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Re: CY 2025 Physician Fee Schedule and Medicare Shared Savings Program Requirements *(CMS-1807-P)*

The Health Care Transformation Task Force (Task Force) appreciates the opportunity to share recommendations on the Calendar Year (CY) 2025 Physician Fee Schedule and Medicare Shared Savings Program (MSSP) Requirements (CMS-1807-P). The Task Force believes these recommendations will help the Centers for Medicare & Medicaid Services (CMS) achieve the goal of increasing access to high-quality, equitable value-based care (VBC).

The Task Force is a collaborative that supports accelerating the pace of delivery system transformation to better pay for the value of care received. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and consumer/patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver better health through high quality care at reduced costs. We strive to provide a critical mass of policy, operational, and technical support that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

Our comments address (1) MSSP (sections I-VI), (2) the Center for Medicare and Medicaid Innovation (CMMI) model elements (sections VII-IX), (3) specialty care (sections X-XI), and (4) primary care (sections XII-XIV). Our recommendations are offered in the spirit of collaboration, with the goal of strengthening CMS' ability to deliver high-quality, accessible, equitable care to all Medicare beneficiaries.

MEDICARE SHARED SAVINGS PROGRAM

I. Prepaid Shared Savings

CMS proposes that MSSP Accountable Care Organizations (ACOs) that have previously earned shared savings will have the option of requesting prepaid shared savings. This option would be available to ACOs in Levels C-E of BASIC or ENHANCED tracks that earned savings in the most recently reconciled MSSP performance year. ACOs would be able to opt into prepared shared savings under new agreements starting on 1/1/26 or later. The prepaid shared savings would be paid quarterly during the performance period, to be repaid through future shared savings. CMS would calculate the maximum prepaid shared savings amount based on the ACO's

most recent two years of per capita savings. The ACO could request to receive a smaller amount of prepaid shared savings, but it is not clear in the proposed rule whether ACOs could request to receive any amount of prepaid shared savings relative to the maximum offered by CMS.

CMS also proposes narrower requirements for how prepaid shared savings can be used relative to regular shared savings. Unlike the usual shared savings paid after reconciliation, none of the funding could be used on performance incentives with clinicians or other provider organizations. Instead, CMS would require that at least 50 percent of prepaid shared savings be spent on patient services not otherwise payable through Traditional Medicare (e.g., meals, transportation, dental, vision, hearing and Part B cost-sharing reductions). CMS specified that Anti-Kickback Statute safe harbor laws would apply to the delivery of these services. This policy aims to incentivize collaboration with community-based organizations (CBOs), in order to address health-related social needs (HRSNs). These collaborations would satisfy ACO regulatory requirements to engage with stakeholders to address population health needs. The remaining prepaid shared savings would be spent to support ACO staffing and infrastructure. However, CMS does not specify how ACOs will be required to document the proportion of funds used for otherwise non-covered services, nor are CMS' enforcement mechanisms outlined.

The Task Force supports the option for prepaid shared savings, because it provides ACOs with additional cash flow options to invest in quality improvement and population health. However, the prohibition against using prepaid shared savings to pay performance incentives will likely limit the number of ACOs that elect this option. Therefore, the Task Force recommends that CMS remove this prohibition. Most ACOs currently use a portion of shared savings to pay performance incentives, as a core element of their provider engagement strategy – especially for specialists. While CMS' proposed policy aligns with the agency's health equity strategy, it runs counter to the specialty engagement strategy by removing a key tool for ACOs to engage specialists.

In addition, the Task Force therefore recommends that CMS refine the prepared shared savings proposals by removing or reducing the 50 percent minimum on services not otherwise covered by Medicare. This would allow ACOs more flexibility in targeting the funds to the needs of their specific organization and community, while minimizing the reporting burden on participants. Overall, the Task Force supports CMS' encouragement of ACOs to provide non-covered services and recognizes this as a key opportunity for alignment with Medicare Advantage. However, the proposed design may limit uptake of the prepaid shared savings option. CMS should increase flexibility by clarifying that ACOs can request any amount of prepaid shared savings, relative to the maximum allowed by CMS.

II. Health Equity

CMS proposes to add a Health Equity Benchmark Adjustment (HEBA) for agreement periods starting 1/1/25 and later. The HEBA would be the third positive adjustment available to ACOs, along with the positive regional adjustment (for historically high-cost ACOs) and the prior savings adjustment (to account for previously earned shared savings). CMS would apply the highest of the three adjustments to the ACO's benchmark. To be eligible for the HEBA, the ACO must have at least 20 percent of assigned beneficiaries with dual eligibility or low-income

subsidy (LIS) status. The HEBA would have a maximum adjustment of five percent national per capita health expenditures, multiplied by the proportion of assigned beneficiaries with dual or LIS status. CMS is seeking feedback on whether to incorporate the Area Deprivation Index (ADI) into the HEBA calculation.

The Task Force strongly supports the HEBA proposal. In addition, the Task Force recommends that CMS expand the beneficiaries included in the HEBA calculation, to include beneficiaries who obtained Medicare coverage due to disability, as well as beneficiaries that live in a high-risk ADI (based on either national or regional rankings). The Task Force also recommends that CMS eliminate the 20 percent threshold to maximize the impact of this adjustment. It is essential that VBC models do not penalize providers that care for higher-risk patients, including both clinical and social risk factors. While patient-level data is the gold standard, validated geographic indices such as the ADI are useful proxies. Using all available data elements on social risk and eliminating the threshold will expand the HEBA's ability to address these issues.

However, relatively few current ACOs are expected to benefit from the HEBA. While the Task Force supports CMS' goal to increase new MSSP participation among providers that care for higher-risk patients, CMS estimated that the proposed policy would benefit fewer than five percent of existing ACOs. **Therefore, the Task Force recommends that CMS expand the scope of the policy, so that it is additive to the existing prior savings and historical efficiency adjustments (rather than only applying if it is the highest of the three adjustments).**

In addition, the Task Force strongly supports the fact that the HEBA would increase resources for ACOs serving underserved patients – to account for historic inequalities – without penalizing other ACOs by reducing their benchmarks. This policy aligns with CMS' health equity goals, as well as with the strategy to have all Medicare beneficiaries in accountable care relationships by 2030.

III. Alternative Payment Model Performance Pathways Plus

CMS proposes to establish the Alternative Payment Model Performance Pathways (APP) Plus quality measure set, which would be mandatory for MSSP ACOs starting in 2025. The APP Plus quality measure set would combine:

- Six measures in the existing APP measure set – of which five are Adult Universal Foundation (UF) measures – that MSSP ACOs were previously required to report starting in 2025
- Five additional UF measures that will be incrementally incorporated from 2025 to 2028 – of which two would begin in 2025 (colorectal and breast cancer screenings)

If CMS updates the UF measures in the future, the APP Plus measures would be updated to match.

In addition to adding new measures, CMS proposes to narrow the options for submitting this data. MSSP ACOs would be required to report measures as electronic Clinical Quality Measures (eCQMs) or as Medicare CQMs. The previous reporting option of Merit-based

Incentive Payment System (MIPS) CQMs would be discontinued. These proposals reflect CMS' goal to move to eCQM reporting as the gold standard. To incentivize the adoption of eCQMs, the agency proposed to extend the eCQM reporting incentive to 2025 and subsequent years. To earn this incentive, ACOs must:

- Report all eCQMs in the APP Plus measures, meeting data completeness requirements
- Achieve a quality performance score of ≥10th percentile for at least one outcome measure
- Achieve a quality performance score of ≥40th percentile for at least one non-outcome measure

CMS also proposed a complex organizational adjustment for eCQM scoring, available to virtual groups and Alternative Payment Model (APM) entities, including MSSP ACOs. For organizations that instead report through Medicare CQMs, CMS proposes to introduce a flat benchmark for each measure's first two performance periods in MIPS. All MSSP ACOs would also be required to meet all Promoting Interoperability reporting requirements, as finalized in previous rules.

The Task Force has repeatedly expressed the concern that the move to eCQM adoption is weakening incentives to participate in MSSP. The large financial outlay and operational complexity of implementing these measures is already impacting ACO networks participation decisions. The Task Force appreciates CMS acknowledging these concerns with three of the proposed policies, including: (1) updating the quality performance score thresholds, (2) maintaining the eCQM reporting incentive, and (3) adding the complex organizational adjustment. These policies are responsive to stakeholder feedback and may help mitigate some challenges related to eCQM adoption.

However, even with these incentives, the transition to eCQMs remains challenging. As many ACOs have shared with CMS, the eCQM requirements are extremely expensive and major electronic health record (EHR) vendors do not yet have standard processes to support their implementation. These challenges will be compounded by two of the proposed changes, including the addition of two new eCQMs and the removal of the MIPS CQM reporting option, for which ACOs will have just a few months' notice. To address these concerns, the Task Force recommends the following:

1. **CMS should delay all new APP Plus quality measures until at least 2027, to give ACOs and other APM entities time to prepare to report additional eCQM measures**. Many ACOs have prepared for years before implementing the existing eCQM measures in the APP measure set, and the contracts for 2025 reporting are already in place. The underlying challenges with eCQMs include reporting across multiple Tax Identification Numbers (TINs) and EHRs, which result in large data inaccuracies that skew results. Even organizations with a single EHR may not have seamless reporting. Certified EHR Technology (CEHRT) requirements do not standardize data collection for all eCQM data elements, meaning that the EHR may not support eCQM reporting. Therefore, adding new measures with just a few months' notice is not operationally feasible for most ACOs. In an attempt to meet the deadline, some ACOs are dropping small practices, which is an unintended negative consequence of this policy proposal.

Instead, delaying for at least two years would give organizations time to implement these new eCQMs and see one round of performance data before reporting becomes mandatory.

2. **CMS should allow MIPS CQM reporting for 2025.** Many ACOs have invested both time and resources in implementing this reporting option to meet the APP reporting requirements in time for the PY 2025 deadline. CMS did not previously indicate it planned to remove this as an option. Discontinuing this option will not only result in many ACOs having wasted valuable time and resources, it will also require these ACOs to quickly pivot to another option over the course of only a few months if this policy is finalized.
3. **CMS should retain Medicare CQM reporting as a permanent option until digital quality measurement and reporting is feasible for all ACOs**, rather than requiring the transition to all-payer eCQM reporting. While we appreciate that CMS offers the Medicare CQM reporting option as a transitional policy, this approach shares many of the operational challenges described above. In particular, ACOs must make significant investments in standing up the infrastructure and processes to support this reporting option. Therefore, many ACOs are choosing to focus on meeting eCQM reporting requirements, since the Medicare CQM option is not permanent. HCTTF recommends that CMS retain the Medicare CQM reporting option as permanent until the challenges described above have been addressed and digital quality measurement and reporting is feasible for all ACOs. At a minimum, CMS should provide ACOs with at least two performance years prior to removing the Medicare CQM reporting option to ensure ACOs have sufficient time to fully transition to eCQM reporting.
4. **CMS should modify the Medicare CQM reporting requirements to only be applicable to an ACO's assigned population, rather than their assignable population.** For ACOs under retrospective alignment, both their assignable and assigned populations will be based on services furnished during the performance year. CMS has indicated that it will provide ACOs with a list of beneficiaries who are eligible for Medicare CQMs prior to the start of the submission period. However, this list may be incomplete due to factors like claims runout, and it is ultimately the ACOs responsibility to report on all eligible beneficiaries. ACOs will generally be aware of their assigned population by the start of the quality submission period. As a result, HCTTF members urge CMS to modify the reporting option to only be applicable to an ACO's assigned population. Additionally, CMS should work with stakeholders to ensure ACOs understand and can report on their assigned patients and should avoid penalizing ACOs that may be unable to identify their full assigned patient population during the initial reporting periods.

Collectively, these recommendations will help providers operationalize the adoption of eCQMs.

IV. Anomalous Billing

CMS proposes to account for improper payments associated with significant, anomalous and highly suspect (SAHS) billing activity during CY2024 or later, by recalculating performance

year and benchmark expenditures to remove SAHS. CMS also proposes to establish a process for ACOs to report SAHS and request that their initial savings/losses determinations be reopened. This proposal complements the proposals in the separately issued proposed rule that addresses SAHS in 2023, called Mitigating the Impact of Anomalous and Highly Suspect Billing Activity on MSSP Financial Calculations in CY2023 (CMS-1799-P).

As we have previously shared, the Task Force fully supports the need to remove SAHS billing from both performance year and benchmark calculations. We believe this policy fairly protects ACOs against anomalous billing outside of their control. In addition, the Task Force recommends that CMS refine the policy by (1) investigating SAHS activity on an ad hoc basis, rather than waiting until a performance period ends, (2) communicating regularly with ACOs that report SAH activity to share any information possible (e.g., even that an investigation is ongoing), (3) eliminating SAHS activity from future agreements to ensure it does not impact future calculations (e.g., removing 2023 SAHS from both benchmarks and performance periods for agreements starting in 2024 to 2026).

V. Beneficiary Notification

CMS proposes to modify the beneficiary notification requirements, which currently require ACOs to send two beneficiary notifications: the first prior to or at the first primary care visit of the agreement period, and the second on the beneficiary's next primary care service or within 180 days (whichever comes first). CMS proposes to simplify these requirements to require the second notification within 180 days.

In addition, CMS proposes to change the notification policy for ACOs under preliminary prospective assignment with retrospective reconciliation. These ACOs would be required to send the notification to beneficiaries who are most likely to be assigned to the ACO. This would replace the current policy that requires the notification be sent to all Medicare fee-for-service (FFS) beneficiaries. Under the proposed policy, CMS defines "beneficiaries most likely to be assigned" as those who received at least one primary care service during the assignment window from a primary care provider (PCP) in the ACO.

The Task Force supports CMS's proposals to allow ACOs more flexibility, while maintaining open and meaningful dialogue with beneficiaries. However, additional changes are needed to reduce beneficiary confusion and operational complexity. The Task Force believes the current requirements are too prescriptive and do not allow ACOs to develop and tailor content to their populations' unique needs. For example:

- **CMS should allow ACOs to edit beneficiary notification templates to include more ACO-specific information, provided all required core elements are included, and to translate notifications into languages that best serve their targeted population.** For example, ACOs should be allowed to tailor the letter to use more beneficiary-friendly wording, including the specific programs that the ACO offers for their ACO's specific population.
- **CMS should also modify the definition of "marketing materials and activities" in MSSP to distinguish between education/communication and marketing and facilitate more ACO-developed education for beneficiaries.** Medicare Advantage

(MA) plans, for example, define marketing materials as a subset of communications, which provides MA plans with more flexibility for developing non-marketing communications, while adhering to regulations on beneficiary protections.

The Task Force believes that these additional requests will allow greater flexibility for ACOs to tailor communications to their patient populations' needs. ACOs should also proactively seek beneficiary and caregiver feedback on their notifications to ensure they align with the needs of patients.

These recommendations are drawn from a resource the Task Force developed in collaboration with the National Association of Accountable Care Organizations (NAACOS).[1] The resource addressed how CMS can strengthen MSSP policies to more effectively engage patients in ACO governance, care delivery redesign, and individual care planning. **We recommend that CMS implement the full list of recommendations in this beneficiary engagement resource through future rulemaking. For example, HCTTF would like to see CMS shift away from requiring ACOs to use a standardized notice and move toward a requirement for ACOs to have a beneficiary-informed education and engagement plan. This plan would be developed in partnership with patients and ACO patient board members, similar to health equity plans in other models.**

VI. RFI: Higher Risk Track

CMS issued a request for information (RFI) seeking comments on financial arrangements that could allow for higher risk and potential reward under a revised ENHANCED track within MSSP. HCTTF members have consistently called for opportunities to accept greater levels of risk within MSSP. The existing ENHANCED track is a two-sided model that represents the highest level of risk and potential reward offered in MSSP. Task Force members support the ENHANCED track and believe that this track should remain an available option.

The Task Force has long supported adding a higher risk sharing opportunity in MSSP, as we have stated in previous letters to CMS. We recommend that CMS add an ENHANCED Plus track in addition to the current ENHANCED track. For those currently in the ENHANCED track who have demonstrated an ability to take on full risk, an ENHANCED Plus track would provide them the opportunity to test care delivery innovations and advance in the program. However, not all ACOs in the current ENHANCED track can take on the additional risk and many would likely remain in the ENHANCED track. Two separate ENHANCED tracks would facilitate greater participation across the program and support both types of ACOs.

The ENHANCED Plus track would also attract ACO REACH participants when the model ends and they seek another full-risk alternative. In addition to taking on full risk, participants in ACO REACH have made large investments in population and health equity through the model. These ACOs are seeking new opportunities for full-risk models when ACO REACH ends. The ENHANCED Plus track would also support former Next Generation ACOs with experience in

[1] Health Care Transformation Task Force. (2024). Reimagining beneficiary engagement in accountable care models. Retrieved from: https://hcttf.org/hcttf-and-naacos-releases-reimagining-beneficiary-engagement-in-accountable-care-models/

full-risk models, as well as current ENHANCED participants who are ready to take on additional risk. The Task Force also supports the ENHANCED Plus track as a means of widening the on-ramp to full risk, and we are also supportive of additional CMMI models testing full-risk ACOs. Full-risk options would help CMS find ways to continue incentivizing ACO participation for organizations with an established track record in accountable care.

A new ENHANCED Plus track should prioritize encouraging experienced ACOs to shift away from FFS payments by offering three things: **(1) greater ACO opportunity for reward and accountability for risk based on costs and quality, (2) capitated payments for both low and high revenue ACOs, and (3) expanded benefit enhancements to allow ACOs flexibility in how they address patient needs.** CMS has repeatedly tested some of these concepts in earlier CMMI ACO and primary care models and has continued to incorporate these concepts into models like ACO REACH. Specifically, we encourage CMS to incorporate the following into MSSP and a new ENHANCED Plus Track:

1. **Offer Greater Risk / Reward Opportunities**: CMS should create the option for MSSP advanced risk tracks above the existing ENHANCED Track that offers ACOs the option of having greater up- and downside risk, including:
    a. **Increased Shared Savings**: First dollar savings at a rate of at least 85%, not to exceed 20% of an updated benchmark. This applies after the minimum savings rate and quality standards are met or exceeded.
    b. **Increased Shared Losses**: First dollar losses at a rate based on quality performance, with a minimum shared loss rate of 55% and maximum of 75%, not to exceed 15% of an updated benchmark. This applies once the medical loss ratio and quality standards are met or exceeded.

2. **Support Capitated Payments:** Allow MSSP ACOs the option of:
    a. **Monthly primary care capitation** payments similar to those offered in the ACO Primary Care Flex (PC Flex) Model. CMS should expand access to PC Flex to include both high- and low-revenue ACOs. High-revenue ACOs do not equate to high financial margins. Instead, high-revenue ACOs are most deeply engaged with multi-specialty practices that often serve more complex patients, so extending primary care capitation to these ACOs would support CMS' goal to integrate specialists in VBC.
    b. **Total cost of care capitation** payments like the global track in ACO REACH. This option would support ACOs interested in better engaging specialists through mechanisms such as shadow bundles, in alignment with CMS' specialist integration goals. This would also provide ACO REACH participants with a clear option after the model concludes, creating greater predictability and encouraging the ongoing participation of these ACOs in CMS models.
    c. **Population Based Payments** similar to what was available under the Next Generation ACO model, allowing ACOs to negotiate fee schedule reductions with specific providers in exchange for the flexibility of a prospective population-adjusted payment.

3. **Increase Benefit Enhancements:** CMS should allow ACOs to improve care delivery and beneficiary affordability by expanding the MSSP benefit enhancement to match those in other models. Enhancements available to MSSP ACOs advanced risk tracks should include:
    a. **Beneficiary Affordability:** Implement lessons from value-based insurance design by allowing MSSP ACOs to:
        i. Waive patient copays and deductibles for visits to ACO providers in advanced risk models, similar to the ACO REACH program. This is particularly important for high-value services such as primary care and services to address patients' HRSNs, such as the Community Health Integration services that became available in 2024. ACOs need the flexibility to offer this to specific patient populations, such as those with only Medicare coverage and not supplemental insurance (*e.g.*, Medigap plans) and are therefore exposed to higher out-of-pocket costs.
        ii. Offer Part B premium rebates tied to tight usage of an ACO's affiliated network.
        iii. Create a framework for Medicare ACO supplemental plan offerings, with lower cost-sharing for care delivered through the ACO.
        iv. Offer direct incentives to beneficiaries in MSSP ACOs through various waivers.
    b. **Telehealth:** Broaden telehealth waivers to apply regardless of ACO assignment methodology, to provide ACOs a stable telehealth policy environment after the end of COVID-related telehealth policy exceptions. In addition, CMS should engage with stakeholders to identify additional services that can be safely and effectively provided via telehealth, leveraging ACOs to test and refine a modernized telehealth policy. More broadly, CMS should extend access to telehealth to the full extent of its regulatory authority through rulemaking.
    c. **Simplify Skilled Nursing Facility (SNF) Three-Day Waiver:** Simplify the requirements for SNF waiver to make it easier for ACOs to implement, by adopting flexibilities implemented during COVID as permanent waivers. This could include encouraging, but not requiring, ACOs to contract with SNFs.
    d. **Home-based services:** Explore adding additional waivers related to home-based services. CMS should adopt the post-discharge and care management home visits waivers in place under the ACO REACH model.

In addition, the Task Force and its members are broadly supportive of administratively set benchmarks. We appreciate that CMS acknowledges the downward ratchet effect created by benchmarking methodologies dependent on historical spending. The current approach threatens to make benchmarking strategies untenable in the long term because participants must continuously find new ways to save money. Left unchecked, this could create a race to the bottom, especially for ACOs with a long history of VBC participation. Acknowledging this challenge, CMS has instituted a new five-year prospective cost growth trend factor known as the Accountable Care Prospective Trend (ACPT) based on U.S. per capita cost (USPCC) as one-third

of a three-way blended trend incorporating the existing national-regional blend. The ACPT does not fully account for ratcheting within an agreement period, but it does reduce the weight of regional trends. The Task Force and its members will monitor the impact of the ACPT on benchmark ratcheting within ACO agreement periods as it is rolled out with new agreements starting in 2024.

The Task Force believes mandatory models can serve an important role in driving model participation. The Task Force's longstanding policy has been to assess our support for mandatory models on a case-by-case basis based on their design and impact. The Task Force cautions CMS that a mandatory ACO model would be more operationally complex than any previous mandatory model. The Task Force urges CMS not to mandate ACO participation for organizations and clinicians that are already engaged in accountable care arrangements. For example, hospitals and clinicians that meaningfully participate in ACOs and other APMs should be given the opportunity to opt out of a mandatory model. **Notably, the Task Force position on mandatory models has been in the context of CMMI models. We do not see a path forward in MSSP to implement a mandatory ACO due to the statutory requirements governing this program.**

CMMI Model Elements

VII. Cardiovascular Risk Assessment

CMS proposes to introduce new payments for cardiovascular risk assessment and management services. This proposal would build on the CMMI Million Hearts Model, which the evaluation found improved quality and reduced costs through disease prevention.

The Task Force supports the new cardiovascular codes as a means of increasing preventive care, improving quality and supporting population health. In addition, the Task Force supports CMS' decision to build upon the lessons learned from CMMI models through rulemaking.

VIII. Advanced Primary Care Management

CMS proposes to introduce three new Advanced Primary Care Management (APCM) codes, including: Principal Care Management, Transitional Care Management and Chronic Care Management. The new codes are intended to provide predictable care management funding for staff and infrastructure, reflecting lessons learned from the CMMI Comprehensive Primary Care (CPC), CPC Plus and Primary Care First Models. The new codes would bundle several current care management and technology-based communication services. Each code may be billed monthly by one provider but may not overlap with other care management codes. The codes include three levels of payment, based on the patient's clinical and social risk, with social risk defined as Qualified Medicare Beneficiaries. The new codes are tied to primary care quality measures through the Value in Primary Care MIPS Value Pathway (MVP) or MSSP reporting requirements.

The Task Force strongly believes care management is central to delivering high-quality, patient-centered primary care. The Task Force supports CMS' goal of providing support to primary care practices by offering stability for their care management staff and infrastructure. As stated above, the Task Force also supports CMS' decision to build upon the lessons learned from CMMI models through rulemaking that incorporates those changes into other Medicare policy areas.

However, the Task Force believes the APCM proposals should be refined to increase their adoption:

1. The APCM codes trigger cost-sharing for patients, which for many patients is a significant barrier to care. Patient advocates and health care providers have long raised concerns about affordability, with specific concerns about care management and other services that trigger patient cost-sharing outside of a normal PCP visit, taking patients by surprise. This limits providers' ability to use the codes and therefore harms patient access to care. **The Task Force believes CMS should work with Congress to establish waivers for patient cost sharing for the new APCM codes. Allowing providers to waive patient cost sharing for these services would mitigate access barriers and increase PCP's adoption of these codes.** In the short term, CMS should mitigate the impact of cost sharing by providing educational materials to providers and beneficiaries with options for covering costs. Additionally, CMS should analyze and publicly disclose the characteristics of the populations exposed to cost-sharing requirements associated with these services.

2. CMS proposes to reimburse for APCM codes using a mix of clinical and social risk. The highest level of reimbursement would be available to patients with Qualified Medicare Beneficiary status, which is used as a proxy for social risk. The Task Force appreciates CMS' intention of incorporating both clinical and social risk. **However, CMS should broaden the definition of social risk used to trigger the level 3 codes, by using all available data on social risk. In keeping with other CMS and CMMI models, CMS should use dual eligibility, low-income subsidy status, eligibility for Medicare due to disability, and national and regional ADI.**

3. This proposal is designed to be cost neutral relative to the current care management codes. While the APCM would not provide more funding, it would require more extensive operational requirements for PCPs. The proposed reporting requirements are roughly equivalent to those required in CPC Plus track 2 and are more extensive than any that have previously been imposed through rulemaking. For example, the proposal would require additional reporting through the Value in Primary Care MVP and the implementation of population health management tools. This proposal is duplicative with other QPP requirements, and breaks with precedent by tying the use of individual primary care codes to quality reporting requirements. If CMS mandates these reporting requirements, it will limit the adoption of these codes. **To support the adoption of APCM codes, CMS should eliminate the reporting requirements from the use of these codes.**

With these refinements, the Task Force believes that CMS will better support the adoption of ACPC, to promote patient access to high-quality care.

IX. RFI: Hybrid Primary Care Payments

CMS seeks comment on hybrid FFS and population-based payments for advanced primary care. CMS would like to know whether and how to implement payment policies that recognize advanced primary care, including: streamlined VBC opportunities; billing; person-centered care; health equity; clinical and social risk; and quality.

The Task Force strongly supports the move to primary care capitation as an option available to ACOs and other accountable care arrangements, as we have expressed in previous letters to CMS. However, we believe that primary care capitation should not occur outside of accountable care arrangements, because payment transformation should be linked to quality measurement. Introducing primary care capitation within accountable care arrangements through rulemaking would expand opportunities for PCPs to engage in VBC. For example, we believe that MSSP ACOs should be able to offer primary care capitation, as it is now available to some ACOs under the ACO PC Flex Model**. The Task Force believes CMS should expand access to PC Flex to include both high- and low-revenue ACOs, to increase the adoption of primary care capitation.**

Due to the brief 60-day comment period, the Task Force is not able to address all of the questions posed by CMS in the RFI, many of which require extensive modelling and stakeholder engagement. However, we express our support for adopting primary care capitation for ACOs through rulemaking to accelerate the adoption of VBC. The Task Force also has general comments to share in response to several of the topics raised in the RFI:

- *Hybrid Payment Definitions:* CMS should work closely with stakeholders to define services that could be capitated as part of hybrid primary care payments. CMS should apply lessons learned from previous CMMI models such as Primary Care First (PCF) and Making Care Primary (MCP), which are currently testing hybrid primary care payments. CMS should work to ensure that the capitated payments directly support primary care practices, as they do in PCF and MCP. CMS should also avoid capitating services where it is beneficial to increase volume, such as vaccinations and other preventive care services. In addition, capitated payments should represent an increased investment in primary care over historic levels.
- *Clinical and Social Risk Adjustment:* Hybrid payments should account for both clinical and social risk factors, building on models that adjust for dual eligibility, LIS status, disability, and national and regional ADI.
- *Health Equity:* Capitated payments should receive upward adjustments for underserved patients, in recognition of the fact that historical spending in these groups reflects an underinvestment in care.

- *Support for Care Redesign*: CMS should develop incentives for PCPs to redesign their practices. This will require investments in infrastructure, as well as performance-based payments that reward quality.
- *Multi-Payer Alignment:* By developing hybrid primary care payments that are triggered by specific billing codes, CMS would be establishing a precedent that other payers could adopt. This would encourage multi-payer alignment, because many private sector payers have identified the lack of precedent and billing codes as barriers to adoption.

The Task Force welcomes the opportunity to engage with CMS in future dialogue about hybrid primary care payments and VBC adoption.

Specialty Care

X. MIPS Value Pathways

CMS proposes to add six new MVPs starting in 2025 – ophthalmology, dermatology, gastroenterology, pulmonology, urology and surgical care – and to consolidate two current neurology-focused MVPs. With these additions, CMS estimates that 80% of specialties would have an applicable MVP. CMS also proposes to maintain the current performance threshold at 75 points for 2025, as well as maintaining the 75 percent data completeness requirement through 2028. In addition, CMS proposes several technical fixes related to clinician costs: topped out quality measures; multiple data submissions; improvement activity requirements; and minimum criteria for qualifying data submissions on quality, improvement activities and promoting interoperability.

The Task Force continues to support the underlying concept behind the MVPs, and we see the value in a mechanism that has the potential to create a streamlined glidepath for providers to participate in Advanced APMs. However, we believe the following recommendations would strengthen the MVP program:

1. **Encourage sub-group reporting and the integration of specialty care measures into the MVP and other value-based programs.** In addition, HCTTF urges CMS to not restrict sub-group participation population to specialty providers. Primary care practices may have different specialties that report to the MVP. Therefore, restricting sub-group participation conflicts with the goal of aligning primary care practices with Advanced APMs.
2. **MVPs occur within a FFS based system that does not provide the stability and flexibility offered by prospective payments.** The use of Total Per Capita Cost (TPCC) and similar measures in MVPs will serve as a deterrent to participation in MVPs and in APMs in the future.

Collectively, these changes support providers as they operationalize MVPs.

XI. RFI: Specialist Engagement in VBC

CMS is seeking comments on how to increase specialist engagement in VBC, while expanding incentives for specialists to coordinate with primary care. To achieve this goal, CMS is exploring the use of mandatory reporting requirements combined with payment adjustments, which would be achieved through future rulemaking and occur no earlier than 2026. CMS is seeking feedback on the participants, performance assessment, payment methodology, incentives for partnering with ACOs and PCPs, health information technology, health equity, and multi-payer alignment.

In the RFI, CMS describes their intention to adjust payments using clinically relevant MVP measures that specialists would be required to report on, with scoring based on the relative performance to others with the same specialty and clinical profile. This would be different than the current MIPS requirements, in which reporting is voluntary and scored relative to all clinicians. CMS could start with MVPs that are already published and scale the program to include additional specialties over time. Quality measures could draw on the five MVPs that currently include patient-reported outcome measures (PROMs) and episode-based costs for chronic conditions, and could assess coordination between primary and specialty care.

The Task Force agrees that specialist integration in VBC is critical to the goal of improving access to high-quality, equitable care. **The Task Force believes mandatory models can serve an important role in driving model participation. The Task Force longstanding policy is to assess our support for mandatory models on a case-by-case basis based on their design and impact. In addition, the Task Force believes it is essential to retain non-financial incentives for Advanced APM participation, which include exemption from traditional MIPS reporting – which includes MVP reporting. Therefore, if CMS envisions a mandatory MVP model, it should exempt Advanced APM participants.**

Primary Care & Health Equity

XII. Payment Policies that Support High-Quality Primary Care

CMS proposes several payment policy changes that support patients and caregivers through high-quality primary care, integrated behavioral health, and related services:

- *Telehealth*: CMS proposes to permanently add audio-only services to the Medicare Telehealth Services List, which could be billed if the provider has video capacity, but the patient does not have or chooses not to use video. CMS further proposes that direct supervision could be provided via real-time audio and video communication. CMS notes that, without Congressional action, on 1/1/25 the statutory restrictions on geography, site of service, and practitioner type will go back into effect. As a result, telehealth coverage for non-behavioral health services will only be available to people in rural areas for services delivered from a facility.
- *Behavioral Health:* CMS proposes to add new codes for behavioral health safety planning and opioid treatment programs.

- *Preventive Services:* CMS proposes to add payment for complex patients (code G2211) in combination with an annual wellness visit, vaccine administration or any Part B outpatient preventive service.
- *Caregiver Training:* CMS proposes to add new codes for caregiver training, including clinical care (e.g., wound care, medication administration, special diet preparation) and caregiver behavioral modifications.
- *Physical & Occupational Therapy*: CMS proposes to allow physical & occupational therapy assistants to deliver remote monitoring under general supervision, to increase access in rural and underserved areas.

The Task Force supports these new codes because they collectively support integrated, whole-person care. In particular, the Task Force thanks CMS for making audio-only care a permanent telehealth policy in cases where the patient cannot or chooses not to use video. We recommend that providers be required to document why a beneficiary declines to participate in a two-way video visit. This policy will support access to care for all patients, and especially for beneficiaries who do not have the resources to use video. The Task Force continues to support ongoing telehealth access to all Medicare beneficiaries, not only those in rural areas, but recognizes the need for Congressional action to make the COVID flexibilities permanent.

In addition, the Task Force recommends that CMS waive the statutory restrictions on scheduling annual wellness visits (AWVs), to allow AWVs to be scheduled and provided once a year at any time during that calendar year. The 12-month timeline results in arbitrary barriers to care and is also implemented differently in different regions at the discretion of the MACs. This has caused confusion, scheduling challenges and uncompensated care.

XIII. RFI: Patient-Reported Outcome Measures

CMS seeks comment on the development of guiding principles to select and implement PROMs and patient-reported outcome performance measures (PRO-PMs). Specifically, CMS is seeking feedback related to the guiding principles the agency proposed on data infrastructure, measure selection, feasible implementation, accessibility, patient engagement, and equity. In addition, CMS is seeking feedback on topics that should be added to this list.

The Task Force highly supports the continued and expanded implementation of PROMs and PRO-PMs in APMs. In addition, the Task Force encourages CMS to add PREMs to these efforts. PROMs and PREMs are distinct but equally important measures. The inclusion of PROMs and PREMs better focuses care delivery on what matters most to patients, and can advance the provision of equitable, culturally competent, person-centered care.

Task Force is broadly supportive of the PROMS guiding principles proposed, and suggests recommendations on how to strengthen them further:

- *Accessibility*: CMS should expand this principle to include accessibility to patients. Patients should be able to complete surveys within a reasonable amount of time and should be offered the survey in-person and online.

- *Patient Engagement & Equity*: Like every aspect of our current health care system, PROMs and PREMs design, testing, implementation, and evaluation should explicitly center on achieving equitable outcomes and experiences. The Task Force believes that patient engagement and equity are necessary guiding principles for engaging in this work. To ensure these measures incorporate a health equity lens, HCTTF recommends the questions be written at a fifth grade reading level, available in different languages, available online, and tested with patient focus groups to ensure they do not contain bias. Staff administering surveys should be sure to communicate with patients why they are asking these questions and how they intend to use the data. The Task Force also encourages the stratification of data by race, ethnicity, and other demographic factors to determine where inequities exist and develop a plan to advance equity.

- *Reducing Burden:* The Task Force believes that CMS should also add a principle to reduce clinician burden in implementing PROMs. CMS should provide financial support and incentives to providers for data collection efforts. CMS should also implement pay-for-reporting measures before moving toward pay-for-performance.

CMS should include a balance of both general and condition-specific measures. General measures should focus on aspects of care that are important to patients regardless of condition or care facility such as "Did your provider take your concerns seriously?" General measures can also gauge whether patients felt they were treated with respect and fairness and without biased or discriminatory care.

In addition to responding to CMS' questions above, the Task Force would like to share several recommendations that we have developed for providers and payers seeking to implement PROMs and PREMs:[2]

- Adopt a stepwise approach that first establishes a PROM and PREM infrastructure before measuring health systems on their performance.
- Include funding in new value-based payment models to advance PROMs and PREMs implementation, reporting, and evaluation.
- Incorporate PROMs and/or PREMs as central outcome measures.
- Provide or support training for physicians and health care providers in how to administer and act upon PROMs and PREMs.
- Support research that informs how PROMs and PREMs can be used to improve clinical care experiences and outcomes at the point of care with the patient.
- Continuously proclaim the importance of PROMs and PREMs to the quality measurement and value transformation enterprises.

[2] Health Care Transformation Task Force. (2023). Accelerating the use of patient-reported quality measures in value-based care. Retrieved from: https://hcttf.org/accelerating-the-use-of-patient-reported-quality-measures-in-value-based-care/

For organizations implementing PROMs and PREMs, these steps address several of the key challenges associated with selecting the right survey, mitigating low patient response rates, embedding measures into existing workflows, and ensuring measure collection efforts are sustainable through financial support.

XIV. RFI: Community Health Integration

CMS is seeking comment on ways to refine the newly implemented codes for Community Health Integration (G0019, G0022), Principal Illness Navigation (G0023, G0024), Principal Illness Navigation-Peer Support (G0140, G0146), and Social Determinants of Health Risk Assessment (G0136). CMS would like stakeholder feedback on how these codes are defined, including whether related services are missing from these codes, and what barriers providers face in using these codes. In addition, CMS is seeking input on personnel types, training requirements and collaboration with CBOs in the deployment of these codes. CMS believes the agency can work within the existing codes to define services that help providers better address HRSNs that interfere with the ability to diagnose and treat patients.

The Task Force recommends that CMS pay separately to both screen for and address HRSNs. Many providers interpret the existing codes to not cover screening if it occurs prior to a visit. CMS should clarify the guidance around the existing codes to ensure that providers can receive reimbursement in cases where patients complete screenings in advance of visits. As of 2024, CMS began reimbursing for Community Health Integration services (G00019 and G0022), including payment for providing tailored support and system navigation after identifying a HRSN that significantly limits the physician's ability to carry out a treatment plan. Medicare also covers assessment of social determinants of health during a visit (G0136). This payment helps providers establish and maintain the staff and data infrastructure needed to collect HRSN data and address these needs. However, many of the screening tools require extensive time and it can be more effective to deliver screening in advance of a visit, to allow for more discussion between patients and providers during the visit itself. CMS should clarify their guidance to pay for screenings that occur prior to a visit to address patients' social drivers of health.

CMS should also provide clarification of how "screening" vs. "risk assessment" are defined, which contributes to the confusion about how the Community Integration Codes can be used. In April 2024, CMS released an FAQ that specified risk assessment is for patients with a known social need, which is not the same as screening entire populations. Many providers have not adopted these codes due to confusion about how these terms are defined and applied to the Community Health Integration codes. **In addition, CMS should recommend – but not require – validated tools that providers could use to conduct screenings, which would aid decision-making about which tools to build into EHRs.**

The Task Force also strongly recommends that CMS should eliminate patient cost-sharing for Community Health Integration services. These services are initiated when patients' HRSNs interfere with diagnosis or treatment of their health conditions. These are often basic needs, such as adequate food and stable shelter, which can at times be urgent. We applaud CMS' efforts to reimburse for the services that directly address these HRSNs and feel the definitions are broad enough to encompass the relevant services. However, the cost-sharing provision

means that many patients must be prepared to pay out of pocket prior to accepting the help of a CHW or other auxiliary personnel. This creates an additional financial burden for patients who already experience a significant lack of resources. While it is only a few dollars, we believe it will disincentivize patients from accepting services that could help them access the resources available to improve both their health and social situations. We recommend CMS make these services exempt from cost-sharing or allow ACOs to waive cost-sharing.

CMS should expand the auxiliary personnel that can deliver Community Health Integration services to include doulas, care coordinators, and non-licensed social workers. In addition, the Task Force supports CMS' proposals for the training and certification of the auxiliary personnel furnishing these services. We advocate for such training and certification to be the responsibility of the employer to facilitate and fund. The alternative means that community members who would make excellent CHWs (or other types of peer-related roles) but who cannot afford the fees and time away from work to undergo the required training on their own would face significant barriers to entering this line of work.

CMS should offer 15-minute time increments for G0022. Flexibility is key when working with both patient populations and CBOs that are resource limited. For the initial encounter, 60 minutes feels like a fair time increment, particularly if it is conducted as a home visit. However, follow-up work often comprises important communication with patients and CBOs that can come up unexpectedly (*e.g.*, if the patient has reached the top of a resource wait list and must claim their spot). Patient engagement cannot always wait to be consolidated with other activities into a billable 30-minute session. CHW follow-up activities can be more easily documented in 15-minute time increments, rather than 30-minute time increments. A shorter time increment, such as 15 minutes, would allow providers to capture revenue for more of the work that legitimately meets the definition of Community Health Integration services and lower operational barriers to implementation.

CMS should provide greater clarity around the compliance implications of initiating this billing in both health system/provider organizations and CBOs. The services that constitute CHI & PIN were previously unbillable for most, if not all patients, making scaling and sustainability difficult. Making such services Part B benefits is a huge step forward in systematizing and sustaining work to address HRSNs. Maximizing this opportunity means adding billing-related documentation and workflows and financial conversations with patients where there previously were none. CBOs have a much bigger learning curve, but even within a large health system this transition has led to many compliance questions and concerns. Specifically, it has been difficult to determine the breadth of providers' obligations to begin generating charges for non-Medicare patients receiving similar services. It is not clear how providers can remain compliant as a Medicare supplier entity, while avoiding additional financial burdens for patients whose health insurance does not cover such services or who are uninsured. CMS should provide greater clarity around the compliance implications of initiating this billing in both providers and CBOs.

CMS should clarify the type of provider documentation that would adequately demonstrate the medical necessity for Community Health Integration. All unmet HRSNs affect health and well-being so it is not difficult to demonstrate how they impact the management of specific conditions. However, providers would benefit from greater clarity on the type of documentation that CMS is seeking.

CMS should provide education on Z codes to both providers and EHR vendors, to increase the adoption of these codes. The role of Z codes in the industry remains unclear, and this makes it difficult to invest the time and resources needed for EHR builds that facilitate code use, as well as related training of providers and staff. As CMS sets the tone for the industry, having clear guidance on the use of Z codes specifically (as opposed to e.g. LOINC codes) would be useful to direct infrastructure investments, and it would help bring other payors and accrediting bodies in line with this expectation.

CMS should partner with federal, state, and local governments to provide sustainable funding to CBOs. This would encourage more collaborations between CBOs and providers, thus ensuring that auxiliary personnel can continue delivering high-quality, community-integrated health services.

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The Task Force appreciates the opportunity to provide feedback on the CY2025 PFS Proposed Rule. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org) or Senior Director Theresa Dreyer (theresa.dreyer@hcttf.org) with questions related to these comments.

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