Advancing High Performance Health

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Alternative Payment Models: Preserve Team-Based Care and Organizational Investment

Overview

Recent policy changes to Alternative Payment Model (APM) participation under 42 CFR Part 414, Subpart O—including the shift toward individual-level Qualifying Participant (QP) determinations and the expansion of mandatory specialty payment models—risk undermining Congress' intent to promote team-based care, organizational accountability, and sustained provider investment in value-based infrastructure. These changes move away from the collective accountability framework that underpins Advanced APMs and instead introduce fragmented incentives, duplicative reporting, and increased administrative burden, contrary to the statutory directive at 42 U.S.C. § 1395l(z)(3) to reduce clinician burden within the Quality Payment Program (QPP).

Advanced APMs were designed around entity-level responsibility for performance, shared financial risk, and coordinated care delivery supported by centralized investments in data analytics, care management, and quality improvement. Policies that shift accountability to the individual clinician level—or impose mandatory specialty models layered on top of existing APM participation—threaten these investments and weaken the organizational structures necessary for long-term success in high-value care.

The recently finalized Ambulatory Specialty Model (ASM) demonstrates the validity of these concerns. While the Centers for Medicare & Medicaid Services (CMS) made targeted improvements in the final rule—including positive scoring adjustments for small practices and providers serving complex patients, clarified attribution tied to actual patient visits, and limited Taxpayer Identification Number (TIN)-level reporting flexibility for small practices—the model remains mandatory, two-sided, and duplicative of existing QPP structures. As finalized, the ASM continues to introduce overlapping accountability, conflicting incentives for specialists already participating in the Medicare Shared Savings Program (MSSP), and operational complexity that undercuts team-based, system-level care transformation.

AMGA's Policy Recommendations

1. **Preserve Entity-Level QP Determinations:** Maintain QP determinations at the APM Entity level under 42 CFR § 414.1425. Entity-level determinations align with the statutory design of Advanced APMs and support coordinated, team-based accountability rather than fragmented, clinician-by-clinician compliance.

2. **Reject Mandatory Specialty Payment Models:** Oppose mandatory participation requirements for specialty-focused models, including the ASM. Even with refinements in the final rule, mandatory specialty models impose duplicative performance frameworks, create conflicts with MSSP participation, and expose specialists to two-sided risk without adequate alignment across programs.

3. **Support Voluntary APM Participation:** Rely on voluntary model testing under 42 U.S.C. § 1315a, allowing organizations to enter APMs when they have the infrastructure, partnerships, and clinical readiness necessary to succeed and generate savings.

4. **Adopt Standardized Quality Measure Sets:** Advance a streamlined, outcomes-focused approach to quality measurement by aligning requirements across APMs, the Merit-based Incentive Payment System (MIPS), and specialty models to reduce duplicative reporting and administrative burden. CMS should build on the Universal Foundation by incorporating AMGA's Value Measure Set consistently across APMs and the MSSP, enabling organizational accountability while prioritizing measures that matter to patients.

5. **Reduce Administrative Burden Across APMs:** Streamline and align reporting and benchmarking requirements under 42 CFR Part 414, Subpart O, and harmonize them with MSSP policies under 42 CFR Part 425 to avoid overlapping measures, conflicting attribution rules, and duplicative reconciliation processes.

Background

Entity-Level Accountability Is Foundational to Advanced APMs

Advanced APM criteria—the use of certified electronic health record technology (CEHRT)-comparable quality measures and the assumption of more-than-nominal financial risk—are inherently organizational. Shifting QP determinations to the individual clinician level fractures this framework, increases administrative complexity, and redirects focus from care improvement to compliance mechanics, contrary to the goals of the QPP.

Mandatory Specialty Models Create Redundant and Conflicting Requirements

Although CMS refined the ASM in the final rule, the model still mirrors the four MIPS

performance categories (quality, cost, improvement activities, promoting interoperability) while nominally exempting participants from MIPS. This structure recreates MIPS-like reporting within a mandatory APM, producing duplicative measurement and reconciliation for specialists—particularly those already accountable under MSSP. Low minimum episode thresholds, even when tied to actual patient visits, continue to raise concerns about statistical reliability and disproportionate performance impacts for clinicians treating complex or low-volume populations.

MSSP Demonstrates the Value of Stability and Alignment

The MSSP, authorized under 42 U.S.C. § 1395jjj, has generated record net savings precisely because it offers stable benchmarks, predictable rules, and entity-level accountability that justify long-term organizational investment. Overlaying mandatory specialty models on MSSP participation fragments incentives, reduces clarity, and risks discouraging continued investment in shared APM infrastructure.

Standardized Measures Reduce Burden and Improve Standardization

Quality measurement is central to APMs, but today's landscape is fragmented and burdensome, with overlapping measures and duplicative reporting across APMs, MIPS, and specialty models. Providers participating in multiple CMS programs often face inconsistent requirements that divert resources from care delivery and undermine team-based accountability.

AMGA's Value Measure Set offers a streamlined, outcomes-focused alternative designed to support organizational accountability and reduce reporting burden. The 14 measures prioritize evidence-based outcomes that matter to patients and populations, addressing widespread duplication that requires practices to report hundreds of measures of limited value. Research shows physician practices spend more than $15.4 billion annually and an average of 785 hours per physician on quality reporting—costs that conflict with Congress' directive at 42 U.S.C. § 1395l(z)(3) to reduce clinician burden.

AMGA supports CMS' Universal Foundation as an important step toward cross-program alignment. Incorporating AMGA's Value Measure Set within this framework and applying it consistently across APMs and MSSP would further reduce burden, improve standardization, and allow participants to focus on care transformation rather than fragmented reporting requirements.

Conclusion

To support the national transition to high-value care and CMS' stated goal of placing all Medicare beneficiaries in accountable care relationships, AMGA urges the Department of Health and Human Services (HHS) and CMS to:

- Retain entity-level QP determinations and avoid a fragmented individual/entity

accountability structure.

- Reject mandatory specialty payment models and prioritize voluntary participation that reflects operational readiness.
- Align APM and MSSP requirements to eliminate duplicative reporting and conflicting incentives.
- Streamline quality measurement across APMs, MIPS, and specialty models by building on the Universal Foundation and incorporating AMGA's Value Measure Set to reduce duplicative reporting, support organizational accountability, and refocus provider resources on patient care.