Affording continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
  - Delivering care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours, as appropriate
- Comprehensive Care Management
  - Overall comprehensive care management may include, as applicable, the following:
    - Systematic needs assessment (medical and psychosocial)
    - System-based approaches to ensure receipt of preventive services
    - Medication reconciliation, management and oversight of self-management
- Patient-Centered Comprehensive Care Plan
  - Development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan. Such a plan will be available in timely fashion within and outside the billing practice, as appropriate, to individuals involved in the beneficiary's care. It can also be routinely accessed and updated by the patient's care team/practitioner, and a copy of the care plan can be shared with the patient and caregiver(s)
- Management of Care Transitions (for example, discharges, emergency department (ED) visit follow-up, and/or referrals, as applicable)
  - Coordination of care transitions between and among health care providers and settings, including transitions involving referrals to other clinicians, follow-up after an ED visit, or follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities, as applicable
  - Ensuring timely exchange of electronic health information with other practitioners and providers to support continuity of care.

[1] Medicare beneficiaries who are enrolled in the QMB eligibility group do not have any Medicare cost-sharing responsibility for copays, deductibles, and coinsurance.

    - Ensuring timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after ED visits and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated
  - Practitioner, Home-, and Community-Based Care Coordination
    - Ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), as applicable, and documenting in the patient's medical record of communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors
- Enhanced Communication Opportunities
    - Enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication technology-based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/EHR referral service(s), to maintain ongoing communication with patients, as appropriate
    - Ensuring access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and E/M visits (or e-visits)
  - Patient Population-Level Management
    - Analyzing patient population data to identify gaps in care and offer additional interventions, as appropriate
    - Risk-stratifying the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients
    - Satisfaction of these requirements by a practitioner who is participating in an MSSP ACO; the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) model; Making Care Primary, or Primary Care First
  - Performance Measurement
    - Assessment of primary care quality, total cost of care, and meaningful use of CEHRT, which can be met in several ways:
      - For Merit-based Incentive Payment System (MIPS)-eligible clinicians, by registering for and reporting the Value in Primary Care MIPS Value Pathways (MVPs)[2]
      - For a practitioner who is part of a TIN participating in a MSSP ACOthrough the ACO's reporting of the APM Performance Pathway
      - For a practitioner who is participating in an MSSP ACO, ACO REACH, Making Care Primary, or Primary Care First, through the quality reporting, assessment, and performance requirement and other program and model requirements.

[2] For APCM services billed in 2025, practitioners would register to report the MVP in 2025, and report the MVP in 2026 for the 2025 performance year/2027 MIPS payment year. For more details, see the 2024 MIPS Quick Start Guide, available at https://qpp.cms.gov/mips/reporting-options-overview.

CMS proposes that practitioners participating in the ACO REACH model, the Making Care Primary model, and the Primary Care First model would satisfy the proposed initiating visit, patient population-level management, and performance measurement APCM service elements and practice-level capabilities by virtue of their model participation. These CMS Innovation Center models promote advanced primary care delivery consistent with the proposed APCM service elements and practice-level capabilities described in the list above. The models all use attribution methods that review the most recently available two years of Medicare claims to identify whether a model participant is responsible for a Medicare beneficiary's primary care, aligning with the initiating visit requirements for APCM services.

Additionally, these three models include risk stratification and quality and cost performance metrics that are aligned or overlap with the Value in Primary Care MVP. Around-the-clock access and continuity of care, patient population-level management, and performance measurement are indicative of, and necessary to, care delivery using an advanced primary care model. CMS is also considering whether certain practitioners in other types of CMS Innovation Center models satisfy the proposed service elements and requirements and seeks comments on this question.

APG members are generally large primary and multispecialty care groups that are accomplished at operating in risk-based models, such as two-sided risk arrangements with MA plans and the more advanced alternative payment models, such as ACO REACH. As such, it is unlikely that they would participate in the type of hybrid fee-for-service payment arrangement contemplated under the Advanced Primary Care Hybrid Payment request for information included in CMS's proposed rule and recently extended by Sens. Bill Cassidy and Sheldon Whitehouse.[3] However, APG believes strongly that is imperative to strengthen primary health care in America and equip primary care physician practices with the tools and capabilities to move into more risk-based alternative payment models over time.

APG commends CMS on the agency's leadership on primary care and appreciates the proposal to establish three new APCM billing codes. APG members strongly support innovative efforts, such as APCM codes and the advanced primary care hybrid payment model described below, to alleviate the pressures that primary care providers face and support movement toward advanced primary care, CTSB, and value. APG believes that ACOs are at the leading edge of value-based care approaches and recognizes the need for on-ramps for physicians that aren't ready to participate in ACOs, but who seek to move in that direction. CMS should ensure that these multiple options serve to prepare physicians for ACOs and don't unduly compete with ACOs for physician or beneficiary participation.

The 10 criteria listed above are a substantial commitment, and physician groups would need to embrace significant practice transformation to meet them. In fact, if anything, given the level of practice transformation required to meet the criteria, the proposed requirements to bill for APCM seem like a rigorous option for an on-ramp. By the time physician groups have implemented this much practice transformation, they should already be close to considering joining or creating an ACO.

- **APG recommends that CMS finalize the propose advanced primary care management billing codes but consider relaxing some of the required criteria at least temporarily to allow for greater participation.**

[3] See https://www.cassidy.senate.gov/wp-content/uploads/2024/05/Whitehouse-Cassidy-Medicare-Primary-Care-RFI.pdf

iv. Payment for Telehealth Services

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

- Adding several services on a provisional basis and remove one service;
- Continuing the suspension of frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations;
- Allowing audio-only if needed or preferred by patient;
- Continuing to allow providers to use their practice location address when working from home;
- Allowing supervisory physicians to supervise through real-time audio and visual interactive telecommunications; and
- Continuing to allow teaching physicians to use telehealth for services furnished involving residents in all teaching settings for virtually furnished services.

APG supports all of 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 that 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 telehealth proposals include in the 2025 proposed rule.**

- **APG recommends that CMS seek additional opportunities to offer telehealth flexibilities to accountable care participants.**

v. Advanced Primary Care Hybrid Payment RFI

Recent evidence reviews show that, although primary care is the only part of the health system in which investments routinely result not only in improved outcomes but also increased equity, the practice and sustainability of the primary care sector is under significant strain.[4,5] A key report by the National Academies of Sciences, Engineering, and Medicine found that many of these challenges relate to a primary care payment system that principally rewards visit volume versus creation and maintenance of longitudinal care relationships over time.[6,7] CMS has set a goal of having 100 percent of traditional Medicare beneficiaries and the vast majority of Medicaid beneficiaries in accountable care relationships by 2030. CMS defines accountable care as occurring when a person-centered care team takes responsibility for improving quality of care, care coordination and health outcomes for a defined

[4] National Academies of Sciences, Engineering, and Medicine (NASEM); Implementing High-Quality Primary Care (https://nap.nationalacademies.org/read/25983).
[5] Milbank Memorial Fund, The Health of US Primary Care: 2024 Scorecard (https://www.milbank.org/wpcontent/uploads/2024/02/Milbank-Scorecard-2024-ACCESS_v06.pdf).
[6] Longitudinal care management is long-term, proactive, relationship-based care management that augments routine and acute visits with intentional, proactive outreach, especially during times of illness and transitions of care.
[7] NASEM, Implementing High-Quality Primary Care (https://nap.nationalacademies.org/read/25983).

group of individuals, to reduce care fragmentation and avoid unnecessary costs for individuals and the health system.[8] CMS believes that advanced primary care is a core mechanism for achieving this goal. With this goal, CMS acknowledges the need to increase the capability of primary care clinicians to engage, maintain, and promote longitudinal and accountable relationships with beneficiaries through incentives and flexibilities to manage quality and total cost of care.

Over the past 11 years, the CMS Innovation Center has tested multiple primary care models: the Comprehensive Primary Care Initiative (CPC); the Comprehensive Primary Care-Plus model CPC+), the Maryland Primary Care Program; the Primary Care First (PCF) model; and the forthcoming Making Care Primary (MCP) and ACO Primary Care Flex models. Each of these primary care models has focused, or will focus, on testing variations of CMS payment for primary care services with hybrid payments (a mix of fee-for-service and population-based payments), as described earlier. Although these models have not met the criteria for expansion to date, the findings suggest advanced primary care may reduce unnecessary utilization and improve diabetes care and cancer screening rates.

In addition to testing new approaches to improve care for beneficiaries by supporting primary care, CMS has focused on approaches to incorporating these innovations into Medicare programs. For example, lessons learned from the CMS Innovation Center's ACO models may be incorporated into MSSP. As such, part of the intent of CMS's proposal to create new APCM payment and coding is that the agency would have a similar foundation to scale advanced primary care model learnings over time.

To strengthen the primary care infrastructure within FFS Medicare, CMS is exploring opportunities to create new sustainable pathways to support advanced primary care, equitable access to high-quality primary care, and continued transformation among a wide variety of practices. One potential strategy to increase access to advanced primary care – and to prepare practitioners in traditional Medicare to engage in more accountable care – is through the creation and ongoing refinement of specific billing and coding under the PFS. Such coding changes would better recognize advanced primary care and incorporate at least some compensation for the resources involved in furnishing longitudinal care and maintaining relationships with patients over time. In this proposed rule, CMS proposes a set of APCM services that make use of lessons learned from the CMS Innovation Center's primary care models, grouping existing care management and CTBS service elements into a bundle for use starting in 2025.

CMS seeks feedback regarding potential further evolution in coding and payment policies to better recognize advanced primary care. Through this Advanced Primary Care RFI, CMS is committed to collaborating with interested parties to lay the path for a more transparent movement to value-based care. Specifically, CMS requests input on a broader set of questions related to care delivery and incentive structure alignment and five foundational components:

- Streamlined Value-Based Care Opportunities
- Billing Requirements
- Person-Centered Care
- Health Equity, Clinical, and Social Risk
- Quality Improvement and Accountability

As stated above, APG members are generally large primary and multispecialty care groups that are accomplished at operating in risk-based models, such as two-sided risk arrangements with MA plans and

[8] https://www.cms.gov/priorities/innovation/key-concepts/accountable-care-and-accountable-care-organizations.

the more advanced alternative payment models, such as ACO REACH. As such, it is unlikely that they would participate in the type of hybrid fee-for-service payment arrangement contemplated under the Advanced Primary Care Hybrid Payment RFI.

However, APG believes strongly that is imperative to strengthen primary health care in America and equip primary care physician practices with the tools and capabilities to move into more risk-based alternative payment models over time. Thus, APG fully supports the concepts behind the Advanced Primary Care Hybrid Payment RFI and is happy to respond to CMS's RFI in the interest of further fleshing out the potential payment mechanism. We look forward to providing more detailed recommendations in response to future proposed rulemaking.

a. Streamlined Value-Based Care Opportunities

As CMS notes in the proposed rule, it is essential to design the advanced primary care hybrid payment system to avoid inducing clinicians to leave effective accountable care relationships and clinician networks that already produce positive results. As such, the advanced primary care hybrid payment system should be envisioned as an on-ramp for physicians not yet in these models to equip them eventually to enter ACOs and other similarly advanced accountable care relationships. This hybrid payment system could be viewed as being perhaps as one step more evolved than the proposed APCM codes if these are finalized.

CMS should include primary-care related billing codes in the bundled payment, such as E&M visits, CCM, PCM, the proposed APCM, and additional CTBS services, such as remote patient monitoring. However, billing codes for integrating specialists and other providers should be reserved for ACOs and other similarly advanced accountable care relationships. In this fashion, primary care providers who met with success in the primary care hybrid payment system would have sufficient incentives to graduate to greater value-based care arrangements.

b. Billing Requirements

If CMS finalizes both APCM codes and advanced primary care hybrid payment, then it makes sense for the latter payment mechanism to be broader and offer greater flexibility to providers. APG offers these responses to the questions that CMS poses in the proposed rule:

- Primary care physicians in group practices should have the option to have the advanced primary care episode attributed to the group rather than individual physicians.
- Given that beneficiaries will be responsible for cost-sharing, including for non-face-to-face services, it is essential to maintain an initiating visit requirement or an alternative mechanism for patients to give informed consent.
- Members of the primary care team should be allowed to bill services under the advanced primary care episode, but as noted above, CMS should strive to limit this group to primary-care related clinicians and reserve inclusion of specialists for more advanced accountable care relationships like ACOs.

c. Person-Centered Care

Addressing health-related social needs must be included in any primary care hybrid payment

model to ensure that care is person-centered. Primary care practices need to have team members who can coordinate and link with community-based organizations and others that can help to address health-related social needs (HRSNs) – transportation, food, and stable housing among them – that, if left unaddressed, can prompt people to need more health services. APG is aware that, in the 2024 PFS final rule, payment was created for person-centered assessments/services designed to address HSRNs, as well as care integration with CBOs and community care hubs, but it is not clear whether these amounts of payment and care integration are sufficient to enable practices to meet the need.

Additional services, such as behavioral health integration, patient portals, and other communication options listed will also positively affect patients' quality of care and the outcomes they receive. We simply caution that it remains unclear how many, or how much, of these services that practices will be able to provide, even with hybrid payment. Many smaller primary care practices do not actively participate in Medicare Chronic Care Management (CCM) because they lack the capacity to monitor patients outside of normal office visits, for example. Until the balance is shifted within the Medicare physician fee schedule toward higher payment for primary care, the amount of overall resources dedicated to primary care payment will remain suboptimal. Substantial advance, upfront payment may also be needed so that smaller physician practices can restructure themselves to provide these additional services.

d. Health Equity, Clinical, and Social Risk

A risk adjustment approach for primary care hybrid payment would need to be designed to address the patient characteristics that drive primary care costs. Such an approach could borrow characteristics of the existing HCC model used for MA, but given that HCCs predict total costs, it is not appropriate to use them for primary care costs alone. In addition, given the rapid and likely ongoing growth of enrollment in MA, if MA enrollment is not included in the risk adjustment calculation of any new approach pertaining to care delivery in the traditional Medicare program, then that calculation will over time be based on a shrinking pool of enrollees, and will not reflect the totality of the Medicare population.

Beyond this reality, a major concern will be devising a new risk adjustment system that avoids some of the deleterious incentives in the current HCC model for MA toward upcoding or overcoding. At minimum, the proposed legislation has the opportunity to avoid some of the worst features of the current risk adjustment system in MA, such as making excessive use of Health Risk Assessments and chart reviews that are carried out by clinicians and other entities that are not patients' primary physicians and that do not have overall responsibility for creating and executing a care plan related to the conditions or other interventions that are coded. We also note that other, simpler alternatives have been advanced, such as using prior utilization of primary care E&M visits and minor procedures as a basis for the risk-adjusted hybrid payment, or even a "simple patient-reported health status survey such as 'How's Your Health'."[9]

Devising a new risk adjustment system that derives diagnoses directly from electronic health records (EHRs) and accompanying patient care plans may be the optimal solution in the long run, to eliminate

[9] Robert A Berenson, Adele Shartzer, Hoangmai H Pham, Beyond demonstra9ons: implementing a primary care hybrid payment model in Medicare, *Health Affairs Scholar*, Volume 1, Issue 2, August 2023, qxad024, https://doi.org/10.1093/haschl/qxad024

added burdens on providers. However, this approach is likely to be problematic to implement with the current population of providers in the short run, given the reliance of many of them on older or less robust EHR systems. In the meantime, APG is aware that certain entities are working on artificial intelligence (AI)-based systems to improve MA risk adjustment, which may be able to be in place sooner. It would be desirable to explore additional technology-based alternatives that could reduce clinician burden as more elaborate risk adjustment systems are developed for the hybrid model.

e. Quality Improvement and Accountability

To the maximum degree possible, the quality measures that accompany this new payment approach should be (1) parsimonious in number and reflective of measures that make the greatest difference in outcomes for patients; (2) closely correlated with other measures that practices now report; (3) harmonized with Universal Foundation principles; and (4) claims based and/or digital to reduce provider burden. If MIPS is revised, as seems likely, replacement quality measures that accompany that program should be reflected in the hybrid payment model. In developing the quality measures for this model, attention should be paid to the fact that many practices entering the model may be unlikely to have sophisticated electronic health record systems that can make quality reporting more seamless than it is otherwise.

v. Ambulatory Specialty Care Model RFI

Medicare beneficiaries' care is becoming more fragmented as they are increasingly seeing (1) more specialists and (2) more specialists, more often, even as the number of visits with their primary care clinicians remain relatively constant. This phenomenon seems likely to grow as access to primary care clinicians becomes increasingly challenged in many parts of the country. What's more, a primary care team must now coordinate with more specialists than ever before to achieve continuity in beneficiary care. Medicare beneficiaries with chronic conditions, in particular, are at high risk of excess emergency department visits due to fragmented care and lack of timely access to primary care.

In 2021, the Innovation Center announced a strategic refresh with a vision for a health care system that achieves equitable outcomes through high-quality, affordable, person-centered care. This vision includes a bold goal of having 100 percent of Medicare fee-for-service (FFS) beneficiaries and the vast majority of Medicaid beneficiaries in an accountable care relationship by 2030.[10]

To expand accountable care among specialists and to drive more person-centered care – thereby improving the quality, clinical outcomes, and affordability of healthcare for beneficiaries – the Innovation Center has created a comprehensive specialty strategy to test models and innovations. This strategy includes (1) enhancing transparency of specialist data and performance measures; (2) maintaining momentum established by episode payment models by extending the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model, launching a new model focusing on beneficiaries with cancer, and testing a new mandatory acute episode payment model; (3) creating financial incentives to improve coordination and collaboration between primary care and specialty care

[10] Centers for Medicare & Medicaid Services. Driving Health System Transformation - A Strategy for the CMS Innovation Center's Second Decade. October 2021. https://www.cms.gov/priorities/innovation/strategic-directionwhitepaper.

in both advanced primary care models and in condition-based models; and (4) creating additional financial incentives for specialists to affiliate with population-based models and move to value-based care.

As part of this strategy, CMS is considering a model design that would increase the engagement of specialists in value-based payment and encourage specialty care provider engagement with primary care providers and beneficiaries. Specifically, CMS is currently exploring developing a model for specialists in ambulatory settings that would build on the Merit-based Incentive Payment System (MIPS) Value Pathways, or MVP, framework.

As currently envisioned, participants in this model would not receive a MIPS payment adjustment. Instead, a model participant would receive a payment adjustment based on (1) a set of clinically relevant MVP measures that they are required to report and (2) comparing the participant's final score against a limited pool of clinicians (other model participants of their same specialty type and clinical profile, who are also required to report on those same clinically relevant MVP measures).

Currently, under MIPS, performance and the subsequent payment adjustment are based on a range of measures voluntarily reported by clinicians, who receive a final score based on the submitted measures. A clinician's performance is assessed against a pool of all clinicians, regardless of specialty type or the services they provide. CMS expects that a more targeted approach in which clinicians are evaluated (1) on a set of relevant performance measures they are required to report, and (2) among clinicians furnishing similar sets of services, would produce scores and subsequent payment adjustments that are more reflective of clinician performance.

A more targeted approach to measurement would also offer more insight into how clinical decisions and processes, such as care coordination, affect patient outcomes. CMS believes this insight is necessary to support and incentivize accountable care, increasing beneficiary access to coordinated specialty care. Furthermore, equipped with more specialty-relevant performance information, CMS expects clinicians would be more likely to invest resources in pursuit of better outcomes, reducing the incidence of poor outcomes arising from care fragmentation, ultimately resulting in better care for patients.

MVPs are a reporting option under MIPS, which is one of the two primary ways a clinician may participate in the CMS QPP. The QPP rewards the delivery of high-quality patient care through two avenues: Advanced Alternative Payment Models (AAPMs) and MIPS for eligible clinicians or groups under the PFS. CMS assesses performance on measures and activities in four performance categories to determine each MIPS eligible clinician's performance under MIPS: quality; cost; clinical practice improvement activities; and Promoting Interoperability.

CMS developed the MVP reporting option in response to concerns made by interested parties that MIPS requirements are confusing and burdensome, and that it is difficult to choose measures from the several hundred MIPS and qualified clinical data registries (QCDR) quality measures that are meaningful to their practices and have a direct benefit to patients. Thus, CMS hopes that the MVP reporting option will lead to a simpler MIPS clinician experience, improve value, reduce burden, and better inform patient choice in selecting clinicians. MVPs provide MIPS-eligible clinicians with a more cohesive subset of measures and activities related to a specific specialty or condition. MVPs are developed in coordination with interested parties through an established process in which clinician and patient perspectives are incorporated. The use of MVPs can create more meaningful performance data, reduce complexity of the

MIPS program for clinicians, and lower the burden on participating clinicians. MIPS-eligible clinicians have been able to report on MVPs beginning with the CY 2023 MIPS performance period.

Like MIPS eligible clinicians participating in traditional MIPS, those who report MVPs receive an adjustment to their Medicare Part B fee-for-service payments 2 years after the corresponding MIPS performance period based on a total score calculated from reported measures and activities across the 4 MIPS performance categories. MVPs are designed to cover a range of medical conditions, care settings, and clinician types, including primary care providers and specialists. For the 2024 performance year, 16 MVPs are reportable, allowing for a range of specialties to report a streamlined set of measures most applicable to services they provide.

Currently, 5 MVPs have quality measures including patient-reported outcome measures and chronic condition episode-based cost measures, which could be the foundation for assessing the value of care provided to chronic care patients. CMS believes coordination among primary and specialty care clinicians is particularly critical to the ongoing management of beneficiaries' chronic conditions, not only for reasons of quality and cost, but also in understanding and addressing beneficiaries' goals, expectations, and experiences with care.

Using the MVP framework as the foundation for a model has many benefits. First, the MVP framework advances value-based care by narrowing the available measure set based upon clinician specialty, medical condition, or patient population. These factors allow for meaningful comparisons to be made across providers and for relevant feedback to be available to participants on their performance, strengthening the foundation for accountability in specialty care. The MVPs provide a framework for reporting a cohesive set of measures and activities focused on the clinician's performance in rendering care for their specialty or clinical condition.

Second, the payment methodology for the model built on MVPs could address concerns that interested parties have raised about the MIPS program. For instance, CMS has heard from interested parties that the current range of Medicare Part B payment adjustments resulting from MIPS participation may be insufficient to encourage meaningful specialty care transformation that results in increased integration between primary and specialty care. The model could test ways to enhance existing incentives, allowing for more specific comparisons to be made between clinicians of the same type who are providing similar services to patients.

Third, such a model could reach a broad range of clinicians of various specialty types that have limited opportunity to participate in Advanced APMs. There are 16 MVPs for the 2024 performance year spanning numerous specialties, and CMS is proposing additional MVPs for the 2025 performance year with the goal of creating MVPs that would be relevant to the practices of 80 percent of MIPS eligible clinicians. Using an existing framework that is agnostic to specialty type, as opposed to creating multiple unique models that are each narrowly defined by a condition or specialty, would allow the Innovation Center to take a more inclusive and unified approach to increasing specialist engagement in value-based payment.

While CMS continues to develop more MVPs for additional health conditions and specialties, an ambulatory specialty model building on the MVP framework could focus on a subset of published MVPs in the initial years of implementation, with the goal of increasing the number of MVPs, and thus the range of health conditions or specialty areas, included in the model over time. Using specific MVPs as the basis for a model would, in part, require that selected MVPs cover a sufficient volume of clinicians,

address chronic conditions with high Medicare expenditures, align with existing Innovation Center models (for example, the Making Care Primary model), and present an opportunity to strengthen the integration between specialty care and primary care.

CMS is soliciting comments on several parameters of a potential model, including considering mandatory participation of relevant specialty care providers to overcome challenges such as selection bias and participant attrition, and to ensure the model is reaching a representative group of providers and beneficiaries to facilitate scaling of the model test. If CMS were to propose a mandatory specialty model, it would be done via notice and comment rulemaking. CMS expects this ambulatory specialty model would be implemented no earlier than 2026, ensuring that participants have sufficient time to prepare for the model.

CMS requests feedback on the design of a future ambulatory specialty model, specifically on the following:

- Participant definition;
- MVP performance assessment;
- Payment methodology;
- Care delivery and incentives for partnerships with accountable care entities and
- Integration with primary care;
- Health information technology and data sharing;
- Health equity; and
- Multi-payer alignment.

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 MVPs 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 Ambulatory Specialty Care Model 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 the Medicare Shared Savings Program (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 recommends that CMS explore options for integrating specialists into existing value-based care approaches such as MSSP and ACO REACH and employing MVPs for the measurement of their performance, rather than establishing a new Ambulatory Specialty Care**

Model.

B. MSSP Quality Measurement

i. Report New APP Plus Quality Measures

For performance year 2025 and subsequent years, CMS proposes to require MSSP ACOs to report the APM Performance Pathway (APP) Plus quality measure set. This measure set currently consists of six measures and will incrementally grow over performance years 2025 through 2028 to comprise eleven measures by incorporating five newly proposed measures from the Adult Universal Foundation measure set.

Beginning with the 2025 performance year, CMS proposes to add the Breast and Colorectal Cancer Screening measures (see Table 2). If finalized, for 2025, MSSP ACOs would be required to report five electronic clinical quality measures (eCQMs)/Medicare CQMs in the APP Plus quality measure set and administer the Consumer Assessment of Health Providers and Systems (CAHPS) for Merit-based Incentive Payment System (MIPS) survey. CMS would calculate two claims-based measures.

Table 2: Measures Included in the APP Plus Quality Measure Set for Shared Savings Program ACOs for Performance Year 2025

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: Hemoglobin A1c (HbA1c) Poor Control	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^
113	Colorectal Cancer Screening	eCQM/Medicare CQM	APM Entity/Third Party Intermediary	Wellness and Prevention	Process
112	Breast Cancer Screening	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 about the developments in clinical quality measurement that appear to be retreating from the previous goal of streamlining quality measures to reduce the reporting burden on clinicians. As it already stands, adoption of new measures, even those that offer an improvement relative to current options, place significant resource demands on ACOs.

APG generally supports CMS's overall strategy of establishing a core set of quality measures in the Universal Foundation to align quality measures across Medicare programs. However, APG cautions CMS that, in addition to seeking alignment, it should continue efforts to reduce undue administrative burdens on clinicians.

As CMS refines the Universal Foundation measure set, the agency must ensure there is not significant growth in the number of measures that ACOs must report. CMS began MSSP with more than 30 quality measures and over time reduced the measure set to reduce providers' reporting burden. APG encourages CMS to adhere to this approach. APG also urges CMS to, first, test measures before making them required and scored measures for ACOs. Finally, APG cautions CMS about implementing multiple major changes to the measure set in performance year 2025 as this is the year that the Web Interface is currently scheduled to sunset as a reporting option for ACOs, particularly as ACOs will now also be considering and preparing for the new reporting option, Medicare CQMs.

- **APG recommends that CMS limit the number of new MSSP quality measures added and test new measures before making them required and scored measures for ACOs.**

ii. Reporting Limited to eCQMs or Medicare CQMs

The types of quality measures that MSSP ACOs are required report have been shifting. As recently as 2023, MSSP ACOs were required to report through the Alternative Payment Model Performance Pathway (APP) and could choose to report using the CMS Web Interface or the eCQMs/MIPS CQMs. For performance year 2024 and subsequent performance years, CMS added the Medicare Clinical Quality Measures (CQMs) for MSSP ACOs as a new alternate collection type. CMS intended Medicare CQMs to serve as a transition collection mechanism to help ACOs build the infrastructure, skills, knowledge, and expertise necessary to report the all-payer/all-patient MIPS CQMs and eCQMs.

For performance year 2025 and subsequent years, CMS proposes to streamline the APP measure collection types to eCQMS and Medicare CQMs. The decision to propose retiring MIPS CQMs was motivated by concerns raised by ACOs that this measure collection type is unattainable for many participants.

APG enthusiastically welcomes CMS's proposal to allow MSSP ACOs to continue to report using Medicare CQMs in lieu of all-payer eCQMs, as APG recommended last year. APG also welcomes the agency's proposal to establish Medicare CQMs for ACOs participating in the MSSP as a new alternative collection mechanism for MSSP ACOs. Medicare CQMs are far better matched to ACOs' reporting capabilities than are all-payer eCQMs. APG continues to urge CMS to make Medicare CQMs a permanent alternative to all-payer eCQMs.

For example, one multi-disciplinary ACO APG member noted that educating its providers on the new standard of reporting for MSSP ACOs has required developing workflow provisions to ensure that all specialists are documenting diagnoses and services fully and accurately so that measure data will map to reporting. If Medicare CQMs prove to be only a temporary fix to transitioning to eCQMs, they will create undue burden and unnecessary cost to move to a third quality measure collection method with providers. Limiting Medicare CQMs as only a temporary reporting option, forces many MSSP ACOs to choose between continuing with preparation for eCQMs or pausing that work to devote attention to Medicare CQMs instead.

- **APG strongly recommends that CMS make Medicare Clinical Quality Measures (CQMs) a permanent reporting alternative to all-payer eCQMs.**

- **APG strongly recommends that CMS continue the Web Interface at least through 2026 to allow more time for providers to implement infrastructure for Medicare CQM if needed.**

iii. Add Complex Organization Adjustment for eCQMs

To account for the organizational complexities faced by Virtual Groups and APM Entities, including MSSP ACOs, when reporting eCQMs, CMS proposes to establish a Complex Organization Adjustment beginning in the 2025 performance period. 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 supports the acknowledgment of the difficulty of challenges in adoption of eCQM collection in virtual groups and APM entities. APG concurs that support is needed in adoption of digital quality measures by groups with numerous providers and practices. However, APG also believes that these challenges will remain past adoption of FHIR, and APM entities will continue to need this quality adjustment.

- **APG recommends that CMS finalize the complex organization adjustment for eCQMs but revisit the anticipated sunsetting of it once FHIR is adopted.**

iv. Extend eCQM Reporting Incentive

CMS proposes to extend the eCQM reporting incentive for meeting the MSSP quality performance standard to performance year 2025 and subsequent years. Collectively, these proposals aim to align the quality measures that MSSP ACO would be required to report with the quality measures under the Adult Universal Foundation measure set incrementally beginning in performance year 2025. They also aim (1) to prioritize the eCQM collection type as the gold standard collection type that underlies CMS's Digital Quality Measurement Strategic Roadmap, while (2) using Medicare CQMs as the transition step in CMS's building-block approach as ACOs progress to full adoption of digital quality measurement.

CMS continues to hear from ACOs and other stakeholders about the challenges with reporting on all-payer/all-patient measures and meeting data management requirements given multiple factors: the muti-practice/multi EHR structure of many clinical entities; the challenges of aggregating data within the health IT infrastructure in use by ACOs; and the current state of interoperability. MSSP quality reporting data over the past two performance years indicate that ACOs have been slow to report eCQMs. In performance year 2021, 5 of 475 ACOs reported eCQMs under the APP. In performance year 2022, among ACOs that reported quality data under the APP, 24 out of 482 reported eCQMs with 7 of these ACOs reporting a combination of eCQMs and MIPS CQMs.

Specifically, CMS proposes that for performance year 2025 and subsequent performance years, an ACO will meet the quality performance standard used to determine eligibility for maximum shared savings and to avoid maximum shared losses, if applicable under the following circumstances:

- The ACO reports all of the eCQMs in the APP Plus quality measure set applicable for a performance year, meeting the data completeness requirement for all eCQMs, and;
- The ACO achieves a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP Plus quality measure set, and;
- The ACO achieves a quality performance score equivalent to or higher than the 40th percentile of the performance benchmark on at least one of the remaining measures in the APP Plus quality measure set.

The eCQM reporting incentive would apply only to those ACOs that report all the eCQMs in the APP Plus quality measure set applicable for a performance year and meet the data completeness requirement for all of the eCQMs. The reporting incentive would not apply to ACOs that report a combination of eCQMs/Medicare CQMs or report only Medicare CQMs. CMS will further assess the need for the eCQM reporting incentive in the future as ACOs continue the transition to adopting eCQMs and may make refinements as needed in future rulemaking.

APG appreciates the extension of the eCQM reporting incentive. However, it is important to note that only 5 percent of ACOs are currently reporting eCQMS. Moving to all payor/all patient digital quality reporting continues to be a threshold that is difficult for ACOs to achieve as evidenced by the low number of ACOs reporting. APG continues to advocate for Medicare CQM to remain in place as a permanent reporting option**.**

- **APG recommends that CMS extends the eCQM incentive for the 2025 performance year.**

- **APG recommends that CMS make Medicare CQMs a permanent reporting option.**

v. Score Medicare CQMs Using Flat Benchmarks

CMS proposes to score Medicare CQMs using flat benchmarks for their first two years in the program consistent with the MSSP policies, beginning with the 2025 performance year. The use of flat benchmarks would allow ACOs with high scores to earn maximum or near maximum achievement points while allowing room for quality improvement and rewarding that improvement in subsequent years. Use of flat benchmarks also helps to ensure that ACOs with high quality performance on a measure are not penalized as low performers.

A quality performance benchmark is the performance rate that an ACO must achieve to earn the corresponding quality points for each measure. Flat benchmarks assign a performance rate range to each decile. In flat benchmarks for non-inverse measures, any performance rate at or above 90 percent would be in the top decile; any performance rate between 80 percent and 89.99 percent would be in the second highest decile, and so on. For inverse measures, this approach would be reversed; any performance rate at or below 10 percent would be in the top decile; any performance rate between 10.01 percent and 20 percent would be in the second highest decile; and so on. The number of measure achievement points received for each measure is determined based on the applicable benchmark decile category and the percentile distribution.

There are scoring scenarios in which ACOs would earn higher measure achievement points under flat benchmarks compared to those in which they would earn under performance period benchmarks. Most notable are scenarios in which ACOs have a tight distribution of performance rates on a measure – for example, a non-inverse measure for which a performance rate of 90.00 percent is in the 8th decile. In this example, an ACO that reported a performance rate of 90.00 percent would be scored in the 8th decile when the hypothetical performance period benchmark is applied. Using the flat benchmarks proposed, an ACO that reported a performance rate of 90.00 percent would be scored in the 10th decile, resulting in greater measure achievement points than under the hypothetical performance period benchmarks described in this example.

APG supports the use of flat benchmarks for performance years 2024 and 2025 since historical Medicare CQMs will not be available until 2026. The implementation of flat benchmarks would avoid the "tournament" approach that is typically found in a group of high performers. Using flat benchmarks allows the opportunity for improvements without penalizing high performers.

- **APG recommends that CMS use flat benchmarks to score ACOs using Medicare CQMs in performance years 2024 and 2025.**

vi. Certified Electronic Health Record Technology (CEHRT) and Promoting Interoperability (PI) Requirements

While CMS has not proposed modifications to MSSP CEHRT and PI requirements in the 2025 proposed rule, policies finalized last year are proving so onerous to APG members that APG addresses these in this letter. Beginning with the 2024 performance year all MIPS-eligible clinicians, Qualifying APM Participants (QPs), and Partial QPs participating in an ACO, regardless of track, are to report the MIPS PI performance category measures and requirements to MIPS, at the individual, group, virtual group, or APM level, and earn a MIPS performance category score. The policy further aligned MSSP with the MIPS program and was intended to promote greater CEHRT use among ACO clinicians.

APG is greatly concerned by CMS's ongoing push to align MSSP and MIPS. MACRA designed separate payment and performance measurement and reporting programs for MIPS and APMs with the clear intent of providing reporting relief for APM participants. It is unclear what goal aligning the requirements between MSSP and MIPS would serve. The MIPS program was designed to assess the quality of performance of individual physicians who opted to remain in the traditional fee-for-service Medicare program. By contrast, quality measurement for MSSP was designed for physicians and other ACO participants who opted to take responsibility as a group for the quality and total cost of care for the Medicare patients they serve.

Reporting multiple individual PI measures is unnecessary for MSSP participants, since ACOs must invest in transforming physician practices to be successful in meeting the program's existing quality measures and achieving shared savings. ACOs that remain in MSSP clearly promote interoperability. Requiring reporting of MIPS PI measures will significantly increase the reporting burden for MSSP participants at a time when CMS wants to encourage physician movement into and retention in accountable care arrangements.

- **APG strongly recommends that CMS remove the requirement that MSSP ACOs fulfill the MIPS Promoting Interoperability (PI) reporting requirements and revert to requiring MSSPs to attest to PI.**

Beginning in performance year 2025, to qualify as an Advanced APM under the QPP, an ACO must require its participating "eligible clinicians" to use CEHRT. The 2024 final rule stated that AAPMs may find it appropriate to apply some limited exceptions, e.g., based on clinical criteria, but not blanket exceptions like percentages. However, ACOs lack clear guidance on how exceptions may be implemented and what exceptions may be acceptable to CMS. In the absence of such clarification, some ACOs are simply dropping practices that cannot ramp up to full CEHRT use by January 1, 2025, to avoid risking Advanced APM / QP status for their entity and participants. Although the deadline for including or dropping practices for 2025 has now passed, CMS should provide clear guidance in sufficient time for 2026 decisions and grant leniency to ACOs in 2025 with provider groups that are found not to fulfill the

CEHRT requirements, including avoiding all impacts on shared savings and losses.

- **APG strongly recommends that CMS provide clear guidance in sufficient time for 2026 participating group decisions and grant leniency to ACOs in 2025 with provider groups that are found not to fulfill the CEHRT requirements, including avoiding all impacts on shared savings and losses.**

C. MSSP Beneficiary Assignment, Notification, and Eligibility

i. Change Beneficiary Voluntary Assignment Methodology

CMS proposes to revise the MSSP regulations to broaden a limited exception to the program's voluntary alignment policy. It would allow a voluntarily aligned MSSP beneficiary to be assigned on the basis of claims to an entity participating in a disease- or condition-specific CMS Innovation Center model. Such assignment would be possible when (1) that model uses claims-based assignment that is based on primary care and/or other services, and (2) the Secretary has determined that a waiver is necessary solely for purposes of testing the model, so that beneficiaries with certain diseases or conditions may benefit from the focused attention and care coordination related to the disease or condition that an entity participating in such a model can offer.

Under the proposed revisions, if a beneficiary voluntarily aligns to an MSSP ACO, CMS would not assign the beneficiary to that MSSP ACO when the beneficiary is also eligible for claims-based assignment to an entity participating in a disease- or condition-specific model under which claims-based assignment is based solely on (1) claims for primary care and/or other services related to treatment of one or more specific diseases or conditions targeted by the model or (2) claims for services other than primary care service, and for which there has been a determination by the Secretary that waiver of the assignment requirement is necessary for purposes of testing the model.

CMS's intention is not to supersede voluntary alignment for CMS Innovation Center models that are not designed to target a specific disease or condition, such as ACO REACH. Although ACO REACH contains design features for organizations serving high needs beneficiaries, it is designed more broadly, and not for beneficiaries with a specific disease or condition. Such models do not target a specific disease or condition. Therefore, a beneficiary's claims-based assignment to an entity participating in such a model would not supersede their voluntary alignment to an MSSP ACO under CMS's proposal.

This proposed expansion of the voluntary alignment exception would support assignment of beneficiaries to entities participating in CMS Innovation Center models, which would reduce barriers for the CMS Innovation Center to conduct viable tests of disease-or condition-specific models and thereby improve access to high-quality, value-based specialty care, such as that provided by an entity participating in a model focused on diabetes care or care provided by specific specialists, such as cardiologists or gastroenterologists. CMS projects that the proposed change will affect less than one percent of beneficiaries.

CMS also proposes to revise the definition of primary care services used for MSSP assignment to add safety planning interventions, post-discharge telephonic follow-up contacts intervention, virtual check-in services, advanced primary care management services, cardiovascular risk assessment and risk management services, interprofessional consultation services, direct care caregiver training services, and individual behavior management/modification caregiver training services

APG recognizes the need to test disease specific models with adequate number of participants to allow valid testing. However, APG is concerned that the proposed change may result in moving beneficiaries from a model they have opted to be assigned to, to a different model with less care coordination focused on whole-person care and less generous beneficiary incentives.

For example, beneficiaries may be in a ACO REACH model based upon their signed voluntary alignment in which they are receiving co-payment relief or care management services, which would be eliminated if they are moved to a different model such as the Oncology Care model that may not have these additional services. Since very few beneficiaries make use of voluntary alignment options, but do so purposefully, APG believes it is important for beneficiaries to be fully informed if they are moved to another model, even if this policy only affects fewer than 1 percent of beneficiaries.

In addition, as CMS continues to expand the number of condition-specific models, APG requests that the agency re-visit applying the proposed change to beneficiary assignment with each new model. APG strongly supports advanced accountable care approaches, such as MSSP and ACO REACH, and views these as the engine that will drive attainment of CMS's goal of having all traditional Medicare beneficiaries and most Medicaid enrollees in an accountable relationship by 2030. APG also recognizes the need for additional models as on-ramps to value-based care but urges CMS to be cautious in prioritizing assignment to new models, thereby diverting enrollment and participation from more advanced accountable care options.

- **APG recommends that CMS as considers new disease-specific models, the agency embrace caution in superseding the beneficiary's choice and prioritizing assignment in these models, diverting enrollment and participation from more advanced accountable care options.**

ii. Modify Beneficiary Notification and Eligibility Requirements

CMS proposes modifications to the beneficiary information notification requirements to reduce administrative burden on ACOs while maintaining beneficiary protections.

First, CMS proposes to modify the requirements for the timing of the follow-up communication to a beneficiary who has received a standardized written notice of participation, opt out of claims data, and voluntary alignment. Under the proposed approach, an ACO would be required to provide the follow-up communication within 180 days from the date the standardized written notice was provided, as opposed to no later than the earlier of the beneficiary's next primary care service visit or 180 days from the date the standardized written notice was provided.

In addition, CMS proposes to require ACOs under preliminary prospective assignment with retrospective reconciliation to provide the standardized written notification to a subset of the Medicare FFS beneficiary population that is more likely to be assigned to the ACO, when compared to the population of beneficiaries who must receive the written notification under current regulations. If finalized, this proposal would reduce the burden on ACOs and confusion for beneficiaries resulting from the current requirement under which ACOs are required to send this notification to a greater number of beneficiaries who may not ultimately be assigned to the ACO.

CMS proposes to sunset the requirement to terminate an ACO's participation agreement and determine that an ACO is not eligible to share in savings for that performance year if an ACO's assigned

population is not at least 5,000 by the end of the performance year specified by CMS in its request for a corrective action plan.

APG supports the modification to the requirement of beneficiary notification to only include the beneficiaries who would qualify under "preliminary prospective assignment with retrospective reconciliation" if the ACO has selected that assignment option. Doing so would eliminate the need to send the notice to all FFS beneficiaries. However, since this notice would have to be done before the first primary care visit, the timing of which would be difficult to predict, it would ultimately increase the burden on physician practices, especially in the first months of the year.

APG also supports the change in the follow-up communication for beneficiaries that received a notice of participation. Modifying the follow-up communication rules to keep one of the two current requirements – that it must occur within 180 days – and eliminating the other – that it must occur prior to the beneficiary's next primary care service visit – will decrease the confusion that frequently is present since the next primary care visit is typically not known and may be as early as the day of the original notification.

APG also understands the requirement to maintain 5,000 assigned beneficiaries and support the additional flexibility that CMS has included in this proposed rule. The proposed language enables CMS to partner with an ACO that has fallen below 5,000 thresholds, allowing it time to recruit additional beneficiaries to maintain compliance with the model requirements.

- **APG recommends that CMS finalize the modification to the beneficiary notification requirement to include only the beneficiaries who would qualify under "preliminary prospective assignment with retrospective reconciliation" if the ACO has selected that assignment option.**

- **APG recommends that CMS finalize the modification to the beneficiary follow-up notification requirement to only within 180 days and eliminating "earlier of beneficiary's next primary care service visit."**

- **APG recommends that CMS finalize the proposal to allow ACOs with less than the required 5,000 assigned beneficiaries additional time to fulfill this requirement.**

D. MSSP Risk Adjustment

On March 31, 2023, CMS released the Announcement of Calendar Year (CY) 2024 MA Capitation Rates and Part C and Part D Payment Policies, which finalized the transition to a revised CMS-HCC risk adjustment model, the 2024 CMS-HCC risk adjustment model, Version 28 (V28). Currently, to perform MSSP risk adjustment calculations, CMS uses the CMS-HCC risk adjustment model(s) applicable for a particular calendar year to identify a Medicare FFS beneficiary's prospective HCC risk score for the corresponding benchmark year or performance year.

When the CMS-HCC risk adjustment model changes, MSSP performance year and benchmark year comparisons will be calculated using different CMS-HCC risk adjustment models. Based on initial results of MSSP analysis, CMS has found that using different CMS-HCC risk adjustment models between the benchmark and performance years negatively impacts ACOs with the highest average risk scores, ACOs

participating in two-sided models, and ACOs that have been in the MSSP longer.

To strengthen risk adjustment in MSSP and consistently apply V28 in the MSSP context, CMS proposes that it apply the same CMS-HCC risk adjustment model used in the performance year for all benchmark years, when calculating prospective HCC risk scores to risk adjust expenditures used to establish, adjust, and update an ACO's benchmark, for agreement periods beginning on January 1, 2024, and in subsequent years. This timetable would constitute the same three-year phase-in of the revised 2024 CMS-HCC model as in MA, which will mean that the underlying model will be 67% of the current 2020 CMS-HCC risk adjustment model and 33% of the CMS-HCC risk adjustment model for performance year (PY) 2024. ACOs in an existing agreement period would continue to have the current methodology for calculating benchmark year and performance year prospective HCC risk scores, using the different CMS-HCC risk adjustment model(s) applied, and are expected to experience smaller adverse impacts as a result of the phase-in of V28 and the existing approach to renormalize prospective HCC risk scores by Medicare enrollment type, among other factors.

APG members who will begin 2024 amid an existing agreement period are concerned about the impact of being subject to different risk adjustment models for benchmark and performance years. Although CMS asserts that the agency expects these ACOs to experience a smaller degree of adverse impact as a result of the phase-in of V28 as compared to MA plans, APG assumes that this assessment constitutes an average for the group. Presumably, there could be significantly different effects on individual MSSP ACOs. APG urges CMS to permit MSSP ACOs that will have an existing agreement period going into 2024 to opt to have the agency apply the same risk adjustment model to both benchmark and performance years.

- **APG recommends that CMS permit MSSP ACOs that will have an existing agreement period going into 2024 to opt to have the agency apply the same risk adjustment model to both benchmark and performance years.**

E. MSSP Benchmarks and Other Financial Methodology Changes

i. Establish a Prepaid Shared Savings Option

CMS proposes to offer a choice of prepaid shared savings to provide an additional cash flow option to ACOs with a history of earning shared savings that will encourage their investment in activities that reduce costs for the Medicare program and beneficiaries and improve the quality of care provided to their assigned beneficiaries. CMS would provide the prepaid shared savings option to certain ACOs that meet the following eligibility criteria:

- The ACO is a renewing ACO entering an agreement period beginning on January 1, 2026, or in subsequent years.
- The ACO must have received a shared savings payment for the most recent performance year that
  (1) Occurred prior to the agreement period for which the ACO has applied to receive prepaid shared savings; and
  (2) For which CMS has conducted financial reconciliation.
- The ACO must have a positive prior savings adjustment at application disposition for the agreement period in which they would receive prepaid shared savings.
- The ACO does not have any outstanding shared losses or advance investment payments that

have not yet been repaid to CMS after reconciliation for the most recent performance year for which CMS completed financial reconciliation.

- If the ACO received prepaid shared savings in the current agreement period or a prior agreement period, the ACO must have fully repaid the amount of prepaid shared savings received through the most recent performance year for which CMS has completed financial reconciliation.
- The ACO is participating in Levels C-E of the BASIC track or the ENHANCED track during the agreement period in which it would receive prepaid shared savings.
- The ACO has in place an adequate repayment mechanism that can be used to recoup outstanding prepaid shared savings.
- During the agreement period immediately preceding the agreement period in which the ACO would receive prepaid shared savings, the ACO
  (1) Met the MSSP quality performance standard; and
  (2) Has not been determined by CMS to have avoided at-risk beneficiaries.

This new payment option would provide prepaid shared savings to ACOs with a history of earning shared savings while participating in the MSSP. These payments would be distributed on a quarterly basis and would be recouped from the shared savings that CMS ultimately determines the ACO to have earned during the annual financial reconciliation cycle. Prepaid shared savings would constitute advance payment of shared savings that are expected to be earned by the ACO. If the ACO does not earn sufficient shared savings to offset the advanced payment of shared savings during the applicable performance year, CMS may withhold or terminate the ACO's prepaid shared savings.

To ensure that prepaid shared savings are provided only to ACOs that are well-positioned to use prepaid shared savings to improve the quality and efficiency of care to their assigned beneficiaries while minimizing the risk of an ACO being unable to repay prepaid shared savings, CMS proposes to limit the availability of prepaid shared savings to those ACOs that have a track record of success in MSSP.

APG applauds CMS for proposing this new option for ACOs to receive prepaid, shared savings payments. Providers have been increasingly frustrated about receiving any shared savings until long after the performance year has ended.

However, APG has concerns that the eligibility criteria indicate that the prepaid option is only available to ACOs that are entering a new agreement. APG does not support the requirement that excludes all ACOs other than ones beginning a new agreement. By contrast, APG favors allowing all ACOs that meet the eligibility criteria, such as history of shared savings, to apply. APG also does not support restricting the spending of the prepaid savings on direct beneficiary services that are not payable in traditional Medicare. APG believes that the ACOs should have the flexibility to determine the best way to address beneficiaries' needs.

- **APG recommends that CMS finalize the proposed prepaid shared savings program with modifications to make ACOs eligible, regardless of new or existing agreement, and to grant ACOs the flexibility to determine the best way to spend prepaid shared savings to address beneficiaries' needs.**

ii. Financial Methodology Updates to Address Suspected Improper Payments

CMS proposes to establish an approach to identify significant, anomalous, and highly suspect (SAHS) billing activity occurring in 2024 or subsequent calendar years, and specify approaches to mitigating the impact of the SAHS billing activity on MSSP financial calculations in 2024 or subsequent calendar years. Under the proposed approach, CMS would exclude payment amounts from expenditure and revenue calculations for the relevant calendar year for which the SAHS billing activity is identified, as well as from historical benchmarks used to reconcile the ACO for a performance year corresponding to the calendar year for which the SAHS billing activity is identified.

Under MSSP, providers and suppliers continue to bill for services furnished to Medicare beneficiaries and receive FFS payments under traditional Medicare. CMS uses payment amounts for Parts A and B FFS claims for calculating benchmark and performance year expenditures and determining benchmark update factors as specified in the MSSP regulations. These operations typically require the determination of expenditures for Parts A and B services under the original Medicare FFS program for a specified population of Medicare FFS beneficiaries or the Medicare Parts A and B FFS revenue of ACO participants. For both Parts A and B claims, CMS excludes payments on denied claims or line items from the calculation, for claims or line items with dates of service within the relevant benchmark year or performance year, processed before the end of the 3-month claims run-out period.

MSSP's existing financial methodology does not fully account for actions taken to protect the integrity of the Medicare program, or address the impact of improper payments, including improper payments resulting from fraud or similar fault on program calculations. For instance, demanded overpayment determinations resulting in adjusted claim or line-item payment amounts after the 3-month claims run-out period, or aggregate amounts that are not linked to specific claims or line items, are not accounted for in MSSP expenditure calculations. Additionally, under the existing financial methodology for MSSP, CMS lacks a means to account for improper payment amounts identified in a settlement agreement between a provider or supplier and the actions of a U.S. federal agency or a court's judgment, including pursuant to conduct by individuals or entities performing functions or services related to an ACO's activities.

Since January 2023, CMS has evaluated several cases where such improper payments may have affected one or more reconciled performance years for an ACO under the MSSP, including cases where ACOs reported concerns about alleged fraud or similar developments to CMS.

To implement the proposed policies, CMS would first need to identify improper payments that have the potential to affect MSSP financial calculations. MSSP depends on input from the CMS Center for Program Integrity (CPI) and law enforcement agencies (including the Department of Justice) to identify and quantify improper payments potentially impacting expenditures used in program calculations that are not otherwise accounted for in MSSP expenditure calculations.

Second, CMS anticipates needing to perform an initial analysis of whether the improper payments would warrant reopening the ACO's payment determination. This analysis may include multiple factors, such as whether the improper payments meet the requirements for reopening for fraud or similar developments, or for good cause. A variety of circumstances could lead CMS, law enforcement agencies, and/or courts to determine whether good cause exists or whether fraud or similar fault has occurred. The timelines associated with the related investigations, and the potential for various actions

to be taken in response, can make it challenging to identify a one-size-fits-all approach to addressing the impact of improper payments on MSSP calculations. CMS notes that once the agency is notified of potential improper payments impacting MSSP calculations, it may take months or years to determine the actual amount of any improper payments impacting an ACO's payment determination, particularly if CMS is awaiting the conclusion of program integrity and law enforcement investigations, among other possible determinations about the related conduct of providers or suppliers.

If CMS estimates that the improper payments have affected the dollar amount of earned shared savings or the amount of shared losses that the ACO owes or has paid to CMS, CMS anticipates reopening an ACO's payment determination. When determining whether to reopen an ACO's payment determination, CMS anticipates considering a combination of factors including the following:

- The dollar value of improper payments and the number of claims or line items involved (if applicable).
- How any related effect on performance year expenditures may compare to the effect on the ACO's updated historical benchmark (which could include considering the effect on benchmark year expenditures and factors used to establish, adjust and update the benchmark). In particular, CMS may consider whether comparing performance year expenditures to the updated benchmark expenditures used in financial reconciliation, once adjusted to account for the estimated impact of the improper payments, would result in a significant change in the amount of shared savings paid to or shared losses owed by the ACO. For purposes of this analysis, CMS may consider the following factors:
    - The Minimum Savings Rate (MSR)/Medical Loss Ratio (MLR) applicable to the ACO for the relevant performance year.
    - Whether the ACO met or exceeded the applicable MSR/MLR with the initial determination.
    - Whether accounting for improper payments would cause a change in the ACO's financial performance compared to its performance under the initial determination, including
        - Causing an ACO to meet or exceed its MSR/MLR when it did not do so under its initial determination, or no longer meet or exceed the relevant threshold when it did so under its initial determination.
        - Causing an ACO that shared savings or owed losses under the initial determination to share in either a higher or lower amount of savings or losses (respectively).
        - Causing an ACO to continue to generate savings or losses less than the MSR/MLR threshold, as it did under its initial determination, and therefore the ACO would remain ineligible for shared savings, except in cases where certain low revenue ACOs participating in the BASIC track may qualify for a shared savings payment and would not be held liable for shared losses.

CMS notes that the agency's existing reopening authority and the proposed financial methodology to address improper payments in such a reopening are not intended to address instances of low-value improper payments which, in an individual case may be to the benefit of either the ACO or CMS and in the aggregate are likely have a de minimis net effect on program expenditures in the long run. CMS would be highly unlikely to reopen in such cases. CMS believes that considering the significance of the potential effect of the improper payments on the ACO's payment determination, in deciding whether to reopen the payment determination, is a key component of striking a balance between improving the

accuracy of the calculations and ACOs' and CMS' interest in administrative finality of payment determinations.

Multiple steps would follow a decision by CMS to reopen the initial determination. CMS would first recalculate the ACO's financial performance for a performance year by applying the proposed methodology. With this recalculation, CMS would determine the amount of shared savings payment the ACO may be eligible to receive or the amount of shared losses the ACO may owe for the performance year after accounting for the impact of the improper payments.

CMS would then issue a revised initial determination to the ACO with the recalculated payment determination for the performance year. CMS would notify the ACO of savings and losses. Depending on the outcome of the recalculation as specified in the revised initial determination, CMS would engage in payment activities and recoupment activities, as needed.

As explained in earlier rulemaking, CMS anticipates considering ways to minimize program disruptions for ACOs that could result from one or more reopenings. CMS may require considerable time after deciding to reopen an initial determination before it can complete the process described above for a variety of reasons.

CMS is considering limiting the instances in which the agency reopens an initial determination to account for improper payments to strike a balance between improving the accuracy of the calculations and ACOs' and CMS' interest in administrative finality of payment determinations. CMS' decision to reopen an initial determination for a performance year is independent of a determination by CMS to reopen an initial determination for any other performance year, including in cases where multiple performance years are impacted by the same improper payments, whether within the ACO's current agreement period, or a past agreement period.

In these circumstances, CMS would need to potentially consider reopening initial determinations for multiple performance years, which may span multiple agreement periods, in cases in which an ACO has continued its participation in MSSP over time. Therefore, CMS is considering applying a combination of the following factors in determining whether to reopen an initial determination:

- Consideration of the timing of reopening and recalculating the payment determination for a performance year, and the timing of financial reconciliation for one or more performance year of a subsequent agreement period that includes the affected period as a benchmark year, and
- Consideration of whether the improper payments result from conduct of individuals or entities performing functions or services related to the ACO's activities.

APG supports the proposed approach in addressing ACOs' benchmarks and other financial calculations related to significant, anomalous, and highly suspected billings. APG agrees that it is important to minimize the reopening of previous years to avoid a perception of instability for the program.

- **APG recommends that CMS finalize the proposed significant, anomalous, and highly suspected (SAHS) billing policy and avoids reopening previous years' financial determinations without significant reasons.**

F. MSSP Requests for Information (RFI)

CMS has described its vision for MSSP and new Innovation Center models as expanding participation in ACOs and other alternative payment models, improving quality and strengthening incentives for savings for participants and for Medicare, and making access to ACOs more equitable – all toward the goal of having all beneficiaries in the traditional Medicare program cared for by health care providers who are accountable for costs and quality of care by 2030. To inform potential future policy developments, to further advance progress towards meeting these goals and building off of a comment solicitation in 2024 PFS rulemaking, CMS seeks comment on incorporating a higher risk track than the ENHANCED track.

i. Incorporating a Higher Risk Track in MSSP

Over time, CMS has considered a higher risk MSSP track under which the shared savings/loss rate would be somewhere between 80 percent and 100 percent (that is, a rate higher than that currently offered under the ENHANCED track). Such an approach would build on the experience of the Next Generation ACO (NGACO) and ACO REACH Models.

"Higher risk" sharing provides a higher level of potential reward to model participants, which may encourage ACOs that would not otherwise have participated in MSSP because of current limitations on potential upside to consider participating. Also, a higher risk-sharing model may incentivize participating ACOs to take on more risk (and potential reward) and incentivize ACOs to improve performance in the program, which may result in reduced health care costs for Medicare, and more effective, efficient care for beneficiaries.

In addition, higher risk sharing may incentivize ACOs to develop new care delivery strategies, such as focusing on specialty care integration and reduced care fragmentation. Offering a higher risk-sharing track may also help CMS reach the goal of having all beneficiaries in the traditional Medicare program in a care relationship with a health care provider who is accountable for the costs and quality of their care by 2030 by encouraging efficient ACOs to continue participation in MSSP.

Currently, under MSSP, ACOs may enter participation agreements under one of two tracks—the BASIC track or the ENHANCED track. The BASIC track allows eligible ACOs to begin under a one-sided model and incrementally transition to higher levels of risk and potential reward through the BASIC track's glide path. The ENHANCED track is a two-sided model that represents the highest level of risk and potential reward currently offered under MSSP.

For agreement periods beginning before January 1, 2024, certain ACOs were only allowed to enter the program in the ENHANCED track, and ACOs entering the program in the BASIC track were limited as to the number of agreement periods they could participate in before being required to transition to the ENHANCED track. Based on changes finalized in the CY 2023 PFS final rule, for agreement periods starting on January 1, 2024, and in subsequent years, participation in the ENHANCED track will be optional (see 87 FR 69818).

Under the ACO REACH Model, REACH ACOs are offered the choice of participating under the Global or the Professional Risk Options. As in the NGACO Model, under both risk sharing options, the ACO REACH ACO is responsible for 100 percent of performance year expenditures for services rendered

to aligned beneficiaries. Because ACOs electing the Global Risk Option retain up to 100 percent of the savings/losses, a discount is applied to the benchmark to ensure that savings are also generated for CMS. Consequently, for ACOs in the Global Risk Option, the benchmark is reduced by a fixed percentage based on the performance year.

The benchmark for ACOs participating in the Professional Option does not include this discount, and these ACOs are only eligible to retain 50 percent of savings or owe 50 percent of any losses. Capitated payments in ACO REACH facilitate the movement out of FFS through monthly payments to participants. Additionally, the opportunity to receive an additional enhanced payment (equal to 7 percent of total costs of care (TCOC) after subtracting Primary Care E/M payments) enabled a funding of infrastructure that was unique to ACO REACH.

When considering including a higher risk track in MSSP, CMS must balance several factors to protect beneficiaries, ACOs, and the Medicare Trust Funds. One factor is that there may be selective participation among ACOs choosing to participate in a higher-risk track, if offered.

For example, MSSP ACOs that have a history of high levels of shared savings or have received a favorable high regional adjustment to their benchmark may be more likely than other ACOs to switch to the higher-risk track upon renewing or early renewing their participation in the program. As a result, they can receive additional benefit from the higher levels of potential reward offered in a higher-risk track.

Section 1899(i)(3) of the Social Security Act grants the Secretary the authority to use other payment models, if the Secretary determines that doing so would improve the quality and efficiency of items and services furnished under Medicare and the alternative methodology would result in program expenditures equal to or lower than those that would result under the statutory payment model under section 1899(d). CMS has concerns that introducing a higher risk track would lead to only select ACOs participating, creating benefits limited almost entirely to those ACOs with no benefits gained for beneficiaries or CMS.

Another consideration is that ACOs in a higher-risk track could have an increased incentive (relative to existing MSSP risk models) to avoid high-cost beneficiaries in the performance year to maximize their potential shared savings payment or avoid or reduce potential shared losses. MSSP truncates individual beneficiary expenditures at the 99th percentile of national Medicare fee-for-service expenditures by enrollment type, which can help to protect ACOs from the impact of expenditure outliers (i.e., prevent a small number of extremely costly beneficiaries from significantly affecting the ACO's per capita expenditures) and reduce the incentive for ACOs to avoid high-cost beneficiaries. MSSP also caps the amount of shared savings that an ACO may receive or the amount of shared losses that it may owe, which can further discourage beneficiary selection.

If introducing a higher-risk track to the program, CMS would need to consider several factors: (1) whether the program's existing approach to expenditure truncation and capping shared savings and shared losses would be sufficient to curb incentives for ACOs to engage in beneficiary selection in light of the higher potential risk and reward, while (2) ensuring that the new risk model would still be attractive to ACOs and improve the quality and efficiency of the care that their assigned beneficiaries receive.

When considering a higher-risk track, CMS also would need to consider the incentives for ACOs to transition to higher levels of risk and potential reward only when they are very confident that it is in their financial interest to do so. The agency would need to balance these considerations against the benefits of increasing ACO participation in MSSP and in two-sided accountable care tracks, all while ensuring sufficient financial safeguards against inappropriately large shared losses for ACOs coordinating and improving quality of care for high-cost beneficiaries.

CMS seeks comment on a participation option that would allow for higher risk and reward than currently available under the ENHANCED track. A participation option of this type would replace the existing ENHANCED track to avoid the self-selection issues that would occur if a higher risk track were to be included alongside the ENHANCED track. If both participation options were made available to ACOs, APG has concerns that only the highest performing ACOs would self-select into the higher of the two risk tracks.

Although CMS included an RFI on the topic in CY 2024 PFS rulemaking, the agency is concerned that ACOs did not have enough detailed information to appropriately weigh the tradeoffs associated with a higher risk/reward option than the current ENHANCED track, and that the additional information generated since then will allow ACOs and other interested parties to provide more forthright and helpful feedback. CMS is interested in public comments on the design of a higher risk option within MSSP that could be enacted under existing authority granted and that would encourage ACOs to participate actively in MSSP while ensuring that such participation leads to savings for the Medicare program.

As of January 1, 2024, 43 percent (207 of 480) MSSP ACOs are participating under the ENHANCED track. Under MSSP policies, all ACOs participating in a two-sided model can select a symmetrical MSR and MLR, which applies for the duration of its agreement period. Among ACOs participating in the ENHANCED track for PY 2024, 61 percent (126 of 207) have selected an MSR/MLR of 0.5 percent or greater while 39 percent (81 of 207) have selected an MSR/MLR of 0.0 percent. Among ACOs that participated in the ENHANCED track for PY 2022, 38 percent (55 of 146) generated gross savings between zero and 5 percent of their updated benchmark expenditures, and 12 percent (17 of 146) generated gross savings of 10 percent or more of their benchmark expenditures.

APG commends CMS for considering refinements to the MSSP program and engaging stakeholders. APG members generally support, but also report mixed reactions, to the possibility of adding a track to MSSP with risk greater than the current ENHANCED track. APG encourages CMS to closely assess the evaluation results from the ACO REACH model to better understand the characteristics of participants that are successful in achieving savings under the Global Risk Option, as well as the characteristics of ACOs that experience losses under this option. APG also urges CMS to review these evaluation results with participants as part of a mixed-methods approach to delve into the qualitative lessons to be learned from their experiences.

In addition, APG urges CMS to consider additional policy refinements to MSSP based on lessons learned from features of the ACO REACH Model beyond risk level. Additional options for including capitated payments (both basic and enhanced) should also be explored. Capitated payments help to fund infrastructure and provide a predictable stream of revenue to reduce dependence on fee-for-service payment. Alternative provider participation arrangements, such as including individual NPIs rather than whole TINs, should also be explored. APG looks forward to continuing to work with CMS as the agency considers refinements to MSSP based on lessons learned from ACO REACH and other models.

- **APG members generally support, but also report mixed reactions, to the possibility of adding a track to MSSP with risk greater than the current ENHANCED track. APG encourages CMS to closely assess the evaluation results from the ACO REACH model to better understand the characteristics of participants that are successful in achieving savings under the Global Risk Option and urges CMS to review these evaluation results with participants as part of a mixed-methods approach to delve into the qualitative lessons to be learned from their experiences.**

G. Quality Payment Program (QPP)

i. Change to AAPM Qualification Criteria

Eligible clinicians who meet threshold levels of participation in AAPMs to become QPs (or partial QPs) are excluded from MIPS reporting requirements and payment adjustments. CMS assesses the level of participation in AAPMs based on payment amounts or patient counts using the threshold percentages specified in statute. The threshold percentages are calculated using the ratio of attributed beneficiaries to attribution-eligible beneficiaries.

Beneficiaries are considered attribution-eligible if they meet the six criteria specified in the definition of "attribution-eligible beneficiary" in regulation. CMS proposes to modify the sixth criterion under the definition of "attribution-eligible beneficiary" that is based on provision of E&M services. Specifically, CMS proposes to include as attribution-eligible any beneficiary who has received a covered professional service furnished by the eligible clinician (identified by their National Provider Identifier [NPI]) for the purpose of making QP determinations.

APG supports the modification of the sixth criteria under the definition of attribution-eligible beneficiary for the purposes of the definition of qualifying participants. Expanding it beyond the provision of E/M services to a covered professional service will facilitate addition of specialists as participating providers in ACO.

- **APG recommends that CMS finalize the modification to the criteria of attribution-eligible beneficiary to include a covered professional service.**

ii. Maintain Data Completeness Threshold

CMS proposes to maintain the data completeness criteria threshold of at least 75 percent for the 2027 and CY 2028 performance periods/2029 and 2030 MIPS payment years rather than increasing the threshold to 80 percent as currently planned.

The data completeness criteria threshold means the following: An individual MIPS eligible clinician, group, virtual group, or APM Entity submitting measure data on QCDR measures, MIPS CQMs, or eCQMs must submit data on at least a specific percent of their patients that meet the measure's denominator criteria, regardless of payer; an individual MIPS eligible clinician, group, virtual group, or APM Entity submitting quality measure data on Medicare Part B claims measures must submit data on at least a specified percent of their Medicare Part B patients seen during the corresponding performance period; and an APM Entity, specifically an MSSP ACO that meets the reporting

requirements under the APP, submitting quality measure data on Medicare CQMs must submit data on at least a specified percent of the APM Entity's applicable beneficiaries eligible for the Medicare CQM, who meet the measure's denominator criteria.

APG appreciates CMS's proposal to maintain the data completeness criteria threshold of at least 75 percent for the 2027 and CY 2028 performance periods/2029 and 2030 MIPS payment years rather than increasing the threshold to 80 percent as currently planned. APG members report that it is not practical to expect ACOs to have data approaching 100 percent completeness when aggregating data across many practices and EHRs. APG urges CMS to maintain exclusions and a 75 percent data completeness requirement for ACOs to account for the very real obstacles ACOs must overcome when reporting data to CMS.

- **APG recommends that CMS finalize the proposal to maintain a 75 percent data completeness requirement for ACO quality measure reporting and encourages the agency to adopt this level as a permanent requirement.**

iii. Value in Primary Care MIPS Value Pathway (MVP)

CMS has long signaled the agency's intention that Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) will succeed MIPS as these support the use of digital measurement and health information technology, support the integrity of program data, and increase the potential return on investment for MIPS participation. To further this vision, CMS proposes that five new MVPs be available with the 2025 performance year, along with revisions to all previously finalized MVPs.

The six newly proposed MVPs are as follows:

1. Complete Ophthalmologic Care
2. Dermatological Care
3. Gastroenterology Care
4. Optimal Care for Patients with Urologic Conditions
5. Pulmonology Care
6. Surgical Care

For several years, CMS has sought to streamline the number of quality measures that physicians are required to report, focusing on evolving to high-value outcome and patient-reported measures. APG is concerned that CMS's proposal indicates that CMS is reversing this trend and is instead returning to expanding the total number of quality measures. APG urges CMS to weigh carefully the value of all new measures against the increase in reporting burden each one introduces. Large quality measure sets require physician practices to spend significant amounts of time and money tracking and reporting data that would be better spent on direct patient care and practice transformation.

- **APG recommends that CMS streamline the number of quality measures that physicians are expected to track and report and prioritize outcome and patient-reported measures.**

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. We look forward to working with CMS as the proposals in this proposed rule are refined and finalized.

Sincerely,

Susan Dentzer
President and CEO
America's Physician Groups
sdentzer@apg.org

####