September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: 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 [CMS-1807-P]

Dear Administrator Brooks-LaSure:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the calendar year (CY) 2025 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule, published in the *Federal Register* on July 30, 2024.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups comprising more than 350,000 physicians. These groups range from small independent practices in remote and other underserved areas to large regional and national health systems that cover the full spectrum of physician specialties.

Key Recommendations

MGMA appreciates the Centers for Medicare & Medicaid Services' (CMS) leadership in overseeing the Medicare program and working to make improvements for patients and providers. We respectfully offer the following comments in response to the CY 2025 PFS proposed rule. CMS should:

- **Work with Congress to provide a positive update to the Medicare conversion factor in CY 2025 and all future years.** MGMA remains deeply concerned with the estimated reduction to the CY 2025 conversion factor and its impact on medical group practices. Conversion factor cuts over the past five years have compounded well-documented administrative and financial pressures facing medical groups. These ongoing cuts coupled with a lack of an inflationary update further exacerbate these issues and undermine the ability of physician practices to provide high-quality care — the current situation is untenable and must be remedied immediately.

- **Work with Congress to extend telehealth flexibilities past the end of 2024 while utilizing its full statutory authority to permanently cover telehealth services**. Medical groups continue to utilize telehealth services to best serve their patients — access to care will be significantly impacted if the current policies in place such as geographic and originating site flexibilities are not extended.

- **Finalize many of the telehealth proposals, including permanently covering audio-only visits, extending its direct supervision policy, and distant site practitioner provisions while continuing to promote the appropriate use of telehealth.**

- **Finalize, with additional flexibilities, the Medicare overpayments proposal that would allow for the suspension of the 60-day repayment deadline under certain circumstances including when a provider identifies an overpayment but needs more time to investigate its full extent.** We appreciate that this extension could last up to 180 days from the date the overpayment is identified, but CMS should include flexibilities for situations that require longer timeframes to investigate overpayments.

- **Provide further clarity and robust guidance surrounding the utilization of HCPCS code G2211 while moving forward with allowing G2211 to be billed with annual wellness visits, vaccine administration, and any Medicare Part B preventative service.**

- **Work to reduce the significant administrative burden medical groups face under the current construction of the Merit-based Incentive Payment System (MIPS)**. CMS should examine comprehensive changes to MIPS — through its regulatory authority and working with Congress — to ensure the program works as intended and promotes Medicare beneficiary access to care.

- **Finalize maintaining the MIPS performance threshold at 75 points**. CMS should ensure its methodology avoids unsustainable increases to a MIPS performance threshold that is already too high. While we support maintaining the performance threshold at 75 points in the proposed PFS, we strongly urge CMS to reduce the performance threshold to an appropriate level.

- **Ensure that MIPS Value Pathways (MVPs) reporting remains voluntary and work with the physician specialties to design MVPs that are workable and appropriate.** Do not sunset the MIPS program in the future before MVPs and other value-based care models are mature enough to capture the full spectrum of medical groups.

- **Reverse its Promoting Interoperability performance category reporting requirements set to take effect in 2025 within the Medicare Shared Savings Program (MSSP).** This requirement is not only being implemented too quickly as it will negatively impact participation next year, but the policy is overly burdensome, and works against incentivizing participation in the MSSP and the intention of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA).

- **Finalize many of the MSSP proposals including the flexibilities related to the attributed patient count, the health equity benchmark adjustment, advanced prepaid savings, and more.** MGMA appreciates CMS including proposals meant to promote participation in accountable care organizations (ACOs) — the agency should ensure these policies are not in conflict with other proposals that may dissuade participation.

- **Work with Congress to reinstate the Advanced Payment Model (APM) incentive payment at 5% and maintain the current Qualifying APM Participant (QP) thresholds instead of increasing them.** The expiration of the current 1.88% incentive payment and transition to a "qualifying APM conversion factor" has the potential to disincentivize participation in APMs — contrary to CMS' intention — and negatively impact current APM participants' ability to

continue providing value-based care. Setting the QP thresholds at an unreachable level further hinders participation in APMs and works to undermine CMS' goal of transitioning to value-based care arrangements.

Physician Fee Schedule

Conversion Factor

CMS proposal (89 Fed. Reg. 61599): CMS estimates the 2025 Medicare PFS conversion factor to be $32.3562, a decrease of $0.9313, or approximately 2.80%, from the CY 2024 PFS conversion factor of $33.2875. This is due to statutory budget neutrality requirements and the expiration of congressional legislation.

MGMA comment: MGMA recognizes that CMS is constrained by statutory budget neutrality requirements, however, we remain deeply concerned about the impact of the estimated reductions to the conversion factor in CY 2025. The 2.8% decrease to the conversion factor, coupled with the current inflationary environment and other ongoing financial pressures — staffing shortages, increased administrative burden, and more — is unsustainable for medical groups. The 2024 Medicare Board of Trustees' annual report outlines the inadequacy of Medicare payment and its potential impact on Medicare participation: "While the physician payment system put in place by MACRA avoided the significant short-range physician payment issues resulting from the SGR system approach, it nevertheless raises important long-range concerns that will almost certainly need to be addressed by future legislation … Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term."[1]

This echoes what medical groups are saying as 87% of groups reported that reimbursement not keeping up with inflation impacted current and future Medicare patient access; as one MGMA member stated, "[b]etween the reimbursement cuts and increasing regulatory costs, keeping the doors open becomes more challenging daily."[2] MGMA has heard from members for years that Medicare cuts significantly undermine their ability to operate. Practices have detailed having to consider limiting the number of new Medicare patients, reducing charity care, reducing number of clinical staff, and closing satellite locations should Medicare payment continue on this trajectory.[3]

Moreover, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress provide a positive update to the PFS for 2025.[4] MGMA members continue to see costs increase, with 92% of respondents of a recent poll citing increased operating costs in 2024. With the Medicare Economic Index (MEI) predicted to be 3.6% for 2025, these cuts — coupled with the lack of an inflationary update — push Medicare reimbursement further away from adequately covering the cost of care, again undermining practices' financial viability.

MGMA asks CMS to work with Congress and advocate for a positive update to the Medicare conversion factor in CY 2025 and all future years. We support the passage of the *Strengthening Medicare for Patients and Providers Act* (H.R. 2474), which would provide an annual Medicare physician payment

[1]2024 Medicare Board of Trustees, Annual Report, May 6, 2024, https://www.cms.gov/oact/tr/2024.
[2] MGMA, 2023 Annual Regulatory Burden Report, Nov. 2023, https://www.mgma.com/getkaiasset/423e0368-b834-467c-a6c3-53f4d759a490/2023%20MGMA%20Regulatory%20Burden%20Report%20FINAL.pdf.
[3]MGMA, Impact of Payment Reductions to Medicare Rates in 2023, Sept. 8, 2022, https://www.mgma.com/federal-policy-resources/impact-of-payment-reductions-to-medicare-rates-in-2023.
[4] MedPAC, Mar. 2024 Report to Congress: Medicare Payment Policy, https://www.medpac.gov/document/march-2024-report-to-the-congress-medicare-payment-policy/.

update tied to inflation as measured by the MEI. Additionally, we support the *Provider Reimbursement Stability Act* (H.R. 6371) that would modernize antiquated statutory budget neutrality requirements that have led to this dire situation.

Telehealth

Expiration of Several Provisions of the Consolidated Appropriations Act of 2023

CMS proposal (89 Fed. Reg. 61789): The proposed rule acknowledges that several important telehealth provisions of the *Consolidated Appropriations Act of 2023* (CAA, 2023) which extended certain telehealth flexibilities instituted during the COVID-19 Public Health Emergency (PHE) through Dec. 31, 2024, are scheduled to expire. These include extending geographic and originating site flexibilities, and the expanded list of qualifying providers to include qualified occupational therapists, physical therapists, speech-language pathologists, and audiologists.

MGMA comment: While MGMA appreciates CMS using its authority to extend certain flexibilities and make permanent several policies expanding access to telehealth, the expiration of these central telehealth policies will make it exponentially more difficult for many patients to receive care. These flexibilities have allowed practices to continue providing necessary telehealth treatment to their communities through a variety of modalities — the agency should work closely with Congress to craft a permanent solution that extends beyond 2024.

CMS should further utilize its full statutory authority to permanently extend more policies that facilitate access to care wherever possible. An abrupt cut off to these vital services could severely impact patients all over the nation.

Direct Supervision

CMS proposal (89 Fed. Reg. 61633): The agency would continue to define direct supervision to allow the presence and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications through Dec. 31, 2025. Further, CMS proposes to permanently define "direct supervision" that allows for the immediate availability of the supervising practitioner using audio/video real-time communications technology (not including audio-only) for the following subset of incident-to services:

- Services furnished incident to a physician or other practitioner's service when provide by auxiliary personnel employed by the billing practitioner, under direct supervision, and for which the underlying HCPCS code has been assigned PC/TC indicator of '5': and,
- Services described by CT code 99211 (Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional).

CMS is proposing an incremental approach to permanently adopting the definition of direct supervision to permit virtual presence for services that are lower risk.

MGMA comment: We continue to agree with CMS' safety and quality concerns that there may be potential consequences resulting from the transition to pre-PHE direct supervision policies. We support the extension of the current direct supervision policy and the permanent adoption of direct supervision to allow virtual presence for lower risk services. Given widespread physician and staffing shortages, these policies help to facilitate care. We urge CMS to consult with practitioners using real-time audio and video

interactive telecommunications to find a permanent workable policy that allows flexibility for additional clinical situations that may arise.

Frequency Limitations

CMS proposal (89 Fed. Reg. 61631): CMS is proposing to extend its flexibilities related to frequency limitations for certain telehealth services. Specifically, the agency will remove the frequency limitations for calendar year 2025 for the following codes: critical care consultation services HCPCS codes, subsequent nursing facility visit CPT codes, and subsequence inpatient visit CPT codes.

MGMA comment: MGMA supports CMS extending its policy removing frequency limitations for certain telehealth services. We believe CMS should permanently lift these restrictions due to the increased adoption of remote models and certain agency programs.

Audio-Only Communication Technology to Meet the Definition of "Telecommunications System"

CMS proposal (89 Fed. Reg. 61632): CMS is proposing to update the regulation of an interactive telecommunications system to include two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site practitioner is technically capable of using an interactive telecommunications system but the patient is not capable of, or does not consent to, the use of video technology. This change would take effect Jan. 1, 2025. The following modifiers must be appended to claims to verify these conditions — CPT modifier "93", and for RHCs and FQHCs, Medicare modifier "FQ." Practitioners have the option to use either or both modifiers where appropriate.

MGMA comment: MGMA applauds CMS for permanently allowing audio-only telehealth services to be utilized past Dec. 31, 2024. These services offer a lifeline to patients who do not have access to broadband or the necessary technology for audio-visual visits and have proven successful in growing access to care. The agency should move forward with this policy and provide guidance to providers.

Distant Site Practitioners

CMS proposal (89 Fed. Reg. 61633): CMS is proposing to continue allowing distant site practitioners to use their currently enrolled practice location instead of their home address when providing telehealth services from their homes through the end of 2025. This policy was scheduled to end on Dec. 31, 2024, without CMS' proposed extension of an additional year.

MGMA comment: MGMA appreciates CMS including this proposed provision in the PFS and supports this policy. During the PHE, CMS allowed practitioners to render telehealth services from their homes without reporting their home addresses on their Medicare enrollment forms and allowed billing from their currently enrolled location. CMS continued its policy of allowing providers to list their work address on their Medicare enrollment form while billing telehealth services from their home until Dec. 31, 2024.

We urge CMS to make permanent the policy it established during the PHE to appropriately balance protecting providers' need for privacy of their home address with program integrity concerns. Security for practitioners at home is paramount as this information may be publicly available should they be required to report. Allowing practitioners to provide these services without requiring reporting of their home address and safeguarding their privacy outweighs the potential benefits of having practitioners home addresses listed publicly.

E/M Services

Add-on Code (HCPCS Code G2211)

CMS proposal (89 Fed. Reg. 61697): CMS previously finalized E/M add-on code HCPCS code G2211 (*Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)*). CMS is allowing for the payment of the G2211 add-on code when the office/outpatient E/M base code is reported by the same practitioner on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service in the office or outpatient setting.

MGMA comment: MGMA has historically agreed with CMS that reimbursement for E/M visits may not always adequately reflect the resources associated with primary care and certain types of specialty visits. We appreciate CMS' proposal to allow G2211 to be billed with vaccine administrations, annual wellness visits, and with any Medicare Part B preventive services. We continue to believe it necessary for CMS to provide more information and overall clarity on the billing of G2211 to ensure practices understand the parameters of the code.

In our previous PFS comments, we raised a series of questions aimed at better understanding how medical groups should utilize HCPCS code G2211, including seeking guidance around documentation and differentiating when to use this code versus billing a higher-level visit, as well as the typical patient who is expected to receive these services. Lack of clarity may impede medical groups' readiness and/or willingness to use HCPCS code G2211. While we are thankful CMS recently released an FAQ on G2211, the agency must share more robust guidance around usage with the provider community.

Behavioral Health

CMS proposal (89 Fed. Reg. 61741): CMS is proposing several new payment and coding policies related to behavioral health including: new add-on G-code (GSPI1) to be billed with an E/M visit or psychotherapy service when Safety Planning Interventions are performed for patients in crisis including those with suicidal ideation or at risk of suicide or overdose; a monthly billing code (GFCI1) for Post-Discharge Telephonic Follow-up Contact Intervention performed following discharge from an emergency department crisis encounter as a bundled service describing four calls in a month; three new HCPCS codes (GMBT1, GMBT2, GMBT3) for the initial patient education and use of an FDA digital mental health treatment device; and six new G codes (GIPC1, GIPC2, GIPC3, GIPC4, GIPC5, GIPC6) that would allow Clinical Psychologists, Clinical Social Workers, Marriage and Family Therapists, and Mental Health Counselors to bill for interprofessional consultations with other practitioners.

MGMA comment: MGMA supports CMS' efforts to expand patient access to behavioral health services and is encouraged by its proposals. However, we urge the agency to ensure that the three related new HCPCS codes (GMBT1, GMBT2, and CMBT3) to support digital mental health treatment do not overlap with the existing CPT codes 98975, 98978, 98980, and 98981. MGMA is concerned that the proposed HCPCS codes and the aforementioned CPT codes could result in confusion. CMS needs to work to provide comprehensive guidance and education that will be needed for providers to understand exactly how to bill these codes.

Advanced Primary Care Management (APCM) Services

CMS proposal (89 Fed. Reg. 61702): CMS is proposing to establish a new set of coding and payment for a newly defined set of primary care services furnished by physicians and non-physician practitioners

who use an advanced primary care model. These three new HCPCS G-codes (GPCM1, GPCM2, GPCM3) would incorporate existing care management and communication technology-based services into a bundle of services that would be stratified to reflect patient medical and social complexity. These new care management services would not be time-based.

CMS is proposing APCM practice level performance measurement requirements for primary care quality, total cost of care, and meaningful use of CEHRT. Providers participating in ACO Reach, Making Care Primary, the Value in Primary Care MVP, and the Primary Care First model would satisfy the performance measurement requirements through their participation in the models.

MGMA comment: MGMA appreciates the agency's efforts to support advanced primary care management services that give providers the flexibility to offer services otherwise not covered. CMS should work closely with primary care practices and the appropriate physician specialties to understand the proposed codes true cost and ensure they are workable in practice.

We also urge the agency to ensure that there are few barriers to utilization. There are numerous concerns surrounding many of the reporting requirements that are amplified in smaller practices such as the well-documented EHR and data reporting infrastructure that is expensive to institute, as well as the onerous 20% co-payment requirements for certain APCM codes. Further, we encourage CMS to ensure there is comprehensive guidance for these new sets of codes that is accessible, clear, and enables providers to appropriately bill these codes.

Advanced Primary Care Hybrid Payment Request for Information

CMS request for comment (89 Fed. Reg. 61724): As part of its desire to increase participation in accountable care relationships**,** CMS is soliciting input regarding a potential CMS Innovation Center (CMMI) model that would offer hybrid payments — a mix of fee-for-service and population-based payments — to primary care physicians who meet certain criteria.

MGMA comment: MGMA appreciates CMS' engagement in developing models to increase value-based care participation. These models must be voluntary, clinically appropriate, and include adequate payments to practices. Medical groups need models that are financially viable and stable to ensure successful participation. CMS should continue to engage and test models, not only for primary care, but for other specialties as well given that 78% of MGMA members reported that Medicare does not offer an Advanced APM that is clinically relevant to their practice.[5]

Cardiovascular Risk Assessment and Management

CMS proposal (89 Fed. Reg. 61728): CMS is proposing new coding (HCPCS code GCDRA) and payment for Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment and risk management. If implemented, the ASCVD would be coded with an E/M visit.

MGMA comment: MGMA agrees with CMS' efforts to expand patient access to cardiovascular risk management services. We encourage the agency to work with physician specialty societies to ensure that this new coding and payment aligns with clinical intent.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

CMS proposal (89 Fed. Reg. 61790): CMS is proposing to continue allowing direct supervision via interactive audio and video telecommunications (excluding audio-only) in FQHCs and RHCs through

[5] *Supra* note 2.

Dec. 31, 2025. The agency plans to continue delaying the in-person visit requirement for mental health services administered by FQHC and RHC via communication technology to patients in their homes until Jan. 1, 2026.

MGMA comment: MGMA applauds CMS' proposal to continue allowing direct supervision via telecommunications and continue delaying the in-person visit requirement for mental health services in FQHCs and RHCs. We urge CMS to consult with practitioners using real-time audio and video interactive telecommunications to find a permanent workable policy that allows flexibility for the various clinical situations that may arise.

Global Surgical Packages

Strategies for Improving Global Surgery Payment Accuracy

CMS proposal (89 Fed. Reg. 61730): CMS proposes to require the use of existing modifiers (-54, -55, -56) for all 90-day surgical packages in any case when a practitioner (or another practitioner from the same group practices) expects to furnish on the pre-operative (-56), procedure (-54), or post operative portions of a global package. This includes, but is not limited to, when there is a formal documented transfer of care or an informal, non-documented but expected transfer of care. CMS is also proposing a new add-on code, GPOC1, for post-operative care services to reflect the time and resources involved with these post-operative visits to account for the resources practitioners utilize when not involved with the surgical procedure.

MGMA comment: MGMA urges CMS to work with surgical specialties to ensure that global surgical packages are accurately valued. There are also questions surrounding what constitutes an informal transfer of care. Significant education will be needed to understand how to use these modifiers appropriately should CMS move forward with this policy. CMS should further clarify any ambiguities with the new add-on code with detailed guidance before implementation.

Overpayment Provisions of the Affordable Care Act (ACA)

CMS proposal (89 Fed. Reg. 62006): CMS is proposing to revise the repayment deadlines for overpayments under Parts A and B. The proposal would allow for the suspension of the 60-day repayment deadline under certain circumstances including when a provider identifies an overpayment but needs more time to investigate its full extent. This extension could last up to 180 days from the date the overpayment is identified. Providers would be required to return the overpayment within 60 days once the 180-day extension expires or the investigation is completed, whichever occurs first.

MGMA comment: MGMA appreciates CMS' intent to increase flexibility for overpayment reporting and repayment. This proposal would allow providers additional time to conduct more thorough investigations of overpayments, which can be complex and administratively burdensome. However, we are concerned that the proposed rule reflects the simplest version of an overpayment investigation. There are instances where complex overpayment identification requires longer investigations; payments made in cases where 180 days allows for only partial investigation could result in administrative challenges such as inaccurate or multiple repayments.

As such, we recommend CMS extend the flexibility offered in the proposed rule and allow for practices to request deadline extensions where applicable. Furthermore, we are requesting additional clarification to ensure that there will be sufficient time for practices to organize payments following an investigation given the proposed rule states payment would be due on the date the overpayment investigation concludes.

Clinical Laboratory Fee Schedule

CMS proposal (89 Fed. Reg. 61812): CMS is proposing to make conforming changes to the data reporting and payment requirements for clinical diagnostic laboratory tests (CDLTs). For the data reporting period from Jan. 1, 2025, through March 31, 2025, the corresponding data collection period will be Jan. 1, 2019, through June 30, 2019. After this period, CMS will continue data reporting every three years. The proposed rule would phase-in payment reductions; payment for clinical laboratory diagnostic tests in CY 2024 would not be reduced below the CY 2023 payment and for CY 2025 through CY 2027, payment would not be reduced more than 15% below the proceeding calendar year rate.

MGMA comment: Laboratory testing furnished at the point of care, such as in a physician's office, enhances patient-centered care and outcomes while also decreasing the costs of care coordination and administrative processes in the healthcare system. MGMA recommends CMS use its authority to avert the significant reduction in payment for critical healthcare tests to maintain patient access to medically necessary diagnostic testing. MGMA has long expressed concerns with the flawed data collection and reporting process used to reduce CDLT payment rates.

MGMA reiterates our concerns about the impact of these reductions on CDLTs which will force physician office laboratories (POL) to cease providing testing in office, reducing patient access to testing. Improving payment for diagnostic testing will support efforts to reduce waste throughout the healthcare system. Patients with chronic conditions, such as diabetes, heart disease, and common cancers, rely on routine testing to avoid costly interventions. MGMA supports the passage of the *Saving Access to Laboratory Services Act* (H.R. 2377) which would require the collection of accurate and representative data from the entire laboratory market that serves Medicare beneficiaries, setting a sustainable path forward for laboratory reimbursement.

Medicare Shared Savings Program (MSSP)

Although many of CMS' proposed MSSP policies would build on its work of the last few years and help support Accountable Care Organizations (ACOs) and medical groups participating within ACOs to provide high-quality, cost-effective care, there are a few glaring omissions in the proposed PFS that would discourage participation. We urge CMS not to implement regressive policies that undermine the fundamental aspects of ACOs and encourage the agency to institute proposals that effectuate sustained ACO success and allow for more practices to voluntarily join these value-based care arrangements.

Quality Reporting under MSSP

CMS proposal (89 Fed. Reg. 61837): CMS has established numerous quality reporting options over the previous years for MSSP ACOs, such as the introduction of the Medicare CQM in the 2024 PFS. The agency intends to sunset the MIPS CQM and the Web Interface reporting options in the 2025 performance year.

MGMA comment: While we supported the establishment of the Medicare CQM for ACOs in the last year's PFS and appreciate the agency not transitioning to all payer/all patient reporting too rapidly, removing the MIPS CQM and Web Interface reporting options penalizes ACOs that have made investments in reporting under these systems and financially hinders their ability to succeed in the program.

We still harbor concerns about CMS moving too quickly to all payer/all patient digital quality reporting without the proper infrastructure being in place. Requiring ACOs to report all payer/all patient digital

measures in the future without significant policy changes is infeasible as ACOs must make changes to operational workflows, secure new technologic capabilities, and familiarize themselves with reconfigured measure sets, all which require the attention of dedicated staff as well as an upfront financial investment for EHR upgrades.

ACOs often are comprised of multiple group practice TINs that all work in concert to achieve the goals of the ACO, and there may be significant data-sharing limitations that groups will encounter moving to all payer/all patient reporting. There are substantial costs associated with making the technological upgrades needed to report all these measures as well. CMS should not move forward with sunsetting MIPS CQMs and the Web Interface reporting options prematurely in 2025, but rather extend these programs for at least three years to facilitate the development of the necessary infrastructure for all payer/all patient digital reporting. Additional financial incentives and support are needed to continue on this trajectory and avoid heaping uncertainty and significant costs onto ACOs and medical groups.

Promoting Interoperability Reporting in 2025

MGMA comment: In the 2024 PFS, CMS finalized the requirement that MSSP participants must report the MIPS Promoting Interoperability (PI) performance category. Starting in the 2025 performance year, unless otherwise excluded, all MSSP participants, including QPs and partial QPs, regardless of track, must satisfy PI requirements.

While CMS did not address this policy in the proposed 2025 PFS, MGMA continues to strongly oppose requiring ACOs to report on the MIPS PI performance category. This policy does not appropriately facilitate the transition to value-based care, but further hampers participation by requiring additional reporting burdens that may harm ACOs and participating groups beginning in 2025.

A major benefit of participating in an ACO that qualifies as an advanced APM is the reduced reporting requirements. QPs are excluded from reporting in the MIPS program as established under MACRA — requiring QPs to report the PI performance category contravenes the intention of the statute. “Relief from MIPS reporting,” as one MGMA member phrased it, is a major incentive to join an APM — this policy undercuts CMS’ value-based care goal of having all beneficiaries in an accountable care arrangement by 2030. MGMA and many other physician organizations have raised substantial issues with this policy to CMS over the past year. We echo these concerns here — we urge the agency not to move forward with these burdensome reporting requirements.

Health Equity Benchmark Adjustment (HEBA)

CMS proposal (89 Fed. Reg. 61887): CMS proposes a health equity benchmark adjustment (HEBA) for agreement periods starting on Jan. 1, 2025. CMS would adjust an ACO’s historical benchmark using a HEBA based on the proportion of the assigned beneficiaries enrolled in Medicare Part D low-income subsidy (LIS) or dually eligible for Medicare and Medicaid. This policy has been informed by the ACO Reach model and is intended to incentivize ACOs to treat beneficiaries in rural and underserved communities while encouraging those already doing so to remain in the MSSP.

CMS would calculate the HEBA as the multiplicative product of the HEBA scaler of proportions of the ACO’s assigned beneficiaries in Medicare Part D LIS or dually eligible for Medicare and Medicaid. An ACO would receive the highest of the positive adjustments it is eligible for under the proposal – either the regional adjustment, prior savings adjustment, or HEBA.

MGMA comment: MGMA appreciates CMS’ intention to incentivize ACOs to treat rural and underserved beneficiaries through the establishment of the HEBA and supports this proposal. We urge

CMS to work with ACOs to ensure the methodology for calculating the HEBA adequately accounts for ACOs treating dually eligible or Medicare Part D LIS beneficiaries. CMS should broaden the eligibility requirements to make sure ACOs that treat the required number of beneficiaries are eligible to receive the adjustment in addition to increasing the per beneficiary adjustment.

Prepaid Shared Savings

CMS proposal (89 Fed. Reg. 61869): ACOs with a history of earned shared savings would be eligible for a new prepaid shared savings option that would be distributed quarterly under CMS' proposed rule. The agency has certain parameters around how the advanced savings could be used, such as allowing ACOs to use the prepaid savings to invest in direct beneficiary services and improved care coordination/quality through staffing or other infrastructure. Fifty percent of the paid savings would be reserved to be spent on direct beneficiary services not payable in Traditional Medicare (dental, visions, hearing, etc.); up to 50% of the prepaid savings can be spent on staffing and infrastructure.

ACOs potentially eligible include those in Levels C-E of the BASIC track or the ENHANCED track with prior success in MSSP. The initial application cycle to apply for prepaid shared savings would be for a Jan. 1, 2026, start date.

MGMA comment: MGMA supports the agency providing greater flexibility to ACOs to use earned savings but urges CMS to provide clarity on how the prepaid savings may be utilized. Allowing prepaid savings to go towards a comprehensive range of services to ensure that MSSP participants can use these funds where they need is essential. CMS should remove the requirement that prepaid savings be spent on certain activities and allow ACOs to utilize these savings in the best manner for providers and participants.

APP Plus Quality Measure Set

CMS proposal (89 Fed. Reg. 61865): CMS is proposing to create the APP Plus Quality measure set and require ACOs to report this measure set starting in 2025. This is intended to align with the Adult Universal Foundation measures as five of these measures are in the APP quality measure set for performance year 2025. The APP Plus quality measure set would gradually grow to comprise of 11 measures — six existing APP quality measures and five newly proposed measures. These 11 measures would be incorporated from performance year 2025 to 2028. The APP quality measure set would no longer be available to report starting in 2025.

This proposal would increase the number of measures for ACOs that report eCQM/MIPS CQM measures from three measures in 2024 to five measures in 2025; ACOs that report CMS Web Interface measures, ACOs would be required to report eight measures instead of ten in 2025. The agency is not including the MIPS CQM collection types for ACOs reporting the APP Plus Quality measure set in effort to encourage the adoption of eCQMs and focus on ACOs implementing the APP Plus. CMS intends to fully transition to digital quality measurement and is working to convert current eCQMs to the FHIR standard.

MGMA comment: MGMA has concerns with CMS requiring ACOs to report the APP Plus Quality measure set as it will institute significant administrative burden and require the reporting of quality measures that may not be applicable for certain specialties and medical groups. Coupled with the significant concerns highlighted above related to quality reporting and the sunsetting of the MIPS CQM and Web Interface reporting options, requiring reporting of these 11 measures will add complexity and burden for ACOs and medical groups participating in the program. We urge the agency to reevaluate its proposal.

Mitigating the Impact of Significant, Anomalous, and Highly Suspect (SAHS) Billing Activity on Shared Savings Program Financial Calculations in Calendar Year 2024 or Subsequent Calendar Years

CMS proposal (89 Fed. Reg. 61909): The agency is proposing to mitigate the impact of SAHS increases in billing in MSSP financial calculations in 2024 or subsequent calendar years. This would align with a recently proposed rule from CMS intended to mitigate the impact of SAHS billing associated with selected intermittent catheter supplies in 2023.

The agency proposes to specify how it would mitigate the impact of SAHS billing activity by excluding payment amounts from expenditure and revenue calculations for the relevant calendar year for which the SAHS billing activity is identified, as well as from historical benchmarks used to reconcile the ACO for a performance year corresponding to the calendar year for which the SAHS billing activity was identified. CMS would examine billing trends and other related information to seek to identify any codes that would potentially trigger the adjustment policy.

MGMA comment: We appreciate CMS working to mitigate the negative consequences that anomalous and highly suspect billing activity may have on an ACO's ability to succeed in MSSP and earn shared savings. MGMA has joined with other stakeholders in supporting the agency's attempts to address situations like the recent catheter billing issue to ensure medical groups are not financially penalized for potential fraud outside of their control in MSSP. CMS should extend a similar policy to medical groups participating in MIPS as SAHS billing activity similarly impacts their cost scores that can reduce performance scores thereby weakening their financial viability.

Reopening ACO Payment Determinations

CMS proposal (88 Fed. Reg. 61892): CMS proposes to establish a methodology to calculate the impact of improper payments in recalculating expenditures and payment amounts used in MSSP financial calculations when reopening a payment determination. The agency would adjust the historical benchmark to account for the impact of improper payments if they recalculate a payment determination in a prior agreement period that corresponds to a benchmark year of the ACO's current agreement period. Further, CMS would establish a process for ACOs to request reopening an initial determination of a shared savings/shared losses.

MGMA comment: MGMA supports CMS' proposals to facilitate the reopening of payment determinations to assist in mitigating the negative effects of improper payments. We appreciate this policy in conjunction with its SAHS proposal above and encourage CMS to streamline the process as much as possible and work with ACOs to address SAHS situations as early as possible.

Beneficiary Assignment Methodology

CMS proposal (89 Fed. Reg. 61843): The proposed PFS would revise the definition of primary care services used for purposes of beneficiary assignment under MSSP to include safety planning interventions, post-discharge telephonic follow-up contacts intervention, virtual check-in service, advanced primary care management services, cardiovascular risk assessment and risk management, interprofessional consultations, direct care caregiver training services, and individual behavior management/modification caregiver training services. CMS also proposes to broaden the existing exception to voluntary alignment to apply to claims-based beneficiaries that are assigned to entities in specific disease- or condition-specific CMMI ACO models.

MGMA comment: We generally support the expansion of the definition of primary care services used for beneficiary assignment to better capture the full range of services medical groups provide to beneficiaries and improve the accuracy of beneficiary assignment. We encourage CMS to continue working to improve beneficiary assignment and ensure these policies work for ACOs.

Eligibility Requirements

CMS proposal (89 Fed. Reg. 61842): CMS is proposing to sunset the requirement that the agency will terminate an ACO's participation agreement and determine that an ACO is not eligible for shared savings in that year if an ACO's assigned population is not at least 5,000 by the end of the performance year specified by CMS. For performance years on or after Jan. 1, 2025, if the ACO's assigned population is not 5,000 by the end of the performance year specified by CMS in its request for a Correction Action Plan, the agency would not be required to terminate the participation agreement. This gives CMS additional flexibility to work with ACOs to help return to the 5,000-beneficiary threshold.

MGMA comment: MGMA supports CMS instituting additional flexibilities to allow ACOs to return to the 5,000-beneficiary threshold without their participation agreement being terminated. These changes appropriately account for fluctuations in assigned beneficiaries outside of an ACO's control and mitigates overly punitive penalties that can result from current policy. CMS should review further scenarios where factors outside of an ACO's control such as geographic location that can lead to fluctuations in their assigned population before taking compliance actions.

Beneficiary Notification

CMS proposal (89 Fed. Reg. 61838): Beginning Jan. 1, 2025, CMS is proposing to modify follow-up requirements for beneficiary notification by removing the requirement that the ACO provide follow-up communication at the next primary care service and would instead require ACOs to provide the follow-up communication within 180 days of the original communication. For ACOs under preliminary prospective assignment with retrospective reconciliation, CMS would limit the population of beneficiaries who must receive notice to beneficiaries that are more likely to be assigned to the ACO when compared to the population of beneficiaries who must receive written notification under current regulations.

MGMA comment: MGMA understands CMS' desire to address beneficiary notification follow-up requirements regarding situations where an ACO may not know when the patient's next visit is scheduled to occur. This situation can result in burden for the ACO in timing follow-up communications. CMS should align these communications with typical processes for follow-up communications for patients after their primary care visit. It is important to increase efficiency in follow-up notifications to avoid issues with the current requirements and effectively engage patients in the most straightforward manner.

Medicare CQMs flat benchmark methodology

CMS proposal (89 Fed. Reg. 61860): CMS would score Medicare CQMs using flat benchmarks for the measures' first two performance periods in MIPS until the historical data is available to establish benchmarks.

MGMA comment: MGMA supports the agency's proposal and asks that they publicly post data from the performance period so ACOs can understand their performance. CMS should retroactively institute this policy to the 2024 performance period for the same reasons the agency proposed to use this scoring methodology in 2025.

Establishing a Higher Risk / Reward Option other than ENHANCED Track Request for Information

CMS request for comment (89 Fed. Reg. 61916): CMS is seeking comment on incorporating a higher risk-reward track that would replace the ENHANCED track. This new potential track would offer higher levels of risk and potential savings. The RFI seeks information on how this potential track would require additional accountability for quality, and whether ACOs in this revised track would be required to report all payer/ all patient quality measures.

MGMA comment: MGMA does not agree with replacing the current ENHANCED track as it would create instability in the program and undercut ACOs already succeeding in MSSP. We do not agree with including a mandatory participation track based on a physician payment infrastructure that is flawed and insufficient. Consistency is critical for the success of medical groups participating in MSSP — we oppose making drastic changes to this aspect of the program.

We recommend the introduction of a new voluntary higher risk track that would offer increased savings and improved patient care for experienced ACOs if designed correctly. This voluntary track could include policies that allow a full risk-option with increased shared savings along with appropriate caps on savings and losses. CMS should work closely with stakeholders to design a new risk track through a transparent and collaborative process to help accomplish the agency's value-based care goals.

Quality Payment Program (QPP)

Merit-based Incentive Payment System (MIPS)

MIPS Final Score and Payment Adjustments

Performance Threshold

CMS proposal (89 Fed. Reg. 62009): The agency proposes to maintain the MIPS performance threshold at 75 points for the 2025 performance year. CMS is proposing to continue using the mean final score of the 2017 performance period, and will continue to use the mean to determine performance thresholds for the 2025 through 2027 performance years.

MGMA comment: MGMA appreciates CMS proposing to maintain the current performance threshold and we agree with not raising it. However, we continue to believe the threshold is unnecessarily high as it is based on a methodology utilizing nonrepresentative years of the current healthcare landscape as 2017 was pre-COVID-19 and occurred in a vastly different MIPS program and care environment. Medical groups participating in MIPS must expend significant resources to comply with program requirements that would be better directed towards patient care. These clinicians provide critical care to Medicare beneficiaries and negative payment adjustments due to a high threshold do not necessarily reflect care quality, but rather administrative issues.

MIPS reporting requirements remain one of the most significant regulatory burdens faced by medical groups — according to our 2023 regulatory burden report, 67.19% of practices surveyed found MIPS reporting requirements very or extremely burdensome.[6] A 2019 study found that physicians spent more than 53 hours per year on MIPS-related activities.[7] The researchers concluded that if physicians see an average of four patients per hour, then these 53 hours could be used to provide care for an additional 212

[6]MGMA Regulatory Burden Report, Oct. 2023, https://www.mgma.com/getkaiasset/423e0368-b834-467c-a6c3-53f4d759a490/2023%20MGMA%20Regulatory%20Burden%20Report%20FINAL.pdf.
[7]Dhruv Khullar, Amelia Bond, and Eloise May O'Donnell**,** *Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System*, JAMA Network**,** May 2021, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947.

patients per year. The same study found that the MIPS program cost practices $12,811 per physician to participate in 2019.

The program remains overly punitive and we urge CMS to incorporate the following policy recommendations that were developed in collaboration with physician organizations to the extent feasible under its statutory authority, while concurrently working with Congress to institute lasting reform that enhances the MIPS program.

- ***Improve the performance threshold.*** The current MIPS threshold of 75 points results in many providers being unnecessarily penalized. Congress should freeze the threshold at 60 points for three years to allow medical groups to continue recovering from myriad significant events such as COVID-19 and the Change Healthcare cyberattack. Further, the Government Accountability Office (GAO) should submit a report to Congress and HHS in consultation with physician organizations that details recommendations for a replacement performance threshold.
- ***Reduce reporting burden and better align performance measures with clinical care.*** Siloes should be removed between the different performance categories; providing multi-category credit for MIPS measures that fulfill multiple categorical functions would avoid the duplicative steps of documenting and reporting on the same activities. The MIPS cost performance category has numerous issues related to measuring costs outside of a provider's control and opaque scoring procedures — it is important to significantly revise this category. Additional changes are needed to improve reporting on quality measures and allow providers reporting through clinical data registries to automatically satisfy promoting interoperability and improvement activities requirements.
- ***Reform how payment adjustments are calculated.*** The current tournament-style model of MIPS needs to be eliminated to stop undermining the financial viability of practices participating in the program who receive a negative payment adjustment. A new model where payment adjustments would be tied to the annual payment update would be more equitable while also continuing to incentivize groups to improve their performance. Groups who score below the performance threshold would receive a reduced payment update compared to those at or above the threshold. The penalties would fund bonuses for the high performers and go towards an improvement fund.
- ***Ensure timely and actionable feedback from CMS.*** Providers do not receive the timely and accurate feedback from CMS needed to understand their performance and be able to make changes to reduce costs or improve scores. A redesigned MIPS program must include this vital feedback, and if quarterly reports are not provided, medical groups should be held harmless from any penalties.

These important reforms would help stabilize MIPS, avoid unintended consequences of disincentivizing participation, and move towards a more equitable framework for medical groups. We urge CMS to work with Congress to enact these recommendations.

Reweighting

CMS proposal (89 Fed. Reg. 62095): The agency is proposing to allow MIPS eligible clinicians to request reweighting for quality, improvement activities, and/or promoting interoperability performance categories where data are inaccessible and unable to be submitted due to reasons outside the control of the clinician due to the clinician delegating submission to their third party intermediary (with a written agreement), and the intermediary didn't submit the data according to applicable deadlines. CMS will consider the following when determining to apply reweighting:

- Whether the clinician knew or had reason to know of the issue with its third-party intermediary's submission of their data;
- Whether the clinician took reasonable efforts to correct the issue; and
- Whether the issue between the clinician and their third-party intermediary caused no data to be submitted.

These requests would be submitted through the QPP Service Center and must be received on or before Nov. 1 prior to the applicable MIPS payment year. These requests could be submitted starting with the 2024 performance period.

MGMA comment: MGMA thanks CMS for recognizing the scenarios where MIPS eligible clinicians may be unable to submit data outside of their control. Given the serious disruptions to practice operations in recent years related to COVID-19 and the Change Healthcare cyberattack, holding practices harmless for the inability of third-party intermediaries to submit their data is a welcomed policy. This policy should also apply when third-party intermediaries submit incomplete or inaccurate data. The agency should continue to develop policies that avoid penalizing medical groups for outside factors and ensure that technical problems with entering performance data do not penalize practices.

CAHPS for MIPS Survey Vendor Cost

CMS proposal (89 Fed. Reg. 62096): The agency is proposing that CAHPS for MIPS survey vendors must submit the best estimate of the cost of their services to CMS. These costs would then be published in an effort increase consistency across requirements and promote transparency.

MGMA comment: MGMA supports this proposal that would inject needed transparency surrounding third-party vendor costs for CAHPS for MIPS Surveys. Physician practices would appreciate a better accounting of the real costs associated with participating in MIPS — this would better allow for planning and success when choosing a third-party vendor.

MIPS Quality Category

Data Completeness Threshold

CMS proposal (89 Fed. Reg. 62008): CMS is proposing to maintain the data completeness threshold of 75% through the 2028 performance period.

MGMA comment: We appreciate CMS not proposing to increase the data completeness threshold, but disagree with the proposal to maintain the unnecessarily high data completeness threshold of 75% through 2028. Groups must predict the quality measures to report that are most likely to meet the completeness threshold and this guessing game instills uncertainty in program reporting and adds unnecessary administrative burden. Medical groups with multiple sites of service that bill under one TIN will face technical hurdles meeting this high threshold.

As discussed in previous comments, in lieu of a percentage-based threshold, we recommend using a minimum number of patients policy that offers greater predictability for medical groups. For cost measures, the agency generally requires only 10, 20, or 35 patient encounters to meet a reliability score of 0.4. For quality measures, MGMA asks CMS to consider a data completeness threshold that meets a minimum reliability score of 0.80, which would increase the confidence that clinicians and groups have on their quality measure performance scores and comparisons. Moving to a minimum number of patients or some other predictable methodology also facilitates the planning of resources and staffing required for this effort.

Topped Out Measures

CMS proposal (89 Fed. Reg. 62076): CMS is proposing to apply a flat benchmarking methodology to the following subset of topped out measures: those that belong to specialty sets with limited measure choice and a high proportion of topped out measures, and in areas that lack measure development, which precludes meaningful participation in MIPS.

MGMA comment: CMS' topped out policies often negatively impact certain specialties more than others and lead to reduced MIPS scores all the while these medical groups are providing high-quality care. We support this policy to mitigate these negative impacts but ask that CMS apply this proposed policy more broadly to additional topped out measures under MIPS.

Multiple Submissions of Quality Data

CMS proposal (89 Fed. Reg. 62036): CMS is proposing to codify its existing practice of handling multiple submissions of quality data where they calculate and score each submission received and assign the higher of the scores. For multiple submissions from the same organization, CMS would score the most recent submission and the new submission would override a previous submission of the same type from the same organization (this won't apply to different submission types by the same organization).

MGMA comment: MGMA urges CMS not to adopt the policy of scoring the most recent submission from the same organization, and urges the agency to utilize the highest score received of multiple scores to ensure practices are not impacted by potential technical complications given the well-documented issues with submitting MIPS performance information. This policy conflicts with other proposals in the PFS and CMS should use the same logic it applies below for multiple submissions in the PI performance category.

MIPS Promoting Interoperability Category

Minimum Criteria

CMS proposal (89 Fed. Reg. 62008): Starting in the CY 2024 performance period, data submission for the promoting interoperability performance category must include all of the following elements to be considered a qualified data submission:

- Performance data, including any claim of an applicable exclusion, for the measures in each objective, as specified by CMS;
- Required attestation statements, as specified by CMS;
- CMS EHR Certification ID (CEHRT ID) from the Certified Health IT Product List (CHPL); and
- The start date and end date for the applicable performance period as set forth in § 414.1320.

Submissions with only a date and practice ID wouldn't be considered a data submission and would receive a null score (also wouldn't override reweighting of the category).

MGMA comment: MGMA appreciates CMS' attempt to mitigate negative financial penalties associated with innocent data entry mistakes that can often penalize medical groups participating in MIPS. Our members have detailed receiving penalties for simple errors not reflective of their actual performance that can have an outsized effect on their final performance scores. We suggest the agency use the full breadth of its regulatory power to avoid these harsh penalties which are ultimately innocent data entry mistakes and continue to alleviate penalties associated with reporting MIPS data across all performance categories.

Multiple Data Submissions

CMS proposal (89 Fed. Reg. 62035): Starting in the 2024 performance period, CMS is proposing that for multiple data submissions received the agency would calculate a score for each submission and assign the highest of the scores. CMS currently assigns a score of zero when they receive multiple submissions with conflicting data for the promoting interoperability performance category.

MGMA comment: MGMA appreciates CMS moving away from its overly punitive scoring policy and proposing to score the highest of multiple submissions for the promoting interoperability performance category. We urge the agency to extend a similar policy to other multiple data submissions proposals in the PFS. Uniformity is critical to prevent instituting competing and confusing submission rules.

MIPS Cost Category

Episode-Based Cost Measures

CMS proposal (89 Fed. Reg. 62009): The proposed rule includes six new episode-based cost measures beginning in the 2025 performance period for implementation at the TIN and clinician level with a 20-epsiode case minimum: Respiratory Infection Hospitalization, Chronic Kidney Disease, End-Stage Renal Disease, Kidney Transplant Management, Prostate Cancer, and Rheumatoid Arthritis.

MGMA comment: As raised in previous comments, MGMA generally supports the transition to episode-based measures and believes that cost measures should be centered around specific conditions or periods of care. These cost measures should reflect the group practice model of care where multiple practitioners utilize a team-based approach to treating patients. We urge the agency to ensure that episode-based cost measures are sufficiently reliable and do not double count costs when physicians report the Total Per Capita Cost (TPCC) or Medicare Spending Per Beneficiary measures. We recommend the agency incorporate feedback from physician specialty societies for specific episodes proposed here to prevent the establishment of impractical episode-based measures.

MGMA reiterates our longstanding concerns related to the cost category and the need for reform. We continue to see issues given the various benchmarking, reliability, and technical problems. CMS does not provide timely actionable feedback to clinicians on this performance category, and it can have an outsized negative impact on practices. There needs to be improved transparency throughout the pre-rulemaking cost measure development. We urge CMS to continue revising flawed attribution and insufficient risk-adjustment methodologies for many measures as we remain concerned with penalizing providers by holding them accountable for costs outside their practices.

Removal Criteria

CMS proposal (89 Fed. Reg. 62055): CMS is proposing to include the following criteria as guidance when considering whether to remove a cost measure:

- It isn’t feasible to implement the measure specifications.
- The measure steward is no longer able to maintain the cost measure.
- The implementation costs or negative unintended consequences associated with a cost measure outweigh the benefit of its continued use in the MIPS cost performance category.
- The measure specifications don’t reflect current clinical practice or guidelines.
- A more applicable measure is available. including a measure that applies across settings, applies across populations, or is more proximal in time to desired patient outcomes for the particular topic.

The agency may maintain a cost measure that meets one or more of the above criteria if they determine the benefit of the measure outweighs the benefit of removing it.

MGMA comment: MGMA appreciates CMS including the above criteria for cost measure removal and recommends the agency utilize these criteria to remove the TPCC measure. As detailed in a letter to CMS earlier this year, we have serious concerns with the TPCC holding physician practices responsible for care outside of their control.[8] There are structural issues with the TPCC, concerns with patient attribution, and lack of timely and actionable feedback. Using the criteria above, CMS should remove the TPCC measure.

Methodology Changes

CMS proposal (89 Fed. Reg. 62083): The agency is proposing to revise the cost scoring benchmark methodology beginning in the 2024 performance period. This new methodology would use a new distribution for cost scoring where the median cost for a measure would be set at a score derived from the performance period for that payment year. The cut-offs for benchmark point ranges would be calculated based on standard deviations from the median.

MGMA comment: We welcome this revised scoring methodology that would help lessen some of the outsized impact of the cost category and urge CMS to implement this retroactively to equitably correct issues with previous scoring methodology. This change is an indication of the agency's understanding of the issues that arise with this performance category. We appreciate CMS working to improve this performance category and believe more work is needed to avoid penalizing medical groups.

MIPS Improvement Activities Category

Number of Required Activities

CMS proposal (89 Fed. Reg. 62036): In order to simplify improvement activity reporting requirements, CMS proposes to reduce the number of activities clinicians are required to attest to completing. For Traditional MIPS, medical groups with the small practice, rural, non-patient facing, or health professional shortage area special status must attest to one activity. All other clinicians, groups, and virtual groups must attest to two activities. For MVPS, clinicians, groups, and subgroups must attest to one activity.

MGMA comment: MGMA supports CMS reducing the number of reported improvement activities needed to obtain a full score as this would better allow for improved participation and reporting. The agency should avoid removal of improvement activities that are helpful for improving clinical activities due to simply being commonly reported.

Activity Weighting

CMS proposal (89 Fed. Reg. 62059): The agency is proposing to remove activity weightings to simplify scoring. Currently, activities are classified as medium-weighted or high-weighted; high-weighted activities are worth two times as many points as medium-weighted activities.

MGMA comment: MGMA welcomes this proposed change to simplify scoring for this performance category and agrees with CMS finalizing this proposal. CMS should continue making adjustments to ease the burden of reporting the improvement activities category.

[8] Acumen, 2024 Public Comment Summary Report for the Comprehensive Reevaluation of the Total Per Capita Cost (TPCC) Measure, May 2024, https://www.cms.gov/files/document/2024-tpcc-public-comment-summary-report.pdf.

Minimum Criteria

CMS proposal (89 Fed. Reg. 62059): CMS is proposing that submissions for the improvement activities performance category musth include a yes response for at least one improvement activity to be considered a data submission and scored. Submissions with only a date and practice ID won't be considered a data submission and will receive a null score.

MGMA comment: CMS should ensure that any policy finalized does not override an approved reweighting request of this performance category. It is essential to avoid unintended consequences that would potentially penalize MIPS participants that qualify for automatic reweighting.

Multiple Submissions

CMS proposal (89 Fed. Reg. 62008): CMS is proposing to calculate and score each submission received and assign the higher of the scores for multiple improvement activity submissions from different organizations. For multiple data submissions from the same organization, CMS would score the most recent submission and the new submission would override a previously submission of the same type from the same organization. This proposal wouldn't apply to different submission types by the same organization.

MGMA comment: There are myriad scenarios where this proposal would cause confusion and potentially result in lower scores for physician practices that are submitting data to be scored as a group. Practices should receive credit for the highest score they submit when there are multiple data submissions; we urge CMS to avoid conflicting multiple submission policies that add complexity to an already burdensome MIPS reporting program.

MIPS Value Pathways (MVPs)

New MVPs

CMS proposal (89 Fed. Reg. 62008): The proposed rule would add the following six MVPs for reporting in CY 2025:

1. Complete Ophthalmologic Care,
2. Dermatological Care,
3. Gastroenterology Care,
4. Optimal Care for Patients with Urologic Conditions,
5. Pulmonology Care, and
6. Surgical Care.

The agency is proposing to consolidate the previously finalized Optimal Care for Patients with Episodic Neurological Conditions and Supportive Care for Neurodegenerative Conditions MVP into a single neurology-focused MVP.

MGMA comment: MGMA continues to believe that CMS should design voluntary MVPs that are clinically relevant and alleviate reporting burden while allowing groups to transition to value-based care. We urge CMS to be cognizant of the infancy of the MVP program and reporting problems within MIPS while attempting to develop new MVPs. CMS should work with physician specialty societies in the development of MVPs to better understand opportunities for quality and efficiency improvements and to avoid repackaging issues with MIPS. The agency should incorporate input from specialty societies to address specific concerns with quality measures and other issues with the proposed MVPs in this year's PFS.

MVP Scoring

Population Heath Measures

CMS proposal (89 Fed. Reg. 62019): The agency would calculate all available population health measures for an MVP participant and apply the highest scoring measure to their quality performance category score under CMS' proposal. MVP participants would no longer be required to select a population health measure as part of their registration.

MGMA comment: Although this proposal is an improvement over current policy, there are longstanding concerns with the population health category. We recognize the importance of improving population health and ask CMS to better incorporate measures into MVP development that accurately capture the reality of the care provided while avoiding increasing administrative burden. We ask CMS to apply this proposal retroactively as well should it continue using population health measures in MVPs.

MVP Adoption and Subgroup Participation Request for information

CMS request for comment (89 Fed. Reg. 62011)*:* The agency is seeking information to address how to best achieve full MVP adoption and subgroup participation as the agency plans to sunset traditional MIPS in the future. They are looking for information about clinician readiness to report MVPs, how to ensure there are applicable MVPs for all clinicians, and policies are needed for multispecialty groups to place clinicians into subgroups for reporting an MVP.

MGMA comment: We continue to hold significant reservations about MVPs amplifying the problems in MIPS as currently designed. CMS should not move forward with sunsetting MIPS by the 2029 performance year and continue to allow MVPs to be a voluntary reporting option — we oppose making MVP participation mandatory. In order to improve the program, CMS should work closely with medical groups and physician specialties to make sure the design of each MVP accurately reflects the reality of clinical care and is not forcing physician practices to report measures under MVPs that are not clinically relevant. There are numerous recommendations on MVPs that have been raised to CMS which, if implemented, would help to bolster the program: align cost and quality measures, develop MVPS for particular episodes of care/ procedures that promote care coordination, address problems with cost measures, and more.

MGMA continues to oppose mandatory subgroup reporting that will be implemented in 2026 as partitioning practices into subgroups could undermine the advantages of the group practice model. The changes in this proposed rule illuminate the difficulty in segmenting multispecialty practices into subgroups as many of the proposed changes illustrate the complexity of these arrangements. Multi-specialty group practices will face increasing administrative burden, additional financial strain, and operational complexities trying implement subgroup reporting. We urge CMS to keep subgroup reporting voluntary and not to implement conflicting directives that complicate compliance.

Building Upon the MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care RFI

CMS request for comment (89 Fed. Reg. 61984): CMS is soliciting feedback on the design of a potential ambulatory specialty care model that would leverage MVPs to increase the engagement of specialists in value-based care and expand incentives for primary and specialty care coordination. As currently conceptualized, participants under the model would receive, in lieu of an MIPS adjustment payment, a payment adjustment based upon a set of clinically relevant MVP measures and how they performed relative to other specialists of their same specialty type and clinical profile.

MGMA Comment: While we appreciate CMS examining ways to improve MVPs, we do not support instituting a new mandatory payment program for specialists in MVPs given the multitude of concerns we have outlined here and in previous comments about the need to reform the current system. As discussed above, MGMA encourages CMS to develop specialty MVPs that are reflective of the coordination across multiple specialties in the treatment of patients with a particular condition, during an episode of care, or procedure. We also encourage the agency to prioritize alignment of the quality and cost measures to alleviate concerns with the existing MVP approach. Once again, we encourage the agency to work closely with physician specialty societies and medical groups when developing MVPs to improve the system.

Advanced Alterative Payment Models (APMs)

Complex Organizational Adjustment

CMS proposal (89 Fed. Reg. 62080): CMS intends to introduce a complex organization adjustment to factor in organizational complexities for APM Entities (including MSSP ACOs) and virtual groups who report eCQMs. The agency would add one measure achievement point for each submitted eCQM for an APM Entity / virtual group that meets data completeness and case minimum requirements. The adjustment may not exceed 10% of the total available measure achievement points in the quality performance category.

MGMA comment: MGMA appreciates CMS' acknowledgement of the complexities inherent in many physician practices participating in the QPP by offering this adjustment. While we support the new complex organizational adjustment, we urge CMS to extend eligibility to all participants in MIPS who have similarly complex arrangements. The agency should further work to address the challenges with submitting data for electronic measures given interoperability and infrastructure challenges. Until the health information technology infrastructure is ripe, policies such as pay-for-reporting should be enacted to accurately reflect the current technological environment.

Patient Attribution

CMS proposal (89 Fed. Reg. 62098): The agency proposes to modify the sixth criterion under the definition of "attribution-eligible beneficiary." The proposal would include any beneficiary as attribution-eligible who has received a covered professional service furnished by an eligible clinician for the purpose of making QP determinations.

MGMA comment: MGMA supports CMS reviewing changes to improve the APM attribution process and address attribution issues that may be dissuading specialties from participating in APMs. CMS discusses its intention of providing more equitable opportunities for APM participants that have different focus areas and goals. We ask for CMS to provide more information and analysis about this change's potential impact on participation in APMs as the proposal does not discuss how the number of participants is likely to be increased, and also states that there may situations where the proposal would limit QP determinations in certain situations.

Use of Certified Electronic Health Record Technology (CEHRT)

MGMA comment: CMS previously removed the requirement that 75% of eligible clinicians participating in an APM entity use CEHRT, and will require 100% utilization in order for an APM to be an Advanced APM beginning in the 2025 performance year. MGMA remains concerned by this policy as it will increase reporting burden for APM entities. Smaller practices looking to join APMs that do not possess the current capacity to use CEHRT may be dissuaded as there is no room for APMs to bring them

into the fold and help them build the necessary infrastructure. Further, it may hamper the development of new models by restricting the ability of certain practices to participate.

The agency should be encouraging practices not currently using CEHRT to join APM models; by requiring full utilization of CEHRT to be considered an Advanced APM without corresponding incentives, glide paths, or other initiatives to promote smaller practices to join, CMS will foreclose another avenue for fostering accountable care growth.

Qualifying APM Participant (QP) and Partial QP Thresholds

CMS proposal (89 Fed. Reg. 62100): Under CMS' proposal, the QP threshold for Medicare payments would increase from 50% to 75%, while the partial QP threshold would increase from 40% to 50% for performance year 2025. The Medicare patients QP threshold would increase from 35% to 50% and the partial QP threshold would increase from 25% to 35% beginning in performance year 2025.

MGMA comment: While we understand the QP and partial QP thresholds are set under 42 CFR § 414.1430, MGMA strongly opposes these significant increases to the QP thresholds beginning in the 2025 performance year. Quality reporting stability is critical to incentivize participation in an Advanced APM — aside from being unreasonably high thresholds to meet for clinicians, previously participating clinicians may be unable to remain within an APM due to this drastic increase.

We urge CMS to call on Congress to act and allow the agency to set the QP thresholds as reasonable percentages so that clinicians can continue participating in Advanced APMs. The *Value in Health Care Act* (H.R. 5013) would make commonsense changes along these lines to ensure stability in the program.

APM Incentive Payment

CMS proposal (89 Fed. Reg. 62102): Congress extended the APM incentive payment at 1.88 % for the 2024 performance year/ 2026 payment year. The APM incentive payment had previously been 5% of the clinician's estimated aggregate payments for covered professional services during the 2019-2024 payment years, and 3.5% for the 2025 payment year. CMS proposes to end the incentive payment for the 2025 performance year and QPs will continue to receive a "qualifying APM conversion factor" of 0.75% of their Medicare PFS update, while non-QPs will receive a 0.25% Medicare PFS update.

MGMA comment: MGMA opposes the expiration of the APM incentive payment as it has had a demonstrably positive effect on allowing practices to transition to value-based care arrangements and make the necessary investments in the technology and infrastructure to succeed in APMs. Its elimination and shift to the lower "qualifying APM conversion factor" will likely reduce participation in Advanced APM models and cause additional uncertainty related to the two new conversion factor adjustments to QPs and non-QPs.

With the substantial financial challenges medical groups continue to experience related to staffing, inflation, and ongoing Medicare reimbursement cuts, the incentive payment is a lifeline for practices to provide high-quality care in APMs. Removing this incentive payment and transitioning to the lower conversion factor adjustment will be another barrier towards moving to accountable care arrangements. We urge CMS to work with Congress to extend the original 5% APM incentive payment by passing *Value in Health Care Act* (H.R. 5013).

Conclusion

We appreciate the opportunity to share our comments regarding the proposed changes to the Medicare PFS and QPP, and to offer recommendations to improve these policies to support group practices as they

provide high-quality care for their communities. Should you have any questions, please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202.293.3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs