Advancing High Performance Health

One Prince Street
Alexandria, VA 22314-3318
O 703.838.0033
F 703.548.1890

September 6, 2022

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, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) "CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medical Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplied (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts [CMS-1770-P], CY 2023 PFS Proposed Rule."

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 2023 PFS Proposed Rule for your consideration. Specifically, we are providing comments on the following:

- **Conversion Factor Decrease**: AMGA requests that CMS not decrease the conversion factor under the Physician Fee Schedule.
- **Split Visit Evaluation and Management (E/M) Policy**: AMGA applauds CMS' decision to delay the split visit E/M policy and urges CMS to abandon the policy altogether.
- **Telehealth Policy**: AMGA has the following comments on the telehealth provisions:
    1. *Telehealth Payment Parity*: AMGA urges CMS to reconsider its proposal to revert to facility payment rates for telehealth services on the 152nd day following the public health emergency (PHE).
    2. *Continuation of Payment for Audio-Only Visits*: AMGA urges CMS to reconsider

its decision not to continue separate payment for audio-only services.

- **Behavioral Health Services**: AMGA supports CMS' proposals to enhance access to behavioral health care.
- **Quality Payment Program**: AMGA makes several recommendations regarding Quality Payment Program proposals, including the Merit-based Incentive Payment System (MIPS) value pathways, MIPS performance threshold, exceptional performance bonus, low-volume threshold, and alternative payment models.
- **Medicare Shared Savings Program**: AMGA makes several recommendations on the proposed changes to the Medicare Shared Savings Program (MSSP). While supportive of the proposal to provide additional time in upside-only models, AMGA recommends CMS modify its proposal to update benchmarks via a three-way blend. AMGA also recommends CMS expand its proposal to account for prior savings when rebasing a benchmark for a new agreement period. AMGA is pleased CMS is proposing to reduce administrative burdens on Accountable Care Organizations (ACOs) by revising marketing requirements and the Skilled Nursing Facility 3-Day Waiver process.

Conversion Factor Decrease

Comment: AMGA is extremely concerned about the impacts of reduced payments on beneficiary care access and, therefore, urges CMS to exercise any and all available authorities to minimize payment cuts.

CMS is proposing a conversion factor of $33.08, which is a decrease of $1.53 from the CY2022 conversion factor of $34.61. Of note, the Protecting Medicare and American Farmers from Sequester Cuts Act (PMAFSCA)[1] of 2021 provided a one-year 3.0% increase to the conversion factor that increased the CY2022 finalized conversion factor from $33.60 to $34.61. However, the PMAFSCA instructed CMS not to factor the 3% increase into future calculations. As a result, CMS calculated the proposed 2023 conversion factor as if the 3% increase did not exist. Effectively, Medicare will reimburse each physician service more than 4% less in 2023 than in 2022. This reduction, however, only considered the decrease in the conversion factor. When combined with the 2% sequestration cut that fully reinstated on July 1, 2022, along with a 4% Pay-As-You-Go (PAYGO) cut scheduled to take effect in 2023, providers are facing significant reductions in Medicare payments.

While AMGA understands these cuts are being proposed because of the PMAFSCA of 2021, and CMS must implement the legislation, we still are adamantly opposed against this reduction in payment. This reduction will certainly have adverse effects on physician practices and their patients. The proposed decrease in the conversion factor, the sequester, and the pending PAYGO cuts would reduce Medicare reimbursement for Part B services by more than 10%. In addition, these cuts would not occur in isolation, but instead would exacerbate the financial pressures facing AMGA members due to inflation, increased supply costs, and an unprecedented healthcare workforce shortage, while they are still contending with an ongoing pandemic.

AMGA members report that the loss of revenue would force numerous operational changes that

[1] Pub. L. 117-71.

have the potential to hinder patient access to service. The negative effects of the payment reduction will force physicians and physician groups to eliminate certain services, slow hiring—particularly in specialties that serve high Medicare fee-for-service (FFS) populations—and delay investments in technology or efforts to address social determinants of health (SDOH), which we understand to be a major priority of this administration. AMGA members are committed to serving all patients, but continuous cuts to Medicare FFS payments may give rise to difficult decisions based on limited resources that could impair access to care for vulnerable beneficiaries. AMGA members report that it is increasingly costly to serve Medicare FFS beneficiaries with different care needs, and yet payments are being reduced while the cost of supplies and other services continue to rise. CMS should recognize the larger financial situation facing physicians, group practices, and integrated systems of care.

As noted earlier, AMGA understands the constraints governing CMS and that these adjustments are a statutory requirement of the Physician Fee Schedule. However, it is important that CMS explain to lawmakers the ramifications that the cut in the conversion factor will have on the ability of healthcare providers to offer meaningful access to care for their Medicare beneficiaries and effectively invest in the services and supports needed to address health disparities and SDOH. AMGA members are closely examining their financial situation and will be forced to make difficult decisions on how to manage their limited resources to continue providing high-quality care. Our members report they are facing unpreceded financial losses that will be exacerbated by additional cuts to the Medicare system.

We urge CMS to consider recent data sources and exercise the full extent of the Agency's flexibilities to avoid payment cuts in consideration of these significant cost pressures. In addition, AMGA recommends increasing the conversion factor by an enhanced percentage in CY2024 to address the massive payment cuts in CY2023. These changes could help to offset the decrease in this year's rule. Further, CMS should consider several years of enhanced payment to help support physicians with growing inflation. To that end, AMGA recommends that CMS use the Office of Management and Budget (OMB) Circular A-19 budget request process to recommend legislative changes as part of the FY2024 President's Budget Request to advocate for increasing the conversion factor to account for the increased cost of delivering care to Medicare patients. AMGA would welcome the opportunity to meet with CMS at the appropriate time to help develop a proposal for the President's budget request.

Delayed Split Visit Evaluation and Management (E/M) Policy

> **Comment:** AMGA applauds CMS' decision to delay the split visit E/M policy and urges CMS to abandon the policy altogether.

In the CY 2022 PFS Final Rule, CMS finalized a policy for E/M visits furnished in a facility setting to allow payment to a physician for a split visit, where a physician and a non-physician practitioner (NPP) provide the service together and the physician performs a substantive portion of the visit. Additionally, CMS finalized the definition of *substantive portion* as history, exam, or medical decision making (MDM), or more than half of total time for CY 2022 and finalized that beginning in CY 2023, the definition of *substantive portion* as being more than half of total time. In the CY 2023 PFS proposed rule, CMS is proposing to delay the definition of *split visit* to "more

than half of the total time" until CY 2024. For 2022 and 2023, CMS is defining the substantive portion of a visit as one of the three key components (history, exam, or MDM) or more than half of the total time spent by the physician and NPP performing the split (or shared) visit.

While AMGA appreciates that CMS is delaying the policy, AMGA also recommends that CMS reconsider the policy altogether. AMGA recommends CMS continue to include MDM to define the substantive portion of the split. CMS notes that it believes "it is appropriate to define the substantive portion of a split (or shared) service as more than half of the total time" even though stakeholders continue to recommend that CMS continue to recognize MDM as the substantive portion. AMGA must reiterate our concern that eliminating MDM creates a situation that devalues physician experience and expertise and treats all time as equivalent. AMGA is concerned that CMS is conflating experience and expertise with time. While a physician may spend, in some cases, less time as part of a visit, the physician's expertise and supervision are the critical factor in the encounter, not simply the number of minutes spent with a patient. Further, it is important to note that the CPT® Editorial Panel also redefined the office/outpatient (O/O) E/M visit codes to be based in part on the level of MDM. Given that MDM is taken into account for the O/O E/M visits, it would seem that the same consideration should be made for the substantive portion of the split.

AMGA recommends that CMS reconsider the proposed changes and permanently allow the inclusion of MDM in defining the substantive portion of the split service.

Telehealth

> **Comment:** AMGA applauds CMS' commitment to facilitate continued access to telehealth services for Medicare beneficiaries, but urges the agency to reconsider its proposal to revert to facility payment rates for telehealth services on the 152nd day following the PHE. In addition, AMGA urges CMS to reconsider its decision not to continue separate payment for audio-only services.

1. **Telehealth Payment Parity**

Many PFS services have two payment rates, depending on whether they are provided in a facility setting (e.g., rate paid for services furnished in a hospital) where Medicare pays separately for a facility fee in addition to paying the billing physician or NPP, or a non-facility setting (e.g., rate paid to physician for services furnished in their office). Before the PHE, CMS paid clinicians at the distant site the facility-based amount, which is lower than the non-facility-based amount, as CMS was under the assumption that it was less costly to provide services via telehealth than in a clinician's office. Prior to the pandemic, all telehealth services were required to be billed using the telehealth place of service (POS) code "02" (to identify the service as being provided via telehealth) and were paid at the facility payment rate. As a result of the pandemic, CMS paid the same PFS rate for telehealth services at the higher non-facility setting amount. For the remainder of the PHE, CMS requires the use of modifier "95" on the claim lines for services furnished via telehealth and required practitioners to report the POS code for the service if it had not been provided via telehealth. Providers could choose to maintain Medicare's billing practice and to continue to use POS code "02" during the PHE.

Beginning on the 152nd day following the end of the PHE, CMS is proposing to revert payment back to the pre-PHE rules and no longer require modifier "95" but to include the appropriate POS code for telehealth services POS "02" as Telehealth Provided Other than a Patient's Home or POS "10" as Telehealth Provided in Patient's Home. This proposal will, in effect, revert payment for these telehealth services to the lower facility rate for the distant site physician or NPP. AMGA disagrees with this position and believes CMS should continue to pay the non-facility payment for telehealth services.

Given CMS' rationale for paying for telehealth services at the non-facility rate during the PHE, it would be reasonable that the same rationale would continue once the PHE has ended. For example, CMS acknowledged in the interim final rule with comment (IFC) published on April 6, 2020, that "it would be appropriate to assume that the relative resource costs of services furnished through telehealth should be reflected in the payment to the furnishing physician or practitioner as if they furnished the services in person, and to assign the payment rate that ordinarily would have been paid under the PFS were the services furnished in-person (85 FR 19233)." This proposal appears to ignore CMS' own reasoning when it previously instructed physicians and practitioners who bill Medicare telehealth services to report the POS code as if the provider furnished the service in person.

AMGA agrees with CMS' rationale as described in the IFC and is concerned that CMS now is moving away from this policy, which will significantly reduce how much Medicare will reimburse providers who bill for telehealth services. For example, as illustrated in the table below, the payment differential for established patient E/M codes is substantial.

HCPCS Code	Short Description	Non-Facility Price	Facility Price	Differential $	Differential %
99212	Office o/p est sf 10-19 min	$57.45	$36.68	$20.77	36%
99213	Office o/p est low 20-29 min	$92.05	$67.48	$24.57	27%
99214	Office o/p est mod 30-39 min	$129.77	$98.97	$30.80	24%
99215	Office o/p est hi 40-54 min	$183.07	$147.08	$35.99	20%

Should CMS pay physicians at the facility price, offering telehealth services will become untenable for AMGA members. The payment amount is not commensurate with the expenses for offering care to patients via telehealth. CMS should not finalize a policy that reimburses providers less for the same care. The staffing and resources needed to provide telehealth are not materially different from what is needed for an in-office visit. Therefore, CMS should continue pay physicians and NPPs at the higher non-facility amount. Further, it would be reasonable to interpret Section 1834(m)(2)(A) of the Social Security Act to align with the higher non-facility payment amount, given the requirement of statute that payment for services furnished to an eligible telehealth individual should be equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system. As such, AMGA believes that CMS should continue to pay the non-facility payment rate or providers will see a significant reduction in reimbursement for telehealth that essentially eliminates telehealth as an option for a significant number of Medicare beneficiaries.

Therefore, AMGA is requesting that CMS reconsider its position and continue to pay appropriately for telehealth services at the non-facility payment rate at the conclusion of the

PHE.

2. **Continuation of Payment for Audio-Only Visits**

During the PHE, CMS reimbursed physicians for telehealth services provided via audio-only telecommunication systems for certain services, including certain behavioral health, counseling, and educational services. CMS will continue to make payment for services furnished via audio-only telecommunications for 151 days after the end of the PHE as required by the Consolidated Appropriations Act (CAA) of 2022. As noted in the CY 2021 PFS final rule, there will be no separate payment for audio-only E/M visits and CMS will assign these codes to the Telephone E/M visit codes "bundled" status. In this proposed rule, CMS does not change this policy and is moving forward with the discontinuation of separate payment for audio-only E/M services at the end of the PHE.

CMS also indicated that the agency rejected requests to permanently add audio-only services to the Medicare Telehealth Services List, as these services are "inherently non-face-to-face services." AMGA believes that CMS should continue to pay for audio-only E/M services on the telehealth list beyond the PHE. CMS acknowledges that many patients do not have access to the devices, such as a smartphone, or the broadband services necessary to receive care through video-based technology. This decision will essentially eliminate another access to care option for a significant percentage of beneficiaries. CMS should reconsider its decision not to continue separate payment for audio-only services. The RVUs for these audio-only codes should be comparable to telehealth and in-person services.

AMGA strongly recommends that CMS permanently add payment for audio-only services rather relegate the Telephone E/M visit codes to "bundled" status.

Behavioral Health Services

> **Comment:** AMGA applauds CMS' commitment to facilitate greater access to behavioral health by permitting certain practitioners to provide behavioral health services under general supervision and establishing new care management service codes for integrated behavioral health services.

In the proposed rule, CMS noted that there is not a separate benefit category under the statute that recognizes the professional services of licensed professional counselors (LPCs), marriage and family therapists (LMFTs), and other behavioral health practitioners. However, CMS noted the need for continuing to provide behavioral health to patients and noted the projected shortage of behavioral health care providers by 2025. As such, CMS is proposing to allow for certain behavioral health practitioners to provide behavioral health services under general supervision instead of direct supervision when provided by auxiliary personnel incident to the services of a physician or NPP.

CMS also proposes to pay for clinical psychologists and licensed clinical social workers for mental health services furnished by these professionals and proposes new care management services codes to provide integrated behavioral health services as part of a patient's primary care team.

This proposal would allow clinicians to practice to the full extent of their license.

AMGA is supportive of both proposals and recommends that CMS finalize as proposed.

Quality Payment Program

1. **MIPS Value Pathways (MVP)**

CMS is proposing to start the MIPS Value Pathways (MVPs) program on a voluntary basis beginning in CY 2023. The MVPs program would include five new MVPs and would revise seven that were finalized in the 2022 Medicare Physician Fee Schedule final rule. While AMGA largely supports the concept of measure alignment—one of the purported goals of the MVP option—the MVP proposal does not improve the faulty traditional MIPS requirements or facilitate the transition to value. AMGA recommends that CMS forgo the MVP concept until improvements are made to the traditional MIPS program. Attempting to reform MIPS without addressing the underlying structural flaws, including the continued inclusion of a low-volume threshold, simply changes the administration of the program without improving the incentives for providers to invest in the infrastructure, staff, and culture change needed to deliver care in a value-based setting.

CMS is also proposing that subgroup reporting will be optional for MVP participants beginning in 2023, but would require multispecialty groups that choose to report through an MVP to participate as subgroups beginning in 2026. CMS further proposes to limit an individual physician to one subgroup. Beyond our general objection to the MVP model, AMGA is concerned that the concept of subgroup reporting undermines the overarching goals of the multispecialty group practice model. Creating subgroups within a group practice would potentially contribute to fragmented care. AMGA opposes the proposal to require multispecialty groups to form a subgroup for MVP reporting.

2. **MIPS Performance Threshold**

CMS is proposing to set the MIPS performance threshold at 75 points. Eligible Clinicians (ECs) with a final score of 75 will receive a neutral payment adjustment. ECs with a final score below 75 will receive a negative payment adjustment. ECs in the bottom quartile (final score of 18.75 or below) will receive a negative payment adjustment greater than -9% and less than 0% on a linear sliding scale. ECs with a final score greater than or equal to 75.01 will be eligible for a positive payment adjustment on a linear sliding scale that ranges from 0% to 9%. The sliding scale is multiplied by a scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality. CMS is basing this threshold by using the mean score from the 2017 MIPS payment year. AMGA agrees with this proposal.

3. **Exceptional Performance Bonus**

As finalized in the 2022 Medicare PFS there will no longer be an exceptional performance threshold in 2023. Under the Medicare Access and CHIP Reauthorization Act of 2015, the $500

million exception performance bonus expires in the payment year 2024. Therefore, 2023 will be the first performance period without a corresponding exceptional performance bonus and exceptional performance threshold. As a result, the only bonuses available for 2023 MIPS participants will be budget-neutral bonuses resulting from penalties to physicians and groups that score fewer than 75 points. As CMS is aware, the MIPS payment adjustments factor in the exceptional performance bonus and in recent years, the bulk of the payment adjustments are based on exceeding the exceptional performance threshold. Without the exceptional performance bonus, the MIPS payment adjustments will be negligible, especially given the program's low-volume threshold. AMGA recommends that CMS work with Congress to develop a plan that would allow for the continuation of the exceptional performance bonus.

4. Low-Volume Threshold

For the MIPS 2023 performance period, CMS is not proposing changes to the low-volume threshold criteria. As a result, those who bill $90,000 or less in Part B-covered professional services, see 200 or fewer Part B patients, and provide 200 or fewer covered professional services to Part B patients will be excluded from the program. However, those who meet at least one, but not all three, of the low-volume threshold criteria may voluntarily opt into MIPS. CMS estimates that 840,224 physicians and qualified healthcare professionals will not be MIPS eligible in the 2023 performance period due to these criteria.[2]

AMGA has long opposed the continuation of the low-volume threshold due to 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. For example, CMS estimates two-thirds of MIPS eligible clinicians will receive a neutral or positive payment adjustment for the 2023 performance period. Conversely, approximately 10% will receive a negative payment adjustment. Such a lopsided distribution of scores creates an unsustainable reimbursement system and undermines congressional intent for the program. Rather than the opportunity to earn a payment adjustment of up to 9%, as authorized by Congress, CMS estimates the maximum payment adjustment will be 2.49%, and the average penalty is calculated to be 1.64%. The maximum bonus would be 6.9%, and the maximum penalty would be 9%. CMS also projects that about 7% of clinicians would receive a score of less than 50 points, resulting in a penalty of more than 3%.

AMGA must object to this policy's continuation, which contributes to negligible payment adjustments. AMGA has concerns that such significantly smaller payment adjustments do not reflect the considerable investments our members have made in transitioning to a payment mechanism that is based on the quality and cost of care provided. Further, the low-volume threshold should be removed from the program. Not only would this improve the distribution of MIPS payment adjustments, but it would also provide meaningful incentives for all providers to move to value-based care.

5. Alternative Payment Models (APMs)

[2] 87 FR 46410.

CMS is proposing, as required by law, to eliminate the 5% Advanced APM bonus at the end of the 2022 performance period. As a result, between 144,700 and 186,000 eligible clinicians will no longer receive MACRA's $600-$750 million payments. The incentive payment was intended to reward physicians and practices who participated in financial risk related to patients' quality outcomes and costs. AMGA notes that the providers are facing significant cuts in Medicare payment and the loss in revenue from the absence of the 5% incentive payment exacerbates the problem. Therefore, it is imperative that CMS uses any available authority to ensure that the 5% qualifying APM participant (QP) bonus is preserved to facilitate continued access to quality care for patients. AMGA opposes the expiration of the incentive payment for these bonuses, which have been instrumental in encouraging participation in risk-based APMs.

AMGA recommends CMS work with Congress to prolong these bonuses and provide this incentive to entice more providers to enter into APMs to extend the benefits to more beneficiaries. AMGA believes that more providers in APMs will lead to improved quality of care provided to patients, while also providing savings to the Medicare Trust fund.

In addition, the thresholds to achieve Medicare Option QP status beginning in the 2023 performance period will increase to 75% for the payment amount and 50% for the patient count. The partial QP thresholds will be 50% and 35% for the payment and patient count methods, respectively. These requirements are unlikely to be met and will not attract the critical mass of physicians and medical groups necessary to ensure the success of the program. AMGA recommends that CMS eliminate these thresholds to allow for more Advanced APM participation.

Medicare Shared Savings Program

AMGA and its members are strong supporters of the transition to value-based care and the MSSP. Based on the changes to the MSSP proposed in this rule, it is evident that CMS has seriously considered comments from the stakeholder community in how to refine and improve the program, its signature value-based care model.

AMGA appreciates that CMS is working to address stakeholder concerns and, as detailed below, agrees with several of the proposed changes. However, for AMGA members to provide care in a value-based model successfully, including through an ACO, and for CMS to evaluate the effectiveness of the model, stability and transparency are vitally important. AMGA is concerned that the MSSP has undergone several substantial changes in a very short timeframe. April 2022 marked the 10-year anniversary of the start of the agreement period for the first ACO. In that time, CMS finalized many significant changes creating instability within the program and confusion for stakeholders. One of the major overhauls only occurred a few short years ago as part of 2018 *Pathways to Success* final rule. Now, not even five years later, CMS is proposing additional changes to the underlying structure of the model. While these changes may be warranted and result in improvements to the program, AMGA is concerned the frequency of the changes may undermine the stability of the model and the ability of providers to effectively model and predict their performance. AMGA recommends CMS trend towards regulatory predictability, and strongly evaluate the needs of ACO providers and the manner in which these providers deliver care before considering further changes.

1. Additional Time in Glidepath

CMS is proposing to amend the current schedule under which MSSP ACOs are required to transition from the one-sided risk model to a two-sided risk model. Under the proposal, for performance years beginning on January 1, 2023, ACOs currently at Level A or Level B of the BASIC track will have the option to continue in their current level of the glide path for the remainder of their agreement period.

For agreement periods beginning on January 1, 2024, inexperienced ACOs may participate in one five-year agreement under a one-sided shared savings model by entering the BASIC track's glide path and remaining in Level A for all five years. These ACOs may be eligible for a second agreement period within the track's glide path for an additional two years, effectively providing these ACOS with up to seven years in a shared-savings-only model. CMS is also proposing to eliminate the limitation on the number of agreement periods an ACO could participate in Level E of the BASIC track. Further, CMS is proposing to make participation in the ENHANCED track optional.

In earlier comments, AMGA noted that although we support the move to risk-bearing models, our members have expressed concern that limiting upside agreements to two years does not take into account operational challenges in transitioning to two-sided risk.[i] AMGA is pleased CMS is providing ACOs with additional time in one-sided models. This additional time will provide ACOs and their participants with the time needed to design care delivery and develop practice patterns based on the cost and quality of the care provided. AMGA also supports the proposal to provide ACOs with the option of advancing beyond the glidepath and into the ENHANCED track. However, CMS may wish to consider adding an option for those already participating ACOs that, due to the changes made as part of the Pathways rule, were required to advance into two-sided risk more rapidly than they would have otherwise. These ACOS may benefit from having the option to revert to a one-sided model or to have the ability to reduce the level of risk on the BASIC track.

2. Proposed Changes to Financial Methodology

CMS is proposing a number of changes to the financial methodology for the ACO program. These changes are designed to create benchmarks that are more accurate and account for an ACO's previous savings. AMGA is pleased to see CMS address these issues but is concerned the program is becoming increasingly complex. Sophisticated modeling is necessary to determine if an ACO has a realistic opportunity to be successful in the program, even before an ACO implements changes in care delivery and quality improvement or other population health initiatives. AMGA is concerned that the increasing complexity of the model will be a barrier to participation in the MSSP. A transparent, clear, and predictable regulatory and governing structure are important aspects of the MSSP if the model is to attract and retain provider participants.

While AMGA conceptually supports several of the proposed changes, the frequency of modifications to the program and their increasing complexity may ultimately hinder, rather than

promote, participation. Despite these concerns, AMGA appreciates the steps that CMS is taking to improve the ACO program and address issues with accounting for previous savings, risk adjustments, and regional adjustments. As proposed, the changes would be restricted to ACOs with new agreements starting in 2024. As a result, few ACOs will have the opportunity to avail themselves of the changes. ACOs should have the option, at their discretion, of opting into the changes without having to complete the early renewal process.

3. Improving Risk Adjustment Methodology

CMS is proposing changes to the MSSP's risk adjustment methodology to account for medically complex, high-cost patients. Under the proposal, CMS would account for changes in the demographic risk scores for the ACO's assigned population across all four enrollment types before applying the 3% cap on HCC risk scores. AMGA agrees with this proposal, as applying the cap at the aggregate level will help address any volatility in year-to-year changes in any of the subgroups, particularly the End-Stage Renal Disease group.

4. Incorporation of Prospective Update Factor

CMS is proposing to use a prospective administrative growth factor to update an ACO's benchmark for each performance year in an ACO's agreement period. Called the Accountable Care Prospective Trend (ACPT), this growth factor would be used to create a three-way blend with the existing national and regional growth rates. The addition of the ACPT is to account for any savings the ACO has earned from unduly influencing an ACO's benchmark. Notably, this adjustment would not remove ACO-assigned beneficiaries from the regional comparison group. AMGA notes that including assigned beneficiaries in calculating regional expenditures undermines the goal of comparing or weighting ACO performance. AMGA is concerned that any changes to the growth factor or examination of regional spending will continue to be flawed if ACOs patients are included in the regional adjustment.

AMGA is not opposed to the use of the ACPT. However, AMGA recommends CMS take steps to ensure ACOs are not harmed by benchmarks that are lower because of the ACPT. Until CMS and the ACO community are confident the ACPT and the three-way blend is the most appropriate method to update the benchmark, they should calculate the updated benchmark with the new method and under the current national-regional blend as finalized in the Pathways to Success rule. The ACO would then select the updated benchmark of its choosing.

CMS also noted that it will retain the option to change the weight given to the ACPT in the new formula. As proposed, the ACPT would account for one-third of the benchmark (with the existing national-regional blend accounting for the other two-thirds). CMS said it could change this one-third to two-thirds ratio. Given that these adjustments could occur during the performance year, CMS should provide additional detail on how and why it would make an adjustment. AMGA is concerned that adjusting the trend could result in additional uncertainty for ACOs and, to avoid this, CMS should streamline this weighting to create stability within the benchmarks to support more predictability for performance.

5. Accounting for Prior Savings in Rebased Benchmarks

CMS is proposing to incorporate an adjustment for previous savings to establish benchmarks for renewing or reentering ACOs. This proposal is an attempt for future benchmarks to account for an ACO's successful efforts to reduce spending growth while meeting the MSSP's quality performance standard. AMGA appreciates that CMS is working to address the "ratchet effect" on an ACO's benchmark by accounting for an ACO's success in lower spending growth. However, CMS should modify its proposal. Instead of adjusting an ACO's earned shared savings by 50%, CMS should use an ACO's maximum shared savings rate from their previous agreement period to prorate the positive average per capita savings.

Reduction of the Cap on Negative Regional Adjustments

The rule includes a proposal designed to reduce the effect of negative regional adjustments on ACO benchmarks. To do so, CMS is proposing to reduce the cap on negative regional adjustments from -5% of national per capita spending to -1.5%. After applying the cap, CMS would progressively decrease the negative regional adjustment amount based on the ACO's proportion of dual-eligible beneficiaries or the weighted-average hierarchical condition code (HCC) risk score increases. Effectively, the decrease in the negative regional adjustment is based on the proportion of dual-eligible beneficiaries or higher HCC risk scores.

CMS estimated that nearly all ACOs would benefit from this proposal. In the rule, CMS notes that it considered, but ultimately opted not to limit the proposal only to those ACOs that would have had a negative weighted average regional adjustment under the current policy. AMGA recommends that CMS finalize the proposal and agrees with CMS' decision not to limit the change and to apply it to all ACOs as applicable. AMGA also recommends that CMS monitor the effect of the proposal on ACOs, particularly those caring for high-cost or medically complex patients.

6. Quality Performance Standard and Reporting

CMS is proposing to eliminate the "all-or-nothing" standard that is used to determine if an ACO's quality performance is sufficient to earn shared savings. CMS is proposing a scaling of shared savings rates for ACOs that are below the quality performance standard, which is the 30th percentile of the MIPS Quality Performance Category Score for PY 2023 and the 40th percentile of the MIPS Quality Performance Category Score for PY 2024 and subsequent performance years. Effectively, an ACO that does not meet requirements under the quality performance standard to qualify for the maximum sharing rate, but does earn a quality performance score equal to or higher than the 10th percentile of the performance benchmark on at least one of the four outcomes measures in the APM Performance Pathway (APP) measure set could still qualify for shared savings, albeit at a lower rate.

AMGA agrees with the proposal. The "cliff" created by the all-or-nothing standard prevented ACOS from earning any savings, even if their quality performance was a fractional amount below the cutoff. AMGA agrees with CMS that this change will mitigate the effect of minor differences in quality scoring.

7. Health Equity Adjustment

CMS is proposing a health equity adjustment for ACOs that report the three all-payer eCQMs/ MIPS CQMs and perform in the top two-thirds and serve a high dual population or a population with a high area deprivation index (API). CMS will add the additional points to the MIPS Quality Performance Category Score that is used to determine shared savings and shared losses.

AMGA agrees with the proposal. However, AMGA requests CMS include the ability for all MSSP ACOs to be able to benefit from this proposal, given the fact that ACOs are also measured on their performance on the two-claims-based measures which include an all-Medicare population. This, in fact, will help to ensure the ACOs serving certain high-risk patients in Medicare will also be rewarded for high-quality care provided to these patients.

8. Beneficiary Notification Requirements

Under current ACO requirements, participants must post signs and provide an annual written notice to beneficiaries that its providers are participating in the MSSP. CMS is proposing to revise the beneficiary notification requirements. CMS is clarifying that beneficiary notification signs must be posted in all ACO participant facilities, even if primary care services are not provided in each facility. AMGA recommends that CMS eliminate the posted notice requirement, particularly in non-primary care facilities. The notices contribute little to beneficiary education, especially given beneficiary confusion around what an ACO is and what is meant by "value-based care."

CMS is also proposing to adjust the frequency of the annual standardized written notices. Instead of the current requirement of once per performance year, ACOs will need to provide the notice only once per five-year agreement period. CMS would require ACOs to provide the standardized written notice either before or at the first primary care service visit during the first performance year in which the beneficiary receives a primary care service from an ACO participant.

AMGA appreciates that CMS is reducing the frequency requirement and recommends that CMS finalize its proposal.

9. SNF Three-Day Rule Waiver Application Review Process

Currently, ACOs in two-sided risk tracks may apply for the Skilled Nursing Home (SNF) Three-Day Rule Waiver. As part of the current application process, ACOs must submit a SNF affiliate list with agreements and narratives describing how the ACO will implement the waiver. CMS is proposing to remove the requirement that ACOs submit a plan narrative and instead allow ACOs to attest that they have them in place. AMGA recommends that CMS finalize this proposal.

AMGA also would encourage CMS to reconsider the restriction of the SNF waiver in the BASIC track to Level C through E models. AMGA strongly recommends that the waiver be available to all ACOs in the BASIC glidepath. As we noted in our original comment to CMS in its 2014 proposed rule, ACO program participants need the ability to redesign their

practice patterns before they are required to take on financial risk. Offering the SNF waiver to all ACOS, regardless of risk level, allows providers to design their care delivery models based on all the tools available. Limiting the SNF waiver to those ACOs under two-sided risk does not serve as an incentive to move into a risk-bearing model, but rather simply withholds an important aspect of modern care delivery. All ACO providers should have the ability to use the SNF waiver.

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

[i] AMGA Comments on "Medicare Program: Medicare Shared Savings Program; Accountable Care Organizations – Pathways to Success," proposed rule (CMS-1701-P). Oct. 16, 2018