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September 9, 2024

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) **CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments [CMS-1807-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 2025 Physician Fee Schedule (PFS) Proposed Rule for your consideration. Specifically, we are providing comments on the following:

- **Conversion Factor Decrease:** AMGA opposes the proposed 2.8% cut to the conversion factor, which threatens provider sustainability and undermines value-based care. We also recommend renaming the Medicare Physician Fee Schedule to the Medicare Ambulatory Services Fee Schedule (MASFS) to better reflect the broad range of providers it covers and to improve public understanding of what is paid under the fee schedule, supporting more accurate policy discussions and the shift to value-based care.
- **G2211:** AMGA supports CMS' proposal to lift the restriction on payment for G2211 when the other outpatient (O/O) evaluation and management (E/M) code is reported on the same day as preventive services, as it promotes continuity of care.
- **Telehealth:** AMGA commends CMS for recognizing the critical role of telehealth in expanding access to care and supports the permanent extension of key flexibilities, including payment parity and the removal of geographic restrictions. We urge CMS to

work with Congress to codify these changes. AMGA also appreciates the extension of protections for provider privacy and urges CMS to make these measures permanent.

- **Supervision & Teaching Policies:** AMGA supports the proposal to extend the virtual presence of teaching physicians during telehealth visits through 2025.
- **Expansion of Advanced Care Management Codes:** AMGA supports the establishment of new HCPCS codes for Advanced Primary Care Management (APCM) services but urges CMS to ensure these codes are accessible to all providers by reconsidering the restrictive billing requirements.

  Behavioral Health Access: AMGA supports CMS' efforts to expand coding and payment for various behavioral health services.
- **Medicare Shared Savings Program:** AMGA supports the proposed updates to the Medicare Shared Savings Program (MSSP) but emphasizes the need for consistency in program rules to ensure ACOs can continue delivering high-quality, value-based care without disruption.
- **Quality Payment Program:** AMGA is concerned that the proposed updates to the Quality Payment Program (QPP) may increase fragmentation and administrative burden and urges CMS to focus on changes that support integrated, patient-centered care while minimizing complexity.

Conversion Factor Decrease

Comment: AMGA strongly opposes the proposed 2.8% cut to the conversion factor, as it is unsustainable for our members and undermines the shift to value-based care. This reduction, combined with ongoing inflation and budget neutrality adjustments, exacerbates financial strains on healthcare providers, widening the gap between Medicare reimbursement rates and the actual cost of care. AMGA also advocates for renaming the Medicare Physician Fee Schedule to the Medicare Ambulatory Services Fee Schedule (MASFS). This change would more accurately reflect the broad spectrum of healthcare providers reimbursed under the fee schedule, enhance public understanding of the services reimbursed under this fee schedule, and support the transition towards interdisciplinary, value-based care.

AMGA is deeply concerned by the proposed 2.8% cut to the conversion factor. This reduction is unsustainable for AMGA's membership and threatens to undermine the ongoing shift towards value-based care. Transitioning to value-based care requires significant upfront investment from practices. The current system, which largely does not account for inflation, has created a significant gap between reimbursement and the cost to provide care, discouraging this investment. For example, this year, the proposed 2.8 % cut to the conversion factor comes in conjunction with a projected 3.6 % increase in the Medicare Economic Index (MEI) for 2025. Yearly reductions to the conversion factor have required Congress to provide legislative relief on a nearly annual basis. While these increases are necessary to preserve access to care, the uncertainty of congressional intervention and wait for relief further discourages investment in establishing or enhancing value-based care infrastructure. For example, the 2.93% increase provided to the 2024 conversion factor by the Consolidated Appropriations Act, 2024 (2024 CAA) was not passed until March. When practices are not reimbursed sufficiently, and any reimbursement relief is delayed until practices have already created their budgets, it is nearly impossible to set aside funds for transition to value.

More immediately, AMGA members will be forced to consider a number of actions to prepare for yet another cut in the conversion factor, along with other expected cuts in Medicare, such as $36 billion in PAYGO reductions. In light of these cuts, AMGA members report they either already have or will implement hiring freezes, furlough staff, delay population health initiatives, eliminate or delay investments to address social drivers of health, and eliminate services. Further, AMGA members report they either are or will no longer accept new Medicare beneficiaries. CMS should not finalize the proposed cut in the conversion factor.

The Medicare Payment Advisory Commission (MedPAC) has recognized the unsustainability of the current system of annual conversion factor updates. To address this flaw, MedPAC is currently exploring a system that would provide annual updates to fee schedule payment rates equal to the MEI minus 1 percentage point. While AMGA does not believe that 1 percentage point needs to be subtracted from the MEI update, especially given the significant gap between cost and payment that has built up from years of insufficient updates, we are encouraged that other stakeholders recognize the current system of annual updates under the Medicare Access CHIP Reauthorization Act (MACRA) is fundamentally broken.

To ensure policymakers fully understand the purpose and role of the Physician Fee Schedule, AMGA strongly recommends that CMS consider renaming the Medicare Physician Fee Schedule (MPFS) to the Medicare Ambulatory Services Fee Schedule (MASFS). The current name not only fails to accurately represent the scope and purpose of the fee schedule but also perpetuates misconceptions that influence policy discussions in a way that is not aligned with the realities of modern healthcare delivery.

The term "Physician Fee Schedule" implies that the fee schedule pertains exclusively to physicians, overshadowing the broad range of Part B clinicians, including nurse practitioners, physician assistants, and various therapists, who are also reimbursed under this schedule. This misrepresentation can lead to skewed policy decisions that do not fully consider the diverse array of healthcare providers impacted by these rates. The term “Physician Fee Schedule” also implies these payments go directly to the physician.

AMGA is concerned the ongoing discussions about reforms to Medicare Part B will be hindered by misconceptions about how the fee schedule functions. Specifically, the current name may lead to the erroneous belief that MPFS reimbursement directly influences physician compensation. Local market forces—such as regional demand for services, cost of living, and competition among healthcare providers—play a much larger role in determining physician compensation levels. The MPFS does not directly dictate individual physician salaries; rather, it is one of many factors that influence compensation.

By renaming the MPFS to the Medicare Ambulatory Services Fee Schedule, CMS can help clarify that physician compensation is influenced by a variety of market dynamics, beyond just Medicare reimbursement rates. This change is necessary to correct misconceptions, improve public understanding, and facilitate more accurate and inclusive policy discussions. It would better reflect the realities of modern healthcare delivery, recognize the contributions of all ambulatory care providers, and support the ongoing evolution towards value-based care.

G2211

> **Comment:** AMGA supports CMS' proposal to lift the restriction on payment for G2211 when billed with same-day O/O E/M and preventive services, as it promotes continuity of care.

AMGA commends CMS for recognizing the additional time and resources necessary to build and sustain a long-term, trusting relationship with patients. We share concerns that the current restriction on payment for G2211 when it is billed alongside a same-day office outpatient evaluation and management (O/O E/M) visit and/or a preventive service conflict with the policy's intended goal. Therefore, we support CMS's proposal to remove this restriction, as it better aligns with the goal of fostering continuous, comprehensive care.

In addition, we urge CMS to better educate patients on the fact that, while there is no cost sharing associated with the annual wellness visit (AWV), other services provided during that visit, such as G2211, will result in a co-pay. We believe that many patients will be confused when they are billed a copay for G2211 when provided on the same day as the AWV once this policy becomes effective.

Telehealth

> **Comment:** AMGA commends CMS for extending key telehealth flexibilities, including payment parity and the use of any location for patient care, and urges collaboration with Congress to make these changes permanent. We also appreciate CMSs efforts to protect provider privacy by allowing the use of practice locations instead of home addresses for telehealth services and strongly advocate for making this flexibility permanent.

AMGA appreciates CMS' recognition of the vital role telehealth has played in expanding access to care, particularly during the COVID-19 public health emergency (PHE). While we acknowledge that CMS's authority to extend certain critical telehealth flexibilities is limited, we commend the agency for maintaining the flexibilities it can. We urge CMS to work with Congress to make payment parity between telehealth services and an in-person office visit, and the ability for patients to receive telehealth services from any location, including their homes, permanent. Without permanent waivers of the geographic and originating site restrictions, telehealth utilization risks regressing to pre-pandemic levels, which would disproportionately impact disadvantaged populations that face barriers to receiving in-person care. AMGA members report they would decrease the availability of telehealth services if payments were reduced.

AMGA also appreciates CMS' extension of audio-only telehealth services and acknowledges the agency's efforts to extend telehealth flexibilities to the full extent of its authority. We view the preservation of payment parity and provider enrollment as significant victories for patient care and provider support. To solidify these gains, we strongly encourage CMS to garner Congressional support for the permanent codification of these flexibilities.

Finally, AMGA expresses gratitude for CMS's diligence in addressing our concern about the implications of requiring providers to report their home addresses when delivering telehealth services from their homes. We commend CMS for proposing to extend the flexibility that allows

distant site practitioners to use their currently enrolled practice location rather than their home address through CY 2025. This change is critical for protecting the privacy and safety of healthcare workers, and AMGA strongly urges CMS to make this flexibility permanent.

Supervision & Teaching Policies

> **Comment:** AMGA supports CMS's proposal to extend the virtual presence of teaching physicians during telehealth visits through 2025, as it enhances medical education and ensures high-quality patient care, building on valuable lessons learned during the COVID-19 PHE.

AMGA supports CMS's proposal to extend the ability for teaching physicians to maintain a virtual presence while providing real-time observation of residents during telehealth visits through 2025. This flexibility, introduced during the COVID-19 public health emergency (PHE), has proven invaluable in ensuring continuity of medical education while adapting to the challenges of a rapidly changing healthcare environment. AMGA believes this policy is a crucial component of the lessons learned during the PHE and should be extended to support the evolving needs of both medical education and patient care in a telehealth context.

Expansion of Advanced Care Management Codes

> **Comment:** AMGA supports the establishment of new HCPCS codes for Advanced Primary Care Management (APCM) services but urges CMS to ensure these codes are accessible to all providers by reconsidering the restrictive billing requirements. Broad accessibility is crucial for maximizing the impact of APCM services and ensuring comprehensive care for patients.

AMGA supports CMS' initiative to establish new HCPCS codes for Advanced Primary Care Management (APCM) services, recognizing the value these codes bring by integrating elements of existing care management services into a comprehensive model that reflects advanced primary care delivery. However, AMGA is concerned that the proposed requirement to report through the Value in Primary Care MIPS Value Pathway (MVP) as a condition for payment might limit the accessibility and utilization of these codes. To ensure that APCM services are fully utilized and reach their intended impact, AMGA urges CMS to consider broader accessibility and flexibility in the reporting requirements, allowing more providers to adopt and benefit from these codes. Making the APCM codes as accessible as possible is essential to promoting their widespread use and ensuring that patients receive the full scope of care management services they need.

Behavioral Health Access

> **Comment:** AMGA supports CMS' efforts to expand coding and payment for various behavioral health services.

AMGA supports CMS' plans to extend Part B coverage and reimbursement for safety planning interventions for patients in crisis and digital mental health treatment devices. This forward-thinking approach underscores the importance of addressing behavioral health as a critical component of overall patient care. By enhancing coverage for these essential services, CMS is taking a significant step toward improving access to timely and effective mental health

interventions. AMGA commends this initiative and believes it will positively impact patient outcomes by ensuring that individuals in crisis receive the support they need while also promoting the integration of digital mental health solutions into mainstream care.

AMGA also supports the exploration of coding and payment options for Intensive Outpatient Programs (IOPs), recognizing their crucial role in providing structured, intensive care for individuals with severe mental health needs. Appropriate coding and payment would enhance access to these valuable services and support better patient outcomes.

Medicare Shared Savings Program

Comment: While AMGA supports many of the concepts of the proposed changes to the Medicare Shared Savings Program (MSSP), such as the addition of a Health Equity Benchmark Adjustment (HEBA), we are generally concerned that ongoing adjustments to MSSP policies will disrupt providers' ability to make long-term investments in the program.

Benchmark Methodology

CMS proposes to update benchmarking methodology for Accountable Care Organizations (ACOs) by introducing a third benchmarking method- a Health Equity Benchmark Adjustment (HEBA). Under this proposal, CMS would adjust an ACO's historical benchmark using the most favorable outcome from three potential adjustments: a positive regional adjustment, the prior savings adjustment, or the HEBA, which is determined by the proportion of an ACO's beneficiaries who are low-income or dually eligible for Medicare and Medicaid. While AMGA recognizes the importance of advancing health equity, we have concerns about the complexity and unpredictability of this model.

The introduction of three potential benchmark adjustments creates uncertainty and volatility in setting financial targets. The difficulty in predicting which benchmark will be applied could lead to negative financial outcomes if ACOs fail to meet the benchmarks set by these variable adjustments. This unpredictability could affect financial stability and overall program effectiveness.

Additionally, AMGA also raises concerns about the potential for unfair competition under the proposed rule. ACOs in higher-cost regions might benefit disproportionately from regional adjustments, while those serving a larger number of low-income beneficiaries could gain more from the HEBA. Additionally, ACOs with significant prior savings could be penalized if their adjustment is not the most favorable, putting them at a disadvantage compared to ACOs that have not yet achieved such savings.

Move Towards Health Equity

Health equity is a fundamental priority in transforming healthcare systems, ensuring that all individuals have equitable access to high-quality care and the opportunity to achieve optimal health outcomes. Integrating health equity into Medicare programs is vital for addressing disparities and improving care for underserved populations. However, while incorporating health equity into ACO benchmarks is a significant stride toward this goal, it also introduces long-term, multistakeholder challenges that may not be fully resolved through benchmark adjustments alone.

AMGA acknowledges the critical importance of advancing health equity and is committed to working closely with CMS and other stakeholders to identify and implement effective solutions.

Move Towards Universal Foundation of Quality Measures
AMGA supports the proposed realignment and standardization of quality measures by moving the Shared Savings Program towards the Universal Foundation of quality measures. This shift aims to simplify reporting across programs, reducing administrative burden, and improve overall quality and efficiency.

Reporting Quality Measures
AMGA acknowledges the proposed transition from MIPS CQMs to eCQMs and the introduction of the Complex Organization Adjustment (COA) as efforts to improve the accuracy of quality reporting and address the unique challenges faced by large ACOs. The COA's recognition of these challenges, by offering additional flexibility in meeting reporting requirements, is an important consideration.

However, AMGA has concerns that the COA may not fully address the difficulties encountered by large physician groups, particularly if scoring policies remain restrictive or if the 10-point cap per measure is too limiting. Further refinements to this policy, such as the addition of support mechanisms to assist large ACOs adapt to the new requirements, would maintain the integrity and objectives of quality reporting while not disproportionately burdening large ACOs.

AMGA also continues to object to the requirement transition away from the CMS Web Interface, which will no longer be available for ACO quality reporting in 2025. Instead, ACOs would be required to report quality data using eCQMs, MIPS CQMs, and/or Medicare CQMs. AMGA remains concerned the timeline for this transition is not feasible and vendors will not be able to support ACOs with reporting the under the eCQM option in the 2024 performance year.

Prepaid Shared Savings Program
AMGA supports the overall goals of the prepaid shared savings proposal, particularly its emphasis on beneficiary engagement and care improvement. However, AMGA has concerns about the financial risks and administrative complexities associated with this initiative and advocates for refinements to ensure that ACOs are supported without facing undue financial burdens.

AMGA is particularly encouraged by the proposal's focus on enabling ACOs to invest directly in beneficiary services, care coordination, and healthcare infrastructure. The flexibility to allocate prepaid shared savings with a 50/50 split between beneficiary services and infrastructure allows ACOs to tailor their investments to meet specific needs, aligning with AMGA’s goals of enhancing care delivery and improving patient outcomes.

Despite these benefits, AMGA is concerned about the financial risks tied to the proposal. The requirement for ACOs to repay prepaid shared savings if they do not meet savings targets could pose significant challenges, especially for smaller or newer ACOs or those operating in volatile markets. In fact, ACOs may be hesitant to opt for a pre-payment option if it is unclear how or when it will be paid back. This financial obligation could deter participation or create instability, even among ACOs that are otherwise performing well.

To address these concerns, AMGA advocates for a balanced approach that mitigates financial risks while still incentivizing effective care improvements. AMGA is pushing for additional safeguards and support mechanisms to help ACOs manage financial responsibilities without compromising their stability. Furthermore, AMGA calls for detailed guidelines from CMS on repayment terms, eligible investments, and monitoring processes to ensure that the proposal is implemented effectively and transparently.

Revised Shared Savings Eligibility Requirement
AMGA supports the proposal to revise Shared Savings Program eligibility requirements by allowing ACOs that fall below the 5,000 assigned beneficiaries threshold until the time of renewal to meet the requirement. This flexibility is crucial for ensuring the long-term stability of ACOs. However, AMGA requests that CMS consider even more flexibility, such as additional support or adjustment periods for ACOs facing significant challenges, and a more gradual enforcement approach for newer or smaller ACOs still developing their infrastructure.

Expanding Beneficiary Assignment Methodology
AMGA supports the proposal to revise the definition of primary care services for beneficiary assignment, as it aligns with our focus on integrated and coordinated care. This change is expected to improve ACOs' ability to capture the full scope of care provided and ensure accurate beneficiary assignment, benefiting both care coordination and financial performance. AMGA advocates for further expansions or clarifications to the definition to ensure it reflects real-world practices and minimizes administrative burdens.

Beneficiary Notification Requirement
AMGA supports the proposed modifications to beneficiary notification follow-up requirements, as they significantly reduce the administrative burden on ACOs. Streamlining these processes allows providers to maintain smoother clinical workflows and use resources more efficiently, making the changes a positive development for improving operational efficiency.
The solicitation for comments on potential future developments is a commendable step towards shaping a more effective and responsive program. As discussions progress, prioritizing transparency and active engagement will be crucial to achieving an impactful and sustainable Shared Savings Program that advances the goals of value-based care.

Quality Payment Program

> **Comment:** AMGA is concerned that the proposed updates to the Quality Payment Program (QPP) could lead to increased fragmentation and administrative burden. While intended to streamline reporting, these changes may disrupt care coordination and shift the program towards a compliance-focused approach. AMGA advocates for CMS to enact updates that better support integrated, patient-centered care and reduce unnecessary administrative complexity.

New MIPS Pathways
CMS is proposing six new MIPS Value Pathways (MVPs) in ophthalmology, dermatology, gastroenterology, pulmonology, urology, and surgical care to better align the Quality Payment Program (QPP) with clinicians' specialties. However, AMGA raises concerns that this approach may inadvertently fragment care coordination, encouraging clinicians to operate within narrow

specialty silos. Such fragmentation could undermine the integrated, team-based care essential for managing complex patient needs and ultimately impact the quality and continuity of care.

Updating MVP Scoring Proposal
For the 2025 performance year, CMS is proposing updates to MVP scoring, including using the highest available score for population health measures and eliminating the requirement for MVP participants to select measures at registration. Cost performance scoring will align with traditional MIPS policies, and improvement activities will be simplified to 40 points each, requiring only one activity for full credit. While AMGA supports aligning cost performance scoring with traditional policies, we express concern that focusing on specialty-specific MVPs may fragment the quality measurement system, detracting from care integration.

AMGA recognizes that aligning these scoring mechanisms with traditional MIPS policies could help create consistency and reduce administrative burdens. However, AMGA asserts that further improvements to the traditional MIPS program are necessary to ensure these changes effectively support a transition to value-based care. AMGA advocates for maintaining traditional MIPS reporting as an ongoing option and opposes a full transition to MVPs. Providers should maintain the option to report via MIPS as originally designed.

Overall, AMGA is concerned that the proposed updates could further isolate improvements in specialty areas rather than enhancing overall patient care. The flexibility granted to subgroups for Promoting Interoperability data reporting is a positive step, however, it may not adequately address fragmentation. A cohesive strategy is essential for improving care coordination.

To address concerns about care fragmentation, while also providing an opportunity for specialists, AMGA recommends CMS develop an MVP for multispecialty group practices. These practices caregivers, who specialize in different areas, yet work together as part of a cohesive team to best address the care needs of their patients. Such an MVP would build off earlier reporting options, such as the Group Practice Reporting Option (GPRO), which as originally model after CMS demonstration projects and designed based AMGA input. Reporting as a group allows for a practice to report one set of quality measures that reflect the efforts of the group, rather than eligible professionals as individuals. AMGA previously endorsed a set of 14 quality measures, which would be an appropriate set of measurements for inclusion in a multispecialty group MVP. AMGA would be pleased to work with CMS on the development of a multispecialty group practice MVP.

New Quality Measure Set
CMS plans to introduce an APP Plus quality measure set within the APM Performance Pathway, allowing MIPS eligible clinicians to choose between the APP and APP Plus sets. AMGA is concerned this could increase the administrative burden on providers, complicating compliance with overlapping metrics. This growing burden on APMs seems disproportionate, especially since the MIPS program itself remains underdeveloped in addressing its existing challenges. While the idea of a universal measure set is supported, AMGA emphasizes that fewer, more meaningful measures would better serve to streamline reporting and enhance care quality.

Data Submission Requirements
CMS proposes new criteria for data submissions within the MIPS program and APP, requiring minimum qualifications across categories. For Quality and Improvement Activities, submissions

must include numerator and denominator data for at least one measure and affirm participation in one improvement activity. For Promoting Interoperability, submissions need performance data, attestations, and other specific information.

AMGA finds the proposed submission requirements generally acceptable but raises concerns about the increasing complexity, particularly in the Promoting Interoperability category. This shift could further turn MIPS into a compliance exercise rather than a mechanism for advancing value-based care, detracting from the program's goal of improving healthcare outcomes.

We thank you for your consideration of our comments. Should you have questions, please do not hesitate to contact AMGA's Darryl M. Drevna, senior director of regulatory affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,

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