September 9, 2024

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1807-P
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850

Submitted electronically via Regulations.gov

RE: CY 2025 Payment Policies under the Medicare Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies

Dear Administrator Brooks-LaSure,

The Alliance of Specialty Medicine (Alliance) represents more than 100,000 specialty physicians across 16 specialty and subspecialty societies. The Alliance is deeply committed to improving access to specialty medical care by advancing sound health policy. On behalf of the undersigned members, we write in response to proposals outlined in the CY 2025 Medicare Physician Fee Schedule (PFS) proposed rule.

CY 2025 Conversion Factor Update

The proposed rule proposes another sharp reduction in Medicare payments to physicians, estimated at -2.8%, due to the implementation of statutory requirements and regulatory changes discussed in the rule. In contrast, CMS finalized sizeable increases in most other Medicare provider 2025 payment rates (e.g., inpatient hospitals (2.9%), inpatient rehabilitation facilities (3.0%), hospices (2.9%), and Medicare Advantage plans (3.7%).

Like other Medicare providers, physician practice costs have increased considerably over the past several years. The increased costs disproportionately impact practices serving small, rural, and underserved beneficiaries — yet our updates do not meaningfully consider the impact of inflation.

In its March 2025 *Report to the Congress*, the Medicare Payment Advisory Commission (MedPAC) highlights that:

> Clinicians' costs, as measured by the Medicare Economic Index (MEI), grew by 1 percent to 2 percent per year for several years before the coronavirus pandemic. MEI growth then increased to 2.5 percent in 2021 and to 4.6 percent in 2022. However, MEI growth is expected to moderate: It is projected to be 4.1 percent in 2023, 3.1 percent in 2024, and 2.6 percent in 2025, although these projections are subject to change. These expected increases in clinicians' input costs are larger than the increases in FFS Medicare payment rates scheduled under current law.[1]

The Commission further states that:

> …[F]or calendar year 2025, the Commission recommends that the Congress update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50 percent of the projected increase in the MEI. Based on CMS's MEI projections at the time of this publication, the recommended update for 2025 would be equivalent to 1.3 percent above current law. **Our recommendation would be a permanent update that would be built into subsequent years' payment rates, in contrast to the temporary updates specified in current law for 2021 through 2024, which have each increased payment rates for one year only and then expired** [emphasis added].[2]

Beginning in CY 2026, physician payment rate updates will be adjusted based on participation in the Quality Payment Program as follows: 0.75 percent per year for qualified physicians participating in advanced alternative payment models (APMs) and 0.25 percent for those participating in the Merit-based Incentive Payment System (MIPS). While an improvement over the flat updates over the past several years, these nominal updates — relative to high rates of inflation and typically negative budget neutrality adjustments — are not sustainable and will impact beneficiary access to care.

While we recognize that CMS does not have the authority to update physician payments using an inflation proxy, such as the MEI, the agency could nevertheless be more thoughtful when proposing and finalizing coding and payment policies that adversely impact the conversion factor. ***We urge CMS to actively search for opportunities that would provide a more meaningful positive payment update.***

Most importantly, however, ***we urge CMS to work with Congress on a permanent solution to the long-standing challenges facing the PFS, including the lack of a meaningful payment update based on practice costs.***

Determination of Practice Expenses

CMS has again postponed using other cost data sources in the physician payment system until the American Medical Association (AMA) effort to collect cost data from physician practices through the Physician Practice Information Survey (PPIS) has been completed. The Alliance agrees with this approach, as using the most current and appropriate data set, particularly for the MEI, is critical.

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[1] Medicare Payment Advisory Commission, Report to Congress: Medicare Payment Policy, March 2024, https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC-2.pdf.

[2] Ibid., page

We also reiterate our prior comments that ***CMS should work toward a more consistent and regular approach to updating all direct and indirect practice expenses.*** CMS is in its final year of the 4-year phase-in of clinical labor price updates, a policy that has created significant reimbursement challenges for many specialties due to the budget-neutral nature of the practice expense (PE) component of the PFS. In fact, some Alliance specialties will have absorbed cuts of as much as 22.04% for critical services they deliver due to this policy. Because CMS has not updated these inputs in more than 20 years, many physicians are now paid *less* for services that cost them *more* to deliver.

We look forward to learning more about the work CMS has contracted with the RAND Corporation to analyze and develop alternative methods for measuring PE and related inputs for implementing payment updates under the PFS, including an analysis of the updated AMA PPIS data as part of that work on a revised PE methodology. In addition, we would support CMS updating direct practices expense inputs (i.e., clinical labor, supplies, and equipment) at least every five years.

Strategies for Improving Global Surgery Payment Accuracy

Individual Alliance member organizations are impacted differently by this policy proposal and will provide feedback in their organization's comments. We remind CMS, however, that the vast majority of specialty societies within the Alliance invest considerable time and resources to participate in the AMA's Specialty Society Relative Value Scale Update Committee (RUC) and develop work and practice expense relative value recommendations for the services they provide. This process is widely recognized as open and transparent, with active participation from CMS staff. If the agency has concerns about the relative value of services paid under the PFS, including the inputs used to establish those values (e.g., post-operative evaluation and management services), they should be addressed through appropriate channels, including the AMA RUC process.

Telehealth

We appreciate CMS proposal to allow audio-only communication technology to meet the definition of "telecommunications system" for the purposes of furnishing telehealth to beneficiaries in their homes, when certain conditions are met. As we have shared previously, audio-only telehealth services enable patients who are unable or unwilling to utilize audio-visual telecommunications technology to continue to receive essential specialty medical care, as clinically appropriate, regardless of whether such patients have the financial resources, local broadband infrastructure or technological wherewithal to utilize more traditional telehealth modalities. However, with the expiration of public health emergency (PHE) telehealth flexibilities on December 31, 2024, a patient's home would no longer be a permissible originating site except in limited cases. ***We urge CMS to continue working with Congressional lawmakers to extend further and make permanent many of the flexibilities provided during the COVID-19 PHE, including removing originating site requirements and geographic restrictions.*** Paired with such extension of statutory flexibilities, we believe that allowing the use of audio-only telecommunications technology to furnish telehealth services as CMS proposed will support ongoing meaningful access to telehealth services for patients who would otherwise struggle to receive medically necessary care.

We also support CMS' proposals to allow for direct supervision via virtual presence using audio/video real-time communications technology on a permanent basis for a subset of incident to services when:

(1) The service is provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision, and for which the underlying HCPCS code has been assigned a PC/TC indicator of '5'; or

(2) The service is an office or other outpatient E/M visit for an established patient that may not require the presence of a physician or other qualified healthcare practitioner.

CMS' proposal to make this permanent in the circumstances above strikes the right balance toward ensuring access to high-quality care while mitigating program integrity concerns. We also support CMS' proposal to extend direct supervision via virtual presence for all other services for an additional year, through December 31, 2025. ***We urge CMS to finalize both policies.***

Finally, we appreciate CMS' proposal to continue permitting practitioners to use their currently enrolled practice location instead of their home address when providing telehealth services from their home through 2025 and ***urge CMS to make this policy final,*** as it will ensure providers' privacy and safety.

Merit-Based Incentive Payment System (MIPS)

RFI: Transforming the Quality Payment Program

In this Request for Information (RFI), CMS expresses interest in fully transitioning to MIPS Value Pathways (MVPs) and sunsetting the traditional MIPS program by performance year 2029. With that in mind, CMS seeks feedback on clinician readiness for MVP reporting, and on MIPS policies needed to sunset traditional MIPS and transition to MVPs. CMS also seeks feedback on whether to establish specific parameters for subgroup reporting, which becomes mandatory for multispecialty groups reporting an MVP beginning in CY 2026.

As we have stated in the past, MVPs should remain a voluntary pathway for clinicians, alongside traditional MIPS, providing clinicians with a choice that best reflects their patient populations and practice needs. Many of our member organizations currently do not have an MVP that applies to their specialty. Given ongoing gaps in the underlying MIPS measure inventory, they will likely not have one in the near future. Rather than focus on this single new pathway, we urge CMS to continue working with stakeholders and Congress to fundamentally reform the program.

The Alliance also remains very concerned that the MVP framework is not enough of a departure from traditional MIPS and that it fails to resolve foundational issues with the program that some Alliance member specialties believe have limited clinician engagement and hampered meaningful progress towards higher quality care. MVPs preserve the siloed nature of the four MIPS performance categories and fail to provide cross-category credit or recognize more comprehensive investments in quality improvement. MVPs also continue to rely on problematic MIPS participation options, scoring rules, and qualified clinical data registry (QCDR) policies that often disincentivize developing and using more clinically-focused measures and participation pathways that better align with clinical practice. Furthermore, MVPs that cut across an entire specialty are of little value to highly subspecialized fields like ophthalmology. When developing MVPs, CMS must also accommodate those focused on subspecialties and the care they provide.

Regarding subgroup reporting, the Alliance supports offering subgroup reporting as an option for groups that find it feasible and clinically meaningful. However, we oppose the subgroup reporting requirement and request that CMS reconsider its earlier decision to mandate subgroup reporting for multi-specialty group practices participating through the MVP pathway starting in 2026. We do not believe that CMS has the authority to mandate subgroup reporting under MACRA. The statute provides significant flexibility to MIPS eligible clinicians regarding participation and where it's prescriptive, it states that CMS must establish a process to assess group practices on the quality performance category of MIPS and enables the Secretary to establish processes for assessing group practices on the other categories of MIPS. The statute also encourages MIPS participation by groups

via combining tax identification numbers (i.e., what is now known as virtual groups) rather than participation by subgroups, which involves subdividing TINs. As such, we do not believe that MACRA AMA can reasonably be interpreted as requiring subgroup reporting. In addition, CMS does not yet have a sufficient foundation of data related to subgroup reporting, nor does it have a sufficiently robust inventory of MVPs or viable subspecialty measures to force groups to segment off into subgroups for purposes of MIPS compliance. CMS reports that about 750 groups and clinicians registered to report MVPs for the CY 2023 performance period/2025 MIPS payment year. While CMS does not report on the number of groups opting to use subgroup reporting to date, we suspect that number is relatively small given the limited number of participants using MVPs. As a result, CMS has very limited data on how subgroup reporting is working. We urge CMS to maintain subgroup reporting as a voluntary option while it collects more data on subgroup reporting patterns, practices, and challenges. This will also allow CMS time to develop additional MVPs to cover more specialties and subspecialties, develop additional measures to populate MVPs, and address MIPS scoring issues that continue to disincentivize the use of more specialized measures. Once CMS has a more robust foundation of data and a more diverse inventory of MVPs and measures, it can work with stakeholders to determine whether subgroup reporting is appropriate.

The Alliance also believes that CMS should not impose restrictions or other parameters around the composition or construction of subgroups. It is important that a group practice maintains control over its MIPS reporting strategy since the group practice knows best how its clinicians interact (or do not interact) with each other and with specific patient populations. Any attempt by CMS to place arbitrary limits on subgroup composition or size could negatively impact team-based care and further erode the program's ability to accurately capture the quality of physician services. It also suggests that CMS cannot trust group practices to make these decisions in a manner that is most beneficial for their patients and assumes group practices will automatically "game the system," which is offensive to clinicians trying their best to do the right thing. Further, groups may innovate or change multidisciplinary care delivery models, and maintaining reporting flexibility allows groups to demonstrate and track how their subgroupings of clinicians are maximizing patient value, which is not feasible with remote mandates. CMS also discusses using the information on Medicare claims data to potentially create subgroup composition restrictions. For example, CMS could analyze subgroups based on the volume of services billed by the clinicians in a group practice for a specific medical condition (e.g., heart failure, joint replacement, etc.) or a specific procedure (e.g., beta-blocker therapy, stent placement, hip and/knee surgery, etc.). Given the limitations of claims data, the Alliance does not support using claims data analyses to set restrictions on subgroups but does see value in providing these analyses to practices for educational/guidance purposes.

As CMS implements the sub-group reporting mechanism, it is critical to incentivize the development and use of a diverse inventory of specialty- and sub-specialty-specific measures that are truly meaningful to both physicians and their patients. As suggested earlier, many specialists continue to lack MIPS measures that can lead to data-driven improvements in quality. Without these measures, subgroup reporting will simply add another unnecessary administrative layer to the program without any positive impact on quality.

MIPS Performance Threshold

CMS proposes to maintain the MIPS performance threshold at 75 points for the CY 2025 performance period/CY 2027 payment year. ***The Alliance supports CMS' proposal to maintain the performance threshold at its current level.*** We agree with CMS that it will provide consistency for MIPS-eligible clinicians, allow additional time for more recent data to become available, continue to provide opportunities for MIPS-eligible clinicians to gain experience with cost measure scoring (particularly if the

revised methodology proposed in this rule is finalized), and ensure that CMS does not inadvertently disadvantage certain clinician types, such as small practices. We also appreciate CMS' recognition of the fact that there are still issues with underlying data from prior periods due to the COVID-19 pandemic and that there is a need to wait for more recent data that better reflects clinicians' performance while continuing to rely on data from the CY 2017 performance period/2019 MIPS payment year, which predated the COVID-19 PHE.

Quality Category

Data Completeness Threshold

For the CY 2024 and CY 2025 performance periods/2026 and 2027 MIPS payment years, CMS previously finalized an increase in the data completeness criteria threshold from at least 70 percent to at least 75 percent, following concerns expressed about CMS' proposal to increase it to at least 80 percent. In this rule, CMS proposes to maintain this higher threshold for two additional years through the CY 2028 performance period/ CY 2023 payment year.

The Alliance opposes any increases to the data completeness threshold until reporting is more seamlessly integrated across providers and settings. While we opposed CMS' original decision to increase the data completeness threshold to 75 percent, we appreciate CMS is proposing to maintain it at this level for two more years rather than increasing it to 80 percent. Specialists often do not have direct control over electronic health record (EHR) systems, particularly when a single Taxpayer Identification Number includes multiple geographic locations and practice settings (e.g., various hospitals), and revisions to accommodate new measure requirements may take time to design and implement. Additionally, sub-regulatory guidance is usually unavailable until late in the performance year, which could result in a change in reporting strategy that makes it challenging to satisfy data completeness requirements. We also remind CMS that no other federal quality programs at the hospital or health plan level rely on sample sizes as high as MIPS.

As we have requested in the past, the Alliance also urges CMS to consider setting different data completeness thresholds depending on the type of measure. For example, a 75 percent threshold might be reasonable for process measures, but for patient-reported outcome measures, meeting even a 50 percent threshold might be challenging. Enabling a lower threshold for patient-reported outcome measures could incentivize more widespread use of these higher value measures.

Revised Topped-Out Measure Scoring

CMS proposes to revise its methodology for scoring certain topped-out quality measures that would otherwise be subject to a 7-point scoring cap. To make determinations about which measures would qualify for this special policy each year, CMS would conduct an annual assessment of MIPS Specialty Measure Sets to determine which specialties have limited measure choice and limited opportunity to maximize their MIPS performance score due to the current topped-out measure scoring policy. CMS would select certain measures that would fall under this policy each year, which would be proposed and finalized through rulemaking. These measures would be subject to a "defined topped-out measure benchmark" which would allow a clinician to score up to 10 points based on performance. For 2025, CMS identified 16 measures that would fall under this policy.

The Alliance appreciates CMS attempting to address the limitations of its topped-out scoring policy but requests that CMS apply the defined topped-out measure benchmark to all topped-out measures subject to the 7-point cap and fully retire its 7-point cap policy. Universal application of this policy would ensure that no clinicians are negatively impacted by the current cap, which limits scoring potential for reasons unrelated to performance and outside of the clinician's direct control. It would also

avoid challenges related to accurately identifying which specific measures should be subject to this policy. For example, the proposed approach seems to disfavor specialty sets with more than ten measures and sets that rely more heavily on cross-cutting or broadly applicable measures. As a result, clinicians in specialties whose measures meet these criteria will not be able to benefit from this policy despite having no control over the available measure inventory.

If CMS objects to applying this policy more universally, then it should at least conduct more comprehensive and granular analyses that are not based exclusively on MIPS specialty sets to ensure that its determinations are accurate and complete, including the identification of subspecialists with limited measure choice. Many specialty sets are broad and do not clearly delineate between subspecialists who may provide very focused care and to which only a small subset of the larger measure set applies. For example, the neurosurgical specialty set includes measures related to spine care, as well as measures related to stroke care. Given the specialized nature of neurosurgery, neurosurgeons focusing on spine care typically do not also provide stroke care and would not use those measures and vice versa. By relying on specialty sets, CMS erroneously assumes that all measures in a specialty set are relevant to all members of the specialty. CMS should instead conduct more granular analyses of measures available to subspecialists. For example, within ophthalmology, CMS should look at the measures available to retina specialists vs. cataract and refractive surgeons vs. other subspecialists.

Additionally, CMS should extend this policy so that it applies to QCDR measures that are topped out and subject to the 7-point cap. A major limitation of CMS' proposal is that specialty sets do not include QCDR measures. Thus, it offers no mechanism to address specialists and subspecialists with a disproportionate share of topped-out QCDR measures, which puts specialists at a scoring disadvantage.

The Alliance also urges CMS to conduct MVP-level analyses to determine whether specialists and subspecialists participating through an MVP can reasonably succeed in the program based on the available set of measures. Our member societies would be happy to help CMS conduct these and other analyses to determine how measures in an MVP (or in the MIPS measure inventory, in general) apply to its different subspecialties.

We also request that CMS work with stakeholders to identify reasonable ways to maintain topped out measures in the program over time, such as offering points for pay-for-reporting so that CMS can continue to track performance over time even if clinicians are not paid based on performance.

Finally, the Alliance requests that CMS clarify why it chose to tie* 97% performance to 7.5 points under this proposal**. Does 7.5 represent 10% of the current year's performance threshold, similar to CMS' cost measure scoring proposal where median performance would be tied to 10% of the performance year's performance threshold? ***The Alliance supports assigning a point value that increases over time in alignment with any increases to the MIPS performance threshold.

Complex Organization Adjustment for Virtual Groups and APM Entities

CMS states that Virtual Groups and APM Entities, in particular, may experience technological barriers to electronic reporting of quality measures, including challenges related to aggregating patient data across multiple tax identification numbers, data de-duplication and interoperability between different health information technology/EHR systems. To account for the organizational complexities faced by Virtual Groups and APM Entities, CMS proposes to establish a Complex Organization Adjustment beginning in the CY 2025 performance period/2027 MIPS Payment Year. Virtual Group and APM Entities would

receive one measure achievement point for each submitted electronic clinical quality measure (eCQM) that meets the data completeness and case minimum requirements.

The Alliance requests that CMS expand this bonus beyond APM Entities and Virtual Groups. Many of our members who participate as individual clinicians or group practices also face challenges using eCQMs, particularly (but not exclusively) when members of the group provide care at multiple sites or sites of service and/or use multiple EHR systems.

EXPANSION OF THE APM PERFORMANCE PATHWAY TO APP PLUS

The APM Performance Pathway (APP) was designed to provide MIPS APM participants with a more predictable and consistent reporting and scoring pathway that reduces reporting burden and encourages alignment with APMs by recognizing efforts already being made through the APM. To date, the APP has been largely irrelevant to specialists since its measures are primary care-focused. In this rule, CMS proposes to offer an optional APP measure set that would be expanded over time to include Universal Foundation measures, a few of which are specialty-specific (e.g., #113: colorectal cancer screening).

The Alliance appreciates CMS' effort to expand the APP over time, but we are still concerned that the measures being offered through this pathway are "universal" measures rather than more specialty-specific measures. We urge CMS to add more specialty-specific measures (e.g., those used in programs such as the BPCI-A) that would make this pathway more accessible to specialists and reduce duplicative reporting.

Cost Category

Removal Criteria

CMS has identified a need to establish and codify objective criteria that can be used to inform the removal of a cost measure from the MIPS cost category since, unlike the MIPS quality performance category, the MIPS cost category does not have clear guidelines for removing a measure established through the notice-and-comment rulemaking process.

CMS proposes to adopt and codify criteria to specify objective bases for the removal of any cost measures from the MIPS cost performance category. Specifically, the agency proposes to adopt the following factors that can be used to guide the removal of a cost measure:

- Factor 1: It is not feasible to implement the measure specifications.
- Factor 2: A measure steward is no longer able to maintain the cost measure.
- Factor 3: 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.
- Factor 4: The measure specifications do not reflect current clinical practice or guidelines.
- Factor 5: The availability of a more applicable measure, 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 population-health total per capita cost measure (TPCC) has long been plagued with problems, going back as far as the Value Modifier program. While many specialties are technically excluded from this measure, they are often unexpectedly pulled into the measure and held accountable for total patient costs due to a severely flawed attribution methodology. As CMS continues to develop more focused episode-based cost measures, we see no reason to maintain such a flawed and confusing measure. ***The***

Alliance urges CMS to finalize the aforementioned cost measure removal criteria and to use these criteria to justify the removal of the TPCC measure from the program once and for all.

Modification to Scoring Methodology for Cost Performance Category

CMS has identified concerns with current cost scoring policies, including the fact that cost category scores overall have been consistently lower than quality category scores and that the current methodology could noticeably lower a clinician's MIPS final score, particularly if the clinician is only attributed a single cost measure. To address these concerns, CMS proposes to modify the methodology for scoring the cost performance category beginning with the CY 2024 performance period/2026 MIPS payment year. Specifically, for each cost measure, CMS would determine 10 benchmark ranges based on the median cost of all MIPS-eligible clinicians attributed the measure, plus or minus standard deviations. CMS would award achievement points based on which benchmark range a MIPS eligible clinician's average cost for a cost measure corresponds. Under this methodology, CMS would award achievement points equivalent to 10 percent of the performance threshold for a MIPS eligible clinician whose average cost attributed under a cost measure is equal to the median cost for all MIPS eligible clinicians attributed the measure (e.g., 7.5 points for median performance on a measure when the performance threshold is 75 points).

CMS estimates that this proposed scoring methodology would not negatively impact MIPS eligible clinicians whose average costs for a specific cost measure are around the median, and overall, it is expected to raise cost category scores. Specifically, CMS estimates that this proposed methodology would increase the mean cost performance category score (unweighted) for clinicians from 59 out of 100 to 71 out of 100 (an increase of 11.9 points). CMS' analysis also showed that under this methodology, the mean final score for MIPS eligible clinicians assessed on at least one cost measure would increase by 3.89 points.

The Alliance very much appreciates and strongly supports CMS' proposal to improve the cost category scoring methodology. However, we are concerned about CMS' proposal to apply it starting only with the 2024 performance year/2026 payment year. CMS has acknowledged that problems with cost category scoring first came to light starting with the 2022 performance year, when CMS began to score the category once again following the pandemic. ***Thus, it is only fair that CMS apply this policy retroactively, going back to the 2022 performance year/2024 payment year, when the cost category rose to its highest value, contributing a weight of 30% of the MIPS final score. If this is not technically feasible, then CMS should apply a zero weight to the cost category starting at least with the 2023 performance year/2025 payment year, but ideally going back to the 2022 performance year/2024 payment year.***

Improvement Activities Category

CMS proposes two changes to the traditional MIPS improvement activities reporting and scoring policies for the CY 2025 performance period/2027 MIPS payment year:

- To eliminate the weighting of activities to simplify scoring.
- To reduce the number of activities a clinician/group must attest to. MIPS eligible clinicians who participate in traditional MIPS would be required to report two activities (20 points each) versus up to four. MIPS eligible clinicians who are categorized as small practice, rural, in a provider-shortage area or non-patient facing would be required to report on only one activity (40 points).
- CMS also proposes that MVP participants would be required to report on only one activity.

The Alliance strongly supports these proposals.

RFI on Building on the MVP Framework to Improve Ambulatory Specialty Care

CMS seeks comment on a potential future Innovation Center model to increase engagement of specialists in value-based payment and encourage specialty engagement with primary care providers. This model would apply to specialists in ambulatory settings and leverage the MVP framework. Participants would not receive a MIPS payment adjustment, but rather an adjustment based on (a set of clinically relevant MVP measures that they are required to report and comparing the participant's final score against only other model participants of the same specialty type/clinical profile who are also required to report on those same clinically relevant MVP measures). CMS sees this as a way to engage specialists without creating multiple unique models that are each narrowly defined by a condition or specialty.

The Alliance is strongly opposed to relying on the MVP framework to fill ongoing gaps in specialty APMs and APM participation. As discussed earlier, the MVP framework sits on the flawed chassis of MIPS rather than offering more innovative reforms and is simply not an adequate solution to the ongoing lack of specialty-focused APMs. ***We also oppose CMS' desire to make this mandatory in nature***, which ignores the fact that each practice has its own unique patient populations, practice setup, and resources/administrative capabilities. Mandatory models also force physicians that have already adopted their own innovative ways to provide high-value care to alter their care processes in ways that might reverse progress made in terms of outcomes and efficiencies.

Qualifying Participants (QPs) in Advanced APMs

Eligible clinicians who meet threshold levels of participation in Advanced APMs to become QPs are excluded from MIPS reporting requirements and payment adjustments. Eligible clinicians who are QPs for the CY 2024 performance year will receive a 1.88 percent APM Incentive Payment in the 2026 payment year, which is the last year that the APM Incentive Payment is available under law. Beginning with the CY 2024 performance year/CY 2026 payment year 2026, QPs will also receive a higher PFS payment rate, calculated using the differentially higher "qualifying APM conversion factor" update, than non-QPs, as discussed in more detail below. QPs will continue to be excluded from MIPS reporting and payment adjustments for the applicable year.

CMS assesses the level of participation in Advanced APMs to determine QP status based on specific payment amount or patient count thresholds that are set in statute. These thresholds are set to increase under law starting with the CY 2025 performance year/CY 2027 payment year. The threshold percentages are calculated using the ratio of attributed beneficiaries to attribution-eligible beneficiaries. If the Threshold Score (using either the payment amount or patient count method) calculated at the APM Entity or individual eligible clinician level, as applicable, meets or exceeds the relevant QP threshold, the relevant eligible clinician or clinicians (either the individual eligible clinician or all those on the APM Entity's Participation List) achieve QP status for such year.

For purposes of these determinations, an "attributed beneficiary" is a beneficiary attributed to the APM Entity under the terms of the Advanced APM as indicated on the most recent available list of attributed beneficiaries at the time of a QP determination. CMS currently defines "attribution-eligible beneficiary" as a beneficiary who, among other things, has:

- At least one claim for E/M services furnished by an eligible clinician who is in the APM Entity for any period during the QP Performance Period; or

- For an Advanced APM that does not base attribution on E/M services, the attribution basis determined by CMS is based upon the methodology the Advanced APM uses for attribution, which may include a combination of E/M and/or other services.

CMS is concerned that the current policy of using E/M services as the default basis for attribution, and to use an alternative approach for Advanced APMs that use a different attribution basis, could result in a complex set of unique attribution approaches for various Advanced APMs and increased variability among the ways CMS defines attribution-eligible when making QP determinations, particularly as CMS anticipates that Advanced APMs will continue to evolve and use novel approaches to value-based care that may emphasize a broad range of covered professional services. CMS also recognizes that primary care practitioners generally furnish a higher proportion of E/M services than do specialists for the same beneficiary. The current reliance on E/M services for attribution in its Threshold Score calculations means that primary care practitioners may contribute more significantly to achieving QP status for an APM Entity group. As such, CMS' current policy may have inadvertently encouraged APM Entities to prefer primary care practitioners over specialists in their Participation Lists.

The Alliance has long voiced concern about barriers to specialty participation in APMs, including the ongoing lack of relevant APMs, but also policies that result in APMs excluding specialists from their Participation Lists. ***As such, the Alliance supports CMS' proposal to expand the definition of "attribution-eligible beneficiary" to include any beneficiary who has received a covered professional service furnished by the eligible clinician for whom CMS is making the QP determination, beginning with the 2025 QP performance period***. This proposal would help to address the current issue of specialists being excluded from APM Participation Lists based simply on the types of services they bill. However, we remind CMS that this alone will not solve all the problems specialists face in access to meaningful APMs. We continue to urge the Innovation Center to work with specialty societies (some of which have invested heavily in the development of thoughtful models) to test innovative APMs that better capture the value of specialty care.

The Alliance also requests that CMS work with us to urge Congress to make technical changes to the Medicare Access and CHIP Reauthorization Act that would extend the APM incentive payment and freeze QP thresholds to encourage continued movement toward value-based payment models, especially among specialists who have had little opportunity to engage meaningfully or to qualify for APM incentive payments to date.

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We appreciate the opportunity to comment on these important issues and welcome the opportunity to meet with you to discuss them in more detail. Should you have any questions or wish to schedule a meeting, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology – Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American College of Osteopathic Surgeons
American Gastroenterological Association

American Society of Cataract and Refractive Surgery
American Society of Dermatologic Surgery Association
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Congress of Neurological Surgeons
Coalition of State Rheumatology Organizations
North American Spine Society
Society of Interventional Radiology