September 27, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: (CMS–1715–P) Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Verma:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the proposed rule, *Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies*.

NAACOS is the largest association of accountable care organizations (ACOs), representing more than 6 million beneficiary lives through more than 350 Medicare Shared Savings Program (MSSP), the Next Generation ACO Model, and commercial ACOs. NAACOS is an ACO member-led and member-owned nonprofit that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health, patient outcomes, and healthcare cost efficiency. We are pleased to provide our detailed comments below on the proposals found in the 2020 Medicare Physician Fee Schedule rule.

Summary of key recommendations:

MSSP Proposals

- **Do not align MSSP quality scoring methodologies with Merit-based Incentive Payment System (MIPS) quality scoring methodologies. Instead, CMS should focus on improving MIPS methodologies in quality comparisons and separately continue to work with ACOs to refine the ACO quality measure set, developing the most appropriate measures for providers in total-cost-of-care models;**
- **Do not finalize the proposal to add ACO-47 to the MSSP quality measure set for 2020. Instead, we urge CMS to maintain the current vaccination measure ACO-14, Preventive Care and Screening Influenza Immunization, with modifications to reduce data collection burdens;**
- **Make ACO-17, Smoking Cessation, pay-for-reporting in both 2018 and 2019 and finalize changes to the measure specification requirements that better reflect clinical practice; and**

- **Prohibit the late notification of quality measure specification changes to ACOs.**

Physician Fee Schedule Proposals

- **Finalize proposals to roll back the agency's policy to collapse office/outpatient Evaluation and Management (E/M) Levels 2, 3 and 4 codes and instead implement a proposed new framework recommended by provider stakeholders;**
- **Implement care management changes to enhance the use and value of care coordination and care management services but avoid short-term disruptions from temporary use of G-codes;**
- **Not finalize new Principal Care Management services for patients with one chronic condition as these proposed codes would lead to duplicative care management by focusing on disease-specific, rather than whole-person, care management;**
- **Clarify that ACOs and ACO participants may rely on physician self-referral law advisory opinions for substantially similar arrangements; and**
- **Finalize proposal to allow certain remote patient monitoring codes to be provided under general supervision and finalize proposal to add certain codes for treatment plan development, therapy, and care coordination for opioid use disorder.**

Quality Payment Program (QPP) Proposals

- **Not finalize a policy to evaluate Alternative Payment Model (APM) risk based on what expenditures would have been in the absence of the APM;**
- **Add a medical home model option to the All-Payer Combination Option and allow flexibility with determining when Other Payer APMs meet risk requirements;**
- **Finalize a policy to allow Partial Qualifying APM Participant (QPs) the option to participate in MIPS for their non-Advanced APM Tax Identification Number;**
- **Exempt all clinicians in Advanced APM ACOs from Promoting Interoperability (PI) reporting requirements and instead award them automatic full credit for this performance category;**
- **Finalize proposals to raise the MIPS performance and exceptional performance thresholds and reduce the number of clinicians exempted from MIPS program criteria;**
- **Adopt an alternative methodology for making quality comparisons in MIPS to create more equitable benchmarks across reporting mechanisms;**
- **Provide ACOs with more detailed performance information for MIPS; and**
- **Exclude MIPS payment adjustments as ACO expenditures.**

MSSP QUALITY MEASURE CHANGES

Aligning ACO Quality Scoring with MIPS Quality Scoring

Proposals: To better align quality scoring methodologies across programs, the Centers for Medicare & Medicaid Services (CMS) seeks comments on whether the agency should alter the current quality scoring approach for MSSP ACOs to instead adopt the quality scoring approach used in MIPS. NAACOS does not support this change for the reasons described below, and we urge CMS to instead maintain the current quality scoring methodology for ACOs. In the proposed rule, CMS outlines several different approaches the agency is considering to better align scoring methodologies across the MSSP and the Merit-based Incentive Payment System (MIPS). One such proposal would include maintaining the minimum attainment level to complete and accurate reporting for ACOs in their first performance year of their first agreement period and change the for pay-for-performance years quality standard, requiring a quality performance score at or above the fourth decile across all MIPS quality performance category scores in order to be eligible to share in savings generated by the ACO. CMS would use the MIPS quality performance score converted to a percentage of points earned out of total points available as the ACO's MSSP quality score. As a comparison, ACOs are currently required to meet minimum attainment levels, defined as the 30th percentile benchmark for pay-for-performance measures, on at least one measure in each domain to be eligible to share in any savings generated. Therefore, this proposed new approach using MIPS scoring methodology for ACO quality performance scores would hold ACOs to a higher standard than is currently required in the MSSP. Another approach discussed would remove the pay-for-reporting year currently provided to ACOs in the first year of their first agreement. Under this proposal, all ACOs would be evaluated on all measures as pay-for-performance measures in all program years.

As an alternative, CMS is considering an option in which CMS would determine MIPS quality performance category scores for all MSSP ACOs as it currently calculates MIPS quality scores for non-ACO group reporters using the CMS Web Interface. This approach would allow ACOs to receive a score for each of the measures they report and zero points for those measures they do not report. This would be a change from the current methodology, which requires ACOs to report all Web Interface measures in order to satisfy the complete and accurate quality reporting standard.

With respect to administrative claims measures, ACOs are currently evaluated on claims-based quality measures ACO-8, All Conditions Readmissions, ACO-38, Acute Admissions Rate for Patients with Multiple Chronic Conditions, ACO-43, Ambulatory Sensitive Conditions Acute Composite. In this rule, CMS considers instead to evaluate ACOs on administrative claims measures used in MIPS, the MIPS 30-Day All Cause Hospital Readmissions Measure and possibly the Multiple Chronic Conditions measure.

Additionally, CMS would continue to assess ACOs on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs Survey, but quality performance would be calculated by MIPS methodologies used in calculating the CAHPS for MIPS survey score. The scoring and benchmarking approach for the CAHPS for MIPS is to assign points based on each summary survey measure (SSM) and then average the points for all the scored SSMs to calculate the overall CAHPS score. In contrast, ACOs currently receive up to two points for each of the 10 SSMs for a total of 20 points.

Finally, with respect to awarding extra points for quality improvement, CMS is considering an option under which the agency would use the MIPS quality improvement scoring methodology as an alternative to the current MSSP quality improvement approach. Under current MSSP rules, ACOs not in their first performance year can earn a quality improvement reward in each of the four quality domains. Under the MIPS approach, improvement points are awarded if a MIPS eligible clinician has a quality performance category achievement percent score for the previous performance period and the current performance period, fully participates in the quality performance category and submits data under the same identifier

for two consecutive performance periods. Under MIPS, improvement is evaluated at the performance category level rather than the individual measure level. The MIPS quality improvement score is equal to the absolute improvement divided by the previous year quality category percent score prior to bonus points multiplied by ten. Up to 10 percentage points are available for improvement.

Comments: While we appreciate CMS's goal of aligning methodologies across programs, we do not support aligning ACO quality scoring with the MIPS quality scoring methodology. First, moving to a MIPS quality scoring approach would hold ACOs to a higher minimum attainment standard by requiring a quality performance score at or above the fourth decile across all MIPS quality performance category scores in order to be eligible to share in savings generated by the ACO. Second, NAACOS has concerns with MIPS quality scoring methodologies that could result in narrow bands for measures with clustered performance, resulting in inequitable scores for very small differences in performance especially when taken on a sample. As an example, if one ACO scored 84.9 percent on a particular measure it would earn 9.9 points for the measure. If another ACO scored 84 percent, it would earn 9.76 points. This small change in actual percentage score can add up quickly but is relatively unbalanced in the actual quality of care provided as it can mean the difference of one or two patients in a sample. Rather, percentile rankings are more meaningful because they provide the larger context and help appropriately adjust the weighting of the actual score.

NAACOS also has concerns with the administrative claims-based measures used for MIPS, and we do not feel these measures would be a better alternative to the administrative claims measures ACOs are currently subject to, including ACO-8, All Conditions Readmissions, ACO-38, Acute Admissions Rate for Patients with Multiple Chronic Conditions, ACO-43, Ambulatory Sensitive Conditions Acute Composite. ACOs currently utilize a very different cost evaluation approach from MIPS, which CMS acknowledges by not scoring ACOs on cost in MIPS. This demonstrates that it may not always be appropriate to align methodologies in all program areas, and we believe this is true in this case as well. ACOs are responsible for total cost of care for their populations; therefore, CMS must use a different approach in evaluating ACOs as compared to individuals or groups reporting quality measures in MIPS, who are not participating in a total cost of care model.

Additionally, NAACOS has deep concerns with CMS's discussion of removing the pay-for-reporting year. Providing ACOs in their first contract year with 12 months to assess performance, study measure specifications and implement workflow and information technology changes necessary to capture data to document quality performance as specified by the measure steward is a huge undertaking. In addition, this time is crucial to educate clinicians and support staff to incorporate processes to implement the quality measure in practice and establish buy-in and support among staff. ACOs are responsible for 24 quality measures for which each has its own measure specifications, exemptions, and requirements. It takes time for new ACOs to educate physicians and staff on the measure specifications and begin tracking performance, making a pay-for-reporting year critical especially for new ACOs.

Removing this pay-for-reporting year would harm ACOs new to the program, and we oppose such a change. Currently when measures undergo significant changes, per §425.502(a)(4), CMS reverts the measure to pay-for-reporting for two additional years to provide time for such ramp-up and evaluation necessary to be held accountable for performance on a quality measure. This demonstrates the acknowledgement that ACOs and their clinicians and support staff need at least one year of preparation prior to being held accountable for performance on the measure. We urge CMS to maintain the current approach of providing all ACOs one pay-for-reporting year in the first year of their first contract as well as additional pay-for-reporting years following implementation of significant measure changes.

In combination, CMS's proposals to raise the minimum attainment level and remove the pay-for-reporting year would be detrimental to ACOs. Additionally, in this rule CMS also proposes major overhauls to the

current MIPS structure and approach, introducing a great deal of uncertainty regarding how the quality scoring methodology may also change in future years under the proposed MIPS Value Pathways approach and how these changes would ultimately affect ACO quality scoring. Introducing such uncertainty and raising quality standards at a time when ACOs are still evaluating the most sweeping program changes made to the MSSP since its inception will lead to more ACOs choosing to leave the program. As was demonstrated recently when small measure specification changes took place late in 2018 to the smoking cessation quality measure, very small changes in quality measures can result in potential losses totaling tens of thousands of dollars to ACOs who have invested heavily in quality performance improvement.

ACOs are high-quality performers: however, this should not serve as a reason for CMS to overhaul the quality performance assessment approach for the MSSP. Instead, we urge CMS to work with NAACOS and other stakeholders to make changes to the current quality measure set for ACOs to further refine the measure set as appropriate for a group of providers who are responsible for total cost of care for the populations they serve. For example, NAACOS supports CMS testing the use of a more limited number of measures with low reporting burdens, including electronic clinical quality measures and claims-based measures. This should be voluntary testing, and we would welcome the opportunity to engage with the agency to implement this strategy to identify the next generation of quality measurement within the existing ACO program structure and methodology. Clinicians in MIPS who are not participating in total cost of care and full accountability payment models should not necessarily have the same quality measure set as clinicians participating in ACOs. We also urge CMS to adopt an alternative methodology for making quality comparisons in MIPS to create more equitable benchmarks across reporting mechanisms, as detailed below.

Given the recent changes to the program's structure in the "Pathways to Success" regulation as well as the increased emphasis and accelerated timeline to move to risk bearing models, this is not the time to introduce more uncertainty and higher quality scoring standards for ACOs. We look forward to working with CMS to improve upon the current MSSP quality measurement approach within the existing quality scoring methodology framework.

ACO Quality Measure Updates Proposed for 2020

Proposals: CMS proposes to add GPRO measure ACO-47, Adult Immunization Status, and remove ACO-14, Preventive Care and Screening Influenza Immunization, from the MSSP quality measure set. ACO-47 is a composite measure with multiple components that evaluate the percentage of members 19 years of age and older who are up-to-date on recommended routine vaccines for influenza, tetanus and diphtheria, or tetanus, diphtheria and acellular pertussis, zoster, and pneumococcal vaccines. This would result in 23 quality measures for MSSP ACOs for performance year (PY) 2020.

CMS also notes changes to ACO-43, Ambulatory Sensitive Condition Acute Composite, from the measure steward, the Agency for Healthcare Research and Quality for PY 2020. Specifically, the measure will include only bacterial pneumonia and urinary tract infection, removing dehydration. Due to these changes, the measure would be pay-for-reporting in 2020 and 2021.

In addition, CMS notes ACO-17, Smoking Cessation, will be a pay-for-reporting measure in 2018 due to measure specification changes that occurred in 2018. However, we are disappointed to see that in this rule, CMS proposes ACO-17 will be a pay-for-performance measure in 2019.

Comments: NAACOS has deep concerns with CMS's proposal to add ACO-47, Adult Immunization Status, to the ACO quality measure set. CMS lacks adequate payment coverage for certain vaccinations included in this composite vaccination measure. In addition, ACOs have shared concerns with supply issues that could be out of the ACOs control and affect performance on such a measure. For these reasons, we urge CMS not

to finalize the proposal to add ACO-47 to the MSSP quality measure set for 2020. Instead, we urge CMS to maintain the current vaccination measure ACO-14, Preventive Care and Screening Influenza Immunization, with modifications to reduce data collection burdens associated with this measure. Specifically, we request CMS allow the patient reported year of vaccination to satisfy measure criteria. Finally, we urge CMS to encourage the development of an updated pneumococcal measure to add back to the MSSP quality measure set given the clinical importance of such a measure.

With respect to ACO-17, Smoking Cessation, we applaud CMS for making this measure pay-for-reporting in 2018 as requested by NAACOS. We reiterate that this measure should be made pay-for-reporting in 2019 as well given the impact of measure specification changes and resulting effect on the benchmarks for this measure as detailed in our recent letter to CMS. In this rule, CMS includes in Table DD, an update to the ACO-17 measure specifications effective for 2019. We urge CMS to finalize changes to the measure specification numerator requirements which better reflect clinical guidelines. Given the late notice of this change and the resulting confusion that may occur, we feel it is appropriate to keep the measure pay-for-reporting in 2019. Finally, we support CMS making ACO-43, Ambulatory Sensitive Condition Acute Composite, pay-for-reporting for two years (2020 and 2021) given the measure specification changes that will take place in 2020 and note the same should be done for ACO-17 (providing two years pay-for-reporting).

Late Notification of Quality Measure Specification Changes

Comments: Regarding the 2018 and 2019 performance periods, CMS has notified ACOs of quality measure specification changes close to the end the performance year or in some cases after the performance year has closed and reporting has started. While these changes come not from CMS but the measure steward, these late notifications result in enormous amounts of time to adjust abstraction and data collection for ACOs. Additionally, substantial and late notification of measure changes can result in poor performance on the measure due to clinical workflows not being adjusted in advance of the changes to appropriately capture the necessary data for the measure. NAACOS applauds CMS for changing the smoking cessation quality measure, ACO-17, to a pay-for-reporting measure in 2018 due to late notification of specification changes, which resulted in inaccurate benchmarks for the measure. While we are pleased CMS has taken action to hold ACOs harmless from performance on this measure, we also urge CMS to provide ample notification of such changes in the future and use multiple forms of communications to ACOs to ensure they receive notice of these changes. This notification must be provided in the form of a widespread, clear communication to ACOs about the quality measure specification changes through multiple communications (such as publication in the ACO Spotlight Newsletter, updates in the ACO-MS, etc.). Additionally, when such changes result in substantial changes to the measure, we request CMS revert to pay-for-reporting only status for such measure for two performance years as required in §425.502(a)(4).

Measure Specification Changes for 2020

Proposals: CMS includes in Table Group D, a number of measure specification changes effective for 2020, some of which are applicable to ACOs including Smoking Cessation, Screening for Depression, Colorectal Cancer Screening, Breast Cancer Screening, Statin Therapy, Depression Remission at 12 months, Diabetes HbA1c Poor Control, and Hypertension measures.

Comments: NAACOS recommends that Physical Therapists are not included in the denominator for ACO-17, Smoking Cessation as this smoking cessation counseling is outside the scope of Physical Therapy. Likewise, we do not support Speech Language Pathologists being included in the denominator for ACO-18, Screening for Depression as this is outside the scope of Speech Language Pathology. We urge CMS to carefully study the impact of such changes on performance and benchmarks for these measures. NAACOS supports the denominator exclusions added for frailty for ACO-19, Colorectal Cancer Screening and ACO-20, Breast

Cancer Screening as well as ACO-27, Diabetes A1c Poor Control and ACO-28, Hypertension, Controlling High Blood Pressure. We request these exemptions are also added for ACO-42, Statin Therapy for Treatment of Cardiovascular Disease measures. We also request that the age restriction is removed from these exclusions, as many of these interventions are not clinically appropriate in those with frailty and limited life expectancy due to advanced illness, regardless of age.

PHYSICIAN FEE SCHEDULE PROPOSALS

Evaluation and Management (E/M) Services

Proposals: CMS proposes numerous modifications to payment and billing requirements for E/M services, rolling back or changing many policies finalized in the 2019 Medicare Physician Fee Schedule in response to continued stakeholder feedback this past year. Specifically, the agency proposes to:

- Adopt new coding, prefatory language, and interpretive guidance framework issued by the American Medical Association Current Procedural Terminology (AMA CPT) for office/outpatient E/M visits;
- Assign separate payment, rather than a blended rate, to office/outpatient E/M visit codes 99202-99215 (CPT is deleting 99201 for new patients but retaining the Level 1 code for established patients);
- Utilize a single new prolonged visit add-on CPT code 99XXX;
- Delete the HCPCS add-on code finalized last year for CY 2021 for extended visits (GPRO1); and
- Simplify, consolidate and revalue two add-on codes, GPC1X and GCG0X, to reflect additional resources so that only GPC1X remains.

If finalized, these changes would be effective January 1, 2021.

Comments: NAACOS strongly supports CMS's efforts to modernize E/M codes and payment to support the delivery of higher quality, lower cost patient care. We are appreciative that the agency considered additional stakeholder feedback this past year, giving particular consideration to an AMA CPT Workgroup on E/M. We support CMS's proposal to not collapse levels 2, 3, and 4 office/outpatient E/M visits for new and established patients and to adopt the RVS Update Committee (RUC) recommended work RVUs for all of the office/outpatient E/M codes and the new prolonged services add-on code. The new coding framework will reduce administrative burdens and better describe office visits as they are performed today. We urge the agency to finalize acceptance of the CPT E/M codes, guidelines and RUC recommendations as proposed. We also recommend that CMS work with the medical community to urge Congress to implement positive updates to the Medicare conversion factor to offset the deserved increases to office visits.

We support CMS's proposal to adopt the RUC-recommended values for the new prolonged visit add-on code, 99XXX. We appreciate CMS's effort to describe and reward the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition through use of add-on code GPC1X. It is important to have add-on codes to reflect additional resources used for E/M codes; however, there is uncertainty around this code and how it would be used. Therefore, we recommend the agency postpone implementation of the proposed GPC1X add-on code, allowing the CPT Editorial Panel to better define the service to meet its intended purpose.

Review and Verification of Medical Record Documentation

Proposals: CMS proposes to establish a general principle to allow physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified nurse-midwives, who furnish and bill for their professional services, to review and verify (sign/date), rather than re-document, information included in the patient's medical record by physicians, residents, nurses, students or other members of the medical team. This would include notes documenting the practitioner's presence and participation in the service and would apply across settings for all Medicare-covered services paid under the Physician Fee Schedule.

Comments: We appreciate CMS's efforts in recent years to alleviate burdensome medical record documentation requirements. This proposal is another step to ease burdens, and we support this proposal and recommend it be finalized.

Care Management Services

Proposals: CMS proposes changes designed to increase use of care management and care coordination codes. The proposals affect services including Transitional Care Management (TCM) service, chronic care management (CCM) services, and a new Principal Care Management (PCM) service.

CMS proposes to allow for payment of new codes concurrently with payment for TCM services. Specifically, CMS proposes to allow the following codes to be reported concurrently with TCM:

- End-Stage Renal Disease (ESRD) Monthly Services (CPT Codes 90960-90970);
- Home and Outpatient International Normalized Ratio (INR) Monitoring Services (93792, 93793);
- Interpretation of Physiological Data (CPT Code 99091);
- Prolonged E/M Without Direct Patient Contact (CPT Codes 99358, 99359);
- Complex Chronic Care Management (CPT Codes 99487, 99489);
- Chronic Care Management (CPT Code 99491) and
- Care Plan Oversight (HCPCS Codes G0181, G0182).

Consistent with recommendations from the RUC, the agency proposes a higher payment, resulting from increasing the work RVUs, for both TCM services, CPT codes 99495 and 99496.

CMS proposes to recognize additional time spent on non-complex CCM, CPT code 99490, by adopting two new G-codes with new increments of clinical staff time instead of the existing single CPT code. The first G-code, GCCC1, would describe the initial 20 minutes of clinical staff time, and the second G-code, GCCC2, would describe each additional 20 minutes thereafter.

CMS also proposes notable changes to complex CCM, CPT codes 99487 and 99489. These codes require establishment or substantial revision of the comprehensive care plan, which the agency notes may be unnecessary. Therefore, CMS proposes to adopt two new G-codes that would be used for billing that would not include the service component of substantial care plan revision. Instead of CPT code 99487, CMS proposes to adopt HCPCS code GCCC3. Instead of CPT code 99489, CMS proposes to adopt HCPCS code GCCC4. The agency notes that it intends for the four CCM G-codes to be temporary until CPT codes are potentially revised.

CCM scope of service includes a patient-centered care plan, a requirement that stakeholders have said can be burdensome and duplicative with other work. CMS responds to those concerns by clarifying that the numerous elements described in the care plan are "typical" elements and are not requirements that must all be included in a care plan for purposes of billing for CCM services. Therefore, the agency clarifies that the comprehensive care plan for all health issues typically includes, but is not limited to, the following elements: problem list; expected outcome and prognosis; measurable treatment goals; cognitive and functional assessment; symptom management; planned interventions; medical management; environmental evaluation; caregiver assessment; interaction and coordination with outside resources and practitioners and providers; requirements for periodic review; and when applicable, revision of the care plan.

Current CCM codes require patients to have two or more chronic conditions. CMS is proposing separate coding and payment for PCM services, which describe care management services for one serious chronic condition. A qualifying condition would typically be expected to last between three months and a year, or until the death of the patient, and may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline. CMS expects initiation of PCM would often be triggered by an exacerbation of the patient's complex chronic condition or recent hospitalization such that disease-specific care management is warranted.

Comments: We applaud CMS's efforts to enhance the use and value of care coordination and care management services. These are designed to better manage patients' chronic conditions and care transitions in order to help them avoid more intensive treatment and care settings by keeping them healthier, thus improving their quality of life. Successful care coordination is a foundational element of ACOs' work and these codes are frequently used by ACOs. While we strongly support the overall effort to improve care coordination and care management codes, we have concerns with the use of temporary G-codes to achieve these goals.

With respect to TCM, we strongly support the proposal to adopt the RUC recommendations that will lead to increased valuation of TCM and request CMS finalize this proposal. For the reporting rules, it adds confusion and administrative burden when CMS implements policy changes that differ from CPT. If CMS finalizes a policy to allow additional reporting of concurrent care management codes, the agency should issue very clear guidance that providers should not use multiple codes to describe the same service. For example, when reporting time-based codes, the same minute should only be counted once.

We greatly appreciate CMS recognizing the additional time many providers spend furnishing non-complex CCM, through CPT code 99490, frequently surpassing the 20-minute monthly requirement without further reimbursement. CMS's goals of improving payment accuracy and reducing administrative burden for CCM are laudable. However, the agency also recognizes there are challenges and administrative burdens with using temporary G-codes in place of CPT codes, which are used across payers. CMS seeks comments on the benefits versus burdens of such a transition. We encourage CMS to limit administrative burdens associated with short-term use of G-codes, and therefore we recommend the agency retain code 99490 and not finalize G-code GCCC1. However, there would be sufficient benefit to finalizing the proposed add-on code GCCC2 *(Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).* We urge CMS to finalize GCCC2 until a new, equivalent CPT code is available.

Should the agency seek to avoid using a combination of 99490 and GCCC2, we recommend that an alternative interim solution would be to increase the Medicare payment for 99490 to reflect the additional time above 20 minutes that many providers spend furnishing the service. This approach could be used while the agency waits for two new CPT codes to accomplish the other goals of the G-codes.

In response to CMS's proposal to replace complex CCM, CPT codes 99487 and 99489, with two new G-codes, we support the agency's effort to alleviate burdens related to the requirement to establish or substantially revise a patient's comprehensive care plan. However, alleviating this administrative burden by temporarily moving to new G-codes, would create many new administrative burdens and we therefore do not support this proposal.

CMS also proposes notable changes to complex CCM, CPT codes 99487 and 99489. These codes require establishment or substantial revision of the comprehensive care plan, which the agency notes may be unnecessary. Therefore, CMS proposes to adopt two new G-codes that would be used for billing that would not include the service component of substantial care plan revision. Instead of CPT code 99487, CMS proposes to adopt Healthcare Common Procedure Coding System (HCPCS) code GCCC3. Instead of CPT code 99489, CMS proposes to adopt HCPCS code GCCC4. The agency notes that it intends for the four CCM G-codes to be temporary until CPT codes are potentially revised.

Also as part of the CCM proposals, we support the proposed revision to the description of a comprehensive care plan. This proposal is a simplification, which we appreciate. The description as revised provides a clear guide for providers on what to include in their comprehensive care plan for CCM recipients. We support the use of a list of "typical" care plan elements that are not a set of strict requirements, which must be included in a care plan for purposes of billing for CCM services. We recommend CMS finalize this proposal.

While we understand CMS's goal with introducing PCM, we have serious concerns that, if finalized, this code would lead to duplicative care management by focusing on disease-specific, rather than whole-person, care management. While there is not a proposed restriction based on specialty for billing PCM services, CMS notes they would most often be billed by specialists focused on managing patients with a single complex chronic condition requiring substantial care management.

CMS acknowledges that many patients have more than one complex chronic condition. If a clinician is providing PCM services for one complex chronic condition, management of the patient's *other* conditions would continue to be managed by the primary care practitioner while the patient receives PCM services for a single complex condition. Managing all but one chronic condition, especially one warranting extra attention, is not an effective approach to overall care management. This fractures a more cohesive care coordination effort, which is something the agency has appropriately emphasized in recent years. This fragmentation could lead to adverse outcomes and would be further exacerbated when the same patient receives PCM services from more than one clinician simultaneously, which CMS acknowledges can happen under the proposal. Therefore, we recommend that CMS not finalize PCM services and instead focus on enhancing existing care coordination codes and specialist engagement through more holistic care coordination initiatives.

CMS is not proposing additional requirements for PCM services beyond the current CCM scope of service requirements, but the agency notes it did consider alternatives such as requiring that the practitioner billing PCM must document ongoing communication with the patient's primary care practitioner to demonstrate continuity of care between the specialist and primary care settings, or requiring that the patient have had a face-to-face visit with the practitioner billing PCM within the prior 30 days to demonstrate an ongoing relationship. While we recommend CMS not finalize PCM codes, should the agency do so, we urge that these requirements be included to prevent care fragmentation and service duplication.

Remote Patient Monitoring

Proposals: CMS proposes to make certain remote patient monitoring services (CPT codes 99457 and 994X0), done mostly through the collection, analysis, and interpretation of digitally collected physiologic data, billable under general supervision. Currently, CMS requires direct supervision, which may limit the utility of the codes that were introduced in January 2019.

After creating several new codes for "virtual check-ins," "communication technology-based services," and other telehealth-related services in the final 2019 Physician Fee Schedule, CMS in 2020 proposes to add three new telehealth codes, all of which describe a bundled episode of care for treatment of opioid use disorders.

Comments: NAACOS strongly supports the proposal that codes 99457 and 994X0 may be furnished under general supervision, rather than direct supervision. NAACOS works collaboratively with other health technology-focused organizations who have called for greater clarification of supervision requirements and appreciate CMS's proposal that will help remote patient monitoring services realize their full potential.

We urge CMS to finalize the proposed HCPCS codes (GYYY1, GYYY2, and GYYY3) for treatment plan development, therapy, and care coordination for opioid use disorder. We agree with CMS's assertion that these services do not require the patient to be present in-person with the practitioner when they are furnished and therefore can be provided through telehealth.

NAACOS continues to appreciate CMS's recognizing in the 2019 Physician Fee Schedule codes that reimburse remote physiologic monitoring. These help providers appropriately care for patients with certain chronic conditions without having expensive or inconvenient office visits. Instead, a patient's health can be followed from their homes, which falls in line with ACOs' goals of providing the right care, in the right setting, at the right time. However, as these technologies become more ubiquitous and opportunities to bill Medicare for remote monitoring becomes a larger opportunity, providers may have additional questions about how to optimize use of these codes and how to appropriately bill Medicare for these services. Therefore, we encourage CMS to develop sub-regulatory guidance on the use of remote monitoring in Medicare. CMS already offers shared learning opportunities, including case studies, webinars, and affinity groups, for ACOs in both the Shared Savings Program and Next Generation ACO Model. These could serve as a model for how CMS can further educate providers on the use of remote monitoring.

Advisory Opinions on the Application of the Physician Self-Referral Law

Proposals: CMS proposes a number of modifications to its process for accepting and responding to advisory opinion requests related to the application of the Physician Self-Referral Law or "Stark Law". CMS is currently prohibited from accepting an advisory opinion request if CMS is aware of a pending or past investigation or proceeding involving a course of action that is "substantially the same" as the arrangement or proposed arrangement. CMS proposes to modify its regulations to allow the agency more discretion to make this determination in coordination with the Department of Health & Human Services Office of Inspector General and U.S. Department of Justice, as applicable. However, CMS would retain its prohibition on advisory opinions in instances where there is an active investigation involving the same matter.

CMS also proposes a number of changes to the process for handling advisory opinion requests, such as shortening the timeframe for the agency to respond to a request from 90 to 60 days, modifying who is eligible to sign a certification related to the validity of information provided by the requestor, and adjusting fees related to requesting advisory opinions.

CMS proposes modifications to its current policies which would allow parties to the arrangement in question (for example, a physician) to rely on the CMS advisory opinion; currently the regulations only provide that the Secretary will not pursue sanctions against CMS advisory opinion requestors. CMS further proposes that they will not pursue sanctions against "any individuals or entities that are parties to an arrangement that CMS determines is indistinguishable in all material aspects from an arrangement that was the subject of the advisory opinion". Finally, CMS requests comment on whether it should limit its current ability under regulation to rescind or revoke an advisory opinion after its issuance.

Comments: We agree with CMS's proposed modifications to its procedures for the acceptance, review and issuance of advisory opinions. We are particularly supportive of CMS's proposal to update its policies to allow for greater reliance on advisory opinions for non-requestor parties (Sec. 411.387) and urge CMS to further expound on these proposed modifications to clarify that ACOs and ACO participants may rely on advisory opinions for substantially similar arrangements.

We note CMS's commentary that, for a party to rely on an advisory opinion, the arrangement must be "indistinguishable in all material aspects" and all facts relied on and influencing a legal conclusion in an issued favorable advisory opinion are material; deviation from that set of facts would result in a party not being able to claim the proposed protection. Further, CMS states that if parties to an arrangement are uncertain as to whether CMS would view it as materially indistinguishable from an arrangement that has received a favorable advisory opinion, then those parties could submit an advisory opinion request to query whether a referral is prohibited under section 1877 of the Act. Understanding that ACO arrangements can take on a variety of forms which may be substantially similar but not *identical* in set of facts, we urge CMS to consider how it might adopt a more flexible approach to provide the desired reliance for substantially similar arrangements.

QUALITY PAYMENT PROGRAM PROPOSALS

Advanced Alternative Payment Model (APM) Criteria and QP Determinations

Proposals: CMS proposes a modification to how the agency determines whether an APM meets the requirement for accountability of more than nominal risk, which would allow the agency to factor in what expenditures would have been in the absence of the APM participation. This change, if finalized, would apply to APMs with benchmark-based risk, which pertains to many ACO models.

CMS proposes, beginning with PY 2020, that Partial Qualifying Advanced APM Professionals (QP) status would only apply to the Tax ID (TIN)/National Provider Identifier (NPI) combination through which the Partial QP status is attained. Therefore, Partial QPs would be required to report on MIPS and be subject to MIPS payment adjustments for TIN/NPI combinations outside the APM Entity, and their APM Entity would still elect whether to participate in MIPS for the TIN(s) associated with the APM Entity.

Comments: NAACOS has serious concerns with the proposal to determine whether an APM meets the nominal risk requirement by factoring in what expenditures would have been in the absence of the APM participation. The statute does not require that each APM Entity spend less than would otherwise have been expected, only that overall Medicare spending be lower than would otherwise have been expected. (Section 1115A(b)(3)(i) states that an APM must "improve the quality of care … without increasing spending under the applicable title.") Adding this type of difference-in-difference evaluation could significantly alter how CMS evaluates APMs, causing potential disruption to whether existing APMs qualify as Advanced. ACOs enter into multi-year agreements after carefully considering numerous factors, such as whether their model qualifies as an Advanced APM. It would be very unfair to change that designation during a multi-year agreement period.

As proposed, there is no indication how frequently CMS would make this assessment. Would this evaluation only occur when a new model is developed or would the agency conduct this evaluation more regularly, perhaps even annually? Another key issue not specified in the proposed rule is at what level the agency would do this evaluation —at the model level (e.g., the Next Generation ACO Model) or at the individual APM Entity level (e.g., a particular Next Generation ACO). Current evaluations are at the model level and should remain so. CMS also does not specify the timeframe for data that would be used for this evaluation. Difference-in-difference modeling often relies on a robust evaluation of claims data from previous years, which could delay CMS's ability to evaluate models in this manner. Additionally, difference-in-difference modeling requires many assumptions to be made, each of which can alter the outcome of an evaluation.

If CMS believes that the benchmarks or target prices in its APMs are too high, it should revise them, rather than create what would appear to be a second set of lower benchmarks or target prices using an unspecified methodology for Advanced APM determinations. Overall, there is considerable complexity with implementing this approach and there is great uncertainty with how this policy would be implemented. The proposed rule lacks adequate detail to address these critical questions. We urge CMS to not finalize this proposal.

NAACOS appreciates CMS's attempt to allow Partial QPs the opportunity to qualify for MIPS bonuses through TIN/NPI combinations outside of their Advanced APM. However, while the agency notes its intent is to help Partial QPs, as proposed CMS would require MIPS participation for TIN/NPI combinations outside the APM Entity, thus placing a new administrative burden upon these providers. If CMS truly wants to help Partial QPs, the agency should modify its proposal to allow Partial QPs the option to participate in MIPS for their non-Advanced APM TINs. We urge CMS to make this change in the final rule. Fair Partial QP policies will be increasingly important as QP thresholds rise and more clinicians are Partial QPs. NAACOS agrees that this is a serious concern and we strongly support corrections to the MACRA statute that would give CMS the authority to modify the QP payment thresholds to correspond better to the actual structure of Advanced APMs and the expected percentages of physician revenues likely to be coming through them. We will continue to advocate to Congress to provide this flexibility.

In the regulatory impact analysis of the rule, CMS estimates between 175,000 and 225,000 QPs in PY 2020, which would result in projected total lump sum APM incentive payments of between $500 million to $600 million for the 2022 payment year. These estimates are similar to projections for PY 2019 (2021 payment adjustment year), reflecting a relatively flat projected growth of QPs in 2020. NAACOS is concerned with the flat growth of QPs over the last few years.

Through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress intended for a meaningful shift of providers from uncoordinated fee-for-service to Advanced APMs. NAACOS is very concerned that CMS has not yet paid the five percent Advanced APM incentive payments to those who achieved QP status for the 2017 performance period. CMS previously indicated that the agency would make these payments in mid-2019, which is already a considerable delay. Providers participating in Advanced APMs invest significant financial and other resources, and the QP incentive payments are supposed to help them with the cost of transitioning into these new models of care delivery. We urge CMS to make these payments as soon as possible.

NAACOS is also concerned that CMS projects in 2022 MIPS bonuses could exceed Advanced APM bonuses, thereby limiting the incentive to participate in an Advanced APM. In the 2020 performance year (corresponding to 2022 payment adjustments), CMS projects a perfect score of 100 points in MIPS could

earn a 5.78 percent positive payment adjustment, exceeding the 5 percent bonus provided to Advanced APMs meeting the QP threshold. We urge CMS to work with Congress to secure additional funding to extend, and potentially increase the Advanced APM bonus, so that providers continue to have an incentive to join and remain in Advanced APMs.

Further it is imperative that CMS consider the connection between policies governing the MSSP and growth of providers in APMs under MACRA. We urge CMS to continue emphasizing the shift to value by designing ACO models beneficial enough to attract new ACOs and to retain existing ACOs. Specifically, we urge CMS to:

- Increase Basic Track shared savings rates to at least the following: Basic Levels A and B: 50 percent; Levels C and D: 55 percent; and Level E: 60 percent;
- Update the risk adjustment rules of the to allow risk adjustment scores to increase at least five percent over a five-year agreement period and apply a cap of up to minus five percent on downward adjustments;
- Eliminate high-low revenue distinction and apply the low revenue policies across all ACOs;
- Provide all ACO participants at least three years in shared savings-only models;
- Make the Enhanced Track voluntary; and
- Modify the benchmarking methodology to remove ACO beneficiaries from the regional reference population under regional benchmarking.

Adding Medical Home Model to All-Payer Combination Option

Proposals: CMS proposes to add an "Aligned Other Payer Medical Home Model" to the All-Payer Combination Option. This new term would include the same characteristics as the definition of Medical Home Model but would apply to Other Payer APM arrangements. Specifically, it would refer to a payment arrangement (not including a Medicaid payment arrangement) operated by an Other Payer that formally partners with CMS through a written expression of alignment and cooperation, such as a memorandum of understanding (MOU), in a CMS Multi-Payer Model that is a Medical Home Model. The arrangement must be determined by CMS to have characteristics such as having a primary care focus (based on clinicians and services), empanelment of each patient to a primary clinician; and at least four of the following: Planned coordination of chronic and preventive care; Patient access and continuity of care; Risk-stratified care management; Coordination of care across the medical neighborhood; Patient and caregiver engagement; Shared decision-making; and/or Payment arrangements in addition to, or substituting for, fee-for-service payments (e.g., shared savings or population-based payments). CMS also proposes to apply the Medicaid Medical Home Model financial risk and nominal amount standards, Other Payer quality and electronic health record (EHR) use requirements and a 50 eligible clinician limit.

Comments: NAACOS supports adding a Medical Home Model to the All-Payer Combination Option, which recognizes the important role of Medical Home Models in the shift to value. We recommend CMS finalize this but limit the prescriptiveness of the proposed criteria to allow for more market driven models, as opposed to government mandated models.

Assessing Risk of Other Payer APM Arrangements

Proposals: CMS proposes that if expected expenditures (that is, benchmarks) under an Other Payer alternative payment arrangement exceed the expenditures that the participant would be expected to incur in the absence of the payment arrangement, such excess expenditures would not be considered when CMS assesses financial risk under the payment arrangement for Other Payer Advanced APM determinations.

CMS proposes to allow an Other Payer APM arrangement to meet the 30 percent marginal risk rate requirement based on an average, which the agency would compute by adding the marginal risk rate at each percentage of level to determine participants' losses, and dividing it by the percentage above the benchmark to get the average marginal risk. This would allow APMs to qualify under the All-Payer Combination Option if they have a marginal risk rate that varies based on losses, as long as the average marginal risk rate is at least 30 percent.

CMS seeks feedback on whether it is appropriate for the agency to allow Other Payer full capitation arrangements to exclude certain items and services and still be considered a full capitation arrangement. If appropriate, the agency seeks comments on what would qualify as permissible exclusions.

Comments: NAACOS has serious concerns with the proposal to determine whether an Other Payer APM meets the nominal risk requirement by factoring in what expenditures would have been in the absence of the APM participation. Adding this type of difference-in-difference evaluation could significantly alter how CMS evaluates APMs, causing potential disruption to whether existing arrangements qualify as advanced. It would be very unfair to implement a policy that changes the evaluation and designation of existing Other Payer APMs, especially those that include multi-year agreements.

As proposed, there is no indication whether CMS would conduct this assessment for Other Payer APMs or if the agency would require payers to do so. It is unclear how CMS would have the necessary data to conduct this evaluation for payers outside of Medicare, and it would add an administrative burden on payers to do so —thus creating another hurdle for them to have their payment arrangements qualify under the All-Payer Combination Option. Further, this policy would likely make it more difficult to qualify as an Other Payer Advanced APM, which would come at a time when participation in the All-Payer Option remains lackluster.

NAACOS has a number of concerns related to this proposal for the All-Payer Combination Option which mirror those for the equivalent proposal for Medicare APMs. Specifically, how frequently CMS would make this assessment? Would this evaluation only occur when a new model is developed or would the agency conduct this evaluation more regularly, perhaps even annually? Another key issue not specified in the proposed rule is at what level the agency would do this evaluation – at the model level or at the individual APM Entity level? Current evaluations are at the model level and should remain so. CMS also does not specify the timeframe for data that would be used for this evaluation. Difference-in-difference modeling often relies on a robust evaluation of claims data from previous years, which could delay the ability to evaluate models in this manner. Additionally, difference-in-difference modeling requires many assumptions, each of which can alter the outcome of an evaluation. Overall, there is considerable complexity with implementing this approach and there is great uncertainty with how this policy would be carried out. The proposed rule lacks adequate detail to address these critical questions. Given the negative consequences of this policy and implementation uncertainty, we urge CMS to not finalize this proposal.

NAACOS supports CMS's proposal to allow an Other Payer APM arrangement to meet the 30 percent marginal risk rate requirement based on an average marginal risk, with some modification. This proposal would allow APMs to qualify under the All-Payer Combination Option if they have a marginal risk rate that varies based on losses as long as the average marginal risk rate is at least 30 percent. NAACOS appreciates

the agency providing flexibility for APMs that have varying marginal risk rates, and we encourage the agency to finalize the proposal with a modification to use a weighted average marginal risk rate.

While we appreciate the flexibility this proposal would provide, it's important to note that overall we remain opposed to including Other Payer requirements for minimum loss rates (MLRs) and shared loss rates. Specifically, we urge the agency to remove requirements that, except for Medicaid Medical Home Models, a qualifying Other Payer risk arrangement must have a marginal risk rate of at least 30 percent of losses in excess of expected expenditures and an MLR at or below 4 percent.

CMS does not require marginal risk rates or MLRs for Medicare Advanced APMs and should therefore not do so for Other Payer Advanced APMs. The agency provides no evidence that these thresholds are appropriate or reflect the amount of risk that is typically required in Other Payer APM agreements. Setting realistic and appropriate thresholds for Other Payer APMs will be especially important in later years when QP thresholds are much higher (i.e., 75 percent of revenue in 2023 and beyond). We urge CMS to survey payers outside Medicare on their APM risk arrangements and make that information publicly available. We see no reason that the risk thresholds for these payers should be higher or more complicated than what is required for Advanced APMs under the Medicare Option and request the agency modify its policies.

Further, requiring providers to manage multiple and conflicting requirements from different payers is a strong disincentive to broader participation in these models and can reduce the ability of physicians to improve quality and reduce spending. Different goals, quality metrics, performance feedback reports, payment models, benchmarks, and attribution and risk adjustment methods increase the time and costs that organizations must spend on administrative activities rather than on patient care. CMS itself has urged alignment of payment structures in the multi-payer models that it has created. Consequently, we recommend that the agency establish the same financial risk requirements for all Advanced APMs regardless of payer in order to facilitate the development of multi-payer models.

Finally, NAACOS supports the proposal to allow Other Payer full capitation arrangements to exclude certain items and services and still be considered a full capitation arrangement. This proposal would provide flexibility for payers and providers to tailor APMs to meet the needs of the payers, providers and patients without losing the Advanced APM designation. Exclusions from full capitation may be appropriate for a variety of items and services, such as hospice care, out of network services for emergency care, or specialty pharmaceuticals. We request CMS finalize this proposal.

MIPS Changes Proposed for 2020

Proposals: CMS proposes a number of changes to MIPS for PY 2020, which will dictate 2022 payment adjustments. Notably, CMS does not propose significant changes to the APM Scoring Standard, which is used to evaluate ACOs subject to MIPS. Therefore, ACOs will continue to receive favorable benefits from their APM participation in MIPS such as no additional quality reporting, no Improvement Activities Performance Category reporting, and no cost evaluation. CMS also proposes to raise the performance threshold from 30 points to 45 points and the exceptional performance threshold from 75 points to 80 points for PY 2020. With this increase in the performance threshold and the maximum penalty amount rising from 7 percent to 9 percent, the maximum projected payment adjustment amount for a perfect score of 100 points is estimated to be approximately 5.78 percent in PY 2020/2022 payment year. Based on the proposals summarized below, CMS estimates 818,000 clinicians will be subject to MIPS in PY 2020.

For the Promoting Interoperability (PI) performance category, CMS proposes a change to the exclusion criteria for hospital-based clinicians for the PI performance category. Specifically, CMS proposes that 75 percent or more of NPIs in a TIN must meet the definition of hospital-based in order to be excluded from this performance category. Previously, CMS required 100 percent of clinicians in a TIN to meet this criterion

to be excluded. As a reminder, CMS does not include providers excluded from PI in an ACO's weighted average PI score.

Comments: NAACOS has consistently urged CMS to continue its commitment to transitioning clinicians to value-based payments by increasing the performance thresholds and criteria in MIPS as required by MACRA, and, therefore, we support CMS's proposals to increase the MIPS performance threshold to 45 points and increase the exceptional performance threshold to 80 points. Gradually increasing performance criteria ensures that clinicians continue to be held accountable for quality and cost.

However, NAACOS is concerned that CMS's policies continue to exempt such a large number of clinicians from the program that the agency is simultaneously discouraging those clinicians who have already made a commitment to value-based care and invested time and resources towards making the shift to value-based care.

Instead, CMS should reward high-performing clinicians who have invested heavily in performance improvement and should therefore be rewarded for this investment, time, and effort. We continue to feel it is important that CMS make good on its commitment to transition providers and Medicare payments to those focused on value. If the agency fails to follow-through on this promise and the intent of MACRA, it discourages those who have proven early commitment to value-based health care and may lose momentum in encouraging those currently progressing along this continuum. While the agency predicts no additional clinicians would be exempt from MIPS as a result of its proposals, we urge CMS to continue to encourage providers to accept accountability for cost and quality by fully implementing the MIPS program as intended by reducing the number of clinicians exempted from MIPS program criteria.
Finally, we support CMS's proposal to change PI exclusion criteria to require 75 percent or more of NPIs in a TIN meet the definition of hospital-based in order to be excluded from this performance category.

MIPS Value Pathway Approach

Proposals: CMS discusses a new approach to the MIPS structure, the MIPS Value Pathway, which would begin in 2021 and aims to streamline reporting for certain specialties, clinical conditions or priority areas. When electing such a pathway, there could be fewer total measures to report overall and the concept strives to make reporting more relevant for certain specialties or clinical conditions. This would be applicable to non-MIPS APMs only; therefore, this would not apply to ACOs. CMS seeks comment on this concept.

Comments: NAACOS has questions regarding how a transition to a MIPS Value Pathway (MVP) approach would affect ACOs subject to MIPS and the MIPS APM Scoring Standard. Currently, our interpretation is that these changes would be outside the MIPS APM Scoring Standard, which is the scoring standard ACOs are currently held to in MIPS. However, as CMS considers making changes to MSSP quality scoring methodologies to align with MIPS in the future, we have questions regarding how this may affect ACO quality scoring more directly should this approach be taken by CMS. In addition, we note that it will be imperative that in any new MIPS approach under MVP, CMS maintain proper incentives and benefits to ACOs subject to MIPS as is currently the case. We reiterate that NAACOS believes ACOs subject to MIPS should have minimal burdens associated with quality reporting and reporting for other performance categories in MIPS to the extent possible. To further reduce administrative burdens for ACOs subject to MIPS, we urge CMS to consider allowing all ACOs to rely on the annual Certified EHR Technology (CEHRT) attestation process to fulfill PI requirements so ACOs can continue to focus their efforts on quality improvement and cost efficiency. Further, we recommend as CMS contemplates a new MVP structure, the agency make changes to quality comparisons in MIPS that result in fair and equitable comparisons across reporting methods, as described previously in this comment letter. We look forward to providing additional input to the agency as this concept is further developed.

Assigning MIPS Quality Points Based on Benchmarks

Comments: CMS currently scores quality measure performance under the APM scoring standard using a percentile distribution, separated by decile categories. For each benchmark, CMS calculates the decile breaks for measure performance and assign points based on the benchmark decile range into which the APM Entity's measure performance falls. The current methodology for comparing quality scores in MIPS results in unfair comparisons, providing an advantage to those using reporting methods for which the provider or organization can cherry-pick patients to report on and have a lower benchmark to compete against.

As demonstrated in example one below, the benchmarks for the Breast Cancer Screening Measure vary greatly depending upon the reporting mechanism used. To earn the highest score for this measure, a clinician must earn greater than or equal to 73.23 for EHR reporting, 87.93 for registry/Qualified Clinical Data Registry (QCDR) reporting, and 100 for GPRO Web Interface reporting. Similarly, as shown in example two below, for the Colorectal Cancer Screening measure a clinician must earn greater than or equal to 82.29 for EHR reporting, 88.15 for registry/QCDR reporting, and 100 for GPRO Web Interface reporting.

Example 1: Breast Cancer Screening Measure Benchmarks by Submission Method

Measure	Submission Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Breast Cancer Screening (112)	EHR	12.41-22.21	22.22-32.30	32.31-40.86	40.87-47.91	47.92-55.25	55.26-63.06	63.07-73.22	≥73.23
Breast Cancer Screening (112)	Registry/QCDR	14.49-24.52	24.53-35.70	35.71-46.01	46.02-55.06	55.07-63.67	63.68-74.06	74.07-87.92	≥87.93
Breast Cancer Screening (112)	GPRO Web Interface	30	40	50	60	70	80	90	100

Example 2: Colorectal Cancer Screening Measure Benchmarks by Submission Method

Measure	Submission Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Colorectal Cancer Screening (113)	EHR	7.35-15.97	15.98-24.66	24.67-33.45	33.46-44.39	44.40-56.19	56.20-67.91	67.92-82.28	≥82.29
Colorectal Cancer Screening (113)	Registry/QCDR	10.08-20.68	20.69-32.73	32.74-45.20	45.21-55.95	55.96-66.31	66.32-77.01	77.02-88.14	≥88.15
Colorectal Cancer Screening (113)	GPRO Web Interface	30	40	50	60	70	80	90	100

These discrepancies across reporting mechanisms are arbitrary and unfair to ACOs that have their reporting mechanism mandated based on their ACO program participation. Therefore, we reiterate that it is critical CMS change this policy. Specifically, we urge CMS to adopt an alternate methodology for making quality comparisons in MIPS. The first potential solution would be to have a common mean and separate standard deviations for each reporting mechanism (e.g., registry, QCDR, EHR, Web Interface). Alternatively, CMS could lower the GPRO Interface mean for purposes of MIPS, scoring to either the lower of the GPRO mean or the average of the EHR and Registry/QCDR mean. The assignment of deciles could then be based on a bell curve of all GPRO reporters for each measure.

These alternative policies are needed to ensure truly fair comparisons in quality for MIPS. Making more accurate comparisons across reporting methods will also be important in the context of making comparisons with publicly reported data for MIPS and other programs evaluating cost. It is critical that CMS establish a fair way to compare reporting mechanisms, otherwise certain performance will be inflated due solely to the clinician or group's choice of reporting method. We also urge CMS to reconsider its proposal to make changes to definitions used in MIPS that are creating confusion regarding this specific proposal and more generally. Making frequent changes to definitions and program terminology, such as changing the Advancing Care Information (formerly Meaningful Use) performance category to the PI performance category, creates confusion and perceived instability in the program.

MIPS Performance Results

Proposals: CMS does not indicate changes in ways the agency will communicate MIPS performance results to ACOs.

Comments: NAACOS members have found the process by which CMS shares MIPS performance results to be insufficient. Many ACOs have reported issues obtaining performance results and mass confusion among its ACO participants and the clinicians in these organizations regarding their MIPS performance results. Many ACOs have also noted their concerns with the accuracy of the performance information being displayed, particularly for the PI performance category. CMS should create a process that is more transparent regarding how the agency came to the results displayed in the Quality Payment Program portal. The results displayed should also be more customized for ACOs and clinicians in ACOs to clearly communicate how the results should be interpreted for ACOs specifically.

Additionally, NAACOS recommends CMS conduct an analysis comparing ACO quality scores to non-ACO quality scores in MIPS. To date, analysis comparing ACO quality to non-ACO quality has been difficult due to the fact that many of the measures are not easily replicated. This would be a valuable comparison for CMS to make as part of its aggregate program performance evaluations.

Counting MIPS Payment Adjustments as ACO Expenditures

Comments: NAACOS urges CMS to exclude MIPS payment adjustments from ACO expenditure calculations. The current framework CMS has established will punish ACOs for their high performance in MIPS. As stated in our previous comment letters, NAACOS believes CMS should recognize Track 1 ACOs as Advanced APMs by accounting for their investments as the mechanism by which they would meet the risk requirements. However, because CMS continues to subject Track 1 and Basic Track Levels A, B, C and D ACOs to MIPS, these ACOs have no choice but to be evaluated under MIPS while also focusing on the ACO program goals. According to a recent evaluation by NAACOS, we predict all ACOs will avoid penalties under MIPS and many ACOs will perform well enough to earn exceptional performance bonuses under the program. These bonuses will then count against the ACO when expenditures are calculated for purposes of MSSP calculations. Therefore, the better an ACO and its eligible clinicians perform in MIPS, the greater they will be penalized when calculating shared savings/losses for the ACO. This is an unfair and untenable policy that

will, therefore, result in fewer ACOs earning shared savings, thus creating the appearance of diminished aggregate MSSP success. CMS must modify its position to exempt MIPS payment adjustments as expenditures in the ACO program. CMS does not count the Advanced APM 5 percent bonus as ACO expenditures, creating additional inequities. Although CMS argues that the agency has maintained this policy under the Value-Based Payment Modifier Program, NAACOS believes CMS has the authority and ability to remove MIPS expenditures from ACO benchmark calculations. In fact, CMS does make claim-level adjustments by adding sequestration costs back to paid amounts when calculating ACO expenditures. CMS also does not apply MIPS adjustments to certain model-specific payments for the duration of an 1115A Model testing beginning in 2019, such as Oncology Care Model per member per month payments. MIPS payments for ACOs should also be treated in such a manner. It was not the intent of Congress to penalize ACOs in MIPS, and, therefore, CMS must alter this policy to continue encouraging provider participation in the ACO program.

Promoting Interoperability Requirements for ACOs

Comments: We applaud CMS for enacting NAACOS' recommendations to allow an annual attestation process for MSSP ACOs to prove they are using CEHRT. Making this change has the potential to save ACOs significant time and resources to devote instead to improved clinical care. However, we want to call to CMS's attention an issue that negates this improvement. Due to the timing of QP status notifications, ACOs do not know whether they meet QP thresholds in time to avoid reporting MIPS PI measures. ACOs in Advanced APM models therefore must still have their practices report on all MIPS PI requirements. Advanced APM ACOs therefore must still have their clinicians submit all required PI measures, engage in ongoing education to support this reporting and submit the new annual ACO CEHRT attestation as well. This has had the unintended consequence of adding burden to Advanced APM ACOs instead of reducing regulatory burden. As a result, we request CMS exempt all clinicians in Advanced APM ACOs from PI reporting requirements and instead award them automatic full credit for this performance category.

Conclusion

In closing, we appreciate the opportunity to comment on these proposals. NAACOS looks forward to working with CMS to implement the changes we have recommended to ensure the continued success of ACOs.

Sincerely,

Clif Gaus, Sc.D.
President and CEO