AMERICA'S PHYSICIAN GROUPS

September 11, 2023

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-2023-0121-1282

Re: 2024 Physician Fee Schedule and Medicare Shared Savings Program Proposed Rule (CMS–1784–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 request for input, and then (III) 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, the Medicare Shared Savings Program (MSSP), and the Quality Payment Program. CMS proposes coding and payment for several new services to help underserved populations, including by addressing unmet health-related social needs that can potentially affect the diagnosis and treatment of medical problems and outcomes for patients.

Primary care is key to high-quality, whole-person care, and CMS recognizes its value by proposing to adopt new payment mechanisms and coding to pay accurately and appropriately for primary care services. These steps align with the goals articulated in the HHS Initiative to Strengthen Primary Care. CMS also continues to promote whole-person care MSSP, and to boost the quality of care through multiple changes to the Quality Payment Program.

III. Summary of APG's Recommendations

A. Recommendations Related to Physician Fee Schedule Proposals to Support Primary Care

- **APG recommends that CMS finalize an add-on payment for HCPCS code G2211 to better recognize the resource costs associated with E&M visits for primary care and longitudinal care of complex patients. APG further recommends that CMS monitor the impact of this payment add-on, and seek opportunities to mitigate the redistributive effect within the Physician Fee Schedule.**

B. Recommendations Related to Social Determinants of Health (SDOH) Risk Assessments

- **APG recommends that CMS finalize the new stand-alone G code, GXXX5, for Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, and incorporate it into MSSP beneficiary assignment and other methodologies.**

C. Recommendations Related to MSSP Quality Measurement

- **APG strongly recommends that CMS finalize adoption of Medicare Clinical Quality Measures (CQMs) as an alternative collection type for MSSP ACOs and as a permanent reporting alternative to all-payer eCQMs.**

- **APG recommends that CMS limit reporting of Medicare CQMs to the patients included on the list issued by the agency to ACOs that are reporting Medicare CQMs.**

- **APG recommends that CMS provide clarification on how the transition to Medicare CQMs will be handled, as well as data analysis results indicating how ACOs would have performed on the Medicare CQMs during the historical period if the measures had been in place during this time.**

- **APG recommends that CMS maintain a 75 percent data completeness requirement for ACO quality measure reporting.**

- **APG recommends that CMS adopt as final the agency's proposal to establish a health equity-adjusted quality performance score.**

- **APG recommends that CMS adopt as final the agency's proposal to use the number of beneficiaries, rather than person-years, for calculating the proportion of the ACO's assigned beneficiaries who are enrolled in the Part D Low-Income Subsidy or who are dually eligible for Medicare and Medicaid.**

- **APG recommends that CMS adopt as final the proposal to provide ACOs – prior to the start of the performance year – with the MSSP quality performance standard that they must meet to share in savings at the maximum sharing rate.**

- **APG strongly recommends that CMS not require MSSP ACOs to fulfill the MIPS Promoting Interoperability (PI) reporting requirements.**

D. Recommendations Related to MSSP Beneficiary Assignment

- **APG recommends that CMS conduct additional analyses including more years of data to ensure that the changes to MSSP beneficiary assignment methodology do not have unintended consequences for certain types of ACOs.**
- **APG recommends that CMS adjust the calculation of ACOs' performance year expenditures to correct for the difference between ACOs that paid for 340B drugs at lower prices during their benchmark years – and at higher prices during their performance years – without ACOs having to early renew their agreement periods.**
- **APG supports CMS's proposal to expand the definition of primary care services used for assignment in MSSP using the proposed services identified by HCPCS and CPT codes.**

E. 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.**

F. Recommendations Related to MSSP Benchmarks

- **APG recommends that CMS finalize the proposal to eliminate the cap on negative regional adjustments for MSSP ACOs.**

- **APG recommends that CMS cap prospective HCC risk score growth in an ACO's regional service area for ACOs with both new and continuing agreement periods.**

- **APG recommends that CMS control for the new risk model phase-in change when the agency applies the new 3 percent regional cap service are cap if it is finalized.**

G. 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.**

H. Recommendations Related to Quality Payment Program (QPP)

- **APG recommends that CMS continue to make Qualifying APM Participant (QP) determinations at the APM Entity level instead of the individual eligible clinician level.**

- **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 recommends that CMS not require ACOs to report on substance use disorder (SUD) treatment until the agency is able to share SUD information with ACOs.**

- **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 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 to Support Primary Care

Beginning January 1, 2024, CMS proposes to implement a separate add-on payment for health care common procedure coding system (HCPCS) code G2211. This add-on code will better recognize the resource costs associated with evaluation and management (E&M) visits for primary care and longitudinal care of complex patients. Generally, it will be applicable for outpatient office visits as an additional payment, recognizing the inherent costs clinicians may incur when longitudinally treating a patient's single, serious, or complex chronic condition. If the proposal is finalized, CMS expects that establishing payment for this add-on code would have redistributive impacts for all other CY 2024 payments, which, comparatively, are less than what CMS initially estimated for this policy in CY 2021, under the Medicare Physician Fee Schedule, due to statutory budget neutrality requirements.

CMS originally finalized this policy in the CY 2021 Medicare Physician Fee Schedule final rule. However, Congress suspended the use of the add-on code by prohibiting CMS from making additional payments under the PFS for these inherently complex E&M visits before January 1, 2024. Arguing that this policy would improve the accuracy of payment for primary and longitudinal care, CMS proposes to implement the policy in calendar 2024.

CMS proposes refinements to the earlier policy, however, after considering information from interested parties, who shared feedback in earlier rulemaking about the agency's utilization assumptions and the estimated redistributive impact of the code on PFS payments. These changes have reduced the redistributive impacts of this policy. Specifically, CMS proposes that the add-on code would not be billed with a modifier that denotes an office and outpatient E&M visit that is itself unbundled from another service (e.g., a procedure where complexity is already recognized in the valuation). Second, CMS has refined the agency's utilization estimates for HCPCS code G2211 in response to public feedback. These refinements collectively reduce the redistributive impact to the CY 2024 CF by nearly one-third of the estimated impact described in the CY 2021 Medicare Physician Fee Schedule final rule.

CMS also proposes to add other codes that would typically be used to bill for services provided by primary care providers, including Social Determinants of Health Risk Assessment, Community Health Integration Services, Principal Illness Navigation Services, Caregiver Training, and Caregiver Behavior Management Training.

APG welcomes CMS's renewed proposal to introduce an add-on payment for HCPCS code G2211 to better recognize the resource costs associated with E&M visits for primary care and longitudinal care of complex patients. Primary care and longitudinal care of complex patients have for too long lacked investment under the traditional, fee-for-service Medicare program. This lack of resources is reflected in diminished beneficiary access to primary care providers and plummeting numbers of medical school graduates opting for a career in primary care.

Although the new G2211 add-on payment will not fully resolve this crisis, adopting it will be an important means to providing reasonable resources for essential primary care services. Despite APG's enthusiasm for the new G2211 code, our organization shares other stakeholders' concerns about the inherently redistributive effects of all changes to the physician fee schedule, given the requirement that all CMS actions be implemented in a budget-neutral manner. APG urges CMS to monitor the impact of the new G2211 add-on payment closely, and to consider all options within the agency's regulatory authority to mitigate the effect on services provided by clinicians other than primary care providers.

- **APG recommends that CMS finalize an add-on payment for HCPCS code G2211 to better**

recognize the resource costs associated with E&M visits for primary care and longitudinal care of complex patients. APG further recommends that CMS monitor the impact of this payment add-on, and seek opportunities to mitigate the redistributive effect within the Physician Fee Schedule.

B. Social Determinants of Health (SDOH) Risk Assessments

There is increasing recognition within the health care system of the need to take SDOH into account when providing health care services. Many Federal agencies are developing policies to better address the impact that the SDOH have on patients, in support of HHS's Strategic Approach to Addressing Social Determinants of Health to Advance Health Equity, as well as the CMS Framework for Health Equity.

CMS has worked to develop payment mechanisms under the PFS to improve the accuracy of valuation and payment for the services furnished by physicians and other health care professionals, especially in the context of evolving models of care. Although Section 1862(a)(1)(A) of the Social Security Act generally excludes from coverage services that are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, practitioners across specialties recognize the importance of SDOH on the health care provided to their patients. The practice of medicine currently comprises the assessment of health-related social needs or SDOH in taking patient histories, assessing patient risk, and informing medical decision-making, diagnosis, care, and treatment. The taking of a social history is generally performed by physicians and practitioners in support of patient-centered care to better understand and help address relevant problems that are impacting medically necessary care. CMS believes that the resources involved in these activities are not appropriately reflected in current coding and payment policies. As such, CMS proposes to establish a code to separately identify and value an SDOH risk assessment that is furnished in conjunction with an E&M visit. SDOH risk assessment refers to a review of the individual's SDOH or identified social risk factors that influence the diagnosis and treatment of medical conditions.

Specifically, CMS proposes a new stand-alone G code, GXXX5 for Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment lasting from five (5) to 15 minutes, and not more often than every six (6) months. CMS is proposing GXXX5 to identify and value the work involved in administering a SDOH risk assessment as part of a comprehensive social history when medically reasonable and necessary in relation to an E&M visit. SDOH risk assessment through a standardized, evidence-based tool can more effectively and consistently identify unmet health-related social needs and enable comparisons across populations. CMS further proposes that the SDOH risk assessment be furnished by the practitioner on the same date as an E&M visit, as the SDOH assessment would be reasonable and necessary when used to inform the patient's diagnosis and treatment plan established during the visit.

APG commends CMS for the agency's ongoing commitment to addressing SDOH and ensuring that all Medicare beneficiaries have the opportunity to receive care and services tailored to their needs. We welcome the new stand-alone G code, GXXX5, for Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment. We ask that, if the proposal is finalized, the new code be incorporated into beneficiary assignment algorithms and all other appropriate methodologies for MSSP.

- **APG recommends that CMS finalize the new stand-alone G code, GXXX5, for Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, and incorporate it into MSSP beneficiary assignment and other methodologies.**

C. MSSP Quality Measurement

i. Medicare CQMs and Reporting Options

For performance year 2024 and subsequent performance years, CMS proposes to establish the Medicare Clinical Quality Measures (CQMs) for Accountable Care Organizations participating in the MSSP as a new collection type for Shared Saving Program ACOs under the APM Performance Pathway (APP).

Medicare CQMs would serve as a transition collection mechanism to help ACOs build the infrastructure, skills, knowledge, and expertise necessary to report the all payer/all patient Merit-Based Incentive Payment System (MIPS) CQMs and eCQMs. CMS's proposal focuses on Medicare patients with claims encounters with ACO professionals and specialty designations used in the MSSP assignment methodology. The proposal would ensure that ACOs have the option to report digitally on their Medicare patients, and that they would not be penalized by serving other patients. It also would reduce barriers to digital measurement to allow MSSP to align with the Universal Foundation for adults in 2025.

In addition to this proposal to report quality data utilizing Medicare CQMs in performance year 2024, ACOs would continue to have the option to report quality data utilizing the CMS Web Interface measures, eCQMs, and/or MIPS CQMs collection types. Under this proposal, in performance year 2025 and subsequent performance years, ACOs would have the option to report quality data utilizing the eCQMs, MIPS CQMs, and/or Medicare CQMs collection types with Web Interface sunsetted.

CMS proposes to use the MIPS data completeness criteria thresholds for Medicare CQMs, establishing data completeness at 75 percent for the calendar year (CY) 2024, CY 2025, and CY 2026 performance periods, and at 80% for the CY 2027 performance period. Data completeness is based on the ACO's matched and aggregated beneficiaries eligible for Medicare CQMs, who meet the Medicare CQM Specification as proposed at § 425.20.

To facilitate population-based activities related to improving health through quality measurement of Medicare CQMs, and to aid ACOs in the process of patient matching and data aggregation necessary to report Medicare CQMs, a given ACO would first request for the data for purposes of population-based activities relating to improving health or reducing growth in health care cost. CMS would then provide the ACO with a list of beneficiaries attributed to the ACO who were eligible for Medicare CQMs. CMS anticipates that the list of beneficiaries eligible for Medicare CQMs would be shared once annually, at the beginning of the quality data submission period.

Since CMS would not have a full run-out on performance year claims data prior to the start of the quality data submission period, the list of beneficiaries eligible for Medicare CQMs would not be a complete list of beneficiaries who should be included in an ACO's Medicare CQMs' reporting. ACOs would have to ensure that all beneficiaries who meet the applicable Medicare CQM specification, and who also meet the definition of a beneficiary eligible for Medicare CQMs proposed under § 425.20, are included in the ACO's eligible population/denominator for reporting each Medicare CQM.

Benchmarks for scoring ACOs on the Medicare CQMs under MIPS would be developed in

alignment with MIPS benchmarking policies. As historical Medicare CQM data would not be available, CMS proposes for performance years CY 2024-2025 to score Medicare CQMs using performance period benchmarks. Similarly, as quality performance data are submitted via Medicare CQM and baseline period data become available to establish historical benchmarks, CMS proposes for performance year 2026, and subsequent performance years, to transition to using historical benchmarks for Medicare CQMs when baseline period data are available, so as to establish historical benchmarks in a manner that is consistent with the MIPS benchmarking policies.

APG enthusiastically welcomes CMS's proposal to establish Medicare CQMs for Accountable Care Organizations participating in the MSSP as a new alternative collection mechanism for MSSP ACOs. Medicare CQMs are far better matched to ACOs' reporting capabilities than all-payer eCQMs, which would otherwise be required if this proposal is not finalized. Yet according to CMS, fewer than 10 percent of MSSP ACOs have reported eCQMs.[1]

- **APG strongly recommends that CMS finalize adoption of Medicare Clinical Quality Measures (CQMs) as an alternative collection type for MSSP ACOs and as a permanent reporting alternative to all-payer eCQMs.**

APG urges CMS to limit reporting of Medicare CQMs to the patient list provided by agency at the start of the reporting period. CMS notes it will not have full claims run-out information at the time of issuing this list, and therefore it will be incumbent on ACOs to ensure the list is complete, adding significant and unnecessary burden for ACOs. CMS should limit reporting of Medicare CQMs to the patients included on the list issued by the agency to ACOs reporting Medicare CQMs.

- **APG recommends that CMS limit reporting of Medicare CQMs to the patients included on the list issued by the agency to ACOs that are reporting Medicare CQMs.**

APG notes that during the transition to Medicare CQMs, information on the three years of historical data with a one-year lag will not be available for the new measures. We ask that in the final rule CMS provide clarification on how this transition will be handled, as well as data analysis results indicating how ACOs would have performed on the Medicare CQMs during the historical period of the measures had been in place during this time.

- **APG recommends that CMS provide clarification on how the transition to Medicare CQMs will be handled, as well as data analysis results indicating how ACOs would have performed on the Medicare CQMs during the historical period if the measures had they been in place during this time.**

Although APG members greatly appreciate CMS's proposal to establish Medicare CQMs, they 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. Adoption of new measures, even those that offer an improvement relative to current options, place significant resource demands on ACOs.

For example, one multi-disciplinary ACO APG member noted that it has started educating its providers on the new standard of reporting for MSSP ACOs. Doing so has required developing workflow provisions to ensure that all specialists are documenting diagnoses and services fully and accurately so

[1] Comment made by John Pilotte at APG MSSP Coalition meeting July 25, 2023.

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. If Medicare CQMs are adopted as proposed, but as only a temporary reporting option, MSSP ACOs will face the choice of continuing with preparation for eCQMs or pausing that work to devote attention to Medicare CQMs instead.

APG requests that CMS clarify aspects of its proposal the final rule.

First, it is unclear whether Medicare CQMs will apply only to beneficiaries attributed to the ACO or to all Medicare fee-for-service beneficiaries that the ACO clinicians treat. APG prefers that Medicare CQMs be assessed for attributed beneficiaries.

Second, it is unclear which data completeness standard the agency proposes to adopt. The proposed rule mentions both establishing data completeness at 75 percent for the CY 2024, CY 2025, and CY 2026 performance periods, as well as 100 percent data completeness in terms of aggregating, matching, and de-duplicating data.

APG urges CMS to specify in the final rule the data completeness requirement for Medicare CQMs. APG also asks CMS to consider carefully the goals for this completeness requirement, particularly in the context of ACOs reporting eCQMs, MIPS CQMs, and Medicare CQMs. Previous reporting methods began with a lower data completeness standard that increased over time. The eCQM, MIPS CQM, and Medicare CQM reporting types have a much a higher burden than reporting of the Web Interface. It is not practical to expect ACOs to have 100 percent complete data when aggregating data across many practices and EHRs. APG urges CMS to adopt 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 for eCQMs, MIPS CQMs, and Medicare CQMs.

- **APG recommends that CMS maintain a 75 percent data completeness requirement for ACO quality measure reporting.**

ii. Health Equity Adjustment Multiplier

Consistent with the goal of supporting ACOs in their transition to eCQMs/MIPS CQMs, CMS proposes that ACOs that report Medicare CQMs be eligible for the health equity adjustment to their quality performance category score when calculating shared savings payments. Specifically, CMS proposes that, for performance years 2024 and subsequent performance years, CMS calculate a health equity adjusted quality performance score for an ACO reporting the three Medicare CQMs, or a combination of eCQMs/MIPS CQMs/Medicare CQMs, in the APP measure set; that the data completeness requirement be observed for each measure; and that the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey be administered. This proposal would advance equity within the MSSP by supporting ACOs that deliver high-quality care and serve a high proportion of underserved individuals. Applying the health equity adjustment to an ACO's quality performance category score when reporting Medicare CQMs would recognize ACOs treating underserved populations and delivering high-quality care.

CMS proposes to modify the calculation of the proportion of assigned beneficiaries dually eligible for Medicare and Medicaid, and the calculation of the proportion of assigned beneficiaries enrolled in the Medicare Part D low-income subsidy (LIS), to use the number of beneficiaries, rather than person

years, for calculating the proportion of the ACO's assigned beneficiaries who are enrolled in LIS or who are dually eligible for Medicare and Medicaid, starting in performance year 2024. The proposed policy recognizes that beneficiaries with partial year as compared to full year LIS enrollment or dual eligibility are also underserved and strengthens incentives for ACOs to serve this population. Inclusion of beneficiaries with partial year LIS enrollment in the underserved multiplier provides increased incentive for ACOs to help facilitate LIS enrollment for beneficiaries who meet eligibility criteria.

APG supports CMS's proposal to make MSSP ACOs that report the three Medicare CQMs, or a combination of eCQMs/MIPS CQMs/Medicare CQMs, in the APP measure set, meet the data completeness requirement for each measure, and administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey eligible for a health equity adjusted quality performance score. APG also supports CMS's proposal to modify the calculation of the proportion of assigned beneficiaries dually eligible for Medicare and Medicaid, and the calculation of the proportion of assigned beneficiaries enrolled in the Medicare Part D low-income subsidy (LIS), to use the number of beneficiaries, rather than person years, for calculating the proportion of the ACO's assigned beneficiaries who are enrolled in LIS or who are dually eligible for Medicare and Medicaid, starting in performance year 2024.

- **APG recommends that CMS adopt as final the agency's proposal to establish a health equity-adjusted quality performance score.**
- **APG recommends that CMS adopt as final the agency's proposal to use the number of beneficiaries, rather than person-years, for calculating the proportion of the ACO's assigned beneficiaries who are enrolled in the Part D Low-Income Subsidy or who are dually eligible for Medicare and Medicaid.**

iii. 40th Percentile Quality Performance Standard

For performance year 2024 and subsequent performance years, CMS proposes to use historical submission-level MIPS Quality performance category scores to calculate the 40th percentile MIPS Quality performance category score. Specifically, CMS proposes to use a rolling three-performance year average with a lag of one performance year. For example, the 40th percentile MIPS Quality performance category score, used for the quality performance standard for performance year 2024, would be based on averaging the 40th percentile MIPS Quality performance category scores from performance years 2020 through 2022.

This approach would allow CMS to provide ACOs with the MSSP quality performance standard they must meet to share in savings at the maximum sharing rate prior to the start of the performance year (for example, the 40th percentile MIPS Quality performance category score, based on historical data and applicable for performance year 2024, would be released on the Shared Savings Program website in December 2023). CMS's proposal would address concerns expressed by interested parties that benchmarks are currently not publicly available prior to the start of a performance year, and that they do not believe that ACOs have a way of determining what quality score they would need to achieve to meet the quality performance standard.

APG supports CMS's proposal to provide ACOs with the MSSP quality performance standard they must meet to share in savings at the maximum sharing rate prior to the start of the performance year. The proposal constitutes a distinct improvement in the predictability and transparency of the MSSP program. Having this information will allow participants to assess their status relative to the 40th

percentile and determine where they need to devote resources to improve to meet this standard.

If Medicare CQMs are established as proposed, there will not be historical data for this measure. Therefore, APG asks CMS to clarify how the proposal to use a rolling three-performance year average with a lag of one performance year will incorporate Medicare CQMs to calculate the 40th percentile MIPS Quality performance category score in the final rule.

- **APG recommends that CMS adopt as final the proposal to provide ACOs – prior to the start of the performance year – with the MSSP quality performance standard that they must meet to share in savings at the maximum sharing rate.**

iv. Aligning ACO CEHRT Requirements with MIPS

Currently, MSSP and MIPS differ in their certified electronic health record technology (CEHRT) requirements. The MIPS Promoting Interoperability (PI) reporting requirements are more comprehensive and address key functions that CMS believes can facilitate better care coordination and quality measurement and improvement than the MSSP requirements.

To align MSSP with MIPS, CMS proposes to remove the MSSP CEHRT threshold requirements beginning in performance year 2024, and add a new requirement, for performance years beginning on or after January 1, 2024, that all MIPS eligible clinicians, Qualifying APM Participants (QPs), and Partial QPs participating in the 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. CMS's proposal would further align MSSP with the MIPS program and promote greater CEHRT use among ACO clinicians.

CMS also proposes to add a new requirement for public reporting to align APP with MIPS, requiring that the ACO must publicly report the number of MIPS-eligible clinicians, QPs, and partial QPs participating in the ACO that earn a MIPS performance category score for the MIPS PI performance category at the individual, group, virtual group, or APM entity level.

To alleviate confusion regarding the reference to case minimum in determining the ACO quality performance standard, for performance year 2024 and subsequent performance years, CMS proposes to replace the references to meeting the case minimum requirement with the requirement that the ACO must receive a MIPS Quality performance category score to meet the quality performance standard. This proposal would correct the purpose of CMS's reference to case minimums by incorporating all the applications of case minimums in CMS's MIPS Quality performance category scoring policies to determine an ACO's quality performance standard under MSSP.

APG is greatly concerned by CMS's proposal to require MSSP participants to fulfill the MIPS PI reporting requirements and any other MIPS quality performance categories. It is unclear what goal aligning the requirements between MSSP and MIPS would serve. The MIPS program was designed to assess the quality 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 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 not require MSSP ACOs to fulfill the MIPS Promoting Interoperability (PI) reporting requirements.**

D. MSSP Beneficiary Assignment

i. Adding a Third Step to the Beneficiary Assignment Methodology

CMS proposes modifications to the assignment methodology, and the definition of an assignable beneficiary, to better account for beneficiaries who receive primary care from nurse practitioners, physician assistants, and clinical nurse specialists during the 12-month assignment window and who received at least one primary care service from a physician in the preceding 12 months. This proposal would increase access by assigning additional Medicare fee-for-service beneficiaries to ACOs, especially among more underserved populations.

For the performance year beginning on January 1, 2025, and subsequent performance years, CMS proposes to revise the stepwise beneficiary assignment methodology, as described in § 425.402, to include a new step three, which would utilize a proposed expanded window for assignment (a 24-month period that would include the applicable 12-month assignment window and the preceding 12 months) to identify additional beneficiaries for assignment. Consistent with the proposal to use an expanded window for assignment in an enhanced stepwise assignment methodology, CMS proposes to revise the definition of an "assignable beneficiary" in § 425.20 to include additional beneficiaries who would be identified using the expanded window for assignment.

The proposed use of an expanded window for assignment would result in a greater number of beneficiaries in the assignable population and, in particular, beneficiaries who tend to come from underserved populations, which CMS has seen over time are less likely to be assigned to ACOs than the overall Medicare fee-for-service beneficiary population. Specifically, beneficiaries likely to be added to the assignable population due to this proposal are also more likely to be disabled, enrolled in the Medicare Part D LIS, or reside in areas with higher ADI scores. The proposed changes to the assignment methodology and the definition of assignable beneficiary would impact downstream aspects of the Shared Savings Program that rely on the assigned population, national assignable population, and assignable beneficiaries identified for an ACO's regional service area. This proposal is also aligned with HHS' Initiative to Strengthen Primary Care, given its improved recognition of the variety of clinician types who participate in delivering high-quality primary care.

APG welcomes CMS's proposal to add a third step to the MSSP beneficiary attribution methodology to better account for beneficiaries who receive primary care from nurse practitioners, physician assistants, and clinical nurse specialists. However, it is essential that the attribution methodology incorporate Taxpayer identification Number/National Provider Identifier (TIN/NPI) combinations to be able to accurately determine if the nurse practitioners, physician assistants, and clinical nurse specialists in question practice in primary or specialty care. APG notes that nurse practitioners, physician assistants, and clinical nurse specialists will also be required to have their specialty designations correct in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).

APG supports CMS's overall goal to expand access to accountable care, particularly for beneficiaries in rural and other areas experiencing primary care physician shortages. Given the numerous program operations that rely on the assignable and assigned beneficiary populations, APG urges CMS to conduct additional analyses including more years of data, and release the results, to ensure that the proposed changes do not have unintended consequences for certain types of ACOs or those operating in particular regions such as rural ACOs.

- **APG recommends that CMS to conduct additional analyses including more years of data to ensure that the changes to MSSP beneficiary assignment methodology do not have unintended consequences for certain types of ACOs.**

However, APG notes that regardless of these CMS proposals, MSSP ACOs will continue to face the so-called ratchet effect, wherein ACO benchmarks will continue to fall over time as ACOs reduce spending in their populations and future benchmarks are rebased on lower historical spending. APG urges CMS to consider future changes to mitigate this rebasing problem, which threatens future participation for ACOs working to create a higher quality, more efficient, and more cost-effective health system. More meaningful benchmarking policies are needed to both attract new participants while keeping existing ACOs in the model.

Lastly, CMS needs to take action to correct an impending issue concerning pharmaceuticals in the 340B program. Since a Supreme Court decision last year, CMS has not addressed the disparity between ACOs that paid for 340B drugs at lower prices during their benchmark years and at higher prices during their performance years.[2] Failing to address this disparity will continue to hurt ACOs with benchmarks that include in their baselines, years 2018 through 2022. APG urges CMS to correct this disparity by adjusting the agency's calculation of ACOs' performance year expenditures to correct for this difference in 340B drug spending without ACOs having to early renew their agreement periods. This adjustment would help ACOs with 340B providers, who help under-served patients and address the health disparities that CMS wants to eliminate.

- **APG recommends that CMS adjust the calculation of ACOs' performance year expenditures to correct for the difference between ACOs that paid for 340B drugs at lower prices during their benchmark years – and at higher prices during their performance years – without ACOs having to early renew their agreement periods.**

ii. Adding Primary Care Codes to Beneficiary Assignment

Based on feedback from ACOs and CMS's further review of the HCPCS and CPT codes that are currently recognized for payment under the PFS, or that CMS proposes to recognize for payment starting in CY 2024, CMS believes that it would be appropriate to amend the definition of primary care services used in MSSP assignment methodology. Under its proposal, the agency would include certain additional codes and make other technical changes to the definition of primary care services for use in determining beneficiary assignment for the performance year starting on January 1, 2024, and subsequent performance years, to remain consistent with billing and coding under the PFS.

CMS proposes to revise the definition of primary care services used for assignment in MSSP

[2] https://www.supremecourt.gov/opinions/21pdf/20-1114_09m1.pdf

regulations to include the following additions: (1) Smoking and Tobacco-use Cessation Counseling Services CPT codes 99406 and 99407; (2) Remote Physiologic Monitoring CPT codes 99457 and 99458; (3) Cervical or Vaginal Cancer Screening HCPCS code G0101; (4) Office-Based Opioid Use Disorder Services HCPCS codes G2086, G2087, and G2088; (5) Complex Evaluation and Management Services Add-on HCPCS code G2211, if finalized under Medicare FFS payment policy; (6) Community Health Integration services HCPCS codes GXXX1 and GXXX2, if finalized under Medicare FFS payment policy; (7) Principal Illness Navigation (PIN) services HCPCS codes GXXX3 and GXXX4, if finalized under Medicare FFS payment policy; (8) SDOH Risk Assessment HCPCS code GXXX5, if finalized under Medicare FFS payment policy; (9) Caregiver Behavior Management Training CPT Codes 96202 and 96203, if finalized under Medicare FFS payment policy; and (10) Caregiver Training Services CPT codes 9X015, 9X016, and 9X017, if finalized under Medicare FFS payment policy.

- **APG supports CMS's proposal to expand the definition of primary care services used for assignment in MSSP using the proposed services identified by HCPCS and CPT codes.**

E. MSSP Risk Adjustment

On March 31, 2023, CMS released the Announcement of Calendar Year (CY) 2024 Medicare Advantage (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 smaller adverse impacts 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.**

F. MSSP Benchmarks

i. Proposal to Mitigate the Impact of the Negative Regional Adjustment on the Benchmark to Encourage Participation by ACOs Caring for Medically Complex, High-Cost Beneficiaries

With the policies finalized in the CY 2023 PFS final rule (87 FR 69915 through 69923), CMS sought to reduce the impact of negative regional adjustments in several ways for agreement periods beginning on January 1, 2024, and subsequent years to incentivize ACOs that serve high-cost beneficiaries to join or continue to participate in MSSP. CMS believes that further mitigating the impact of the negative regional adjustment, thereby resulting in higher benchmarks for ACOs compared to the recently finalized methodology, could further bolster the business case for MSSP participation.

Under the proposed approach, ACOs that would face a negative overall adjustment to their benchmark based on the methodology adopted in the CY 2023 PFS final rule would benefit, as they would now receive no downward adjustment. Additionally, ACOs that have a negative regional adjustment amount and are eligible for the prior savings adjustment, under the policy adopted in the CY 2023 PFS final rule, would also be expected to benefit from the proposed policy, because CMS would no longer offset the prior savings amount by the negative regional adjustment amount when determining the final adjustment that would apply to the ACO's benchmark. ACOs that have an overall positive regional adjustment amount would continue to receive the same adjustment to their benchmark as they would under the methodology finalized in the CY 2023 PFS final rule.

APG welcomes CMS's proposal to eliminate the cap on negative regional adjustments, i.e., ensure that ACOs would not face a negative overall adjustment to their benchmark. For ACOs with a negative regional adjustment, this change will benefit some ACOs materially through an increase to their financial benchmark. Milliman has found that this beneficial effect will extend to ACOs focused on higher risk populations, for which the risk-adjusted regional benchmark does not fully capture the populations' expected cost level.[3]

- **APG recommends that CMS finalize the proposal to eliminate the cap on negative regional adjustments for MSSP ACOs.**

ii. Proposal to Cap Regional Service Area Risk Score Growth for Symmetry with ACO Risk Score Cap

CMS proposes to modify the calculation of the regional component of the three-way blended benchmark update factor (weighted one-third accountable care prospective trend (ACPT), and two-thirds national-regional blend), for agreement periods beginning on January 1, 2024, and in subsequent

[3] https://www.milliman.com/en/insight/early-thoughts-on-proposed-mpfs-changes-cms-mssp

years. The proposed approach would cap prospective HCC risk score growth in an ACO's regional service area between benchmark year three and the performance year using a similar methodology as the one adopted in the CY 2023 PFS final rule (87 FR 69932 through 69946) for capping ACO risk score growth, while additionally accounting for an ACO's aggregate market share. This cap on regional risk score growth would be applied independently of the cap on an ACO's own prospective HCC risk score growth, meaning that this proposed cap on prospective HCC risk score growth in an ACO's regional service area would be applied whether or not the ACO's prospective risk score growth was capped.

The effect of the proposed regional risk score growth cap would be to increase the regional component of the update factor for ACOs in regions with aggregate regional prospective HCC risk score growth above the cap. ACOs in regions with aggregate regional prospective HCC risk score growth below the cap would not be affected by the proposed policy. The proposal would maintain a disincentive against coding intensity for ACOs with high market share by adjusting the regional risk score growth cap based on ACO market share.

CMS expects that this proposed approach would – by symmetrically limiting risk score growth within both an ACO's assigned beneficiary population and its region – improve the accuracy of the regional update factors for ACOs operating in regional service areas with high risk score growth, particularly in later years of the five-year agreement period when the differences are expected to be the greatest. CMS believes capping regional risk score growth would strengthen incentives for ACOs to form or continue to operate in regions with high risk-score growth and thereby incentivize ACOs to care for higher risk beneficiaries. This approach would also offer an incentive for potential applicant ACOs that may be examining recent risk score growth in their region and making the decision whether to participate in MSSP.

APG notes that this policy will apply only to ACOs with new agreement periods in 2024. Although most ACOs will not be affected by this change, some ACOs will see their regional update factor increase if they have observed significant risk score growth in their region since base year 3. This rule change is expected to affect more ACOs as the average gap increases between benchmark years and performance years. CMS' simulation on PY 2021 ACOs found that approximately 11 percent of ACOs would have been subject to the cap. ACOs in regions with risk score growth below the cap would not be affected. CMS proposes to scale the cap to the ACO's market share within a region meaning that ACOs with larger market shares would see smaller increases compared to ACOs with a smaller market share, if their region's risk scores increase above the 3 percent cap.

- **APG recommends that CMS cap prospective HCC risk score growth in an ACO's regional service area for ACOs with both new and continuing agreement periods.**

APG is concerned about the interaction of multiple risk adjustment changes that will coincide in 2024, especially the risk score growth cap and the phase-in of the new risk adjustment model. Some ACOs could experience risk score growth for their populations as a result of the new V28 risk model rather than resulting from diagnosis coding changes. This trend would clearly disadvantage ACOs based on a methodological change adopted by CMS, and not through any actions on the part of the ACO. APG urges CMS to control for the new risk model phase-in change when it applies the new 3 percent cap, assuming that it is finalized.

- **APG recommends that CMS control for the new risk model phase-in change when the agency**

applies the new 3 percent regional cap service are cap if it is finalized.

APG is also concerned that CMS's existing and proposed policies on risk score growth are founded on a perspective that participants are routinely and consistently overcoding. However, there are ACOs that serve populations whose health risks do increase substantially over time or whose historical health risks were not fully documented by reported diagnoses. This reality of empirical differences in population risk makes the act of capping risk score growth artificial. CMS's approach makes sense if the agency thinks that participants are gaming the system, but hurts good actors along with bad actors, if a tiny minority are gaming the system. APG members note that there is no evidence to indicate that most physicians in MSSP are deliberately manufacturing codes to improve reimbursement.

G. 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, CMS seeks comment on multiple topics. APG provides comments on one: 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 Realizing Equity, Access, and Community Health (ACO REACH) Models.

"Higher risk" sharing provides a higher level of potential reward, 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 healthcare 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 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 with regard to which ACOs would choose 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 an ACO may receive or the amount of shared losses it may owe, which can further discourage beneficiary selection.

If introducing a higher-risk track to the program, CMS would need to consider 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 ensuring that the new risk model would still be attractive to ACOs and improve the quality and efficiency of the care 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 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 therefore seeks comment on the following: (1) policies/model design elements that could be implemented so that a higher-risk track could be offered without increasing program expenditures; (2) ways to protect ACOs serving high-risk beneficiaries from expenditure outliers and reduce incentives for ACOs to avoid high-risk beneficiaries; and (3) the impact that higher sharing rates could have on care delivery redesign, specialty integration, and ACO investment in health care providers and practices.

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.**

H. Quality Payment Program (QPP)

i. APM Performance Pathway (APP)

CMS proposes multiple policy changes to the APM Performance Pathway (APP) that ACOs use to report data on quality measures.

First, the agency proposes to make QP determinations at the individual eligible clinician level only, instead of the APM Entity level. CMS would calculate all covered professional services, not just E&M visits, at the individual NPI level. This change may mitigate disincentives to add specialists to ACOs.

Second, CMS proposes changes to current regulations that require that 75 percent of eligible clinicians in each participating APM Entity (for example, an ACO) use CEHRT if the APM is to be deemed an Advanced APM. CMS proposes to remove the numerical 75 percent threshold and specify that, to be an Advanced APM, the APM must require the use of certified EHR technology, which means EHR technology certified under the ONC Health IT Certification Program that meets: (1) the 2015 Edition Base EHR definition, or any subsequent Base EHR definition (as defined in at 45 CFR 170.102); and (2) any such ONC health IT certification criteria adopted or updated in 45 CFR 170.315 that are determined applicable for the APM, for the year, considering factors such as clinical practice areas involved, promotion of interoperability, relevance to reporting on applicable quality measures, clinical care delivery objectives of the APM, or any other factor relevant to documenting and communicating clinical care to patients or their health care providers in the APM.

Given that ACOs do not have a choice of measures that they can report under the APP, CMS does not want to adversely impact shared savings determinations for events outside the ACOs' control, such as that a measure is excluded. Therefore, CMS is proposing that, for performance year 2024 and subsequent performance years, if (1) an ACO reports all required measures under the APP, and meets the data completeness requirement for all required measures, and receives a MIPS Quality performance category score, and (2) the ACO's total available measure achievement points used to calculate the ACO's MIPS Quality performance category score for the performance year is reduced due to measure exclusion, then CMS would use the higher of the ACO's health equity adjusted quality performance score or the equivalent of the 40th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, to determine whether the ACO meets the quality performance standard required to share in savings at the maximum rate under its track (or payment model within a track) for the relevant performance year. This policy aims to alleviate the potential adverse impacts to shared savings determinations that may arise in the event that one or more of the quality measures required under the APP is excluded.

APG is concerned about CMS's proposal to make QP determinations at the individual eligible clinician level only, instead of the APM Entity level, as this proposal could deter specialist participation in ACOs. ACOs need specialists to be able to adequately align and coordinate across the continuum of care, succeed on quality measures, and achieve cost savings. Yet there is already growing indication that physicians, especially specialists, prefer to remain in traditional, fee-for-service Medicare due to a variety of factors.

MACRA-designed fee schedule reimbursement mandates that physicians choose between MIPS or AAPM, since a Qualifying Participant cannot submit under MIPS. In 2024, MIPS participants will receive

an annual 0.25 percent payment update and are eligible to receive up to a 9 percent bonus for quality performance. AAPM participants will receive an annual 0.75 payment update with no bonus available for performance years after December 31, 2023, unless current law is changed (they had received a 5 percent bonus up through performance year 2022, reduced to 3.5 percent for for PY 2023). To be clear, once physicians achieves Qualifying APM Participant (QP) status, they cannot report under MIPS -- which means that if Congress does not extend the AAPM bonus payment, physicians will face a choice of participating in an AAPM that receives a 0.75 percent annual update, or participating in MIPS with a 0.25 percent annual update and the chance of receiving up to a 9 percent bonus. As a result, far too many specialists and other physicians could find the value of participating in AAPMs outweighed by the greater financial rewards of remaining in MIPS, undercutting CMS's goal of moving all Medicare beneficiaries into accountable care by 2030.

- **APG recommends that CMS continue to make Qualifying APM Participant (QP) determinations at the APM Entity level instead of the individual eligible clinician level.**

ii. Universal Foundation Quality Measures

Under the goals of the CMS National Quality Strategy, CMS is moving towards a building-block approach to streamline quality measures across CMS quality programs for the adult and pediatric populations. This "Universal Foundation" of quality measures will focus provider attention on a narrower set of important measures, reduce burden, help in identifying disparities in care, prioritize the development of interoperable, digital quality measures, allow for cross-comparisons across programs, and help to identify measurement gaps.

CMS intends to propose future policies aligning the APP measure set for MSSP ACOs with the quality measures under the "Universal Foundation" beginning in performance year 2025. It also proposes to adopt these Universal Foundation measures into the existing Value in Primary Care MVP. Through alignment with the Universal Foundation in the Value in Primary Care MVP and the APP measure set by 2025, primary care clinicians would develop familiarity with the same quality measures that are reported in the APP while in MIPS. CMS expects this alignment would reduce the barriers to participation in the MSSP.

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 to balance alignment with efforts to reduce administrative burdens.

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 maintain 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 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.

APG supports CMS's efforts to reduce health inequities and incentivize screenings for social drivers of health. However, CMS must recognize the current state of this work and begin with efforts around data standardization before any such measures are required in performance-based programs like MSSP. CMS should not require ACOs to report on substance use disorder (SUD) treatment until the agency is able to share SUD information with ACOs, as this information is currently suppressed from data shared with ACOs for care coordination activities. APG cautions CMS that the new screening for SDOH measure must be tested before making this a required measure.

- **APG recommends that CMS not require ACOs to report on substance use disorder (SUD) treatment until the agency is able to share SUD information with ACOs.**

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

Following the pause during the COVID-19 public health emergency, CMS plans to resume the Quality Payment Program (QPP). CMS proposes policies that continue the development and maintenance of Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs), 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.

CMS has long signaled the agency's intention that MVPs will succeed the current iteration of MIPS. To further this vision, CMS proposes that five new MVPs be available with the 2024 performance year, along with revisions to all previously finalized MVPs.

The five newly proposed MVPs are as follows:

1. Focusing on Women's Health
2. Quality Care for the Treatment of Ear, Nose, and Throat Disorders
3. Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
4. Quality Care in Mental Health and Substance Use Disorders
5. Rehabilitative Support for Musculoskeletal Care.

CMS included in the proposed rule a Request for Information (RFI) on MIPS Value Pathway (MVP) Reporting for Specialists in MSSP ACOs. Beginning in CY 2023, specialists who report under MIPS, including specialists who participate in MSSP ACOs, have the option to register to report MVPs for the applicable performance period as a group, subgroup, or individual and to report on relevant MVP quality measures. CMS needs to allow for specialists to report relevant data and applicable quality measures, and to allow patients and referring clinicians to make more informed decisions regarding the specialists involved in a given patient's care. In this proposed rule, CMS is soliciting comments on potential future scoring incentives that could be applied to an ACO's health equity adjusted quality performance score, beginning in performance year 2025 when specialists who participate in the ACO report quality MVPs.

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

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