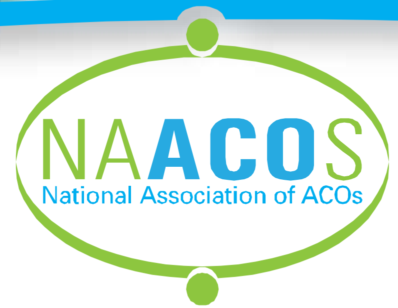

November 17, 2015

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Submitted via www.Regulations.gov

Re: Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models (File Code CMS-3321-NC)

Dear Acting Administrator Slavitt:

The National Association of ACOs (NAACOS) is the largest organization of Medicare Shared Savings Program (MSSP) ACOs representing approximately 150 MSSP and Pioneer ACOs. NAACOS is a member-led and member-owned non-profit organization that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health and outcomes, and health care cost efficiency.

NAACOS is pleased to submit the following comments and recommendations in response to the Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models (the "RFI"). This RFI is the direct result of the Medicare Access and CHIP Reconciliation Act of 2015 (MACRA), which repeals the sustainable growth rate (SGR) formula and fosters the adoption of alternative payment models (APMs), such as accountable care organizations (ACOs).

[Please note that our comments below focus on Section II, subsection B. Alternative Payment Models, paragraph 1. Information Regarding APMs of the RFI and the letter headings align with the RFI accordingly.]

d. Nominal Financial Risk
Each of the 400 ACOs participating in the MSSP is unique in the patients they treat, the strategies employed to achieve high-quality care, and the providers and suppliers that have organized to form the ACO. What is not unique is the substantial capital, human, and patient care investment costs incurred by every ACO required to begin operations, along with the necessary ongoing investment that permits continued participation in the MSSP. This financial investment, or more appropriately, a financial risk, may never see a positive return. By the very design of the MSSP, and as experienced during the first three years of the program by dozens of ACOs, even ACOs that save the Medicare program millions of dollars may not see one dollar of shared savings. As the organization representing ACOs, our members both large and small routinely point to an annual patient investment costs of at least $1.5 million simply to permit ongoing participation in the MSSP.

The financial risk of establishing and operating an MSSP ACO, without the benefit of a guaranteed return on investment, is exactly the type of financial risk that Congress intended to reward to encourage Medicare providers to move away from fee-for-service and into alternative payment models (APMs) such as ACOs. The MSSP is the

key APM contained in the Affordable Care Act (ACA) and through MACRA, Congress sought to further encourage greater participation in the MSSP.

An ACO incurs a financial risk in that the revenue from the APM may not cover the costs of participating in it. In other words, payments from the APM may not be enough to cover reduced fee-for-service revenues that result from providing fewer or less expensive billable services or high-value services not payable under the physician fee schedule. The definition of more than nominal financial risk should not be based on the relative gain or loss to the Medicare Trust Fund, but on how much the physician practice or APM Entity gains or loses.

a. QPs and Partial Qualifying APM Participants (Partial QPs)
Eligible professionals who receive enough Medicare payments through an EAPM entity will receive a 5% bonus payment from 2019 through 2014. The threshold increases over time and in 2021, a "combination all payer and Medicare payment" threshold is introduced. For example, in 2019 and 2020, professionals who receive at least 25% of Medicare payments through an EAPM entity will qualify for the bonus payment. Only those professionals who reach the threshold will receive the payment.

NAACOS supports the MACRA bonus payment and believes it will enhance the participation in the MSSP and the transition to APMs. As such, we strongly encourage CMS to impose a de minimis threshold to ensure that providers are rewarded for participating in APMs. It would be counterproductive to the goals of HHS and the need for continued delivery system reform to penalize a provider who achieved 23% or 24% in 2019 or 2020 by failing to qualify for the bonus. We recommend that CMS apply a 2% de minimis threshold to ensure that every eligible professional who likely meets the applicable threshold receives a bonus payment. A de minimis threshold would ensure that a small variation from year-to-year, which could be the result of unintentional data or claims issues, would not penalize providers. This threshold also aligns with the Obama Administration's implementation of the ACA. Specifically, HHS provided a de minimis variation of 2% to determine whether a qualified health plan's actuarial value achieved the appropriate level (bronze, silver, gold, platinum). HHS recognized that, while the statute provided a definitive "60, 70, 80, and 90" percent threshold, a de minimis variance of 2% was warranted. CMS should use the same discretion to achieve the intended results of MACRA.

c. Patient Approach
The MACRA provides HHS with the authority to base the determination of whether an eligible professional is a qualifying APM participant by using counts of patients, rather than payments, while using the same percentage thresholds. NAACOS supports this authority and recommends that CMS utilize a patient count approach as well. As we have noted, MACRA's bonus payments for APMs is designed to rapidly expand the adoption of APMs by Medicare practitioners. Payments received and patients treated are comparable measures and both should be used to determine whether the applicable threshold has been met.

As we recommend above, if CMS chooses to use the patient-count approach, CMS should adopt a de minimis variation to ensure that all providers are encouraged to join and remain in APMs, such as ACOs participating in the MSSP.

f. Regarding EAPM Entity Requirements

(1) Definition
All MSSP ACOs should be considered EAPM entities. All ACOs experience initial and ongoing financial risk without taking into account one-sided versus two-sided risk, actual shared savings, incurred shared losses, or reduced spending that does not result in shared savings due to the minimum savings rate. The MACRA bonus payments encourage participation in APMs (i.e., the MSSP). The alternative is fee-for-service Medicare. CMS has recognized that taking-on two-sided risk in the MSSP is not a realistic goal in the first six years of an ACO's operation for the vast majority of ACOs. Thus, an MSSP ACO may participate for six years (i.e., two agreement periods) as a one-sided risk ACO. The MACRA bonus payments are similarly provided for six years.

One of the goals of the ACA, the Administration's delivery system reform efforts, and MACRA is to encourage providers to enter into APMs, and thus, transition away from fee-for-service. CMS should not bifurcate MSSP

ACOs into MACRA "winners" or "losers." As the early evidence of the MSSP clearly demonstrates, the vast majority of MSSP ACOs are participating through one-sided risk. This trend may become a permanent program reality if one-sided ACOs, many of whom reduce spending but do not earn shared savings, are further damaged by a CMS-imposed exclusion from the MACRA bonus payments. Without adequate buy-in from all ACOs, the Medicare program will remain a fee-for-service system.

(2) Quality Measures
An eligible EAPM entity must participate in an APM that requires quality measures comparable to those required of the Merit-based Incentive Payment System (MIPS). NAACOS believes that the MSSP and EAPM entity quality measures should be synonymous. For too long, providers have been overburdened by multiple quality reporting requirements, often inconsistent with the practice of medicine, while adding to the administrative complexity that hinders patient care. Medicare providers participating in an ACO should not be worried that the quality measures required of the MSSP may somehow fall short of the MACRA requirements as implemented by CMS. CMS should be working toward a unified quality measure set for all physicians and all payment models.

As CMS develops quality measure comparability requirements for the combination Medicare and all-payer threshold, we reiterate our recommendation regarding quality measures. CMS should work with private stakeholders to develop quality measures that work across all payment models and across all payers, public and private. Only through true uniformity of quality measurement will providers have the tools to most-effectively improve patient care and outcomes.

(3) Use of Certified EHR Technology
Under MACRA, an eligible EAPM entity is an APM that requires participants to use certified EHR technology (CEHRT). To date, the intent of CEHRT has been to accommodate the needs of the Meaningful Use (MU) program, which is primarily based on process measures and threshold achievement. Current generation EHRs are built on the prescriptive requirements that reflect the needs of the MU program.

NAACOS recommends that CMS' CEHRT requirements for APMs be separate from the MU program's requirements. While all EHRs should meet the base EHR definition and related functionalities mandated under the HITECH ACT, vendors should have a pathway to certify a "laundry-list" of specific additional functionalities of their choice. Thus, entities wanting to develop or engage in a particular APM can choose an EHR system having the unique set of certified functionalities required for successful participation within that model. The regulations developed to support MACRA implementation should be consistent with this approach.

Conclusion
In 2014, an estimated 20% of Medicare reimbursements had shifted from fee-for-service to APMs. In January 2015, HHS announced an ambitious goal of having 30% of Medicare payments tied to APMs by the end of 2016 and 50% by the end of 2018. The MSSP and ACOs are at the heart of this ambitious agenda. In its overhaul of the SGR formula, Congress provided additional ammunition to Medicare providers to transition away from fee-for-service and into APMs. The bonus payment contained in MACRA is designed to reward ACOs who undertake the financial uncertainty of participating in the MSSP. It is a bonus payment separate from the shared savings of the MSSP and recognizes that many MSSP ACOs will not receive shared savings payments, despite providing high-quality and cost-efficient care. This bonus payment helps ensure continuing and expanding participation in the ACA's primary delivery system reform, the MSSP.

Thank you for your consideration of our comments,

Clifton Gaus
CEO