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June 17, 2024

Chairman Ron Wyden  
U.S. Senate  
Committee on Finance  
Washington, DC 20510

Ranking Member Mike Crapo  
U.S. Senate  
Committee on Finance  
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo,

On behalf of AMGA and our members, I appreciate the opportunity to respond to your white paper on physician payment reform, *Current Challenges and Policy Options in Medicare Part B*. The system needs much reform, and we applaud your focus on this critical issue so that patients can access the best care available. Founded in 1950, AMGA represents more than 440 multispecialty medical groups and integrated delivery systems, representing about 175,000 physicians who care for one in three Americans. Our member medical groups work diligently to provide high-quality, cost-effective, patient-centered medical care. Congress must ensure that the necessary infrastructure is in place so AMGA members can continue to provide the highest quality care to their patients.

#### **Addressing Payment Update Adequacy and Sustainability**

As indicated in the Senate Finance Committee's white paper, decreasing reimbursement rates, coupled with increased labor and supply chain costs make providing quality care increasingly difficult year after year.<sup>i</sup> A more sustainable reimbursement system must be created so that providers are not subject to similar cuts during this critical time, and medical groups can continue caring for their communities.

Providers have faced almost 8% in cuts to Medicare Part B reimbursement over the past four years. Congress continues to pass partial, temporary patches to the Medicare Part B conversion factor (CF), which converts relative value units into an actual dollar amount. Medicare updates the CF annually according to a formula specified by statute and, importantly, within the constraints of Medicare Part B's budget-neutral financing system.<sup>ii</sup> However, in 2025, providers expect a larger conversion factor cut than last year, even with past partial relief provided by Congress.

Last year, AMGA surveyed its membership on what actions they would be forced to take if these Medicare Part B cuts continued. They were also asked what actions they took in 2023 in reaction to those Medicare cuts. Twenty-four percent of AMGA respondents either furloughed or laid off employees in 2023. Forty-nine percent of respondents said they will be forced to furlough or lay off employees in 2024 if the cuts continue. Additionally, 44% of these provider groups eliminated services to Medicare patients in 2023, and 65% expect to continue to do so in 2024. Twenty-one percent of respondents instituted delays in social determinants of health investments, and 57% are expected to continue these delays in 2024.<sup>iii</sup> Our members have also had to limit disease management programs for conditions such as palliative care, congestive heart failure, chronic obstructive pulmonary disease, and

diabetes. Another example of how the lack of steady reimbursements has led to less care coordination is that some of our members have halted medication management programs, as well as some home-based care medicine programs. All of those programs have been proven to lead to better care for patients, but with a strained reimbursement system, our members are having to make tough staffing and programmatic decisions. It is clear that continued Part B payment reductions will impact Medicare patients' access to care.

In addition to the past and looming cuts facing providers and patients, the CF includes no inflation-related annual adjustments to keep up with increasing practice expenses. As indicated in your analysis, in its March 2024 Report to Congress, the Medicare Payment Advisory Commission reported that clinicians' input costs are estimated to have grown faster than the historical trend and that the Medicare Economic Index (MEI) should be factored into annual payment adjustments.<sup>iv</sup> Please refer to the chart at the end of AMGA's comment to CMS for the CY 2024 Medicare Physician Fee Schedule proposed rule which illustrates the proposed decreases in physician payment compared to the actual costs of delivering care.<sup>v</sup> In order for medical groups and health systems to continue to invest in the infrastructure necessary to provide the best care, there must be a stable and predictable Medicare payment update so they can adequately budget for patient needs.

#### **Budget Neutrality Adjustments to the Conversion Factor**

We agree that budget neutrality policies currently in the Medicare system negatively impact patient access to care and the ability of providers to keep up with the cost of delivering care. As indicated in your analysis, the current budget neutrality threshold of \$20 million was enacted into law over 30 years ago when the Medicare population and spending were much less. AMGA supports raising this limit to at least \$53 million and allowing future triggers to consider the MEI when determining thresholds.<sup>vi</sup> Factoring increased costs into the practice of medicine is preferred over an across-the-board cut whenever policies are deemed to impact the overall outlay of the Medicare program. Stability and predictability are key tenets needed in the physician payment system.

#### **Incentivizing Participation in Alternative Payment Models**

Recently, the Centers for Medicare & Medicaid Services (CMS) announced that the Medicare Shared Savings Program (MSSP) saved the Medicare program \$1.8 billion in 2022 compared to spending targets. This marked the sixth consecutive year the MSSP generated overall savings compared to expected Medicare expenditures. It represents the second-highest annual savings accrued for Medicare since the program's inception over 10 years ago. About 63% of participating Accountable Care Organizations (ACOs) earned shared savings payments for their performance in 2022.<sup>vii</sup>

The success of the MSSP demonstrates the importance of the 5% Advanced Alternative Payment Model (APM) incentive payment. When the Medicare Access to CHIP Reauthorization Act of 2015 (MACRA) was enacted, it set in motion a transition to value-based Medicare physician payment. Part of the law created a 5% Advanced APM incentive, which provided a meaningful incentive to move toward value-based payment models. Congress temporarily extended the eligibility to earn incentive payments, which expires at the end of 2024. But after 10 years of MACRA, much work still needs to be done to ensure more providers make the transition to value. In fact, 386,000 Medicare providers are in the Advanced APM program, which accounts for less than 40% of the total amount of providers in the CY 2024 Physician Fee Schedule.<sup>viii</sup>

In addition to the lack of stability in the Advanced APM bonus structures, there are many other factors that make moving to value much more difficult than it ought to be. Incentives to participate in value

should remain permanent for providers. Policymakers should develop a common set of regulatory requirements and flexibilities for value-based models that do not vary. In the past, we have urged the administration to ensure providers are adequately reimbursed so they can invest in the infrastructure needed to deliver care in a value-based model. In addition, flexibilities regarding telehealth, skilled nursing care, and beneficiary incentives should not fluctuate based upon which model is being deployed. Otherwise, providers will need to adjust how they deliver care, which not only makes it difficult to apply any lessons learned in value-based models, but also serves as a disincentive to participate in a model. AMGA is concerned that regulations designed to mitigate fee-for-service incentives do not account for the significant investment required to engage in these population health models, including those that, for the time being, are in a shared-savings-only arrangement. Limiting waivers and beneficiary incentive opportunities to only certain models risks undermining efforts to promote value-based care under the Medicare program.<sup>ix</sup>

AMGA supports the improvement of financial benchmarking in the ACO program.<sup>x</sup> CMS continues to propose refinements that aim to improve the program's attractiveness for ACOs and support their active participation. With these improvements and reforms also comes inconsistency in an already unstable reimbursement model. If providers are to partner with the federal government, more predictable and consistent benchmarks would entice more of them to begin or continue their value journey.

AMGA supports the *Value in Health Care Act (Value Act)* (H.R. 5013/S. 3503) which reinforces the shift to value-based care by extending the 5% Advanced APM incentive payments for an additional two years. This legislation also strengthens the MSSP by updating it to recognize and reward ACOs. Specifically, the bill eliminates the artificial distinction between high- and low-revenue ACOs, revises benchmark development and shared savings policies, and mandates more technical assistance from the federal government. This legislation also establishes a voluntary ACO track to enable participants to take on higher levels of risk. Congress must extend this incentive payment program and implement reforms to the ACO program by approving the *Value Act*.

### **Reducing Physician Reporting Burden Related to MIPS**

As a transition to Advanced APMs, MACRA created the Merit-based Incentive Program (MIPS) to measure providers in fee-for-service (FFS) across four areas: quality, improvement activities, promoting interoperability, and cost.<sup>xi</sup> The MACRA law then required payment adjustments based upon these measures, but throughout the implementation of this policy, CMS has continued to exclude many providers through the low-volume threshold. AMGA has consistently emphasized that this threshold undermines the fundamental purpose of MIPS, which is to drive the transition toward value-based care. The promise of MIPS has never been realized because the low-volume threshold prevents top performers from achieving meaningful payment adjustments and instead excludes too many clinicians.

The substantial impact of this threshold is undeniable, as CMS projects that 603,302 clinicians in 2024 will not participate due to not meeting the criteria or opting out, even if they partially qualify. Among the 820,047 expected participants, payouts are diminished because clinicians who partially qualify can simply opt out if they anticipate negative adjustments.<sup>xii</sup> If value is the goal of MIPS, policymakers must not separate payment adjustments from quality reporting. Currently, MIPS is a regulatory compliance exercise, rather than a program for encouraging better quality of care, as it was intended. All providers need to be involved in this transition if real progress is to be made.

This is an ongoing problem. In fact, AMGA has long opposed the continuation of the low-volume threshold because of concerns that the number of clinicians excused from MIPS remains high. Excluding

such a large number of clinicians who would otherwise be required to participate in MIPS will continue to have adverse consequences for both those who participate in the program and those who do not. Due to the budget-neutral nature of MIPS, eliminating a substantial percentage of MIPS participants collapses the range of positive and negative Composite Performance Scores, which in turn causes a substantial decline in the payment adjustments that providers will earn. For example, CMS estimates about 93% of clinicians will receive a neutral or positive payment adjustment for the 2020 performance period. Conversely, approximately 8% will receive a negative payment adjustment.

Such a lopsided distribution of scores creates an unsustainable reimbursement system and undermines congressional intent for the program. It does not provide a realistic and meaningful opportunity to earn a payment adjustment of up to 9%, as authorized by Congress. Instead, CMS estimates the maximum payment adjustment will be between 6.9% and 7.4%, and the aggregate adjustment will be 1.3%. This estimate is misleading, however, as all payment adjustments of more than a positive 1% are possible only through the exceptional performance bonus. As illustrated in Figure A on page 50319 of the Federal Register, those who earn a score higher than the performance threshold but below the exceptional performance score can expect a nominal update. CMS also notes it is possible that even more clinicians will score higher than the performance threshold, which will further reduce the payment adjustments.<sup>xiii</sup>

Reporting requirements as well as various rules contribute to the administrative burden that AMGA members face every day when trying to develop a value-based care program to benefit patients. At the end of the document, please refer to Table 1, which is a list of rules and regulations that could be eliminated or reformed as they don't contribute to the value of patient care and actually hinder many of our members in their efforts to provide care for their patient population.

### **Supporting Chronic Care Benefits in FFS**

Chronic care management (CCM) is a critical part of coordinated care. As a result, Medicare began reimbursing physicians for CCM under a separate billing code in the Medicare Physician Fee Schedule in 2015. This code is designed to reimburse providers for non-face-to-face care management. Providers and care managers have discovered several positive outcomes for CCM beneficiaries, including improved patient satisfaction and adherence to recommended therapies, improved clinician efficiency, and decreased hospitalizations and emergency department visits.<sup>xiv</sup>

Currently, the U.S. Preventive Services Task Force does not classify CCM as a preventive service, consequently requiring providers to charge and collect a 20% coinsurance fee from beneficiaries for these services. This cost-sharing requirement creates a barrier to care, as beneficiaries are not accustomed to cost-sharing for care management services. This is also an additional administrative burden for providers to bill and collect these coinsurance fees. The latest data reveals that only 4% of Medicare beneficiaries potentially eligible for CCM received these services, amounting to 882,000 out of a potential pool of 22.5 million eligible CCM beneficiaries.<sup>xv</sup>

AMGA contends that eliminating the coinsurance payment for Medicare beneficiaries receiving CCM services would facilitate more comprehensive management of chronic care conditions and improve the health of Medicare patients. AMGA, along with 26 healthcare stakeholder groups, sent an endorsement letter of this policy to your committee on April 11 in anticipation of your hearing on chronic care reform. These organizations agree that removing the coinsurance payment requirement would facilitate more comprehensive management of chronic care conditions and improve the health of Medicare patients. Additionally, eliminating patient coinsurance may facilitate greater care coordination for vulnerable patient populations.<sup>xvi</sup> Reps. Suzan DelBene (D-WA) and Jeff Duncan (R-SC) introduced the AMGA-

endorsed Chronic Care Management Improvement Act (H.R. 2829), which waives Medicare's CCM code coinsurance requirement. Passage of this legislation will ensure patients have access to more integrated care.

### **Patient Engagement**

Patient engagement is the cornerstone of value-based care delivery. Patients play a crucial role in their own healthcare, and it is crucial to foster a more personalized and patient-centered approach to care. Patients should experience tangible benefits that positively impact their health outcomes and overall satisfaction with their healthcare. In addition to benefiting the patient, this shift toward patient engagement and empowerment will additionally benefit providers by reducing administrative burden as the patients take on more responsibility in their care experiences.<sup>xvii</sup> Potential policy actions include:

- Develop strategies that actively involve and engage patients for a more proactive approach to healthcare. By actively involving patients in decision-making processes and treatment plans, we can provide patients with a more seamless and integrated care experience.
- Incentivize patients to actively participate in their care. This not only aligns with the ethos of value-based care, but also reinforces the idea that engaged and empowered patients contribute to the sustainability of value-based care models. For this reason, incentives for individuals to save money through preventive measures should be integrated into patient engagement strategies.
- Prioritize empowerment through education to promote preventative care and early detection of health issues. The engaged patient is more likely to adhere to treatment plans, participate in preventative care, and effectively manage chronic conditions.
- Highlight the lack of cost-sharing exemption in existing codes, such as chronic care management, and how this results in both confusion and underuse of the codes. Address this gap by encouraging providers to utilize available codes to benefit their patients.
- Propose that being a patient in an ACO should carry certain benefits. Develop specific benefits for patients within coordinated care plans.

### **Telehealth**

AMGA applauds the committee's support of telehealth in the Medicare program. Telehealth experienced an unprecedented expansion during the COVID-19 pandemic, ushering in a new era of patient access to care as a result of policymakers waiving certain Medicare requirements for telehealth. In the years following the pandemic, patients have come to expect telehealth as a standard service from their provider. To maintain this standard, policymakers need to waive geographic limitations and originating site requirements permanently, continue payment parity for in-office and telehealth services, and continue separate payments for audio-only services.

We thank you for your consideration of our comments. Should you have questions, please do not hesitate to contact AMGA's Senior Director of Government Relations James Miller at 703.838.0033 ext. 341 or [jmiller@amga.org](mailto:jmiller@amga.org).

Sincerely,



Jerry Penso, MD, MBA  
 President and Chief Executive Officer, AMGA

**Table 1.**

<b>Barrier</b>	<b>Issue</b>	<b>Citations/Reference Points</b>
<b>Prior Authorization</b>	The prior authorization process leads to payment reductions due to cumbersome requirements and errors, resulting in payers forgoing payment for appropriate medical services.	42 CFR Chapter IV, Subchapter B: §422.122, §422.568, §422.570, §422.572
<b>Merit-based Incentive Payment System (MIPS)- Low Volume Threshold</b>	Exempting too many providers from the Merit-Based Incentive Payment System (MIPS) undermines the program and minimizes rewards available due to budget neutrality requirements.	42 CFR Chapter IV, Subchapter B §414.1310
<b>Patient-Threshold Requirements for CMS Value-Based Care Models</b>	Arbitrary minimum patient numbers eliminate smaller, non-urban practices from participation in CMS value-based programs.	<a href="#">CMMI models: Request for Application</a>
<b>Telehealth Prescription of Controlled Medication</b>	Expiring flexibilities for telehealth prescriptions of controlled medications will burden patients and providers.	42 CFR Part 12 Chapter II § 1307.41
<b>Excessive Penalties for Information Blocking</b>	Pending regulations could result in significant disincentives for Medicare-enrolled providers accused of information blocking.	45 CFR Part 171; RIN 0955-AA05; 21st Century Cures Act
<b>Face-to-Face Requirements for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)</b>	Unclear Medicare rules for durable medical equipment cause administrative burdens and care delays.	42 CFR 410.38(d)(2)
<b>DMEPOS Written Order/Prescription</b>	Documentation requirements for durable medical equipment orders add unnecessary burdens.	42 CFR 410.38(d)(1)
<b>Home Health Services Timeframe Requirements</b>	Rescheduling visits requires physician permission, creating administrative burdens.	42 CFR 424.22(b)(1)
<b>Skilled Nursing Facility 3-Day Rule</b>	Requirement for a 3-consecutive-day inpatient hospital stay prevents appropriate care settings.	Section 1861(i) of the Social Security Act and 42 CFR 409.30
<b>Medicare Advantage Surveys</b>	Patients need help understanding surveys, potentially leading to negative penalties for providers.	42 CFR 422.162(a) "CAHPS"
<b>Dual-Special Needs Plans (D-SNP) Education for Providers</b>	Redundant education requirements for providers increase administrative burdens.	42 CFR 422.107(c)
<b>Documenting Suspect Conditions from Home Assessments</b>	Inaccurate "suspect" conditions must be documented, potentially leading to care denials.	42 CFR 424.22(c)(1)
<b>Preferred Provider List</b>	Providing a list of preferred post-acute care facilities can improve patient outcomes and care	<a href="#">Next Generation ACO Demonstration</a>

	coordination. This policy should be extended beyond the Next Generation ACO demonstration and apply to all providers in Medicare value-based arrangements.	
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<sup>i</sup> Senate Committee on Finance, (2024, May 17), *Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B* (White Paper), [finance.senate.gov/imo/media/doc/051723\\_phys\\_payment\\_cc\\_white\\_paper.pdf](https://finance.senate.gov/imo/media/doc/051723_phys_payment_cc_white_paper.pdf)

<sup>ii</sup> Medicare Payment Advisory Commission, (2023, October), *Physician and Other Health Professional Payment System*, [medpac.gov/wp-content/uploads/2022/10/MedPAC\\_Payment\\_Basics\\_23\\_Physician\\_FINAL\\_SEC.pdf](https://medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_Physician_FINAL_SEC.pdf)

<sup>iii</sup> AMGA, (2024), Stop the Cuts Survey Results, [amga.org/getmedia/75400037-5d72-48e9-94e0bedf7fb2dd73/AMGA\\_CY24\\_MA\\_Advance\\_Notice\\_Final\\_3-6-23.pdf](https://amga.org/getmedia/75400037-5d72-48e9-94e0bedf7fb2dd73/AMGA_CY24_MA_Advance_Notice_Final_3-6-23.pdf)

<sup>iv</sup> Medicare Payment Advisory Commission, (March 2024), Report to the Congress: Medicare Payment Policy Chapter 4, pp. 87-127, [medpac.gov/wp-content/uploads/2024/03/Medicare-Payment-Policy-Chapter-4.pdf](https://medpac.gov/wp-content/uploads/2024/03/Medicare-Payment-Policy-Chapter-4.pdf)

<sup>v</sup> AMGA letter on CY 2024 Physician Fee Schedule, (2023, September 11), [amga.org/AMGA/media/PDFs/Advocacy/Public\\_Policy/letters/AMGA\\_CY24\\_PFS\\_Comment\\_9\\_11\\_23\\_Letter\\_FINAL.pdf](https://amga.org/AMGA/media/PDFs/Advocacy/Public_Policy/letters/AMGA_CY24_PFS_Comment_9_11_23_Letter_FINAL.pdf)

<sup>vi</sup> Coalition letter on Medicare physician payment budget neutrality policies, (2023, October 31), [searchf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Ffsohn.zip%2F10-31-2023-Signed-On-Letter-Budget-neutrality.pdf](https://searchf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Ffsohn.zip%2F10-31-2023-Signed-On-Letter-Budget-neutrality.pdf)

<sup>vii</sup> Centers for Medicare & Medicaid Services, (2023, August 24), Medicare Shared Savings Program Saves Medicare More Than \$1.8 Billion in 2022 and Continues to Deliver High-quality Care (Press Release), [cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-andcontinues-deliver-high-quality-care](https://cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-andcontinues-deliver-high-quality-care)

<sup>viii</sup> Quality Payment Program, Participation and Performance Data, [qpp.cms.gov/resources/participation-and-performance-data](https://qpp.cms.gov/resources/participation-and-performance-data)

<sup>ix</sup> AMGA, *RE: Request for Information (RFI): HHS Initiative to Strengthen Primary Health Care*, (2022, August 1) [amga.org/getmedia/630af5f8-4b7c-45d7-9f4d-50c29c23332e/OASH\\_Primary\\_Care\\_RFI\\_Comment\\_Letter\\_080122.pdf](https://amga.org/getmedia/630af5f8-4b7c-45d7-9f4d-50c29c23332e/OASH_Primary_Care_RFI_Comment_Letter_080122.pdf)

<sup>x</sup> AMGA letter on CY 2024 Physician Fee Schedule, (2023, September 11), [amga.org/AMGA/media/PDFs/Advocacy/Public\\_Policy/letters/AMGA\\_CY24\\_PFS\\_Comment\\_9\\_11\\_23\\_Letter\\_FINAL.pdf](https://amga.org/AMGA/media/PDFs/Advocacy/Public_Policy/letters/AMGA_CY24_PFS_Comment_9_11_23_Letter_FINAL.pdf)

<sup>xi</sup> Quality Payment Program, Traditional MIPS Overview, [qpp.cms.gov/mips/traditional-mips](https://qpp.cms.gov/mips/traditional-mips)

<sup>xii</sup> AMGA letter on CY 2024 Physician Fee Schedule, (2023, September 11), [amga.org/AMGA/media/PDFs/Advocacy/Public\\_Policy/letters/AMGA\\_CY24\\_PFS\\_Comment\\_9\\_11\\_23\\_Letter\\_FINAL.pdf](https://amga.org/AMGA/media/PDFs/Advocacy/Public_Policy/letters/AMGA_CY24_PFS_Comment_9_11_23_Letter_FINAL.pdf)

<sup>xiii</sup> AMGA letter on Medicare Fee Schedule Proposals for 2021, (2020, October 5), [cms.amga.org/AMGA/media/PDFs/Advocacy/Correspondence/CMS%20Correspondence/Physician%20Fee%20Schedule/Cmts-on-Medicare-Fee-Schedule-Proposals-for-2021.pdf?\\_gl=1\\*1ffc6zq\\*\\_gcl\\*\\_au\\*MTEwMDYzMzIzLjE3MTU3ODY0ODU.\\*\\_ga\\*MjAxOTc4NTg1OS4xNzAwMDc2MDYz\\*\\_ga\\_7RDR78RJMM\\*MTcxNzc4MzMwNC45My4xLjE3MTc3ODQ4NTUuNjAuMC4w](https://cms.amga.org/AMGA/media/PDFs/Advocacy/Correspondence/CMS%20Correspondence/Physician%20Fee%20Schedule/Cmts-on-Medicare-Fee-Schedule-Proposals-for-2021.pdf?_gl=1*1ffc6zq*_gcl*_au*MTEwMDYzMzIzLjE3MTU3ODY0ODU.*_ga*MjAxOTc4NTg1OS4xNzAwMDc2MDYz*_ga_7RDR78RJMM*MTcxNzc4MzMwNC45My4xLjE3MTc3ODQ4NTUuNjAuMC4w)

<sup>xiv</sup> Schurrer, et. al., Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report, CMS, 2017, [innovation.cms.gov/files/reports/chronic-care-mngmt-finalevalrpt.pdf](https://innovation.cms.gov/files/reports/chronic-care-mngmt-finalevalrpt.pdf)

<sup>xv</sup> Colligan, et. al., Analysis of 2019 Medicare Fee-for-Service (FFS) Claims for Chronic Care Management (CCM) and Transitional Care Management (TCM) Services, ASPE, 2022, [aspe.hhs.gov/sites/default/files/documents/31b7d0eeb7decf52f95d569ada0733b4/CCM-TCM-DescriptiveAnalysis.pdf](https://aspe.hhs.gov/sites/default/files/documents/31b7d0eeb7decf52f95d569ada0733b4/CCM-TCM-DescriptiveAnalysis.pdf)

<sup>xvi</sup> AMGA, Coalition letter on chronic care management, (2024, April 11), [amga.org/AMGA/media/PDFs/Advocacy/Coalition%20letters/CCM\\_Senate\\_Finance\\_coalition\\_April\\_2024\\_Letter\\_FINAL.pdf](https://amga.org/AMGA/media/PDFs/Advocacy/Coalition%20letters/CCM_Senate_Finance_coalition_April_2024_Letter_FINAL.pdf)

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<sup>xvii</sup> Centers for Medicare & Medicaid Services, Patient Role in Value-Based Care, [cms.gov/priorities/innovation/key-concepts/patient-role-in-vbc](https://www.cms.gov/priorities/innovation/key-concepts/patient-role-in-vbc)