September 9, 2024

Submitted via www.regulations.gov

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

RE: **CMS-1807-P CY 2025 Medicare Physician Fee Schedule Proposed Rule**

Dear Administrator Brooks-LaSure:

Aledade, a public benefit corporation, is the largest network of independent primary care in the country, helping independent practices, health centers and clinics deliver better care to their patients and thrive in value-based care. Through its proven, scalable model, which includes cutting-edge data analytics, user-friendly guided workflows, healthcare policy expertise, strong payer relationships and integrated care solutions, Aledade empowers physicians to succeed financially by keeping people healthy. Together with more than 1,900 practices, federally-qualified health centers and community health centers in 45 states and the District of Columbia, Aledade shares in the risk and reward across more than 200 value-based contracts representing more than 2.5 million patient lives under management. More than 65% of our practices are in Primary Care Shortage Areas and 50% are in Medically Underserved Areas. Aledade embraces a health care culture where all are included, valued, and cared for.

Aledade thanks CMS for its continued commitment to primary care, value-based care, and the Medicare Shared Savings Program (MSSP). We commend CMS for continuing to strengthen and enhance the MSSP to meet the goal of having 100 percent of Traditional Medicare beneficiaries in accountable care relationships by 2030. A number of provisions in this proposed rule move us closer to that goal. We look forward to continuing to work with CMS and other stakeholders to improve health outcomes and enable the ACO model to thrive. There are important proposals in this proposed rule that will help primary care grow, flourish, and bring us closer to the goals of increasing access to accountable care and improving health equity. Our comments will focus both on proposals that we feel need additional consideration, as well as proposals we strongly support and commend CMS for including.

Summary of Aledade's Comments

MSSP Proposals

- **CMS should maintain accurate quality reporting for ACOs while continuing to move health information exchange forward.** Evidence demonstrates that an all-payer, all-patient census quality measurement will yield a less accurate quality score for an ACO than a well-designed sampling methodology. CMS should maintain accurate quality reporting through sampling. We recognize that CMS has more goals than just accuracy. We conducted comprehensive testing of the current state of eCQMs. Our strong recommendation is that CMS allow for the use of mature QRDA-III files rather than requiring the use of less mature, resource intensive QRDA-I files. Regarding Medicare CQMs, our testing shows a drop in accuracy that will cost ACOs millions of dollars in shared savings. We appreciate CMS's proposals in this area and note that further work is needed. CMS should adjust benchmarks to account for the observed drop in accuracy. MIPS eCQMs and MIPS CQMs do not create comparable benchmarks as they use QRDA-III files and represent only the practices' best scores, not the average of all the reporting practices.
- **Introducing a Health Equity Benchmark Adjustment (HEBA)**. We support the introduction of the HEBA but urge CMS to go further in proposals so that more ACOs could benefit from serving high risk and complex patient populations. Specifically, stacking HEBA on top of prior year savings or regional efficiency up to the five percent cap for each. We encourage CMS to identify additional ways to support health care professionals caring for underserved populations. As noted elsewhere in this comment letter, the benchmark ratchet threatens the overall success of the program. Additionally, developing and implementing initiatives to address social drivers of health and health inequities requires significant, sustained funding that many providers, particularly small practices and rural providers, do not have.
- **Aligning Prospective HCC Risk Score Cap:** Aledade supports CMS' proposal to make a conforming change to regulation to clarify that it will use ACOs' benchmarks that have been adjusted for prior year savings, HEBA and the regional adjustment to align the 3 percent cap on HCC scores with that of the ACO's region.
- **Addressing Cash Flow Challenges through Prepaid Shared Savings**. We commend CMS for the proposal to make Prepaid Shared Savings available, but ask for more flexibility in reporting and using the funds, since Shared Savings do not have these restrictions. We also recommend CMS not require rebasing and a new contract. CMS has expressed a desire for certainty in achievement and the most certain savings rate are those in the later years of a contract not in the beginning years of a new contract after the ratchet.

- **Considering a Higher Risk Track in MSSP.** We continue to commend CMS for carefully thinking through strategies to offer a higher risk in MSSP but we caution against replacing the current Enhanced track. In our comments, we suggest an easier way to prevent a loss of Medicare savings due to ACO selection. We also articulate the benefits a higher savings rate on the next savings dollar can have on future innovation in ACOs.
- **Ensuring ACOs are Protected from Anomalous and Highly Suspect Billing Occurrences**. Aledade supports CMS' efforts to address significant, anomalous, and highly suspect (SAHS) billings in ACOs' financial methodology. We ask that CMS consider improving the feedback loop of communication with ACOs when suspected fraud is first recognized, and make recommendations for improved transparency on enactment of SAHS billing.

Proposals to Strengthen Primary Care

- **Strengthening Advanced Primary Care Management.** Aledade appreciates CMS' proposals to support advanced primary care delivery and address gaps in billing code utilization and payment for care management services. To reduce administrative burden for participating practices, we encourage CMS to reconsider the use of Qualified Medicare Beneficiary (QMB) status, provide additional clarity on the documentation requirements, and expand the requirements automatically met by ACOs.
- **Addressing Physician Payment Cuts in the Long and Short Term.** We recognize that CMS does not have the authority on its own to make the necessary improvements around forthcoming payment cuts and we appreciate CMS's continued efforts to use regulatory levers to bolster support for equitable access to comprehensive primary care. We commend CMS for using its available authority to continue to invest in primary care in the CY 2025 PFS and look forward to working with the agency and other stakeholders to further support the critical work of primary care in the short and long term.
- **Supporting Telehealth Flexibilities and Leveraging Learnings from the Public Health Emergency.** Aledade strongly supports the continuation of critical flexibilities that remain in place after the Public Health Emergency. We support maintaining certain telehealth policies through 2025 but ask that CMS consider making these policies permanent.

Proposals to the Medicare Shared Savings Program

Quality Reporting in MSSP

We appreciate the continued dialogue between CMS and the ACO community on the proposed move to eCQM quality measurement. This approach will require ACOs to utilize electronic reporting on the quality of care for all patients treated by all ACO participating providers covered

by all payers, despite MSSP being a program for Medicare beneficiaries. Currently, MSSP allows ACOs to report on a statistically valid sample of Medicare patients using multiple data sources.

We understand that CMS has proposed this change in quality reporting for multiple reasons: to ease the burden of quality reporting; to improve coordinated care outcomes; to promote interoperability between EHR systems; and to track population health outcomes. We share these goals and believe ACOS have made progress in all these areas with support and incentives from CMS. For example, ACOs have created a viable market for admission, discharge, and transfer feeds. And, to power population health, ACOs have built numerous clinical interfaces between EHRs and with Health Information Exchanges. But, if CMS wants to accurately measure ACO quality, we recommend the agency pause the move to eCQMs as proposed and re-think this strategy.

CMS Should Pause to Re-think the Proposed eCQM Strategy

The evidence indicates that a sampling approach that allows the use of electronic data from multiple sources would provide the most accurate measure of quality. The health services and statistics literature tell us that, for populations of the size in MSSP, sampling will produce a more accurate measure of the quality of care delivered than a census approach.[1] We urge CMS to continue the quality reporting based on sampling methodology with improved samples to better address equity and other errors the current sample size may be lacking. Shared savings should be based on these accurate calculations.

The world of health information technology is moving beyond the concept of a single instance of an EHR holding all of a patient's data. With Trusted Exchange Framework and Common Agreement (TEFCA), FHIR APIs, Health Information Exchanges, and more, the information necessary to coordinate care for a patient, and for population health, will be readily available on demand from multiple sources not stored on a single server. Yet, CMS's approach to eCQMs still requires data completeness at the individual provider's EHR and QRDA files are still designed for that outdated world. We urge CMS to maintain accurate, sample based quality reporting for MSSP and to directly incentivize ACOs to be leaders in getting us to a more interoperable world. eCQMs and QRDAs are neither accurate nor do they advance interoperability.

We recognize that CMS has been signaling the move to eCQMs for several years so Aledade has been conducting rigorous testing to prepare for that reporting. In this section, we describe our findings from that testing and then describe the policy implications of our findings.

[1] The one exception in current practice is using claims which are census driven. No organization from CMS to health care providers ever discusses making the type investments that have been required for claims processing which costs over $50 billion a year just for public programs.

eCQM Reporting Differs Significantly, Depending on ACO Composition

Physician practices have been successfully reporting electronic CQMs in the MIPS program for several years now. However, ACOS that are composed of multiple practices using different EHRs will have to rely on a fundamentally different approach than individual practices.

In MIPS, with practically the push of a button, an individual practice can generate a QRDA-III file that encompasses all the data necessary for MIPS CQM reporting. Practices can submit these files directly to CMS and they will be credited under MIPS only for the measures where their performance was the best. The relatively small number of ACOs in a single practice and on a single EHR will probably have a similar experience, except for the scoring rules.

But ACOs that have multiple providers on multiple EHRS must have each practice first generate a QRDA-I file which reports quality data on every individual patient seen by the provider (who qualify for the specific measure). However, as the data presented later will show, many CEHRT cannot readily produce the necessary QRDA-I files. And, even if an ACO can obtain the QRDA file, then ACO will then have to de-duplicate patients across these voluminous files, independently decide on exceptions and exclusions, and then calculate the measured performance.

Lesson 1: QRDA-I reporting is incomplete and unsuccessful out of the box. Accessing functional QRDA-Is is difficult across EHRs.

To prepare for eCQM reporting, we worked with some of our practices for a trial run of this reporting and we learned that the QRDA-I files on which this process relies are not readily available. This was surprising because Certified EHR Technology (2015 Cures Act edition) and in some cases older versions should be able to produce a QRDA Level I file. An ACO will need to ingest and normalize millions of lines in these files to produce a quality report to CMS in MSSP.

To our knowledge, no CEHRT creates QRDA-I files and then summarizes them into a QRDA-III. We recently learned that there may be confusion in policy circles that everytime a QRDA-III is created all the necessary QRDA-I files are also created. This is not how it works. Our testing demonstrated the computational effects. When we made the QRDA-I request several well known CEHRTs simply timed out on the request. Data is mapped internally by the CEHRT to create the QRDA-III directly. Results of our testing are in the table below.

CEHRT Vendor	QRDA-I Outcome	QRDA-III Outcome
Greenway Intergy	**Successful**	**Successful**
AdvancedMd	**Unsuccessful** *Invalid Codes throughout the document*	**Successful**
AthenaClinicals	**Partially Successful** Requires over 1-2 weeks to extract	**Successful**
Azalea EHR	**Partially Successful** BP passed, A1C did not pass	**Successful**
Epic	**Functionality Unknown** Outreach has been attempted, with long wait times.	**Successful**
Practice Fusion	**Unsuccessful** Retired data sources with invalid outputs	**Successful**
Nextgen Office	**Unsuccessful** Ineligible Data	**Successful**
eClinicalWorks ($350 / NPI / Year)	**Unsuccessful** 48 hours per extract, invalid data	**Successful**
PrognoCIS EHR by Bizmatics	**Unsuccessful** Invalid documentation	**Functionality Unknown**

Primary Barrier	Vendor	Impact
Health System Engagement	Epic Hosting Entity	22/123 (18%) Practices w No Interface Median 243 days to go-live
	MEDITECH Hosting Entity	6/11 (55%) Practices w No Interface Median 739 days to go-live
	Cerner Hosting Entity	4/14 (29%) Practices w No Interface Median 475 days to go-live
Technical Capability	PracticeFusion	71 Practices w Manual C-CDA Only
Cost	eClinicalWorks	20/410 (5%) w No Interface

Primary Barrier	Vendor	Impact
All Others	-	57/1059 (5%) w No Interface Typically due to pending EHR transitions impacting integration timelines

Lesson 2: QRDA-Is are not a financially feasible solution for all ACOs

We also found that the process and cost of accessing QRDA-I files from CEHRT vendors is highly variable. Some vendors charge for QRDA files, some do not. The highest charge we have encountered is $768 per clinician from Veradigm Pro.

Some CEHRTs offer QRDA-I on demand, others require requests to be made of staff members at the CEHRT. The accuracy of mappings can vary widely. When CMS accepts the best six measures from a MIPS clinician, they are just as likely to accept the best six mappings of those measures as they are to accept the best performance on quality by that clinician.

Sometimes an ACO can obtain this information through a clinical interface much more efficiently than through a QRDA-I, essentially doing what the CEHRT does internally to produce a QRDA-III summary. However, this method is unsupported by 2015 Edition Cures Act requirements and therefore is even more unreliable from vendor to vendor.

Note an ACO has to pay for each clinician but can mostly only generate revenue on a primary care clinician. CMS seeks to encourage speciality participation, but a multi-specialty clinic with a ratio of one primary care to four specialists would be in a bad spot. If that primary care physician has 100 assigned beneficiaries, savings of 0.8% would have to be generated on those 100 beneficiaries just to pay the vendor fees for those five physicians. Admittedly a worst case, but also a real case based on real fees, an ACO with lots of speciality participation and the MSSP average savings rate could spend 20% of their MSSP revenue just buying access to QRDAs.

QRDA-III is a More Proven and Reliable Solution than QRDA-I

Upon reflection, these findings make sense. QRDA-IIIs have been in demand for years from practices to report meaningful use and then MIPS eCQMs, they are less computationally expensive to generate (one document per report), and they involve lower complexity and less detailed dataset to export, requiring less configuration and EHR mapping. By contrast, QRDA-Is have not been in demand (no practices or ACOs use these for actual operations), they are more computationally expensive because tens of thousands of documents are generated for each

measure, and they involve much higher complexity, requiring extensive configuration and detailed data mappings for an export.

Many of the QRDA-I's that we obtained for testing failed CMS QRDA Pre-Submission Validation tools. Others gave significantly different scores in QRDA-I than in QRDA-III. Again this is likely because QRDA-III files are not actually summations of QRDA-I files.

One of the reasons these findings are novel is because the clinical interfaces that ACOs have invested in to improve care coordination use C-CDA files, FHIR-based application requests, and custom builds. They have not used Quality Reporting Document Architecture (QRDA) files. Unfortunately, quality reporting by 2015 Cures Act Certified EHR Technology (CEHRT) only has one tool, QRDA files. QRDA files are not useful for coordinating care or alerting a primary care physician of a hospitalization., QRDAs are not used to power population health platforms because these files were designed and certified for a singular purpose, to report quality metrics to outside parties.

However, because QRDA-IIIs provide clearer quality reporting and require significantly fewer resources to prepare and understand than QRDA-1s, if CMS moves forward with its eCQM strategy, CMS should allow ACOs to utilize these files until CEHRT vendors can reliably produce QRDA-I files accurately, timely, and at lower cost.

Lesson 3: Electronic Quality Reporting Will Drive Erroneously Low Scores

In our trial runs, we also noticed that the two proposed reporting options (Medicare CQMs and eCQMs) generated misleadingly low scores for ACOs, as indicated in this table below.

Measure	Aledade 2023 Web Interface Performance	Data Completeness	M-CQM Performance (Est)	eCQM Performance (Est)
Diabetes	80th	57%	40th - 60th	30th - 40th
Blood Pressure	70th	72%	50th - 60th	50th - 60th
Depression	80th	24%	10th - 30th	10th - 30th
Breast Cancer	70th	32%	10th - 30th	10th - 20th

Colorectal Cancer	70th	33%	20th - 30th	10th - 20th

These findings demonstrate that the proposed quality reporting mechanism misrepresent the actual quality of care being delivered to ACO patients. This means that, at least for the foreseeable future, CMS and the public would not have a reliable indication of the quality of care delivered by ACOs under the proposed rule. CMS acknowledges these problems by significantly adjusting the quality benchmarks, though proposed the M-CQM benchmarks are likely still too high.

It's instructive to understand some of the realities that generate this poor quality measurement. When the MSSP sampling methodology is used, if an A1c is in the medical record, but not in the electronic quality reporting location, it can be retrieved in a chart review. In an electronic-only census approach, that is not possible. A CEHRT might have three designated places to store A1c values, excluding unstructured notes, but map only one location for its quality reporting. 2015 Cures Edition does not require that all locations where an A1c is stored to be mapped for quality reporting. This creates situations where everything appears to the practice to work fine, but quality reporting fails. Now imagine this scenario repeating across all vendors, all labs, all practices and the errors compound to have a dramatic effect on scoring.

It is not a coincidence that blood pressure is the only measure to be above seventy percent data completeness. Blood pressure is the only measure that meets two critical criteria. First, the result is numeric and true/false. Second, and more critically, all elements of the measure can be captured in a single office visit. This greatly reduces the opportunities for errors. Nor is this unique to Aledade. In 2022, the only publicly available data, ACOs reporting through Web Interface averaged a score of 77 on Depression Screening but in eCQMs this score drops to 55; the Web Interface score for Diabetes (poor control) is 10.5, but the eCQM score is only 33; the Web Interface score for Controlling Blood Pressure is 76, but the eCQM score is 71. We note these drops occur among self-selected groups who voluntarily reported and presumably did so because they were better situated to do so. Our own internal data shows a similar pattern with even larger drops. Thankfully, there is every reason to believe that Medicare beneficiaries are actually receiving high quality care despite these scores. The health services research literature, and indeed statistical research in general, tells us that for populations of this size a sampling approach would capture a more accurate measure of reality of the quality of care delivered than an electronic-only census approach.

Low-revenue ACOs are Disadvantaged Compared to High-revenue ACOs

CMS' proposal will put low revenue ACOs at a particular disadvantage compared to high revenue ACOs. Low revenue ACOs will face challenges in the technical configuration of EHRs due to the use of less capable EHRs and the lack of dedicated IT staff, compared to hgh revenue ACOs. Low revenue ACOs are also less likely to be connected to HIEs and other data sharing networks. Physician practices in low revenue ACOs are more likely to rely on paper workflows for things like PHQ2/9 whereas high revenue ACOs may have well-configured patient portals, tablets for patient forms, and dedicated staff support for processing.

Medicare CQMs Could be a Good Transition Pathway, but Benchmarks are Biased

Because ACOs have expressed concerns about eCQMS over the past few years, CMS has also proposed a temporary pathway for ACOs to report Medicare CQMs. While Medicare CQMs could be a good transition pathway, there are challenges with them as well. Compared to eCQMs, Medicare CQMS have more realistic requirements for data submission but harder performance benchmarks. But, ACOS performance on Medicare CQMs will be compared to MIPs reporting practices that are scored only on their best six measures, and all of these measures are topped out.

There are Alternative Paths for Policy Intervention, with Small Details Playing a Large Role

CMS should maintain and improve on the sample methodology in order to retain the most accurate quality report on MSSP ACOs. No matter how good eCQMs get, an electronic-only census approach will always be a less accurate measure of quality than a well- designed sampling methodology. CMS also should allow alternative electronic data sources to supplement data from the provider's EHR. We recommend CMS pause its eCQM strategy to consider this alternative pathway. Any additional years of sample methodology has our support.

Due to the reduced accuracy, we support CMS's proposal to continue to require a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP Plus quality measure set and 40th percentile on at least one other measure.

Because of the problems identified with the current state of QRDA-I files, we highly recommend that CMS in the preamble and subregulatory guidance make it clear that ACOs can take a weighted average of QRDA-IIIs from its participating practices to report at the ACO level. This

would massively decrease the cost and burden of reporting eCQMs while increasing the accuracy of the eCQMs. In prior years, CMS declined to make this clarification because it would result in a few patients being counted multiple times in the denominator of a measure if a patient went to multiple practices. When CMS made this decision both CMS and the ACO community itself were unaware of the far reaching ramifications of this decision. Given today's awareness, the balance is clearly in favor of using a weighted average of QRDA-III files. Any small loss in accuracy due to duplication will be far surpassed by the increase in accuracy due to better mapping and better data availability. CMS can save the industry millions of dollars and get more accurate data through this simple clarification.

If CMS continues to require QRDA-I files to be aggregated at the ACO level, we recommend that the data completeness requirements for eCQMs in 2025 be reduced to 50 percent. Our testing shows that 50 percent is an expensive but attainable target. Seventy percent completeness is nearly impossible for depression screening. We also recommend that CMS delay breast cancer screening and colorectal cancer screening till 2026. Another byproduct of moving to a census report is that the implementation timeline for changes is January 1, 2025, not February 2026. If a workflow is currently storing information in the wrong location, fixing that only affects the future not the past.

We appreciate CMS proposing to refine the Medicare CQMs away from the retrospective curve that would move a set number of ACOs below the line. We are concerned that the proposed percentiles that mimic the topped out measure methodology would still result in many ACOs falling below the 40th percentile and losing savings when in the accurate sample methodology they would have succeeded. The measures are topped out based on MIPS reporting which is both simpler at the practice level and cherry-picked among the best scores for the practice. This is of particular concern for us for depression screening. The topped out nature in MIPS eCQM for depression screening came and then went and is now back. It is also based on only those who did well on that measure. We recommend CMS consider the portion of practices using depression screening as one of their measures compared to the number using blood pressure. We believe CMS will find that these are not comparable. We recommend that CMS not score depression screening as occurred in 2023 and other years. Alternatively, CMS should consider the benchmarking based on all data submitted for depression screening, not just those submissions where depression screening was a top six score for the practice. We support the concepts behind the depression screening measure, but we must all acknowledge that it lags considerably behind the other measures in maturity of data collection and reporting.

For all Medicare CQMs, we recommend that CMS create an adjustment factor to the percentiles based on the experienced drop in eCQMs, MIPS CQMs, and Medicare CQMs reported in 2023 and

2024 compared to Web Interface reporting. All data from any source shows that there will be a drop in scores and that should be reflected in the benchmarks.

We support the proposal for complex organizations bonuses and given the challenges outlined above, strongly urge CMS to apply that bonus to both Medicare CQMs as well as eCQMs.

Recommendations to Benchmarking Proposals

Health Equity Benchmark Adjustment

CMS proposes to add a Health Equity Benchmark Adjustment (HEBA) that would upwardly adjust benchmarks for some ACOs for new agreements in 2025 and beyond. The adjustment would be based on the proportion of assigned beneficiaries who are enrolled in the Medicare Part D Low Income Subsidy (LIS) or dually eligible for Medicare and Medicaid. ACOs with at least 20 percent of their aligned beneficiaries meeting these criteria would be eligible for the HEBA. Like the regional adjustment and prior savings adjustment, the HEBA could not exceed 5 percent of the national assignable per capita expenditures. Additionally, ACOs would receive the higher of the HEBA, prior savings adjustment, or the regional adjustment. Accordingly, CMS estimates that while 20 percent of ACOs in 2023 would be eligible to qualify for the HEBA, only 5 percent of ACO would have an adjustment higher than either their regional or prior savings adjustment. For those ACOs, the HEBA would increase benchmarks by 1.57 percent.

Aledade supports this policy, but we believe CMS should stack the HEBA on top of prior year savings or regional adjustments. As noted elsewhere in this comment letter, the benchmark ratchet threatens the overall success of the program. Initiatives to address SDOH and health inequities nearly always fall into the variable cost category and require sustained funding. The bar for investment in variable costs is set by year six and year eleven in MSSP; these are the years that represent the regulatory low points in shared savings. A 1.57 increase in benchmark creates funding of $9.80 per person per month in an Enhanced contract and $6.50 per person in a Basic contract, essentially supporting about 2 to 3 people per 5,000 beneficiaries. If that is the highest of the three adjustments in year six then almost all of that money will have to go to meeting quality reporting and other administrative functions. However, stacked on top of regional adjustment or prior year savings it can stay focused on addressing health equity while the prior year savings or regional adjustments cover the operations of the ACO in year six.

Aligning Prospective HCC Risk Score Cap

CMS proposes to make a conforming change to regulation to clarify that it will use ACOs' benchmarks that have been adjusted for prior year savings, HEBA and the regional adjustment to align the 3 percent cap on HCC scores with that of the ACO's region. If finalized, the change would

be reflected in reconciled PY 2024 performance calculations. In last year's rule, CMS capped the risk score growth in an ACO's region for agreements beginning in 2024, making the cap on the ACO and its region symmetrical. Aledade supports this change because it updates benchmarking calculations to reflect new policies.

Addressing Cash Flow Challenges through Prepaid Shared Savings

CMS proposes to create a new option for ACOs with a history of earned shared savings to elect to receive prepaid shared savings payments. The current time lag between when an ACO earns shared savings and when it actually receives payment is one of the fundamental flaws of the program that must be solved to incentivize wider participation in MSSP and to allow ACOs to make more consistent and timely investments in care improvements. This change should make progress for MSSP in two ways. First, practices that have not joined ACOs will be more likely to join as they recognize that CMS has corrected one of their primary frustrations with the ACO model. Second, this change would move us closer to the point where shared savings are a regular source of revenue and practices adopt the mindset that their success is fully tied to accountable care. We applaud CMS for their continued focus in this important area. Aledade supports the concept of Prepaid Shared Savings but encourages CMS to consider several essential changes before finalizing this proposal.

Allowable and Prohibited Uses

CMS proposes to specify how Prepaid Shared Savings may be used and to place restrictions on the amount of funds that can be spent within proposed categories of allowable uses. Allowable expense categories would include staffing, healthcare infrastructure, and direct beneficiary services (DBS). ACOs would be prohibited from using Prepaid Shared Savings for any expense outside of the allowable uses.

We believe placing restrictions on these funds would undermine both of the potential benefits of Prepaid Shared Savings. Practices that have been reluctant to join ACOs will not be enticed into the program if they see CMS becoming more directive in how ACOs spend their funds. Similarly, if our goal is to get practices to see shared savings as their regular source of revenue, we should not be making that pathway look more regulated and more restrictive than the current rules. Current law and regulation place no requirements on how shared savings are used, so it is unclear why CMS would propose restrictive requirements around the use of Prepaid Shared Savings.

However, CMS opens an important policy window with its proposed requirement for ACOs to dedicate a portion of Prepaid Shared Savings for Direct Beneficiary Services (DBS). CMS defines DBS as "in-kind items or services provided to an ACO beneficiary that are not otherwise covered by traditional Medicare but have a reasonable expectation of improving or maintaining the health

or overall function of ACO beneficiaries." This could include cost-sharing support, meals and nutrition support, housing assistance, transportation, caregiver support services, home visits, home or environmental modifications, vision, hearing or dental care, and other such services. This list of services is very similar to the supplemental benefits typically offered by Medicare Advantage Organizations. But the funding for MAOs and ACOs are not comparable – both in terms of level of funding and predictability – so it is unreasonable to expect ACOs to be able to administer and fund these types of benefits using existing shared savings dollars. However, Aledade welcomes CMS' initiating this conversation on how to level the playing field between MAOs and provider-sponsored ACOs to offer Medicare beneficiaries more choices.

While our strong preference is that ACOs retain full flexibility in how to use Pre-paid Shared savings, if CMS retains some of these requirements in the final rule, we urge CMS to not require a specified minimum amount that must be used for direct beneficiary services. MSSP ACOs have assumed clinical and financial accountability for their patients, and thus are already incentivized to invest in cost-effective services and benefits for their patient population.

Eligibility

While more timely payment of shared savings would help fund ACO initiatives throughout the performance year, CMS once again offers a regulatory improvement to MSSP but makes it available only to ACOs that undergo rebasing. As CMS has acknowledged, rebasing and ratchets weaken, "...incentives to participate in the Shared Savings Program" and impedes progress towards CMS' goal of increasing accountable care relationships. CMS has also recognized that MedPAC and researchers have expressed a similar concern and, "...the general consensus that eliminating ratcheting effects is essential for the long-term sustainability of the Shared Savings Program.[2]" Yet, CMS continually requires ACOs to undergo rebasing in order to take advantage of almost all improvements in MSSP when they are created.

As an illustration of the cost of rebasing, Aledade analyzed our 50 ACOs to ensure that any ACOs we considered recommending or submitting applications for the new Flex model would not lose revenue from rebasing, since starting a new contract is a requirement to participate in the model. This led us to recommending fewer than one-third of our 2025 MSSP contracts for Flex because the others would lose 3-7% of total cost of care in shared savings. While Prepaid Shared Savings would be helpful to these ACOs, it is not sufficient to justify losing this much revenue.

This rebasing requirement would penalize ACOs for seeking to accelerate care improvements and would inevitably slow down adoption of an important programmatic improvement. Therefore, we respectfully recommend that CMS should not require rebasing for ACOs seeking to participate in

[2] CMS–1770–P CY 2023 Medicare Physician Fee Schedule Proposed Rule (p. 351)

the Prepaid Shared Savings Option. At a minimum, CMS could add an option for MSSP ACOs that renewed for 2025 to indicate their interest in this model for 2026 before signing the participation agreement in December 2024.

Considerations for a Higher Risk Track in MSSP

Aledade strongly supports CMS adding a new track to the Medicare Shared Savings Program that would include full risk. By "full risk" we mean a track with at least a [100/95/85] percent shared savings/shared loss rate, and a discounted MSSP benchmark to guarantee savings for the Medicare program. We believe that the higher risk/higher return opportunity would accomplish two things: 1) it would encourage more private investment in growing participation in MSSP and 2) it would incentivize top performing ACOs to increase savings and quality improvements. To best serve the needs of beneficiaries, ACOs, and CMS, we offer the following considerations for the design of this new track. The full risk track should be offered alongside existing risk tracks, not as a replacement for the Enhanced Track.

Progress towards CMS' goal of getting 100% of Traditional Medicare beneficiaries in accountable care relationships has been slow because the things that attracted early adopters and innovators are not the things that will entice mainstream providers to make the leap into value-based care. The early adopters lean in because they believe in the cause and are willing to make sacrifices to forward its goals and values. By contrast, the mainstream market prefers to take a wait-and-see approach. To get the latter group to adopt, CMS must create a compelling reason to act by increasing incentives, reducing burden, and allowing flexibility for those that make the leap to accountable care.

CMS has worked for more than 10 years to improve the financial model of MSSP to ensure it balances the needs of the trust funds, beneficiaries, and providers. Over that time, CMS has made a number of important improvements to the program but, as CMS acknowledges, more work needs to be done. One area that requires improvement is increasing the returns for high performing ACOs. Currently, when these ACOs generate cost savings for Medicare, they face in-year ratchets (though these are diminishing somewhat thanks to CMS actions) and significant revenue disruptions from periodic rebasing. While the revenue disruptions from rebasing were originally set to be only once every five years, CMS has required rebasing more frequently for ACOs wishing to participate in various enhancements to MSSP that CMS has enacted over the years.

CMS has proposed to have this higher risk track replace the existing Enhanced Track because of concerns about selection and its effects on Medicare's share of savings from MSSP. But CMS is likely to increase participation in MSSP by creating a range of risk tracks and there are simpler ways to prevent selection. The simplest way to do this would be to set an ACO's benchmark

discount equal to the net shared savings CMS realized in the Enhanced Track in the prior year (adjusted for any changes in its composition of practices going into the new year). For example, consider an ACO that generated 10 percent gross savings and 7.5 percent net shared savings in an Enhanced track ACO in 2025. Medicare's realized savings in this case were 2.5 percent of the ACO's benchmark. Therefore, if that ACO wants to participate in the full risk track in 2026, CMS should discount its benchmark by 2.5 percent. This way, CMS does not lose any expected savings from historical levels and the ACO generates additional shared savings only if it increases the gross savings it generates in 2026, removing any concerns of selection bias and arbitrage based on track selection. In this scenario, CMS would also be indifferent to whether an ACO was in the Enhanced Track or the new Full Risk Track, so there would be no need to eliminate the Enhanced Track.

What would the option of a revised ENHANCED track allow an ACO to do that they are unable to do currently?

- **Increase Investment.** The primary result of adding a higher risk track would be to increase private investment in promoting participation in MSSP and, similarly, more investment in generating additional savings in MSSP. Most of the growth in MSSP in recent years has been led by enablement companies that support providers in their MSSP participation. Increasing the returns on care improvements will spur these organizations to generate more care improvements by recruiting more providers and increasing their practice capabilities.
- **Expand Interventions.** A higher risk track would also expand the universe of interventions that an ACO can undertake. Today, under the MSSP financial model, if an ACO saves Medicare $1, the ACO will receive, at best, 75 cents in return. Therefore, an ACO will invest in a care improvement only if the expected return on that investment is greater than 1/0.75 or 1.33:1. When the sharing rate (the denominator in this equation) increases, the required ROI for an intervention goes down. Thus, the purpose of creating a higher risk track is to reduce the break even point on a marginal investment so that a broader range of ACO investments are financially viable. It's impossible to predict the full scope of new interventions that will be made viable by a higher risk track, but we can share some examples that we are working on at Aledade.

  We have had a partnership with an organization that specializes in kidney care management. We conducted a randomized control trial that produced very promising clinical and financial outcomes. However, the intervention is costly and under current Medicare billing rules, our partner organization cannot bill Medicare directly for their care management services (because they don't have an initial face to face encounter with the patient; they receive the patient referral from our PCPs.)

If we received a higher rate of return on this investment in these patients, it would go a long way to making this a viable clinical program that we could roll out to our entire network. Moreover, a higher risk track would incentivize us to broaden our horizons in exploring future opportunities.

What additional flexibilities or features (for example, benefit enhancements, advance payments, capitation payments, etc.) would ACOs in a revised ENHANCED track with higher risk and potential reward want CMS to offer to help them be successful in improving the quality of care and reducing costs?

Over the last 10-plus years, CMS has deployed successful innovations in accountable care through the CMS Innovation Center. When considering what features to add to new tracks within the Medicare Shared Savings Program, that experience should serve as a guide for features that will be successful and that helped to transform care for Medicare beneficiaries. Specifically, many of the lessons learned from the Next Generation ACO, Direct Contracting and ACO REACH models can be applied to determine what additional flexibilities and features providers would respond to and what has worked to improve care delivery. And taking these lessons from CMMI models and moving them into MSSP would be consistent with CMS' intent to use MSSP as a "chassis" for innovation to increase participation in accountable care.

Full Risk Track Considerations

In the development of a full risk track, we recommend the following features:

- **Allow ACOs to Elect 100% Shared Savings/Losses and Choice of Savings/Loss Cap.** Next Generation ACOs selected between two risk arrangement options for savings and losses: (1) partial risk, 80 percent; or (2) full risk, 100 percent. In addition, because Next Gen was a first dollar full risk model, participants had the ability to select a symmetrical cap on their savings and losses between 5 and 15 percent. The higher level of risk and reward in the Next Gen model is attractive to organizations as they continue the transition to two-sided risk.
- **Infrastructure Payment and Population-Based Payment Options.** Next Gens had the ability to participate in alternative payment arrangements, including infrastructure payments and population-based payment. The infrastructure payment options provide an upfront payment that is recouped against savings or in addition to losses. This structure allows smaller organizations to participate in full risk by providing investment funding upfront. In the population-based payment arrangement, certain ACO providers agree to receive reductions to their FFS reimbursements from CMS. Next Gens successfully used this option to negotiate payment arrangements with Skilled Nursing Facilities, laboratory service providers, and other entities to improve population health for their patients and

drive value in their local communities. We encourage CMS to retain these options for organizations participating in the full risk offering.

- **Ability to Tailor Cost Sharing Support for Part B Services.** CMS allowed some Next Gen providers to reduce or eliminate cost sharing for certain Part B services for attributed beneficiaries. The goal of this benefit has been to allow ACOs to reduce financial barriers for beneficiaries, encouraging better adherence to treatment plans. CMS gives Next Gens the flexibility to identify certain beneficiaries to receive these benefits. This waiver, and the flexibility for the ACO to determine how to implement the benefit, are features of the model that should be added to MSSP for ACOs taking on performance-based risk.

Global Risk Track Considerations

Several features of the current ACO REACH model are critical to ongoing transformation among its participants. These include:

- **Lower Attribution Thresholds for Participation.** The ACO REACH model has introduced lower attribution thresholds that allow different types of entities to participate in accountable care initiatives and expand the reach of accountable care consistent with the agency's 2030 goals. While the Medicare Shared Savings Program and prior ACO initiatives required at least 5,000 beneficiaries, some ACO REACH tracks allow entities to participate with substantially fewer aligned beneficiaries. This flexibility also encourages expansion into new markets. We recommend retaining that flexibility to allow a wide array of entities to participate in future models.
- **Multiple Risk-Sharing Options.** ACO REACH offers lower-risk sharing arrangement – 50% savings/losses with one payment option for participants, Primary Care Capitation Payment, a risk-adjusted monthly payment for primary care services provided by the ACO's participating providers; and a higher risk sharing arrangement with 100% savings and losses that offers two payment options, Primary Care Capitation or Total Care Capitation payment, a risk-adjusted monthly payment for all services provided by the ACO's participating providers. Flexible participation options, alongside the Medicare Shared Savings Program, allow providers to select the level of risk and payment approach most appropriate for their organization and their population. We strongly support this optionality throughout the Medicare ACO portfolio.
- **Primary Care Capitation.** This payment mechanism creates additional flexibility to move away from reliance on a flawed fee-for-service payment system which still dominates in traditional Medicare today. In addition, it creates cash flow necessary to transform care delivery and make important and continuous investments required to redesign the delivery system. We encourage CMS to continue to make this available as an option for participants within the CMS accountable care portfolio.

- **Claims Payment Flexibility.** ACOs participating in Innovation Center models have had the ability to have certain providers reduce their claims by a percentage and instead be paid by the ACO. This population-based payment element is unique to the Innovation Center ACO portfolio and can create new and innovative payment approaches and quality accountability strategies for organizations that want to pay their contracted providers. In recent Innovation Center ACO models, participants have shown that this flexibility can be beneficial to improving care outcomes and should be retained as an option in future models.
- **Streamlined Set of Quality, EHR and Patient Experience Metrics.** Burden reduction is a key benefit for providers who participate in accountable care models, particularly two-sided risk models. Consistent with that approach, the ACO REACH model includes a streamlined set of claims-based quality measures, which are calculated by CMS, and an attestation approach to electronic health records certification. In contrast, for example, CMS recently finalized a requirement that participants in the Medicare Shared Savings Program report the MIPS promoting interoperability performance category measures instead of the attestation requirement. This requirement adds, rather than reduces, burden for APM participants. We request that the Innovation Center retain the streamlined requirements for ACO participants whether in MSSP or a future Innovation Center model.
- **Alignment Options including Paper-Based Voluntary Alignment.** A key element of success for ACOs as they continue along the glidepath to greater levels of risk and reward is beneficiary engagement. Voluntary alignment strategies should continue to be an option in future ACO models at the CMS Innovation Center and MSSP. The agency should work with ACOs and beneficiary representatives to see whether these strategies can be expanded to lead to more effective participation in accountable care.

Other Features

- **Participation at the TIN-NPI Level.** Under MSSP regulations, CMS defines an ACO participant as an entity identified by a Medicare-enrolled billing TIN through which one or more ACO providers/suppliers bill Medicare. In other words, all providers operating under that TIN are required to be a part of the ACO. In contrast, Next Gen allowed participation at the TIN-NPI level. This flexibility allows Next Gens to create high-performing, primary care-focused networks. This flexibility should be retained for full risk models as an additional incentive to move to higher levels of risk and reward. In addition, we request that CMS use the ACO-UI system which allows participants to track participating TIN-NPIs.
- **Cost Sharing Waivers for Part D and DME.** CMS should consider affording additional flexibility for ACOs to cover beneficiary cost sharing, including for Part D and DME.

- **Flexibility to Bypass DME Prior Authorization Requirements.** While prior authorization requirements in LCDs and NCDs make sense in the context of fee-for-service, they are not necessary in the context of two-sided risk bearing ACOs.

Should a revised ENHANCED track with higher risk and potential reward require ACOs with earned shared savings to share savings with beneficiaries or spend a flat dollar amount or a certain percentage on beneficiaries in the form of items or services not covered by original Medicare (for example, meals, dental, vision, hearing, or Part B cost-sharing reductions)?

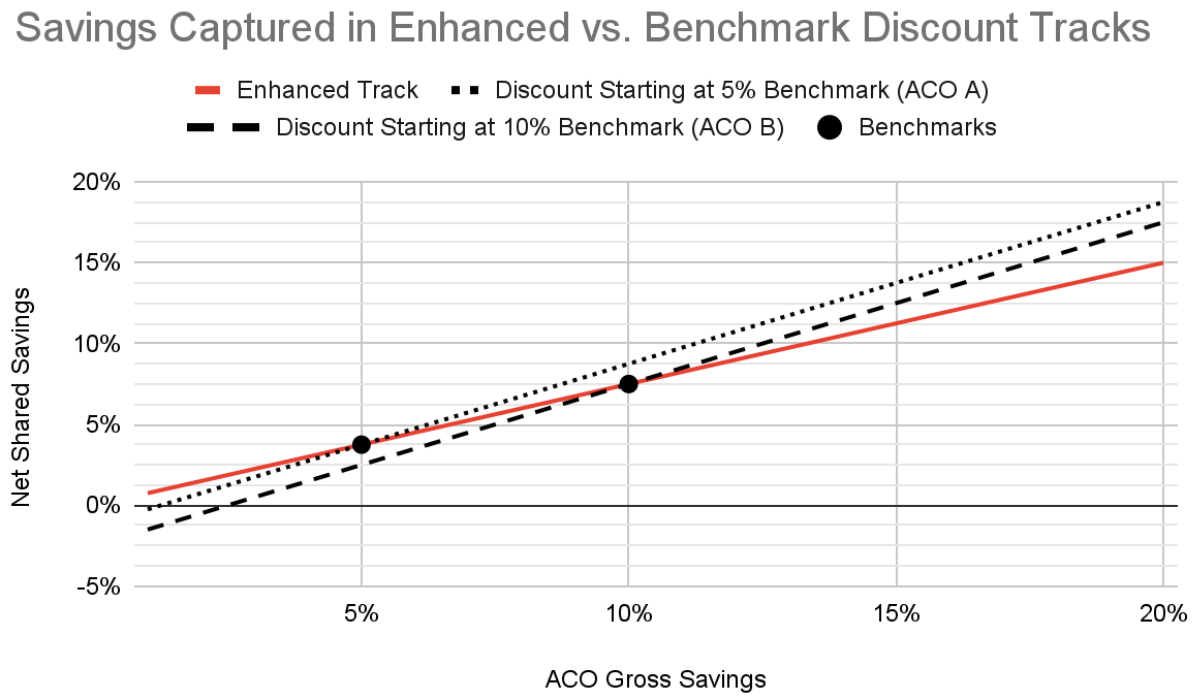
If CMS hopes to achieve its goal of getting 100% of traditional Medicare beneficiaries in accountable care relationships by 2030, it would be unwise to increase the regulatory requirements in MSSP. Instead, CMS should be considering how to make the program more attractive to the mainstream market of physicians who have chosen not to participate in MSSP.

How should CMS consider the discount, sharing rate, and risk corridors or marginal savings bands in the design of a higher risk option that can realize savings for Medicare? Are there special considerations that CMS should bear in mind when thinking through such features for different types of ACOs (for example, low revenue, high revenue, health system-based, safety net, etc.)?

We understand CMS' concern that the ACOs that would select a full-risk track would be disproportionately those that are likely to generate shared savings. Steps should be taken to ensure the creation of the new risk track does not result in a net loss in savings to the Medicare program. The simplest way to do this would be to set an ACO's benchmark discount equal to the savings CMS realized in the Enhanced Track in the prior year (adjusted for any changes in its composition of practices going into the new year). For example, consider an ACO that generated 10 percent gross savings and 7.5 percent net shared savings in an Enhanced track ACO in 2025. Medicare's savings in this case were 2.5 percent of the ACO's benchmark. Therefore, if that ACO wants to participate in the full risk track in 2026, CMS should discount its benchmark by 2.5 percent. This way, CMS does not lose any expected savings from historical levels and the ACO generates additional shared savings only if it increases the gross savings it generates in 2026, removing any concerns of selection bias and arbitrage based on track selection. In this scenario, CMS would also be indifferent to whether an ACO was in the Enhanced Track or the new Full Risk Track, so there would be no need to eliminate the Enhanced Track.

The figure below compares the savings captured as a function of ACO performance in the current Enhanced Track with two examples of a discounted full risk track as described above for two hypothetical ACOs: one with a current gross savings of 5% (ACO A), and another with a gross savings of 10% (ACO B). Each ACO can choose between the current Enhanced Track and a full risk track with a discount specific to that ACO, where in each discount track, the discount is set so that the savings captured in that track and the Enhanced Track at that performance benchmark

are the same. In this example, the discount for ACO A's full risk track would be 1.25%, and the discount for ACO B's would be 2.5%. Therefore, each ACO will only earn more through the full risk track (the dashed lines) compared to the Enhanced Track (the red line) if they improve their own performance and outperform their ACO-specific benchmark:



This example assumes that CMS does not require rebasing to move to full risk. Requiring rebasing would force each ACO to take one last ratchet and defeat many of the goals of moving to administrative benchmarking and full risk.

We are interested in ways to increase participation by healthcare providers and suppliers in the Shared Savings Program and future Innovation Center ACO models, including how an ACO model

Progress towards CMS' goal of getting 100% of Traditional Medicare beneficiaries in accountable care relationships has been slow because the things that attracted early adopters and innovators are not the things that will entice mainstream providers to make the leap into value-based care. The early adopters lean in because they believe in the cause and are willing to make sacrifices to forward its goals and values. By contrast, the mainstream market prefers to take a wait-and-see approach. To get the latter group to adopt, CMS must create a compelling reason to act.

- **Switch from Bells and Whistles to Proven Solutions.** The mainstream market is not looking to be innovators or to participate in pilot tests. CMS should make it clear to providers there is a core model and they are expected to join it. For accountable care, that would be the Medicare Shared Savings Program (MSSP), which is a statutorily-mandated program that has been around for 12 years with proven success. Offering a "proven solution" will also require that CMS solve two of the long-standing challenges with MSSP. Providers do not see the current benchmarking system as providing a business case for long-term program participation because of ratchets and rebasing. And the MSSP model creates cash flow challenges even for the most successful ACOs. CMS has acknowledged both of these challenges and is working on solutions.
- **Assemble the Whole Product.** The mainstream wants to just plug it in and have it work. The biggest challenge here for accountable care is the need to assemble all the different value- based contracts across multiple private payers. The lack of meaningful participation by commercial payers was highlighted by the Commonwealth Fund as a major inhibitor of primary care participation in value-based care.. CMS must extend its goal for accountable relationships to beneficiaries enrolled in Medicare Advantage plans and provide incentives for plans to achieve this goal – perhaps through the Stars quality bonus Program.
- **Make Space for the Simplifiers.** Late adopters are not do-it-your-selfers – they are service oriented and want to minimize time spent on installation and technical implementation. We have seen this occur as expected in MSSP. In the early years of the program only 2-3% of Medicare beneficiaries were in ACOs organized by third party enablers. This has grown to almost 25%. These enablers appear to have contributed all the recent growth in the program and without them the program would be much smaller. A single-minded focus on accountable care brings not only scale efficiencies, but also greater competence and performance. In the most recently released public results, Aledade ACOs comprised 7% of the MSSP program's lives but included 5 of the top 10 highest savers. There should be actual, explicit, encouragement and support from CMS towards enablement partners to go out and get this done. There's currently no special program to direct practices towards recognized high quality enablement partners, no special data considerations (we currently have to manually download separate reports for 50 different portal accounts), and no explicit acknowledgment or API connection point for aggregators into the programs.

Making Refinements to Beneficiary Assignment

Definition of Primary Care Services Used in Assignment

CMS is proposing to add several codes to the definition of primary care services used to assign beneficiaries to ACOs:

- Safety Planning Interventions (HCPCS code GSPI1)—add-on code would only be included when the base code is also a primary care service code included in the definition
- Post-Discharge Telephonic Follow-Up Contacts Intervention (HCPCS code GFCI1)
- Virtual Check-in Service (CPT code 9X091)—directly replaces G2012, which is currently included in the definition
- Advanced Primary Care Management Services (HCPCS codes GPCM1, GPCM2, GPCM3)
- Cardiovascular Risk Assessment and Risk Management Services (HCPCS codes GCDRA, GCDRM)
- Interprofessional Consultation Services (CPT codes 99446, 99447, 99448, 99449, 99451, 99452)
- Direct Caregiver Training Services (HCPCS codes GCTD1, GCTD2, GCTD3)
- Individual Behavior Management/Modification Caregiver Training Services (HCPCS codes GCTB1, GCTB2)

Aledade supports the addition of these codes, which support delivery of comprehensive, coordinated, whole-person primary care. We encourage CMS to finalize the additions as proposed.

Voluntary Alignment

Currently there is an exception to the MSSP statutory requirement that voluntary alignment supersedes any other assignment, for CMMI models with claims-based assignment methodologies that do not include primary care services. CMS proposes to expand the current exception to include CMMI models that employ a claims-based assignment methodology using both primary care and non-primary care services. Aledade opposes this, as this change would weaken voluntary alignment. There are three situations in particular where voluntary alignment overcomes flaws in the current data available for claims based alignment. First, many physicians are board certified in internal medicine and in another speciality. They function in the other speciality, but because they were certified first in internal medicine it ends up in the first slot on their PECOS enrollment. Thus claims based alignment treats a cardiologist as primary care. Second, nurse practitioners and physician assistants increasingly work in speciality clinics, but have no enrollment identification to that effect. Thus claims based alignment treats them as

primary care even if they work in a dermatology office. Third, the requirement for a visit with a physician is a national policy in an area where scope of practice varies greatly from state to state. In some states, the supervision requirements are quite high. In others there is independent practice. In independent practice states the requirement for a physician visit is virtually impossible to meet and voluntary alignment is the only path forward. Voluntary alignment is a fix for claims based alignment in many situations. It is inappropriate to them reverse out voluntary alignment based on another model's claims based alignment that likely contains at least some of these flaws. CMS should exercise significant caution when applying such exceptions to preserve patients' longitudinal primary care relationships and avoid cycling patients in and out of models. We encourage CMS to take a nuanced approach to model overlap policies and prioritize stable participation in the permanent program.

Voluntary alignment in MSSP is a difficult online process, which has limited its use. CMS should address the current barriers to using voluntary alignment more broadly in MSSP. CMS could provide information to beneficiaries on how to select a primary care provider when they enroll in Medicare and explain why this is beneficial to their care. CMS should also confirm voluntary enrollment once every three years with a visit to the named provider. One of the hesitations our physicians have had with voluntary alignment is it essentially has to be accomplished twice. Once to enroll and then once more to disenroll in cases where beneficiaries move or otherwise switch their source of care. Confirmation every three years and a more streamlined process with a non-online option would improve the voluntary alignment.

Monitoring Compliance with 5,000 Beneficiary Threshold

Current regulations require that CMS terminate the participation agreement of, and deem ineligible for shared savings, any ACO that does not have at least 5,000 assigned beneficiaries by the end of a given performance year. CMS proposes to remove this requirement to give the agency more flexibility to work with ACOs to increase their assigned populations and continue participation in MSSP. CMS notes that this does not change the requirement to have at least 5,000 assigned beneficiaries and ACOs will still be subject to compliance action if their assigned population falls below 5,000.

Aledade supports this proposal, which offers more flexibility in compliance and supports continued participation in MSSP. We encourage CMS to finalize this change as proposed.

Beneficiary Notifications

CMS proposes two minor changes to the beneficiary notification requirements. First, CMS proposes to modify the timing requirements for the follow-up communication requirements such that it must be provided within 180 days of the initial beneficiary notification, rather than the

earlier of 180 days or the next primary care service visit. Aledade supports this change. Second, CMS proposes to modify language to clarify which beneficiaries ACOs operating under preliminary prospective assignment with retrospective reconciliation are required to furnish the beneficiary notice and follow-up to. Aledade appreciates CMS's attempt to address issues with the beneficiary notification requirements. Unfortunately, this proposal does not resolve the issues with ACOs' ability to identify which beneficiaries must receive the notice within the required timing.

Because CMS requires that the notice be provided prior to or at the beneficiary's first primary care service visit with an ACO professional, the only way to be fully in compliance would be to put all of the burden on frontline primary care practices to furnish, document, and track the notifications. While these proposed changes are a positive step in the right direction, they do not go far enough to resolve the many issues with the beneficiary notification requirements. These requirements present challenges for ACOs, participating providers, and the Medicare beneficiaries they serve. Some patient and consumer advocates have expressed that the notices are not valuable to patients and may exacerbate mistrust in the health care system.

To address these shared concerns, Aledade has been participating in the NAACOS and the Health Care Transformation Task Force (HCTTF) efforts to convene ACOs and patient and consumer advocacy organizations to develop joint recommendations for improving beneficiary engagement in ACO programs. We encourage CMS to implement the recommendations, which promote moving away from the current form letter approach to a more tailored beneficiary education and engagement plan, to advance its accountable care goals.

Ensuring ACOs are Protected from Anomalous and Highly Suspect Billing Occurrences

Aledade supports CMS' efforts to address significant, anomalous, and highly suspect (SAHS) billings in ACOs' financial methodology. Unaddressed, SAHS billing can impact ACOs' shared savings and losses, historic benchmarks, assigned beneficiaries, high-low revenue determinations, among other ACO program factors. Aledade also supported CMS's previous efforts to hold ACOs harmless from anomalous billing for catheters in 2023.

We ask that CMS consider the following in implementation of this policy:

- **Effects Occur at the ACO level.** The levels of decision making in the Medicare Shared Savings Program are participants to join an ACO and ACOs to participate in the program. Every aspect of MSSP is just the summation of those decisions. National trends play a very small role in those decisions and usually are arbitrage opportunities for those decisions. Localized SAHS billing can have far more consequences on an ACO's savings/revenue than national issues. SAHS that hits one particular ACO with $50 million

in costs can bankrupt an ACO without even being a basis point in national trends. The greatest effect SAHS policies can have on MSSP participation is if they are evaluated at both the ACO level and the national level. Evaluating only at the national level is the twenty percent of the problem in the classic 80/20 rule.

- **Feedback Loop with ACOs.** Currently, when ACOs notify CMS and the Department of Health and Human Services Office of the Inspector General of suspected fraud, there is little to no response. We recognize that fraud investigations by CMS and the HHS OIG can take years; however, ACOs need information to inform their patient communications and make decisions about future participation. We ask CMS to explore additional ways to notify ACOs of potential actions. For example if CMS is placing some claims into escrow, then it could notify ACOs via their regular claims feeds about these claims.
- **Transparency on Enactment of SAHS Billing.** We request that when an ACO requests a consideration for SAHS billing, CMS provides written feedback of why the situation does or does not meet the criteria.

Proposals to support primary care and physician payment

Evaluation & Management visit complexity add-on code G2211

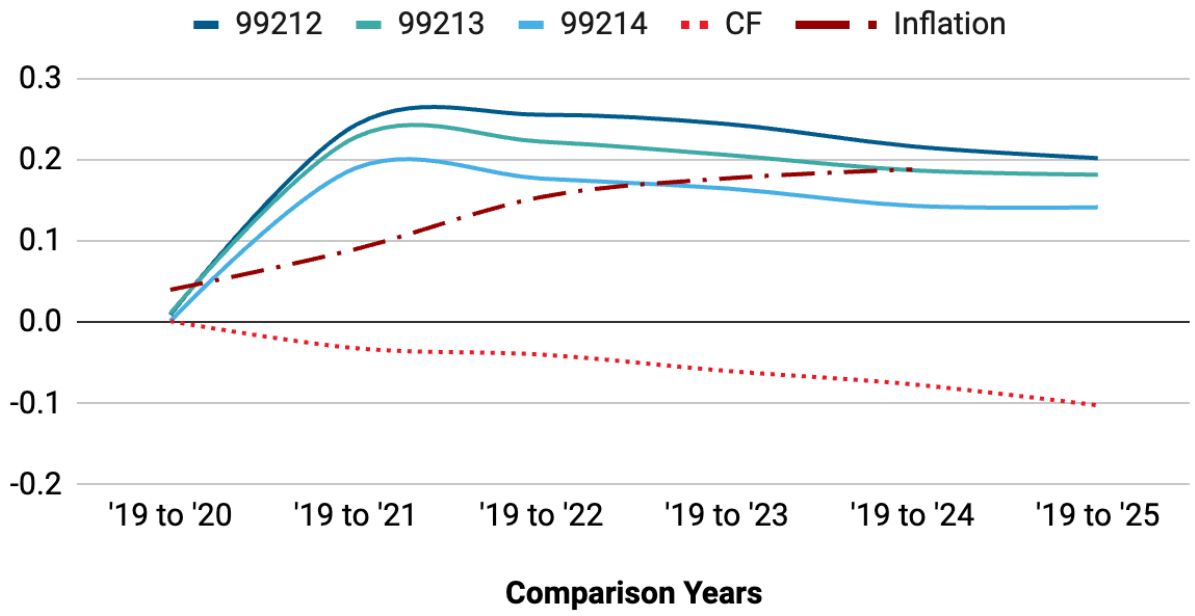
CMS proposes a payment policy change for the office and outpatient (O/O) E/M visit complexity add-on code G2211, which was finalized for use beginning CY 2024. The agency proposes to allow payment when the O/O E/M code is reported by the same practitioner on the same day as an annual wellness visit (AWV), vaccine administration or any Medicare part B preventive service furnished in the office of outpatient setting. Aledade supports this change.

Recognition of the Need to Physician Payment Cuts in the Short and Long Term

Most physician practices continue to rely on FFS payments for most of their Medicare revenue. As FFS rates increasingly fail to cover practice costs and support the advanced capabilities and services these practices provide, physicians find it increasingly challenging to generate shared savings or invest in new interventions for their patients. Comprehensive and sustainable primary care payment is critical to meet the goal of having physician practices care for more low-income patients, close gaps and care, and achieve better health outcomes.

The uncertainty surrounding annual Medicare fee schedule payment cuts harms the shared goals of improving health outcomes and reducing health disparities. We recognize that CMS does not have the authority on its own to make these necessary improvements, and we are working to advocate to members of Congress to immediately avert forthcoming payment cuts and

strengthen the Medicare physician fee schedule by enacting positive annual payment updates that account for rising costs. Our analysis shows that the inability of the fee schedule to keep up with inflation has already wiped out the real effects of the re-weighting of E&M that occurred in 2021. That change decades in the making has already been caught by inflation and no longer represents an investment in primary care in real terms. All of the levers are connected whether CMS has control of them or not.



We greatly appreciate CMS's efforts in this proposed rule to use regulatory levers to bolster support for equitable access to comprehensive primary care. CMS has demonstrated a strong commitment to correcting historical fee schedule imbalances that have devalued and driven underinvestment in primary care. We commend CMS for using its available authority to continue to invest in primary care in the CY 2025 PFS and look forward to working with the agency and other stakeholders to further support the critical work of primary care.

Considerations for Strengthening Primary Care through Advanced Primary Care Management Services

CMS proposes new coding and payment for advanced primary care management (APCM) services for use by practitioners who are the continuing focal point for all needed health care services and responsible for all primary care services for a beneficiary. CMS aims to increase stability in coding for care management services and increase interaction with codes for these services, which have historically been limited. These proposals will add new reimbursement opportunities to drive comprehensive primary care delivery, including care management services

between visits. Aledade supports this overall proposal for continued primary care innovation and appreciates CMS' efforts to better recognize the resources required to deliver advanced primary care and to reduce administrative burden associated with billing these services. We commend the attention to advance primary care delivery and encourage CMS to finalize the APCM service proposals with the following proposed modifications.

APCM Service Codes

CMS proposes to establish three new, tiered HCPCS codes for APMC services that bundle existing care management and communications technology-based services (CTBS) codes. With these proposed codes, primary care practitioners acting as the central point of care for patients could receive per member per month payments to support all advanced primary care services. The proposed APCM codes shift emphasis from time-based to capacity-based coding and billing, removing time frame restrictions. Aledade supports this flexibility, as time-based requirements and associated documentation have contributed to the limited use of existing care management codes.

CMS proposes the following APCM code stratification based on patient characteristics:

- Level 1 (GPCM1): patient with one or fewer chronic conditions
- Level 2 (GPCM2): patient with two or more chronic conditions
- Level 3 (GPCM3): patient that is a Qualified Medicare Beneficiary (QMB) with two or more chronic conditions

Aledade supports the APCM Level 1 code and appreciates CMS creating opportunities to reduce the gap in payment for care management services for patients without multiple chronic conditions. However, incorporating all other patients into Levels 2 and 3 may not sufficiently address the variability in expenses for beneficiaries with varying levels of chronic conditions. Aledade urges CMS to recognize the additional resources required when furnishing advanced primary care to beneficiaries with greater complexity and incorporate this into the framework.

Aledade opposes the use of QMB status as the indicator of social risk required for billing Level 3 APCM services. While we appreciate that CMS recognizes that patients with social risk factors and multiple chronic conditions generally may require more resources to ensure appropriate and effective care management, the use of QMB does not account for the care and resources actually delivered to those beneficiaries. Additionally, including this indicator could create greater administrative burden for practices as practitioners may not readily have access to a patient's status. In other policies, CMS has used a combination of dual status and enrollment in the Part D Low Income Subsidy (LIS) program as indicators of social risk and we encourage the agency to align its approach for APCMs with these policies.

We recommend that CMS share data on beneficiaries who are receiving the LIS with MSSP participants. We commend CMS' attention and efforts in recent years to have more data transparency and data sharing. The more our member practices know about the beneficiary population, whether it is if they qualify for LIS, and for the dual eligible beneficiaries, their health plan data, and what additional services and supplemental benefits they might quality for, the more the practices can improve their outreach and help connect these beneficiaries to transportation or other services for which they are eligible. This is particularly important for ACOs to coordinate services for this patient population who have a lot of unique needs.

Required Elements and Practice Capabilities

CMS defines 10 service elements and practice-level capabilities as necessary for the provision of advanced primary care. Under these proposals, CMS would not require practitioners to furnish all elements included in the code descriptors to every beneficiary during each month in which the service is billed, but the billing practitioners must have the ability to furnish each service element as appropriate for a given beneficiary during any given month. Aledade supports this proposal, which recognizes that patients' needs will vary month-to-month. Table 21 of the proposal rule provides additional details on the required elements and capabilities, which are 1) consent; 2) initiating visit for new patients: 3) 24/7 access to care and care continuity; 4) comprehensive care management; 5) patient-centered care coordination; 6) management of care transitions; 7) home and community-based care coordination; 8) enhanced communication opportunities; 9) patient population-level management, and 10) performance measurement.

CMS proposes that providers participating in MSSP, ACO REACH, Primary Care First, or the Making Care Primary models would be considered to have automatically met requirements 2, 9, and 10 by virtue of their participation in such models. Aledade supports this proposal and we strongly encourage CMS to expand the elements that ACO providers are automatically considered to have satisfied. Comprehensive care management, patient-centered care planning, and enhanced communications are core competencies of ACOs and, therefore, ACO providers should be considered to have additionally met elements 5 and 8. This will reduce administrative burden for ACO providers and create an incentive for other providers to join or form ACOs, which would support CMS' 2030 accountable care goal.

Aledade has concerns with the potential burden associated with documenting the required service elements and practice capabilities in order to bill for APCM services. Many ACOs provide centralized services to ACO beneficiaries, rather than from the individual practice level. We recommend that CMS clarify the requirements allowing for the use of centralized services. We urge CMS to clarify how it will determine whether these elements and capabilities have been satisfied and to minimize the burden with any documentation requirements.

Concurrent Billing Restrictions

CMS considers certain care management services and CTBS to be duplicative of APCM services, including chronic care management, principal care management, transitional care management, interprofessional consultation, remote evaluation of patient images/videos, virtual check-in, and e-visits. CMS proposes that these services could not be billed by the same practitioner within the same practice for the same patient during a given calendar month in which the patient receives APCM services. We are concerned about the inclusion of transitional care management. It is one of the most intensive, impactful, and costly services delivered in the mix. Also depending on the reason for hospitalization, the physician providing the service can vary. While usually part of primary care, cancer and surgery are two areas where it may be a different provider. Also a single TCM for a Level I patient would put that patient far in the negative financially for the year. We recommend that CMS remove TCM from the services included in APCM and revalue accordingly.

Valuation

CMS proposes to use the current valuation and uptake of the codes that make up the APCM bundle to inform valuation of APCM services. CMS assumes that Level 1 APCM services would be equivalent to two billing units of non-complex CCM services over the course of a year. Level 2 APCM services are assumed to be equivalent to five billing units of non-complex CCMS and three billing units of add-on codes over the course of a year. CMS proposes to account for underutilization of CCMS services by adding a billing unit of complex CCM to the utilization estimate, in total calculating Level 2 APCM services based on five billing units of non-complex CCMS, two billing units of non-complex CCM add-on, one billing unit of complex CCM, and one billing unit of complex CCMS add-on. For Level 3 APCM services, CMS proposes to use the difference in per person per year spending for dually eligible beneficiaries versus non-dually eligible beneficiaries, which as of 2021 was 218 percent. Therefore, CMS proposes to multiply the RVUs of APCM Level 2 by 2.18 to arrive at the valuation of Level 3 APCM services. In all, CMS proposes to value APCM services as follows:

- Level 1 (GPCM1): RVU of 0.17 and estimated national payment rate of $10
- Level 2 (GPCM2): RVY of 0.77 and estimated national payment rate of $50
- Level 3 (GPCM3): RVU of 1.67 and estimated national payment rate of $110

Aledade appreciates CMS' attempt to account for the underutilization of CCM services in the valuation of APCM services. However, we are concerned that the proposed valuations do not include other care management services or CTBS that are part of the proposed APCM services. Particularly, in the context of the proposed concurrent billing restrictions, the payment rates may be insufficient to justify billing for APCM services rather than its components. For example, the payment level for one billing unit of interprofessional consultation is greater than the monthly

payment level for Level 1 APCM services. This creates a disincentive to bill for APCM services. We encourage CMS to explore changes to the proposed valuations to better reflect the full scope of CTBA and care management services included in the APCM services.

Preliminary analysis of practices working with Aledade who have regular billing of the codes under consideration would result in approximately 40 percent reduction in overall payment. Our analysis excluded TCM as we recommend. Inclusive of TCM the reduction would be much higher. We assumed approximately 15% level 3, 50% level 2, and 35% level 1. Pricing for "PMPM" style services is always difficult because it involves forecasting of future needs by the beneficiaries. We further emphasize our recommendation to not include TCM in APCM for this reason. Most of the other services are naturally just different levels of the same service. TCM is a unique event driven service.

We Support Continuing Some of the Telehealth Flexibilities

Aledade strongly supports the proposal to permanently allow interactive telecommunications systems to include two-way, real-time, audio-only communication for any telehealth service furnished to a beneficiary in their home if the distant site practitioner is capable of using an interactive telecommunications system, but the patient is not capable of, or does not consent to, the use of video technology. Since having this flexibility during and after the Public Health Emergency, many of our practices appreciate having fewer barriers to outreach and patient care. Additionally, we support maintaining certain telehealth policies through 2025 but ask that CMS consider making these policies permanent. This includes use of virtual supervision, allowing clinicians to use their enrolled practice location instead of home address, and allowing teaching physicians to have a virtual presence for services furnished involving residents in all teaching settings.

Sincerely,

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