Advancing High Performance Health

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Brooks-LaSure:

On behalf of AMGA, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) "Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program Proposed Rule [CMS-1784-P]."

Founded in 1950, AMGA is a trade association leading the transformation of health care in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high-performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality, high-value care. Over 177,000 physicians practice in our member organizations, delivering care to more than one in three Americans. Our members are also leaders in value-based care delivery, focusing on improving patient outcomes while driving down overall healthcare costs.

AMGA is pleased to offer comments on the CY 2024 PFS Proposed Rule for your consideration. Specifically, we provide comment on the following issues:

- **Conversion Factor Decrease:** AMGA urges CMS not to implement this proposed decrease. Consequences of such a reduction include further exacerbating the financial pressures AMGA members face and, critically, threatening access to care for Medicare beneficiaries.

- **Evaluation and Management (E/M) Add-on Code G2211:** AMGA appreciates CMS's recognition of the increased costs posed by complex cases during E/M visits. AMGA is concerned the add-on code (G2211) will lead to additional across-the-board cuts, which illustrate the flaws inherent to the physician fee schedule's budget neutrality requirements.

- **Telehealth Policy:** AMGA agrees with CMS's proposal to reimburse telehealth provided to patients in their homes based on the "non-facility" rate and supports all proposals to extend telehealth flexibilities.

- **Split Visit Evaluation and Management (E/M) Policy:** AMGA agrees with CMS's decision to delay the split visit E/M policy and urges CMS to forgo the policy altogether.

- **Appropriate Use Criteria (AUC)**: AMGA commends CMS for recognizing implementation challenges with the AUC program and supports the Agency's decision to review its direction. CMS's acknowledgement of operational complexities highlights the need for a comprehensive reassessment of its feasibility.

- **Behavioral Health Access:** AMGA supports CMS's efforts to expand behavioral health access.

- **Social Determinants of Health Assessment (SDOH) at Annual Wellness Visit:** AMGA supports CMS's proposal to reimburse providers for administering a SDOH assessment.

- **Medicare Shared Savings Program (MSSP)**: AMGA supports efforts to move toward value-based care but is concerned about the frequent modifications to the MSSP, as maintaining policy stability is key to the program's success.

- **Quality Payment Program (QPP):** AMGA opposes the proposal to determine QPP status at the individual as opposed to group level. AMGA also objects to CMS's ongoing reluctance to fully address the challenges presented by the Merit-based Incentive Payment System (MIPS) low-volume threshold.

Conversion Factor Decrease

Comment: AMGA strongly opposes the proposed reduction in the Medicare conversion factor. Over the past three years, our members have navigated reductions in physician reimbursement despite the increasing costs of delivering care to Medicare beneficiaries. Together with the healthcare labor shortage and persistent inflation, costs are poised to rise even further. Additional Medicare reimbursement cuts are unsustainable for providers and a grave risk to beneficiary access to healthcare services. **AMGA urgently calls upon CMS to utilize all possible measures to mitigate these payment reductions.**

CMS proposes a 3.36% decrease in the conversion factor, from $33.89 to $32.75. While AMGA recognizes the statutory basis for the conversion factor, it is critically important to consider the consequences a conversion factor cut will have on providers' ability to provide care to Medicare beneficiaries. The healthcare industry faces unprecedented workforce shortages, burnouts from the COVID-19 pandemic, record inflation, and a rapidly growing Medicare population. An additional cut to physician Medicare reimbursement will be devastating and threatens providers' ability to deliver care to existing and newly eligible Medicare beneficiaries. AMGA members are deeply committed to serving Medicare beneficiaries; however, it is unrealistic to expect providers to meet the increasing demand for Medicare services if reimbursement rates continue to drop and costs continue to rise. Please refer to *Attachment A* for an illustration of the proposed decreases in physician payment compared to the actual costs of delivering care.

AMGA urges CMS and the Administration to explore alternative options to avoid a decrease to the conversion factor including a recommendation of legislative change via the Office of Management and Budget (OMB) Circular A-19 budget request process.
The proposed cuts are unsustainable. Persisting with the practice of reducing reimbursement amidst escalating costs will result in limited beneficiary access to care.

E/M Add-on Code G2211

> **Comment:** AMGA appreciates CMS's recognition of the increased costs posed by complex cases during E/M visits. However, AMGA is concerned the add-on code (G2211) will still lead to additional across-the-board cuts due to budget neutrality requirements.

AMGA appreciates the adoption of G2211 as it values the complexity of primary care and other office and outpatient E/M visits. This code may help foster care coordination and earlier detection of diseases, which ultimately will result in fewer inpatient visits. However, the budget neutrality alterations triggered by the inclusion of this code exacerbates the already unsustainable Medicare reimbursement levels for specialty physicians. While we value the strides towards fairer compensation for primary care, we hold reservations about the potential decline in Medicare underpayment for specialty physician care.

We appreciate CMS's recognition of the heightened resources necessary for primary care providers to act as intermediaries among specialties and the fact that existing reimbursement does not adequately address these efforts. While CMS indicates that the refinement of the add-on code will result in less frequent use, we remain concerned the implementation of the code will disproportionately affect non-primary care physicians.

Telehealth

> **Comment:** AMGA applauds CMS's proposal to reimburse telehealth provided to patients in their homes based on the "non-facility" rate. Maintaining the COVID-19 Public Health Emergency (PHE) payment policy for this care is vital to ensuring it remains a viable option for AMGA members and Medicare beneficiaries.

Telehealth has become a fundamental healthcare delivery tool for AMGA members and Medicare beneficiaries continue to benefit from the flexibility and access provided by these services. AMGA appreciates CMS's willingness to reconsider its previously finalized policy, which would have reverted Medicare to a pre-COVID-19 approach to telehealth services. We welcome the proposed payment parity between telehealth services and in-office care and AMGA strongly encourages CMS to finalize this proposal. AMGA would like to thank CMS for its willingness to engage with AMGA members on this important issue.

CMS also proposes extending audio-only payment and coverage parity though 2024. While AMGA is pleased that CMS will continue to make payment for services furnished via audio-only telecommunications through December 31, 2024, as required by the Consolidated Appropriations Act of 2023, AMGA believes it is critical for CMS to continue payment for audio-only E/M services on the telehealth list beyond this date. Many Medicare beneficiaries simply do not have access to the devices or broadband services necessary to receive care through video-based technology and, therefore, AMGA strongly recommends CMS permanently add payment

for audio-only services.

Finally, AMGA is concerned about the lack of clarity regarding public disclosure of home addresses for providers who deliver telehealth services. It appears the flexibility of not reporting a home address, allowed during the PHE, will expire on Jan. 1, 2024. AMGA strongly maintains Medicare providers should be able to safeguard sensitive home address information. AMGA urges CMS to clarify the policy so providers are not required to share their personal information.

Delayed Split Visit E/M Policy

> **Comment:** AMGA stresses the importance of allowing physicians to include medical decision-making (MDM) in defining the substantive portion of split or shared E/M services. This approach not only respects physician expertise but also maintains alignment with the evolving landscape of equitable billing practices, as evident from CMS's own approach for determining E/M visit levels.

In the CY 2022 Physician Fee Schedule Final Rule,[1] CMS introduced a policy requiring a physician's presence with a patient for over half of the total time in a split or shared E/M visit to qualify for billing the service (excluding critical care services). However, in this proposed rule, CMS proposes delaying the implementation of this policy until at least Dec. 31, 2024. Consequently, physicians will continue to bill split or shared visits based on the current "substantive portion" definition, which encompasses elements like history, examination, medical decision-making, or more than half of the total time spent.

AMGA emphasizes this proposed alteration could potentially disrupt established team-based practice models and necessitate significant internal process adjustments, including modifications to information systems, to accommodate a transition to tracking visits based on time rather than MDM.

AMGA contends that excluding MDM from the equation would undervalue the significance of a physician's expertise and experience, essentially treating all time intervals equivalently. While it is true that a physician might spend less time during certain visits, the physician's competence and oversight is the key aspect of the encounter. Therefore, AMGA strongly urges CMS to reconsider these proposed changes and to permanently allow the incorporation of MDM in defining the substantive portion of split services.

Furthermore, we wish to highlight that as of January 1, 2023, CMS introduced a progressive approach to determine visit levels, based on medical decision-making or time, for most Evaluation and Management (E/M) visit categories. We recommend that CMS apply this same approach to split and shared visits.

Appropriate Use Criteria (AUC)

> **Comment:** AMGA applauds CMS for acknowledging the challenges in implementing the AUC program and its decision to reassess the program's trajectory. The operational complexities highlighted by CMS underscore the need for a thorough reevaluation of its viability.

[1] 86 FR 64996

AMGA recognizes the significance of measures enhancing high-quality care and appropriate utilization of medical services. While the AUC program's intentions are commendable, it is crucial any regulatory endeavor is both practical and effective within real-world healthcare settings.

The proposed indefinite pause aligns with AMGA's reservations concerning the feasibility of real-time claims-based reporting requirements. We urge CMS to use this opportunity to engage with physician groups and stakeholders to explore alternative avenues that achieve the program's goals without causing undue administrative complexities or disruptions to beneficiary care. Striking a balance between advancing quality care and maintaining efficient clinical workflows is critical.

Lastly, as the AUC program is temporarily paused, we commend CMS for its ongoing support of clinical decision support mechanisms to harmonize clinical workflows with healthcare practitioners' needs.

Social Determinants of Health Risk Assessment (SDOH)

Comment: AMGA strongly supports CMS's proposal to add a SDOH assessment to the Medicare annual wellness visit (AWV) and to reimburse providers for administering this assessment in conjunction with an E/M visit.

CMS proposes to reimburse SDOH assessments using a new stand-alone G code, which would be added to the Medicare Telehealth Services List. The SDOH assessment would also be added as an optional component of the AWV and would include an additional payment. AMGA's members are committed to addressing health inequities and incorporating an assessment of beneficiaries' SDOH into their care plan. We appreciate CMS's recognition of the additional resources required for this assessment and strongly urge CMS to finalize the proposed policy.

Behavioral Health Access

Comment: AMGA supports CMS's efforts to expand behavioral health access**.**

CMS outlines plans to extend Part B coverage and reimbursement for the professional services rendered by marriage and family therapists (MFTs) and mental health counselors (MHCs). In addition, CMS proposes the establishment of new HCPCS codes for crisis care psychotherapy with an upward adjustment to the work relative value units (RVUs) for psychotherapy codes. AMGA supports these proposals and considers them decisive steps toward broadening access to behavioral health services for the Medicare population.

Provider Enrollment Issues

Comment: AMGA opposes proposed changes regarding provider enrollment.

Timeframes for Reversing a Revocation

CMS is proposing to reduce the timeframe for reversing a revocation from 30 days to 15 days. Under current law, CMS can reverse revocations if a provider or supplier terminates a contract with the offending party within 30 days of the revocation notification.

AMGA recommends CMS maintain the 30-day period, as 15 days is too short for a provider to conduct due diligence and notify CMS of the termination of any relevant contracts.

Stay of Enrollment

CMS is proposing a new 60-day "stay of enrollment" designation that would delay revocation or deactivation of Medicare enrollment for certain paperwork errors or missed deadlines. This "stay" would be available to providers who can correct the problem by submitting the appropriate paperwork. AMGA appreciates CMS offering a reasonable opportunity to come into compliance before deactivating or revoking enrollment status. However, CMS also is proposing not to reimburse providers for services for Medicare beneficiaries during this "stay of enrollment." This effectively dis-enrolls the provider. AMGA opposes moving providers into a non-payment status, particularly for providers who can come into compliance quickly.

Medicare Shared Savings Program (MSSP)

> **Comment:** AMGA supports CMS's MSSP proposals as they signify a major step toward value-based care. While we welcome most of the proposed changes, we do wish to note our concern about frequent changes to the program, which tend to dissuade providers from participation. Again, AMGA stresses program stability as paramount in garnering sustained engagement and investments.

Assignment Methodology

CMS proposes an additional step in the claims-based alignment process to broaden beneficiary assignment within the MSSP. While the intention to better account for beneficiaries receiving primary care from non-physician practitioners during an expanded window is commendable, a detailed estimate of the effects on assignable populations, particularly those in underserved communities, is necessary. By quantifying the potential outcomes and carefully considering the duration of the expanded window, CMS can ensure that this adjustment aligns with program goals and avoids unintended consequences. This analytical approach will empower stakeholders to provide informed feedback and contribute to a well-rounded and effective assignment methodology. AMGA therefore urges CMS to conduct a comprehensive modeling of the potential impacts before finalizing this change.

Expanded Window

AMGA supports CMS's proposal to define the "expanded window for assignment" as the 24-month period that includes the applicable 12-month assignment window and the preceding 12 months. This approach addresses the need for alignment in timeframes, recognizing the different 12-month assignment windows used by accountable care organizations (ACOs) operating under prospective assignment versus preliminary prospective assignment with retrospective reconciliation. It promotes fairness and consistency across ACOs.

Definition of Assignable Beneficiary

AMGA appreciates the recognition of nurse practitioners, physician assistants, and clinical nurse specialists in the beneficiary assignment methodology. By better reflecting the role of these healthcare professionals, CMS strengthens an inclusive and comprehensive approach to primary care, a core tenet of value-based care. However, CMS should conduct an analysis using additional years of data before implementing a revised definition of an assignable beneficiary to align with the proposed expanded window for assignment. AMGA also encourages CMS to

consider the appropriateness of assigning a beneficiary who had only one visit with an ACO's provider for an acute condition, as opposed to a primary care or chronic disease visit. For example, it is possible under the proposed changes for an ACO to be responsible for a beneficiary who received care for an acute condition, such as a sprained ankle, in an urgent care setting. If this is the extent of the ACOs relationship with the beneficiary, it is not a true reflection of the ACO's ability to improve costs and quality of care and such beneficiaries should be excluded.

Primary Care Services Used in Assignment

CMS proposes to add additional codes to the definition of primary care services used to determine beneficiary assignment. AMGA agrees with the addition of the following codes:

- Smoking and Tobacco-use Cessation Counseling Services (CPT® codes 99406 and 99407)
- Cervical or Vaginal Cancer Screening (HCPCS code G0101)
- Complex E/M Services Add-on (HCPCS code G2211)
- Community Health Integration Services (HCPCS codes GXXX1 and GXXX2)
- Principal Illness Navigation Services (HCPCS codes GXXX3, GXXX4)
- SDOH Risk Assessment (HCPCS code GXXX5)
- Caregiver Behavior Management Training (CPT codes 96202 and 96203)
- Caregiver Training Services (CPT codes 9X015, 9X016 and 9X017)

AMGA supports the addition of these codes to the definition of primary care services as proposed.

Benchmarking Methodology

AMGA supports the improvement of financial benchmarking in the ACO program. CMS's proposed refinements will improve the program's attractiveness for ACOs and support their active participation. We do note, however, the importance of considering the reforms in the larger context of having a stable and predictable model for ACO participants.

Negative Regional Adjustment Changes and Prior Savings Adjustment

CMS is proposing to eliminate the negative regional adjustment to prevent any ACO from receiving a regional adjustment that would cause its benchmark to be lower than it would have been without the regional adjustment. ACOs that would face a negative overall adjustment to their benchmark based on the methodology adopted in prior rulemaking would no longer receive a downward adjustment. In addition, those ACOs eligible for a prior savings adjustment would not have those savings offset by a negative regional adjustment. CMS is proposing to implement this change for new agreements starting in 2024. While AMGA supports this change and recommends CMS finalize the proposal, CMS should apply this change to all ACOs, not just those starting new agreements in 2024.

Capping Regional Risk Score Growth

AMGA agrees with CMS's proposal to cap the growth of an ACO's aggregate risk score at 3%. Under current policy, CMS does not apply the same cap to the population that an ACO is compared to, which results in inequities. For example, should an ACO's risk score increase 6% and the region's risk score also increases 6%, CMS will calculate risk-adjusted cost growth as if the ACO's risk score increased by only 3%, while also assuming the risk score of the comparison population increased by 6%. The resulting imbalance reduces an ACO's performance by 3%

simply through a quirk in how growth is calculated. To address this problem, CMS is proposing to cap an ACO's region's grow in risk scores at 3% percent, similar to how it caps the ACO's own risk score growth. AMGA agrees with this proposal.

Quality Reporting

Under the proposed rule, ACOS would have the option of reporting quality data using the CMS Web Interface, eCQMs, MIPS CQMs, and/or Medicare CQMs collection types. CMS notes the CMS Web Interface, however, will no longer be available for quality reporting in 2025. AMGA is concerned the timeline for this transition is not realistic, and suggests CMS allow ACOs to elect (rather than require) to report eCQMs. AMGA also strongly recommends ACOs maintain the ability to report via the Web Interface.

Alignment of Shared Savings CEHRT Requirements with MIPS

CMS aims to align CEHRT threshold requirements between all ACOs—regardless of track—and the MIPS Promoting Interoperability requirement by replacing the MSSP CEHRT threshold requirements with MIPS PI category objectives, applicable to all clinicians participating in an ACO. AMGA asserts that the proposed change introduces administrative burden without clear evidence of improved program operations, potentially diverting resources from patient care and coordination. Ultimately, this approach could undermine the mission of ACOs: fostering high-quality, patient-centered, and cost-efficient care. ACOs play a distinctive role in value-based care and should not be subject to complex MIPS reporting requirements. Despite surface-level alignment between CEHRT and PI requirements, the nuanced operational challenges should be thoughtfully considered.

Instead of streamlined reporting, ACOs that qualify as Advanced Alternative Payment Models (APMs) would face MIPS regulations, undercutting potential efficiencies and quality improvements. AMGA recommends CMS take a measured approach, preserving proven flexibility and incentives that promote progress. It is essential to maintain ACOs' unique attributes while enhancing program effectiveness and supporting a successful transition to value-based care.

Consistency in Risk Modeling

The proposal to apply risk adjustment from Medicare Advantage to the MSSP raises several concerns. The introduction of distinct risk models for an ACO's benchmark and performance years in the 2024 CMS-HCC risk adjustment model is likely to introduce inaccuracies, potentially undermining fairness and precision of performance assessments.

Consistency in risk models across all ACOs is paramount. Regardless of the specific model employed, maintaining uniformity in risk adjustment is essential for equitable comparisons and fair evaluations. Any deviations from this uniformity may lead to unjustified fluctuations in ACO shared savings payments, diminishing the trust in program effectiveness.

CMS itself has acknowledged that the application of this approach in 2021 would have resulted in an 11% reduction in ACO shared savings payments, emphasizing the unintended consequences of such a proposal. AMGA opposes finalizing a plan that could introduce such unwarranted discrepancies into the ACO payment system, underscoring the importance of equitable evaluations that accurately reflect an ACO's efforts and outcomes. Further, AMGA is

concerned this proposal would discourage new or continued participation in the MSSP, making it even more difficult for CMS and the provider community to reach the goal of 100% of Medicare beneficiaries in a value-based model by 2030.[2]

Future Considerations

New Track (Above ENHANCED)

AMGA welcomes the initiative to explore new avenues for advancing value-based care within the MSSP. Improving the health outcomes for Medicare beneficiaries with innovative measures while maintaining program consistency is crucial to success. We therefore strongly support CMS's efforts to maintain uniform processes, procedures, and flexibility across different tracks. This approach not only ensures a level playing field for participating ACOs, but also streamlines the operational experience and minimizes complexity.

AMGA appreciates the solicitation for comments on potential future developments to make MSSP a more effective and responsive program. Stakeholder input and transparency will result in a more sustainable MSSP while advancing the goals of value-based care.

Quality Payment Program

> **Comment:** AMGA is concerned that the proposal to assess Qualifying Participant (QP) status individually, rather than by entity, may distance the advanced APM program from its core, collaborative patient-care approach. AMGA remains concerned that CMS overlooks the problems caused by the MIPS low-volume threshold. This undermines the program's purpose by reducing incentives for non-threshold providers to shift to value-based care and decreasing payouts for those meeting the threshold.

Qualified Participant Determination

CMS proposes to conduct QP determinations at the individual rather than the entity level and calculate thresholds separately for each National Provider Identifier (NPI) linked to an Advanced APM. In effect, thresholds would encompass all covered professional services, as opposed to exclusively using E/M services as the default calculation method. AMGA recognizes CMS's concerns regarding the current program structure discouraging specialty physician enrollment in APMs due to their lower service contribution and its impact on APM Entity's Threshold Score. However, we maintain our perspective that determining QPs at the individual level is not the solution.

As we emphasized in our response to CMS's initial proposal in the CY 2017 Quality Payment Program proposed rule,[3] the group practice model's strength lies in its collaborative approach to patient care. We support CMS's proposal to count all covered professional services, rather than exclusively E/M services, as a more effective means to address barriers facing specialists than moving QP determination to the individual level.

MIPS Value Pathways

[2] https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper
[3] 81 FR 28319

CMS proposes to establish five new MVPs, consolidate the Promoting Wellness and Managing Chronic Conditions MVPs into a single primary care MVP, and modify the existing MVPs. While AMGA acknowledges the goal of measure alignment, we assert that adjusting MIPs without addressing the fundamental structural issues, including the low-volume threshold, fails to produce substantial impact. Comprehensive reform, rather than tweaks, is required to rectify the program's underlying flaws.

Low Volume Threshold

CMS has not proposed any changes to the low volume threshold, and AMGA has consistently emphasized that this threshold undermines the fundamental purpose of MIPS, which is to drive the transition towards value-based care. The substantial impact of this threshold is undeniable, as CMS projects that 603,302 clinicians will not participate due to not meeting the criteria or opting out, even if they partially qualify. Such providers lack the incentive to embrace value-based care. Among the 820,047 expected participants, payouts are diminished because clinicians who partially qualify can simply opt out if they anticipate negative adjustments.

While AMGA acknowledges CMS's projection of increased MIPS payouts, this uptick stems from heightened standards for participating clinicians, and the projected average payout of 3.35% still falls short of the actual cost associated with the transition to value-based care. Raising the performance threshold to 82 points while retaining the low-volume threshold exacerbates MIPS barriers for smaller-serving practices. These practices are often either excluded due to low volume or opt out foreseeing performance standard challenges. Now, when they eventually join, the hurdle will be even higher.

AMGA is concerned that raising performance standards while allowing small practices to be excluded from MIPS deters providers from transitioning to value-based care, and ultimately deprives the Medicare populations they serve of its benefits. Eliminating the low-volume threshold would incentivize all providers toward value-based care, and boost payouts for those embracing this shift, without inflating the necessary standards for attaining these payouts.

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We appreciate your consideration of our comments. Please contact Darryl M. Drevna, Senior Director of Regulatory Affairs, at ddrevna@amga.org or 703.838.0033 ext. 339, with any questions or concerns.

Sincerely,

Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer, AMGA

Attachment A