

April 10, 2024

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445–G 200  
Independence Avenue, SW  
Washington, DC 20201

Dear Administrator Brooks-LaSure:

The undersigned, which include dozens of national physician organizations representing hundreds of thousands of physicians, as well as over one hundred Accountable Care Organizations (ACOs), health systems, hospitals, clinics, and practices from across the country write to express our unified, strong opposition to two recently finalized policies in the 2024 Medicare Physician Payment Schedule pertaining to certified electronic health record technology (CEHRT) utilization requirements for ACOs, Alternative Payment Model (APM) Entities, and their participating practices. We have serious concerns that these policies will significantly increase burden and jeopardize participation in the Medicare Shared Savings Program (MSSP) and other Medicare Advanced APMs with a disproportionate impact on small practices and the patients they serve.

The first policy requires that all MSSP participants, regardless of Qualified Participant (QP) status or track, report Merit-based Incentive Payment System (MIPS) Promoting Interoperability (PI) data starting with the 2025 performance year. The second policy updates the CEHRT use criterion for all Advanced APMs from 75 percent to “all” eligible clinicians, also starting in 2025. If implemented, these policies will detract from the overall progression to value because APMs will need to remove practices that do not have the resources to adopt CEHRT and advanced APM participants will lose the incentive of being exempt from all categories of MIPS. This is counter to the Centers for Medicare & Medicaid Services’ (CMS’) goal to have all patients in an accountable care relationship by 2030.

An alternative solution of leveraging data reported to the Office of the National Coordinator for Health IT (ONC) from health IT developers would be a better approach to achieving CMS’ goals of advancing CEHRT adoption and utilization among APM participants while alleviating burden on participating practices and avoiding a litany of possible unintended consequences.

Accordingly, we recommend:

- **CMS should repeal both policies changing the CEHRT requirements for MSSP ACOs and other APM participants in 2025.**
- **CMS should instead take a two-pronged approach to validate CEHRT adoption and utilization across the ACO and APM community by: (1) instituting a “yes/no” attestation to demonstrate CEHRT adoption and use and compliance with information blocking requirements; and (2) leveraging ONC CEHRT data that are**

already being collected directly from certified health IT developers, such as information from the new Insights Condition and Maintenance of Certification finalized in the Health Data, Technology, and Interoperability (HTI-1) Final Rule.

- **At a minimum, CMS should delay both policies until at least the 2027 performance year and establish additional flexibilities**, such as a time-limited exception for new ACOs, APM Entities, or newly participating practices, as well as applying the MIPS small practice exemption towards the new MSSP PI reporting requirements.

### **Expanding MIPS is Not the Answer**

As required in the Medicare Access and CHIP Reauthorization Act (MACRA), physicians and other clinicians who meaningfully participate in APMs have been exempt from burdensome MIPS requirements as recognition that they are engaged in enhanced care coordination and data sharing by virtue of being held accountable for cost and quality performance within the APM. Congress established this “two track” system in recognition of this fact, which has also been embraced by CMS as a way to mitigate burden while incentivizing participation in APMs. With Advanced APM incentive payments set to decrease and expire under current law, exemption from MIPS is one of the last remaining incentives under MACRA for physicians to participate in ACOs and other APMs. Requiring MSSP practices to report PI data represents a significant step backward and would substantially undermine CMS’ [goal](#) of having 100 percent of Medicare beneficiaries in accountable care relationships by 2030. Expanding MIPS is not the path forward as longstanding concerns with MIPS, including the PI Category, have been well-documented.<sup>1,2</sup>

Meanwhile, CMS has touted the MSSP as its “flagship” ACO program, [announcing](#) last year that the MSSP saved \$1.8 billion in 2022 relative to spending targets, making it the sixth consecutive year of savings while demonstrating high quality care, which the agency credited to superior care coordination. As the program is clearly achieving its objectives, including leveraging CEHRT to coordinate care, under the program’s existing structure and requirements, it is not clear why CMS would risk disrupting the program with burdensome new requirements stemming from one of its most heavily criticized programs. CMS should be building off the successes of the MSSP, not changing core elements a decade into the model to resemble a historically flawed program. It is time to reform the PI category and MIPS more generally, not expand these flawed policies to practices leading the transition to value-based care.

Similarly, MACRA dictated that to qualify as an APM, “certified electronic health record technology is used.” This definition was intentionally broad in recognition of the varying and quickly evolving nature of electronic health record (EHR) technology. The new CEHRT use criterion of “all” (i.e. 100 percent) of eligible clinicians is extreme and appears to run counter to the original statutory intent of MACRA.

### **Policies Will Increase Cost and Burden on ACOs and Participating Practices**

CMS claims that the new PI reporting requirement will alleviate burden because ACOs will no longer have “the burden of managing compliance with two different CEHRT program

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<sup>1</sup> <https://jamanetwork.com/journals/jama/article-abstract/2799153>.

<sup>2</sup> <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947>.

requirements.” Yet, the undersigned, which collectively represent hundreds of ACOs and hundreds of thousands of physicians all with direct experience in operating and participating in the program, know that **ACOs will unquestionably face more burden under this policy, not less.** This is especially true given that CMS has made the decision not to apply the MIPS small practice exception to MSSP participating small practices, the reason for which is unclear. APMs can make investments in small practices to support use of CEHRT, but these investments take time and are often funded by the saving generated from the model, which is not available until months after the performance year concludes. By requiring all participant practices to use CEHRT from day 1, CMS is removing the flexibility for ACOs to bring small practices into value-based care and expand their resources and capabilities over time.

CMS argues that ACOs can reduce burden by reporting at the ACO level. In reality, this is not logistically easier for many ACOs. The vast majority of ACOs are comprised of multiple practice Tax Identification Numbers (TINs). Out of 456 MSSP ACOs in 2023, only 28 were a single TIN.<sup>3</sup> Practices in multi-TIN ACOs use a variety of certified health IT products and instances which do not easily work together to transmit or consolidate data. Furthermore, many multi-TIN ACOs have a single convening organization that performs the administrative and coordination elements of running an ACO, but does not itself deliver clinical services and may therefore not own or operate its own central CEHRT, which can cost 48,000-\$58,000 on average per physician or other health care professional in the first five years, often higher.<sup>4</sup> As a result, reporting at the ACO-level would likely result in more burden and expense for many ACOs, not less. CMS has thus far not provided guidance with expectations for how multi-TIN ACOs would report PI data without incurring substantial burden and additional costs.

CMS has cited ONC’s Certified Health IT Product List (CHPL) as one possible tool that could enable the reporting of MIPS PI performance category measures and requirements across an ACO’s participating TINs with different CEHRT products. However, ONC’s CHPL only provides the ability to compile a list of the certified products that an ACO’s participating TINs are using to fulfill CEHRT requirements. CHPL does *not* allow for the collection and reporting of the granular MIPS PI measures and requirements for each certified product within each TIN of an ACO so it is unclear that CHPL could facilitate compiling and reporting of PI data at the ACO-level in the way CMS envisions.

Further, if even one practice fails to satisfactorily report PI data, it could jeopardize the entire ACO’s ability to satisfy the CEHRT utilization requirement and could lead to serious consequences including termination from the program and/or denial of shared savings payments. Because MIPS data are reported after the performance year concludes, this would become known only after the ACO has already invested substantial time and resources. This harsh reality is forcing many ACOs to reconsider participation for any practice they are not fully confident can meet new PI requirements. The practices most likely to be removed from the ACO’s participation list are small, rural, safety net, and other types of practices with fewer resources to possess CEHRT and successfully comply with all of the PI requirements.

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<sup>3</sup> Analysis of data available through the Virtual Research Data Center (VRDC).

<sup>4</sup> <https://www.healthit.gov/faq/how-much-going-cost-me>.

Similarly, an entire APM Entity could fail to meet the new CEHRT use criterion for Advanced APMs if a single participating practice fails to use CEHRT, drastically increasing burden for CMS and APM Entities alike because APM Entities will have to submit a hardship exception for every one-off circumstance, even if it achieves 99 percent compliance. By requiring *all* practices to be compliant day 1, APM Entities will no longer have the ability to help participating practices build CEHRT capabilities over time, using shared savings or other model payments to help fund those investments. This zero-margin-for-error threshold will needlessly deter future participation in the MSSP and other APMs, particularly by practices in need to time and resources to gradually build up CEHRT capabilities. CMS reasons in the rule that the vast majority of current APM participants already report at or near 100 percent. However, this threshold represents not the average but the floor for all APMs, including new tracks and models that do not yet exist, as well as APM Entities and practices that are new to existing models.

ACOs cannot afford these drastic increases in reporting burden, particularly as the CMS Web Interface quality reporting option is set to sunset at the end of 2024. As CMS knows, any increase reporting burden has a disproportionately negative impact on small, independent, rural, and safety net practices, meaning these types of practices will face even greater hurdles to joining APMs and the patient populations they serve will be less likely to participate in an accountable care relationship, despite being the very populations that could stand to benefit most.

### **A Better Solution is Possible**

The undersigned organizations recommend CMS instead utilize a “yes/no” attestation to indicate CEHRT adoption and utilization and information blocking attestations among ACOs as it works collaboratively across the U.S. Department of Health and Human Services (HHS) to use data collected from the ONC CEHRT program to achieve its goals of monitoring overall adoption of CEHRT. When fully implemented, ONC’s new Insights Condition will require certified health IT developers to report on use of their products across four areas related to interoperability: individuals’ access to electronic health information, clinical care information exchange, standards adoption and conformance, and public health information exchange. Importantly, this information will reflect real-world physician use of CEHRT in actual clinical settings rather than check-the-box reporting. Using a yes/no attestation combined with Insights Condition metrics and other robust ONC data, ACOs will more effectively demonstrate how CEHRT is being utilized across the entire health ecosystem without the need to collect duplicative data from clinical staff, allowing them to focus on patient care. Importantly, this ONC data can be leveraged for MIPS and APMs to promote alignment across programs.

We believe there is a misperception within CMS that requiring reporting on PI measures would solve the challenges ACOs are experiencing with adopting electronic clinical quality measures (eCQM) and eventually digital quality measures (dQM). However, the challenges with eCQM adoption among MSSP participants is related to the lack of maturity of health information technology standards and interoperability across EHRs, often even within instances of the same EHR, which reporting PI data would do nothing to address.

## **CMS Action is Needed Now to Avert Unnecessary Participation Declines**

**For all these reasons, the undersigned call on CMS to repeal both flawed policies.**

Unfortunately, time is running short to act as we are already seeing the harmful impacts of these policies play out ahead of September 2025 participation decision deadlines. One mid-sized ACO reports potentially needing to remove 24 practices, all small practices, as a direct result of these policies. These are practices that could have otherwise been engaged in value-based care building towards savings that could be reinvested into CEHRT. But, with a looming final participation list deadline in September, ACOs across the country are being forced to rapidly make the difficult decisions that cut these trajectories short. Repealing, or at the very least delaying, both policies would mitigate trepidation among ACOs and APM Entities, avert rushed decisions to drop participants which are disproportionately small practices ahead of 2025 participation decisions, and allow CMS time to gather additional feedback from stakeholders.

**Should CMS move forward with these policies despite our concerns, adequate flexibilities will be paramount to blunt the immense burden of these new policies.** CMS does not currently plan to extend the MIPS small practice exception to MSSP ACO participating practices for reporting PI data. We strongly urge the agency to reconsider. We further urge CMS to establish a time-limited exception to both new requirements for new ACOs, APM Entities, and newly participating practices. Doing so would allow time to generate and reinvest savings into CEHRT for participating practices, thus expanding EHR adoption and utilization, which is the ultimate goal. We likewise urge CMS to ensure that new model-specific CEHRT use criterion and exceptions are sufficiently broad. We are concerned CMS does not expect new model-specific CEHRT flexibilities to “substantially differ” from MIPS CEHRT requirements and urge the agency to reconsider.

Additionally, despite CMS repeatedly promising additional guidance, model-specific CEHRT use criterion and exceptions have yet to be announced. This information is critical to participation decisions. Meanwhile, the September deadline to confirm final MSSP participation lists rapidly approaches. Given the importance of these policies, we believe it is incumbent on CMS to collect feedback on these policies before finalizing them. Once these new policies are finalized, developers will need to appropriately calibrate new products, practices and developers will need to negotiate new contracts, and downstream participating practices will need to train staff on changes. This all takes time, further reiterating the urgent need to repeal or delay both policies.

Thank you for your consideration of our concerns. If you have any questions or need any additional information, please do not hesitate to contact Margaret Garikes, Vice President of Federal Affairs, at [margaret.garikes@ama-assn.org](mailto:margaret.garikes@ama-assn.org).

Sincerely,

American Medical Association  
National Association of ACOs  
American Academy of Allergy, Asthma and Immunology  
American Academy of Family Physicians  
American Academy of Neurology

American Academy of Physical Medicine and Rehabilitation  
American Association of Neurological Surgeons  
American College of Allergy, Asthma and Immunology  
American College of Cardiology  
American College of Physicians  
American College of Surgeons  
American Gastroenterological Association  
American Medical Group Association  
American Osteopathic Association  
American Psychiatric Association  
American Society for Dermatologic Surgery  
American Society for Gastrointestinal Endoscopy  
American Society for Radiation Oncology  
American Society of Anesthesiologists  
Association for Clinical Oncology  
American Society of Nephrology  
American Society of Plastic Surgeons  
American Society of Retina Specialists  
American Thoracic Society  
America's Physician Groups  
Association of American Medical Colleges  
College of American Pathologists  
Congress of Neurological Surgeons  
Health Care Transformation Task Force  
Medical Group Management Association  
National Rural Health Association  
Premier Inc.  
Renal Physicians Association  
Society of Hospital Medicine  
Society of Interventional Radiology  
The Partnership to Empower Physician-Led Care  
The Society of Thoracic Surgeons

**Health Systems, Hospitals, Physician Practices, Health Clinics, and ACOs**

AdvantagePoint Health Alliance - Blue Ridge, LLC  
AdvantagePoint Health Alliance - Bluegrass, LLC  
AdvantagePoint Health Alliance - Great Lakes, LLC  
AdvantagePoint Health Alliance - Hot Springs, LLC  
AdvantagePoint Health Alliance - Laurel Highlands, LLC  
AdvantagePoint Health Alliance - Western North Carolina, LLC  
AdvantagePoint Health Alliance, LLC - Northwest  
AdvantagePoint Health Alliance, LLC - Tennessee Valley  
Agilon Health  
Aledade  
Anna Fontenot Medical Center DBA Dupre Medical Clinic  
Arizona Care Network

Arkansas Health Network, LLC  
Ascension  
Avera Health  
Baptist Health - UAMS Accountable Care Alliance  
Beaumont ACO  
Better Health Group  
Bluestone Physician Services  
Buena Vida y Salud LLC  
Bullitt County Family  
CAMC Health Network  
CareConnectMD DCE LLC  
Central Florida ACO llc  
Central MN ACO, LLC  
CHESS  
CHI Saint Joseph Health Partners  
Cleveland Clinic  
Coastal Carolina Health Care, PA  
CommonSpirit Health  
Community Care Collaborative  
Community Care Collaborative of PA and NJ  
Community Care of Brooklyn IPA  
Community Care Partnership of Maine  
Community Health Provider Alliance (CHPA)  
Community Healthcare Partners ACO, Inc.  
Curana Health  
Dr. David A. Myers, LLC  
Envoy Integrated Health ACO  
Essentia Health  
EVMS Medical Group  
Evolut Care Partners - The Accountable Care Organization, Ltd.  
Family Medical Specialty Clinic  
Five Star ACO, LLC  
Freedom Healthcare Alliance  
Generations Primary Care  
Georgetown Internal Medicine  
Gundersen ACO  
HarmonyCares Medical Group  
Healthway, internal medicine and pediatrics  
Henry Ford Physicians Accountable Care Organization dba Mosaic ACO  
Heritage Valley Healthcare Network ACO  
IHC Quality Partners, LLC  
IHCI ACO LLC  
Imperium Health  
Independence Health ACO  
Inspira Health  
Integra Community Care Network

Lancaster General Health Community Care Collaborative  
LTC ACO  
MaineHealth Accountable Care Organization  
McLaren High Performance Network LLC  
Milan Medical Center  
Mt Sterling Clinic  
MultiCare Connected Care ACO  
MultiCare Health Partners ACO  
NH Cares ACO  
Norsworthy Medical Associates  
Northwestern Medicine  
Novant Health Accountable Care Organization I, LLC  
NW Momentum Health Partners ACO  
OhioHealth Medicare ACO  
Orlando Health  
Owensboro Medical Practice, PLLC  
Palm Beach Accountable Care Organization  
Pearl Medical  
Physician Partners ACO  
Physician Quality Partners, LLC  
PQN - Georgia, LLC  
Privia Health  
Providence Health  
PSW ACO  
Responsive Care Solutions  
Richmond Primary Care PLLC  
Scripps Accountable Care Organization, LLC  
Select Physicians Associates ACO LLC  
Singh Medical Associates  
Southwestern Health Resources  
Space Coast ACO LLC  
Summit Health  
TC2  
The Queen's Clinically Integrated Physician Network  
Torrance Memorial Integrated Physicians, LLC  
TriValley Primary Care  
Tryon ACO, LLC  
Tulane University Medical Group  
TUMG  
UNC Senior Alliance/UNC Health Alliance  
UnityPoint Accountable Care  
UT Health San Antonio  
Village MD  
Vytalize Health  
West Florida ACO  
West Michigan ACO



Wood County Hospital