September 9, 2024

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1807-P
P.O. Box 8016
Baltimore, MD 21244-8016.

Submitted electronically via regulations.gov

RE: CMS-1807-P: Medicare and Medicaid Programs; 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

Dear Administrator Brooks-LaSure:

On behalf of Families USA and the undersigned organizations, thank you for the opportunity to respond to the calendar year (CY) 2025 Medicare Physician Fee Schedule proposed rule. As you know, Medicare payment policy sets the standard for physician payment across health care payers, including Medicaid and commercial insurers. To that end, we offer these comments to both strengthen Medicare physician payment policies and to advance payment reforms across the health care system. If implemented, the payment changes we recommend have the potential to catalyze the transformational changes needed to drive high-value care and advance health equity throughout the U.S. health care system.

The comments detailed in this letter represent the consensus views of organizations spanning labor groups, employer groups, consumer advocates as well as other signers and interested parties. We ask that these comments, and all supporting citations referenced herein, be incorporated into the administrative record in their entirety.

We applaud CMS's continued progress in several key areas.

- We strongly support the inclusion of audio-only communication technology for telehealth services under Section II.D of the proposed rule. This critical change, which Families USA has long supported and previously recommended, would continue to make telehealth services more broadly available to families.[1]
- We appreciate that CMS created the G2211 add-on code in the CY24 MPFS Rule, which recognizes the value of primary care services, and we support the current proposal to allow physicians to use that code for services delivered on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventative service, as included in Section II.F.[2]
- We applaud CMS's continued efforts to create consistent quality measures across multiple programs and to connect physician payment with the quality of health care delivered. With that in mind, we support the inclusion of five new quality measures within the APM Performance Pathway (APP) Plus program, as detailed in Section III.G. These additional quality measures will

help align payment for physicians engaged in alternative payment models (APMs) with MIPS Value Pathways (MVPs), the Medicaid Core Sets, and the Marketplace Quality Rating System, which will reduce the administrative burden on physicians and ease the transition to APMs. We strongly support the addition of Screening for Social Drivers of Health as a mandatory quality measure to further promote health equity within APMs.

Our comments below focus on the following sections of the proposed rule:

- II.G Enhanced Care Management
- III.G Medicare Shared Savings Program
- IV. Updates to the Quality Payment Program

II.G. Enhanced Care Management 2. Advanced Primary Care Management (APCM) Services (HCPCS codes GPCM1, GPCM2, GPCM3)

In the CY2025 proposed rule, CMS proposes to establish new coding and payment for the delivery of advanced primary care management (APCM) services under the Medicare Physician Fee Schedule (PFS). These new codes and payments recognize the value of, and the additional costs associated with, the delivery of advanced primary care, which CMS defines as the "delivery of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities."

CMS proposes creating three new billing codes that physicians and other practitioners can bill to on a per month basis for the delivery of specific care and care management services that are integral to the delivery of APCM. These codes are designed to be used by primary care providers who are responsible for the patient's primary care and management of their care needs over time.

The proposed APCM codes bundle together a set of care management and communication technology-based service codes that providers previously billed separately. Services included in the bundled codes include 24/7 patient access to their clinical care teams, services that ensure the continuity of care, comprehensive care management, care transition services, and asynchronous communication. Importantly, CMS would not require providers to furnish every service included in the APCM codes to every patient in order to receive payment. Instead, CMS proposes to allow providers to decide which APCM services are medically necessary for an individual patient, as long as the provider is capable of delivering all of the service elements in the APCM codes. Bundling these services together under a single code gives providers more flexibility to furnish the APCM services that each patient needs while helping to reduce administrative burden by streamlining the billing process for providers who previously had to bill separately for each care management service.

Under the proposed guidelines, these APCM codes can only be billed once per calendar month per patient, and the codes are broken down into three payment levels based on patient acuity and social risk factors. The level 1 APCM code will be used for patients with one or no chronic conditions; the level 2 code will be used for patients with two or more chronic conditions; and the level 3 code will be used for patients with two or more chronic conditions who are also Qualified Medicare Beneficiaries.

Payment rates are scaled to accommodate the greater potential care management needs and costs associated with sicker or lower-income patients, with level 1 code reimbursed at the lowest rate and level 3 at the highest. The level 3 designation is intended to identify and support beneficiaries with social risk factors that might require more health care resources to address. CMS is proposing to base the initial valuation of these codes on historical utilization of the care management service codes.

CMS also proposes to hold providers accountable for the quality and cost of APCM services they deliver by requiring providers to meet certain performance standards to be able to bill for APCM services. Providers can meet these standards through participation in certain Advanced Alternative Payment Models (AAPMs) such as the Medicare Shared Savings Program and select CMMI models such as ACO REACH, or by registering and reporting to the Value in Primary Care MIPS Value Pathway (MVP).

Primary care is the entry point to the health care system for individuals and families across the country.[3] For many people, it's where mental and behavioral health care issues are first identified, where they are referred to specialty care, or where they obtain key preventative services such as vaccinations and screenings.[4] Unfortunately, the nearly 100 million people in the U.S. without a usual source of primary care often put off their health care needs until they become emergencies.[5] For example, two-thirds of all emergency department visits could be avoided with earlier primary care intervention.[6] Moreover, the cost of treating these conditions in a primary care setting is 12 times lower than the cost of providing the same care in a hospital, and 10 times lower than providing that care in an urgent care facility.[7]

Central to improving the health and health care of our nation's families is ensuring that primary care clinicians are empowered in our health care delivery system and are paid sufficiently to reflect their value.[8] However, fee-for-service (FFS) payment continues to be the predominant payment system used to reimburse health care providers across the U.S. health care system, including under Medicare through the Physician Fee Schedule. Because of the way Medicare establishes payments under the fee schedule, primary care services have historically been severely undervalued relative to specialty care, resulting in much lower payments for primary versus specialty care.[9] Additionally, FFS has historically offered little or no payment for health care services that address health-related social needs, including certain forms of care management.[10]

The historic underinvestment in primary care services through the current FFS payment system is an important driver of the inadequate supply of primary care clinicians, which has limited many families' access to comprehensive primary care and other high-value services such as behavioral health care.[11] CMS has tried to address this underinvestment, including through the adoption of several codes for chronic care management and transitional care management.[12] Providers, however, have been reluctant to use these codes, in part because of the administrative burden of billing separately for these services.[13] The three new G-codes, which bundle 12 pre-existing care management and 15 pre-existing communication technology-based services, could address that problem by significantly reducing the administrative burden that providers face in billing for primary care services, thereby increasing patient access to APCM.[14]

As such, we strongly support the adoption of these three new HCPCS G-codes for the delivery of advanced primary care management services. Access to APCM services is associated with decreases in

both emergency room utilization and acute hospitalizations for patients as well as increased operating margins for hospitals.[15] Additionally, patients connected to APCM through alternative payment models like CPC+ receive more important primary care services such as annual wellness visits and vaccinations than patients not participating in these models.[16] Adoption of payment codes for APCM services is a crucial step in moving away from fee-for-service economics for primary care delivery and toward hybrid- or population-based payments that support the provision of higher value care. By affording providers the flexibility to deliver the advanced primary care services that best meet patients' needs, the use of bundled APCM payment codes could result in more patients receiving high-quality health care from providers that are held accountable for care quality rather than volume and could help form a foundational evolution away from an over-reliance on FFS payment in the U.S. health care system. The streamlined G-codes will also help to reduce the administrative burden of billing for individual care management services, which may incentivize physicians to provide APCM services more frequently. Reduced administrative burden has the added benefit of giving providers more time to spend with patients rather than navigating complex billing codes.[17] Further, patients— who report that they want better access to their doctors, better communication between providers, and more personalized care— can benefit from APCM services such as 24/7 access to the care team, continuity of care, and comprehensive care management.[18]

In basing the proposed APCM code valuation on historic care management utilization, CMS must be careful to avoid the prior underinvestment into APCM services, and primary care services more broadly, when they determine the value of the three new HCPCS G-codes for APCM services. We appreciate that CMS has pre-emptively accounted for the impact of this underutilization in its initial APCM code valuation.[19] **We recommend that CMS closely monitor the valuation and utilization of these codes over the following year and make changes as necessary if utilization of the new APCM codes is higher than anticipated, indicating that providers may be delivering more services than they are compensated for.**

We applaud CMS for incorporating some level of risk adjustment by stratifying the APCM codes into three levels in a way that acknowledges the varying complexity and additional cost associated with treating patients with underlying social risk factors and complex care needs. In the past, failure to account for such factors has unfairly penalized providers who disproportionately serve patients from low-income, historically under-resourced communities.[20] By recognizing it often takes more resources to address care needs of patients from these communities, CMS empowers primary care providers to deliver care that best meets each patient's unique health needs.[21] Ultimately, however, the future of primary care payments should not rely only on code-based reimbursement. We see the addition of payment codes for APCM services as both an important achievement and a stepping stone to transition away from traditional FFS economics toward a future built upon capitated, population-based payments that ensure providers are financially incentivized to provide high-quality, efficient health care that both reduces costs and improves health outcomes.[22] CMS must continue efforts to invest in primary care, streamline billing processes, and move away from the inefficiencies of traditional FFS through the creation of a hybrid (both FFS and capitated) payment for primary care providers and the advancement of more mandatory models from the Center for Medicare and Medicaid Innovation (CMMI).[23]

II.G. Enhanced Care Management 3. Request for Information: Advanced Primary Care Hybrid Payment b. Solicitation of Public Comments

In addition to proposing new APCM payment codes in the proposed PFS rule, CMS poses questions regarding additional changes the agency could make to billing and payment rules in Traditional FFS Medicare to further promote the delivery of advanced primary care for Medicare beneficiaries. The undersigned organizations respond below to three of those questions.

1. *Should CMS evolve the proposed APCM services into an advanced primary care payment that includes E/M and other relevant services, or maintain a separate code set for APCM?*

Shifting health care payment away from FFS provider payments and towards population-based payments should be a major focus of all efforts to reform physician payment across the U.S. health care system. Population-based payments pay a group of health care providers or a health system a single monthly payment, which covers some or most health care related costs for a set patient population. Such payment arrangements are then coupled with strong quality and outcome measures to ensure providers make money when they provide efficient, high-quality care, and lose money if they are wasteful or provide poor-quality care. In this way providers are "at risk" for care that does not improve or protect patients' health, thereby incentivizing them to deliver well-coordinated, high-quality, person-centered care.[24] Moreover, these payments give providers flexibility to deliver a wider range of high-value services that are often historically undervalued or not paid at all under FFS, such as preventive health care, care coordination, wellness services, and services that address the social determinants of health.[25]

Therefore, we strongly recommend that CMS evolve the proposed APCM services into a comprehensive advanced primary care payment that includes E/M and other relevant services alongside the services included in the current APCM-related proposal. Incorporating the total package of primary care services into a single hybrid payment would simplify reimbursement for primary care providers, offer primary care providers a critical and reliable source of payment, and ensure that all eligible patients have access to the E/M and APCM services necessary to best meet their individual health needs. Including additional services within bundled, hybrid, or population-based payments and coupling that with strong cost and quality measures will move toward a health system that holds providers accountable for the delivery of high-quality and affordable care. This is essential for addressing the flaws of traditional fee-for-service payment and achieving a value-based, patient-centered care system for American families.

2. *What risk adjustments should be made to proposed payments to account for higher costs of traditionally underserved populations?*

We applaud CMS for stratifying social risk within the proposed G-codes based on Qualified Medicare Beneficiary status. Qualified Medicare Beneficiaries (QMBs) are Medicare Part A beneficiaries with an income at or below established federal or state standards.[26] The proposed rule makes a clear distinction between the Level 3 G-code, applicable only to lower income patients who are QMBs with two or more chronic conditions, and the Level 2 G-code, applicable to everyone else with two or more chronic

conditions. The difference in payment rates between the two codes reflect the additional complexity needed to address barriers and health needs of lower-income patients. However, income is not the only factor or proxy that indicates a potential need for risk adjustment.

Risk adjustment is a critical safeguard for ensuring population-based payments reflect the resources needed to treat a given patient population.[27] Risk adjustment is a payment adjustment based on the characteristics and health status (i.e. diagnoses) of each patient to help account for differences in health care costs between patients and to ensure providers are incentivized to treat patients regardless of their health status and other factors that affect the cost of providing high quality care.[28] Providers who want to maximize profits may "cherry pick" patients by treating only healthier patients while avoiding sicker patients that are associated with higher treatment costs.[29] Risk adjustment mitigates this harmful behavior by increasing payments for providers who care for more medically complex patients, accounting for the higher costs associated with patients with greater health and social needs.[30]

Yet, current risk adjustment methods have significant flaws that can actively harm patients and drive low-quality care and exacerbate health disparities.[31] First, they often underestimate the resources needed to treat certain patients, particularly those with serious illnesses and social needs such as inadequate housing and food insecurity, which drive up treatment costs.[32] As a result, providers are discouraged from treating the most marginalized and medically complex patients.[33] Second, current risk adjustment methods are susceptible to industry gaming, including "upcoding," which is when a provider uses billing codes that offer higher reimbursement than the code that accurately reflects the services that the patient received.[34] Not only has this led to billions of dollars in wasteful spending, but it can also hurt patients, as providers can manipulate the system to increase payments without providing more or higher quality care to their patients.[35]

As the health care system moves away from FFS payments and towards bundled payments and population-based models, it is critical to redesign risk adjustment methodologies to prevent industry gaming and to fully account for, and encourage the treatment of, patients who are less healthy and have greater health-related social needs. These patients may need more services to achieve their best health.[36] **As such, we recommend that risk adjustment methodologies incorporate robust social needs and social services data so that they accurately consider patients' social needs and the higher costs of treating socially vulnerable and marginalized populations, driving towards equity and improved protections against adverse selection.**

3. *How can CMS ensure clinicians will remain engaged and accountable for their contributions to managing the beneficiary's care?*

Fundamental to ensuring clinicians remain engaged and accountable for managing the health care of a beneficiary is the movement away from volume-based payments under traditional FFS towards value-based population payments that, through strong quality metrics, reward providers for providing high-quality health care, reducing inequities, and improving health outcomes. Providers who use the proposed APCM codes will be evaluated on performance, including primary care quality, total cost of care, and meaningful use of certified electronic health record technology (CEHRT). This evaluation is an important step in ensuring that providers who use the proposed APCM codes deliver high-value,

patient-centered care. However, APCM payment still relies on flawed FFS infrastructure that fails to fully hold providers accountable for the quality of care they provide. By moving away from financial incentives inherent in fee-for-service economics and changing payment incentives to encourage providers to focus on delivering more high-value primary care services rather than increasing service volume, CMS can address the primary factors that govern physician behavior. To ensure that physicians remain engaged and accountable for their contributions to managing their beneficiaries' care, physician payment outcomes must be directly tied to delivering high-value care, not high service volume.[37]

CMS could also consider implementing a patient attribution system, which would further strengthen the relationships between patients and providers. Implementing prospective attribution systems, which tell providers or Accountable Care Organizations (ACOs) upfront which patients' care they will be evaluated on, is one way to ensure that providers take full ownership of effectively managing their patients' health conditions and health care needs.[38]

Continuing to move toward hybrid or population-based APCM payments gives providers the flexibility to focus on the things that truly improve patients' health – including hiring staff, investing in infrastructure, and coordinating care.[39] Decoupling payments from specific billing codes can enable providers to make crucial investments not included in current billing codes that improve patient outcomes. Efforts to adopt hybrid or population-based payments must be packaged alongside robust and transparent quality measures, including patient-reported outcome measures (PROM) tied to reimbursement so that providers are incentivized to ensure patients receive the highest quality care.[40]

III.G. Medicare Shared Savings Program 7. Financial Methodology b. Health Equity Benchmark Adjustment (2) Proposed Revisions

CMS is proposing to implement a new health equity benchmark adjustment (HEBA) for the Medicare Shared Savings Program (MSSP) that accounts for historically suppressed health care spending levels that under-resourced communities experience. Under the proposed adjustment, ACOs participating in MSSP that serve more than 20% of beneficiaries from under-resourced communities will be eligible to receive an increased benchmark adjustment based on the product of two factors: the national per capita expenditures for assignable beneficiaries and the proportion of beneficiaries who are enrolled in Medicare Part D Low Income Subsidies or who are dually eligible for Medicare and Medicaid. The purpose of the proposed HEBA is to discourage providers that are evaluated against a spending benchmark from trying to treat only healthier, less costly patients and avoid treating more marginalized or sicker patients with higher expected health-related costs. The proposed HEBA is based on a similar adjustment designed for the ACO Reach model that is associated with increased participation in ACOs by safety net providers.[41]

Benchmarks are the cost targets used to measure an ACO's financial performance. They determine whether an ACO receives shared savings or, in the case of ACOs in two-sided risk agreements, must pay CMS because their costs exceeded their benchmark.[42] Benchmarks are a critical component of the design of certain types of alternative payment models. When improperly calculated, they can penalize

providers working to meet the needs of marginalized, low-resource communities; restrict access to care for these communities; or they can reward providers who fail to improve quality and outcomes.[43]

This proposed rule would establish HEBA as a third method of adjustment in MSSP. An eligible ACO's benchmark would be based on the most advantageous adjustment for which the ACO is eligible: the regional adjustment, prior savings adjustment, or health equity benchmark adjustment.[44]

The regional adjustment combines an ACO's historical spending with the average spending in its region, resulting in providers with higher baseline spending receiving lower benchmarks.[45] For some providers who spend more to treat the complex health needs of a higher acuity patient population, this results in a more difficult benchmark to meet.[46] The prior savings adjustment is intended to account for the effect that occurs when an ACO's expenditures are lower than the benchmark which then generates lower benchmarks in subsequent years, making continued savings more difficult to achieve. As a result, CMS offers these ACOs a portion of prior savings as a positive adjustment to its benchmark.[47] Neither the regional nor the prior savings adjustments are likely to result in positive adjustments for ACOs with a large proportion of low-income patients due to the higher levels of expenditure needed to address the health needs of these populations.[48]

The addition of a HEBA will address this problem by providing these ACOs with additional funds to meet their patients' needs, something that existing adjustments do not adequately account for. A regulatory impact analysis conducted by CMS in the proposed rule suggests that 20 ACOs in 2023 would have received an increase in payments if the HEBA was in place, with an average increase of $230 per capita or 1.57% increase to their historical benchmarks.[49] The analysis also predicts that implementing the HEBA could result in an additional 30 ACOs participating in the model over the next 10 years, attracting providers who were previously apprehensive about joining an ACO due to concerns they would be penalized for failing to meet cost and quality targets as a result of providing care to a higher percentage of patients from marginalized communities.[50] **We applaud CMS's efforts to improve uptake of ACO participation in under-resourced communities and strongly support the adoption of a health equity benchmark adjustment in the Medicare Shared Savings Program.**

While we applaud creation of the HEBA, it's important to highlight that the underlying need for such an adjustment raises more foundational questions around the existing benchmarks within MSSP. The foundation of MSSP benchmarks is an ACO's historical spending over the three previous benchmark years. While historical spending is an important data point for establishing benchmarks, this approach often inadvertently embeds and worsens existing health inequities and disparities in health care access and utilization.[51] Historic health care spending and utilization reflect long-term disparities in health care access and affordability experienced by rural and other marginalized communities.[52] For instance, Black and Hispanic families are more likely to skip or delay seeking care due to high health care costs, despite experiencing higher rates of diabetes, heart disease, and other chronic illnesses. [53] In turn, providers who serve predominantly under-resourced communities may receive benchmarks that are set too low, especially when considering the greater health care needs often experienced by under-resourced communities.[54] It is critical that providers serving these communities not be penalized for addressing

historic health inequities. In the short-term, the proposed HEBA policy will be beneficial to those providers most engaged in supporting beneficiaries from under-resourced populations.

Importantly, the proposed HEBA cutoff for MSSP fails to sufficiently incentivize most providers to serve larger numbers of low-income patients or to provide additional care in those communities. The cutoff is structured so that providers only benefit from the HEBA if it is larger than the regional adjustment or prior savings adjustment.[55] This means providers who earn more from either of these other adjustments but continue to serve low-income patients would not receive payment adjustments that account for the greater health needs of under-resourced communities. As noted above, CMS estimates that just 20 ACOs would currently benefit from this proposed HEBA.[56] It is essential to keep in mind that providers in hundreds of other ACOs who treat many low-income patients would not receive the proposed HEBA. Additionally, establishing the proposed discrete cutoff for HEBA would create an all-or-nothing incentive that results in some providers refraining from spending the additional funds necessary to serve the greater health needs of underserved communities, as the meaningful threshold to attain a positive HEBA will be out-of-reach. Long-term, this means many providers may not serve larger numbers of low-income patients or communities as this may increase their expenses without qualifying them for a positive payment adjustment.

In short, while this policy makes meaningful progress toward supporting those providers with the highest proportions of low-income beneficiaries in the short term, it is not sufficient to drive long-term changes to MSSP benchmarks to adequately meet the needs of providers that disproportionately serve lower-income patients. **Therefore, we urge CMS to continue to take additional actions to address health inequities by ensuring all providers have the resources to deliver high-value, patient-centered care for low-income beneficiaries. Over the long-term, CMS must move towards more foundational changes to benchmarking and risk adjustment that move the needle on addressing historic inequities for all ACOs, not just those who would benefit from the proposed HEBA.**

As discussed in our comments in Section II.G above, risk adjustment is an important tool to ensure that providers are incentivized and able to care for more medically complex patients or patients with greater health-related social needs. The most significant barrier to adequate social risk adjustment is a lack of reliable and consistent data on social needs, particularly on the individual level.[57] Efforts to incorporate social risk factors into risk adjustment often do so on the community level through metrics such as Area Deprivation Index (ADI), which map the relative socioeconomic conditions of communities using census data.[58] While community level data like ADI is integral to the allocation of resources to under-resourced communities, individual level data on social needs is also important to adequately account for a wide array of social needs, particularly in communities with large socioeconomic disparities.[59] Alongside the use of community level metrics, policymakers must try to collect more detailed data, including self-reported demographic and social needs data.[60] In the short-term, existing sources of data including ADI, claims data, and administrative data should be leveraged to more accurately account for social risk. Specifically, Z-codes, which are diagnosis claims codes that document a wide variety of social drivers of health, can be better leveraged to inform Medicare risk adjustment methodologies. Z-codes provide a standardized system for documenting and sharing social risk data. Unfortunately, there has been minimal provider uptake of these codes.[61] Nevertheless, Z-codes provide an important opportunity to

expand and streamline social needs data within a system that has historically neglected these aspects of health. **We recommend that CMS update its risk adjustment methodology by utilizing and eventually requiring more enhanced data collection such as social needs assessments and self-reported data**.[62] **We also encourage CMS to continuously incorporate these enhanced data, including accurate measures of health equity, within the benchmarking process itself to ensure that provider payment is truly accountable to the quality and cost of care delivered.**

IV. Updates to the Quality Payment Program A. CY 2025 Modifications to the Quality Payment Program 3. Transforming the Quality Payment Program b. The Role of MVPs in Transforming MIPS (3) Sunset of Traditional MIPS

CMS is proposing to eventually sunset the traditional Merit-based Incentive Payment System (MIPS) payment adjustment and fully implement the MIPS Value Pathways (MVPs), which requires clinicians to report on a set of measures more directly relevant to their clinical specialties. Under this proposal, CMS will continue to develop and maintain new and existing MVPs to support an eventual full transition from MIPS to MVPs. CMS is anticipating a period of 6 to 7 years during which traditional MIPS is still available, giving providers time to prepare for MVP reporting.

The MIPS program was established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to tie provider payments to the provision of quality and cost-efficient care. MACRA established the two-track Quality Payment Program (QPP) which required most physicians enrolled in the Medicare program to choose one of two participation tracks: MIPS or Advanced Alternative Payment Models (AAPMs). Physicians who choose the AAPM track participate in payment models that move away from FFS and directly tie payment to the provision of high-quality, cost-effective care. Physicians that opt into the MIPS program continue to be paid through traditional FFS, but their payments are adjusted based on their performance on submitted measures of quality, cost, improvement activities, and promoting interoperability.[63] Originally the maximum positive adjustment for MIPS participants was a 1.5-2.5% payment increase in payment years 2019 through 2023; in 2024, this adjustment increased to 8.25%.[64] Over the same time period, the incentive payment bonus awarded to providers participating in the AAPM track decreased from 5% to 3.5%.[65] Rather than drive providers into APMs and toward more comprehensive, coordinated, patient-centered care which was the intended goal of the AAPM track, providers have a larger incentive to stay in MIPS because the program now offers a higher bonus payment.

This is particularly problematic given that there are a number of underlying flaws within the MIPS program that have allowed some providers to game the system and engineer favorable payment outcomes.[66] One notable program design flaw is that clinicians can choose their own set of measures to report across nearly all domains within MIPS.[67] Importantly, the underlying economic incentives in the MIPS program create a financial incentive for most clinicians to choose measures they already excel at, which means they can receive substantial bonus payments even if they have little or no behavior change.[68] As a result, in 2021, nearly 800,000 clinicians received upward performance-based payment adjustments compared to just 3,000 clinicians who received downward adjustments.[69] Additionally, these payment bonuses are structured as a percentage increase to current fee-for-service payment

rates, which further incentivizes increases in service volume.[70] **As a result, we strongly support sunsetting the MIPS program, a flawed system which has failed to incentivize improvements in quality or cost.[71]**

As noted, the significant financial incentives that providers receive under MIPS have created a distinct financial disincentive for providers to transition to AAPMs. **We encourage CMS to ensure that the transition from MIPS into MVPs is designed to address these problems and does not perpetuate the broken incentives of fee-for-service economics.**

We also urge CMS to revamp performance measures under MVPs and standardize the measures on which clinicians must report for each specialty.[72] As currently proposed, MVPs continue to rely on flawed MIPS policies that reward providers for reporting on measures at which they know they will excel. It is essential that MVPs are not designed as the end point for providers. Instead, it should be designed as a stepping stone to prepare and equip providers for more foundational payment reform with accountability for total cost of care and population health outcomes. Once providers are successful under MVPs (or in the short run under MIPs), they should promptly be encouraged to take on more upside and downside risk and engage further in alternative payment models, rather than stagnate under MIPS or MVPs, as has happened in the past.

IV. Updates to the Quality Payment Program A. CY 2025 Modifications to the Quality Payment Program 3. Transforming the Quality Payment Program k. Overview of QP Determinations and the APM Incentive

CMS proposes to modify the definition of "attribution-eligible beneficiary" for the calculation of threshold scores under the Quality Payment Program (QPP). The proposed change broadens the current definition to include any beneficiary who has received covered professional services from an eligible clinician. Currently, beneficiaries are only eligible if they have received E/M services furnished by a clinician within that ACO.

Patient attribution is the process of identifying and assigning a set of patients to a group of health care providers, such as an ACO, who are then held accountable for the cost and quality of care those patients receive.[73] Data on health care quality and related costs are then used to evaluate the providers' performance, which influences their ability to receive shared savings, losses, bonuses, or penalties.[74] This is a critical mechanism in realizing the promise of population-based payment models to incentivize the delivery of the high-quality, whole-person care that our nation's families need and deserve. [75] Health care providers need to know which patients they will be held accountable for so they can effectively manage the health conditions and health care needs of their patients by delivering the longitudinal care services that best support their patients' health.[76] Importantly, accurate patient attribution is also essential to ensure that health care providers are only held accountable for the patients for whom they actually provide care and manage health conditions, and that they are not accountable for care delivered to patients they do not oversee.[77]

As previously explained, the QPP program established under MACRA was intended to incentivize providers to join alternative payment models. Under this program, providers participating in advanced

APMs must meet the Qualifying APM Participant (QP) Threshold to receive the bonus payment for APM participation. The threshold requires providers to receive either 50% of their payments or 35% of their patients through an APM.[78] The proposed change to attribution will significantly impact providers' QP Threshold determinations, as some specialists in ACOs currently provide services to beneficiaries not attributable to their ACO under the current "attribution-eligible beneficiary" definition.[79]

Under the current system, providing services to unenrolled beneficiaries would count against a physician in QP determination calculations, putting their ability to receive the APM Incentive Payment at risk and disincentivizing specialist participation within ACOs.[80] The proposed change ensures that QP determinations for such specialty providers would better reflect their patient populations, since specialty providers are less likely to deliver E/M services.[81] As a result, more specialty providers will meet the QP threshold.[82] Several CMMI models, including the Bundled Payments for Care Improvement (BPCI) model and the Maryland Total Cost of Care (TCoC) model, have already used this methodology to identify attribution-eligible beneficiaries.[83] The proposed update to the definition of "attribution-eligible beneficiary" would therefore help to standardize QP determination across all ACOs and APMs.

We support more widespread attribution of beneficiaries into ACOs and changes to QP determination that support additional practitioners entering advanced APMs. As noted above, the proposed changes to attribution will result in more accurate linkages between providers — especially specialists — and the patients who they deliver care to, as well as more accurate evaluations of the quality of care they deliver to their attributed beneficiaries.

Separately, CMS uses their statutory authority to propose an update to the Consolidated Appropriations Act of 2024 to provide that eligible QPs will receive an APM Incentive Payment equal to 1.88% of their estimated aggregate payment amounts for Medicare Part B covered professional services in payment year 2026. In effect, this change extends a 1.88% APM Incentive Payment (which was 5% from 2019-2024 and 3.5% in payment year 2025) through payment year 2026. Beginning with the 2026 payment year, the PFS will contain two separate conversion factors, one for QPs and the other for items and services not furnished by a QP.

We strongly support the proposed statutory change to extend a 1.88% advanced APM incentive through 2026. Following its inception, the 5% advanced APM Incentive Payment resulted in significant growth in AAPM participation and was associated with 36% higher savings compared to non-AAPM ACOs.[84] While this incentive was originally intended to be phased out following widespread adoption of AAPMs, this process has been much slower than anticipated and total AAPM bonuses are significantly lower than initial projections.[85] Without this bonus, MIPS-eligible clinicians have little financial incentive to continue transitioning toward alternative payment models, potentially further stagnating the uptake of APMs with nearly 60% of Medicare physician payments still occurring in fee-for-service arrangements.[86] **While re-authorization of the advanced APM Incentive Payment beyond 2026 would require legislative action, we urge CMS to collaborate with lawmakers to re-establish this critical lever.**

Thank you for considering the above recommendations. Please contact Alicia Camaliche, Policy Analyst at acamaliche@familiesusa.org for further information.

Sincerely,

Families USA
Allergy and Asthma Network
American Association on Health and Disability
Clear Health Advocacy
Colorado Consumer Health Initiative
Connecticut Oral Health Initiative
Democratic Disability Caucus of Florida
The ERISA Industry Committee (ERIC)
Health Care Voices
National Partnership for Women and Families
Lakeshore Foundation
Lighthouse Community Development Center
Maine Equal Justice
National Consumers League
The Coalition for Hemophilia B
Third Way
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